

Alternative care options and social protection policy choices to support orphans and vulnerable children: A Comparative study of Mozambique and Guinea-Bissau

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Abstract

The number of orphans in Sub-Saharan Africa reached 51,900,000 in 2013. There has been limited research, particularly in the countries of Mozambique and Guinea-Bissau, on the role of social protection policies, types of alternative care, and fulfillment of basic needs in ensuring the welfare of this vulnerable population. The goal of the present thesis was to examine the interconnections between these factors and their relations to the overall well-being of 122 orphans and vulnerable children between the ages of 10 and 17 years in the two countries. Using a mixed-method approach, both quantitative data (health, basic needs fulfillment, domains of well-being) and exploratory qualitative interview-based data were collected. A literature review on the social protection policies of orphans and vulnerable children (OVC) was undertaken prior to data collection in the field. Caregivers and local authorities were also interviewed. The results showed a marked difference in the way basic and psycho-social needs were met in the different types of alternative care situations children experienced in the two countries. The well-being of children varied widely among the care centres within each country, and indicated a comparative advantage for those children living in residential centres. The findings also indicated that the efforts to support orphans and vulnerable children were more advanced in Mozambique than in Guinea-Bissau at the policy-level, but this did not necessarily translate into higher overall well-being for children in that country. Significant associations were also found between the overall well-being of orphans and vulnerable children and their social situation in the community, food, health, and education situations. Taking these findings into account, the researcher calls for more comprehensive social protection policies in the two countries, promoting community integration of these children.

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Acronyms

ACRWC African Charter on the Rights and Welfare of the Child

ADE Apoio Directo a Escola

ANOVA Analysis of variance

BMI Body Mass Index

CDC Center for Disease Control

CRC Convention on the Rights of the Child

CRIC Centre for the Rehabilitation of Children

DSF Douleurs Sans Frontières

ECD Early childhood development

EFA Education for all

GAM Global Acute Malnutrition

GDP Gross domestic product

GDRC Geneva Declaration of the Rights of the Child

GNI Gross national income

GNP Gross national product

HIPC	Heavily indebted poor countries
IATT	Inter-Agency Task Team
ICESCR	International Covenant on Economic, Social and Cultural Rights
ILC	International Labour Conference
ILO	International Labour Organisation
IMF	International Monetary Fund
IMR	Infant mortality rate
IPHD	International Partnership for Human Development
LEAP	Livelihood Empowerment Against Poverty
MICS	Multiple Indicator Cluster Surveys
NHIS	National Health Insurance Scheme
NYSPCC	New York Society for the Prevention of Cruelty to Children
OECD	Organisation for Economic Co-operation and Development
OPPEI	OVC Policy and Planning Effort Index
OVC	Orphans and vulnerable children
PMTCT	Prevention of mother-to-child transmission
POFO	Positive Outcomes for Orphans

PPP	Purchasing power parity
PRSP	Poverty Reduction Strategic Plans
PSA	Programa de Subsídio de Alimentos
SADC	Southern African Development Community
SLA	Savings and loan associations
UNCRC	United Nations' Convention on the Rights of the Child
UNDRC	United Nations Declaration of the Rights of the Child
UNGASS	United Nations General Assembly Special Session
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations' International Children's Emergency Fund
WFP	World Food Programme
WHO	World Health Organization

Map of Mozambique and Guinea-Bissau on the African continent



Source: Maps Of World, 2013.

Chapter 1

Introduction: Social policies for orphans and vulnerable children in Mozambique and Guinea-Bissau

The number of orphans worldwide has been increasing at an alarming rate. There were an estimated thirty-five million children who had lost one or both parents due to different causes in 2000 (Hunter et al., 2000). By 2013, this number has quadrupled, to almost 140 million (UNICEF, 2014a). In Sub-Saharan Africa – the region affected the most by the HIV/AIDS pandemic with the adult HIV-prevalence six times higher than the global average, increase in the number of orphans is ever-more alarming (UNICEF, 2014a). In 1990, less than one million children under the age of fifteen in this region reported that they had lost one or both parents to HIV/AIDS (UNICEF/UNAIDS/USAID, 2004). By 2013, over fifteen million children were estimated to have become orphans due to HIV/AIDS, comprising nearly eighty-six percent of the world total orphans (UNICEF, 2014a). In South Africa, for instance, the number of children who have lost both parents has nearly doubled from 2002 to 2006 (Meintjes, 2009). This has been both in terms of number and in terms of proportion to overall population of children, from approximately 400,000 to 700,000, which meant an increase from two to four percent of all children in South Africa (Meintjes, 2009). Moreover, losing one or both parents is not the only way that children have been affected by HIV/AIDS. Other children have been made vulnerable by HIV/AIDS through having an ill parent, having HIV themselves or being in poor households that have taken in orphans (UNICEF/UNAIDS/USAID, 2004).

Despite this global tendency, there has been limited research into the real situation of orphans and vulnerable children (OVC), especially in the Lusophone countries of Africa. This study thus attempts to look into the situation of orphans and vulnerable children under different forms of alternative care, taking two Lusophone African countries as case-studies, namely; Mozambique and Guinea-Bissau. This study will analyse whether the care and support

provided through the alternative care options under existing social policies address the real needs of the children. The study follows the adjusted-version of the Taylor Conceptual Framework (Taylor, 2008), by first presenting the background of the broad social policies concerning orphans and vulnerable children in Africa. This will be followed by presentation of concepts around this theme, including; adopted values, principles and functions regarding children, childhood vulnerability and orphaned children, as well as clarification of concepts and terms around social protection as a comprehensive response to orphans and vulnerable children. It will then shift focus to the case studies of Mozambique and Guinea-Bissau, which will consist of analyses of their socio-economic contexts, and results of field studies conducted on orphans and vulnerable children in twelve alternative care centres in the two countries. Based on the analysis of the socio-economic contexts of each country, in addition to the field findings, the goal of the two final chapters will be to examine the adequacy of the existing policies and then recommend further policy reforms.

Chapter 1 presents a statistical overview of orphans and vulnerable children and the respective social policy frameworks first on the global level, then in Sub-Saharan Africa, and finally in the two case-study countries of Mozambique and Guinea-Bissau. At the end of the chapter, the main objectives and questions addressed by the study shall be clarified.

1.1 Global and regional trends of orphans and vulnerable children

As mentioned above, the number of orphans has quadrupled worldwide between 2000 and 2013. The second highest proportion of world's orphans (36 percent) is found in Sub-Saharan African region, where the rate at which number of orphans due to AIDS has increased is the most pronounced, as illustrated in Figure 1.1.

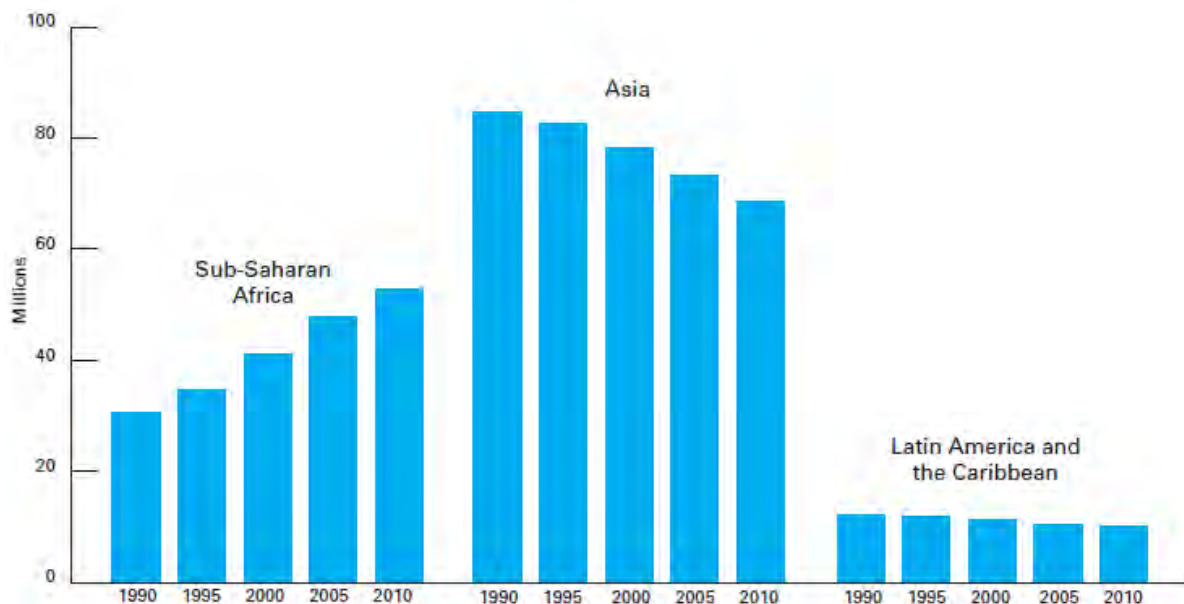


Figure 1.1. Number of orphans aged 0-17 by region, 1990-2010

Source: UNICEF, 2006, p. 3 (based on UNAIDS and UNICEF estimates, 2006)

The impact of this increasing number of orphans on the economies and societal functions in these areas of the world is worrying, especially in countries that are already struggling with poverty and high rates of HIV-infection. At the household-level, the wealth level declines as a result of AIDS, due to increased medical and funeral expenses, decreased ability to work, and the inability to generate income (UNICEF, 2006). In Botswana, for example, the United Nations estimated that between seventeen and twenty-five percent of households have lost an income-earner in the last decade due to AIDS, and overall household per capita income having fallen by eight percent, or even as much as thirteen percent for the poorest households (Beresford, 2001). In Mozambique and Guinea-Bissau, as many as 810,000 and 21,000 children respectively are estimated to have lost one or both parents due to AIDS (UNICEF, 2014a). The required budget needed to support double orphans was estimated at USD 1.1 - 1.7 billion per year in Sub-Saharan Africa, according to Stover and colleagues (Stover et al., 2006). The increasing incidence of HIV/AIDS accompanied by the loss of the main income-earner throws households into financial and social crisis. In addition to these effects, many

governments in this region have been facing difficulties in responding with appropriate social policies because of their own constraints in terms of budget and capacity.

In this context of household crisis, orphaned children have been put into different forms of alternative care. According to the UN Guidelines for the Alternative Care of Children, alternative care may take the form of informal care via any private arrangement or formal care by a competent administrative or judicial authority. Alternative care may be provided through one of the following set-ups:

1. Kinship care: family-based care within the child's extended family or with close friends of the family known to the child, whether formal or informal in nature;
2. Foster care: situations where children are placed by a competent authority for the purpose of alternative care in the domestic environment of a family other than the children's own family that has been selected, qualified, approved and supervised for providing such care;
3. Other forms of family-based or family-like care placements;
4. Residential care: care provided in any non-family-based group setting, such as places of safety for emergency care, transit centres in emergency situations, and all other short-and long-term residential care facilities including group homes;
5. Supervised independent living arrangements for children

(UN, 2010, p. 6)

In general, the practice of informal placement of children – especially with extended families such as uncles, aunts and grandparents – continues to be the main form of alternative care in many parts of Sub-Saharan Africa, including Mozambique and Guinea-Bissau (UNICEF-

ESARO, 2008a). As seen in Figure 1.2, most orphaned children between the ages of 0 and 14 live with their grandparents or other relatives in the nine African countries analysed, which includes Mozambique (UNICEF, 2006).

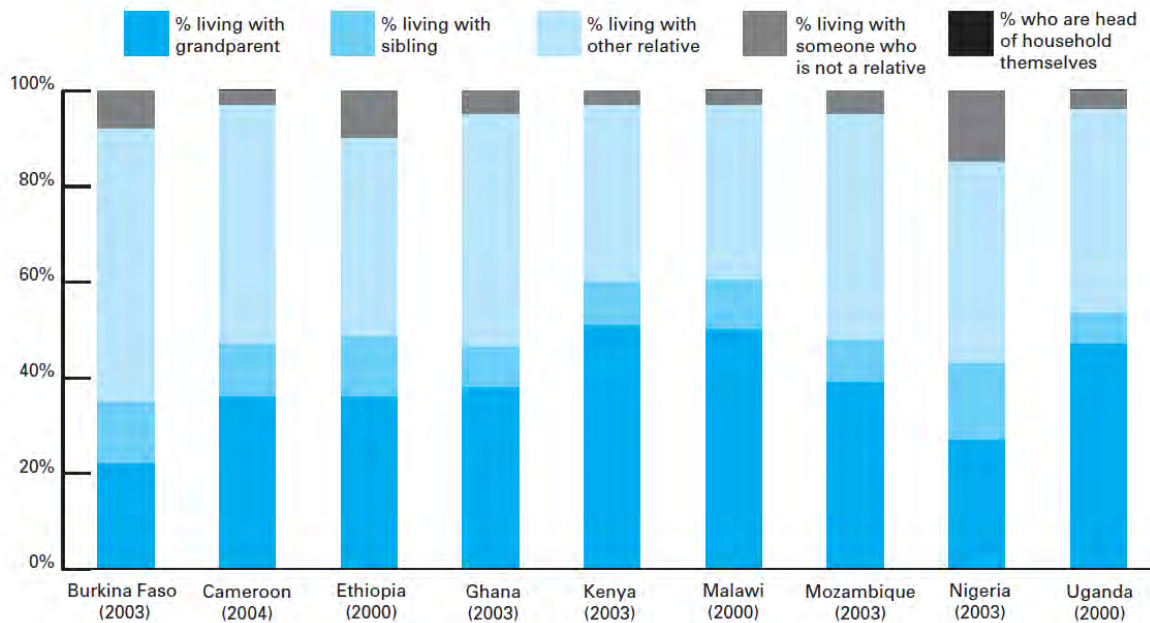


Figure 1.2. Percentage of orphans (not living with surviving parent), aged 0-14, by relation to head of household.

Source: UNICEF, 2006, p. 17 (based on Demographic and Health Surveys, 2000-2004).

For children who were abandoned, abused, neglected or whose families were in extreme poverty, the most prevalent type of alternative care in this region has been residential care run by local communities, faith-based or non-governmental organizations (UNICEF, 2006). In these cases, the statistics are not clear due to lack of data in many countries on this. Many of the alternative care providers are operating informally and not properly registered, resulting in a lack of oversight by the appropriate government authorities to ensure the well-being of children under their care (UNICEF, 2006).

To date, there has been very little evidence-based research conducted on the situation of

orphans and vulnerable children living under informal family-based care – be it by extended families or non-relatives. Some reports indicate that regional public authorities lack the capacity to regulate, manage, support, or supervise this type of placement (UNICEF, 2006). There is also a danger that caregivers of orphans will themselves succumb to HIV/AIDS, further diminishing the number of potential alternate caregivers and leaving children to be “orphaned” more than once (UNICEF, 2003a). Some earlier research has shown that residential care especially for children under the age of five could have negative impacts on children, such as: developmental delays, physical stunting, and potentially irreversible intellectual and psychological damage (Better Care Network, 2009). More studies and debates over kinship care and residential care will be further discussed in Chapter 2.

While the United Nations’ Convention on the Rights of the Child (UNCRC or CRC) requires signatory governments to ensure that institutional care be used only as a last resort, it also stipulates that they have the responsibility to provide alternative care to children when necessary.¹ Despite a general consensus in favour of family-based care over residential care for orphaned children, the existing limited capacity of communities and governments to care for the growing number of orphans and vulnerable children in Sub-Saharan African countries leaves some children in need of many types of support. This can be seen in the growing number of problems with residential care (UNICEF-ESARO, 2008a). Under such circumstances, it is critical to assess the outcomes of the available care modalities for children and identify the essential factors that might contribute to problems and potential options for improvement of the various types of support for orphans and vulnerable children.

¹ Article 20.1 of Convention on the Rights of the Child, adopted and opened for signature, ratification and accession by General Assembly resolution 44/25 of 20 November 1989, entry into force 2 September 1990.

The future livelihoods of orphans and vulnerable children have become a growing concern, particularly in Southern Africa where HIV/AIDS has had a detrimental impact on the human capital of these countries (IATT, 2008). As Wild, Flisher and Robertson (2011) have pointed out, many of the adolescent children who have lost one or both parents to an AIDS-related illness come from poor socio-economic backgrounds. In their study, older adolescents were found to be more vulnerable than younger children, which could be due to the reluctance of relatives to assume custody for older over younger children (Wild et al., 2011). Under such circumstances, there has been more recent recognition of the importance of programmes that equip vulnerable children and youths with livelihood knowledge and skills, such as vocational and life-skills training. This is especially imperative for orphans who may not receive the same level of support from family members as children with living parents (IATT, 2008). Not only do they not receive family support, but they often have to care for their siblings as well. In the case of HIV-affected cases, older children may be responsible for the care of sick family members, including their medical expenses.

These situations demand an urgent need to assess the overall situation of orphans and vulnerable children under various alternative care settings, not only in terms of the level of application of the minimum standards as outlined in the UN Guidelines for the Alternative Care of Children, but also in terms of the level of effectiveness of the existing support for orphans and vulnerable children via caregivers, both informal and formal. Only a few studies conducted have actually assessed orphaned children's well-being under different forms of alternative care in developing countries. Two of those are the study by Nelson and Smyke in Romania, and Whetten's study of orphans in Cambodia, Ethiopia, India, Kenya and Tanzania (Smyke et al., 2010; Whetten et al., 2009). There is thus a need for further research to build on the knowledge base regarding the well-being of orphans in other countries.

It must also be noted that the subjects of both of these studies were younger children. Whetten's

team focused on children ages 6 to 12, while Nelson's team traced orphans from approximately three and a half years old. Few academic studies have been done regarding the situation of orphaned children in early-adolescence in Africa, despite the fact that they are faced with multiple vulnerabilities and thus are among the group most at risk. Wild and her colleagues published research in 2011 on the psychological well-being of orphaned adolescents in South Africa, which is one of the few academic studies in this area, but it did not compare the different types of care (Wild et al., 2011).

Moreover, the studies conducted on this theme in the Lusophone part of Africa, such as Mozambique and Guinea-Bissau are even more limited, with the latter having almost no academic publication available in English on the topic of orphans or orphan care. The current study will contribute to the solution of the problem of assisting large numbers of orphans and vulnerable children by providing information about how current services succeed or fail. To do this, this dissertation also contributes objective analysis regarding the effectiveness of policy options in these countries in terms of their legislations, programme designs, and financial and institutional capacities. The results of this analysis may lead to recommendations for policy and programme changes that will be most helpful in supporting the real needs of children under different forms of alternative care.

1.2 Global and regional policies that affect orphans and vulnerable children

In the context of the large and growing number of orphans, as discussed above, this section will present information on the steps that have been taken by global and regional organisations, including policies, and legislative measures adopted at the global and regional levels, in response to this crisis. In particular, the focus will be on the existing policies in Sub-Saharan Africa. It is important to comprehend these global and regional policy frameworks in order to determine where Mozambique and Guinea-Bissau stand in comparison to other countries.

There have been several significant state attempts to protect orphaned children throughout history. As early as 1623, laws preventing the killing of children born out of wedlock in Great Britain were enacted. However, the acceptance of the right of children to universal protection emerged only in the 20th century (Cregan et al., 2014). In the mid-19th and early-20th centuries, many Westernized countries made schooling as well as vaccination and periodic health check-ups compulsory for children, at least through to a certain age (Cregan et al., 2014). An important development in this movement was made by a Swedish educator, Ellen Key, who, in 1900, launched an advocacy programme that focused on children's rights. Her idea was that children are the future of humanity, and as such deserve basic rights. She outlines her theory in her book titled, *The century of the child*, stating that, "(t)he duty and responsibility towards the children will be all the more strict as society learns to regard it as one of its principal duties to hinder all thoughtless and undeserved suffering" (Key, 1909, p. 5). Key's book, which was translated and published in several European languages as well as in Japanese, helped elevate the issue of children's rights from a state matter to a universal concern. The publication of this book was followed by the establishment of international agencies to protect children, such as Save the Children Fund in 1919, and United Nations' International Children's Emergency Fund (UNICEF) in 1946 (Cregan et al., 2014). On the legislative front, the League of Nations adopted the Geneva Declaration of the Rights of the Child (GDRC) in September 1924, which recognized that "mankind owes to the child the best that it has to give" (League of Nations, 1924, p. 1) and approved the following duties as universal:

1. A child must be given the means requisite for its normal development, both materially and spiritually;
2. A child that is hungry must be fed; a child that is sick must be nursed; a child that is backward must be helped; a delinquent child must be reclaimed; and the orphan and the waif must be sheltered and succoured;

3. A child must be the first to receive relief in times of distress;
4. A child must be put in a position to earn a livelihood, and must be protected against every form of exploitation;
5. A child must be brought up in the consciousness that its talents must be devoted to the service of fellow men.

(League of Nations, 1924, p. 1).

The Declaration was followed in 1959 by the United Nations Declaration of the Rights of the Child (UNDRC). The declaration elaborated further on some of the GDRC articles. For example, it included additional principles regarding children's need for identity and citizenship (Principle 3), for social security with emphasis on health (Principle 4), education (Principle 7), as well as for love and understanding (Principle 6). Finally, it also included a particular mention on the needs of children with disabilities (Principle 5). It is important to note that Principle 6 also included a clause to promote support for orphans and vulnerable children, stating that, "Society and the public authorities shall have the duty to extend particular care to children without a family and to those without adequate means of support." (UN, 1959, Principle 6).

In the decades following, the need arose for the 1959 UNDRC to establish standards for the children's care and welfare to be imposed on the UN member states, which resulted in the adoption in 1989 of the UNCRC, as mentioned earlier. In comparison to the 1959 UNDRC, the UNCRC was more explicit about the civil and political dimensions and specifically mentioned the civil and political rights of children in many of its articles, articulating that "States Parties shall undertake all appropriate legislative, administrative, and other measures for the implementation of the rights recognized in the present Convention." (UN, 1989, Article 4). The UNCRC thus took the 1959 UNDRC a step further by reframing the children's needs as rights

and holding the states responsible to fulfil these.

The UNCRC was not openly accepted everywhere in the world. In Africa, for example, an alternative document was developed in 1990, titled the “African Charter on the Rights and Welfare of the Child” (ACRWC) by the Organization of African Unity (former name of the African Union). The ACRWC differed from the UNCRC in its articulation of a set of responsibilities African children must fulfil, described below:

The child, subject to his age and ability, and such limitations as may be contained in the present Charter, shall have the duty;

1. To work for the cohesion of the family, to respect his parents, superiors and elders at all times and to assist them in case of need;
2. To serve his national community by placing his physical and intellectual abilities at its service;
3. To preserve and strengthen social and national solidarity;
4. To preserve and strengthen African cultural values in his relations with other members of the society, in the spirit of tolerance, dialogue and consultation and to contribute to the moral well-being of society;
5. To preserve and strengthen the independence and the integrity of his country;
6. To contribute to the best of his abilities, at all times and at all levels, to the promotion and achievement of African Unity

(AU, 1990, Article 31).

In comparison to global views of the rights of children, some parts of African society adopting

a responsibilities-based versus rights-based agenda to address the conditions affecting children. In defence of the ACRWC, Lewis (1998) pointed out the risk of contextualizing children's interests in a rights-based agenda that was generated through a philosophical and political approach developed mainly in the West, as well as imposing a standard for the care and welfare that might seem alien to other cultures, especially to those countries that lacked the resources to provide the level of care and welfare suggested by global entities (Lewis, 1998). Despite such attempts and concerns, 194 states have ratified the UNCRC, making it the most rapidly and widely ratified human rights treaty in history (UNICEF, 2014b). On a smaller scale, ACRWC has been ratified by 47 out of 54 member states of the African Union within 25 years since its adoption in 1990 (AU, 2015).

The provisions of UNCRC have been incorporated into constitutions, national legislation, legal systems, and child rights codes, featuring policies regarding health, education, and child protection (UNICEF, 2014b). Norwegian jurist and Chairperson of the Committee on the Rights of the Child, Kirsten Sandberg, pointed out, however, that the level of actual realization of such policies has varied across countries (cited in UNICEF, 2014b). Some countries in all areas of the world have made significant progress in state provisions and protection to protect child rights with respect to health, education, juvenile justice, as well as child participation (UNICEF, 2014b). In many other cases, countries – ostensibly due to a lack of financial resources – have yet to build good systems to support child rights, or to make fulfilment of children's rights a priority (UNICEF, 2014b).

In spite of such variation, the realization of UNCRC has shown notable progress globally in the past twenty-five years in one area in particular, the expansion of social protection programmes (UNICEF, 2014b). Such programmes, when designed in a child-sensitive manner, have proven effective to cope with the risks and vulnerabilities caused by chronic multidimensional poverty (UNICEF-ESARO, 2008b). In particular, cash-transfer programmes,

in which small cash payments are made to the most impoverished families in the region, enable poor families to invest in their children, resulting in increases in school enrolment, improved access to health care, and reduced rates of malnutrition (UNICEF, 2014b).

In Africa, a comprehensive report by Taylor (2008) on social protection designed to prevent the worst outcomes of extreme poverty showed that existing social protection systems in most countries remained limited to contributory social security programmes or social cash transfer programmes, and those were only applicable to salaried workers (Taylor, 2008). Nevertheless, social protection has emerged as one of the important policy agendas in many African countries in recent years, due to increasing in-country concern over families who suffer in chronic poverty that has been exacerbated by food insecurity, with increased vulnerability caused by HIV/AIDS. The urgency to address this problem has increased due to the limited impact of developmental interventions in poverty reduction, and recurrent humanitarian crises followed by appeals for aid (Devereux. et al., 2009).

Concerns about the modest success of responses to these significant and growing problems have been addressed in several case studies. Case studies have illustrated some countries have shifted away from providing from conventional social security or humanitarian relief and food aid towards more predictable social assistance, such as cash transfers. The latter is at times provided through welfare initiatives by the governments themselves (Devereux. et al. 2009). Cash transfers have also been considered “an essential policy instrument for poverty reduction, promotion of household well-being and support critical economic objectives” (Taylor, 2008, p. 61).

In the context of children affected by HIV/AIDS, there has been increasing emphasis by governments in African countries on the importance of establishing a more comprehensive social protection framework that is not limited to cash transfers, but also encompasses essential

social service provisions (health, education, water and sanitation, etc.) as well as social welfare and other child- and- family-oriented support and protection policies (Greenblott, 2008). Some examples of such services and policies, based on a survey of programmes in Sub-Saharan African countries include early childhood development (ECD), legal empowerment, psychosocial support, bereavement counselling, community-based child protection committees, referral mechanisms, sustainable options for alternative care, family re-integration, legislations and regulations to ensure equity and quality of social services, and programmes to promote livelihoods and employment of vulnerable youths (Greenblott, 2008). The structure and successful function of such services and policies should be examined from a human-rights and human-security viewpoint in order to address some of the risks faced by orphans and vulnerable children with the aim to achieve social justice, manifested by increased well-being of children at risk. Without the human-rights and human-security perspective, such social policies would remain marginalized, serving only a small portion of individuals whose needs could not be met anomalously due to a margin of institutional malfunctioning or resource constraints.

In this context, there have been attempts to set policy and regulation standards regarding support for orphans and vulnerable children at the global and regional levels. In the 26th United Nations General Assembly Special Session (UNGASS) held in 2001, the Declaration of Commitment on HIV/AIDS was unanimously adopted and signed by the 189 member states, pledging to substantially increase both resources and attention to fight the HIV/AIDS epidemic. The pledge also set the aim in its paragraph 65 that:

By 2003, develop and, by 2005, implement national policies and strategies to build and strengthen governmental, family and community capacities to provide a supportive environment for orphans and girls and boys infected and affected by HIV/AIDS, including by providing appropriate counselling and psychosocial support, ensuring their enrolment in school and access to shelter, good nutrition

and health and social services on an equal basis with other children; and protect orphans and vulnerable children from all forms of abuse, violence, exploitation, discrimination, trafficking and loss of inheritance. (UN, 2001, p. 29).

This was followed up at the regional level in 2004 at the “African-European Consultation on Children Orphaned and Made Vulnerable by HIV/AIDS in Africa”, where parliamentarians of participating countries agreed on the “Cape Town Declaration on an Enhanced Parliamentary Response to the Crisis of Orphans and other Children made Vulnerable by HIV/AIDS in Africa”, outlining the necessary steps for African nations to take in order to mitigate the impact of this pandemic on the continent (UNICEF-ESARO, 2008b). The declaration included the commitment to develop the “National Plans of Action for Orphaned and Vulnerable Children”. Furthermore, in 2006, under the auspices of the African Union, thirteen countries in Eastern and Southern Africa also pledged under the Livingstone Accord to develop national social protection strategies for orphaned children (UNICEF-ESARO, 2008b).

Since that time, the degree of development in social protection for orphans and vulnerable children varies widely within Sub-Saharan Africa. In 2007, the UN drafted the guidelines for the “Appropriate Use and Conditions of Alternative Care for Children”, which was adopted in 2010. In 2008, the Southern African Development Community (SADC)² agreed on the “Framework and Programme of Action for Orphans, Vulnerable Children and Youth”, in order to articulate a regional response to meet the needs of orphans, with emphasis on holistic and integrated approaches to issues that represent risk for orphans (FAO, 2010a). In western and central Africa, child-related social protection systems remained generally very weak; few

² As of August 2011, the SADC consists of Angola, Botswana, Democratic Republic of Congo, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Zambia, Seychelles, South Africa, Swaziland, United Republic of Tanzania, Zambia and Zimbabwe.

countries having viable national social protection systems in place (UNICEF-WCARO, 2009).

The UN has undertaken a situational analysis on orphans and vulnerable children, resulting in the publication of reports at the global, regional and country levels that shed light on the situation of orphans, using statistical figures (UNICEF/UNAIDS/USAID, 2002; UNICEF/UNAIDS/USAID, 2004; UNICEF-UNAIDS-WHO-UNFPA, 2008; UNICEF-UNAIDS-WHO-UNFPA, 2009). As mentioned earlier, the estimated number of children in Africa who have lost one or both parents has nearly quadrupled in the last two decades. However, it must be noted that there has been a decreasing trend in Asia, Latin America and the Caribbean regions, while the rate of increase in Sub-Saharan Africa has been so significant that it outweighs the progress made in the other regions (UNICEF/UNAIDS/USAID, 2004). Within Sub-Saharan Africa, the situation is equally bad throughout the region, with the number of orphans increasing by over fifty-three percent, from 17.9 million in 2001 to 27.4 million by 2007 in the Eastern and Southern regions, compared to a fifty-eight percent increase from 16.4 million to 25.9 million in Western and Central Africa (UNICEF, 2003a). Mozambique and Guinea-Bissau, the two countries chosen for this dissertation's case study, face similar challenges to support increasing numbers of orphans in their countries.

Further analysis indicates that despite the decrease in overall percentage of orphans in some countries in the Eastern and Southern regions, such as in Burundi, Eritrea, Rwanda, Somalia and Zimbabwe, their progress has been offset by the substantial increases taking place elsewhere, in countries such as Botswana, Lesotho, Mozambique, Namibia, South Africa and Swaziland (UNICEF-ESARO, 2008b). This mostly coincides with the level of HIV infection rates in these countries (UNICEF/UNAIDS/WHO/UNFPA, 2008). On the other hand, some studies and analysis of policies on OVC support in these countries have shown that there is significant improvement in the development of the policies and legal framework for orphans and vulnerable children (UNICEF, 2007; MTT, 2005). For instance, in Swaziland, forty-one

percent of households with orphans and vulnerable children received some kind of external support in 2006 (UNICEF-ESARO, 2008a).

In terms of alternative care options, there is a general consensus that kinship care, foster care or national adoption should be prioritized over residential care. This comes especially from the emphasis on permanency and consistency in care and support, as well as cost implications (Better Care Network, 2009; UNICEF-ESARO, 2008a; Dunn et al., 2004; Browne, 2009; Oleke et al., 2007). Some additional schemes have also proven successful in some parts of the world, such as gatekeeping and access to care services, grassroots-level capacity development for safety nets, community- or school-based counselling services, financial support mechanisms to caregivers, and monitoring and support systems for foster children (Gudbrandsson, 2004; Hutchinson, 2009; Smart, 2003; Redeny, 2009; Tolfree, 2003; MTT, 2005; Yablonski, 2007). Existing studies include those conducted by the UN and the Partners' Alliance for livelihood-based social protection for orphans and vulnerable children, which have mainly been agriculture-focused (UN and Partners' Alliance, 2007).

The need for social protection is significantly greater than in any other region of the world in sub-Saharan Africa, where half of the population lives in chronic poverty. Related to this, there is a wide range of additional factors that make its population particularly vulnerable. For instance, the prevalence of malnourishment across the African continent is double that of the 'developing world' as a whole, which was worsened by the global food crisis in 2008, as well as continuing recurrent famine (Devereux et al., 2009). Another factor is the high rate of HIV infection, as mentioned earlier, and the occurrence of these risk factors in the context of perpetual conflicts in some countries in this region. Due to the social situation created by the combination of these factors, governments have shifted away from emergency food aid towards predictable cash transfers, which have become the dominant instrument of the new social protection agenda.

Conventionally, social protection in the majority of Sub-Saharan African countries used to mainly take the form of humanitarian relief and food-based safety nets. Nevertheless, the recent trend in the social protection agenda in this region has been more focused on social assistance; specifically unconditional cash transfers (Devereux et al., 2009). In some countries such as South Africa, the government has implemented conditional cash transfers aimed at vulnerable children. The experience from South Africa indicates that it was effective to reach the most vulnerable groups in the country, with relatively high take-up rates. On the other hand, some challenges faced included large gaps in coverage and the dilution of benefits in large households (Samson et al., 2006). In the next section, the existing social protection measures in the two countries of case study will be analysed, with particular focus on measures that directly target orphans and vulnerable children.

1.3 National policies on orphans and vulnerable children in Mozambique and Guinea-Bissau

In light of the global and regional policy frameworks discussed thus far, this section will present the existing policies and legislative frameworks for orphans and vulnerable children in Mozambique and Guinea-Bissau. These two countries initially faced huge gaps in social protection services. They nevertheless took steps towards introducing new policies and legislations – although the pace of these steps differs significantly between the two nations.

In Mozambique, the “Multi-sectoral Plan for Orphans and Vulnerable Children” (2006-2010) paved the way for a comprehensive response for orphans and vulnerable children, as did the Social Protection Law, which was passed in 2007 (Waterhouse et al., 2009; Mause et al., 2011). Moreover, the Council of Ministers approved the creation of the National Children’s Council in 2009 (CRC, 2009). This is an independent body entrusted with coordinating implementation of children’s rights, following the approval of the Children’s Act in 2008.

The existing national unconditional cash transfer programme in Mozambique (Programa de Subsídio de Alimentos - PSA) reaches 166,824 direct beneficiaries and 145,592 indirect beneficiaries, an estimated sixty percent of whom are children (Hodges et al., 2010). The application for an extensive impact evaluation of the PSA is expected to contribute to mounting evidence of the impact of advocacy and programme development in social protection in the coming years. Another major achievement is the approval by the Council of Ministers of the Regulation for Basic Social Security in 2009 and the National Strategy for Basic Social Security in 2010, which secure inclusion, for the first time, of a specific provision for social transfers aimed at vulnerable children and child-headed households³ (Mausse et al., 2011). Some key social sectors, such as education and health, are also attempting social protection measures, such as the abolition of user fees and implementation of subsidies for vulnerable populations (Hodges et al., 2011). In spite of these gains, the state budget funding for social protection remains insufficient given the extent of the need.

As for Guinea-Bissau, the country is lagging behind, especially in terms of social protection, with no comprehensive social protection policy currently in place. The Children's Act is still in the process of adaptation among the international standards of national laws and regulations (Germain et al., 2008). The country drafted and approved the National Strategy on Social Protection for orphans and vulnerable children in 2009, but in terms of implementation, it is not yet clear or agreed upon, as the action plan on support to orphans and vulnerable children has not yet been finalized, even after at least three years of appeals (Handem et al., 2011).

³ Child-headed households are commonly defined as households where households where all members are under age 18 due to the death, illness, or incapacitation of the children's parents or other adult caregiver, and an older child often assumes most of the parental responsibilities (Meintjes et al, 2009; Roux-Kemp, 2013).

The Ministry of Women, Family and Social Cohesion of Guinea-Bissau has a cash transfer programme for orphans, people with disabilities and elders, which is said to be covering less than one percent of the total population (Germain et al., 2008). However, the access to this social protection system is apparently limited to public servants and private sector employees (MEPIR, 2011). Due to lack of access to the cash transfer programme, support to orphans and vulnerable children has been going on in a rather ad-hoc and needs-based manner, with mainly external organisations responding to expressed needs for support (Germain et al., 2008). Most support has been direct support to orphans and vulnerable children in the form of in-kind services, such as food, clothing and other consumable items, and/or assistance in accessing basic social services, such as education, health care and birth registration (Handem et al., 2011). There was a pilot attempt of cash transfers to fifty vulnerable families of a type of street children called *Talibe*⁴ in 2010/11, by UNICEF via an NGO Association with Juventude Islamica (S. Polonio, personal communication, 11 July 2015). The result of this pilot is expected to inform the future orientation of the social protection in the country. Otherwise, the other support that has reached many children, including orphans and vulnerable children, was conducted in the education and health sectors, namely; school fee abolition, free distribution of textbooks, mosquito nets, vitamin supplements, and free vaccination for children (UNICEF-Guinea Bissau, 2013). Nevertheless, these were externally-supported interventions that have not yet been integrated as a part of the state social protection system.

1.4 The main objectives and questions addressed by the study

This study thus aimed to assess whether the above-mentioned current OVC policies and programmes are serving the basic needs of orphans and vulnerable children between age 10

⁴ *Talibes* are children who attend Koranic schools, many of whom are forced to beg in the streets and are exposed to abuse and exploitation.

and 17 under different forms of alternative care in two relatively less-researched countries of Mozambique and Guinea-Bissau. From the policy viewpoint, this study reviewed and analysed whether the existing policies are reaching or not reaching the orphans and vulnerable children. The findings from this study inform the recommendations on the policy options towards a comprehensive social protection system. Specifically, this study answers the following questions:

- What are the current policies and programmes intended to support orphans and vulnerable children in Mozambique and Guinea-Bissau?
- Are these policies and programmes serving the basic needs of orphans and vulnerable children?

From the programmatic viewpoint, the research findings shall shed further light on the alternative care options, through answering the following questions:

- What methods of care are being used to support overall well-being of orphans and vulnerable children?
- What is the role of the state in alternative care for orphans and vulnerable children?
- Should the state serve as custodian of orphans and vulnerable children who are placed within institutions or should this responsibility be delegated to service providers?

The answers to these questions help to inform the future policy orientations of the two countries in terms of care provision to orphans and vulnerable children.

Chapter 2

A framework for understanding social protection policies in relation to alternative care for orphans and vulnerable children

The last two decades have seen noticeable concern by many individuals, communities, and organizations over the increasing numbers of orphans and vulnerable children in the African region, as discussed in Chapter 1. The range of those concerns is accompanied by varying interpretations and understanding of terminology, as well as identification of important concepts surrounding this issue. Therefore, the aim of this chapter will be to clarify some basic definitions, theories and concepts to be used in this dissertation, using the adjusted version of Taylor's Conceptual Framework, as illustrated in Figure 2.1. below (Taylor, 2008, p. 33).

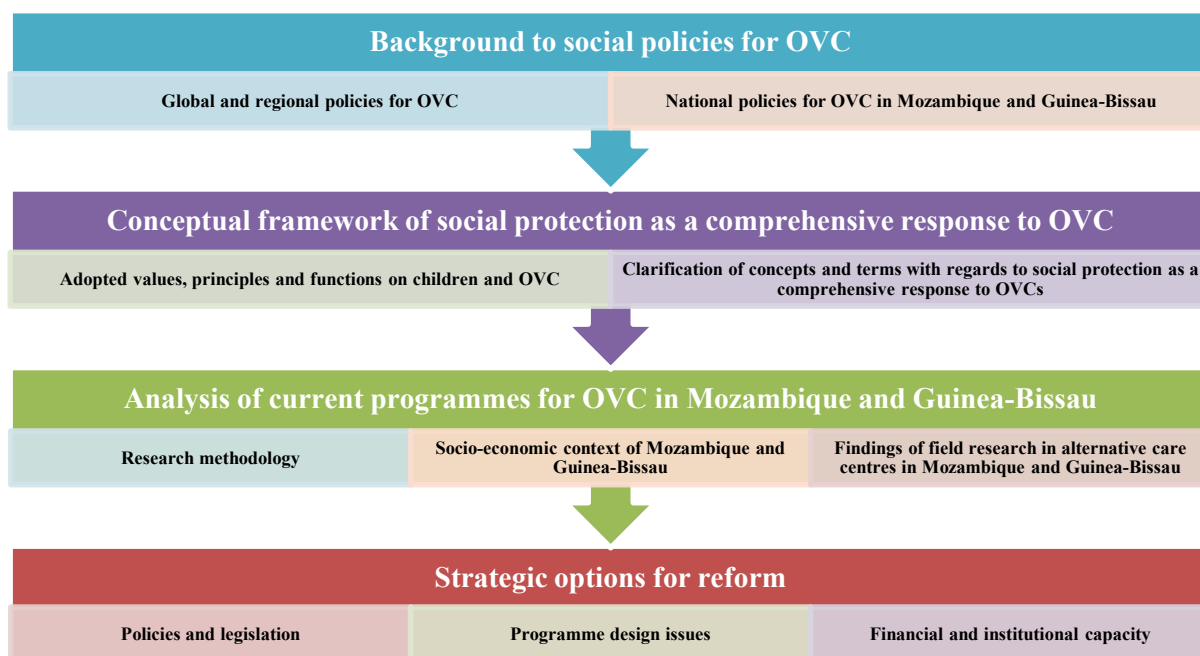


Figure 2.1. Conceptual framework for the study (adjusted from the Taylor Conceptual Framework).

Based on the epidemiological context of the OVC situation and a review of the relevant social policies presented in the previous chapter, the current chapter shall look into the conceptual

framework proposed by Taylor, as it applies to efforts toward social protection for orphans and vulnerable children. This will be achieved by first presenting some adopted values, principles, and functions of and for children, childhood vulnerability, and orphaned children. This will be followed by the clarification of concepts and terms related to social protection, prevention, empowerment and resilience, social policy, social welfare, and social security. The discussion will then focus in more detail on social protection for orphaned children, including alternative care options.

2.1 Adopted values, principles and functions for children and orphans

In general terms, a ‘child’ is defined as a person below the age of 18, unless the laws of a particular country set the legal age for adulthood younger, as per Article 1 of the Convention of the Rights of the Child (UN, 1989). Contemporary theorization of children and childhood generally consider the child as a being in the process of development and socialisation (Cregan et al., 2014). According to Jean Piaget’s stages of psychological growth of human beings, children are expected to develop abilities, skills and responsibilities in stages (Winberg, 2008). Although these developmental stages could be considered generally universal to all children, the value and the position of children in a given society may vary depending on time, culture, social, and economic contexts.

Researchers Kate Cregan and Denise Cuthbert argue that the definition of ‘child’ and ‘childhood’ depend largely on social, political and historical contexts, and that even within the same country, these have varied widely over time (Cregan et al., 2014). For instance, French social historian Philippe Ariès analysed the use of these terms between the 14th and 16th centuries and found that a period recognizable as ‘childhood’ did not exist in the same way historically, but was known as either infancy or an extended period of youth, which was followed by old age (Ariès, 1962). Further, in many European cultures up until the 17th century,

children were considered to have acquired rational capacities by age seven and were sent as apprentices, indentured servants, or into the military forces in Western Europe (Heywood, 2001; Bishop, 1982).

