



The Kingdom of Lesotho

# National Standards and Guidelines for Care for Vulnerable Children



2014

Ministry of Social Development



The Kingdom of Lesotho

NATIONAL STANDARDS AND GUIDELINES  
FOR  
CARE FOR VULNERABLE CHILDREN  
2014

A framework of standards and guidelines for caregivers, programmers, civil society organizations working for protection, care and support for orphans and vulnerable children

Ministry of Social Development

Lesotho

# National Standards and Guidelines for care for Vulnerable Children

September 2014

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Sciences for Health Building Local Capacity in  
Southern Africa Project





*.....We do not own this world, we borrowed it from our  
ancestors, and owe it to your children*

# FOREWORD

The Situation Analysis of Orphans and other Vulnerable Children conducted in 2011, and the National Strategic Plan on Vulnerable Children (NSPVC) April 2012 - March 2017, highlighted various challenges facing the children, and caregivers in caring for their children as a result of disease burden, poverty, and identified several gaps in the national response.

The NSPVC also defined strategic priorities and recommendations aligned with the regional (SADC) and international guidelines, for a coordinated system-based response, and called for the domestication of regional guidelines to develop the national standards of care to regulate the quality of care and support.

Premised on the realisation that facing vulnerable children are complex and multi-faceted and require a unified approach, the government initiated a multisectoral approach to improve the quality of life of vulnerable children and their caregivers.

Lesotho's national response involves: 1. Creating an enabling policy environment at the national level, with a conducive operational environment for quality service delivery and coordination at the district and community levels; and 2. Engaging stakeholders to harmonize and align their responses and programmes for vulnerable children and caregivers with national priorities and guidelines.

In order to create and sustain policy and legal environment reform that ensures the protection and well being of children in accordance with the provisions of the UN Convention on the Rights of the Child and the African Charter on the Rights and Welfare of the Child (ACRWC), Lesotho has developed several policies and legal frameworks. These include: the National Strategic Plan for Vulnerable Children and the Child Protection and Welfare Act 2011, the OVC Policy, and Child Protection Strategy, and developed these standards of care for vulnerable children.

Domesticating and developing the standards involved a long process of research, negotiations and consultations with a wide range of stakeholders, but has been a worthwhile journey. In developing these standards the MOSD: 1. Conducted an orientation workshop for the stakeholders on the Minimum Package of Service facilitated by the SADC secretariat, 2. Established a Reference Group to provide technical guidance, 3. Conducted a contextual analysis, 4. Conducted a workshop for stakeholders on setting standards of care. Making a choice between minimum package of services and standards of care, amidst the passionate debates on 'minimum versus standard' was a challenge. The ministry, however, maintained a balance to ensure that each child, based on the needs, must have access to a minimum package of services as articulated in the SADC Minimum Package of Services for Orphans and other Vulnerable Children and Youth, ensuring that each of the components package meets agreed upon quality standards.

It is the expectation of the government that, service providers and organizations shall design and provide services to respond to a child's identified and established needs, based on a life cycle and family-centred approach, and not token services. For example, Lesotho's child protection must be

premised on the framework of social protection, and the services need to align accordingly to bring this effort to fruition.

Finally, this National Standards and Guidelines represent our initial step towards ensuring that the Bastho children have access to quality care a services they deserve, and is an important milestone in the history of our national response for vulnerable children in Lesotho.

It is a living document. The implementation of these standards and guideline will be monitored through integrating into the National Operational Plan and the National monitoring and evaluation (M&E) plan, evaluated for efficiency and efficacy, and will be reviewed accordingly.

I wish to thank and congratulate everyone involved in developing this document, and urge all the stakeholders to use and apply these guidelines, and to work always in the best interest of the child upholding their fundamental human rights.

A handwritten signature in black ink, appearing to read 'M. Matebatso Doti'.

**Honourable Mrs Matebatso Doti (Mrs)  
Minister for Social Development**

**September, 2014**





# ACKNOWLEDGEMENTS

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**September, 2014**



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### 3 ACRONYMS AND ABBREVIATIONS

ACRWC	African Charter for the Rights and Welfare of the Child
AIDS	Acquired Immune Deficiency Syndrome
ARI	Acute Respiratory Tract Infection
ART	Anti Retroviral Therapy
CGPU	Child and Gender Protection Unit
CBO	Community-Based Organisation
CPW Acat	Child's Protection and Welfare Act
CRC	Convention on the Rights of the Child
CSO	Civil Society Organisation
DCPT	District Child Protection Team
DHS	Demographic Health Survey
ECCD	Early Childhood Care and Development
FAO	Food and Agriculture Organization of the United Nations
FBO	Faith-Based Organisation
FIDA	International Federation of Women Lawyers
GFATM	Global Fund to fight AIDS, Tuberculosis and Malaria
HBC	Home-based Care
HES	Household Economic Strengthening
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
ICP	International Cooperating partner
IGA	Income Generating Activities
ILO	International Labour Organization
M&E	Monitoring and Evaluation
MDG	Millennium Development Goal
NACS	Nutrition Assessment and Counseling Services
NPA	National Plan of Action
NGO	Non Governmental Organisation
OVC	Orphans and Vulnerable Children
OVCY	Orphans and other Vulnerable Children and Youth
PEPFAR	(US) President's Emergency Plan for AIDS Relief
PLWH	Person(s) Living with HIV
PMTCT	Prevention of Mother-To-Child Transmission
PSS	Psychosocial Support
REPSSI	Regional Psychosocial Support Initiative
SADC	Southern African Development Community
SRH	Sexual and Reproductive Health

STI	Sexually Transmitted Infection
SOP	Standard Operating Procedure/Standard of Practice
TB	Tuberculosis
UNICEF	United Nations Children's Fund
UNESCO	United Nations Education, Science and Cultural Organization
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing

## 4 BACKGROUND

### **Lesotho national quality standards for OVC framework initiative**

The Situation Analysis of Orphans and Other Vulnerable Children in Lesotho (SitAn) conducted by the Ministry of Social Development (MOSD) in 2011 carried out a nationwide survey providing quantitative and qualitative data associated with the state of orphans and vulnerable children (OVC) in Lesotho. This comprehensive study analyzed issues affecting OVC; identified the services provided; highlighted strengths, weakness and gaps associated with service provision; and recognized several challenges and factors determining the outcome of the national response. The evidence gathered through the study supported a paradigm shift in response to the situation of OVCs in Lesotho. Some of these included:

1. Engaging community stakeholders to more actively participate in the provision of services, building more accountability in implementation and increasing the prospects for sustainability.
2. Recognizing the need to better target those in most need and increase the effectiveness behind program interventions.
3. Introducing a human rights based systems-approach to deliver more sustainable and cost-effective results that are able to catalyse policy formulation, legal reform, and law enforcement affecting vulnerable children.
4. Emphasizing the need to shift service delivery from individual targets towards enhancing coping mechanisms and capacities at multiple levels, including the child, caregivers, households, and communities.

The National Strategic Plan on Vulnerable Children (April 2012 - March 2017) reiterated the need to develop National Standards of Care to regulate the quality of care and support.

In response, the MOSD initiated a process to develop the standards and guidelines for care and support for OVC in the country, adopting the Southern African Development Community (SADC) Minimum Package of Services for Orphans and Other Vulnerable Children and Youth, 2011, and the Regional Conceptual Framework for Psychosocial Support for Orphans and Other Vulnerable Children And Youth, 2011.

#### **Purpose for developing Standards of OVC care in Lesotho**

The purpose for developing the national standards of OVC care and programming is based on the premise that, by adopting defined desirable standards and a minimum package of services, the stakeholders, including civil society organizations (CSOs) in Lesotho, will operationalize the standards at the local level and ensure that they improve the quality of service delivery. The MOSD main goal through this process is to help service providers translate standards into service delivery protocols that improve the quality and contextualization of OVC programming in Lesotho.



## 5 SECTION TWO

### 5.1 INTRODUCTION

Evidence and experience from African countries that have been severely affected by the HIV and AIDS epidemic have shown that the loss of a productive family member exerts a financial burden on the household and can have serious consequences for a child's access to basic needs such as: shelter, food, clothing, health and education. This lack of income puts extra pressures on a household and particularly on orphaned children to contribute financially to the household, in some cases driving them to the streets to work, beg, or seek food<sup>1</sup>.

The extended family is an important feature of the Basotho culture as a mutual support system, but has been severely strained by decades of migrant labour, poverty and disease burden. As the HIV and AIDS epidemic and poverty continue to strain already under-resourced and over-stretched systems in the country, it becomes imperative to support households, extended families and communities to ensure that increasing numbers of children do not fall out of this crucial safety net. Hence, the overarching principle of the national response is - strengthening the families and communities

### 5.2 LESOTHO – COUNTRY PROFILE

Lesotho is a mountainous kingdom and enclave country c surrounded by the Republic of South Africa. The country is divided into 10 administrative districts, with a total area of about 30,355 square kilometers. Less than 10 per cent of the land is arable. Rainfall varies from 700 mm to 800 mm in most parts of the lowlands, and most rain falls between the months of October-April. Lesotho is primarily a country of subsistence farming.

#### **a. Governance**

Lesotho is a constitutional monarchy, with the King as the head of state, but not actively involved in political affairs. Government is headed by a Prime Minister, who holds executive authority. Since independence in 1966, Lesotho has gone through a number of cycles of political uncertainty, but the situation has stabilized in recent years. The Constitution provides for an independent judicial system, comprised of a High Court, a Court of Appeals, magistrates' courts and traditional courts.

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<sup>1</sup>Monsasch and J. Ties Boerma (2004), Orphanhood and childcare patterns in Sub-Saharan Africa: an analysis of national surveys from 40 countries', AID 18 (supplement 2).

Traditional authority is the basis of village government. The system of chieftaincy follows the progression of paramount chief (the king), senior chiefs, sub-chiefs, headmen and sub-headmen. Their primary role is the authority to distribute the land of the nation to the people and oversee traditional law.

### **b. Population**

According to the 2006 census, the population of Lesotho was 1,876,633. Almost one-quarter (23 per cent) of the population lives in urban areas. Population growth slowed dramatically in the previous few decades, largely due to HIV and AIDS. From 1996-2006, the population grew at an annual rate of only 0.08 per cent, compared to 1.5 per cent between 1986 and 1996; 2.6 per cent from 1976-1985, and 2.3 percent from 1966 until 1975 (Bureau of Statistics, 2009a).

### **c. Poverty**

The OVC situational analysis indicates that, in 2006, 17.3 per cent of the population was classified as “very poor,” and an additional 32.5 per cent was classified as “poor,” for a total of 49.8 per cent of the population living below the poverty line. Due to HIV and AIDS and the decline in remittances from South African mines, general poverty had increased and was standing at over 68 per cent of the population (Government of Lesotho, 2006b). Poverty in Lesotho is:

- Highest in rural areas and in the mountains.
- Not significantly variable whether the household head is male or female.
- Lowest where the household head is employed, self-employed or is an employer.

The ultra-poor households are less likely to have a secure income from the wage sector, and are more likely to depend on some type of agricultural activity than others.

In 2009, 52 per cent of all children were living in absolute deprivation. This deprivation was associated with a lack of access to basic needs such as shelter, food or health care, with significant differences across location: 31.3 per cent of children in the lowlands suffered from two or more severe deprivations (i.e. Absolute deprivation) in 2009, compared to 59.2 per cent in the foothills, 73.1 per cent in the Senqu River Valley, and 83.8 per cent in the mountains.

A report on child poverty in Lesotho (UNICEF /Lesotho, 2012) observed that the last 20 years have been a period of economic, social and demographic upheaval in Lesotho, with severe consequences for the country’s children. Changing patterns of livelihood, gender roles and household structures – in conjunction with HIV and AIDS – have impacted on child well-being, overwhelming the capacity of households, extended families and communities to protect and care for the next generation.

#### **d. Socio-cultural norms**

Lesotho is a blend of past and present, traditional and modern beliefs and practices.

The domestic unit consists of any number of the extended family. Often a second or third cousins become "brothers" or "sisters." Grandmothers become mothers or caregivers.

The country has made significant progress in closing the gender gap. Remarkably, the country ranks 9th out of 135 countries on the World Economic Forum's Global Gender Gap Index in 2011, well ahead of countries like the United Kingdom, the United States and France. Lesotho has closed the gender gap in literacy and education, and female educational gains are filtering into the job market. Most notably, women now make up the majority of the high-skilled workforce. The women also hold the majority of positions at the local government level. However, the gender situation in Lesotho remains elusive. On one hand, women are educated and engaged as pillars of the economy and on the other, they are denied rights and responsibility to make family decisions ranging from taking a sick to health facility for treatment to preparing a family inheritance will.

"It takes a village to raise a child" is a well-known and accurate description of African practices, so is the case in Lesotho. Every village woman is eligible to correct an erring child, to rescue one in difficulty, and to encourage all. When a child begins school (age varies from five to ten years old) the mandatory school dress or a shirt is passed from one family to another. Many boys do not attend school for years because they begin at age five or six years to herd and care for the livestock.

