Toolkit For Positive Change

Providing Family-Focused,
Results-Driven and Cost-Effective
Programming for Orphans and Vulnerable Children

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Programming for Orphans and Vulnerable Children

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Foreword

Ethiopia is home to a culture which is rich in traditions, age-old customs and strong relationships among family, kin and community members. The onset of HIV and AIDS has tested those bonds and created enormous challenges for children, families and communities. Despite the enormity of the situation, it has also provided an opportunity for people to come together and respond to an issue which could appear insurmountable. One of the largest groups in need of support is orphans and vulnerable children directly affected by HIV and AIDS, extreme poverty, continuous risk of famine, and internal and external migration. With more than five million Ethiopian children considered to be orphaned or vulnerable -- 77,000 of those children living in child-headed households -- the situation calls for us all to respond.

Fortunately, the determination, commitment and the same age-old traditions of Ethiopia's people have provided the foundation for a massive response. Individuals, community groups, national organizations and local government structures have risen to the challenge and come together to support a united vision; a brighter future for orphans and vulnerable children (OVC) of Ethiopia. One by one people have joined to meet the needs of OVC and have provided a ray of hope in a once gray horizon. The caregivers, Iddir members, Core Community Groups, community-based organizations, Kebele's, local non-governmental organizations, and the international partners have become positive change agents; bringing support, services and care to children and communities affected by HIV and AIDS. This Toolkit is not the story of Save the Children, USA and their international partners. It is the story of concerned and committed Ethiopians who were provided tools, skills and knowledge which helped them respond to the needs of more than 530,000 orphans and vulnerable Ethiopian children.

The impact of HIV and AIDS continues to dramatically impact families and children in Africa. Responses, particularly to address the needs of orphaned and vulnerable children have been many, but until now have remained at small scale. The Postive Change: Children, Communities and Care (PC3) Program has harnessed community, regional and national support to address the needs of OVC by creating a broad network of support and strengthened the capacity of 35 national NGOs and 575 community-based organizations who together deliver coordinated and comprehensive care and support services. The level of support generated at scale in Ethiopia provides an important guide for similar responses in Africa and globally. Key to achieving this level of support at scale, and discussed in detail in this Toolkit, are the following strategies:

Design for Scale ~ Harnessing Partner Strengths: The PC3 Program used the design process to join partner strengths and capacities and build an approach that would be sustainable at scale from the initiation of the program. Building a network of concerned individuals, caregivers, and group institutions who would be able to provide support and care was carefully considered. Together with key collaborating partners program principles, values and code of conduct were jointly established to assure protection of children and quality services.

Multi-Level Tiered Approach: The institutional and technical capacity of existing grassroots, community-based organizations and local NGOs was built to provide sustainable, long-term safety nets and services to OVC and their families.

Building on Existing Community Coping Mechanisms and Groups: Ethiopia is home to a proud culture, rich in traditions, age-old customs, and strong relationships among family, kin and community members. PC 3 has built on positive Ethiopian traditions and culture which care for vulnerable children that have unified individuals, community groups, local government structures, and national organizations to rise to the challenge and come together to support a united vision and a brighter future for OVC in Ethiopia

Empowering Community Mobilization: The Community Action Cycle (CAC) was applied by communities themselves to organize, assess, plan and act collaboratively to increase and improve care and support to orphans and vulnerable children. The process built community ownership and sustainability from the start and supported communities to reach their identified goals for vulnerable children.

Capacity Building at Multiple Levels: Capacity-building of partners assures standardization of training and effective roll out of comprehensive, family focused coordinated care services to children and households impacted by HIV and AIDS. Partners at all levels build critical organizational and service delivery skills.

Quality services defined by Children and Their Caregivers: Involvement and active participation in decisions which affect their own lives have lead to integrated support including access to education, food and medical care, psychosocial counseling, legal advice and protection, life skills training, micro-credit for income-generating activities, and safer homes.

This Toolkit shares the key strategies and tools which were used by concerned and committed Ethiopians to address the needs of vulnerable children in their communities. It is the hope of all who have been involved in The Positive Change: Children, Communities and Care (PC3) Program that the Ethiopian experience will be utilized and applied wherever OVC need support, services and care. The tools presented herein are tested, family-based, cost-effective and child-centered. They have proven to be effective and have restored hope to half a million Ethiopian children and their families. We would like to see them positively affect the lives of millions more in Ethiopia and around the world.

Acknowledgements

We would like to acknowledge the President's Emergency Plan for AIDS Relief (PEPFAR) and the United States Agency for International Development (USAID) for allowing us the opportunity to implement the Positive Change: Children, Communities and Care (PC3) Program. Their constant support, technical assistance, and interest in the program provided us with valuable guidance and leadership throughout all the varying stages and phases of this effort. Tier I, II, and III partners thank you for your unending cooperation, leadership and support.

This toolkit could not have been developed had it not been for the hard work, dedication and commitment to making positive change in the lives of orphans and vulnerable children (OVC) demonstrated by the thousands of volunteers who were the life force behind the Positive Change: Children, Communities and Care Program. Their desire to improve the well-being of OVC in Ethiopia was the driving momentum and heartbeat of this program. The endless hours they selflessly dedicated to trainings, meetings and home visits is what, in the end, resulted in significant improvements in the lives of vulnerable children in their communities. We extend our sincere gratitude and appreciation to the PC3 program partners including, the 575 community-based organizations, 35 non-governmental organizations and the five international organizations for working cooperatively to provide the lessons, promising practices and the tools that are shared in this Toolkit.

Finally, we thank the technical reviewers from each international partner, particularly Kendra Blackett-Dibinga, Ronnie Lovich, Carol Miller and Gail Snetro of Save the Children USA, Dr. Assefa Amenu of CARE, and Aragaw Biru Muhammed of World Learning.

List of Acronyms

ART	Anti-Retroviral Therapies
BCC	Behavior Change Communication
BDS	Business Development Services
CAC	Community Action Cycle
CHAD-ET	Child Aid Ethiopia
CBO	Community Based Organization
CCF	Christian Children Fund
OVC CCG	Orphans and Vulnerable Children Community Core Group
CM	Community Mobilization
CRC	Convention on the Rights of the Child
CTC	Community Therapeutic Care
CSI	Child Status Index
CSSG	Community Self-help Savings Group
ECCD	Early Childhood Development
EFDA	Education for Development Alliance
ENA	Essential Nutrition Action
FBO	Faith Based Organization
FBOYA	Fikir Behiwot Orphans and Youth Association
FHI	Family Health International
HACI	Hope for the African Children Initiative
HAPCO	HIV and AIDS Prevention and Control Office
HCP	Health Communication Partnership
IMCI	Integrated Management of Childhood Illnesses
IGA	Income generating Activities
INGO	International Non-Governmental Organization
IR	Intermediate Result
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MFI	Micro-Finance Institutions
MIS	Management Information System
MOU	Memorandum of Understanding
NGO	Non-Government Organization
OI	Opportunistic Infections
OVC	Orphans and Vulnerable Children
OVC CCG	Orphans and Vulnerable Children Community Core Group

PC3	Positive Change: Children, Communities and Care
PCI	Project Concern International
PEPFAR	President's Emergency Plan for AIDS Relief
POTCAT	PC3 Organizational and Technical Capacity Assessment Tool
PSNP	Productive Safety Net Program
PSS	Psychosocial Support
PTA	Parent Teacher Association
QAI	Quality Assurance Improvement
ROSCA	Rotating Savings and Credit Associations
RTUF	Ready to Use Foods
SC/US	Save the Children USA
SHG	Self Help Group
SNNPR	Southern Nations Nationalities and Peoples Region
SO	Strategic Objective
SP	Strategic Planning
STI	Sexually transmitted infection
TB	Tuberculosis
UN	United Nations
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing
WFP	World Food Program
WL	World Learning Ethiopia
WV	World Vision Ethiopia
YAK	Youth Action Kit

Glossary of Terms

Bereavement: The emotional process related to the loss of a person through death.

Caregiver: A relative or someone in the community who has taken over the parental responsibility of a vulnerable child or children because his/her parent is unable to care for him/her. One who provides cognitive, emotional, financial, spiritual and physical support and gives a child, a safe and nurturing environment

Child-headed Households: A child-headed household is one in which a child or children (typically an older sibling), assumes the primary responsibility for the day to day running of the household, providing and caring for those within the household.

Community Mobilization: a capacity building process through which individual, groups or organizations plan, implement and evaluation activities in a participatory and sustained basis to improve their needs, either on their own initiative or stimulated by others. [1]

Double orphan: Child who has lost both parents

Iddirs *(Christian, Muslim or non-faith based)* and **Afoacha** *(Muslim)*: Social support groups within Ethiopia.   Members of these CBOs take responsibility for all burial ceremonies and household activities from 3 to 7 days after a death. Members of these groups are required to pay a regular fixed monthly contribution. Most groups have written internal regulations and an assigned leadership committee, which members nominate for a fixed period of time.

Kebele: Local administrative unit in Ethiopia

Livelihoods: Actions which aim to ensure economic stability and food security of a household or community. Common interventions include income generating activities (IGA), micro-lending, and vocational training.

Orphans and Vulnerable Children (OVC): Children who have been orphaned by AIDS and/or affected by the HIV and AIDS pandemic (children living with sick parents, children living in highly affected communities, children living without adult care).   Vulnerable may also include children whose rights to care and protection are being violated or who are at risk of those rights being violated (see definition below).

Psychosocial support (PSS): An ongoing process of meeting the emotional social, mental, spiritual and physical needs of a child. This is done through ongoing care and contact with the child.

Single Orphan: Child who has lost one parent

Vulnerable Child: A vulnerable child is a child who is less than 18 years of age and whose survival, care, protection or development might have been jeopardized due to a particular condition, and who is found in a situation that precludes the fulfillment of his or her rights.

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[1]   Grabman and Snetro (2003), *How to Mobilize Communities for Health and Social Change*, Health Communication Partnership

Chapter 1
Introduction and Context

Introduction to the PC3 Program

a) The Situation of HIV and AIDS and OVC in Ethiopia

Ethiopia has a population of 76,062,142 (2007 Census First Draft Report, CSA. Extrapolation to 2008 population figures using 2.9% growth rate) making it the second most populous country in Africa. HIV and AIDS have dramatically impacted Ethiopian society and have resulted in a large segment of the population living with HIV and AIDS[2], chronically ill or already deceased. All of these factors have resulted in a significant population of children orphaned and vulnerable due to the epidemic. In 2009 it is estimated that, 1,116,216 adults are living with HIV and AIDS; 2.3 percent of the total adult population of Ethiopia[3]. Adult prevalence in urban areas is estimated to be 7.7 percent of the urban population accounting for 695,413cases and the rural prevalence is 420,802 cases; 0.9 percent.[4] Children (ages 0-14) account for an additional 72,945 HIV and AIDS cases and of that number 14,140 cases were new in 2009; an increase of almost 4,800 cases in one year. [5] The Orphans and Vulnerable Children Rapid Assessment, Analysis and Action Planning Report Ethiopia (RAAAP) produced by UNAIDS, WFP, UNICEF, USAID and the Government of Ethiopia referring to the 2000 Ethiopia Demographic Health Survey (EDHS) mentions that an estimated 18% of all Ethiopian households are caring for an orphan.

Almost more startling than the aforementioned statistics is the number of Ethiopian children who are classified as one or two parent orphans (age 0-17) in 2009. A total number of 855,720 children are maternal, paternal or dual orphans due to loss of one or both parents to HIV and AIDS. An estimated 5,453,313 children make up the <u>total</u> number of orphans and vulnerable children[6] (see chart in Annex 1). This astounding number represents more than six percent of the overall population of Ethiopia. Fortunately, due to the improvement and increase of Anti-Retroviral Therapies (ARTs) and other medical and social support systems which have increased in coverage over the past five years, the number of both HIV orphans and non-HIV-related orphans is expected to slowly decrease in the next few years.[7]

The multifaceted impact of this disease across generations, communities and individual households has been significant and presents enormous challenges as to how to best address the myriad of needs that children, families and communities face due to HIV and AIDS and other issues including extreme poverty, food insecurity, and limited social safety nets. When children are confronted with these issues combined with their susceptible status as minors the result is inevitably one of extreme vulnerability.

Children affected by HIV and AIDS face immense challenges as they attempt to thrive in what is already a difficult environment. Access to health care, education and psychosocial support are

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[2]   Ethiopia stands 3rd in absolute numbers of people living with HIV and AIDS behind South Africa and Nigeria.

[3]   Ethiopian Ministry of Health and Federal HIV and AIDS Prevention and Control Office, 2008. *Single Point HIV Prevalence Estimate Document*, Addis Ababa, Ethiopia

[4]   Ibid, pp. 7-8

[5]   Ibid, p.6

[6]   Ibid, p.6

[7]   Ibid, p.6

extremely limited and children without caregivers frequently fall through the cracks of the minimal social safety net programs that do exist. OVC are particularly vulnerable to exploitation, both physical and economic, violence, including physical and sexual abuse. The impact on girls is especially profound as girls face sizeable challenges,[8] including early initiation of sexual activity, exploitation, abuse, sexual violence and female genital cutting; all factors which lead to greater risk of becoming infected with HIV. These risks are enhanced by the precarious life situation of female OVC who may not receive parental or other adult guidance and protection. For children whose parents or primary caregivers have died or are critically ill, legal protection for property and inheritance rights is essential so that their already vulnerable situation is not exacerbated by loss of shelter, land, and other material property. Creation and provision of a comprehensive package of key social, medical, psychological, educational, economic and legal support services to OVC and their families is a critical component of a basic safety net necessary for preventing, at a massive scale, unnecessary illness and death, school desertion, exploitation in its many forms and child abandonment.

b) The Positive Change: Children, Communities and Care (PC3) Program Response

The Positive Change: Children, Communities and Care (PC3) Program is a five-year (2004-2009) integrated and comprehensive program designed to provide care and support to more than half a million orphaned and vulnerable children and their families throughout the country of Ethiopia. The Program emphasizes community-based, results-oriented, and family-focused efforts which reduce the negative impact of HIV and AIDS on children, families and communities and increases capacity of local organizations and communities to positively respond to the needs of OVC.   The PC3 Program is a consortium of international and local non-governmental organizations (NGOs) and community groups working in partnership to address the needs and unrealized rights of OVC, together with the Government of Ethiopia, private sector and the communities and families themselves. Funded by the President's Emergency Plan for AIDS Relief (PEPFAR) through the United States Agency for International Development (USAID), Save the Children USA is the lead agency and works in close collaboration with four international NGO (INGO) partners including CARE, Family Health International (FHI), World Learning (WL) and World Vision (WV). In addition, key PC3 partners include 35 national NGOs and 575 community-based organizations who together deliver coordinated and comprehensive care and support services to 530,000 orphaned and vulnerable children and their families in seven regions of Ethiopia, including Addis Ababa, Amhara, Afar, Benshangul-Gumuz, Dire Dawa, Oromia and Southern Nations, Nationalities and Peoples Region (SNNPR). The map below illustrates the regions in which PC3 is present.

The Geographic Map of the
PC3 Program Implementation Sites

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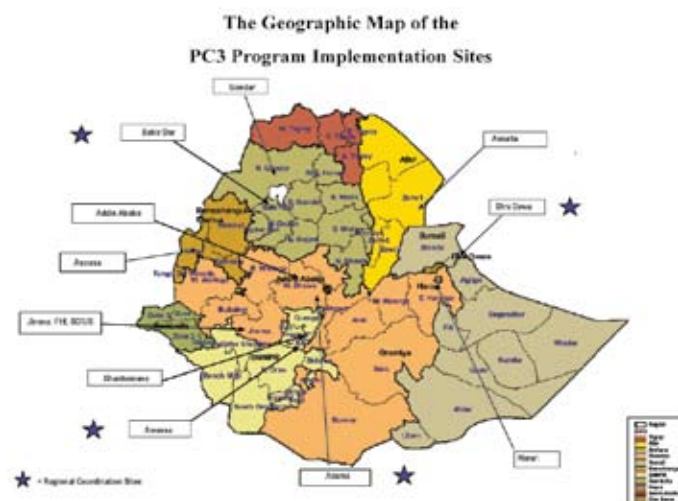
[8]   Monasch, R., Presentation at OVC Technical Consultation, 2003. UNICEF NY

PC3 is currently the largest OVC program in Africa. The tiered approach implemented by the PC3 Program is unique as it reflects the principal strategy of building the institutional and technical capacity of grassroots or community-based organizations to provide sustainable, long-term safety nets and services to OVC and their families. The program's concepts, activities, reach and impact have grown exponentially over the lifespan of the program by strengthening the capacities of local NGOs, community-based organizations (CBOs), community groups such as Iddirs and Afoacha, faith-based organizations (FBOs), women and youth groups and Parent-Teacher Associations (PTA).

c) Key Objectives and Intermediate Results of PC3

The Strategic Objective (SO) of the PC3 Program is to increase the use of community- based care and support services and protective practices for OVC, families, and caregivers through strengthened and expanded capacity of communities to respond to the needs of OVC households in Ethiopia. This is achieved through the following Intermediate Results (IR):

IR 1) Increased availability, quality and consistency of community-based support services for OVC and families affected by HIV and AIDS;

IR 2) Improved capacity of Ethiopian Civil Society Organizations (CSOs) to plan, implement, monitor, evaluate, manage and report on OVC programs and services; and

IR 3) Enhanced supporting environment for OVC and their households developed through strengthened coordination, networking and advocacy.

d) Key Results

The results of the PC3 Program speak for themselves and demonstrate how community mobilization and creation of local responses to OVC can be done on a national scale. The PC3 Program has created and strengthened effective community-based support services for OVC and their families and made the issue of OVC priority at the community and the national level. Over the lifespan of PC3, noteworthy results have been achieved within each Immediate Result (IR). PC3 has succeeded in the provision of quality social services and support to over 530,000 Ethiopian OVC. Also notable under IR 1 is the support provided to households to strengthen economic capacity and improve livelihoods through the establishment of Community Self-help Savings Groups (CSSG). To date, more than 700 CSSGs have been established and supported by the PC3 program. These groups have saved over Birr 800,000 ($80,000) since program initiation, providing members with the opportunity to borrow against these savings to meet household needs including starting small businesses which have helped to bring income and support household needs such as food and education for children. Service standards for OVC have been developed, piloted and validated and will become an integral component of the project and benefit future implementation of OVC programs and services. Supporting the focus on quality, PC3 has also introduced an innovative tool, the Child Status Index (CSI), for assessing the level of vulnerability of OVC over the course of program implementation. This tool provides a framework for evaluating each child's situation thus providing essential information necessary for developing an individual case plan for children. Using the tool, PC3 has ensured improvements in the quality of life for all children on the program as the tool allows identification of gaps and development of improvement plans.

Under IR2, the program has assisted in building the capacity of national and community level organizations through targeted training of Tier II and Tier III partners. Utilizing several methodologies, including a Training of Trainers (TOT), the focus on strategic planning, resource mobilization, budgeting and reporting are particularly important as the partners prepare to take on more and more responsibilities and strengthen their own capacities to successfully respond to the needs of OVC in their communities. To date, more than 610 national and community level groups have mobilized, organized themselves and have built capacity to respond to the needs of the most vulnerable children in their communities. The groups have improved capacity to deliver quality OVC programs and services and have systems in place for monitoring and tracking progress. Service data is collected and is incorporated into decision-making processes. Additionally, quality improvement service standards have been developed and promising practices and successes have been documented and shared with others. Some of the community groups have transformed from informal to para-formal organizations and have office space and fundraising plans in place. NGOs and CBOs have received training and now produce funding proposals to support OVC work. These groups have built successful partnerships with private sector and individuals are raising more resources to support their programs.

Within IR3, significant results focused on coordination, partnership and advocacy activities. The National OVC taskforce has been strengthened and provides leadership for national coordination and policy formulation around OVC issues. Advocacy activities have been implemented throughout all three tiers and have included successful lobbying for waiving school and medical fees for program beneficiaries as well as involvement of the private sector to financially support certain key aspects of services and support for OVC. Publicity and public awareness around OVC issues have been very successful through coordinated efforts such as World AIDS Day and commemoration of Day of the African Child.

Partnerships are a key theme in PC3 and successful linkages and collaborative efforts have been developed with government entities, both at the federal and local level. Strategic linkages with other PEPFAR programs such as Urban Gardening, Food Security through World Food Program, Intrahealth's pediatric ART treatment and Clinton's HIV and AIDS Initiative for nutrition services, were strengthened to provide comprehensive support to OVC and their families.

e) Motivation for Creating the Toolkit

The primary motivation prompting the creation of the toolkit is to provide guidance, tips and resources for adapting the PC3 model both locally and internationally. This document provides a road map for OVC program implementation and at the same time offers suggestions and tools on evidence-based approaches which could be applied to facilitate rapid scale-up and effectiveness of services for OVC. The tools presented within this document have been tested, adjusted and proven to be cost-effective, results-oriented and most importantly, family and community-based. Sharing the tools of the PC3 Program, in a user-friendly format, provides an excellent opportunity to spread the positive impact generated by the Ethiopian experience to other communities worldwide that are confronting the challenges of HIV and AIDS. Children, families and communities need support to become healthy, educated and participatory members of their communities. This toolkit provides the expertise and tools needed to create an environment which promotes that goal. Within this document are the building blocks necessary for fostering local expertise and commitment, generating and strengthening partnerships, and empowering communities to successfully respond to the needs of its youngest members affected by HIV and AIDS.

The second reason for creating this toolkit is to celebrate the children, families and communities that made PC3 a success. These groups have given their time, resources and commitment to serve OVC with the end goal of improving their overall well-being. The PC3 Program was created on the assumption that parents and communities want to do what is best for their children. PC3 provided them the opportunity to do so and the results have been tremendous. Children, once overwhelmed by the myriad of challenges faced due to HIV and AIDS have now received the critical support they need to flourish in their childhood. Parents and caregivers have been empowered to care for their children, both economically and emotionally, and communities have confronted challenges which were once deemed insurmountable, with courage, grace, and determination.

This toolkit documents their work though the efforts of the many valuable partnerships focused on improving the lives of OVC, their caregivers and their communities.

f) Target Audience

The Toolkit is appropriate for use at the donor, policy and practitioner level. The donor community can use this Toolkit to help make informed decisions regarding investment of their resources Policy makers, such as governments, could use it to inform decision-making regarding the package of interventions and services for OVC which would produce the desired outcomes. For practitioners, this document is a how-to for successful implementation of a comprehensive package of services and interventions which support and empower OVC and their caregivers.

g) How to Use the Toolkit

The Toolkit is organized according to a program development cycle. The Toolkit follows the natural rhythm of program development and can be utilized as a whole or as a reference for specific stages of a program cycle or component. Each tool contains a clear and concise definition, a description of who, when and for whom it should be used, a how-to for using the tool, a promising practice story(s) highlighting the value of the tool, as well as facts, figures, diagrams or photos of the tool. There are additional references at the back of the document including related readings, websites and how to access a CD containing many of the tools mentioned in this toolkit.

