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CASE STUDY

IMPLEMENTING STANDARDS-BASED QUALITY IMPROVEMENT PROCESSES AT THE COMMUNITY LEVEL FOR ORPHANS AND VULNERABLE CHILDREN: The Strengthening Community Safety Nets (SCSN) Project, Ethiopia



OCTOBER 2011

This case study was prepared by University Research Co., LLC (URC) for review by the United States Agency for International Development (USAID) and authored by Catherine Howell of URC for the Strengthening Community Safety Nets Project (SCSN) and the USAID Health Care Improvement Project (HCI). Both SCSN and HCI are made possible by the generous support of the American people through USAID. Support for the development of the case study was provided by the U.S. President's Emergency Plan for AIDS Relief (PEPFAR).



UNIVERSITY RESEARCH CO., LLC

On the cover: The final act of a drama written and performed by children in Debre Zeit.

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Catherine Howell, University Research Co., LLC

DISCLAIMER

The views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development or the United States Government.

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ABBREVIATIONS

ACRWC	African Charter on Rights and Welfare of the Child
CBO	Community-based Organization
CCFC	Christian Children's Fund of Canada
CCG	Community Caregiver
CRC	United Nations Child Rights Convention
CSI	Child Status Index
FBO	Faith-Based Organization
FHAPCO	Ethiopia Federal HIV/AIDS Prevention and Control Office
FHI	Family Health International
HCI	USAID Health Care Improvement Project
INGO	International Non-governmental Organization
MOWCYA	Ethiopia Ministry of Women's, Children's and Youth Affairs
NGO	Non-governmental Organization
OVC	Orphans and Vulnerable Children
PC3	Positive Change: Children, Communities, and Care Program
PCI	Project Concern International
PEPFAR	United States President's Emergency Plan for AIDS Relief
PLHA	People Living with HIV/AIDS
PTA	Parent-Teacher Association
QI	Quality Improvement
SCSN	Strengthening Community Safety Nets Project
SO	Strategic Objective
SSDG	Standard Service Delivery Guidelines for Orphans and Vulnerable Children's Care and Support Programs
UNICEF	United Nations Children's Fund
URC	University Research Co., LLC
USAID	United States Agency for International Development
VCC	Vulnerable Children's Committee

INTRODUCTION

The Strengthening Community Safety Nets (SCSN) project, managed by ChildFund International with its partners University Research Co., LLC (URC) and Christian Children's Fund of Canada (CCFC), was a three-year (September 2008 – August 2011) project in Ethiopia. Its goal was to promote healthy child development for 50,000 orphans and vulnerable children (OVC) and to assist 8,500 primary and secondary caregivers through comprehensive, family-centered, and child-focused care and support services. The project served nine Ethiopian catchment areas with high HIV prevalence rates, poverty levels, and numbers of vulnerable children and with limited coverage of social and health services. The catchment areas served were five urban areas of Addis Ababa (Gulele, Kolfe Keranyo, Nefasilk Lafto, Arada, and Akaki Kality sub-cities) and four *woredas* (districts) of the Oromia region (Fentale, Dugda, Debre Zeit, and Shashemene).

To meet the overall project goal, SCSN set three strategic objectives (SOs):

- SO1.** Increase access to and utilization of comprehensive, coordinated, and family-centered care for 50,000 OVC.
- SO2.** Expand service access and coverage through enhanced collaboration, coordination, and referrals among community, non-governmental organization (NGO), and government actors serving children.
- SO3.** Improve service quality and coverage through enhanced community data collection and program monitoring services.

To accomplish these objectives and assure the quality of project deliverables, SCSN worked to adopt the Ethiopian government's *Standard Service Delivery Guidelines for Orphans and Vulnerable Children's Care and Support Programs* (SSDG). First issued in 2006 and revised in 2010, the SSDG was intended "to provide standardized service delivery to vulnerable children and to enable key stakeholders to uniformly provide services to beneficiaries at varying levels..."¹ The standards addressed inconsistencies in and lack of OVC care that were documented throughout the country.



Children at an early childhood center in Debre Zeit. Their attendance was made possible through SCSN project initiatives.

In order to improve care given to vulnerable children through SCSN initiatives, the science of quality improvement (QI) was used to ensure that the newly adopted standards were met at points of service delivery (where services are delivered to vulnerable children, including schools, health centers, and homes). QI uses quantitative and qualitative methods to improve the effectiveness, efficiency, and safety of service delivery processes and systems as well as the performance of human resources in delivering products and services. The fundamental concept underlying improvement is that a system left unchanged can only be expected to continue to produce the same results it has been achieving. To achieve a new level of performance, it is essential to change the system. The methodology emphasizes changes in processes and systems of service delivery in ways that enable the implementation of high-impact, evidence-based interventions. It also identifies unnecessary, redundant, or incorrect parts of processes and then changes them to yield streamlined and efficient service delivery.

In order to determine how the standards could be practically and efficiently implemented in the context of the SCSN project, members of the community involved in coordinating the delivery of services to vulnerable children at four model sites, including local leaders, representatives from NGOs, representatives from community-based organizations (CBOs), health officials, teachers, and legal specialists, along with

1 SSDG. Federal Democratic Republic of Ethiopia Ministry of Women's, Children's, and Youth Affairs and Federal HIV/AIDS Prevention and Control Office, 2010, p. 1.

vulnerable children themselves and other beneficiaries, were engaged in a QI process. This case study details QI efforts at the four sites, explains how communities were engaged, discusses how changes were tracked and what changes were seen, and presents specific lessons learned from the process.

BACKGROUND

CURRENT SITUATION IN ETHIOPIA

Of Ethiopia's population of 73.9 million, 55.5% are children under the age of 18. Ethiopia has 5.5 million vulnerable children, one of the largest populations of vulnerable children in Africa, and 16% of Ethiopian children were orphaned by HIV/AIDS. These children are susceptible to HIV/AIDS, extreme poverty, hunger, armed conflict, child labor practices, and other health, socioeconomic, psychological, and legal problems.²

The rights of children were articulated in the Ethiopian Federal Constitution³ that was promulgated in 1995. Ethiopia is also a signatory to and has ratified both the United Nations Child Rights Convention (CRC) and the African Charter on Rights and Welfare of the Child (ACRWC), and the country's domestic laws and policies have been harmonized with the provisions of both conventions. Ethiopia's policy environment has opened the door for a considerable number of NGOs, international non-governmental organizations (INGOs), faith-based organizations (FBOs), CBOs, and bi-lateral and multi-lateral organizations to initiate operations within the country and to provide various types of care and support services to vulnerable children and their caretakers.