Socio-cultural norms are rapidly changing in Lesotho. These include: 1) Household structures resulting from shifts in employment characteristics and the impact of HIV and AIDS; 2) Marriage is occurring later in life; 3) Fewer new households are being created; and 4) Households are becoming bigger as younger generations do not move out and more children are being born outside of marriage. Young couples who have managed to establish a household are often surviving on very little income, and are often supported by parents or older relatives. The increased vulnerability of these households has led to an increase in broken marriages and relationships, causing women to return to their parental home with their children, or to leave their children with grandparents while they lead separate lives in urban areas.

As Basotho value cows more than money, cattle represent wealth. Men are primarily responsible for the livestock. Boys begin training for herding at age five or six years. In the highlands, where the pasture is scarce, herdboys often spend months alone with their flocks in a mountain valley some distance from their home.

Girls similarly begin a life-role training as soon as they are able to carry a sibling on their back and a pail of water on their head. Most of the agriculture and home building is done by the women. They hoe, plant, weed and harvest the crops. They walk great distances to obtain firewood and carry the load home on their backs, often with an infant wedged between the tree branches. Water must be carried from the village pump for cooking, drinking, washing and laundry.

The findings of the OVC Situation Analysis further highlight the continued strength of social capital in Lesotho, although social networks are under severe strain due to HIV and AIDS, and economic shocks. Community support mechanisms are still relatively resilient.

#### **e. Development and economic outlook**

In 2009, Lesotho's gross national income per capita was US\$1,020 – close to the sub-Saharan Africa average of US\$1,147 but well below the levels for eastern and southern Africa at US\$1,496 (UNICEF , 2011a).

The World Bank, in a 2008 report, outlined trends in economic diversification in Lesotho. The report noted that, until the 1980s, almost half of the country's gross national product (GNP) was generated in neighbouring South Africa, largely through mining remittances. However, by the end of the 1990s, Lesotho was producing well over half of its GNP within the country, reaching 80 per cent by 2006 – almost half of this from the garment sector. The export of water, electricity, textiles, mining and agricultural products, and labour were the main revenue sources, other than disbursements from the Southern African Customs Union (SACU).

The report on child poverty in Lesotho (UNICEF /Lesotho, 2012) pointed out that SACU revenues, which made up 55.6 per cent of Government revenues in 2008/9, were declining, coupled with the global economic recession, which resulted in the layoff of many Basotho men and a drop in Lesotho's textile exports as buyers in the US favoured countries with shorter lead-times to minimize their risks in the face of uncertain demand.

#### **f. OVC Situation**

UNAIDS' HIV and AIDS estimates (2013) for Lesotho indicate an HIV prevalence of 22.9 percent among adults. Between 350,000-380,000 people are living with HIV, including 330,000 adults aged 15 and above, and 36,000 children under the age of 14 years. An estimated 16,000 deaths occur in a year, resulting in 150,000 orphans. Just over a third (33.8 per cent) of all children are orphans. Of these, the majority are paternal orphans, who make up 19.8 per cent of all children and 58.7 per cent of all orphans. Maternal orphans made up 6 per cent of all children and 17.8 per cent of all orphans. Double orphans comprise 8 percent of all children and 23.6 per cent of all orphans. Of a total child population of 1,072,974, it is estimated that 363,526 are orphans (213,248 paternal orphans; 64,647 maternal orphans; and 85,631 double orphans).

It is estimated that, around 125,000 (nearly 12 per cent of all children) are vulnerable to specific, serious challenges, of whom 30,000 are considered most vulnerable and in urgent need of targeted assistance.

The Honourable Mrs Matebatso Doti, Minister for Social Development, notes “.....*despite the success of our economic and social policies, the remarkable resilience of Basotho households, the support of civil society organisations, communities and their leaders, and the sound and sustained commitment of donors, there are still many children who are vulnerable in Lesotho. Something needs to be done. These children are our leaders of the future.*”

### 5.3 NATIONAL RESPONSE FOR ORPHANS AND VULNERABLE CHILDREN

In order to address the issues affecting OVC and to ensure their protection, care and support, the Government of Lesotho has initiated a sustainable national response that is guided by the National OVC Strategic Plan 2006-2010 (DSW, 2006b) and the National Policy on OVC (DSW, 2006a),

The following specific paradigm shifts move the national response to vulnerable children from “business as usual” to a human rights and results-based response:

- i. **A shift from welfare to social development:** The shift from social welfare to social development will be gradual, taking cognizance of existing capacity and institutional changes and systems. The National Strategic Plan on Vulnerable Children (NSPVC) will support strategies for the change process. In addition, the Government of Lesotho is formulating a social development policy that will inform and guide the process.
- ii. **A focus on vulnerability rather than orphaned status:** While the focus on orphaned status has had some benefits, it has not been sufficient to provide meaningful support to vulnerable children, and it is stigmatising. The response will shift from focusing on orphaned status to a child’s vulnerability, with orphanhood being one of the many possible causes of vulnerability.
- iii. **Focus on the life cycle of the vulnerable child:** The response will focus on the life cycle of vulnerable children, taking cognizance of specific needs according to their age and stage of development as well as challenges, and the overall development requirements during the passage from childhood to adolescence to adulthood.
- iv. **A family-focused approach:** A family setup provides the most important social safety net for vulnerable children. In most cases, vulnerable children live in vulnerable households, and it is therefore important to address the needs of individual vulnerable children in the context of the needs of their families.
- v. **A child rights-based approach:** The planning of the national response is premised on a human rights-based approach to programming in order to ensure that duty bearers (service providers), including other sectors and stakeholders, are accountable for service

delivery, and the rights holders (beneficiaries) are able to claim their rights to access and utilise the services.

- vi. **Systems strengthening:** Efficient and effective service delivery for vulnerable children and their families is premised on the existence of strong and functional social protection, systems, community and health systems. However, the strategic plan will focus on social protection systems, given that health and community systems strengthening are already on-going activities with other sectors. Advocacy work will be carried out to promote partnerships and collaboration between sectors to ensure effective service delivery to vulnerable children.
- vii. **Making use of indigenous practices:** Caring for and protecting vulnerable children is a family as well as a community responsibility. The strategic plan will facilitate a process where good indigenous practices in care, support and protection of children are adequately utilised.
- viii. **Gender dimensions of the response:** Stakeholders will take into account gender differences between boys and girls and the associated risks and vulnerabilities while developing their respective responses. This is important given that boys and girls are affected differently.

The national response to OVC adopted a framework that focuses on pursuing a human rights-based approach to programming, while recognizing that some needs must be given priority over others. Human rights, in this case, were those defined by the UN Convention on the Rights of the Child, to which Lesotho is a signatory.

The national response also comprises the governance framework, social-policy framework, and development-management framework in which programmes are designed and implemented.

#### a. A human rights-based approach

The national response adopts a human rights approach that is consistent with the new Children's Protection and Welfare Act (Government of Lesotho, 2011) which states: "The objects of this Act are to extend, promote and protect the rights of children as defined in the 1989 United Nations Convention on the Rights of the Child, the 1990 African Charter on the Rights and Welfare of the Child and other international instruments, protocols, standards and rules on the protection and welfare of children to which Lesotho is a signatory."

In 2004, UNICEF published its annual report on the State of the World's Children. The report annexed a "statement of common understanding" of a human rights-based approach to programming. The following principles were elaborated:

- Universality and inalienability – all persons have rights, and they cannot be taken away or given up.
- Indivisibility – regardless of the type of right, whether it is civil, cultural, economic, political or social, it cannot be ranked as being more or less important than another right.
- Interdependence and interrelatedness – rights are often linked and co-dependent
- Non-discrimination and equal – all persons are entitled to fulfillment of their human rights, regardless of any differences.
- Participation and inclusion – all persons are entitled to engage actively, freely and meaningfully in their own development.
- Accountability and the rule of law – States and other duty-bearers are answerable for the observance of human rights, complying with legal norms in this regard.

#### **b. Social protection framework**

The national response adopts the Environmental Scan for Child and Gender Sensitive Social Protection Strategy (UNICEF/Lesotho, 2010a) which defined social protection as “programmes, policies and informal arrangements through which poor and vulnerable people are buffered against harmful strategies for coping with shocks and risks (i.e. Depletion of assets; high risk borrowing; reduction of expenditure on food, health and education; withdrawing children from school for child labour, etc.).” Effective social protection, the report noted, is enabling people to “invest in human capital development to break the inter-generational cycle of poverty, and keep from falling or moving further into poverty.”

#### **c. Policy and legal frameworks**

The Government of Lesotho’s national OVC response created an enabling policy environment that is comprised of the following policy and legal frameworks: the 2006-2010 Lesotho National Plan of Action for OVC (see the review in DSW, 2009a), the 2006 National Policy on OVC (DSW, 2006a) and the National OVC Strategic Plan 2006-2010 (DSW, 2006b). The 2006 National Policy on OVC was contextualized in terms of existing national legislation and policies, including the Constitution, the Child Protection Act of 1980, the Sexual Offences Act of 2003, the National Social Welfare Policy of 2003, and the Gender and Development Policy of 2003 (see Open Society Institute of Southern Africa, 2010). It was also significantly informed by HIV and AIDS planning, which over time focused increasingly on impact mitigation. Lesotho Children’s Protection and Welfare Act 2007.

#### **d. Institutions and structures guiding the OVC response**

In 2012, the Government of Lesotho created the Ministry of Social Development, transitioning welfare into development. Prior to this, the Department of Social Welfare (DSW), first established in 1976, was placed under the Ministry of Health and Social Welfare. The Child Welfare Unit within the DSW served as the locus of the response, implementing the National OVC Strategic Plan (2006-2010) within the context of the National Policy on OVC. In 2010, the DSW, headed by a Principal Secretary, was charged with leading the response to OVC, while coordination was provided by the

NOCC and covered the following departments: Social Rehabilitation; Clinical Social Welfare; Child Welfare; and Elderly Care Services.

The Child Welfare Unit has been responsible to: (1) develop, review and monitor child welfare policies and programmes; (2) provide a protective environment for child care and survival and ensure placement of children in need of care; (3) mitigate the impact of HIV and AIDS among children; (4) monitor and regulate child care facilities; (5) provide recreational and facilities, child protection services, and adoption and foster care services and ; (6) and capacitate community child welfare and other stakeholder structures.

#### **e. Coordination – National and sub-national levels**

The multisectoral National OVC Coordinating Committee (NOCC) and the District Child Protection Teams (DCPTs) were established at national and district levels in 2006 to coordinate the national OVC response and serve a networking function among the agencies involved to avoid fragmentation and duplication of efforts.

The NOCC, awaiting statutory authority, is chaired by the Principal Secretary and supported by an OVC coordinator. It includes representatives from virtually all the roleplayers involved in the OVC response, including over half of all Government ministries.

At the sub-national level, 10 DCPTs, one in each district, has been established to coordinate child protection activities. The DCPTs are made of members representing government agencies and district-level CSOs. DCPT are chaired by the District Social Development Officer or the District Council Secretary. Community Councils, which cover urban neighbourhoods and clusters of villages in rural areas, are responsible for supporting the OVC response at the local level.

#### **f. Civil society partnerships in the OVC response**

The National Policy on OVC (DSW, 2006a) states that “the Government shall build sustainable partnerships with and provide support to civil society organizations, to design, implement and monitor initiatives for improved care and support for the protection of OVC.”

MOSD partnerships with line ministries and government agencies include: the Parliamentary Committee on HIV and AIDS; the Ministry of Education and Training; the Ministry of Local Government and Chieftainship; the Ministry of Justice and Human Rights; the Ministry of Law and Constitutional Affairs; the Ministry of Gender, Youth, Sports and Recreation; the Ministry of Agriculture and Food Security; the Ministry of Finance and Development Planning; the Ministry of Communication; the Ministry of Employment and Labour; and the Lesotho Mounted Police Services (through the Child and Gender Protection Unit).



MOSD collaborations with civil society actors include international and national and International nongovernmental organisations (NGOs), faith-based organisations (FBOs) and community-based organisations (CBOs).

Key development partners in the OVC response include: the European Union; Global Fund to Fight AIDS, Tuberculosis and Malaria; United Nations Children’s Fund (UNICEF); United States Agency for International Development (USAID); and U.S President’s Emergency Plan for AIDS Relief (PEPFAR). The Development Partners’ Consultative Forum is the main platform where development partners came together to discuss AIDS-related issues.

Despite significant accomplishments, the national response has experienced several constraints, including: leadership and management challenges; capacity gaps; uncertain funding due to poor economic outlook; and diminishing donor support.

## 6 KEY CONCEPTS AND DEFINITIONS

Historically, Lesotho’s response to OVC was primarily focused on orphanhood status. While the focus on orphanhood status has had some benefits, it has not been sufficient to provide meaningful support to other most vulnerable children, and has contributed to stigmatising OVC. Consequently, Lesotho has made a strategic paradigm shift from focusing on orphanhood status to a child’s vulnerability, informed by the articulation of the guiding principles of the NSPVC, and the operational definition of vulnerabilities and vulnerable children.

