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Quality Programs for Orphans and Vulnerable Children

A Facilitator's Guide to Establishing Service Standards



NOVEMBER 2008

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Table of Contents

<i>Abbreviations</i>	ii
Making a Difference for Children: A Visit with Tarisai	1
<i>Commonly Asked Questions</i>	3
Part I: Setting the Context for Improving the Quality of OVC Services	5
<i>The Scope of Care for Children Affected by HIV/AIDS</i>	5
<i>Overview of a Standards-based Approach to Quality Improvement</i>	6
<i>A “Roll-out” Plan for Improving the Quality of Care for OVC</i>	7
<i>Coordination of Care</i>	8
Part II: A Workshop to Establish Service Standards for OVC	11
<i>Before the Workshop: Situation Analysis</i>	11
<i>The Workshop</i>	14
<i>After the Workshop</i>	29
Part III: Overview of QI Strategies to Implement Standards	30
<i>Strategies for Supportive Supervision</i>	30
<i>Process Improvement and the PDSA Cycle for Quality Improvement</i>	30
<i>Collaboratives and Communities of Practice</i>	31
<i>Case Study on Monitoring and Improving the Quality of OVC Service Delivery</i>	32
Part IV: The Relationship of Monitoring and Evaluation (M&E) to QI	34
<i>The Role of Measurement and Indicators in Quality Improvement</i>	34
Conclusion	36
Bibliography	37
Appendix A: Description of Core Services	40
Appendix B: Child Status Index and Record	42
Appendix C: Obtaining Children’s Input for the Development of Quality Standards for OVC Services	45
Appendix D: Resources for Workshop to Establish OVC Service Standards	51
<i>Appendix D-1 Workshop Agenda</i>	51
<i>Appendix D-2: Participant Handout: Key Concepts Related to Service Standards for OVC</i>	52
<i>Appendix D-3: Instructions and Worksheets for Group Exercises</i>	56
<i>Appendix D-4: Workshop Evaluation Form</i>	61
Appendix E: Illustrative Composite Standards for Core Services/Coordination of Care .	62
Appendix F: Case Study on Monitoring and Improving Quality of OVC Services	82
<i>FACILITATOR’S VERSION (with responses in italics)</i>	82
<i>PARTICIPANT HANDOUT</i>	90
Appendix G: Glossary	95

Abbreviations

AIDS	Acquired immunodeficiency syndrome
ARV	Anti-retroviral treatment
CLPIR	Community Level Program Information Reporting for HIV/AIDS Programs
CSI	Child Status Index
FHI	Family Health International
HCI	Health Care Improvement Project
HIV	Human immunodeficiency virus
H/W	Height and weight
IMCI	Integrated management of childhood illness
M&E	Monitoring and evaluation
MVC	Most vulnerable children
NGO	Non-governmental organization
NPA	National Plan of Action
OGAC	Office of the U.S. Global AIDS Coordinator
OVC	Orphans and vulnerable children
PDSA	Plan-Do-Study-Act
PEPFAR	President's Emergency Plan for AIDS Relief
PMTCT	Prevention of mother-to-child transmission of HIV
QAP	Quality and Workforce Development Project
QI	Quality improvement
RAAAP	Rapid Assessment, Analysis and Action Plans
REPSSI	Resources for Psychosocial Support
USAID	United States Agency for International Development
USG	United States Government
WHO	World Health Organization

Making a Difference for Children: A Visit with Tarisai

In a small African town, a women's organization provides services to orphans in the surrounding rural communities. The group, founded and resourced by an expatriate and staffed almost entirely by women from local church groups, visits each home on average once a month. During the visit, which lasts about half an hour; the women check on the children and drop off donated goods such as flour, oil, and salt. One of the families they assist is headed by a 12-year-old girl named Tarisai, who lost both parents to HIV/AIDS. Tarisai, who has cared for her nine-year-old brother and six-year-old sister since she was ten, is at home when the volunteers arrive. Her grass-thatched home is spare; with a metal teapot and set of plates arranged neatly on a mud shelf, and thin bedrolls stacked in the corner. Outside is neither livestock nor trees for shade. The granary stands dilapidated and empty. Soon after the visitors go inside, two men from the homestead next door enter without asking permission. They sit against the far wall and stare at Tarisai throughout the visit.

Tarisai does not attend school because she has to care for her siblings. Her brother does not attend because he does not have a uniform or school supplies—when he tried to attend in his only set of clothes, the other children made fun of him. Tarisai's sister does not attend school because she is regularly ill. Tarisai spends five to ten days a month traveling to the health center with her sister. Because she is a child herself, Tarisai is not allowed to make health decisions for her younger sister, which has made access to needed care difficult.

The home visitors have been able to speak to Tarisai without the men present on only one occasion. During that visit she burst into tears and could not be consoled. The visitors could not get her to calm down enough to talk. They stayed as long as they could, but had to move on to visit the other families on their list. The visitors believe that the men probably take the food goods that they bring to Tarisai and her siblings every month, and they fear that Tarisai is sexually abused as well.

—Adapted from Kendall and O'Gara (Spring 2007).

Introduction

The example of Tarisai illustrates how difficult it can be to respond to the complex needs of vulnerable children. In this case, Tarisai had adequate shelter in the home left to her by her parents; she was receiving food assistance; and she had access to education and medical care. Further, the community was aware of her needs and making efforts to monitor her well-being. Unfortunately, these services apparently made no difference for Tarisai. The education and health systems that were in place were not prepared to deal with her special needs and those of her siblings. The food assistance was not provided in a way that guaranteed that it was consumed by the intended beneficiaries, and, in spite of the fact that caring volunteers were visiting Tarisai at home regularly, her physical and emotional safety were not protected.

The aim of this facilitation guide is to assist communities, governments, and civil society organizations to examine services for children like Tarisai through the lens of quality improvement (QI). Through a standards-based approach to care, the laudable intentions, commitment, and effort of these actors can be translated into real improvements in child status and well-being. This tool outlines a process whereby organizations can agree on common guidelines for care for the various core services for vulnerable children. These standards should be *evidence-based* and *appropriate* to the local setting.

This facilitation guide also addresses standards for coordination of services, so that children receive the right cluster of services to meet their needs. Without the right cluster of *quality services*, children cannot receive *quality care* that makes a difference to their well-being. For example, nutritional support and ARV treatment work together synergistically, and are much less effective individually. Similarly, access to education without the needed psychosocial support may invalidate educational benefits for a child. In the case of Tarisai, she did not receive legal protection from abuse or needed economic strengthening. Because she did not have the right cluster of services, the services she did receive were rendered ineffective. Coordination of care, including an accurate needs assessment, to determine the proper cluster of services is critical not only to ensure *effectiveness*, but also to ensure *efficiency*. In an environment where resources are scarce, providing a child with an unnecessary service means withholding that care from a child in need. Thus, it is critical to provide children with the right cluster (no more, no less) of services, specific to their needs and appropriate to age, gender and situation.

Once valid, appropriate, and reliable standards and guidelines for service delivery are established, their impact can be ensured and enhanced with other QI strategies such as effective *supervision, monitoring, and process improvement*. Development of networks for sharing, called *communities of practice*, can also facilitate rapid sharing of innovations in care and scaling up services to reach as many children as possible. The process for facilitation of standards presented here is placed in a context of a four-phased process for incorporating these critical QI activities into the management of care for vulnerable children.

Commonly Asked Questions

Quality? Aren't we already doing that?

In recent years, many important initiatives relating to vulnerable children have addressed quality, both directly and indirectly. Progress has been made in efforts to define and address the needs of orphans and vulnerable children through the development of national outcome standards, National Plans of Action (NPAs), and Rapid Assessment, Analysis and Action Plans (RAAAPs). Efforts to standardize and harmonize monitoring and reporting requirements, such as the Community Level Program Information Reporting for HIV/AIDS Programs (CLPIR) promise to improve program consistency and accountability. The aim of the standards-based QI effort presented here is to establish consensus on ***the content and process of care*** for each service outlined in NPAs for OVC and the PEPFAR OVC Guidance. The facilitation process builds on progress to date by enabling implementers to express OVC service expectations, in the form of ***standards***, in order to assure that services truly make a difference for children.

Aren't coverage and access more important than quality?

Quality care as defined here includes access as one of its dimensions, with effectiveness and efficiency as two others. Thus, a QI approach aims to improve coverage (reach more children), effectiveness (make a difference for each child), and efficiency (coordinate providers of various services to avoid duplication, wasted resources and unnecessary care). The quality approach enables rapid spread of innovation and best practices, which leads to further progress in coverage rates.

Given the crisis, shouldn't we focus on "good enough" care to as many children as possible, rather than providing the highest quality care to a few?

Quality care does not necessarily mean optimal care. The focus here is on the minimum essential actions for each of the core services, which still achieve the desired impact. These "essential actions for quality," which can also be thought of as the critical minimum, helps programs make a difference for children, and at the same time avoids wasting resources on ineffective or unnecessary care. The concept of performance thresholds adds further flexibility, in that realistic goals for "good enough" care can be defined and then revised over time as appropriate in the local context.

How does this QI effort relate to routine monitoring and evaluation (M&E) of services delivered?

Routine M&E of services delivered is very important. These data inform program managers and donors about the number of children served and, when related to population-based data, may allow you to estimate how well you are meeting the needs in your community or service area. However, historically, ***routine indicators have not sufficiently captured the quality of those services or whether or not you made a difference for the children served.*** Integrating concepts from QI into routine monitoring will complement information about the number of services delivered or children served to better demonstrate that the care you provided was effective. Routinely evaluating quality is a powerful way to assure that you are meeting your pledge to children. It can also be helpful in your efforts to generate additional resources, both from sources inside and outside the communities served.

How can I use this guide?

This guide is intended for facilitators who have expertise in OVC care, quality, or both. Though this manual is particularly addresses programs working with children affected by HIV/AIDS, the principles are applicable to programs working with all vulnerable children regardless of cause.

It is intended to be studied completely, but used flexibly, as every local context will require adaptation. ***The insights of local leaders almost always outweigh the internal logic of the methods, which can and should be used creatively!***

Part I of this guide provides a framework for a consensus-based standard-setting effort. It reviews the ***core services*** that comprise a continuum of care for orphans and vulnerable children. It outlines the ***Quality Triangle*** and a ***four-phase strategy for introducing and implementing QI*** into programs for vulnerable children. This section also presents some key concepts relating to coordination of care, and underscores the important role of the ***Child Status Index*** as a compact instrument that can be used to assess a child's status and determine which services are needed.

Part II presents the core of the ***standard-setting process*** in the format of workshop guidelines that draw on local best practices and the evidence base for OVC care. The workshop employs basic concepts related to quality, such as an operating definition of quality care and the dimensions of quality. Drawing on these resources the workshop takes the group through a process of developing and drafting service standards, with illustrative examples from core services for orphans and vulnerable children. This section also provides guidance about proper preparation for and follow-up to the workshop, which are critical for success, both in terms of ***reaching consensus about standards*** and ***ensuring that the standards are of high quality***.

Part III gives a brief overview of QI strategies that can enhance implementation of standards and foster quality improvement. It focuses on ***supervision, process improvement***, and the ***Community of Practice*** model for ongoing coordination and collaboration. This section also presents a ***case study*** that can be used in workshops or group settings to describe issues related to implementation of standards and the development of improvement strategies.

Part IV discusses the relationship of ***monitoring, evaluation and reporting***, and QI. It discusses information gathering implications of the various QI strategies and addresses the importance of coordination and streamlining data gathering efforts.

Appendices provide resources for developing standards including, a description of core services, the Child Status Index, a guide for obtaining children's input, composite illustrative standards for core services, a sample agenda for a standard-setting workshop, and forms and guides to use in the workshop. A glossary of quality-related terms is also included.

Part I: Setting the Context for Improving the Quality of OVC Services

According to UNICEF, the number of orphans due to AIDS in sub-Saharan Africa is increasing rapidly, rising from 550,000 in 1990 to an estimated 20 million in 2010. These estimates do not include many children who, while not orphaned, will be made vulnerable by their family's exposure to HIV/AIDS. These children are vulnerable because of the direct impacts of parental illness, associated emotional and economic stress, and the burden of being a child caregiver for parents and/or siblings. In the face of this great need, it is urgent to reach all these children quickly and support their care with quality services.

The Scope of Care for Children Affected by HIV/AIDS

The aim of OVC programs is to enable children who are vulnerable due to HIV/AIDS to develop and thrive in a safe and healthy environment. Their complex needs require a multi-sector approach that begins with an understanding of the assets and resources available within a community. Implementing agencies may then support and complement family and community resources so that the children's needs are met. Thus, services should be offered in the context of a community-based, child-centered process that includes such elements as identification of needs and assets, training, monitoring, and evaluation. This section describes the core needs of vulnerable children and outlines a process for coordination of care that ensures that the right cluster of services reaches vulnerable children and their families.

Core Services

The United States President's Emergency Plan for AIDS Relief (PEPFAR) defines six core service areas that can be used in combination with economic strengthening efforts to assist children, families, and communities. Taken together these seven components define a broad continuum of care that can provide for the complex needs of children. They are:

- 1) Food and nutrition support:** These services have the desired outcomes of food and nutrition security and supporting proper development with appropriate nutrition.
- 2) Shelter and material care:** These services have the desired outcomes of children having protective shelter, clothing, or access to clean safe water or basic personal hygiene.
- 3) Protection:** These services have the desired outcomes of eliminating stigma, social neglect, and physical and sexual abuse and exploitation as well as access to legal support (birth registration, inheritance claims, and no sibling separation).
- 4) Health care:** These services have the desired outcomes of meeting the preventive and curative health needs of children in an age-appropriate way, providing primary care, immunization, treatment for children when they are sick, HIV testing if known to be exposed or if exposure status is unknown, ongoing treatment for HIV-positive children, and HIV prevention, especially age-appropriate HIV prevention education for older OVCs.
- 5) Psychosocial support:** These services have the desired outcomes of children having the human relationships necessary for normal development and enabling children to participate cooperatively with other children and adults in activities such as school, recreation, and work.

6) Education and vocational training: These services have the desired outcomes of vulnerable children receiving educational and vocational opportunities in accord with community norms and market-driven employment options.

7) Economic strengthening: These services have the desired outcome that households caring for children can meet their own basic needs, in spite of changes due to HIV/AIDS.

A more detailed description of each service, based on programming guidance for U.S. Government implementing partners, is found in Appendix A.

Overview of a Standards-based Approach to Quality Improvement

“The impact of the HIV/AIDS epidemic is most profoundly reflected in the lives of children, whose very survival and development are at stake.”

—UNAIDS, UNICEF and USAID (2004)

To make a meaningful difference for children made vulnerable by HIV/AIDS, we need to ensure that they have access to the broad spectrum of coordinated services described above. Further, the services must be based on best practices and evidence and must reflect expert and indigenous knowledge and wisdom about the needs of children.

Quality improvement (QI) can 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 actual results/outcomes are routinely identified and addressed. QI strategies address concerns about service effectiveness, access, and efficiency. They can enable service providers to innovate and scale up rapidly, so that OVC programs and services can reach as many children as possible.

QI is based on several core principles, including: 1) data-based decision making, 2) a reliance on a multi-disciplinary team approach, 3) a client-focus, and 4) a methodology that stresses system modeling and process analysis. These principles are reflected in the standards development process described below as well as the other QI strategies outlined in Part IV.

QI efforts comprise three complementary and interdependent activities, often referred to as the quality triangle. They are: 1) defining quality, which focuses on setting standards and designing systems; 2) measuring quality, which gathers information about process and outcomes, both on a routine and ad hoc basis for the purpose as assuring and improving quality; and 3) improving quality, which includes a variety of methods of varying complexity that are oriented toward closing the gap between what is expected and actual performance.

The Quality Assurance Triangle



A “Roll-out” Plan for Improving the Quality of Care for OVC

To achieve desired outcomes, quality improvement strategies can begin with any point on the QI triangle, depending on the needs of a given situation and the activities that have already been carried out. In practice this will be a fluid and iterative process, in which efforts to define quality, measure quality and improve quality complement and reinforce each other.

OVC programs face special challenges because of the evolving nature of best practices and the need for rapid implementation and scale-up. QI experts have judged that in this situation defining quality through a standards-based approach is the most effective starting point for QI in OVC care. This means that programs will be encouraged to work together to define quality (based on mutually agreed-upon desired outcomes and the dimensions of quality), set and communicate standards, and support implementation with a variety of QI strategies.

The following “roll-out plan” introduces QI in manageable phases that work synergistically with existing efforts to plan and deliver services and monitor outcomes. Phases I and II are oriented toward defining the *desired outcomes* at the center of the triangle and *defining quality*. Phases III and IV focus on implementing those standards and using tools related to *measuring quality* and *improving quality*. Thus, these phases provide a roadmap for implementing agencies that will help them introduce QI tools and approaches to improve service quality.

Phase 1: Desired Outcomes and Situation Analysis

The situation analysis phase ensures that before embarking on a participatory standards-setting exercise, all the current relevant information related to OVC programming and partners is available. This phase focuses on the heart of the QI triangle by *defining and clarifying desired outcomes* for OVC care. Defining outcomes includes reviewing existing efforts (national plans, monitoring and evaluation efforts, etc.), including the perspectives of children themselves, and drawing on the Child Status Index. Situation analysis also includes *exploring the evidence base and best practices* for services to be considered so that a body of locally relevant information is available. Finally, during this first phase of introducing QI, it is

important to **identify and involve all actors** who should be involved in defining how care is provided and coordinated. It is particularly important to identify **local leaders** in government and civil society who can serve as champions for QI and follow through on the process of achieving consensus and implementation.

Phase 2: Defining Quality: Establishing Consensus about Service Standards

During this phase, an interactive format, usually a two- to three-day workshop (described in Part II), is employed to develop a set of common service standards in line with national plans for OVC care. This phase uses a participatory process to develop or review standards with the QI methods, followed by an iterative review and revision until approval by partners is achieved. The methodology starts from desired outcomes and applies the dimensions of quality to enable systematic analysis of services and care. Perspectives of various stakeholders are taken into account (children, caretakers, communities, service providers, civil society, government leaders, etc.). This information, combined with input about best practices and existing programs, is then used to draft standards. Once standards are drafted, they are reviewed, revised, and approved by participating partners.

Phase 3: Employing QI Strategies to Implement and Monitor Standards

During this phase, selected QI strategies are used to ensure implementation of standards at an operational level. These strategies can include training, supportive supervision, and developing simple systems for monitoring compliance with standards and selected outcomes. This phase is expected to result in: 1) quality operational standards, job aids, and other tools to enhance quality, and 2) quantitative evidence of compliance with standards (i.e., measuring quality).

Phase 4: Ongoing QI Support to Maintain and Enhance Service Quality/Improving Quality

Once standards are in place, additional QI strategies, including process improvement and the development of networks or communities of practice, can be employed to sustain improvements, foster scale-up, and enhance rapid adoption of effective innovations and advances in best practices. Quality OVC services need on-going attention, both in terms of monitoring and in terms of actions to achieve improvements (i.e., improving quality).

Coordination of Care

Coordination of care is the **critical integrative activity** that ensures that services have the desired impact. Coordinated care can be broadly defined as a child-focused process that identifies needs, and augments and coordinates existing services and manages child wellness through advocacy, communication, education, and identification of and referral to services. While it is critical that care is coordinated for each child, there are many activities that must be carried out at the community, region, and system level. The discussion below addresses coordination of care at the point of service delivery, presents a tool for assessing and monitoring child status, and describes coordination of care challenges at the community and system level. Appendix E includes examples of service delivery guidelines for coordination of care.

Coordination of Care at the Point of Service Delivery

At the child/household level, coordination of care involves assessing needs, planning care for a child or family, monitoring care, and making adjustments to the combination of services when needed. Coordinators of care will usually provide both **direct care** and **referral for services**. For example, a care coordinator might directly provide psychosocial support and assistance with

registration for school but may be in a referral role with respect to legal and health services. Ideally, coordination of care involves a home visit so that all the relevant aspects of the child's situation may be reviewed, but tools and approaches can be modified so that this individual assessment can take place in a group setting, such as a school, feeding program, or youth group. Regardless of whether the needed service is directly provided or arranged through referral, the home visitor/coordinator should monitor ALL the services that the child is receiving on an ongoing basis.

Coordination of Care at the Community and System Level

Effective coordination of care at the point of service delivery requires a great deal of coordination and information sharing at other levels. The following activities must be carried out to enable coordinated care and referral at the household level:

Community mobilization is required to organize the resources (human and other) to design, lead, and implement activities related to OVC care at the local level. This usually involves forming committees at the village levels or empowering existing groups to address OVC issues. The process involves dialogue within the community to foster recognition and ownership of the problem, identification of community resources, setting priorities, and developing and implementing action plans. Community leadership from the outset facilitates success and sustainability of coordinated care.

Service mapping is needed to identify resources and gaps in the continuum of care at the local level. Information about what services are available, who is eligible, and how services are accessed (registration procedures, criteria, etc.) must be gathered and relayed to the service providers who will coordinate care at the household level. Care coordinators, in turn, can then educate caretakers about available services.

Network building is also critical for coordinated care. Network building refers to the development of a web of relationships among implementing partners, civil society organizations, government agencies, donors, and experts in universities and the private sector. Network building involves meetings, sharing of information, and joint efforts to make policy and to plan, implement, monitor, and evaluate programs.

Finally, it is important to note that coordination of care is a ***joint responsibility of the community, government, civil society, and implementing agencies***. Each of these will have different organizational strengths, technical capabilities, and resources.

The Child Status Index

A tool that can be helpful in assessing and tracking priority services a child needs is the Child Status Index and the accompanying Child Status Record. Equally useful for initial assessment and follow-up monitoring, the tool focuses on essential actions and is flexible enough that users can adapt criteria to the local context. Data from the Child Status Index and community mapping of services can be used together to inform coordination of care.

The Child Status Index is based on 6 domains with 12 measurable goals related to the six core services that, taken together, approximate a standard for overall child health and well-being. The CSI goals are presented below under each of the 6 domains of care and are parallel with the six core service areas described previously:

1. **Food and Nutrition**
 - a. **Food security:** The child has sufficient food to sustain an active and healthy life at all times.
 - b. **Nutrition and growth:** The child is growing well compared to others of same age in village.
2. **Shelter and Care**
 - a. **Shelter:** The child has shelter that is adequate, dry, and safe.
 - b. **Care:** The child has at least one adult who provides consistent love and support.
3. **Protection**
 - a. **Protection from abuse and exploitation:** The child is safe from any abuse, neglect, or exploitation.
 - b. **Legal protection:** The child has access to legal protection services as needed.
4. **Health**
 - a. **Wellness:** The child is healthy.
 - b. **Health services:** The child has access to needed services: preventative and treatment.
5. **Psychosocial Support**
 - a. **Emotional health:** The child is happy and content and has a generally positive attitude.
 - b. **Social interaction:** The child is cooperative and enjoys participating in activities with other children and adults.
6. **Education and Vocational Training**
 - a. **Educational/vocational performance:** The child is achieving well at home, school, job training, or work and is acquiring knowledge and skills as expected.
 - b. **Educational/vocational participation:** The child is enrolled and attends school, vocational training, or works (appropriate for age).