OVERVIEW OF THE SCSN PROJECT

The SCSN project, which was built upon existing community resources and assets, including local NGOs, CBOs, and other organizations, supported the development of an innovative approach to coordinated care and support for vulnerable children by setting up a system of community volunteers to monitor the children and tend to their needs. Coordinated care is a child-focused process that augments existing



VCC members in Gulele sub-city of Addis Ababa.

services and manages child wellness through advocacy, communication, education, referral for services and follow-up. In order to organize at the local level, project staff identified existing community groups along with community leaders and technical experts to serve on a vulnerable children's committee (VCC) in each *kebele* (the lowest administrative unit in Ethiopia). The VCCs are a gender-balanced mix of representatives from the community (including caregivers, people living with HIV/AIDS [PLHA], and vulnerable children), local government partners, and child service organizations. VCCs are intended to guide project start-up and scale-up, promote and support new partnerships and collaboration among service providers, advocate for additional support for vulnerable families, and lead in the identification of vulnerable children. They are also intended to facilitate long-term, post-project coordination of OVC care by building local capacity for and fostering community ownership of OVC services. The VCCs and SCSN partner organizations undertook a wide range of community mobilization activities to engage communities, including community conversations, organizing youth mentors to provide life skills training to vulnerable children, and other similar interventions.

Through the VCCs, SCSN set up a network of volunteer community caregivers (CCGs) in each *kebele*. CCGs were trained to identify needs and ensure the provision of

2 SSDG. Federal Democratic Republic of Ethiopia Ministry of Women's, Children's, and Youth Affairs and Federal HIV/AIDS Prevention and Control Office, 2010, p. 1.

3 Ethiopian Federal Constitution, 1995, Article 36.

coordinated care to each child to whom they were assigned. Coordinated care requires the CCGs to assess all needs of individual children on a regular basis, plan carefully with the child and caregiver to effectively meet those needs in an organized and safe manner, and attend to those needs or refer children to the service points at which they can receive assistance. As the needs of individual children vary in nature and severity, they require assistance at different service points and levels. CCGs also advocate for child needs to VCCs and other service providers.

ETHIOPIA SERVICE DELIVERY STANDARDS FOR VULNERABLE CHILDREN

Because of the high number of vulnerable children and the increasing number of stakeholders operating in the country on OVC issues, the Ethiopian government and other stakeholders determined that a unified approach to assessing OVC needs and providing care and support was imperative in order to ensure that vulnerable children were being cared for effectively and that available resources were being efficiently used. The absence of service delivery standards not only resulted in fragmented and repetitive efforts but also made measuring progress difficult.

In response to this need, the Ethiopian government, through the Ministry of Women's, Children's and Youth Affairs (MOWCYA) and the Federal HIV/AIDS Prevention and Control Office (FHAPCO), joined with the United States President's Emergency Plan for AIDS Relief (PEPFAR)-funded partners⁴ and donors⁵ in February 2007 to collaboratively arrive at a definition of "quality" for OVC care. Using *Establishing Service Standards for Improving Quality of OVC Services: A Facilitator's Guide*⁶, implementers drafted service standards based on current best practices. This process engaged implementers across Ethiopia toward a common vision of quality in OVC services.

In 2008, the PEPFAR-funded Care that Counts initiative, supported by the USAID Health Care Improvement Project (HCI), partnered with the PEPFAR-funded Positive Change: Children, Communities, and Care (PC3) program⁷ to pilot test the draft standards and determine their feasibility and effectiveness in improving quality of care. The case study *Applying the Science of Improvement to Achieving Quality Care for Vulnerable Children in Ethiopia*⁸ details the pilot process. The pilot showed that, "Applying service standards and organizing for improvement at points of service delivery actually makes a difference in the quality of programs and makes a measurable difference in children's wellbeing."⁹

The piloted, evidence-based standards were published in February 2010 in the *Standard Service Delivery Guidelines for Orphans and Vulnerable Children's Care and Support Programs* (SSDG). The standards had been officially endorsed by the National OVC Task Force in May 2009, and work on their implementation began the same year. The SSDG is intended to harmonize OVC service delivery, increase access to and improve the quality of care and support to vulnerable children, and set up an OVC data management system. Standards were developed for the following seven service components:

- Shelter & Care
- Economic Strengthening
- Legal Protection
- Health Care
- Psychosocial Support
- Education
- Food & Nutrition

The SSDG specifies the desired outcomes, dimensions of quality, and critical minimum activities for each of the seven service components. Table I illustrates these attributes for the service component Shelter & Care.

4 PEPFAR partners on this initiative were Project Concern International (PCI), Pact, Hope for Children, Save the Children, Family Health International (FHI), World Learning, and CARE.

5 Donors on this initiative were the United States Agency for International Development (USAID), the United Nations Children's Fund (UNICEF), and the Italian Development Cooperation.

6 DiPrete Brown, 2008. Published by University Research Co., LLC (URC) and Pact for the United States Agency for International Development (USAID). Available at: <http://www.hciproject.org/node/1056>.

7 PC3 was implemented by Save the Children.

8 USAID Health Care Improvement Project, 2009. Published by University Research Co., LLC (URC) for the United States Agency for International Development (USAID). Available at: <http://www.hciproject.org/node/1330>.

9 *Applying the Science of Improvement to Achieving Quality Care for Vulnerable Children in Ethiopia*, p.11.

Table 1. SSDG Service Component Attributes

Attribute	Definition	Example: Shelter & Care
Desired Outcome	Defines the ultimate overall goal for vulnerable children in each component.	Shelter & Care: All OVC have adequate shelter, clothing, and personal hygiene and an adult care giver in accordance with community norms.
Dimensions of Quality	Defines quality characteristics in ten dimensions of quality: safety, access, effectiveness, technical performance, efficiency, continuity, compassionate relations, appropriateness, participation, and sustainability.	Shelter & Care: Safety – Ensure that shelter is safe (i.e., has walls, a roof, windows, and a latrine; is close to a water source; is clean).
Critical Minimum Activities	Defines activities that form the basis of a quality service, represent what is doable by all service partners irrespective of financial and human resources, and must be done by all partners implementing services for vulnerable children.	Shelter & Care: Regularly assess the needs of OVC for shelter.
Additional Activities	Defines activities that will enhance the organization’s ability to achieve measurable improvements in the lives of children being served by their program but are not mandatory activities.	Shelter & Care: Provide short-term shelter for abandoned and other needy children.

More information on all attributes, including all critical minimum activities and additional activities for the seven service components, can be found in the annex to this report on pages 20-23.

The SSDG also identifies coordination of care as an “overall guiding principle through which services would be delivered in an integrated manner”¹⁰ and provides a desired outcome and dimensions of quality for that component.

QUALITY IMPROVEMENT FOR ACHIEVING STANDARDS IN SCSN PROJECT INITIATIVES

SCSN used QI processes based on the SSDG to ensure that its OVC care and support services met the standards. While QI processes have been applied extensively in clinical settings to improve health care facility and provider performance, they have had limited use in community settings. This case study describes the experience of community groups guiding and implementing QI processes to improve the ways that existing social structures function to care for an entire population.