The following are some of the definitions of the various terms and concepts used in the standards for OVC care programming, adopted from the National OVC Policy and the National Strategic Plan for OVC, and the SADC guidelines on Mimum Package.

Term	Definition
<b>Abuse</b>	An act of ill treatment that can harm or is likely to cause harm to one’s safety, well-being, dignity and development.
<b>Adolescent</b>	According to the United Nations, this is a person aged 10 to 19 years.
<b>Caregiver</b>	A <b>caregiver</b> is any person giving care to a child in the home environment. The <b>primary caregiver</b> is the main person who lives with a child and provides regular parenting care for the child in a home environment. This often includes family members, such as parents, foster parents, legal guardians, siblings, uncles, aunts and grandparents or close family friends. <b>Secondary caregivers</b> include community members and professionals, such as nurses, teachers or play centre minders, who interact with a child in the community or visit a child at home but do not necessarily live with the child. <b>Child and youth caregivers</b> include children and youth who are caring for other children, ill parents and relatives and/or heading households.
<b>Child</b>	Any person younger than 18 years (United Nations, 1989; African Union, 1999).
<b>Child work</b>	Children’s participation in economic activity that does not negatively affect their health and development or interfere with their education. Work that does not interfere with their education (light work) is permitted from the age of 12 under the International Labour Organisation (ILO) Convention 138. (See <b>Child Labour, Economic activity, Hazardous work</b> ).
<b>Child labour</b>	Refers to children working in violation of the above standards (i.e. Child work). It means all children under the age of 12 years working in any economic activities, and those aged 12 to 14 years engaged in harmful work, and all children engaged in the worst forms of labour (i.e. being enslaved, forcibly recruited, prostituted, trafficked, forced into illegal activities and exposed to hazardous

	work) (See <b>Child work, Economic activity, Hazardous work</b> ).
<b>Comprehensive response</b>	An intervention or effort that meets the complete set of basic needs, or defined minimum standards across multiple services that address the survival, development, protection and participation rights of children and youth while addressing vulnerability.
<b>Community</b>	A group comprising of men, women, girls and boys, which should be established and/or strengthened, and will be responsible for identifying orphans and vulnerable children, implementing, and monitoring OVC programmes in communities. It could be an existing village or community committee, age, grade, and so on, which can effectively take on the added responsibility of ensuring child welfare.
<b>Counselling</b>	Counselling is talking to another person who is trained to listen and understand about your situation and your problems and worries. The counsellor will help you make plans and decisions, give you information and help you find answers to your questions. Counselling is not about telling you what to do; it is about helping you decide what you think is best to do and giving you support for following your decisions through (Save the Children UK, 2003:19). Counselling may take place in a one-to-one situation or in groups and may be facilitated by a professional or lay counsellor.
<b>Deprived</b>	A situation in which the basic survival, development, protection and participation needs and rights of children and youth have not been met (SADC, 2008).
<b>Disability</b>	An umbrella term, covering social, mental and physical impairments that may lead to limitations in activity and restrictions in participation. An ‘impairment’ is a problem in body or mental function or structure; an ‘activity limitation’ is a difficulty encountered by an individual in executing a task or action; while a ‘participation restriction’ is a problem experienced by an individual with involvement in life situations. Thus disability is a complex phenomenon, reflecting an interaction between features of a person’s body and features of the society in which he or she lives.
<b>Duty bearers</b>	Individuals or institutions that are responsible for the progressive realisation of specific rights. Duty bearers acquire duties through designation, position or election. They will include the family, community, national, state and local government.
<b>Economic Activity</b>	A broad concept that encompasses most productive activities undertaken by children, whether for the market or not, paid or unpaid, for a few hours or full time, on a casual or regular basis, legal or illegal. It excludes chores undertaken in the child’s own household or schooling. To be counted as economically active, a child must have worked for at least one hour on any day during a seven-day reference period (ILO 2006). (See <b>Child Labour, Hazardous work</b> ).
<b>Family</b>	A social unit created by blood, marriage, adoption or defined by common line of kinship or relationship of a paternal or maternal

<b>Extended family:</b>	<p>nature. This can be biological or adoptive. It can be described as nuclear (parents and children) or extended (the conjugal family as well as other relatives or descendants of the husband and/or wife) (SADC, 2008).</p> <p>A collection of a number of households or families of individuals who are related by blood and social ties and responsibilities towards one another. Most communities, especially in the rural area depend on extended families for nutrition, care and support</p>
<b>Gender.</b>	The social relationship between women and men as opposed to biological sex differences
<b>Gender Mainstreaming</b>	A strategy to ensure that an analysis of the relationship between males and females is used to incorporate the needs of women and men, constraints and potentials into all development policies and strategies and into all stages of planning, implementation and evaluation of development interventions.
<b>Gender sensitivity</b>	The ability to recognize issues related to the relationship between males and females, and especially the ability to recognize differences in perceptions and interests between males and females arising from their different social position and different gender roles
<b>Guardian</b>	Any person caring for a non-biological child
<b>Holistic approach</b>	A procedure for ensuring that different options or strategies are considered and applied flexibly in appropriate combinations that ensure comprehensive or optimal fulfillment of the well-being and development of a child.
<b>Hazardous work</b>	<p>Any activity or occupation that, by its nature or type, has or leads to adverse effects on the child's safety, physical or mental health, and moral development.</p> <p>Hazards could also derive from excessive workload, physical conditions of work, and/or work intensity in terms of duration or hours of work, even where the activity or occupation is known to be non-hazardous or safe (ILO 2006). Hazardous work is a subcategory of child labour, which in turn is a subcategory of economically active children. (See <b>Child Labour, Child work, Economic activity</b>)</p>
<b>Household</b>	A social unit of people (not necessarily related) living together in the same house or compound, sharing the same food or cooking facilities (SADC, 2008).
<b>Human Rights</b>	Human rights are the right people have simply because they are human beings, regardless of their nationality, ethnicity, gender, language, race or other status. They are the basic standards without which people cannot live in dignity. They are held by all persons equally, and forever. Human rights are universal, interdependent, inalienable and indivisible, and are based on equality, human dignity, non-discrimination and responsibility.
<b>Integrated approach</b>	A procedure for incorporating additional approaches, interventions

	or services into existing programmes or services or social practices to ensure improved service delivery efficiency and comprehensive developmental outcomes (SADC, 2008).
<b>Life skills</b>	Psychosocial, interpersonal and self-management skills that help people make informed decisions, communicate effectively and cope with adversity.
<b>Marginalised</b>	A term used to refer to persons who are deprived of opportunities for living a respectable and reasonable life that is regarded as normal by the community to which they belong
<b>Mental health</b>	“Mental health is a set of positive mental attributes in a person or in a community. It is a state of well-being in which an individual realizes his or her abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community” (Hermann, et al., 2005). The Alma Ata Declaration defines mental health as a conscious, dynamic, evolving capacity and not a pre-determined, unchangeable, all-or-nothing state. <b>Child and adolescent mental health</b> is the capacity to achieve and maintain optimal psychological functioning and well-being; it is directly related to the degree of age-appropriate physical, psychological and social development achieved using available resources (Dawes, 2003).
<b>Orphan</b>	A child aged 0–17 years whose mother (maternal orphan) or father (paternal orphan) or both (double orphan) are dead. The term ‘social orphan’ may be used to describe children whose parents may be alive, but who are neglected or abandoned by their parents or whose parents are no longer fulfilling any of their parental duties (SADC, 2008).
<b>Poverty</b>	The state in which a person is living at a subsistence level that is below the minimum requirements for physical well-being, usually based on a quantitative proxy indicator such as income (less than one dollar a day) or calorie intake, but sometimes taking into account a broader, qualitative package of goods and services.
<b>Psychosocial</b>	The term psychosocial is used to emphasize the close connection between psychological aspects of the experience (thoughts and emotions) and the wider social experience (relationships, practices, traditions and culture), both of which interact to form the human experience. It also takes into account spiritual (values systems, beliefs) and physical aspects of an individual.
<b>Psychosocial support</b>	A continuum of care and support that addresses the social, emotional, spiritual and psychological well-being of a person and influences both the individual and the social environment in which people live (SADC, 2008). Attempts have been made to distinguish between ‘psychosocial care’ and ‘psychosocial support’. In different countries, the terms ‘care’ and ‘support’ have different meanings. For this document, ‘psychosocial support’, or PSS, is used as shorthand for ‘psychosocial care and support’ (REPSI, 2010).
<b>Psychosocial well-being</b>	Refers to the state of being in which an individual has the ability to

	make sense of, and have a degree of control over, their world, with hope for the future and to be a responsible, productive and caring member or leader of a community (Antonovsky, 1979). It includes material, cognitive, emotional, spiritual and cultural aspects of a child's/youth's life and their interpersonal relationships. With regard to children, the Psychosocial Working Group (2003) defines psychosocial well-being as the positive age- and stage-appropriate outcome of children's development. It is characterized by the individual's ability to: (1) make appropriate decisions that have short- and long-term benefits to the individual and to society, (2) assume and maintain social responsibility and healthy social relationships and behaviours and (3) maintain a condition of mental capability and absence of temporary or long-term mental impairment.
<b>Resilience:</b>	The human capacity to face, overcome and be strengthened by or even transformed by the adversities of life, and the ability to bounce back after stressful and potentially traumatizing events. A child's ability to cope depends a lot on his/her resilience. Resilient children generally cope better with life's adversities
<b>Risk</b>	The possibility, chance or threat that one will be deprived in the immediate or long terms.
<b>Social protection</b>	All public and private initiatives that provide income or consumption transfers to the poor, protect the vulnerable against livelihood risks and/or enhance the social status and rights of the marginalized, with the objective of reducing the economic and social vulnerability of the poor, vulnerable and marginalized groups (SADC Secretariat, 2008).
<b>Social transfer</b>	Regular, predictable transfers (cash or in kind, including fee waivers) from governments and community entities to individuals or households that can reduce child poverty and vulnerability, help ensure children's access to basic social services and reduce the risk of child exploitation and some forms of abuse. This includes social security income transfers for people experiencing unemployment, poverty, disability or other forms of vulnerability.
<b>Sustainability</b>	To ensure that human development efforts achieve lasting improvement in the lives of children, youth and their families/caregivers and communities without bringing about any harm or compromising their well-being and that of others in the present or the future (SADC Secretariat, 2008).
<b>Vulnerability</b>	A state of high risk of deprivation or, according to the World Bank, "an expected welfare loss above a socially accepted norm, which results from risky or uncertain events and the lack of appropriate risk-management instruments" (SADC Secretariat, 2008).
<b>Vulnerable children</b>	Children who are unable or who have diminished capacity to access their basic needs and rights to survival, development, protection and participation as a result of their physical condition or social, cultural, economic or political circumstances and environment and

	require external support because their immediate care and support system can no longer cope (UNICEF, 2004).
<b>Vulnerable households</b>	Households that are unable or that have diminished capacity to access the basic needs and rights of their members.
<b>Vulnerable youth</b>	Persons between ages 18 and 24 years who are unable or who have diminished capacity to access their rights to survival, development, protection and participation and may be at risk of being harmed, exploited and/or denied necessary age-specific developmental needs as a result of their physical condition, such as disability, unemployment, HIV infection or AIDS, armed conflict and war, living on the street, being neglected by parents, undocumented migrant status, and substance abuse.
<b>Young person</b>	, this refers to any Any person aged 10 to 24 years and includes some children, all adolescents and youth (United Nations)
<b>Youth</b>	For the purposes of this framework, youth are persons aged 18–24 years. This definition recognizes that the period of transition from childhood to adulthood places young people at greatest risk of deprivation of basic services and rights. However, UNICEF and the World Health Organization define youth as every person between the ages of 15 and 24 years and young person as aged between 10 and 24 years; and the African Youth Charter (2006) defines youth or young person as aged between 15 and 35 years.

Since the focus the national response is on vulnerability rather than orphanhood status, understanding the following exoanded definitions for orphan and vulnerable children is considered imperative, because these definitions impact programming, in terms of targeting and prioritising outreach.

**Orphan:** The Child Protection and Welfare Act, adopted in March 2011, has defined a vulnerable child as *“a person who is below the age of 18, who has one or both parents who have deserted or neglected him, to the extent that he has no means of survival and as such is exposed to the dangers of abuse, exploitation or criminality and is therefore in need of care and protection.”*

**Vulnerable children:** The historic definition by the Ministry of Health and UNICEF (1998) described vulnerable children as “children who are at risk of neglect, abuse, extreme hunger or homeless. This may apply to children who are already or who may soon become orphaned. They also include the children heading their own households because both parents died due to AIDS or other causes.”