The Child Status Index includes a four-point scale for each goal so that the child's well-being can be assessed as good, fair, bad, or very bad. Composite scores can also be calculated. The goals themselves, as well as the rating guidance, are phrased in ways that allow for some local variation, yet the measures are still meaningful and specific. The accompanying Child Status Record, which records status over time, indicates services received and identifies critical events that have occurred in the life of the child. A family version is also included for scoring multiple children from one family. These can serve as tools for ongoing coordination of care. The Child Status Index and Child Status Records (individual child and family versions) are in Appendix B.

A note about economic strengthening activities: While most of these domains of care are parallel with the services and activities provided by implementing agencies, it can be noted that economic strengthening activities are not listed as one of the domains of child status. Rather, economic strengthening, when effective, is expected to have an enhancing effect on a number of the 12 measures listed here. Since the CSI focuses on the well-being of the child, the CSI does not address direct measurement of these economic strengthening services. In practice implementing agencies may want to determine measures for economic strengthening as well. The composite illustrative standard for economic development included in Appendix E suggests measures for this purpose.

Part II: A Workshop to Establish Service Standards for OVC

This section presents a process for developing consensus about service standards for vulnerable children. It then describes the preparations a facilitator should carry out before a workshop; presents a process for standard setting, organized into seven sessions that can be carried out as a series of meetings or in a two-day workshop. It follows with a description of the follow-up tasks necessary after the workshop to ensure that local partners revise and refine the draft standards, achieve true consensus, and implement the new service standards.

Before the Workshop: Situation Analysis

As is described above, situation analysis before the workshop aims to ensure that all relevant background information about standards, best practices, and standards-related activities carried out to date locally are reviewed and summarized before the workshop so that the workshop can be grounded in local realities. Key pre-workshop activities include: 1) determining which services will be addressed, 2) defining and clarifying desired outcomes, 3) exploring the evidence-base and best practices for services, 4) identifying who should participate in the standard-setting process, and 5) identifying local champions for QI who will facilitate the process of achieving consensus and implementation.

The pre-workshop preparations should involve a **level of effort of one- to four-person weeks** depending on the number of services and organizations involved and the amount of background that workshop planners already have. Ideally, in-country experts who have in-depth knowledge of programs, implementing agencies, and policy initiatives undertake this phase. Outside consultants can perform this work if local guidance is provided.

1. Determine Which Core Services Will Be Addressed in the Workshop

The decision about what services the workshop should address should be made in advance and in consultation with key stakeholders from the community, government, civil society, and donor communities. While it is tempting to try to address all services, it is often wise to focus initially on three or four, along with coordination of care, which should always be addressed. In this way the group can learn the process well and apply it to the remaining services with a second workshop or series of meetings. Some questions to help stakeholders decide which core services should be chosen are:

- What are the most-needed services?
- What services are most implementing agencies involved in providing?
- In what areas are improved service standards most likely to make a difference?

For the development of service standards, it is preferable to *focus on services that are provided directly by the implementing agencies rather than services where referral alone is involved* (for example, health care and legal services). While referral is important to ensure that the child receives the complete cluster of needed services, it will be addressed in coordination of care, and meaningful service standards cannot be developed without the involvement of the actual service providers.

2. Define and Clarify Desired Outcomes for Each Core Service

In order to complete the process of drafting standards in the timeframe of a two-day workshop, it is important to begin with well-defined desired outcomes that reflect what is happening nationally and internationally in OVC care. Desired outcomes can be defined with stakeholders based on the following sources:

- National Plan of Action for orphans and vulnerable children
- M&E indicators defined to date
- Desired outcomes from the Child Status Index

Based on the above and discussions with stakeholders, develop a simple list of desired outcomes for each service to use at the workshop

3. Explore the Evidence Base and Best Practices for Services

It is challenging to find a peer-reviewed evidence base for every aspect of OVC care. While it may be true that common sense dictates what the content of care should be for some services, there is a knowledge base about what makes a difference for children, as well as information about well-intentioned care that might be harmful. Thus, it is important to review the evidence base, program-based best practices, and local experiences. Some sources of information might be the following:

- Published literature about needs and care guidelines for vulnerable children from various implementing agencies.
- Local experts who can speak about best practice and evidence-based care in specific areas. If available, such experts speak at the workshop.
- In the absence of or in addition to the above, it is important to begin with some grounding in current practice. Selected participants can be asked to prepare information about the services they provide or to bring their guidelines if any: if they lack written guidelines, they could be asked to prepare a flowchart (described below) of a specific service in advance of the meeting. Experience shows that simply asking for these materials is not enough. Organizers should follow up so that there is something about local practice for each service available in advance of the meeting.

While this is a challenging aspect of preparation, a focus on best practices is very important to ensure that the standards that result from the process are valid and effective. Brainstorming and consensus are not enough to produce a quality standard.

4. Obtain Children's Input for the Development of Standards for OVC Services

A core principle of QI is a focus on the client. This means the standard-setting process should engage children so that their perspective is incorporated in the outcomes and how services will be delivered. In the development of minimum standards for OVC service quality, one way to include children's perspectives is to hold a children's input workshop. The goal of the workshop is to suggest a desired outcome and standards for each of the seven core service areas described in the PEPFAR OVC guidelines. Appendix C provides a detailed guide that addresses topics such as selection of children, location of the workshop, creating the right environment, and the use of older children as facilitators. A sample agenda for a workshop with a description of how to carry out each session is also provided.

5. Identify Who Should Be Involved in the Standards Development Workshop

QI is based on the principle of a participatory process analysis that includes multi-disciplinary expertise, administrative representatives, and client perspectives. This kind of participation in the process is important not only because it ensures that the standard is of high quality, but also because it leads to ownership and commitment to the new standard, making implementation go more smoothly. An initial standard-setting exercise will likely include program managers and some key staff from across PEPFAR OVC programs, as well as other-funded programs and government representatives. OVC program managers and other stakeholders will have the role of taking the drafted standards back to other staff and volunteers for further refinement. These participants will take the lead for harvesting input on the initial draft of standards. Others who will need to be engaged include frontline workers, volunteers, caregivers and children, program administrators, community leaders, and individuals with expertise in each of the service areas.

Experience shows that the workshop works best with a minimum of 25 participants (sufficient for the service-specific small group sessions) and a maximum of 50 participants (particularly if you will review four or more services). Ideally the workshop should include representatives from government, civil society organizations, and community-level implementing organizations. In many situations rather than convening the complete group of stakeholders, the aim will be to convene a representative group, with others being involved in the process of review and refinement after the workshop. Consider the following in determining who will attend the workshop:

- Consult with various stakeholders to determine who should attend. Explain that while not everyone can do so, there are other opportunities for involvement once standards are drafted.
- The perspectives of children and caregivers should be included in the workshop. They can participate as integral members of small groups. Alternately they can be asked to comment and respond on the presentations of small groups. Their input can be sought before hand or in separate meetings. Organizers should consider the best ways for children and caretakers to participate meaningfully and comfortably.

6. Identify Local Champions for QI and Following through on the Process of Achieving Consensus and Implementation

Ideally, workshop planners will identify one or two leaders who are willing to facilitate the post-workshop standard-setting process. Success in the effort requires leaders in government and civil society who can serve as important champions for this effort and their insights and commitments. If additional commitment and leadership potential are identified during the workshop, these leaders can be added to the team. Facilitators should try to keep the leadership team small and assist the group to clarify roles and responsibilities during the workshop or soon after.

You are ready to conduct a workshop when the following conditions are met:

- You have a **list of participants** who represent key implementing agencies who will participate. You have developed strategies to include the perspectives of children, caregivers, communities, and implementing agencies.
- You have a **list of desired outcomes** and agreement about which **OVC core services** the workshop will address.
- You have arranged for **children's input** before or during the workshop.

- You have **summary information about local and regional best practices and evidence basis for services** for each of the services that you plan to address, and if possible, local leaders who can represent that expertise in the workshop.
- You have identified **local leader(s)** who will follow up and facilitate the process after the workshop.

The Workshop

The aim of this workshop is to provide a facilitated process for developing consensus on evidence-based service standards. Appendix D has workshop resources, including an illustrative workshop agenda, a participant handout summarizing core content, instructions and worksheets for group exercises, and an evaluation form that can be adapted for local use.

Workshop Objectives

- To present a participatory methodology for developing common service standards that are based on agreed upon desired outcomes;
- To share best practices and evidence basis for essential actions in OVC care;
- To develop service standards for selected core services;
- To encourage ownership and adoption of new standards by encouraging all implementing agencies to interact, modify and refine best practices; and
- To introduce QI strategies that can support implementation of standards and other quality improvements.

Facilitator Qualifications

The facilitator/workshop team should have the following experience and expertise:

- Familiarity with OVC programs;
- Communication and facilitation skills (if possible in local language);
- Practical understanding of indicators, data collection and use for program improvement;
- QI skills, especially in developing standards;
- Training skills;
- Ability to modify workshop as needed to achieve objectives.

Workshop Content

<i>Session 1: Welcome, Introductions and Icebreaker: Making a Difference for Children</i>

Time: 1 to 1.5 hours

Materials: Blank paper (half sheets without lines) and writing implements

Methods: Presentation, reflection, and discussion

Session content:

- Welcome (local officials and sponsors)
- Overview of workshop objectives with question and answer session (facilitator)
- Introductory icebreaker: Making a difference for children (facilitator)

State that the overall goal of QI for OVC is to make a measurable difference in the health and well-being of children served. One very powerful way to do this is by naming the children served by those present and focusing on their specific needs. A focus on the individual child at

the point of service delivery helps program efforts stay aligned with desired outcomes in a complex environment. The critical question at all levels is “Are we making a difference for children?”

Read “A Visit with Tarisai” from the front of this guide, then engage the group in a brief discussion of the case. **Guiding questions: What did Tarisai need? What services did she receive? Did they make a difference for her or her siblings?**

Ask participants to reflect on the situation of a child that they know who is vulnerable due to HIV/AIDS. On the blank half sheet of paper, they will draw the child (profile or face) and write the child’s name and some key words that tell his or her story. **Guiding questions: What challenges and problems is this child facing? How does this child feel? How does this child cope with his or her situation?**

Read the poem “All Alone”, below, or brief poem or narrative written by a child from the country where the workshop is being held to initiate the reflection period.

All Alone
Out and unguarded
Feeling of mourning
Cautious ways
No way around
Fearing life
Confused
Wanderer
But a gift from the heart... is hope's call.
—K. Brown (2006)

Introductions: After 5–10 minutes ask participants to introduce themselves (name and organization) and to introduce their drawn children with a brief description. The profiles can be posted on a wall or flip chart in collage form to be visible throughout the workshop.

Summary: The facilitator can make summary remarks and lead into the next session by stating that QI is a set of tools and strategies that help ensure that programs make a difference for children.

Session 2: Desired Outcomes and the Quality Triangle

Time: 1 hour

Materials: Participant handout: Key Concepts Related to Service Standards for OVC (Appendix D-2)

Methods: Presentation and discussion

Session content:

What are “outcomes”? Outcomes are benefits or changes in participants’ knowledge, attitudes, values, skills, behavior, condition, or status. The term outcome does not only include the long-term or final outcome, but may also refer to more measurable, proximate outcomes that are important indicators of effectiveness or improved child status. The phrase “desired results” may also be used.

Why focus on desired outcomes? First, awareness about desired outcomes and how to achieve them helps staff and volunteers at all levels focus on priorities in their daily work, so that services can be more effective and efficient. Second, assessment of outcomes provides objective feedback to organizations about how well they are achieving their goals and objectives. Third, a focus on desired outcomes helps programs discern which strategies are effective or ineffective, which facilitates the development of an evidence base for services, enhancing the organization's ability to achieve desired outcomes in the future. Fourth and most importantly, an outcomes orientation keeps the focus on making a difference in the lives of children.

What are desired outcomes for each core service? Donors and leaders in several countries have defined desired outcomes. Some PEPFAR-defined desired outcomes are in the table below. The specific measurable goals that are listed in the table on the following page are from the recently developed Child Status Index and Record (see Appendix B). These outcomes express clear and measurable outcomes for children, and at the same time allow for some flexibility in interpretation that will allow for local adaptation.

What are the desired outcomes for _____ (name country where workshop is being held)? Now that internationally defined outcomes have been reviewed, the facilitator, a representative of government, or leading non-governmental organization (NGO) should present the desired outcomes that have been defined for the country where the workshop is taking place. Based on the situation analysis done before the workshop, a simple list should be prepared, and a brief summary of the sources given. Below is an example of the desired outcomes for Ethiopia that was used in a workshop in February 2007. Participants should receive a handout of desired outcomes for their reference.

Desired Outcomes: Ethiopia

- Education: Child is enrolled and attends school.
- Psychosocial services: Child is self-confident.
- Economic strengthening (called Livelihood): Caretaker has enough income to support child with basic needs.
- Food/nutrition: Child has enough to eat regularly.
- Health: Child has access to health services as needed (treatment and prevention).
- Legal: Child has access to legal services as needed.
- Life skills: Children have training in life skills to be able to protect themselves.

Discussion: The group should consider the extent to which their nationally defined desired outcomes are aligned with the international outcomes. **Guiding questions: What outcomes are the same or very similar? Which services have desired outcomes that are very different?** The goal here is not to conform to international standards (although discussion might lead to a decision to modify desired outcomes so they are in alignment), but to come to a common understanding of where agreement and disagreement occur. And to understand the reasons for variations that may be based on unique national characteristics or needs, other evidence, philosophical differences, or other causes.

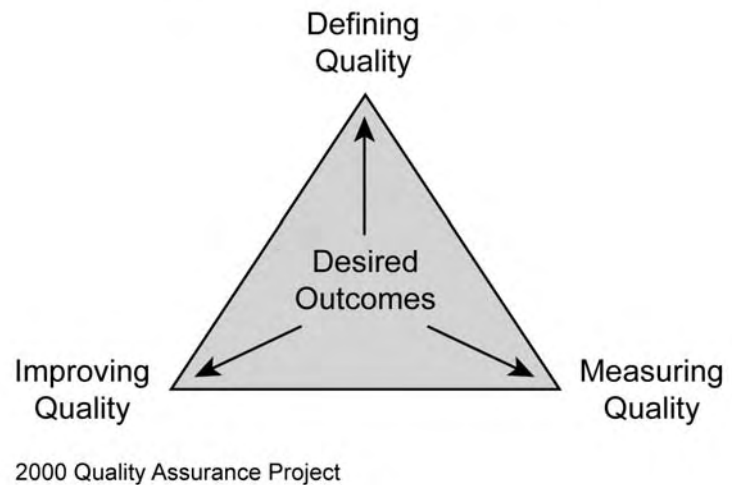
Desired Outcomes for Core OVC Services

Core Service	Desired Outcome	CSI Measurable Goals (2008 version)
<i>Food and nutrition support</i>	To enhance nutritional status and prevent deaths due to malnutrition among vulnerable children.	Food security: The child has sufficient food to sustain an active and healthy life at all times. Nutrition and growth: The child is growing well compared to others of same age in village.
<i>Shelter and care</i>	No child goes without shelter, clothing, access to clean safe water, or basic personal hygiene. Children have one adult who provides love and support.	Shelter: The child has shelter that is adequate, dry, and safe. Care/attachment: The child has at least one adult who provides consistent love and support.
<i>Protection</i>	To reduce stigma/social neglect, ensure access to basic rights (birth registration, inheritance claims, and unification of siblings) and services, and protect children from abuse and exploitation.	Abuse and exploitation: The child is safe from abuse, neglect, or exploitation. Legal protection: The child has access to legal protection as needed: he or she has civil registration; protected inheritance rights; and an identified future guardian, if necessary.
<i>Health care</i>	Children receive primary care, immunization, treatment when they are sick, HIV testing if exposed or exposure is unknown, ongoing treatment if HIV-positive, age-appropriate HIV prevention.	Wellness: The child is healthy. Health services: The child has access to needed services: preventative and treatment
<i>Psychosocial support</i>	Children have the human attachments necessary for normal development and participate cooperatively in school, recreation, and work with other children and adults.	Emotional health: The child is happy and content and has a generally positive attitude. Social interaction: The child is cooperative and enjoys participating in activities with other children and adults.
<i>Education and vocational training</i>	Children receive age-appropriate educational and vocational opportunities in accord with community norms and market-driven employment options.	Educational/vocational performance: The child is achieving well at home, school, job training, or work and is acquiring knowledge and skills as expected. Educational/vocational participation: The child is enrolled and attends school, vocational training, or works (appropriate for age).
<i>Economic strengthening</i>	Families can meet their needs economically, in spite of changes in the family situation due to HIV/AIDS.	-----

What is the quality triangle? The quality triangle is a graphic representation of a simple way to represent a variety of quality and improvement strategies. It has been used to frame QI work in developing countries for over 20 years. **All QI activities are anchored in desired outcomes.** The triangle includes three key activities that lead to improvement, problem-solving and innovation. These three activities are:

- 1) **Defining quality:** Setting standards and defining systems.
- 2) **Measuring quality:** Gathering information about processes and outcomes, and
- 3) **Improving quality:** Closing the gap between what is expected and actual performance.

The Quality Assurance Triangle



QI strategies to achieve desired outcomes can begin from any point of the triangle, depending on the needs of a given situation and the activities that have already been carried out. However, QI experts have judged that defining quality through a standards-based approach will generally be the most effective starting point for OVC care. Thus, the focus of this workshop is to encourage programs to work together to define quality (based on mutually agreed upon desired outcomes), set and communicate standards, and support implementation with a variety of QI strategies. Ongoing monitoring of compliance with standards, and ongoing revision of standards as the knowledge base about best practices grows will also be critical to QI efforts in OVC care.

Session 3: Quality and its Dimensions

Time: 45 minutes

Materials: Refer to Participant Handout: Key Concepts Related to Service Standards for OVC

Methods: Presentation and discussion

Session content:

What is quality care? Quality care for vulnerable children can be defined as the degree to which the services provided to children, families, and communities maximizes benefits and minimizes risks, so that children may grow and develop. Quality care implies the correct mix of services for each child, family, and community, and is offered based on current best practices and indigenous and expert knowledge. Children, families and communities play a leadership role in decisions about the care and services they receive.

Discussion: Give participants a moment to reflect on this definition. **Guiding questions:** **What do they like about the definition? What would they change? Is there anything missing?**

What are the dimensions of quality? Quality can be defined as a degree or grade of excellence or worth. However, applying this simple concept can be difficult because of the many ways that

people implicitly or explicitly define excellence or worth. Quality experts have found that defining dimensions of quality permits a more systematic, objective and transparent analysis of the quality of a product or service. The dimensions of quality are presented below. Experience to date has shown that these concepts are powerful tools for systematic analysis as well as motivation, and are an important foundation for defining and implementing standards. The facilitator should introduce each of these dimensions, illustrating their importance with an example from OVC services.

The Dimensions of Quality

Dimensions of Quality	Definition
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 resources needed to achieve the desired results are minimized and the reach and impact of programs are maximized
Continuity	The delivery of ongoing and consistent care as needed, including timely referrals and effective communication among providers
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, community context, culture, or socio-economic factors.
Participation	The participation of caregivers, communities, and children in the design and delivery of services and in decision-making regarding their care.
Sustainability	The degree to which the service is designed so that it can be maintained at the community level, in terms of direction and management as well as procuring resources, in the foreseeable future

Adapted from Franco et al. (2003).

Discussion: A brief reflection and discussion of the dimensions will help participants to absorb the content and begin to master these concepts. This can be done in plenary or in partners, by asking participants to refer to the dimensions of quality table in their handout and discuss the following questions with each other. **Guiding questions: Which of these dimensions seem most important to you? Are there any that you would eliminate? Are there any aspects of care that are not covered by these dimensions? If so, what dimension would you add?**

How can the dimensions of quality help me in my day-to-day work? The dimensions of quality are useful in themselves, as *a tool for evaluation or self-assessment*. They help program managers and service providers consider many facets of the care they provide to anticipate problems, correct errors, and service children and families better. The dimensions of quality can also be used as an *analytical tool to map quality characteristics* for OVC services. Using the dimensions of quality as an analytical tool permits a systematic consideration of the multi-dimensional aspects of quality for a specific service. Once quality characteristics are mapped out, program

managers can make judgments about which of these characteristics are *essential* to making a difference for children. (While all are *desirable*, this prioritization is a step toward defining *essential actions*.)

What is a quality characteristic? A quality characteristic is an observable and measurable aspect of care that indicates that it is in line with best practices and what would be expected to produce specific desired outcomes. It is important to note that these characteristics are more specific than the robust indicators or outcomes that are articulated in national monitoring and evaluation plans. While the M&E outcomes and measures are by design intended to summarize what is happening in a program, the characteristics identified by the process presented here will cover more facets of care and will be more specific. Standards based on these characteristics will facilitate achieving program outcomes.

Example: Food and nutrition: The table on the next page illustrates how the dimensions of quality matrix can be used to map quality characteristics for food and nutrition support. The desired outcomes and CSI measures used here are taken from the USG Guidance and the Child Status Index. Locally defined measures, which will often be very similar to these, can also be used as the starting point of analysis.

The quality characteristics in the table guide the development of standards by directing attention at the process of service delivery. For example, the safety dimension encourages program managers to think about food storage conditions, which leads to more food being distributed, more caloric intake, improved health status, and, in turn prevention of death due to malnutrition. Similarly, guidance about gender issues related to pregnant teens could lead to better nutrition and improved birth-weight.

Discussion: A brief discussion of the example will help participants see the value of the matrix and prepare them for the analysis that they will do in Group Exercise 1. **Guiding questions:** *Which of these quality characteristics are critical for effective care? Which are desirable but optional? Which are of questionable value?*

Summary: Reflection on the dimensions of quality is a critical step toward achieving service quality. Even in the absence of other quality-related interventions, this analysis is a powerful tool for awareness-raising and transformation at the individual and organizational level. The dimensions matrix identifies many quality characteristics that might be important to effective care. Implementing agencies must then decide which of these elements are critical for program success.