QUALITY IMPROVEMENT IMPLEMENTATION

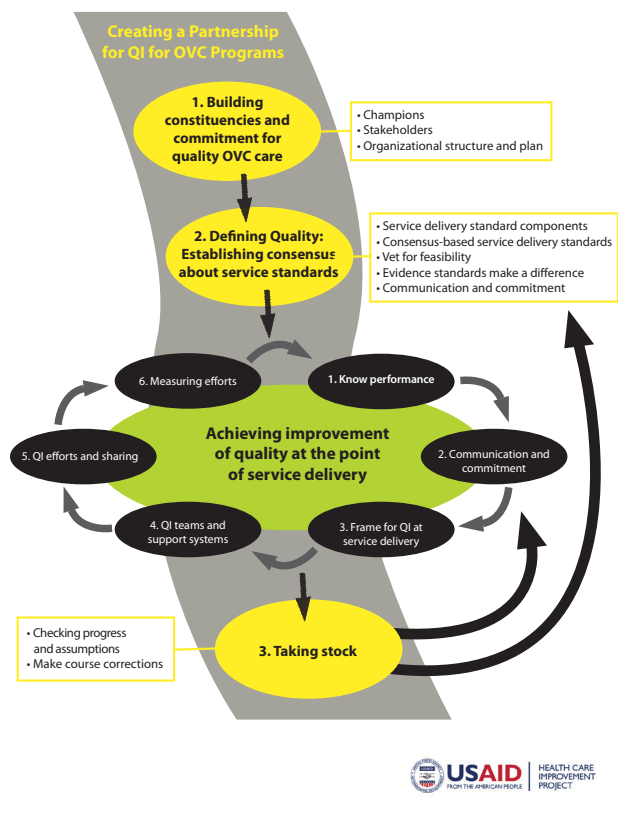
SCSN QUALITY IMPROVEMENT MODEL

By having VCCs serve as focal points for QI coordination and oversight, SCSN implemented a standards-based QI model specifically designed for OVC care and support at points of service delivery. In standards-based QI, services and overall care are systematically monitored and evaluated to ensure that program standards are being met. The results and lessons learned by implementing QI are used to regularly update collective knowledge. These processes also ensure that gaps between expectations and actual outcomes are routinely identified and addressed. QI strategies are intended to improve service effectiveness, access, and efficiency. Best practices identified through QI can enable service providers to rapidly scale up effective OVC programs so that services can reach as many children as possible.¹¹ SCSN applied the standards-based QI model, presented in Figure 1, which was developed by HCI and adapted from the classic QI model used regularly at health care facilities worldwide.

¹⁰ SSDG. Federal Democratic Republic of Ethiopia Ministry of Women’s, Children’s, and Youth Affairs and Federal HIV/AIDS Prevention and Control Office, 2010, p. 27.

¹¹ DiPrete Brown, 2008. *Establishing Service Standards for Improving Quality of OVC Services: A Facilitator’s Guide*. Published by Pact and University Research Co., LLC (URC) for the United States Agency for International Development (USAID). Available at: <http://www.hciproject.org/node/1056>.

Figure 1. Standards-Based QI Model – Road Map for Improving the Quality of Programs for OVC



Phases one and two of the model (phase 1 – building constituencies and commitment for quality OVC care and phase 2 – defining quality: establishing consensus about service standards) were completed before the start of the project in 2008 and during the first phase of project implementation. In phase 1, stakeholders focused on setting the context for improving the quality of OVC services by advocating for quality standards among government agencies and officials, donors, NGOs, CBOs, and community leaders. During phase 2, the Ethiopian government and its partners established, tested, and endorsed the SSDG.

In SCSN, implementation of QI processes at points of service delivery for vulnerable children was carried out in four model project sites. QI processes followed the six-step cyclical process depicted around the green oval in Figure 1. Table 2 gives an overview of each step, and additional information on implementation of each component is provided in the next section of this document.

Table 2. SCSN Application of the Six-Step Process to Improve Quality at the Point of Service Delivery

Step	Application in SCSN Quality Improvement
Know Performance	VCC in model sites evaluated their current performance in delivering coordinated care against the standards through a self-assessment exercise. A gap analysis was conducted to determine where the greatest needs for improvement to reach the standards were in OVC care and support.
Communication & Commitment	Representatives from VCCs and other key stakeholders were trained on the standards, presented with the findings of the self-assessment, and asked to commit to QI processes to align service delivery with the SSDG.
Frame for QI at Service Delivery	The structure of the QI process was determined by SCSN project partners. Each VCC agreed to work on QI for only one of the SSDG components and then to share information learned with the other VCCs.
QI Teams & Support Systems	QI teams (involving representatives from key stakeholders including VCC members, local government representatives, caregivers, and children) were set up at each site, and coaches were trained and assigned to each team to guide implementation of QI processes. (The <i>Quality Improvement Training Handout for Coaches</i> , which was used as part of a guided training session for all coaches, can be found as an annex to this report.) Meeting schedules and documentation processes were established.
QI Efforts & Sharing	Baseline assessments were conducted to determine the current status of OVC care and support services in each site. QI teams determined improvement objectives to meet the standards for their respective components and established indicators to monitor progress toward those objectives. QI teams then decided on specific improvement activities and established action plans. Action plans were revised continuously as implementation of improvement activities revealed the need for changes. Coaches guided QI teams in action plan implementation and revision. Learning sessions and QI team exchanges brought team members from different sites together to share methods, discuss progress, and disseminate best practices.
Measuring Efforts	Assessments based on the Child Status Index (CSI), developed by MEASURE Evaluation and Duke University with support from USAID and PEPFAR to assess the well-being of a child, were conducted yearly to determine project progress. Coaches also continuously monitored QI team progress to ensure timely implementation of QI processes and action plans. Finally, teams documented efforts and findings in a scrapbook, which contained documentation of every activity undertaken by each team; results of OVC assessments and other monitoring and evaluation processes; and key sentiments, observations, or recommendations expressed by group members.

4. QI Team Formation and Orientation

(July-August 2009): QI teams were formed to address the gaps in services identified through the assessment process. The teams were tasked with proposing changes to improve the quality of services and to meet the critical minimum actions defined in the standards. In most cases, QI teams were composed of two representatives from a parent committee, two vulnerable children (a boy and a girl around twelve years old), a CBO representative, the *kebele* HIV/AIDS desk officer, a *kebele* administrator, an HIV/AIDS association representative, a representative from a local NGO dealing with OVC service delivery, and technical experts in the SSDG component chosen to be addressed by the VCC (such as school teachers for the education component or representatives of the judicial system for the legal protection component). Coaches oriented QI teams on improvement science and processes.

5. First Round of Learning Sessions

(July-August 2009): During a first round of learning sessions, QI team members from different sites came together to discuss assessment and gap analysis results and QI processes to be followed. They discussed areas of potential improvement for each model site and identified potential priority activities for QI team work plans.

