# THE WAY WE CARE

A Guide for
Managers
of Programs
Serving
Vulnerable
Children and
Youth

BY LUCY Y. STEINITZ
in collaboration with Kimberly Green,
Marika Matengu, Tanya Medrano, and Lydia Murithi,
with original artwork by Marika Matengu

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# Preface

There are many reasons why children and youth all over the world become orphaned or vulnerable, including the consequences of armed conflict, disease, extreme poverty and malnutrition, child abuse (including child labor and child trafficking), and severe disability. Though HIV and AIDS appeared on this ruinous list only recently, the disease has a prominent place on it. More than 20 million people worldwide have died of AIDS, and the scale of the pandemic has overwhelmed dozens of countries, thousands of communities, and tens of millions of families. Of 33.2 million people worldwide currently living with the virus, approximately 2.1 million are children, about 90 percent of whom live in sub-Saharan Africa. In that region, about 12 million children ages 0–17 have lost one or both parents to AIDS.

Since the 1990s, Family Health International (FHI) has been at the forefront in the response to the needs of vulnerable children and youth who are infected by HIV and affected by the epidemic. Throughout the 10-year, USAID-funded Implementing AIDS Prevention and Care (IMPACT) Project, we partnered with governments, private entities, and local implementing partners as we directed efforts to support programs in 13 countries in Africa, Asia, and the Caribbean. FHI developed a strategic framework titled *Child Outreach Strategy* in 2001, revising it in 2007 to guide the design, implementation, monitoring, and evaluation of programs that support orphans and other vulnerable children. Our 2009 publication, *Quality Improvement Guidelines for Care and Support Programs for Orphans and Other Vulnerable Children,* also provided crucial program guidance.

Numerous lessons that emerged from our global experience and leadership in managing these programs are consolidated in this manual. Its practical information, knowledge, and key concepts should prove invaluable to program managers, especially those new to the field. While *The Way We Care* is intended as a reference for FHI staff and our partners whose work has contributed so much to our program achievements, we hope it will benefit all individuals and organizations across the globe who share the goal of a disease-free generation and improved lives and opportunities for children and youth.

Albert Siemens, PhD
Chairman and CEO
Family Health International

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# Acronyms

| | |
|---|---|
| AIDS | Acquired immune deficiency syndrome |
| ART | Antiretroviral therapy |
| ARV | Antiretroviral drug |
| CBO | Community-based organization |
| CHBC | Community- and home-based care |
| CSI | Child Status Index |
| FHI | Family Health International |
| GICA | Greater involvement of children who are affected |
| GIPA | Greater involvement of people living with HIV/AIDS |
| HIV | Human immunodeficiency virus |
| MIS | Management information system |
| NGO | Nongovernmental organization |
| OVC | Orphans and vulnerable children |
| PEPFAR | US President's Emergency Plan for AIDS Relief |
| PLHIV | People living with HIV |
| QA | Quality assurance |
| QI | Quality improvement |
| REPSSI | Regional Psychosocial Support Initiative (East and Southern Africa) |
| SAfAIDS | Southern Africa HIV and AIDS Information Dissemination Service |
| SWOT | Strengths, weaknesses, opportunities, threats |
| UN | United Nations |
| USAID | US Agency for International Development |

**If you want to travel fast, walk alone. If you want to travel far, walk together.**

African proverb

# 1. Why Another Manual?

This self-teach manual is designed to help new and recently promoted managers of programs serving vulnerable children and youth who are affected by disease, extreme poverty, and trauma. *The Way We Care* promotes a child-focused and family-centered approach and emphasizes the newest literature, as it highlights the integration of prevention, care, and treatment and addresses both HIV and risk factors for other diseases.

This manual resulted from a concern at Family Health International (FHI) that our staff needed to be trained to strengthen our programs and interventions and increase our leadership in this growing field. Few educational programs teach new managers and program officers what is required of them, and an increasing number of FHI staff have called for the kind of information that this manual contains, written in down-to-earth style for readers of English as a second language.

