QUALITY ASSURANCE AND IMPROVEMENT STANDARDS FOR OVC PROGRAMS IN ETHIOPIA

Produced by the National OVC Taskforce with support of USAID/PEPFAR

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Acronyms

AIDS	Acquired Immuno-deficiency Syndrome
ANC	Antenatal Care
ART	Anti-retroviral Therapy
BCC	Behavior Change Communications
CBO	Community-Based Organizations
CPU	Child Protection Unit
EDHS	Ethiopia Demographic and Health Survey
HAPCO	HIV/AIDS Prevention and Control Office
HBC	Home Based Care
HH	Household Chores
HIV	Human Immuno-deficiency Virus
IEC	Information, Education and Communication
IGA	Income Generating Activities
KETB	Kebele Education and Training Board
MOH	Ministry of Health
NGOs	Non-Governmental Organizations
OVC	Orphans and Vulnerable Children
PEPFAR	United States of America's President's Emergency Plan for AIDS Relief
PC3	Positive Change: Communities, Children and Care Program
PLWHA	People Living with HIV and AIDS
PRA	Participatory Rapid Appraisal
PSS	Psychosocial Support Services
PTA	Parent Teachers Association
QAI	Quality Assurance Indicator
USA	United States of America

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SECTION I. OVERVIEW

BACKGROUND

Ethiopia has a strong cultural and language tradition, yet is severely challenged by decades of conflict, food insecurity and poverty. One of the groups most profoundly affected is children. Children under the age of 18 constitute about 18 percent of the population which exceeded 78 million in 2007 and continues to grow rapidly.

Ethiopia's under-5 mortality rate is among the highest in Africa. Half of infant deaths occur in the first month of life and one in eight children die before age five (2005 Ethiopia Demographic and Health Survey-HDHS). As a child's age increases, the likelihood of the child living with both parents decreases. Only 65.2% of 10-14 year-olds and 52% of children 15-17 live with both parents (2005 EDHS). Lack of parental care and support exposes children to increasing vulnerability, such as food insecurity and chronic malnutrition, lack of protection/shelter, lack of access to education and physical and sexual abuse. These vulnerabilities can, in turn, increase children's risk for contracting HIV/AIDS.

HIV/AIDS while relative low compared to many sub-Saharan countries has impacted society by increasing the burden of orphaned children and children living with HIV/AIDS. Ethiopia faces one to the biggest burdens of orphaned children in Africa.

The Ministry of Health (MOH) conducted a single point estimate exercise in April 2007 to combine ANC surveillance data with the 2005 EDHS data. Additional information from these data sources can be found on the Ethiopian AIDS Resource Center website http://www.etharc.org . According to the single point estimate results, Ethiopia has over 5,441,556 orphans, of which an estimated 898,350 are due to AIDS. The *Single Point HIV Prevalence Estimate* document (June 2007) from the MOH also states that among children 0-14 there are an estimated 64,800 HIV positive children. The MOH made estimates by region and took into consideration rural vs. urban statistics. Below is a chart that consolidates information about Orphaned or Vulnerable Children (OVC) and HIV prevalence rates by region.

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

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

Children affected by HIV/AIDS face tremendous challenges. Orphaned children are less likely to be enrolled in school than non-orphans. The challenges to remain in school are even greater for those who have lost both parents or a parent and who have to care for the remaining parent living with HIV/AIDS.

A National Taskforce for OVC was established to provide guidance in development of a comprehensive National HIV/AIDS and OVC policy. Even with a plan, the capacity of local NGO/CBOs to carry out a national plan is limited. Groups at the woreda (district) and Kebele (county) levels are motivated towards action but often lack the capacity to carry our sustainable action given the magnitude of the problem. Thus, it is increasingly important to use available resources in the most effective and coordinated manner.

INTRODUCTION

As part of the effort to use resources in the most effective coordinated manner, representatives from PEPFAR-funded organizations in Ethiopia participated in a workshop in February 21-22, 2007, to develop consensus-based standards for selected OVC services. The workshop, based on quality assurance principles, employed participatory methods to develop draft standards for Education, Economic Strengthening, Psychosocial Support and Coordination of Care. PEPFAR OVC partners met again on March 29, 2007 and May 9, 2007 to review the document and address the additional services of Food and Nutrition, Access to Health Care, Shelter, and Legal Protection. These meetings constituted a field test of the methodology, thus, the Ethiopian PEPFAR partners were among the first in the world to apply this standards method to OVC care.

This report presents the revised standards that came out of the PC3 technical staff workshop, the feedbacks from local partners and the children workshop which basically incorporates the views of children on the subject matter. For the last three months (August to December 2007) the draft was reviewed by the participating organizations, the PEPFAR OVC Technical Working Group, the National OVC Task Force, subcity and Kebele level HAPC Departments, government representatives and others. The document is enriched and revised based on PC3 organizational experience, locally-relevant expertise, and indigenous knowledge. The standards will continue to be used as critical minimum standards for quality across the PC3 program implementing partners. While PC3 is an HIV/AIDS program, these standards are encompassing enough to be used by any OVC implementer.

A dimension of quality matrix is also included so that partners may refer back to that analysis as a cross-check. Appendix 1 reviews key concepts related to this work including the definition of quality, the quality triangle and dimensions of quality. Appendix 2 includes the proceeding from the technical review of the document and Appendix 3 is the questionnaire developed to standardize the responses regarding the document..

We would like to express our appreciation for the invaluable support from USAID and PEPFAR which introduced the concept and trained relevant staff on QAI. Save the Children USA as a lead organization in the development and piloting of the QAI would also like to acknowledge with gratitude the contributions of the local partners and their lead international organizations – CARE International, World Learning, World Vision, and Family Health International who participated in the development and field test of this Quality Assurance (QA) methodology for standard setting. Our special thanks to the community based organizations who gave their genuine feedback and support during the field work.

Why Focus on Quality?

With increased funding from donors to address the needs of vulnerable children, it is more important than ever to assess how well the needs of vulnerable children are being met. While each provider organization has attempted to determine if they are improving children's lives, each has its own focus. Measurable outcomes across programs made it difficult to measure progress in achieving overall outcomes for children. This effort is an attempt to coordinate the assessment process across a broad spectrum of providers. The focus is on quality and progress towards achieving overall outcomes for children as opposed to counting numbers or purely access to services. Participants from a wide spectrum of national level organizations within Ethiopia collaborated to define what quality standards look like for each of eight key components of care. The goal was to establish agreed-upon common criteria by which to measure the quality of the services provided.

The development of quality standards will therefore set a framework within which actors intervening in the area of orphans and vulnerable children can operate to ensure attainment of outcomes for children.

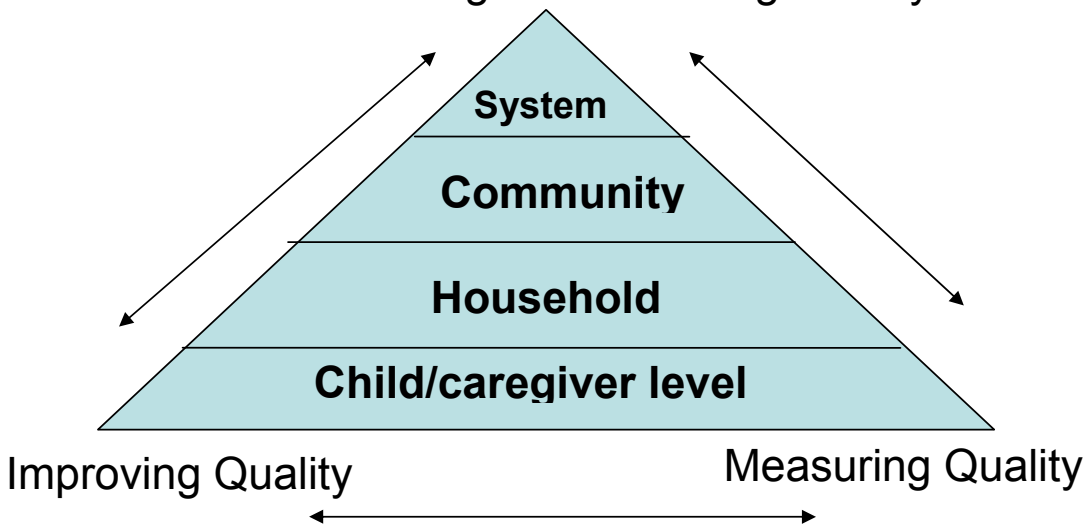
These standards will also be used by service providers and donors for program planning, monitoring and evaluation to improve overall service delivery for orphans and vulnerable children in the family. In addition, the information gathered by utilization of the standards may help inform national level efforts in the development of a national OVC policy framework.

Quality at different levels

As programs attempt to define quality, it is important to understand that quality can be defined, measured and improved at all levels. Those receiving services including the children and their caregivers have a role to play both in defining quality from their own perspective and providing input into the measurement and ultimate improvement of quality services. It is also critically important as we move up the service delivery ladder that other key stakeholders be involved to ensure the appropriate interplay between defining, measuring and improving quality. Key stakeholders must include all levels of those involved in providing services as well as representatives of the communities such as schools, churches, and other social groups, governing agencies and donors.

Thus, in order to develop the quality standards, program partners met with children, households, community institutions/organizations and state government. The objective was to reach consensus on the dimensions of quality as well as critical minimum activities which must be followed in order for actors to claim that they are delivering quality services. Critical minimum activities were developed for each service component typically found within OVC programs - food and nutrition, health services, psychosocial care and support, shelter and care, legal protection, and economic strengthening. Due to its importance, Care coordination was added

Figure 1: Defining Quality



Based on the input obtained from the key stakeholder, quality of OVC services in Ethiopia will be assessed at four levels, the child/caregiver, the household, the community and the system as is illustrated by Figure 1.,

For each of the four levels, the ten dimensions of quality listed in Table were used in developing the quality indicators for the critical minimum activities.

Table 1. Dimensions of Quality

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

The Framework and Guiding Principles

The framework and guiding principles were developed in collaboration with all the partners. The Annex contains the participating organizations and their representatives.

In developing the framework, the partners agreed to use a broad definition of the target OVC population. In Ethiopia, an orphan is defined as a child who is less than 18 years old and who has lost one or both parents, regardless of the cause of the loss. A vulnerable child is a child who is less than 18 years of age and whose survival, care, protection or development might have been jeopardized due to a particular condition, and who is found in a situation that precludes the fulfillment of his or her rights. However, for these standards a more inclusive definition is used which includes all of the following:

- A child who lost one or both parents;
- A child whose parent(s) is/are terminally ill and can no longer support the child;
- A child living in the street;
- A child exposed to different forms of abuses (physical, sexual);
- A child offender;
- A child prostitute;
- A child with disabilities;
- A child whose labor is abused; and
- An unaccompanied children due to displacement (external or internal).

It was also agreed to use the PEPFAR Service Package as the foundation for the standards. The PEPFAR standards are set forth in *Quality Programs for Orphans and Vulnerable Children: A Facilitator's Guide to Establishing Service Standards,* DiPret Brown, 2007. The PEPFAR Service Package differs somewhat from the Ethiopian Service Package as can be seen in Table 1.

Table 1 Comparison of Ethiopian Government Service Package to PEPFAR Service Package

ETHIOPIAN GOVERNMENT SERVICE PACKAGE*	PEPFAR SERVICE PACKAGE
Health Care and Medical Support	Health Care
Food and Nutrition	Food and Nutrition Support
Shelter and Clothing	Shelter and Care
Economic Support	Economic Strengthening
Psychosocial Counseling	Psychosocial Support
Spiritual Support	
Legal Support	Protection
Information, Educational and Communication	Education and Vocational Training
	Coordinated Care

***Source: Comprehensive Community-Based Care and Support Guideline for PLWHAs, OVCs and Affected Families, HIV/AIDS Prevention and Control Office (HAPCO), January 2006, Addis Ababa.**

Most importantly, Coordinated Care was selected to be the overall guiding principle through which services would be delivered in an integrated fashion so as to reduce duplication and inefficient use of resources by service providers. All partners agreed that in order to deliver quality services to OVC coordination should occur at all levels of organization not just at service

delivery, regional, or national levels. The coordination of care is the critical integrative activity that assures that services have the desired impact.

Coordinated Care can be defined as a child-focused process that augments and coordinates existing services and manages child wellness through advocacy, communication, education, identification and referral of services. This involves planning care for a child or family, monitoring that care, and making adjustment to the combination of services when needed. Coordinated care requires linkages with all sectors including public and private sectors to ensure the appropriate mix of services for program beneficiaries. It does not mean that programs should provide all the services. However, in order to ensure quality service provision, partners should be able to monitor children's/households' receipt of necessary services through linkages and referrals.