6. Development of Improvement Objectives, Indicators, Improvement Activities, and Action Plans

(August-September 2009):

QI teams, with guidance from their coaches and SCSN QI advisors, started by defining specific improvement objectives to address the gaps identified in OVC service delivery. Objectives were structured to ensure that OVC services met the critical minimum activities identified in the SSDG. Teams then identified specific indicators to measure progress toward achievement of objectives. Next, teams developed a list of improvement activities to be undertaken in order to achieve the improvement objectives and put them in order of priority. Finally, the QI teams organized improvement activities into cohesive action plans, determining responsible parties for individual activities and setting up a timeline for implementation.



Documenting best practices and continuing needs in Gulele.

7. Action Plan Implementation, Testing, and Revision

(September 2009 – April 2010):

QI teams began the process of action plan implementation, while constantly reviewing the feasibility, effectiveness, and efficiency of improvement activities and revising the activities and action plans as necessary. Coaches guided teams in a cyclical QI process of testing changes, analyzing results through regular assessments and qualitative observations, and revising actions based on findings. Through this process of constant review and revision, QI teams worked to develop methods for OVC care that match the standards set out in the SSDG.

8. QI Team Exchange and Activity Scale Up

(April 2010 – present): Representatives of QI teams made visits to other sites to learn about their QI implementation relating to other SSDG components. Using information gleaned from QI team exchanges, teams began to develop objectives, indicators, activities, and action plans for additional SSDG components. In addition, other project sites began the process of QI based on the experiences of the model sites.

9. Second Round of Learning Sessions

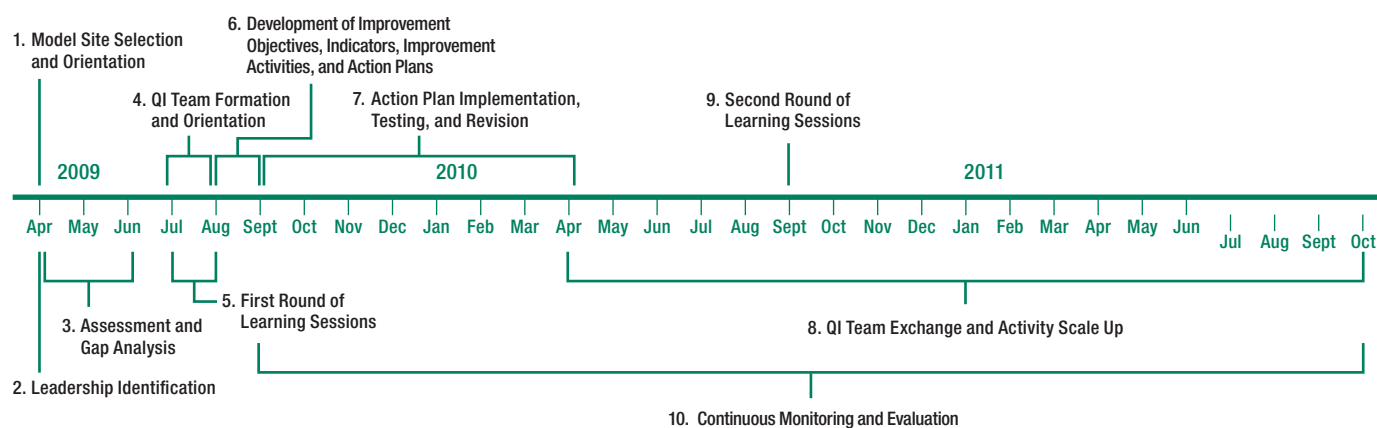
(September 2010): Formally facilitated learning sessions were held with representatives from the model site QI teams to share their experiences in implementing and revising action plans. Minutes of the learning sessions were shared with teams in the model sites and in other project catchment areas to aid in expanding QI activities to other project sites.

Table 3. Gulele Model Site QI Experience to Meet Education Standards

The VCC at the Addis Ababa model site agreed to work to improve service delivery related to the education standards. Highlights of the QI team’s work are shown below:

Gap Analysis	<ul style="list-style-type: none"> • Children were not attending school due to the inability of caregivers to pay for their tuition, uniforms, and other materials necessary for school attendance. • Children that were attending school were performing poorly.
Improvement Objectives	<ul style="list-style-type: none"> • Identify and engage all stakeholders, including parent-teacher associations (PTAs) and CBOs. • Build capacity to support vulnerable children among PTAs, teachers, community representatives, and local government officials. • Identify vulnerable children in need of educational services. • Identify and address barriers to education on an individualized basis for each child. • Support life skills and livelihood opportunities as an integral part of the education program. • Monitor child enrollment, attendance, performance, and completion (and adjust the services as needed).
Indicators	<ul style="list-style-type: none"> • The names of stakeholder contact persons are readily available. • Meetings are held regularly with each stakeholder group to obtain their cooperation in meeting the needs of vulnerable children. • Children’s records reflect that volunteers check at each visit on education of children for attendance and performance and discuss how to resolve any issues. • Schools offer life skills training. • Schools give guidance on livelihood opportunities. • OVC records reflect that the volunteers have checked with schools to verify children’s attendance and performance. • OVC records reflect that children with poor performance are provided with tutoring. • OVC records reflect that children are encouraged to improve attendance and work on barriers addressed.
Improvement Activities (later organized into a detailed action plan)	<ul style="list-style-type: none"> • Assess individual children to determine whether each child is enrolled in school and his/her school performance. • Identify opportunities to provide vulnerable children with tuition-free schooling. • Regularly meet with teachers and other members of the community to discuss child-specific needs. • Identify and work to acquire uniforms and other materials needed for school attendance. • Identify opportunities to provide tutoring for vulnerable children in need of additional academic support.
Results/Outcomes	<ul style="list-style-type: none"> • 206 vulnerable children were identified as being unable to attend school. • The VCC now has a file on all vulnerable children in its catchment area and is able to track individual children’s progress in education. • 40 vulnerable children are now able to attend school tuition-free. Letters have been sent to other schools to request that vulnerable children be allowed to attend tuition-free, and several schools have promised free attendance to vulnerable children next school year. • 108 vulnerable children struggling with academics were provided with additional tutoring. • Teachers are in regular contact with the VCC to report on children’s well-being in schools. They report an improvement in children’s academic performance.

Timeline for Quality Improvement Process Implementation



10. Continuous Monitoring and Evaluation

(September 2009 – present): Monitoring and evaluation of QI processes were done in several ways. First, project staff and CCG volunteers conducted the CSI assessment on a yearly basis; the assessment was conducted in April 2009, March 2010, and March 2011 to determine child well-being and to evaluate the effectiveness of QI action plan implementation at each site. Individual children were also regularly evaluated on home visits from CCGs. In addition, SCSN staff conducted reviews of QI teams every six months to evaluate site action plans, assist teams in developing solutions to implementation problems, and document progress. Finally, coaches consistently monitored team progress and provided guidance on the QI processes to ensure their efficient implementation.