*The Way We Care* fills a niche. It presupposes a love of children, but not necessarily an advanced educational degree or previous work experience with vulnerable children and youth. The manual brims with practical information, how-to advice, and key concepts derived from the latest research and from FHI's experience with programs for vulnerable children worldwide. Initially developed for staff at FHI and implementing agencies, the manual aims to assist program managers, technical officers, service coordinators, and supervisors of international partners, international and national NGOs, and staff of national and local line ministries that are working on behalf of vulnerable children.

*The Way We Care* aims to develop awareness and understanding, build capacity, and reinforce the knowledge of individuals and local organizations who must address the pressing needs and human rights of millions of vulnerable children. Because the manual covers the basic concepts of building resilience among vulnerable children, its information can be used by staff and local volunteers to help children enhance their coping skills, increase their access to locally available services, and improve their quality of life. The manual also addresses critical values related to children's rights and how to obtain input from children on issues that affect them. In short, it covers key principles in the design, implementation, monitoring, and quality improvement of care and support programs for vulnerable children.

Divided into four sections, the manual provides a broad introduction to all areas of practice that staff in this field should know. The first, the foundation section, includes cross-cutting concepts and a primer on child development. The planning section covers service-delivery issues, strategic planning, and basic project management. The implementation section has a special focus on community mobilization, monitoring and evaluation, care management, and quality improvement. The fourth and final section addresses sustainability: volunteer and staff recruitment, supervision, and prevention of burnout.

Quotes from children are scattered throughout. Those from Namibia are taken from the 2008 publication *Our Home is Where the Heart Is.*[1]

## Three legs upon which this manual stands

Like a traditional cooking pot that must stand on all three legs to remain upright, this guide rests on three explicit foundations:



- The first is FHI's strategic approach in mobilizing, supporting, and strengthening the capacity of local communities, families, local organizations, and government institutions to work with children and youth.

- The second is outlined in FHI's *Child Outreach Strategy*, which seeks to mitigate the impact of HIV and improve the quality of the lives of children and their families through an integrated and scaled-up continuum of HIV-related and social sector support services, in partnership with governments, civil society, the private sector, and the children themselves. *FHI Quality Improvement Guidelines for Care and Support Programs for Orphans and Other Vulnerable Children,*[2] published in 2009, is based on this outreach strategy.

- The third foundation is the need to supply relevant, action-oriented information that is applicable to programs serving vulnerable children and youth worldwide.

## Guiding principles

You may want to consider accepting the following guiding principles and integrating them into your work with children and families:

### 1. Focus on both children and youth.

The United Nations Convention on the Rights of the Child defines a child as a person up to age 18. However, adult responsibilities among vulnerable children often begin a lot earlier than age 18, and childhood experiences such as attending school may extend beyond age 18 if schooling has been interrupted. Many youth in their early and mid-20s remain within their families of origin so they can take care of younger siblings, particularly when parents have died and grandparents are too frail to take an active role. In this manual, children and youth are thought of collectively as a generation between ages 0 and 24. Unless otherwise specified, "children" refers to everyone in that large age group.

That said, many of the interventions and references cited refer to the age span 0–18. Programs, tools, and activities may need to be adapted for young people ages 18–24. To assist this process, program managers may need to increase their understanding of the challenges faced by young people who are developmentally more mature than the age group targeted by many programs and interventions and make adjustments for an older age group.

### 2. Eliminate stigmatizing labels.

This manual has minimized the use of the term "orphans and vulnerable children" and eliminated the acronym OVC because it is labeling and stigmatizing. Unless the context requires otherwise, it uses "children," "vulnerable children," or "children who need support."

### 3. Incorporate children's voices.

Child participation is a principal element in programming for vulnerable children. We aim to practice what we preach, so children were consulted on key issues included in this manual and it incorporates some of their words.