In addition, partners have derived other key guiding principles noted below:

- Programs should utilize families and communities are the first line of response;
- Programs should provide services in a non-stigmatizing way;
- Programs should be community owned/led;
- Programs should utilize evidence based interventions;
- Programs should build on local knowledge/skills and values;
- Programs should strengthen partnerships and leverage resources through linkages;
- Programs should be implemented in an age-appropriate manner;
- Programs should seek to reduce overall vulnerability of intended beneficiaries (i.e. do no harm); and
- Programs should promote gender equity.

Who are the Standards For?

The standards were specifically developed for use by partners implementing programs targeting OVC affected by HIV/AIDS who are also funded by PEPFAR or have utilized the guidelines developed by PEPFAR for targeting OVC. However, It is important to note that although the guide was specifically developed for these programs, developers worked with the understanding that all programs addressing the needs of vulnerable children irrespective of cause would benefit from the implementation of standards. Given the move toward the creation of a national OVC policy in Ethiopia, a concerted effort was made to keep the standards generic enough to capture all vulnerable children while at the same time identifying key indicators specific to OVC affected by HIV/AIDES.

When applying the standards for PEPFAR funding purposes, the population is more restrictive than that used in the development process. As an HIV-focused program, PEPFAR defines orphan and vulnerable children as follows:

> *A child, 0-17 years old, who is either orphaned or made more vulnerable because of HIV/AIDS.*
>
> *<u>Orphan:</u> Has lost one or both parents to HIV/AIDS*
>
> *<u>Vulnerable:</u> Is more vulnerable because of any or all of the following factors that result from HIV/AIDS:*
>
> - *Is HIV-positive;*
> - *Lives without adequate adult support (e.g., in a household with chronically ill parents, a household that has experienced a recent death from chronic illness, a household headed by a grandparent, and/or a household headed by a child);*
> - *Lives outside of family care (e.g., in residential care or on the streets); or*
> - *Is marginalized, stigmatized, or discriminated against.*

Key areas of Protection, Care and Support for OVC

Standards were developed in the following eight key areas:

- Food and nutrition;
- Shelter and care;
- Legal Protection;
- Health;
- Psychosocial;
- Education and work;
- Economic strengthening; and
- Coordinated Care.

The standards contribute to the realization of key outcomes for children and can assist in achieving national level goals for children. These include:

- the creation of an enabling environment for the healthy growth and participation of vulnerable children and families;
- the delivery of comprehensive, coordinated and integrated services to vulnerable children that are of "good enough" quality; and
- the enhanced capacity of households, communities, organizations and institutions to delivery integrated services according to agreed upon quality standards.

Two workshops were held in Addis Ababa to test the relevance and appropriateness of the eight areas for which standards were developed. The eight areas were found to include the key needs as identified by children. In these workshops, the need for shelter was the greatest need identified for OVCs. This finding is in contrast to earlier studies in which education was identified as the greatest need. Education was still a high priority need (3rd) according to the children. The change may be a reflection of the success of the government's strong push to provide education to all Ethiopians through grade 8. However, some of the difference maybe partially attributed to differences in methodology. The Workgroups were conducted with youth known to the Agencies who are more likely to have their education needs met. A full report on the Workshops is contained in the Annex.

Table Program Level Critical Minimum Activities and Desired Outcomes for the 8 Key Areas and the Relevant National Indicators (HAPCO in 2006).

Service Area	Desired Outcome	Relevant National Level Indicators*	Critical Minimum Activities
Education	Child is enrolled, regularly attends, and completes a minimum of primary school (grade 8)	Key strategies but not specific standards -Strengthen school involvement and ensure access to education -Increase school enrollment and attendance -Prohibit discrimination based	- Work with community/PTA/KETB/CBOs to identify OVC in need of education services - identify and address barriers to education on an individualized basis for each child - facilitate enrollment of OVC into an educational opportunity (academic or vocational) - provide early childhood development services for

		on or presumed HIV status	children - build capacity to monitor child enrollment, attendance and completion
Economic Strengthening	Households caring for vulnerable children have sufficient income to care for them	-PLWHAs and their families trained in IGAs, micro financing -PLWHAs and their families involved in IGAs -PLWHAs and their family members provided with financial support for household expenditures such as house rent, blanket, bed sheets, clothes, soap etc.	- Identify elder OVC/guardian/relatives and assess their needs - map market demands and service providers - Provide training for beneficiaries on business development, financial management and? - support beneficiaries for economic engagement after training - link trainees to market opportunities

Psychosocial Support	OVC develop personal strengths and skills to become self-confident, happy, hopeful, and able to cope with life's challenges	-Care providers trained on counseling skills -PLWHAs accessing counseling services -PLWHAs families that have accessed counseling services -Support group established -Community members tat have accessed appropriate information HIV/AIDS towards stopping discrimination -establishment of referral links and feedback	- Build local capacity on PSS issues, providing training to caregivers and volunteers on how to recognize and address PSS needs of children - Provide PSS to caregivers caring for the OVC and households - Provide individualized "curative" support to traumatized OVC - Mainstream and integrate PSS services into overall OVC program - Provide safe and supportive environments for recreation, play, cultural, and spiritual activities in conjunction with other children - Sensitize communities on PSS needs of OVC in order to address stigma and discrimination
Food and Nutrition	Adequate food is available for the child to eat regularly throughout the year for healthy and active life	Trained HBC providers on balanced diet/proper nutrition -Number of OVC and families who received information on balanced diet and	- Train caregivers on proper food handling and nutrition practices - Link severely malnourished children to therapeutic feeding - for children receiving food support, ensure that they are growing well - Increase household production of food using methods such as

		nutrition -Number provided food and nutritional support from the community initiative -Number who have received food/nutrition aids -establishment of referral links and feedback	backyard gardening, urban agriculture production - train caregivers on age-appropriate feeding practices including exclusive breastfeeding, safe complementary feeding practices - Link OVC to food resources where available (i.e. WFP and other community feeding initiatives)
Legal Protection	Child receives legal information and access to legal services as needed, including birth registration, will writing, property inheritance and is protected from all forms of abuse and violence	-Sessions held to create awareness about PLWHA's right -People trained on the rights and responsibilities of PLWHAs -Communal law to protect PLWHA and OVCs -PLWHAs that have been provided legal support -Referral made and feedback received	- identify and verify legal services available in community including Child Rights Committees, NGOs, CPU through mapping - Conduct community education and awareness raising around child rights, child related laws - Refer and link OVC and their caregivers with appropriate legal services when required - Once referred, monitor outcomes of legal cases - sensitize media to inform the public about the rights and needs of OVC - abuse is reported and dealt with immediately through referrals to appropriate authorities - children are able to report abuse in safe/confidential environment without fear of retribution - Advocate for the establishment and strengthening of CPU - Establish and strengthen networking systems with legal provision such as shelter, medical care and psychosocial support.
Health Services	Child has access to health services, including HIV/AIDS prevention, care and treatment	-Trained HBC providers -Active HBC providers -HBC kits initially supplied and refilled -PLWHA provided with appropriate information -PLWHA family	- identify and verify the health services available in the community - ensure formal referral systems exist and facilitate free services for OVC - Conduct regular home visits for children - for HIV + caregivers, ensure that caregivers understand how

		members provided with information -PLWHAs whose medical expenses have been covered -PLWHAs who have been visited and been provided with medical/nursing care. -establishment of referrand feedback links	to recognize health and other needs of children in the household - ensure and verify that OVC receive full immunization - for HIV+ children, ensure access to treatment - provide age-appropriate health education/information

Shelter Care	All OVC have adequate shelter, clothing, personal hygiene and adult care giver in accordance with community norms	-PLWHAs renting kebele houses in urban sites -Houses constructed for PLWHAs in rural sites -PLWHAs who have obtained expenses for housing renting- -Awareness raising and advocacy sessions on the subject of stigma and discrimination	- Assess the needs of OVC on shelter and care regularly - Identify and mobilize community resources for shelter and care needs of OVC - Construction, improvement and renovation of shelters of OVC as needed - Making alternative schemes for shelter and care (day care, temporary shelter,) - An adult/foster care giver visits the child at home and provides appropriate support - conduct advocacy around the shelter and care needs of OVC at all levels - facilitate birth registration for OVC
Coordinated Care		Not set as standard but as strategy -Establish mechanisms to ensure information exchange and collaboration of efforts -Strengthen partners and partnerships at all levels and build coalitions among key stakeholders	

Source: Comprehensive Community-Based Care and Support Guideline for PLWHAs, OVCs and Affected Families, HIV/AIDS Prevention and Control Office (HAPCO), January 2006, Addis Ababa.

Guidelines for Application of the Standards

The responsibility for implementation of program level standards lies on a number of actors. It is not only the program itself that should monitor these standards but governments, institutions and communities have a role to play. In so doing, key principles should be kept in mind:

- The implementation of standards should minimize risks to program beneficiaries. Programs should strive for consistent application of the standards within agreed upon dimensions. In order to minimize risks, various strategies may be adopted such as, for example, seeking community level input when implementing programs and ensuring their consistent and continued participation:

- Programs should seek to enhance beneficiary participation. In the implementation and monitoring of the standards it is crucial to get beneficiary feedback. This participation will only enhance the quality of services and ensure that services are provided according to the need of the beneficiaries and that they are appropriate;

- Programs should facilitate linkages with other programs and services in a coordinated and integrated fashion that allows for all the needs of beneficiaries to be met. The implementation of the quality standards will assist programs to achieve higher level collaboration by understanding key gaps in service provision; and

- Standards enable programs to enhance their monitoring and evaluation systems. For example, programs should use these standards to ensure that their processes are leading to the intended outcome/impact.

Monitoring of Quality Standards

Who should Monitor the Implementation of the Standards?

The monitoring of quality should be done at various levels. Communities have a role to play as they are closest to the beneficiaries. Program implementers as facilitators of many of the services also must have a role to play in monitoring quality. Furthermore, in order to ensure that referrals serve their intended purpose (i.e. that the beneficiary receives the necessary service and is better off as a result), quality monitoring should also be done at institutional/government level. Lastly, input can be received from the beneficiaries themselves around the quality provision of services. Programs should facilitate the monitoring from all of these levels to ensure that program beneficiaries are receiving quality services from their own perspective.

How Should the Standards be Measured?

Development of Indicators

In order measure standards, there is a need to develop indicators. In the absence of a national plan for OVC, program partners have reviewed national frameworks for children which include various development indicators. These indicators may serve as a guide to monitoring achievement of objectives. In some countries like Uganda for example, indicators for OVC are phrased in terms of achievement in the same core program areas for non-OVC. While this may be relevant for the Uganda example, we may have to look at achievement rates of OVC in and of

themselves given that current research is showing that OVC are actually not worse off than non-OVC.

In addition, tools such as the Child Status Index which looks at outcomes in children and related services provided may offer some guidance on what should be measured/monitored. Ideally, if the standards are followed, it is expected that we will see the intended outcome. Programs embracing these standards should therefore adopt measures that are easily measurable within the context of their program and do not necessarily need large scale evaluations to show evidence.

Development of Quality Checklists

It is recommended that monitors develop a quality checklist to aid in monitoring. Use of check lists ensures that all indicators are covered and will assist in documenting progress in the provision of services over time. Examples of a quality checklist can be found in the annex. However, it is also recommended that the work group continue and develop suggested procedures to be followed to determine if a standard is met. For example, the group could recommend picking a random sample of 3 children who have been assisted in finding shelter and then visit their shelter to determine if the quality standards are met in terms of being safe, dry and sanitary. Then, if a problem is detected, visit more to determine if the problem was isolated or more systemic.

How frequently should programs be monitored?

Partners should jointly establish a schedule of monitoring so as to minimize the burden on providers who may have multiple funding sources. However, at least one monitoring visit per program should be conducted annually. More frequent monitoring is recommended for new programs or programs that have substantial deficiencies on the last visit. Additional unscheduled monitoring may be indicated in the event of serious or numerous allegations of problems.

Summary

The purpose of Section 1 is to clarify why and the importance of standards for assessing quality, the process and framework used to develop the standards, and how the resulting indicators of quality should be used.

Section 2 gives in detail for each of the 8 service components the following;

- ✓ Desired outcome;
- ✓ Matrix which gives the quality characteristic for each of the 10 Dimensions of quality; and
- ✓ Draft Standards of Care which lists the major activities needed to meet the desired outcome and identifies the critical minimum activities that must be achieved and type of standard that is recommended.

For some measures, a flow chart or diagram is provided to lend additional guidance to monitors as to how the system should work.