The toolkit may act as a reference, a helpful resource, or as a how- to- guide in assisting community groups, national organizations and international organizations in their efforts to develop key concepts, activities, and services of a successful OVC program. The lessons learned throughout the five-year implementation cycle of the PC3 Program have been significant and have provided useful insight into how to best meet the needs of individuals and households affected by HIV and AIDS. The tools presented herein are not only specific to the Ethiopian context. They are general enough as to be adapted to communities globally where there is a need to improve or strengthen support and services to orphaned and vulnerable children.

Chapter 2

Formative Assessment

Key Elements of the OVC Toolkit

Formative Assessment

There are two types of formative assessments which may be done before initiation of an OVC Project. They include a rapid assessment and a baseline survey. Both of these activities assist in gathering critical information which can be utilized later in the program design phase.

a) Rapid Assessment

Definition

Following the awarding of the grant, PC3 partners organized teams to conduct rapid formative assessment which aimed to 1) understand the context and OVC situation in each region 2) map out existing programs and services for OVC 3) discuss partnership with regional governments, and 4) introduce the program to the targeted communities and prepare them for the role they would be expected to play over the five years and beyond. The information generated from the formative assessment was used in various ways: to refine the design of the program; facilitate development of memoranda of understanding (MOU) with regional governments to ensure commitment to playing a key role in program implementation; and identification of potential NGO and CBO partners. The assessments were conducted in each region by the Monitoring and Evaluation (M&E) team with guidance from the community mobilization and capacity building specialists. The team used qualitative methods (FGDs and key informant interviews) to collect data. Each region had one team to ensure that this process was completed in a rapid manner. The results were consolidated and submitted to program leadership to facilitate the refinement of program strategies and development of implementation plans.

How the Rapid Formative Assessment is Used

To implement a Rapid Formative Assessment, Question Guides were used to facilitate interviews with various individuals and groups. These guides were developed to facilitate the collection of key information regarding: community awareness of OVC issues and community actions to address those issues; identification of already existing services and whether or not they were adequate; gaps in services; means of identifying OVC and volunteers within the community; and how to identify community groups that were already involved or interested in supporting OVC.

Methods

There are several methods that may be used when completing a rapid assessment. Participatory methods are preferred when conducting rapid formative assessment. This helps to not only inform the process, as the community members are often more informed than outside researchers, but also to engage with the community in the program right form the start. The involvement of the community helps to keep their interests and need at the center of the program by ensuring that the real issues feature in the assessment and are eventually incorporated into the program's intervention plans. Some of the participatory methods, which were used by the PC3 program included: focus group discussions (FGDs), key informant interviews (KII) and observations. There

are other participatory approaches that new programs can use such as participatory rapid appraisal, which require more intense training and analyses. A FGD is a research technique that involves data collection through the involvement of a homogeneous group that is knowledgeable, affected by or a potential beneficiary of the subject of discussion or project. For instance, in an OVC program, caregivers, school teachers, and older OVC may be recruited as participants.

The FGD is conducted with a group usually numbering 6-12 by a knowledgeable individual assisted by a note taker. The discussion centers around the knowledge, opinions and practices of the group as well as on the key issues that the intended project seeks to address. The responses of the group are recorded methodically both in written notes and audio recording to allow for systematic analyses. The KII is a much more focused method of information gathering that centers on the knowledge and experiences of an informed individual. Key informants in OVC programs may include faith leaders, HIV and AIDS committee leaders or members, local community leaders and ongoing program implementers. These individuals are interviewed by a knowledgeable individual who attempts to solicit their opinion about the real issues about OVC and possible solutions.

Observation is often viewed as the easiest yet not so simple method of gathering important project information. It involves having knowledgeable individuals visit a couple of sites where OVC spent significant amounts of their time. These places range from home to school but may also involve other institutions and service delivery points. The observation is deliberate and systematic with the observers looking for key features such as state of shelter, clothing, general look of homes and communities, interactions between and among children and adult caregivers, and participation of children, among other things. The observations are systematically recorded to ensure that any trends are captured. This method is used to complement other methods of data or information gathering and is particularly useful in verifying information about physical aspects of individuals and communities.

Tools Utilized in Rapid Assessment

FGD, KII and Observation Guides must always be used to conduct effective rapid formative assessments. The tools should be developed for each audience to ensure that questions asked are appropriate and relevant. Questions in the FGD and KII guide are frequently open-ended and are intended to seek participant's experiences, opinions and attitudes with regard to the subject matter, in this case OVC care and support. Some questions may be close-ended but must be followed by open-ended question. The tools must also always have probe questions, which are intended to generate more detailed information about the subject matter. For instance, the interviewer may ask the question, "*Is HIV and AIDS a common problem in this community are there particular factors that make HIV and AIDS are problem in this community?* This is a close-ended question. The interviewer would have to ask a follow on question, "*Why do you think HIV and AIDS is a common problem?*" This is an example of an open – ended question. The interview would then follow up with a probe question such as, "*Which one of these factors are most responsible for making HIV and AIDS a serious problem her?*" This pattern of questioning should be applied for all the questions asked in the question guide.

Analysis of information is further discussed within Section II b.

Promising Practice:

When developing new programs and initiatives, taking advantage of the good will of community gate keepers in building strong relationships, fostering community ownership of new ideas and initiatives and creating a conducive and supportive environment are key components of overall program success. Completing a rapid formative assessment before a program begins helps familiarize community leaders, CBOs and volunteers with the program and program staff. Gaining the support of community leaders before the program starts is as important as fostering partnership with them during implementation.

b) Baseline Survey

Definition

A baseline survey is a systematic and scientific social inquiry aimed at generating data and information for program planning and design. It also engenders data for formulating or re-defining output and outcome indicators to be tracked by a grogram over time. Information from a baseline survey may be used to determine bench marks and refine program level indicators.

Why, by Whom and When it is Used

The PC3 Program conducted a baseline survey in the initial stages of the program. The baseline, carried out by an external research firm used both quantitative and qualitative methods of data collection to interview 2500 OVC, caregivers and community leaders. External consultants were involved in the baseline survey to assure objectivity and swift completion to provide needed information supporting program planning. Quantitative methods were used to generate quantifiable data around benchmarks and program indicators that could be used to determine the changes facilitated by the program. Qualitative methods were applied to complement quantitative methods and provide detailed descriptions around issues that may not necessarily be explained via standardized questionnaires such as stigma and discrimination around OVC and HIV and AIDS. Combining the two methods is an effective way to ensure that complete information and data are gathered and analyzed to support program planning.

How a Baseline Survey is Used

To conduct baseline survey effectively the following key steps should be taken:

Step 1: Determine purpose and objectives of the survey.

Step 2: Identify individuals or groups with relevant technical expertise in research to conduct the survey. If resources don't allow, provide training to M&E staff to oversee the process with supervision of a research professional.

Step 3: Identify target beneficiaries; primary and secondary and design sampling methodology, which should indicate how many of each beneficiary group should be interviewed. Sampling frames can be developed to assist with this process. The sample selection process should be systematic and scientific to eliminate biases and errors. The idea of a sample is to ensure that each beneficiary has an equal chance of being interviewed. The research team should ensure that the sample is representative with respect to regions, gender, sex and geographic and/or cultural diversity. The sample should be identified before the start of field work and include a mechanism for replacement and documentation of sampled individuals who cannot be reached or refuse to take the interview.

Step 4: Develop research tools. These may include questionnaires, focus group discussion topics, key informant interview guides, and socio-demographic data forms and observation checklists.

Step 5: Identify and train enumerators and supervisors. Ideally these should be people from the targeted communities who understand the context and can easily locate the sampled households and individuals. Effective training is the key to conducting a successful baseline survey. The enumerators and supervisors should be familiar with the purpose of the study, ethical considerations, research tools, and interviewing techniques.

Step 6: Conduct field work and data collection. Data collection should be closely supervised to assure quality. Supervisors should ensure that questionnaires are completed correctly by the enumerators not the interviewees. They should also review the notes and recorded tapes to ensure that respondents are addressing the questions and providing the required information. All FGDs should be tape-recorded and transcribed on the day of the discussion when the note-takers and moderators can still recall the context of the responses provided by respondents.

Step 7: Process data using computer software. Data on questionnaires should be cleaned, coded and entered into a computer data analysis program such as Special Program for Social Scientists (SPSS) or EPI-info. Qualitative data can be analyzed using software as well such as Nudist or Envivo but can also be analyzed manually by using the thematic approach where key themes are identified and coded and responses categorized according the themes.

Step 8: Analyze data against the objectives and use results to refine program design and indicators. Analyzed data should be used to prepare the baseline report, which should be disseminated to all project partners and communities to enhance their understanding of the issues they need to address and the suggested approaches provided by respondents. Records and data from the baseline should be maintained carefully through the entire life of the project to help complete analyses of the outcomes when end line survey is conducted.

Step 9: Disseminate and use findings to strengthen program design. Baseline as well as end line survey results should be disseminated widely to communities that participated and regional as well as national leaders to increase understanding of OVC issues and support advocacy that may be required to address program gaps and challenges. Dissemination can take various forms such as distribution of final report, short publications/reports (extracted from the large report), regional and national workshop or a combination of these approaches. If regional workshops are used, the project team should ensure that participants are given a chance to comment on the findings and to suggest ways to address any major issues in the report.

Chapter 3

Program Design and Community Mobilization

Program Design and Community Mobilization Approach

After the formative assessment phase is completed, the program design phase begins. This process involves severa activities focusing on overall program design and community mobilization.

a) Program Design

Definition

Program Design is a critical process through which partners decide on the developmental, approaches, strategies and activities they will utilize to achieve the overall goal and objectives. During the program design process results from the Formative Assessment(s) undertaken are utilized to understand the underlying issues affecting OVC and how the program should best respond. Considerable analysis of a variety of approach options is necessary in order to generate the most appropriate responses.

How Program Design Was Applied

In the PC3 Program, the Tier I partners received training on the critical organizational and service delivery sectors and then provided similar trainings to Tier II and Tier III partners (more detailed presentation of the Tiered Approach and specific roles and responsibilities are discussed in *Chapter 4* of the Toolkit). This is essential to ensure standardization of training and effective roll-out of comprehensive, family-focused coordinated care services to children and households impacted by HIV and AIDS. Technical specialists from Tier I partners provided follow-on training and coaching to staff and volunteers of Tier II and III to enhance capacity of these partners to deliver the required services to children.

After training, the monitoring and evaluation team should visit these partners routinely to track progress and provide technical support. Once a quarter the M&E team conducts joint monitoring visit in which representatives of Tier I partners participate and provide feedback to partners visited. This design of the program has not changed but has been strengthened over time as new ideas emerge, lessons are learned and needs of communities increase. It is advisable that OVC implementing agencies revisit the design regularly (in the case of PC3 bi-annually) to ensure that it responds to the needs of targeted beneficiaries and facilitates the achievement of program goals.

b) Community Mobilization

The PC3 Program has drawn on Save the Children USA's global experience in community mobilization to empower communities to create and sustain positive change over time. Community mobilization in this context is described as: *a capacity building process through which individuals, groups or organizations can plan, implement, and evaluate activities in a participatory and sustained basis to improve their health and other needs, either on their own initiative or stimulated by others.*[9] Community mobilization, when used successfully can:

- Bring community members together to address issues that are affecting their lives;
- Increase community decision-making and bring added resources into community;
- Build community skills to address the key issues and reduces barriers to positive change; and
- Increases quality and availability of services

[9]   Grabman and Snetro, 2003. How to Mobilize Communities for Health and Social Change, *Health Communication Partnership*

From the beginning and throughout the program it is essential to empower communities to address the needs of vulnerable children in their community, foster ownership and involvement. PC3 developed a Community Mobilization (CM) Plan together with its partners. Additionally, during the initial phase of program design for CM, partners developed program principles to guide all partners' activities and efforts related to OVC. An example of the principles developed by PC3 partners includes:

- *Vulnerability*: Vulnerability in PC3 addresses all children orphaned due to any cause who are exposed to economic social, psychological and legal problems. More specifically, vulnerability addresses the following category, disabled children and care givers, children living with chronically ill families, elderly care givers, HIV and AIDS infected children, sexually abused children, street children, children with internally displaced families, unaccompanied (child headed household) .
- *Ownership*: PC3 promotes ownership of the program by the community. The role of the mobilizers should be limited to facilitate the process.
- *De-Stigmatization*: The program promotes an environment that does not stigmatize HIV and AIDS affected individuals or groups from taking part in the decision-making process of the program. PC3 also avoids creating stigma by targeting support to vulnerable households and orphan children where the majorities of families are living in poverty.
- *Linkages*: Encourages networking and linkages and service referrals to various activities among various community-based groups working for care and support of OVC.
- *Gender relations*: PC3 pays special attention to women and girl children who are made more vulnerable because of their gender. This includes their active participation and representation in community-based groups.
- *Cultural Values*: It is important that mobilizers understand the cultural practices and values of the communities they are working with, and act in culturally appropriate ways.
- *Participation:* Identification and involvement of key stakeholders such as elders and formal leaders is important throughout the mobilization process. In addition, those most vulnerable and marginalized are encouraged to participate, including those living with HIV and AIDS, poor women and grandmothers taking care of OVC, and others considered 'voiceless' by community members. Involving influential community members such as, teachers, health workers, traditional leaders, religious leaders & respected community organizations is also an important element in efforts to empower communities.
- *Child centeredness*: The process creates an environment where children's voice can be heard and they can express themselves freely. Children as primary beneficiaries are encouraged to participate in determining program design and implementation.
- *Equity/Equality*: The well-being and best interest of the child is prioritized to ensure that all children are treated equally, and emphasize children's rights to survival, protection, development and participation in decision-making.
- *Community Initiatives and Motivation*: Efforts focused on avoiding community dependency on PC3.
- *Volunteerism*: PC3 program strategy includes a community- based OVC intervention that can be implemented and owned by community members. This requires the involvement of volunteers in the implementation of program activities.

Another key component of the community mobilization approach is the Community Action Cycle (CAC).

c)   Community Action Cycle (CAC)

Definition and Description of the Approach

The Community Action Cycle (CAC) is the process by which the community themselves organize, assess, plan and act collaboratively to increase and improve care and support to orphans and vulnerable children. The Phases of the Community Action Cycle are: Preparing to Mobilize; Getting Organized, Exploring the OVC Issues in the Community; Planning Together; Acting Together, Evaluating Together and Preparing to Scale-up. The CAC acts as a guide defining the process of community mobilization and capacity building of community-based organizations. Building community capacity to implement the CAC is key to sustaining support to vulnerable children after the life of the project.

The Community Action Cycle (CAC)

The Community Action Cycle
Save the Children Federation. Inc.

Why, by Whom and When it is Used

The Community Action Cycle (CAC) is applied throughout the life of the project. Tier I and II partners support the community to implement the CAC by providing training and capacity building for each Phase. Use of the CAC *by communities* builds community ownership and sustainability. The CAC process assists communities in taking control of the community mobilization process and supports their efforts to reach their identified goals. Targeted training and coaching for partners at all levels (Tier I, II and III) is provided at the initial stages of the project in order to roll-out effective community mobilization through application of the CAC.

How the CAC Is Used

Phase I: Prepare to Mobilize

During this Phase, Tier I and II partners prepare themselves prior to entering communities. In this Phase PC3 refined and defined who the OVC and the target communities were, the Tier I team were trained as trainers in how to mobilize communities, further information was gathered about how communities were organized and what existing groups were currently working on supporting vulnerable children. Additionally, resources and constraints were identified and a community mobilization plan was developed for the project.

Phase II: Getting Organized

During this phase, Program partners orient communities to the overall goal of care and support for OVC, built relationships, trust, and credibility with communities, and invited community participation through the formation of Community Core Groups (CCG). These groups may be identified as key Tier III partners who would support OVC initiatives. In PC3, CCGs were typically selected from existing groups already helping children such as Iddirs. CCGs should define their overall roles and responsibilities and formalize responsibilities through identification or election of chairperson, vice chair, secretary and accountant. Specific roles, responsibilities and activities of the CCG include one, several or all of the following:

- Raise community awareness around OVC issues and role of CCG;
- Assess OVC needs in community and develop intervention plans to address issues;
- Implement a mapping activity to identify OVC, OVC services, and gaps;
- Mobilize community, identify key individuals and resource persons with in the community to provide care and support for OVC;
- Prepare project proposals and solicit fund from donors and local community;
- Reach out for those affected by HIV and AIDS through the volunteer care givers
- Develop management systems and structures appropriate to their own capacity.
- Monitor program activities, using methods appropriate to their own capacity.
- Create networking and referrals with other similar community groups working on OVC care and support programs
- Manage the project fund and report on the financial utilization and support given to OVC.

Phase III: Explore the OVC Issues in the Community:

During this phase, the CCG explores the OVC issues within their community, and sets priorities for action. In the PC3 Program it was during this phase that communities defined who is an OVC, and went on to identify OVC in their community through a careful analysis based on community-defined criteria. The PC3 Program guided communities to not narrowly define only children affected by HIV and AIDS, but to also include those made vulnerable for a variety of reasons. A registration process was carried out by the CCG in a manner as to not further stigmatize these children, usually by going door to door to assess, review and register. During this phase, it also recommended that the CCG conduct a Service Mapping of health, social, educational and protection services available to OVC within the community. An example of a Service Map and how it is undertaken is further addressed in *Chapter 6* of the Toolkit.

Phase IV: Planning Together

In this phase the CCG develop their Action Plan to address the needs of OVC in their communities. During this stage, the CCG prepares an action plan for care and support of OVC, which should

include the following:
- What the community would like to achieve and how it would achieve it (which activities);
- What resources were needed and how the community would obtain them;
- Who was responsible for each activity and for results;
- When and where activities would be implemented; and
- How the community would monitor progress and know when results were achieved.

Phase V: Act Together

In this phase, Tier I and II partners focus on strengthening the community's capacity to carry out their own action plan. CCG members monitor their own progress against their action plans, highlighting service delivery and coordinated care for OVC. During this phase Tier I and II partners work in an advisory role to CCGs.

An institutional capacity assessment may be carried out during Phase V to prioritize training and coaching needs. Highlighted are skills needed for CCGs to carry out their action plans, including leadership, conflict resolution, financial management, resource mobilization and monitoring and evaluation (M&E). Results of this assessment guide the implementing partner(s) in the creation of a skill development and training plan for the Community Core Group.

Phase VI: Evaluate Together

During this phase, efforts focus on defining what participants wanted to learn from the evaluation, an evaluation plan and instruments should be developed and the evaluation is completed. Results should be analyzed and feedback provided, including lessons learned and recommendations for future activities, to all interested stakeholders.

Phase VI: Prepare to Scale-up

In the case of PC3, design and implementation was already at scale from project start up. However, this phase should result in continued scale-up of community actions and ideas, and an increase in coverage, both in numbers of beneficiaries and/or geographic coverage.

Expected Results

The expected result of the Community Action Cycle is the creation of a solid base of well-organized and mobilized Community Core Groups providing quality care to OVC. This process should also result in continued scale up of community actions and ideas, and an increase in coverage, both in numbers of beneficiaries and/or geographic coverage. Utilizing the CAC approach supports the development of efficient, effective and empowered community groups cognizant of and committed to positively responding to the needs of orphans and vulnerable children in their communities. Additional positive results of the CAC include strengthening of linkages between international, national and community organizations, clear identification of community resources (via mapping exercises) and gaps in services, and improved capacity for mobilization of human and material resources.

Promising Practice

The Community Action Cycle is a participatory approach which assists community groups in strengthening their own capacity to better serve orphans and vulnerable children in their communities. The CAC approach empowers communities to identify the needs and determine the response in a culturally accepted and appropriate manner thus encouraging more sustainable actions. The partnership approach fosters information and experiential learning and brings together key players that can learn

from each other and benefit from the expertise that each organization or community group brings. This approach builds on community mobilization and promotes local responses to OVC issues.

Results of the Community Action Cycle with an Ethiopian Community-based Organization

Chilanchil Anti- AIDS Club was established in 2004 as a core group in the Kirkos area of Addis Ababa. In 2005, it was selected by the PC3 Tier II partners, Addis Ababa Muluwongel Church Relief and Development Program, to receive support. The selection criteria used by the Tier II partner included:

• Institutional capacity (office, office furniture and linkages with other community partners;
• Legal status (registration with municipality, by-laws, focus on OVC issues stipulated in the by-laws;
• Human resource capacity and experience working in OVC and HIV and AIDS issues; and
• Interest in working with children, the community and other stakeholders.

Members of the Anti-AIDS club received training from the PC3 project on various subjects that aided in the creation of functional structures within the club. Some of the topics covered in the training were: institutional capacity development; financial management; community mobilization; social services and support for OVC; and program planning and monitoring. As a result of the training and partnering with the Tier II group, the Anti-AIDS club is structured and functioning as a formal institution. The Anti-AIDS Club has a Chair Person, Treasurer, Finance Officer, Property Manager and 20 volunteer and service providers. This team is able to serve over 150 OVC in their community on a monthly basis.

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d)   Community Mobilization Guide for Tier III Partners

An additional tool which may be utilized to strengthen the CAC process and assist in strengthening the skills and knowledge of CBOs and OVC CCGs is the Community Mobilization Guide for Tier III Partners. This Guide is a training manual developed for CBOs/Tier III partners which provides assistance in effectively managing community mobilization activities The purpose of the Guide is to build the capacity of OVC CCGs effectively implement community mobilization processes in their communities. The Guide outlines a process for CBOs to assess their current community mobilization capacity, identify strengths and challenges, and increase their capacity to organize, plan, implement and monitor community level mobilization actions.

Why, by Whom and When it is Used

The Community Mobilization Guide for Tier III Partners is designed for use by all CBOs working with OVC. The Guide may be used by new CBOs as well as by organizations and community groups who already have experience in community building and action; it is a good refresher. The Guide may also be useful to Tier II organizations when they reflect on community mobilization actions and results. It is recommended that Tier II staff occasionally revisit this guide to strengthen mobilization efforts and evaluation and assess current actions. The Guide may be used as a training curriculum for Tier II organizations to provide to Tier III partners.

Key Concepts Covered in the Community Mobilization Guide

The Guide begins by reviewing the CAC and gives suggestions for how to develop OVC CCGs, including structure, processes and roles and responsibilities. The second part of the Guide covers issues related to mapping, identification of strengths and weaknesses, including human and financial resources, possible strategies for addressing the needs and identification of referral network. The third section of the Guide highlights the planning and proposal development process. The Guide gives simple, step by step instructions for how to develop a funding proposal and what kind of information needs to be included in the document. The final section of the Guide targets management (human, financial and property), team building, conflict resolution and monitoring and evaluation. This section provides simple, easy to understand information which is critical to the successful management of an OVC CCG/CBO. The sections of the Guide can be done together, in two or three days, or as separate, stand-alone trainings, depending upon the needs of the OVC CCG/CBO receiving the training.

Chapter 4

The Tiered Approach to Partnership

Partnerships

PC3 is currently the largest OVC program in Africa. Partnership is one of the cornerstones of the Program and has facilitated many of its successes. Partnership in this context includes working closely with several international organizations, dozens of national organizations and hundreds of community-based organizations. Working through partnerships has been a critical element in expanding, exponentially, the reach and coverage of the program. Throughout the five-year implementation period efforts and resources have focused on the strengthening of local NGOs, CBOs, Iddirs/Afoacha, FBOs, PTAs and community groups.   The three levels (or Tiers as they are referred to) of organizations work together to both build capacity at all levels and promote locally inspired and appropriate responses to OVC issues.