Conceptualization in terms of ‘children’ and ‘childhood’ broadly falls into two categories. First is the psychological perspective, which regards the child as being in the process of development, and second is the sociological approach, which regards the child as being in the process of socialization (Cregan et al., 2014). In the psychological approach, children are considered to be in a period of development, thus they are characterised as generally irrational, untrained and ignorant beings that require care, protection and guidance in order to develop into adult human beings (Cregan et al., 2014). On the other hand, the sociological approach holds that children are part of a larger societal whole and must be considered active, as opposed to passive, social participants (James et al., 1990). Studies on children’s social lives indicate that their local and cultural identities are shaped by their everyday social experiences (James et al., 1998).

In the 17th century, the British philosopher John Locke introduced the idea that human consciousness at first is a *tabula rasa* (*clean slate*). At birth, children are thought to be blank slates upon which the products of adult identity and teaching are written (Cregan et al., 2014). This perspective was followed, historically, by the conception of children as ‘noble savages’ by Jean-Jacques Rousseau (Rousseau, 1762), who viewed children as premature entities who are at a beginning stage of progressive development:

Nature would have them children before they are men. If we try to invert this order we shall produce a forced fruit immature and flavourless, fruit which will be rotten before it is ripe; we shall have young doctors and old children. Childhood has its own ways of seeing, thinking, and feeling; nothing is more foolish than to try and substitute our ways; and I should no more expect

judgment in a ten-year-old child than I should expect him to be five feet high. Indeed, what use would reason be to him at that age? It is the curb of strength, and the child does not need the curb (Rousseau, 1762, p. 56).

Rousseau introduced the idea of childhood as a distinct state separate from adulthood and children as premature and irrational beings that require force and discipline to support proper maturation. As such, up until the early 20th century, children were expected to contribute to labour in the household and family endeavours as soon as they became rational and useful (Cregan et al., 2014). It is only recently, in the later part of the 20th century, that the contemporary view of children as innocent and dependent beings has become widely accepted. More recently, this view has further transformed to the notion of children as more autonomous, competent, yet difficult to manage beings (Prout, 2005; Winberg, 2008).

Such a shift in the perception of children has not only occurred in Western society but also in African society, although this shift is likely due to different factors that are unique to African culture. Unlike in the Western world, where the shift was mainly triggered by a common understanding that children have the right to be treated with care, a shift happened in many African societies due to circumstances such as the loss of parents and having to earn a living to support themselves and siblings (Winberg, 2008). Such children have often had to take on more responsibilities than they are prepared for at a young age, making them more burdened and vulnerable than those children who did not have to face such circumstances.

Although both the psychological and sociological conceptualisations of childhood share the common understanding that children are non-adults, the two schools of thought differ in their beliefs about the age at which children attain rational decision-making capacity, the evaluation of children's physical and intellectual ability compared to that of adults, and about whether a child should participate in labour or take on economic responsibility as part of their families or

communities (Cregan et al., 2014). Cregan and Cuthbert concluded that, “there is a lack of universality or universalizability of current understandings of children and childhood with respect to the past” (Cregan et al., 2014, p. 20). They also argue that the value of a child also varies according not only to national and socio-cultural contexts, but also to a child’s gender, class, ethnicity and citizenship status, as well as how the child represents economic, social, psychological and, at times, political value to adults – or more particularly, parents. Moreover, there have been cases in which a state has deemed children of some categories (e.g., class, ethnicity, family, political ideology) to be less valuable, to be superfluous, or even to represent a threat (Cregan et al., 2014). These children are at risk for systematic mistreatment, including neglect or abuse, making them even more vulnerable (UNICEF, 2014b).

This study will use the contemporary notion of child: children are innocent and they need care; they can function autonomously and competently if given the tools to succeed during childhood. The arguments in this paper are based on the assumption that children, regardless of their nationality or gender, hold equal value and deserve the same rights to care, protection and social services.

2.1.1 Vulnerability and poverty

According to Zimmerman and Arunkumar (1994, p. 2), vulnerability is defined as “the individual’s predisposition to develop varied forms of psychopathology or behavioural ineffectiveness” and “susceptibility to negative developmental outcomes that can occur under high-risk conditions”. Situations that are beyond one’s control can make people vulnerable, causing possible consequences that range from sudden unexpected events, such as a terrorist attack, a violent conflict, an epidemic breakout, or a financial crisis, to more chronic circumstances, such as poverty, pollution, lack of health care or access to potable water. Certain categories of people are more likely to be vulnerable to shocks and risks than others and, as a

result, in more need of specific social policy responses (Shibuya et al., 2013). Children and the older people who are living in chronic states of poverty are seen as especially vulnerable and at risk for serious negative outcomes (Shibuya et al., 2013). Other factors such as age, geographical location (rural, urban), levels of income, poverty, asset poverty and deficiencies in healthcare and education, also put individuals at risk for negative life events, especially if the factors exist in combination. Some studies have found a correlation between poverty and family structure, such as the fact that the average income of a single-mother household was only forty-two percent of that of married-couple households in the USA (Korbin et al., 2014). In countries affected by HIV/AIDS, Richter and Desmond (2008, p. 1019) pointed out that “poverty is a pitiless backdrop to the AIDS epidemic and needs to be at the heart of strategies to address the needs of all vulnerable children in hard-hit communities”.

Poverty, as defined by Barrientos (2013, p. 46), is “a state of significant deficits in well-being considered unacceptable in a given society”. According to Barrientos, the basis of well-being can be understood as the resources at the disposal of individuals or households such as basic utilities, and primary goods and/or capabilities that are necessary to realise life plans (Barrientos, 2013). Recent research and discourse on social policy and social protection adopt a more multidimensional approach to poverty, as opposed to a more conventional monetary approach. Little attention has been focus on a more nuanced understanding of issues regarding at-risk and vulnerable groups (Hoogeveen et al., 2005). Effective targeting of social policies requires better understanding of the links between poverty, risk, vulnerability and those who are likely to be or become vulnerable. In the context of social protection policies, it is important to analyse the connections between risk factors and poverty dynamics, and examine the range of strategies that are deployed to address this risk (Shibuya et al., 2013).

A life cycle analysis and an analysis of social and economic trends especially in the SADC region revealed the vulnerability of a certain category of the population, namely orphans and

vulnerable children (Shibuya et al., 2013). This subset of the population is exposed to multiple levels of vulnerability, risk and hardship. The increasing number of orphans in many African countries, including Mozambique and Guinea-Bissau, requires comprehensive social policy responses. Without specific governmental and other focused, social interventions, these children are likely to become part of another vulnerable population demographic group based on extreme poverty and unpredictable life cycle changes (Shibuya et al., 2013). From this perspective, protection via various social policy measures has been considered the best way to prevent further vulnerability and protect this vulnerable group of children (JLICA, 2009).

Studies of the effects of poverty and other forms of socio-economic disadvantage have underscored the impact that these conditions can have on the emotional, physical, and intellectual development in children and youth (Felner, 2006). Poverty, for example, has been a risk factor for children's well-being throughout history, but the type of impact caused by extreme poverty has changed based on modern life (Goldstein et al., 2006). To discuss resilience in the face of poverty requires a framework that reflects full awareness of the variable nature of poverty. Additionally, these factors can guide action toward affecting resilience in the different contexts and conditions that might be associated with poverty (Felner, 2006). Exposure to conditions of risk such as poverty is not a simple addition to the overall impact of other risk factors, but can exponentially increase the probability of developmental difficulties (Sameroff et al., 1989). As L.B. Schorr (1988) described:

Poverty is the greatest risk factor of all. Family poverty is relentlessly correlated with school-aged childbearing, school failure, and violent crime.... Virtually all other risk factors that make rotten outcomes more likely are also found disproportionately among poor children (p. xxii).

It is important to recognise that vulnerability is not the same as poverty (Chambers, 2006). Even

without poverty as a factor, orphans lack the critical component of parental support. As a result, they are likely to experience various forms of insecurity and will be exposed to risks and shocks unless parenting support systems are put into place. As mentioned earlier, orphaned children constitute a particularly vulnerable part of any population, because they are going through their childhood without the main requirement for any human – the care of a parent. Without systematic social policy interventions this group is more likely to experience multiple deprivations, such as poor education, health care, and later risk for homelessness and social isolation. These children are also at risk of having their basic human rights violated. In the context of extreme poverty, orphaned children are more likely to lack the physical and emotional maturity and resilience to cope with and overcome the stresses of orphan-hood (Shibuya et al., 2013).

Interestingly, a study conducted by Wild and colleagues (2011) revealed that the adolescents orphaned due to AIDS were less economically disadvantaged than other orphans, which could be attributed to the social support targeting the population affected by HIV/AIDS. This as well as other studies showed that the level of poverty tends to mediate the association between orphan-hood and psychological problems (Cluver et al., 2009). Nevertheless, as a result of the increasing population of orphans and endemic poverty, existing support systems have been further stretched, resulting in diminishing attention to psycho-social issues such as bereavement and loss (Davids et al., 2006).

2.1.2 Childhood and adolescence vulnerability

Children are generally considered vulnerable because their physical, emotional and cognitive maturity are still in the process of development, due to their basic biology (Nordenfors, 2006). Four aspects characterise the nature of childhood vulnerability in comparison with adult vulnerability: (a) multi-dimensionality; (b) changes over the course of the lifecycle; (c) relational nature; and (d) voicelessness (Jones et al., 2007). Childhood vulnerability is multi-

dimensional in the sense that it encompasses not only survival, but also development, protection and participation in society as the child continues to mature. It is relational in the sense that a child's vulnerabilities may be tied to the vulnerabilities of their caregivers, intra-household dynamics, community-child relations and macro-micro policy linkages (Jones et al., 2007). For instance, a child made vulnerable in one aspect – such as a terminally ill parent– runs the risk of undergoing an aggravated degree of vulnerability as a result of reduced or no family income, dropping out of school due to the need to care for the ill parent, and/or weakened health due to being over-worked while possibly eating less due to decreased family income. One British research study showed that children are twenty-four percent more likely to be poorer than the population as a whole, with additional risk observed among the children of unemployed or single parents (Evans, 2008).

The degree of vulnerability of a child depends on many factors including age, sex, geographical location (e.g., rural, urban, etc.), levels of income and asset poverty, as well as health/well-being, education and environment (such as family and society), as can be seen in Table 2.1. Action for Child Protection, an American advisory firm for child welfare agencies, has identified additional factors that make a child vulnerable, such as the child's personality and his/her relations with adults, which may include provocative, non-assertive, defenceless or powerless dynamics (Action for Child Protection, 2003). According to Engle, Castle, and Menon (1996), the risks that cause vulnerability in the process of a young child's development begin when the child is conceived, and such risks continue into the child's later life. Examples of the risk factors that have significant impact on the psycho-social development of a child include nutrition in terms of its relation to psycho-social outcomes; family dynamics and their structures such as child fostering; and experiences of violence be it domestic or political (p. 2).

Among these three risks, family dynamics shall be analysed further in this dissertation. British psychiatrist John Bowlby and others argued that a child, especially during the sensitive period

of infancy, needs continuous love and care from certain adults, principally from the mother or a permanent mother-substitute. Major separations between this primary caregiver and the child could cause a detrimental effect on the child’s emotional and social development (cited in Barns, 1995). The gravity of such a negative effect also depends on various other factors, such as the child’s relationships with other family members, the socio-economic conditions of the child or the family, and the consistency and quality of care provided after the separation (Garnezy, 1983; Barns, 1995). There are cases in which children who lost their parents often face the risk of having their inherited property – such as house or land – stolen by adult members of their extended families, especially given the social and/or legal limitations in many countries against children owning or controlling property (Winberg, 2008).

Table 2.1. Definition and illustration of key concepts related to vulnerability and resilience of children

Term	Definition	Example
Vulnerability	Individual susceptibility to undesirable outcomes	Anxious children often find school transitions more difficult
Adversity	Environmental conditions that interfere with or threaten the accomplishment of age-appropriate developmental tasks	Poverty, homelessness, maltreatment, community violence, etc.
Risk	An elevated probability of an undesirable outcome	The odds of developing schizophrenia are higher in groups of people who have a biological parent with this disease.
Risk factor	A measurable characteristic in a group of individuals or their situation that predicts negative outcome on a specific outcome criterion	Poverty, premature birth, malnutrition, parental loss/divorce, parental mental illness, domestic violence, etc.
Proximal risk	Risk factors experienced directly by the child	Witnessing violence, associating with delinquent peers
Distal risk	Risk arising from a child’s	High community crime rate, inadequate

Term	Definition	Example
	ecological context but mediated through more proximal processes	or inaccessible health care
Cumulative risk	Increased risk due to (a) the presence of multiple risk factors, (b) multiple occurrences of the same risk factor, or (c) the accumulating effects of ongoing adversity	Children in homeless families often have many risk factors, including a single parent with insufficient or no education, a history of poor health care, poor schooling, inadequate nutrition, and exposure to many negative events like family/community violence
Resilience	A pattern of positive adaptation in the context of past or present adversity	High-achieving, well-liked, and well-behaved child who has endured serious neglect and maltreatment
Asset/ Resource/ Compensatory factor	A measurable characteristic in a group of individuals or their situation that predicts general or specific positive outcomes	Good cognitive skills, effective parents, good schools
Protective factor	Quality of a person or context or their interaction that predicts better outcomes, particularly in situations of risk or adversity	Health insurance, neonatal intensive care nurseries, suicide hotlines
Cumulative protection	The presence of multiple protective factors in an individual's life	Child in poor neighbourhood who has warm, attentive parent(s), safe home, supportive kin, school tutor, active religious community.
Psycho-social competence	The adaptive use of personal and contextual resources to accomplish age-appropriate developmental tasks	The active engagement of intellectual ability and positive relationships with teachers often results in school success
Developmental tasks	Expectation of a given society in a historical context for the child's accomplishment of specific tasks at the appropriate stage of development	Toddlers learn to walk and talk, school-aged child achieve in school, develop friendships, follow rules.

Source: (Adjusted from Wright et al., 2006, pp. 19-20).

Vulnerability due to separation from primary caregivers is commonly viewed as the foundation

of psychological difficulties, such as acute distress reactions, that may develop when children face additional stressors. These effects often increase the probability of psychiatric disorders later in life as well (Garmezy, 1983). Van Eerdeweghm and his team conducted a study in 1982 comparing orphaned children using a control group of children with living parents (Van Eerdewegh et al., 1982). The study showed that children who had lost their parents exhibited symptoms of depression, including feelings of sadness, irritability, withdrawal, sleep difficulties, decreased appetite and poor school performance (Van Eerdewegh et al., 1982). Although the data from this study also demonstrated that such an immediate reaction following parental death subsided after a while, another study by Brown and Harris (1978) showed that the loss of a child's mother before age eleven significantly influenced the impact of stress on the bereaved child, often eliciting depression (Brown et al., 1978). Therefore, even if parental death on its own may not necessarily be a determinant vulnerability factor, certain forms of early loss, including death and/or separation from parents, are often considered "a source of trauma that could increase the child's emotional vulnerability to later losses" (Rutter, 1983; Monahan, 1993).

Children from age ten onwards are considered adolescents. According to the World Health Organization (WHO), adolescence is "the period in human growth and development that occurs after childhood and before adulthood, from ages 10 to 19. It represents one of the critical transitions in the life span..." (WHO, 2015). Psychologist Erik Erikson characterised adolescence as a period of identity crisis, or facing the internal conflict of identity versus role confusion (as cited in Sigelman et al., 2012). During adolescence, many biological, cognitive and emotional changes occur, triggering changes in attachment relationships. It is during this period that the exploratory part of the attachment system is more active, but still dependent on the secure base (parental and/or familial relationships) as a safety net for the young person to move out into the world with greater autonomy (Smith, 2011). This means that for adolescents

to grow into independent and autonomous individuals, they usually require security and the encouragement from supportive parents or guardians (Scharf et al., 2004).

According to Barber and his colleagues (Barber et al., 2005), healthy adolescent development can be associated with “experiences of ‘connection’ (loving, supportive relationships with significant others), ‘regulation’ (supervision, structure, and monitoring), and ‘respect for individuality’ (acknowledging and respecting an adolescent’s individual self by avoiding intrusive, exploitative, or manipulative behaviours)” (cited in Wild et al., 2014, p. 143). This means that adolescents’ functioning is typically influenced by these conditions in different social contexts, such as family, school, neighbourhood, and peers. Research also shows that deficits in experience in one context can be compensated for by experience in others (Barber et al., 1997). Thus, there is a possibility that if orphaned adolescents experience meaningful connections, regulations and respect for individuality in their significant relationships, homes and communities, they could be protected from experiencing adjustment problems (Wild et al., 2014).

According to research by Allen and Land in 1999, adolescents’ attachment patterns and psychosocial development were found to be interlinked (Allen et al., 1999). For instance, adolescents who had developed preoccupied strategies were associated with depression, while those who had developed dismissing strategies were related to substance abuse (Allen et al., 1999). Thus, adolescents who do not receive such psychological support from their primary caregivers face additional susceptibility during this naturally vulnerable period of transition. In light of this, it is not surprising that in a study by Wild and colleagues (2011), older adolescents were found to be more vulnerable than younger ones, which could be due to the reluctance of relatives to assume custody for older adolescents than for younger children (Wild et al., 2011). Moreover, the strongest negative effects of sexual abuse are found when the abuse occurred during adolescence. This gives support to the idea that adolescence is a time of greater vulnerability

for the development of sexual problems in response to child sexual abuse (Smith, 2011). In order for adolescents to cope with such vulnerability and environmental risks, it is important to cultivate resilience in them through warm, supportive relationships, opportunities to exercise autonomy and decision-making, and appropriate supervision and monitoring by parental figures, teachers, and neighbours (Rutter, 2000).

2.1.3 Orphaned children

Definitions of orphans differ across countries. For instance, the legal definition in some countries includes all children under 18 who have lost one or both parents, whereas in other countries, only the children who have lost both parents qualify as orphans. This difference in understanding of the terminology has created “the inaccurate belief in the Global North that there are millions of ‘orphaned’ Global Southern children in need of rescue through adoption and other interventions,” according to Cregan and Cuthbert (2014, p. 93). This dissertation will use the definition of UNICEF and its international partners, in which an orphan is considered to be a child who has lost one or both parents. This broader definition was adopted in the mid-1990s by various international organisations, as a result of the growing crisis caused by the AIDS epidemic as mentioned earlier, which has killed millions of people worldwide, leaving an increasing number of children without one or both parents (UNICEF, 2010). Therefore, data that show an increase in orphans can be a very strong indicator of the impact of an AIDS epidemic.

This broader definition of orphan-hood requires a shift in focus, as it has implications for policies and programmes for children. For instance, not all of these orphans need a new family, home or individual care as the majority of them still have one parent or extended family members. It might rather be that these family members and communities caring for orphans need support. Such a shift in focus brings to the fore a wider range of factors that cause

children's vulnerability, such as the poverty level of the household, their property ownership, the child's caregivers' educational level, and/or the relationship between the child and the head of the household (UNICEF, 2010).

In this dissertation, orphans are grouped in three mutually exclusive categories: "maternal orphans" whose mothers have died but whose fathers are alive, "paternal orphans" whose fathers have died but whose mothers are alive, and "double orphans" whose mothers and fathers have both died. It is worth noting the sensitivity that should be employed when defining a child as an orphan in a society. As Meintjes and Bray (2006, pp. 407-430) point out, "the labelling of a child (as an orphan) is not only stigmatizing of the child, but a direct insult to those participants in the social network providing care and support to the child... the global preoccupation with the category of 'orphans' centres analytical attention on absence of parents, and loses sight of their presence."

In terms of the vulnerability of orphans, they are more likely to face risk factors not only in terms of their emotional and psycho-social development, but also in terms of physical health and poverty level, as mentioned earlier. A study from Tanzania showed that maternal orphans have on average one year less of schooling and are two centimetres shorter in height compared to non-orphans (Beegle et al., 2005). Data from South Africa also showed that orphaned children were less likely to be enrolled in school, more likely to drop out of school, and had less money spent on their education compared to non-orphans (Case et al., 2004). In the long term, a child who has lost their mother often has to face a psychological loss of the father subsequently. For instance, the father may remarry, but step-mother and previous children may not be able to live harmoniously (Rentchnick, 1989). Therefore, for a variety of reasons, potential separation from parents or caretakers causes a trauma that can result in significant stress for a child (Garmezzy, 1983, p. 52). According to several studies, such traumas can trigger depression in the child either during childhood or adulthood, although this alone may not

necessarily be the direct cause (Robins, 1983).

Research also exists that suggests that becoming an orphan does not, in and of itself, lead to susceptibility to risk (Eisenstadt et al., 1989; Akwara et al., 2010; Richter et al., 2008). For instance, a study by Eisenstadt and colleagues (1989) analysed nearly 700 eminent figures (artists, philosophers, scientists, etc.) in history and compared them to a group of juvenile court inmates. The findings indicated that highly successful, talented, and well-known individuals contained a higher proportion of orphans than the young criminals, compared to their proportion in the general population (Eisenstadt et al., 1989). One possible explanation to this finding was that vulnerability and frustration caused by parental death or absence triggered the urge to seek an alternative sense of security and a compensatory model, resulting in an “aggressive search for power or public recognition” (Rentchnick, 1989). More specifically, in the context of countries affected by HIV/AIDS, Akwara and others (2010) analysed data from sixty household surveys and found that being an orphan is not necessarily a determinant factor that leads to child vulnerability in terms of delinquency, school attendance, and early sexual activity (Akwara et al., 2010). The study by Richter and Desmond in South Africa (2008) also concluded that orphan-hood is not the only determinant of hardship, although it is likely to increase the risks for children in communities affected by HIV/AIDS. Rather, “what is important is ... who takes on the care of the child and in what circumstances? There are other indicators of risk that could better guide responses, including stability, income predictability and food security” (Richter et al., 2008, p. 1026).

There are certain circumstances that cause many children to separate from or lose their parents at once or within a relatively short period of time. The HIV/AIDS epidemic is one of them, especially in the African continent, as mentioned earlier. Another example is the appearance of unexpected situations, such as natural disasters or armed conflicts, where children are physically separated or displaced from their parents by a sudden external force or for safety

reasons, often making it difficult to locate and reunite with their parents later, even if they are still alive. For such children, the United Nations High Commissioner for Refugees (UNHCR) prefers to use the term ‘unaccompanied children’ rather than ‘orphans’:

Unaccompanied children are those who are separated from both parents and are not being cared for by an adult who, by law or custom, is responsible for doing so. The children should not be described as ‘orphans’, but as ‘unaccompanied children’. It cannot be assumed that unaccompanied children in Rwanda and in the refugee camps are orphans. The status of being an orphan always requires careful verification since the term ‘orphan’ is sometimes used in the region for children who have lost one parent. Even though some children have come from orphanages in Rwanda ... many, if not most, alleged orphans have living parents (who) may have entrusted their children to an orphanage as a security measure or to ensure adequate provision of food and shelter (UNHCR, 1994).

If orphaned or unaccompanied children are adolescents, they face another kind of vulnerability because of their psycho-social stage of development in life cycle. As described earlier, adolescence is the period when, under ordinary circumstances, a child would be negotiating a change in relationship with parents. In the case of orphaned or unaccompanied children, this process is interrupted or aborted, while “early experiences of danger and attachment strategies designed to meet it may still be powerfully at work” (Smith, 2011, p. 80). A study of adolescents coming out of foster care found that eighty percent of surveyed youths exhibited two distinct profiles based on their experience with type of alternative placement and caregivers (Keller et al., 2007). The youths who underwent multiple placements including non-family settings, and who also experienced abuse, showed distressed and disconnected attachment profiles, while young people who had changes in placement but were placed with kin showed competent and connected attachment profiles (Keller et al., 2007).

Therefore, orphan-hood on its own may not necessarily cause more vulnerability or increased need for support in comparison to impoverished children, for example. It might be worthwhile for existing policies and programmes to shift their focus from the orphan-hood alone to a wider range of factors and situations that may make these children vulnerable, such as the child's age, the household's poverty level, the child's relationship to the head of the household, and the parents' education level (UNICEF, 2012). It is therefore important to clarify the different understandings of relevant terms and concepts that concern orphans and vulnerable children, as they will affect the formulation of policy objectives and programme targeting when designing responses to support these children.

2.2 Clarification of terms and concepts with regards to social protection as a comprehensive response to orphans and vulnerable children

A state often tackles its social issues, such as poverty, unemployment, crime or domestic abuse by developing and executing a set of social policies that address these problems. Scope and approach of these policies vary widely depending on the nature of the social problem in question and the socio-political and economic context of the country. In this section, the fundamental concepts around social policies, more precisely those responding to orphans and vulnerable children, will be explored, in order to determine where Mozambique and Guinea-Bissau's social policy approaches rest when it comes to children.

2.2.1 Protection, prevention, empowerment and resilience

Vulnerable people, including children, are often in need of support through protection, prevention and empowerment measures. Through safeguarding people from threatening situations, minimizing the possibility of recurrence of such threatening situations, people may be better able to enhance their resilience to counter such situations (Commission on Human Security, 2003). Protection involves efforts to develop and enforce national and international

norms, processes and institutions, and to address vulnerabilities in a systemic, comprehensive and preventive manner. Empowerment, on the other hand, supports and encourages people's potential and capacity to act on their own behalf and eventually on behalf of others, so that the community at large might be more resilient against future possible shocks (Commission on Human Security, 2003). Being empowered is not only about claiming basic human rights, but also about being able to claim them from appropriate authorities in charge of ensuring them to the people (UNICEF, 2003b). Empowerment measures include providing education and information, so that people are better equipped to scrutinise social situations and take collective action through local leadership and public discussion (Commission on Human Security, 2003). This concept of empowerment, applied to children, could mean that an abused child knows how and from whom to seek help from the authorities in charge of child protection.

'Child protection' is defined by British professor Parton (2014, p. 14) as "the laws, policies and professional practices that have been developed to respond to the problem of child abuse and neglect". Looking back through history, measures to protect vulnerable children have progressed over time. One of the earliest forms was introduced in 1623 in Great Britain, aiming to monitor and control unmarried mothers to stop them from committing infanticide, as mentioned earlier. By the 19th century, following industrialisation in Europe, the plight of poor children who were often compelled to engage in dangerous labour became the focus of reformed laws and philanthropic movements in Europe and in the USA (Cregan et al., 2014). In 1873, in the midst of this wave, an historic – if not the first – case of the law stepping in to protect a child took place. An orphaned girl was being abused by her caretaker, and the situation was identified through investigation; she was rescued as a result of protective removal (NYSPCC, 2015). Subsequent court proceedings ordered her temporary placement and the criminal prosecution of her guardian (NYSPCC, 2015). Following this effective intervention, the New York Society for the Prevention of Cruelty to Children (NYSPCC) was established in

1874 as the first organisation devoted to child protection with the following objective:

...to rescue little children from the cruelty and demoralization which neglect, abandonment and improper treatment engender; to aid by all lawful means in the enforcement of the laws intended for their protection and benefit; to secure by like means the prompt conviction and punishment of all persons violating such laws and especially such persons as cruelly ill-treat and shamefully neglect such little children of whom they claim the care, custody or control (NYSPCC, 2015).

Since the establishment of NYSPCC in 1874, similar organisations were founded throughout the USA, England, and Australia, and the accompanying public and political campaigns resulted in the creation of the first set of laws that criminalised cruelty to children, giving authority to public agencies to protect and remove mistreated children from abusive homes (Parton, 2014). The type of child protection services initiated by the NYSPCC, which was simultaneously also conducted by religious missionaries driven by the spirit of charity, has continued until the 20th century, when some of their services have been replaced by public professional social work agencies (Cregan et al., 2014; Parton, 2014).

In the early 20th century, British sociologist Webb (cited in Ward, 2011) called for a shift in the social policy agenda for the prevention of vulnerability – particularly poverty. This prepared the ground for the emergence of Britain's welfare state (cited in Ward, 2011). On the international stage, this was followed by the adoption of the GDRC in September 1924, as mentioned earlier. A critical step forward on behalf of children was seen in 1948, as part of the introduction of the Children's Act (Parton, 2014). In that statement, providing a context that would best foster development in children became a priority, and this principle was put into practice through the establishment of the children's departments associated with local

authorities and agencies to execute this goal of the state (Parton, 2014). By the 1950s, these departments had begun to expand their scope from just protection to include prevention, with the recognition that “waiting until children came into care was doing too little, too late” (Parton, 2014, p. 18). This idea of prevention resulted in a shift toward family services, providing earlier support to families in need so that children could be prevented from having to come into foster care. Various European countries also adopted this family service approach (Parton, 2014).

The concept of prevention was further elevated to the notion of promotion –also referred as ‘empowerment’ – in Britain in the 1980s, through the elaboration of the Children’s Act of 1989 that stated under Section 17 on the “Provision of services for children in need, their families and others” that:

1. It shall be the general duty of every local authority (in addition to the other duties imposed on them by this Part) –
 - a. To safeguard and promote the welfare of children within their area who are in need; and
 - b. So far as is consistent with that duty, to promote the upbringing of such children by their families, by providing a range and level of services appropriate to those children’s needs
- (The National Archives, 1989, Section 17).

This legislation was significant because it elevated the goal of preventing children from coming into care to a goal of promoting healthy care and upbringing of children in their families, which involved parents, families as well as the children themselves. With this, the state’s duty became much broader, from prevention of children coming into care to provision for services to promote holistic care and development of children within their families and communities (Parton, 2014). A similar shift in the concept of child protection is happening in other parts of

the world, including the Sub-Saharan African countries such as Mozambique and Guinea-Bissau (TRG, 2012).

It should be noted that certain services, such as education and health care, fall into both preventive and developmental categories. They are preventive in the sense that these services assist children from falling into further vulnerability, and are developmental in the sense that the outcome of these services would be expected to enhance the capabilities of children to participate in a wider variety of activities in the future (Taylor, 2008).

At the state level, such developmental strategies are followed by transformative strategies which aim to change policies and attitudes so that inequities and vulnerabilities might be reduced (Devereux et al., 2009.). In the long-run, such transformative strategies have extraordinary results, often reaching beyond the original scope of beneficiaries and producing social and economic growth on a wider scale (Taylor, 2008). For developing countries like Mozambique and Guinea-Bissau, where the majority of the population lives under the poverty line, this aspect is especially important to take into account as a way to improve the average living standards and contribute to poverty alleviation.

At the individual level, developmental or empowering support has been expected to enhance the child's resilience to counter future vulnerabilities. The term 'resilience' can be defined as, "a process of, or capacity for, or the outcome of successful adaptation despite challenging and threatening circumstances" (Garmezy et al., 1991, p. 459). This concept arose as a result of three longitudinal studies conducted from the 1970s to the 1990s by Garmezy, Rutter, and Werner. Their findings revealed that despite being exposed to similar levels of high risks, certain children managed to grow up without being affected by these risks. They became competent, confident, and caring adults (Zimmerman, 1994). Resilience is facilitated by protective factors, such as assets or resources of children, their families, and their wider social

environments, that distinguish high-functioning children at risk from those who are negatively affected by it (Luthar et al., 2000). The question is thus; how does empowering support effectively enhance a resilient mind-set in vulnerable children, while at the same time providing them with opportunities to develop the necessary skills to cope with upcoming adversities they may encounter on their path to adulthood? (Goldstein et al., 2006) This approach based on resilience has largely offset negative assumptions seen in deficit-focused approaches about the development of children under risk, who are growing up in the conditions of disadvantage and adversity (Masten, 2001). According to Robert D. Felner (2006), the proximal developmental contexts such as family, school and the neighbourhood all have the potential to create powerful “compensatory effects” that are “not only protective in their own right, but that provide developmental experiences that facilitate the development of individual level competencies in the children and youth and then magnify the potential for positive outcomes” (Felner, 2006, p.128).

The question of resiliency is not particularly straightforward. The studies by Werner and Smith as well as by Luthar indicate that the resiliency process may differ for males and females and that some children may be resilient in some risk conditions but remain vulnerable to others (Werner et al., 1992; Luther, 1999). Thus, defining which vulnerability needs to be addressed and designing programmes that cultivate resilience against the identified vulnerabilities are important. For adolescents, earlier research has shown that connection, regulation, and respect for individuality are three central parenting dimensions that influence adolescents (Barber et al., 2005). A study conducted by Wild and colleagues (2011) on orphaned adolescents further demonstrated that their psychological well-being was significantly influenced by the extent to which alternative or surviving caregivers, friends, and/or community adults were able to provide stable experiences for them. Thus, if an orphaned adolescent has the opportunity to form strong connections with a friend and/or adults in the community, and receives adequate

respect for his/her individuality from the caregiver, it is more likely that s/he will attain greater emotional resilience (Wild, 2011).

The above-mentioned strategies are depicted visually in Figure 2.2. below, bringing together the ideas from Taylor (2008), Guhan (1994), Devereux and Sabates-Wheeler (2004) into a single framework.

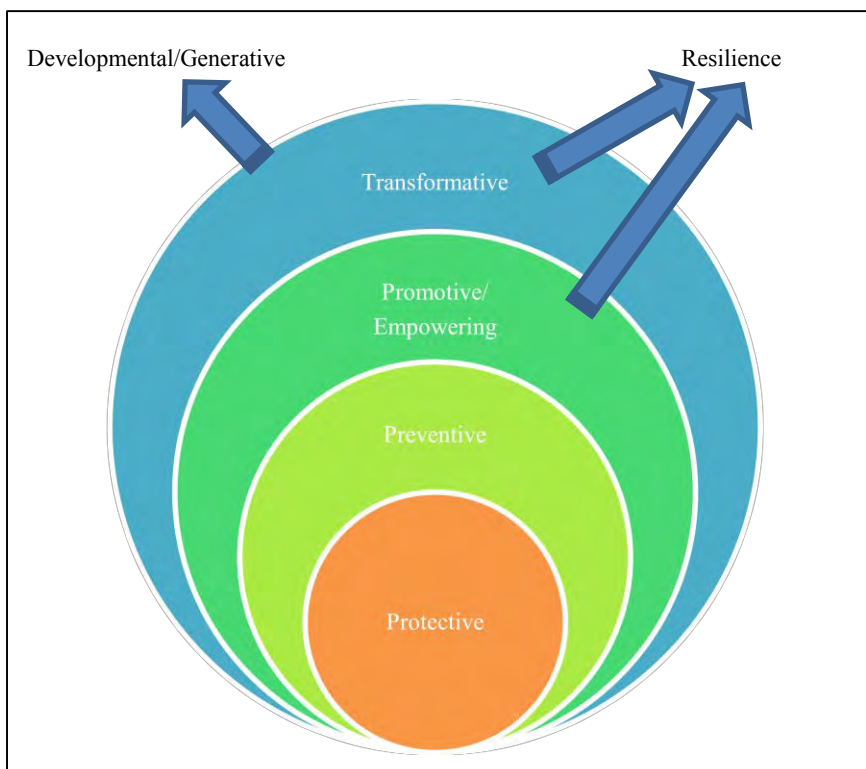


Figure 2.2. Level of strategies to support vulnerable children (Adapted from Taylor, 2008; Guhan, 1994; and Devereux and Sabates-Wheeler, 2004)

2.2.2 Social policy, social welfare and social security

One way for a state to address basic human needs is through social policy. There are various understandings of the concept of social policy, but Gil (1992, p. 24) attempted to define it as “guiding principles for ways of life, motivated by basic and perceived human needs. ... Social policies tend to, but need not be codified in formal legal instruments. All extant social policies of a given society at a given time constitute an interrelated, yet not necessarily internally

consistent, system of social policies” (Gil, 1992, p. 24). Through their implementation, social policies are expected to bring change in the ways of life of target individuals, groups, and classes in terms of living circumstances, power, nature and quality of human relations and/or overall quality of life, as presented in Table 2.2. below (Gil, 1992). It means that appropriate social policies could improve the life conditions of target populations, such as orphans and vulnerable children. The effectiveness of a given social policy could be evaluated by the extent to which basic and perceived needs of the target population could be met. It is important to keep in mind that social policies implemented by governments are not only potential solutions to social problems, but that existing or previous policies may be one of the original causes of the problem.

Table 2.2. Conceptual model of social policies

Sources of social policies	Institutional systems or processes	Outcomes
Basic/perceived needs, including: <ul style="list-style-type: none"> ● Biological-material ● Social-psychological ● Productive-creative ● Security ● Self-actualisation ● Spiritual 	<ul style="list-style-type: none"> ● Development, management and conservation of natural and artificial resources ● Organization of work and production ● Exchange and distribution of goods, services rights and responsibilities ● Governance and legitimation ● Reproduction, socialization and social control 	Improvement in: <ul style="list-style-type: none"> ● Circumstances of living of individuals, groups and classes ● Power of individuals, groups and classes ● Nature and quality of human relations among individuals, groups and classes ● Overall quality of life

Source: Gil, 1992, p. 26.

Among various social policies, those that bring direct impact on people’s welfare could be considered social welfare policies (Gilbert et al., 1986). The primary function of social welfare is to support individuals whose human needs have not been sufficiently met through other

social institutions such as family, religious institutions, economic or political entities. These insufficiencies occur for a number of reasons, including sickness, loss of a wage-earner, or inadequate functioning of economic institutions. Orphaned children are among the target groups of social welfare, because their basic needs are frequently not met by primary social institutions, and/or family, usually due to loss of one or both of their parents. Because social welfare often sets certain eligibility requirements for beneficiaries, it tends to remain a residual activity, serving only as a safety net for the basic institutional structure (Gilbert et al., 1986). Although most of the literature on social welfare deals with state provisions, there are also informal provisions, philanthropic efforts, professional social work and commercial social welfare programmes conducted to promote human welfare (Midgley, 1997).

There have been varying ideas regarding social welfare, with the residual (or safety net) approach on the one hand, and the institutional (or main-line) approach on the other. The former considers social welfare to serve only a small portion of anomalous individuals whose needs could not be met by a small margin of institutional error (Gilbert et al., 1986). The latter approach, in contrast, considers social welfare to be a basic social institution, as depicted in Figure 2.3. This latter concept is also in line with the normalisation principle, originally developed in Denmark in the 1950s and later adapted by other countries in the world, in which social welfare supports the everyday life of vulnerable people so that they can exercise their various rights (Sakata, 2014). In the case of social welfare for children, the choice over these approaches can be characterized by two fundamental questions: “Is having children a matter of personal choice and, thus, personal responsibility? Or, does the public, [and] therefore the government, have some sort of interest in and hence responsibility for the economic lives of children?” (Ozawa et al., 2008, p. 372). In developing countries such as Mozambique and Guinea-Bissau, social welfare tends to be residual due to lack of financial and institutional capacities. These countries have not raised themselves existentially out of the rampant poverty

that exists, thus the situation calls for exactly the type of institutional approach to social welfare that these countries have not yet been able to produce.

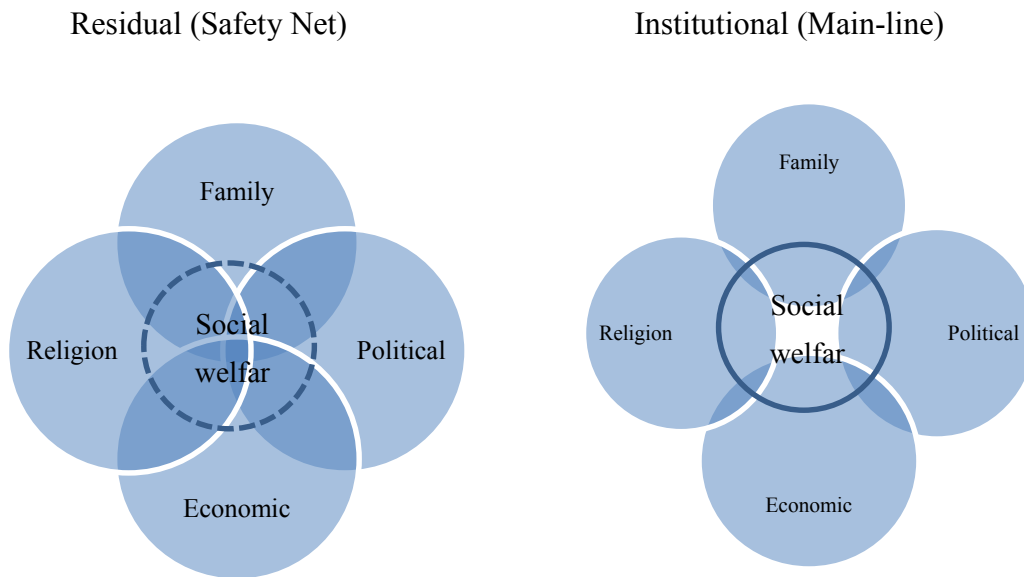


Figure 2.3. Conceptions of social welfare

Source: Gilbert et al., 1986, p. 9.

Social security policies have largely evolved around formal sector employment, aiming to protect against “loss of (formal wage) income” and/or protecting workers to enhance productivity at the work place (Taylor, 2008; Kaseke, 2004). It excludes those outside of formal employment or those in informal employment. . The majority of the population in many African countries falls into the latter category, and social security policies are often regarded as “a luxury reserved for the rich countries” (Kaseke, 2004; Mouton, 1975). Typical social security schemes include some form of social insurance and social assistance, both requiring a regulatory framework to limit beneficiaries and conditions (Taylor, 2008). Such limitations to social security benefits often give rise to the need for more inclusive social protection framework that reaches beyond conventional social security and social welfare schemes, which is illustrated in Figure 2.4. below.

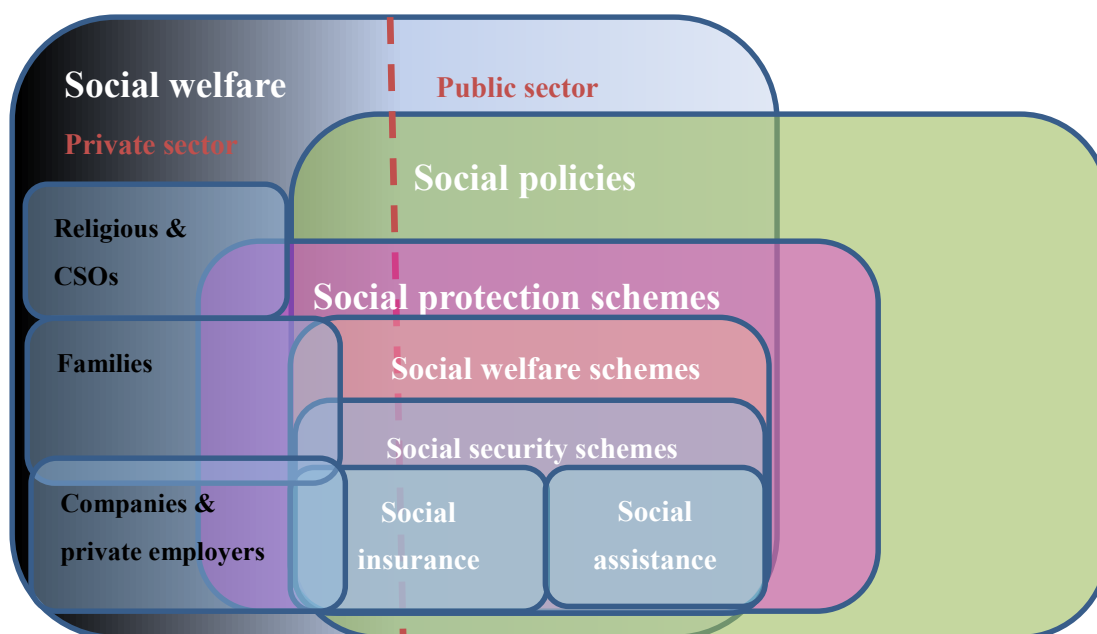


Figure 2.4. Organogram of social welfare, social policies, social protection schemes, social welfare schemes and social security schemes (Constructed by the author)

In order to understand the situation of social protection in Africa today, it is worthwhile to look back in history, to see how the notion of social welfare evolved into social security, especially in Europe, as the European system was inherited through colonialism by many African countries. According to some researchers, the notion of social welfare dates back to millennia ago, to the Code of Hammurabi, developed during the first Babylon dynasty in Mesopotamia in the 18th century BCE. The code contained several injunctions related to welfare matters (Chambliss, 1954). In India in the 4th century BCE, Chandragupta Maurya, the founder of the Mauryan Empire and the first emperor to unify most of Greater India, mentioned in his treatise on politics and economics, called Arthashastra, the concept of welfare as a way to protect the weaker part of society, such as children, women, aged, slaves and prisoners (Drekmeier, 1962). By the 7th century in the Middle East, public treasuries were established by the Caliph Omar so that *zakat* contributions, which are similar to tax, were used to support the needy (Hasan, 1965). In 13th-century Central America, the Incas apparently maintained communal lands

where the population was required to cultivate crops to support widows, orphans and infirmed people (Mesa-Lago, 1978). By the 16th century in France, several cities had established organised systems to collect alms for the poor. This was eventually followed by the enactment of the first legislation in 1536 that required churches to register and support the poor (de Schweinitz, 1943).