SECTION 2 SERVICE DELIVERY STANDARDS

This section is organized by the following eight service components:

- **Shelter and Care:** Services strive to prevent children from going without shelter, clothing, access to clean safe water or basic personal hygiene, and that children have at least one adult who provides them with love and support.
- **Economic Strengthening:** Services seek to enable families to meet their own needs economically, in spite of changes in the family situation due to HIV/AIDS.
- **Legal Protection:** Services aim to reduce stigma and social neglect, insure access to basic rights and services, and protect children from abuse and exploitation.
- **Health care:** Services include provision of primary care, immunization, treatment for children when they are sick, ongoing treatment for HIV positive children, and HIV prevention.
- **Psychosocial Support:** Services aim to provide OVC with the human attachments necessary for normal development and life skill that allow them to participate cooperatively in activities such as school, recreation and work with other children and adults.
- **Education:** Services seek to ensure that orphans and vulnerable children receive educational, vocational and occupational opportunities needed for them to be productive adults and that school programs take into account the special needs of OVC.
- **Food and Nutrition:** Programs aim to ensure that vulnerable children have similar nutritional resources as 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.
- **Coordinated Care:** Coordinated care is a child-focused process that augments and coordinates existing services and manages child wellness through advocacy, communication, education, identification and referral of services.

As can be seen in Table 2, 358 indicators of quality were identified and the number of minimum critical activities was 59 which represents only a portion of the 143 major activities identified.

There is some overlap in quality characteristics and activities specified for a particular service with Coordinated Care and thus with other services. Coordinated Care is one of the overarching principles that leads to quality and the duplication was thought essential to ensuring that programs adopt the principles of such care.

Table 2 summarizes the number of key elements developed for Quality Characteristics, Activities Required to Provide Quality Services and the Minimum Critical Activities

Service Component	Number of Quality Characteristics	Numbers of Activities identified	Number of Minimum Critical Activities
Shelter and Care	**38**	**17**	**6**
Economic Strengthening	**42**	**17**	**6**
Legal Protection	**39**	**9**	**10**
Health Care	**35**	**12**	**5**
Psychosocial Support	**90**	**25**	**12**
Education	**45**	**15**	**6**
Food and Nutrition	**44**	**26**	**9**
Coordinated Care	**25**	**12**	**5**
Total	**358**	**143**	**59**

I. NAME OF SERVICE COMPONENT: SHELTER AND CARE

DESIRED OUTCOME: All OVC have adequate shelter, clothing, personal hygiene and adult care giver in accordance with community norms

DIMENSIONS OF QUALITY MATRIX: SHELTER AND CARE	
Dimensions of Quality	**Quality Characteristics For Shelter and Care**
Safety	• Shelter is safe i.e. has walls, a roof, ventilation, latrine and close to water source and is clean according to community norms. • Ensure the shelter is environmentally safe dry with ventilation, with materials such as clothing etc which meet minimum standards • Ensure children have appropriate adult supervision • Ensure shelter is free from risk of any abuse and violation of child rights
Access	• Children will be able to stay in a safe shelter within their communities. • Ensure shelter provides basic service facilities (i.e. toilet, water…) • Shelter provision by linking children with kebele and sponsors/fosters, caretakers • Link children to community support services (counseling, HIV, day care..) • All children have access to shelter including temporary shelter in case of high vulnerability (i.e. children on the street, children abused).
Effectiveness	• Shelters are safe, warm, dry, and there is access to water and sanitation i.e. latrines. • Children are taken care of by an adult who understands their needs, who has strong parenting skills.
Technical Performance	• Build the capacity of stakeholders to network and advocate for children's right to proper shelter and care • Care is provided according to age appropriate needs of child. • Care and shelter are in accordance with community standards
Efficiency	• Shelter services are provided to the ones who need it. • Local community response for OVC needs (shelter) is enhanced by proper use of time and resources. • Ensure that the optimization of resources does not lead to overcrowding. • Ensure that services provided are of minimum cost • Children are taken care of by an adult with parenting skills. • Linkages with other community based shelter services are

	identified.
Continuity	• Vulnerable children are taken care of by members of their community. • Reunification /reintegration of OVC with relatives • Community resource mobilization through adoption, foster families, etc. • Advocacy • Stigma and discrimination awareness and interventions • Provided services are monitored • No gaps exist between needs assessment and provisions of service. • Children don't lose their assets, their homes at times of parents' deaths.
Compassionate Relations	• Service does not increase stigma and discrimination. • Criteria are well set for selection of children and household who receive the services. • Shelter is provided accordingly to need and in accordance with community norms. • Communities are involved in setting criteria for need. • Establish confident and responsive relation with caretaker • Create an environment where children live and express their feeling, ideas freely etc • Ensure children get love and affection from their caretakers
Appropriateness	• Adequate space for the child (in case of institutionally care, the dormitory is divided by age; gender; equal conditions for all children) • Gender sensitive and priority for female children • Responsive to the existing community's style of living • Shelter services are provided based on results of needs assessment and the consent of OVC/caretaker.
Participation	• Community involved in the service provision • Activities are carried out with the consent and participation of OVC and their guardians, and community members. • Children, communities, key local stakeholders are involved in decision-making processes and provision of service.
Sustainability	• Strengthen indigenous family relationship and ties • Advocacy and community mobilization • Communities and other stakeholders are involved in the provision and support of safe and environmentally sound shelter to OVC. • Family reunification is actively sought out.

Major Activities to achieve outcome (list or flow chart)

- Assess the needs of OVC on shelter and care regularly
- Identify resources for shelter and care needs of OVC in the community
- Ensure communities plan appropriate activities and mobilize identified resources
- Improve and renovate shelters of OVC as needed (built new houses or rent appropriate spaces)
- Provide child reunification and family reintegration as needed
- Provide short- term shelter for abandoned and other needy children (legal protection)
- Recruitment, training and assignment of an adult/foster care giver or adopters for OVC based on consent from OVC and caregiver Train and provide continuous support to caregivers to provide PSS to OVC
- Make sanitary facilities(water and toilets) and materials accessible to OVC
- Provide clothing to OVC
- Educate OVC on hygienic practices (personal, home and environmental)
- Link with kebele administration to secure home which is warm ,safe and meet the local standards for OVC and their caretakers Link with legal institution thereby OVC get /inherit families' home and other items
- Ensure day-care services are available and accessible to OVC
- Sensitize community, line government offices and other stakeholders to monitor progress of the children (status of shelter and care)
- Advocate and Network to improve services
- Community Mobilization

QUALITY STANDARDS: SHELTER AND CARE

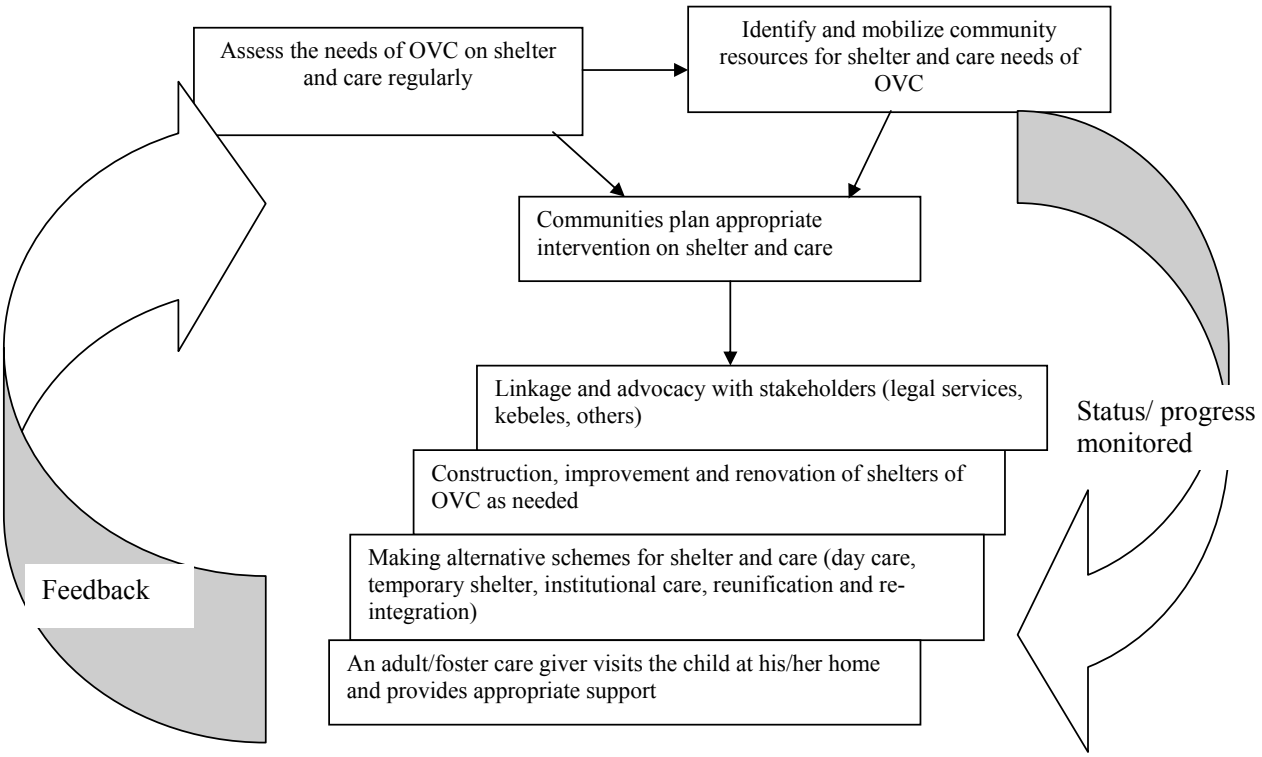
Critical Minimum Activities: (cross-check with dimensions of quality)

- Assess the needs of OVC for shelter and care regularly
- Identify and mobilize community resources for shelter and care needs of OVC
- Construct, improve and renovate shelters of OVC as needed
- Make alternative schemes for shelter and care (daycare, temporary shelter, etc.)
- Ensure that an adult/foster caregiver visits the child at home and provides appropriate support
- Link and advocate with stakeholders (legal services, kebeles, others)

Which type of standard is most appropriate? (please check one)

___Guideline ___Protocol _√__Checklist

Shelter and Care Program Delivery Strategy



II. NAME OF SERVICE COMPONENT: ECONOMIC STRENGTHENING

DESIRED OUTCOME: Households caring for vulnerable children have sufficient income to care for them.

Economic Strengthening Support Framework

DIMENSIONS OF QUALITY MATRIX: ECONOMIC STRENGTHENING	
Dimensions of Quality	**Quality Characteristic of Economic Strengthening**
Safety	▪ Develop financial service delivery mechanism to reduce indebtness (saving led financial services) ▪ The Child Rights Policy (child labor) is maintained. ▪ OVC and employers of OVC are properly trained on procedures for a safe and working environment. ▪ Confirm that illegal or dangerous IGAs are avoided.
Access	▪ Convenience to target groups considered in service delivery. ▪ All training materials are prepared in the local language. ▪ Geographical proximity to OVC should be considered when arranging service delivery. ▪ Selection criterion is transparent and prioritizes the most vulnerable. ▪ Families should have access to financial resources.
Effectiveness	▪ Income generated is used to care for children ▪ Low capital /resource requirement of the scheme ▪ Households' assets (economic and social) bases are built to withstand shocks as result of HIV/AIDS. ▪ A financial service delivery mechanism is developed to reduce debt (saving led financial services). ▪ Households' income source is sustained and diversified.
Technical Performance	▪ Support considered the natural circumstance. ▪ Service are managed by the community ▪ IGAs are environmentally sustainable. ▪ Families and caregivers know/are trained how to manage financial resources. ▪ Services have inbuilt mechanisms to minimize risk. ▪ IGA are based on market assessments (supply/demand driven) ▪ Progress of beneficiaries should be monitored and documented.
Efficiency	▪ Service delivery strategy should have a low operation cost. ▪ Leverage public and private sector resources. ▪ Service delivery strategies are consistent with community norms and values. ▪ IGA opportunities are diverse.
Continuity	▪ Referral service is appropriately linked with other service providers. ▪ Service delivery strategy is managed by the community. ▪ Services are consistent with local laws and regulations.

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	▪ Services are built on indigenous community knowledge and tradition. ▪ Services are based on local resources and outlets. ▪ Those trained are linked to potential employers. ▪ Communities are facilitated to interact or build relationships with the private sector.
Respectful Relations	▪ Service delivery is participatory ▪ Need based service delivery not supply driven ▪ Services and products made should not be labeled to avoid stigma.
Appropriateness	▪ HIV+ OVC and HIV+ caregivers are not engaged in activities that are overly laborious. ▪ Service delivery should be demand driven. ▪ Services are based on local tradition norms and values. ▪ Services are focused on primary needs of most vulnerable.
Participation	▪ Caregivers and OVC participate in selection, planning and management of the activities. ▪ Flexibility of service delivery ▪ Community convince is considered in conducting activities ▪ Selection of beneficiaries is transparent. ▪ Community is involved in decision making leading to empowerment.
Sustainability	▪ Local laws and regulations maintained and recognition are given to innovative service delivery mechanism ▪ The services that are provided are built on strengthening traditional coping mechanisms. ▪ Referral system is properly linked and maintained. ▪ Resources are leveraged from private and public sector. ▪ Beneficiaries are trained in business management, savings, and investment.