SCSN-COMMUNITY PARTNERSHIP

QI processes have been used for the improvement of health care delivery in facilities around the world; however, many SCSN services were delivered outside facilities, so community involvement was essential in order to ensure better care and support services for local children. While project staff were responsible for strategic planning across implementing sites, developing QI tools for utilization in the field, providing training on QI processes to all implementers, and conducting staff recruitment, the QI processes themselves were guided and implemented by local communities.

Local implementing partner CBOs ran the model sites. QI coaches and project officers were local partner staff. In addition, all members of VCCs and QI teams were members of the local community, including technical experts like teachers and health care workers. Consequently, QI objectives, indicators, improvement activities, and action plans were all designed, implemented, measured, evaluated, and revised by local community members for the benefit of local children. In addition, through advocacy from the VCCs and QI teams, several of the model sites obtained key support from influential informal socio-economic institutions called *idirs*, which are established among community members to raise funds for use during emergencies. *Idirs* provided project sites with office space for VCCs, scholarships for vulnerable children, and funds for other urgent OVC needs.



In Dugda, one community member donated the land to build an early childhood center after seeing the work that the VCC and QI team were doing. He explained his generosity, saying, “These children should be in a safe place.”

PARTICIPATION OF VULNERABLE CHILDREN

Vulnerable children served as major contributors to the SCSN QI processes. They were involved on all QI teams and on many of the VCCs, where they helped to identify other children for enrollment in available services, develop improvement objectives and activities, and evaluate the effectiveness of interventions. In addition, 254 vulnerable children ages five to eleven were brought together at workshops near the end of the SCSN project to report on their own well-being, to help prioritize their needs, and to advise on the needs of other children in similar situations. The information that children provided during the workshops has been used to help determine the relevancy of the standards to perceived OVC needs and has aided local implementers in planning for future interventions.

FINDINGS AND RESULTS

FINDINGS AND RESULTS FOR VULNERABLE CHILDREN

Overall changes for vulnerable children were tracked primarily through the yearly CSI assessments, and individual children were assessed on regular home visits from CCGs. CCGs were required to fill out forms to report on each child's well-being at each visit, and VCCs reviewed the forms and acted on immediate OVC needs. VCCs kept notes on vulnerable children in individual child records and scrapbooks that were regularly updated, and local SCSN implementing partners in charge of each model site aggregated data from all CCGs.

Qualitative observations from VCCs, CCGs, and QI teams help to portray a well-rounded picture of the effect of QI on vulnerable children. These groups report that exact needs of individual children are being addressed more effectively, and services available to vulnerable children are of a higher quality than they were before. In addition, larger numbers of children are being reached because they are being systematically identified through VCC efforts. Many CCGs report that the children that they work with have improved self-esteem and self-confidence. Furthermore, more children now have access to legal assistance, and at some sites vulnerable children have access to legal documents like birth certificates and inheritance documents. Children also have greater access to medical services, and their environments are visibly cleaner. Additional vulnerable children are enrolled and participating in schools, and many have improved their school performance. Furthermore, children specifically involved in QI processes indicated that they felt empowered by their inclusion: they were able to share their feelings, have their opinions heard, effect change, and develop leadership skills over the course of the project.

Many vulnerable children continue to be in need of a number of services, however. At the OVC workshops delivered at the end of the project, both urban and rural children identified their biggest problems to be sexual abuse, labor exploitation, food shortage, child trafficking, school dropout, and lack of access to education. SCSN was only in operation for three years, however; major changes with OVC populations will likely take longer to materialize.



Toys made by children in Debre Zeit as part of programs set up by the VCC.

FINDINGS AND RESULTS FOR ORGANIZATIONAL PROCESSES

Changes in organizational processes were tracked through scrapbooks, which documented all QI activities and were kept by each QI team and by the VCCs. These scrapbooks contained documentation of all activities and results of OVC assessments and other monitoring and evaluation processes. In addition, they also frequently included key sentiments, observations, or recommendations expressed by group members and documentation related to other activities, ranging from resumes of team members to drawings from children being served.

Scrapbooks and other qualitative data collected indicate that QI processes brought about a major shift in the delivery of services to vulnerable children. Care for vulnerable children has become more coordinated, links between different service providers have become much stronger, and waste and redundancies have been reduced. Care services now look at all aspects of child well-being as indicated by the standards (including nutrition, education, and psychosocial support). Care is based on quality rather than quantity alone, and services are provided on the basis of individual children's needs (often identified by the children themselves) rather than on assumed needs of all vulnerable children. Services are now delivered with the goal of making a difference in children's lives and of improving the community overall rather than of meeting a quota.



“With QI we give the right support to the right child.”
– VCC member in Dugda.

Gaps in services are now identified more through real evidence than through assumptions. Some formal tools have been developed to measure quality and impact, and certain indicators are used to track changes at some sites. Roles for certain stakeholders have been defined to enable more efficient implementation of action plans. In addition, VCC and QI team members report that they are more knowledgeable about methods that are effective in improving child well-being. Some sites now indicate that they are able to meet many of the critical minimum activities identified in the SSDG.

Organizational change was made more difficult, however, by the fact that many stakeholders, including project staff, volunteers, and community members, were initially hesitant to use QI processes. Stakeholders were used to international donors providing handouts (including food, blankets, toys, pots and pans, etc.) to vulnerable children rather than requiring changes in processes and contributions from the community. Consequently, implementation of improvement activities was sometimes slow and inconsistent.

FINDINGS AND RESULTS FOR COMMUNITIES

Although changes among communities were not tracked deliberately, VCCs, QI teams, CCGs, and other SCSN staff have noted some significant changes in community attitudes toward OVC services. Communities increasingly recognize children’s rights, understand OVC needs more fully, and see OVC care as the responsibility of all citizens rather than just specific caregivers. Communities are less inclined to expect handouts for OVC care and are taking

ownership of OVC support services. Governments, civil society organizations, and individual citizens have increased capacity to participate in the delivery of OVC support services, are engaging in the QI process, and are even showing a willingness to commit community funds to certain needed services. More community members understand the standards, are now equipped to identify OVC needs, and are taking the lead in involving relevant stakeholders in developing solutions to problems. Community members, initially skeptical of QI processes, increasingly see the value of QI and are participating more in gathering data to determine if care is effective. In addition, volunteers are more respected within communities than they were before, and there has been an increase in the number of people volunteering to support vulnerable children.

“ We dream of a world where orphans are not only accepted but loved for who they are and not judged for what they have lived through.”

– Quote from the community in Dugda QI scrapbook

OVERALL LESSONS LEARNED

Successes from QI implementation during the SCSN project led to a number of lessons learned that were applied in expanding QI to other SCSN sites and can be used for OVC interventions in other settings. Most importantly, the experience in the model sites demonstrated that community-based QI work is possible. This kind of QI implementation leads to more involvement and ownership of the process among community members. It allows for greater integration of services and can help to produce higher quality services. In addition, it better identifies individual OVC needs and provides practical solutions at the local level to gaps in service. The experience of the model sites showed that it is essential to involve community leaders and OVC caregivers in the process from the beginning and that it helps to consistently recognize their contributions.