The European Renaissance brought landmark steps in social welfare in Europe. Firstly, the enactment of the Elizabethan Poor Law in 1601 in England, which bestowed upon the state the responsibility to support those in need of care. The law also established a national administrative and fiscal system for its implementation (Midgley et al., 1997). Second, the French Revolution in 1789 resulted in a radical secularisation of the relief systems in France, bringing them under state control and introducing a clear distinction between work for the able-bodied and care for the incapacitated (Rothschild, 1995). Thirdly, there was the introduction in Germany of the first social insurance programs for low-income workers in 1883 by the Chancellor Count Otto von Bismarck (Midgley, 1997). In the following decades, many other countries emulated the latter German innovation in particular. Britain introduced its first social insurance scheme in 1906, while Sweden introduced its first comprehensive social insurance retirement programme in 1913. Japan enacted its Health Insurance Law in 1922, and the USA passed the Social Security Act in 1935, which introduced universal retirement for older people and a survivor/invalidity scheme for all employees (Midgley, 1997; Sakata, 2014).

The concept of social insurance reached a more sophisticated level when the Beveridge Report was published in 1942 (Sakata, 2014). This report popularised the notion of a ‘welfare state’ and a ‘national minimum’ security – notions that were adopted by many nations following World War II (Sakata, 2014). Then in 1952, the Social Security Convention by the International Labour Organisation (ILO) was introduced as the first international instrument to establish minimum standards for all nine branches of social security: (a) medical care; (b) sickness

benefit; (c) unemployment benefit; (d) old-age benefit; (e) employment injury benefit; (f) family benefit; (g) maternity benefit; (h) invalidity benefit; and (i) survivors' benefit (ILO, 2006). Furthermore, the International Covenant on Economic, Social and Cultural Rights (ICESCR) adopted in the UN General Assembly in 1966 required in its Article 10 for states to give the widest possible protection and assistance to the family, particularly for the care and education of dependent children. It also specified that “special measures of protection and assistance should be taken on behalf of all children and young persons without any discrimination for reasons of parentage or other conditions” (OHCHR, 1996).

This was later followed by the Convention on the Rights of the Child (CRC) that established social security as one of the basic rights of children, in its Article 26 which defined:

1. States' Parties shall recognize for every child the right to benefit from social security, including social insurance, and shall take the necessary measures to achieve the full realization of this right in accordance with their national law.
2. The benefits should, where appropriate, be granted, taking into account the resources and the circumstances of the child and persons having responsibility for the maintenance of the child, as well as any other consideration relevant to an application for benefits made by or on behalf of the child.

(UN, 1989, Article 26).

Since then, social welfare policies including social security have developed in varying degrees in different parts of the world. In many countries in Western Europe, the government provides extensive social welfare. In some states such as France, Belgium, Denmark and Finland, this resulted in their spending more than thirty percent of total gross domestic product (GDP) on social programs in 2012/13 (OECD, 2014). Some other industrialized countries, such as Canada,

Switzerland, Austria and the United States, have either less state involvement or decentralised/pluralist systems of social welfare, which amounts to less than twenty percent of their GDPs being spent on social programmes (Midgley, 1997; OECD, 2014). Many former Soviet states in Eastern Europe were able to provide universal social security, free and universal health care, education systems, and even extensive housing subsidies at varying levels of quality (Midgley, 1997). Since the collapse of the Soviet Union, however, many of the welfare systems in these countries have been facing serious strain since gaining their independence, often due to socio-economic problems that they inherited following Soviet rule (Midgley, 1997).

Many developing countries' social policies have likewise evolved in varying degrees since the end of World War II, yet share common features of progression. Firstly, many of them share a similar colonial legacy and regional cooperation that have shaped the basis of their governments' social provisions (Midgley, 1997). The colonial legacies are evident in the differing levels of social provision in the Anglophone and Francophone African states. The former have introduced 'provident funds' – compulsory savings programmes for workers which allow them to receive pension after retirement. The latter created social insurance schemes with family benefits, maternity insurance, and child and mother health support (Dixon, 1989; Mouton, 1975). As for the Lusophone African states, they apparently had limited colonial legacy in terms of social welfare, as Portugal had "not yet fully internalized the conception of public welfare as a matter of right, and in some respects goes on conceiving it as a matter of state benevolence" (Santos, 1991, p. 34). Formerly-colonised Asian countries seem to have developed mixed models, whereas Latin American countries have extended their social insurance programs to cover income maintenance, health care and other social services (Midgley, 1997). In developing regions such as Africa, the state social security systems inherited from European models have become less relevant and less appropriate, due to widespread poverty, chronic inequality and the exclusion of the informal sector, where the extent of rural and self-employment comprises nearly

half of all jobs (Taylor, 2002). Moreover, in many African countries where there were limited social assistance and social security measures even before colonialism, the shift from social welfare provision to market economies in the 1990s often resulted in the withdrawal of state subsidies from social welfare services with devastating consequences (Taylor, 2001; Adejumobi, 2004). This was the case for Mozambique and Guinea-Bissau (Marshall, 1990; Rudebeck, 1990).

This variation across different countries could partially be attributed to their varying ideological beliefs toward welfare, which are listed in Table 2.3. below. The countries that opt for less state involvement tend to be anti-collectivism, while former communist countries that had offered universal social service coverage as would be consistent with welfare economy.

Table 2.3. Different perspectives of welfare

Type	Attitude towards the welfare state	Political tradition
Anti-collectivism	State welfare limits individual freedom, initiative and choice, and leads to excessive demands. Provision should mainly come from private/voluntary sectors and through family and self-help.	Right wing, free market, economic liberalism
Social reformism (3 types)	State welfare provision necessary for national efficiency and alleviation of worst deprivation, but can also come from private/voluntary sectors ('mixed economy of welfare' or 'welfare pluralism').	Political liberalism and social democracy
• Non-socialist welfare collectivism		
• Fabian socialism	Welfare state is central to the transformation of society through redistribution of wealth and the creation of a more equal, just and harmonious society to counter the inequalities of the private market.	Social democracy, Fabian socialism
• Radical social	Welfare state is central to a socially	Fabian socialism,

Type	Attitude towards the welfare state	Political tradition
administration	planned society, which consists of radical redistribution of wealth and resources and the pursuit of equality.	democratic socialism, Marxism
Political economy of welfare	Welfare states is an outcome of fundamental conflict between capitalism and working class, but unable to meet need under capitalism.	Marxism
Feminist critique	State welfare provision is important for amelioration of women's lives but also reinforces female dependency and the sexual division of labour.	Liberal/socialist/radical feminism, Marxism
Anti-racist critique	State policy reflects shifting relations between imperialism, capitalism and patriarchy. Welfare state is part of institutionalized racism of society, by denial of access, second-class provision, and reproduction of racial divisions and maintenance of immigration controls.	Black radicalism/ socialism/Marxism/ Black feminism

Source: Williams, 1989, pp. 16-17

Regardless of the type of approach to social welfare, state social provisions have had to undergo various criticisms and consecutive reforms in many countries in recent years, as can be seen from the report by Organisation for Economic Co-operation and Development (OECD) in 1981 titled "The welfare state in crisis: an account of the Conference on Social Policies in the 1980s" (Midgley, 1997; Sakata, 2014). This critical view coincided with the takeover of conservative parties, such as the Thatcher Cabinet in Britain, the Regan Administration in the USA and the Nakasone Cabinet in Japan, calling for reduced government involvement in social welfare (Sakata, 2014). This trend was followed by the imposition of structural adjustment programs, as mentioned earlier, by the International Monetary Fund and the World Bank, retrenching

social programs particularly in the developing countries (Midgley, 1997). Despite the original intention of these programs, which was designed to benefit the poor, scholars such as Kevin Watkins (1995) have criticized these programs as guilty of passing on their costs to the poor, and that the damage caused by these programs would take decades to rectify.

Concerns over the situation where those most in need do not receive the care and support required in existing social security schemes gave rise in the 21st century to the need for more inclusive social protection frameworks (Taylor, 2008). In Sub-Saharan Africa, where adjudication and enforcement of social security rights are often not sufficiently regulated, it becomes ever more evident that poor and vulnerable people have been excluded from exercising their social security rights. Olivier and Kalula (2004, pp. 46-47) suggested that:

It would, therefore, appear that there is a dire need for streamlining, simplifying and integrating adjudicating institutions within SADC. In fact, establishing a uniform, simplified and consistent system of social security adjudication in the different SADC countries would go a long way towards ensuring that the respective systems are made accessible to the poor and the vulnerable.

This need was felt elsewhere as well during the global financial and economic crisis of 2008, which resulted in the adoption of the Social Protection Floor concept by the United Nations Chief Executives Board in 2009. The concept states that, “at present four out of five people worldwide do not benefit from a level of Social Protection that allows them to realize these human rights. Ensuring a basic level of Social Protection and a decent life for these people – many of whom are struggling just to survive, is a necessity and an obligation under the Human Rights Instruments” (ILO, 2014b). The worldwide necessity of this concept is visualized in Figure 2.5. below.

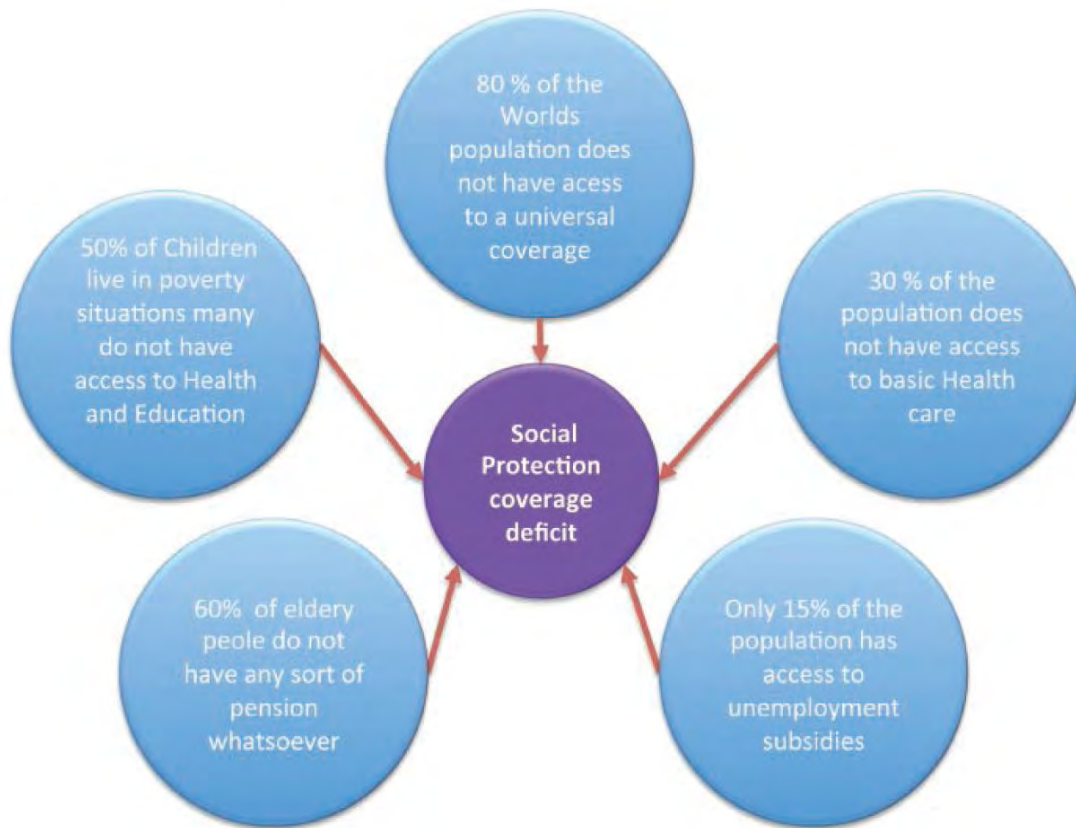


Figure 2.5. The need for social protection and the coverage deficit.

Source: Cattaert, 2014, slide 08.

In the case of developing countries such as Mozambique and Guinea-Bissau, Hall and Midgley (2004) state that addressing long-term issues of poverty and social deprivation require a more comprehensive, holistic and cross-sector livelihood analysis. In this sense, there have been growing expectations for the goals of social policy, from poverty alleviation, to social protection, to social inclusion and the promotion of human rights (Hall et al., 2004).

2.2.3 Social protection

There are various approaches and definitions of social protection, ranging from those with emphasis on employment-related or social insurance measures, to others that encompass a broader scope of public actions that address risk, vulnerability and chronic poverty (Zhang et

al., 2009). This dissertation used a more comprehensive understanding of social protection, which can be defined as a set of “social policies and interventions that protects individuals, families and communities against economic crises and other forms of vulnerabilities as well as promotes growth and human development” (Taylor, 2008, p. 40). This marks a distinctive shift from safety net or welfare measures, which represent incremental approaches to poverty (Taylor, 2008).

Social protection has a potential to serve five functions: (a) protective; (b) preventive; (c) developmental; (d) transformative; and (e) developmental/generative, as depicted in Figure 2.2. presented earlier (Taylor, 2008). Some studies on South Africa, which has three social provisions, namely; Social Old Age Pensions, Disability Grants and Child Support Grants, confirmed that these grants have contributed significantly in reducing income poverty during the 1990s up to the mid-2000s (Patel et al., 2008). Moreover, the concept of social protection could be particularly instrumental to orient support to orphans, as it provides an integrated vision which encompasses not only social transfers to ensure income security, but also an adequate supply of basic entitlements, such as health, education, water and sanitation services, comprehensive support services and policies, including family support and child protection services, and alternative care and livelihood development (Greenblott, 2008).

Social protection is cross-sectorial in nature and includes different tools, from policies and laws, to programmes, services, and social transfers. Private transfers within extended families could be considered a more traditional form of social protection mechanism, which is based on principles of solidarity and reciprocity – values which are often deeply rooted in local cultures. However, recent trends of modernisation and urbanisation, as well as changes in the nature of the family unit have gradually undermined such traditional mechanisms, which are often inadequate to deal with a larger variety of risks (Hodges et al., 2010). In this context, Amartya Sen (1990) developed the “capabilities approach”, which has served as the basis for the

development of more comprehensive social protection packages in which basic income, services and assets figure as main components of social protection, as in Table 2.4 below (Taylor, 2002):

Table 2.4. Matrix of means and ends

Means Ends to promote	Creation of entitlements	Improvements in terms of exchange	Building capacities
Health	Access to healthcare, water, sanitation	Grants and institutional reforms	
Productivity	Redistribution of assets	Restructuring of markets and redistribution of opportunities	Improving access to and affordability of education and economic services
Secure lives	Tenure rights	Social welfare and safety nets	Community and individual safety

Source: Taylor, 2002, p. 31.

More recently in Recommendation No. 202 from the International Labour Conference (ILC) held in May 2012, the notion of the Social Protection Floor was further refined. Refinements included four basic social security guarantees that are legally established and aim to ensure the following:

“(i) **Essential health care, including maternity care**, at a nationally defined minimum level that meets the criteria of availability, accessibility, acceptability, and quality; (ii) **Basic income security for children** at a nationally defined minimum level, including access to nutrition, education, care, and any other necessary goods and services; (iii) **Basic income security** at a nationally defined minimum level **for persons of active age who are unable to earn sufficient income**, in particular in the case of sickness, unemployment,

maternity, and disability; and (iv) **Basic income security** at a nationally defined minimum level **for older persons**” (ILO, 2014b, Paragraph 5).

Although the recommendations say that the guarantee should be nationally defined, it also provides guidance on its appropriate level in paragraph 8(b), where it stipulates that “basic income security should allow [for] life in dignity”. This takes into account necessary goods and services, national poverty lines, income thresholds for social assistance or other comparable thresholds (ILO, 2014b). Furthermore, the recommendation calls for universality of protection, setting out that the basic social security guarantees should be provided “to at least all residents and children, as defined in national laws and regulations” (ILO, 2014b, Paragraph 6).

In Sub-Saharan Africa, modern social protection measures include four broad components, namely; social insurance, social transfers, social welfare services and protective legislation, according to Hodges and Pallerano (2010).

1. **Social insurance:** Contributory by nature though often subsidised by the state, social insurance is based on risk-pooling and expenditure-smoothing principles. Often linked to employment especially in the formal sector, it requires the payment of premiums by employees and their employers. In most African countries, the coverage rarely exceeds 10-15 percent of the population and generally excludes the vast majority of the poorest and most vulnerable, many of whom depend on the informal sector (Hodges et al., 2010; Taylor, 2008). Some attempts have been made to extend social insurance to the informal sector, often through community-based micro-insurance mechanisms such as mutual health organisations; these efforts have not been successful, on the whole (Hodges et al., 2010). In a few African countries like Ghana and Rwanda, national health insurance schemes have been established with the state subsidy,

in order to extend insurance coverage and improve access to basic health care (Hodges et al., 2010).

2. **Social transfers:** Non-contributory by nature, social transfers usually target specific population categories, such as poor households, children or the elderly, and they mainly refer to transfers in cash, in kind or through vouchers. In most of Sub-Saharan Africa, social transfers are often limited to small cash transfer programmes only targeting the ultra-poor or malnourished children, accompanied by in-kind transfer programmes such as school feeding, nutritional support and/or free or subsidised agricultural inputs like seed and fertiliser (Ellis et al., 2009). Some programmes use vouchers, a form of quasi-cash tied to purchases of particular types of goods or services. Most social transfer programmes in African countries are heavily dependent on financing by donors and/or on international agencies and NGOs for implementation, despite their important developmental and generative impact on the local society and economy (Taylor, 2008). Some important examples do exist in which large government-led programmes, notably the Child Support Grant in South Africa and the Productive Safety Nets Programme in Ethiopia, that reach a large segment of the population. Examples of other smaller government-sponsored programmes include the universal pension in Lesotho, the Livelihood Empowerment against Poverty cash transfer programme in Ghana, the programme of vouchers for subsidised fertiliser in Malawi, and the PSA programme in Mozambique (Hodges et al., 2010). It must be noted that some transfer programmes require beneficiaries to observe certain conditions, such as sending their children to school or attending health centres for regular check-ups, while others, such as the PSA and South Africa's Child Support Grant, are

unconditional (Hodges et al., 2010). Social transfers, in a broader perspective, could also include other types of programmes and measures than those mentioned above, namely; consumer subsidies, user fee abolition and labour-intensive public works, as detailed below:

- **Consumer subsidies** are indirect transfers to households which consume goods with subsidised prices. Subsidies are often used to cope against inflationary shocks, so that purchasing power can be protected and social unrest prevented. However, this approach is often criticised by entities such as the IMF because of the high budgetary cost and poor targeting (Hodges et al., 2010).
- **User fee abolition** in certain social sectors, such as for education and health, could also be interpreted as a form of indirect transfer to households which consume these social services. The provision of free or heavily subsidised basic social services for some households or social sectors has a social protection character as it is intended to overcome financial barriers of access to essential services. Numerous African governments have abolished fees for primary education as part of efforts to achieve the objectives of ‘education for all’ (EFA) and Millinium Development Goals 2 and 3, although some financial barriers often remain, such as those for school materials and uniforms (Hodges et al., 2010). User fee abolition in the health sector, with a focus on maternal and child health services, has also been introduced in some African countries, though this practice is not as widespread as in education. This has resulted in varying degrees of success due to the complexity of the accompanying measures required for the strengthening of financing,

human resources and supply chains to meet the surge in demand (Hodges et al., 2010).

- **Labour-intensive public works programmes** also provide a kind of conditional transfer in the sense that the beneficiaries are required to work. By far the largest example in Africa is the Productive Safety Nets Programme in Ethiopia, which provides payments in cash and food to some eight million people in return for work on local infrastructure projects (Ellis et al., 2009, pp. 30-32).

3. **Social welfare services:** Non-monetary components of social protection are social welfare services that aim to prevent or respond to various types of risks faced by children, women, the elderly, persons with disabilities and other population categories with specific types of vulnerabilities. The risks addressed are generally socio-cultural in nature (absence of parents, family breakdown, domestic violence, early marriage, etc.), but sometimes economic (child labour, child trafficking, sexual exploitation). These programmes include awareness-raising, psycho-social support, family counselling and responsive interventions. In many African countries, they tend to be small-scale, poorly coordinated, largely dependent on donor aid and difficult to sustain (Hodges et al., 2010). This was the case for many of the alternative care schemes studied as part of this dissertation.
4. **Protective legislation:** Various laws, decrees and regulations and their associated mechanisms for enforcement have a protective purpose and can also be regarded as constituting part of a country's social protection framework. These include laws to protect the rights of children, women, persons with disabilities and other vulnerable groups, including anti-discrimination

legislation, as well as laws to protect workers from exploitation and work-related hazards. Weak enforcement and weak links to related services often undermine the protection provided by such legislation in African countries with low levels of institutional capacity (Hodges et al., 2010).

Taking South Africa as an example, the Committee of Inquiry proposed the social protection measures according to the poverty type, as below:

Table 2.5.

Comprehensive Social Protection Package and Components Proposed in South Africa

Components of Social Protection Package		
	Application	Key Components
Income Poverty	Universal	Basic income grant Child support grant Maintained State Old Age grant
Capability Poverty	Universal/Eligibility	Free and adequate publicly-provided healthcare Free primary and secondary education Free water and sanitation Free electricity Accessible and affordable public transport Access to affordable and adequate housing
Asset Poverty	Universal/ Eligibility criteria	Access to productive and income-generating assets such as land and credit. Access to social assets such as community infrastructure
Special Needs	Eligibility criteria	Reformed disability grant COIDA RAF

Source: Taylor, 2002, pp. 32-33.

There are some aspects of social protection that directly address children’s needs in general, such as free education and health services, as well as protective legislation. Some others address vulnerable children in a direct manner, such as social welfare services, whereas others do so in an indirect manner, such as through social insurance and the other forms of social transfers, including free education and health services. The importance of the latter has been increasingly recognized in recent years since epidemiologists Wilkinson and Pickett (2009, pp. 23-24) argued that, “child well-being is strongly related to inequality (within a country), and ... it is not at all related to average income in each country”. Cross-regional comparisons actually reveal a surprising pattern; public expenditure on child benefits varies widely, but that variability is not consistent with the proportion of children in the total population. Africa ranks far worse than the other continents, in this respect, as can be seen in Figure 2.6. below.

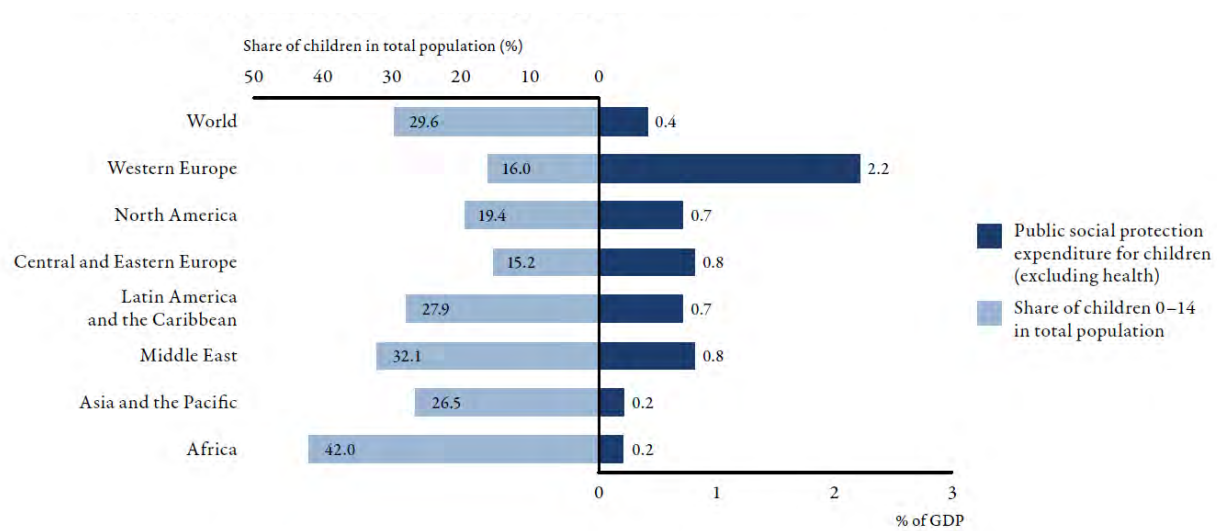


Figure 2.6. Public expenditure on child benefits by region, and proportion of children aged 0-14 in total population, 2010/2011 (percentage of GDP)

Source: ILO, 2014a, p.14 (based on ILO Social Protection Department database).

2.2.4 Social protection for orphaned children

In terms of social protection for children who have been separated from or lost their parents, the UNCRC states in its Article 20:

1. A child temporarily or permanently deprived of his or her family environment, or in whose own best interests cannot be allowed to remain in that environment, shall be entitled to special protection and assistance provided by the State.
2. States' Parties shall in accordance with their national laws ensure alternative care for such a child.
3. Such care could include: inter alia, foster placement, kafalah of Islamic law, adoption or if necessary placement in suitable institutions for the care of children. When considering solutions, due regard shall be paid to the desirability of continuity in a child's upbringing and to the child's ethnic, religious, cultural and linguistic background (UN, 1989, Article 20).

The ACRWC also states in its Article 25 on "Separation from parents" that:

1. Any child who is permanently or temporarily deprived of his [or her] family environment for any reason shall be entitled to special protection and assistance;
2. States' Parties to the present Charter:
 - a. shall ensure that a child who is parentless, or who is temporarily or permanently deprived of his or her family environment, or who in his or her best interest cannot be brought up or allowed to remain in that environment shall be provided with alternative family care, which could include, among others, foster placement, or placement in suitable

- institutions for the care of children;
- b. shall take all necessary measures to trace and re-unite children with parents or relatives where separation is caused by internal and external displacement arising from armed conflicts or natural disasters.
3. When considering alternative family care of the child and the best interests of the child, due regard shall be paid to the desirability of continuity in a child's upbringing and to the child's ethnic, religious or linguistic background (AU, 1990, Article 25).

One way to ensure that these rights are being respected is to analyse the situation using a human rights-based approach. As opposed to needs-based or service-delivery approaches, a human rights-based approach has been used widely in recent years due to the recognition that it is more effective to combine human rights, development and activism than to make progress on any single front (UNICEF/UNESCO, 2007). By integrating the norms, standards and principles of international human rights into the entire process of planning and decision-making – for instance regarding social policy or social protection –it reminds governments and other relevant institutions of their obligations to fulfil, respect and protect human rights and to support individuals and communities to claim their rights. The approach is informed by such principles as: 1) universality and inalienability; 2) indivisibility; 3) interdependence and interrelatedness; 4) equality and non-discrimination; 5) participation and inclusion; 6) empowerment; and 7) accountability and respect for the rule of law (UNICEF/UNESCO, 2007).

Application of a human rights-based approach to social protection is critical in developing countries with limited resources, such as Mozambique and Guinea-Bissau. This is especially true when the state attempts to meet the needs of its population – not to mention redress their rights - because it demands both the political will and commitment to fulfil rights to social

protection of its citizens (Taylor, 2008). This approach is also beneficial for orphans and vulnerable children when applied in light of the CRC, which enjoins the state, as mentioned earlier, to provide protection and assistance – including alternative care – to children who are temporarily or permanently deprived of their family environment.

2.2.5 Alternative care

From the viewpoint that orphans and vulnerable children have the right to ‘alternative care’, the State is required to ensure such care in accordance with national laws. Such care could be informal or formal. Informal care is often initiated by the child, his or her parents, or another relevant person, instead of an administrative or judicial authority. In informal care, a private arrangement is made in a family environment for relatives or friends to look after the child in an ongoing or indefinite basis (UNICEF-ESARO, 2008a). On the other hand, formal care is ordered or authorized by a competent administrative body or judicial authority, and provided in a family environment or residence, including private facilities, regardless of administrative or judicial measures (UNICEF-ESARO, 2008a).

As mentioned earlier, alternative care situations include: (a) kinship care by the child’s extended family or family friends; (b) foster care by a family other than the children’s own, which is selected, qualified, approved and supervised by competent authority in charge of placing the child in need of such care; (c) residential care provided in a non-family-based group setting, with care provided by adults who would not be regarded as traditional caregivers within the wider society, including “children’s homes”; (d) adoption, often considered as permanent care, involving a judicial process to terminate the legal obligations and rights of a child toward the biological parents and create new rights and obligations between the child and the adoptive parents; (e) kafalah, an alternative form of child care under Islamic law, in which a family cares for a child who lives with them on a permanent, legal basis, without entitlement to use the

family's name or to inherit from the family, or (f) supervised independent living arrangements for children (UN, 1989; UN, 2010)

According to UNICEF (2008b), kinship care is generally considered the best option for children whose parents are unable to provide, and almost half of informal orphan placements were indeed with grandparents in Malawi, South Africa, Swaziland and Zambia. In Africa, such placements are not necessarily limited to orphans, but could also occur with other children whose parents may still be alive but had to migrate for work or are unable to provide for their children. Indeed in Ghana, almost twenty percent of children under age 11 were living away from their parental homes in 1985 (Hegar et al., 1999).

Even though kinship care has been socially and traditionally accepted and at times seen as beneficial to improve children's opportunities in many African countries, there have been advantages and disadvantages found in kinship care. In South Africa, studies have shown that orphaned children identified extended family members as a source of practical care, comfort, and consolation (Wild et al., 2011). On the other hand, another study conducted in Sierra Leone showed that children in this type of foster care were disadvantaged in terms of nutritional outcome compared to those who live with their mothers (Bledsoe et al., 1988). In another study on kinship care in Africa, caregivers were found to burden orphaned children with domestic chores, resulting in disrupting their school attendance (Jacques, 2003). Another study revealed that children who are taken in by the extended families are more likely to be mistreated, abused or exploited, although the difference between how the caregivers treat them and their biological children was yet to be proven significant (Foster, 2004a). The 1998 Rapid Assessment on the Situation of Orphans in Botswana identified some cases of sexual abuse by caregivers of girls between ages 15 to 18, in some case resulting in pregnancy and school drop-out (cited in Malinga, 2011).

It is noteworthy that there has also been a resurgence of kinship care in other parts of the world, such as the United States, where the number of children living with grandparents rose by 44 percent between 1980 and 1990 (Roberts, 2001). This situation prompted some scholars, such as Kurts (1994) to raise the question of whether informal kinship placement contributes to exponential increase in foster care caseload as well as prolonging the duration of such care, saying:

...by accepting the formalization of kinship foster care, all participants unintentionally move to a point of greater risk in the face of state intervention. The parent assumes a greater risk of having parental rights terminated, the relative a greater risk of an agency decision to transfer the child, and the children a greater risk of losing family. Child welfare laws and policies fail to acknowledge that relationships, behaviour, and needs of all family members in kinship arrangements are likely to be different than when children reside in traditional foster care settings. The failure of the legal system and the child welfare system to recognize viable kinship networks which exist independent of foster care and the priority placed by both systems on a narrow conceptualization of permanency may in many cases gratuitously, or unnecessarily, result in the severance of significant family relationships from the lives of children, particularly poor children of colour. (Kurtz, 1994, pp. 1520-1521)

In the case where the child's relatives are not available or are incapable of caring for the child, foster care by non-relatives could be the second option. There have been limited records about this practice in African countries in general. Among the four countries studied, there are only records in South Africa, which show that only twelve percent of fostered children were cared for by non-relatives (UNICEF-ESARO, 2008a). In contrast, in the United States, forty-seven

percent of the 397,122 children in need of care in 2012 were placed with non-relative foster care (Children's Bureau, 2013). There have been some comparative studies over this type of care and the kinship care. Hegar (1999) pointed out that kinship placement has advantages in terms of continuity of family identity and knowledge, including ethnic, religious, and/or racial community life of origin. Possible access to relatives beyond the kinship foster parents includes biological parents and siblings, and familiarity founded upon pre-existing relationships between the kinship foster parents and children (Hegar, 1999). A research conducted by Zuravin and her colleagues revealed that kinship caregivers were less likely to have a confirmed case of abuse against the fostered children than the non-related caregivers (Zuravin et al., 1993). They also found that among former foster children, those who were placed in kinship care appeared to have attained higher levels of self-sufficiency than those placed in other types of foster care, although both groups scored lower when compared with those who avoided placement as children (Zuravin et al., 1999).

Another concern over the foster care by non-relatives is the placement disruption. O'Neill (2011) found through her analysis of 562 children in foster care in the United States that children placed in foster homes were eighty percent less likely to achieve placement stability, compared to children placed in kinship homes (O'Neill, 2011). In the United States, there is evidence that extensive use of kinship care has been replaced by other models of alternative care for children (Hegar et al., 1999). As mentioned earlier, there have been contradicting opinions about kinship care, due to the finding that children who enter kinship care tend to remain for long durations in such placement with relatives, resulting in parents and kinship foster parents perceiving reunification efforts to be unnecessary (Hegar et al., 1999). Whether care is provided by biological family or not, many are concerned by foster care in general, as a situation in which abuse and neglect by foster parents might arise. Anthropologist Silk (1987, p. 46) concluded, "Adopted and foster children may be required to work harder, be disciplined

more forcefully, or allocated fewer family resources than natural children”.

When there is no possibility of foster care available to a child, the third option is residential care –sometimes referred to as ‘children’s homes’. Care in children’s homes is often provided in a group setting, with adults who would not be regarded as traditional caregivers looking after the children. In 2012, fifteen percent of children in need of care in the USA were in residential care either in the form of a group home or institution, whereas in the UK, twelve percent of such children were in residential care (Children’s Bureau, 2013; Parton, 2014). In many African countries, residential care has increased considerably in the last decades (UNICEF-ESARO, 2008a). Only the minority of residential care homes are managed by the state, and many private initiatives remain unregistered (UNICEF-ESARO, 2008a). Children are admitted to these homes for various reasons, ranging from orphan-hood or parental neglect, to domestic abuse, poverty and educational needs (UNICEF-ESARO, 2008a). In light of various studies that showed certain undesirable effects of such care on children’s intellect, as well as on their psychological and physical health, residential care came to be regarded as a last resort. In the 1940s, American psychiatrist William Goldfarb (cited in Barnes, 1995) compared early experiences of thirty children who had been separated from their natural mother before nine months old, half of whom were then cared for by foster parents. The other half were placed in residential care until about age three and a half, before shifting to foster parents. The results showed disadvantaged outcomes by the time they were aged ten to fourteen for those who had lived under the residential care in terms of their intellectual and speech development, and their reading and arithmetic abilities (cited in Barnes, 1995). A more recent longitudinal study was conducted in Romania by Nelson, Smyke and colleagues on 169 children aged three and a half who had been institutionalised since birth (Smyke et al., 2010). The children were randomly chosen based on those who continued residential care and others who were shifted to foster care, both of which were then compared to family-reared children. The results revealed that

children placed in foster care before age two and those who were never institutionalised had greater likelihood of forming secure attachments, while the cognitive development of those who continued residential care were more likely to have organised attachments but not necessarily secure ones (Smyke et al., 2010).

On the other hand, there have been studies that challenged such negative conclusions, such as the one conducted in 1976 by Clarke and Clarke (cited in Barnes, 1995), showing evidence that improved arrangements for residential care have resulted in significantly fewer negative effects, and that children were able to make remarkable recoveries from severe deprivation (cited in Barnes, 1995). Tizard and colleagues (1975) also revealed from a longitudinal research study carried out in the 1970s of sixty-five healthy children admitted into residential care from infancy to age two that the children's cognitive, linguistic and emotional development at age four and a half was not so different compared to the control group (Tizard et al., 1975). More recently, the Positive Outcomes for Orphans (POFO) Research Team led by Whetten (2009) conducted a comparative study of the levels of well-being of 2,837 children in institutional and community-based care in Cambodia, Ethiopia, India, Kenya and Tanzania. The study concluded that the overall health, emotional and cognitive functioning, and physical growth were not worse for children in institutions than those in communities, but still generally better than the children in communities who were cared for by adults other than a biological parent (Whetten et al., 2009).

Considering that these studies indicated that not all children in residential care showed negative outcomes, there has been more focus in recent years on the quality and content of care – elements such as staffing, residential settings, and availability of therapeutic programmes – as factors that could determine children's outcomes (Barns, 1995; Garmezy, 1983). The study by Tizard for instance found that a large number of caregivers interfered with a child's capacity to form close relationships, which may incur possible consequences for their later social

development (Tizard et al., 1975). At the same time, Whetten's research revealed that many residential institutions in African and Asian countries had been established by the community to meet the need of caring for the growing number of orphans. Thus, they are more a part of the community rather than conventional institutional care isolated from the community (Whetten, 2009).

Another alternative care option – considered to be a more permanent solution – is adoption, which usually involves a judicial process to terminate the legal obligations and rights of a child toward the biological parents, and create new rights and obligations between the child and the adoptive parents. Once again, there have been limited recorded data regarding adoption in many African countries, except for South Africa, where 1,280 children were recorded as being adopted via the state child welfare system in 2005 (UNICEF-ESARO, 2008a). Some other countries did not have officially-registered independent adoption agencies (UNICEF-ESARO, 2008a). In Westernised countries where statistics were available, there are often more children waiting to be adopted than the actual adoption cases that materialise (Children's Bureau, 2013; Parton, 2014). On the other hand, inter-country adoption, particularly of children from disaster zones, has been reported to involve dubious legality and at times criminal child-trafficking (Cregan et al., 2014). To regulate such situations, the Hague Convention on the Protection of Children and Co-Operation in Respect of Intercountry Adoption was established in 1993 to “establish safeguards which ensure that intercountry adoptions take place in the best interests of the child and with respect for the child's fundamental rights” (HCCH, 1993). This was then followed by the Inter-agency Guiding Principles on Unaccompanied and Separated Children in 2004, which was intended to ensure that all actions and decisions concerning separated children are oriented by a protection framework, while respecting the principles of family unity and the best interests of the child (ICRC, 2004). Such international efforts, particularly the Hague Convention, resulted in the significant reduction of children who were made available for intercountry adoption (Cregan et al., 2014).

Although adoption has been considered ‘a permanent care’, various studies conducted in the USA have consistently showed disruption⁵ rates of the placement ranging between ten to twenty-five percent, while dissolution⁶ rates were estimated to be about one to five percent (CWIG, 2012). Some causes were attributed to the children, such as older age, emotional and behavioural issues, strong attachment to biological mother, or being a victim of pre-adoptive sexual abuse (CWIG, 2012). Other causes attributed to adoptive families included aspects such as being a new or matched parent instead of the child’s foster parent, lack of social support, particularly from relatives of the adoptive parents, and/or unrealistic expectations (CWIG, 2012). Some other factors attributed to adoption agencies included not providing sufficient information about the child and his/her history, inadequate parental preparation, training, support and services, discontinuity in support staff, and/or inadequate number of caseworkers (CWIG, 2012). Even if the adoption succeeded without disruption, adopted children as a group were likely to be more vulnerable to various emotional, behavioural, and academic problems than their peers living with their biological parents, although they were still within the normal range of functioning (Brodzinsky, 1993).

There are various social protection measures to support children in different forms of alternative care. The measures for kinship and/or non-relative foster care include cash transfers, such as the Foster Care Grants and the Child Support Grant in South Africa (UNICEF-ESARO, 2008b). In addition to cash transfers, community-based orphan support such as orphan visiting programmes by volunteers selected from within the community has been found effective (Drew et al., 1998).

⁵ The term disruption is used when an adoption process ends after the child is placed in an adoptive home but before the adoption is legally finalized (CWIG, 2012).

⁶ The term dissolution is used when an adoption process ends after the adoption is legally finalized (CWIG, 2012).

For residential care, especially in the African context, material and financial support have been provided more from the private sector – particularly NGOs and faith-based organizations – than from the state (UNICEF-ESARO, 2008b; Foster, 2004b). Some efforts to set minimum standards for these types of institutions have been under way in many of these countries, but there have also been arguments that community-based residential care should not be hindered by blanket policies covering all institutions (Whetten, 2009). As for adoption, many African countries have not yet developed systematic support for this type of care (UNICEF-ESARO, 2008a). A study on the British adoption system found that parenting interventions could be an effective support, especially when the intervention is more intensive, structured and customized (Rushton, 2007). Such government policy decisions on certain types of alternative care have effects on other types of alternative care, and eventually on the overall well-being of the children involved, as Lindsay and Shlonsky (2008, pp 6-7) pointed out:

It is interesting to note that there has been a substantial reduction in the length of time that children linger in long-term foster care and a substantial increase in the number of adoptions through public child welfare agencies during the 21st century, as a result of the public policy shift brought [on] by advance[s] in child welfare research... Mark Testa's work in the area of kinship care, permanency, guardianship, and adoptions outlined the theoretical foundations of the use of kinship care as a placement resource of choice, drawing on an emerging body of evidence to support his position.

2.3 Conclusion

In this chapter, the conceptual framework used to examine issues related to orphans and vulnerable children and social protection was first presented, followed by those issues concerning adopted values, principles and functions on children, vulnerability and poverty,

childhood and adolescence vulnerability, and orphaned children. It was discussed that, among the already vulnerable population suffering from poverty in Sub-Saharan Africa, children and adolescents who had lost one or both parents often experience further vulnerability, risk and hardship on multiple levels. Although orphan-hood in itself does not always lead to vulnerability, it is likely to increase the risks for children in stressed or impoverished communities, such as those affected by HIV/AIDS, depending on other factors such as the care and the circumstances of the child.

The second-half of the chapter was devoted to the clarification of concepts and terms around social protection for orphans and vulnerable children. It started with general concepts with regard to protection, prevention, empowerment and resilience, and then developed further into social policy, social welfare and social security, showing how these concepts developed in the course of history in real terms, and how it has evolved into a more comprehensive concept of social protection today. The last part of the chapter narrowed the focus to social protection for orphans and vulnerable children, including the advantages, disadvantages, and ramifications of the different alternative care options available and their effects on children, based on results of earlier studies conducted in a range of countries. Based on the literature review, arguments for and against two forms of alternative care in particular were presented, namely; kinship foster care and residential care.

In the context of the above-mentioned debates over various forms of alternative care, this study will look into the concrete examples of different types of alternative care provided in Mozambique and Guinea-Bissau and the situation of children in these centres in the following chapters. The next chapter focuses on research methodology.

Chapter 3

Research methodology

This chapter explains the research methodology used in this study, and the approach taken for the field research conducted in the two case study countries. In order to understand the real situation of orphans and vulnerable children in different forms of alternative care in Africa and whether policies in place address their needs, this dissertation takes two Lusophone African countries as case studies, namely Mozambique in Southern Africa and Guinea-Bissau in West Africa. In this research, the comparative case study approach was adopted, because – as Yin (2004) described – case studies allow researchers to capture and compare both a phenomenon, such as the real life event, as well as its context, such as the natural setting.