DRAFT STANDARDS : ECONOMIC STRENGTHENING

How should these activities be carried out? (This is the content of your standard which may vary by organization).

Identify elder OVC/ guardians/relatives and assess their needs

- Identify vulnerable children using community defined criteria + structures (Kebeles, Idirs).
- Identify family/caregiver participants using community structures – Kebeles, Idirs.
- self selection of target groups while forming solidarity group
- Consider innovation and natural talent in selecting and organizing
- Allow competition to enhance entrepreneurial capacity and innovation
- Identify family /caregivers participants using community structures

Map market demands, service providers and leverage resource

- Conduct evidence-based market assessments.
- Use and update existing provider information.
- Forge private and public partnership forums.

Provide training for older OVC and caregivers on how to generate and mange income

- Base training on talents, experience, interest, aptitude and dreams of the participant – look for opportunities to break gender stereotypes.

- Provide holistic training which includes basic business skills.
- Include training to improve safety in the training or working environment.

Support for Actual Economic Engagement

- Provide one or more of the following: business incubation centers, materials, equipment, soft loans, and concrete job opportunities, apprentices, and link with micro finance institutions and other service providers such as micro and small enterprise development agency.
- Provide coaching and guidance.
- Identify market outlets.

Assessment

- Follow-up using acceptable monitoring and evaluation practices including participation of stakeholders, documentation, and dissemination.
- Include examination of
  - Actual income of targeted households before and after intervention;
  - Satisfaction level of clients;
  - Any unintended outcomes or negative effects; and
  - Actual improvement of care of children in the targeted household.

Critical Minimum Activities (cross-check with dimensions of quality)

- Identify older OVC/guardians/relatives and assess their needs.
- Map service providers and leverage resources.
- Conduct market analysis for business viability.
- Help households caring for OVC to get financial resources.
- Provide training on how to generate and manage income.
- Provide materials, financial, and job opportunities.
- Monitor/document progress of beneficiaries through an assessment checklist.

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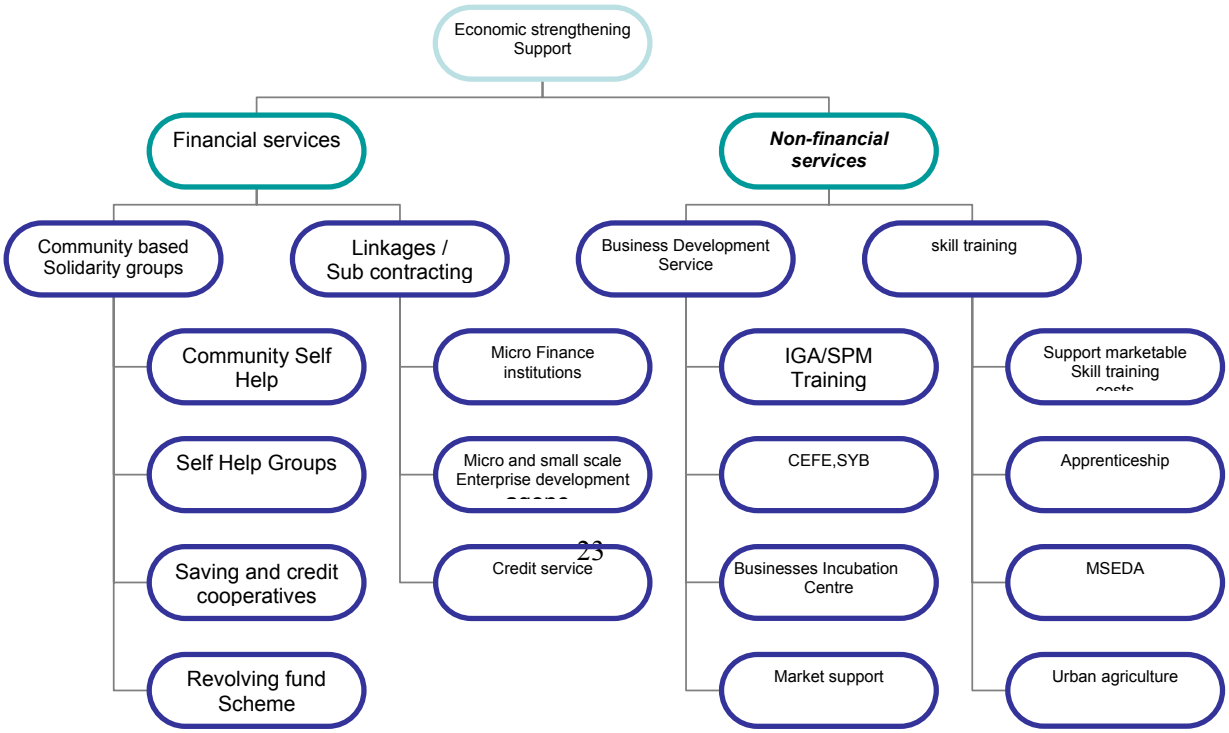
√ *Guideline* ___*Protocol* ___*Checklist*



III. NAME OF SERVICE COMPONENT: LEGAL PROTECTION

Desired Outcome: OVC receive legal information and access to legal services as needed, including birth registration and property inheritance plans. And is protected from all forms of abuses and violence.

DIMENSIONS OF QUALITY MATRIX: LEGAL PROTECTION	
Dimensions of Quality	**Quality Characteristics For Legal Protection**
Safety	• Reporting mechanism protect the identity of the person reporting (to reduce the chances of retribution). • The records, information and files in the police station, public prosecutor office and the Court be confidential Privacy of the child protected by the media. • Safe interrogation of children is enforced.
Access	• Legal services are affordable or free for OVC. • Strong referral network are established between stakeholders. • Service are child-friendly and information is easily understandable. • Services are provided proactively to children instead of the child having to go to them. • A current service map is available which identifies legal service providers. • Information about services is available in a variety of media including electronic, print and public forums such as schools, kebele, media etc.
Effectiveness	• Information and advice is relevant and accurate. • OVC have timely access to legal assistance (i.e. before the issue becomes too serious). • OVC legal issues are followed-up on to determine if more advice/assistance is needed. • OVC are represented in court. • Legal issues are resolved according to the law and where the law does not protect OVC, advocate for change. • OVC and caregivers learn/trained to identify when they have a legal problem and how to access assistance.
Technical Performance	• Service providers are sensitized to OVC legal rights and needs. • Legal advice is accurate and appropriate to the child or caregivers level of understanding. • Legal issues of OVC are followed until successful resolution. • Legal and enforcement institutions, NGOs, CBOs and local government establish formal referral systems. • Provide training for legal bodies and service providers on different dimension (emotional, social impact and child development needs and stages),
Efficiency	• Information is accessible and available to OVC when needed.

	• OVC or caregivers know when to access information or ask for legal help. • OVC's legal problems are resolved quickly with appropriate follow-up. • A comprehensive approach is taken so that legal needs are not addressed in isolation of other issues, and when other needs are discovered, children are appropriately referred to the services that they need. • Referral, reporting systems and networks are established for easy acquisition of evidence for speedy trial. • Legal assistance and follow-up is undertaken by the same person and child is not passed from person to person and follow-up is documented and timely so that legal problems are resolved quickly.
Continuity	• Education about the law, standards, and reporting mechanisms are given to OVC and caregivers.
Compassionate Relations	• OVC are dealt with sensitively and are listened to. • OVC are represented in court or in negotiations where they need it. • Child-friendly courts are established or advocated for (especially for taking evidence in abuse cases).
Appropriateness	• Information and services are child-friendly appropriate and accessible by age, culture, grade and for children with disability.
Participation	• Children and their caregivers are listened to and involved in solving their legal problems. • Through education about the law and legal system, children and their caregivers are empowered to identify when they have a legal issue and how it should be resolved and who to look to for assistance. • Steps are taken to increase community participation in protecting children from abuse, reporting abuses, resolving issues out of court where appropriate and helping children to access legal help; • Government is empowered to more actively participate in protecting children through Child Protection Units (CPU) and Child Rights Committees. • Insure political participation of children through programs such as the child parliament.
Sustainability	• Promote community ownership and awareness about children's rights, the legal system in Ethiopia and access to services. • Strengthen Child Rights Clubs and Committees and CPUs. • Establish and strengthen referral networks.

DIMENSIONS OF QUALITY MATRIX: LEGAL PROTECTION

How should these activities be carried out? (This is the content of your standard which may vary by organization).

- Mapping of legal service providers and stakeholders.
- Provision of education and awareness raising in the community, in the schools, about child-related laws, self protection skills, timely reporting of cases, child participation and child rights through child friendly and culturally appropriate material.
- Provision of information (for example in brochures and newsletters) on common legal issues and what to do and widely distribute systematically to reach as many audiences.
- Advocate and network with Government and stakeholders for the change of laws that are not fair to children or for the enforcement of laws that protect children.
- Capacity building of stakeholders, particularly sensitizing police, judges Child Rights Clubs and Child Rights Committees to the needs of children and how to

compassionately assist them.
- Provide awareness raising and technical support on will writing and succession planning.
- Promote birth registration
- Advocate for the establishment and strengthening of CPU
- Establish and strengthen networking systems with legal provision such as shelter, medical care and psychosocial support.

Critical Minimum Activities (cross-check with dimensions of quality)
- Identify and verify legal services available in the community, including Child Rights Committees, NGOs, Child Protection Units etc (mapping)
- Community education and awareness raising on child-related laws and child rights.
- Identify vulnerable children and their caregivers and visit regularly.
- Refer and link OVC and their caregivers with appropriate legal services when required.
- Establish tracking and monitoring system for OVC identified to have a legal problem to ensure proper follow-up.
- Sensitize the media to inform the public about the rights and needs of OVC.
- Provide awareness raising and technical support on will writing and succession planning.
- Promote birth registration
- Advocate for the establishment and strengthening of CPU
- Establish and strengthen networking systems with other service providers such as shelter, medical care and psychosocial support.

Which type of standard is most appropriate? (please check one)
- √ Guideline ___Protocol ___Checklist

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IV. NAME OF SERVICE COMPONENT: HEALTH CARE

DESIRED OUTCOME: Child has access to health services, including HIV/AIDS prevention, care and treatment

DIMENSIONS OF QUALITY MATRIX: HEALTH CARE	
Dimensions of Quality	**Quality Characteristics for Health Care**
Safety	• Services are provided in a confidential manner (do no harm) by skilled professionals • Referrals are made to skilled professionals and on the basis of need • Health services are provided safely (according to recognized standards) and in appropriate settings with appropriate equipment and supplies

Access/*Reach*	• Create a referral network of local services • Strengthen community based services • Services are provided locally (either in the community by community based workers or at local health facilities or service providers) • Barriers to health care services are assessed and addressed (i.e. transportation, fee waivers) • Ensure ongoing access to treatment (including ART)
Effectiveness	• Child is recovered • Preventative health -seeking behaviors increased • Child receives appropriate care for the identified needs • Activities to promote health seeking behaviors are implemented • Follow-up on referrals
Technical Performance	• Service providers are sensitized to children's needs and holistic approach • Children receive services appropriate to their ages and assessed needs • Children recover from illness • Effective referral systems in place including counter-referrals • Home based care providers are trained to recognize needs of children
Efficiency	• Comprehensive services are provided in one location • Caregivers identify problems in a timely manner and through regular interaction at household level • Provide basic routine health screening to identify problems (i.e. community case finding for OVC) • Provide continuous access to necessary drugs, care (i.e. home based care) and care provider
Continuity	• Promote recipients completing the full course of medication • HIV prevention messages are continuous • Ensure ongoing access to treatment (including ART) and adherence • Follow up on referrals
Compassionate Relations	• Provision of service is sensitive and child friendly • Recruit observant volunteers/care givers who listen and recognize needs • Health care is provided with dignity and respect

Appropriateness (Relevance)	• Health care and medication are age-appropriate (including ARSH for adolescents and immunizations for children under five) • Services are relevant and need based (on the basis of diagnosis)
Participation	• Health care workers listen to and observe the child in the provision of care • Ensure caregivers, CBOs, and children are actively involved in their treatment, health education and other health cares activities
Sustainability	• Community ownership and health education is promoted • Empower caregivers to seek health service • Involve civil society & private health facilities, improve the quality of health care. • Community knowledge of health issues and ability to relay this information • Prevention activities and referral linkages are in place, strengthened and well functioning • Increased Government resources for system strengthening and coverage to improve access and quality of services