The Situation Analysis of Orphans and other Vulnerable Children in Lesotho (2011), states: *“vulnerable children are those whose rights to survival, development, protection and participation are not met because of certain conditions or circumstances*

In recognizing vulnerabilities as the premise for the national response, Lesotho also acknowledges that:

- “The main determinants of child vulnerability in Lesotho derive from challenges to livelihoods overall, in particular problems facing working age adults in securing reliable incomes...”
- “The major problems of vulnerability are not specific to vulnerable children, but are rather threats to households overall; and that the vast majority of children do not need specific, targeted support, suggesting that it may be possible to reach those most in need of services if these are well targeted.”

Vulnerable children therefore include orphans; children living on and off the streets; children with challenging behavior; children in need of legal and other forms of protection; children who have been or are physically, psychologically, emotionally, or sexually abused; neglected children; children who behave in a manner that may harm them; children involved in child labor; children with disabilities; children involved in commercial sex work; children who frequent the company of immoral persons; children infected or affected by HIV and AIDS and other chronic diseases; children whose parents are delinquent and/or children who cannot be supervised by their parents or guardians; and children who by virtue of their age are vulnerable (under 5 years old).



# 7 STANDARDS OF CARE

## 7.1 OVERVIEW

The purpose and scope of quality standards for the minimum package of services is to cover the needs and services that are absolutely essential for children’s and youth’s optimum development and well-being. The emphasis is aligned with the SADC minimum package of services recognize that most of the targeted children and youth are likely to require a combination of services.

Establishment of minimum standards shall focus on what services can be provided as determined by available resources, existing capacity and feasibility, with equal attention to services which allow children and youth to realise and apply their human potential and capabilities.

For the purpose of this manual, a ‘**standard**’ is defined as a recognized and agreed-upon level or benchmark of expected level of service and performance that is evidence-based and measurable to the greatest degree possible.

“Quality standards” include access, effectiveness and efficiency, relevance, responsiveness, and based on evidence, innovation and best practices.

**The intended audience of the standards:** The standards in this document apply to caregivers, OVC care programmers, CSOs, and service providers working with children age 0–17 years who are orphans or made vulnerable due to any causes, and youth.

**Application of the standards:** The tools are designed to be used *together and in conjunction with* the NSPVC and the National Operational Plan, as well as with other current and future OVC-related policy and planning instruments.

They can be used to:

- Support advocacy efforts for enhanced dialogue and action for OVC;
- Inform policy development and planning;
- Assist in identifying service requirements;
- Articulate consistent and quality protection, care and support;
- Strengthen and standardise assessments of existing protection, care and support services;
- Facilitate staff, community and caregiver development by promoting discussion and learning and identifying training needs;
- Minimise negative outcomes for OVC through the correct and consistent application of standards;

- Enhance the participation of OVC and other beneficiaries;
- Facilitate coordination, strategic partnerships and collaboration across sectors;
- Serve as a basis for accountability, auditing and management; and
- Monitor and evaluate (M&E) programmes and services.

All children, especially vulnerable children, need quality care, support, and protection to thrive, grow and lead a normal childhood, and have their needs met and rights realized. Standards ensure a minimum level of quality of services of care and support for children in the country. The purpose for the national standards and guidelines is to provide a structure and methodology for the development and application of relevant standards for the comprehensive, integrated protection, care and support of OVC at all levels, with the following objectives:

1. To provide guidance for the development and implementation of interventions for the care, support and protection of orphans and vulnerable children in Lesotho.
2. To provide minimum standards in quality of services and activities related to all areas of care, support and protection of orphans and vulnerable children that are socially, culturally and internationally acceptable, in line with national and international instruments that Lesotho has acceded regarding children and their protection.
3. To provide a clear understanding of the guiding principles and define roles and responsibilities for stakeholders on issues of vulnerable children.
4. To enhance collaboration and strategic partnership among stakeholders through effective referrals and coordination.
5. To provide a framework for monitoring and evaluation.

### 7.1.1 Developing the national standards

In developing the framework of standards and guidelines, the MOSD adopted the SADC Minimum Package of Services to Lesotho's specific context, aligning them to the country's policies and frameworks including the NSPVC and the Child Protection Strategy.

The framework of the national standards intends that the national policy and legal frameworks and the policy's desired outcomes at the national level can be translated, via quality standards, into appropriate services and delivery mechanisms at the local level through guiding CSOs and government at all levels to plan, design and implement OVC services.

The MOSD established a Reference Group to provide technical guidance and resources. The Reference Group includes key stakeholders, including CSOs, bilateral agencies and development partners, conducted a literature review of essential national and international documents, including model guidelines from other countries in sub-Saharan Africa, the NSPVC, the CPW Act, and the

International Convention on the Rights of the Child. In addition, it held consultations with CSOs, CBOs, care providers, and service providers.

In order to ensure that the intended national standards are grounded on the local context, principles, objectives and interventions that are consistent with SADC regional guidelines on minimum packages and other international standards, the MOSD engaged other Ministries, UNICEF, CSOs and district representatives to review, revise and ratify the draft standards in a workshop that further served to build consensus among the role players and garner their commitment to implement and raise others' awareness of the standards. The Government of Lesotho then adopted these quality standards OVC services and service delivery through programming.

Development of these guidelines has been informed by extensive consultations with the various stakeholders as well as interrogation of existing policy and legal frameworks in order to inform development of standards, operational guidelines and a monitoring system of care for vulnerable children. They incorporate the following support and care domains: *Health, Food Security and Nutrition, Psychosocial Support, Education, Shelter, and Legal Support and Protection.*

### 7.1.2 Guiding principles for standards

The standards and guidelines for OVC care and support ensure that programming is based on the premise that the stakeholders, including CSOs in Lesotho, develop and implement standard-based quality of services/programmes for vulnerable children, informed by the following guiding principles enshrined in the NSPVC:

- Adopt a human rights-based approach to programming for vulnerable children.
- Consider the definition of child vulnerability as: *a child is vulnerable if, through condition and/or circumstance, the child's rights to survival, development, protection or participation are not fully met.*
- Ensure that OVC programmes prioritize those most in need when providing services, and do not automatically treat orphans as more vulnerable than other children.
- Provide services based on the established specific needs of a child, rather than a blanket cover of minimum package of services.
- Integrate referral linkages to complementary services for holistic care.
- Enhance the advocacy roles of the National OVC Coordinating Committee (NOCC) and MOSD.

In addition, the programmes that are targeted to serve vulnerable children are required to be relevant to Lesotho's socioeconomic and cultural context, with service providers delivering services in the program areas that they work in through adopting standards that have been defined for the country.

Development of standards for the minimum package of services has taken into cognizance the availability of resources as well as the capacities and competencies to ensure compliance to the standards. Stakeholders have the responsibility for implementation of programme-level standards. In terms of monitoring the standards, programme-implementing CSOs, FBOs, CBOs, Government, institutions and communities have a role to play as well.

### 7.1.3 OVC Programming approaches

While the MOSD oversees the national response by providing the policy and programming environment, and donor and development partners support investment into the national response, each of the implementing CSO and service providers are responsible for developing a strategic portfolio that includes prioritized, focused, responsive, and evidence-based interventions that are appropriate to the Lesotho country and community context, and that which addresses children's most critical care needs in a sustainable manner.

**i. Community based-family centred approach**

The standards of care employ a “child-focused, family-centered” approach to targeting and reaching OVC and youth to underline the importance of investing in, and integrating the family and the community that support holistic care in a sustainable manner. The family-centred approach and associated interventions improve child-care giver relationship, and overall care within the household, whereas the ‘child-only’ services isolate the child from the household

**ii. Vulnerable children-focused:**

Programme designers and implementers should ensure that interventions consider the ages and developmental stages of the children, and tailor services to their holistic needs. This implies that all stakeholders providing services for vulnerable children will do so taking into consideration the principle of the “**best interests of the child**” and in particular vulnerable children as per the NSPVC.

**iii. Minimise risk and vulnerability:**

Provision of services to vulnerable children should seek to prevent vulnerabilities and their impact. Adherence to the standards and guidelines when implementing programmes for vulnerable children should minimise/eradicate risks of harm and not exacerbate the already vulnerable status of the beneficiaries. Programmes should strive for consistent application of the standards upon agreed dimensions. In order to minimise/eradicate risks, various strategies may be adopted through seeking community input when implementing programmes, ensuring the consistent and continued participation of vulnerable children, their caregivers and all other interested stakeholders.

**iv. Participation of vulnerable children and their caregivers:**

Programmes should seek to enhance the participation of all beneficiaries and their caregivers. In the implementation and monitoring of the standards of care guidelines, it is crucial to have active beneficiary feedback. This participation will enhance the quality of services and help to ensure that services are being provided according to the true needs and desires of the beneficiaries. Participation also enhances sustainability of service provision, as such services will be informed by the prioritised needs of vulnerable children who would have participated in the planning, prioritisation, and implementation of interventions that are intended to benefit them. Meaningful participation by vulnerable children in decision making, planning, implementation and evaluation is a prerequisite for successful implementation of programmes. Therefore, strategies that promote vulnerable children's participation will be mainstreamed in all aspects of the response as a crosscutting issue. Children will be mobilised and will be given adequate opportunities to voice their views and issues of concern. Specific efforts will be made to encourage and support vulnerable children to actively engage and participate in the national programmes.

**v. Gender equity:**

Ensuring gender equity in service provision for vulnerable children is an important principle that these Standard Service Delivery Guidelines promote. Programmes should ensure that interventions and services meet the specific individual needs of both girls and boys, irrespective of the difference in gender as stated in the Constitution of Lesotho. In the implementation of the standards, gender dimensions that put children at risk of new infections or violence and sexual abuse, or contribute to the factors that disadvantage them socially, economically or otherwise, will be addressed with special attention to the girl child as highlighted in the NSPVC of March 2012-April 2017.

**vi. Ethical compliance and confidentiality:**

To obtain the desired results, confidentiality should be observed by all aspects of the programme. The programme staff and volunteers with knowledge of personal information should make all efforts to ensure that the information shared by vulnerable children, such as their personal history or HIV status, is not disclosed unnecessarily without the child's and/or family's consent. Programmes should not promote or allow stigmatisation and discrimination of a child due to his/her past experiences.

**vii. Respect, promote and protect the rights of vulnerable children:**

All stakeholders/any service providers will endeavour to promote, respect and protect the rights of all vulnerable children and their families.

**viii. Results-oriented:**

Focus on the anticipated outcomes of services and support for vulnerable children should be a key priority for programme implementers. The Standard Service Delivery

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

**ix. Multisectoral and decentralised response:**

The standards of care and guidelines are designed to support a multisectoral and decentralised response involving all relevant stakeholders in the public and private sectors, including civil society organisations. It is anticipated that different sectors will identify their respective niches in programme implementation based on individual sector mandates, comparative advantages and harmonisation, as well as mainstream with sector plans on supporting the national response to vulnerable children.

**x. Coordination:**

The needs of vulnerable children may not be met by a single organisation or an individual's support, but by a coordinated effort of the different stakeholders and a holistic approach to maximise available resources. Therefore, in order to fulfill the vast needs of vulnerable children, all service providers, at the community, district and national level should coordinate interventions and services to address the unmet needs and avoid duplication. The MOSD, the NOCC, DCPTs and standing committees on social service of the community councils should identify and fill the service gaps by facilitating coordination.

#### 7.1.4 Target group of OVC programmes

The orphans, vulnerable children and their caregivers who fall under the categories listed in this section should be the priority groups when programmes and interventions for the care, support and protection of orphans and vulnerable children are being designed and implemented. There may be overlaps across categories, since a single individual can belong to several vulnerable groups due to the composite nature of the vulnerability. Some of these children live or are found on their own and are in need of re-integration into a family under the care of a loving adult. Others are already found within a household, but the capacity of that family to cope with their unique vulnerability needs to be improved. It is important to recognize that there are marked differences in manifestations of vulnerabilities among communities.

Therefore, identification and targeting of the most vulnerable children should involve local decision-making at the community level to determine the factors that contribute to child vulnerability and the children and households who are at greatest risk. The criteria for selecting the children and households should be developed and agreed on in consultation with the community and should be consistent with the target group

identified. Intervening as an early, speedily, and adequately as possible without inadvertently undermining the coping capacities of the children, their households and communities should reduce vulnerability.