## How to use this manual

*The Way We Care* brings together key elements of child development, resilience-building, program design, and implementation, as well as a focus on supervision, monitoring and evaluation, and sustainability.

The manual was designed as a one-stop, self-study reference to teach core knowledge and concepts to people who design, implement, and manage programs for vulnerable children. You are not expected to read it from cover to cover. Rather, refer to any chapter that interests you and then look over others that offer additional insight. Most chapters include references to information you should consult in other sections and chapters (for example, I, chapter 3) and internet-based toolboxes and further reading. Appendix 1 lists additional websites.

That said, you should not feel limited by the manual's contents. This is a rapidly changing field of practice, and most of us learn best from our experiences and from spending time with people who are directly affected by the issues we care most about. Never skimp on real-life experiences. Through this process and for the sake of the children who need us most, we hope your work becomes a labor of love.

# 2. Vulnerability: It's a Tough Way to Grow Up

## Defining vulnerability

Vulnerability is a complex concept to define. A host of factors are viewed as major causes of vulnerability, including HIV and AIDS, extreme poverty, armed conflict, gender imbalance, harmful cultural practices, exploitation, and natural disaster. UNAIDS defines a vulnerable child as one living in circumstances with high risks, whose prospects for continued growth and development are seriously threatened. The US President's Emergency Plan for AIDS Relief (PEPFAR) uses this definition and adds that a child is under age 18. The definition includes most orphans but is not restricted to them. More often than not, the concept of vulnerability extends to the entire household, not to one individual within it.

Different communities and different countries maintain their own definitions of who is a vulnerable child (table 1).[3]

## Table 1. Vulnerable children, as defined in four countries

| BOTSWANA | Child laborers<br>Children in remote areas who belong to indigenous minorities<br>Children who are neglected<br>Children who are sexually exploited<br>Children with disabilities<br>Street children |
|---|---|
| GUYANA | Children under age 18 who, due to social and economic circumstances, are at a high risk with respect to health, wellbeing, safety, and development. Their very survival is at grave risk |
| SOUTH AFRICA | Children abused or ill-treated by caretakers<br>Children born to single mothers<br>Children who are neglected, destitute, or abandoned<br>Children with a terminally ill parent<br>Children with unemployed caretakers<br>Disabled children |
| VIET NAM | Children affected by HIV and AIDS: who are HIV-positive or most at risk of HIV infection; orphaned due to AIDS (lost one or both parents); or living with HIV-positive parents or guardians<br>Child drug users<br>Children in migrant or mobile populations<br>Children of commercial sex workers and drug users<br>Children who engage in commercial sex work or who are sexually exploited<br>Children who live in institutions<br>Orphans due to all causes<br>Street children<br>Trafficked children |

## Don't worry if other children try to bully you. Just believe in yourself and you will make it.

Koes, 15

Vulnerability is affected by cultural environments. Some beliefs and practices lead to violations of children's rights, especially the rights of girls. For example, girls may not be allowed to attend school during their menstrual periods or when their help is needed at home. Child marriage is a leading cause of obstetric fistula and maternal death, and female genital mutilation can cause enormous health-related and psychological damage.[4]

Understanding child vulnerability in the local context is critical. Local community members are in the best position to determine which children are at greatest risk, what factors should be used to assess vulnerability, and priorities for local action. You may be able to assist by making them aware of contextual issues (such as issues related to the country's laws, disease-prevalence rates, and child-rights), but you require a clear understanding of a community's perspectives to get a real sense of where to introduce interventions or support.

To that end, you must spend time listening to people in the community, particularly to family members, caretakers, and the children themselves. Tools such as the REPSSI *Journey of Life* community workshop curriculum[5] can help communities identify factors that contribute to the vulnerability of local children and help them determine who are most in need of assistance.