3.1 Research problem

This research addresses the limited academic literature available on the actual situation of children under alternative care, especially the early-adolescence age group of 10 to 17 years old. At the time this research was undertaken, there were limited academic studies available that included field research on the situation of children under alternative care in developing countries. Two such studies conducted – one by Whetten’s team and the other by Nelson’s team – focused on younger children, as mentioned earlier (Whetten et al., 2009; Smyke et al., 2010). Whetten’s team studied a group of children ages 6 to 12, while Nelson’s team traced a group with children as young as one and a half years. One joint research was conducted in 2006 in Mozambique by two international development agencies, UNICEF and USAID, but it was not of an academic nature (UNICEF/USAID, 2006). Due to the limited number of studies, there was an information gap in academic literature regarding the situation of orphans and vulnerable children of early-adolescence under alternative care in Mozambique and Guinea-Bissau. Further research into this issue is critical, given the fact that children in this

group have multiple vulnerabilities due to being temporarily or permanently deprived of their family environment, and as such, are among the children who are most at risk.

The countries of Mozambique and Guinea-Bissau were chosen for this study, because they ranked among the ten least developed countries in terms of the Human Development Index (UNDP, 2014). At the same time, there is little academic research available in English on these Lusophone countries, especially Guinea-Bissau, a topic on which social research of this kind is almost non-existent. This may be partially due to the fact that both countries are Portuguese-speaking. This research thus attempts to contribute to the small pool of academic literature in English on these countries. The fact that the author was based in these countries at the time of the research was another reason for the choice of these countries, as it facilitated identifying and accessing the alternative care sites, many of which were not publicly known.

3.2 Research aims

This study aimed to assess whether the above-mentioned current OVC policies and programmes are serving the basic needs of orphans and vulnerable children under different forms of alternative care in the two countries of Mozambique and Guinea-Bissau. From the policy viewpoint, this study reviewed the effectiveness of existing policies in reaching the children themselves, by answering the following questions:

- What are the current policies and programmes in place to support orphans and vulnerable children in Mozambique and Guinea-Bissau?
- Are these policies and programmes serving the basic needs of orphans and vulnerable children?

From the programmatic viewpoint, the research findings were intended to shed further light on alternative care options.

- What methods of care are being used to respond to the needs of orphans and vulnerable children?
- What is the role of the state in supporting alternative care for orphans and vulnerable children?
- Should the state serve as custodian of orphans and vulnerable children who are placed within institutions or should this responsibility be delegated to service providers?

The answers to these questions may inform the recommendations on the policy options towards a comprehensive social protection system.

Certain assumptions were made in conducting this research. First, that policies and programmes on orphans and vulnerable children already exist and are being implemented. Secondly, that the governments in each country were involved in the policies of orphans and vulnerable children. Thirdly, that the care currently being provided is addressing the needs of orphans and vulnerable children. Fourthly, that the programmes to address the needs of orphans and vulnerable children are being run in partnership with the government and donor organizations. Lastly, that the policies enacted and implemented concerning social protection have a direct effect on the quality of care at the child care institution level. Whether these assumptions held true or not shall be discussed in Chapter 7, taking into account the findings presented in Chapters 5 and 6. The findings and conclusions of this study confirm or refute these assumptions.

3.3 Research approach

This research first examined each country's context through a literature review, which included a review of official or public documents that contain information and data relevant to the

subject. Part of the literature review was comprised of a close study of policy documents and legislation of the governments of the two countries mostly published between 2000 and 2015, as well as research reports, household surveys and strategy papers produced by the governments, United Nations, and other non-governmental organisations. According to David and Sutton (2011), there are three types of literature reviews: (1) a systematic review that seeks to define the parameters of searching, selection and analysis in an explicit and deductive manner; (2) meta-analysis, which is a form of qualitative secondary data analysis when the available data are strictly comparable; and (3) narrative reviews, in which a range of previous research is compared and contrasted, but not necessarily in a systematic way. This research used systematic review and narrative review to address the aims set out for the study. In seeking defined sets of information regarding the key indicators or key legislations in the two countries, a systematic review was conducted. In collecting and comparing a range of existing research, a narrative review was conducted. Meta-analysis was not used in this research, because the data collected in similar studies were not necessarily comparable between the two countries. In a few exceptional cases where the needed information was not readily available in the existing documents – which was especially the case for Guinea-Bissau, the information was obtained from the United Nations specialists in charge of social protection in the given country through personal communication, such as interview or e-mail exchange. Through the literature review process, the research question “What are the current policies and programmes intended to support orphans and vulnerable children in Mozambique and Guinea-Bissau?” was expected to be answered.

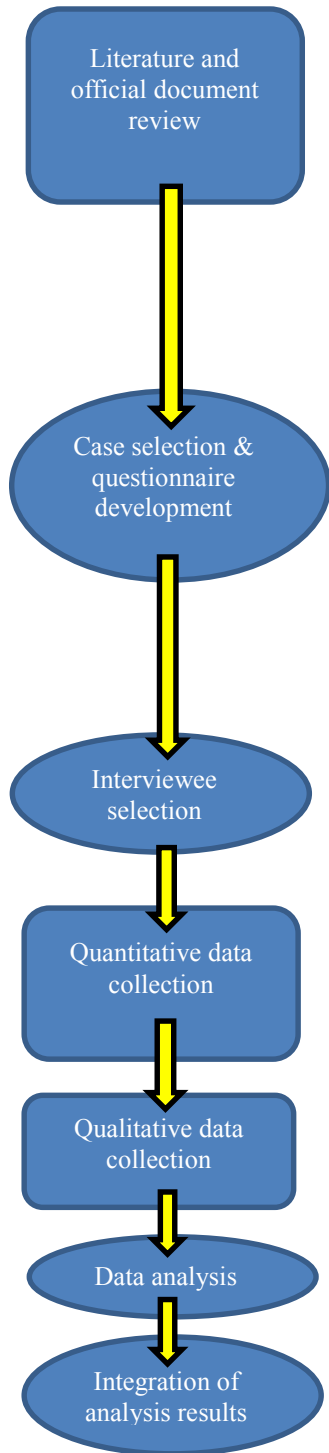
The literature review was followed by field research in the two countries to assess the physical and psycho-social situation of children under various forms of alternative care and whether the existing social protection measures were reaching and serving them in the intended manner. As part of the field research, a mixed methods approach was used, combining quantitative data

analysis and exploratory qualitative interviews, with the use of questionnaires, and surveys via personal interviews, and by observation. The researcher chose the mixed methods approach because it has the advantage of allowing a more complex understanding of social phenomena (Fielding, 2008). In the current study, the mixed methodology allowed the comparison of data between children in different care centres in the two countries. Information was collected by quantitative surveys to measure incidence or average levels of child well-being outcomes, care resources, and government funding. At the same time, qualitative information on children's real-life experiences was collected by asking follow-up, open-ended questions with the expectation that the answers provided would shed light on the children's lived experiences.

Quantitative and qualitative research are considered to have different and often contrasting attributes: quantitative research, with the appropriate research design, allows causal analysis and generalisability especially with larger sample sizes, while qualitative analysis is subject to the specifics of individual lives, experiences, and their general context, using smaller sample sizes (David et al., 2011). This particular research, which followed the pattern of a transformative paradigm, attempted to inform an agenda for reform "that may change the lives of the participants, the institutions in which individuals work or live, and the researcher's life" (Creswell, 2003, pp. 9-10). The quantitative method of research allowed for the analysis of parallel findings about children in various alternative care scenarios in the two countries in a comparable manner, and could demonstrate outcomes that have credibility and consistency for scholars and policy makers. The qualitative dimension was important to identify real experiences, issues and feelings of the children and caretakers beyond expected answers to the pre-prepared questions. The field research was intended to answer the research questions, "Are the existing policies and programmes serving the basic needs of orphans and vulnerable children?", "What methods of care are being used to respond to their needs?", and "What are the impacts of alternative care on the overall well-being of orphans and vulnerable children?"

Table 3.1

Diagram of Research Methods Procedures

Phase	Procedure	Product
 <p>Literature and official document review</p>	<ul style="list-style-type: none"> • Systematic review of public policy documents, legislations, household surveys. • Narrative review of research and situation reports, strategy papers and concept notes of the governments, United Nations and non-governmental organisations. 	<ul style="list-style-type: none"> • Comparison table of key statistical indicators and policy information. • Comparative narrative description of the policy context of the two countries.
<p>Case selection & questionnaire development</p>	<ul style="list-style-type: none"> • Stratified selection of alternative care centres of different care types in the regions with high orphan rate. • Development of interview questions for children, care takers and public authorities. 	<ul style="list-style-type: none"> • Sample alternative care centres. • Questionnaires. • Sample interviewee children.
<p>Interviewee selection</p>	<ul style="list-style-type: none"> • Purposeful selection of 10 children per alternative care centre prioritizing orphans between age 11 and 16. 	<ul style="list-style-type: none"> • Coded data. • Numeric data. • Coded data.
<p>Quantitative data collection</p>	<ul style="list-style-type: none"> • Conducting multiple choice questionnaires. • Measuring height, weight and BMI. 	<ul style="list-style-type: none"> • Text data (testimonies). • Descriptive statistics.
<p>Qualitative data collection</p>	<ul style="list-style-type: none"> • Conducting observation. • Discussing and collecting comments. 	<ul style="list-style-type: none"> • Theme categories.
<p>Data analysis</p>	<ul style="list-style-type: none"> • Frequencies and mean analysis. • Thematic and cross-case analysis. 	<ul style="list-style-type: none"> • Discussion. • Implications.
<p>Integration of analysis results</p>	<ul style="list-style-type: none"> • Interpretation and explanation of the quantitative and qualitative results. 	<ul style="list-style-type: none"> • Future research.

The findings from the literature review and field research are presented in Chapters 4 and 5. In Chapter 4, findings from the literature review will first be discussed, in terms of the macro, socio-economic, demographic and political contexts of the two studied countries. This is followed by a comparative analysis of the policy and planning frameworks for orphans and vulnerable children between the two countries. In Chapter 5, findings from field research in the two countries are presented, to assess and cross-analyse the physical and psycho-social situation of children under various forms of alternative care visited. These research findings are followed in Chapter 6 by the analysis of existing social protection measures in the two countries in light of the field research findings.

3.4 Methods of data collection

The field research was conducted from November 2010 to January 2011 in Mozambique and from November 2011 to January 2012 in Guinea-Bissau. As mentioned earlier, very little empirical research had previously been undertaken in these two countries in the area of support to orphans and vulnerable children, so the current study used a mixed methodology to obtain relevant data. The mixed methods consisted of quantitative data analysis and exploratory qualitative interviews, using questionnaires, personal interviews and observation on 122 orphans and vulnerable children between the ages of 10 and 17, as well as their caregivers and local authorities, all from different forms of alternative care in the two countries.

Data collection on these 122 children was done through individual interviews based on an open-ended questionnaire, and observations based on a monitoring sheet to measure the psycho-social situation of each child. Physical data of each child were also collected, through measurement of weight, height and Body Mass Index (BMI). Information about the child's level of education and livelihood was also obtained. Further, interviews were conducted with the caregivers of the children, with questions focusing on the types of care that the involved children received. The

local authorities in charge of vulnerable child placement, including each country's Ministry of Social Action, were also interviewed in order to obtain general information on the kinds of support that was available to orphans and vulnerable children in his/her district, as well as an assessment of the caregivers of the involved children. The author conducted all the interviews in Portuguese, but as some children did not understand or could not express themselves fully in Portuguese, one or two local research assistants accompanied the interviewer to translate the questions into local languages for children, in cases of necessity.

In order to find the answer to the research question "What is the impact of alternative care on the overall well-being of orphans and vulnerable children?" the field research questionnaire for children (Appendix 1) was developed based on the "Orphans and vulnerable children well-being tool" used by Catholic Relief Services (CRS, 2009). Upon analysis from the human-rights based approach as discussed in Chapter 2.2.4, the tool was considered adequate as it covered the key rights articulated in the CRC, such as the right to good health (Article 24), nutrition and housing (Article 27), education (Article 28), expression (Article 13) and association and assembly (Article 24). The tool had already been tested and used in nine countries, including Ethiopia, Haiti, India, Kenya, Malawi, Rwanda, Tanzania, Vietnam and Zambia (CRS, 2009). For this research, some parts of the tool have been further elaborated to cover the following aspects of well-being:

- Health: body mass index, frequency of illness in the past two weeks, and nutrition deficiency symptoms.
- Psycho-social: Emotional well-being as measured by frequency of psychological feelings (happiness, loneliness, frustration, anger, hopelessness, fear, etc.) and symptoms (nightmares, conflicts with others, sleeping and eating patterns, socialization), and experience of stigma.

- Education: school attendance, level of education attained, and when possible, reading speed and comprehension, writing and calculation levels.
- Living condition: Living arrangements, sources of income, water source(s), food consumption patterns.

The children responded verbally to the questions under each of these items on a 3-point scale ranging between 0 (never), 1 (sometimes) and 2 (always). The questionnaire for children was accompanied by an observation sheet for each child (Appendix 2), on which researchers noted the visual impression of the child, whether s/he looked healthy, happy and/or at ease with others, as well as any other remarks that any child made outside of the standard interview questions.

In order to answer the research question “What methods of care are being used to respond to the needs?” the content of the questionnaire for caregivers was developed based on the monitoring tool of UNICEF in Mozambique for alternative care (Appendix 3), covering the following issues that were expected to be important for this research question:

- Support provided: food, shelter, special attention. (as per UN Guidelines, 2010)
- Knowledge of the child: frequency of illness (as compared to the child’s response), school attendance.
- Support received: monitored visits by authorities, social transfer.
- Livelihood: Employment, sources of income, economic situation.

To answer the research question of “Are the existing policies and programmes serving the real needs of orphans and vulnerable children?” the content of the questionnaire for public authorities (Appendix 4) was defined, which was intended to collect information on:

- General OVC situation: number of orphans in the district, proportion covered

by public and private care, other existing mechanisms of support, difficulties faced.

- OVC support provided: monitoring, supervision. (as per UN Guidelines, 2010).

These questionnaires were first tested in a residential care centre outside of the sample group in Maputo, Mozambique in October 2011. It took approximately twenty to thirty minutes per child to conduct the questionnaire consisting of 50 questions, the observation consisting of 10 items, the measurement of weight and height, and the interview where children were invited to freely express their feelings and concerns. Based on this experiment, some questions, their order and their wording were revised in the questionnaire for children to ensure a better understanding among the children.

3.5 Sampling

The field research examined two general categories of living and care arrangements that orphaned children experienced: family-based care, and residential care. Both types of arrangements were studied in Mozambique and Guinea-Bissau. Family-based care situations ranged from kinship and non-relative foster care in which the child is placed in a family-setting while receiving support from public, private or community service providers. Residential care, defined as children living as a group with care providers, was being run by public and private institutions, in community or individual homes. Seven centres in Mozambique and five in Guinea-Bissau were studied, resulting in a total of 122 children surveyed between ages 10 and 17, as described in Table 3.2.

Table 3.2.

Sample Site, Type and Size

Participants by Type of Care and Country				
Country	Site	Type of care	Care provider	No. of children interviewed
Mozambique	Gatembe	Residential	Private	10
	Chokwe	Family-based	Private	10
	Chinde	Residential	Community	11
	Chimoio	Family-based	Private	13
	Beira	Residential	Private	10
	Boane	Residential	Private	10
	Nampula	Residential	Public	10
Guinea-Bissau	Bissau	Residential	Private	11
	Biombo	Residential	Community	7
	Bafata	Family-based	Private	10
	Tombali	Family-based	Community	10
	Cacheu	Residential	Private	10
TOTAL				122

The seven centres were selected based on non-probability stratified sampling, so that the chosen centres were from different regions of the two countries. Each centre offered different types of alternative care (family-based/residential, public/community/private). Within each centre,

children were originally to be selected via random and representational sampling, but due to the nature of the priority target group (orphans), it was difficult to identify them without the assistance of someone who knew the background of each child. The selection of children also depended on their presence and availability at the site during the period which the research was conducted. Thus within a non-probability sampling, a mixture of availability and purposive sampling methods was used to select the children. In addition to the children, this research also administered questionnaires on their caregivers, as well as local authorities in charge of the placement of vulnerable children (under the Ministry of Social Action) as mentioned earlier.

The following section provides a brief presentation of the twelve sites researched under this study, of which seven were in Mozambique and five in Guinea-Bissau, to give a better idea of each site.

3.5.1 Mozambique

a Gatembe

Gatembe is a rural town across the bay from the capital city Maputo. ‘Family Homes of Hope’, or ‘Casas de Esperança’ is a residential care facility run by a small-scale NGO called IMAGINE, which was founded in 2007 by a British couple, to support orphaned children in the area. Its compound consists of five houses, each with four bedrooms, a living room and kitchen. The houses each has the capacity for twelve children and two full time foster parents, creating a family-like environment. When the centre was visited in October 2010, it had forty-seven children, aged 2 to 19, of which twenty-four were boys and twenty-three were girls. The children resided there under the care of foster parents, who provided them with food, clothing, and other material needs, as well as day-to-day care and general parental guidance. The NGO was registered and had received referrals and monitoring visits from the district officers of the Ministry of Women and Social Action. It received basic technical assistance, such as clothing,

from the government, such as clothing. The majority of its revenue came from private donations.

b Chokwe

The Centre for the Rehabilitation of Children (CRIC) was founded by a French NGO, Douleurs Sans Frontières (DSF), with support from UNICEF in semi-rural Chokwe in Gaza province, about 150 km from Maputo. CRIC is a day-care centre that provides a range of services to orphans and vulnerable children, including basic life-skills, vocational training, health care, play therapy, psycho-social support and educational activities such as sports, drama, and music. When the researcher visited in December 2010, the centre had 530 registered children, of which there were 205 boys and 325 girls from 6 to 18 years old. This group, included five HIV positive children. About fifty children come to the centre each day to participate in the centre's activities, although the centre does not offer food/meals. The centre also has over 100 volunteers and facilitators who visit surrounding communities for sensitivity and awareness-raising about health, education and civil registration services. The centre was founded with technical support from the Provincial Directorate of the Ministry of Women and Social Action, but most of its financial revenue comes from the external sources, such as UNICEF and the headquarters of DSF.

c Chinde

Located in a rural town called Chinde in Zambezia province, 1,550 km from Maputo, 'Centro Orfanato Chinde Chama Bari' is a residential care facility started by members of the community of Chinde in 1989 to support orphaned children in and around Chinde. At the time of the researcher's visit in November 2010, the centre was caring for fifty children, ages 0 to 18, of which twenty-six were boys and twenty-four were girls. These children had not yet been tested for HIV/AIDS. Originally, the facility consisted of a single house with five bedrooms, housing on average ten children per room. More recently, the facility received a donation from an Italian

church that allowed them to construct and equip a proper house with five large rooms. In 2010, the centre, which is run on a voluntary basis by the community members, was not yet formally registered and had received almost no support from the government other than sporadic visits and donations of textiles and notebooks by the Ministry of Women and Social Action. The centre was providing the children with food cultivated from its own garden. Its only substantial source of income was the revenue from the two boats it possessed to hire for income-generation. At the time of the researcher's visit, only one boat was in working condition, decreasing the already-tight budget of the centre.

d Chimoio

Originally started as a project in 2004 by a local association, the 'Centro de Criatividade para apoair Orfaos' in semi-urban Chimoio, about 1,130 km from Maputo, offered day-care activities for orphans and vulnerable girls, providing education in life-skills, HIV/AIDS prevention and hygiene/sanitation sensitisation. The facility also supported income-generating skills training such as crafts production for those over the age of fourteen. The facility did not offer food or meals. When the researcher visited in October 2010, it was attended by an average of fifty girls per day, from ages 9 to 14. They had not yet identified the HIV/AIDS situation of these children. It was registered with the Ministry of Women and Social Action, but it had not yet received any financial or technical support from the government. Much of its funding was coming from the U.S. Embassy or a religious congregation called Church World Service.

e Beira

Founded and run by a Spanish church congregation since 2007, 'Lar Sao Geronimo' is in peri-urban Beira, about 1,200 km from Maputo. It is a well-constructed and equipped residential care facility and vocational training centre, consisting of four houses and occupied by a total of fifty children between ages 6 to 18, of which thirty-eight are boys and twelve are girls. Five

of the children were living with HIV/AIDS as of November 2010. This centre offers meals and vocational training including carpentry, dress-making, welding, masonry, electrical wiring and computer skills. In 2010 it was receiving regular monitoring visits from the Ministry of Women and Social Action, but no financial support. The facility's main support came from the Spanish congregation.

f Boane

Located in semi-rural Boane, about 30 km from Maputo, 'Casa Gaiato' was a well-established residential care facility run by Portuguese Catholic priests and nuns, founded in 1991. In its large compound, there are six residential houses, as well as a primary and junior-secondary school for Grades 1 through 10, a health centre, and a computer room. When the researcher visited in December 2010, 152 children between the ages of 7 to 16 resided there. Six of the children were living with HIV/AIDS. The house also assisted fifty-six orphans who were living in the surrounding communities with cash support consisting of MTZ 3,000 (about USD 100) per month. In addition to this, the centre provided food support to more than 1,000 individuals, including adults and children, in the surrounding communities. This centre received material support from the Ministry of Health in the form of basic medicines, and the Ministry of Women and Social Action provided solely monitoring visits. The centre's support comes mainly from a Portuguese church congregation, as well as cooperative aid from the Portuguese and Spanish governments.

g Nampula

The only government-run centre visited under this research, 'Infantario de Nampula' is located in urban Nampula, the second-largest city in Mozambique, 2,100 km-away from Maputo. It is believed to have been founded immediately prior to the independence of the country, in 1974. It was poorly maintained, presumably due to inadequate funding. This residential care facility

had proper infrastructure with two large dormitories, each with a capacity for twenty-five children. As of December 2010, the centre housed thirty-five children between the ages of 3 and 17 years, of which twenty-seven were boys and eight were girls. One child was living with HIV/AIDS. The centre provided meals and occasional recreational activities supervised by government staff and international volunteers. Unlike the other centres, as of 2010 this centre was fully run by government funding. Many needs were not met at this centre, including a means of transportation, school materials, clothing, maintenance of the facilities, and communication tools. As it is run by the Ministry of Women and Social Action, it received monitoring visits by its district officers and medical support from the Ministry of Health via the local health centre when necessary.

3.5.2 *Guinea-Bissau*

h Bissau

Founded in 1995 by a Portuguese Catholic nun, 'Casa Emanuel' is a residential care facility that has grown over the years into a complete compound consisting of an orphans' residence, primary school, and children's hospital. The facility offers meals to the children, and also contains a library and computer room. As of November 2011, this centre served the needs of 150 children from 0 to 18 years of age, including 18 children with disabilities and 11 children living with HIV/AIDS. Though recognized by the Ministries of Social Action, Education and Health, it had not received any substantial support from the Ministry of Social Action other than occasional monitoring visits. Textbooks were received from the Ministry of Education and some medicine from the Ministry of Health. On occasion, it had benefitted from food and gasoline donations from the government's unit for HIV/AIDS response. Most of its running costs were covered by the funding received from the Portuguese cooperation agency.

i Bafata

Located in peri-urban Bafata, 150 km from the capital Bissau, ‘SOS Talibe’ is a residential care facility run by a local *Mallam* (an Islamic scholar of theology and sacred law) since 2001. It had originally been operating in a poorly-maintained structure, but a new building with new equipment was built with support from UNICEF in 2011. In addition to twenty-two children between ages 7 and 17 in residence at the time of the researcher’s visit, this facility also had a *madrasa* (a Muslim religious school) serving 217 children. According to the *Mallam*, none of the children were HIV positive, but some of their family members were. This centre was also providing support to thirty-six children in the surrounding communities who had been rescued from either child trafficking in the form of *talibe* (children forced into begging on the street) or forced marriage. Registered with the Ministry of Social Action in 2011, the centre had received technical support from the ministry in terms of training and guidance, while some food and material aid came from the community. Most of the necessary funding had been received from UNICEF as well as Canadian and French cooperative agencies.

j Tombali

The centre that was among the most difficult to access in Guinea-Bissau is ‘Orfanato Sembe Jassi in Catio’ in the Tombali region, 280 km from Bissau. The last part of the journey is on a non-paved road. The project was started by a Muslim man in the community in 2000. The centre, which was transformed from his own mud-brick house, provided residential care for thirty-five children and primary education for 303 children in simple mud-brick structures at the time of the visit in December 2011. The HIV/AIDS situation of these children was not known. The centre had not yet been registered with the Ministry of Social Action, thus no support had been received from them, although its primary school component had received textbooks from the Ministry of Education. To feed the children in residence, the centre received

food support from an American NGO called International Partnership for Human Development (IPHD). Otherwise, the centre received very little other support at the time of the visit.

k Biombo

The residential care facility located in peri-urban Biombo on the outskirts of Bissau is another initiative started by a local female primary school teacher in 1990, – with the goal of responding to the need to care for orphans in the community. As of December 2011, she was caring for twenty children between ages 3 to 20, of which 9 were girls and 11 were boys in her own home. The house was poorly-maintained and in need of repair. The children had not yet been tested for HIV. It was not yet officially registered, and thus she had not received any support from the state. This centre was mainly self-funded, from her salary as a primary school teacher (approximately XOF 60,000 or USD 120 per month). This centre received sporadic donations from churches and individuals. Despite such limited funding, she fed all the children under her care, sent them to school, and sought out medical attention in the local health centre when it was needed. Funding for the work was not consistent and could not always provide for anything beyond the children’s essential needs.

l Cacheu

As one of over 500 residential care facilities world-wide run by the international NGO SOS Children’s Villages, the SOS Village of Cachungo is in the Cacheu Region, about 70 km away from Bissau. The facility served 108 children between 0 and 12 years of age, of which 50 were boys and 58 were girls, as of January 2012. Its modern and well-built compound consisted of twelve houses, each housing nine children and a caretaker who served as a mother-substitute for the children. In addition to the residential care, the centre also provided assistance to 465 vulnerable children in the surrounding communities in the form of support for schooling and income-generating support to their families. The centre was well-organised, and its managing

entity was formally registered as an NGO with the state as of 2011. The centre had not received more than minimal support from the government; and most of its funding has come from its headquarters in Austria.

3.6 Analysis of findings

The findings from literature reviews, such as the key indicators, key legislations or programmes in the two countries, have been analysed first to determine whether each country meets the benchmark recommended by international organisations in terms of its efforts to support orphans and vulnerable children. These analyses were done with the goal of answering the research question, “What are current policies and programmes intended to support orphans and vulnerable children in Mozambique and Guinea-Bissau?” In terms of the conceptual framework presented earlier, these findings constitute the “Background on social policies for orphans and vulnerable children”, “[the] Concept of social protection as a comprehensive response to orphans and vulnerable children” as well as the “Analysis of current programmes for orphans and vulnerable children in Mozambique and Guinea-Bissau,” – particularly the part on the “Socio-economic context of Mozambique and Guinea-Bissau”.

When analysing the field research findings, a quantitative method was first used to conduct statistical analysis for each country to describe the characteristics of the alternative care situations. Second, the data on children’s well-being – in terms of health, nutrition, living condition, education condition and psycho-social situation – were compared across the two countries together, by comparing the information gathered through responses to questionnaires by each group of children in each alternative care centre. The data analysis was initially descriptive; responses to the questionnaires and findings from observations were analysed in order to identify commonalities and assess differences between family-based and residential care schemes. Microsoft Excel was used to analyse tendencies and to produce a comparative descriptive analysis

for different centres, calculating frequencies, averages, standard deviations, and percentages, as appropriate, for key variables. To further compare these findings across the two countries, the questions were grouped into twelve key indicators of child well-being, namely; physical observable well-being, psycho-social observable well-being, psychological observable well-being, food situation, health situation, living conditions, education conditions, financial situation, psychological state, the social state of family and friends, community social state, and support situation. These composite indicators were aggregated with equal weighting method, using the “average” function in Microsoft Excel. These indicators were then scaled from 1 to 3 (1 = poor, 3 = good), and averaged, resulting in scores ranging between 1.0 and 3.0. The total score of the twelve indicators was used as a dependent variable to conduct cluster analysis, correlation matrices, and linear regression analysis using statistical software, namely SPSS and R. While explaining the results obtained from the quantitative analysis, qualitative information was used to illustrate the findings with actual comments or examples expressed by the interviewees, to support the researcher’s interpretation of the findings.

This field research was not conducted with any specific hypothesis in mind, as is usually the case for a quantitative study. Rather, it explored the possible answers to the questions “Are these policies and programmes serving the real needs of orphans and vulnerable children?”, “What methods of care are being used to respond to their needs?” and “What are the impacts of alternative care on the overall well-being of orphans and vulnerable children?” as mentioned earlier. Nevertheless, given that there has been debate over the benefits and limitations of residential care as opposed to kinship care, the significance of an association between type of care and the overall well-being of children was important to established; this issue was addressed through analysis of variance (ANOVA). In terms of the conceptual framework presented earlier, these findings constitute the “Findings of field research in alternative care centres in Mozambique and Guinea-Bissau” under “Analysis of current programmes for orphans and vulnerable children

in Mozambique and Guinea-Bissau”.

3.7 Ethics

The research was conducted in accordance with the “Guide to Research Ethics: Research on Human Subjects” established by the Faculty of Humanities at the University of Cape Town (Faculty of Humanities, 2006). Due to the nature of the topic and the subject of the research, ethical boundaries had to be respected with extra care, particularly in the field study portion of the research because a vulnerable population (child orphans) was being interviewed directly.

The author did not undertake this research to cause further stigmatisation for orphans. First of all, all interviews and observations were conducted after obtaining permission from the guardians of the children at each centre. At the same time, all the children interviewed were consulted at the beginning for informed assent, sharing with them the objectives and contents of the research, as well as what they would be expected to do. The researcher also ensured protection from harm by formulating and conducting questionnaires in such a way that they would not hurt the privacy of the interviewees, as well as respect the interviewees’ right to withdraw by explaining that they were free not to answer and withdraw, without prejudice, in case they did not feel comfortable. They were also informed that their personal information would remain confidential. Only the children who verbally agreed to participate were interviewed.

The privacy of interviewees was fully respected by the researcher’s practice of keeping the person’s participation confidential. Therefore, the quotes used in this dissertation remain anonymous other than mentioning age, sex or function of the interviewees. Any names used are assumed and not real, in order to protect against personal identification. At the same time, during the interviews, especially during data collection and analysis, the author paid extra attention to the development or application of personal biases, and attempted to ensure that interpretations were fair and sound. Furthermore, it followed the advice of David and Sutton (2004) that the

social researcher must also reflect on using their work to guard against any abuse.

At the end of work at each research site, time was taken to debrief the respondents, and whenever possible, the researcher tried to follow up with the centres after completing the field research to provide any information or materials requested during the visit, to serve the double purposes of data collection and possible sensitisation or information to improve the conditions of the centres, thus making it an actionable research study.

3.8 Scope and significance of the study

This research analysed the situation of orphans and vulnerable children between the ages of 10 and 17 in Mozambique and Guinea-Bissau in Sub-Saharan Africa. In the existing literature on social protection in Africa, there has been some research done on younger children, but not much has been done on this age group encompassing early adolescence. This research was expected to provide significant value to the field and existing literature, because it focused on this under-researched age group, who are vulnerable and at risk for multiple reasons, including the transitional phase of the human life-cycle (adolescence), as well as the conditions of orphan-hood and poverty. It was hoped that this study would provide insights about the appropriateness of alternative care options for this age group in the two countries.

3.9 Limitations of the study

Given the relatively limited size of the sample, it should be noted that the research conclusions can only be generalised to situations and contexts that are similar to Mozambique and Guinea-Bissau. It is possible that these two countries, and the mechanism of alternative care, may not be representative of the resources available to orphans in most African nations, and this could not be known without studying additional countries. The mechanism of selection of the alternative care centres, and the idiosyncratic nature of the care centres is likely another

limitation, given the small sample of centres in the study. At the same time, the children under family-based care interviewed in this research were limited mostly to those who were in day-care centres. The research therefore did not intend to compare family based care and residential care in an explicit manner. The centres had been selected on the basis of a non-probability quota, sampling from different regions of the two countries so that the research would not concentrate on one particular geographic, ethnic or religious group.

The level of willingness to respond by the children and caregivers interviewed might be another limitation, although it is possible that this problem may have been addressed by the fact that research assistants who were able to speak to children in the child's local language in order to make the participants feel as relaxed as possible. Although some children remained more reserved than the others, almost all of them eventually provided answers to all the questions, and some even confessed their private feelings and emotions.

Another limitations of the study is that the data were collected in 2010, 2011 and 2012 – some years before the actual reality of the moment of submission of this dissertation. Rapid development of the field of social protection in recent years might mean that the reality of social protection measures in one year could be different in the following year. This aspect has been taken into account in formulating the analysis and conclusions of the study.

3.10 Conclusion

This chapter described the process of the design, preparation and administration of the measures involved in this research. This section explained the choices made to determine the methodology, the characteristics of the sample and the questionnaires, as well as the modality of analysis of the findings. It also showed how ethics were respected in conducting this study on the sensitive target group of orphans and vulnerable children. In the next chapter, the actual findings will be presented on the two case-study countries, Mozambique and Guinea-Bissau,

starting from the findings of the review of government documents, policies and census data to present the socio-economic contexts surrounding orphans and vulnerable children in the two countries. This will be followed by a presentation of the field findings in Chapter 5.

Chapter 4

Socio-economic context of Mozambique and Guinea-Bissau

This chapter looks into the macro, socio-economic, demographic and political contexts of the two countries, followed by a comparative analysis of their policy and planning frameworks for orphans and vulnerable children. This comparative analysis will then be followed by discussion of findings from field research in the two countries, which will be explored further in the next chapter.

4.1 Historical background

Mozambique and Guinea-Bissau share a similar history of colonisation by Portugal, which was the first colonial power to begin the slave-trade in the fifteenth century in Africa, and which was also the last to abolish it (Rodney, 1972). Marked by commercial development, evangelisation, colonisation and slave trade in the subsequent centuries, Portugal continued its control over its seized African territories, including Mozambique and Guinea-Bissau, throughout the age of imperialism and “the scramble for Africa” from 1885 to 1890 (Ferro, 1994). During the period of colonisation in general, many more social investments were made for the benefit of the colonising powers than for the local population, resulting in considerable regional variations within the individual countries in terms of the construction of roads, schools and hospitals. The variations were directly related to what the different parts of a given county had to offer the colonialists’ economy (Rodney, 1972). Even within a single district of a given colony, there would be discrimination in providing social amenities, privileging productive institutions such as plantations. Some companies would offer hospitals exclusively for their workers in order to minimally maintain the workers’ health for economic production, while at the same time those who made their living by subsistence farming were completely ignored (Rodney, 1972). Likewise, under colonisation, education was generally used in the interests of

the colonial regime, as recorded in Mozambique's Liberation Front (FRELIMO) statement in 1968 which said, "In the colonial society, education is such that it serves the colonialists ... In a regime of slavery, education was but one institution for forming slaves" (Rodney, 1972, p. 439).

As a result, the gap between the standard of living in Europe and its colonies became increasingly aggravated over the centuries, from 1.9 to 1.0 in 1860, to 3.4 in 1914, 5.2 in 1950, and continued to get worse even after the end of the colonial period (Ferro, 1994). It was often the early missionaries who provided social services by building schools and hospitals as a means of penetrating into local societies in order to evangelise the population (Ferro, 1994). Portugal in particular considered it to be its mission to 'civilise' the local population, even though they did not possess equal rights – if at all any – as proper citizens of the colony (Meneses, 2010). Further discrimination against local people by the colonists occurred within the country, where people received different treatment according to the color of their skin. The darker-skinned indigenous population was discriminated against in terms of access to education and employment until Mozambique won independence in 1975 (Meneses, 2010). In the colonial context, social welfare was limited to a few elites, if at all, and the colonial legacy has continued to have a negative impact on social policies in the developing countries even after the colonisation ended (Midgley, 1997). Moreover, the government of Portugal itself was not among the advanced nations in terms of welfare. As Santos (1991, p. 34). puts it, "(its) public welfare administration has not yet fully internalized the conception of public welfare as a matter of right, and in some respects goes on conceiving it as a matter of state benevolence."

Mozambique and Guinea-Bissau won independence from Portugal in 1975 and 1974 respectively, along with three other countries colonised by Portugal in Africa, namely Cape Verde, Angola and Sao Tome (Salgado, 2016). However, with an exception of Cape Verde, which managed to achieve a successful democratisation process since then, the four other

countries went through a prolonged period of political instability, and Mozambique and Guinea-Bissau experienced civil conflicts during 1980s and the 1990s respectively (Salgado, 2016; CIA, 2016a; CIA, 2016b). Mozambique emerged from political upheaval and held its first free elections in 1994, and the country has remained stable since then (Mausse et al., 2011). Guinea-Bissau also held its first democratic elections in 1994, but these were undermined by a series of political crisis in the following two decades (CIA, 2016b). After another coup d’etat in 2012, a transitional government was in power for almost two years until the current government was democratically elected in 2014 (CIA, 2016b).

4.2 Comparison of key socioeconomic indicators

Today, four decades after Mozambique and Guinea-Bissau became independent, the socio-economic situation in the two countries continues to be a challenge, as can be seen in the following table.

Table 4.1.

Comparison of key Socio-economic Indicators: Mozambique and Guinea-Bissau

Key Indicators	Mozambique	Guinea-Bissau
General		
1 Population (in thousands)*	25,833	1,704
2 Child population (in thousands, under 18 years)+	13,392	817
3 Rank in Human Development Index *	178/187	177/187
4 Territory size (km ²)	801,590	36,125
5 GNI per capita (USD)*	1,011	1,090
6 GDP per capita (USD) - PPP-adjusted*	971	1,164

7	People living below \$1.25 per person/day (%)*	59.6	48.9
<hr/>			
Health and nutrition			
<hr/>			
8	Life expectancy at birth*	50.3	54.3
9	Maternal mortality ratio (per 100,000 live births)*	490	790
10	Under-5 mortality rate (per 1,000 live births) ⁺	87	124
11	Infant mortality (per 1,000 live births) ⁺	62	78
12	Malnutrition prevalence (stunting) (%) ⁺	43	32
<hr/>			
HIV and AIDS ⁺			
<hr/>			
13	Adult HIV prevalence rate (% , 15-49 years) ⁺	10.8	3.7
14	Children living with HIV/AIDS (est. 2013) ⁺	190,000	6,000
<hr/>			
Protection ⁺			
<hr/>			
15	Orphans (thousands/% of child population) ⁺	2,100,000/16%	120,000/15%
16	Orphans due to AIDS (estimate 2013) ⁺	810,000	21,000
17	Orphans whose household received support (%) ⁺	22	8
18	Children under 5 whose birth was registered (%) ⁺	48	24
19	Children age 5-14 involved in child labour (%) ⁺	22	38
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Water and sanitation ⁺			
<hr/>			
20	Use of improved drinking water sources (%) ⁺	49	74
21	Use of improved sanitation facilities (%) ⁺	21	20
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Education ⁺			
<hr/>			
22	Female (15-24) literacy rate (%) ⁺	51	57
23	Primary net school attendance ratio (%) ⁺	86	71

Sources: * UNDP, 2014; + UNICEF, 2015.

The economic index of gross national income (GNI) and GDP per capita should nevertheless be understood with caution, as the exchange rate does not necessarily correctly reflect the actual local prices and corresponding purchasing power within the local currency. If the purchasing power parity (PPP) conversion were used to adjust exchange rate, the GDP per capita would increase substantially in some African countries with untied currencies. For instance, standard gross national product (GNP) per capita and PPP-adjusted GNP per capita for Nigeria was USD 260 and USD 1,220 respectively in 1995, while that of Mozambique was USD 80 and USD 810 respectively (Obadina, 2008).

4.3 Country context of Mozambique

Located in southern Africa, Mozambique shares borders with six other countries and more than 2,500 km of Indian Ocean coastline. It consists of eleven administrative provinces (INE, 2013). Out of the total population of twenty-five million, children account for nearly half (INE, 2015). In terms of gender, slightly more than half of the population is women, with a ratio of men to women of 93:100 (INE, 2015). The demographic pyramid of Mozambique indicates a decline in population of the age group 25-29 and 30-34 years, especially among women. The population density in Mozambique is low, at around thirty inhabitants per square kilometre, and around seventy percent of the population live in rural areas (INE, 2015). The size of an average household is estimated to be 4.6 members in urban areas and 4.3 members in rural areas, giving a national average of 4.4 (INE, 2013).

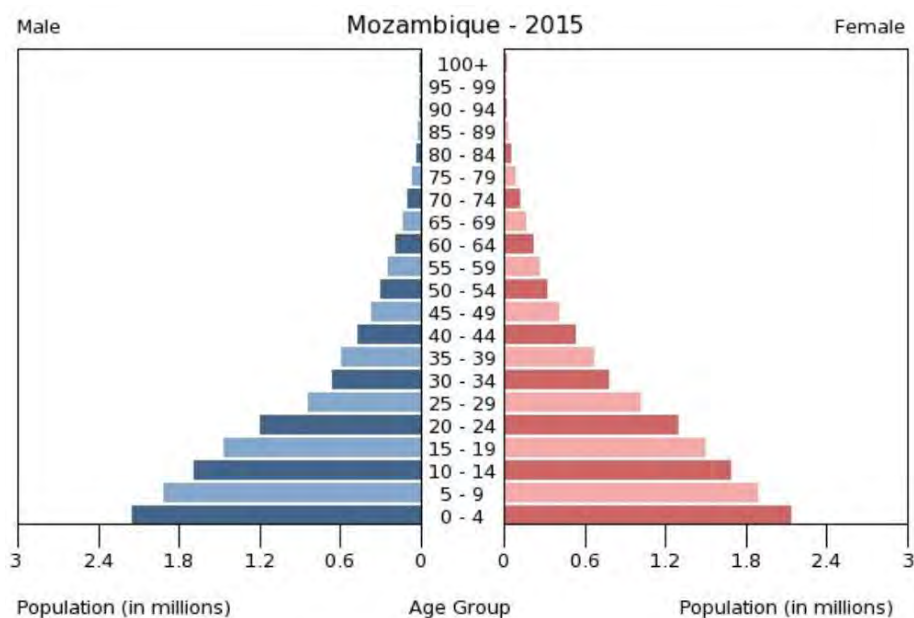


Figure 4.1. Demographic pyramid of Mozambique (2015)

Source: CIA, 2016a.

While Mozambique’s GNI per capita USD 1,011 is well below the sub-Saharan average of USD 3,152 (UNDP, 2014), the country has made significant progress in terms of economic growth in recent years, with its GDP growth averaging 8.7 percent per year between 2001 and 2006, largely due to expansion in private investment (Mausse et al., 2011). At the same, Mozambique has succeeded in reducing poverty, with the proportion of population living below the national poverty line⁷ reducing from sixty-nine percent in 1996 to fifty-four percent by 2003 (INE, 2009). The proportion of children experiencing two or more deprivations also decreased from fifty-nine percent in 2003 to forty-eight percent in 2008 (INE, 2009). The country has made progress in the area of health, with its under-five mortality rate decreasing from 201 deaths per 1,000 live births in 1990 to 87 per 1,000 live births in 2013 (INE, 2009;

⁷ The national poverty line is defined as the poverty line deemed appropriate for a country by its authorities, which may differ from the international poverty line of USD1.25 a day in purchasing power parity terms (UNDP, 2014).