STANDARDS: HEALTH SERVICES

***Major Activities to achieve outcome*:**

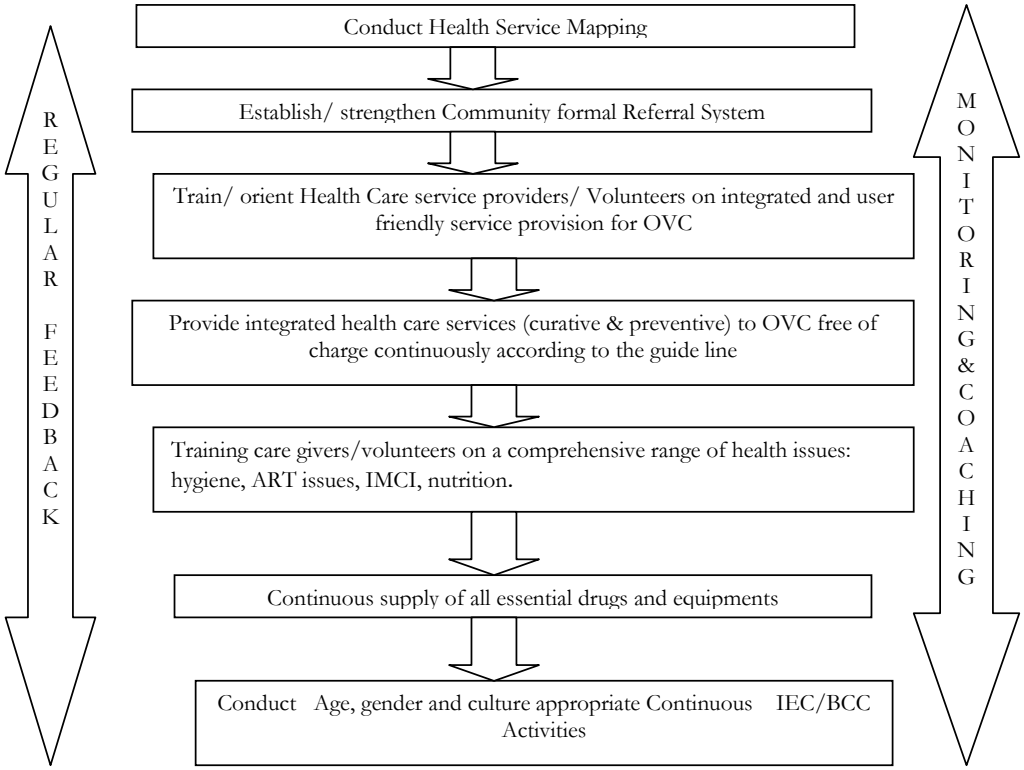
- Complete a community service mapping of health facilities (public, private) and related services.
- Establish referral linkages.
- Cover fees, drugs, transportation, facilitating free medication papers.
- Train caregivers and volunteers on basic health care, hygiene, VCT, ART adherence. HIV/AIDS prevention education and referral as needed to children and community members. Refresher training needed for health messaging around HIV/STI/RH including gender issues, gender-based violence, and alcohol use.
- Provide water and sanitation service.
- Provide health education to volunteers on HIV/AIDS, personal hygiene, water and sanitation, and other health care issues including Sexual and Reproductive Health (SRH) for youth aged 14 and up.
- Conduct regular home visits.
- Make referrals for rape/child abuse/emotional problems, holistic care and follow up.
- Follow up on all referrals.
- Document the health status of children through an initial health screening when possible.
- Conduct activities to sensitize the community on health issue-MCH, STI, OVC, HIV/AIDS.
- Mobilize community resources.

Critical Minimum Activities *(cross-check with dimensions of quality)*

- Identify and verify the health services (including health education) available in the community.
- Ensure formal referral systems exist and beneficiaries receive Kebele IDs and are reimbursed for medical fees.
- Conduct regular monitoring/home visits so that all children (especially Child-Headed Households) have adult interaction.
- Provide basic age-appropriate health education and ensure that children receive HIV/AIDS education either directly from the CBO or through another partner, church, community.
- Train care givers/volunteers on a comprehensive range of health issues: hygiene, ART issues, IMAI, nutrition.

Which type of standard is most appropriate? (please check one)
___Guideline ___Protocol √__Checklist

Health Service Framework



V. NAME OF SERVICE COMPONENT: PSYCHOSOCIAL SUPPORT

DESIRED OUTCOME: Ensure that children develop personal strength and skills to cope with life's challenges.

DIMENSIONS OF QUALITY MATRIX: PSYCHOSOCIAL SUPPORT	
Dimensions of Quality	**Quality Characteristics for Psychosocial Support**
Safety	▪ Programs should be conducted in physically safe environment ▪ OVC should be protected from harsh punishments, stigma and labeling ▪ OVC should be protected from all types of abuses (child labor exploitation, emotional abuse such as insulting, warning, belittling, bullying, teasing etc.), especially when they report cases of abuse ▪ OVC have the ability (knowledge, skill, emotional strength) to say NO to dangerous situations ▪ OVC can go to a stable and predictable environment to the extent possible. ▪ Children know that they will get rightful inheritance and other rights. ▪ Caregivers and workers with children should not be known or suspected child abusers. ▪ Confidentiality of information related to counseling, testing and treatment should be kept and of high quality. ▪ Children should equally participate on different activities. ▪ Ensure that BCC, IEC materials are tailor made. ▪ Facilities and environments should be child friendly. ▪ Maintain group dynamics by age, religion, etc.
Access	▪ Children should have access to play materials and environment ▪ Training and other service areas are convenient. ▪ Make sure that materials and services are in line with beneficiarie cultural and linguistic settings. ▪ Every child should have access to counseling – initially may be at a Para-professional and lay-level, but with referral and follow-up to more professional services if needed. ▪ All services in community should be accessible regardless of gender, disability, etc. ▪ Every child/caregiver should have information about where and how to access resources/services ▪ Environment & participation should be free from stigma and discrimination. ▪ All community services should be child- friendly. ▪ HIV related counseling, testing, and treatment should be confidential and of high quality. ▪ Children have access to guidance and therapy as needed.
Effectiveness	▪ Children are happy, participating in games and are not isolated. ▪ Children are interactive, confident and decision makers.

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	▪ Children are protected from HIV/AIDS and other reproductive health associated problems. ▪ Programs and services actively promote self-confidence, nurture hope, and facilitate happiness. ▪ OVC has opportunities to fulfill his/her potentials – e.g. talents, skills, interests (to pursue his/her dreams). ▪ OVC have opportunity for fun and laughter. ▪ The environment is open, supportive, nurturing, accepting of children and promotes opportunities for a child to meet needs and fulfill dreams. ▪ Children learn leadership and life-skills. ▪ Caregivers have knowledge about parenting, disciplining, communication and children needs. ▪ Adults in community are competent to deal with trauma, grief, bereavement, inheritance and capable of providing emotional and spiritual supports.
Technical Performance	▪ Every child should have one competent adult with whom there is regular and genuine contact, to whom he/she can go for guidance, encouragement, problem-solving, support. ▪ Parents disclose their health status and make the necessary succession planning for children together with them. ▪ Emotional, social etc status are monitored. ▪ Make sure that Peer-Groups and Youth Clubs are formed and children consistently attend regular activities. ▪ Service providers are role models: ethical, passionate, caring, open-minded, and trustworthy. ▪ Participating community members respect confidentially. ▪ Participating community members have assessment and referral skills (and conduct follow-up). ▪ Life-skills trainers' capacity is built and sequence of activities are maintained. ▪ IEC, BCC materials should contain appropriate information.
Efficiency	▪ Use volunteers to provide service components sufficiently. ▪ Use referral linkages for professional counseling, play materials, LS trainings. ▪ Children are fully integrated into family and community life – their lives are as normal as possible; they are not isolated or alone. ▪ All OVC programs & services should include PSS.
Continuity	▪ Clubs for children and caregivers should be established. ▪ Service providers should be motivated. ▪ Strengthen referral systems for professional counseling, spiritual support, LS training etc. ▪ PSS competence should be achieved by actors at community level, so that it is ongoing and sustainable. This means that there should be basic training/knowledge in active listening and responding skills, child development, referral (coordination of care). ▪ Community should provide support for the caregivers. ▪ Children should be encouraged and/or supported to have an ongoing

	spiritual life (religious affiliation and relationship).
Compassionate Relations	▪ Children should be treated equally, but not the same, by caregivers, service providers, trainers and community. ▪ Both OVC and Non-OVC should participate on services to avoid stigma and discrimination. ▪ Children should not be neglected. ▪ Every child should be able to express feelings & concerns without fear of punishment. ▪ All services should be provided with dignity, respect, and care. ▪ All adults in community should positively acknowledge and engage children.
Appropriateness	▪ Services should be designed in line with cultural, language, age etc set-up. ▪ Materials should be adopted to respective cultural, religious etc context. ▪ Services and programs should be individualized – that is, they should recognize the uniqueness of each child and be tailored to the relevant aspects of the child's own needs and situation. ▪ Services should be gender and age specific (sensitive).
Participation	▪ Children should participate equally and voluntarily in different games and activities. ▪ Children and caregivers should participate in deciding on types of services, where and when to get services, selecting their leaders in clubs and peer-groups. ▪ Children should participate in providing, monitoring, and evaluating services. ▪ Related to this, OVC should have feed-back loops (to evaluate their services, situation). ▪ Children should participate in setting rules and regulations in their clubs and peer- groups and in selecting their caregivers. ▪ OVC should be given the opportunity and support to succeed in something that is meaningful – that is, to engage in self-expression, to explore talents, to fulfill dreams. ▪ OVC should be encouraged/ trained in good communication skills. ▪ Community and systems-level – should encourage child involvement and participation (may require attitude-change). ▪ OVC have the right to design and choose services, activities, affiliations, adult linkages.
Sustainability	▪ Make advocacy works to mainstream PSS and LS in primary school and community set-up.(E.g. Curriculum and play ground.) ▪ Personal history of parents should be kept/documented for childre (i.e. memory work) ▪ Ensure community involvement in providing support. ▪ Establish formal referral linkages between community and service providers. ▪ Use locally available, child friendly and culturally sound materials. ▪ PSS should be integrated into Idirs (traditional burial societies - local CBO). ▪ Community leaders and structures should be encouraged/ trained in

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	PSS. ▪ Youth should be empowered to become leaders (peer supports and youth-models). ▪ Child rights model should be applied for systems-change.

DRAFT STANDARDS: PSYCHOSOCIAL SERVICES

Major activities to achieve outcome:

- Assist /support caregiver with disclosure of HIV status:

Counseling available to discuss disclosure strategies and assist parent/ caregiver with planning how they will talk to their children about how HIV/AIDS if affecting their lives.

- Assist in succession planning which includes at a minimum options and preferences about who will care for the child when the parent is no longer living and legal advice on how to best protect the child's inheritance if any :

Counseling with parents, children, caretakers to discern options and preferences about who will care for the child when the parent is no longer living. Assistance and referrals for legal advice and will writing, protection of inheritance.

- Attachment and personal history are recorded and contact with relatives and siblings is adequate: Work with families to prepare memory book that will help to preserve memories of personal and family history.

This can be done in a workshop setting or during home visit. Ask child if visits occur and if he or she sees family as often as she would like. Encourage extended family to visit child as frequently as possible.

- Counseling Services with respect to Grief, HIV and youth counseling with drug and alcohol counseling provided as needed. Ensure that caregivers, teachers and home visitors are prepared to support the child in grief in an age appropriate way.

Care must be taken to follow the lead of the child and avoid re-traumatization. Counsel about how to avoid/ handle stigma, safe sex practices, address other concerns about illness. Refer to support groups as appropriate. Educate youth about the dangers of drugs and alcohol. Ask if drugs and alcohol are abused by adults in the household. Screen for signs of drug or alcohol use and refer any household member for treatment as needed.

- Ensure that the child is living a normal life in terms of school, recreation and links to community.

Ensure that children are enrolled in school, attending school, and that the child does not feel isolated or stigmatized at school. Verify that recreational activities are available and that the children have access to community networks (religious institutions, extended family, etc.) Play with children (as appropriate).

- Ensure that children have opportunities to participate weekly on different play activities such as drama, music, drawing, games

So that children can regularly (once a week) participate on such activities. Occasional exhibition should be arranged in order to give children a chance to show their works to communities and caregivers in save environment. Children should be encouraged to attend activities that build their resilience, confidence, trust etc.

- Religious leaders and elder should provide children with Spiritual Support and promote positive cultural norms.

Children should be encouraged to attend religious programs. Volunteers and caregivers can take them to such places once a week.