## Orphanhood: A common cause of vulnerability

Orphaning remains the most visible, extensive, and measurable impact of AIDS on children. In itself, being orphaned does not mean that a child is vulnerable; one who remains in a loving household with sufficient income and consistent caregiving is probably not a vulnerable child. Vulnerability generally occurs when children lack the emotional and other support they need to become healthy, self-sufficient adults.

There are some specific definitions relating to orphans: single orphans have lost one parent; double orphans have lost both parents; maternal orphans have lost their mothers; and paternal orphans have lost their fathers. UNICEF defined an orphan as a child under 18 whose mother, father, or both parents have died from any cause.[6] However, chronological age does not define vulnerability or orphanhood, and a young person's situation does not automatically change when he or she turns 18. Many young people who are 18 and older lack the family support they need. To discover where to introduce interventions and what the priority issues are, you must understand the community's perspectives, including the factors they think should be used to assess vulnerability and set priorities.

## The added effects of HIV

HIV and AIDS have ripped apart the social fabric of communities and put millions of children at risk—physically, emotionally, and economically. AIDS robs children of their parents, their primary line of protection. It weakens their whole support network, since those sick and dying include teachers, medical personnel, and other adults upon whom children depend.

UNICEF enumerated numerous ways in which children are affected by the illness or death of a parent:

■ *Economic hardship:* As parents succumb to sickness and are unable to provide for their children

According to UNAIDS, children are more vulnerable if any or all of the following factors are present:

- They are HIV-positive.

- They lack adequate adult support—for example, when they live with chronically ill parents, in a household headed by a grandparent or a child, or in a household that has experienced a recent death from chronic illness.

- They live outside of family care, perhaps in residential care or on the streets.

- They are marginalized, stigmatized, or discriminated against.

financially, needs such as school fees and clothing fall by the wayside.

■ *Lack of love, attention, and affection:* Children of all ages need emotional support and stimulation. A lack of responsive care may stunt a young child's emotional development and sense of wellbeing.

■ *Withdrawal from school:* When sickness devours families' finances, school fees, supplies, and uniforms become unaffordable. In addition, children who become caretakers of sick parents may not be able to attend school.

■ *Psychological distress:* Distress results not only from a child's fear of losing a parent diagnosed with HIV, but also from the stigma that often accompanies the disease.

■ *Loss of inheritance:* In many countries, property and inheritance laws do not protect the rights of orphans and widows. Even when these laws are on the books, they are often not enforced.

■ *Increased abuse:* When no parents look out for their interests, children can fall prey to abuse and exploitation, including to prostitution, child trafficking, and child labor.

■ *Increased risk of HIV infection:* Orphaned and vulnerable children may be forced to engage in high-risk behavior that puts them at an elevated risk for contracting HIV and other sexually transmitted diseases. Caring for and protecting these children is an HIV-prevention strategy.

■ *Malnutrition and illness:* Orphaned children and children affected by HIV are at an elevated risk for malnutrition and illness, and they may lack access to healthcare. This may lead to deadly consequences, especially for HIV-positive children.

The 2004 UNICEF and UNAIDS *Framework for the Protection, Care and Support of Orphans and Vulnerable Children* noted some staggering statistics:

- In Tanzania, the school-attendance rate for double orphans was 52 percent, and over half the children working fulltime in mines were orphans.

- In Addis Ababa, Ethiopia, more than 75 percent of child domestic workers were orphans.

- In parts of Zambia, 65 percent of the children engaged in commercial sex and 56 percent of the children living on the streets were orphans.

Sadly, the situation may not have improved since 2004. If anything, given the rising number of orphans worldwide, it is probably worse.

■ *Stigma, discrimination, and isolation:* Common misunderstandings about how HIV is transmitted may cause children orphaned by AIDS to be discriminated against and isolated. They may also have to leave familiar surroundings to live with extended family members who do not readily accept them.