The tiered partnership approach taken by the program is unique as it reflects the principal strategy of building the institutional and technical capacity of grassroots, community-based organizations to provide and sustain the provision of safety nets to OVC. Partnership within all levels and all phases of the program has been beneficial to all program stakeholders; practitioners, community leaders, caretakers and OVC. Taking advantage of the expertise of all three tiers of the program has provided an opportunity for shared learning across all levels, increased collaboration between organizations and institutions that might not have collaborated in the past, and perhaps most importantly, a shared vision of how communities can and should support orphans and vulnerable children. An added benefit of the partnership approach is the trickle-down effect it has on other aspects of a program. Working in partnership inevitably fosters that same approach and helps support coordination and coalition building between other organizations/institutions supportive of OVC efforts including the private sector, Government institutions and multi-lateral organizations such as the United Nations Children's Fund (UNICEF) and the World Food Program (WFP).

> a) The Tiered Approach

Definition and Description

The tiered approach is a triad partnership focusing on capacity building whereby international NGO partners (Tier I) provide ongoing skill building and technical guidance to local NGOs; local NGOs and associations of PLHIV (Tier II or "mentor" organizations) support direct programming through frontline community mobilizers and implementers (Tier III) who then provide direct services to households affected by HIV and AIDS. The tiered approach was chosen in the case of PC3 to gain national reach and coverage in a limited amount of time.   The tiered design also facilitates program delivery by ensuring that all partners are following the same package of services. The tiered approach allows partner organizations to significantly contribute in areas where they are strong and have expertise, thus promoting a more comprehensive approach than could be established by just one organization. Strong monitoring and evaluation is integral to all service implementation and capacity building activities. This approach increases reach and coverage and emphasizes participatory approaches aimed at building ownership and commitment at the community level.

This approach brings together, in partnership, a majority of implementers in a care and support response, allowing links to networks and building capacity for collective advocacy around common issues. The expected end-goal is that over time, the role of Tier I partners diminishes and Tier II and III partners become programmatically and financially sustainable.

Why, for Whom and When it is Used

The tiered approach (partnership) is utilized to both support collaboration between different kinds of organization as well as to utilize the expertise of older/larger organizations in strengthening the capacities of smaller, community-based organizations. The end goal of this approach is strong, sustainable community-based organizations providing culturally appropriate and accepted services and support to OVC in their community. This approach may be used by international organizations, national organizations, non-governmental and governmental, and community-based organizations. Additionally, the tiered approach may be utilized by donors as means of increasing scale and coverage. The tiered approach may begin at program conception and last throughout the lifespan or it may be incorporated into specific phases of a program. In the case of PC3, the tiered approach was an integral component of the program design from inception until completion. This approach, as demonstrated in the PC3 Program, enables partners to replicate, on a national scale, key concepts and components of the program.

How the Tiered Approach is Used

The partnership approach, in this instance, has three levels of organizations involved in the partnership. Tier I organizations provide general oversight and management of the program. They are seen as a leader or facilitator providing organizations and programmatic capacity by example. Tier II organizations are seen as mentoring organizations and provide support and technical assistance to the Tier III organizations. The Tier III organizations are community-based and are responsible for providing direct services to OVC. Specific responsibilities of each "tier" or partner include the following:

Tier I: Organizations at this level are typically international organizations with vast experience, human and material resources and support and recognition by the donor community. The role of the Tier I organizations is that of a leader, a facilitator, and a provider by example of organizational and programmatic capacity. The Tier I organization provides on-going skill-building and support to the Tier II partners (i.e. mentoring organizations or national NGOs). During the program design, specific roles and responsibilities for Tier I partners were defined as:
- Build the capacity of local NGO partners (Tier II) and provide technical assistance.
- Develop CM strategy that takes into account community dynamics and existing community response/strengths.
- Coach Tier II partners in the community action cycle.
- Facilitate exchange of experience and information amongst Tier I partners and with Tier II partners.
- Monitor the performance of Tier II partners and ensure accountability for the recipients of funding.
- Accurately articulate the views and expectations of communities in policy/ advocacy work with government and donors.
- Catalyze and support national policy formulation on OVC issue.
- Mobilize financial resources for national and local OVC effort.
- Develop capacity of stakeholders to provide adequate technical support to the community based organizations.

One Tier I organization usually has a direct relationship with the donor. All the Tier I organizations sub-grant to Tier II organizations who have a demonstrated track record assuming a management and mentoring role for local community groups to scale up and out the provision of care and support services to OVC and PLWHIV within the target communities (for more information on sub-granting in a tiered approach, see Chapter 5).

Tier II: This second tier of organizations is made up of competent, nationally-based NGOs with some experience in program implementation and management. The role of a Tier II organization is that they act as the main links to a diverse group of CBOs at the community level and build the technical and institutional capacity of these entities to implement programs that improve the lives of OVC and children and families affected by HIV and AIDS and other risk factors. The role of the organization in this tier is to mentor and provide capacity-building technical assistance to Tier III partners (Ethiopian CBOs). Specific roles and responsibilities of Tier II partners include:

- Assess community based organizations needs and capacity to provide support for OVC.
- Actively maintain local ownership through empowerment of the community-based groups.
- Identify, document and share good practice information on community OVC initiatives and support from community based groups and NGOs.
- Coaching Tier III partners in the community action cycle.
- Provide appropriate technical and financial support to CBOs.
- Train Tier III partners in community mobilization and technical core service areas, and conduct follow-up training on key areas such as leadership, planning, etc.
- Facilitate participatory planning, monitoring and evaluation of care and support program for OVC
- Actively participate in development of OVC policy at the national level, based on field experience.
- Facilitate the formation of networks and referral systems between community-based groups and other services in the community.
- Facilitate community-based groups' access to financial, technical and other resources through funding proposal development or community based fund raising efforts.
- Provide training and develop the capacity of community-based groups to carry out needs assessment, problem identification and prioritization, project design, community and resource mobilization, management and conflict resolution.

Tier III: The third tier of organizations is community-based groups who are the primary implementers of care and support programs that address the needs of OVC and their caregivers within the target geographic areas. They are usually classified under a broad stroke as CSOs or OVC committees but can include other locally based groups such as a Parent-Teacher Association (PTA) or a youth group. The number of organizations in this tier is significant as the expectation is that they do the bulk of direct service implementation at the community level. As the program expands the number of these groups also grows to ensure that each is taking care of a manageable number of OVC. Specific roles and responsibilities of Tier III partners include:

- Facilitate identification and prioritization of the OVC needs.
- Provide assistance to community-based groups in identifying orphans and other vulnerable children and their guardians.
- Initiate and encourage the community to support OVC.
- Link the community initiatives with other NGO & Govt organizations.

- Gather and document information/data/ on OVC care and support activities within the community.
- Create networking and referrals with other similar community groups working on OVC care and support programs.
- Facilitate experience and information sharing among CBOs.
- Monitor the care provided to OVC.
- Resource mobilization.

The PC3 Tiered Approach to Sub-granting and Technical Support to Partners
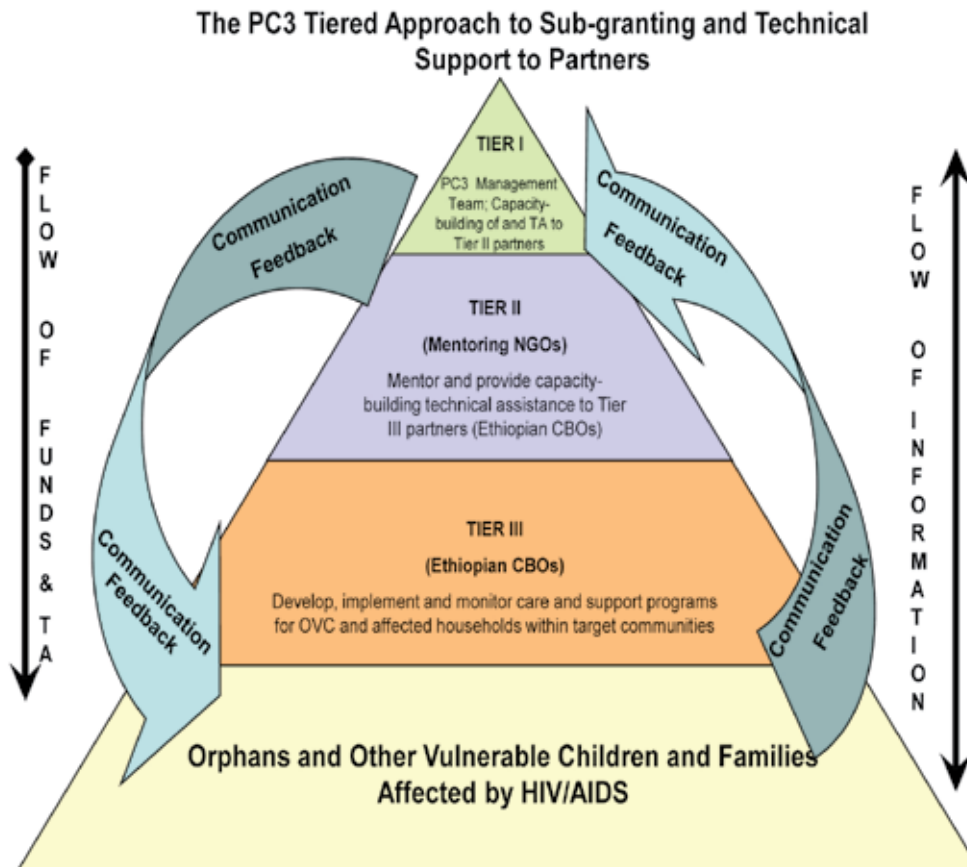
Promising Practice

The tiered approach has had significant results in terms of supporting and strengthening the capacities of community-based organizations to effectively respond to OVC issues in their area. The tiered approach provides international and national organizations to provide guidance, resources and technical assistance to a significant population (in the case of Ethiopia more than 575 CBOs) thus promoting rapid increase of coverage and impact.

Chapter 5
Building Capacity of National and Local Level Partners

Capacity Building of Communities and Organizations and Systems

Utilizing a partnership approach and focusing efforts on strengthening the capacity of local NGOs and CBOs requires significant time and resources. The first step in the capacity building process is to conduct an institutional assessment to gain insight into the organization's organizational, technical and financial capacity. The role of Tier I organizations is to facilitate and provide training and technical assistance to the mentor organizations (Tier II) in these areas thus providing greater opportunity for mentor organizations and the CBOs to implement and manage their own activities. The trickle down effect of the tier approach allows Tier I organizations to provide Tier II organizations with the tools and technical capacity to provide the same assistance to the CBOs or Tier III partners who are actually implementing and sustaining the program. The major activities within capacity development are the assessment of the capacity of the Tier II and III organizations and training on various organizational and programmatic sectors depending on the identified gaps. The PC3 Program has designed several tools to facilitate capacity assessment processes.

a)   PC3 Organizational and Technical Capacity Assessment Tool (POTCAT)

The Organizational and Technical Capacity Assessment Tool (POTCAT) is divided into organizational and technical activities. It is a manual designed to assist organizations in doing a thorough assessment of the organizational and technical capacities of another organization, with a particular focus on leadership and governance, decision making processes, and human and financial resource management.

Definition

The POTCAT is an instrument that can be utilized to collect, assess and summarize the organizational and technical capacities of an organization. POTCAT facilitates a participatory organizational and technical assessment whereby staff of an organization are given the opportunity to self-reflect on the performance of their organization in general on 13 identified key issues. The information collected in the POTCAT assessment can then be used in the development of a capacity building plan of action. The POTCAT utilizes a participatory process based on the assumption that the most effective way to initiate organizational change is to involve staff members and other key stakeholders in a transparent assessment and consensual planning.

Why, for Whom and When it is Used

The POTCAT is used to help determine the organizational and technical capacities of an organization. The information collected in the POTCAT assessment is then utilized in creating a capacity building plan and helps determine future technical assistance needs from other organizations. The information gathered in the assessment tool provides an overview of the governance, decision-making, and human and financial management capabilities of an organization. This is critical information affecting decisions around sub-granting, program management and other areas. The tool may be utilized by any organization; international, national or community-based. In the PC3 Program, the POTCAT was used by Tier I organizations assessing Tier II organizations and Tier II organizations assessing Tier III CBOs or NGOs. The tool should be used at the early phase of a project as the information collected may be incorporated into the capacity-building technical assistance plans that are implemented at a later stage of the program.

How the POTCAT Tool is Used

The POTCAT assessment is a three-phase process made up of three steps in each phase. It involves preparing for the assessment, conducting the assessment, and integrating the results into organizational activities. The POTCAT process is highlighted in the chart below:

Phase	Steps
Preparing for the Assessment	*Step 1:* Plan the assessment *Step 2:* Hold an initial meeting and develop a schedule *Step 3:* Review the POTCAT instrument/tool
Conduct the Assessment	*Step 4:* Carry out the assessment and complete the assessment form *Step 5:* Prepare a summary for each component *Step 6:* Develop a unit level action plan
Integrating Results into Organizational Activities	*Step 7:* Reach consensus on priority actions at a one-day workshop *Step 8:* Develop an integrated action plan for the whole organization *Step 9:* Link the action plan to annual operational planning, budgeting, and monitoring.

Phase I: Preparing for the Assessment

Before conducting the POTCAT an orientation workshop should be held for all organizations/ individuals conducting the assessment. The workshop should provide participants with information regarding the concept of capacity building, the objective of capacity building, the POTCAT tool and clear instructions as to how to conduct the actual assessment. At the end of the workshop, the organization(s) will draft a plan which includes how they will introduce the tool and when the assessment will be conducted.

There are two teams of people involved in the POTCAT process including the Core Team and the Assessing Team. The core team is responsible for planning and conducting the assessment, monitoring its progress, leading the development of an action plan focused on improvements, and advocating for the institutionalization of the plan within the organization's planning and monitoring systems. The Core Team should contain a cross-section of program and financial staff. The Assessment Team contains members of the Core Team as well as senior management and other staff persons from other levels of the organization. The eclectic mix of staff persons with varying degrees of responsibility provides an opportunity for balanced views. The Assessment Team should be comprised of no more than 15 persons.

> - **35 Tier II organizations** have received training utilizing POTCAT and each organization developed capacity building plans – which they have implemented with support of the respective Tier II partner.
> - **More than 500 Tier III organizations** have received training utilizing POTCAT. Tier III organizations also completed assessments and action plans and received training through the Tier II partner to address capacity gaps. Some of the gaps such as monitoring and evaluation required coaching and mentoring over the life of the program rather than one time training.

Phase II: Conducting the Assessment

Once the teams have been introduced and trained on how to do the assessment they are ready to conduct POTCAT. During the assessment participants will be provided with the tool and based on their understanding of the criteria will rate the organization.

The POTCAT instrument consists of two types of forms. The first is the assessment form which includes 13 organizational and financial components. The assessment criteria are divided into four levels of organizational capacity. The forms also include a blank space for individual comments on each item. Finally, the form contains space for summary of the assessment where the comments and decision of the group will be recorded. The 13 organizational and financial components covered in the POTCAT assessment include the following:

- Governance & leadership;
- Strategic & operational planning;
- Structure: roles and responsibilities;
- Structure: delegation of authority and decision- making;
- Staffing and human resource management;
- Partnering and networking;
- Financial planning and budgeting;
- Cash and banking;
- Accounting and record keeping and procurement;
- Distribution, stock and inventory management and management information system (MIS).

When completing the assessment, the team should document evidence used in the assessment, thus justifying why the response and keeping the process transparent. Evidence utilized in the assessment process might include the following:

- **Verification of documents and records,** such as: annual and long-term plans; personnel records; job descriptions; organizational charts; financial reports; financial statements; and, bank statements.
- **Examination of system tools and manuals,** such as registers, vouchers receipts book, purchase requests, inventory forms, policies and procedures manuals, and supporting forms.
- **Physical examination of facilities,** such as store rooms, warehouses, and other facilities that maintain inventory.

The second form is the Action Plan which is used after the completion of each unit/component. The POTCAT contains a template of the action plan which can be used both at the end of each unit assessment and in a final workshop of stakeholders. The template includes a timeline, person(s) responsible, resources needed and indicators for achievement for each activity recommended in the action plan.

Phase III: Integrating Results into Organizational Activities

After the actual assessment is conducted the Assessment Team and Core Team create a plan of action that will address the concerns/gaps highlighted in the assessment. The Action Plan should include areas for training, technical assistance, material support, experience sharing, etc. During this phase, it is very important that the team members reach consensus regarding the areas addressed in the action plan as well as how what steps will be taken to make improvement in the identified areas. To solidify organizational buy-in for the action plan, it is important that the entire staff of the organization be present and participates in the presentation of the action plan by the Team. Including all staff in the final presentation of the Action Plan greatly improves understanding of the process and will promote ownership and buy-in thus supporting future efforts responding to the recommendations made in the Action Plan.

b)   Financial Training

Once the POTCAT training has been completed, Tier II and Tier III organizations should have a completed action plan with identified areas for improvement. A key area of assessment is financial planning and management within an organization. To assist organizations in strengthening their abilities to plan, manage and record financial actions of their organization, training in the specifics of the aforementioned topics should occur during the early stages of the Program. The PC3 Program has developed a training manual entitled "Financial Planning and Budgeting Training Module for Tier II." The training module is designed to strengthen Tier II organizations in planning, implementing and managing their own activities. Given the tiered, sub-granting approach (described in detail in Section IV e) it is critically important that the financial management capacity of mentor organizations be strong and sustainable.

Why, for Whom and When it is Used

The financial training module was designed as a tool to help support and increase the financial planning and management capabilities of Tier II (mentor or national NGOs). The training module is first provided by Tier I (INGOs) organizations with mentor organizations being the participants. After the mentor organizations receive the training, they are expected to provide the same training, (tweaked to meet specific needs) to the Tier III organizations (i.e. CBOs).

The objective of the training module is to enhance the capacity of Tier II organizations in preparing a financial plan for their respective organizations. Additionally, training participants who have successfully completed the training should be able to execute their financial plans (budgets) effectively and as a result, are able to fulfill organizational goals and objectives. Using the concepts, techniques and skills derived from the training, the second objective is that the mentor organizations are then able to provide the necessary advice, technical support and guidance to CBO partners in preparing and implementing their budgets.

How the Financial Planning and Budgeting Training Module is Used

The Financial Planning and Budgeting Training Module includes both a Facilitator's Guide as well as a Participant's Workbook. The concepts covered in both documents are designed to be applicable to other programs besides PC3 and may be utilized by large, medium-sized NGOs as well as CBOs. The course uses a problem-solving approach to facilitate comprehension of the principal components of Financial Planning and Budgeting. It is based on a participatory approach to learning, and includes team work, individual activities and plenary sessions. It offers training participants a systematic approach to acquiring the knowledge and skills they need to successfully plan and budget within their own Tier II organizations.

Facilitator's Guide:

The training module is designed to be completed in three seven-hour days. The Facilitator's Guide is for use by course trainers (in the first round of training, this is typically the INGO or larger organizations). The guide provides the facilitator with format for course delivery and suggested answers to possible questions posed by and to participants. It also includes answers/solutions which should be concluded during the group exercises. The easy-to-read format is designed so that each learning session of the Facilitator's Guide corresponds to a learning session in the Participant's Workbook. A combination of training methods are utilized in this training module, including: interactive lectures; participant presentations and discussions; brainstorming; and case analysis.

The course facilitator is considered the general "manager" of the course and therefore he or she should have thorough knowledge of financial planning and budgeting as well as previous experience with participatory training methods. A strong commitment to this approach is essential for successful implementation of the course. The facilitator should work hard to create a safe space where both facilitators and participants are able to speak freely and share positive and constructive feedback with one another.

To prepare for the course, the facilitator should read all course materials well in advance. He/she must be very familiar with the material in both the Facilitator's and the Participant's Guides and the case studies and readings. It is recommended that the course be given by two or more facilitator's thus highlighting a "team" approach to learning and strengthening the overall partnership theme promoted throughout the Program. The Facilitator's Guide is set up in an easy to follow format. Each session design includes a section for timeframe; necessary materials; group formation; course objectives and content and individual activity instructions.

Participant's Workbook

The participant's guide serves a dual function. First, it is the roadmap guiding the participant through each phase of the course. Secondly, it contains the module content and supplemental printed materials (pretest questionnaire, all exercises by module and course evaluation form) needed during the course.

The group work is designed to allow participants to express opinions, develop their own ideas and learn from the experiences of other participants. The groups analyze exercise/case studies and are able to propose to solutions to the given challenge. Group work is completed in both small working groups and larger teams. Each group should identify a team moderator changing each time thus allowing every participant an opportunity to fill that role.

Activities and case studies are an essential part of the learning approach utilized in this course. These cases may not provide all of the required information for evidence-based decision-making, thus encouraging participants to use their own experiences and resources to identify additional information required. At the beginning of each session, the Participant's Workbook contains timeframe, course objective, session content, materials needed and group formation.

c)   Strategic Planning

Building upon the achievements and knowledge gained in the POTCAT and Financial Planning and Budgeting Training, the next step in capacity building of mentor organizations and CBOs is to focus on strategic planning. This specific training module is designed to leverage the operational capacity building effort of the implementing organizations (Tier II).   As with the Financial Planning and Budgeting Training Module, the INGOs provide training to the mentor NGOs who are then expected to mentor, support and train the CBOs.

Why, for Whom and When it is Used

The overall goal of this training module is to improve participants' abilities and skills in developing a strategic plan for their organization. After completion of the training module, participants should have the skills necessary to provide strategic planning within their own organization and therefore should:
- Understand the role long term strategic planning within their organization and its relationship with operational/action planning;
- Apply strategic planning framework when embarking on long-range planning for their organization;
- Understand and be able to utilize techniques linking goals, objectives and strategies of their

organization.

The training is designed for INGOs (Tier I) to deliver to mentor organizations (Tier II) that are then expected to provide training, guidance and support to the CBO's (Tier III) they work with. As with the aforementioned training guides, this training module may be tweaked and adapted to meet the needs of a specific program and/or organization.

How the Strategic Planning Training Module is Used

The course is designed to be completed in two and a half seven-hour days. A suggested timetable is included in the Facilitator's Guide but may be adapted according to the needs of the facilitator and training participants. The Strategic Planning Training Module includes both a Facilitator's Guide as well as a Participant's Workbook. The course utilizes an activity-based approach to foster an experiential learning environment. The training module is based on participatory methodology wherein participants work in teams and gain insight via shared experiences. The training module offers participants a systematic approach to acquiring the knowledge and skills needed to apply a strategic planning framework within their own organization. The five sessions in this training module will take the participants through the steps that are needed to develop a strategic plan for an organization. The five sessions cover the following: understanding planning and strategy; organizational vision, mission and values; organizational goals and objectives; strategic options and action planning.