UNICEF, 2014a). Similarly, maternal mortality has decreased from an estimated 1,000 maternal deaths per 100,000 live births in the early 1990s to 490 per 100,000 live births in 2013 (INE, 2009; UNICEF, 2014a). In terms of education, there has been significant increases in school enrolment and attendance rates over the past decade, with eighty-six percent of primary-school children (aged 6-12 years) attending primary school, with only a two percentage point difference between boys and girls (UNICEF, 2014a).

In spite of these achievements, Mozambique continues to rank among the world’s poorest countries, placed at 178 out of 187 countries on the 2014 Human Development Index (UNDP, 2014). A large majority continues to experience poverty, with a huge gap between the poor and a small proportion of the richest, as can be seen in the graph below.

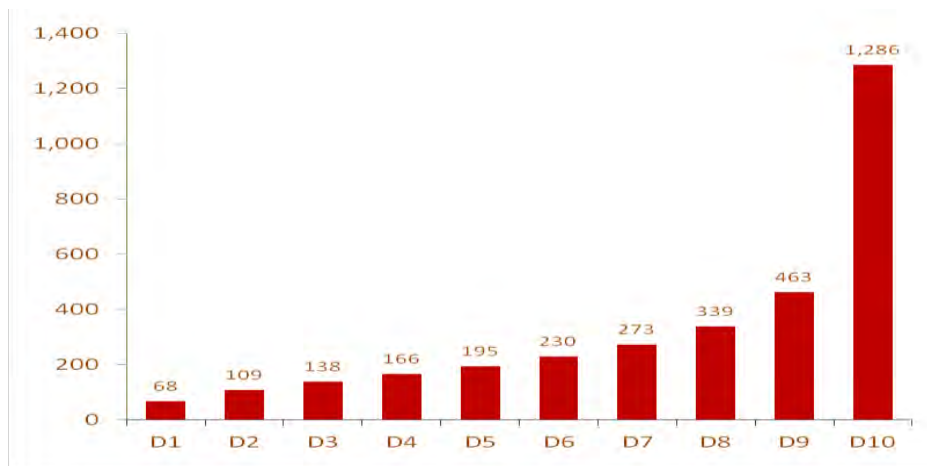


Figure 4.2. Monthly consumption expenditure per capita by deciles in Mozambique (2002/03)

Source: Hodges et al., 2010, p. 56.

The AIDS epidemic has been stabilising in Mozambique, and the HIV prevalence rate among adults has decreased from thirteen percent in 2001 to eleven percent in 2013 (UNICEF, 2003a; UNICEF, 2014a). HIV incidence in children below the age of fifteen years has been decreasing, from an estimated 38,500 new infections in 2005 to about 12,000 in 2013 (UNICEF-

Mozambique, 2011; UNICEF, 2014a). Nevertheless, 190,000 children aged between zero to fourteen were estimated to be living with HIV in 2013, while approximately 2,100,000 children have lost one or both parents, of which 810,000 children became orphans due to AIDS (UNICEF, 2014a).

4.4 Country context of Guinea-Bissau

Situated in West Africa, Guinea Bissau covers an area of 36,125 km², including the Bijagos archipelago which is composed of about eighty islands (CIA, 2016b). The estimated population is 1.7 million, of which forty-eight percent are below age 18 and a ratio of men to women of 95:100 (CIA, 2016b). As can be seen in the demographic pyramid below, there has been a relative decline in the age groups of 35-39 and 45-59 years old particularly among women.

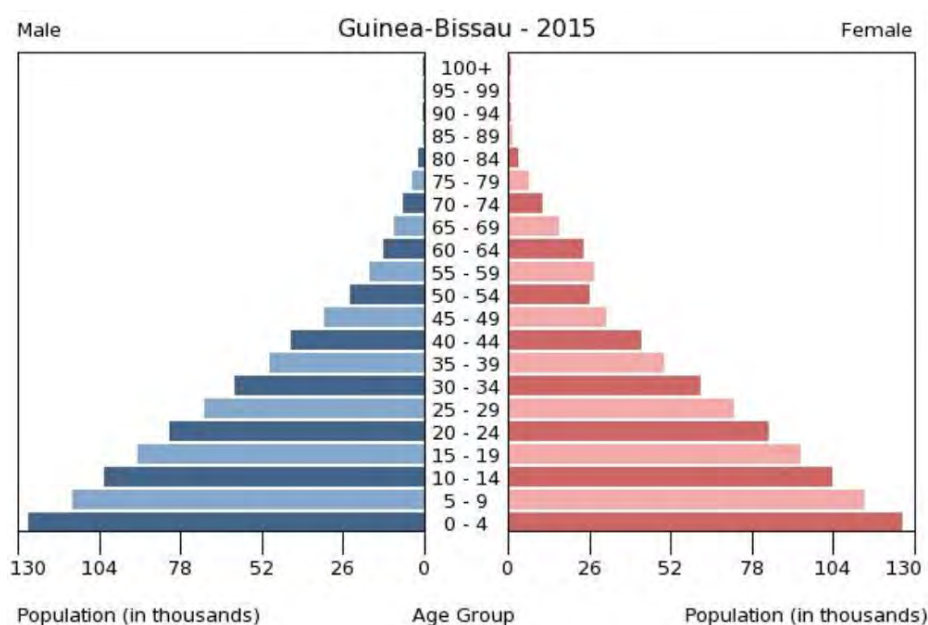


Figure 4.3. Demographic pyramid of Guinea-Bissau (2015)

Source: CIA, 2016b.

Due to the context of political instability that marked the country since its independence, the country's economy has remained weak, as demonstrated by its negative GDP growth rate that

decreased from 6.5 percent in 2005 to 4.5 percent in 2010 and then to mere 0.3 percent in 2013 (UN, 2016). As a result, the country still continues to suffer from weak infrastructures, including a weak private sector and a limited presence in the country of financial donors, international NGOs, although the administration in power since 2014 has been making efforts to regain economic stability (UNICEF-Guinea Bissau, 2013; CIA, 2016b). The country continues to rank very low at 177 out of 187 nations on the Human Development Index, with about half of its population living below the international poverty line of USD 1.25 per day (UNDP, 2015). In fact the 2010 Multiple Indicator Cluster Surveys (MICS) and the 2010 Light Poverty Survey (ILAP) revealed that the proportion of extreme poverty (those living on less than USD 1 per day) has increased from 24.8 percent in 2002 to 39.8 percent in 2010 (INE/UNICEF, 2010; INE/UNDP, 2011). There is a notable regional difference in the incidence of poverty; with nearly sixty-nine percent of the people in Tombali considered poor, as opposed to only three percent in Bissau (MEPIR, 2011).

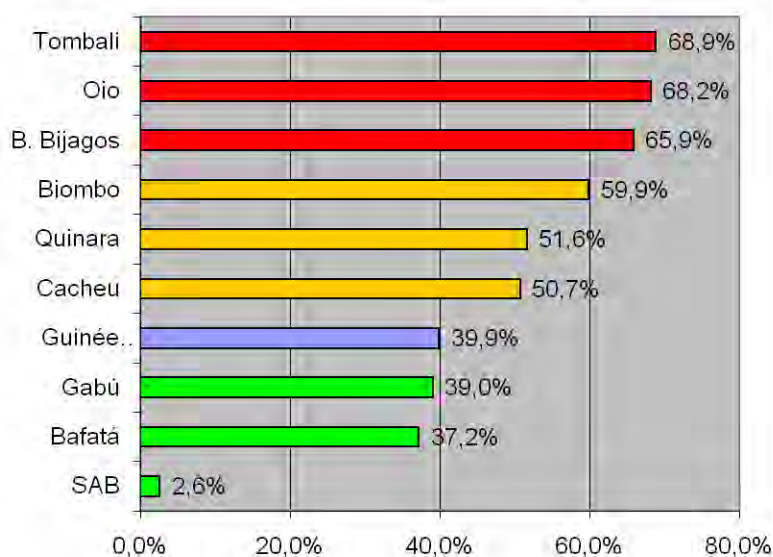


Figure 4.4. Incidence of poverty per region in Guinea-Bissau

Source: MEPIR, 2011.

As a result of decades of political instability and its side-effects, including weak economy and

limited social services, the population in general remains vulnerable. Health outcomes remain low, as can be seen in the mortality rate of children under age five at 124 per 1,000 live births and the infant mortality rate at 78 per 1,000 live births (UNICEF, 2014a). In terms of education, net attendance rate for primary education remains at seventy-one percent, with gender parity index at 0.94 (UNICEF, 2014a). Access to and quality of education is still limited as infrastructure remains insufficient and of poor quality, with incomplete schools, a double- to triple-shifting system and untrained teachers (Pole de Dakar, 2012). One solace for Guinea-Bissau is that it has not been affected significantly by HIV/AIDS yet. The estimated HIV prevalence rate among adults is 3.7 percent, while approximately 6,100 children under age 14 are living with HIV in 2013 (UNICEF, 2014b). Nevertheless, due to poor health services, maternal mortality remains high at 790 per 100,000 live births in 2013 (UNICEF, 2014a). As a result, 120,000 children are estimated to have lost one or both parents, of which 21,000 have become orphan due to AIDS (UNICEF, 2014b).

4.5 Cross-country analysis of OVC support situation

In terms of social protection, the level of development varies somewhat between Mozambique and Guinea-Bissau. As mentioned earlier, Mozambique already has social security measures in place for sickness, maternity, old age, invalidity, survivors and family allowances (ILO, 2014b). The country had also successfully paved the way for comprehensive response for orphans and vulnerable children by 2006, with the development of the Multi-sectorial Plan for Orphans and Vulnerable Children (2006-2010), the adoption of the Social Protection Law of 2007 and the Children's Act in 2008 (Waterhouse et al., 2009). The Social Protection Law in particular effectively organized the country's social protection system on three levels: basic social security, obligatory social security and complementary social security (Mausse et al., 2011).

Following the approval of the Children's Act in 2008, the National Strategy for Basic Social

Security was also approved by the Council of Ministers in April 2010, comprehensively including four programmes, namely; basic social subsidy, direct social support, social service, and productive social action (MMAS, 2012). Another major achievement was the approval by the Council of Ministers of regulations for the Basic Social Protection Law, which will secure inclusion, for the first time, of a specific provision for social transfers for vulnerable children and child-headed households (Mausse et al., 2011). In key social sectors, such as in education and health, there are other initiatives for social protection, such as abolition of user-fees and subsidies for vulnerable populations (Hodges et al., 2010). In spite of these gains, the state budget funding for social protection remains insufficient, given the extent of the need. Mozambique has indeed been regarded as an example country in terms of progress in the social protection area (MMAS, 2012).

In contrast, Guinea-Bissau is on the other extreme, lagging behind in the social protection area. The country supposedly has social security legislation for old age, employment injury, invalidity and survivors (Germain et al., 2008). However, the national laws and regulations of Guinea-Bissau are not yet aligned with international standards of the Children's Act. The country drafted and approved the National Strategy on Social Protection for orphans and vulnerable children in 2009, but in terms of implementation, it is still not yet clear and agreed upon, as the action plan for OVC support has not yet been finalized, even after nearly three years of elaboration process (Handem et al., 2011).

Support to orphans and vulnerable children is provided on a rather ad-hoc and needs-based manner, mostly by external organisations responding to the specific requests for support. Most support has been delivered via direct support to orphans and vulnerable children in the form of in-kind service, such as food, clothing and other consumable items, and/or assistance in accessing basic social services, such as education and health care (Handem et al., 2011). Other than the pilot attempt of cash transfers to fifty families of *talibes* (as noted, children who were

forced into begging on the street) in 2010 by UNICEF via the NGO Association Juventude Islamica, there have been no other social protection measures. In the education and health sectors, some interventions, such as school fee abolition, free distribution of textbooks, mosquito nets and vitamin supplements, as well as free vaccination of children (UNICEF Guinea-Bissau, 2013) have reached many children, including orphans and vulnerable children. Nevertheless, these were externally-supported interventions that have not yet been integrated as a part of the state social protection system.

The OVC Policy and Planning Effort Index (OPPEI) can be used for a systematic comparison of the level of effort in responding to OVC needs between Mozambique and Guinea-Bissau. The criteria, called “OPPEI criteria for measuring policy and planning of a country’s response to OVC” (UNICEF, 2008, p. 3) are presented as the following:

- An up-to-date, published, comprehensive participatory national situation analysis of OVCs of good quality, which includes at least an inventory of organizations involved, a literature review, and specific recommendations.
- An effective consultative process, which assures that all stakeholders are actively involved and meet regularly, including at least one “national consultation” per year.
- An effective formal coordinating mechanism which has been established to coordinate national action for OVCs which has a permanent structure, has a constitution/terms of reference, statutory authority and has met within the last three months.
- A multi-sectoral nationally agreed action plan for OVCs developed by a broad group of stakeholders. It includes estimates of cost, specifies sources of funding, prioritizes interventions, has been adopted by government and provides clear guidance to all ministries and departments involved as well as to non-government stakeholders.
- An effective special policy for OVCs, developed by a broad group of

stakeholders, adopted by the government and made public. The policy includes at least: educational, health, nutritional and psychosocial support for OVCs and is linked to broader policies on HIV and AIDS.

- A review of existing legislation and effective special laws to protect OVCs, which have been enacted and implemented with adequate resources to fully enforce these laws.
- A national monitoring and evaluation system implemented and coordinated by one mandated organization. Interventions by government and non-governmental organizations are both monitored and evaluated. Findings are made public, used in policy formulation and include at least estimates of the number of OVCs, indicators of vulnerability, number of OVCs reached, and the cost of interventions.
- A response that is adequately financially resourced as the government is actively soliciting funds from the international community, providing funds to NGOs, assisting NGOs in their fundraising efforts, and expenditure is made in terms of an overall national policy or plan.

The comparative analysis of the OPPEI results conducted in 2004 and 2007 is summarized in the following table.

Table 4.1.

OPPEI in Mozambique and Guinea-Bissau - 2004/2007 (UNICEF, 2008, pp. 28-29)

OVC Policy and Planning Effort Index (OPPEI)	Mozambique		Guinea-Bissau	
	2004	2007	2004	2007
National situation analysis	53	86	20	33
Consultative process	49	60	55	63
Coordination mechanism	64	75	10	80

OVC Policy and Planning Effort Index (OPPEI)	Mozambique		Guinea-Bissau	
National action plans	59	77	23	50
Policy	4	55	33	25
Legislative review	10	72	0	30
Monitoring and evaluation	43	40	2	47
Resource mobilisation	48	60	68	48
OPPEI Total Score	41	65	26	47

In Table 4.2, the efforts made by the two governments in the different areas related to supporting orphans and vulnerable children as defined in Box 4.1. were measured out of a possible score of 100. General improvement in the scores between 2004 and 2007 can be observed in both countries, with Mozambique scoring higher than Guinea-Bissau in almost all areas except for consultative process, coordination mechanism, and monitoring and evaluation in 2007. When looking at these scores in light of the OVC situations of these countries, the impact of policy and planning on the actual targeted children is depicted in the graphic below:

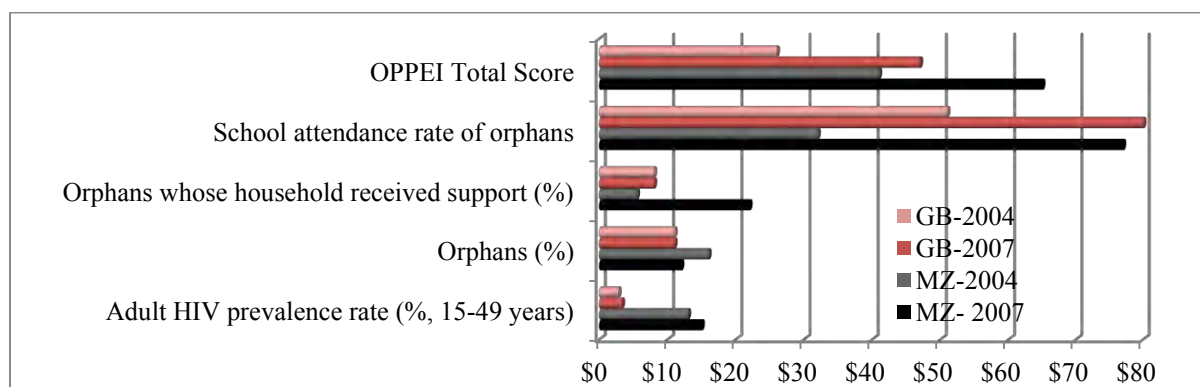


Figure 4.5. OVC situation and OPPEI in Mozambique and Guinea-Bissau - 2004/2007

Sources: Based on data from UNICEF, 2008, and UNICEF/UNAIDS/WHO/UNFPA, 2009

This quick analysis demonstrates how OVC policy and planning has improved between 2004 and 2007 in each country, as indicated in improvement in the OPPEI total score. In Mozambique, this might have contributed to four times more households with orphans and vulnerable children receiving support by 2007 than in 2004. As for Guinea-Bissau, whose progress in the policy arena has been relatively less, the proportion of households with orphans and vulnerable children receiving support remained stagnant, although there has been an improvement in the school attendance of orphans between 2004 and 2007. When analysed in the light of the staging model of social protection discussed in Chapter 2 (Figure 2.2) that brought together the ideas from Taylor (2008), Guhan (1994), Devereux and Sabates-Wheeler (2004), Mozambique can be placed on the transition from protective to preventive, whereas Guinea-Bissau still stands at the stage of protective, or even still in the process of getting there.

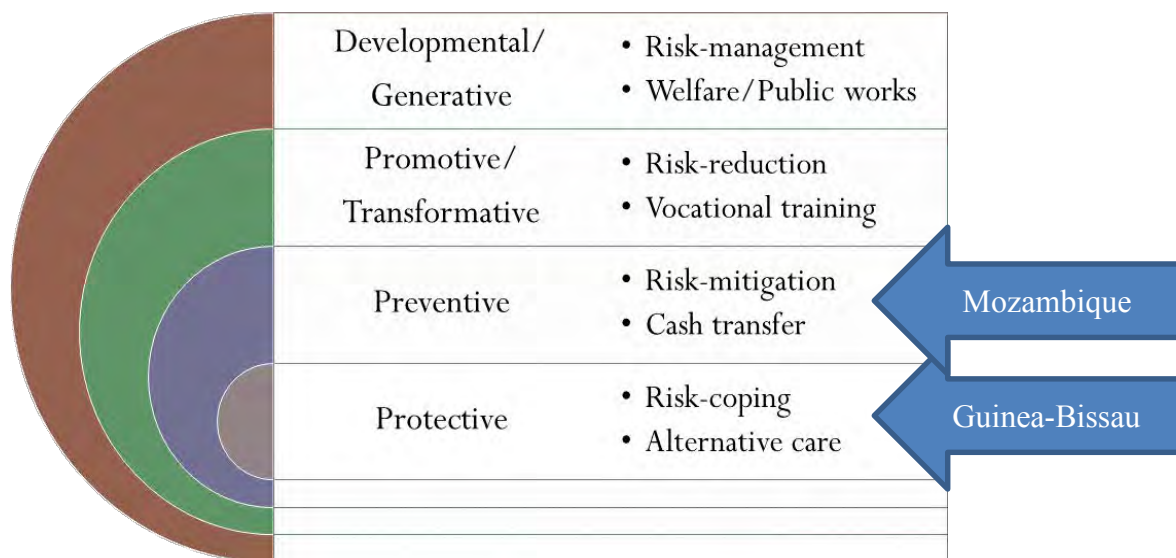


Figure 4.6. Stages of social protection

Source: Based on the ideas from Taylor (2008), Guhan (1994), Devereux and Sabates-Wheeler (2004)

4.6 Conclusion

In this chapter, the common historical background shared by Mozambique and Guinea-Bissau – the two countries studied for this case study – are presented and compared. Understanding the context of colonialism and civil conflict makes it easier to understand the socio-economic indicators of each country, which were presented and compared. Although the two countries stand at similar ranking in terms of the Human Development Index, the political stability and engagement observed in Mozambique since independence have translated into notable progress in terms of policy environment for OVC support. As a result, its current social protection policy level could be considered in the ‘preventive’ stage in the combined model of social protection presented in Chapter 2. In contrast, the recurrent political instability of Guinea-Bissau has caused a virtual standstill in the development of policies for OVC support. Guinea-Bissau therefore still stands in the ‘protective’ stage in terms of social protection policy. How do these policy differences manifest in the actual support that reaches orphans and vulnerable children in these two countries? Have the policies in Mozambique made a difference for the target children? What do the lack of sufficient policies in Guinea-Bissau mean for orphans and vulnerable children there? These questions will be answered in the next chapter, which presents the findings of the field research in the two countries.

Chapter 5

Analysis of current alternative care programmes for orphans and vulnerable children in Mozambique and Guinea-Bissau

This chapter presents the results of the analysis of the field research conducted in Mozambique and Guinea-Bissau of 122 orphans and vulnerable children between ages 10 and 17. Table 5.1. presents the descriptive statistics of the main profile of the interviewed children by country. This chapter first presents the findings by country, mainly using descriptive statistics. It then conducts a comparative analysis of the findings from the two countries using correlation, cluster and regression analysis.

Table 5.1. Descriptive statistics disaggregated by country

		Mozambique	Guinea-Bissau
		Frequency	Frequency
Sex	Male	41	25
	Female	33	23
Age group (years)	10-13	42	33
	14-17	32	15
Type of care	Family/ Day care	24	14
	Residential	50	34
	No care	1	0
Care provider	Community	11	10
	NGO	34	20
	Private	0	7
	Public	10	0
	Religious	20	11

		Mozambique	Guinea-Bissau
		Frequency	Frequency
Grade*	0-4	13	28
	5-10	61	20
Area	Urban	33	21
	Peri-Urban	21	7
	Rural	21	20

* Value “0” indicates that the child was not attending school at the time of interview.

5.1 Findings from Mozambique

The field research in Mozambique was conducted between November 2010 and January 2011. It was carried out by visiting seven centres that provide support to orphans and vulnerable children in seven different provinces (Figure 5.1.). A total of seventy-five children between ages 10 and 17 – at least ten children from each centre, were interviewed. Forty-five percent of those interviewed were girls and fifty-five percent were boys. A brief check of their physical situation was also taken, and an interview with one to three caregivers in each of the seven centres was conducted. The seven visited centres had different types of management and provided various forms of support to orphaned children, as summarized in Table 5.2. below.

In this section, the situation of the seventy-five interviewed children is analysed, including information about their family background, their psycho-physical situation, their socio-developmental situation, and their psycho-social situation. It will then look at the level of support received by the seven centres where these children resided.



Figure 5.1. Map of the seven selected centres in Mozambique

Source: Nations Online Project, 2016.

Table 5.2. Profile of the seven selected centres in Mozambique

Sites	Gatembe	Beira	Chimoio	Chinde	Chokwe	Boane	Nampula
Types of care	Resident, family-type	Resident	Day-care, skills training	Resident,	Day-care, skills training	Resident, skills training	Resident,
Management	NGO	Religious group	NGO	Community	NGO	Religious group	Government
Total number of children	47 (24 boys, 23 girls)	50 (38 boys, 12 girls)	50 (All girls)	50 (26 boys, 24 girls)	40 (20 boys, 20 girls)	152 (All boys)	35 (27 boys, 8 girls)

5.1.1 Mozambique: Children's profile

Out of the seventy-five total interviewed children in the seven centres, half had one or both parents still alive, while the other half had lost both parents. As can be seen in Figure 5.2, the majority of those with living parents had mothers. Among those who had lost both parents, a quarter of them had no other family members alive, while two-thirds still had at least one grandparent, aunt or uncle, and one-sixth had siblings either with them in the same centre or at another centre.

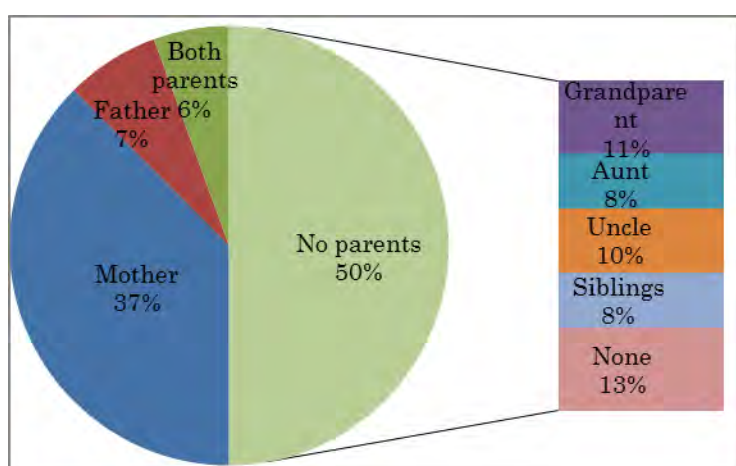


Figure 5.2. Family-situation of the interviewed children in Mozambique

Nevertheless, the family background of the children varied considerably among the seven visited centres. For instance, almost all the children in Chokwe had their mothers or even both parents alive, while almost ninety percent of the children in Beira were double orphans.⁸ Among the children who were interviewed, the majority had at least one parent alive in Nampula, Chokwe, Chimoio and Gatembe, while Boane, Chinde and Beira had more children

⁸ It must be noted that some centres were visited during the weekend or school break, which might have resulted in the children with existing family members being away from the centre visiting them.

who had lost both parents.

5.1.2 Mozambique: Children's psycho-physical situation

There was an observable degree of variation among the physical situations of the interviewed children in the seven centres. The children in Nampula were slightly younger than the other centres on average, probably due to the difference in target population by some other centres. Meanwhile, the measured value of BMI as well as body fat level measured by the Bioelectrical Impedance method (adjusted for sex and age) demonstrated that the children in Chimoio and Chokwe were thinner on average than the children in the other centres (Figure 5.3.). This finding coincided with the fact that the two centres are day-care centres that do not provide food, whereas the other centres are residential and offer meals, although the quantity and frequency of meals varied among those centres. According to a Gatembe district officer of the Provincial Department of Women and Social Action, the state has not been able to provide any significant support with food, especially for family-based care.

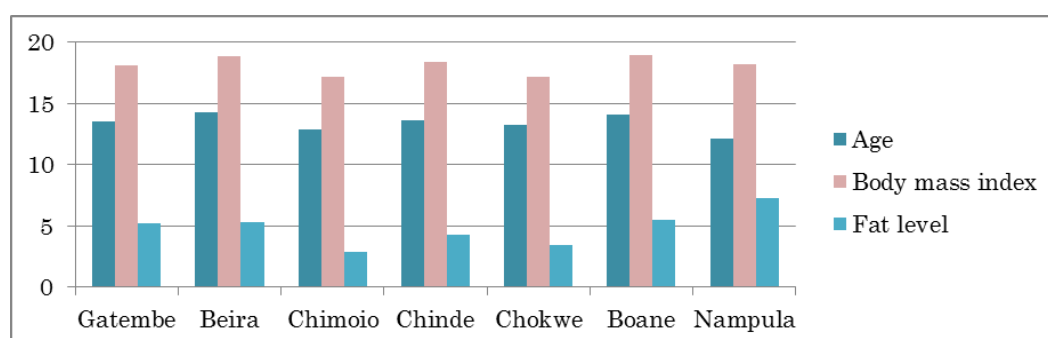


Figure 5.3. Average age, BMI and body fat level of the children in seven centres in Mozambique

When children were asked about the state of their health as well as their food intake, their data showed that the children in the residential centres were generally better off than those in day-care centres, with the exception of Chinde (Figure 5.4. right). Not surprisingly, the eating pattern was proportional to the reported situation of health among these children, which

reflected more health concerns in Chimoio and Chinde than other centres (Figure 5.4. left). Chokwe, on the other hand, showed an inversely proportional tendency. One fourteen-year-old girl in Chimoio confessed: “I feel bad when I have to go to school without eating, and going to bed on an empty stomach.” She said that she lives with her grandfather, who cannot get enough work to earn a living. Some studies indicate that there is a strong correlation between mal-nutrition and shorter adult height, less schooling, reduced economic productivity, and lower offspring birthweight in the case of women (Victora, 2008). This means that the vulnerable children who are undernourished are more likely to go into a negative spiral of further poverty and vulnerability as a consequence of mal-nutrition during childhood.

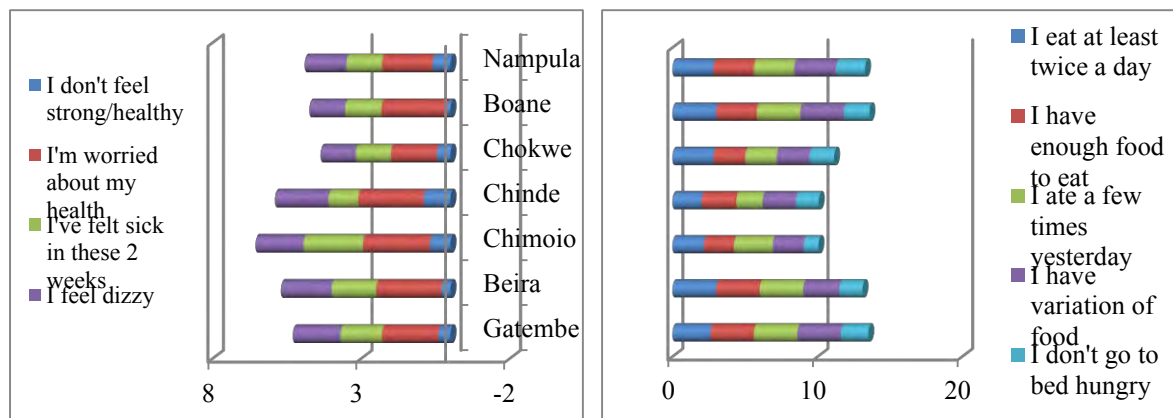


Figure 5.4. Situation of health and food of children in the seven centres in Mozambique

5.1.3 Mozambique: Children’s socio-developmental situation

In terms of education, the children of Beira, Gatembe, Nampula and Boane appeared to have enough materials to study and felt that they were treated well enough at school, as opposed to the children in Chimoio, Chinde, and – to a lesser extent – Chokwe (Figure 5.5). Nevertheless, this tendency is not necessarily in line with the grade level of children. For instance, children in Chinde and Chokwe have on average completed seventh Grade, as opposed to an average completion up to fifth Grade in Gatembe and Nampula. This could also reflect competencies in reading and arithmetic, as can be seen in the discrepancy between a Grade three boys who could

read, write and calculate in Chinde and Chokwe, as opposed to a Grade six boy who could not read, write or calculate sufficiently in Nampula. At the same time, almost all children who were under the care of the seven visited centres were attending school, but some orphans living with families who did not receive support from such centres that were interviewed during this study were not attending school. A double orphan girl in Chinde, for instance, who was being cared for by a pastor in the same community along with her brother, dropped out of school to look after her little brother. In Chokwe three school-aged boys, whose father had passed away, live with their mother only, and were not attending school since they all had eye infections. As they do not attend any support centre, they did not have any access or information to available support services.

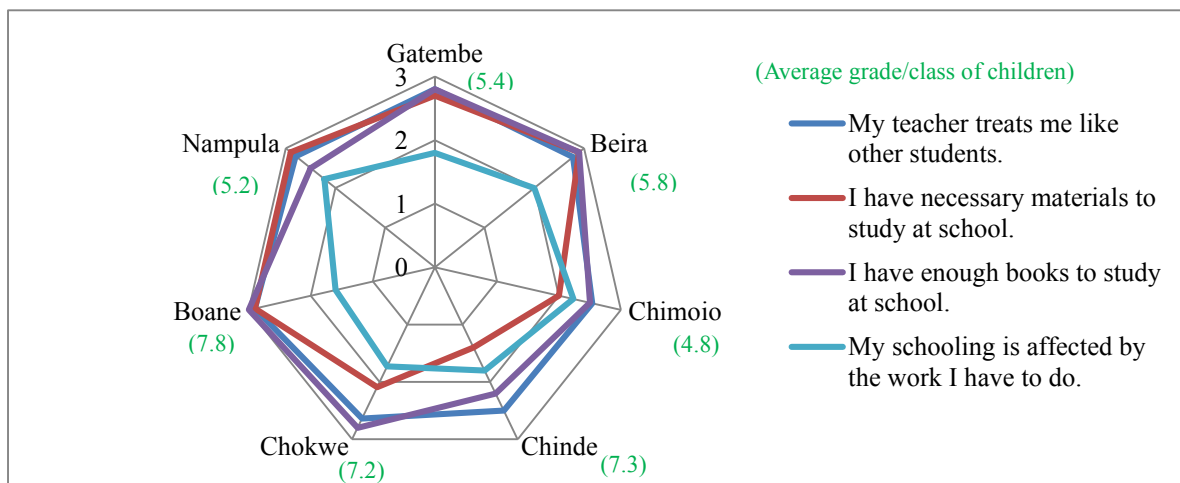


Figure 5.5. Education state of children in the seven centres in Mozambique

With regard to living conditions and sense of security, the centres did not vary significantly, although Chimoio appeared to be an outlier in that respect, as indicated in Figure 5.6. The children participating in the day-care in Chimoio reported feeling unsafe either in their own neighbourhood or at home, with some even confessing episodes of mistreatment by foster families or step parents. About five percent reported instances of violence, including physical or verbal abuse. How did this occur in a household with orphans? One eleven-year-old girl in

Chimoio confessed: “I am afraid of my step-father who comes home drunk and yells at me, because he does not want me in the house.” This testimony confirms the conclusions of some studies presented in Chapter 2 that reported the tendency of abuse and mistreatment of children under kinship foster care (Foster, 2004a; Malinga et al., 2011). Such abusive behaviours could cause trauma and affect the involved children in various negative ways, resulting in them feeling fears and anxieties, having developmental and behavioural regression, experiencing unwanted images and thoughts, losing pleasure in enjoyable activities, withdrawn and constricted, having sleep-related difficulties, suffering from aches and pains, and even going through personality changes (Monahon, 1993). Depending on the frequency, duration and severity of abuse, the degree to which these signs manifest would vary. Moreover, sexual abuse during childhood or adolescence is known to profoundly affect one’s sense of self and feelings about sex itself (Smith, 2011). Frequently identified outcomes of childhood sexual abuse include either a heightened or a diminished sexuality (Smith, 2011). Such situations indicate the need to better prepare foster families about appropriate ways to take care of children before the authorities categorically denouncing residential care and sending orphans to unprepared households.

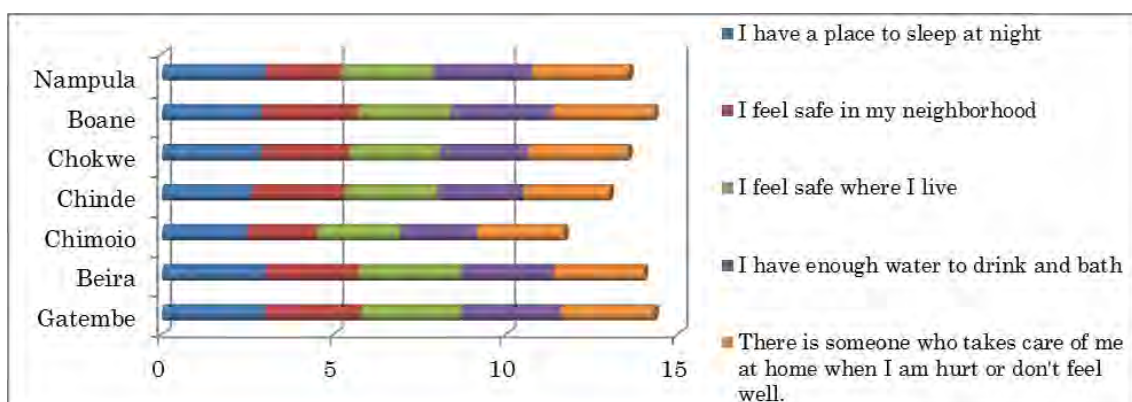


Figure 5.6. Situation of shelter and living environment of the children in the seven centres in Mozambique

An analysis of the poverty and livelihood situation surrounding the children in the seven centres shows a level of poverty rather proportional to that of each district. Rural Chinde, Chokwe and Chimoio tend to have poorer living conditions than those of Beira, Nampula or Gatembe (Figure 5.7).⁹ In the centre in Chinde, twelve boys slept on a crowded floor in one room, and at times there was not enough space for all of them. A widow with four children in Chokwe lived in a mud-brick house consisting of only one room for five people in the household. Many interviewed children in Chimoio said they do not always have enough water to drink or bathe, because their families do not have enough money to pay for water.

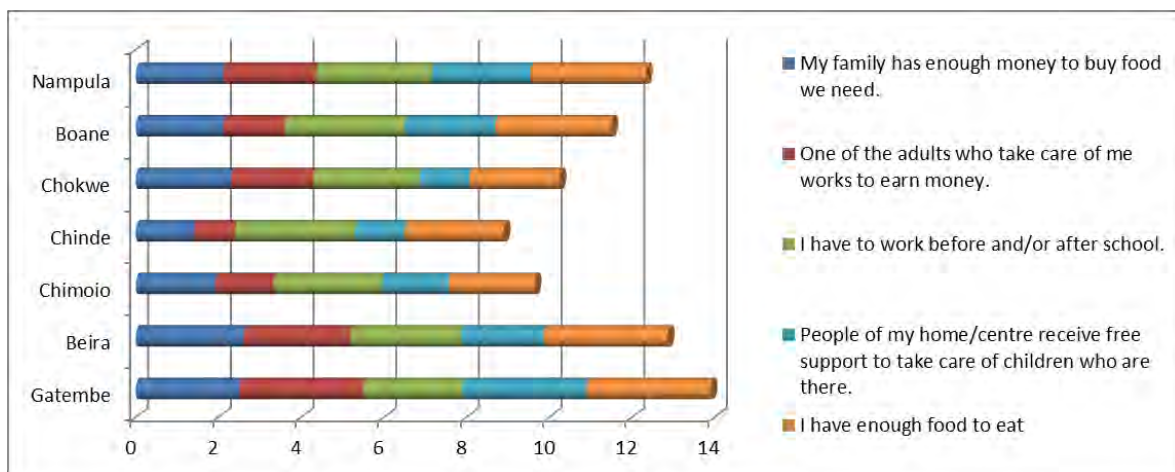


Figure 5.7. Poverty and livelihood situation around children in the seven centres in Mozambique

5.1.4 Mozambique: Children’s psycho-social situation

In terms of the state of social support and integration, a similar trend has been observed among poverty and livelihood, with the children in Gatembe, Beira and Nampula receiving better

⁹ It must be noted that some children, especially double orphans, do not naturally have any point of reference to assess the financial level other than the centres they were living in, making it difficult to assess comparisons between situations.

social support and attaining better social integration than those of the children in Chimoio and Chinde (Figure 5.8. above). Nevertheless, better social support and integration do not always translate directly into a better psychological state for children in the cases of Gatembe and Chokwe, as can be seen in Figure 5.8. below.

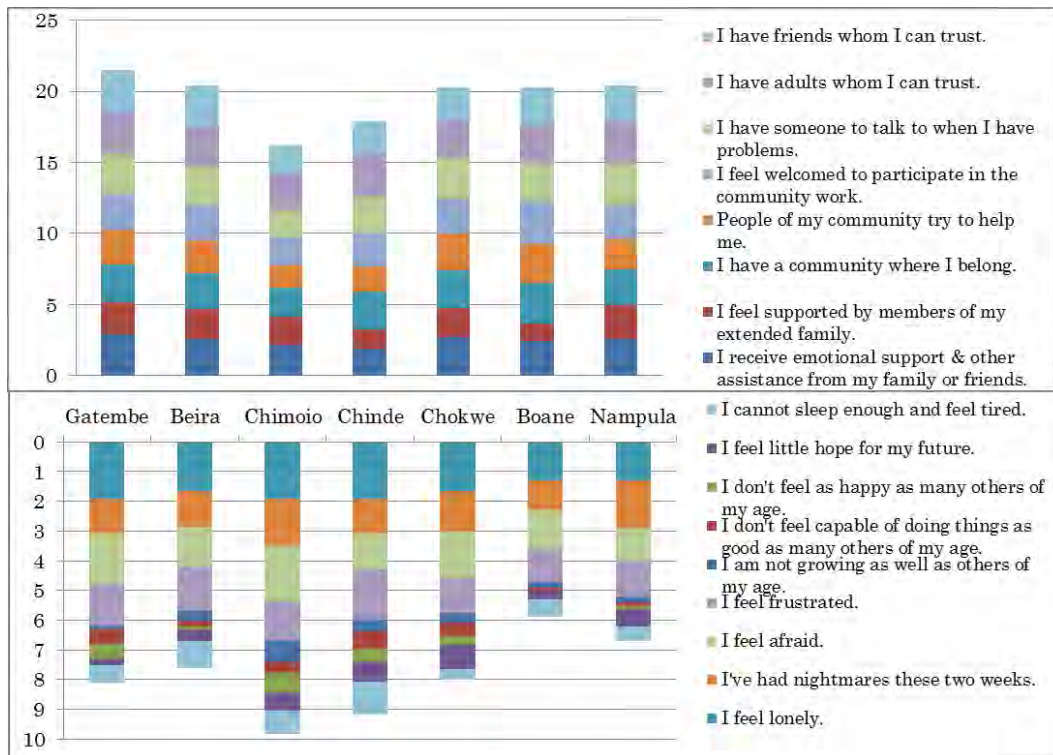


Figure 5.8. Situation of social integration /support vs. psychological state of children in the seven centres in Mozambique

The children of Chimoio and Chinde tend to report more incidents of causing them to experience negative emotions. An eleven-year-old girl in Chimoio who lived alone with her grandmother started to cry during the interview, saying, “I don’t have any hope for the future. I am afraid that my brother (who lives in another place) may die soon and I will be left with nobody.” At the same time, the children of Gatembe who appear to benefit from more social support and integration still reported relatively higher levels of negative feelings compared to the children in Boane, Nampula or Beira. Some children in Gatembe mentioned that their living family members do not visit them, and a twelve-year-old girl confessed that she misses her

family. It was difficult at this point to measure the impact of skills training courses on the psychological motivation of the children conducted in some centres including Beira, Chimoio and Chokwe. Further statistical analysis is needed in this regard.

5.1.5 Mozambique: Level of public support received by the centres

In terms of support from the government received by the seven different centres, almost all of them had received referrals of children from the district authorities or public hospitals. All centres except one had received monitoring visits. Although it had been irregular and rare in some centres, only two had received capacity development training, and only three had received medical or material support, for example. It is noteworthy that five out of seven centres had the children tested for HIV and had been receiving anti-retroviral (ARV) treatments for those living with HIV/AIDS. In terms of education materials, most children said that they received textbooks at school, while other learning materials were sometimes provided by centres or sometimes by the schools themselves.

The public centre in Nampula was certainly the most well-supported of the centres. All of its running costs and other needs had been provided by the state. On the other hand, the other centres all shared similar struggles to obtain funding and support needed to maintain their centres and their services. “The government has become more demanding about setting the standards, without providing any needed support,” complained one of the interviewed centre managers. At the same time, many of the district authorities in the Department of Women and Social Action explained that they do not have a reliable means of transport to conduct monitoring visits to the centres and foster families, and lacked funding to provide the needed support. Among the seven centres, the day-care centre in Chimoio and the community-run residential care centre in Chinde appeared to receive the least support. The common factor in these two cases was that both areas were more difficult to access than all the other locations.

5.2 Findings from Guinea-Bissau

For the second part of the case study, field research was conducted in Guinea-Bissau between November 2011 and January 2012 by. The researcher visited five centres that provided support to orphans and vulnerable children, each located in one of five different regions (Figure 5.9). A total of forty-eight children between ages 10 and 17 – about ten children from each centre, resulting in forty-five percent girls and fifty-five percent boys – were interviewed and were evaluated for physical health status. One to three caregivers in each of the five centres were also interviewed.