Given the multidimensional effects of HIV on children, you should always remain sensitive to children who have been orphaned and made vulnerable by the disease. At the same time, addressing only HIV-related

**Managing a household [by yourself] is a hard job. It takes a lot of courage.**

Sarah, 17

problems and ignoring other causes of children's vulnerabilities does not make sense. Other than for some medical issues, you should never make distinctions at a programmatic level between children orphaned by AIDS and those orphaned for other reasons. Instead, programs that target geographic areas seriously affected by HIV and AIDS should support efforts that help organize community residents to identify and assist the most vulnerable children and households regardless of the specific causes of vulnerability.

## The final blow: The impact of poverty

Poverty, HIV, and orphanhood are a terrible combination. Poverty inhibits access to HIV care, and HIV-related illnesses and stigma often cause a poor family to lose what little they have. When poor children become orphans, they fall victim to a whole host of dangers. To support themselves and younger siblings, they frequently drop out of school. They may fall prey to sexual exploitation and prostitution, co-opted into joining militias or armed groups, or forced into domestic servitude.

Economic strengthening for poor families and families affected by HIV is crucial to improving outcomes for children.[7] Adequate income means that families can afford to send their children to school and can access food, healthcare, and shelter. Adequate income means that children are less likely to be forced by desperate poverty and hunger into child labor, commercial sex work, or other forms of exploitation. Poverty alleviation is not the only solution to childhood vulnerability, but it has an important role to play.

# 3. Understanding Child Development: A Basic Primer

The famous African saying "It takes a village to raise a child" tells us that children are influenced by their families, many different people, and their environment. All play a role in helping children to become responsible adults. It also tells us that there is no single right way to raise a child. Other primary caregivers can step in with loving and consistent care if parents are not able to raise their own children.

## The core developmental needs of children

No matter what the setting or circumstance, every child has seven core developmental needs: unconditional love, validation, structure and stability, understanding, healthy modeling, challenges, and inclusion.[8] All these needs do not need to be met 100 percent of the time, and caregivers—parents as well as others who play a parenting role—do not have to be perfect. We aim for "good-enough parenting," which means that we try to foster conditions that ensure that these needs are met as consistently and as fully as possible.

*1. Unconditional love* refers to physical and emotional warmth and closeness, through good and bad times. Unconditional love builds trust and forms the foundation for a mutually respectful, nurturing relationship between caregiver and child. The concept of unconditional love may also play a part in a child's religious upbringing (such as in the saying that God loves you), but spiritual love by itself is not enough.

*2. Validation* refers to the affirmation of a child's thoughts, feelings, ideas, efforts, and individuality. Validation is expressed by a caregiver's highly attuned attention to a child through active listening and genuine appreciation of his or her experiences.



## The best time to plant a tree is twenty years ago. The second best time is now.

African proverb

Children who are praised and whose efforts are acknowledged with hugs or pats on the back come to feel that their feelings truly matter. Children build healthy self-esteem when they feel solidly supported by their families.

*3. Structure and stability* refer to an environment of healthy limits in which a child can grow and thrive. Good structure for children is a matter of balance. As they mature, children need to experience age-appropriate, continually expanding boundaries. Limits may be negotiable but, once agreed upon, they should be enforced with compassionate discipline. The ultimate goal is to teach children self-discipline and self-motivation and to help them develop a sense of security in themselves and in the world around them.

*4. Understanding* refers to the need for children to learn from their mistakes without being shamed or degraded. Children gain emotional security from knowing they can make mistakes and even behave badly. They learn the lessons of life more fully when guided with an empathetic hand, rather than being subjected to anger or harsh punishment.

*5. Healthy modeling* refers to fact that children learn from the adults with whom they have regular contact. For better or worse, caregiver behavior is the most powerful life-teacher children have. Caregivers must model emotional generosity toward others, calm and effective problem-solving skills, healthy coping strategies in response to setbacks, and the ability to set goals and sustain efforts in achieving them. By contrast, children who frequently witness or experience violent and addictive behaviors are more likely to take on these behaviors as adults.