Dimensions of Quality	Quality Characteristics for <u>Food and Nutrition</u>
	<p>Desired outcome(s): To enhance nutritional status and prevent deaths due to malnutrition among vulnerable children.</p> <p>CSI measures: Food security: Child has sufficient food to sustain an active and healthy life at all times of the year. Nutrition and growth: Child is growing well compared to others of same age in village/community.</p>
Safety	<p>Food chain is secure. Food is free of contaminants and safe to eat. Safe and reliable water supply is available.</p>
Access	<p>Distribution site is convenient for recipients.</p>

	Distribution occurs on schedule.
Effectiveness	Recipients consume food as intended. OVC in household realize improved nutritional status. OVC do not die of malnutrition. OVC achieve median height and weight (H/W) for their community.
Technical performance	Food provided is appropriate to the setting (can be prepared easily, is nutrient rich, is acceptable to recipients, and fits climate). Families and caregivers know how to prepare the food. Nutritional education is provided. Nutritional status is monitored. Needs of breastfed and weaning children are addressed.
Efficiency	Food aid is directed to OVC most in need. Wrap-around services and more sustainable feeding solutions are identified in a timely manner.
Continuity	Referral process with health care system is in place. Care providers refer children at risk for nutritional assessment. No gaps exist in coverage or timing of food provision.
Compassionate relations	Recipients perceive that food is distributed with dignity. Service does not lead to social stigma for recipients. Counseling is carried out with respect and confidentiality.
Appropriateness	Absence of gender-based disparities in food distribution Food provided meets household need. HIV-positive mothers and pregnant women receive appropriate advice about feeding their newborns.
Participation	Caregivers and OVC participate in decisions about what they will receive and how it will be distributed.
Sustainability	Efforts are underway to find other sources of nutritional support through food programs, community gardens, etc.

Group Exercise 1: Dimension of Quality Matrix (Worksheet 1, Appendix D-3)

Time: 1 hour

Materials: Dimensions of quality matrix (Worksheet 1); refer to list of desired outcomes

Methods: Interactive group work

Instructions for group work:

1. Note the core service, desired outcomes, and relevant CSI measures in the top of the matrix.
2. Ask group members to state quality characteristics for each dimension (some will involve more than one dimension, which can be noted). Be sure that quality characteristics are observable and measurable.
3. Once the quality characteristics have been listed, note with an underline or other indication, which ones are **ESSENTIAL** for effectiveness.

Session 4: Review of Best Practices and Evidence-based Service Standards

Time: 1 hour

Materials: Materials related to best practices and evidence-based care (from situation analysis)

Methods: Presentation and discussion

Session content:

What is a standard? A standard can be defined as a statement of what is expected. The term “service standard” refers to a comprehensive description of the content of care, so that it can be used as a guide for service delivery and a basis for training and supervision of service providers.

Care providers often question how services can be “standard” for every child, when children have unique characteristics, strengths, and needs. They often feel that the care that they give is complex, requiring expertise, and subjective judgment. The “art” of this type of care cannot be codified the way manufacturing tasks or more routine jobs can. Leaders of implementing organizations may also resist standards, feeling that standardization of care infringes on their right to define their own mission and to respond to local needs in the manner they see fit.

The format for OVC care standards presented here provides a balance of structure and flexibility that addresses these concerns. The format links desired outcomes and measurable goals to essential actions that define the service. While it is intended that implementing organizations at the country level will **agree on this common core of essential actions**, it is also understood that the **detailed guidelines for each essential action would be flexible** and vary by organization in order to adapt the service to the local context. Thus, the standards provide flexibility, while assuring that consistency across programs is achieved.

Below is an illustrative composite standard for Access to Health Care. This standard is a synthesis of standards developed by leaders in a number of African countries, based on the participatory approach set forth in this facilitator’s guide. The standard includes a statement of **desired outcome, measurable goals** based on the Child Status index, **essential actions** that define the service, and **guidelines** (which may vary by organization) that explain how the essential actions should be carried out. Appendix E includes illustrative composite standards for all 6 domains of care, economic strengthening and coordination of care.

<i>Service : ACCESS to HEALTH CARE</i>	
<i>Desired Outcome:</i> Children receive preventive, curative and promotive health care services as needed: primary health care, immunization, treatment when they are sick, HIV screening, ongoing treatment for children known or presumed to be HIV-positive, and education about HIV prevention.	<i>Measurable Goals (from Child Status Index):</i> <ul style="list-style-type: none"> • Wellness: The child is healthy. • Health Services: The child has access to needed services: primary health care, immunizations, HIV screening, treatment as needed for children known or presumed to be HIV-positive, education about HIV prevention.
<i>Essential Actions that define this service</i> <ul style="list-style-type: none"> • Identify/map health care services and health education opportunities for children and their caretakers • Determine and Monitor child health status and access to services (immunization, primary health care, HIV screening and treatment, curative care, health education) 	

<ul style="list-style-type: none"> • Assist children and their caretakers to overcome barriers to health care access (economic, geographic, cultural, linguistic) • Provide health education at the household and/or community level 	
<i>Essential Actions</i>	<i>Guidelines</i>
Health Service Mapping	<ul style="list-style-type: none"> • Work with local health authorities and communities to identify available public and non-public health care services (location, services offered, access cards, referral mechanisms, sources of medicines, and fees that may apply) • Work with local health authorities, including community health workers and volunteers, to identify sources of health promotion and health education related to nutrition, child health, living with HIV, hygiene and sanitation • Where service gaps exist, work through regional and national committees to advocate for needed services • Update service mapping annually. • Determine any gaps in demand and supply for child health services and actions for resolving.
Monitor health status and access to care and address barriers to health care access	<p>Through community care coordinators, community committees or during other individual or group settings, routinely assess the following:</p> <p><i>Assessment:</i></p> <ul style="list-style-type: none"> • Caretaker knowledge about where to access curative and preventive health services. • Barriers to care seeking (distance, financial, other) • Utilization of preventive services (Immunization is up to date according to health card, use of malaria control nets, etc)? • Access to age-appropriate HIV counseling and testing? • If known or presumed to be HIV-positive, child being monitored and taking ARV or prophylactic cotrimoxazole as indicated? • Adequate consumption of nutritional foods? (Informal assessment, based on observations) • Child ill at time of assessment? • Child showing signs of trauma of physical/sexual abuse? • Household water and hygiene conditions adequate? (water supply and storage, management of waste, etc.) • Is child satisfied with health services received? • Does the child or caretaker report barriers to care? (distance, financial, other problems with access) • Does caretaker report satisfaction with health services? <p><i>Action:</i></p> <ul style="list-style-type: none"> • Staff/volunteers refer children for all appropriate health care services and follow up. • Staff/volunteers/community committees seek available solutions to barriers to care (financial, geographic, cultural etc.) • Staff/volunteers provide health education and/or refers for group education activities (nutrition, hygiene, etc.). • Resources to fill gaps in health services are sought

	<ul style="list-style-type: none"> • If urgent care is needed at the time of assessment, staff/volunteer assist caretaker in taking child to health center. • Health care providers treat children and families with respect and confidentiality. • Staff/volunteers keep a record of services needed, addressing barriers to care, and following up during next visit. <p>Support and Supervision:</p> <ul style="list-style-type: none"> • Supervisors are available to assist staff when needed so that difficult problems are resolved. • Staff should be trained in the above tasks and receive ongoing supervision. • Implementing agency has clear policy on how frequently children should be monitored and how many visits staff is expected to do each month.
Health Education	<p>Implementing organization works with community and local health authorities to offer health education in the following areas:</p> <ul style="list-style-type: none"> • Basic health care • Hygiene, water and sanitation • Nutrition • Living with HIV (age appropriate, including PMTCT and pediatric AIDS treatment when needed) • Malaria prevention • Sexual and reproductive health (age and gender appropriate).

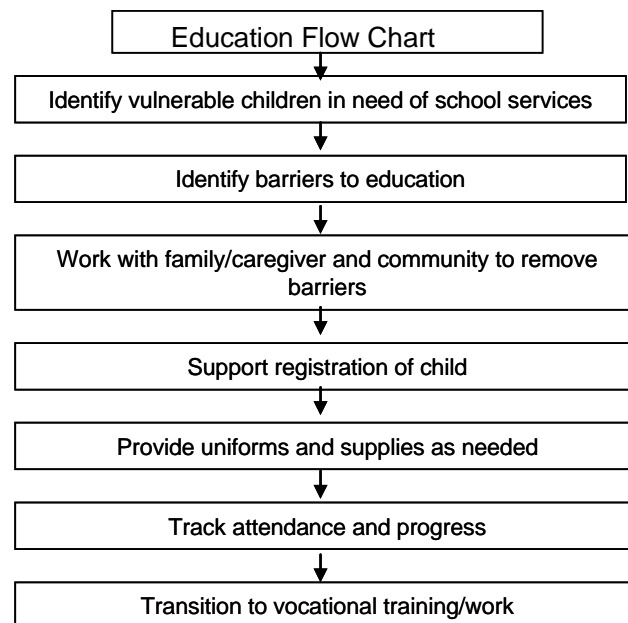
What makes a good standard? Good standards should be valid, realistic, reliable, and clear. A **valid** standard is one that is evidence-based, taking into account best practices and expert knowledge. A **realistic** standard is one that is achievable in the setting where it is to be applied. A **reliable** standard leads to the same result each time they are applied. A **clear** standard is stated as simply as possible, so that caregivers and supervisors can work with it.

What does it mean for a service standard to be evidence-based? Evidence-based practice “integrates individual practitioner expertise with the best available evidence while considering the values and expectations of clients for their care.” (Johnson and Austin, 2005). This may be mean considering research-based evidence as well as standards or best practices from leading organizations. Another strategy is to solicit advice from a local or international expert. Some or all organizations participating in the workshop might also share how the services are currently performed in their setting. The facilitator should arrange for a concise presentation of evidence and best practices, with ample time for group members to comment on the extent to which what was presented is suitable to their setting. Strengths and weaknesses should be discussed, and suggestions for adaptations and modifications to fit local circumstances should be made.

One challenge that facilitators face is how to manage the evidence for three or four services in a single workshop. One strategy is to share this information in the small groups, which gives time to deal with each topic in detail. Another strategy is to present this content in plenary, as there will be likely a great deal of interest in the topics and to adjust time spent on other sessions accordingly. If possible, a summary of best practices for all the services being addressed at the workshop could be given in the plenary session, with more detailed follow up discussions in the small groups.

How can we develop a standard that meets the needs of our local situation? Once you have reviewed best practices and the evidence base for care, the group must decide what essential actions will be effective and feasible in the local setting. Through group discussion and reflection of implementation experience, the group should develop a **list of essential actions or flowchart** that define the service and make **notes about the content of care** for each of these essential actions. It is important that the group exercise judgment about what to include and what to leave out. The task is not to develop an optimal standard of care that includes every aspect of best practice, but rather to identify only the actions that are essential if care is to be effective.

How do we prepare a flowchart? The essential actions that define the service, organized in the order that they are to be carried out, make up a flowchart that will serve as the foundation for a more detailed service standard. The flowchart provides a logical structure for organizing information about quality characteristics and requirements for the new standard. For example, a flowchart providing service in the area of education might include the following essential actions:



How do we define the content of care for each step? The flowchart shows the essential actions required to provide quality educational support. Providing this care by carrying out these essential actions requires consideration of many more details. To determine which detailed recommendations and steps to include, participants will refer to the DIMENSIONS OF QUALITY MATRIX and other information they have about BEST PRACTICES. Details are best documented as notes to each step on the flowchart. Team members can all contribute details to the flowchart in this way. Thus, the flowchart remains simple and clear, but the important details are not lost.

For example, the notes to the second step “identify barriers” to education would include a list of barriers such as 1) inadequate funds for school fees and supplies, 2) gender inequity; 3) child is providing care for family members, and 4) social stigma. The notes relating to removing barriers would address each of these, employing referral to support service, counseling, community-based interventions, etc.

Your group will now **consider the evidence base** for each service, **construct a list of essential actions/flowchart**, and develop **notes about each step**. These three activities are the building blocks of your draft standards.

Group Exercise 2: Review of Best Practices and Flowcharting (Worksheet 2, Appendix D-3)

Time: 1.5 hour

Materials: Materials related to best practices and evidence-based care for the group's specific core service, participation of a content expert if possible, and Worksheet 2: Flowchart of Service Delivery

Methods: Interactive group work

Instructions for group work:

1. Content expert or group member presents **summary of best practices** and evidence base for service under consideration. In addition to (or in the absence of this information) the group should also review the **illustrative service standards** from Appendix E or other examples provided by the facilitation team and refer to the **dimensions of quality matrix** from exercise 1.
2. Group evaluates the relevance and applicability of what has been presented to the local context. **Guiding questions: Could these service standard/best practices work in our setting? What activities would have to be altered or added?**
3. Group constructs a list or flowchart of **essential activities**, in chronological/logical order, that must occur for service to be effective in the local context.
4. Once the flowchart is complete, the group can begin to make **notes about the content of care** for each activity. These notes are the building blocks of the draft standard.

Session 5: Putting It All Together: Drafting a Service Standard

Time: 30 minutes

Materials: None

Methods: Presentation and discussion

At this point the group is ready to draft standards and may decide to ask an individual or pair of people to prepare a draft for group review, or they may decide to do the draft as a team, reviewing and composing together. They will use the dimensions of quality matrix to cross-check their standard for accuracy and completeness, the flowchart, and notes, as well as any best practice models that seem appropriate. Each standard should begin with a desired outcome that clearly expresses what is expected. Each should also include the essential actions (from the flowchart) that must be in place for this service. Depending on the type of standard chosen, the content of service specifications should be formulated as a set of guidelines, checklist, series of steps, or algorithm. Participants should expect that an iterative review process will be necessary to gain consensus on the draft standard.

The group can carry out an ongoing check of its work by remembering to consider whether the standard they are drafting is **valid** (based on current best practices and expert knowledge), **realistic** (achievable), **reliable** (causes the same outcome each time), and **clear** (stated as simply as possible). The group should also cross-check with the **dimensions of quality matrix** to be sure that the important quality characteristics are addressed in each standard. In effect, they are asking, "Will the standard we are developing lead to the desired quality that we described?"

Once standards are drafted, participants will have to go back to their organization to share the draft and make plans for implementation. At this point a similar, though possibly simpler, participatory process should take place. Rather than simply presenting the new standards, those who will be involved in implementing the standards should have an opportunity to comment and suggest changes. Often those who participated in the initial process will summarize their experience for their home organization, describing quality and its dimensions, best practices, and the evidence base for the standards, and presenting the new standards. Group discussion and adaptation to the organizational setting would then take place. It is important to note that some participants in the initial process may feel that they need assistance in developing support for the new standards at the organizational level. Technical resources and collaboration between organizations should be made available to support this process.

Resistance to new standards should be expected. Organizations can overcome this with strong leadership by example (leaders show they are willing to learn, change, be innovative) and by engaging the entire staff in a reflection on quality and giving them the opportunity to comment, recommend changes, and fine tune the guidelines.

Once each OVC partner has decided to implement standards, it is important to plan an organization-wide strategy to communicate them. Training may be one part of this strategy, and posters, job aids, and on-the-job supervision (this is a large and important task—requiring people and time—the organization needs to think through how to support momentum) should support standards implementation. In addition to learning to follow the new guidelines, staff will also need orientation about new data collection or tracking responsibilities that may be introduced to evaluate the new standards. Staff will need time to internalize the new standards and incorporate them into their daily work. Further, adjustments may be needed in terms of resources and work settings before staff can fully implement the new standards.

Group Exercise 3: Drafting a Standard (Worksheet 3, Appendix D-3)

Time: 1.5 to 3 hours (depending on how much advancement and clarity were achieved in Group Exercise 2).

Materials: New flip charts for drafting, as well as other materials used and produced in Step 2 will be needed. These items include flowchart, notes, model standards, illustrative standards from Appendix E, etc. Having each group draft on a computer makes editing easier, but if computers are not available typing up of group work by one of the group members or a typist should be arranged.

Instructions for group work:

1. For each essential action in the flowchart for the service, explain what the service provider needs to do for the child and what other things need to happen for care to be complete and effective.
2. Review each step of standard to be sure that it is valid, reliable, realistic, and clear.
3. Review/cross-check ESSENTIAL quality characteristics from DIMENSIONS OF QUALITY MATRIX. Will this standards lead to the hoped for quality?
4. Questions about optimum (ideal) or minimum levels of care will arise; in order to move through the process, the group is encouraged to identify both optimal and minimum effective practice. Then, through discussion, they can determine where to set the local standard based on national policies, resources, and local realities.

Session 6: Plenary Presentation of Draft Standards

Time: 2 hours

Materials: none

Methods: Group presentation and discussion

Each group should present its work in plenary, with ample time for comments and suggestions from the audience. Each group should present their: 1) desired outcome, 2) completed dimensions of quality matrix, 3) flowchart, and 4) draft standard. Under time constraints groups could present the draft standard only, since it is a culmination of the other steps. This strategy has the advantage that more time can be spent in discussion. However, with so many new ideas being absorbed in a brief workshop, groups often want to present their work thoroughly and in its entirety.

Session 7: QI Strategies for Implementing Standards

Time: 1 hour

Materials: None

Methods: Presentation and question and answer session

During this session the facilitator can review the four-stage process for introducing standards (see **Part I** for content) and help participants to see where they are in that process. A summary of QI strategies (see **Part III** for session content) that could be used to implement standards can also be offered. The aim of the session is not to foster competency in these skill areas, but simply to give participants an idea of where they are going and what more they can do to enhance quality once their standards are defined and agreed upon. Participants may also have questions about how the standard-setting process and implementation of standards relates to program reporting. Some of their questions are anticipated and addressed in **Part IV**. That material can be shared with the group, or the facilitator may choose to use it as a resource to help answer questions as they arise. This content will help the group to plan next steps.

Note: if additional time is available the workshop could include the **Case Study on Monitoring and Improving the Quality of Service Delivery**. Two one-hour sessions are recommended for this activity, and all needed materials are included in Appendix F.

Planning Next Steps: Timeline for Revision and Approval of Standards

Time: 30 minutes

Materials: Flip chart and markers

Methods: Discussion

The purpose of this session is to develop a list of tasks with assignment of responsibility and approximate dates of completion for each. Some of the follow up tasks that would be expected are:

1. Reviewing draft standards with larger group of stakeholders with revisions as indicated
2. A follow-up meeting to assess progress and determine whether consensus has been reached
3. Planning a strategy for communicating standards and provide needed training and support for implementing agencies.

Time: 30 minutes

Materials: Evaluation form (Appendix D-4)

Methods: Presentation and discussion

Time should be taken after the planning session to allow participants to provide a written evaluation of the workshop (see sample evaluation form in Appendix D-4, which can be modified as needed).

The wrap-up should review the objectives and extent to which they were achieved. It is also important to acknowledge the contributions of the attendees as well as those involved in preparation. Finally, participants should be invited to make comments, summary remarks, or suggestions orally. The following questions could be used to stimulate comments and discussion:

1. What aspects of this workshop were most helpful to you?
2. How will you carry out your work differently because of the workshop?
3. In your opinion, what is the most important thing program managers can do to improve service quality for children?

After the Workshop

While the delivery of a successful workshop is essential, what happens afterwards is equally important! If the workshop has successfully motivated participants, they are likely to want or need follow-up support to complete the standards development process and put them in practice.

The workshop leaders or designated others should serve as coaches or mentors in working with participants to carry out the following activities after the workshop:

- Monitoring completion of standards and providing facilitation assistance as needed,
- Planning follow-up visits/communications to assist with building consensus and implementation,
- Developing a plan for a quality improvement collaborative as a strategy for implementing standards, and
- Working with participants to identify competency-based training needs related to implementation of standards.

Part III: Overview of QI Strategies to Implement Standards

While there are many methods and tools for quality and improvement, the following are particularly appropriate to support and reinforce standards-based efforts: supportive supervision, team-based process improvement, and improvement collaboratives and communities of practice. This section gives a brief overview of these strategies. To apply them, additional QI skills and resources would be needed. A case study that can be used to further explore monitoring and quality improvement is also outlined here. This can be used by groups that have begun the standards development process so that they may begin to see how the new standards can be used and so that they can have a step-by-step example of how quality improvements would be identified and implemented. The complete case study is included in this Facilitator's guide as Appendix F.

Strategies for Supportive Supervision

Supportive supervision is a process that promotes quality at all levels of the system by strengthening relationships within the system, fostering compliance with program standards and guidelines, focusing on the identification and resolution of problems, and helping to optimize the allocation of resources. Supportive supervision can employ the following methods:

- Review and feedback/support by supervisor
- Peer assessment
- Self-assessment
- Feedback from children and families served

In addition to occurring in the context of scheduled supervisory visits, supervision can happen on an ongoing basis, during routine work, and in team meetings. Supervisory visits themselves involve feedback on performance, assistance in solving problems, and ongoing monitoring. Another very important aspect of supervision is for the supervisor to provide support by making sure that service providers have the resources, materials, and working conditions to do their jobs.

Tools for supervision include structured supervision guides, record reviews, and observation of care. Actions and decisions should be recorded so they can be followed up on in future visits. Supervisors may also benefit from training in communication and feedback skills. To the extent possible, it is helpful if information gathered during supervision can be related to or included in M&E plans. This serves to give weight to supervision in general and service quality specifically, it also helps in the alignment of program actions with goals and objectives.

For more information on supervision, see Steinitz (2005) and Marquez and Kean (2002) in the bibliography.

Process Improvement and the PDSA Cycle for Quality Improvement

The Plan-Do-Study-Act (PDSA) Cycle, also known as Shewart's Cycle, is a quality improvement technique that can be used on an ad hoc basis, for simple problems, or on a continuous basis as a format for monitoring a core service or activity. The process is generally employed by a team,

but can be carried out by an individual if the problem is small and within the control of the individual. Once a specific goal for improvement is determined, the team gathers available information and analyzes the possible causes and solutions to the problem. The **plan** step involves selecting an indicator or indicators to monitor, clarifying the action that is to be taken, and communicating the plan to staff. The **do** step involves implementing the change and gathering the related data. **Study** includes reviewing data to verify that the change was implemented and to determine if the desired outcome occurred. The **act** step involves making further changes if the cycle was not successful and moving on to another problem, determining the change desired, and returning to the plan step. If the process has been successful, the team will need to decide if ongoing monitoring is required or not. This will depend on the process and overall usefulness of the indicator chosen. Alternatively, after a period of implementation and monitoring, the team may decide that the change has become sufficiently routine that monitoring is no longer necessary.

Tools for analyzing and monitoring care include the flowchart and the run chart. **Flowcharts** are graphic representations of how a process works and can be simple or complex. They are used to understand processes, identify key activities, and pinpoint areas for monitoring. A **run chart** plots data chronologically over time, making it easy to detect trends and determine whether the change in a process has changed its results. In the context of the PDSA cycle it can be very useful to plot a key indicator on a run chart and post it in an area where staff can easily see it. If the changes in the process have their desired effect, the results will be reflected on the run chart.

Details about the PDSA Cycle, how to use it, and a description of affiliated tools and their uses are in Massoud et al. (2001).

Collaboratives and Communities of Practice

Another potent strategy for improving the quality of services for vulnerable children is the formation of quality improvement collaboratives. An improvement collaborative is a network of sites organized for shared learning. Through quality improvement teams (also described in Massoud et al. [2001]) and communication about changes and results, rapid and significant improvements in quality of care are achieved.