Figure 5.9. Map of the five centres in Guinea-Bissau

Source: Nations Online Project, 2016.

The five visited centres had different types of management and provided various forms of support to orphaned children, as summarized in Table 5.3. below.

Table 5.3. Profile of the five selected centres in Guinea-Bissau

Sites	Bissau	Bafata	Tombali	Biombo	Cacheu
Types of care	Residential	Residential & Day-care/school	Residential & Day-care/school	Residential (private home)	Residential, family-type
Management	Christian NGO	Muslim NGO	Individual	Individual	International NGO
Total number of children	150 (70 boys, 80 girls)	22 (17 boys, 5 girls)	303 (131 boys, 172 girls)	20 (11 boys, 9 girls)	18 (50 boys, 58 girls)

5.2.1 Guinea-Bissau: Children’s profile

Out of the forty-eight children interviewed in Guinea-Bissau, two-thirds had one or both parents still alive, while a third of them had lost both parents. As can be seen in Figure 5.10, the majority of those with living parents had fathers, while the others had mothers alive. Among those who had lost both parents, most of them still had at least one grandparent, aunt, uncle or siblings, a small percentage had no family at all.

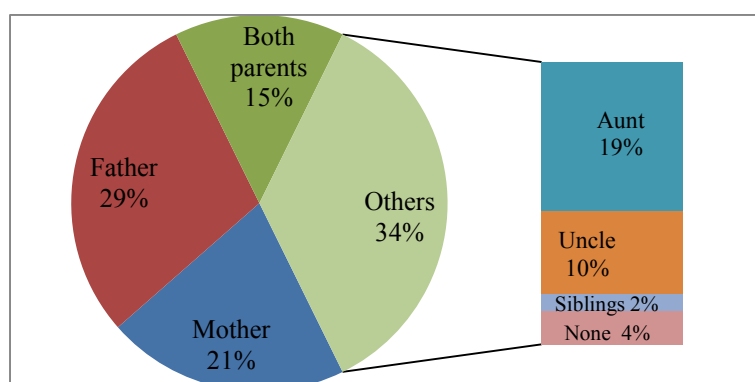


Figure 5.10. Family-situation of the interviewed children in Guinea-Bissau

This trend seemed apparent across the five centres, with a considerable percentage of them

having either one of their parents – or both – still alive. In Biombo and Bissau, many children had fathers alive, while Bafata, Tombali and Cacheu had more children whose mothers were still alive. This difference could result from a greater number of parents in those centres who were still alive, but who are not capable – financially, physically or psychologically – to take care of their own children.

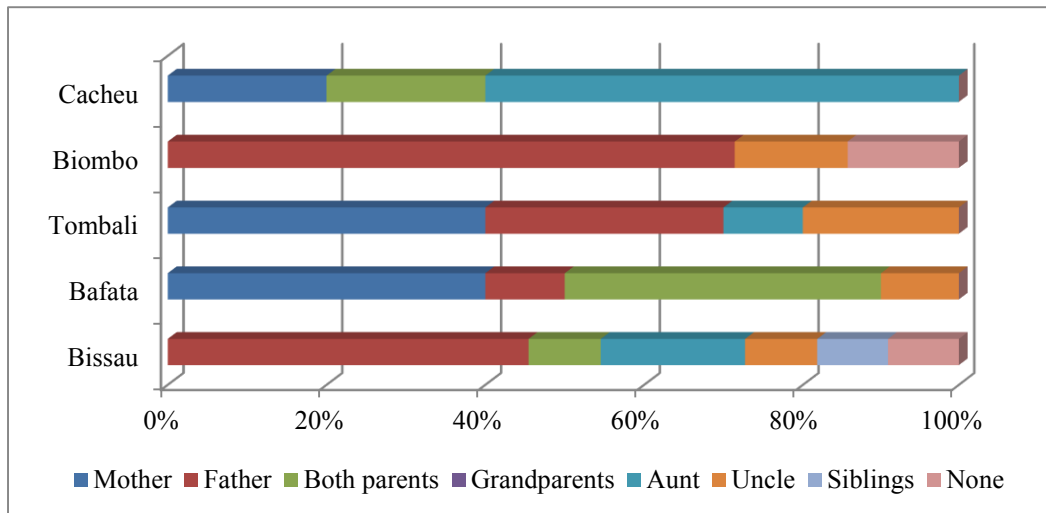


Figure 5.11. Family-situation of children by centre in Guinea-Bissau

5.2.2 Guinea-Bissau: Children’s psycho-physical situation

In terms of the physical situation of the interviewed children, the five centres in Guinea-Bissau did not show marked differences from each other, unlike Mozambique. Only the children of Tombali seemed to be leaner than children in the four other centres (Figure 5.12). This could be explained by the fact that it was the only centre in this study that did not provide food to the day care children. Indeed, six out of ten children interviewed in Tombali had eaten only once or less the previous day; two had not eaten at all. For example, a twelve-year-old girl there who lives with her uncle said, “I could not eat yesterday, because there was no rice left. I always go to bed feeling hungry, and I am always worried about my health.”

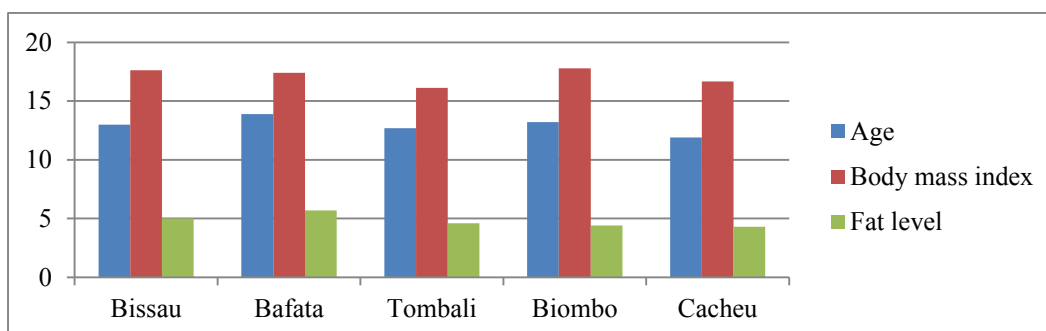


Figure 5.12. Average age, BMI and body fat level of the children in the five centres in Guinea-Bissau

This pattern seemed to be similar for the observed psycho-physical state of the interviewed children, with most centres scoring more or less the same as one another. A slight difference was seen for the children of Tombali, who seemed to be more tired, anxious and nervous than the children of the other centres; this can be seen in Figure 5.13. Again, this could be explained by the fact that they are undernourished in general, compared to the children of the other centres.

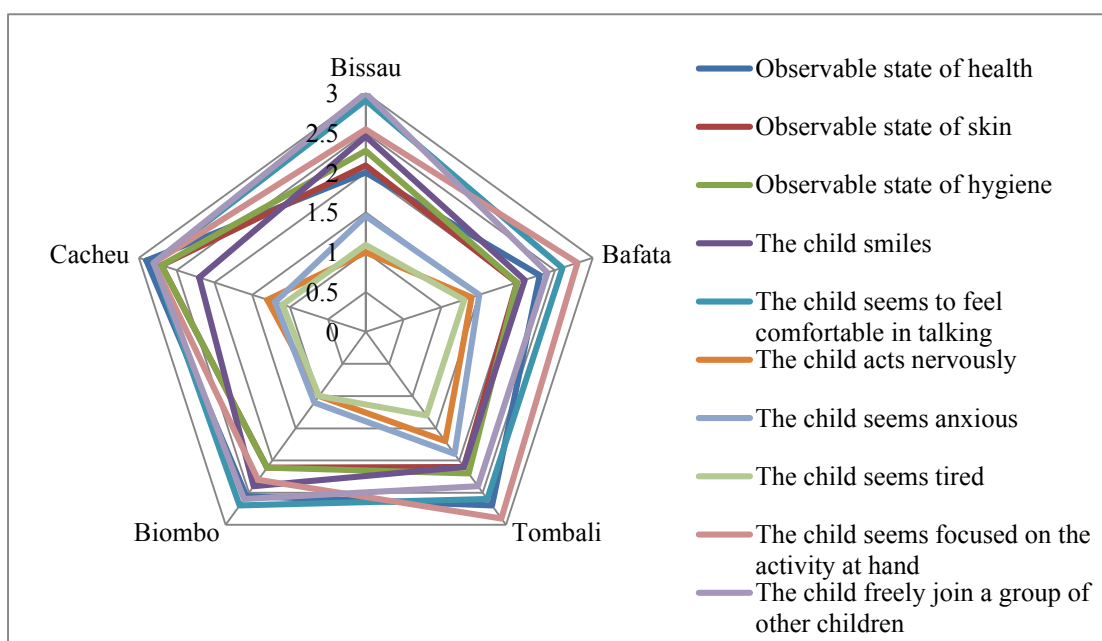


Figure 5.13. Psycho-physical state (observed) of the children in the five centres in Guinea-Bissau

The children’s situations regarding health and food intake also showed a similar trend, with the children of Tombali scoring lower than the others, as can be seen in Figure 5.14. It is noteworthy, however, that the children of the Bissau centre – despite being better fed than all others – reported more feelings of illness than the others. Among the children who live with their extended families and are receiving care from one of the centres in Cacheu, Bafata and Tombali, some were facing hunger. A boy in Cacheu, age twelve, who lived with his uncle’s family confided, “My uncle treats me more like a slave, forcing me to do hard labour and sell in the market. I don’t get to eat regularly or, at times, not at all until the next day. When he receives some food from the centre, the uncle’s children benefit first, and sometimes they even hide the food for their children [away from me].” Another boy in Cacheu, age fourteen, who was also being cared for by his uncle, said that he is not cared for in an equal manner with his uncle’s children. He reported that especially when he gets sick, he may not receive medical care immediately unless his situation gets really bad. These statements support the conclusions of earlier studies that revealed numerous cases of abuse, exploitation and mistreatment in the kinship foster care setting (Jacques, 2003; Foster, 2004a).

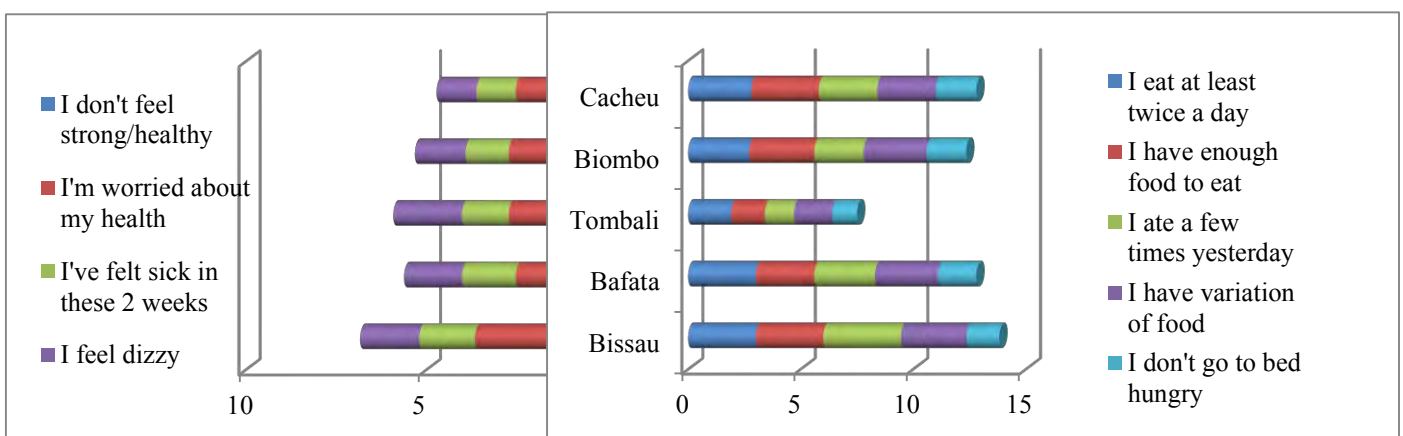


Figure 5.14. Situation of health and food of children in the five centres in Guinea-Bissau

5.2.3 Guinea-Bissau: Children’s socio-developmental situation

In terms of education, the children of Bissau, Bafata and Tombali were generally lagging behind, compared to Biombo and Cacheu, and more importantly, far behind most of the interviewed children in Mozambique. The average grade attained in Guinea-Bissau was 4.4 years, while that in Mozambique was 6.3 years. This shows a deficit in the Bissau-Guinean education system in general, where only forty-five percent of children have access to schools that have grades five and six. Within Guinea-Bissau, the children in Tombali seemed to be facing more difficulty in obtaining the necessary learning materials, as can be seen in Figure 5.15. Some children reported that what worries them the most was not having school materials to be able to study, like pens and notebooks. In the centre in Bafata, which serves also as the local *madrassa*, six out of ten interviewed children could not read at all, or read only with difficulty.

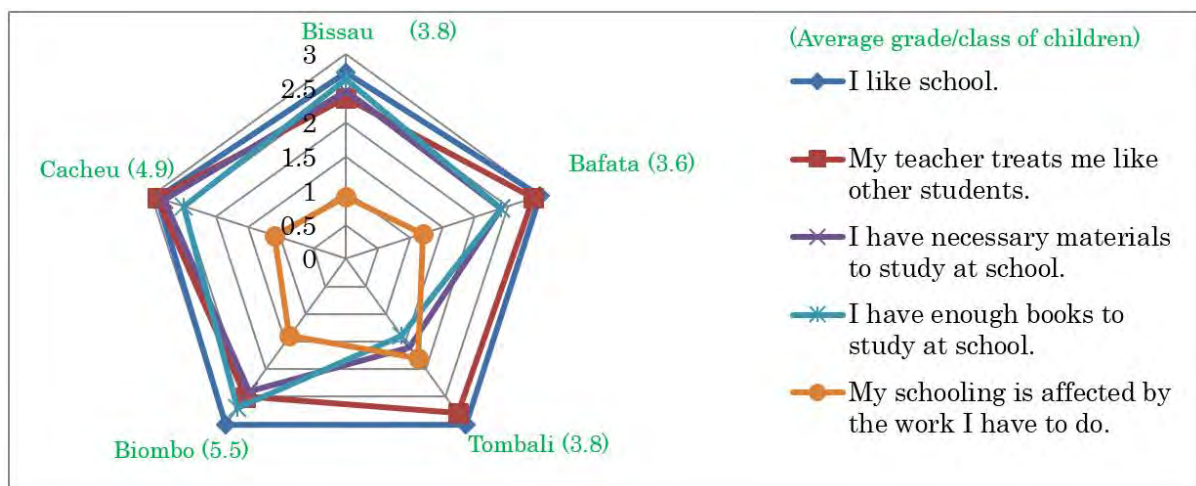


Figure 5.15. Education state of children in the five centres in Guinea-Bissau

In terms of living conditions, the children of Tombali once again scored lower than the others, with significantly lower percentages of children having access to water than the other centres, as indicated in Figure 5.16. These children, as well as those from Bafata, did not seem to feel

safe where they live. The two centres provided day-care as well, which could explain the variation in living conditions from the other centres. “We never feel safe in my community, because there are robbers. Our chickens were stolen. My step-mother treats her own sons better than me. I only feel safe when my father comes home,” said a fourteen-year-old boy in Tombali, who had lost his mother.

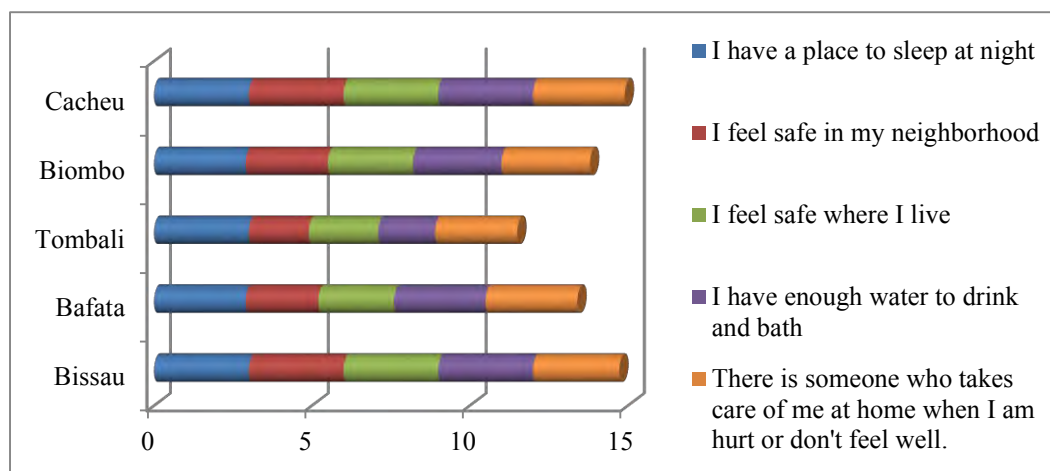


Figure 5.16. Situation of shelter and living environments of the children in the five centres in Guinea-Bissau

The poverty and livelihood situations surrounding the children in the five centres show the same trend as with the other outcome measures. The children in Tombali remarkably showed lower scores in this area than those in other centres. (Figure 5.17). Some children are forced to work, often performing jobs such as selling things on the street, in order to earn money for themselves and/or the family. Children in Bissau, when referring to their biological families, seemed to be in relatively worse situations than the children of Bafata, Biombo or Cacheu. This could be due to the fact that many children of the Bissau centre are mother-orphans, whose fathers are still alive but have difficulty finding employment to earn a living—especially in the urban-setting where there is no land to cultivate, unlike the rural areas.

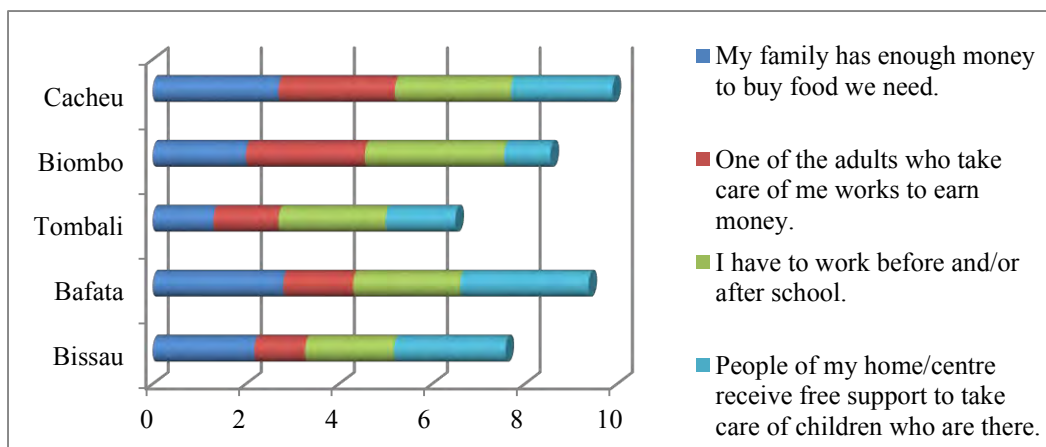


Figure 5.17. Poverty and livelihood situation around children in the five centres in Guinea-Bissau

5.2.4 Guinea-Bissau: Children’s psycho-social situation

As for the state of social support and integration, the children of Tombali and Bafata – who received day-care – reported negative feelings, as shown in Figure 5.18. A twelve-year-old girl in Tombali, who is a father-orphan and lives with her mother and sister, reported that they manage to eat only once a day. She cried throughout the interview, saying that she missed her father. On the other hand, Cacheu seems to have provided more social support in its family-type residential setting, resulting in better psycho-social states in the children there, compared to those within the centre. However, those who were in the family-based care setting seemed to be doing worse, despite the support that their foster relatives were receiving on their behalf. This was apparently as a result of mistreatment or unequal treatment by their relatives. Interestingly, the children of Biombo, despite receiving similarly little social support, did not seem to be as unhappy as the children of Tombali or the three other centres. “Our mother [of the centre] always stands by us and takes care of us. I am happy that I have been raised here,” said a fourteen-year-old girl with a big smile. She had lost both parents when she was a baby and had been brought up in this centre since then. Many children did however express concern over the lack of support from their extended families, in case they had.

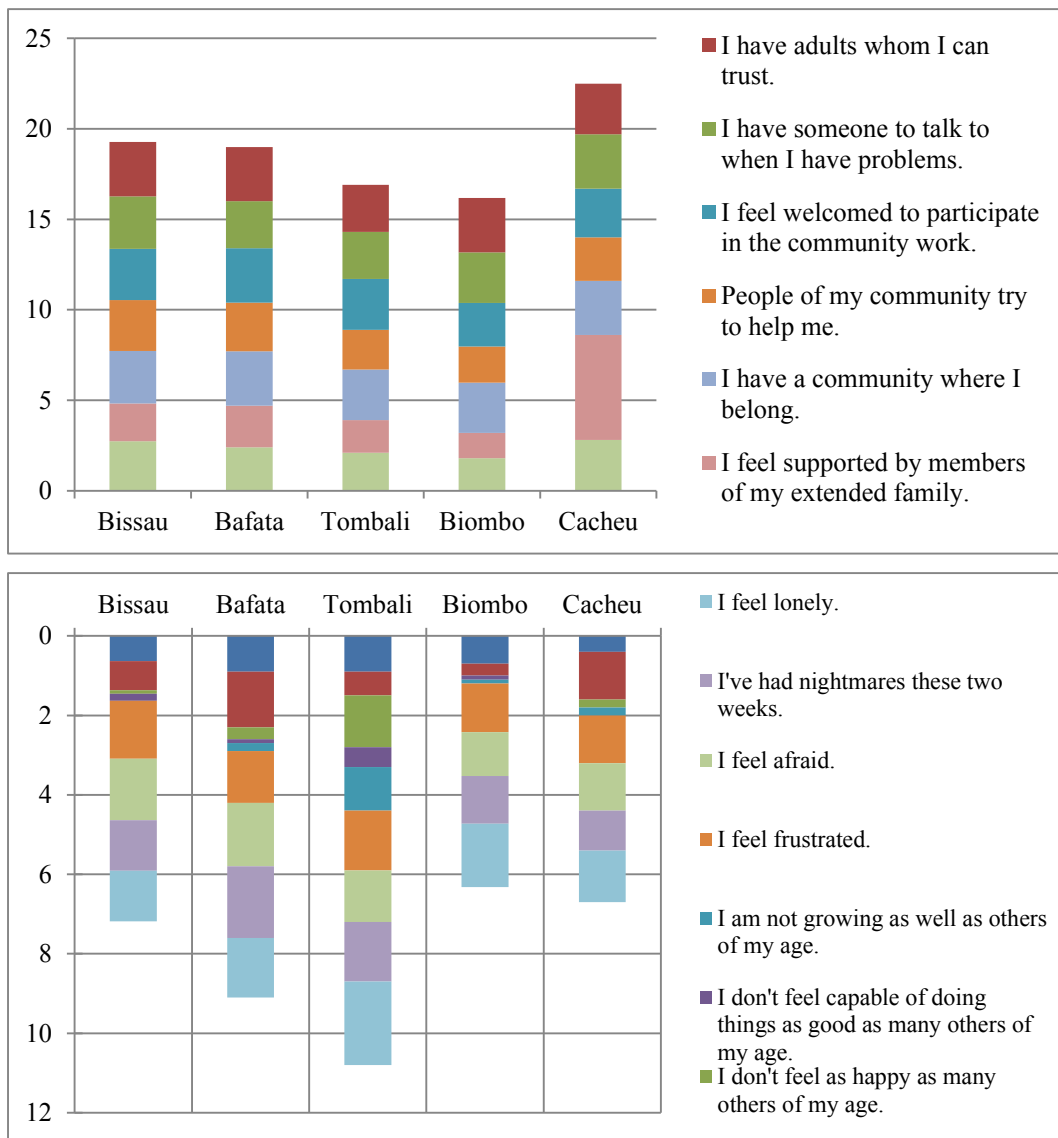


Figure 5.18. Situation of social integration and support versus psychological state of children in the five centres in Guinea-Bissau

5.2.5 Guinea-Bissau: Level of public support received by the centres

Unlike Mozambique, only three centres in Guinea-Bissau had a referral system through which children in need of support were brought by the local authorities or the public hospitals to the centres. The other centres were receiving children directly from the extended families or community members of the deceased parents. Only three centres had received monitoring visits from the Ministry of Social Affairs, of which one centre had been visited only once ever since

it had been founded over eleven years before, while the two other centres were visited at best once a year, if at all. The centre in Bafata had only once received training via monitoring of their activities from the Ministry.

Many of the centres had not received any support from the government, and many of them reported that they had to fight for other sources of support in order to ensure the basic functioning of their centres. One example is the centre in Biombo, which could more accurately be described as a private home of a generous woman who had been taking care of twenty orphans, brought to her by community members and others, since 1985. She said, “The only source of income to care for the kids is my salary as a teacher, which is XOF 60,000 (approximately USD 120) per month. We have not received any support or guidance from the government, so we have not registered either.” This example shows that there is a lack of support not only in the system of monitoring, but also in the advisory and information system for the existing alternative care providers.

5.3 Comparative analysis between Mozambique and Guinea-Bissau

The patterns of descriptions of the two countries show distinctive differences. First, in terms of demography of the children receiving support from the different care centres, there were more boys than girls (41 to 33) in Mozambique, whereas there were about the same number of boys and girls (25 to 23) in Guinea-Bissau. This may have been due to better organization in the Mozambican centres, which allowed some of them to limit their centres to accept only boys or only girls. The Bissau-Guinean centres accepted children of both sexes.

On the other hand, fifty percent of Mozambican children were double orphans, compared to thirty-four percent of those studied in Guinea-Bissau. The incidence of maternal orphans was also much higher in Guinea-Bissau than in Mozambique, as only twenty-one percent of the Bissau-Guinean children studied had their mothers alive, while thirty-seven percent of Mozambican children

studied had their mothers alive. On the other hand, more paternal orphans were seen in the centres studied in Mozambique; only seven percent of the Mozambican children studied had their fathers alive, compared to twenty-nine percent of the Bissau-Guinean children studied.

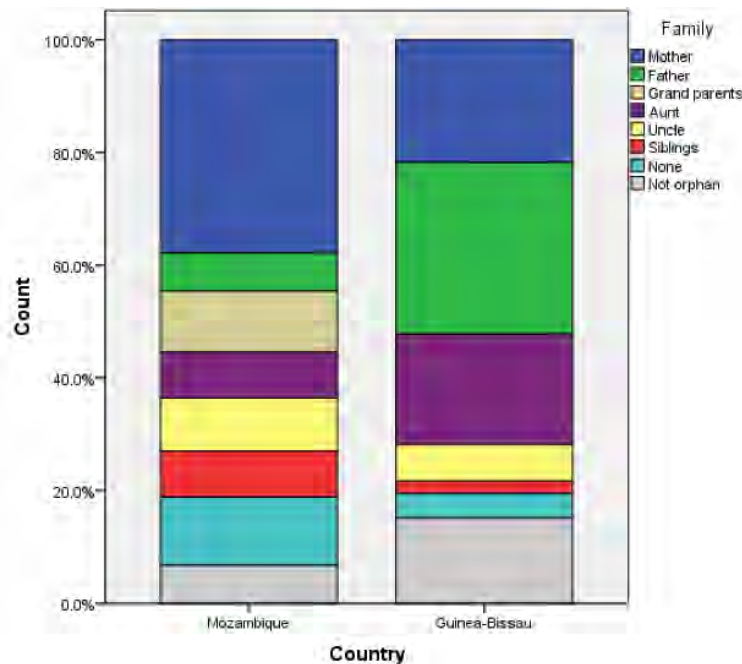


Figure 5.19. Comparison of family situation of the interviewed children in Mozambique and Guinea-Bissau

Comparing the demographic pyramids of the two countries as in Figure 5.20, there appeared to be a significant pattern of difference in the proportional trend of women in the 25-29 and the 30-34 age groups. In Mozambique, the women between 25 to 29 years old are proportionately lower than in Guinea-Bissau, whereas the trend was reversed among the women aged 30 to 34. One possible explanation is the highest HIV infection rate in Mozambique is among the women aged 25-29, which stood at 16.8 percent in 2009, compared to the average for women of all age groups at 13.1 percent (MISAU/INS, 2010). At the same time, the maternal mortality ratio is much higher in Guinea-Bissau than in Mozambique (790 per 100,000 live births compared to 490 per 100,000 live births respectively), which could explain the decrease in the proportion of Bissau-Guinean women beyond 30 years old. This may be one of the reasons for the higher proportion of maternal orphans

among the children interviewed in Guinea-Bissau than those in Mozambique. On the other hand, the men between 25 to 29 years old are proportionately lower in Mozambique than in Guinea-Bissau, which could be one of the reasons for higher rate of paternal-orphans in Mozambique.

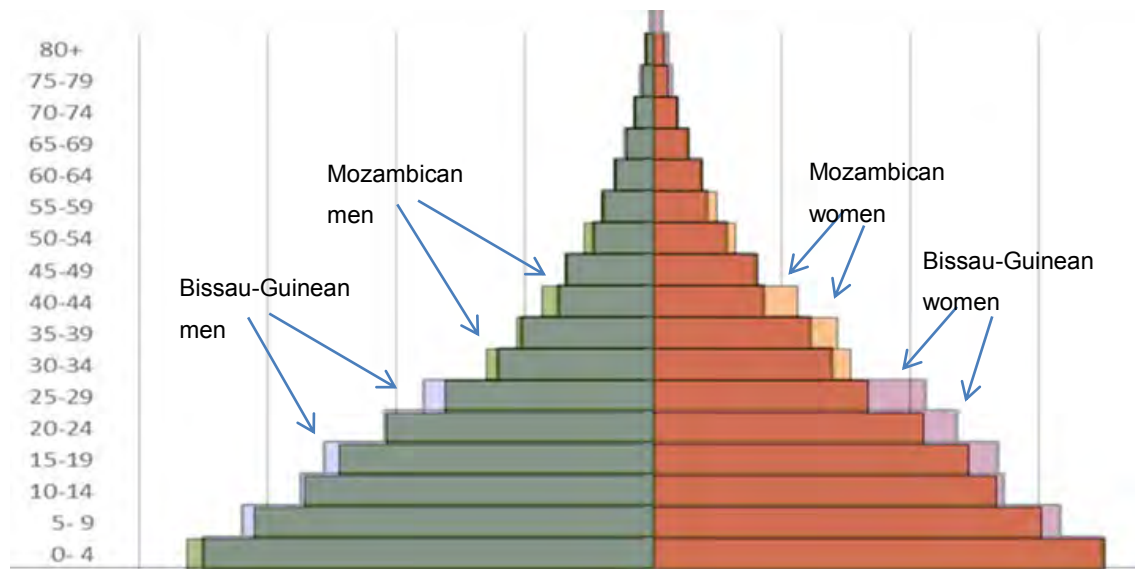


Figure 5.20. Juxtaposition of the demographic pyramids of Mozambique and Guinea-Bissau

Sources: Based on the population data obtained from National Institute of Statistics (INE) in Mozambique (2010) and in Guinea-Bissau (2009)

Among the double orphans, one fifth of them in Mozambique were living with their grandparents, whereas no Bissau-Guinean orphans were cared for by their grandparents. This is despite slightly shorter life expectancy in Mozambique compared to Guinea-Bissau, with 50.3 years and 54.3 years respectively (UNDP, 2014). The juxtaposition of the demographic pyramids nevertheless shows a higher proportion among women and men in the age groups of 40-44 years old and 50-54 years old in Mozambique than Guinea-Bissau,

The research also shows that fifteen percent of Bissau-Guinean children in the OVC support centres actually had both parents still alive, but their parents were not able to care for them. In Mozambique, only six percent of interviewed children had both parents alive. This could imply that the Mozambican centres have a better system of screening and targeting. It could also be

an indication of fragmentation of the family in Guinea-Bissau where households are split over different sites as a survival strategy, which is one of the characteristics of poverty defined by the Committee of Inquiry in a Comprehensive System of Social Security for South Africa in its 2002 report (CICSSSSA, 2002). This finding is an example of ‘unaccompanied children’ defined by UNHCR, whose parents have entrusted them to an alternative care to ensure adequate provision of food and shelter, as discussed in Chapter 2 (UNHCR, 1994).

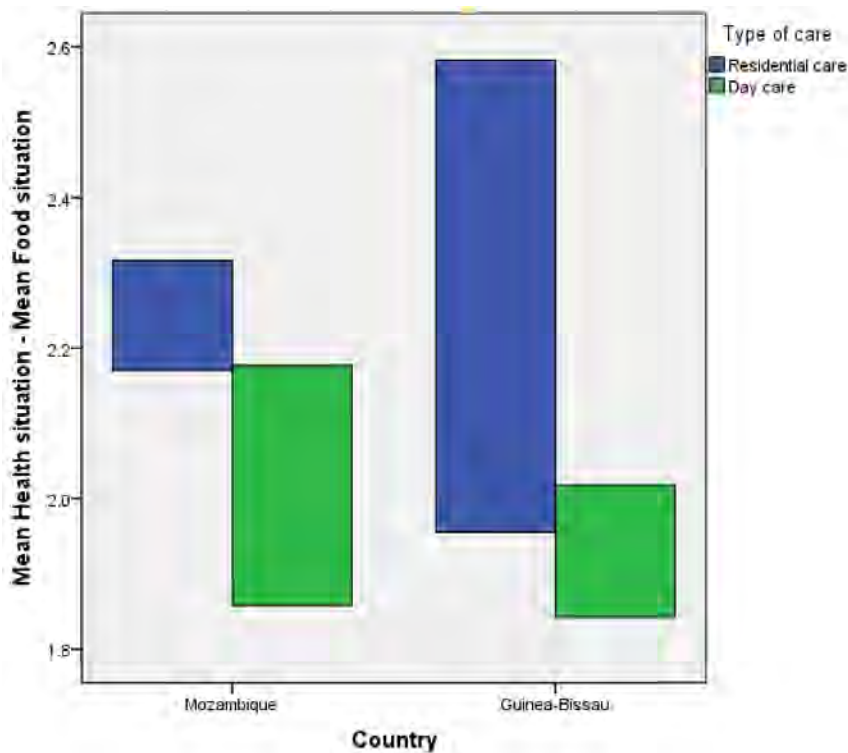


Figure 5.21. Comparison of health situation in relation to type of care in the visited centres in Mozambique and Guinea-Bissau

The physical status of children varied among the centres that had both boys and girls in Mozambique, with a difference of 1.68 points in BMI between Beira and Chokwe, which was similar to the 1.67-point difference between Biombo and Tombali in Guinea-Bissau. Nevertheless, children were generally thinner in the centres studied in Guinea-Bissau, with average BMI at 17.0 compared to 18.1 in the centres studied in Mozambique. Both countries showed the expected connections between food situations and self-reported state of health; the

children in day-cares that did not necessarily provide food reported more cases of physical weakness than those in the centres that offered both food and boarding. This finding should be analysed in light of the theory by Engle, Castle and Menon (1996) discussed in Chapter 2.1.2, who raised nutrition as one of the risks that have significant impact on the psycho-social development of a child.

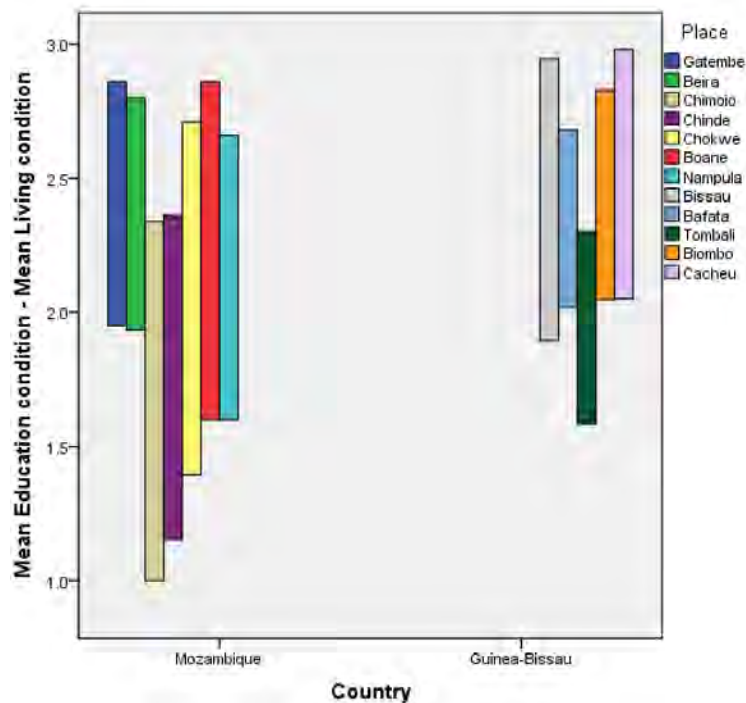


Figure 5.22. Comparison of health situation in relation to type of care in the visited centres in Mozambique and Guinea-Bissau

On the contrary, there was a remarkable difference when it came to education. Despite the fact that their average ages were not so different, at 13.3 years in Mozambique and 12.9 years in Guinea-Bissau, Mozambican children were already in Grade six on average, as opposed to Grade four in Guinea-Bissau. This could be due to the level of development of the education sector in general in the two countries, where most primary schools in Mozambique were complete with all six grades, whereas only twenty percent of schools in Guinea-Bissau had a complete primary education system (Pole de Dakar, 2012). It should also be noted that Bissau-

Guinean children were three times more likely to have repeated a grade than the children in Mozambique. However, many Bissau-Guinean children had better access to learning materials and textbooks than the Mozambican children, which could be due to the distribution of these items by NGOs and international agencies in Guinea-Bissau.

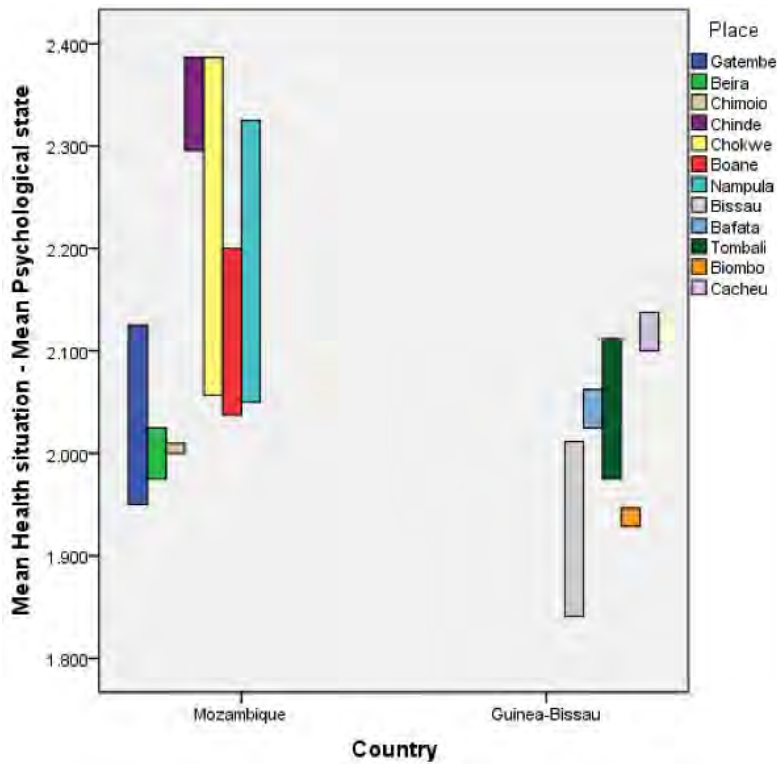


Figure 5.23. Comparison of health and psychological state per visited centre in Mozambique and Guinea-Bissau

The findings of their health and psychological state revealed that the interviewed children of Mozambique generally scored better than those in Guinea-Bissau, including feeling strong and healthy. This could be due to better coverage of health care for children in Mozambique, especially those affected by HIV/AIDS, as a part of its social welfare schemes. Another possible factor is better public and community recognition of such centres in Mozambique than in Guinea-Bissau, accompanied by better training and preparation that the centre staff had received in Mozambique, although this was mostly done by private initiatives instead of organized by the government. Nevertheless, the children who were not boarding, and thus were

living with their extended families or with their half-parents, reported being mistreated by their uncles or their stepfathers both in Mozambique and Guinea-Bissau. In the case of Guinea-Bissau, the support for these children provided through the families they were staying with was actually not reaching them in a few cases.

Although the situations of shelter and living environment were not distinctively different between the studied children of the two countries, the poverty and livelihood situations in Guinea-Bissau were relatively worse, as twenty-seven percent of the interviewed Bissau-Guinean children felt that their centres or the families they were staying with never had the resources to buy enough food, while only nineteen percent of the Mozambican children felt that way. Likewise, thirty-nine percent of the Bissau-Guinean children reported that their centre or home never received any support to take care of children, whereas thirty-two percent of the Mozambican children felt the opposite. This finding is in line with the information provided by the centre managers of the two countries, as presented earlier. At the same time, although Mozambican centres might be receiving slightly more support than the Bissau-Guinean centres, the supports have been provided in an incremental manner and barely sufficient to cover the basic needs of the children in these centres. This means that the social welfare services in Guinea-Bissau have been delivered under the residual approach rather than the institutional approach, confirming the necessity for more comprehensive social protection frameworks, as discussed in Chapter 2.2.4. (Taylor, 2008).

Comparing the outcomes of the two countries against one another according to the type of care (residential or family-based), the data patterns showed that a larger proportion of children in family-based care in both countries had living mothers, compared to those in residential care (Figure 5.24). This means that the father-orphans tended to opt for family-based care than the mother-orphans. At the same time, among those in residential care, there were children with no family members alive in both countries, while all the children in the family-based care had at

least one member of their immediate or extended families still alive in both countries. This shows that the residential care centres have served as the last resort for the double orphans in both countries, as stipulated by the UNCRC (UN, 1989).

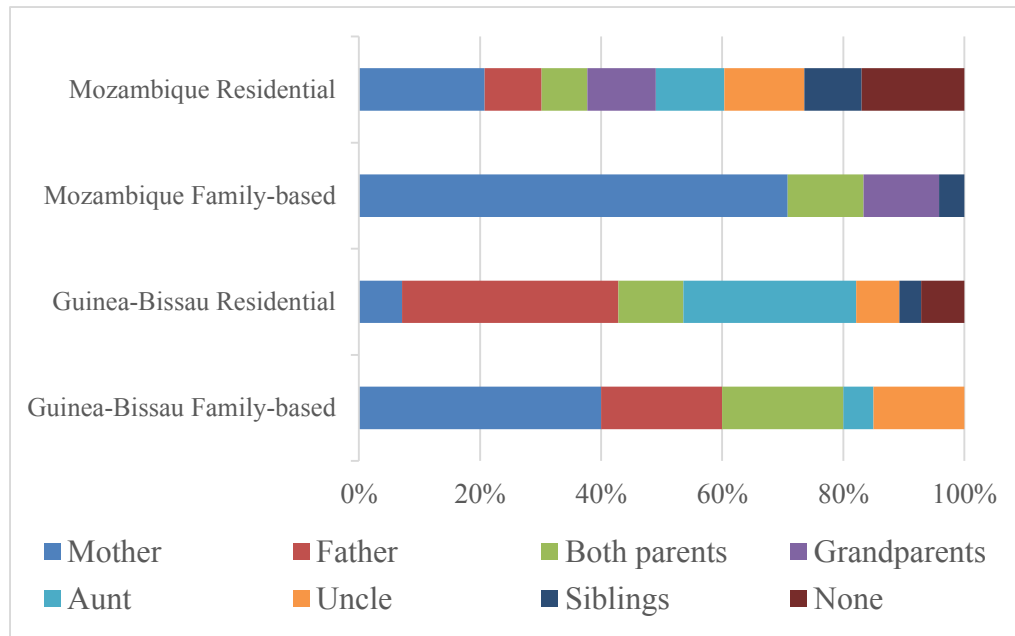


Figure 5.24. Family situation of the interviewed children by the type of care per country

Overall, when the association between the type of care and the overall well-being of children was tested with a one-way analysis of variance according to ANOVA, the Fisher statistic was 23.9 with a p-value <0.01. The results suggests that the average overall well-being for children benefitting from residential care in the two countries was significantly greater than the average overall well-being for children benefitting from family-based day care. This finding is contrary to the results of the earlier studies by Nelson and Smyke (2010) in Romania discussed in Chapter 2.2.5, which showed more negative outcome for the children in residential care (Smyke et al., 2010). This finding rather confirms the results of more recent studies conducted by Whetten (2009) in five developing countries that indicated children in residential care were generally better off than the children in communities in terms of health, emotional and cognitive functioning (Whetten et al., 2009).