*6. Challenges* refer to the need for children to have age-appropriate opportunities to learn life's emotional and practical lessons. To strengthen their ability to solve problem and achieve their goals, children's minds need to be stimulated by learning new skills and overcoming obstacles. At the same time, even if they do not reach their goals, children should be encouraged and praised for their efforts.

## Table 2. Normal stages of child development

| STAGE | KEY THEMES | NEEDS AND RESPONSES |
|---|---|---|
| 0–2 YEARS | Safety and security; stimulation of the senses | Children need protection and love. At about 6 months, they begin to take control of their movements and express basic needs and attachments. |
| 3–5 YEARS | Curiosity | Children begin to develop imagination and want more involvement in family life. They always need reassurance and praise when they are doing well. |
| 6–9 YEARS | Learning | Children begin to test their caregivers, gain insights, learn right from wrong, and develop a conscience. |
| 10–12 YEARS | Peer acceptance | Children need to conform with their peers and begin to challenge rules with adults. (Adults should pick which battles to fight). |
| 13–15 YEARS | A time of change | Youngsters are often insecure and confused, critical of family and friends, and untidy and disorganized. They have raging hormones and a focus on me–me–me, but they still need care and support. |
| 16 + YEARS | Decision-making | Youngsters are prone to risk-taking behaviors. They face issues and begin to take responsibility for their future. |

*7. Inclusion* refers to a sense of belonging to a family group and a community. A healthy attachment to their primary caregivers is the first way that children learn to feel that they are welcome and valuable members of a family. This sense of belonging is what enables them to move confidently into the world and reach out to others in a spirit of good will and kindness. It is also important that children take responsibility for chores or family duties so they experience the satisfaction of having other people depend on them. In this way, children learn to be responsible to themselves, their families, and society.

## Stages of child development

Understanding key themes related to normal child development is particularly important when working with children who have experienced a major loss or trauma. Table 2 lists six normal developmental stages of children and key themes at each stage, together with descriptions of children's needs and how they respond.[9]

When working with children, their caregivers, or program coordinators, you should always aim to do what is in the best interest of the children and listen to their input and concerns. At the same time, you must remember that every child is part of a family context. This means that there are always others—parents, relatives, other caregivers, and concerned community members—who are (or who should be) involved in promoting each child's physical, cognitive, and emotional development. The amount of involvement varies; it generally diminishes as a child approaches maturity.

## Outcomes of good child development

While some developmental needs are generally considered more important than others, ultimately all are necessary for children to become self-actualized adults who have healthy self-esteem, are comfortable with themselves and others, and have the capacity to build and sustain relationships, act with spontaneity,

and function well in society. When children's developmental needs are met, healthy self-esteem and self-actualization will occur naturally.

■ *Healthy self-esteem* refers to core feelings of self-acceptance, self-confidence, and self-respect. Children develop healthy self-esteem when their feelings, ideas, and achievements are accepted, valued, and supported. Unlike arrogance—which is often a coping mechanism for covering up underlying feelings of worthlessness—healthy self-esteem provides a foundation for understanding, respecting, and valuing others.

■ *Self-actualization* refers to a child's growing recognition of his or her unique thoughts and abilities throughout the growing-up process. The prime goal of parenting or caregiving is to prepare children for independence in adulthood. Caregivers must therefore consistently encourage children in their journey toward autonomy and help them to thrive—emotionally, materially, and spiritually.

## Threats to normal child development

From the time they are born, nearly all children have the potential to become healthy and productive adults. That said, each child is unique in the way that he or she develops throughout each stage. Good and bad factors can help or hinder this process and influence a child's development.

Families threatened by the HIV pandemic, extreme poverty, armed conflict, and natural disaster often lack the ability to provide healthy, nurturing environments for their children. In affected communities, children may live outside of family care or without adequate adult support. Deprived of guidance, love, and protection by their parents or primary caregivers, these children are more vulnerable to exploitation, discrimination, sexual abuse, physical violence, child trafficking, and child labor.