Facilitator's Guide:
The Facilitator's Guide should be used by course facilitators and trainers. The guide clearly outlines the suggested format for course delivery and suggested responses to typical questions posed by course participants. Each section of the Facilitator's Guide corresponds to a section in the Participant's Workbook. The facilitator should refer participants to the relevant section of the workbook at the appropriate time so that they can relate the discussion to the context of their own organization and allow them to take some readily useful material when they finish the training. The Training Module is divided into five sessions, as mentioned above and each session includes a suggested timeframe, course objectives, materials needed, and activities. The course facilitator is the overall manager of the course and should have through knowledge of the material in both the Facilitator Guide and Participant Workbook. She/he should also have previous experience and/or familiarity with a participatory, problem-solving approach to training. As with the other training modules, it is recommended that this training be completed by a team of facilitators, when it is feasible, thus promoting a team approach.

Participant's Workbook:
The main purpose of the workbook is to assist participants and guide their learning of the strategic planning process. At the end of the Strategic Planning Training, participants should feel comfortable and empowered in their ability to lead a Strategic Planning (SP) process within their own organization and recognize that a successful SP process and action plan results in the following:[10]
- Provides a clear understanding of what the organization needs to do in order to achieve
- its goals;
- Guides the organization in prioritizing and making decisions;
- Allows the organization to focus limited resources on the most beneficial actions; and
- Provides a tool to help the organization communicate its intentions to others.

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[10]   Shapiro, Janet, *Toolkit on Overview of Planning,* Civicus: Civil Alliance for Citizen Participation.

Promising Practice

Abdu Hussein Said, 48 was born and has always lived in Akaki area in Addis Ababa. He has been the leader of the local Iddir group for 22 years. Abdu is a dynamic and active community leader. When he was approached in 2006 by a PC3 program partner, he was quick to engage with the program. He saw way beyond what the PC3 partner described as the benefits of partnering with the program. He immediately developed a vision for OVC in his community. He saw this opportunity as one that would enable his community to provide sustainable care and support to OVC, which had by then become a serious challenge not only to families and communities, but to the entire country. The first few months, his Iddir went through training on leadership, organizational development, community organization, resource mobilization, and financial management, among others.

The first few months, his Iddir went through training on leadership, organizational development, community organization, resource mobilization, and financial management, among others. The training helped to sensitize Abdu and a few other members of his group to the needs of OVC and the advocacy role that they could play to address the needs of these children. What followed this was a series of initiatives that have since transformed the Iddir into a vehicle for social change.

The Iddir built a kindergarten so that children of the community would not have to travel too far to attend school; negotiates with all schools to waive school fees and provide tutorial classes for OVC; ensures that orphans inherit their parents' house or land and other property; has established a saving association for its members to be able to get loans to do businesses that improves household incomes; is helping sick people to get the right health care; and organizes lots of social activities to advocate the need to support children in need, among many others. The Iddir has learned to advocate for children's needs as Abdu explains. "All these activities are made possible because the group has actively raised funds by contacting the government so that health centers can treat vulnerable children and their families without fees."

d)   Governance and Leadership

To complete the organizational development capacity building phase of a program, the final training module focuses on governance and leadership issues. This training module highlights the need for mentor organizations and CBOs to work closely with stakeholders as well as incorporate positive leadership concepts, principles and actions into the management and governance structures of their organizations. As with the other training modules, the Tier I organizations provide training to the mentor NGOs, who are then expected to mentor, support and train the CBOs.

Why, for Whom and When it is Used

The goal of the Governance and Leadership Training Module is to provide participants with the skills and knowledge necessary to successfully govern and lead mentor organizations and/ or CBOs. At the end of the training module, participants should be able to understand, articulate and incorporate the following into their role as leaders within their organization: meaning, benefits and challenges of governance; principles and characteristics of successful and unsuccessful governance; role of stakeholders in governance and leadership; board governance and legal status; definition and differences of leadership and management; characteristics of leadership as well as other key concepts.

How the Governance and Leadership Training Module is Used

The course is designed to be completed in two seven-hour days. The Governance and Leadership Training Module is divided into three units. Unit one is an introduction to governance and leadership and is designed to familiarize participants and the facilitator(s) with each other and review the training agenda and discuss the expectations of participants. Unit two highlights governance including the definition, benefits and challenges of governance. It also reviews the principles and characteristics of successful and unsuccessful governance, the role of stakeholders,

importance of legal status, elements of a governance framework, and ways to strengthen governance. Unit three highlights leadership. In particular, this unit covers the meaning of leadership, how leadership differs from management, and characteristics of an effective leader, styles of leadership and transformational leadership and facilitation.

The Training Module utilizes a participatory learning approach and includes plenary sessions, individual work as well as group work in small and large teams. The training offers participants a step-by-step approach to acquiring the knowledge and skills needed to successfully govern and lead community-based organizations.

- Within the PC3 Program, more than 575 community-based organizations received sub-grants.
- Grants to Tier III groups ranged from $3,000 to $10,000 per year depending upon the organizational capacity and number of OVC supported.
- To date, more than 520,000 OVC have benefited from services and programming.
- PC3 is recognized as having the most extensively united OVC network in all of Africa mostly as a result of the tiered approach to program implementation.

Facilitator's Guide:
The facilitator's guide is for use by course facilitators and trainers. The guide provides the course facilitator with guidelines for course delivery and suggested response for typical questions that might arise during the training. As with the other training modules, each learning unit of the Facilitator's Guide corresponds to a learning unit in the Participant's Workbook. The course facilitator is considered the overall "manager" of the course and therefore should have sufficient knowledge and experience with the topics. Each unit of the Facilitator's Guide includes unit objectives, activities, timeframe and required materials. The step-by-step guide is easy to follow and clearly describes what the facilitator should cover and how the information should be presented so that participants leave with a thorough understanding of the topics covered in the training module. As this training covers gender and leadership it is strongly recommended that the training facilitator(s) be sensitive to the issue and promote the topic by equally representing both genders.

The Participant's Workbook:
The Participant's Workbook serves a dual function as both the roadmap guiding the participant through each unit as well as containing the supplemental information needed to support the course. The Workbook contains the course syllabus, schedule, activity description, and course evaluation forms. Participant's are expected to be active and involved to get the most out of the participatory approach utilized in the training. As mentioned above, the training module does have a section on gender and leadership and therefore training organizers and participants should try to have equal gender representation of participants. It is strongly recommended that each participating organizations send both male and female participants.

e) The Tiered Sub-granting Approach

Definition
A Tiered Approach to Sub-granting is defined as one group (tier) of experienced organizations sub-granting funds to smaller, national or community-based organizations in an effort to expand and

increase program coverage while simultaneously fostering the capacity of local organizations to manage program implementation and financial resources. The tiered approach maximizes financial resources by supporting the growth and development of a significant number of Tier II and Tier III organizations with small, but important, sub-grants.

Why, for Whom and When it is Used

Utilizing the Tiered Approach as described above, Tier I organizations provide sub-grants to already existing Tier II and III partners. The Tier II and III organizations are pre-selected for this program based on their experience implementing HIV AND AIDS and OVC programming. Tier II groups are frequently grouped geographically and coordinate efforts in designing program implementation to reduce the possibility of duplication as well as strengthen the opportunities for shared learning and collaboration.

Tier III partners are the front line implementers of chosen strategies. Organizations, such as *Iddirs and Afoacha*, anti-AIDS Clubs, youth and cultural organizations, women's groups, FBOs, PTAs, school girls advisory committees and associations of PLWHIV are linked in a coordinated manner to care and support responses at the community level. Iddirs were a major Tier III partner and accounted for 80% of the CBOs. In most cases, these Tier III partners are selected either by Tier I or Tier II partners and are provided with technical assistance so that they can build their capacity to more effectively implement strategies and activities planned through the community mobilization process. In most cases, these Tier III agencies are provided with "fixed price grants," which are more appropriate and more easily monitored by Tier II agencies than other types of grants.

Within the PC3 program, more than 65% of Program funds of Tier I organizations were allocated to Tier II organizations who then sub-granted 65-70% of their funds to Tier III organizations. As mentioned above, this strategy allowed program resources (including human and material resources) and programmatic concepts to gain exponential reach and coverage through the strengthening and support of more than 575 CBOs.

How the Tiered Sub-granting Approach is Used

The sub-granting tier system utilizes several tools within the different phases of the sub-granting process including selection of Tier II and Tier III organizations and monitoring of program funds. It is important to note, that if a tiered approach to sub-granting is utilized, it might require a longer lead-in time given the additional requirements and collaborative work. The design requires a high level of consistency and homogeneity in approach and therefore, does require significant time in the early stages of the program.

Chapter 6
Developing a Coordinated Care Approach to Service Delivery

The Coordinated Care Approach

Once mentor organizations (Tier II) and community-based organizations (Tier III-implementing organizations) have received focused, results-oriented training in organizational development and capacity building in the key areas mentioned above, the next step is to focus efforts on creating a community-based response to OVC issues. Strengthening the community capacity to undertake long-term, child-focused interventions is a core component of any successful and sustainable OVC program. The PC3 Program has focused its efforts on creating, supporting and promoting, family-focused interventions based on a "Coordinated Care" model. Simply stated, Coordinated Care is an organized care and support approach to addressing the diverse needs of OVC in a comprehensive and sustainable manner. The model depends upon the ability of a community core group through teams of volunteers (Home Visitors) to assess the whole needs of an OVC on a regular basis, and identify and refer needy OVC to the service points where these needs can be met. Specific needs of the child may be varied and may require services at different points and levels. Providing coordinated care means knowing all the needs of a child and his/her family and planning carefully with the child and caregiver how to effectively meet these needs in an organized and safe manner.

To strengthen the ability of mentor organization and/or community-based organization to implement a coordinated care approach, a training manual has been created, implemented and improved based on the experience of PC3 participating organizations. The training module focuses on four key strategies for improving and implementing quality coordinated care services, which include:

- Incorporating service mapping into first phase of program to improve linkages to services and create or strengthen a referral systems to those services;
- Reinforcing home visits as a key component to the program and assessing and addressing the *needs* of *whole* child through referral or direct service provision by the Core Group/Volunteer;
- Utilizing the Home Visit tools for a thorough assessment of the whole child. Strongly recommend the use of the *Home Visitors Guide-Caring for the Needs of the Whole Child* for every staff member or volunteer working in the Program; and
- Improving coordination of existing volunteers and building broad network of home visitors to increase coverage and response to OVC needs.

a) Service Mapping

Definition

Service mapping is defined as a participatory activity involving community-based groups, beneficiaries of programs and volunteers which aims to facilitate coordination of and access to comprehensive care services by identifying and creating functional referrals to and linkages with existing service delivery points/organizations.

Why, for Whom and When it is Used

Service mapping is a tool that may be utilized by all kinds of organizations, including mentoring organizations, CBOs and OVC CCGs. Service mapping is a way to create referral linkages so that OVC, caregivers, volunteers, and organizations are aware of what services exist in their community and what gaps in services. This information may be utilized when creating a referral process and when strengthening linkages between the different service providers and institutions providing support to OVC. The service mapping process should be completed after the OVC CCG or CBOs have been trained in key organizational concepts and received capacity building support. Completing the service mapping process is an excellent way to begin the process of developing a coordinated care approach to OVC services and support. By identifying what already exists in the community and what the gaps are, a CBO or OVC CCG is then able to clearly define and plan for additional training, support and resources to help fill the missing services.

How the Service Mapping Tool is Used

To begin a service mapping process, CBOs or OVC CCGs select a group of staff or volunteers to receive training on the topic from mentor organizations (Tier II). The training should focus on how to build capacity in using participatory assessment tools and methodologies to map services. After successful completion of the training, the participants select a team of community members (may include staff, volunteers or beneficiaries), bring them up to speed on the topic and create a plan for implementing the service mapping procedure.

Service mapping should include identifying the following:
- Schools and early childhood education centers to support education needs;
- Hospitals and health centers; specifically those serving OVC and providing ARTs;
- Police and courts that can respond when a child is in danger or his/her rights are violated;
- Local government structures, both formal and informal (e.g. Kebele);
- Possible alternative care options such as foster homes;
- Faith institutions like churches and mosques, counselors or trained persons with skills to provide psychosocial support; and
- Organizations or CBOs which might provide IGA, life skills and other support services and training opportunities; and
- Other government and non- governmental organizations that provide services where the OVC program has linkages.

Once the sights mentioned above are visited, the group comes together and creates a map of the community which clearly highlights location of key organizations, institutions and facilities which will be included in a coordinated care strategy (see photo below). The map should be presented to all staff, volunteers and beneficiaries and will be a vital tool in creating a referral system for OVC and their families.

Promising Practice

Yetebaberut Sertegnoch Iddir is one of the Tier III partners that has successfully conducted service mapping. The OVC CCG of this Iddir first identified a central area in their Kebele and started plotting various geographical landmarks like roads, walk paths, rivers and buildings. Once these were plotted, the team observed and confirmed the location and availability of services in that geographical area. During their walks, they raised the curiosity of locals who questioned their actions. Members of the team mentioned that it provided a wonderful opportunity to inform community members about the work the Iddir was doing for OVC. The completed map included essential information about health facilities, pharmacies, schools, police stations, government offices, factories, churches, mosques and hotels. Equally as important as the map, was the face to face time and relationship with service providers that was strengthened during the service mapping process.

b)   Recruitment, Training and Retention of Community Volunteers

Why Are Volunteers Important to the Coordinated Care Approach?

The Coordinated Care Approach has it's foundation in the use of volunteers who are managed by a local community group implementing an OVC care program. Coordinated Care is based on the ability of a Volunteer Home Visitor (in most cases a community member) to assess the whole needs of an OVC on a regular basis. The whole needs approach to coordinated care means that the seven service areas are assessed and the Volunteer Home Visitor has the knowledge, skills and resources to refer the child, caregiver and family, if necessary, to the appropriate service. Because volunteers are an integral part of the Coordinated Care Approach it is essential to have clear guidelines and standards in place for volunteer recruitment, training, retention and supervision.

Incorporating volunteers into the program is an excellent way to build community ownership of the program. Volunteers are also from the community and therefore have valuable insight into the cultural norms and values that an outside "professional" might not have. Utilizing volunteers in a coordinated manner is also cost effective as it provides excellent programmatic support without the cost of salaries and other financial inputs. Given the cost effectiveness of utilizing volunteers in the program, it is easier to gain broader coverage and reach more OVC given that costs are not a prohibitive factor. If volunteers are recruited, trained and managed appropriately, it is also a good way to create sustainability of program concepts, actions and results, although this can be tricky as volunteer burn-out is common and therefore strategies to avoid this as much as possible need to be in place.

Volunteer Recruitment Strategies

Recruiting community members to become volunteers (in the case of PC3, their role was as Volunteer Home Visitor but this information is applicable to any role/position a volunteer might have within a program) is a very important first step. To begin the process, the OVC CCG or CBO needs to first create a map which includes where OVC live and know how many OVC there are in the community. This information will determine how many volunteers need to be recruited for a specific geographic area bearing in mind a volunteer should be in charge of no more

than 15 OVC. Based on that number, strategies should be developed to help recruit volunteers. Possible methods of recruitment include speaking at religious institutions (churches, mosques, etc.), women's associations, Parent-Teacher Associations (PTA), and neighborhood groups to increase awareness of the OVC burden and appealing to their sense of social responsibility for the care of OVC. If the aforementioned groups do not exist in any given area, the OVC CCG or CBO might hold a community meeting and announce it through flyers at the market or other community gathering spots such as the health clinic or school.

Simultaneously, OVC CCG members and CBO staff should also be encouraged to approach their family members, colleagues, and friends and encourage volunteerism by modeling their own involvement in OVC activities. If there are volunteers currently involved in the work of the OVC CCG or CBO suggest that they become Volunteer Home Visitor emphasizing that their insight will be valuable to the process. If current volunteers are interested, they will still need to participate in the specific training for Volunteer Home Visitor.

For successful volunteer recruitment and retention of volunteers it is very important to have clear guidelines as to what the volunteer selection requirements will be.   Based on the experience of PC3 partners, selection criteria include the following:

- Familiar with the concept of volunteer (i.e. understands that it is not financially compensated);
- Able to give 4-6 hours per week dedicated to home visits, assessments, referrals and other tasks;
- Respected in the community;
- Mature adult is preferred although younger persons might also fit the profile;
- Good understanding of the cultural values and norms of the community;
- Male or female;
- Literacy is *not* a necessary requirement;
- Live in neighborhood where OVC are located;
- Physically able to walk as this is necessary for home visits;
- Understands the concept of confidentiality;
- Available to participate in training activities outside of the typical 4-6 hour commitment per week; and
- Free of criminal record and willing to sign the child protection or safety policy

After a core group of volunteers who meet the selection criteria above have been recruited and accepted, the CBO should document information regarding the volunteer. Suggested information includes full name, gender, date of birth, educational level, marital status and number of dependents and address. Other important information to document includes: if volunteer is currently or previously involved as a volunteer and if so, in what capacity; number and name of villages served; number of OVC served; means of transport and distance between villages served; source of income; training received and training needs.

Responsibilities of a Volunteer

Volunteers should receive an initial training regarding their role and responsibilities before they begin making home visits. Training might cover the importance of confidentiality; ways to gain the trust of OVC, the coordinated "whole child" approach, understanding the mapping and referral process, and how to utilize the home visit checklist and other tools for tracking service

delivery. The home visit checklist utilized within the PC3 Program is based on the ten questions, which revolve around: observing housing and shelter conditions; observing child play and interaction with others; assessment of the health situation of caregivers; assessment of the health and immunization status of the child; assessing the nutritional status of the child; determining the educational status and needs of the child; assessing if the child is vulnerable to abuse or exploitation or drugs; evaluating if there is conflict within the family, especially in situations where the child is cared for outside of parental care; determining the income of the family and if the family would benefit from IGA activities; and creating an improvement plan for the child's care in conjunction with the caregiver and if appropriate, with the child.

Once the Volunteer is trained in and familiar with his/her role and responsibilities and the tools utilized in home visits, a schedule should be developed by the volunteer(s) and the CBO. The schedule should take into consideration the ratio of Volunteer to OVC (recommended ratios range from 1:10 or 1:15 depending on the number of OVC per household). Also important to consider is the frequency of home visits. This can range from one home visit per month in the case of a secure and stable OVC or once visit per week for the most vulnerable OVC which includes: child-headed households; homes where one parent is chronically ill; where a child is taking ARTs; situations where the child is ill or presents signs of abuse; cases of street children and children living with kin, foster families or adoptive families.

Managing Volunteers

An important part of retaining quality volunteers is having good management practices in place. Community-based organizations and/or Core Community Groups (OVC CCGs) should consider the following when developing a volunteer management structure and plan for their organization:

- Designate volunteer coordinator(s) inside CBOS/OVC CCG (it is recommended that there are at least two to not overburden). Clearly identify tasks including orientation and training of volunteers, facilitation of meetings and discussions, and supervision of caseload.
- Determine the volunteer to OVC ratio (recommendations are 1:10 and 1:15, see above for detail).
- Assign female volunteers to visit female and female OVC and male volunteers for boys.
- Assign Volunteers to OVC who live in their same neighborhood to decrease travel time When assigning case load, keep in mind that volunteer tasks should not exceed 4-6 hours per week to prevent burnout and overburdening
- Keep clear and updated Volunteer Register (recommended update is once a month)

The Volunteer Guide is an excellent tool for maximizing volunteerism at the community level and provides very helpful suggestions for working with and promoting volunteers within project. Given that volunteer recruitment can be a long process, identifying key ways to enhance that process is important. The Volunteer Guide has four key objectives: provide clear standards for volunteerism; provide information to assist volunteer leaders and volunteers in successful volunteerism; guide Community Core Groups in motivating and supervising volunteers; and promote uniformity in practice of volunteerism.

An important element within the Volunteer Guide is the Volunteer Code of Conduct, which includes:

- Putting the best interest of OVC and the program ahead of personal interest;
- Treating the OVC and their families with honesty, dignity and integrity at all times;
- Protecting confidential information and exercising good judgment—remembering they represent the OVC CCG;
- Being supportive rather than critical or competitive when working with others;
- Collaborating with OVC CCG to problem solve and report any abuse of children to authorities;
- Accepting responsibility by planning and evaluating on a regular basis (weekly/monthly); and
- Respecting the Volunteer Agreement signed with the OVC CCG.

The Volunteer Guide provides helpful information regarding the orientation process for the volunteer and supervisory roles and responsibilities. There are also suggestions for documentation, codes of conduct and a volunteer contract. Given the challenges of retaining volunteers, the guide also contains a section on motivating and recognizing volunteers which are critical elements involved in volunteer retention. The guide contains several annexes which include helpful information such as possible job descriptions for volunteers, volunteer application and agreement forms, volunteer review format and helpful references regarding volunteerism. The PC3 Program involved thousands of volunteers across the country and the lessons learned from this process have been included in the Volunteer Guide making it a practical and user-friendly guide for organizations wanting to include a volunteer component in their work.

Child Protection Policy

The Volunteer Guide provides helpful information regarding the orientation process for the volunteer and supervisory roles and responsibilities. There are also suggestions for documentation, codes of conduct and a volunteer contract. Given the challenges of retaining volunteers, the guide also contains a section on motivating and recognizing volunteers which are critical elements involved in volunteer retention. The guide contains several annexes which include helpful information such as possible job descriptions for volunteers, volunteer application and agreement forms, volunteer review format and helpful references regarding volunteerism. The PC3 Program involved thousands of volunteers across the country and the lessons learned from this process have been included in the Volunteer Guide making it a practical and user-friendly guide for organizations wanting to include a volunteer component in their work.

Because the CBO or OVC CCG and the volunteer team are working directly with children, it is essential that a Child Safety Policy be in place, be discussed, and that everyone understands that they must abide by the Policy if they wish to be part of the organization. As an organization working for and having direct contact with vulnerable children, the CBO and OVC CCG are obligated to create and maintain an environment that aims to prevent the sexual exploitation and abuse of children. Save the Children USA has developed and approved its own Child Safety Policy for staff and volunteers and it may be used as a guide for developing a Child Protection/Safety Policy for each NGO, CBO or OVC CCG. Once a Child Safety Policy is developed and instituted by a CBO or OVC CCG, it is strongly recommended that a plan be put in place whereby all staff and volunteers are made aware of the policy and the consequences should it be violated. Following are recommended steps used by Save the Children USA.

- **Awareness**: Ensuring that all representatives (including partner organization staff, community groups and volunteer care givers) are notified of and made aware that they are expected to comply with the policy.
- **Prevention**: Striving, through awareness and good practice, to minimize the risks to children, and taking positive steps to help protect children who are the subject of any concerns.
- **Reporting**: Ensuring that all individuals and organizations working with the children know what steps to take where concerns arise regarding the safety of chi1dren.
- **Responding**: Engaging in action that supports and protects children when concerns arise regarding their safety; supporting those who raise such concerns; investigating or cooperating with any subsequent process of investigation; and taking appropriate responsive action.

Promising Practice

Emebet Leta, a PC3 volunteer in Dire Dawa was visiting OVC in her cluster area as she always did. On one of her home visits, she found that two of the children she is responsible for, Helen Samuel, 13, and a 7th grade student and Weynehareg Areaya, 16, a 9th grade student were seriously ill, having been bed-ridden for 4 to 5 days. Because of their illness they had not been to school for a couple of days. Both children live with a relative and when asked why they did not try to go to the health facility they responded that it was because their guardian did not consider their health status priority.. Emebet obtained a letter from the Kebele to enable the children access free medical services and took them to hospital. The medical doctor who attended them diagnosed both with acute pneumonia, which could have killed them had they not been brought to the hospital in time. The students took the medicines prescribed by the physician, and within a couple of days their health improved. Finally they healed completely and are currently doing well in school, thanks to Emebet, who is a committed volunteer and member of the health and nutrition sub- committee of the local OVC CCG.