The categories of children to be targeted include, but are not limited to:

- 1. Children affected by HIV or other chronic illnesses**
  - Children living with HIV or other chronic illnesses
  - Children living in households where the breadwinner is living with HIV or other chronic illnesses, and which are impoverished
  - Children living in households with the recent death of a working aged adult (breadwinner)
  - Children in poor households that are caring for orphans and vulnerable children
  
- 2. Children in need of alternative family care**
  - Children in child headed households
  - Children who are homeless or unaccompanied
  - Children in institutional care
  - Children living with aged grandparents or caregivers
  - Children whose parents are dead and who have been relocated to other poor households
  - Children whose parents are alive but are extremely poor
  - Children whose parents are divorced or separated and who are deprived of care
  - Children whose parents are commercial sex workers, drug addicts or convicted persons
  - Children in prison with their mothers
  
- 3. Children who are abused or neglected**
  - Children who are working (child labour) or are exploited
  - Children who are subjected to harmful cultural and religious practices
  - Children who are sexually abused and exploited
  - Children who are physically abused or neglected
  - Child parents, especially child mothers
  
- 4. Children in 'hard-to-reach' areas**
  - Children belonging to transient communities, such as fishing and nomadic communities
  - Children whose parent(s) are in prison
  - Children living in difficult-to-reach terrains
  
- 5. Disability-related vulnerability**
  - Children with disability (e.g. Mental, physical, or other forms of disability)
  - Children whose parent(s) or caregiver(s) has a disability in a poor setting
  
- 6. Children affected by armed conflict**

- Children whose safety, well-being or development are at direct risk of armed conflict
- Child militia (e.g. *Egbesu*)
- Children who are abducted
- Children who are refugees
- Children who are internally displaced
- Children whose parent(s) dies as a result of conflict

## 7. Children in need of legal protection

- Children in conflict with the law
- Children institutionalized in remand homes, rehabilitation centres, and children's homes
- Children who are denied their inheritance rights
- Children who are forcefully denied access to either of a living parent

### 7.1.5 Programming for quality and standards

The following strategies should be used by the programme implementers in complying with the minimum standards and guidelines for vulnerable children in service delivery:

- i. **Capacity-building:** All key stakeholders involved in providing services and support to vulnerable children should ensure that users of the Standards at all levels, including national, district and local levels, are trained in the application of the standards and guidelines. The stakeholders should also ensure implementers have the technical, financial and management capacity necessary to successfully utilise the Standards and Guidelines.
- ii. **Use existing coordinating mechanisms at all levels:** There are a number of existing structures that support programmes for vulnerable children at the national, district and community levels which need to be used and built upon rather than establishing new ones.
- iii. **Community advocacy and social mobilization:** Empowering communities to mobilise and utilise existing resources will help generate ownership and sustained action to support vulnerable children. Programmes should ensure that families and communities have the necessary support to take responsibility for addressing the needs of vulnerable children. Such an approach will work towards ensuring ownership of the services by families and communities and hopefully enhance the sustainability of services and support. As observed in the Situation Analysis for Vulnerable Children in Lesotho (2011), the most immediate and direct safety net for response to vulnerability is through empowering families and communities with the knowledge and skills to take a proactive role in caring for and protecting vulnerable children, including the use of positive indigenous practices. Programmes need to invest in sensitising key stakeholders and beneficiaries to the importance of the standards of care and advocate for its integration into the overall design and planning of programmes for vulnerable children. Advocacy efforts should



focus on the quality of services and support for all vulnerable children programming efforts and policy improvement as contained in the 2012-2017 NSPVC.

- iv. **Partnerships:** Partnering and collaborating with other actors involved should enhance the ability to apply the three-one principle (one coordinating body, one agreed framework and one M&E system), thus allowing the Standards to be utilised at greater scale and impact.
- v. **Family-centred approach:** Children should be reached through a family-centred approach to minimise friction, stigma, and disharmony in their households, while at the same time maintaining the focus on children who are most in need and at risk of falling through the cracks through improved targeting.
- vi. **Resource optimisation and mobilisation:** Short-term and long-term plans of actions for resource mobilisation should be a part of every organisation or group providing services and support to vulnerable children. Resource mobilisation may be done both domestically and internationally.
- vii. **Sectoral mainstreaming:** Programmes for vulnerable children should advocate for mainstreaming of services in key sectors such as education, health, psychosocial support and youth development to expand the scope for service delivery. Once mainstreaming is achieved, stakeholders should ensure that the Standard Service Delivery Guidelines are applied by the role players in the aforementioned sectors to ensure quality service delivery to vulnerable children.

## 8 ILLUSTRATIVE STANDARDS OF CARE AND SERVICES

The following illustrative standards are developed and adapted from: the SADC minimum package of Services, National Strategic Plan on Vulnerable Children, Guidance for orphans and vulnerable children programming PEPFAR OVC Programming, and several other documents developed by the industry leaders globally and in the region. The MOSD has engaged in a series of consultations to ensure that all stakeholders had an active participation in the research, debate and proposal associated with these quality standards.

The framework provides a definition for each care service, challenges and the specific areas of need that are fulfilled through each service, desired outcomes, measurable goals, and standards.

The users of the document are also expected to recognize the several dimensions of quality for each of the services under the Child Status Index. These include: safety, access, effectiveness, technical performance, efficiency, appropriateness, continuity and sustainability.

### 8.1 CARE SERVICE: EDUCATION AND TRAINING

Education and training services seek to ensure that OVC and youth receive educational, vocational and occupational opportunities ranging from early childhood development, primary, secondary and tertiary education, non-formal education and vocational training.

The basic educational services required to fulfill the need for education and vocational skills vary significantly, depending on the age, situation the child is in, from providing tuition fees, school uniforms, educational materials (stationery and instructional materials), safe learning environment, psychosocial skills, entrepreneurial and livelihood training and income-earning skills.

National OVC situation analysis recognizes that education and health care are among the most commonly received services by the OVC, and highlights the following gaps and challenges in access to education:

- Some of the Early Childhood Care and Development (ECCD) centres are not registered with the Ministry of Education and Training (MOET) and hence children attending such centres are also not registered. Vulnerable children who are not registered cannot access bursaries and this becomes a critical bottleneck.
- Shortage of qualified and experienced ECCD and pre-school teachers.
- Fees charged by ECCD centres are high, not regulated, and barrier to enrollment of vulnerable children who cannot afford.

- Limited budget for bursaries for vulnerable children attending ECCD. In 2008, the budget could only support 200 vulnerable children.
- Many communities, especially in the mountain districts lack capacity to establish ECCD centres, resulting in lack of pre-school education for their children
- Access to the affordable and quality education remains a national challenge, contributing to poor retention of pupils, resulting in lack completion of primary education, and transition to tertiary education.
- High cost of secondary education prevents vulnerable children from accessing bursaries, since many vulnerable households and children are unaware of these bursaries.

**Desired outcome and measurable goals:**

- Families meet the basic needs of all members of the household in spite of changes in the family situation due to prevailing poverty and HIV and AIDS.
- Life skills education is mainstreamed into schools as a strategy to reduce HIV infections among learners.
- Vulnerable children in households have adequate food, clothing, shelter, and resources for fees related to education and health care.
- Vulnerable children in the community are sent to and retained in the school, on par with other children

**Operational strategies:**

- Facilitate the generation of evidence to inform the understanding of the extent and impact of stigma and discrimination on vulnerable children.
- Intensify awareness and education on stigma and discrimination among vulnerable children and their families.
- Conduct advocacy work to enforce policies and legislation on stigma and discrimination reduction.

Interventions and strategies	Quality standards and guidelines
	<ul style="list-style-type: none"> <li>• Education interventions promote access, attendance, and a safe school environment.</li> <li>• Interventions ensure access to ECCD programs.</li> <li>• Schools create child-friendly and HIV/AIDS- and gender-sensitive classrooms.</li> </ul>

	<ul style="list-style-type: none"> <li>• Community-school relationships, including partnering with out-of-school programming are strengthened.</li> <li>• Education interventions aim to support post-primary school programming and especially the transition for girls from primary to secondary school.</li> <li>• Vocational trainings, interventions and material supports should be practical, appropriate to the country and community context, based on evidence.</li> </ul>
<p><b>Community mobilisation for education</b></p>	<ul style="list-style-type: none"> <li>• Communities are engaged to mobilize resources to support educational efforts for children vulnerable due to HIV and AIDS.</li> <li>• Schools and communities are engaged to ensure continuity of education from primary school to secondary school and higher.</li> <li>• All stakeholders (community leaders, Parent-Teacher Associations, school administrators and teachers, agencies implementing assistance, caretakers, and children themselves) are included in all discussions about the educational needs and the rights of all children, including the importance of early childhood development.</li> <li>• Community interventions include advocacy for and facilitate integration of curricula that meet the need for life skills training, development of self-esteem, and knowledge of HIV prevention.</li> <li>• Conduct anti-stigma activities in school and community.</li> <li>• The communities CSO ensure that schools are safe (children can travel to school safely, are free from abuse in school, building is safe, etc.) Linkages to health, legal, nutritional and psychosocial services are available so that teachers can easily refer children to needed services.</li> <li>• Stakeholders participate and evaluate their progress in meeting the educational needs of children in the community.</li> </ul>
<p><b>Identification of children in need of educational support services</b></p>	<ul style="list-style-type: none"> <li>• Communities are supported to identify children in need of support to be able to attend pre-school, school or vocational training, and children in need of special attention.</li> <li>• Communities are engaged to identify school eligible children who are not enrolled in school or not attending regularly and are not gaining any non-formal education.</li> </ul>

	<ul style="list-style-type: none"> <li>• Communities participate to determine the criteria that will be used to decide which children and families receive educational support.</li> </ul>
<p><b>Monitor enrollment and progress and provide support as needed</b></p>	<ul style="list-style-type: none"> <li>• All school-eligible children from families who are caring for vulnerable children are registered for school or receiving non-formal education.</li> <li>• Assistance with school fees, supplies, shoes, uniform, backpacks etc.) are based on the evidence that lack of these are absolute barriers to school attendance related to gender, disability, caretaking responsibilities for parents or siblings, or economic issues.</li> <li>• Children in complex situations are referred to supervisors/social workers/school officials for assistance.</li> <li>• Children are counseled about te school experience (does she like school, feel safe, treated respectfully by teachers and peers)</li> </ul> <p>Explore and address the problems related to in-school experience including relationship with teachers and caretakers and address through counselling and other interventions related to social integration, safety, or stigma .</p> <ul style="list-style-type: none"> <li>• Families are made aware of available academic support activities such as homework clubs, tutors etc.</li> </ul>
<p><b>Community-based day care and preschool programs</b></p>	<ul style="list-style-type: none"> <li>• The communities are engaged in developing local programs for preschool children that provide a safe environment and stimulate child health and development (breakfast/play programs, day care programs or cooperatives) as well as support to caregivers with skills in caring for very young children.</li> <li>• Beneficial activities for caretakers (group education or income generating opportunities while children are in care program).</li> <li>• Caretakers are aware of educational/day care programs for pre-school children (if applicable).</li> <li>• Communities are supported to develop day care and pre-school opportunities where feasible.</li> </ul>
<p><b>Transition to vocational school and work</b></p>	<ul style="list-style-type: none"> <li>• All youth in the households are counseled about vocational and work options available upon completion of school (begin discussions 6 months to 1 year before completion).</li> <li>• Plans for transition with youth and caretakers are developed.</li> <li>• Start-up support for youth who are ready to begin working (help with identifying employment opportunities or materials or funds to start a small business) is accessible.</li> </ul>

	<ul style="list-style-type: none"> <li>• Monitoring, advice and support are available as needed during transition from school to vocational training, and from vocational training to work.</li> </ul>
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## 8.2 CARE SERVICE: ACCESS TO HEALTH CARE AND SANITATION:

The basic services required to fulfill the need for good health and sanitation and which are primarily the responsibility of health and other related sectors include immunization; micronutrient supplementation, therapeutic feeding and oral rehydration therapy for younger children; prevention, treatment, care and support for HIV and AIDS, tuberculosis and other diseases; sexual and reproductive health care and age-appropriate provisions for adolescents and youth; and counselling and support for psychosocial disorders and problems. Among the complementing services that could be provided with the support of other sectors are the provision of clean water, sanitation and environmental protection services and social protection services that enable access to health care and sanitation services. The following are some of the challenges highlighted in the National OVC Situation Analysis 2011

- High attrition of qualified and experienced staff in the health sector. This has been attributed to unfavourable conditions and lack of benefits of employment.
- High costs of health services in hospitals - unaffordable to most vulnerable households.
- Limited resources for health service delivery.
- Inadequate sanitation and availability of decent toilets. The Demographic and Health Survey 2009 shows that 76% of all households do not have access to improved sanitation facilities, while 66.7% don't have decent toilets.

### **Desired Outcome**

- Children receive preventive and curative and health promoting care services including primary health care, immunization, treatment when they are sick, HIV screening, ongoing treatment for children known or presumed to be HIV positive, and education about HIV prevention.
- Vulnerable children have access to comprehensive care and support services, including provision of ART and treatment of other opportunistic infections.
- Nutritional supplements are being provided to clinically malnourished children, including children under 5 years.

- At community level home-based care services is provided and accessible to vulnerable children and their families.
- Children have improved their health status.
- The child has access to needed services: primary health care, immunizations, HIV screening, treatment as needed for children known or presumed to be HIV positive, education about HIV prevention.

### Operational strategies

- i. Advocate for the strengthening of health systems to ensure friendly access and utilisation of affordable health services by vulnerable children.
- ii. Advocate with health service providers for the development of strategies to support vulnerable children transiting from paediatric to adult ART.
- iii. Collaborate with Ministry of Social Development. to strengthen the monitoring system to track treatment adherence for vulnerable children especially those in vulnerable households.
- iv. Advocate for the improvement of water and sanitation for vulnerable households and provision of decent toilets.
- v. Facilitate advocacy work for the development of decent shelter for vulnerable households.