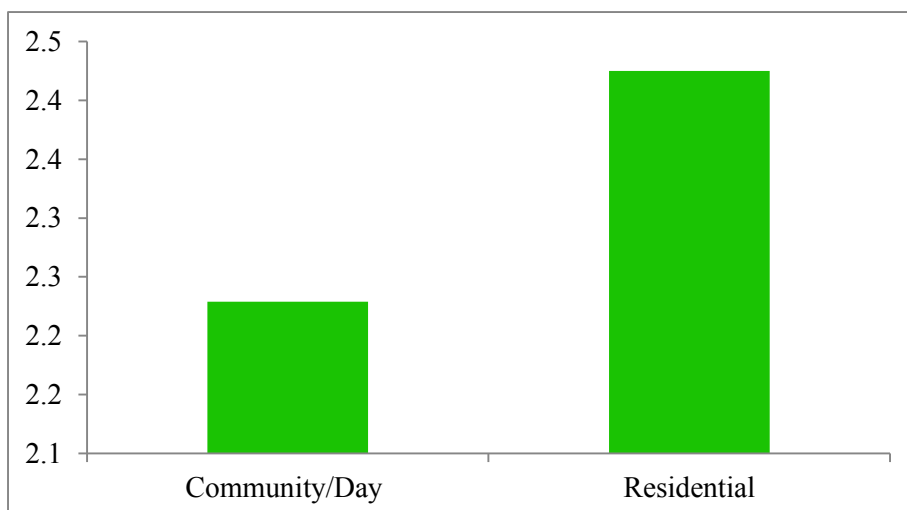


Figure 5.25. Average total well-being by type of care

In particular, the situation of the two family-based care centres in Mozambique (Chokwe and Chimoio) scored lower than the other centres in the country, whereas for Guinea-Bissau, only one family-based care centre (Tombali) did not score well, while the other one (Bafata) had relatively better outcomes. Nevertheless, one outcome – namely the incidence of negative feelings – was relatively worse among the children in family-based care in both countries.

Otherwise, the poorer outcomes in general were more remarkable in two centres in particular, namely the residential care in Chinde in Mozambique, and the family-based care in Tombali in Guinea-Bissau. Both centres are more rural in terms of access, and located in regions where the poverty level is more severe, than other centres in the same country, namely Zambezia in Mozambique and Tombali in Guinea-Bissau. It should also be noted that these two centres, as well as the residential centre in Biombo in Guinea-Bissau, were rather a demand-driven community initiative that has been created and ran in an ad hoc manner by local volunteers, thus did not necessarily fit into a conventionally-known model of residential or family-based care provided by the state or NGOs.

In order to identify the variables that have relatively more impact on the overall well-being of

the children than the others, cluster analysis of the combined data of the two countries was conducted, using the K-means method to build two clusters with twelve well-being indicators, grouped the 122 children into two clusters: Cluster 1 contains children with relatively lower well-being, while Cluster 2 contains children with relatively higher well-being (Figure 5.26).

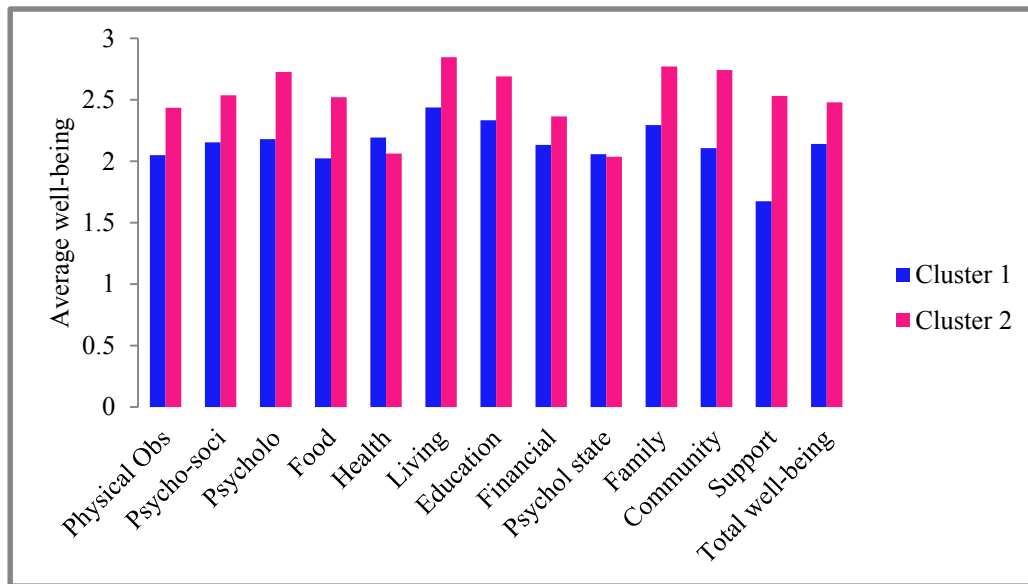


Figure 5.26. Average well-being of the children in each cluster

When the profile of children in each cluster was analysed as in Table 5.4, the characteristics of those with relatively higher well-being include being older children aged 14-17, being in residential care run by religious congregations, and/or attending higher grades in school. These four variables show significant p -value < 0.05 in terms of characterisation of clusters. For example, grade at school affected characterised clusters (p -value < 0.05), with 89% of children in Cluster 2 in Grade 5 or higher, while 50% of children attending Grade 5 or higher were in Cluster 1. Sex does not significantly characterise clusters, given that p -value was greater than 0.05. Sex was identically distributed in the two clusters.

Table 5.4. Descriptive statistics of categorical variables disaggregated by cluster

		Cluster 1	Cluster 2	p-value of Fisher test
	Value	relative frequency (N =70)	relative frequency (N = 48)	
Sex	Male	47.1	60.9	0.18
	Female	52.9	39.1	
Age group (years)	10-13	81.4	34.8	0.00*
	14-17	18.6	65.2	
Type of care	Community/Day	41.4	17.4	0.00*
	Residential	58.6	82.6	
	No care	0.0	0.0	
Care provider	Community	17.1	13.0	0.01*
	NGO	51.4	37.0	
	Private	5.7	6.5	
	Public	11.4	2.2	
	Religious	14.3	41.3	
Grade	0-4	50.0	10.9	0.00*
	5-10	50.0	89.1	
Area	Urban	45.7	41.3	0.89
	Peri-Urban	22.9	26.1	
	Rural	31.4	32.6	
Country	Guinea-Bissau	47.1	28.3	0.05
	Mozambique	52.9	71.7	

* Significant at 0.05 level (Fisher Exact test of independence)

The finding that older children fared relatively better than younger children could be related to differences in developmental stages that Erikson described, as presented in Chapter 2.1.2 (cited in Sigelman et al., 2012). Those who are shifting towards adolescence face a period of identity crisis, thus are more vulnerable than the others. The findings of this research are contrary results to the 2011 study conducted by Wild and her colleagues (2011) that showed older adolescents to be more vulnerable than younger children. On the other hand, the outcome that sex was not a significant factor according to ANOVA should be investigated further, in light of the studies

by Werner (1992) and Luthar (1999) showing the difference in resiliency processes between boys and girls. It could be that they do not differ in the outcome of this study, because girls have learnt to cope with the situation differently than boys did. Therefore, future research is needed to further explore the relations between age, gender and well-being of orphans and vulnerable children.

Further analysis via correlation of the overall well-being in the two countries indicated that the overall well-being of a child was not significantly associated with sex, but it was associated with living conditions, education conditions, social state (including family, friends and community) and support situation, as can be seen in Table 5.5. below. The figure shows Pearson correlation coefficients between well-being indicators. The absolute values of correlation coefficients are less than 0.5, indicating a moderate linear relationship between them. By using *cor* and *rcorr* commands from R to compute correlation matrixes and significance tests, the null hypothesis was tested to see whether each correlation coefficient equals zero. The analysis results were generated with the values marked with one asterisk indicating that the p-value is less than 0.05, while those marked with two asterisks mean that the p-value is less than 0.01, and those without an asterisk mean that the p-value is greater than 0.05. For example, the correlation between physically-observable well-being and educational-financial condition is 0.23. This suggests a moderate and a significant linear relation at a level of 5% ($r \neq 0$). The correlation between physically-observable well-being and community social state is 0.14. This suggests a moderate and a non-significant linear relation at a level of 5% ($r = 0$). In general, the correlation analysis indicates that most of the variables, except for the health situation, affect the overall well-being of a child in an interrelated manner. This outcome supports the call for more comprehensive, holistic and cross-sector approach for social policy, as addressed also by Hall and Midgley (2004).

Table 5.5. Pearson correlation coefficients between well-being indicators

	Physical Observable well-being	Psycho-social Observable well-being	Psychological Observable well-being	Food situation	Health situation	Living condition	Education condition	Financial situation	Psychological state	Family & Friends Social state	Community Social state	Support situation
Physical Observable well-being	1											
Psycho-social Observable well-being	0.29**	1										
Psychological Observable well-being	0.25**	0.24**	1									
Food situation	0.08	0.13	0.46**	1								
Health situation	-0.08	-0.03	-0.1	-0.12	1							
Living condition	0.05	0.19*	0.41**	0.46**	-0.06	1						
Education condition	0.23*	0.29**	0.40**	0.48**	-0.12	0.47**	1					
Financial situation	0.12	-0.04	0.17	0.32**	0.01	0.32**	0.20*	1				
Psychological state	0.06	0	-0.02	-0.17	0.16	0.12	0.02	-0.03	1			
Family & Friends Social state	0.23*	0.36**	0.35**	0.34**	0.06	0.35**	0.35**	0.05	-0.08	1		
Community Social state	0.14	0.30**	0.24**	0.23*	-0.02	0.34**	0.30**	-0.01	0.26**	0.34**	1	
Support situation	0.30**	0.19*	0.20*	0.37**	0.01	0.36**	0.31**	0.19*	-0.01	0.47**	0.33**	1

* Significant at 0.05 level (Pearson correlation coefficient)

** Significant at 0.01 level (Pearson correlation coefficient)

The field findings in terms of the public support received by the alternative care centres visited showed that those in Mozambique had received more support than those in Guinea-Bissau, which was in line with the policy-level analysis results in terms of comparative levels between the two countries (Table 5.6). At the policy-level, a more advanced level of structure and framework in Mozambique may have allowed for better referral and targeting of children in the alternative care centres, compared to Guinea-Bissau, where such government and community frameworks have not been developed yet.

Table 5.6. Public support received by the alternative care providers in Mozambique and Guinea-Bissau

Public support received	Mozambique	Guinea-Bissau
Referral	78.6%	50.0%
Monitoring	64.3%	30.0%
Staff training	21.4%	10.0%
Education support	83.3%	76.7%
Medical support	14.3%	10.0%
ARV	71.4%	20.0%
Average coverage	55.6%	32.8%

Despite such advantages for Mozambique at the policy-level, the overall well-being of Mozambican children was slightly lower than that of Bissau-Guinean children, as indicated in Figure 5.27. In line with the policy-level findings, Mozambican children reported better outcomes in terms of support, financial and health situations. Nevertheless, these outcomes seemed to be outweighed by the higher outcomes of Guinea-Bissau in community- and family-relations, education and living conditions, which positively impacted on psychological and psycho-social states. When linear regression was used to analyse the degree of association between the country of residence and the overall well-being, a 0.032-point decrease was expected in the total well-being for children living in Mozambique, compared to those living in Guinea-Bissau, holding other variables fixed. However, the association was not significant enough ($p\text{ value} > 0.05$). It may be that Bissau-Guinean children are generally more optimistic about life, or that Mozambican children are more demanding than Bissau-Guinean children. This difference could be studied further in future research.

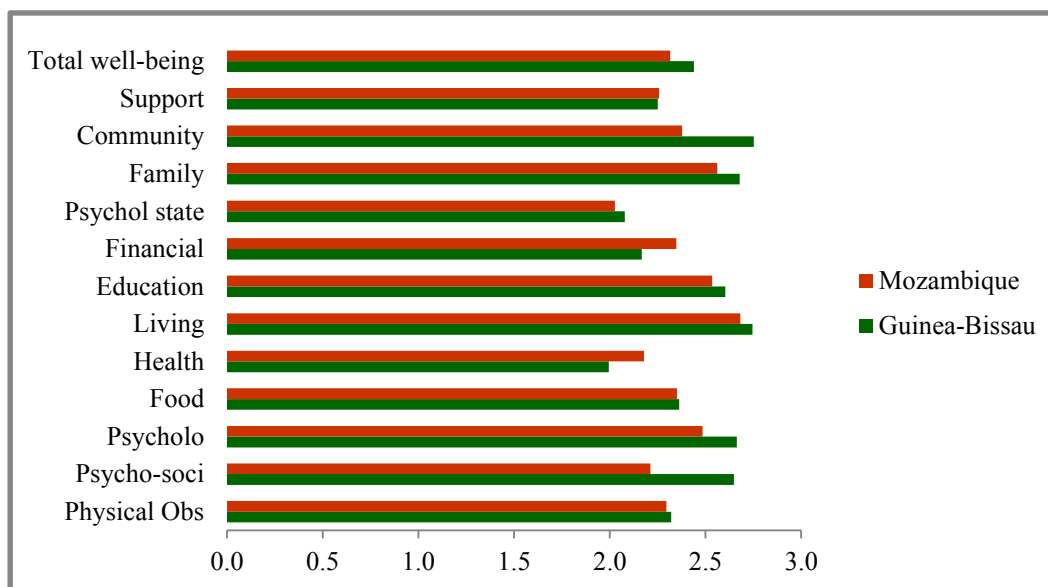


Figure 5.27. Average well-being in each country per variable group

Further analysis of the association between total well-being and other key variables using linear regression showed that each of the four variables is significantly associated with overall well-being (p -value < 0.01), with the multiple R-squared at 0.622. This means that the four variables (education condition, community social state, food situation and health situation) explain 62.2 percent of the overall well-being variability, suggesting a strong linear association between these variables and overall well-being. Equality of coefficients was tested using the Student and Z-tests. The results of this analysis are presented in Table 5.7. below.

Table 5.7.

Results of linear regression with total well-being as dependent variable

Variable	Coefficients	P-value
Education condition	0.134	< 0.01
Community Social state	0.213	< 0.01
Food situation	0.180	< 0.01
Health situation	0.137	< 0.01

The results suggest that community and social states have the most significant impact on overall well-being, at a level of five percent. Food situation is the second most influential factor, followed by health situation and education conditions. The difference in education conditions and health situation is not significant (p -value >0.05). Living conditions were found not to be significantly associated with the overall well-being of a child, compared to the other variables mentioned above. The finding of the correlation between the community and social states with overall well-being also supports the study of Wild and colleagues (2011) in which the psychological well-being of orphaned adolescents was significantly related to the extent to which alternative or surviving caregivers, friends, and/or community adults managed to provide stable experiences to them. The findings from the two studies suggest a positive link between community/social relations and emotional resilience for orphaned adolescents.

5.4 Conclusion

In this chapter, the findings from the field research were presented, first on Mozambique, then on Guinea-Bissau, which was then followed by a cross-country comparison and analysis. The descriptive statistics per country indicated that there were higher percentages of double orphans among the children in the Mozambican alternative care centres than those in Guinea-Bissau. On the other hand, there were higher incidence of maternal orphans among the children studied in Guinea-Bissau than in Mozambique. Among the double orphans, one fifth of them in Mozambique were cared for by their grandparents, whereas none of the orphans of Guinea-Bissau were cared for by their grandparents. Rather, the majority of Bissau-Guinean orphans were presumably supported by their aunts or uncles. The well-being of children varied widely among the centres within each country, indicating general disadvantage at a significant level for those in family-type day care centres, especially among groups aged 10 to 13, and those

attending lower grades in school. Children in the rural areas and girls seemed to be facing more difficulties in quantitative interviews, but the association of these variables with the overall well-being of children was statistically not significant. During the interviews, some children who were cared for by families, often their uncles, aunts or step parents, reported feeling abused or mistreated. Some of them also reported, in the case of foster families, that caregivers were spending the received support on their own children, rather than the orphans and vulnerable children they were supposed to be caring for.

The results of the field research also indicated that the alternative care providers in Mozambique were relatively receiving more public support than those in Guinea-Bissau, but the provided supports were incremental, indicating that both countries have been taking the residual approach of social welfare. The findings also revealed that the overall well-being of children was slightly better in Guinea-Bissau than Mozambique. Nevertheless, the overall well-being of Mozambican children was slightly lower than that of children in Guinea-Bissau, although the association was not significant at $p\text{-value} > 0.05$. The outcome of the correlation analysis showed the interrelation among different variables, except for the health situation. On the other hand, a significant association was found between the overall well-being of children and the social situation in the community, as well as with the food situation, the health situation and the education conditions, in the order mentioned.

Taking these field findings into account, the next two chapters present some policy options that aim to respond better to the basic needs of orphans and vulnerable children in the two countries and draw conclusions to the five research questions presented in Chapter 1.

Chapter 6

Strategic options for supporting orphans and vulnerable children

Taking into account the findings from the literature review and the field research presented in the two previous chapters, this chapter will more closely examine whether the current social protection systems in the two countries respond to the basic needs of orphans and vulnerable children, particularly in terms of policies and legislations, programme design, and financial and institutional capacity. This analysis will be followed by recommendations in terms of strategic options at each level.

From the viewpoint that social protection policies and programmes are intended to address the main causes of risk and vulnerability, both Mozambique and Guinea-Bissau have not yet reached the promotive/transformational stage that encompasses mechanisms to manage risks and reduce vulnerability, as discussed in Chapters 3.3. and 4.5. In this context, orphans and vulnerable children in each of these two countries are subject to multiple layers of vulnerability, risks and deprivations. They not only lack parental support, but also support from the state, as there were no established welfare and safety-net systems in either country at the time of the field research. These orphans and vulnerable children are among the most vulnerable of the vulnerable social sector, and without specific social interventions, they could easily become part of a growing demographic of high-risk population because of extreme poverty and life cycle changes. They are thus among the population group that needs to be prioritised in terms of social protection.

Taking into account the differences between the two cases in the context of country development, including respective demographic characteristics and ranking in the stages of social protection, the two countries may require different approaches to reach a comprehensive social protection system. When the field research was conducted, orphans and vulnerable

children interviewed in the two countries were supported, if at all, by rather sporadic and incremental service provision limited to certain centres and with varying degrees of support without much consistency, creating “a silo-like fragmentation of social protection provision” in these countries (Hodges, et al. 2010, p. 79).

There are nevertheless a few findings that need to be taken into account for both countries. Firstly, in the context of limited government budgets in the two countries, the role of the state in alternative care for orphans and vulnerable children has been limited to a residual one in terms of service provisions. The only public services that were reaching most of the children in the researched sites were the general provisions for education, and, to a lesser degree, health. At the same time, considering that most alternative care is being provided by non-governmental entities such as community, private or international organisations, the regulatory role of the state seemed ever more important to ensure the quality of care and social responsibility of care providers. Mozambique has been attempting to play the regulatory role by establishing service standards to ensure adequate quality of care, while Guinea-Bissau is at the stage of preparing instruments to be able to regulate (UNICEF-Mozambique, 2009; Republic of Guinea-Bissau, 2009b).

Secondly, the field findings indicated that the children’s social relations with the community were highly associated with the overall well-being of the children. This finding reinforced the results of the study referred in Chapter 2 conducted by Wild and her colleagues, which emphasised, “the important role that social support plays in facilitating healthy outcomes in orphaned adolescents” (Wild et al., 2011, p. 156). The findings suggest that policy options, especially in terms of the scope of programme design, should address further strengthening of community integration of these children. To date, however, in both countries, the field research revealed that the focus has so far been limited to provisions of material or financial support and/or essential services.

Thirdly, despite the earlier studies that demonstrated the negative effects of residential care on children's development and well-being, the present research – in line with more recent studies such as those of Whetten's team (2009) – does not show this effect for orphans and vulnerable children in these two developing countries. Instead, the findings from this research indicated better overall well-being for children in residential care than those under family-based care. As noted in the previous chapter, some children under family-based care even reported the experience of mistreatment or abuse by one of their caregivers, often their uncles or stepfathers. It was also observed that the demand-driven initiatives started by the communities or local individuals as a response to the increasing number of orphans and vulnerable children did not necessarily fall under simple 'residential care' or 'family-based care' categorisations, also echoing Whetten's findings. These aspects thus need to be taken into account so that positive support, including residential care, would not be "hindered by blanket policies about institutions" (Whetten, 2009, p. 9). Rather, more nuanced policies should take into account the context of each residential centre, instead of applying measures that categorically disfavour residential care in general. If a residential centre was providing adequate care that contributes to the overall well-being of the children, the offered services of the centre should rather be supported and improved so that it continues to play a role as a temporary home to children until they could reunite with their remaining or adoptive families, if any, or until they become independent.

Fourthly, regardless of the type of care, the socio-economic situations of the zones where the centres were located – as reflected by the socio-economic situation of the centres and the caregivers – affected children's psycho-social well-being. This finding is in line with another study conducted by Escueta and her colleagues that showed the associations between wealth and emotional difficulties among the orphaned and abandoned children in Cambodia, Ethiopia, Kenya, India, and Tanzania, as presented in Chapter 2 (Escueta et al., 2014). It is thus important

to take into account not only the measures to improve the socio-economic situation of the children in the centres, but also of the zones where these centres are based, which would mean promoting more geo-economical equity within the country. While economic and material support alone may not directly improve the overall psycho-social well-being of orphans and vulnerable children, it could improve their outcome in physical well-being. The ways to address the economic equity is further discussed in Section 6.2. on programme design issue.

6.1 Policies and legislation

In the publication titled “Policies for Orphans and Vulnerable Children: A Framework for Moving Ahead”, Smart (2003) suggested a policy package to ensure care and support to orphans and vulnerable children, consisting of the following twelve components: (1) Laws protecting the rights of all children; (2) National HIV/AIDS strategies that include an explicit focus on orphans and vulnerable children; (3) National OVC policy and guidelines; (4) Targeted issues-based advocacy; (5) A multi-sectoral OVC structure; (6) Situation analysis and needs assessment; (7) Regular national OVC consultations; (8) Mechanisms for defining and identifying the most vulnerable children; (9) State support for orphans and vulnerable children (education, food security, etc.); (10) An OVC focus within development and Poverty Reduction Strategic Plans (PRSP) and as a criterion for HIV/AIDS-related funding; (11) An emphasis on education; and (12) Monitoring of policy implementation (Smart, 2003, pp. 14-15).

This section looks at the policy and legislative contexts in Mozambique and Guinea-Bissau in regard concerning orphans and vulnerable children in light of this suggested package.

The Government of the Republic of Mozambique ratified the CRC in 1994, which was followed by the Declaration of the Rights of the Mozambican Child, as well as the inclusion of clauses concerning this in the Constitution of the Republic, showing the country’s commitment to children (CRC, 2009). In its new constitution that came into effect in January 2005, the rights

of children and the obligation of their parents are as follows:

“Article 47

(Rights of children)

1. Children have the right to protection and to the care necessary for their welfare.
2. Children may freely express their opinion on matters concerning them, in accordance with their age and maturity.
3. In all actions concerning children, whether undertaken by public or private institutions, the best interests of the child shall be a primary consideration (...).”

“Article 120

(Motherhood and fatherhood)

1. Motherhood and fatherhood shall be dignified and protected.
2. The family is responsible for the harmonious growth of children and shall educate the new generations with moral, ethical and social values.
3. The family and the state shall ensure the education of children, teaching them with values of national unity, respect for the nation, equality between men and women, respect and social solidarity.
4. Fathers and mothers shall provide care for children born in and out of marriage (...).” (CRC, 2009).

The constitution further detailed the right to protection of vulnerable children including orphans, in its Article 121 that says:

“Article 121

(Childhood)

1. All children have the right to protection from their family, society and the state, in order to ensure their full development.
2. Children, particularly orphans, disabled children, and abandoned children, shall enjoy the protection of the family, society and the state against any form of discrimination, ill-treatment, and against abusive authority in family and other institutions.
3. Children may not be discriminated against, or subjected to ill-treatment, by reason of their birth.
4. Child labour is prohibited, whether the child is of school age or any other age”
(CRC, 2009).

At the same time, Mozambique’s Social Protection Act of 2007 aimed to satisfy the basic needs of the most vulnerable population, including children in a difficult situation, through provision of services, programmes and projects (Republic of Mozambique, 2007, pp. 75-76). This was further reinforced by the approval in 2006 of the National Action Plan for Children (PNAC) for 2006-2011, to promote the holistic welfare of children, with special attention on vulnerable children, including abandoned children, children living in absolute poverty, children who are victims of abuse and violence of any kind, orphans, disabled children and children suffering from chronic illnesses (CRC, 2009).

Mozambique has also developed two key policy-level instruments, namely the Multi-sectoral Plan for Orphaned and Vulnerable Children for 2006 – 2010, and the third National Strategic Plan for the HIV and AIDS Response (NSP III) for 2010 – 2014, which includes orphans and vulnerable children as its target group (UNAIDS, 2014). A situation analysis on orphans and

vulnerable children was also conducted in 2006, while advocacies have been done to ensure that orphans and vulnerable children are included in various social protection schemes (UNICEF-Mozambique, 2009). Key sectors such as education have also developed sector-specific social action policies that target orphaned and vulnerable children (MEC, 2008).

Similarly, in terms of social protection, the foundational efforts to put the legal framework for social protection in place have been implemented with the adoption of the Social Protection Law in 2007, the approval of the Regulations of the Basic Social Security Sub-system in 2009, the National Basic Social Security Strategy 2010-2014 in 2010, as well as the new package of Basic Social Security Programmes in 2011 and the Regulations of the Basic Social Security Sub-system in 2009 (as cited in MMAS, 2012). The OVC aspect is also reflected in the country's PRSP, also called PARPA, while multi-sectoral mechanisms for OVC support were also in place (UNICEF-Mozambique, 2009). It could thus be concluded that Mozambique has the essential policy framework required to deliver support for orphans and vulnerable children in the country.

Nevertheless, the review of the literature and the field research indicated that while a policy framework exists in Mozambique for the care and provision of needs of children, this has not yet been translated into action (MMAS, 2006). Thus, the next challenge that Mozambique faces is effective implementation of the framework so that the policies translate into reality at the grass-roots level for beneficiaries. For a country whose private sector is expanding due to growth in mining and petrol production, the government could consider measures to encourage market-oriented privatisation of alternative care services. Another option could be decentralising the care and services to the provincial level, so that implementation requires less administrative process, becoming more efficient and more accessible to the field.

As for Guinea-Bissau, the government ratified the CRC in 1990, but little has been done to

incorporate the CRC into national legislation (CRC, 2013). In terms of the Constitution, its Part II provides for a number of rights that apply to children as to adults, but Children's Act is not yet integrated in national law (CRIN, 2012). Nevertheless, some efforts have been made in the recent years to strengthen the legal and political framework for child protection, including the drafting of National Strategy of Social Protection for Children in 2009, and the adoption in July 2011 of a law criminalising female genital mutilation and a law against the human trafficking (Republic of Guinea-Bissau, 2009a; UNICEF-Guinea Bissau, 2013). The country's National Poverty Reduction Strategy (DENARP II) and the Government's Priority Action Plan included child protection issues, such as human-trafficking and sexual abuse and exploitation (UNICEF-Guinea Bissau). The country has begun drafting Children's Act as well as Action Plan on OVC Support, but they have not yet been finalised (S. Polonio, personal communication, 11 July 2015).

Similarly, the Minimum Standards for Residential Care of Children were developed in 2009, without being put fully into effect yet (Republic of Guinea-Bissau, 2009b). Nevertheless, efforts have been underway since early 2014 for setting up a working group on alternative care, led by the Ministry of Women, Family and Social Cohesion with the main support coming from UNICEF and international NGOs such as FEC and Caritas (S. Polonio, personal communication, 11 July 2015). The group has conducted an assessment of the residential care situation and mapping of the main transit centres and orphanages in the country, and it has also developed a set of tools for regulation and guidance of foster families and centres (S. Polonio, personal communication, 11 July 2015).

Guinea-Bissau will first have to establish these fundamental instruments, as well as develop realistic policies to support orphans and vulnerable children. The World Bank recommends taking the following steps in developing appropriate policies: firstly, identify possible options; second, set the OVC policy framework; third, narrow down the policy options; finally, after

conducting a final check, proceed to planning implementation (WB, 2005). Guinea-Bissau already conducted the situation analysis of orphans and vulnerable children in 2009, on which the draft action plan was developed, but has not yet validated it. Therefore, the next step would be to set the OVC policy framework from the options already identified in the draft action plan in line with the national strategy of social protection (Republic of Guinea-Bissau, 2009a) – which is quite comprehensive covering legislative, operational and institutional aspects with some specific measures included such as cash transfers and social welfare interventions – in a more organised and systematic manner, followed by the exercise of realistically prioritising the policy options, taking into account the available limited resources. In this way the national strategy can be translated into feasible operational plans that could be used not only by the government but also by various actors supporting social protection, who are also the main implementers.

The field findings also revealed that the care centres located in the regions most affected by poverty and vulnerability, such as Chinde in Mozambique and Tombali in Guinea-Bissau, had even fewer resources and less support. This means that the residual approach of social welfare, discussed in Chapter 2.2.2, was not reaching the most vulnerable population in either country. HIV/AIDS may no longer be the pressing threat as it once posed in Mozambique, but the situation of orphan-hood continues for the children who have lost their parents to HIV, or for any other reason. For those orphans and vulnerable children who live in the poorer parts of the countries, poverty and limited health and education services predispose them to further vulnerability, confirming the theory by Wilkinson and Pickett about the association between child well-being and inequality within a country, as mentioned in Chapter 2.2.3 (Wilkinson et al., 2009). The situation thus calls for an institutional and comprehensive approach to social protection to make sure that the most vulnerable children who are in more disadvantaged parts of the country be covered by the care they need. This should be addressed at the policy-level,

by ensuring multi-sectorial and integral service provisions targeting the most vulnerable regions in the country. Different options to design and deliver such services will be explored in the following section.

6.2 Programme design issue

Once the policy frameworks are in place to support orphans and vulnerable children, the next consideration should be the programme design of the interventions to be delivered to the orphans and vulnerable children. As discussed in Chapter 2.2.3, modern social protection measures in the African context include mainly four broad components: social insurance, social transfers, social welfare services and protective legislation (Hodges et al., 2010). When designing programmes for increasing access to essential services for orphans and vulnerable children, the key objectives should include: targeting and identifying orphans and vulnerable children, defining the package of services to be offered in OVC support interventions, and defining the delivery method specific to area-based OVC support (Schierhout et al., 2007).

In terms of targeting, available options are; geographical targeting, community targeting, categorical targeting, means-testing, self-targeting or a combination of these (UNICEF-ESARO, 2008b). For the cash-transfer programmes in Africa, the narrow means-testing has been found to cause the opposite effect from its original intention to reach those who are the most in need (Kaseke, 2004). On the other hand, combination methods have shown effectiveness in more accurate targeting in many countries (Coady, 2004). There have been attempts to set national criteria to identify orphans and vulnerable children in order to provide poverty alleviation support locally, but in the experience of South Africa (Schierhout et al., 2007) this proved to be not as effective as criteria targeted to specific locale. The alternative approach, in which responsible adults within the community identified the orphans and vulnerable children themselves, apparently worked better (Schierhout et al., 2007).

A programme designed for a targeted population to increase access to essential services such as free schooling and free basic health care, can be effective, sustainable and generalizable, in the sense that it will not have to duplicate the investment already made for all children by the state. This approach is in line with Amartya Sen's perspective on the capabilities approach perspective discussed in Chapter 2.2.3, in that it increases access to basic services such as education and health care and addresses both entitlements creation and capacity building, which are essential for comprehensive social protection package (Taylor, 2002). In the country context where these essential services are not yet as effectively delivered to all children of the target age group as they should be, a targeted programme should take into account ways to strengthen systems and to implement and raise awareness of the available essential services (Schierhout et al., 2007).

Of course a programme targeted for orphans and vulnerable children must assess whether the package of services offered match the basic needs of orphans and vulnerable children, and how they are being delivered, which are two of the most crucial aspects that determine effective reach of services to the orphans and vulnerable children in line with the human-rights based approach. Existing programmes in the two countries when this research was conducted are described below and analysed in light of the general principles outlined above. In Mozambique, while the improved legal and policy framework has led to a more protective environment for children, the main challenge has been to translate new legislation into effective regulations and programmes. Mozambique already has various programmes intended for social protection, such as cash transfers via PSA, education support via free textbook distribution, school feeding and capitation grants from Apoio Directo à Escola (ADE) and medical support via anti-retroviral (ARV) provision (Hodges et al., 2010). The PSA at the time of the research was only reaching 166,824 direct beneficiaries and 145,592 indirect beneficiaries, an estimated sixty percent of whom are children, thus approximately 87,500 children (Hodges et al., 2010). When

this figure is compared to the overall orphan population of 1.4 million, the PSA program covered merely six percent of the potential needs, which was obviously too limited.

The centres visited and considered for this research which were not public had not received any substantial support from the state other than sporadic monitoring, with the exception of textbook distribution and the anti-retroviral (ARV) drugs provision. These centres were rather run with support from external donors, whether religious or civil organizations. The data revealed that the proportion of orphans and vulnerable children receiving basic support from national funds were relatively better-off children than the poorer children, as can be seen in the figure below.

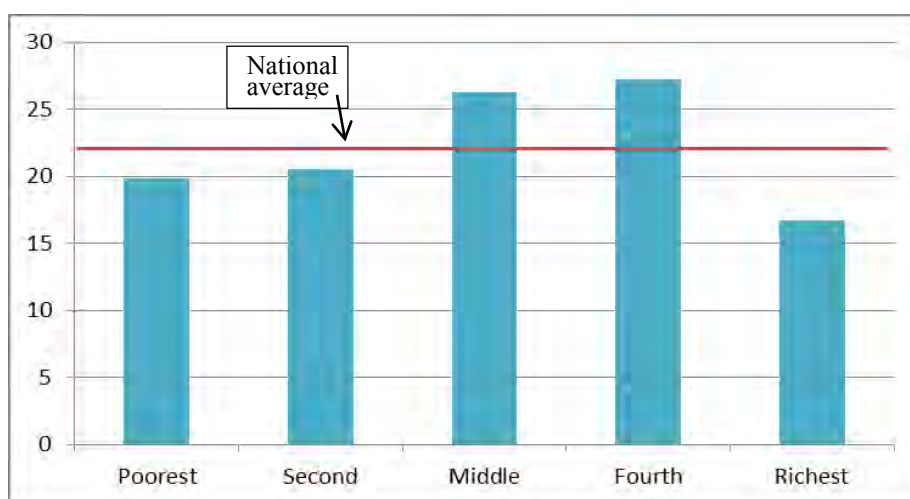


Figure 6.1. Percentage of orphans and vulnerable children whose household receives free basic external support due to AIDS in caring for the child by wealth quintile in Mozambique (2008)

Source: INE, 2009.

This unequal distribution of social support indicates that the next challenge for OVC programmes in Mozambique is more effective targeting and scaling-up. The trend of grandparents looking after orphaned children in Mozambique, for instance, suggests that interventions that package old-age pensions and OVC support could be an effective protective approach. At the same time, as a

preventive measure, HIV-prevention efforts targeting women in their twenties as well as girls of younger age could be enhanced to mitigate loss of life due to HIV/AIDS that result in maternal orphans. Indeed, some of these recommendations are already reflected in a set of new programmes introduced since 2010, such as the cash-transfer to the ultra-poor households, known as the Basic Social Subsidy Programme (PSSB), the temporary social-transfer scheme, or the Direct Social Support Programme (PASD), and the temporary residential support scheme, or the Social Action Social Service Programme (PSASS) (MMAS, 2012).

On the other hand, in Guinea-Bissau, the only government support that seemed to reach the interviewed orphans and vulnerable children were free textbooks. Some centres located adjacent to schools benefitted from the school feeding programme co-implemented by the government and World Food Programme (WFP). As mentioned earlier, the Ministry of Women, Family and Social Cohesion of Guinea-Bissau theoretically has a cash transfer programme for orphans, people with disabilities and elders, which only reached about 0.2 percent of the total target population (Germain et al., 2008). This transfer was not reaching any of the children interviewed by this research. As was the case for Mozambique, but possibly more limitedly, centres in Guinea-Bissau had not received any state support, but only external support – if any at all. One such cash transfer program provided by an NGO was directed not only to the centre in Cacheu but also to the families raising orphans and vulnerable children in the surrounding communities. According to the testimonies of the orphans and vulnerable children, this support only benefitted the direct family members who were receiving it on behalf of the children they were caring for, but not reaching the children themselves.

Due to political instability in the country which has repeatedly exposed the entire population to vulnerability, not only about fourteen percent of children have lost one or both parents by 2014, but there are also many children living in orphan-like situations, because poverty has caused fragmentation of the family. In this context targeting in Guinea-Bissau should be considered for

the larger scale with an intention to enhance the resilience capacity of families and communities in general. As an added measure to prevent more children losing their mothers at birth, health support to women in their late 20s and beyond should be reinforced to reduce maternal mortality. Next, an analysis should be conducted on pilot programmes in Guinea-Bissau that has a potential for future expansion, in order to inform the designing of a national programme.

Table 6.1. Cash transfer programmes in Mozambique and Guinea-Bissau in 2008

Country	Mozambique	Guinea-Bissau
Executing agencies	Ministry of Women and Social Action	Ministry of Women, Family and, Social Cohesion.
Target group	Age and health status	Orphans, people with disabilities and elders.
Geographic distribution	Urban and peri-urban areas	Urban and rural
Number of people reached	166,824 direct beneficiaries (about 1.2 percent of the total population)	2,500 direct beneficiaries (about 0.2 percent of the total population)
Value of transfer	MTZ 100 (about USD 4) every month	FCFA 10,000 (about USD 20) every three months

Source: Hodges et al., 2010; Germain et al., 2008.

There have been programmes other than direct cash transfers that have been piloted in other countries. For instance in Kenya, there was the Community-Based Care for Orphans and Vulnerable Children (CBCO) programme implemented from 2005 to 2011 in the Eastern Province, which included microcredit through savings and loan associations (SLAs) for OVC caregivers. A case study on this programme revealed that such a low-cost microcredit model alone was not sufficient enough to generate significant impacts in terms of household food

security and OVC educational attainment (Larson et al., 2013). In the context where most of the households supporting orphans and vulnerable children are trapped in poverty to begin with, it is difficult to pool necessary resources within these households to lift them out of poverty. The study team thus concluded that, “an SLA model within an OVC support program may make sense as a foundation for a program, but additional poverty alleviation activities (e.g., direct cash transfers, direct transfers of agricultural inputs, new jobs, etc.) are still needed” (Larson et al., 2013, p. S45). It is therefore important to take into account the promotive and transformative functions of social protection, discussed in Chapter 2.2.1, to enhance the capabilities of households and to reduce inequities and vulnerabilities.

The field research also found a significant association between the overall well-being of a child and his/her education situation. This finding should be considered in view of the results of the other studies in Tanzania and South Africa that showed the correlation between orphaned children and less level of schooling, as discussed in Chapter 2. Thus, to mitigate the risk of education deprivation, the importance of ensuring free education service for all must be reiterated, along with the means necessary to make use of it, such as textbooks and learning materials. Furthermore, orphans and vulnerable children need additional support to cover other education-related costs. In order to do so, often-tested modalities such as block grants to schools and scholarships to individual children could be implemented. The evaluation conducted by Bryant and his team (2011) demonstrated that block grants tend to be more cost-effective than scholarships, so long as the number of children supported is large enough: at least over ten children at a time (Bryant et al., 2011).

The findings from both Mozambique and Guinea-Bissau indicated that the foster families who are not well prepared to receive orphans could actually do serious harm to children, possibly worse than in a residential care set-up, confirming the findings of earlier studies conducted in Sierra Leone and Botswana (Bledsoe et al., 1988; Malinga et al., 2011). Given this, it is

important to take proper measures to carefully select and mentally prepare foster families to prevent possible abuse or mistreatment of children. Screening procedures should be used for the selection process, not only of the foster families (even if they are related), but also for the volunteers and other support providers to ensure that they are motivated, capable and trustworthy (Schierhout et al., 2007). Regular checks and balances, and accountability to other adults are also important. In this regard, it would be worth looking into piloting a child protection programme similar to the successful one in South Africa called *Isolabantwana*, meaning “the eye on the child”, in which community volunteers liaise with social workers to ensure full-time protection service for children at risk of abuse and neglect (Butterfield et al., 2013).

At the same, considering the cases of potential child abuse reported by the children in family-based care, it is recommended to consider programmes designed to prevent adverse effects of stressors such as abuse on children’s mental health. As Nigel Parton pointed out, a clear relationship exists between social group, physical discipline and abuse, with the prevalence of abuse significantly greater in the lower social classes (Parton, 2014). This means that the adults of poorer households are more likely to engage in abusive behaviour towards children than the adults from wealthier households. This is in line with the theories presented in Chapter 2.1.1. which classified poverty as the greatest risk factor and that exposure to conditions of such risk factor as poverty exponentially increases the probability of developmental difficulties (Schorr, 1988; Sameroff et al., 1989). Although there is no guarantee that poverty alleviation contributes to reduction in child abuse, research does show an association between small increases in income and a decrease in the likelihood of reports of child maltreatment (Cancian et al., 2010). In this sense, poverty-alleviation measures, such as the cash-transfers as mentioned above, could be one indirect preventive measure. As a more direct prevention and response policy, the government might introduce early intervention and preventive services,

such as early screening to detect children who are most at risk, followed by necessary interventions such as home visiting, parental education and skills training. As a long-term prevention measure, a combined approach of services to support and promote families with children in need along with public health approaches with the notion of primary prevention and minimally-sufficient intervention packages in mind should be made available to all families with children (Parton, 2014).

The future livelihoods of orphans and vulnerable children have become a growing concern, particularly in Sub-Saharan Africa where HIV/AIDS has had a tremendously detrimental impact on the human capital of the countries (IATT, 2008). Under such circumstances, there has been more recognition of the importance of programmes that equip vulnerable children and youths with livelihood knowledge and skills, such as vocational and skills training, especially for orphans who cannot receive the same level of support from family members as other children and youths (IATT, 2008). Some centres in Mozambique, such as the ones in Gatembe, Chimoio and Beira, are already offering such programmes, which children seemed to find useful. It would be useful to draw from lessons learned from other programmes piloted in Africa, such as the agricultural training programmes in Uganda, micro-financing accompanied by business training in Tanzania, artisanal and vocational training in Lesotho, and food and cash crop cultivation in Malawi (White et al., 2005; FAO, 2010b). The Ugandan agricultural training, for instance, enabled at least seventy percent of graduates, who were vulnerable children including orphans, to continue farming in their local areas. The training also assisted fifteen percent of graduates in generating enough revenue to purchase land or fund their completion of formal education (White et al., 2005). Nevertheless, most of these interventions are either run by NGOs or funded by external agencies, which puts into question the sustainability and feasibility of scaling up. Further study of the effectiveness of the existing initiatives in Mozambique is recommended to determine how they might become sustainable

and scaled up.