Building in the participation of children in the process also helps to identify OVC needs, gives children a feeling of empowerment, and teaches them leadership skills.

The QI process is effectively guided at the local level by the development of improvement objectives, indicators, improvement activities, and action plans. Well-trained local coaches are essential to QI implementation at the local level, as are volunteers who can conduct home visits that allow vulnerable children to be assessed regularly and to have their specific needs identified. Individualized OVC support leads to better quality of care for children. Sufficient funding must be allocated to ensure that coaches are available to provide frequent support to teams and that teams at different sites can come together repeatedly to share experiences.

Challenges faced during the course of implementation also led to lessons learned. Initially, a number of individuals both staffing the project and in the community were skeptical of QI processes and had trouble understanding the value of such methods. Many community members expected instead to have solutions provided in handouts as had been done by international donors in the past. In addition, because VCC and QI team members were also involved in a number of other activities to further community support for OVC, they sometimes did not distinguish between QI and other project initiatives. Introducing the QI methodology, securing participation from all stakeholders, and obtaining consensus on the meaning of quality at the local level took longer than project planners expected. Future implementers should be prepared for skepticism, misunderstandings, and community resistance and plan timelines accordingly.

Project implementers also had significant problems with gathering, aggregating, and analyzing data from all project sites. Data collection relied largely on volunteer CCGs, who may have misreported data for several reasons. First, the CCGs who were collecting the data on individual children were also asked to coordinate care for those children. Many feared that giving children in their care poor ratings would reflect badly on their own job performance. Second, many CCGs were reluctant to conduct assessments because they worried that asking vulnerable children about their needs unfairly raised children's expectations concerning services that would

be provided. Finally, many CCGs had limited formal education and insufficient training in monitoring and evaluation processes, and they may have recorded data inconsistently in a number of cases.

Many VCC and QI team members also had little or no previous exposure to the importance of routine data collection and systematic documentation. Although training and coaching in QI advanced their skills in and appreciation for record keeping, VCC and QI teams often recorded information only indirectly related to QI in their scrapbooks, which were originally intended to be the primary register of QI data. VCCs may also have made errors in aggregating data collected by CCGs, or data aggregation errors may have been made when data from groups of VCCs were compiled by CBOs overseeing an area or when all data collected were organized at the primary SCSN office. Because of the issues encountered with collecting and aggregating data, this report relies heavily on qualitative data to report successes and challenges. However, data on each child were used at the local level to determine services needed by individual vulnerable children. Future implementers may need to invest more funding in training volunteers and staff in data collection, entry, and aggregation techniques or in having assessments done by impartial parties.

Time limitations also presented a serious project challenge. Because communities were initially skeptical about the usefulness of QI processes, at several sites those processes took more time to begin than expected. For example, it typically took between three and eight visits for CCGs to be granted admission to OVC homes to do initial assessments of children. Consequently, there was not enough time to fully implement, track, and adjust QI processes. It was also difficult to fully assess the effectiveness of the program in the short time allotted. QI implementation at the local level needs more time to be effective and to show results.

CONCLUSION

The SCSN project's effort in the model sites to implement standards-based QI processes at the point of service delivery proved that the QI model typically used to improve the quality of services at health care facilities can be adapted to improve the overall quality of services for a population within a community. At the community level, QI involves greater time and personnel commitments than are required for traditional improvement models. In order for QI to be effective at the local level, all project implementing partners must be committed to using it. All stakeholders, including project staff, local partners, community members, and project beneficiaries, must understand the QI process from the beginning. An explicit plan for integrating QI into other activities and a clear strategy for scaling up beyond the model sites can help to ensure that QI is both successful and sustainable. When properly implemented, QI processes can lead to more efficient and effective local care and support services and to a higher quality of life for entire communities.



Before and after pictures from children show how they believe their lives will improve as a result of SCSN project initiatives. These pictures were included in the QI scrapbook from Debre Zeit.

ANNEX

**QUALITY IMPROVEMENT TRAINING
HANDOUT FOR COACHES**

STRENGTHENING COMMUNITY SAFETY NETS PROJECT

2009



USAID
FROM THE AMERICAN PEOPLE

ChildFund
International



UNIVERSITY RESEARCH Co., LLC

This handout was prepared by University Research Co., LLC (URC) for use in a facilitator-led training of quality improvement coaches for the United States Agency for International Development (USAID) Strengthening Community Safety Nets (SCSN) Project. SCSN is made possible by the generous support of the American people through USAID. The project is managed by ChildFund International under the terms of cooperative agreement number 663-A-00-08-00415-0, in cooperation with URC and Christian Children's Fund of Canada (CCFC). The views expressed in this handout do not necessarily reflect the views of USAID and the United States Government.

Quality Improvement Coaching

Coaching Roles and Responsibilities

Quality improvement (QI) coaches have three main roles:

- 1. Facilitator** – A facilitator will observe QI team processes and give both supportive and constructive feedback to the team about the way members interact and the way work gets done.
- 2. Trainer** – A trainer imparts knowledge and builds skills among individual team members and with the team as a whole.
- 3. QI Consultant** – A QI consultant is an expert in directing the steps in problem solving, quality design, data gathering, and analysis.

For this training, we are focusing on the first two roles: facilitator and trainer. In these capacities, the QI coach:

- Helps the QI team leader plan, conduct, and evaluate meetings;
- Delivers just-in-time training¹ on QI and team-building topics;
- Observes team processes and gives both supportive and constructive feedback to the team about the way members interact and the way work gets done; and
- Facilitates interpersonal interactions among the team, perhaps by assisting with conflict management, decision-making skills, or group exercises.

Coaching Goals

It is important that the team sees the coach as a catalyst, promoting the team's ability to deal with its task. The coach does not solve problems, but helps the leader and the team to become self-sufficient in the use of appropriate tools and procedures.

As the coach, team, and leader work together, the team and the team leader will become more skilled, and the coach's involvement will diminish. Ultimately, the coach is no longer needed because the team is functioning well on its own.

Internal vs. External Coaching

An internal coach is a member of the team who has the additional responsibility of observing the team process, training the team in QI concepts and tools, and facilitating discussions and interactions.

An external coach is not a member of the team, but has been invited to provide training and to observe group process and act as a facilitator when needed.

¹ "Just-in-time training" is training that is launched just before the knowledge and skills are used on the job.