Chapter 7
Coordinated Care Services

Coordinated Care Key Service Delivery Components

The Coordinated Care Program includes seven <u>key service-provision areas</u> for OVC and their caregivers. These service components, provided together, address the child in a holistic manner and aim to improve the overall well-being, safety and protection of the child and the supporting caregivers. Coordinated care is a child-focused process that augments and coordinates existing services and manages child wellness through advocacy, communication, education, identification and referral of services. To facilitate positive service delivery in the seven service areas, several training manuals have been developed by the PC3 Program and are excellent tools for training volunteers or professional staff in how to provide quality services to OVC and their families within each core service area. The training manuals cover specific service areas and aim to foster overall strengthening of family and community-based care which ensures that the rights of the child are respected and at the same time works towards lessening the economic, psychosocial and health related burdens associated with HIV and AIDS.

The Coordinated Care Approach is illustrated in the table below which shows the "menu" approach. There are "core" services considered "fixed menu" items and optional services, considered "a la carte". The Coordinated Care Approach is based on the belief that children need and deserve a comprehensive package of services. OVC CCG are encouraged to provide as many as they are able to without jeopardizing quality and for those that they cannot provide, they should <u>ensure</u> that linkages or referrals to the other services is part of the package. Coordinated Care emphasizes the need to appropriately assess the needs of children and then provide or refer the children to those services based on the assessment. The service highlighted in the table show the ideal "package of care" that communities should offer to OVC and families affected by HIV and AIDS via their Tier II and III organizations.

Fixed and Optional Programming Choices for Care and Support for OVC

Fixed Programming Choices (Fixed menu)	Optional Programming Choices (A La Carte)
Educational support	Early Childhood Development (ECD)
Psychosocial Support and Life Skills Training	Professional Counseling for caregivers
Food and Nutrition	Supplementary feeding program for malnourished OVC
Livelihood support	Seed funding for IGAs for households
Child protection and Legal support	Aspects of social protection such as cash transfers to households
Health Care Support including Pediatric ART	None
Shelter and Care	Alternative Care such as Foster Care and Adoption

Based on the table above, there are seven key service components which form a complete coordinated care approach. The seven key service components and supporting tools are described, in detail, below.

a)   Education Service Component

Definition and Why it is Important

The education service component includes the establishment of formal or non-formal educational mechanisms, emphasizing primary level enrollment, attendance, retention, and promotion to upper levels for OVC. It also focuses on girls' education and quality education that accentuates teacher training and support. This service component aims to ensure a child's right to education, foster an understanding of the value of education for future endeavors, and support inclusion of OVC into community schools ensuring retention through school fee waivers, support with books and uniforms, etc.. Other important and successful practices identified by the PC3 Program was addressing nutritional needs through school feeding programs, provision psychosocial support addressing trauma and anxiety which frequently. These kinds of additional services within the education service component addressed serious barriers to enrollment, retention and educational success. Providing additional support in these areas was a critical component of school success for thousands of OVC.

Early Childhood Development (ECCD) is considered part of the education service component and focuses on the promotion of Community Based Child Care Centers (CBCCCs) to provide ECD for children between the ages of 3 and 6, emphasizing the integration of OVC with other children in the community. This component focuses on providing young children, teachers, parents and community members with an understanding of and skills necessary to promote and support ECD. This component promotes the involvement of community resources where available such as labor, materials and food inputs for the benefit of young children in the community.

Tools Developed to Support Education Service Component

To promote education focused activities within Tier II and Tier III organizations, several training tools were developed. The first of these tools was the School-based Support Manual, developed by Tier I partner, World Learning. Schools and education institutions were recognized as partners in the effort to improve services and support to OVC because:

- Schools are a key location where OVC and other children may encounter/express both need and opportunity for support;
- School attendance is something that both OVC and other children can and should do together;
- Education is a critical factor in improving quality of life and future employment opportunities; and
- Schools are a key entry point for OVC, are typically a central meeting area and recognized community meeting place and thus provide an excellent location for service referral.

The overall goal of providing OVC support through schools is to instill in community members the belief in and commitment to the important role that education plays in the lives of children and the community. *Taking ownership of and responsibility for improving the quality of education, increasing access to education and strengthening the role of schools as a central institution within the community* is the expected outcome the training aims to achieve. The School-based Support Manual was developed to provide school directors, staff, support personnel, teachers, members of the Kebele Education and Training Management Board (KETMB), members of Parent-Teacher

Associations, and other interested stakeholders with information, knowledge and skills aimed at improving their ability to address the needs of OVC in their communities and especially within their schools.

The information covered in the manual may be presented in two seven-hour days. The manual highlights the following topics, including: community mobilization for schools and key personnel involved in educational activities and support; project planning and implementation, with a particular focus on improving the conditions of life and learning for children at the school; advocacy related to educational issues; means of providing and the role of psychosocial support of children at risk, particularly OVC; monitoring, reporting and Evaluation techniques for education-focused programs; and ways to promote inclusion and limit stigmatization of OVC.

In the area of Early Childhood Education and Development, the Program developed the *Guide for Establishing Early Childhood Care and Development Centers (ECCD)* to support and facilitate CBO's ability to set up ECCD programs in their community. An ECCD Center in this context is described as a community-based parent/childcare service administered by parents and the community. It promotes the holistic development of children 0-8 years, especially vulnerable children. Services range from learning and stimulation activities, psychosocial care/support, nutrition, health, parent education, and protection.

The Manual is divided into five steps. The first step is focused on creating demand mobilizing the community. Activities and recommendations include a community awareness campaign/effort aimed at promoting the positive effects of ECCD and the impact on child's growth and development. Step 2 involves developing a community-based ECCD program. This section includes defining what care and education are as well as doing a community needs assessment and following that up with setting of community priorities. Step three includes recommendation for setting up an ECCD site including specific activities and guidance as to how to establish and design the facility. Steps four and five provide helpful information on how to form linkages with other community actors and institutions as well as suggestions for training and management. The manual provides step-by-step guidance in an easy to read format. The information is general enough to be adapted to the local context and needs of the community.

Promising Practice

An example of the impact that this type training can have on a community is illustrated in the case of Hibret Primary School in Wondogenet Woreda, Sidama Zone. The school has a population of 4,063 students, a significant population of this number considered OVC. A typical classroom has 100 children average family size includes 5-7 children. Food insecurity coupled with economic challenges and HIV and AIDS have significantly affected the number of OVC in this community.

Hibret Primary was among the first schools identified in 2006 by the Woreda education office to participate in the PC3 program through World Learning, one of the five Tier I partners. Upon recruitment, two teachers and a member of the Parent Teacher Association (PTA) were trained on the core concepts and practical aspects of care and support for OVC. The initial training focused on community mobilization but was followed by a host of other trainings tailored to develop capacity of the teachers to effectively deliver a comprehensive package of care and support services to OVC. One of the immediate assignments the three trained teachers was to conduct orientation sessions for the entire staff and form a core group of 16 members involving teachers and selected members of the PTA to oversee program implementation.

The school started to provide a package of the seven (psychosocial support, health care, food and nutrition, education, shelter and care, protection, and economic strengthening) key services. A room was allocated to the core group to use for planning, meeting and counseling. The school set up a peer support group comprising both OVC and non-OVC to discuss life skills and other issues of identified by children and adolescents. Non OVC were involved in these activities to avoid negative labeling and to increase discussion of issues that concerned children. When provided with a safe location, the children began to talk not only about the pain of losing or living with a parent or guardian with HIV but also painful topics such as sexual violence, poverty, child labor and exploitation. The core group mobilized the school community to donate clothes and food for the most vulnerable kids – some who whom skipped school because they were too hungry to attend. Fellow students donated their extra clothes, books and pens to support the OVC. Having started with 159 OVC in 2006, the school currently supports over 400 orphaned and vulnerable children, providing critical services and support once non-existent in their community.

b)   Psychosocial Support Component

Definition and Why it is Important

This service component includes the provision of counseling for individuals, peer groups and families to support and promote the psychosocial well-being of children and caregivers and facilitate transition plans if situation requires including the transfer of guardianship.

Tools Developed to Support Psychosocial Component

Strengthening a community's ability to provide quality psychosocial services and support to OVC and their caregivers is a key element of the coordinated care approach. Psychosocial support is a key component of a comprehensive care package. It is also one of the most cost-effective and easy to provide services as it only requires trained personnel able to provide one-on-one support, a listening ear, and confidential counseling services. The Psychosocial Training Module was developed by the PC3 program and is a valuable tool for promoting quality psychosocial care for OVC and their caregivers. The training module is designed to enhance the capacity of adults to listen and speak to OVC and children of terminally ill parents. The Psychosocial Training Manual specifically aims to: provide information regarding children's psychological development especially around death and bereavement; introduce basic psychological concepts especially around the emotional impact of HIV and AIDS on children and ways/methodologies for counseling children; and create an understanding of the impact that HIV and AIDS has, emotionally, on children.

The manual is designed for use by volunteer community members concerned about and involved in OVC issues, practitioners working with local organizations and CBOs, education professionals, representatives of local government institutions, and representatives of religious communities such as churches and mosques. Ideally, anyone who is interested in and compassionate about providing psychosocial support to OVC and their families may benefit from the information provided in the manual. The training utilizes a participatory-based approach and incorporates a significant amount of group work therefore a safe learning environment where mutual respect is promoted is essential to the success of the training. The training manual is easy to read and gives a step by step guide to what is required within each topic area (e.g. description of activity, methodology, and required materials, duration and trainers notes). The training is designed to be completed in two to three 7-hour days. The end goal of the training manual is equipping community members with a better understanding of the emotions, challenges and concerns related to HIV and AIDS, bereavement and the death and dying process so that they are well prepared to support OVC and their caregivers whom are dealing with these issues.

Promising Practice

Helena Youth Anti-AIDS is a Tier III partner in Bahir Dar, Ethiopia. The organization includes 8 volunteers who have received TOT support from Tier II organizations. The trained volunteers provide psychosocial support to more than 350 OVC. Many of the OVC are double orphans and present a great need for attention and one on one interaction. The volunteer counselors provide psychosocial support and life skills training through home visits, group counseling, tutorial support, and facilitating a child's participation in recreational activities. As HYAAA Chairperson, Asanaka, remarked; "many OVC were depressed and dropping out of school. After receiving psychosocial support from our volunteers, they are happier and participate in school and educational activities." Six-year-old OVC, Meseret recognizes the importance of the volunteer in her life "we love our friend, Tsega because she helps us study and plays with us and tells us stories."

c) Life Skills Component

Definition and Why it is Important

The Life Skills component specifically targets youth (ages 10-18 years) by creating opportunities for out-of-school adolescents. This service component emphasizes decision-making skills, psychosocial and coping skills, linkages to vocational training, and planning for the future, with particular emphasis on supporting female youth. This component also includes activities which promote behavior aimed at preventing HIV and AIDS and works towards developing community leaders. Given that many youth are head of households it is critical that they be given the skills and knowledge necessary to succeed and be positive role models within their own families and within their communities.

Tools Developed to Support Life Skills Component

To assist in successful implementation of the Youth Skills Component, PC3 developed a Life Skills Implementation Strategy. OVC face psychosocial impacts particularly if the loss of the parents is due to HIV AND AIDS. The psychosocial distress faced by OVC is often significant and lasting negative effects. A child may face grief, fear and hopelessness over the future, anxiety over how they will survive and who will care for and protect them, loss of parental guidance, and stress from changes in their life circumstances (moving to new home, street, leaving school, taking on new roles and responsibilities). OVC, especially adolescents, may lose models (parents or other caregivers) that pass on important human skills, such as self awareness, self esteem, self confidence,

problem solving, communication and interpersonal relations. Stigma and discrimination related to HIV and AIDS is another aspect which significantly impacts OVC. The aforementioned issues present enormous challenges for young people to overcome. The Youth Skills Strategy describes the training component (see below for descriptions of the Youth Action Kit) and non-training activities such as provision of information related to HIV and AIDS prevention and reproductive health, creation and/or strengthening of a referral system to other community-based youth support systems and programs, and a tiered-approach monitoring and evaluation plan. The Life Skills Implementation Strategy may be used as a guide for what key elements a program should include in the life skills component. The Youth Action Kit (YAK) is the main tool utilized in this component and is described below.

To support the Life-skills component of the comprehensive care package, a Youth Action Kit (YAK) is one of the main tools used to assist this population of OVC. The YAK was developed by the Health Communication Partnership (HCP Program). The focus of the YAK is to promote the creation of youth groups which provide a safe space for adolescents and give them an opportunity to lead efforts related to their well-being, including HIV and AIDS prevention, care and support. The Youth Action Kit is designed as a Training of Trainers with youth being the leaders and the participants. Topics covered in the manual include values, communication, decision-making, relationships and HIV and AIDS.

The central aim of the YAK is to promote not only learning but more importantly action by adolescents in the community. Through ownership and action by this core population transfer of ideas, information and activities to friends, family, teachers and leaders will occur. The YAK provides a model for adolescents to develop their own clubs, creating a safe place for youth to discuss topics that are important to them. It is a model for community awareness building and action. The YAK is made up of 25 activities related to HIV and AIDS prevention, decision-making, values and relationships. Each activity includes the purpose, key message, activity overview and necessary materials. It also includes step by step instructions for the facilitators and worksheets to be utilized in the training and at home. The instructions include a section with recommendations about how the information can be shared at home and/or with friends thus fostering transference of key concepts and ideas.

Complimentary training material, the Beacon School Life Skills Training Manual, has been developed targeting participants between the ages of 10-14 years of age.

Promising Practice

Lubaba, age 19, lives in Addis with her brother and five sisters. Her father was employed as butcher butchery for 45 years and took care of the entire family with the small income he earned. However, the butcher shop closed and her father lost his job. Lubaba was registered as vulnerable child and become a beneficiary of PC3 program through CARE's tier III partner, Bet Abraham Iddir, where her parents are members. As an adolescent she was in need of life skills training and support and was enrolled in a six month hairdressing course. Lubab successfully completed her training and graduated. Today Lubaba is employed in a beauty salon and is earning a reasonable monthly salary. Lubaba talks with confidence how this opportunity has changed her life and made her more confident. She would eventually like to open her own business and help other girls like herself.

Definition and Why it is Important

Provision of support interventions in this service component include nutritional support to OVC and OVC households; provision of health care and palliative support for OVC, parents and their guardians; training of health care providers; behavior change communication techniques promoting improved health seeking behavior, nutrition, and the reduction of stigma and discrimination against PLHIV and OVC; promotion of essential child survival interventions (EPI and Integrated Management of Childhood Illnesses (IMCI) adapted for HIV positive children); and growth monitoring. The Health component of the coordinated care approach is significant in that it takes a three-pronged approach including promoting education and prevention, palliative care and support, and accessibility to treatment and appropriate nutrition.

Tools Developed to Support Health and Nutrition Component

The PC3 Health and Nutrition Interventions Partners Guide is a helpful document developed to promote stronger linkages between health services and parents and caregivers of OVC. The document provides guidance in how to address the specific health and nutritional needs of PLHA and information for early detection of HIV and HIV-related illnesses such as tuberculosis (TB), sexually transmitted infections (STIs) and opportunistic infections (OI). Key Principles addressed in the guide, include: guidance on how parents and caregivers can keep children healthy; how to provide practical support to those caring for children with HIV and AIDS; how to strengthen caregiver's ability to provide good nutrition to OVC and other practical advice related to the health and nutritional needs of OVC.

Changing Communities: Health and HIV and AIDS

Because HIV and AIDS has changed the face of the "traditional" family, caregivers of OVC are now grandparents, other extended family members or children themselves as is the case with child-headed households. Therefore traditional health training targets must be changed to include this most recent phenomenon. Children are primary caregivers in many cases and this training manual is designed, in a simple and easy to use way, so that children and other caregivers are able to benefit from its content and improve the health practices and knowledge in their own homes and daily lives.

Changing Communities: Health and HIV AND AIDS, Care and Support for Orphans and Vulnerable Children in Ethiopia is a manual designed to support caregivers, child heads of households and orphans and vulnerable children infected or affected by HIV AND AIDS. Activities within the training are focused on providing participants with an understanding of their own health needs, the daily challenges they face, assists them in evaluating available resources, and gives them the tools to find simple and low-cost solutions to their problems. This manual provides guidance on how to confidently deal with basic health, hygiene and sanitation issues faced by caregivers and child heads of households. The training manual places emphasis on prevention of infectious diseases, and highlights home based solutions to specific illnesses as well as the importance of seeking proper medical attention on a timely manner

This manual is intended for use by anyone who is interested in working with caregivers, child heads of households and orphans and other vulnerable children affected and/or infected by HIV in: the household; school settings, both formal and informal; religious institutions; community groups

and youth centers; Iddirs, Afoachas and other community-based institutions. Ideally, this training could be implemented and understood by Tier I, II, and III groups as the information provided within is of interest to all who work with OVC. The Training Manual provides the facilitator with clear guidance on how to implement the training including: learning objective, methodology, recommended number of participants, materials needed, time allotment, and a sample training agenda. The training is designed to take place over 5 days and is the first in a series of four training module

e)   Livelihoods Support Component

Definition and Why it is Important

This service component focused on strengthening of household economic resources through initiatives that enable households to be economically independent and reduce economic vulnerability. The intended result is economic independence, dignity and the ability to economically provide and care for one's family. Activities may include income generating activities (IGA), agricultural interventions, micro-finance and other financial services such as Community Self-help Saving Groups (CSSG), vocational training and support for a socio-economic enabling environment that may involve support to start an income generating activity.

Livelihood support is an essential aspect of the "fixed menu" for OVC care and support services. Recognizing that complex coping mechanisms are set in motion by AIDS-affected households from the onset of AIDS-related illness, livelihood support is particularly critical in Ethiopia where precarious economic household security is threatened by significant shocks. The illness and death of a parent can lead to loss of time investment in livelihood activities and the potential loss of critical household assets in order to cover expenses related to caring for the ill. Other coping mechanisms include reduced expenditure in the household on health care and nutrition, reduced investment in and prioritization of education. Several tools were developed within this component to support livelihood programming efforts. The methodology is based on CARE International's livelihood framework.

Tools Developed to Support Livelihoods Component

Income Generating Activity (IGA) Selection, Planning and Management Training Guide
This Income Generating Activity (IGA) intervention is focused on the identified specific needs of targeted beneficiaries and applied in the context of Need-Based Business Development Service provision. In a demand-driven Business Development Services delivery methodology the service to be delivered to the targeted beneficiaries should be based on the needs identified by the beneficiaries themselves with proper assistance/facilitation of the field agent in the process. The ultimate objectives of this Training Guide are to enable the beneficiaries to select an IGA that is appropriate for their living conditions, properly plan for the successful start and running of the IGA, and manage the IGA effectively, so that they can generate an income for their livelihoods. This Training Guide is prepared in such a way that it will fit for both illiterate and literate target groups. The training guide is divided into five sessions and the entire training module may be completed in 4½ to 5 days. Specific topic-related exercises, stories and appropriate energizers are also included so as to make the learning process easy and interesting.

The IGA Training Guide contains helpful information for the trainer including objectives of the training, timeframe, resources required and methodology. The training is participatory in approach and allows significant interaction among participants, on the one hand, and between participants and the trainer on the other. The training methodology is very practical and includes opportunities for participants to develop their own IGA ideas and work through the process and procedures necessary including creating a business plan, marketing, and other essential components of IGA.

Community Self-help Savings Group (CSSG) Methodology

In recent years, development professionals in the fields of both micro-finance and HIV and AIDS have become aware of the important link between these two genres of programming. Increased awareness of these issues has resulted in significant study of the synergistic relationship between HIV and AIDS and micro-finance activities. The PC3 Program has adopted community based micro finance as a strategy for its livelihood component. CARE Ethiopia, as the lead Tier I organization overseeing the livelihoods component has utilized the village savings and lending (VS&L) methodology as one of the primary livelihoods strategies. Within Ethiopia, this program is called Community Self-help Savings Group (CSSG).

The CSSG methodology promotes local savings and credit groups that build on the traditional Rotating Savings and Credit Associations (ROSCAs) known in Ethiopia as Iqqubs. CSSGs add innovative twists that make them more flexible and potentially attractive to participants. The periodic contributions to the group are accumulated with an end date in mind for distribution of all or part of the funds to the individual members. This lump sum distribution provides a large amount of money that each member can then apply to his/her own needs. From this perspective it is primarily a savings club. Members make use of the funds for short-term credit needs on a continual basis so the funds are constantly working for them, earning interest and not just sitting idle in the group or the bank. These loans allow the members to meet their small, short-term financial needs for income generating activities, social obligations and emergencies without having to borrow from a money lender, take an expensive supplier advance, or rely on their relatives. This adds a limited credit perspective to the group.

The basic principle of CSSG methodology is that members regularly pool their savings and individuals can borrow from these funds and pay back at agreed upon interest and time period. In terms may be longer, but this will depend on the group's experience and decision. All transactions are carried out in front of the General Assembly and all members have passbooks in which their savings are recorded. Members are savers and may choose to contribute one to three times the base savings at every meeting. There is a payout after each cycle in which the group's money is equally divided up amongst members, based on the total amount saved by each individual. A key principle of the CSSG is that participation is open to all community members with no discrimination based on gender, age or health. Members have equal voting power regardless of savings amounts. The CSSG Methodology Manual includes information on the initial five-module training plan for the creation of CSSGs. Each of the five modules includes objectives, timeframe and methodology. The manual also includes a step by step guide into how to develop CSSGs, including constituents, training, group loan appraisals, and a field officers guide to group development cycle. The manual is a how-to guide for developing CSSGs from the initial stage through the final stage and includes excellent information and recommendations for training, supervision and monitoring of the CSSGs.

Need based BDS Delivery Guide

Business Development Services (BDS) are defined as activities that are non- financial in nature and enhance market access, business management and production skills and/or improve technology in a business. The Tier I organization, CARE, developed a Need-based BDS Delivery Guide to assist Tier II and Tier III organizations implement their business development programming as part of the livelihood component. This is the third tool within the livelihood component and fits nicely with the other two aforementioned training manuals and methodologies.

The BDS Guide was prepared for use in identifying and delivery of a need-based BDS. The guide has three modules entitled; *Introductory Module, What are Need-Based BDS, and BDS-Identification, Action Planning and Managing Delivery*. There are four sessions dealing with identification of the need of the target group, preparation of an action plan, management of the delivery of the service and follow-up. The BDS Delivery Guide is prepared for use in training focused on BDS delivery and should be conducted over a period of five days. The five modules include training objectives, materials needed and timeframe and provide a step by step guide for training implementation

Promising Practice

Community Self-help Saving Group methodology is a key approach used by the PC3 program to build economic stability among households impacted by HIV and AIDS. The methodology is derived from CARE's successful Village Savings and Lending (VSL) approach and builds upon the traditional saving system in Ethiopia known as Iqqub. A CSSG is a self- selected group of people ranging from 10-20 who pool their money into a fund from which members can borrow for life cycle events, emergencies and investments. Each member saves an agreed amount of money on a monthly basis. Members get loans and repay within an agreed period of time. Groups are trained to manage the funds themselves and plan for larger investments.