- Enhance Caregivers and community awareness on parenting, disciplining,

communication, open dialogue with children on RH and HIV/AIDS issues etc. Caregivers support group should be formed in order to discuss on different issues. Community trained facilitators will take the responsibility to make such facilitation.

- Monitor household dynamics vis-à-vis caregiver and siblings:

Discuss household dynamics with child and caretaker. Refer for parenting skills, conflict management or protection services as appropriate.

- Establish mechanism to address burnout of caregivers such as support groups to counsel/support caregivers to protect caregivers from burnouts and enable them to cope
- Age appropriate Life Skills training should be provided:

Community awareness shall be increased to openly dialogue with children on their RH and HIV/AIDS related issues and participating children on different issues through tailored IEC, BCC materials, music, drama, poems, sport festivals, coffee ceremony etc.

- Implement Beacon School and YAK training program

to render the training. Beacon School and YAK trainings will be provided to trainers; teacher, students, club members and members of the community groups. Trainers will train youth using the age appropriate training manuals both in and out of school set-ups.

- Form Peer Groups right after Beacon and YAK training:

Peer Groups will be formed right after training sessions which will consolidate and help children to develop the necessary skills. Trainers will help children on the formation and management of Peer Groups. In Peer Groups, children will rehearse what they have learnt during training and sport and quiz competitions etc will be performed. Peer Group is believed to be the nucleus of LS development.

- Assist and counsel children who have lived outside of family care:

Address special needs of children who have lived outside of family care with intensive counseling and verify that they are sleeping in the designated household every night.

- Implement a Role Modeling program where renowned people can be invited to share their experience and success.
- Re-integrate children who have lived outside home to their family and relatives so that they can be brought up in community cultural set up and receive guidance.
- Have programs for volunteers to sponsor children during holidays.

Volunteers and community group members can make linkage with different organizations and religious institutions to celebrate public and religious holidays together.

Critical Minimum Activities

- Succession planning for children is in place.
- Attachment and personal history are being kept and contact with relatives and siblings are adequate.
- Counseling services provided to OVC and caregivers as needed.
- Re-integration services are provided for children who have lived outside of family care.
- Establish support groups (children and guardian support groups and clubs) to counsel/support caregivers/children
- Children should be allowed to participate on play activities.
- Religious leaders and elders should provide children with spiritual support and promote cultural norms.
- Renowned and successful people should be encouraged to work as volunteer for role modeling.
- Sponsoring children during holidays.

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- Enhancement of caregivers and community awareness on parenting, disciplining, communication, open dialogue with children on RH and HIV/AIDS issues etc.
- Age appropriate life skills training should be provided and peer groups should be formed.

Which type of standard is most appropriate? (please check one)
√ *Guideline* ___ *Protocol* ___ *Checklist*

Deleted: <#>Assist and counsel children who have lived outside of family care.¶
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VI. NAME OF SERVICE COMPONENT: EDUCATION

DESIRED OUTCOME: Child is enrolled, regularly attends school and completes a minimum of primary school (8th grade).

DIMENSIONS OF QUALITY MATRIX: EDUCATION	
Dimensions of Quality	**Quality Characteristics for Education Services**
Safety	▪ Security from abduction, rape and harassment when children walk to school. ▪ Services provided to OVC are the same or similar to those provided to other students (i.e. no special uniforms for OVC or made from more expensive or different materials) so that nothing would identify them as receiving special services. ▪ Confidentiality of HIV status for OVC to reduce stigma leading to isolation, bullying, and other forms of harassment and psychological abuse. ▪ Protect children from abuse (physical and emotional) from teachers other students, caregivers or community members. ▪ Help OVC to have a secure home-base rather than living on the street or in a temporary structure. ▪ Promote a safe environment for the child at school, at home and in the community.
Access/*Reach*	▪ Eliminate school charges (fees), even when primary school attendance is free; there are other school costs that keep children out of school. ▪ Encourage government and community to build additional schools as distance and lack of security may keep OVC out of school. ▪ Encourage government and community to increase the availability of pre-schools especially in rural areas. ▪ Promote gender equity by encouraging parents to send their daughters to school rather than having girls remain home to perform household chores of perform other work. ▪ Provide sufficient school materials, supplies and uniforms so that OVC are encouraged to remain in school. ▪ Organize a school, community or home based feeding program to ensure that hunger does not prevent OVC from attending school.

	▪ Address child labor exploitation issues so that OVC are not denied educational opportunities because of the need to sustain themselves.
Effectiveness	▪ Advocate and bring OVC issues to the attention of communities. ▪ Empower community bodies such as Parent-Teacher Associations (PTA) or Idirs to support OVC needs. ▪ Increase promotion rates among OVC through tutorial classes, summer programs and other supplementary educational support. ▪ Enhance OVC performance at school through improvements in the quality of learning. ▪ Increase community and OVC understanding the Child Rights protection policy. ▪ Promote more effective school supervision through increased parental involvement in school affairs and more intense supervision by Woreda educational officials.
Technical Performance	▪ Increase capacity building for PTA and teachers through better planning, provision of tutorials and other methods to support OVC in school. ▪ Use school based data to make help school and communities make more informed decisions. ▪ Mobilize resources locally in addition to accessing government and NGO support. ▪ Develop more effective communication channels between school and the home (caregivers) for OVC.
Efficiency	▪ Work to increase enrollments, class promotions rates, and retention, and reduce drop-outs. ▪ Prioritize school and individual needs. ▪ Target the neediest. ▪ Leverage local resources.
Continuity	▪ Assist OVC with making the transition from primary to vocational school or other economic opportunities. ▪ Strengthen livelihood provision for families to continue OVC support after project life ends. ▪ Sensitize community to continue support for OVC after external projects end.
Compassionate Relations	▪ Train para-counselors from the community to mentor and encourage OVC on a continuous basis. ▪ Promote nurturing relationship and communication between teachers and students. ▪ Ensure confidentiality for OVC. ▪ Respect, trust, value, and recognize OVC as individuals rather than as a group. ▪ Provide services with dignity and in a respectable manner without stigmatizing beneficiary OVC.

Appropriateness (Relevance)	▪ Provide needs-based support. ▪ Match services with need, sex and age. ▪ Provide tutorial and supplementary assistance to all academically deficient children in school to reduce stigma and discrimination. However, the majority of participants should be OVC. Programs should be scheduled when OVC are free from helping guardians with chores at home. ▪ Develop health care referral system for OVC in-school.
Participation	▪ Encourage age appropriate child involvement in planning, and implementation of programs that affect them. ▪ Facilitate active participation by beneficiaries and caregivers in decisions made about them.
Sustainability	▪ Create sense of community ownership for OVC support by involving all stakeholders in programs (PTA, KETB, Caregivers, Woreda Education Officers, community members, OVC). ▪ Generate long-term commitment from community. ▪ Develop a broad community vision beyond a short-term focus on OVC needs. ▪ Develop a resource generation focus that is multisectoral not only from community or government (synergy of resources).

DRAFT STANDARDS FOR EDUCATION

Major Activities to achieve outcome:

- Identify stakeholders including
- Strengthen and empower PTA and teachers through training, especially on PSS.
- Mobilize community such as PTAs and others to conduct regular community sensitization and meetings.
- Develop work plan and priorities in collaboration with local communities, Kebeles, Idirs, CBOs, and FBOs.
- Establish OVC education, identification and screening committees in conjunction with PTA and School Administration.
- Conduct resource and service mapping.
- Plan for local resources mobilization on regular basis including income generation activities (IGA).
- Develop school and community action plans for OVC support.
- Initiate/implement OVC policy and programs at different educational system levels.
- Integrate life skills and livelihood opportunities into educational programs.
- Develop tracking, monitoring and feedback mechanisms with educational program referral services and community.
- Establish OVC identification criteria in conformity with PEPFAR and government guidelines and community standards.
- Community participation in identification of OVC.
- Identify and address barriers to education (providing relevant services to meet those needs).
- Monitor child's progress

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Critical Minimum Activities

- Identify and engage all stakeholders, including Kebele Education and Training Board, PTAs and CBOs, etc.
- Build capacity to support OVC among PTA, teachers, community representatives and local government officials.
- Identify OVC in need of educational services.
- Identify and address barriers to education on an individualized basis for each OVC.
- Support life skills and livelihood opportunities as an integral part of the education program.
- Monitor child enrollment, attendance, performance and completion (adjust the services as needed).

Which type of standard is most appropriate? (please check one)
_x_ Guideline ___ Protocol ___ Checklist

VII. NAME OF SERVICE COMPONENT: FOOD AND NUTRITION

DESIRED OUTCOME for **FOOD AND NUTRITION: Food security: Ensuring that enough food is available for the child to eat regularly throughout the year for a healthy and active life.**

DIMENSIONS OF QUALITY MATRIX: FOOD AND NUTRITION	
Dimensions of Quality	**Quality Characteristics for Education Services**
Safety	▪ Ensure child has food REGULARLY ▪ Ensure child has fresh food, unexpired, and NUTRITIOUS enough for the his/her healthy development; Potable water which is free from chemicals (no pesticides used) ▪ Avoid child labor exploitation during food collection such as expecting children to travel long distance to get food aid and carry it by themselves ▪ Encourage caretakers to exercise better food handling practices such as using good sanitation (Hand wash exercise before and after meal) and safe food preparation and handling. ▪ Food preservation ▪ PMTCT and VCT are available for pregnant women and newborns ▪ Therapeutic feeding for malnourished children (community based initiatives…)

Access/*Reach*	▪ Ensure local availability of food for OVC throughout the year ▪ Encourage exclusive breast feeding (up to six month) and safe complementary feeding practices. ▪ Devise coping mechanisms during bad times such as eating unusual food such as rice during disaster time rather than expecting standard food products and distribution of available food ▪ Improve transportation and infrastructural facilities such as availability of potable water with in a short distance. ▪ Encourage caretakers to practice good food sharing practices
Effectiveness	▪ Increase awareness and practice for child, family/caregivers and community on the value of balance diet and nutrition ▪ Develop skills in food production, preparation and handling ▪ Ensure that OVC have access to food even though children traditionally eat after adults are served
Technical Performance	▪ Promote awareness of community members on supplementary feeding programs and how to Identify of cases for referral to feeding programs ▪ Develop criteria for where the community will refer the children ▪ Innovate and learn from best practices ▪ Build capacity of service providers relating to nutrition provision ▪ Mobilize local resources ▪ Create opportunities for capacity building through out the year.
Efficiency	▪ Enhancing local agricultural production knowledge; Maximizing local markets; Mainstreaming food and nutrition aspect in all service areas; ▪ Proper food management and storage to use it for a long period of time; ▪ Caregivers should be sensitive to the food need of children/OVC; ▪ Food has to be distributed fairly (OVC have to come first); ▪ Prioritizing the neediest OVC.
Continuity	▪ Encourage families to produce twice in a year using alternative agricultural technology (like irrigation) to ensure availability of food through out the year ▪ Promote diversification of food sources ▪ Integrate food production with other income generating activities so that OVC/ caregivers have enough income to buy food ▪ Ensure absence of food supply gap through out the year by promoting such things as food storage for bad times ▪ Train OVC on food production and preparation in the absence of the caregivers ▪ Build resilience of the caregivers against hunger and disaster
Compassionate Relations	▪ Promote informed community decision making in meeting the nutrition needs of OVC so as to minimize disturbances to the normal life of the community ▪ Design programs to prevent stigma during food and nutrition provision for OVC ▪ Provide food with respect, dignity and care ▪ Design programs that are responsive to culture (should be accepted in the community) ▪ Encourage community members to care for OVCs with love and respect.

Appropriateness (Relevance)	▪ Services are provided at the household level ▪ Services and education are age and need specific ▪ Services should discourage dependency ▪ Services are culturally sensitive and responsive ▪ Training is given in the primary language of the household
Participation	▪ OVC and caregivers participate in decisions that affect their lives ▪ Stakeholders participate at all levels of program planning and implementation ▪ Distribution of food is based on the actual need of OVC in the home.
Sustainability	▪ Planning and implementation is linked with other stakeholders, economic sectors and government systems ▪ Programs are integrated into school system (Example, vegetable production at school compound and nutrition education) ▪ Promote school attendance through food supply ▪ IGA and community initiatives to create access to food for the OVC ▪ Mobilize sustainable food/nutrition supply (long term not only immediate support) ▪ Best practices of agricultural production in the community are identified and shared. ▪ Work on changing some of the nutritional cultural norms in the community (some groups of the community will not eat seafood during fasting times, which is essential for child health development) ▪ Promote community ownership and participation in operating and financing the program including contribution of cash or commodities

DRAFT STANDARDS FOR FOOD AND NUTRITION

Activities to achieve outcome:

Resource mobilization

- Identification of OVC and targeting of the neediest ones identified by the community members.
- Food support for direct beneficiary regularly on temporarily basis.
- Identifying and engaging other stakeholders to strengthen linkages and referral systems.
- Advocacy work and networking with government offices and potential stakeholders.
- Discuss general situations of OVC with these stakeholders, identify and prioritize the existing problems.
- Discuss the response of the community and various stakeholders in the past to the need of OVC and identify the unmet gaps.
- Identify the possible solutions with the stakeholders to fill these gaps.
- Work on service and resource mapping to start resource mobilization to fill the unmet gaps.