Coaching Knowledge and Skills

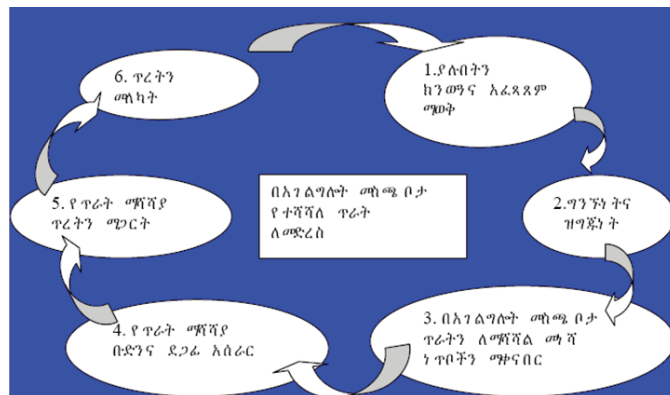
QI Process Steps

A coach needs a combination of communication, facilitation, and training skills to work across the QI process steps.

Figure 1. Quality Improvement Process Steps – English



Figure 2. Quality Improvement Process Steps – Amharic



Necessary Coaching Skills

QI coaches need to have the following skills:

- 1. Communication Skills** – Coaches must have skills in the following areas:
 - Active listening
 - Provision of supportive and constructive feedback
 - Effective questioning techniques

2. Facilitation Skills – Coaches must be able to facilitate the following:

- Movement through the stages of team development
- Effective meetings
- Decision making
- Conflict identification, management, and resolution
- Change
- Expression of creativity in team members
- Communication with the organization through the preparation of written records of the team’s work, such as storyboards and oral presentations

3. Training Skills – Coaches must know the following to train QI teams effectively:

- Principles of competency-based, just-in-time training
- Methods for creating and maintaining a positive team training climate

4. QI-Specific Skills – To coach teams on using effective QI methods, coaches must be able to do the following:

- Understand and explain dimensions and perspectives of quality, key processes of QI, and methods for QI
- Help a team define and clarify a topic (problem) to work on
- Construct and analyze flowcharts, if needed, for the program analysis or solution
- Guide a team through cause-and-effect analysis and through construction and analysis of cause-and-effect diagrams
- Help a team determine how to collect data and information to verify causes of problems
- Help a team analyze and display data and use run charts, bar charts, and pie charts, if needed
- Help a team develop and test solutions
- Help a team monitor results to see if improvements have occurred

QI Coach as a Facilitator

Group facilitation is defined as, “a process in which a person who is acceptable to all members of the group... intervenes to help a group improve the way it identifies and solves problems and makes decisions, in order to increase the group’s effectiveness.”²

As a facilitator, the coach will:

- Assist with team building
- Observe group processes and intervene to address issues of group communication
- Give and receive feedback
- Assist with making decisions, managing conflicts, conducting effective meetings, managing change, enhancing creativity, and communicating with the organization

A useful process to follow for intervening in a group process is:

1. Observe what is happening in the group.
2. Listen actively to what all members are saying.
3. Ask effective questions.
4. Provide constructive feedback.

Effective Questioning

Facilitators often ask questions in order to guide a group’s conversation or process. Keep in mind the following:

- The primary purpose of questioning is to encourage people to think.
- By answering questions, the team is encouraged, even forced, to take the lead in making changes.

Do not use questions to play a guessing game with teams. Instead, pose constructive questions to enable teams to think systematically through their initiatives and decisions.

Giving Feedback on Group Process

Establish ground rules with the team leader and team members, and plan for how you want to give feedback. Regardless of your process for providing feedback (directly to the team or through the team leader), your approach must be:

- Supportive of the team leader
- Supportive of the team
- Focused on the goals

2 Schwartz, Roger M. *The Skilled Facilitator: Practical Wisdom for Developing Effective Groups*. San Francisco: Jossey-Bass, 1994

Dimensions of Quality for Service Components

The *Standard Service Delivery Guidelines for Orphans and Vulnerable Children’s Care and Support Programs* (SSDG) defines ten dimensions of quality that all of the seven service components should adhere to. They are detailed in the following table.

Table 1. Dimensions of Quality

Dimension of Quality	Definition of Quality Dimension
Safety	The degree to which risks related to service provision are minimized, with specific focus on the “do no harm” principle.
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 accordance 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 and stability 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 design of a service in a way that it can be directed and managed at the community level and that resources can be procured in the foreseeable future.

Service Component Essentials and Additional Activities

The SSDG addresses seven core service components, and these are the areas to be addressed by the QI teams. For each service, there are critical minimum activities and additional activities, as shown in the table below. The critical minimum activities are activities that must be done by all partners implementing services for

OVC. These activities form the basis of a quality service and represent what is doable by all service partners irrespective of financial and human resources. Additional activities are activities that will enhance the organization's ability to achieve measurable improvements in the lives of children being served by their program, but they are not mandatory actions. These activities often rely on additional financial and human resources.

Table 2. Service Components, Critical Minimum Activities, and Additional Activities

Service Component	Critical Minimum Activities	Additional Activities
<p>Shelter and Care</p> <p>Desired Outcome: All OVC have shelter, clothing, personal hygiene, and an adult caregiver, which are the same as or similar to those found in the non-OVC community.</p>	<ul style="list-style-type: none"> • Regularly assess the needs of OVC for shelter. • Identify and mobilize community resources to construct, improve and renovate shelter for OVC. • Advocate for the provision of alternative options to housing children such as daycare, temporary shelter, etc. • Link and advocate with stakeholders (legal services, <i>kebeles</i>, others). • Regularly assess the shelter and care needs of OVC. • Ensure that an adult/foster caregiver visits the child at home and provides appropriate support. • Refer children without adequate support to other services including temporary shelter. • Sensitize community, line government offices and other stakeholders to monitor progress of the children (status of shelter and care). • Recruit, train and assign an adult/foster care giver or adoptive parents for OVC based on consent from OVC and the caregiver. Train and provide continuous support to caregivers to provide psychosocial support services (PSS) to OVC. 	<ul style="list-style-type: none"> • Provide short-term shelter for abandoned and other needy children (e.g. legal protection). • Make sanitary facilities (water and toilets) and materials accessible to OVC. • Link with <i>kebele</i> administration to secure a home that is warm, safe and meets the local standards for OVC and their caretakers. • Link with legal institutions to ensure inheritance rights, especially to the home, for OVC. • Educate OVC on hygienic practices (personal, home and environmental). • Provide clothing to OVC. • Provide child reunification and family reintegration as needed. • Ensure daycare services are available and accessible to OVC.
<p>Economic Strengthening</p> <p>Desired Outcome: Households caring for OVC have additional and diversified sources of income to care for the family.</p>	<ul style="list-style-type: none"> • Assess household situation in which OVC live and determine if there is income to support the needs of children. • Refer caregivers to income generating activity (IGA) opportunities (savings groups, etc). • Map service providers and leverage resources from the private sector for training and future employment of those trained. • Conduct market analysis for business viability before training. • Help households caring for OVC to get financial resources. • Provide training on how to generate and manage income. • Provide materials and financial and job opportunities. • Monitor/document progress of beneficiaries through an assessment checklist. 	