Interventions and strategies	Quality standards and guidelines
<p><b>Community based health services</b></p>	<ul style="list-style-type: none"> <li>• Community based health care and health education services and service providers are identified, mapped and updated annually.</li> <li>• Children and their caretakers in the community have access to information on health care and health education services such as types of services available, location of services offered, access cards, referral mechanisms, sources of medicines, and fees that may apply</li> <li>• CSO and CBOs implementing programs work with local health authorities, including, community village health workers and volunteers, to identify sources of health promotion and health education related to nutrition, child health, living with HIV, hygiene and sanitation. They should also work with communities to identify available public and non-public health care services</li> <li>• Where service gaps exist, OVC programs work through regional and national committees to advocate for needed services</li> </ul>

<p><b>Monitor health status and access to care and address barriers to health care access</b></p>	<p>Through village health workers, health facility outreach teams, community care coordinators, and community based groups, routinely assess the following:</p> <p><b>Assess;</b></p> <ul style="list-style-type: none"> <li>• Caregivers’ knowledge about where to access preventive and curative health services.</li> <li>• Barriers to care seeking (distance, financial, other).</li> <li>• Utilisation of preventive services, including immunization are up to date according to health cards.</li> <li>• Access to age-appropriate HIV counseling and testing.</li> <li>• If known or presumed to be HIV+, children are being monitored and taking ARV or prophylactics as indicated?</li> <li>• Consumption of nutritional foods, including frequency.</li> <li>• Health status of child, including signs of trauma of physical/sexual abuse.</li> <li>• Household water and hygiene conditions.</li> <li>• Barriers to care (distance, finances, other problems with access).</li> </ul> <p><b>Action:</b></p> <ul style="list-style-type: none"> <li>• Project staff, community caregiver/volunteers and village health workers refer children for all appropriate health care services and follow up.</li> <li>• Project staff, community caregiver/volunteers and village health workers and community groups seek available solutions to barriers to care (financial, geographic, cultural etc.)</li> <li>• Project staff, community caregiver/volunteers and village health workers provide health education and/or refers for group education activities (nutrition, hygiene, etc.).</li> <li>• If urgent care is needed at the time of assessment, staff/volunteer assists caretaker in taking the child to the health center.</li> </ul>
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	<ul style="list-style-type: none"> <li>• Health care providers treat children and families with respect and confidentiality.</li> <li>• Project staff, community caregiver/volunteers and village health workers keep a record of services needed, addressing barriers to care, and following up during next visit, to ensure efficient case management</li> </ul> <p><b>Support and Supervision:</b></p> <ul style="list-style-type: none"> <li>• Supervisors are available to assist staff when needed so that difficult problems are resolved.</li> <li>• Staff should be trained in the above tasks and receive ongoing supervision.</li> <li>• CSO has a clear policy on how frequently children should be monitored and how many visits staff is expected to do each month.</li> </ul>
<b>Health Education</b>	<ul style="list-style-type: none"> <li>• Implementing organization works with community and local health authorities to offer health education in the following areas: <ul style="list-style-type: none"> <li>• Basic health care</li> <li>• Hygiene, water and sanitation</li> <li>• Nutrition</li> <li>• Living with HIV (age appropriate)</li> <li>• Sexual and reproductive health (age and gender appropriate).</li> </ul> </li> </ul>

### 8.3 Care Service: Food and Nutrition Support:

The basic services required to meet the need for food and nutrition, ensure that vulnerable children have access to similar nutritional resources as other children in their communities. These services often fall under the primary mandate of the agriculture and natural resources sectors and include food security and the production and provision of nutrition-rich food for different age groups. sectors that coordinate child and youth development also play a critical and direct advocacy and monitoring role, and must be engaged, to address the following challenges identified in the national strategic plan on vulnerable children:

- The food insecurity and it’s seasonality, especially in rural areas, even among communities heavily dependent on wage labour , thus contributing to the cycle of poverty.
- About one-in-six households lack staple foods in reserve.

- The relationship between HIV infection, food and economic insecurity, particularly in households with limited coping capacities has significant negative impact overall wellbeing of the households and children.
- Malnutrition is an underlying factor in child deaths, and is particularly acute among HIV-positive children.
- Children, younger than 5 years, frequently suffer from moderate or severe malnutrition and are underweight. Micronutrient deficiencies of particular concern in the country. (African Union, 2005)
- Lack of food is a significant barrier to educational success as it affects school enrollment, educational attainment and productivity.
- Inadequate implementation of policies intended to improve food security and nutrition, compounded by lack of sufficient investment in food security and nutrition interventions.
- Uncoordinated interventions leading to duplication of efforts by service providers working towards improving household food security and nutrition uptake.

### **Desired outcome**

- Households and children are food secure with the required balanced nutrition in accordance to their age and circumstances.
- Free micronutrients for malnourished infants are provided through health facilities.
- The household has access to sufficient food to help children thrive and sustain an active and healthy life.
- The child is growing well on par with the others of the same age in community.

### **Operational strategies**

- i. Strengthen household food production systems and food support mechanisms to promote food security and access to nutrition.
- ii. Increase family and community knowledge and skills in nutrition (including aspects such as frequency and diversity of feeding).
- iii. Accelerate the implementation of policies and regulations that promote community and household food security.
- iv. Strengthen coordination mechanism of service providers involved in food security.

Intervention strategies	Quality standards and guidelines
<b>Community mobilization and engagement</b>	<ul style="list-style-type: none"> <li>• Community leadership is engaged in the awareness of nutritional needs of OVC, identification of children in need, provision of services and support, including Nutrition, Assessment, Counselling and Support (NACS).</li> <li>• Consultative meetings and dialogues with community (school, religious institutions, other organizations) are carried out to understand community needs, assets and roles/responsibilities, and outside available resources.</li> <li>• Community based groups involved to identify vulnerable children and households and participate in service delivery (home visits, feeding programs, gardens etc.).</li> <li>• Develop collaborative relationship with community structure to establish and support community based initiatives.</li> <li>• OVC and caregivers participate in decisions that affect their lives.</li> <li>• Stakeholders participate at all levels of program planning and implementation.</li> </ul>
<b>Assess and monitor food security and nutritional intake in the household</b>	<ul style="list-style-type: none"> <li>• Assess access to food in the household, noting overall quality and adequacy (number of meals per day, a variety of foods, etc.) as well as disparities in distribution related to age, gender, disability, or OVC status through a household visit or interview with caretaker and children.</li> <li>• Assess access to safe drinking water at the household level.</li> <li>• Assess access to nutritional foods and adequate consumption.</li> </ul>
<b>Nutrition education</b> <i>(Ongoing in group settings, or during household visits)</i>	<ul style="list-style-type: none"> <li>• Nutrition assessment findings are used to develop nutrition education approaches and content.</li> <li>• Caregivers and older children are educated and counseled on nutrition and nutrient rich local food sources, food preparation (including how to use food supplements), food storage, basic hygiene and sanitation, signs of malnutrition, importance of exclusive breastfeeding with appropriate advice for HIV+ mothers.</li> <li>• A nutritional educational package is developed for malnourished children, HIV+ children, and those on ART included as appropriate</li> </ul>
<b>Sustainable access to community based food security and interventions</b>	<ul style="list-style-type: none"> <li>• Mechanisms are established linking households with economic strengthening programs to address livelihoods and protect household assets.</li> </ul>

	<ul style="list-style-type: none"> <li>• Support for viable and practical local food production and provision efforts (e.g., animal husbandry, urban gardens, farming skills, school-based feeding) are available.</li> <li>• Communal farming established to ensure that the family land in households affected by HIV and AIDS is being farmed by the extended family or community, and that vulnerable children benefit from this planning and implementation is linked with other stakeholders, economic sectors and programmes.</li> <li>• Programmes are integrated into school system (e.g. vegetable production at school compound and nutrition education).</li> <li>• School attendance is promoted through school feed programme</li> <li>• Income generating activities (IGAs) and community initiatives create access to food for OVCs.</li> <li>• Best practices of agricultural production in the community the mobilise sustainable food/nutrition supply are identified and shared.</li> </ul>
<p><b>Food supplementation and feeding programs</b></p>	<ul style="list-style-type: none"> <li>• Determine eligibility criteria for food supplementation, as well as guidelines for distribution to the community based on the government and programmatic guidelines.</li> <li>• Ensure food preservation and safety.</li> <li>• Distribute food at a safe and accessible site so that transport of food is not a burden.</li> <li>• Be reliable in distribution schedule.</li> <li>• Provide foods that are appropriate and acceptable to the recipients</li> <li>• Inform recipients about the schedule, foods to expect, etc.</li> <li>• Recipients feel that food and meals are provided with respect, dignity and care.</li> <li>• Give special attention to children on ARVs, malnourished children, and infants.</li> <li>• Food distribution times are used as an opportunity to improve access to school, health screening and care, and other needed services when feasible.</li> </ul>

<b>Referral mechanisms in the community for the critically malnourished children</b>	<ul style="list-style-type: none"> <li>• Critically malnourished children should receive immediate assistance, including appropriate food or drink, information about health services, health card, and assistance with transport to emergency feeding center or health facility if needed.</li> </ul>
<b>Leveraging programs and services</b>	<ul style="list-style-type: none"> <li>• Programmes should identify providers of food, water and nutrition services in the area, coordinate with local/regional actors to enhance coverage and efficiency, enhance local agricultural production knowledge; maximize local markets, and mainstream food and nutrition aspect in all service areas.</li> </ul>
<b>Integrate nutrition education in basic health programs</b>	<ul style="list-style-type: none"> <li>• Programmes and communities should identify points of contacts with the children and caregivers during which nutrition counseling are provided. These may include: (immunization visits, IMCI, HIV/AIDS services for caregivers and children)</li> </ul>

## 8.4 CARE SERVICE: CHILD AND YOUTH PROTECTION:

These services aim to reduce stigma, discrimination and social neglect, ensuring access to basic rights and services, protecting children from violence, abuse and exploitation.

The African Charter on the Rights and Welfare of the Child explicitly prohibits harmful social and cultural practices, including early marriage – it specifies 18 as the minimum age for marrying. Civil registration is crucial for children and youth to realize their rights and access basic services.

Having a family is considered the most essential need for a child; thus remaining with extended family is best for children’s development in the event of death or other absence of both parents – but only if that family provides trusting relationships. Institutional care should only be used as a last resort. Through social protection, extended families can be supported to keep the children.

Some of the gaps and challenges related to child protection include:

- The CPWA 2011, has been disseminated, but is yet to be operationalised with a regulatory framework for it to be rolled out.
- Some legal statutes are obsolete and have a negative impact on vulnerable children. Examples include the Births and Deaths Act 1978, and the Administration and Estates Proclamation to regularize inheritance of family properties by orphaned children.
- Conflicting interpretation of customary and statutory laws as they relate to the welfare of children, e.g. marriage of under-aged children.

- Inadequate capacity of the judicial system to handle cases involving children as offenders, victims and or witnesses.
- Inadequate application of policy guidelines for reporting and dealing with cases involving children.
- Insufficient understanding and experience of children, families and communities of how to use the judicial system for children’s protection.
- The courts’ handling of children’s cases is often not child-friendly.

**Desired Outcome:**

- Vulnerable children are free from physical and sexual abuse, neglect and exploitation and are legally protected, and show no signs of physical abuse.
- Children have civil registration, and a legal guardian and an inheritance plan if appropriate.
- Accelerated the implementation of strategies that enforce existing legislation that protects children from all forms of violence, abuse, exploitation and neglect.
- The capacity of service providers is strengthened to execute legal responsibilities for the protection of children.
- Functional referral systems are set in place between service providers.
- The capacity of the judicial system is strengthened to handle children’s cases more efficiently and sensitively, in line with the principle of the “best interests” of the child.
- Advocate for the accelerated efforts to consolidate the various legal instruments related to inheritance.
- The “regulations” necessary to operationalise the implementation of the Children’s Protection and Welfare Act.

**Operational strategies**

- i. Advocate for the strengthening of social protection systems (police and justice sub-systems) to ensure efficient and effective service delivery.
- ii. Engage and support frontline auxiliary social welfare workforce
- iii. MOSD provides effective coordination, monitoring and evaluation of the national vulnerable children’s response, in addition to capacity for social services delivery.