Collaboratives can be used to design services. In this model, sites work together to learn how to implement effective services at the community level. They can also be used to foster scale-up or expansion of services by involving a large number of sites through which the effective practice spreads to a larger area. This may be done all at once or in waves.

Collaboratives are an especially useful method for the work proposed here because they depend on national networks to provide coordinated leadership and to select topics and indicators. A large network of providers can work together, drawing on the existing evidence base to improve and expand services.

Collaboratives create an environment in which teamwork, shared learning, and more rigorous monitoring play key roles. Because practices are always in need of review and revision, it is often desirable to have the collaborative evolve into a permanent working group called a community of practice. A **community of practice** can be defined as an informal network of professionals/organizations that have similar goals and responsibilities. They communicate regularly about standards of care and advocacy issues.

The formation of collaboratives or communities of practice holds great promise for enabling the needed rapid scale-up of quality services for vulnerable children. Experimentation with this framework, and the standard-setting exercises outlined here, can be thought of as a simplified “collaborative” process. In addition, it can be considered a stepping stone for forming an ongoing community of practice to generate and disseminate improvements in care and changes in the state-of-the-art.

Case Study on Monitoring and Improving the Quality of OVC Service Delivery

This guide presents some powerful conceptual tools for quality improvement, including the quality triangle, the dimensions of quality matrix, a format for standards development, and introductory ideas about supervision, process improvement, and communities of practice. This case study on monitoring and improving the quality of OVC service delivery detailed in Appendix F provides a hands-on experience that will allow participants to 1) see how these tools and approaches can work together and 2) anticipate issues related to implementation of standards and quality improvement. The case study begins with a description of a home visit to a family that is caring for two children who have lost their parents due to HIV/AIDS.

Lucy the Home Visitor

Lucy Mbele is a home visitor with your NGO. She is responsible for serving 100 Most Vulnerable Children (MVC) spread over three villages that are between 2 and 8 kilometers from her home. She is expected to visit 57 households once each month.

Today she is visiting Msichana (age 7) and her younger sister, Zoke (age 3). She began visiting them just after their mother died about 1 year ago. Their father had passed away due to AIDS a few years earlier. The girls, both civilly registered, are now cared for by their paternal uncle Thomas and Aunt Jasmine, who are their legal guardians. This young couple both age 26 already had six of their own children (ages 3-10). The family lives in a two-room mud thatched house with their paternal grandfather. While the house is in fairly good condition, during her previous visit, Lucy noticed that the roof was leaking near where the children slept. She had reported this to the community committee last month. Today she is hoping that repairs have been made. In recent months Lucy has been able to provide the family with 2 mosquito nets, and a Community Health Care Card which provides free services for up to 5 children. Lucy had also arranged for monthly food rations for the two girls who are small for their age.

Since she has been visiting the family, Lucy has become aware of how difficult it is for Thomas and Jasmine to care for all these children. She has asked them about their desired family size, and they have replied that these things are in the hands of God. Thomas and Luke (age 10) do most of the farming while Jasmine occasionally works at a food kiosk.

When Lucy arrives the family has just finished eating their porridge. Today she notices that Zoke's hair has a dull orange tint. Jasmine shares her worry that as the dry season approaches, it is increasingly difficult to serve more than one meal a day.

Msichana is playing with the other children, while Zoke is sitting off to the side watching. Lucy greets the girls and asks them how they are doing. Msichana smiles and responds, but Zoke remains silent as she has in past visits. Lucy asks another question to draw her out, but Zoke looks at the ground and Msichana answers for her.

Knowing that Msichana is not enrolled in school, Lucy explains to Msichana that she is eligible to go to school and that she can get help to stay in school, such as a backpack, a uniform, and notebooks. Jasmine is listening, and though she is relieved that Msichana will be going to school, she also thinks of Luke who does not attend school with his 3 younger brothers because she and Thomas cannot afford the school fees.

Lucy reviews the health card and asks whether either girl was ill since her last visit. Jasmine replies that they have not been ill, but that she tried to use the card when Luke was ill. She took him to the clinic, but payment was required and they left

without treatment. Lucy has to explain that only Msichana and Zoke are registered on the card; the other 3 spots (for free care) are for 3 other vulnerable children being cared for by a neighboring family. Jasmine sighs at this news, but does not reply.

On the way out, Lucy notices that the roof has been fixed. She notes this on the home-visit form and further notes that Msichana is to receive educational support services. She wishes she could do more for the family and hopes that what she has done is “good enough”.

Once they have read the case, a two-part exercise walks participants through a series of steps that allows them to develop skills in the following areas:

- 1) Become more familiar with Child Status Indicators and tools and use them for evaluation during a household visit.
- 2) Explore the value of CSI for case management.
- 3) Use information about the service as it should be (standards) and as it is (actual practice) to determine what actions might be taken for improvement.
- 4) Develop a plan of action for improvement and select indicators that can be used to monitor change.

This Case Study is an excellent way for participants to review what they have learned and relate it to the daily realities of the programs they implement.

Facilitators may also choose to use the story of Lucy and her household visit (as well as the case of Tarisai, described at the beginning of this guide), as a way to frame an open-ended discussion about the issues and challenges that face OVC programs as they try to improve quality.

Participants can discuss questions such as, “What aspects of care are working well?” “What areas need improvement?” “Is the service standard being implemented correctly?” “Is the service standard itself adequate to the real situation?” or, perhaps most importantly, “What can be done to be sure that the desired outcomes for this child/these children are achieved?”

Whether used as a structured exercise or as the basis for a more open discussion, this case study (and the Tarisai case as well) provides a helpful learning tool. After exploring many powerful ideas about quality, these cases bring the group’s focus back to the point of service delivery and the important task of making a difference for children.

Part IV: The Relationship of Monitoring and Evaluation (M&E) to QI

The Role of Measurement and Indicators in Quality Improvement

In addition to any ad hoc data that might be collected to see if changes implemented to improve services to children have resulted in improvement, routine monitoring and evaluation is critical to program improvement. It will be necessary to collect information on a routine basis to verify that guidelines are implemented correctly and to provide a knowledge base for periodic evaluation and revision of the standards. The information collected should be directly linked to the quality standards developed in each specific context. Through the QI process, countries or programs define their desired outcomes and measurable goals. Indicators should be developed and defined based on the standards for each service. Each service should have, at minimum, an output and outcome indicator; however, it may be necessary to have additional indicators depending on the nature of the service being monitored. The type of information collected will also depend on the size and technical capacity of the organization. Information sources will include program records; observations; and interviews with staff, caregivers, and children. Some indicators may be explicit, specifying objective criteria, while others may be implicit, relying on the observer's judgment.

Selecting indicators involves careful consideration about what information is really needed, as well as what can be collected reliably without placing an undue data collection burden on staff. The data collected should be usable by the staff for program evaluation and management. Indicators that are not useful for these purposes should be eliminated. Data systems can be designed so that data are collected and compiled at various levels in a pyramid structure; that is, the details of care would be monitored by the provider, who also collects the indicator data; supervisors would review and compile those data; and then the data are compiled across the organization and reported as monitoring and evaluation indicators for the organization.

In addition to selecting indicators that correspond to service standards, it will be necessary to agree on performance thresholds or targets. Thresholds define acceptable performance levels at a given time. While there may be a temptation to set ideal thresholds for performance, doing so can lead to frustration for service providers who may feel they have failed if the ideals are not reached. Setting achievable goals and then gradually increasing the threshold as program capacity permits is likely a better strategy. If the threshold is revised routinely so that providers do not become complacent, this can be an effective way to improve services. For example, an implementing partner that has been handing out school uniforms could decide to expand services to include monitoring school attendance. Depending on the size of the service area, the partner may decide to verify the attendance of 50% of the children served during the coming three months. In subsequent quarters that threshold could be raised until all children are being monitored for school attendance.

How is this different from data that we collect to report to donors and ongoing M&E efforts? QI indicators should be incorporated into a comprehensive M&E framework that includes data collection for all purposes. The reporting required by donors such as PEPFAR generally focuses on output measures such as the number of services delivered or beneficiaries reached, etc. This reporting is related to utilization of services or coverage. It characterizes the

scope and scale of services, but does not always sufficiently reflect the extent to which the needs of children and families are met. Adding output and outcome indicators which monitor the implementation of standards and quality improvements based on those standards (often a sample can be used) is key to making the M&E system more robust. Tools, such as the Child Status Index, can be used for monitoring the status of the child, but can also feed into outcome indicators in an M&E framework. Program managers can combine data on outputs with data on outcomes to evaluate the extent to which their programs are having the intended outcomes and impact.

How does this relate to the data used for formal research? Can QI data be used to validate standards? In general it is not realistic for implementing agencies to carry out sophisticated operations research studies or controlled studies. While implementing partners may participate in such activities, it would be expected that special funding would be provided and that research expertise from universities or research institutes would contribute to design and research oversight. Further, it is important to note that validation studies, while important, do not need to be carried out in every implementing agency. Like health care clinics around the world, programs for vulnerable children can base their care on a relatively small number of validation studies provided that cultural and context variables are taken into account. Findings from pilot testing of the application of standards can be used to inform validity of the service standards.

That said, implementing partners can plan for routine program evaluation, which takes data from the M&E system one step further. Analysis can be done on a smaller scale, with less rigor than operations research, to answer key programmatic questions.

Conclusion

The process outlined here for improving quality by defining service standards promises to be an effective way for stakeholders to agree on standards and guidelines for care that will allow them to implement effective programs and gather consistent information about their services. As a result, organizations and partners, together with governments and donors, will have more reliable information about how many children are served and what services they are receiving. This in turn, provides program accountability and supports policy formulation, planning, and funding decisions at the national and international levels.

This process goes beyond counting to enhancing the effectiveness, efficiency, reach, and appropriateness of the services provided by participating organizations. Working together across programs to define common goals and service standards is an excellent way to develop and spread evidence-based strategies rapidly to maximize outcomes for vulnerable children and expand coverage.

It is further hoped that the clear guidelines that result from this process will reinforce the mission of service delivery organizations, and align services and activities with desired outcomes. A quality focus can provide direct service providers at the community level with the motivation and means to provide care that is “good enough” and getting better all the time, so that vulnerable children and their caregivers can survive, thrive and move through the life cycle with resilience and hope.

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In addition to the references below, many useful documents can be accessed directly through www.OVCsupport.net, a web site serving the OVC community. A page on that web site for the Quality Improvement Initiative for OVC Programs became operational in June 2008.

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Appendix A: Description of Core Services

1. Food and nutrition programs aim to ensure that vulnerable children have nutritional resources similar to those of other children in their communities. Conceived of as a time-limited strategy, these programs should aim to leverage other partners and identify more sustainable solutions. Depending on the context, the range of services might include: 1) child level: nutritional assessment and counseling, supplementary feeding, and links to other health and nutrition interventions; 2) caregiver/family level: training on nutrition, diet, and food preparation; 3) community level: community-based strategies to support vulnerable children, including gardens, feeding programs, etc., and 4) systems level: policy development, regional and national coordination, technical assistance to the food industry, and advocacy.

2. Shelter and care services have the desired outcomes of ensuring that no child goes without shelter, clothing, access to clean safe water or basic personal hygiene and that children have at least one adult who provides them love and support. Depending on the context, services might include: 1) child level: identifying potential caregivers prior to parent death, reintegration of children in institutional care, transitional care, and support of child-headed households; 2) caregiver/family level: assisting with reunification to take children off streets, referral to programs that provide incentives for adoption, and foster care, 3) community level: support of family-based care with home visits and other strategies, developing innovative community alternatives when family-based care is not an option; and 4) system level: policy development, regional and national coordination, education, anti-stigma efforts, and monitoring of institutional care when needed.

3. Protection services have the desired outcomes of reducing stigma and social neglect as well as ensuring access to basic rights and services and protecting children from abuse and exploitation. Depending on the context, the range of services might include: 1) child level: assisting with birth registration and inheritance claims, preventing sibling separations, removing children from abusive situations, 2) caregiver/family level: support with parenting and care-giving responsibilities, assisting with access to available services, and 3) community level: support for child protection committees, training members of the community to identify and assist children needing assistance; 4) systems level: legal and policy development and social marketing campaigns to support values that protect children.

4. Health care services have the desired outcomes of meeting the health needs of children according to their age, providing primary care, immunization, treatment for children when they are sick, ongoing treatment for HIV-positive children, and HIV prevention. Depending on the context, the range of services might include: 1) caregiver/family level: teaching caregivers to effectively monitor health and seek care appropriately, involving caretakers in HIV prevention education and 2) community: training providers of HIV/AIDS care, including community volunteers, to refer children in family/household for health and social services as appropriate, and 3) systems level: policy development to ensure access and a service delivery model that meets the needs of vulnerable children.

5. Psychosocial support services have the desired outcomes of ensuring that children have the human attachments necessary for normal development and that children can participate cooperatively in activities such as school, recreation, and work with other children and adults. Services include support in dealing with anxiety, grief, and trauma related to parental illness and death, and services to prevent and treat alcohol and drug abuse. Depending on the context, services might include: 1) child level: activities that support life skills and self-esteem, activities

that strengthen the connection between child and traditional social networks, counseling for children, rehabilitation for children who abuse drugs or alcohol; 2) caregiver/family level: parenting and communication skills for caregivers, support during illness (assist with disclosure of information, grief management, succession planning, preserving memories, etc.) and 3) community level: increasing community understanding of psychosocial needs of vulnerable children 4) system level: providing trained counselors within school systems to identify at-risk children in need of psychosocial support (for example).

6. Educational and vocational training services have the desired outcomes of ensuring that vulnerable children receive educational and vocational opportunities in accord with community norms and market-driven employment options. Further, they aim to ensure that school programs at all levels take into account the special needs of vulnerable children in terms of sensitizing teachers to identify signs of distress, promoting the availability of support groups and counseling services, supporting efforts to make curricula more flexible and responsive, and supporting anti-stigma programs. Services might include: 1) child level: school registration initiatives, direct assistance to subsidize school costs, creating early childhood development programs, and access to vocational training and employment; 2) caregiver level: training health providers and caregivers to identify and refer children who are not in the educational system, anti-stigma campaigns; 3) community level: community mobilization and advocacy related to increasing access and developing appropriate curricula (introduction of life skills and job skills); and 4) systems level: support services (fee-waivers, referral to psychosocial support, tutoring, etc.)

7. Economic strengthening services have the desired outcome that families can meet their own needs economically, in spite of changes in the family situation due to HIV/AIDS. Depending on the context, services could include: 1) child/caregiver/family level: vocational training for caregivers, income-generating activities involving small business, agriculture, household labor-saving devices, access to credit; 2) community level: community-based child care, community-based asset building, 3) systems level: government-supported guarantees for income-generating activities and microfinance institutions.

Source: Orphans and Vulnerable Children Programming Guidance, Office of the U.S. Global AIDS Coordinator, PEPFAR, 2006.

Appendix B: Child Status Index and Record

CHILD STATUS INDEX (CSI)

8DOMAIN	1— FOOD AND NUTRITION		2— SHELTER AND CARE		3—PROTECTION	
	1a. Food Security	1b. Nutrition & Growth	2a. Shelter	2b. Care	3a. Abuse and Exploitation	3b. Legal Protection
GOAL	<i>Child has sufficient food to eat at all times of the year.</i>	<i>Child is growing well compared to others of his/her age in the community.</i>	<i>Child has stable shelter that is adequate, dry, and safe.</i>	<i>Child has at least one adult (age 18 or over) who provides consistent care, attention and support.</i>	<i>Child is safe from any abuse, neglect or exploitation.</i>	<i>Child has access to legal protection services as needed.</i>
Good = 4	Child is well fed, eats regularly.	Child is well grown with good height, weight and energy level for his/her age.	Child lives in a place that is adequate, dry and safe.	Child has a primary adult caregiver who is involved in his/her life and who protects and nurtures him/her.	Child does not seem to be abused, neglected, do inappropriate work or be exploited in other ways.	Child has access to legal protection as needed.
Fair = 3	Child has enough to eat some of the time, depending on season or food supply.	Child seems to be growing well but is less active compared to others of same age in community.	Child lives in a place that needs some repairs but is fairly adequate, dry, and safe.	Child has an adult who provides care but who is limited by illness, age or seems indifferent to this child.	There is some suspicion that child may be neglected, over worked, not treated well or otherwise maltreated.	Child has no access to legal protection services, but no protection is needed at this time.
Bad = 2	Child frequently has less food to eat than needed, complains of hunger.	Child has lower weight, looks shorter and/or is less energetic compared to others of same age in community.	Child lives in a place that needs major repairs, is overcrowded, inadequate and/or does not protect him/her from weather.	Child has no consistent adult in his/her life that provides love, attention and support.	Child is neglected, given inappropriate work for his or her age or is clearly not treated well in household or institution.	Child has no access to any legal protection services and may be at risk of exploitation.
Very Bad = 1	Child rarely has food to eat and goes to bed hungry most nights.	Child has very low weight (wasted) or is too short (stunted) for his/her age (malnourished).	Child has no stable, adequate, or safe place to live.	Child is completely without the care of an adult and must fend for him- or herself or lives in child headed household.	Child is abused, sexually or physically, and/or is being subjected to child labor or otherwise exploited.	Child has no access to any legal protection services and is being legally exploited.

DOMAIN	4—HEALTH		5— PSYCHOSOCIAL		6—EDUCATION AND SKILLS	
	4a. Wellness	4b. Health Care Services	5a. Emotional Health	5b. Social Behavior	6a. Performance	6b. Education/Work
GOAL	<i>Child is physically healthy.</i>	<i>Child receives health care services, including medical treatment when ill and preventive care (e.g. health education, immunizations)</i>	<i>Child is happy and content with a generally positive mood and hopeful outlook.</i>	<i>Child is cooperative and enjoys participating in activities with adults and other children.</i>	<i>Child is progressing well in acquiring knowledge and life skills at home, school, job training or an age-appropriate productive activity.</i>	<i>Child is enrolled and attends school or skills training or is engaged in an age-appropriate activity or job.</i>
Good = 4	In past month, child has been healthy and active, with no fever, diarrhea or other illnesses.	Child has received all or almost all necessary health care treatment and preventive services.	Child seems happy, hopeful, and content.	Child likes to play with peers and participates in group or family activities.	Child is learning well, developing life skills and progressing as expected by caregivers, teachers, or other leaders.	Child is enrolled in and attending school/training regularly. Infants or preschoolers play with caregiver. Older child has appropriate job.
Fair = 3	In past month, child was ill and less active for a few days (1 to 3 days), but she/he participated in some activities.	Child received medical treatment when ill, but some health care services (e.g. immunizations) are not received.	Child is mostly happy but occasionally he/she is anxious, or withdrawn. Infant may be crying, irritable or not sleeping well some of the time.	Child has minor problems getting along with others and argues or gets into fights sometimes.	Child is learning well and developing life skills moderately well, but caregivers, teachers or other leaders have some concerns about progress.	Child enrolled in school/training but attends irregularly or shows up inconsistently for productive activity/job. Younger child played with sometimes but not daily.
Bad = 2	In past month, child was often (more than 3 days) too ill for school, work or play.	Child only sometimes or inconsistently receives needed health care services (treatment or preventive).	Child is often withdrawn, irritable, anxious, unhappy or sad. Infant may cry frequently or often be inactive.	Child is disobedient to adults and frequently does not interact well with peers, guardian or others at home or school.	Child is learning and gaining skills poorly or is falling behind. Infant or preschool child is gaining skills more slowly than peers.	Child enrolled in school or has a job but he/she rarely attends. Infant or preschool child is rarely played with.
Very Bad = 1	In past month, child has been ill most of the time (chronically ill).	Child rarely or never receives the necessary health care services.	Child seems hopeless, sad, withdrawn, wishes to die or wants to be left alone. Infant may refuse to eat, sleep poorly or cry a lot.	Child has behavioral problems, including stealing, early sexual activity and/or other risky or disruptive behavior.	Child has serious problems with learning and performing in life or developmental skills.	Child is not enrolled, not attending training or not involved in age-appropriate productive activity or job. Infant or preschooler is not played with.

Public Domain: Developed by support from the U.S. President's Emergency Fund for AIDS Relief through USAID to Measure Evaluation & Duke University. O'Donnell K., Nyangara F., Murphy R., & Nyberg B., 2008

Family Version of Child Status Record

Location: District _____ Ward/Division _____ Village/Neighborhood _____ Primary Caregiver's Name: (M / F) _____ # children in household: _____

Evaluator's Name or ID:	Child: M / F Age:	Child Name: Relationship to caregiver:	Child: M / F Age:	Child Name: Relationship to caregiver:	Child: M / F Age:	Child Name: Relationship to caregiver:	
I. CSI SCORES:	Date:		Date:		Date:		
Domains	Scores (Circle One)	Action taken today / comments:	Scores (Circle One)	Action taken today / comments:	Scores (Circle One)	Action taken today / comments:	
1—FOOD & NUTRITION							
1a. Food Security	4 3 2 1		4 3 2 1		4 3 2 1		
1b. Nutrition & Growth	4 3 2 1		4 3 2 1		4 3 2 1		
2—SHELTER & CARE							
2a. Shelter	4 3 2 1		4 3 2 1		4 3 2 1		
2b. Care	4 3 2 1		4 3 2 1		4 3 2 1		
3—PROTECTION							
3a. Abuse & Exploitation	4 3 2 1		4 3 2 1		4 3 2 1		
3b. Legal Protection	4 3 2 1		4 3 2 1		4 3 2 1		
4—HEALTH							
4a. Wellness	4 3 2 1		4 3 2 1		4 3 2 1		
4b. Health Care Services	4 3 2 1		4 3 2 1		4 3 2 1		
5—PSYCHOSOCIAL							
5a. Emotional Health	4 3 2 1		4 3 2 1		4 3 2 1		
5b. Social Behavior	4 3 2 1		4 3 2 1		4 3 2 1		
6—EDUCATION AND SKILLS							
6a. Performance	4 3 2 1		4 3 2 1		4 3 2 1		
6b. Education/Work	4 3 2 1		4 3 2 1		4 3 2 1		
Source(s) of information: (Circle all that apply.)	Child, Parent/Caregiver, Relative, Neighbor, Teacher, Family Friend, Community Worker, Other: _____		Child, Parent/Caregiver, Relative, Neighbor, Teacher, Family Friend, Community Worker, Other: _____		Child, Parent/Caregiver, Relative, Neighbor, Teacher, Family Friend, Community Worker, Other: _____		
II. IMPORTANT EVENTS: (Check any events that have happened since last CSI assessment if applicable.)	<input type="checkbox"/> Child left program <input type="checkbox"/> Child pregnant <input type="checkbox"/> Child died <input type="checkbox"/> Parent ill <input type="checkbox"/> Parent/guardian died (specify: _____)		<input type="checkbox"/> Family member died <input type="checkbox"/> Change in caregiver/adoption <input type="checkbox"/> Change in living location <input type="checkbox"/> Community trauma (Violence, famine, flood, etc. _____) <input type="checkbox"/> Other: _____		<input type="checkbox"/> Child left program <input type="checkbox"/> Child pregnant <input type="checkbox"/> Child died <input type="checkbox"/> Parent ill <input type="checkbox"/> Parent/guardian died (specify: _____)		
III. TYPES OF SUPPORT / SERVICES PROVIDED (at present):	What was provided?	Who provided services? (E.g. NGO, neighbor, teacher, church, or other.)	What was provided?	Who provided services? (e.g., NGO, neighbor, teacher, church, or other.)	What was provided?	Who provided services? (e.g., NGO, neighbor, teacher, church, or other.)	
a. Food & nutrition support (such as food rations, supplemental foods)							
b. Shelter & other material support (such as house repair, clothes, bedding)							
c. Food & nutrition support (such as food rations, supplemental foods)							
d. Shelter & other material support (such as house repair, clothes, bedding)							
e. Care (caregiver received training or support, child placed with family)							
f. Protection from abuse (education on abuse provided to child or caregiver)							
g. Legal support (birth certificate, legal services, succession plans prepared)							
h. Health care services (such as vaccinations, medicine, ARV, fees waived, HIV/AIDS education)							
i. Psychosocial support (clubs, group support, individual counseling)							
j. Educational support (fees waived; provision of uniforms, school supplies, tutorials, other)							
k. Livelihood support (vocational training, micro-finance opportunities for family, etc)							
l. Other:							
Suggestions for other resources or services needed.							