Training and Capacity building

- Set screening criteria for OVC and their caregivers
- Identify OVC and their caregivers.
- Training on nutrition (balanced diet, food preparation, preservation, handling and exclusive breast feeding.)
- Training community health agents/volunteers on basics of malnutrition diagnosis and referral system.

- Target OVC and their caregivers for various trainings based on their needs, the resource at hand and the magnitude of the problem.
- Conduct training for these OVC and their caregivers on sanitation, food production, preparation and preservation using the local languages.
- Train volunteers on basic malnutrition diagnosis and referral systems.
- Require that trainees develop action plan for future follow-up and implementation of the skill and awareness they get during the training.
- Training on food production (livestock and crop production) and input provision

Support delivery

- Following the training, provision of agricultural inputs to the targeted OVC caregivers based on their needs.
- Identify potential feeding centers and create referral systems with these emergency feeding centers.
- Encouraging exclusive breast feeding.

Monitoring and Evaluation

- Use developed action plan as one of the monitoring means during the actual implementation.
- Develop OVC and caregiver profiles as the baseline to measure impacts in the future.
- Establishing some tracking and monitoring systems in delivering the food to the OVC.
- Monitoring the progress of the nutritional status of OVC.

Critical Minimum Activities

- Training and education on nutrition and food handling.
- Identifying and engaging other stakeholders to strengthen linkages and referral systems.
- Food provision for critical malnourished OVC whenever possible.
- Linkages and referrals to emergency feeding center whenever possible.
- Identify most vulnerable OVC and their caregivers.
- Establishing some tracking and monitoring system in delivering the food to the child.
- Monitoring the progress of nutritional status of OVC.
- Encouraging exclusive breast feeding and safe complementary feeding practices.
- Ensure PMTCT and VCT services are provided to women who gave birth
- Community capacity building.

Which type of standard is most appropriate? (please check one)
√ *Guideline* ___ *Protocol* ___ *Checklist*

VIII. COORDINATION OF CARE

DESIRED OUTCOME for Coordination of Care provided in Ethiopia**:** Child's needs are assessed and met in a coordinated way.

DIMENSIONS OF QUALITY MATRIX: COORDINATION OF CARE	
Dimension	**Quality Characteristics for Coordinated Care**
Safety	▪ Ensure confidentiality; child-sensitive assessments; prevention of stigma, and transparency in network practices transparency ▪ Provide a watch-dog function to verify safety and quality across groups in the coordinated care mechanism.
Access	▪ Engage government resources (money, physical, human) engaged ▪ Undertake service mapping ▪ Enhance availability of capacity for coordinated care to meet demand ▪ Ensure information is available on where and how to access services (child friendly) ▪ Service access mechanisms are established and functioning.
Effectiveness	▪ Ensure services responsive to needs of the whole child ▪ Stakeholders are involved in planning for OVC ▪ Established objectives that are being met.
Technical Performance	▪ Problems of double counting resolved ▪ Promising practices are identified, disseminated and applied ▪ M&E in place across all participating partners ▪ Procedures established to monitor capacity to avoid over extension ▪ Ensure that joint planning is dynamic not static ▪ Train staff regarding child-centered assessment so that services are based on need and not organizational offerings.
Efficiency	▪ No duplication of effort ▪ Resources utilization is transparent and mobilized ▪ Lead responsibility honored without competition ▪ National or regional level coordination is in dialogue with local level to increase service assess.
Continuity	▪ Coordination is a long-term commitment ▪ Networking is established, nurtured, and functional ▪ Unified push for a long-term perspective from donors ▪ Systems are formed and functioning across stakeholders ▪ Care plans for individual children are completed and followed.
Compassionate Relations	▪ Non-competitive atmosphere is fostered ▪ Child-friendly coordination mechanisms are practiced.
Appropriateness	▪ Child-friendly services ensured ▪ Services are responsive to gender, age, and special needs of children.
Participation	▪ Child input informs needs assessment as age appropriate ▪ Procedures are in place for the children to provide feedback on service provision.
Sustainability	▪ Existing community structures are used ▪ Shared ownership of care provision is fostered ▪ Plan developed for reduction in external resources ▪ A range of multi-sector stakeholders are engaged in planning, implementation and monitoring ▪ Capacity building is a priority.

Innovation	▪ Creative use of resources is fostered ▪ Approach to coordination is flexible and responsive to community changes ▪ Forums are conducted periodically to stimulate and encourage new ways to coordinated is in place.

DRAFT STANDARD FOR COORDINATION OF CARE

How should these activities be carried out? (This is the content of your standard which may vary by organization).

Service mapping and resource mobilization

- Identify existing services – who is doing what, where and for whom in terms of families and children.
- Identify existing structures and capacity to coordinate and provide services to families and children.

Support a coordinating task force

- Multi-sectoral and vertical representation.
- Clear Terms of Reference.
- Formalize referral network, process and tools for follow-up (formal agreement between the providers and the task force).

Plan for children in place (identification, assessment and prioritizing) with a Costed National Plan of Action

- Community plan developed by Task Force.
- Care plan for child in context of family.
- Continuous information on coordination of care.
- Making sure that the coordinating structures are aware of and up-dated on resources.

Dissemination of information on an ongoing basis to families, children and communities so that they know what is available and how to access it.

Supportive supervision and monitoring

- At least one supportive adult volunteer for every household.
- Volunteers trained and able to provide regular supportive visits to families and to coordinate services and follow up referrals as needed.
- Mechanism for families and children to be able to safely provide feedback on care received.

Critical Minimum Activities (cross-check with dimensions of quality)

- Conduct service mapping and resource mobilization.
- Support functioning of coordinating task force.
- Create and implement plan for children, which includes identification, assessment and prioritizing of need.
- Facilitate the dissemination of continuous information on coordination of care (to communities, families and children).
- Provide regular supportive supervision and monitoring.

Which type of standard is most appropriate? (please check one) *_√__Guideline ___Protocol ___Checklist*

APPENDIX I: Technical Group Workshop

October 1 -2, 2007 at Rift Valley Hotel, Nazareth

Agenda
To discuss:

1. Introduction of the quality assurance and improvement concept,
2. Introduce the service standards which include outcome, quality dimension and critical minimum activities for six plus two services,
3. Assist technical staff to revise the standards to PC3 framework,

Discussion
The participants discussed 'quality as a degree or grade of excellence or worth'. However, it was difficult to unify the concept as people implicitly or explicitly defines excellence or worth in many ways. Quality expertise has found that defining dimension of quality permits a more systematic, objective and transparent analysis of the quality of a product service. The following quality dimensions are important foundations for defining and implementing standards. These are safety, access, effectiveness, technical performance, efficiency, continuity, compassionate relations, appropriateness, participation and sustainability. The definition of each quality dimensions had been clearly discussed.

Presentation of six plus two services and reflection from Technical staff : Annex II

1. Education and Vocational Training
   Reflection from participants was discussed as follows:
   - The out come is beyond the scope of PC3 and should include ECCD
   - Some activities seems outcome
   - Wording should be revised
   - School performance should be included (producing a competitive child)
   - Out come should be divided into Primary school and Vocational skill training because the two seems two different components,
   - Continuity and sustainability issues are addressed by linking government and other concerned parties
2. Coordinated Care
   - The out come shouldn't describe as "coordinated way" rather correct mix of services/ holistic services. The outcome is corrected as " child's need are assessed and holistic service is provided"
   - To ensure the continuity government and other concerned parties should be included
   - Appropriateness part correct mix of services should be included

3. Economic strength
   - Flexibility of LH intervention should be indicated in appropriateness part
   - The difference between IGA and Fund raising was discussed. Accordingly, IGA is micro business activity which is done by older OVC/ Caregivers. While fund rising, the fund raised by other concerned Parties for the support of OVC. fund raising is not part of LH support
   - The issue of credit access to OVC headed families should be included
   - Unclear words should be avoided like "strings"
   - The issues on continuity and sustainability are almost similar, revise it
   - "Over laborious" should go to safety rather to appropriateness

4. Shelter and Care
    - There is no performance indicator, should be measurable
    - Minimum quality should be set according to our context
    - On safety " environmentally safe" rather OVC shouldn't be below or above the community standard , discrimination should be avoided
    - On access, when we talk about shelter are we refereeing street children? The response was, not only but for all children who need the service. The issue is not only taken care of by PC3 rather by strong other resource leverage and community participation
    - " seems ideal" the response was there are some initiative already, advocacy should be done to duplicate the effort further
    - "Construction or rent?" both are already there some CBO pay rent

5. Health and Care
    - Continuous supply of drug should come to access
    - Free certificate is not practical in most case rather it is card
    - The quality of service provided in most gov't health institution is beyond our level
    - Safety "supply essential drugs" seems not feasible
    - On safety we should include safety precaution specially on HIV related cases e.g. when treating HIV positive family

6. Psychosocial
    - Repetition of the same idea should be twined
    - On continuity part, ongoing activities and the role and participation of other parties should be included
    - The presentation does not include our country context e.g. professional counseling however the group respond there are professional counselor though few. It can also be adopted to our country context easily

7. Legal protection

    - On the outcome part the word" legal service" include "protection" so avoid redundancy
    - Including birth registration for the existing and newborn is important
    - On access part , abuse detection , reporting and follow up should be included
    - On effectiveness, community participation on protecting and insuring OVC well being should be included.
    - Children should also be aware their responsibility
    - Networking should also be considered both in prevention and protection with concerned parties

8. Food and Nutrition
    - On outcome part it will be better to change the word "enough" to "adequate"
    - On effectiveness, it is better to include micro nutrient efficiency and food variety through home gardening
    - Care givers bring the supported child to take the food support, this should be avoided
    - Direct food supply is not advised unless the beneficiaries are under 6 age or PLWHAS

- On appropriateness, there is home based feeding and school feeding program which is more appropriate? The response was home based feeding is more appropriate but school feeding is also applicable in some cases too.

1. Critical Minimum Activities for Six Plus Two Services

- Presentation of six plus two services, Annex III

1. Education and Vocational Training
   - the list should include minimum activities but the indicated list are optimal activities
   - some of the lists seems outcome rather than activities
2. Food and Nutrition
   - Some are not activities e.g." increasing accessibility to safe and clean water"
   - Put the activities in measurable way.
   - Some of the activities are not under our capacity and objective
3. Shelter and Care
   - The original draft takes shelter only,

4. Legal protection
   - Awareness creation and sensitization should be included as a minimum activity
   - When cases happens, application of legal procedures and use of referral for concerned body to get justice should also be a minimum activity
   - Over punishment of child/ child abuse should be clearly indicated though tried to be explained by child club to report on this kind of cases.

5. Coordinated care
   - Since resources are limited, focus should be given only to the best need of the child and holistic service provision.
   - Some activities listed seems objective than activity
   - All tiers are responsible to implement the activities
6. Economic Strengthening
   - The support shouldn't create stigma
   - The support shouldn't be at the expense of the beneficiary future prospect e.g. engaging older OVC on IGA support than helping the child with education support…..
   - Entrepreneur skill development should be indicated clearly with the minimum activity
   - The danger of providing seed money to the beneficiaries was also major point of discussion as it creates dependency, discrimination and market distortion. Besides sustainability cannot be attained by this way.
   - Presenting the activity in simple way as it should be understand by everybody.

7. Health care
   - Supply of essential drug cannot be the minimum activity as it cannot be achieved by the program rather referral, health education and follow up should be clearly indicated. The group respond as, essential drugs for common diseases are mandatory for saving life.
   - precaution are not also clearly indicated
   - health seeking is an outcome should not be indicated as activity, the activity could be health education

8. Psychosocial (includes life skill):

- Pre and post test counseling is very important and currently there is a linkage with VCT centers , this activity shouldn't be overlooked
- Resilience, role model , conflict management and many other activities are included in the manual though not clearly indicated in the minimum activity
- Embravement and teachers' involvement should be clearly indicated. The group responded that detail activity is included in the manual and teachers are a resource person
- When accessing religious leaders for counseling, we should be cautious that children are not forced to change their belief

APPENDIX II: Children Workshop

Overview

Two workshops were held in Addis Ababa with children. The purpose was to provide input on the relevance and appropriateness of the standards being developed. The workshops differed in format and number of participants. A summary report was completed for each workshop which is provided below. For participants in both workshops, being on the street or a lack of shelter was seen as the biggest need of OVC. Interestingly, education was seen as a lesser need for OVC than children in general by the group that ranked both although that later group in a consensus building session selected education as the most needed service.