<b>Interventions and strategies</b>	<b>Quality standards and guidelines</b>
<b>Laws and policies</b>	<p>Programmes establish relationships with, and support as feasible, the groups involved in:</p> <ul style="list-style-type: none"> <li>• Changing laws and policies that deny children, their rights.</li> <li>• Enforcing laws and policies that protect children’s rights.</li> <li>• Free civil registration.</li> </ul>
<b>Community Mobilization and Awareness</b>	<p>Community mobilization and awareness practices aim to:</p> <ul style="list-style-type: none"> <li>• Raise community awareness of children’s rights.</li> <li>• Work with community leaders to publicly express support for Children’s rights and a zero tolerance of discrimination, abuse, exploitation, disinheritance, neglect of children.</li> <li>• Educate children, families, general public, as well as all agencies working with children (i.e., health, education, justice) about legal and other protective services available.</li> <li>• Encourage community to recognize signs of abuse and neglect, to report suspected cases, and to build infrastructure to assist victims and punish perpetrators.</li> <li>• Educate community about the importance of civil registration, succession planning and guardianship.</li> <li>• Mobilize community members to actively support legal and other protective services through volunteering, fund-raising, donations, advocacy, etc.</li> </ul>
<b>Prevent abuse, neglect and exploitation.</b>	<p>Programs should aim to prevent the circumstances that may lead to abuse, neglect, exploitation by providing (or referring) children and families to services that meet their basic need for healthcare, shelter, food, and clothing.</p> <ul style="list-style-type: none"> <li>• Provide (or, refer for) parent/caregiver psycho social support such as linking to support groups, household help, and counseling.</li> <li>• Help families to develop and expand their informal support networks, including friends, extended family, neighbors, and community members.</li> <li>• Provide (or refer for) parenting and caregiver training, including age appropriate discipline skills.</li> <li>• Provide, or refer for services to prevent neglect such as child care or</li> </ul>

	<p>daycare, night shelters, substance abuse and mental health support.</p> <ul style="list-style-type: none"> <li>• Prevent exploitation by working with (or encouraging) justice and business community to identify potential or existing exploitative situations such as the worst forms of child labor, sexual trafficking and prostitution.</li> <li>• Work with, and support community based groups (including schools), to make communities safer for children by 1) mapping risk areas and creating plans to reduce risks; 2) identifying and creating new communal safe spaces for children including separate spaces for adolescent girls.</li> <li>• Establish or encourage community child protection committees to monitor safety of children at highest risk, including child-headed households, girls without female caretakers, and children living outside of family care.</li> <li>• Build self-protective capacity of children through gender appropriate skills training and through education about abuse.</li> <li>• Establish assessment procedure and regular monitoring mechanisms to verify that children the organization serves: <ul style="list-style-type: none"> <li>• Are free from abuse, neglect and exploitation.</li> <li>• Are civilly registered (birth registration).</li> <li>• Have a succession plan that includes a will, which has been identified, agreed upon and respected by a legal guardian. .</li> </ul> </li> </ul>
<p><b>Assure that children are protected in the context of service delivery or referral by organization or agency</b></p>	<ul style="list-style-type: none"> <li>• Establish a written child protection policy; and orient all staff/volunteers to the policy, including any repercussions for failure to follow the policy.</li> <li>• Ensure, prior to hiring or engaging, that potential staff and volunteers that will work directly with children (especially those that have unsupervised interaction with children) do not have known offenses for abusing or mistreating children.</li> <li>• Procedures for identifying and immediately dismissing and referring persons that harm children, to the legal authorities. Verify with community members, especially children of potential or current staff/volunteers/caregivers are not perpetrators.</li> <li>• Inform all children and families (in writing where appropriate) that they can confidentially report any questions about staff or volunteer behavior to the organization’s leadership.</li> </ul>
<p><b>Service Access</b></p>	<p>Programs must:</p> <ul style="list-style-type: none"> <li>• Identify and map existing legal and other protective services</li> </ul>



	<p>(government, faith based and community).</p> <ul style="list-style-type: none"> <li>• Work with national, district and community level stakeholders to establish legal and other protective services where critical gaps exist</li> <li>• Create and annually update service directories to encourage access and referrals.</li> <li>• Establish mechanisms to encourage referrals and follow up between protective services and other children and family services.</li> <li>• Establish with stakeholders reliable, safe, and continuously available means to rapidly connect children in need to protective services.</li> <li>• Work with providers of legal and other protective services to: <ul style="list-style-type: none"> <li>○ Ensure accessibility for children and families with access constraints (e.g, illiteracy, mental and physical handicaps, language barriers, poverty, transport, etc.).</li> <li>○ Plan special interventions to reach out to children at highest who are least likely to have access (for example, child headed households, street children, child brides).</li> <li>○ Support interventions to remove any administrative, managerial or bureaucratic barriers that impede or significantly slow down access to protective services.</li> </ul> </li> </ul>
<p><b>Build capacity of selected staff, volunteers and community members to provide (or refer for) protective services.</b></p>	<p>Work with legal and other protection experts to build capacity of staff, volunteers and community members (especially police, teachers, health providers and others directly involved with children) through training, exchange visits, written materials, to:</p> <ul style="list-style-type: none"> <li>• Identify signs of abuse, neglect, and exploitation; and circumstances where such events are more likely to occur.</li> <li>• Make and monitor referrals to protective services.</li> <li>• Facilitate access to culturally appropriate health, emotional and social support services to children who have survived abuse, exploitation, neglect.</li> <li>• Provide life skills training to children, particularly adolescent girls.</li> <li>• Support children and families in creating succession plans, including naming a guardian and will-writing.</li> </ul>

	<ul style="list-style-type: none"> <li>• Facilitate civil registration</li> <li>• Establish [or support others to] safe temporary family based solutions for children who must be removed from their homes such as emergency foster care programs.</li> </ul>
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## 8.5 CARE SERVICE: PSYCHOSOCIAL SUPPORT

These services aim to provide OVC with the human relationships necessary for normal development. It also seeks to promote and support the acquisition of life skills that allow adolescents in particular to participate in activities such as school, recreation and work and eventually live independently. The services required for psychosocial well-being are crosscutting and address a wide range of needs, including: psychological and social skills and knowledge, emotional, social and spiritual well-being. They also address the following challenges:

- The majority of service providers that are working with vulnerable children do not possess adequate psychosocial skills.
- Lack of data of empirical evidence on the psychosocial needs of children and how those needs are being or have been addressed.
- Resource capacity limitations prohibit sufficient provision of psychosocial support to vulnerable households by service providers.

### **Desired Outcome:**

Children have the human attachments necessary for normal development and participate cooperatively in school, recreation, and family settings (caregivers or host families) and interact with other children and adults. Children get required care and stimulation they need to develop normally, enroll, attend and progress through school (pre-school, elementary, secondary) and/or tertiary, vocational or non-formal trainings to prepare them to earn an income, have the life skills and psychosocial support necessary to live healthy and productive lives.

- All vulnerable children and youth and their caregivers, where appropriate, access preventive and curative health care, including that related to HIV and AIDS .
- All vulnerable children and youth receive adequate nutritious food, appropriate clothing, shelter, clean water, and sanitation services.
- All vulnerable children and youth are protected from all forms of exploitation, unfair treatment and harm and have a national identity.
- All vulnerable children and youth and their families or caregivers are guaranteed an acceptable standard of living through a social protection system that includes social transfers, a functioning social welfare system and other safety nets.

All youth who have completed formal or informal education or training or are out of school are able to earn income or engaged in a livelihood activity formally or informally.

### Operational strategies

- i. Strengthen the capacities of families and communities to respond to the psychosocial needs of vulnerable children and their caregivers.
- ii. Accelerate the up-scaling of psychosocial support services, through mainstreaming psychosocial support in pre-service training programmes for service providers such as police social workers, nurses, teachers, as well as in major programmes and services or interventions targeting vulnerable children.
- iii. Accelerate provision of psychosocial support at households level and other forms of children’s groups or clubs.

Intervention strategies	Quality standards and guidelines
<b>Strengthen resilience of families</b>	<ul style="list-style-type: none"> <li>• Provide guidance and training that enable families and caregivers to support children’s emotional and social development based on assessment of needs, which include:               <ul style="list-style-type: none"> <li>○ Stages of child and adolescent development</li> <li>○ Coping with grief and loss</li> <li>○ Stigma associated with HIV/AIDS</li> <li>○ Identifying signs of depression, trauma other psycho-social distress in children and adolescents</li> <li>○ Communication skills (e.g., effective listening, involving children in decision-making)</li> <li>○ Parenting skills (e.g., building resilience of children, accommodating gender differences in emotional and social development, constructive discipline,)</li> <li>○ Succession planning</li> <li>○ HIV status disclosure</li> <li>○ Caring for children with special needs ( exposed to or living with HIV, living with disabilities)</li> <li>○ Age-appropriate guidance about sexuality, relationships, birth control.</li> <li>○ Use assessment findings to inform activities to assist families and identify areas that may need additional support from the community (friends, neighbors, places of worship, schools, adult mentors, CBOs, counseling services)</li> </ul> </li> </ul>
<b>Build capacity of communities to</b>	Work with children and adolescents, families and community to determine areas or issues that would benefit from community support of children’s

<p><b>support children and families</b></p>	<p>emotional and social wellbeing.</p> <p>Training and follow-up (supervision, coaching, mentoring) are offered to community members who have contact with children (teachers, children’s group leaders, community volunteers, and older children, as well as parents and caretakers) in:</p> <ul style="list-style-type: none"> <li>• Adjusting to loss.</li> <li>• Verifying that contact is maintained with relatives and siblings.</li> <li>• Providing life skills, adult mentoring, and/or lay counseling.</li> <li>• Arranging for counseling and testing for children and caregivers that may be living with HIV.</li> <li>• Providing drug and alcohol counseling/referral as needed</li> <li>• Supporting children who have lived outside of family care with counseling and follow up.</li> <li>• Engaging communities to reflect on their roles to provide emotional support to HIV affected children and adolescents.</li> </ul> <p>Work with community members to consider group activities for children and adolescents (for example: mentorship groups, integrated lifes kills groups, sports clubs, overnight camps, groups oriented toward the dance and the arts, faith-based youth groups, after school programs and others). These activities should:</p> <ul style="list-style-type: none"> <li>• Be offered under the leadership of trained adult mentors</li> <li>• Offer the opportunity to develop friendships with peers and trusting relationship with mentors.</li> <li>• Increase self-esteem, self-awareness and self-expression</li> <li>• Build problem-solving and coping skills</li> <li>• Provide structure and a safe, confidential way to seek help if needed</li> <li>• Monitor child emotional and social wellbeing</li> <li>• Be based on participatory decision-making and engagement.</li> </ul>
<p><b>Monitor psychosocial status and provide referrals and follow up</b></p>	<p>Service providers, including volunteers establish and monitor referral mechanisms whereby adult mentors, home visitors, lay counselors and others who work with children and adolescents know when, how and where to refer them or their caregivers to support programs or counseling by para-professions or professionals (social worker, psychologist or other formally trained mental health professional).</p>
<p><b>Ethical Practice</b></p>	<p>All staff, caregivers and volunteers working with children and their families abide by a code of conduct that:</p> <ul style="list-style-type: none"> <li>• Provides confidentiality, privacy, respect, safety and avoids stigma and discrimination. They agree to zero tolerance for physical and sexual abuse, and are compiled and supported to report such abuses if observed.</li> <li>• Actively involves children in decisions that affect his or her emotional and social well-being.</li> </ul>

	<ul style="list-style-type: none"> <li>• Avoids age, gender, or special needs stigma and discrimination.</li> <li>• Facilitates equity and continuity of care.</li> </ul>
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## 8.6 SERVICE: SOCIAL PROTECTION

Because the immediate family care and support system for vulnerable children and youth often fail to cope, and direct external financial and social assistance to restore services and rehabilitate often extreme cases of deprivation. In this regard, targeted social protection is essential and thus considered a basic need. Social protection is often provided by multiple sectors and systems that are responsible for coordinating access to finance, economic development and poverty reduction-related services as well as donor inputs.

Social protection can be used to break the cycle of poverty, such as when older children and youth and families of vulnerable children are empowered with sustainable livelihood and self-reliance capabilities (through preferential laws, policies and programmes). Social protection can take different forms, such as direct cash transfers or in-kind support to better access services, community-initiated and driven systems for supporting the vulnerable and the poor, assisting with income-generating activity or the pairing of child-headed households with an attentive caregiver or to institutions for livelihood support. Social transfers need to be linked effective social welfare system and poverty eradication strategy.

**Economic Strengthening:** Portfolio of strategies and interventions that provide, promote, and protect, physical, financial, human and social assets, because the poorest families are unlikely participants in income generation programmes, especially if they are labour-constrained. Their extreme vulnerability – and correspondingly high aversion to risk – often renders them unwilling to take on any activity that would expose them to higher risk, such as starting a business.

To bring these families to the point where they are willing to accept the small amount of risk necessary to generate income, social assistance programmes such as cash transfers and subsidies are often the best options.

### **Gaps and challenges that require social protection include:**

- Lack of awareness of existing resources for supporting community livelihood initiatives, as well as lack of procedures or systems to access those resources to support sustainable livelihood.
- The current operating environment is not enabling households to secure their economic livelihood given the economic downturn.
- Most livelihood projects are unsustainable. While several initiatives for vulnerable children and their families are being developed and implemented, the linkage between them with government rural livelihood programmes is limited.