Child Status Record (1 child, 1 visit)

Child's Name: _____ **Age in years:** _____ **Gender:** M/F ____ **Child ID:** _____
Location: District _____ Ward/Division _____ Village/Neighborhood _____
Caregiver's Name _____ **Relationship to Child** _____

I. CSI SCORES:	Date:	Evaluator's Name or ID:
Domains	Scores <i>(Circle One)</i>	Action taken today:
1—FOOD & NUTRITION		
1a. Food Security	4 3 2 1	
1b. Nutrition & Growth	4 3 2 1	
2—SHELTER & CARE		
2a. Shelter	4 3 2 1	
2b. Care	4 3 2 1	
3—PROTECTION		
3a. Abuse & Exploitation	4 3 2 1	
3b. Legal Protection	4 3 2 1	
4—HEALTH		
4a. Wellness	4 3 2 1	
4b. Health Care Services	4 3 2 1	
5—PSYCHOSOCIAL		
5a. Emotional Health	4 3 2 1	
5b. Social Behavior	4 3 2 1	
6—EDUCATION AND SKILLS		
6a. Performance	4 3 2 1	
6b. Education/Work	4 3 2 1	
Source(s) of information: <i>(Circle all that apply.)</i>	Child, Parent/Caregiver, Relative, Neighbor, Teacher, Family Friend, Community Worker, Other <i>(Specify)</i> : _____	
II. IMPORTANT EVENTS: <i>(Check any events that have happened since last CSI assessment if applicable.)</i>	<input type="checkbox"/> Child left program <input type="checkbox"/> Child pregnant <input type="checkbox"/> Child died <input type="checkbox"/> Parent ill <input type="checkbox"/> Parent/guardian died (specify _____)	<input type="checkbox"/> Family member died <input type="checkbox"/> Change in caregiver/adoption <input type="checkbox"/> Change in living location <input type="checkbox"/> Community trauma (Violence, Famine, flood, etc. _____)
	Comment(s) if necessary:	
III. TYPES OF SUPPORT / SERVICES PROVIDED (at present):	What was provided?	Who provided services? (e.g. NGO neighbor, teacher, church, or other)
a. Food & nutrition support (such as food rations, supplemental foods)		
b. Shelter & other material support (such as house repair, clothes, bedding)		
c. Care (caregiver received training or support, child placed with family)		
d. Protection from abuse (education on abuse provided to child or caregiver)		
e. Legal support (birth certificate, legal services, succession plans prepared)		
f. Health care services (such as vaccinations, medicine, ARV, fees waived, HIV/AIDS education)		
g. Psychosocial support (clubs, group support, individual counseling)		
h. Educational support (fees waived; provision of uniforms, school supplies, tutorials, other)		
i. Livelihood support (vocational training, micro-finance opportunities for family, etc)		
j. Other:		
Suggestions for other resources or services needed.		

Appendix C: Obtaining Children’s Input for the Development of Quality Standards for OVC Services

By Lucy Y. Steinitz, PhD¹

PEPFAR OVC guidelines mandate that we actively involve orphans and vulnerable children in determining their own futures.² In the development of minimum standards for the quality of services for OVC, one way to include children’s input is to hold a Children’s Input Workshop where a select group of OVC are brought together to take a “first crack” at recommending outcomes, activities, and indicators (e.g., minimum levels and other measurements of each activity) for each of the seven PEPFAR core service areas.

Participation ought to:

- Provide children with a genuine opportunity to influence decision-making, albeit with up-front clarity about the extent and limits of their influence;
- Ensure that children are respected and able to freely express their views and ideas;
- Build self-esteem and self-confidence in children so that they feel they can contribute and air opinions that are worthy of others’ attention;
- Encourage the involvement of socially excluded groups and ensure that their voices and experiences are given equal weight in discussion;
- Foster a process of learning and discovery (both personally and collectively), enabling children to receive new information, understand what it means, and then use it and/or respond to it on the basis of their own experience;
- Be flexible, in order to respond to children’s expectations—even if they are different than anticipated;
- Promote the best interest of the child and enhance the personal development of each.

Following the Children’s Input Workshop, the adult stakeholders should modify or expand the recommendations they received from the children and then develop an implementation strategy to ensure that these quality standards will permeate all OVC activities in their country or target area.³ Variations to this approach may occur, for example, by holding several Children’s Input Workshops around the country, by involving the adult stakeholders first and then bringing the children together, etc.

¹ Lucy Y. Steinitz, PhD, Family Health International, Windhoek, Namibia, lucy@fhi.org.na. Special thanks to Dee Dee Yates and also to Patricia Williams of Pact Namibia for her input.

² There are many other reasons to promote the active participation of children:

- It makes public and organizational decision-making on children’s issues more relevant and appropriate, by ensuring that those with the direct experience of a situation are heard.
- It brings particular benefits to the poorest and most marginalized groups of children who more than most children have been excluded from the social, cultural, political, and economic life of their communities.
- It acknowledges a shift in the view of children as “beneficiaries” of adult interventions toward respect for them as “rights holders” who are key “makers and shakers” of their own destinies and communities. This is supported by the U.N. Convention on the Rights of the Child.
- It helps children prepare for the adult responsibility.

³ This process may be informed by the facilitation guide “Quality Programs for Orphans and Vulnerable Children: A Facilitator’s Guide to Establishing Service Standards” by Lori DiPrete Brown (2008).

A sample workshop agenda follows. In designing one or more Children’s Input Workshops for quality in your setting, here are some key issues to consider:

1) Selecting the Children

We recommend involving 16–35 orphans and other vulnerable children from a wide range of backgrounds. Generally, age 15–18 works best, including youngsters who are in or out of school from both rural and urban areas and who are roughly evenly divided between boys and girls. In one workshop in Zimbabwe, several children with severe disabilities added enormously to the experience. The key issue is that all the children should be able to express themselves easily in the language of the workshop.

2) Location of the Workshop

Children’s input should be treated with the same dignity and respect that would be given to that of adults, so we recommend holding the workshop in an attractive and secure setting with good food and a pleasant atmosphere. Depending on logistical and cost considerations, this may involve one or two overnights. Having evening hours available provides an opportunity for the children to learn from each other and make new friends; educational videos and various leadership-exercises may be incorporated.

3) Creating the Right Environment

Meaningful participation does not happen by accident. It requires pre-conditions that contribute to creating the right environment for children’s involvement, including:

- Requiring that everyone involved—children and adults—respect each other’s views and work together for a positive outcome;
- Understanding the child’s development and relative maturity in relation to his or her age and then using methods and approaches that respect and build on that recognition;
- Providing sensitivity and responsiveness to the context in which the children live;
- Knowing when and how to intervene to support the process, while at the same time encouraging children’s growth and development;
- Allowing sufficient time for the children to work together and develop their own recommendations;
- Explaining to the children why their participation is important, but also being clear that they have the right not to participate in all or part of the workshop; and
- Ensuring access to relevant information that is presented in a child-friendly way.

4) Older Children as Facilitators

We recommend including one young facilitator (someone with strong leadership skills who is somewhat older than the other participants) for each sub-group (representing core service areas on which you will be concentrating. These facilitators should be trained briefly before the workshops (e.g., in the early morning or the previous day) to ensure that the small group discussions are inclusive and on-track. In the small groups, they should also make sure that there are good notes that can be submitted to the Workshop Coordinator for inclusion in the final report. They may also be asked to “represent” the children’s input at the workshop to establish OVC service standards. Accompanying staff from the organizations that are bringing the children to the workshop may be used for this purpose.

5) Focus of the Discussions

The goal of the Workshop is to suggest a desired outcome and standards for four or five of the seven core service areas described in the PEPFAR OVC guidelines. You can ask the children to vote for the most important service areas, which also makes for interesting information. The vote would occur after each service area is described, e.g., by way of a short PowerPoint presentation and/or with an accompanying hand-out. Then the name of each core service area could be written on a large piece of paper and taped to the wall, and each participant would be asked to place an “X” on the four (or five) services he or she would prioritize. The winning services would be the focus of the workshop discussions. During the morning tea-time, the participants would then sign up for one of the groups, resulting in four to seven children per group.

6) A Word on Selecting Desired Outcomes

If desired outcomes have not yet been set for any of the core service areas, this should be the first topic of discussion. (If they have already been drafted, the children should have the opportunity suggest changes. Be sure to remind the children that their role is to have input into the adult discussion on the same topic and that one cannot guarantee that what they suggest is what will ultimately be adopted and implemented.) Participants should be reminded that the goal for each core service is that OVC should have the same opportunities as non-OVC children in their community.⁴ But what does that mean in concrete terms? By way of example, participants in the Children’s Input Workshop in Zimbabwe recommended the following desired outcomes in their chosen service areas:

- Education: All children should have access to quality primary school education and preferably secondary.
- Health: Medicines and health care should be easily available and affordable.
- Shelter: Housing should include an appropriate degree of privacy and hygiene for all vulnerable children, e.g., one room where boys sleep, another for girls, and another for adults.
- Food and nutrition: Children should have at least two nutritional meals a day and access to a garden.

7) Ensure the Children’s Safety

Here are some helpful tips:

- Good practice in child protection means, among other things, that all children under age 18 who are involved in consultations/meetings should be accompanied by an adult who is responsible for their safety and well-being.
- Accompanying adults should be fully briefed on their role and responsibilities before departure. (This may involve establishing a code of conduct.)
- In addition to accompanying adults, focal persons should be assigned by the meeting-organizers, as an extra safeguard for questions or concerns. The children must know the names of these focal persons and where to find them (e.g., with phone numbers) to be able to report a concern.
- Children and young people should also be briefed on child protection issues.
- Make sure someone is responsible at the meeting for collecting information about the children who are participating, specifically any special requirements and medical needs.

⁴ Although the term OVC is used here for brevity’s sake, we recommend using “youth” or “children” to indicate respect for participants.

- Each accompanying adult should have written permission from the child's guardian(s) that the child may participate in the meeting and the accompanying adult can act on the child's behalf in an emergency.
- A first aid kit should be available on site.

8) Follow the Agenda

Please look at the following sample agenda, including the options and instructions for each session. Feel free to make changes that suit your situation.

9) Final Evaluation

Be sure to include an evaluation of the workshop, if only a simple tabulation of:

- ☺ What was the best part?
- ☹ What should have been different? and
- ☹ Other comments.

Child participants should be given a certificate of appreciation and possibly some school supplies (e.g., notebooks, pens) to take home (i.e., on the way out); this is optional. It would be nice to make a group photograph and send a copy to all children afterwards.

What Next?

When holding the Workshop to Establish Service Standards for OVC, be sure to inform them of the Children's Input, by way of a hand-out, poster-board, and/or participation of the young people who facilitated to ensure that the children's messages are incorporated in the standards.

Children’s Workshop on OVC Service Standards: Sample Agenda

8:00–8:30 **Welcome/ Registration and Goals of Workshop**

8:30–9:15 **Introductions**

Participants pair up with someone new and each introduces the other. The introduction should include their names, where they are from, and “something I am proud of in my life.”

9:15–9:50 **What do we mean by “quality”?**

Overview of recommended outcomes for the seven core orphan and vulnerable children services

Use a simple PowerPoint or Overview with hand-outs

9:50–10:00 **Preparing for small group work**

Selection of four/five services participants think are most important

Signing up a group

10:00–10:20 **Tea**

10:20–11:00 **[Select either Option A or B]**

OPTION A (remain in plenary session): “Listen to Our Priorities”

If you could give every child only one thing (or one activity/service/opportunity), it would be _____

Every child has the responsibility to _____

To assist children, every other compatriot (e.g., Namibian, Tanzania, Kenyan) should _____

Each participant will be given three post-its on which to answer these questions, one per paper. Completed post-its will be grouped by staff and presented to the whole group in the afternoon.

OPTION B (in small groups): “Expanding Our Understanding of Each Service Area”

Question 1: Where can you get this service in your community?

On a piece of paper draw all the different places, people, or ways this can be fully or partially achieved. Think creatively; all ideas are welcome!

Then, for each one of these, answer the following questions:

Question 2: What prevents all children who need this service from getting it?

Question 3: What can be done to overcome the problems or obstacles you have described in Question 2?

Question 4: Who should take responsibility for solving the problem or taking away the obstacle?

11:00–13:00 **Small groups: outline**

Review the existing (recommended) outcome for your service area: Do you agree with this, or would you want to make changes? (10 minutes)

What activities could help us move toward this outcome? (Every participant gets three pieces of paper and writes on each one way that indicates whether a child in-need is getting this service. These are clustered, and the facilitator tries to pull them together such that everyone in the small group can agree on three to six indicators.) (30 minutes)

Of these activities, what are the two or three most important? (20 minutes)

What standards do you want for these activities, to show that these activities are successful? For example, how much do you want, or how should these activities be provided? (20 minutes)

Prepare a short presentation of your recommended outcome and two or three most important activities. As part of your presentation, feel free to use drama, drawings, song, etc. (30 minutes)

13:00–14:00 ☺ **LUNCH** ☺

14:00–15:30 **Short energizer and presentation of the morning sessions**

Each group should have one or two A-1 papers: the first would have the “drawing” for the Option B exercise (if this was done); the second would have the desired outcome and three major recommended activities for the service area. Additional details from that discussion should be handed in to the workshop facilitator for the final notes, but need not be presented in detail for the group as a whole (8–15 minutes per group, depending on the number of small groups and the time available.)

15:30–15:45 **Tea**

15:45–16:15 **Modifications and additions to the small group presentations**

Presentation of Option A from the morning session, if applicable

General Discussion

16:15–16:35 **Evaluation and thanks**

Presentation of certificates of appreciation

16:35–17:00 **Ending Ritual: “One thing I won’t forget about today is…”**

Each participant is asked to complete this sentence.

Group photograph (optional)

Appendix D: Resources for Workshop to Establish OVC Service Standards

Appendix D-1 Workshop Agenda

Quality Programs for Vulnerable Children: Establishing Service Standards

Date:

Objectives:

- Present methodology for developing common service standards;
- Share best practices and evidence basis for essential actions that define OVC services;
- Develop service standards for selected core services;
- Encourage refinement and adoption of new standards;
- Introduce QI strategies that can support implementation of standards.

Day 1

8:30–10:00 am	Session 1: Welcome, Introductions and Icebreaker: Making a Difference for Children
10:00–11:00 am	Session 2: Desired Outcomes and the Quality Triangle
11:00–11:15 am	Break
11:15–noon	Session 3: Quality and its Dimensions
12:00–1:00 pm	Lunch
1:00–2:00 pm	Group Exercise 1: Dimension of Quality Matrix (Worksheet 1)
2:00–3:00 pm	Session 4: Review of Best Practices and Evidence-Based Standards
3:00–4:30 pm	Group Exercise 2: Flowchart Exercise (Worksheet 2) Break during working group
4:30–5:00 pm	Session 5: Putting it all Together: Drafting a Service Standard

Day 2

8:30–10:00 am	Group Exercise 3: Drafting a Standard (Worksheet 3)
10:00–noon	Session 6: Plenary Presentation of Draft Standards
12:00–1:00 pm	Lunch
1:00–2:00 pm	Continue Session 6 Plenary
2:00–3:00 pm	Session 7: QI Strategies for Implementing Standards
4:00 pm	Planning Next Steps: Timeline for Revision and Approval of Standards
4:30 pm	Evaluation
4:45 pm	Wrap-up

Materials Recommended for Inclusion in Participant Packet:

Key Concepts Related to Service Standards for OVC (Appendix D-2)
Instructions and Worksheets for Group Exercises (Appendix D-3)
Child Status Index and Record (Appendix B)

Appendix D-2: Participant Handout: Key Concepts Related to Service Standards for OVC

Definition of Quality and the Quality Assurance Triangle

Definition of quality care for vulnerable children: The degree to which the cluster of services provided to children, families, and communities maximizes benefits and minimizes risks, so that children may grow and develop. Quality care implies the correct mix of services for each child, family, and community and is based on current best practices and indigenous and expert knowledge. Children, families, and communities play a leadership role in decisions about the care and services they receive.”

The Quality Assurance Triangle



2000 Quality Assurance Project

Appendix D-2: Participant Handout: Key Concepts Related to Service Standards for OVC

The Dimensions of Quality

Dimensions of Quality	Definition
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 resources needed to achieve the desired outcomes are minimized and the reach and impact of programs are maximized
Continuity	The delivery of ongoing and consistent care as needed, including timely referrals and effective communication among providers
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, community context, culture, or socio-economic factors.
Participation	The participation of caregivers, communities, and children in the design and delivery of services and in decision-making regarding their care.
Sustainability	The degree to which the service is designed so that it can be maintained at the community level, in terms of direction and management as well as procuring resources, in the foreseeable future

Adapted from Franco et al. (2003).

Appendix D-2: Participant Handout: Key Concepts Related to Service Standards for OVC

Dimensions of Quality Matrix: Food and Nutrition

Dimensions of Quality	Quality Characteristics for <u>Food and Nutrition</u> Desired Outcome(s): To enhance nutritional status and prevent deaths due to malnutrition among vulnerable children. CSI Measures: Food security: Child has sufficient food to sustain an active and health life at all times of the year. Nutrition and growth: Child is growing well compared to others of same age in village.
Safety	Food chain is secure. Food is free of contaminants and safe to eat. Safe and reliable water supply is available.
Access	Distribution site is convenient for recipients. Distribution occurs on schedule.
Effectiveness	Recipients consume food as intended. OVC in household realize improved nutritional status. OVC do not die of malnutrition. OVC achieve median height for weight for their community.
Technical performance	Food provided is appropriate to the setting (can be prepared easily, is nutrient rich, is acceptable to recipients, and fits climate). Families and caregivers know how to prepare the food. Nutritional education is provided. Nutritional status is monitored. Needs of breastfed and weaning children are addressed.
Efficiency	Food aid is directed to OVC most in need. Wrap-around services and more sustainable feeding solutions are identified in a timely manner.
Continuity	Referral process with health care system is in place. Care providers refer children at risk for nutritional assessment. No gaps exist in coverage or timing of food provision.
Compassionate relations	Recipients perceive that food is distributed with dignity. Service does not lead to social stigma for recipients. Counseling is carried out with respect and confidentiality.
Appropriateness	Absence of gender-based disparities in food distribution Food provided meets household need. HIV-positive mothers and pregnant women receive appropriate advice about feeding their newborns.
Participation	Caregivers and OVC participate in decisions about what they will receive and how it will be distributed.
Sustainability	Efforts are underway to find other sources of nutritional support through food programs, community gardens, etc.

Appendix D-2: Participant Handout: Key Concepts Related to Service Standards for OVC

Desired Outcomes for Core OVC Services

Core Service	Desired Outcome	CSI Measurable Goals
<i>Food and nutrition support</i>	To enhance nutritional status and prevent deaths due to malnutrition among vulnerable children.	Food security: The child has sufficient food to sustain an active and healthy life at all times. Nutrition and growth: The child is growing well compared to others of same age in village.
<i>Shelter and care</i>	No child goes without shelter, clothing, access to clean safe water, or basic personal hygiene. Children have one adult who provides love and support.	Shelter: The child has shelter that is adequate, dry, and safe. Care/attachment: The child has at least one adult who provides consistent love and support.
<i>Protection</i>	To reduce stigma/social neglect, ensure access to basic rights (birth registration, inheritance claims, and unification of siblings) and services, and protect children from abuse and exploitation.	Abuse and exploitation: The child is safe from abuse, neglect, or exploitation. Legal protection: The child has access to legal protection as needed: he or she has civil registration; protected inheritance rights; and an identified future guardian, if necessary.
<i>Health care</i>	Children receive primary care, immunization, treatment when they are sick, access to HIV testing and ongoing treatment if HIV-positive, HIV prevention.	Wellness: The child is healthy. Health services: The child has access to needed services: preventative and treatment.
<i>Psychosocial support</i>	Children have the human attachments necessary for normal development and participate cooperatively in school, recreation, and work with other children and adults.	Emotional health: The child is happy and content and has a generally positive attitude. Social interaction: The child is cooperative and enjoys participating in activities with other children and adults.
<i>Education and vocational training</i>	Children receive educational and vocational opportunities in accord with community norms and market-driven employment options.	Educational/vocational performance: The child is achieving well at home, school, job training, or work and is acquiring knowledge and skills as expected. Educational/vocational participation: The child is enrolled and attends school, vocational training, or works (appropriate for age).
<i>Economic strengthening</i>	Families can meet their needs economically, in spite of changes in the family situation due to HIV/AIDS.	-----

Appendix D-3: Instructions and Worksheets for Group Exercises

Group Exercise 1: Dimension of Quality Matrix (Worksheet 1)

Time: 1 hour

Materials: Dimensions of quality matrix (Worksheet 1), refer to list of desired outcomes

Methods: Interactive group work

Instructions for group work:

1. Note the core service, desired outcomes, and relevant CSI measures in the top of the matrix.
2. Ask group members to state quality characteristics for each dimension (some will involve more than one dimension, which can be noted). Be sure that quality characteristics are observable and measurable.
3. Once the quality characteristics have been listed, note with an underline or other indication, which ones are **ESSENTIAL** for effectiveness.

Group Exercise 2: Review of Best Practices and Flowchart to Define the Essential Actions that Define the Service (Worksheet 2)

Time: 1.5 hour

Materials: Materials related to best practices and evidence-based care for the specific core service being considered, participation of a content expert if possible, info from situation analysis.