Interestingly, food was not rated as a high a need for OVC-4-or 5 as caring or love, the types of issues covered in psychosocial services. Also, food was seen as high or higher problem for children in general. This may attest to the success of programs target at OVC or the methodology where children known to the service agency who are receiving food support were included.

Overall the results of the workshops support the need to develop indicators in the 8 areas identified.

Children Workshop Report 1

Introduction

Children workshop held at Love for Children child centre located at Ledeta Kifle Ketema in Addis Ababa on Saturday, October, 2007 with the aim to inform and enrich the Quality standards crafted by technical specialist and other staff members of positive change program implementing partners drawn from representative of tier I and IIs partner, seventeen adolescent aged 10 – 13 came together to give their input. Children were briefed about the process of the QSI development and introduced with team of three members tasked to facilitate the workshop. These were preceded with two sets of tasks: The first task was to *list out and prioritize problems that faced children in general and orphan and vulnerable children in particular in their localities.* The second task was to *list out what types of support needed to tackle the problem faced by each group of children and then rank then prioritize the types of support needed.*

Workshop process:

Attendance, started with 17 children, 7 of them at age of 10 and 11 and the rest 10 with age of 12 and 13 years old. As part of the facilitation process participants' children were invited to get to know each other. This was done by asking the children to form pair and conduct interview one another on the following: names, ages, grades and when they start to come to the project

The summary of the interview is presented as follow as:

Grade		***Age***	
Level	Number of Children	Category	Number of children
4	2	10	1
5	7	11	6
6	4	12	6
7	4	13	4
Total	17		17

Then, in order to get border perspective the children were grouped into two small groups based on their educational background that is directly related with age at the same time. Grade 4 and 5 students grouped into the first group and named their group as Ethiopia Tikdem; where as the second group contains grade 6 and seven student and named their group as Ethio-Millennium . Each group was given with flip charts , marker and invited to write their opinion on the two sets of questions.

Then each group presented their ideas and views to the larger plenary. This generated much discussion and sometimes disagreement. Although time was limited, the workshop produced very informative ideas how the children perceive service qualities in their respective areas.

The participating children listed out what they believe are the problems of children in their localities. The problems of children in the program area varied by educational level.
Table 1 : List of problems and their priority faced children in general

Group I –Grades 4-5	Group 2-Grades 6-7
Lack of care	Rape
Education	Education
Work load (HH chores)	Shelter
Food	Food
Shelter	Clothing
Clothing	Health
	Educational materials
	HH chores

The two groups also differed somewhat in terms of their list of problems and priority ratings faced by OVC. Although both groups rated being on the street as the top issue. It was also observed that sometimes children mixed up their perception with what they have heard in the media and taught in schools. Table 2 lists out the problems and priority ratings of the two groups for OVCs

The difference in rated problems between children in general as reported in Table 1 and for OVC is striking. For example, rape was the biggest rated problem for Group 2 children in general, but rated 8th for street children who one would think are more vulnerable. Education was the second issue for children in general and for younger OVC . However was rated 7th for older OVCs reflecting their need for security.

Table 2: list of problems and their priority faced OVC in particular

Group I-Grades 4-5	Group 2-Grades 6-7
Streetism	Streetism
Lack of Educational opportunities	Lack of family Care
Lack of family Care	Health problem
Health problem	Food problem
Substance abuse	Shelter problem
discrimination	Clothing problem
	Lack of Education opportunities
	Rape

Listing out and prioritizing the children perception on types of support needed for OVC is an interesting area of the workshop. The children in both groups actively participated in this activity and had hot and long debate on prioritizing . Since it was difficult to reach agreement in small groups in terms of prioritizations, it was agreed to use ranking methods so that to use average raking to prioritize support.

As can be seen, there was lack of consensus, although protection received the overall lowest rank.

Table 3 : Types of support needed for OVC as perceived by group II

Sr	Types of support	Individual rank							
		1	2	3	4	5	6	7	8
1	Care	2	6	3	6	6	1	1	7
2	Food	1	3	1	5	2	7	7	2
3	Education	6	1	4	3	1	2	2	5
4	Educational material	4	2	6	4	3	5	5	3
5	Health	3	5	2	2	4	3	3	6
6	Shelter	5	4	5	1	5	6	6	1
7	Protection	7	7	7	7	7	4	4	4

Table 4 : Types of support needed for OVC as perceived by group II

Sr	**Types of support**	**Individual rank**							
		1	2	3	4	5	6	7	8
1	Education	3	6	3	6	2	2	1	2
2	Educational materiuals	6	5	5	5	1	4	2	4
3	Protection from substance abuse	7	1	1	3	4	5	6	1
4	Care	2	4	2	1	3	1	7	6
5	Health	1	2	4	7	5	6	4	7
6	Shelter	4	7	7	2	7	7	5	3
7	Free from HH work loan	5	3	6	4	6	3	3	5

Finally, consensus building at plenary was done where agreement was reached as indicated below. However, the top identified need is that of the older children who may be more articulate in a larger group and may reflect socially acceptable positions as compared to the private rankings.
Table Five: group I and II priorities by service area

Service area	Children's age group 10&11 priority	Children's age group 12&13 priority	consensus
Education	Fourth place	First place	First place
Protection	Sixth place	Fifth place	Fifth place
Health	Fifth place	Second place	Fourth place
Shelter	First place	Sixth place	Sixth place
Food	Second		Second place
Psychosocial support	Third place	Fourth place	Third place

Children Workshop Report 2

A children's workshop was conducted in Addis Ababa to test on the relevance, appropriateness and feasibility of the standards developed by PEPFAR fund recipient agencies and revised by the PC3 the technical staff. A total of 53 children participated in the workshop.

The children were divided in to two main groups of age 7 to 13, and 14 to 18. There were four and three sub-groups respectively. Each group discussed seven to eight of the main challenges and problems orphaned and vulnerable children specifically face in their community.

Subsequently, they came-up with the responses or solutions to the problems identified. Each individual child was given the chance to prioritize the needs identified on the score sheet using the PRA technique. Prior to the ranking staff grouped the needs identified by the children into the service categories. Table 6 gives typical words used by the children that were classified into the service categories.

The four groups with children aged 14 to 18 came up with relatively similar results and a wider group discussion was held to build consensus with the other groups.

PC3 program Staff working at Tier I and II levels were also asked to rank the needs as identified in the service package.

The resulting of the rankings of the 14-18 are presented in Table . Shelter was the number one concern identified by children. This result was surprising as in the 2003 study in which a large sample of children were interviewed, 90 percent identified education as the top priority.

Other reports also have identified education as a top priority. Children in this exercise actually rated education third with economic help and protection from abuse being rated second.

Table six: Ranking of need by Children and Staff

No	**Need as rated by the children**	**Need as rated by Staff**
1	Shelter, being off he street	Education
2	Economic strengthening, IGA to protect children from abuse	Economic Strengthening

3	Education	Psychosocial Support
4	Care (emphasis on love, adult support, avoidance o f stigma and discrimination)	Food and Nutrition
5	Food	Health Care
6	Clothing	Legal Protection
7	Life skills/Psychosocial support (emphasised trust and moral support	Shelter & Care
8	Protection (specially labour exploitation and sexual abuse)	Coordinated Care
9	Health Care	

*For one group care includes adult supervision, food and clothing.

Economic support was qualified by the children as a means of protecting them from being abused by adults.

Reasons for the difference in ratings may reflect the great improvements made by the government to increase access education but may partly be a function of the methodology (children known to agencies and thus available to participate in the study are receiving some educational support). Participating children were asked not only to reflect on their needs, but to reflect on the needs of all children in similar situations. However, even adults judge situations on personal experience.

The quality dimensions that children want to see irrespective of service component are:

1. Children should be consulted on their problems, needs and even solutions;
2. Professional consultation should be done to assess the expressed need of the child is beneficial/useful for his/her future development;
3. Priority should be given to children who live on the street;
4. Children who don't get the minimum care from parents should be considered similar to orphans and need to be assisted;,
5. Young adults who are of a working age should be enabled to engage in income generating activities;
6. Continuous follow-up and supervision should be made after provision of services;
7. Children should come together, express themselves and share what ever they have in all matters;
8. The service provider should clearly identify and help the most needy children;
9. The organization make sure resources are used for the designed activities;
10. The support should be given at the right time (children should not have to wait to receive services in a crisis due to procedural issues); and
11. The support should fulfil the specific need of the child.

Appendix III: Summary of Responses by **Tier III partners on the Quality Assurance and Improvement Standards**

Kolfe Keranyo Sub city HAPCO representatives, Tier II and Tier III partners (which include youth groups, Anti-AIDS clubs and six Iddirs) located in kebele 02, 10, 11, and 12 of Addis Ketema Sub city and Kebele 08, 09 an 10 of Lideta subcity were briefed on the contents of the QAI. Their reactions and responses are summarized as follows:

Exhaustiveness of the proposed quality dimensions

They have stressed that the quality dimensions are comprehensive and exhaustive but they have also emphasized the importance of focusing on sustainability and continuity of care for OVCs to be given more attention. They have expressed their concern on sustaining some of the activities like food support .

Applicability of the dimensions

They believe that most of the dimensions are applicable especially those activities facilitated through community mobilization, negotiation and referral. However they questioned the applicability of activities related to urban agriculture, assistance in disclosure of HIV status, follow-up of reported legal issues, ensuring drug supply, provision of enough school materials, ensuring financial support for IGA activities as the activities require land, water, professional expertise and capital. Other wise they underlined the applicability of other activities through negotiation and productive dialogue with stakeholders to come up with effective referral system and collaboration for support. According to their suggestion these activities can be realized through HBC providers, health facilities and local NGO partners.

Understanding about outcome

Both the Tier II and community partners indicated that there were not clear outcomes for each service category. Accordingly, they have defined the outcome for all components as "helping the OVCs and fulfilling their needs". The members of the community core groups, the HAPCO representative and the local NGO partner staff are satisfied with the list of minimum activities on although they have expressed their doubts on applicability of some of the major activities mentioned above. According to their response, these minimum activities apply for most of the non orphaned and vulnerable children due to the rampant nature of poverty and significant number of commercial sex workers in their locality

Use and Monitoring of the QAI

According to their response; HBC providers, local NGOs, health workers and others can use these tool to monitor and check whether they are delivering quality services. Regarding monitoring the quality standards the participants suggested Idir core group members, relevant sector offices, service providers, HBC providers and Kebele level supervisors have the responsibility to ensure quality service delivery.

APPENDIX IV:

Piloting Checklist for Quality Assurance and Improvement Standards

Name: _____Name of Technical Person: _____
Tier I _____ Tier II _____ Tier III: _____

Quality Assurance/Quality Improvement Parameters

No	Question	Response
1	Walk through and review the draft quality assurance and improvement standards to the community core group?	
2	Do you think the list of proposed dimensions of quality for _____ (name the service component) is exhaustive? a. If No, please mention the missing dimensions of _____ (name of service component) quality? b. Why did you think this dimension should be included? c. Do you clearly understand the list of dimensions? d. Are these dimensions applicable/relevant to context in which you provide OVC services ____ (name component of service)? Why? Why not? e. If applicable what are the key considerations to implement the dimensions? f. Who can monitor the dimensions?	
3	a) Do you understand what an outcome is? What does it mean to you? b) The QAI standards list at least one possible outcome; Do you think the list represents what you would consider as minimum outcomes for _____ (Name of service component) intervention for OVC? c) If not, what would you add? Why? d) Do you understand all the outcomes on this list? e) Are the listed outcomes, applicable or relevant to the context in which you are implementing an OVC program? Please explain?	
4	a) The QAI standards list a couple of activities to be implemented in providing ____ (name service component). b) Do you think the minimum standard activities are sufficiently described? c) What is missing from this minimum list of activities? What would you like to be added? d) Why this/these activities? e) Are all the activities listed here clearly defined? If not, what needs to be defined? f) Are the activities listed applicable or relevant to the context in which you provide ____ (name of service component) services to OVC? Why? g) Does the services apply for all children or only for OVC? h) Which of the activities has your organization implemented in the past two years? i) Why has your organization not implemented the others? j) Who and how can implement the activities? k) What are the key considerations to implement the activities?	

5	After looking at draft QAI standards, whom do you think should use them?	
6	How do you think you might apply the QAI standards for _____ (name service component) in your program?	
7	Do you have any other additions or improvements to make on the draft QAI standards? Which ones if so?	

Thank you for your time and contributions!