Since 2006, 800 CSSGs with 50,761 members (60% female) have been established and savings are estimated to be 357,124.00 USD. Significant improvements have been observed in asset building, diversification of investments, and empowerment of households. Women's financial independence, gender relations and leadership roles have been enhanced. Through the CSSG methodology awareness on HIV, life skills and psycho-social wellbeing have been enhanced. Over 80% and 95% of the groups have reported improvements in savings and loans, and business expansion, respectively. Some groups clustered and have been able to access loans from micro-finance enterprise agencies to expand their investments.

CSSG is a promising livelihoods methodology for economically vulnerable individuals and household who cannot access loans from larger financing institutions. The approach has significant contributions to HIV awareness, prevention and stigma reduction. Since it is group driven, the methodology promotes ownership and collective responsibility, which are key to successful investments.

Legal Support and Child Protection

Both these service components are considered key elements of the coordinated care approach. Although no tools were specifically developed for these components, information, training, and concepts were incorporated from existing documentation authored by established organizations such as UNICEF and Save the Children UK. Key elements of the legal support and child protection components included networking, creating linkages, and providing education to caregivers, community members and Tier II and III organizations about the important of legal support and child protection measures within an OVC framework.

The Legal Supports component and promotes the support for OVC and caregivers against property grabbing and other inheritance issues utilizing community advocates who are trained to support and promote the legal rights and benefits of OVC and their caregivers. This may involve working

with PLHIV to ensure that their children and future guardians will benefit, especially through education, from their assets.

The Child Protection Component includes the provision of support and services aimed at protecting children from neglect, abuse, harassment, homelessness and exploitation (sexual and labor). This component includes training of OVC CCG in the importance of child protection strategies for volunteers, identification of signs of abuse and neglect in OVC, reporting strategies and mapping of services, and education and awareness for children and adults around the Convention on the Rights of the Child (CRC). This component is cross cutting within the other six components as child protection concepts are included within all aspects of the program. No specific tools were developed by Tier I partners, rather the CRC and other pertinent UNICEF and Save the Children documents related to child protection were utilized and incorporated into other trainings.

Promising Practices

Child Protection: Tsedale, 13, came from Manze, Northern Shewa, to live with her sister in the outskirts of Dukem town and Dalota village. She is one of the OVC supported by PC3 program through Dukem elementary school. She was 10 when she came to this area. Tsedale lost both of her parents to HIV and AIDS and as a result she couldn't continue to live in Manze, so she moved to live with a relative in Dukem. While Tsedale was on her way to school one day in January 2007, she was abducted by a 45 year old man, who sexually abused her. When they heard the information about Tsedale's abduction, the Dukem elementary school core group members sought the help of the Police and were able to seize the perpetrator and his collaborators with the support and Tsedale's sister and her husband. The core group of Dukem elementary school worked with determination to ensure that the perpetrator was brought to justice. The court handed the perpetrator a 15-year jail term and twelve years for his collaborators. Tsedale's brother- in- law was imprisoned for three months for his involvement in the abduction. Currently Tsedale is living with one of the teachers of Dukem elementary school. The core group provided post trauma and HIV counseling and encouraged her to get tested. She did and fortunately tested negative. Now, Tsedale is back to school in Grade 2.

Legal Protection: Two OVC living in Dire Dawa were being threatened by their step-father. After the death of their mother, the step-father tried to sell the house, of which he was not an owner. The orphans were frightened that if he sold the house they would be left homeless and destitute. They brought their case to the OVC CCG who responded immediately. The step-father had no legal right, without the legal consent of the children to sell the house. The OVC CCG legal sub-committee followed up with the local authorities and court to ensure that the property would not be sold. Authorities agreed and the case was successfully resolved in support of the two children.

f)   Shelter and Care

Definition and Why it is Important

The Shelter and Care Component has a two-pronged approach; shelter and care of OVC. This component of the coordinated care approach includes assistance to OVC and their families to ensure adequate housing and protection. This component was developed after program initiation when it was identified as a major issue faced by OVC. It also includes assisting communities in identifying needs; specifically housing that does not ensure the well-being of children, providing temporary foster care to children without parental care, covering rental costs for OVC in child-headed households and other related activities which work to ensure that OVC are in safe housing.

Within the shelter component, the main tool used to identify issues related to this component, is the home visitor report and accompanying observations. The Home Visitor should observe the

home of the OVC and if the shelter is determined to be inadequate, unsafe or in such disrepair that it poses a threat to the well-being of the OVC, the Home Visitor should report that to the OVC CCG or CBO providing oversight. The CBO or OVC CCG helps mobilize appropriate support which could be from the community members, from the Iddirs or from the local Kebele's. The Kebele's frequently have property and are willing to make special arrangements for OVC until other secure housing can be arranged.

The care component is also dependent upon the observations of the Home Visitor. If the Home Visitor sees or feels that the OVC is at risk in their care environment or that that they do not have any appropriate caregiver or support, the Home Visitor will begin to identify possible solutions. Those solutions might include exploring options with extended family or an older sibling, temporary foster care with a community member and linkages or referrals to other support mechanisms within the community.

Guidelines and suggestions for how the Home Visitor can document observations and promote community mobilization in response are included in the Home Visitors Guide referenced in *Section IV b*. Additional support and information regarding measurement of well-being may be found in section VIII a explaining the Child Status Index (CSI) tool.

Promising Practice

Adugna Aschalew is nine years old and lives with his two sisters and one brother in Addis Ababa. Adugna lost his father at an early age. Shortly thereafter, his family home was burnt to the ground and everything was lost. The worst part of this was that Adugna was severely burnt in the fire and remained hospitalized for a significant amount of time. After the fire, the family had no belongings, no resources, no food and the children had to leave school. Tesfa Social and Development Association (TSDA), with the help of a Tier III partner supported Adugna and his family by helping them to build a new house and to purchase a few household items. The tier II partners mobilized local funds to support the construction of reasonable shelter for the family. They ensured that the children were able to re-enroll in school. They also ensured that hospital bills were waived.

Chapter 8
Improving Quality of Services

Quality Assurance Improvement and Standards of Practice

Once the program has developed and is providing a comprehensive package of services, the next step is to create systems and standards and incorporate them into the program to ensure that the quality and impact of those are measurable. Quality Improvement may be defined as a process or processes that systematically monitor and evaluate services or overall care to ensure that program standards are being met and are regularly updated to reflect current knowledge, and that gaps between expectations and actually results/outcomes are routinely identified and addressed. [11]An important change in service implementation is reviewing progress towards achieving overall outcomes for children as opposed to only counting access to services. Tools created and/or utilized for measurement of quality and impact include standards and Child Status Index (CSI). Both tools have had significant influence on Tier I, II and III organizations ability to measure impact and improve service delivery based on findings gathered from the tools Quality care centers concentrates on maximizing benefits and minimizing risks. It focuses on child well-being and improvement over a simple count of services provided.

a) Quality Improvement Service Standards

Given the vast number of organizations working not only in the PC3 program but in other OVC-related programs in Ethiopia, it was critical that there be some consistency in for the quality and package of services for children and their households. The effort to create the **Quality Assurance and Improvement Standards for OVC** in Ethiopia included participation by a broad spectrum of providers and stakeholders. National level organizations collaborated to define what quality standards should look like for each of seven key components of care. The goal was to establish agreed-upon common critical minimum standards and criteria by which to measure the quality of the services provided. The goal of developing standards is that it will create a framework within which actors intervening in the area of OVC can operate to ensure attainment of outcomes for children. Thus, in order to develop the quality standards, program partners met with children, households, community institutions/organizations and state government. The objective was to reach consensus on the dimensions of quality as well as critical minimum activities which must be followed in order for actors to claim that they are delivering quality services.

Definition

A standard may be defined as an agreed upon outcome based on quality and impact. Standards are typically defined by incorporating best practice.

Why, for Whom and When it is Used

These standards, developed over the course of two years and officially endorsed by national and regional stakeholders in May 2009 will be used by service providers and donors for program planning, monitoring and evaluation to improve overall service delivery for orphans and vulnerable children. In addition, the information gathered by utilization of the standards may help inform national level efforts in the development of a national OVC policy framework.

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[11] USAID, Pact and USAID (2008). Quality Programs for Orphans and Vulnerable Children: A Facilitator's Guide to Establishing Service Standards

How it is Used

The quality improvement standards are intended to be used by program implementers to standardize services and assure quality in services delivery to OVC. The standards define dimension of quality to be observed by OVC programs as well as the critical minimum activities and/or services for each component.

Dimensions of Quality	
Safety	The degree to which risks related to care are minimized; do no harm.
Access	The lack of geographic, economic, social, cultural, organizational or linguistic barriers to services.
Effectiveness	The degree to which desired results or outcomes are achieved.
Technical performance	The degree to which tasks are carried out in accord with program standards and current professional practice.
Efficiency	The extent to which the cost of achieving the desired results is minimized so that the reach and impact of programs can be maximized.
Continuity	The delivery of care by the same person, as well as timely referral and effective communication between providers when multiple providers are necessary.
Compassionate Relations	The establishment of trust, respect, confidentiality and responsiveness achieved through ethical practice, effective communication and appropriate socio-emotional interactions.
Appropriateness	The adaptation of services and overall care to needs or circumstances based on gender, age, disability, culture or socio-economic factors.
Participation	The participation of caregivers, communities, and children themselves in the design and delivery of services and in decision making regarding their own care.
Sustainability	The service is designed in a way that it could be maintained at the community level, in terms of direction and management and procuring future resources.

The critical minimum activities typically reflect the standard services provided in OVC programs. The dimensions of quality describe the various aspects of quality that program should observes as they plan to implement and deliver services, as illustrated in the table above.[12] In Ethiopia, standards were developed and included a desired outcome, relevant national indicators and critical minimum activities for *each* service area. As mentioned above, the critical minimum activities are the "basic" or standard activities that must be included within a specific service area. Examples of critical minimum activities included in the Quality Assurance and Improvement Standards of Care and Protection for OVC Programs in Ethiopia (DRAFT) are highlighted in the chart table below.

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[12]   National OVC Taskforce, PEPFAR and USAID (2008). Quality Assurance and Improvement Standards for OVC Programs in Ethiopia

Service Area	Desired Outcome	Relevant National Level Indicators	Critical Minimum Activities
Education	Child is enrolled, regularly attends and completes a minimum of primary (grade 8)	▪ Key strategies but not specific standards, includes: ▪ Strengthening school involvement and ensure access to education; ▪ Increasing school enrollment and attendance; and ▪ Prohibiting discrimination based on or presumed HIV status.	▪ Work with community/ PTA/KETB/CBOs to identify OVC in need of education services; ▪ Identify and address barriers to education on an individualized basis for each child; ▪ Facilitate enrollment of OVC into an educational opportunity (academic or vocational); provide early childhood development services for children; and ▪ Increase capacity to monitor child enrollment, attendance and completion.

Food and Nutrition	Adequate food is available for the child to eat regularly throughout the year for healthy and active life.	▪ Trained HBC providers on balanced die and proper nutrition.
		▪ Number of OVC and families who received information on balanced diet and nutrition.
		▪ Number of OVC provided food and nutritional support from the community initiative.
		▪ Number who have received food/nutrition aid.
		▪ Establishment of referral links and feedback.
			▪ Train caregivers on proper food handling and nutrition practices
			▪ Link severely malnourished children to therapeutic feeding programs
			▪ Ensure proper growth is occurring for children that are receiving food support
			▪ Increase household protection of food utilizing:
			  o Backyard gardening
			  o Urban gardens
			▪ Train caregivers on age-appropriate feeding practices including exclusive breastfeeding and safe complementary feeding practices.
			▪ Link OVC to food resources, such as WFP, where and when appropriate.

In Ethiopia, the initial trial period for standards was done using an Improvement Collaborative approach. This is an approach that is "a shared learning system that brings together a larger number of teams to work together to rapidly achieve significant improvements in processes, quality, and efficiency of a specific topic area, with intentions of spreading these methods to other sites."[13] In addition, it provides an opportunity to learn from others through forums such as Learning Sessions where all partners are able to share their successes and challenges as well as work together on common objectives/indicators and best practices. This was the best option, as the QI project was piloted within the PC3 program which provided an excellent entry point given the tiered nature of the partnership which includes international and national NGOs and well as local CBOs who are providing services directly to OVC and their families. At the national level, the work with the national OVC task force also helped facilitate the cross learning between levels from the national to the local level and also incorporated all levels of government.

The initial trial period of the standards were done through a collaborative mechanism in selected program sites. A steering committee of seven government offices, local and international NGOs was established to lead the national process for finalizing and adoption of the QAI standards. The committee was briefed on the content of the draft quality assurance standards and asked to develop a plan for completing the adoption process. The team plans engaged more players including those with specific expertise in various service components, to review the document in light of other national and international standards, held regional and national level consultative meetings to finalize and disseminate the document.

Six community partners in Dire Dawa participated in an exercise aimed to test the feasibility of using the draft quality improvement service standards to improve service quality. Each community group focused on specific service components and sought to answer the question: *do the service standards work to improve quality?* With the help of the PC3 technical staff, the community groups met on a regular basis to document the changes they observed as a result of applying the standards and made recommendations for revision of activities that were found to be least effective in creating the desired changes and outcomes. This process was linked to the review of the quality improvement service standards being facilitated by the national OVC task force and provided useful evidence to support the validation of these standards nationally. The OVC service standards are currently being used by most program implementers in Ethiopia to standardize services and to improve quality across programs.

Before using the standards, it is important that each CBO or NGO complete an assessment. The PC3 Program developed an assessment tool, specifically for Tier III (NGOs or CBOs) to use at this stage. This allows for each CBO to decide what their own strengths are and how to best care for the OVC as they are the point of service delivery. Next a gap analysis should take place based on the Critical Minimum Activities within the standards in order to have a starting point of how well the CBOs are assessing the OVC. A baseline data collection is also essential as it provides a starting point for monitoring and a way to evaluate the long term impacts that quality improvement has made in the life of the OVC.

The next phase of the process should be the development of performance improvement indicators. This step is critical as it provides a goal and the activities the CBOs should implement to reach their final outcome. Thus, once these plans are designed the CBOs are able to begin implementation of the Critical Minimum Activities that are laid out clearly in the standards.

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[13] "The HCI Project: USAID'S Resource for Health Care Improvement", USAID, May 2008

Data should be continually collected and documented throughout the QI process. Within the PC3 Program, this was done both by the Tier III and Tier II partners, with guidance from the Tier I partners. A scrapbook has been shown to be extremely successful for data collection and documentation purposes at the community level. Additionally, at the LNGO level assessment checklist and a monthly monitoring tool at the national level can provide the essential data.

Monitoring progress on reaching the standards is important. It is recommended that an evaluation be done every six months to a year. After the assessment, the NGO or CBO needs to determine where they are in meeting the expected outcomes and adjust as needed to try and reach the identified targets. At the end of the specified time period or end of project, it is also strongly recommended that an assessment be completed to identify where expected outcomes were met, what helped reached those targets, if they were not met, determine why they were not and document lessons learned. This process will provide ample information and hopefully assist in the next phase of program implementation and work towards reaching expected outcomes identified for each service standard.

b)   Child Status Index (CSI)

Once the program has developed and is providing a comprehensive package of services, the next step is to create systems and standards and incorporate them into the program to ensure that the quality and impact of those are measurable. Under the PC3 program and in collaboration with other OVC program implementers in Ethiopia, quality improvement service standards were developed. An important change in service implementation is reviewing progress towards achieving overall outcomes for children as opposed to only counting access to services. The Child Status Index (CSI Tools are utilized for measurement of quality and impact of the program on child wellbeing. Both tools have had significant influence on Tier I, II and III organizations' ability to measure impact and improve service delivery based on findings gathered from various sources.

Definition

The Child Status Index (CSI) is a method for measuring several components of a child's wellbeing including food and nutrition, shelter and care, protection, health, psychosocial and education and skills. Each component has a stated goal and measurement of the child is based on that goal. The scoring system goes from 1 to 4 with 1 being very bad and four being good. The CSI tool was developed for the US President's Emergency Fund for AIDS Relief (PEPFAR) and USAID by MEASURE Evaluation.. The tool has been utilized within the PC3 Program as well as in other PEPFAR-funded OVC programs across Africa. The Child Status Index was developed in both written and picture form so is appropriate for use with both literate and non-literate populations.

Why, for Whom and When it is Used

With technical support from MEASURE Evaluation, PC3 has been applying the child status index (CSI) tool to measure child-level outcomes and to plan for improvements in service delivery. The CSI tool was developed for use by community volunteers and staff of NGOs and CBOs working with OVC. The tool was developed to enhance case management, planning and evaluation through individualized assessment of each child based on the six aforementioned areas. The CSI tool should be utilized during home visits with OVC; ideally at the initiation of the case and then with successive visits to determine improvement and outcomes. The tool provides 12 sub-domains and a set of questions that guide community workers to make the best judgment of a child's wellbeing.

How the Child Status Index is Used[14]

Domains	Sub-domains
Food and Nutrition	▪ Food Security ▪ Nutrition and Growth
Shelter and Care	▪ Shelter ▪ Care
Protection	▪ Abuse and Exploitation ▪ Legal Protection
Health	▪ Wellness ▪ Health Care Services
Psychosocial	▪ Emotional Health ▪ Social Behavior
Education and Skills	▪ Performance ▪ Education/Work

The CSI tool is to be utilized during home visits and should be used in addition to discussions with the child, caregivers, teacher, and neighbors. It requires thoughtful observation of the home, the child and interactions between the child and caregiver, child and siblings or other children in the home as well as between the child and the caseworker (CBO staff or volunteer). Before using the CSI, volunteers or staff should be trained in how to use it. The training may take 1-2 days. During the home visit, it is important to explain the CSI procedure to the child and the caregiver, mention why the information is being collected and receive verbal consent from the caregiver and the child. It is also important that the volunteer or home visitor utilize open-ended questions during the assessment which helps to gather more complete information.

The Field User's Guide is a helpful tool developed to assist practitioners in understanding how to use the CSI tool. Developed by MEASURE, the *Field Users' Guide* is intended to assist those who are directly responsible for providing care and support to children affected by HIV and AIDS. It provides information which is helpful to persons utilizing the CSI as an assessment tool of child well-being. The *Guide* is divided into two main sections. The first provides details as to how the CSI was developed. The section provides clear instructions as to how to use the CSI. The Guide may be used as an excellent resource for training focusing on the how, why and when of CSI utilization.

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[14]   Developed by MEASURE Evaluation, USAID and Duke University.

Promising Practice

The PC3 program has used the CSI Tool successfully to measure child level outcomes and to make significant improvement is service delivery. The first CSI assessment involving over 11,000 OVC was conducted by PC3 program partners in January 2008. The OVC were randomly selected from each Tier III partner using the Lot Quality Assurance Sampling Technique (LQAS). The aim of the assessment was to systematically measure and progress made by children towards improved wellbeing while services targeting their needs are being provided. The findings of the second assessment suggested improvements of between 2-3% in all aspects of service delivery with the largest improvement being in education support, particularly improved academic performance of OVC. Even more significant improvements were recorded in subsequent assessments as community caregivers became more acquainted with the assessment process and more linkages to services created to address the identified gaps in needs of children. Recognizing the benefits of applying the CSI to monitor progress, some partners, especially partners in southern Ethiopia, completed CSI forms for all their beneficiary children and used the outcomes to address the needs of these children accordingly.

Promising Practices

How QAI standards help to improve psychosocial, health and academic performance

Adugna Aschalew is nine years old and lives with his two sisters and one brother in Addis Ababa. Adugna lost his father at an early age. Shortly thereafter, his family home was burnt to the ground and everything was lost. The worst part of this was that Adugna was severely burnt in the fire and remained hospitalized for a significant amount of time. After the fire, the family had no belongings, no resources, no food and the children had to leave school. Tesfa Social and Development Association (TSDA), with the help of a Tier III partner supported Adugna and his family by helping them to build a new house and to purchase a few household items. The tier II partners mobilized local funds to support the construction of reasonable shelter for the family. They ensured that the children were able to re-enroll in school. They also ensured that hospital bills were waived.

Chapter 9
Mobilizing Local Resources

Resource Mobilization

An important part of promoting sustainability of community-based projects and services is to identify successful resource mobilization techniques. Given the diversity of the Tier II and Tier III partners within the program, the continuing needs of OVC, and a clear timeframe for PEPFAR funding via the PC3 project, it was essential that organizations and OVC CCGs were able to implement local resources mobilization efforts to assist in program continuation and sustainability. Ensuring resources was completed utilizing several methods including local resource mobilization efforts, creation of public and private partnerships, grant applications and leveraging existing programs through linkages to other programs. All of these efforts were supported via training and technical assistance from Tier I and Tier II organizations. Additionally advocacy, alliance-building and networking by all Tier levels with other local community groups, local and regional governmental structures, private businesses and other donor agencies were important techniques for ensuring necessary resources to continue providing services and support to OVC services and support, both during the lifespan of the project and after.

a)   Mobilizing Local Resources

One of the key elements involved in technical assistance and support of Tier I and II organizations to Tier III partners is mobilizing local resources to support OVC. OVC CCGs and Iddirs utilize local support and a common practice such as contribution to the Iddir's to promote support for OVC. There are several ways of mobilizing local resources including establishing member fees for Iddirs and OVC CCGs, establishment of income generating activities (IGA) such as shop-keeping, community gardens or raising livestock. The possibilities are many and depend upon the local context, needs and available resources of the community. In 2007, the total cash contributions made by community partners were estimated to be 1.5 million ETB per year (US$150,000). Local government (Kebele and Woreda offices) supported the program beneficiaries by allocating land and providing capital to start income generating activities (IGA).

Promising Practices

Karagutu Primary school is found in Desie Town, South Wollo Administrative Zone of Amhara Regional State. The School was established in 1997 and has a student population of 901 (439 boys and 462 girls). In June 2005, the school was among the 240 schools mobilized by a PC3 program partner to undertake care and support activities for OVC. Like others, the school received training in community organization, resource mobilization and management and in specific aspects of care and support for OVC. With small financial support of 12,000 birr ($1280) from the PC3 program, the school leadership mobilized the PTA to establish a core group. Apart from delivering education, psychosocial support and other services, the school has implemented successful business enterprises that generate funds to support needy OVC in the school. Since inception of the small business enterprises, the school has registered a net profit of over 4,000 birr ($425) per year. The profit is saved in the school's bank account and used to address emerging needs of children. Furthermore, the school has been quite successful in mobilizing additional income from the local community. In 2007 the school mobilized 9,832.00 birr ($1045). Through these efforts, the school has changed the lives of over 500 OVC in the past two years and created a sustainable mechanism for providing care to many others in the future.

b)   Public-Private Partnerships

Definition

Initiating partnership with private partners such as hotel owners and other business people is a positive way of fostering linkages and income or resource generation. In this scenario, business people commit support both in cash and kind. For instance they give cash to support direct services to OVC. They also provide food, clothing and educational materials to community partners and schools directly.