Methods: Interactive group work

Instructions for group work:

1. Content expert or group member presents **summary of best practices** and evidence base for service under consideration. In addition to (or in the absence of this information) the group should also review the **illustrative service standards** from Appendix E or other examples provided by the facilitation team and refer to the **dimensions of quality matrix** from exercise 1.
2. Group **evaluates the relevance and applicability** of what has been presented to the local context. ***Guiding questions: Could these service standard/best practices work in our setting? What activities would have to be altered or added?***
3. Group constructs a list or flowchart of **essential activities**, in chronological/logical order, that must occur for service to be effective in the local context.
4. Once the flowchart is complete, the group can begin to make **notes about the content of care** for each activity. These notes are the building blocks of the draft standard.

Group Exercise 3: Draft Standards (Worksheet 3)

Time: 1.5 to 3 hours (depending on how much advancement and clarity were achieved in Group Exercise 2).

Materials: Editing will be easier if each group can draft on a computer. New flip charts for drafting and other materials used (model standards, illustrative standards from Appendix E, etc.) and produced in Exercise 2 (flowchart, notes, and draft standards).

Instructions for group work:

1. For each essential action in the flowchart for the service, explain what the service provider needs to do for the child and what other things need to happen for care to be complete and effective.
2. Review each step of standard to be sure that it is valid, reliable, realistic, and clear.
3. Review/cross-check ESSENTIAL quality characteristics from DIMENSIONS OF QUALITY MATRIX. Will this standards lead to the hoped for quality?
4. Questions about optimum (ideal) or minimum levels of care will arise; in order to move through the process, the group is encouraged to identify both optimal and minimum effective practice. Then, through discussion, they can determine where to set the local standard based on national policies, resources, and local realities.

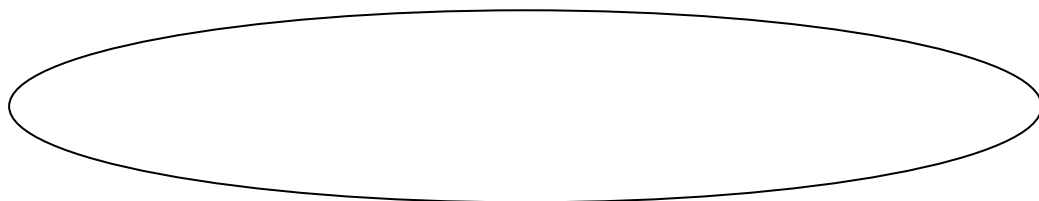
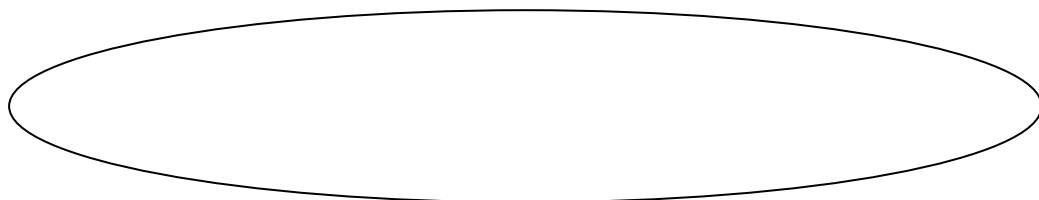
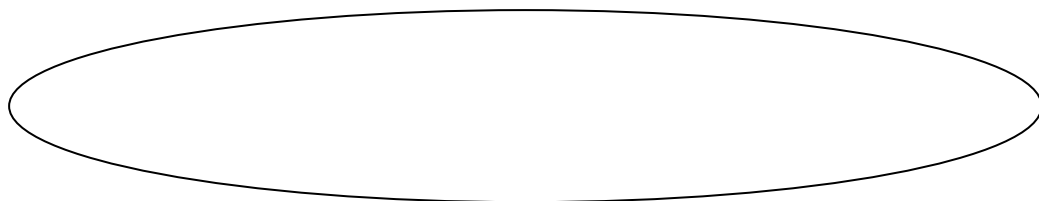
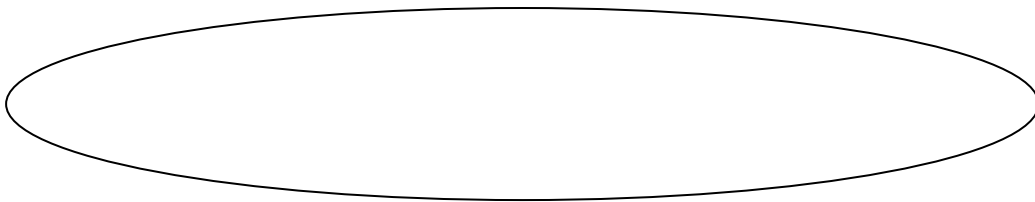
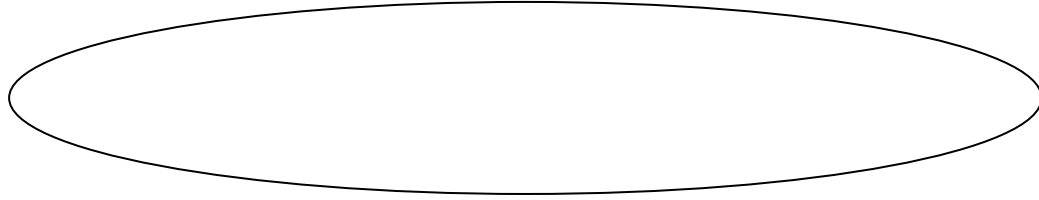
Worksheet 1: Dimensions of Quality Matrix

Dimensions of Quality	Quality Characteristics for _____ Desired Outcome: CSI Measures:
Safety	
Access	
Effectiveness	
Technical Performance	
Efficiency	
Continuity	
Compassionate Relations	
Appropriateness	
Participation	
Sustainability	

Worksheet 2: Flowchart of Service Delivery

Core Service _____

Instructions: List essential actions for service delivery in each flowchart oval. Actions should be listed in order and have a logical flow.



Worksheet 3: Template for Service Standards and Guidelines

<i>Service :</i>	
<i>Desired Outcome:</i>	<i>Measurable Goals (from Child Status Index):</i>
<i>Essential Actions that define this service</i>	
1. 2. 3. 4. 5. 6.	
<i>Essential Actions</i>	<i>Guidelines</i>
	1. 2. 3.
	1. 2. 3.
	1. 2. 3.
	1. 2. 3.
	1. 2. 3.
	1. 2. 3.
	1. 2. 3.
	1. 2. 3.
	1. 2. 3.
	1. 2. 3.

Appendix D-4: Workshop Evaluation Form

We would like your candid reaction to this workshop in order to improve the methods and materials for future use. Please answer the questions below and add any additional comments that you may have. Thank you.

On a scale from 1 to 5, please circle the number that best represents your agreement with these statements.

	Strongly Disagree			Strongly Agree	
1. This content has application to my work.	1	2	3	4	5
2. The information was presented in an understandable way.	1	2	3	4	5
3. My expectations for the workshop were met.	1	2	3	4	5

Please rate the following items using a scale where 5 = excellent; 4 = very good; 3 = good; 2 = fair; 1 = poor

4. Format (discussion, lecture, group work)	1	2	3	4	5
5. Visuals	1	2	3	4	5
6. Participant handouts	1	2	3	4	5
7. Based on your previous knowledge and experience, the level of the workshop was: <input type="checkbox"/> Too basic <input type="checkbox"/> Appropriate <input type="checkbox"/> Too complex If not appropriate, please state reasons:					

8. Please rate the appropriateness and usefulness of these sessions:					
Session 1: Welcome, introductions, and icebreaker	1	2	3	4	5
Session 2: Desired outcomes and the quality triangle	1	2	3	4	5
Session 3: Quality and its dimensions	1	2	3	4	5
Group exercise 1: Dimensions of quality	1	2	3	4	5
Session 4: Review of best practices and evidence-based service standards	1	2	3	4	5
Group exercise 2: Best practices and flowcharting	1	2	3	4	5
Session 5: Putting it all together: Drafting a service standard	1	2	3	4	5
Group exercise 3: Drafting a service standard	1	2	3	4	5
Session 6: Plenary presentation of draft standards	1	2	3	4	5
Session 7: QI strategies for implementing standards	1	2	3	4	5

Please answer the following questions on the back of this page as needed.

9. What was the most effective part(s) of the workshop?
 10. What was the least effective part(s)?
 11. What are your suggestions for improving the materials or workshop?
 12. Suggested topics and/or faculty you would like for future activities:
-

Appendix E: Illustrative Composite Standards for Core Services/Coordination of Care

- Food and Nutrition
- Shelter and Material Care
- Protection
- Health Care
- Psychosocial Support
- Education and Vocational Training
- Economic Strengthening
- Coordination of Care

The following illustrative standards are composites of standards developed by leaders in a number of African countries, based on the participatory approach set forth in this facilitator's guide. Each standard includes a statement of *desired outcome*, *measurable goals* based on the Child Status Index, *essential actions* that define the service, and *guidelines* that explain how the essential actions should be carried out. It is an important goal of this process to enable implementers in a given country to reach agreement about a *common core of essential actions* that should be carried out for each service. However, it is expected that detailed guidelines would vary somewhat by organization in order to adapt the standards to the local context. Thus, the standards provide flexibility, while assuring that consistency across programs is achieved.

Service : FOOD AND NUTRITION SUPPORT	
Desired Outcome: Children are food secure with the required nutrition in accordance to their age and circumstances.	Measurable Goals (from Child Status Index): <ul style="list-style-type: none"> • Food security: The child has sufficient food and water to sustain an active and healthy life. • Nutrition and growth: The child is growing well compared to others of same age in community.
Essential Actions that define this service: <ul style="list-style-type: none"> • Engage community leadership in terms of awareness of nutritional needs of OVC, identification of children in need, and provision of services and support. • Support sustainable food access including providing families and communities with enhanced skills for household-based agricultural production (small gardens, small scale live stock keeping). • Provide education related to nutrition, food preparation and hygiene. • Support efforts to improve water supply when appropriate. • Assess and Monitor food access including adequate nutritional intake. • Provide supplementary food when appropriate. • Refer critically malnourished children to health system. • Identify and leverage available food/nutrition resources and programs. • Integrate education on nutrition with other basic health services: immunization, IMCI and others. 	
Essential Actions	Guidelines
Community leadership <i>(ongoing)</i>	<ul style="list-style-type: none"> • Meetings with community (school, religious institutions, other organizations) to understand needs, community assets and responsibilities, and outside resources available. • Determine how community will identify service recipients (children/households) and participate in service delivery (home visits, feeding programs, gardens etc.). • Determine how partner organization will support community effort.
Monitor food security and nutritional intake	<ul style="list-style-type: none"> • Assess access to food in the household, noting overall adequacy (number of meals per day, variety of foods, etc.) as well as disparities in distribution related to age, gender, disability, or OVC status. (This can be done through a household visit or interview with caretaker and children.) • Assess access to safe drinking water at the household level. • Assess access to nutritional foods and adequate consumption.
Referral of critically malnourished children	<ul style="list-style-type: none"> • Critically malnourished children should receive immediate assistance including appropriate food or drink, information about health services, health card, and assistance with transport to emergency feeding center or health facility if needed.
Nutrition education <i>(ongoing in group settings or during household visits)</i>	<ul style="list-style-type: none"> • Educate caregivers and older children about nutrient rich local food sources, nutrition, food preparation (including how to use food supplements), food storage, basic hygiene and sanitation, signs of malnutrition, importance of breastfeeding with appropriate advice for HIV-positive mothers. Use assessment

	findings to guide content and implementation of nutrition education. Special nutritional needs of malnourished children, HIV-positive children, and those on ART included as appropriate.
Sustainable access to food	<ul style="list-style-type: none"> • Link with economic strengthening programs to address livelihoods and increasing household assets. • Support viable local food production and provision efforts (e.g., animal husbandry, urban gardens, farming skills, school-based feeding). • Ensure that family land in households affected by HIV/AIDS is being farmed by extended family or community and that vulnerable children benefit from this.
Food supplementation and feeding programs	<p>Use assessment findings to inform the following:</p> <ul style="list-style-type: none"> • Determine eligibility criteria for food supplementation, as well as guidelines for distribution with community (consult government and programmatic guidelines). • Store food in a hygienic area. • Distribute food at a safe and accessible site so that transport of food is not a burden. • Be reliable in distribution schedule. • Provide foods that are appropriate and acceptable to recipients (educate about need for flexibility in times of scarcity). • Inform recipients about schedule, foods to expect, etc. • Food is free of contaminants and safe to eat. • Recipients feel that food and meals are provided with respect, dignity and care. • Give special attention to children on ARVs, malnourished children, and infants. • Food distribution times are used as an opportunity to improve access to school, health screening and care, and other needed services when feasible. • Introduce school feeding programs when feasible in collaboration with families and communities.
Water supply	<ul style="list-style-type: none"> • Increase community understanding of the impact of diseases such as diarrhea on nutritional status of the children. • Support community efforts to procure safe drinking water when needed. • Refer families and community to area programs that can assist with improving access to safe drinking water.
Leveraging programs and services	<ul style="list-style-type: none"> • Identify providers of food, water and nutrition services in the area. • Coordinate with local/regional actors to enhance coverage and efficiency.
Integrate nutrition education in basic health programs	<ul style="list-style-type: none"> • Identify points of contacts with the children and care givers when nutrition counseling can be shared: (immunization visits, Vitamin A distribution campaign or other campaigns, IMCI, HIV/AIDS services for care givers and children).

Service : SHELTER AND MATERIAL CARE	
Desired Outcome: Child has protective shelter, clothing, access to safe water, and sanitation facilities.	Measurable Goals (from Child Status Index): <ul style="list-style-type: none"> • Shelter: The child has shelter that is adequate, dry, and safe. • Material care: Child has clothing, bedding, sanitation facilities to meet hygiene needs and protection from disease.
Essential Actions that define this service: <ul style="list-style-type: none"> • Assess the shelter and material care needs of OVC in accordance with context. • Determine existing sources for provision of shelter and material care and establish means for working together to meet gaps identified in assessment. • Monitor adequacy of shelter, clothing, hygiene and care for OVC on an ongoing basis. • Link OVC to legal services related to inheritance of family home and other property if needed. • Enlist community and outside resources to support house repair and/or construction as needed. • Link with economic strengthening efforts to support permanent, financially stable households for OVC. • Transition assistance for shelter and material care after death of a caregiver. • Advocate for and assist in transitioning children from institutional care settings or living on the street to family care setting or community-based shelter. 	
Essential Actions	Guidelines
Assess shelter and material care needs	Undertake an assessment to determine if: <ul style="list-style-type: none"> • Shelter is safe, dry and protected from the elements. • Safe water and sanitation facilities accessible for personal hygiene and protection from disease. • Child has adequate clothing to protect from environmental elements. • Child has bedding, blanket and bed nets if appropriate to the setting. • Sleeping and other arrangements afford the child privacy and safely appropriate to age and gender.
Determine existing sources	<ul style="list-style-type: none"> • Map who is providing what type of support relating to provision of shelter and material care. • Approach other providers to determine ways for working together, especially meeting gaps noted in assessment. For example, link with programs that can provide iron sheeting, bore holes, clothes or shoes. • Work with caretaker to make improvements in shelter and bringing in community and external sources as needed.
Monitor shelter and care of OVC <i>(ongoing)</i>	<ul style="list-style-type: none"> • Verify that <u>shelter</u> and material care needs are met through a home visits, observations, and interactions with child.

Legal referral	<ul style="list-style-type: none"> • If child has rights to parental property verify that legal procedures have been completed to secure inheritance. If not refer for legal assistance.
Repair and construction	<ul style="list-style-type: none"> • Work with community volunteers to do need chores or make small repairs and/or teach caretakers and older OVC to make repairs. • For larger efforts (rebuilding a house) involve community and outside agencies as needed.
Link with economic strengthening services	<ul style="list-style-type: none"> • Protect OVC existing assets so that they don't lose them. • Link OVC programs with community-based safety nets, including possible community-based insurance schemes. • Refer caretaker and older OVC to appropriate vocational or income-generating activities.
Transition assistance after caretaker death	<ul style="list-style-type: none"> • Work with households, especially children, to continue shelter and material care provision following the death of a caregiver.
Advocate and assist with transiting to family setting	<ul style="list-style-type: none"> • Communicate and educate on the importance of family care settings. • Assist with shelter and material care needs of children who are moving from streets or institutional care to family settings • Identify short-term, protective shelter for children living outside of family care. • Work with other providers to establish day shelters for children who work on the street.

Service : PROTECTION	
Desired Outcome: The child is free from physical and sexual abuse, neglect and exploitation and is legally protected.	Measurable Goals (from Child Status Index): <ul style="list-style-type: none"> • Protection: Child shows no signs of physical abuse, sexual abuse, neglect, or exploitation. • Legal rights: Child has access to legal protection services as needed, e.g., help to obtain civil registration, a legal guardian and inheritance plan if needed.
Essential Actions that define this service: <ul style="list-style-type: none"> • Support efforts to establish and implement laws and policies that protect children’s rights. • Educate families and communities to have zero tolerance for discrimination, abuse, neglect and exploitation of children. • Establish mechanisms that facilitate identification, assessment, referrals and monitoring related to protective services. • Take measures to prevent abuse by all persons in contact with OVC (i.e., project staff and volunteers; family and community members). • Build capacity among community members to identify and monitor children who are at high risk and to provide or refer them to protective services (legal and other). 	
Essential Actions	Guidelines
Laws and policies	Establish relationships with, and support as feasible, groups involved in: <ul style="list-style-type: none"> • Changing laws and policies that deny children their rights. • Enforcing laws and policies that protect children’s rights. • Free civil registration.
Service access	<ul style="list-style-type: none"> • Identify and map existing legal and other protective services (government, faith based and community). • Work with national and local stakeholders to establish legal and other protective services where critical gaps exist. • Create and annually update service directories to encourage access and referrals. • Establish mechanisms to encourage referrals and follow up between protective services and other children and family services. • Establish with stakeholders reliable, safe, and continually available means to rapidly connect children in need to protective services. <p>Work with providers of legal and other protective services to:</p> <ul style="list-style-type: none"> • Ensure accessibility for children and families with access constraints (i.e., illiteracy, mental and physical handicaps, language barriers, poverty, transport, etc.). • Plan special interventions to reach out to children at highest risk who are least likely to have access (for example, child headed households, street children, child brides). • Support interventions to remove any administrative, managerial or bureaucratic barriers that impede or significantly slow down access to protective services.

<p>Community mobilization and awareness</p>	<p>Use communication and mobilization practices that :</p> <ul style="list-style-type: none"> • Build community awareness of child rights. • Work with community leaders to publicly express support for child rights and a zero tolerance of discrimination, abuse, exploitation, disinheritance, neglect of children. • Educate children, families, general public, as well as all agencies working with children (i.e., health, education, justice) about legal and other protective services available. • Encourage community to recognize signs of abuse and neglect, to report suspected cases, and to build infrastructure to assist victims and punish perpetrators. • Educate community about the importance of civil registration, succession planning and guardianship. • Mobilize community members to actively support legal and other protective services through volunteering, fund-raising, donations, advocacy, etc.
<p>Prevent abuse, neglect and exploitation</p>	<ul style="list-style-type: none"> • Prevent circumstances that may lead to abuse, neglect, exploitation by providing (or referring) children and families to services that meet their basic need for health care, shelter, food, & clothing. • Provide (or refer for) parent/caregiver stress relief services such as respite care, support groups, household help, and counseling. • Help families to develop and expand their informal support networks, including friends, extended family, neighbors, and community members. • Provide (or refer for) parenting and caregiver training including age appropriate discipline skills. • Provide (or refer for) services to prevent neglect such as child care or daycare, night shelters, substance abuse and mental health support. • Prevent exploitation by working with (or encouraging) justice and business community to identify potential or existing exploitative situations such as worst forms of child labor, sexual trafficking and prostitution. • Work with, or encourage local groups (including schools), to make communities safer for children by 1) mapping risk areas and creating plans to reduce risks; 2) identifying and creating new communal safe spaces for children including separate spaces for adolescent girls. • Establish or encourage community child protection committees to monitor safety of children at highest risk including child-headed households, girls without female caretakers, and children living outside of family care. • Build self-protective capacity of children through gender appropriate skills training and through education about abuse.
<p>Assure that children are protected in the context of service</p>	<ul style="list-style-type: none"> • Establish a written child protection policy; and orient all staff/volunteers to the policy including any repercussions for failure to follow the policy.

<p>delivery or referral by organization or agency</p>	<ul style="list-style-type: none"> • Confirm, prior to hiring or engaging, that potential staff and volunteers that will work directly with children (especially those that have unsupervised interaction with children) do not have known offenses for abusing or mistreating children. Establish procedures for identifying and immediately dismissing persons that harm children. Verify with community members, especially children if potential or current staff/volunteers are not perpetrators. • Inform all children and families (in writing where appropriate) that they can confidentially report any questions about staff or volunteer behavior to the organization’s leadership.
<p>Build capacity of selected staff, volunteers and community members to provide (or refer for) protective services</p>	<p>Work with legal and other protection experts to build capacity of staff, volunteers and community members (especially police, teachers, health providers and others directly involved with children) through training, exchange visits, written materials, etc. to:</p> <ul style="list-style-type: none"> • Identify signs of abuse, neglect, and exploitation and circumstances where such events are more likely to occur. • Make and monitor referrals to protective services. • Facilitate access to culturally appropriate health, emotional and social support services to children who have survived abuse, exploitation, neglect. • Provide life skills training to children, particularly adolescent girls. • Support children and families in creating succession plans including naming a guardian and will-writing. • Facilitate civil registration. • Establish [or support others to] safe temporary family based solutions for children who must be removed from their homes such as emergency foster parents programs.
<p>Assess and monitor children at risk</p>	<p>Establish initial intake assessment procedure and regular monitoring mechanisms to verify that children the organization serves:</p> <ul style="list-style-type: none"> • Are free from abuse, neglect and exploitation. • Are civilly registered (birth registration). • Have a succession plan that includes a will, and the identification and agreement of a [legal] guardian, and; that this plan is being respected.