Service Component	Critical Minimum Activities	Additional Activities
<p>Legal Protection</p> <p>Desired Outcome: Child receives legal information and access to legal services as needed, including birth registration, will writing, and property inheritance, and is protected from all forms of abuse and violence.</p>	<ul style="list-style-type: none"> • Assess legal needs of children (i.e. birth certificates, wills and other issues such as rape, abuse, etc.). • Refer OVC to legal protection services. • Conduct mapping of legal services available in the community, including Child Rights Committees, non-governmental organizations (NGOs), Child Protection Units (CPU), etc. • Conduct community education and raise awareness on child-related laws and rights. • Identify vulnerable children and their caregivers and make regular visits. • Monitor protection needs of vulnerable children and caregivers. • Sensitize the media to inform the public about the rights and needs of OVC. • Promote birth registration. • Establish and strengthen networking systems with other service providers such as shelter, medical care and psychosocial support. 	<ul style="list-style-type: none"> • If a CPU does not exist, advocate for the establishment and strengthening of one. • Raise awareness within the community and in the schools about child-related laws, self-protection skills, timely reporting of cases, child participation, and child rights through child-friendly and culturally-appropriate material. • Widely distribute information (e.g., in brochures and newsletters) regarding common legal issues. • Advocate and network with government and other key stakeholders for changes in laws that are not fair to children or for the enforcement of laws that protect children. • Sensitize stakeholders, particularly police, judges, Child Rights Clubs and Child Rights Committees, to the needs of children and ways to compassionately assist them.
<p>Health Services</p> <p>Desired Outcome: Child has access to health services, including HIV and AIDS prevention, care, and treatment.</p>	<ul style="list-style-type: none"> • Assess and monitor the health status of OVC through household visits. • Refer OVC to health services based on need. • Follow up to ensure receipt of health services and determine whether sick children are showing improvement. • Conduct mapping of health services in the community with participation of key stakeholders. • Ensure that formal referral systems exist. • Provide basic, age-appropriate health education and ensure that children receive HIV and AIDS education either directly from the community-based organization (CBO) or through another partner, church, or community. • Train caregivers/volunteers on a comprehensive range of health issues: hygiene, anti-retroviral therapy (ART), integrated management of adolescent issues (IMAI), and nutrition. • Make referrals for rape/child abuse/emotional problems, holistic care and follow up. 	<ul style="list-style-type: none"> • Cover fees, drugs, and transportation to medical facilities, and facilitate free medication papers. • Train caregivers and volunteers on basic health care, hygiene, voluntary counseling and testing (VCT), and ART adherence. Provide HIV and AIDS prevention education and referral as needed to children and community members. • Provide water and sanitation services to OVC. • Provide health education to volunteers regarding HIV and AIDS, personal hygiene, water and sanitation, and other health care issues including sexual and reproductive health (SRH) for youth aged 14 and up. • Conduct activities to sensitize the community on health issues – maternal and child health (MCH), sexually-transmitted infections (STIs), OVC, HIV and AIDS. • Mobilize community resources.

Service Component	Critical Minimum Activities	Additional Activities
<p>Psychosocial Care and Support</p> <p>Desired Outcome: OVC develop personal strengths and skills to become self-confident, happy, hopeful, and able to cope with life's challenges.</p>	<ul style="list-style-type: none"> • Assess psychosocial needs of children. • Identify and address barriers to PSS for children. • Follow up regularly to monitor children's status. • Map PSS services, including those delivered by child-friendly centers and religious leaders. • Train volunteers in recognition of PSS needs and counseling. • Provide re-integration services for children who have lived outside of family care. • Establish support groups (children and guardian support groups and clubs) to counsel and support caregivers and children. • Develop safe spaces for children to engage in play. • Increase awareness amongst caregivers and the community on parenting, positive discipline, communication, and open dialogue with children on reproductive health, HIV/AIDS issues, etc. • Provide life skills training through peer groups. 	<ul style="list-style-type: none"> • Assist and support caregivers with disclosure of HIV status. • Assist in succession planning (wills). • Assist families in creating memory books. • Provide counseling services with respect to grief and HIV disclosure. • Educate youth about the dangers of drugs and alcohol. Ask if drugs and alcohol are abused by adults in the household. Screen for signs of drug or alcohol use and refer any household member for treatment as needed. • Ensure that the child is living a normal life in terms of schooling, recreation and links to community. • Ensure that children are enrolled in and attending school, and that children do not feel isolated or stigmatized at school. • Monitor household dynamics vis-à-vis caregivers and siblings. • Establish a mechanism to address burnout of caregivers, such as support groups to counsel caregivers and enable them to cope. • Assist and counsel children who have lived outside of family care. • Implement a role modeling program where renowned people can be invited to share their experience and success.
<p>Education</p> <p>Desired Outcome: Child is enrolled, regularly attends, and completes a minimum of primary school (grade 8).</p>	<ul style="list-style-type: none"> • Regularly assess educational needs of OVC (enrollment, retention, promotion). • Identify and address barriers to education on an individualized basis for each OVC in collaboration with key stakeholders. • Conduct resource mapping for educational services. • Refer OVC to educational resources for tutoring and school materials (uniforms, etc). • Regularly follow up on children's status. • Identify and engage all stakeholders, including the <i>kebele</i> education and training board, parent-teacher associations (PTAs), CBOs, etc. • Build capacity to support OVC among PTAs, teachers, community representatives and local government officials. • Support life skills and livelihood opportunities as an integral part of the education program. 	<ul style="list-style-type: none"> • Strengthen and empower PTAs and teachers through training, especially on PSS. • Mobilize community organizations, such as PTAs and others to conduct regular community sensitization and meetings. • Plan for local resource mobilization on regular basis, including IGAs. • Develop school and community action plans for OVC support. • Initiate and implement OVC policies and programs at different educational system levels. • Develop tracking, monitoring and feedback mechanisms with educational program referral services and communities.
<p>Food and Nutrition</p> <p>Desired Outcome: Adequate food is available for the child to eat regularly throughout the year for a healthy and active life.</p>	<ul style="list-style-type: none"> • Assess food and nutritional needs of children. • Refer malnourished or food insecure children and families to food sources. • Follow up to ensure that children have received food or other rehabilitative/therapeutic service and monitor their status. • Identify (through mapping) and engage other stakeholders to strengthen linkages and referral systems for food. • Encourage exclusive breast feeding and safe complementary feeding practices. 	<ul style="list-style-type: none"> • Provide food to households on temporary basis. • Train households on nutrition (balanced diet, food preparation, preservation, handling and exclusive breast feeding). • Train community health agents/volunteers on the basics of malnutrition diagnosis and referral systems. • Conduct training for these OVC and their caregivers on sanitation, food production, preparation and preservation. • Conduct training on food production (livestock and crop production) and input provision. • Identify potential emergency feeding centers and create referral systems.

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