Results of the field work also showed a significant statistical association between the food situation and the overall well-being of the children. The data reinforces Patrice Engle and colleagues' finding that the level of nutrition constitutes one of the risk factors that have significant impact on the psycho-social development, discussed in Chapter 2.1.2. (Engle et al., 1996). According to findings in the field, the children of the centres who were offered meals were in better health, so the expansion of such food programmes, or integration into existing food programmes, in the future could also be considered, depending on availability of funds.

It is important to underscore the fact that the orphans and vulnerable children being served by twelve centres studied for this research were generally living in better conditions than the orphans who could not participate in any of these programmes. Discussions with orphaned children encountered outside the centres visited for this research project suggested that the latter, who generally resided with families or on the streets, received no information or support. Given this, it might be useful to refer to the two feeding programme implemented in Botswana. One is sponsored by the government to offset the additional burden placed on individuals or families who care for the orphaned children of their relatives who had passed away due to the HIV epidemic. The other is run by organizations supported by foreign aid and provides food and day-care support directly to orphaned children. The two programmes showed strengths and weaknesses from the viewpoint of the caretakers of orphans. The government-sponsored food basket programme was appreciated because it not only provided a lifeline to poor households caring for orphans, but it was also culturally-sensitive to local patterns of kinship care. However, it received some criticism for perversions of duty by caretakers and for creating dependence within families (Dahl, 2014; Feranil et al., 2010). As for the food and support programme supported by foreign aid, it was welcomed for directly helping orphans who were not receiving enough food from their caretakers, but it was also criticized for over-providing for them (in

relation to local norms), thus creating a new form of inequity as well as alienating them from the cultural tradition of “reciprocal caregiving,” where adults are supposed to be responsible for providing food and other necessities to children, who in turn are expected to help with household chores as a part of daily domestic life. (Dahl, 2014).

The lessons learnt from the two programmes cited above indicate that a feeding programme should be carefully planned in terms of targeting and ration-designing. WFP recommends a multi-dimensional approach to targeting, combining economic and socio-demographic indicators, accompanied by some degree of spot-checking through house-to-house verification in order to identify the most vulnerable households (WFP, 2008). This approach emphasizes the importance of community awareness and participation in the process of defining criteria and beneficiaries (WFP, 2008). At the same time, such food provision programmes – especially those targeting households – should take into account reinforcement of livelihood activities, as mentioned earlier. The Botswana experience showed that food basket beneficiaries were “unable to establish meaningful livelihood options as an alternative to receiving food baskets and other social welfare benefits” (Feranil et al., 2010, p. 37). To prevent setting up this kind of dependency, a programme implemented in the North West province of South Africa, called the Tapologo HIV/AIDS project, could be considered as a good example. This community-based care project provides not only food parcels, but also support in the form of income generating activities at the local community centre and in developing skill areas such as knitting, sewing, gardening and fence-making (Setwe et al., 2007). The project also offers support for grants management, as well training in identification and dealing with violence and sexual abuse against children, as well as psycho-social counselling (Setswe et al., 2007).

Finally, the findings from the field corroborate the important role of social relations and support in facilitating the sense of well-being among orphaned children found elsewhere. As for Mozambique, the interviewed children generally reported feeling a lower degree of social

inclusion and community support. They are in line with the study conducted by Wild and her colleagues, discussed in Chapter 2.1.1. that also found correlations between positive emotional resilience of orphaned adolescents and their surrounding social factors, such as family regulations and respect for individuality, peer connections, community connections and regulations (Wild et al., 2011). It also mirrors findings from studies conducted in South Africa that showed the importance of the presence of caring and supportive primary caregivers, extended families, friends, and community members as components in the overall well-being of orphans and vulnerable children, discussed in Chapter 2.1 (Cluver et al., 2007). This finding indicates a need for sensitisation activities to promote community understanding and engagement to support orphans and vulnerable children, as suggested by Nyambedha (2011) in his report on OVC coping mechanisms by communities. At the same time, programmes that include support to reinforce social relations and community connections surrounding these children should be encouraged. Some examples of such support bring together children in the community, for instance through daily after-school activities in South Africa or through ‘Kids Clubs’ in Zambia (Scott et al., 2010). This programme was positively evaluated to have contributed to psycho-social and emotional well-being of orphans and vulnerable children between ages 12 and 17 (Scott et al., 2010).

As mentioned in Chapter 2.1.2, addressing resilience is crucial for attaining long-lasting positive outcomes among children and adolescents. Designing programmes to develop resilience depends on the experience and background lived by children. According to Stein (2005), children who have experienced instability and disruption often require more after-care support than those who have benefitted from stability and continuity. For the children who have had even more damaging pre-care experiences, more focused resources and longer-term therapeutic support is required (Bolger et al., 2012). In the Handbook of Resilience in Children (2012), Felner recommends that:

“... resilience enhancement efforts for children and youth whose lives are characterized by poverty and disadvantage should include focused strategies that: (1) seek to reduce levels of conditions of risk or increase levels of protective factors; (2) directly, or indirectly through the previous step, reduce the incidence rates of personal-level vulnerabilities or the enhancement of personal competencies and strengths; and (3) alter levels of conditions of risk and of protective factors that have been shown to interact with acquired vulnerabilities and strengths to trigger the onset of a more serious disorder or to produce resilience in the face of serious challenges” (Felner, 2006, p. 113).

While some interventions to create resilience have been studied and evaluated, much work remains to understand processes – such as mediating, moderating, promoting, and compensating – well enough to be able to use them most effectively and efficiently to the benefit of children. As Wright and Masten pointed out, “only by identifying the multifaceted processes underlying successful adaptation under adverse conditions will we find ways to intervene successfully in the lives of those who remain vulnerable” (Wright et al., 2006, p. 22). The process of identifying the protective factors that contribute to strengthening resilience was depicted by Felner (2006) in Figure 6.2. below.



Figure 6.2. Felner diagram on Risk/Protective Factors, Acquired vulnerability/Strengths and competencies and Resilience/Disorder

Source: Felner, 2006.

6.3 Financial and institutional capacity

Contextual factors critical for sustainable implementation and scaling-up include not only an enabling policy environment, but also strong government commitment and well-trained and motivated staff (Kadiyala, 2004). One way of gauging the level of a government's commitment as a duty-bearer (to use the language of human-rights based approach) is through analysis of the allocation of state budgets and other necessary resources, including capable human resources, to ensure adequate care and services for orphans and vulnerable children (UNICEF, 2003b). The field research in Mozambique and in Guinea-Bissau shows that government support that exists does not necessarily reach the centres in the rural areas. Results of interviews from these centres show that even regular monitoring and guidance by the local authorities in charge of social protection was lacking.

According to the ILO World Social Protection Report 2014/2015, public expenditure on social protection benefits specifically aimed to meet the needs of children amounted to 0.4 percent of total GDP worldwide, or 7.4 percent of total social protection expenditure (excluding that on health), with regional variation ranging from 2.2 percent in Western Europe to 0.2 percent in Africa, Asia and the Pacific, as discussed in Chapter 2.2.4. (ILO, 2014a) In Africa, where revenues from natural resources have dominated the rise in tax revenues, the expansion of anti-poverty transfer programmes has been slow (Barrientos, 2013). In 2009, Mozambique had allocated 6.8 percent of its state budget to the Ministry of Women and Social Action, compared to a mere 1.9 percent in Guinea-Bissau to the Ministry of Women, Family, Social Cohesion and Poverty Reduction (FDC, 2010; MF, 2009). Mozambique budgeted 0.4 percent of its GDP for social security and social transfers in 2009, as compared to 0.1 percent of GDP in Guinea-Bissau in 2010 (Hodges et al., 2010; ILO, 2014a).

A positive trend in budgeting for social protection benefits can be seen in Mozambique, which

increased its budget allocation for social assistance programmes by about thirty-three percent from 2011 to 2012. During the same period, the country planned to allocate between 0.4 and 0.8 percent of GDP for expansion of its cash transfer programme to reach 815,000 poor households (MMAS, 2012). This takes into account the creation of additional fiscal capacity via public spending which could eventually reach 2.5 percent of the GDP by 2022 (MMAS, 2012). The creation of the common fund for child protection in Mozambique is also another promising sign to secure funding for the programmes that support orphans and vulnerable children (UNICEF-ESARO, 2008b). In stark contrast, due to political instability, Guinea-Bissau had an extremely limited government budget, with its GDP growth rate decreasing from 6.5 percent in 2005 to 4.5 percent in 2010 and then to mere 0.3 percent in 2013 (UN, 2016). In this context of the negative GDP growth, Guinea-Bissau allocated only 0.1 percent of GDP to social security and social transfers in 2010, as mentioned earlier (ILO, 2014a).

In the countries with serious budget constraints, other ways to ensure funding for the social protection programmes need to be conceived. UNICEF suggests the following mechanisms as possible ways to create fiscal space:

- (i) increasing revenue through two main channels: increased economic activity, i.e. real growth in gross domestic product (GDP) and increases in the average tax yield as a proportion of GDP;
- (ii) reallocating spending from lesser to higher priorities and from lesser to more effective and productive programmes;
- (iii) reducing debt by writing off all or part of a country's debt stock with a view to freeing up resources that would otherwise be spent on meeting [the] government's future debt service obligations;
- (iv) increasing borrowing from either external or domestic sources;
- (v) increasing aid in the form of grants and

concessional loans; and (vi) seignorage¹⁰, or generating revenue by money creation (UNICEF-WCARO, 2009, P. 10).


Among these options, the mechanisms that are more sustainable in creating lasting fiscal space for social protection in the less economically developed countries such as Mozambique and Guinea-Bissau are increasing revenue and re-allocating spending (UNICEF-WCARO, 2009). It must be taken into account that an increased expenditure in social protection, whether it be in the form of cash transfer or in the form of service provision, incurs economic effects on two levels: firstly on the level of the beneficiaries or the service providers who spend more with the money earned through the social security scheme, and secondly on the level of the general market as a result of the increased consumption (Sakata, 2014). Studies on the experiences of South Africa, Ethiopia and Zambia have shown that social protection programmes could actually contribute to economic growth, and that productive returns from investment in social protection could potentially increase the affordability of social transfers in the long-run, promoting sustainability (Samson et al., 2006). Guinea-Bissau had not yet implemented a large-scale social transfer programme at the time of this research. Considering possible returns it might generate in terms of economic growth, the government might consider this option in its future planning. At the same time, Barrientos' suggestion (2013, p. 176) that “the policy focus in developing countries should be on achieving a moderate rise in social assistance budgets, while making a strong effort to improve the effectiveness of expenditure”, holds true for Guinea-Bissau.

A comparative study of cash transfer programmes in different African countries indicated that those targeting poorer households with children were more effective in reaching the orphans

¹⁰ Seignorage is the revenue generated by a central bank printing money in order to lend it to the government (UNICEF-WCARO, 2009).

and impoverished children than those that either targeted only orphans and vulnerable children or only age-/disability- vulnerable households (Stewart et al., 2011). This finding supports the argument to consider targeting poorer households with children when designing future cash transfer programmes. Re-allocation of spending from lesser to more effective and productive programmes can also lead to increased cost-effectiveness in the context of Guinea-Bissau's limited state budget. Table 6.2 shows the costs of different alternative care models in South Africa, which indicate community-based support structures to be the most cost-effective. If the country was to promote this option, it should provide the means to support and monitor the community-based initiatives. National guidelines and standards for care providers as well as protection mechanisms need to be established to ensure that children are properly cared for, especially in light of the possible mistreatments reported by some interviewed children

Table 6.2. Models and costs of alternative care: Example of South Africa

	Models of alternative care	Costs in South Africa (exchanged to USD)	South African Rand per minimum standard child care per month
More formal 	Statutory residential care	323 (440*)	2590 (3525*)
	Statutory adoption and foster care	51	410
	Unregistered residential care	120	957
	Home-based care and support	38	306
	Community-based support structures	35	276
	Less formal	Informal fostering/Non-statutory foster care	40

Source: UNICEF-ESARO, 2008b, p. 50.

In terms of institutional capacity, realisation of effective OVC support requires coordinating, referral, and monitoring capacity not only at the central but especially at the decentralised level, closer to the beneficiary children. Coordinating capacity is important because of the multi-sectorial nature of the required support. Referral capacity is essential to identify the orphans and vulnerable children and orient them to the appropriate services, and monitoring capacity is crucial to prevent maltreatment of children and ensure the quality of offered services and the welfare of children after the service provisions. A study by Schierhout and Nxumalo in South Africa found that interventions embedded within credible pre-existing institutional structures or centres were more successful than the other stand-alone models (Schierhout et al., 2007). This suggests that capacity development of existing institutional structures should be prioritised over investing in the creation of new structures.

In Mozambique, Sylvestre and colleagues (2009) found that the limited number of social workers or social action agents to treat the increasing demands to expand social assistance programmes both in numbers and in geographical coverage posed a serious capacity gap. Many of the social action delegations at the decentralised (local) level only had one or two agents, many of whom did not possess a university degree, not to mention any expertise in social work, and had to rely heavily on community volunteers to conduct beneficiary identification and programme follow-ups (Hodges et al., 2010). This community based system has both its strength and its weakness: strength in the sense that beneficiaries have a supportive framework at the community-level at a low cost to the government, weakness in the sense that reliance on the good will of community volunteers who work for very little remuneration, if at all, may not be able to cope if the caseload were to increase significantly, not only in terms of the number of social transfer beneficiaries but also in terms of monitoring alternative care centres (Ellis et al., 2009). Another challenge is that the different data systems had been established before any attempts to create an integrated database of the beneficiaries of the various social protection

programmes, making it difficult to monitor beneficiaries across different sectors and institutions (Hodges et al., 2010). Recognising the challenges in its institutional capacity at all levels, the Ministry of Women and Social Action has launched since 2012 training of its high and medium-level professionals in technical areas such as social assistance and early childhood development (MMAS, 2012). The government also endeavoured to develop a new information system that links various social protection programmes (Hodges et al., 2010). Including these and other programmes, significant investments in capacity development have been reported in recent years, showing promising signs that implementation could be improved in the coming years (Hodges et al., 2010).

In contrast, Guinea-Bissau continues to face a major capacity gap, as Germain and Handem analysed:

“In the last years, formulation, execution and evaluation of the social policy of the state of Bissau-Guineans have been affected by i) adverse political-institutional context, instability of the leadership and lack of political continuity; ii) insufficient budgets, profound discrepancy in the budget announced in the State General Budget Law and the actual disbursement, dependence on donors; iii) reduced management capacity, due to reduced staff personnel who are also without necessary capacity in planning, implementation, monitoring, evaluation and coordination of various actions. As a result, the efforts to reduce poverty and the actions to expand and improve the quality of the basic social policies, which constitute the basis of social policy, have been insufficient and failing to ensure the improvement of life conditions of the most vulnerable segment of the population” (Germain et al., 2008, p. 85).

In Guinea-Bissau, the Ministry of Internal Administration at the central level established in

2006 a cabinet in charge of attending and assisting children and women (Gabinete de Atendimento e Assistência à Criança e Mulher), which was staffed with just four personnel to cover the entire country, while no agent posted at the decentralised level (Rodrigues et al., 2007). It is clear that the serious gap in management capacity needs to be improved, both in terms of number and in terms of technical knowledge and skills. Another challenge is that the legal structure has been conceived without any system of reinforcement, which was evident from the way the alternative care centres visited in this research were forced to run without any official orientation or framework. Guinea-Bissau thus faces challenges on three levels which are inter-related and need to be tackled simultaneously: political instability, budget constraints, and management capacity gap. Political instability goes beyond the scope of this study, but it could directly affect the social welfare area, as happened when the transitional government of 2012-2014 suddenly decided to integrate the Ministry of Social Action into the Ministry of Health in 2013. The budget insufficiency could be addressed through the UNICEF recommendations for creating fiscal space mentioned above. The challenge of the management capacity gap can be addressed by government support of technical capacity development, not only at the central administrative levels but also, and especially at the decentralised local-level, for those involved in the direct implementation of the programmes. This contrasts markedly from, for instance, the UK, where the legislation clearly states that “local authorities are responsible for all looked after children and should discharge their duties of care in the manner of a good enough parent. This is often referred to as the role of the ‘corporate parent’” (Bolger et al., 2012, p. 313). It may be unrealistic for Guinea-Bissau to replicate the UK approach given that the country contexts are completely different, but it could eventually aim toward this principle.

Aside from the institutional capacity of the state actors, the participation and capacity of the communities are crucial in effective implementation of OVC support activities in general

(White et al., 2005; Schierhout et al., 2007). Not only should community participation be encouraged, but rather the community-driven projects should be prioritised, incorporating community strengthening activities, such as income-generating measures for the beneficiary caregivers and the surrounding community members. Furthermore, it is crucial that scarce budget resources be allocated equitably to sectors that contribute to children's well-being and development – especially to education, health care, water, sanitation and social protection. Within these sectors, the equitable allocation of resources across states and programmes is also a key to reducing prevailing disparities.

6.4 Conclusion

This chapter analysed the current social protection systems in both Mozambique and in Guinea-Bissau in terms of policies and legislations, programme design, and financial and institutional capacity, taking into account the findings from the literature review and field research. It showed that a policy framework for the care and provision of needs of children already exists in Mozambique and is also under preparation in Guinea-Bissau, but this has not been translated into action in either country. It also showed that programme design in both countries requires better targeting and tailoring in order to respond to the needs of the orphans and vulnerable children, including strengthening community relations and resiliency. In terms of financial and institutional capacity, the two countries – with Mozambique to a lesser extent than Guinea-Bissau – face significant capacity gap, calling for the need for action in terms of planning, budgeting and monitoring. In Chapter 7, the answers to the research questions and the assumptions will be discussed, with overall recommendations as the way forward for the policy options to support orphans and vulnerable children in the two countries.

Chapter 7

Way forward

This final chapter aims to analyse the conclusions of this study in light of the research questions and the assumptions made in Chapters 1.4 and 3.2, which will then be followed by policy recommendations on the way forward in the two researched countries.

In answering the first research question “What are the current policies and programmes in place to support orphans and vulnerable children in Mozambique and Guinea-Bissau?”, the study showed in Chapter 4 that the first two assumptions hold partially true in the two countries: (i) that the policies and programmes for orphans and vulnerable children already exist and are being implemented, although to a limited extent, and (ii) that the governments in both countries are involved in the policies of orphans and vulnerable children, as discussed in Chapters 4.5 and 6.1.

The findings presented in Chapter 5 were used to address the following three research questions “Are these policies and programmes serving the basic needs of orphans and vulnerable children?”, “What methods of care are being used to respond to the needs of orphans and vulnerable children?”, and “What are the impacts of alternative care on the overall well-being of orphans and vulnerable children?” The third assumption, consistent with the first question here, was that care provided to orphans, whether by family-based or residential supports, addressed the needs of orphans and vulnerable children. This assumption was confirmed as partially, but not entirely, true. Children’s basic needs for shelter and education, and to a lesser degree, food and health, were being supported in many of the alternative care centres that were studied. However, the field research indicated that no particular support was systematically provided to promote children’s need for social association and integration. This is an important finding, because social association and integration provided in the care centre was positively

and significantly associated with the overall well-being of the children. As for the second and third question, which addressed (1) the methods characterising alternative care, and (2) the impact of differences in alternative care on overall well-being in children, the findings in this study showed that children under residential care were doing better than those children under family-based care. It is important to note, however, that although many centres developed as part of a community response to the OVC crisis, they also did not fall squarely in the simple categorisation of alternative care types used for this study. This study also revealed the interrelationships among different components of children's well-being, with the exception of health situation scores. These correlations point to the importance of an integrated approach to social protection when developing programming to support orphans and vulnerable children.

Finally, the research questions “What is the role of the state in alternative care for orphans and vulnerable children?”, “Should the state serve as custodian of orphans and vulnerable children who are placed within institutions?”, and “Should the state serve as custodian of orphans and vulnerable children who are placed within institutions or should this responsibility be delegated to service providers?” were discussed in Chapter 6 with regard to government roles in setting legislation, producing policy frameworks and developing service quality norms. Government also has the ability and/or responsibility for provision of care services, ensure and effective referral system, and monitor the quality of care to support orphans and vulnerable children. The findings from the current study suggest that the two countries have made efforts to set legislation and policy frameworks, although Mozambique has done so to a degree greater than Guinea-Bissau. Implementation of policies is still underway and thus the expected improvements in support for orphans had not reached most of the alternative care centres at the time when the centres were visited by the researcher in these two countries. As a result, most of these facilities were run by community or private initiatives that were not necessarily in partnership with the government and donor organisations, refuting the fourth assumption of the

study. This was more evident in Guinea-Bissau than in Mozambique. Likewise, the fifth assumption regarding the effect of the policies on the quality of care, it varied depending on the level of knowledge, qualification and staffing level of the care centre managers and personnel. Given the current gap in financial and institutional capacity, the realistic way forward would be for the governments to delegate the responsibility as custodians to service providers at the decentralised level and focus instead on offering technical support and monitoring to the service providers while state capacities reach a level that will allow them to fully assume custodianship within a comprehensive social protection framework.

As mentioned earlier, the 2012 ILC held in May 2012 agreed in its recommendation (No. 202) on guidance to establish, maintain, and implement social protection foundations that are nationally defined sets of basic social security guarantees aimed at preventing or alleviating poverty, vulnerability, and social exclusion (ILC, 2012). Social protection foundations are expected to consist of “(i) essential health care, including maternity care, at a nationally defined minimum level that meets the criteria of availability, accessibility, acceptability, and quality; (ii) basic income security for children at a nationally defined minimum level, including access to nutrition, education, care, and any other necessary goods and services; (iii) basic income security at a nationally defined minimum level for persons of active age who are unable to earn sufficient income, in particular in the case of sickness, unemployment, maternity, and disability; and (iv) basic income security at a nationally defined minimum level for older persons” (ILC, 2012).

Globally, public expenditure on social protection benefits that particularly aim to guarantee support for the needs of children account for 0.4 percent of total GDP worldwide, or 7.4 percent of total social protection expenditure (ILO, 2014a). These expenditures include child benefits as well as benefits targeting families with children, such as cash transfer programmes for children and families, whether provided in cash or in kind. However, provisions for health and

education, two important policy areas for children's well-being, are not included in that calculation (ILO, 2014a). As mentioned earlier, the allocation of social protection for children in Mozambique and Guinea-Bissau is much lower than this global average, namely 0.4 percent and 0.1 percent respectively. To attract sufficient resources to ensure alternative care for orphans and vulnerable children in need, the two governments could reinforce the convening role of international donors and NGOs to facilitate the provision of resources in a more organised and coordinated manner by mapping out the funding needs and gaps, and matching them to the aid priorities of different donors and NGOs. This should be done in addition to the governments' efforts to create fiscal space, as mentioned in Chapter 6.3.

Orphans and vulnerable children in the two researched countries are among the most vulnerable populations in the world, given the low human development level of the two countries in the global ranking. As a result, many of these children are living under alternative care, be it formal or informal, residential or family-based care. Although there were propositions or plans being conceived (Rodrigues et al., 2007; UNICEF-Mozambique, 2009), these children were receiving limited support from the government at the time this research was conducted. Improving the lives of these children requires both immediate as well as long-term support coming in different forms. Immediate support is required in the form of provision of essential services, such as education and health, to which most of the researched children had access, but were not necessarily of good quality or free of charge, especially in terms of health care. With regard to essential services such as education and health care, Case et al. (2004, p. 30) propose that "policies aimed at reducing the bias against orphans should operate by reducing the price of investments in orphans relative to non-orphans, for example through educational subsidies or non-transferable vouchers for schooling that are earmarked for orphan[s]". Block grants to schools could also be an option, as mentioned in Chapter 6. Such incentives, especially to educate children, could also reduce the incidence of child labour and of early marriage.

As a long-term method of support, the provision of cash transfers, as discussed in Chapters 2 and 6, to extended families or alternative caregivers of these children, especially during their school age years, has proven in recent years to be effective, especially in improving their education and nutrition outcomes (UNICEF-ESARO, 2008b; Samson et al., 2006). Mozambique is in the process of scaling up its experimental initiative of cash transfers that also target orphans and vulnerable children. Guinea-Bissau is still in its initial stage in terms of cash transfer programmes. Taking into account the findings from various studies that reported inferior nutritional status and schooling situations for orphans, especially among the poor in some cases, Devereux and Sabates-Wheeler (2011) suggest that special attention should be given to orphans within the households hosting them, arguing that:

Targeting resources at households hosting orphans might not achieve the desired impact because the problem is not necessarily lack of resources at the household level but intra-household discrimination in the allocation of resources. It follows that social protection interventions should target orphans directly, but in ways that correct for intra-household bias against them. (Devereux et al., 2011, pp. 228-229).

The two countries could therefore refer to the successful experiences of South Africa's Child Support Grant and Ghana's Livelihood Empowerment Against Poverty programme. The Child Support Grant of South Africa that reached 10.8 million children in 2012, or over half of all children in the country, has proven to have successfully provided income security to impoverished children by targeting poorer households and making marked improvements in children's lives (ILO, 2014a). Its gradual expansion since 2003 in terms of age and income threshold also worked well, resulting in monthly provisions of ZAR 300 (approximately USD 28) per child to caregivers who are South African citizens or permanent residents, whose annual earnings are below ZAR 34,800 for a single adult and ZAR 69,600 for a couple (ILO, 2014a).

Evaluations also showed positive effects beyond poverty alleviation, in terms of early childhood development, school attendance and educational attainments, namely improvements in the schooling of children whose mothers have less education, in overall health status, as well as reductions in risky behaviours by adolescents and increased access to the labour market for unemployed caregivers, especially for women (ILO, 2014a).

Similarly, the Livelihood Empowerment Against Poverty (LEAP) programme in Ghana is a conditional cash transfer programme, covering 246,115 beneficiaries (48.2 percent are children under age 17) in nearly half of the districts nationwide, who are from extremely impoverished households that include one or more orphans or vulnerable children, people over the age of 65, or people with a severe disability (ILO, 2014a). For the monthly benefit of about GHS 24–45 (about USD 9–17), beneficiary households with children under the age of fifteen commit themselves to certain co-responsibilities, such as school attendance (with a maximum absenteeism of twenty percent) and vaccinations and health check-ups for children under age five (ILO, 2014a). As the LEAP beneficiaries are automatically registered in the National Health Insurance Scheme (NHIS), they are more likely to be covered under the NHIS than non-recipient households (Handa et al., 2013).

It must also be taken into account the fact that almost half of orphaned children in Africa are between the ages of 12 to 17, and often caring for younger siblings as child-headed households (Devereux et al., 2011). Although these households are susceptible to impoverishment and intra-household conflicts, they often cannot access most social grant programmes, as those under eighteen are not recognised as heads of household or primary caregivers of younger children (Devereux et al., 2011). These adolescents thus need specific and targeted attention in social protection, especially in terms of transformative social protection policies. As mentioned earlier, there is a real need for livelihood programmes, but these programmes are under-funded, resulting in limited coverage (Devereux et al., 2011). Prioritising resource allocation to the

livelihood programmes for child-headed households would therefore be important.

Last but not least, the importance of the presence of caring and supportive primary caregivers, extended families, friends, and community members in the overall well-being of orphans and vulnerable children has been confirmed in this research. Statistical analysis of the data obtained from the field research found a significant association between children’s overall well-being and their social situation within the community. It is therefore recommended that measures to strengthen community integration of orphans and vulnerable children should be enhanced. Drawing on lessons learnt from the examples of psycho-social support in Zambia, OVC policies and strategies need to include the components and activities that encourage OVC psycho-social well-being.

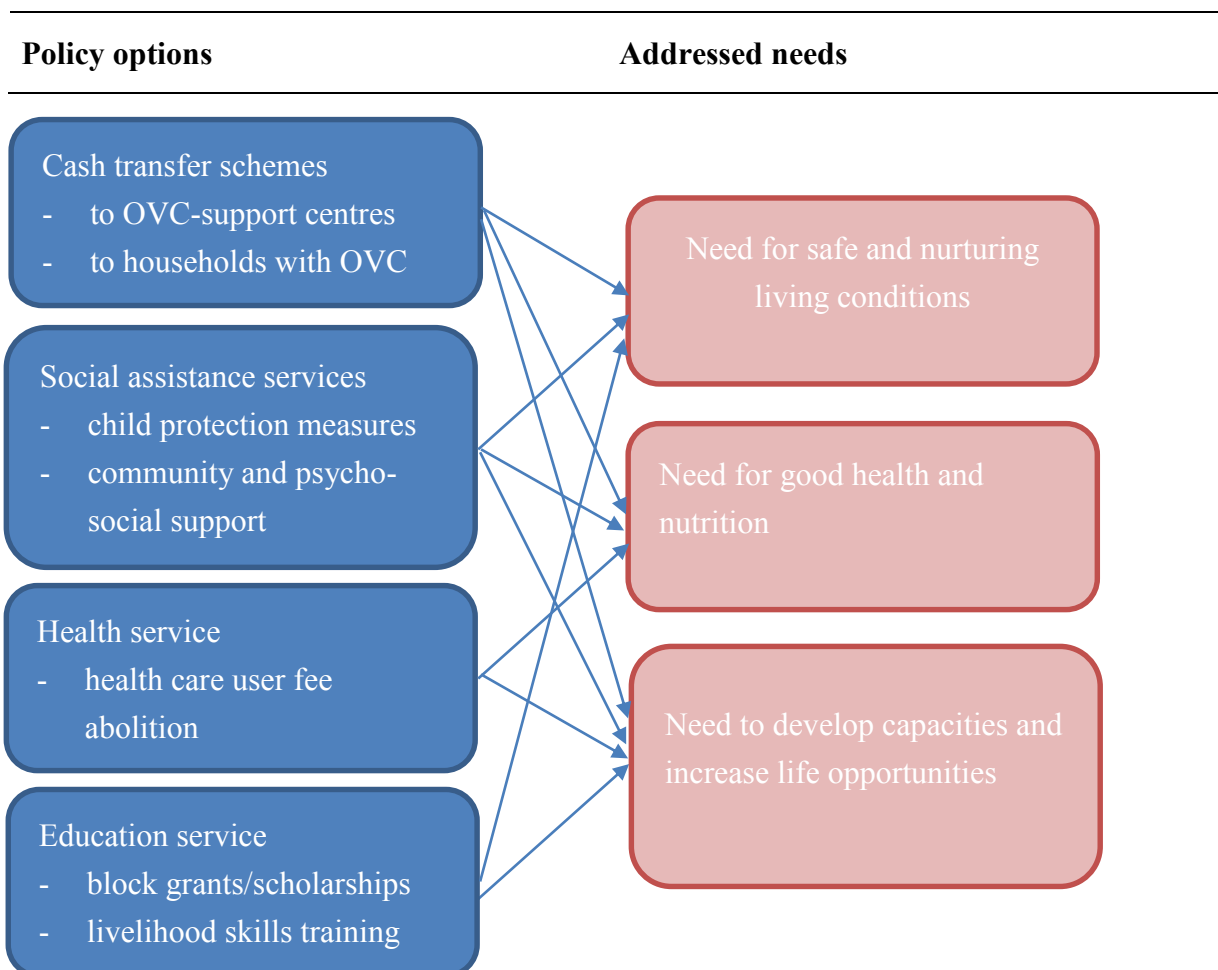


Figure 7.1. Policy options and addressed needs of orphans and vulnerable children

The recommended policy options mentioned above could be summarized according to the needs of orphans and vulnerable children that are addressed directly or indirectly, as in Figure 7.1. To ensure that these aspects are reflected for the best interest of children at the policy level, Blank, Devereux and Handa (2011, p. 24) call for a “child-sensitive” social protection system, which:

- Avoids adverse impacts on children and reduces or mitigates social and economic risks that directly affect children’s lives;
- Considers the age- and gender-specific risks and vulnerabilities of children throughout the life-cycle;
- Intervenes as early as possible where children are at risk to prevent irreversible impairment;
- Makes special provisions to reach children who are particularly vulnerable and excluded, including children without parental care and those who are marginalized within their families or communities due to their gender, disability, ethnicity, HIV status or other factors;
- Mitigates the effects of shocks, exclusion and poverty on families, recognizing that families raising children need support to ensure equal opportunity;
- Considers the mechanisms and intra-household dynamics that affect how children are reached, paying particular attention to the balance of power between men and women within households and the community;
- Strengthens the capacity of states, communities and families to respect, protect and fulfil rights; and

- Promotes a coherent legal framework to protect children and women, which includes the voices and opinions of children, their caregivers and youths in the understanding and design of social protection systems and programmes.

At the practical level, the experience of Zambia helps to organise immediate as well as long-term support in a larger social protection perspective, as a continuum of community-based social services for children in need of social protection. The model, which integrates a method of case management, social work, counselling and cash transfers, includes three categories of services for three target groups, namely highly-vulnerable children, children in vulnerable situations, and children in general (TRC et al., 2012). Firstly, for the highly-vulnerable children, the child-sensitive model offers protective services such as intensive family support, including alternative care, as well as crisis, rehabilitation, and adaptation centres. Secondly, for children in vulnerable situations, a child-sensitive model would offer services aimed to mitigate risks, such as early intervention and family support including psycho-social counselling, economic support including cash transfers, housing support, and day-care centres. Thirdly, for children in general, the child-sensitive model offers essential and universal services such as health and education, as well as awareness-raising aimed at the local communities regarding the needs of children and families in vulnerable situations (TRC et al., 2012). This is supposed to be accompanied by a universal safeguarding measure in the long-run, in order “to create a society that is caring and protective of children, through public sensitization and education to prevent child abuse and mistreatment” (TRC et al., 2012, p. 39).

Within this continuum of support, it is highly important to take into account the interventions that cultivate the resilience of orphaned and vulnerable children, especially for those reaching adolescence. In this regard, measures to promote family regulation, respect for individuality, peer connection, community connection, and regulation are the key, as identified by the study conducted by Wild and her colleagues (2011). Family-based support should therefore consist

of awareness-raising and training on how to discipline and encourage children and adolescents while respecting their individuality. In an ideal scenario, the families who are deemed inadequate to provide psycho-social care in this manner would have their suitability as caregivers of orphaned children reconsidered, because they would actually be increasing the vulnerability of the orphans they are ostensibly caring for. Then, such family-based support should be accompanied by community programmes that facilitate social integration, cultivate a sense of connection, both among peers and community members, and enhance the atmosphere of community regulation. The goal is to cultivate resilience among children and adolescents, especially, but not limited to, those who have lost one or both parents.

When measured against the ILC Recommendation that includes support for children, Mozambique is already on the right path in terms of the policy and planning to support orphans, whereas Guinea-Bissau still has a long way to go. As pointed out earlier, this should be accompanied by measures to guarantee provision of essential social services such as education and health because it would not be appropriate to stimulate demand via social cash transfers for essential social services that do not exist or that are inadequate (Devereux et al., 2011). At the same time, the socio-economic contexts in the two countries call for a more systematic and comprehensive social policy response and implementation that efficiently addresses both chronic poverty and vulnerability due to HIV/AIDS, particularly among orphans. Therefore, further development of the existing support centres and programmes, accompanied by realisation of comprehensive social protection measures to improve the living standards of communities, including foster families, would be the way forward to better support the orphans and vulnerable children in the two countries studied under this research. Such comprehensive social protection measures also require resources to ensure implementation, thus the government commitment to allocate enough state budget is crucial.

As Devereux and Sabates-Wheeler (2011, pp. 234-235) argue:

Of course, cash transfers are unlikely to change the social attitudes and cultural practices that result in systematic marginalization or abuse of vulnerable categories of individuals, such as fostered girls. Transformations are needed in gender relations, attitudes and behaviours within households, communities and institutions, complementing programs that deliver targeted assistance and social services (including child protection) directly to children, with legislation, awareness raising and sensitization campaigns. The key is an integrated approach to national social protection strategies that responds to the multiple risks and deprivations that children face, by tackling the structural causes of their material and social vulnerabilities.

Without such comprehensive social protection measures implemented, these children will continue to be at risk of being under the care of either foster families who have neither the financial nor social capacity to look after them, or alternative care centres who manage to support them within the capacity of their own limited funding and own quality control, which may not be sufficient nor sustainable in the long run.

Appendix

Appendix 1: Questionnaire for children

Child Question Form

Name of OVC: _____

Identification Number: _____

Gender: Male ____ Female ____

Age: _____ School: _____ Grade: _____

Family situation: _____

Statement	Never	Some-times	Always
I eat at least two meals a day			
I have enough food to eat			
I ate yesterday (number of meals: _____)			
I eat a variety of food			
I go to bed hungry			
I feel strong and healthy			
I worry about my health			
I felt ill in these two weeks			
I feel light-headed			
I have a house where I can sleep at night			
I feel secure in my neighbourhood			
I feel safe where I live			
I have enough water to drink and bath			
I'm treated differently from the other children in my household			
At home, I have someone to look after me if I get hurt or feel sad			
I like school			
My teachers treat me like the other students			
I have the materials I need to do my class work			
I am not treated as well as the other students in my class			
I have enough books and supplies for school			
My school attendance is affected by my need to work			
My family has enough money to buy the things we need			
One of the adults taking care of me earns money working			
I have to work before and after school			

I'm treated differently from other children in my village, neighbourhood, compound			
I do not get enough sleep and feel tired			
I have people I can talk to when I have a problem			
I am able to do things as well as most other people			
I am as happy as other kids my age			
I feel lonely			
I feel hopeless about my future			
I had nightmares in these two weeks			
I feel worried (why? _____)			
I feel angry (why? _____)			
I feel afraid (why? _____)			
I feel frustrated (why? _____)			
I have adults that I can trust			
I have friends that I can trust			
I get the emotional help and support I need from my family or friends			
I feel I am supported by my extended family			
I am growing as well as other kids my age			
I have a community that I belong			
People in my community try to help me			
I feel welcome to take part in community services			
My household receives free support to care for the children who live here			
I like the programme/care I participate			
The programme/care has been useful			
The programme/care brings hope			

Source: Based on the “Orphans and vulnerable children well-being tool” used by Catholic Relief Services (2009).

Appendix 2. Observation sheet for children

Child Observation Form

Name of OVC: _____

Identification Number: _____

Gender: Male ____ Female ____

Age: _____ School: _____ Grade: _____

Family situation: _____

Observation	Never	Some-times	Always
Height			
Weight			
Body fat rate			
Thin-Fat level			
Body type/situation			
Body mass index			
Minimum calories			
Observable state of health	Bad	Ok	Good
Observable state of skin	Bad	Ok	Good
Observable state of hygiene	Bad	Ok	Good
The child smiles			
The child seems to feel comfortable in talking			
The child acts nervously			
The child seems anxious			
The child seems tired			
The child seems sad			
The child seems focused on the activity at hand			
The child freely join a group of other children			
<u>Any other observations</u>			
<u>Ask child if s/he has any comments or questions</u>			

Appendix 3. Questionnaire for caregivers

Residential Care Institution Assessment Form

Name(s) of interviewees: _____

Position of interviewees in the Centre: _____

Date of visit: _____

Name of the Centre: _____

Address of the Centre: _____

Telephone Number: _____

Date founded: _____

About the Centre
Who owns the premises? _____
Type of construction of building _____
Number of floors _____
Separate Sleeping accommodation for boys and girls? Describe _____
Is there a fire escape? _____
Number of working fire extinguishers? _____
Number of toilets for boys _____ Number of toilets for girls _____
Number and type of washing facilities _____
Are there separate washing facilities for boys and girls? Y/N _____
Water supply: Tap _____ Other please state _____
Is there a school nearby? Y/N _____
Which supports are provided? Nutirion, Education, Financial, Legal, Health, PSS
Facilities
Number of children per bedroom/dormitory _____
Number, type and condition of beds _____
Number of TVs _____ Number of computers that work _____
Availability of toys and books _____
Where do the children eat? _____
What leisure and play facilities are available? _____
Food
What meals are provided? _____
Times of meals _____
Who does the food preparation? _____
What is the hygiene standard like? _____
Is there drinking water available? _____

Finance
Does the Centre receive a Govt subvention? _____
Give other sources of funding in cash or kind:
Management
Name of Person in Charge/Administrator _____
Management Committee Members:
With which authority is the home registered: with MMAS/INA; as a Company; NGO; Private
Discipline
Are any rules for the Centre written up for all to see? Y/N
How are the breaking of the rules dealt with?
Is staff beating of a child allowed? Y/N
Is the isolation of a child allowed? Y/N
Information on the Children
Number of children in residence today: _____
Number of Children seen _____
Current Total Number of Boys : _____ Current Total Number of Girls: _____
Age range of boys: _____ Age range of girls: _____
How many children have disabilities? _____
How many children of school age do not attend school? _____
Case Records
Is there a separate case record for each child?
What of the following is in that file: birth certificate, medical card, school reports, photos (child, parents),
home or relative's address, mementoes from home, case report notes, monthly review,
IDTR (Tracing done, Result, Verified, Reunified Previously?)
Is there a care plan for each child? Y/N
List Names of Care
Staff
Type of Training Gained and level: Degree, diploma, certificate,
Length of time spent training
Position Held
Number of other paid staff (eg cooks, guards, clerks, etc) _____
Numbers of : cooks _____ guards _____ clerks _____ other paid staff _____
Authority for keeping the children
When a child is received at the Centre is there a document signed by the parent or guardian placing the child that they authorise your looking after the child? How many children have these documents? _____

How many children have written authorisations by the court? _____
How many have written authorisations by the Probation Department? _____
How many times did a Probation Officer visit in 2006? _____
Health and Safety
Do you have a first aid box? _____ Check condition _____
Do you have a sick bay? _____
Do you have a trained medical person on the staff? _____ Name _____
Where do you take children with minor ailments and injuries _____
How far away is it? _____
Where do you take children who have a serious medical condition? _____
How far away is it? _____
How many children are HIV infected _____
Do they receive ARV drugs and food supplements? _____
What are the homes external contacts?
How frequently may parents/relatives visit their child? _____
Who else visits the home and when _____
Do children go to scouts, youth clubs, sports clubs, discos _____
Any other information

Appendix 4. Questionnaire for public authorities

District Authority (DPMAS/SDMAS) Assessment Form

Name(s) of interviewees: _____

Position of interviewees in the DPSMAS: _____

Date of visit: _____

General Information re- the District

Name of the District: _____

Telephone Number: _____

General Information on OVC in the District	Response
Number of children identified as orphans	
Number of children reunited with families	
Number of alternative cares available	
Types of alternative cares available	
Number of children referred to basic services	
Nutrition	
Education	
Financial support	
Legal support	
Health	
PSS	
Others	
What are some difficulties faced?	
How do you assess the alternative care visited?	

Questions	Yes	No
1) Sensitization on OVC takes place in the communities?		
2) Are the activities being monitored?		
3) Do they have any monitoring data (figures from the Gabinetes, schools, community)		
1) Technical Working groups/NumCOV exists, and meet periodically?		
2) Training activities take place?		
1) Community Committees exist?		

2) Are they operational?		
3) Any evidence exist?(list of members, list of children they support, kind of support they provide, A -visit to the committee when applicable		
1) Monitoring visits are carried out?		
2) Evidence exists? (Trip reports, Guias de Marcha signed and stamped, existing monitoring data)		
1) Is DPMAS providing Material support to children?		
2) Where are the children receiving this support (school, home or other)		
3) Are children being referred to school? (list of children referred to school, name of school)		
4) Is there any evidence of material and non support to OVC? (Children and families report to have received material, that children were referred to school. Visible materials received by the beneficiaries,)		

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