Public partnerships include partnering with institutions such as colleges and universities for OVC to access free or subsidized education. In addition it includes partnering with public businesses to obtain support in cash and kind to support OVC.

Why, for Whom and When it is Used

Public-private partnerships are developed to leverage funding – realizing that resources from the donor alone are not sufficient to meet the diversified needs of OVC. We also do so to assure sustainability since most partners are close enough to the affected communities and are more likely to commit longer term support. This kind of resource mobilization approach occurs through the entire cycle of the project and is a continuous process to ensure that resources are always available to address the needs of OVC and their households. Developing public-private partnerships is also an excellent way to increase public awareness about the situation of OVC and how others may contribute to the program. Private businesses enjoy the positive recognition they get by contributing to a "humanitarian" issue and this helps encourage other businesses or public institutions to get involved.

How it is Used

In most cast cases, the OVC CCG has a small committee in charge of resource mobilization. This committee receives training from PC3 on the community action cycle (described in section III a), which has important guidance on resource mobilization. Once trained, the group develops strategies and opportunities for resource mobilization. Using the mapping exercise, they identify potential individual and groups that can support their program and then approach them first to seek and opportunity to meet and discuss their need and then follow up with a written request for support. In some cases they will organize a meeting in the community and invite potential supporters. This meeting is aimed to increase their awareness of the needs of OVC and to influence them to donate. In addition, the OVC CCG should be encouraged to develop proposals and submit to potential supporters and request them to fund specific areas of the program.

Promising Practices

In 2006 the PC3 program partnered with Coca Cola East Africa, the manufacturers of Coke and other soft drinks, to provide livelihood support to at least 40 older OVC and their households in Kolfe sub-city, Addis Ababa. In this partnership Coca Cola East Africa committed resources to support the youth to start small income projects – largely the sale of Coke to promote economic stability in their households. An MOU was signed between the two partners to ensure that each played its role to support OVC in this community. Save the Children's role was largely to provide training and to monitor the performance of the OVC and households once businesses were up and running. Coca Cola East Africa was to provide start-up materials including kiosks and trolleys for all beneficiaries. The 40 OVC and their caregivers were trained by Save the Children staff on the management of small scale business enterprises and income generating activities to equip them with skills to manage small businesses. On completion of the three-month training, the youth graduated and each received a trolley with Coke as start up capital. They were expected to sell the first supply and use the income to restock their businesses. With the trolleys they were able to move from place to place selling Coke products. In addition, the youth were grouped in eight and each group provided with a Coke kiosk, which were located in secure and convenient places that were accessible to the public. So the youth sold Coke products both at the kiosks and along the streets using the trolleys to support themselves and their families. To date most of the youth are still selling and making money. Many of their businesses have been diversified to include trading in other products.

c)   Application for Other Grants

An important element of facilitating sustainability of project concepts and services is ensuring that the Tier II and III organizations have the skills and ability to develop strong, fundable project proposals. This was first addressed in the initial capacity-building, community action cycle (CAC) phase of the project (see section III b). Tier I and Tier II groups provide in-depth training at how to develop funding proposals including step by step instructions detailing what information should be included. Identification of possible funding sources is an on-going activity that every Tier II and III partner organization needs to support. . In reality, there is at least one person, but ideally a team of people in each OVC CCG that is responsible for identifying potential funding sources, developing funding proposals following-up with potential donors. Given the volatility of funding to NGOs and CBOs, constant oversight and exploration of funding sources cannot be stressed enough. Most PC3 partners have been able to obtain funding from government through the HIV and AIDS Prevention and Control Office (HAPCO) at regional level and from other agencies such as the UN and embassies.

Tools Developed to Assist with Grant Application

The tools developed to promote successful proposal development are included in the Community Action Cycle Guide (see section III b). The final section of the Guide targets management (human, financial and property), team building, conflict resolution and monitoring and evaluation. This section provides simple, easy to understand information which is critical to the successful management of a OVC CCG/CBO. The sections of the Guide can be done together, in two or three days, or as separate, stand-alone trainings, depending upon the needs of the OVC CCG/CBO receiving the training.

Promising Practices

Fikir Behiwot Orphans and Youth Association (FBOYA) was established in 2006. The organization was created by 21 older orphans who wanted to promote awareness regarding the challenges of orphanhood and the negative effects it has on children. The association is made up of 330 members and 519 associate members and is supervised by nine board members.

Muluwongel Development Organization, a Tier II partner of World Vision, approached Fikir Behiwot in February 2007 to determine if they were interested in receiving support and technical assistance aimed at strengthening their organizational capacities. FBOYA was very interested and agreed to receive "mentoring" from Muluwongel Development Organization. With training and capacity building support the Tier II organization, FBOYA has increased their capacity to serve OVC through education, life skills and food support. Older OVC are providing tutorials for younger OVC. A result, four members have been accepted into higher education. For others, the association was able to secure scholarships to attend private vocational schools. FBOYA secured financing from HAPCO to send 15 students to catering schools. These children have now formed a group which provides catering services thus ensuring an income-generating activity for the children and youth. Most exciting was the accomplishment of securing more than 230,000 birr (approximately $23,000) which allowed all 300 members of the organization to attend school.

d)   Linkages to Leverage Services and Resources

One method of promoting successful continuation of OVC services is to create linkages with governmental and non-governmental initiatives. This action can increase resource mobilization and prevent duplication. The first step in creating linkages with other service providers and resources is to develop a resource/service map such as the process described in section VI a of this Toolkit. Identification of institututions, organizations or other initiatives which would enhance coverage and support to OVC is a critical part of creating linkages. Linkages may be formed at the community, regional or national level, with the end goal being increased support, services and resources for OVC, their caregivers and the OVC CCGs or organizations serving them.

Why, for Whom and When it is Used

Coordination of care requires linkages to other institutions, organizations or persons who provide services that OVC need. Examples may include ART, food security, nutrition and health care. For these linkages to be meaningful and beneficial to OVC and are realistic and sustainable for the programs or OVC CCGs developing them, , program implementers must ensure that services are negotiated and memoranda of understanding (MOU) developed to commit each partner to avail or deliver the required services. A functional referral mechanism has to be put in place to avoid bottlenecks. In the case of PC3, linkages and leveraging occurs at two levels; at the national and the local level. At the community level, partners utilize service maps to locate service points and discuss long term partnerships to ensure that services can be provided in a sustainable manner.

Donor resources are not always sufficient to meet needs and forming strategic linkages at all levels is a way to expand coverage and resources and enhance possibilities for sustainability. Through leveraging, for instance, PC3 received over $500,000 worth of ready to use therapeutic food (RUTF) from the Clinton Foundation between 2007 and 2009. Resources have been leveraged from other agencies such as the UN World Food Program (WFP) and the Government of Ethiopia.

How is Leveraging Used

The leveraging process begins with identification of potential partners, typically done through a mapping exercise. The mapping exercise may be done at all levels of the system; community, regional and national. After possible partners or linkages are identified, meetings should be scheduled to present both the needs of the program as well as the benefits of creating a linkage with the identified institution/organizations. Networking is also a helpful tool when beginning the leveraging process. It is important to note that leveraging does not also imply economic resources. Leveraged resources are typically in the form of services or materials provided to beneficiaries through the implementing partner.

Promising Practices

Ruth, age 8, was abducted by strangers from her village for the purpose of child labor. Given that she was only 8 and not used to the demands of domestic work, the woman who exploited her soon kicked her out; leaving her living on the streets of Dire Dawa. Yehwalashet, a young girl of 17 was also a domestic earning approximately $7 month. One day while at the market, she met Ruth and heard her story. It was very similar to her own story and they felt a mutual and immediate bond with one another. Yehwalashet offered Ruth a place to stay in her own humble shelter. Yehwalashet wanted to send Ruth to school; something she herself had not been able to do. With ProPride's (a Tier II organization) assistance, Yehwalashet participated in a weekly radio show in Dire Dawa and explained her situation. After hearing the story, a group of colleagues from an organization decided to cover their monthly house rent on a permanent basis as well as additional support to ensure that Ruth could go to school. ProPride Dire Dawa introduced these children to its tier III partner Iddir in Kebele 04. The Iddir has now assigned a caregiver to Ruth. The Yibekal radio program is a Pro Pride initiative which creates awareness on the issues affecting OVC and advocates for greater attention to their needs. Yibekal is the first radio program focusing on the needs of OVC in the region.

Chapter 10
Monitoring and Evaluation

Monitoring, Evaluation and Reporting

Monitoring and Evaluation (M&E) are critical components of an OVC program. Developing a sound M&E system is a good way to ensure that program services and outputs can be measured and decisions for improvements and changes can be made in a systematic and informed manner. The development of an M&E system starts with a clear understanding of the program goal, strategic objectives, expected outputs, outcomes and the required inputs. This is followed by the definition of indicators and tools required to track the outputs and outcomes. Usually this step involves the development of a systematic program monitoring plan (PMP), which outlines the steps required to track performance and to ensure that expected outputs and outcomes are achieved within the planned time frame.

The PC3 program uses a variety of monitoring tools and approaches, including volunteer recording sheets, a database with unique identification numbers for each child, joint monitoring visits, regular review meetings at different levels and documentation of best practices and promising practice stories. Monitoring and evaluation has been a critical element of this project and has presented new and interesting challenges given the size and coverage of the PC3 program.

The project implementation phase is well documented and data is available at every level, including specific services received by a child or family. The challenges of developing monitoring and evaluation systems which covered the necessary requirements of both the donor (PEPFAR), the Tier I international organizations, the Tier II national organizations and the Tier III OVC CCG/CBOs presented an enormous, but doable challenge. It required significant dialogue, exchange of information and a team approach to developing the specific monitoring requirements of all involved. Inputting data, reporting and documenting promising practices required significant training of Tier II and III organizations by Tier I partners. Incorporating a focus on quality assurance and improvement also presented unique challenges at all three tier levels. The importance of documenting both quantitatively and qualitatively was essential for program management and has proven beneficial in terms of documentation and utilization of information to further program concepts, identify additional funding resources and share

a) Database

The challenge of securing a database system large enough to include the more than 520,000 OVC served through this program was enormous. Incorporating the data reporting requirements of PEPFAR and the international Tier I organizations was also a challenge. On top of this, including a QAI focus which includes looking not only at children served but the impact the service had on children was an additional hurdle in the development of an appropriate database system. The development of the database system occurred in 2006 and provided for allocation of a unique ID for every child which eliminated double counting. It helped to track performance of each OVC and service provision by caregivers to ensure a child receives the designated support.

Why, for Whom and When it is Used

Timely and effective collection of data is useful to several stakeholders including donors, implementing organizations, community members, and the OVC themselves. Keeping track of significant data related to program implementation is useful when developing policy, new funding proposals, writing reports and analyzing cost benefits of specific program elements. Data collected within a database allows program implementers to reflect on strengths and weaknesses of the program in a timely fashion, thus making responses more effective. Output and outcome data along with other records of measurable results are needed to track improvements in the well-being of children served and the effectiveness and quality of programs. It is important for information regarding program results to flow in both directions. Standardized formats should be developed so that all Tier partners are reporting similar information. PC3 has created several standardized data collection formats which were used at all levels of the Program. Additionally, a detailed Data Collection and Referral Guide was developed and directed data collection processes and procedures.

Tools for Data Collection

Data Collection and Referral Guide

During the course of the Program PEPFAR introduced new guidelines regarding OVC Programmatic implementation and reporting requirements. This presented the Monitoring and Evaluation Team with an excellent opportunity to refine data collection processes and fine-tune the kind of information that was being collected by all partners. PEPFAR required program and national-level monitoring and evaluation. Specifically, the desired information includes total number of OVC served, both directly and indirectly, number of caregivers trained and money spent. Additionally, more detailed information regarding progress and improvement (impact) made towards child well-being was also collected. This information reflects the use of the Child Status Index Tool (CSI) and the incorporation of standards of care which are tools which assist in collecting key information regarding child well-being.

Development of the Data Collection and Referral Guide was completed based on the following objectives:
- To introduce the newly adopted formats/tools and data base system;
- Redefine responsibilities of each tier level in the data management and reporting;
- To maintain the data quality; and
- To avoid confusions while collecting, recording and reporting data.

Tier II and Tier III staff responsible for monitoring and evaluation were trained in specific M &E techniques and requirements using the Data Collection and Referral Guide as a training tool. Specifics related to how to collect data, when to collect data, how and when to report it and how to safeguard it are all topics covered in the Guide. Additionally, specific tools/ reporting formats are covered in detail. To ensure accurate and thorough data collection, the program developed the following data collection formats to be utilized by Tier III partners working directly with OVC.

Format 2: OVC Profile Record

This reporting format is utilized at the moment an OVC is served by a Tier III partner (see annex 3). It includes key information such as name, address, date of birth, gender, status of OVC, services to be provided and information regarding the caregiver. Additionally, it contains information related to the Tier II partner. Each OVC Profile Format (02) is first submitted to the Tier III

partner and then submitted to the Tier II organization were it will be given an individual ID code. The ID code is a unique number given to each OVC while recoding her/him on the data base in sequential order. Each individual child has their own ID Code. The ID Code is comprised of specific numbers assigned to each tier I, each tier II, each tier III, and each OVC.

Format 3: OVC Care and Support Service Provision Record

The information gathered in this format is about the type of services the child receives (see annex 4). The format should be completed by the service provider (Tier III) and or caregiver or anyone else responsible at the Tier III level. All OVC receiving services and support should be recorded in this format based on the date of the service provision. The same ID code given to the child in Format 2 should be utilized in this reporting phase as well to ensure accurate and complete information is being provided. The key service components are those highlighted in Section VII of the Toolkit. The completed OVC Care and Support Service Provision Record (03) should be submitted to the Tier II partner on a monthly basis. All records should also be maintained within the Tier III partner as well.

Format 4: Parent/Guardian Support Provision Record

This reporting format contains information regarding service provision to the parents or caregivers of the OVC (see annex 5). In the case of a child-headed household, the child would be recorded using this format but not on Format 3. The completed Parent/Guardian Support Provision Record should be submitted to the Tier II partner on a monthly basis. Tier II partners then report quarterly to Tier I partners.

Format 5: Community Mobilization Record

This format collects information regarding community mobilization activities and includes topic, date, type of participants and number of participants broken down by gender (see annex 6). The completed format should be reported on a monthly basis to the respective Tier II partner and is compiled into a larger report and submitted to Tier I partners on a quarterly basis.

Format 6: Referral Follow-up Slip

This format includes information regarding referral services outlined in Formats 03 and 04 (see above) (see annex 7). If the OVC or caregiver is referred to another organization for services or support, this format is a way to ensure the referral has been made. As with the other formats, this should be sent to Tier II partners on a monthly basis who then send it to Tier I partners on a quarterly basis.

Format 7: Referral Slip

The Referral Slip is completed by the Tier III partner and outlines what services are being referred and where they are being referred to (see annex 8). The bottom half of the format also includes a referral follow-up/confirmation slip. This is filled out by the referred to organization as means of confirming that the OVC has received the services. Typically, this format is completed after Formats 03 and 04 and therefore there is a difference in date.

Format 8: Training Record

This reporting format collects information related to training provision including topic, number of participants broken down by gender, location, time, and training facilitator (see annex 9). Similar

to other formats, information is provided to Tier II partners on a monthly basis who then supply information to Tier I partners on a quarterly basis.

Format 9: PC3 Program Quarterly Report and OVC Served by Core Program Areas by Gender

This summary sheet will be produced quarterly at the tier II level. Table 1 and table 2 of this sheet will be generated by the data base by each Tier II partner (see annex 10). Each Tier I partner will have the responsibility to collect/compile the quarterly summary sheets of all its partners and produce a single summary report. Each of the Tier I reports are then utilized to complete quarterly and annual reports submitted to donors and HQ of the Tier I partners. The information gathered is not only beneficial to donors but should be reported back to the Tier II and Tier III partners as well as to the beneficiaries themselves. This information can be relayed verbally, via written reports or in other forms of communications such as newsletters.

PC3 Monitoring and Evaluation Database, User Manual

Collecting the data via the reporting formats is the first stage of data collection. The second stage involves inputting the information into the database. To assist Tier II organizations in how to use the database, the PC3 Monitoring and Evaluation Database, User Manual was created. The objective of the User Manual is to provide step by step instructions, in user friendly manner, in how to input data collected by Tier III partners and recorded in the formats 2-9 listed above. The guide provides easy to read information related to data input into the database system.

Chapter 11
Documentation of Lessons Learned
and Promising Practices

Documentation and Dissemination

Documentation and dissemination of information is a critical part of promoting program initiatives, building a sense of ownership and "pride" and communicating valuable lessons learned and promising practices of the program. Documentation and dissemination should occur on three levels; with the donor community, among project implementers, and among project stakeholders including but not limited to caregivers, community members, and OVC. Documentation and information dissemination may include donor reports, newsletters, quarterly meetings, and sharing of "promising practices."

a)   Donor reports

Definition

Donor reports are not only a requirement but are an extremely useful tool in documenting and disseminating key information, successes, challenges and lessons learned of the project. Donor reports should be reader friendly and donor useful. Some donors such as USAID will provide a template to be followed. Program implementers should always ensure that the template is followed and all required information provided. It is always better to provide more than less information in a donor report. If a template is not provided the implementer should develop one and use systematically to standardize reporting. The following items should be included in the standardized format:

- Cover page;
- Executive summary/summary of achievement
- List of Acronyms
- Detailed description of achievements by activity or results area; this should include outcomes with specific focus on the impact (see section VIII) of activities and not merely outputs;
- Challenges and how they were addressed;
- Attachments, which could include success stories, service data, selected key activity reports, and lists of participants, partners, project sites etc.

In a multi-tiered program such as PC3 it is important to include all partners in the data collection and reporting. For example, a standardized reporting format for Tier III organizations is used on a quarterly basis. The same is done for Tier II organizations who incorporate and synthesize the information shared from Tier III reports in their own. The Tier I partners then synthesize the information from all three levels to include in one overall program report for the donor. Incorporating this kind of system ensure that information from all levels of the program are being heard by and shared with donors.

b)   Dissemination of Successes and Achievements

In addition to providing the donor with information, statistics and stories about the program, it is equally important to share that information with partners, stakeholders, communities and the beneficiaries. A three-tiered approach to information dissemination includes: donor community;

program implementers; and beneficiaries. This approach to information-sharing can be done in several different formats including quarterly meetings, staff meetings and newsletters. Stakeholders not only enjoy but are motivated when they hear or view their achievements. Promoting this kind of activity is essential for building a sense ownership and motivating key staff and beneficiaries. Sharing information is also a key part of the PC3 annual planning session. Key players in the OVC arena are invited to participate, are provided with information and are encouraged to give feedback and share lessons learned; all as means of enhancing program outcomes and promoting ownership of program ideas, concepts and activities. A key practice used in this information sharing was producing PC3 newsletter, The Promise, in the local language and sharing them all stakeholders at national and regional meetings. Responsibility to create the newsletters was shared amongst several partners and leveraged funds were used to produce and disseminate the newsletters. Additionally, a booklet highlighting key achievements of all program partners was printed and widely distributed, free of charge, to all program partners, implementers, stakeholders and beneficiaries. The booklet was an excellent mechanism for highlighting key achievements and was positively viewed by the donor community, Government of Ethiopia institutions, INGOs, and community-based organizations and stakeholders.

c)   Communities of Promising Practice

Definition

Within the context of PC3, Promising Practices are defined as a set of actions which are exhibiting inconclusive evidence of success or evidence of partial success.[15] Specifically, it refers to actions, outputs or impact that a specific activity or program concept has had on key stakeholders within the program such as OVC CCGs, Iddirs, NGOs, caretakers, and OVC. Examples of a Promising Practice include the following:

- Activities or approaches that are promoting change in child status or service delivery;
- Communities taking action to solve their won problems;
- Communities demonstrating ownership over OVC issues;
- Communities raising funds for greater sustainability; and
- Action which helps inform program implementation or may lead to best practice and may be possible to adapt.

Why, for Whom and When it is Used

The concept behind Promising Practices is to tell the story of and lessons learned within a project by capturing the voices of communities and beneficiaries of the project. The documentation process allows children and communities to find their voice, tell their story, monitor successes and become communities of "promising practice" that can share strategies for OVC care and support. In an effort to understand impact beyond which is demonstrated by quantitative data and promote greater learning, this process engages partners at all levels in a process of identifying, reflecting, documenting and sharing promising practices and lessons learned.

Promising practices may be recognized throughout the lifespan of the project. Ideally, the first promising practices should be highlighted after there is sufficient time for project implementation and gathering of lessons learned (e.g. six-twelve months after project initiation). Promising practices may be presented by project management, staff, volunteers, caregivers and children.

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[15]   Adapted from *Advance Africa*, a USAID health project implemented by Management Sciences for Health

How Promising Practices are Used

To gather this kind of information, traditional methods such as interviews, reports and site visits may be utilized. To gain insight and stories from children, caregivers or volunteers who might not find a voice in the traditional methods of information gathering, the Significant Change Technique[16] may be utilized. This is a story-telling technique which seeks to discover any positive change that has occurred in the life of an OVC and/or caregiver or community member. It gathers this information by asking "*Looking back over the past six months, what do you think was the most significant change in the quality of your life?*"

Community core groups and other Tier II and Tier III organizations may be trained in using this tool and can then implement it within their own projects to document positive change and monitor service delivery. Another option is to identify and support the "Communities of Practice." Communities of Practice are defined as a well-functioning Community Core Group (OVC CCG) and its respective community who are applying the principles of community mobilization and have demonstrated effectiveness in supporting OVC and their caregivers. A Community of Practice is open to sharing their Promising Practices and learning from other communities. To promote incentives for the OVC CCGs the PC3 Program has, twice a year, evaluated well-functioning OVC CCGs against a list of criteria (see annex 2) and selected for a Certificate of Achievement Award which includes a small stipend. This recognition is an excellent way of encouraging and motivating OVC CCGs to identify promising practices in their community as well as collect lessons learned to share with other communities. Promoting experience exchanges through site visits and one on one mentoring has provided a mechanism for diffusion of knowledge that goes beyond a traditional training model and promotes communities as facilitators of change.

Example of a Promising Practice

One example of a Promising Practice within a Core Group was highlighted in the PC3 Publication, *The Promise, Vol. I, Issue I*, December 2007.

> The Akaki Core Group has significant lessons to share with the peers in terms of supporting vulnerable children. The group has mobilized managers of different industries and secured free school books, food, and medicines for children. A school built by the OVC CCG has fees that are much lower than the average school fee in their area (25 birr per month compared to 40 birr). Most importantly, the school waives the school fee for OVC in the community. Additionally, the group also collects monthly contributions of 10 birr from each Iddir member and other community members, typically raising more than 10,000 birr per month. The money is used to support social gatherings where the whole community is invited. Common concerns and pressing topics are addressed such as HIV and AIDS, employment and education. One third of the money collected is used for the care and support of OVC in the community. Finally, the OVC CCG has created a Community Self Saving Group (CSSG) to leverage additional funds. Members of CSSGs can borrow up to 6,000 birr to start small businesses or use for specific medical or educational needs. This loan is paid back with interest on a monthly basis and the interest earned is then available as loans for other community members.