Service : ACCESS to HEALTH CARE	
Desired Outcome: Children receive preventive curative and promotive health care services as needed: primary health care, immunization, treatment when they are sick, HIV testing, ongoing care and treatment for children known to be HIV-positive, and education about HIV prevention.	Measurable Goals (from Child Status Index): <ul style="list-style-type: none"> • Wellness: The child is healthy. • Health services: The child has access to needed services: primary health care, immunizations, HIV testing, treatment as needed for children known or presumed to be HIV-positive, age-appropriate education about HIV prevention.
Essential Actions that define this service: <ul style="list-style-type: none"> • Identify/map health care services and health education opportunities for children and their caretakers. • Determine and monitor child health status and access to services (immunization, primary health care, HIV screening and treatment, curative care, health education). • Assist children and their caretakers to overcome barriers to health care access (economic, geographic, cultural, linguistic). • Provide health education at the household and/or community level. 	
Essential Actions	Guidelines
Health service mapping	<ul style="list-style-type: none"> • Work with local health authorities and communities to identify available public and non-public health care services (location, services offered, access cards, referral mechanisms, sources of medicines, and fees that may apply). • Work with local health authorities, including community health workers and volunteers, to identify sources of health promotion and health education related to nutrition, child health, living with HIV, hygiene and sanitation. • Where service gaps exist, work through regional and national committees to advocate for needed services. • Update service mapping annually. • Determine any gaps in demand and supply for child health services and actions for resolving.
Monitor health status and access to care and address barriers to health care access	Through community care coordinators, community committees or during other individual or group settings, routinely assess the following: Assessment: <ul style="list-style-type: none"> • Caretaker knowledge about where to access curative and preventive health services. • Barriers to care seeking (distance, financial, other). • Utilization of preventive services (immunization is up to date according to health card, use of malaria control nets, etc.)?

	<ul style="list-style-type: none"> • If possibly exposed to HIV (mother HIV-positive or unknown HIV status), has child been tested for HIV infection? • If known to be HIV-positive, child being monitored and taking ARV or prophylactic cotrimoxazole as indicated? • Adequate consumption of nutritional foods? (Informal assessment, based on observations). • Child ill at time of assessment? • Child showing signs of trauma or physical/sexual abuse? • Household water and hygiene conditions adequate? (water supply and storage, management of waste, etc.) • Is child satisfied with health services received? • Does the child or caretaker report barriers to care? (distance, financial, other problems with access) • Does caretaker report satisfaction with health services? • If child is 10 years or older, has child received HIV education and prevention services as needed? <p>Action:</p> <ul style="list-style-type: none"> • Staff/volunteers refer children for all appropriate health care services and follow up. • Staff/volunteers/community committees seek available solutions to barriers to care (financial, geographic, cultural etc.). • Staff/volunteers provide health education and/or refer for group education activities (nutrition, hygiene, etc.). • Resources to fill gaps in health services are sought. • If urgent care is needed at the time of assessment, staff/volunteer assists caretaker in taking child to health center. • Health care providers treat children and families with respect and confidentiality. • Staff/volunteers keep a record of services needed, addressing barriers to care, and following up during next visit. <p>Support and Supervision:</p> <ul style="list-style-type: none"> • Supervisors are available to assist staff when needed so that difficult problems are resolved. • Staff should be trained in the above tasks and receive ongoing supervision. • Implementing agency has clear policy on how frequently children should be monitored and how many visits staff is expected to do each month.
Health education	<p>Implementing organization works with community and local health authorities to offer health education in the following areas:</p> <ul style="list-style-type: none"> • Basic health care • Hygiene, water and sanitation • Nutrition • Living with HIV (age appropriate) • Malaria prevention • Sexual and reproductive health (age and gender appropriate). • HIV prevention education and services (age and gender appropriate)

Service : EDUCATION AND VOCATIONAL TRAINING

<p><i>Desired Outcome:</i></p> <p>Children enroll, attend and progress through school (pre-school, elementary, secondary and higher) and vocational or non-formal training, or an age-appropriate activity or job. Pre-school children get the stimulation they need to develop normally.</p>	<p><i>Measurable Goals (from Child Status Index):</i></p> <ul style="list-style-type: none"> • Educational/vocational participation: The child is enrolled and attends school, vocational training, or engages in age appropriate work. Pre-school children are stimulated by play. • Educational/vocational performance: The child is progressing well in acquiring skills at home, school or job training and is acquiring the knowledge and skills expected.
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<p><i>Essential Actions that define this service:</i></p> <ul style="list-style-type: none"> • Community mobilization to develop resources and capacity to support educational efforts for children vulnerable due to HIV and AIDS. • Work with the community to identify children in need of support to be able to attend school or vocational training, and pre-school children in need of special attention. • Engage schools and communities to ensure continuity of education from primary school to secondary school and higher. • Monitor early childhood development, and then enrollment, progress and retention of all children in households caring for vulnerable children, provide support as needed. • Work with communities to develop day care and pre-school opportunities where feasible. • Work with communities, including teachers and mentors, to increase their understanding of emotional stress as a barrier to learning; increase skills in providing emotional supportive learning environments for children affected/infected by HIV/AIDS. • Assess the market needs and demands regarding vocational training programs. Develop partnerships with private sector to increase vocational training opportunities for OVC. • Provide monitoring, advice and support as needed during transition from school to vocational training, and from vocational training to work. 	
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<i>Essential Actions</i>	<i>Guidelines</i>
<p>Community mobilization for education</p>	<ul style="list-style-type: none"> • Engage all stakeholders (community leaders, Parent-Teacher Associations, school administrators and teachers, agencies implementing assistance, caretakers, and children themselves) in a discussion about the educational needs and rights of all children, including the importance of early-childhood development. • Work to develop curricula that meet the need for life skills training, development of self-esteem, and knowledge of HIV prevention. • Conduct anti-stigma activities in school and community.

	<ul style="list-style-type: none"> • Work with community to ensure that schools are safe (children can travel to school safely, are free from abuse in school, building is safe, etc.) • Provide linkages to health, legal, nutritional and psychosocial services so that teachers can easily refer children to needed services. • Develop needed academic support (tutors, homework clubs etc.). • Identify resources (financial and in-kind contributions) from within and outside the community that can support education efforts. • Decide how stakeholders will evaluate their progress in meeting the educational needs of children in the community.
Identification of children in need of educational services	<ul style="list-style-type: none"> • Work with communities to identify pre-school children in need of attention and support. • Work with communities to identify school eligible children who are not enrolled in school or not attending regularly and are not gaining any non-formal education. • Work with community to determine the criteria that will be used to decide which children and families receive educational support.
Monitor enrollment and progress and provide support as needed	<ul style="list-style-type: none"> • Verify that all school-eligible children from families who are caring for vulnerable children are registered for school or receiving non-formal education. • Assist with registration as needed (provide information, help with school fees, supplies, shoes, uniform, backpacks etc.). • Determine if there are additional barriers to school attendance related to gender, disability, caretaking responsibilities for parents or siblings, or economic issues. Refer these complex situations to supervisors/social workers/school officials for assistance. • Ask child about school experience (does she like school, feel safe, treated respectfully by teachers and peers). • Address problems related to school experience with teachers and caretakers (provide training or interventions related to social integration, safety, or stigma). • Ask child/caretaker about school attendance/absenteeism, educating family about importance of regular attendance. • Assess school progress in an appropriate way (ask child/caretaker, review report card, check in with teacher). • Make family aware of available academic support activities such as homework clubs, tutors etc. • Cross-check on enrollment, attendance and progress with school records where possible. A weekly or monthly check in with school(s) can be a mechanism for early identification of children who are dropping off in attendance or performance.
Develop community-based	<ul style="list-style-type: none"> • Work with community to develop local programs for pre-school children that provide a safe environment and

<p>day care and preschool programs</p>	<p>stimulate child health and development (breakfast/play programs, day care programs or cooperatives) as well as support to caregivers with skills in caring for very young children.</p> <ul style="list-style-type: none"> • Link with beneficial activities for caretakers (group education or income generating opportunities while children are in care program). • Verify that caretakers are aware of educational/day care programs for pre-school children (if applicable).
<p>Ease transition to vocational school and work</p>	<ul style="list-style-type: none"> • Counsel all youth in household about vocational and work options available upon completion of school (begin discussions 6 months to 1 year before completion). • Make a plan for that transition with youth and caretakers. • Provide start-up support for youth who are ready to begin working (help with identifying employment opportunities or materials or funds to start a small business).

Service : PSYCHOSOCIAL SUPPORT	
Desired Outcome: Children have the human attachments necessary for normal development and participate cooperatively in school, recreation, family settings (caregivers or host families) and work with other children and adults.	Measurable Goals (from Child Status Index): <ul style="list-style-type: none"> • Emotional health: The child is happy and content and has a generally positive attitude. • The child is cooperative and enjoys participating in activities with other children and adults.
Essential Actions that define this service: <ul style="list-style-type: none"> • Strengthen family ability to support emotional and social development of children and adolescents. • Build the capacity of communities (friends, neighbors, places of worship, schools, etc.) to provide emotional and social support to children and adolescents and their caretakers. • Provide monitoring, referral and follow up for children and adolescents needing counseling by professionals or para-professionals, or other psychosocial support services. • Promote ethical practices for all who work with children so that care is appropriate in terms of gender, age, and special needs, and so that equity of care, safety concerns, and continuity of care are safeguarded. 	
Essential Actions	Guidelines
Strengthen families	<p>Provide guidance and training that enables families or caregivers to support children’s emotional and social development based on assessment of needs. Areas to assess include:</p> <ul style="list-style-type: none"> • Stages of child and adolescent development • Coping with grief and loss • Stigma associated with HIV/AIDS • Identifying signs of depression, trauma other psycho-social distress in children and adolescents • Communication skills (e.g., effective listening, involving children in decision-making) • Parenting skills (e.g., building resilience of children, accommodating gender differences in emotional and social development, constructive discipline) • Succession planning • HIV testing and HIV status disclosure • Advocating for rights of children and adolescents • Caring for children with special needs (exposed to or living with HIV, living with disabilities) • Age-appropriate guidance about sexuality, relationships, birth control. <p>Use assessment findings to inform activities to assist families and identify</p>

	<p>areas that may need additional support from the community (friends, neighbors, places of worship, schools, adult mentors, community-based organizations, counseling services).</p>
<p>Build capacity of communities to support children and families</p>	<p>Work with children and adolescents, families and community to determine areas or issues that would benefit from community support of children’s emotional and social wellbeing. Training and follow-up (supervision, coaching, mentoring) are offered to community members who have contact with children (teachers, children’s group leaders, community volunteers, and older children, as well as parents and caretakers). Training can be offered through group meetings, print materials, mass media etc. Particular attention will be given to:</p> <ul style="list-style-type: none"> • Adjusting to loss. • Verifying that contact is maintained with relatives and siblings. • Providing life skills, adult mentoring, and/or lay counseling. • Arranging for counseling and testing for children and caregivers that may have been exposed to HIV or have unknown exposure status • Providing drug and alcohol counseling/referral as needed. • Supporting children who have lived outside of family care with counseling and follow up. • Engaging communities to reflect on their roles to provide emotional support to HIV affected children and adolescents. • Engaging communities to reflect on their roles to prevent sexual exploitation of OVCs <p>Work with community members to consider group activities for children and adolescents (for example: mentorship groups, integrated life skills groups, sports clubs, overnight camps, groups oriented toward dance and the arts, faith-based youth groups, after school programs and others). These activities should:</p> <ul style="list-style-type: none"> • Be offered under the leadership of trained adult mentors • Offer the opportunity to develop friendships with peers and trusting relationship with mentors. • Increase self-esteem, self-awareness and self-expression • Build problem-solving and coping skills • Provide structure and a safe confidential way to seek help if needed • Monitor child emotional and social well-being • Be based on participatory decision-making and engagement.
<p>Monitor psychosocial status and provide referrals and follow up</p>	<p>Service providers including volunteers establish and monitor referral mechanisms whereby adult mentors, home visitors, lay counselors and others who work with children and adolescents know when, how and where to refer them or their caregivers to support programs or counseling by para-professions or professionals (social worker, psychologist or other formally trained mental health professional).</p>

Ethical practice	All staff and volunteers working with children and their families abide by a code of conduct that: <ul data-bbox="550 264 1385 546" style="list-style-type: none"><li data-bbox="550 264 1385 405">• Provides confidentiality, privacy, respect, safety and avoids stigma and discrimination. They agree to zero tolerance for physical and sexual abuse, and are compelled and supported to report such abuses if observed.<li data-bbox="550 405 1385 479">• Actively involves children in decisions that affect his or her emotional and social well-being.<li data-bbox="550 479 1385 517">• Avoids age, gender, or special needs stigma and discrimination.<li data-bbox="550 517 1385 546">• Facilitates equity and continuity of care.
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Service : ECONOMIC STRENGTHENING	
Desired Outcome: Families can meet the basic needs of all members of the household in spite of changes in the family situation due to HIV/AIDS.	Measurable Goals: <ul style="list-style-type: none"> • General household: Head of household reports that basic needs of the household are met. • Basic needs of vulnerable children: Vulnerable children in household have adequate food, clothing, shelter, and resources for fees related to education and health care.
Essential Actions that define this service <ul style="list-style-type: none"> • Map economic strengthening opportunities in community. • Work with community to identify eligible households and participants (caretakers and older children). • Work with participants and economic growth specialists to make decisions about economic strengthening strategies. • Implement vocational training, labor saving devices, small-business loan programs as indicated. • Support actual economic engagement. • Assess income before and after intervention to verify improvements. • Evaluate whether increased income is being used to meet basic needs of household, especially children in household, and if child well-being improved. 	
Essential Actions	Guidelines
Map economic strengthening opportunities in community	Work with community and economic growth programs to identify: <ul style="list-style-type: none"> • Vocational training programs • Loan and mutual aid programs • Jobs available or anticipated in area • Small business opportunities (needed goods or services) • Labor-saving devices that are context appropriate (especially related to food production/preparation, and other household tasks)
Identify eligible households and participants	<ul style="list-style-type: none"> • Work with community structures to establish criteria for selection of participants with attention to avoiding stigma or discrimination or gender inequities. • Consider all adults in household as well as older children.
Select economic strengthening strategies	<ul style="list-style-type: none"> • Consult with economic growth specialists on viable options and strategies given desired outcomes, target audience, market considerations, and context. • Participants choose the economic strengthening activities that they will participate in. • Consider his/her talents, experience, interest, goals and dreams. • Take into account market/economic viability. • Combine strategies where appropriate (for example, labor-saving devices and micro-finance).

<p>Implement vocational training, labor saving devices, loans, as indicated</p>	<p>Vocational training</p> <ul style="list-style-type: none"> • Based on market demand • Safety procedures followed • Trainers are skilled • Skills training recognized by appropriate authority <p>Small business loan programs</p> <ul style="list-style-type: none"> • Review to be sure loan program is fair and reputable. • Assure that grantee understands responsibilities and financial risks associated with loans. • May include merry-go-rounds (popular in E Africa) = mutual aid savings programs. <p>Labor saving devices</p> <ul style="list-style-type: none"> • Appropriate technology • Training for safe use • Information about maintenance and repair provided <p>Business Skills</p> <ul style="list-style-type: none"> • Money management skills training (basic recording of income and expenses) • Projecting needed resources to reinvest • Ensure that ongoing help is available. • Marketing information and assessment.
<p>Support actual economic engagement</p>	<ul style="list-style-type: none"> • Assist with identifying job opportunities. • Provide start-up resources (tools, materials, loans, seed money etc.). • Provide occupational counseling/guidance. • Assist with identifying markets for products and services.
<p>Assess income /benefit before and after intervention to verify improvements</p>	<ul style="list-style-type: none"> • Estimate weekly or monthly earnings before intervention. • Estimate weekly or monthly earnings after intervention. • Estimate time saved via labor-saving device (daily, weekly, or monthly).
<p>Evaluate whether increased income is being used to meet basic needs of household, especially children in household</p>	<ul style="list-style-type: none"> • Identify areas where basic needs are not being met before economic strengthening (insufficient food, clothing, shelter, access to health care and education). • Measure improvements in the areas of need identified before the economic intervention. • Determine if basic needs of children in the household are being consistently met. • Evaluate participant satisfaction with program. <p><i>Note:</i> Assessment methods will vary by organization; CSI measures related to food, shelter, education, health may be used.</p>

Service : COORDINATION OF CARE	
Desired Outcome: Children’s needs are met through a cluster of core services that is routinely reviewed so that they receive all needed services but no unnecessary ones.	Measurable Goals (from Child Status Index): <ul style="list-style-type: none"> • Overall Child Status: Child is in good or fair condition for measures of all six domains (food and nutrition, shelter and care, psychosocial support, education, protection, and health). • Appropriateness of service cluster: Child is receiving services in all domains where child’s status is bad or very bad. Child is NOT receiving services in domains where status is good or fair without support.
Essential Actions that define this service: <ul style="list-style-type: none"> • Map services relevant to child well-being. • Determine viability of existing or establishing community structure to oversee comprehensive service provision to include functioning referral system. • Enable community care coordinators or committees to monitor needs and age-appropriate provision of services based on prioritized needs of vulnerable children from birth up to age 18 years. • Document unavailable but needed services and identify how they may be pursued. 	
Essential Actions	Guidelines
Service mapping and referral system	<ul style="list-style-type: none"> • Service providers work together to map services. • Barriers and gaps to functioning referral system identified and strategies for addressing are implemented. • Actions are taken to avoid duplication of service provision and increase service efficiency. • Service providers meet on a regular basis to review referral system and make needed changes.
Assess viability of Community structure	<ul style="list-style-type: none"> • Consult community members to determine ability of existing structures to assist with assessing and prioritizing needs and monitoring coordination of service provision to household caring for vulnerable children. • Strengthen local structures as needed or work with community to establish coordinated care structure.
Monitor needs and provision of coordinated services	<p>Community care coordinators or committees are supported to:</p> <ul style="list-style-type: none"> • Develop and implement protocol for engaging caregivers and children in prioritizing their needs and evaluating satisfaction with and effectiveness of services. • Establish a system for assessing and monitoring the needs of vulnerable children to include food and nutrition security, household economic stability, health status, school enrollment and completion, adequate shelter, protection, and emotional and social stability. • Assess well-being of caregivers to determine need for education or social support or economic strengthening.

	<ul style="list-style-type: none">• Verify with recipients that services received are satisfactory, effective, and reflect gender equity.• Verify referral system or service provider coordination is functioning to meet demand and when not have ability to mobilize or seek resources to make needed improvements.• Determine how unavailable but needed services can be pursued and, as opportunities arise, take steps to advocate for their availability.• Ensure continuity of care, especially during times of transition (for example, project or external supports ending, death or illness in household, migration of household members).
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Appendix F: Case Study on Monitoring and Improving Quality of OVC Services

This case study will use a single case to provide hands-on experience in evaluating outcomes and services delivered – i.e., the Child Status Index tool, and in applying QI techniques to examine the process of care provided, determining improvements to test and monitor results. The Facilitator’s version is below, followed by a participant’s version.

FACILITATOR’S VERSION (with responses in italics)

Learning objectives of the case:

Knowledge:

- CSI indicators and record sheet, and how to use them to evaluate a child
- Importance of outcomes in focusing improvement efforts
- Value of CSI in monitoring and for case management of children
- Role of data in improving quality (not just for assessing quality and outcomes, but also for verifying whether actions taken are effective)
- Role of children/youth, family, community and workers on the front line in improvement efforts
- Every system is perfectly designed to achieve the results it achieves – improvement requires change

Skills:

- How to evaluate a child using the CSI
- How to use that information to make decisions about where to focus quality improvement efforts
- How to determine *who* needs to be involved in an improvement effort (teamwork)
- How to examine a current OVC service delivery process in light of standards and determine specific areas for improvement focus
- How to develop an action plan and indicators for improvement

Materials needed:

1. Case study for participants (parts 1 and 2)
2. CSI tool and toolkit
3. Flipchart and markers for each group
4. Standards developed for each of the 3 service areas covered in case, including flow chart of major steps (like the example for education in the Facilitators’ tool)

Instructions: Participants are asked to imagine they are working together in a non-governmental organization (NGO) that aims to address the needs of vulnerable children, and are confronted with the situation described below and are trying to figure out HOW to improve the quality of OVC service. Participants are to stay in this role throughout the entire exercise, acting as people in the process, not as external evaluators.

Lucy Mbele is a volunteer home visitor with your NGO. She is responsible for following up on children identified by the Most Vulnerable Children (MVC) committee in her village.

Today she is visiting Msichana (age 7) and her younger sister, Zoke (age 3). She began visiting them just after their mother died about 1 year ago. Their father had passed away due to AIDS a few years earlier. The girls are now cared for by their paternal uncle Thomas and Aunt Jasmine. This young couple both age 26 already had six of their own children (ages 3-10). The family lives in a two-room mud thatched house with their paternal grandfather. While the house is in fairly good condition, during her previous visit, Lucy noticed that the roof was leaking near where the children slept. She had reported this to the MVC committee last month. Today she is hoping that repairs have been made. In recent months Lucy has been able to provide the family with two mosquito nets, and a Community Health Care Card which provides free services for up to five children. Lucy had also arranged for monthly food rations for the two girls who are small for their age.

Since she has been visiting the family, Lucy has become aware of how difficult it is for Thomas and Jasmine to care for all these children. She has asked them about their desired family size, and they have replied that these things are in the hands of God. Thomas and Luke (age 10) do most of the farming while Jasmine occasionally works at a food kiosk.

When Lucy arrives the family has just finished eating their porridge. Today she notices that Zoke's hair has a dull orange tint. Jasmine shares her worry that as the dry season approaches, it is increasingly difficult to serve more than one meal a day.

Msichana is playing with the other children, while Zoke is sitting off to the side watching. Lucy greets the girls and asks them how they are doing. Msichana smiles and responds, but Zoke remains silent as she has in past visits. Lucy asks another question to draw her out, but Zoke looks at the ground and Msichana answers for her.

Knowing that Msichana is not enrolled in school, Lucy explains to Msichana that she is eligible to go to school and that she can get help to stay in school, such as a backpack, a uniform, and notebooks. Jasmine is listening, and though she is relieved that Msichana will be going to school, she also thinks of Luke who does not attend school with his three younger brothers because she and Thomas cannot afford the school fees.

Lucy reviews the health card and asks whether either girl was ill since her last visit. Jasmine replies that they have not been ill, but that she tried to use the card when Luke was ill. She took him to the clinic, but payment was required and they left without treatment. Lucy has to explain that only Msichana and Zoke are registered on the card; the other three spots (for free care) are for three MVC being cared for by a neighboring family. Jasmine sighs at this news, but does not reply.

On the way out, Lucy notices that the roof has been fixed. She notes this on the home-visit form and further notes that Msichana is to receive educational support services. She wishes she could do more for the family and hopes that what she has done is "good enough".

CASE EXERCISE

PART 1: Evaluating outcomes and services – Using the Child Status Index (1 hour)

A. Filling in the Child Status Index report form

- 1) At your seat, based on the CSI indicators sheet, evaluate the children Lucy is visiting today and fill in the Child Status Report form.

B. Using the Child Status Index to evaluate children

- 1) Move to your groups. Give your scores to the Facilitator to put on a flip chart
As participants move into the room, place their scores on a flip chart so that you have all the scores in one place.

- 2) Using the scoring of the Child Status Index, list as a group which scales reflect areas needing addressing.

Ask the participants to look at the results, and without paying attention to variation in the scores among participants, ask them to identify which areas are ones of NEED for this family. (See example of filled-out CSI form “cheat sheet” below.)