- Over fifty six percent of Lesotho population lives in vulnerable households that are characterised by poverty, food insecurity, poor shelter and inadequate access to clean water and sanitation. It is these households that need social protection most. However, social protection has been compromised by lack of adequate knowledge of social protection systems, human and financial resources. These challenges are further compounded by issues of stigma, discrimination, isolation, gender-based violence, and physical, emotional, and sexual abuse.

### Desired Outcome

Families can meet the basic needs of all members of the household in spite of changes in the family situation due to HIV and AIDS

**General household:** Head of household reports that the basic needs of the household are met.

**Basic needs of vulnerable children:** Vulnerable children in the household have adequate food, clothing, shelter, and resources for fees related to education and health care.

### Operational strategies

- i. Advocate for the strengthening of social protection systems (police and justice sub-systems) to ensure efficient and effective service delivery.
- ii. Support the strengthening of social welfare systems and in particular the MOSD to provide effective coordination, monitoring and evaluation of the national vulnerable children’s response.
- iii. Household Economic Strengthening (HES): HES aims to reduce the economic vulnerability of families and empower them to provide for the essential needs of the children in their care through:
  - a. 1) Money management interventions for savings, access to consumer credit, and fostering knowledge and behaviors for better family financial management
  - b. 2) Integration of HES activities with complementary interventions, such as parenting skills
  - c. 3) Income promotion using low-risk activities to diversify and stimulate growth in household income

Intervention strategies	Quality standards and guidelines
Map economic strengthening opportunities in community	Work, engage and collaborate with community and economic growth programs to identify:: <ul style="list-style-type: none"> <li>• Vocational training programs</li> <li>• Micro-loan, savings and mutual aid programs</li> <li>• Small business opportunities (needed goods or services)</li> <li>• Labor saving devices that are context-appropriate</li> </ul>
Identify eligible households and	<ul style="list-style-type: none"> <li>• Work with community structures to establish criteria for selection of participants with attention to avoiding stigma or discrimination or</li> </ul>

participants	<p>gender inequities.</p> <ul style="list-style-type: none"> <li>• Consider all adults in the household as well as older children</li> </ul>
Select economic strengthening strategies	<ul style="list-style-type: none"> <li>• Consult with economic growth specialists on viable options and strategies given desired outcomes, target audience, market considerations, and context.</li> <li>• Counsel households/participants to choose the economic strengthening activities that are appropriate and feasible.</li> <li>• Combine strategies where appropriate (for example, labor saving devices and micro-finance).</li> </ul>
Implement vocational training, labor saving devices, loans, as indicated	<p><u>Ensure that vocational trainings:are:</u></p> <ul style="list-style-type: none"> <li>• Are based on market demand, and are safe..</li> <li>• Performed by trainers who are skilled and are recognized by the appropriate authority.</li> </ul> <p><u>Small business loan programs should:</u></p> <ul style="list-style-type: none"> <li>• Ensure loan programs are fair and reputable.</li> <li>• Assure that grantees understand the responsibilities and financial risks associated with loans.</li> <li>• Explore appropriate technology.</li> <li>• Provide training and information about maintenance and repair.</li> </ul> <p><u>Provide business skills in:</u></p> <ul style="list-style-type: none"> <li>• Money management training, such as basic recording of income and expenses.</li> <li>• Projecting needed resources to reinvest.</li> <li>• Marketing information and assessment.</li> </ul>
Support actual economic engagement	<ul style="list-style-type: none"> <li>• Facilitate linkages to access start-up resources (tools, materials, loans, seed money etc.)</li> <li>• Provide occupational counseling/guidance.</li> <li>• Assist with identifying markets for products and services.</li> </ul>
Assess income /benefit before and after intervention to verify improvements	<ul style="list-style-type: none"> <li>• Estimate weekly or monthly earnings after intervention.</li> <li>• Estimate time saved via labor saving device (daily,. weekly, or monthly).</li> </ul>
Evaluate whether increased income is being used to meet basic needs of household, especially children in household	<ul style="list-style-type: none"> <li>• Identify areas where basic needs are not being met before economic strengthening (insufficient food, clothing, shelter, access to health care and education).</li> <li>• Measure improvements in the areas of need identified before the economic intervention.</li> <li>• Determine if the basic needs of children in the household are being consistently met.</li> </ul> <p>Evaluate participant satisfaction with programme</p> <p><b>Note:</b> Assessment methods will vary by organization, CSI measures related to food, shelter, education, health may be used.</p>

## 8.7 SHELTER AND CARE:

These services strives to prevent children from going without shelter and work to ensure sufficient clothing and access to clean, safe water or basic personal hygiene. An additional focus is ensuring that vulnerable children have at least one adult who provides them with love and support.

**Desired outcome and measurable goals:** Child has protective shelter, clothing, access to safe water, and sanitation facilities to meet hygiene needs and protection from disease. The child has shelter that is adequate, dry, and safe.

### Operational strategies

- i. Advocate for the improvement of water and sanitation for vulnerable households and provision of decent toilets.
- ii. Facilitate advocacy work for the development of decent shelter for vulnerable households.

Intervention strategies	Quality standards and guidelines
Assess shelter and material care needs	<p><b>Undertake an assessment to determine if:</b></p> <ul style="list-style-type: none"> <li>• Shelter is safe, dry and protected from the elements</li> <li>• Safe water and sanitation facilities accessible for personal hygiene and protection from disease</li> <li>• Children have adequate clothing to protect from environmental elements</li> <li>• Children have bedding, blanket and bed nets if appropriate to the setting</li> <li>• Sleeping and other arrangements afford the child privacy, and safely appropriate to age and gender</li> </ul>
Determine existing sources	<ul style="list-style-type: none"> <li>• Map who is providing what type of support relating to the provision of shelter and material care.</li> <li>• Approach other providers to determine ways for collaboration to meet gaps noted in assessments. For example, link with programs that can provide iron sheeting, bore holes, clothes or shoes.</li> <li>• Work with caretaker to make improvements in shelter, while engaging, bringing in community and external sources as needed</li> </ul>
Monitor shelter and care of OVC <i>(Ongoing)</i>	<ul style="list-style-type: none"> <li>• Verify that shelter and material care needs are met through home visits, observations, and interactions with children.</li> </ul>
Legal referral	<ul style="list-style-type: none"> <li>• If a child has rights to parental property verify that legal procedures</li> </ul>



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

## 9 OPERATIONALISING STANDARDS OF CARE

In order to achieve the intended purpose the national standards of OVC care and – to provide the vulnerable children and their caregivers, minimum package of services of desired standards, it is essential that all CSO and service providers adopt, adhere to and operationalise these national quality standards at the service delivery level, and ensure that they ultimately result in a quality improvement of the services that are delivered to OVCs in need as part of the national response.

In order to guide and assist the key stakeholders understand and apply the standards, MOSD shall: 1) publish and disseminate the standards and guidelines (including simplified posters, brochures and pocket guides); and 2) orient/train the CSOs, stakeholders and service providers to help translate the national standards into service delivery protocols that will improve the quality of OVC programmes.

CSOs working on issues affecting OVC shall be required through memoranda of understanding with the MOSD to demonstrate that they adopt the standards to design, develop and manage OVC programs.

The stakeholders, including service providers shall follow the guiding principles and programming approaches highlighted in these guidelines in order to promote coordination and fostering collaboration with different government departments and entities, and service delivery sectors to address the needs of vulnerable children and youth.

For adoption and application of standards, there shall be: political will and buy-in by the leadership; recognition of the importance of standards; adequate resources; participation key stakeholders including beneficiaries; collaborations; and functional and competent monitoring and evaluation mechanism.

### 9.1 OBJECTIVES OF OPERATIONAL GUIDELINES

- i. Conduct advocacy with policy and decision makers, and development partners.
- ii. Provide guidance for the integration of standards in the development and implementation of care, support and protection programs for OVC in Lesotho, through the existing coordinating structures: National OVC Coordinating Committee (NOCC) and District Child Protection Teams, and Community Council Child Protection Teams.
- iii. Provide guidance on minimum standards in quality of services and activities related to all areas of care, support and protection of orphans and vulnerable children that are socially, culturally and internationally acceptable, in line with national and international instruments that Lesotho.

- iv. Provide a clear understanding of the guiding principles, and define roles and responsibilities for stakeholders in issues of vulnerable children.
- v. Enhance collaboration and strategic partnership among stakeholders to support adherence to standards, through effective referral and coordination.
- vi. Provide a framework for monitoring and evaluation of integration, adherence, efficacy and efficiency of standards of care

## 9.2 ADVOCACY FOR SUPPORT FOR ADOPTION OF STANDARDS

Adoption of the standards for care services that ensure overall quality of care needs, requires enabling policy environment, political support, and adequate resources. In a resource constrained environments, maintain the balance between the minimum basic services and services that meet the basic standards are often perceived as competing choices. Hence, it is necessary to advocate for standards of care, to help understand and appreciate the importance and benefits of the standards to:

- Promote policy support and commitment from policy makers, senior official and managers, donors and development partners.
- Promote monitoring, and evaluating service delivery and reporting.
- Promote collaboration and coordination among the different service provider for efficient referral mechanisms.

Advocacy interventions may include to:

- Conduct a contextual/situational analysis to highlight the current standards of service, identify gaps and needs, assess strengths and opportunities, and identify resource challenges for integrating the standards of care.
- Collect, manage and disseminate data, information and evidence to inform policy.
- Mobilize stakeholders.
- Establish and coordinate networks that can promote the implementation of these standards.
- Establish, orient and coordinate referral mechanisms.
- Educate and orient stakeholders and service providers.

### 9.3 INTEGRATION AND COORDINATION OF STANDARDS AND GUIDELINES

- a. At the national level: Integration of standards and guidelines into the National Strategic Plan on Vulnerable Children and the National Operational Plan, along with the implementation of the recommendations of the annual review of the NSPVC.

The National OVC Coordinating Committee (NOCC), all the line ministries, the members the CSO constituencies, and International NGO and development partners represented in the NOCC are oriented on the national standards and advocacy to consider adopting these standards into programming and service delivery.

- b. District level: All the representatives of the District Child Protection Team (DCPT), including the Government, CSO and Service providers represented in the DCPT are oriented on the standards to coordinate integration of standards into the service delivery at the district and community council levels.
- c. Community Council level: Orient the council secretaries, relevant sub-committees and stakeholders, including the service providers, on the standards of care services.

### 9.4 TECHNICAL COMPETENCE AND CAPACITY BUILDING

Adopting and applying the standards of care requires the adequate technical capacity of OVC programme designers, managers and service providers. Assessment of capacity gaps and needs, and implementing capacity strengthening strategy for the key stakeholders are conducted through:

- Strengthening technical capacity of stakeholders through training, orientation, mentoring and experience/knowledge sharing.
- Documenting and sharing of best practices.
- Working with government departments through consultative forums.
- Supporting the establishment and management of M&E systems.

## 10 MONITORING AND EVALUATION OF STANDARDS

Strong monitoring and evaluation (M&E) systems are essential for ensuring adherence to standards of care, and the overall quality, efficiency, efficacy and impact of the OVC programs and services. Quality M&E also provides the evidence and essential information for strategic planning, program improvement, accountability of funds and effort, and advocating for standards.

MOSD, implementing partners, service providers and CSO are obligated to ensure quality assurance, accountability and ethical imperatives, monitor and report.

This section highlights a few of the critical elements specific to the monitoring and evaluation of standards of care.

### 10.1 QUALITY OF OVC M&E SYSTEMS

The mechanism to implement and monitor the standards of care adopts the M&E frameworks of PEPFAR, UNAIDS and SADC guidelines, to generate a harmonized data collection and tracking system, and to use them for effective decision making.

The framework includes two mechanisms. The primary mechanism is used for data collection, verification and analysis. The secondary mechanism represents the planning and human resources needed to support data collection and use.

At the national level, the MOSD shall:

- i. Establish and strengthen community based monitoring and evaluation systems to identify barriers that influence service delivery.
- ii. Support stakeholders and sectors represented in the NOCC, DCPT, and the service providers to disaggregate and report as per the national M&E Plan.
- iii. Strengthen the capacity of service providers and sectors to the extent to which services areas are reported.
- iv. Ensure and support the implementing partners to collect data that feeds into the national database.
- v. Monitor the implementation of standards of care through the use of checklists, surveys and evaluations.
- vi. Compile and report on the national progress on integrating the standards of care.

Further, the MOSD shall:

Conduct assessment and evaluation of the standards to:

- i. Determine the extent to which the service standards are understandable and feasible at the field level.
- ii. Identify what organisations need in order to be able to implement and adhere to the standards—identify best practices that facilitate the ability to meet the standards.
- iii. Ascertain whether adherence to the standards improves the quality of programming and services delivered (as articulated in the dimensions of quality outlined during the standards development process) .
- iv. Investigate whether implementation of standards leads to a measurable difference for children (adequacy and effectiveness of the standards).
- v. Ensure that there is a data management system for vulnerable children’s issues that can be used to monitor and evaluate service delivery.