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[16] Dart, J. and Davies, R (2003) Adapted from A Dialogical Story-based Evaluation Tool, the Most Significant Change Technique, American Journal of Evaluation

Chapter 12
Sustaining OVC Services

Planning for Sustainability

Responsible program management requires a timely, well-planned transition phase which aims to foster sustainability of program concepts, services and impact. The development of the exit strategy should be participatory, involving players at all levels; including community, staff and government partners to assure ownership. The strategy should be reviewed frequently at review and planning meetings to ensure that it remains relevant and applicable to the program context. In March 2008, Tier I partners met (1 ½ years before the end of the program) to develop a phase-out strategy. The committee developed a discussion guide and held meetings with technical specialists and other PC3 staff at all levels. The transition committee developed a transition strategy which included the following objectives:

1. Provide clear directions regarding the plan to support community groups to continue to provide services to OVC when the PC3 program ends. As noted above, programs should create the exit strategy ahead of time and provide ample time and opportunities for partners to understand and familiarize themselves with the strategy.

2. Create a common understanding among program staff and beneficiaries about what needs to be accomplished before program ends, and clarify specific roles and responsibilities of community groups for taking forward program activities. A clear action plan which identifies responsibilities and timeframes for successful implementation of exit strategy activities is an important tool to develop. Involving all stakeholders and encouraging implementation of the action plan is key to promoting continued commitment to the program. If all actors are clear as to what their roles and responsibilities are and what expectations are for community groups after the lifespan of the program, this will help generate a continued sense of ownership and will hopefully facilitate sustainability.

3. Provide focus to program staff as they work towards building sustainability and strengthening community structures that are required to assure uninterrupted service delivery to OVC. Programs must be clear about which structures are involved in and responsible for providing services beyond the lifespan of the specific program.

4. Serve as a tool for initiating dialogue with community groups and beneficiaries to prepare them for phase-out of PC3 program. Program leadership at all levels should initiate constant open and transparent communication with all stakeholders. Providing consistent and timely information and guidelines facilitates easy transition from one stage to the next.

There were several strategies which were originally built into the beginning phases of the PC3 program to ensure sustainability both at implementation and service delivery levels. These include:

Community Action Cycle – Community Mobilization
A phase-out strategy was in-built into the program from the beginning. The tiered capacity building approach and the community mobilization strategies were aimed to support the communities to

take over ownership of the program over time. Focus was placed on ensuring the sustainability and continuation of OVC CCG activities.

Organizational and Technical Capacity Building: Partners were trained on these subjects to strengthen their organizational capacities. Providing training and capacity building exercise for community-based organizations was one of the cornerstones of the PC3 Program. By giving local organizations the necessary skills to form linkages, create funding proposals and initiate fundraising activities were important methods of promoting sustainability, at the local level, of PC3 concepts and services.

Coordination of Services and Programs

The PC3 experience shows the importance of coordination in program effectiveness. Coordination of services can be achieved using the coordinated care approach described in the Toolkit. Specifically, this should involve mobilizing and organizing key service players and providers to ensure that services to individuals and families are systematic and attain the desired results. This should also involve establishing a functional referral system that enables children and their households to access services in a convenient manner. Coordination of programs on the other hand should happen at geographic or regional levels. OVC programs in similar geographic areas need to work together in a complementary manner to ensure that the services of each program can be leveraged by others. At the same time, coordination should help to ensure that most needy children are identified and linked to services and duplication is reduced to the minimum.

Livelihood Activities

The livelihood activities in terms of CSSG and revolving fund activities show impressive results in terms of organization and technical capacities to sustain themselves. Programs such as CSSG, small business enterprises and skills development and training for older OVC can provide opportunities for growth in most vulnerable households. Many OVC supported by the PC3 program have benefited directly from livelihood activities initiated by caregivers and older OVC with the support of the program. Stories are being told of many OVC caregivers who are able to cloth, feed and send their children to school as a result of successful small business enterprises they have initiated individually or in groups. These groups have been formed and given training and skills to be able to operate beyond the lifespan of PC3. The end goal is that livelihood activities be incorporated into existing community structures and continue to operate long after the conclusion of the PC3 Program.

Resource Mapping and Mobilization

Resource Mobilization activities were supported and partners have been successful mobilizing additional resources. However, such funds are still too small to support key services to OVC and community partners may have to double efforts to generate more resources. Providing technical assistance and capacity building in resource mobilization such as proposal development was a key activity aimed at promoting sustainability of community-based organizations. Additionally, promoting public-private initiatives as means of leveraging resources was also encouraged and demonstrated by PC3 partners.

Data Collection and Utilization

Data collection and utilization enhances improvement of services to children. The PC3 program ensures that data on services is analyzed at community and program level to make the necessary

improvements. Lessons from the PC3 program show that when service data is consistently analyzed by programs, specific and significant changes can be made at all levels to improve service delivery. For instance, service data can support decisions for resource allocation, revision of approaches and prioritization of services to meet needs of a particular category of beneficiaries

Once the phase-out strategy was designed it was important that all Tier I partners understood their roles and responsibilities during the final 1 ½ years of the program. Key considerations and scenarios which were discussed, evaluated and decided upon included exiting specific geographical areas, phasing out services to graduating OVC (18 years old and beyond), funding of Tier III partner directly by Tier I partners, and a strong emphasis on building linkages to other donors, public and private partnerships and community ownership. A clear timeframe was developed for end transition activities and each Tier I partner worked extensively with Tier II partners to ensure that information was being disseminated, lessons documented, and plans developed in due time. Action plans were developed by Tier I partners related to phase-out at both the organization/ contractual level as well as at the community/beneficiary level.

Resources Mentioned in the Toolkit for Positive Change

The following resources may be found on the internet:

Information about HIV and AIDS and OVC in Africa:
- Foster, G. & Williamson, J. (2000). A Review of Current Literature of the Impact of HIV and AIDS on children in Sub-Saharan Africa. Retrievable at http://www.ovcsupport.net/graphics/OVC/documents/0000116e00.pdf
- HIV and AIDS Office of United States Agency for International Development (USAID) http://www.usaid.gov/our_work/global_health/aids/
- Hunter, S. & Williamson, J (2004). Children on the Brink-Strategies to Support Children Isolated by HIV and AIDS.
  Retrievable at: http://www.aidsalliance.org/graphics/OVC/documents/0000008e00.pdf
- UNICEF (2004). A Framework for the Protection, Care and Support of Orphans and Vulnerable Children Living in a World with HIV AND AIDS. Retrievable at: http://www.aidsalliance.org/graphics/OVC/documents/0000292e.pdf
- USAID (2008). Second Annual Report to Congress- Supporting Highly Vulnerable Children:
  Progress, Promise and Partnership. Retrievable at: http://pdf.usaid.gov/pdf_docs/PDACM265.pdf
- Bottlenecks and Drip-feeds, channeling resources to communities responding to orphans and vulnerable children in southern Africa, by Geoff Foster, Save the Children, 2005. Retrievable at: http://www.hsrc.ac.za/Document-2179.phtml

Community Mobilization, Building Capacity of National and Local Level Partners:
- Grabman & Snetro (2003). How to Mobilize Communities for Health and Social Change, *Health Communication Partnership*, Retrievable at: http://www.jhuccp.org/mmc/index.stm
- Shapiro, J. The Toolkit for Action Planning. Retrievable at: http://www.civicus.org/new/media/Action%20Planning.pdf
- Demystifying Community Mobilization http://www.savethechildren.org/publications/programs/health/ACCESS_Demystifying-Community-Mobilization.pdf
- Community Action and the Test of Time: Learning From Community Experiences and Perceptions: Case Studies of Mobilization and Capacity Building to Benefit Vulnerable Children in Malawi and Zambia, Save the Children, USAID, Project Concern, Jill Donahue and Louis Mwewa, July 2006. Retrievable at http://www.usaid.gov/our_work/humanitarian_assistance/the_funds/pubs/reportback_june07.pdf

Developing a Coordinated Care Approach to Service Delivery, Promoting Volunteerism and Creating Sustainable Linkages:
- UN Convention on the Rights of the Child retrievable at http://www.unicef.org/crc/
- Child Protection Guidelines and other research, articles and documents related to alternative care. Retrievable at www.bettercarenetwork.org

- Child Rights Information Network (CRIN) www.crin.org
- The Framework for the Protection, Care and Support of Orphans and Vulnerable Children Living in a World with HIV and AIDS. UNICEF, UNAIDS, et al. Retrievable at http://www.unicef.org/aids/files/Framework_English.pdf
- Save the Children's Policy on Protecting Children from Abuse and Exploitation retrievable at the Save the Children Alliance website http://www.savethechildren.net/alliance/resources/publications.html#exp
- Save the Children Child Protection Policy retrievable at http://www.savethechildren.net/alliance/resources/publications.html#exp
- Community-based Care for Separated Children retrievable at http://shop.rb.se/Product/Product.aspx?ItemId=2968322&SectionId=2017326&MenuId=74347

Improving Quality of Services
- Quality Programs for Orphans and Vulnerable Children (A Facilitator's Guide to Establishing Service Standards retrievable at http://www.hciproject.org/Pubs/PDFs/Facilitator_Guide_OVC_Standards_Nov08.pdf
- Child Status Index Tool, retrievable at www.cpc.unc.edu/measure

Information Dissemination, Lessons Learned and Promising Practices:
- Dart & Davies (2003). A Dialogical, Story-based Evaluation Tool, the Most Significant Change Technique. Retrievable at http://aje.sagepub.com/cgi/content/abstract/24/2/137
- Grabman & Snetro (2003). How to Mobilize Communities for Health and Social Change, *Health Communication Partnership*, Retrievable at: http://www.savethechildren.org/publications/programs/health/ACCESS_Demystifying-Community-Mobilization.pdf

The following resources are available through Save the Children USA.
If you would like additional information or copies of the documents, please contact:
Save the Children USA in Ethiopia
ussave.children@savechildren.org.et

Information about HIV and AIDS and OVC in Ethiopia:
- Ethiopian Ministry of Health-Federal HIV and AIDS Prevention and Control Office 2007) Single Point HIV Prevalence Estimate Document

How to Mobilize Communities and Maximize Partner Buy-in
- Community Mobilization Guide: Training Tier III Groups
- Scaling-UP HIV AND AIDS Interventions through Expanded Partnership, A Community Mobilization Handbook for HIV AND AIDS Prevention, Care and Mitigation, Save the Children USA Malawi Experience, 2004.
- PC3 Community Mobilization Plan

Building Capacity of National and Local Level Partners:
- The PC3 Organizational and Technical Capacity Assessment Tool (POTCAT)
- Financial Planning and Budgeting Training Module-Tier 1-Facilitator's Guide
- PC3 Financial Planning and Budgeting Training Module- Tier II-Participant's Workbook

- Strategic Planning, PC3 Program Training Module, Facilitator's Guide
- Strategic Planning, PC3 Program Training Module, Participant's Workbook,
- Governance and Leadership, PC3 Program Training Module, Facilitator's Guide
- Governance and Leadership, PC3 Program Training Module, Participant's Workbook
- Improving Quality of Care for OVC through a Coordinated Care Approach—A Guide for
- Community Core Groups. Training Manual includes the Home Visitors Guide-Caring for the Needs of the Whole Child as an annex

Developing a Coordinated Care Approach to Service Delivery, Promoting Volunteerism and Creating Sustainable Linkages:

- Positive Change: Children, Communities and Care Volunteer Guidelines
- Manual to Assist School-based Care and Support for Orphaned and Vulnerable Children (DRAFT)
- Guide for Establishing Early Childhood Care and Development Centers (ECCD, Developed by Save the Children, USA
- Psychosocial Training Manual for OVC and Their Caregivers
- Save the Children, Sweden (2004). Psychosocial Counseling Training manual on care and protection of children affected by HIV AND AIDS
- Youth Action Kit (YAK)
- Lifeskills Checklist for Monitoring and Supervision
- PC3 Lifeskills Component Implementation Guidelines
- The Revised Lifeskills Implementation Strategy
- Changing Communities, Health and HIV Training Manual
- PC3 Health and Nutrition Interventions Partners Guide (DRAFT)
- IGA SPM Guide-Economic Strengthening
- Community Savings Self-help Groups (CSSG) Methodology and Implementation Guidelines PC3 Business Development Services (BDS) Guide-Economic Strengthening

Improving Quality of Services:

- Quality Assurance and Improvement Standards for OVC-Ethiopia
- Assessment Tool for Tier III Partners
- Monitoring Tool for Tier III Partners per Service Area
- Monthly Reporting Tool at National Level
- Learning Session I: Identifying Gaps and Actions
- Table for QAI Actions
- Table for QAI Barriers
- Table for QAI Success
- Child Status Index (CSI) Field User's Guide
- Child Status Index (CSI) Tool
- Child Status Index Revised Indicator Guide

Monitoring and Evaluation:

- PC3 Data Collection and Reporting Guide
- PC3 Program Monitoring and Evaluation Database, User Manual

Annexes

Annex 1: Ethiopian Ministry of Health HIV Estimates

Ethiopian Ministry of Health Single Point Estimates for 2007, June 2007

Region	Total Orphans (age 0-17)	Orphans due to AIDS (age 0-17)	HIV Population (age 0-14)	HIV Prevalence (age 15-59)
Tigray	319,229	45,277	4,067	2.7%
Afar	89,669	12,424	965	1.9%
Amhara	1,542,751	356,539	24,573	2.7%
Oromia	1,852,737	201,799	16,511	1.5%
Somali	250,148	24,957	1,426	0.8%
Benishangul	45,774	4,118	385	1.8%
SNNPR	1,091,528	126,978	9,849	1.4%
Gambella	14,222	2,243	191	2.4%
Harari	13,261	3,289	189	3.2%
Addis Ababa	194,244	112,647	6,097	7.5%
Dire Dawa	27,992	8,100	560	4.2%

Annex 2: Community Mobilization Monitoring Checklist

CM "Management" Standards	Validation
CO Directors and Program Managers oriented to the SC CM Community Action Cycle (CAC), principles and practices	CO Directors Understanding of SC CM approach
All relevant staff/teams are trained & mentored in SC CM CAC, in a phased-in approach that mirrors program implementation.[18]	All staff utilizing CM approaches have been trained and mentored
Staff/teams who have been trained monitor trainees to ensure sound application of the Community Action Cycle	All CM programs have undertaken 100% of the CAC checklist (see appendix)
Staff/Teams implementing CM approaches: ▪ Demonstrate understanding of & respect for community and culture ▪ Ensure broad participation & transparency ▪ Ability to identify and bring out the strengths of others ▪ Support those with & affected by HIV and AIDS to live positively	Staff undertaking community cultural, historical, social inventory Performance Appraisals & community interviews
The HIV and AIDS Program has developed a CM Program Plan as a framework for implementation, & integrated this plan into the overall Detailed Workplan for the program	CM Program Plan (framework) in place and incorporated into DIP [2]
The HIV and AIDS Program has included CM Indicators in the PMP	PMP has CM Indicators
Community have their own CM Action Plan in place	100% of communities have written CM Action Plans
Community-based Information Systems enabling communities to monitor & use data for decision-making	Communities making decisions based on CBMIS
CM Program Plan is monitored and shared with community and partners	Regular monitor by staff of CM Program Plans undertaken and shared with communities
CM Program plan evaluated at the end of the program against standard indicators	CM Programs have measured their achievements against the plan
Communities participating in 360 degree evaluation of SC CM approaches	360 degree evaluation carried out with communities

[18] SC Community Mobilization Basics or Training of Trainers, "How to Mobilize Communities for Health and Social Change Trainers Guide," Howard-Grabman, L. & Snetro, G.
[19] See sample, pg. 39, "How to Mobilize Communities for Health and Social Change Field Guide", Howard-Grabman, L. & Snetro, G.

OVC PROFILE RECORD

REGION _____ ZONE _____ TOWN _____ WEREDA/SS _____ KEBELE _____

NAME OF TIER I PARTNER _____ NAME OF TIER II _____ NAME OF TIER III _____ NAME OF RECORDER _____

No.	ID CODE	DATE OF REGISTRATION	NAME	ADDRESS			SEX	AGE	EDUCATIONAL LEVEL	STATUS OF OVC							SERVICES IDENTIFIED TO BE PROVIDED								PARENT / GUARDIAN			
				SUB CITY/WEREDA	KEBELE	HOUSE NUMBER				MATERNAL ORPHAN	PATERNAL ORPHAN	DOUBLE ORPHAN	CHILD HEAD OF HOUSE HOLD	CHILD WITH CHRONICALLY ILL PARENTS	CHILD CARED BY NEIGHBOURS/COMMUNITIES	OTHER/ SPECIFY	FOOD & NUTRITION	HEALTH CARE	PROTECTION	EDUCATION & VOCATIONAL TRAINING	PSYCHOSOCIAL SUPPORT	SHELTER & CARE	ECONOMIC STRENGTHENING	OTHERS	SEX	AGE	RELATION WITH OVC	OCCUPATION

Annex 4: OVC Care and Support Service Provision Record

NAME OF TIER I _____
NAME OF TIER II _____
NAME OF TIER III _____
MONTH/ _____
YEAR _____

REGION _____
ZONE _____
TOWN _____

WEREDA/SS _____
KEBELE _____

NAME OF RECORDER _____

S.No.	ID CODE	NAME OF OVC	SEX M	SEX F	DATE	TYPES OF SERVICE PROVIDED: FOOD & NUTRITION 01= Nutritional Supply 02= Other	HEALTH CARE 01= Health Education 02= Medical Expenses Covered 03= Immunization 04= Others	PROTECTION 01= Legal Support 02= Others	EDUCATION & VOCATIONAL TRAINING 01= Uniform /Educational Material Support 02= School Enrollment 03= Tutorial 04= Vocational Training/Formal/ 05= ECCD Service 06= Others	PSYCHOSOCIAL SUPPORT 01= Counseling 02= Recreation / Child Plays 03= Life Skill Training 04= Others	SHELTER & CARE 01= Reintegration / Family Reunification 02= Provision of Temporary Shelter 03= Adoption Referrals 04= Others	ECONOMIC OPPORTUNITY 01= Trained on IGA 02= Forming self support groups or Micro credits 03= Vocational Training /Non formal/ 04= Others
1												
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												

PARENT/GUARDIAN SUPPORT PROVISION RECORD

Code

NAME OF TIER I	REGION	_____
NAME OF TIER I	TOWN	_____
NAME OF TIER II	ZONE	_____
NAME OF TIER III		
MONTH/YEAR		

			WEREDA/SS: _____
			KEBELE: _____

NAME OF RECORDER _____ SIGNATURE _____

S.No.	NAME OF PARENT/GUARDIAN	SEX		HOUSE NUMBER	DATE	TYPES OF SERVICES PROVIDED						
		M	F			FOOD & NUTRITION	HEALTH CARE	PROTECTION	PSYCHO SOCIAL SUPPORT	SHELTER & CARE	ECONOMIC STRENGTHENING	OTHERS
1												
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												

COMMUNITY MOBILIZATION RECORD

REGION _____ TOWN _____

ZONE _____ WEREDA/SS _____ KEBELE _____

NAME OF TIER III PARTNER _____

NAME OF RECORDER _____ SIGNATURE _____

MONTH/ YEAR _____

S.N.	DATE	THEME OF COMMUNITY MOBILIZATION/ SENSITIZATION	TYPES OF PARTICIPANTS (PARENTS/GUARDIANS/ RELIGIOUS LEADERS/ KEBELE ADMINISTRATORS TEACHERS/ ANTI-AIDS CLUB MEMBERS ETC.)	NUMBER OF PARTICIPANTS			NUMBER OF BCC MATERIALS DISTRIBUTED				
				MALE	FEMALE	TOTAL	POSTERS	LEAFLETS	FLIP CHARTS	OTHERS	TOTAL
1											
2											
3											
4											
5											
6											
7											

REFERRAL FOLLOW UP SHEET

Region _____ Town _____

Zone _____ kifle ketema/Woreda _____ Kebele _____

Name of Tier III

Partner _____

Name of Recorder _____ Signature _____

Month/Year _____

No	Date	Referred person				House Number	Referred to service							Referred to organization
		Parent/guardian		OVC			Nutrition	Health Care	Protection	Education and Vocational Training	Psychosocial Support	Shelter and Care	Economic Strengthening	
		M	F	M	f									
1														
2														

PC3 PROGRAM
REFERRAL SLIP

Date: _____

Referred From (Name of Tier III Partner):_____
Referred To (Name of Organization):_____
Referred Client's Name: _____ID CODE_____ Age____ Sex _____
Address (Name of Town/City):_____ Zone_____
Kifle ketema/Woreda:_____
Kebele: _____ House number: _____

Reasons for Referral: (Note: refer the back of the page for the code services)
1) _____
2) _____
3) _____
4) _____

Referred By (Name): _____**Position** _____**Signature:** _____
....

REFERRAL FEEDBACK (To be filled by Organization Client Referred To)
Date: _____ID Code: _____Serial Number: _____

Name of Organization Received Client Referral: _____
Name of Organization Client Referred From: _____
Client's Full Name: _____Age_____ Sex_____
Address (Name of Town/City):_____ Zone_____
Kifle ketema/Woreda:_____ Kebele: _____House number: _____

Types of Service Provided ((Note: refer the back of the page for the code services)
1)_____
2)_____
3)_____
4)_____

Comment

_____
_____

Feedback Slip Filled By: _____Position: _____Signature: _____

Annex 9: Training Record

TRAINING RECORD
(TO BE USED AT TIER I AND TIER II LEVELS)

REGION: _____ TOWN: _____ ZONE: _____ WEREDA/SUB CITY: _____

KEBELE: _____

NAME OF TIER I/ TIER II PARTNER _____

MONTH/ YEAR.: _____ NAME OF RECORDER: _____ SIGNATURE _____

S.No.	TYPE OF TRAINING	DATE	NUMBER OF PARTICIPANTS			LOCATION OF TRAINING	TRAINING PROVIDED TO	TRAINING FACILITATED OR PROVIDED BY
			M	F	TOTAL			
1								
2								
3								
4								
5								
6								
7								

Annex 10: Program Quarterly Report and OVC Served by Core Program Areas by Gender

PC3 PROGRAM QUARTERLY REPORT

QUARTER: _____

MONTH: _____ TO _____

NAME OF TIER I
PARTNER: _____ Ratson

NAME OF TIER II
PARTNER _____

Table 1: Summary of Target Beneficiaries by Region, Sex and Age

Region	Beneficiary level	Under 2 years			2-4 years			5-11 years			12-17 years			Total		
		Sex		Total	Sex		TOTAL	Sex		TOTAL	Sex		TOTAL	Sex		TOTAL
		Male	Female		Male	Female		Male	Female		Male	Female		Male	Female	
Addis Ababa	Primary															
	Supplemental															
	Total															
Afar	Primary															
	Supplemental															
	Total															
Amhara	Primary															
	Supplemental															
	Total															
Benishangul Gumuz	Primary															
	Supplemental															
	Total															
Dire Dawa	Primary															
	Supplemental															
	Total															
Oromiya	Primary															
	Supplemental															
	Total															
SNNPR	Primary															
	Supplemental															
	Total															
GRAND TOTAL	Primary															

Positive change in action!

**For more information about the
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Telephone: +251-113 728 055-61
Email:** ussave.children@savechildren.org.et