C. Examining the process of using the Child Status Index

- 1) Did everyone agree on all the scores? Why or Why not?

Looking for scores with variation among participants, ask participants to explain why there are differences.

Highlight those that might be:

- *due to the fact that this is a case study and therefore maybe participants are making different assumptions where the facts are not complete enough [which might not be the case in a real home visit where Lucy would be observing more than might be written in the case description]. We do not have the opportunity to ask questions for clarification.*
- *due to possible variation in understanding of the scoring system itself and the definitions of the various levels.*

- 2) Were there scales you felt you could not assess? What questions could you have asked to be able to assess those scales? (See Facilitator’s Guide, Appendix A for ideas.)

Ask participants to identify scales they had difficulty assigning scores because they did not have enough information (from the case). What would they have liked Lucy to have asked or observed? Use the Appendix 1 of the CSI Toolkit (page 23) for more ideas.

- 3) What “Important Events” did you check? *SEE CHEAT SHEET*

- 4) What services did you list as being provided? *SEE CHEAT SHEET*

D. Using the Child Status Index for decision making regarding services

- 1) Based on the scores/assessment of the current status of the children, what services do you think Lucy should be providing? ***Get feed back from group. Any area scored with a “2” or “3” should be addressed. A score of “1” needs to be observed and possibly addressed. Discussion could include suggestions for actual activities of service delivery***

Family Version of Child Status Record

Location: District _____ Ward/Division _____ Village/Neighborhood _____ Primary Caregiver's Name: (M) (F) Jasmine # children in household: 8 - 6 of their own, 2 nieces

Evaluator's Name or ID: <u>Lucy</u>	Child: M (F) <u>(F)</u> Age: <u>7</u>	Child Name: <u>Muchana</u> Relationship to caregiver: <u>niece</u>	Child: M (F) <u>(F)</u> Age: <u>3</u>	Child Name: <u>Zoke</u> Relationship to caregiver: <u>niece</u>	Child: M (F) <u>(M)</u> Age: <u>10</u>	Child Name: <u>Luke</u> Relationship to caregiver: <u>brother son</u>
I. CSI SCORES:						
Date:		Date:		Date:		Date:
Scores (Circle One)		Action taken today / comments:		Scores (Circle One)		Action taken today / comments:
1—FOOD & NUTRITION						
1a. Food Security		4 3 <u>(2)</u> 1 Limited in dry season		4 3 <u>(2)</u> 1 Limited in dry season		4 3 <u>(2)</u> 1 same
1b. Nutrition & Growth		4 3 <u>(2)</u> 1 Small for age		4 3 2 <u>(1)</u> Small for age, hair orange tint		4 3 2 1 ? Didn't see child.
2—SHELTER & CARE						
2a. Shelter		4 <u>(3)</u> 2 1 Recent roof repair but crowded		4 <u>(3)</u> 2 1 Recent roof repair but crowded		4 <u>(3)</u> 2 1 same
2b. Care		4 <u>(3)</u> 2 1		4 <u>(3)</u> 2 1		4 3 2 1 ? No discussion
3—PROTECTION						
3a. Abuse & Exploitation		<u>(4)</u> 3 2 1		<u>(4)</u> 3 2 1		4 <u>(3)</u> 2 1 Is working when should be in school
3b. Legal Protection		<u>(4)</u> 3 2 1		<u>(4)</u> 3 2 1		<u>(4)</u> 3 2 1
4—HEALTH						
4a. Wellness		<u>(4)</u> 3 2 1		<u>(4)</u> 3 2 1		4 <u>(3)</u> 2 1 He was working today so he must be better
4b. Health Care Services		<u>(4)</u> 3 2 1		<u>(4)</u> 3 2 1		4 3 2 <u>(1)</u>
5—PSYCHOSOCIAL						
5a. Emotional Health		<u>(4)</u> 3 2 1		4 3 <u>(2)</u> 1 Very withdrawn		4 3 2 1 ?
5b. Social Behavior		<u>(4)</u> 3 2 1		4 3 <u>(2)</u> 1 Does not play or speak to others		4 3 2 1 ?
6—EDUCATION AND SKILLS						
6a. Performance		4 <u>(3)</u> 2 1 She was playing with others		4 3 <u>(2)</u> 1 Only watches. Does not participate.		4 3 2 1 ?
6b. Education Work		4 3 2 <u>(1)</u> Need to enroll in school		4 3 <u>(2)</u> 1		4 3 2 <u>(1)</u> Not in school - help get to school
Source(s) of Information: (Circle all that apply.)						
<u>(Child, Parent, Caregiver)</u>		<u>(Child, Parent, Caregiver)</u>		<u>(Child, Parent, Caregiver)</u>		<u>(Child, Parent, Caregiver)</u>
II. IMPORTANT EVENTS:						
(Check any events that have happened since last CSI assessment if applicable.)						
<input type="checkbox"/> Child left program <input type="checkbox"/> Child pregnant <input type="checkbox"/> Child died <input type="checkbox"/> Parent III <input checked="" type="checkbox"/> Parent/guardian died (specify: _____)		<input type="checkbox"/> Family member died <input checked="" type="checkbox"/> Change in caregiver/adoption <input type="checkbox"/> Change in living location <input type="checkbox"/> Community trauma (Violence, Famine, flood, etc. _____) <input type="checkbox"/> Other: _____		<input type="checkbox"/> Child left program <input type="checkbox"/> Child pregnant <input type="checkbox"/> Child died <input type="checkbox"/> Parent III <input checked="" type="checkbox"/> Parent/guardian died (specify: _____)		<input type="checkbox"/> Family member died <input checked="" type="checkbox"/> Change in caregiver/adoption <input type="checkbox"/> Change in living location <input type="checkbox"/> Community trauma (Violence, Famine, flood, etc. _____) <input type="checkbox"/> Other: _____
Comments (if necessary)						
III. TYPES OF SUPPORT / SERVICES PROVIDED (at present):						
What was provided?		Who provided services? (E.g. NGO, neighbor, teacher, church, or other.)		What was provided?		Who provided services? (E.g. NGO, neighbor, teacher, church, or other.)
a. Food & nutrition support (such as food rations, supplemental foods)		Food ration ngo		same		same
b. Shelter & other material support (such as house repair, clothes, bedding)						
c. Food & nutrition support (such as food rations, supplemental foods)						
d. Shelter & other material support (such as house repair, clothes, bedding)		Home repair Community committee		same		same
e. Care (caregiver received training or support, child placed with family)						
f. Protection from abuse (education on abuse provided to child or caregiver)						
g. Legal support (birth certificate, legal services, succession plans prepared)		Civil reg. etc Ngo?		same		
h. Health care services (such as vaccinations, medicine, ARV, fees waived, HIV/AIDS education)		Bed nets, health card ngo		same		
i. Psychosocial support (clubs, group support, individual counseling)						
j. Educational support (fees waived; provision of uniforms, school supplies, tutorials, other)						
k. Livelihood support (vocational training, micro-finance opportunities for family, etc)						
l. Other:						
Suggestions for other resources or services needed.		Health access for other children, school support, family planning		Needs nutritional and psychological assessment		Needs health card and school support.

CASE EXERCISE

PART 2: Improving the process (1 hour)

A. Clarifying what you want to improve

1) Examining the results of your evaluation of the children using the child status index (outcomes and services delivered), brainstorm with the group a list of good practices (i.e., in favor of quality) and a list of practices that could be improved (opportunities to improve quality).

Good practices	Practices that could be improved
<ul style="list-style-type: none"> • <i>Lucy follows up on whether the community committee repaired the roof</i> • <i>Lucy has ensured the two children have a health care card and mosquito nets</i> • <i>Lucy has arranged monthly food rations</i> • <i>Lucy asks about family size (family planning)</i> • <i>Lucy notices nutritional status indicators (small size; orange tint to hair)</i> • <i>Lucy gets information about how many meals the children are eating</i> • <i>Lucy tries to engage each child</i> • <i>Lucy discusses education and is arranging for education services</i> • <i>Lucy asks about the girls' health status</i> 	<ul style="list-style-type: none"> • <i>Lucy does not take into account the other "vulnerable* children" in the family, such as Luke</i> • <i>Lucy does not address the fact that Zoke clearly has signs of kwashiorkor – neither referral nor nutritional counseling</i> • <i>Although the children should be getting food rations, Lucy does not follow up on whether the family is receiving them or how they are being used (given Zoke's state)</i> • <i>Lucy does not address the psychosocial needs of Zoke who is showing signs of withdrawal</i> • <i>Lucy does not address the issues that school fees might also present a problem for Msichana to be in school</i> • <i>Lucy does not address the issue of Luke not attending school</i> • <i>Lucy does not address the issue of possible exposure to HIV of these children whose parents both died of AIDS</i>

*Vulnerable because they are living in a household fostering HIV/AIDS-affected children

2) From your list of opportunities to improve, choose, as a group, one of the service areas listed below for your group to focus on in this case study. Review the standards for that service area that are in Appendix E of the Facilitators' Guide.

Possible areas for improvement:

- *Education*
- *Food security and nutrition*
- *Psychosocial support*
- *Economic strengthening*

3) For the service area you have chosen, develop one improvement objective, referring to the Child Status Index to choose the appropriate "goal".

Examples of improvement objectives:

1. **Food Security** *Child has sufficient food to eat at all times of the year.*

2. **Nutrition & Growth** *Child is growing well compared to others of his/ her age.*
3. **Social Behavior** *Child is cooperative and enjoys participating in activities with adults and other children.*
4. **Education** *Child is enrolled and attends school or skills training, or is engaged in an age-appropriate productive activity or job. Infant or preschooler is stimulated by play with caregiver.*

B. Determine what changes are needed to be able to follow the standards

1) For the OVC service area you have chosen to focus on, using the composite illustrative standards from Appendix E in Facilitators' Guide, place the *Desired Outcome* in the first row. Place the CSI goal in the second row.

List out the ***essential actions for service delivery*** (relevant for the children in this household) in third row/first column of Table 1. Place only one ***essential action*** in each box. Go back to the details in the case study and describe the actual practice used by your field worker in second column related to each essential action.

2) Refer again to the illustrative standards from the facilitators guide. Compare the guidelines for care that relate to each essential action from the standards to actual practice. Which essential actions are most problematic? Mark the problematic activities with a circle. For each problematic action, chose one *change* in the way things are currently done that would move you towards the standard.

Participants can use the essential actions for service delivery from the Illustrative Composite Standards in Appendix E. to compare with what Lucy did.

Table 1: Analysis of Process Flow Chart

Desired Outcome: <i>All vulnerable children have access to age-appropriate food and nutrition</i>		
Child Status Index goal: <i>vulnerable children have sufficient food to eat at all times of the year; vulnerable children are growing well compared to others of his/ her age</i>		
Essential Actions:	Actual practices:	Changes for improving the care: (see service delivery guidelines for ideas)
<i>Household has access to adequate food (food security)</i>	<i>Lucy has arranged for food rations for the two girls but these do not appear adequate since there are signs of malnutrition and only serving one meal a day</i>	<i>Verify that monthly rations are being obtained and how they are being used. Because there are six other children in the family, these rations may need to be increased to include those children as well. Or refer to community committee to see what other economic strengthening activities can be added to the family</i>
<i>Children receive normal meals (as defined by the community)</i>	<i>Lucy learned that the family is having a hard time serving more than one meal a day and she did not ask about the quality ("normal")</i>	<i>Provide or refer for nutritional education (food preparation) appropriate especially for the younger children</i>
<i>Nutritional status of the child is assessed and monitored</i>	<i>Lucy has done a visual check of nutritional status but not checked any growth monitoring information nor referred to the health center</i>	<i>Refer Zoke (at least) to the health center for nutritional assessment and possible nutritional recuperation. Verify or refer all younger children in the household for growth monitoring</i>
<i>Safe water is accessible</i>	<i>Not assessed in the case study</i>	<i>Ask/ verify water supply and explore community responses as needed.</i>
<i>Monitor household dynamics vis-à-vis gender disparities in food distribution</i>	<i>Not assessed in the case study</i>	<i>Ask/ observe how food is distributed; discuss with head of household</i>

C. Choosing and planning out an improvement.

Choose one change from Table 1 and answer the following questions:

Improve food security actions: include all the children in food rations and discuss about how food rations are being used for the children (food security)

- 1) List *WHO* should be involved in designing and implementing the change. Think about who is actually involved in the process, about who will benefit from the improvement -- how children/youth might be involved in your improvement process, who you refer to or need to link to, etc.?

Lucy (volunteer home visitors)

Lucy's (volunteer) supervisor

Community committee

Vulnerable families

Organizations providing and distributing monthly rations

- 2) Describe *HOW* the change would happen – what would you need to do to introduce this change?

- *Check with organizations providing food rationing on eligibility*
- *Supervisor discusses with the community committee about eligibility for food rations*
- *Checklist for Lucy (and other volunteers) about what to do in case of signs of lack of food security (verification that rations are received, verification on how being used)*
- *Monitoring to check if changes implemented and children receiving food*

- 3) Describe how you will *know* if your change is actually implemented. What will you measure to know if the change actually took place and that it was making a difference for the children?

Lucy will check and record every month whether food rations are actually being received.

Lucy will ask the children what they ate in the previous day and record.

Lucy will refer (and then check the health card) for growth monitoring of children for improvement.

Lucy will follow up with someone on the community committee every visit.

D. Prepare a flip chart of the following for the plenary:

- Service area of focus
- Improvement objective
- Essential actions where standards and current practice don't match
- The change you chose to introduce
- How you will know the change is implemented and achieving your improvement objectives

CASE STUDY ON MONITORING AND IMPROVING THE QUALITY OF OVC SERVICE DELIVERY:

PARTICIPANT HANDOUT

Instructions: Participants are asked to imagine that they are working together in a non-governmental organization (NGO) that aims to address the needs of vulnerable children. They are confronted with the situation described below and are trying to figure out HOW to improve the quality of OVC service. Participants are to stay in this role throughout the entire exercise, acting as people in the process and NOT as external evaluators.

Lucy Mbele is a volunteer home visitor with your NGO. She is responsible for following up on children identified by the Most Vulnerable Children (MVC) committee in her village.

Today she is visiting Msichana (age 7) and her younger sister, Zoke (age 3). She began visiting them just after their mother died about 1 year ago. Their father had passed away due to AIDS a few years earlier. The girls are now cared for by their paternal uncle Thomas and Aunt Jasmine. This young couple both age 26 already had six of their own children (ages 3-10). The family lives in a two-room mud thatched house with their paternal grandfather. While the house is in fairly good condition, during her previous visit, Lucy noticed that the roof was leaking near where the children slept. She had reported this to the MVC committee last month. Today she is hoping that repairs have been made. In recent months Lucy has been able to provide the family with two mosquito nets, and a Community Health Care Card which provides free services for up to five children. Lucy had also arranged for monthly food rations for the two girls who are small for their age.

Since she has been visiting the family, Lucy has become aware of how difficult it is for Thomas and Jasmine to care for all these children. She has asked them about their desired family size, and they have replied that these things are in the hands of God. Thomas and Luke (age 10) do most of the farming while Jasmine occasionally works at a food kiosk.

When Lucy arrives the family has just finished eating their porridge. Today she notices that Zoke's hair has a dull orange tint. Jasmine shares her worry that as the dry season approaches, it is increasingly difficult to serve more than one meal a day.

Msichana is playing with the other children, while Zoke is sitting off to the side watching. Lucy greets the girls and asks them how they are doing. Msichana smiles and responds, but Zoke remains silent as she has in past visits. Lucy asks another question to draw her out, but Zoke looks at the ground and Msichana answers for her.

Knowing that Msichana is not enrolled in school, Lucy explains to Msichana that she is eligible to go to school and that she can get help to stay in school, such as a backpack, a uniform, and notebooks. Jasmine is listening, and though she is relieved that Msichana will be going to school, she also thinks of Luke who does not attend school with his three younger brothers because she and Thomas cannot afford the school fees.

Lucy reviews the health card and asks whether either girl was ill since her last visit. Jasmine replies that they have not been ill, but that she tried to use the card when Luke was ill. She took him to the clinic, but payment was required and they left without treatment. Lucy has to explain that only Msichana and Zoke are registered on the card; the other three spots (for free care) are

for three MVC being cared for by a neighboring family. Jasmine sighs at this news, but does not reply.

On the way out, Lucy notices that the roof has been fixed. She notes this on the home-visit form and further notes that Msichana is to receive educational support services. She wishes she could do more for the family and hopes that what she has done is “good enough”.

PART 1: Evaluating outcomes and services – Using the Child Status Index

A. Filling in the Child Status Index report form

- 1) At your seat, using the CSI indicator form, evaluate the children Lucy is visiting today and fill in the Child Status Report form.

B. Using the Child Status Index to evaluate children

- 1) Move to your groups. Give your scores to the Facilitator to put on a flip chart
- 2) Using the scoring of the Child Status Index, list as a group which scales reflect areas needing addressing.

C. Examining the process of using the Child Status Index

- 1) Did everyone agree on all the scores? Why or Why not?
- 2) Were there scales you felt you could not assess? What questions could you have asked to be able to assess those scales? (See Appendix A for ideas.)
- 3) What “*Important Events*” did you check?
- 4) What services did you list as being provided?

D. Using the Child Status Index for decision making regarding services

- 1) Based on the scores/assessment of the current status of the children, what services do you think Lucy should be providing?

Part 2: Improving the process

A. Clarifying what you want to improve

1) Examining the results of your evaluation of the children using the child status index (outcomes and services delivered), brainstorm with the group a list of good practices (i.e., in favor of quality) and a list of practices that could be improved (opportunities to improve quality).

Good practices	Practices that could be improved

2) From your list of opportunities to improve, choose, as a group, choose one service for your group to focus on in this case study. Review the standards for that service area that are in the Facilitators' Guide (generic standards are on pages 62-81).

3) For the service area you have chosen, develop one improvement objective, referring to the Child Status Index to choose the appropriate "goal".

B. Determine what changes are needed to be able to follow the standards

1) For the OVC service area you have chosen to focus on, using the OVC service standards in the Facilitator's Guide (pages 62-81), place the *Desired Result* in the first row (this would be your desired outcome). Place the CSI goal in the second row.

List out the essential actions for OVC care relevant for the children in this household in the third row/first column of Table 1. Place only one essential action in each box. Go back to the details in the case study and describe the actual practice used by your field worker in second column related to each essential action.

2) Compare the essential actions listed in the standard to actual practice. Which activities are most problematic? Mark the problematic actions with a circle. For each problematic essential action, chose one *change* in the way things are currently done that would move you towards the standard.

Table 1: Analysis of Process Flowchart

Desired Outcome(s):		
Child Status Index goal:		
Essential Actions:	Actual practices:	Changes for improving the care: (see service delivery guidelines for ideas)

C. Choosing and planning out an improvement.

Choose one change from Table 1 and answer the following questions:

- 1) List *WHO* should be involved in designing and implementing the change. Think about who is actually involved in the process, about who will benefit from the improvement -- how children/youth might be involved in your improvement process, who you refer to or need to link to, etc.?

- 2) Describe *HOW* the change would happen – what would you need to do to introduce this change?

- 3) Describe how you will *know* if your change is actually implemented. What will you measure to know if the change actually took place and that it was making a difference for the children?

D. Prepare a flip chart of the following for the plenary:

- Service area of focus
- Improvement objective
- Essential actions standards and current practice don't match
- The change you chose to introduce
- How you will know the change is implemented and achieving your improvement objectives

Appendix G: Glossary

Access: The lack of geographic, economic, social, cultural, organizational, or linguistic barriers to services.

Algorithm: A description of how to provide care; it is written as a flowchart or decision tree. This format provides a quick visual reference that can be referred to during the process of service delivery.

Characteristics of quality: Specific measurable and observable aspects of care that should be in place to assure quality.

Cluster of services: A group of services provided to meet the integral needs of the child, family, or community. Service clusters may be provided by one or more organizations, but must be provided in a coordinated manner that results in effective compassionate care that is also efficient.

Compassionate relations: The establishment of trust, respect, confidentiality, and responsiveness achieved through effective communication and socio-emotional interactions.

Continuity: The delivery of care by the same person, as well as timely referral and effective communication between providers when multiple providers are necessary.

Dimensions of quality: Explicit aspects of quality such as safety, access, effectiveness, technical performance, efficiency, continuity, compassionate relations, appropriateness, participation, and sustainability.

Effectiveness: The degree to which desired results or outcomes are achieved.

Efficiency: The extent to which the cost of achieving the desired outcome is minimized.

Evaluation: The use of research methods to assess a program's effectiveness in terms of outcomes (short-term and long-term outcomes and impact outcomes) at the population level in the target population.

Gender appropriateness: The adaptation of services and overall care to special needs or circumstances based on gender.

Guidelines: Recommendations to assist service providers in providing appropriate care. They should be evidenced based when possible. Rather than prescribing specific actions, guidelines serve as a resource for service providers, who use their experience, expertise, and judgment to determine appropriate care.

Impact: The share of the observed outcomes, either short- or long-term, that can be attributed to a given program, service, or cluster of services.

Monitoring: The process of routine data collection to assess if program activities are being implemented as planned and the utilization of those data for project management and decision-making.

Orphan (due to HIV/AIDS): A child 0–17 years old, who has lost one or both parents to HIV/AIDS.

Other vulnerable child (due to HIV/AIDS): A child who is HIV-positive or because of HIV/AIDS: 1) lives without adequate adult support; 2) lives outside of family care; 3) is

marginalized, stigmatized, or discriminated against; or 4) has suffered other consequences due to HIV/AIDS (such as death of teacher).

Outcome: Changes resulting from exposure to a service, a cluster of services, or a program.

Participation is used here to refer to situations where caregivers, communities, and children themselves play a role in the design and delivery of services and in decision-making regarding their own care.

Protocol: Definition of technical component of service delivery for specific situations. Protocols outline each step that must be taken by the care provider. Protocols are distinct from a standard operating procedure in that they refer to technical rather than administrative aspects of care.

Quality: A degree or grade of excellence or worth.

Quality improvement: A program for the systematic monitoring and evaluation of the various aspects of a project, service, or facility to ensure that standards of quality are being met, and that areas where there are gaps between expectations and outcomes are routinely identified and addressed effectively. Core QI activities include standard setting, monitoring, and improvement or problem-solving activities.

Quality care: The extent to which an appropriate cluster of services is delivered in a way that maximizes realization of desired outcomes. Quality care means that children, families, and the community receive all needed services and no unnecessary services.

Safety: The degree to which risks of harm resulting from a service component or overall care is minimized.

Service quality: The degree to which a service conforms to standards or guidelines.

Service standard: A statement of what is expected for a given service.

Standard operating procedure: Instructions on how to carry out administrative procedures under specific circumstances.

Technical performance: The degree to which tasks are carried out in accord with standards and meet technical expectations.

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