Other traumatizing experiences and early-life challenges can also rob children of their childhoods and hamper their development. Children who grow up in unhealthy environments are more likely to have low self-esteem and to lack the ability to recognize their uniqueness and potential. Some may lose interest in school or exhibit disciplinary disorders. Lacking hope and feeling shame that their lives seem worthless, they may cause harm to themselves and others through alcohol abuse, high-risk sexual behaviors, crime, or violence.

But it doesn't have to be this way. Even in the most difficult circumstances, children can be helped to rekindle the flame of hope by giving them access to the services and support they need.

## Recommended readings and toolkits

■ Family Health International/Cambodia, *Nora Coloring Book,* 2008
A short story and coloring book, suitable for very young children, that aims to de-stigmatize HIV in the family. www.fhi.org/en/CountryProfiles/Cambodia/index.htm

■ Family Health International/Cambodia, *Parenting Club Curriculum*, 2008.
A curriculum written to enable family-care community assistants to set up and facilitate 18 monthly sessions of parenting clubs in rural Cambodia. The publication includes step-by-step instructions for each session, including for games, educational activities, and open discussions. www.fhi.org/en/HIVAIDS/pub/guide/res_Parenting_Club_Curriculum.htm

■ International HIV/AIDS Alliance, *A Parrot on Your Shoulder: A Guide for People Starting to Work with Orphans and Vulnerable Children*, 2004.
An illustrated guide for facilitators and trainers who are starting to work with children affected by HIV and AIDS. The guide contains 30 activities for engaging children in group work, active listening, and analytical skills. It draws on field experiences, incorporating cultural and gender considerations within its ideas for ice-breakers and energizers and advice on using drama, mime, role play, painting, and drawing. www.aidsalliance.org/graphics/secretariat/publications/poys0704_parrot.pdf

■ Judy Rankin, *The Child Within: Connecting with Children Who Have Experienced Grief and Loss*, 2008.
Part of the "Called to Care" series, this 68-page workbook promotes resilience in children who have suffered grief and personal loss by enabling adult caregivers to rediscover and appreciate their own child within. Although based on research on child and adolescent development, the book is written in clear, simple language and is easily accessible to non-professional child caregivers. www.stratshope.org/b-cc-06-child.htm

■ In addition, check out www.bernardvanleer.org; www.jlica.org; www.repssi.org; www.youthwg.org; and other websites listed in appendix 1.

# 4. Helping Children Cope with Loss

Children and adults deal with loss and death differently. In part, how they do this will depend on the local culture, a subject on which you should be informed. Children's reaction to loss or death also depends on their age, how much they understand, and how supportive other people are (I, chapter 3). Young children may not realize that death is permanent: they may expect the person to come back, even after you try to explain this is not possible. They may also ask the same questions over and over. Other children may want to know a lot more about illness and what caused the death of their mother or father. They may also have lots of questions about what happens to a person's body and soul after death. Some may become so attached to other family members that they are afraid when they leave them, even if only for a short visit to town.

Following a big loss, children and youth often want their lives to be the way they used to be and for things to be as normal as possible. They want to laugh and have fun, even if only for a short time. They may have difficulty crying or they may cry all of a sudden. Remember that crying is not just for girls; it is natural, appropriate, and helpful for everyone's healing process. Some children may react in anger and become rough with their toys, animals, or other children. Others may become sad and moody and have trouble sleeping.

Even though they may not say this in so many words, many children feel that somehow the loss or death of their loved one was their fault. Thus children may need to be reminded that nothing they did or said could have caused that person's death. They may also need to be told they don't need to worry that all the other people they love will die.

**My mother died when I was seven. My father has HIV. All I know is that ART and good food will keep me healthy. I am going to be a doctor when I grow up.**

Anusha, 13

It is often best to help children to talk about their feelings or put them down on paper, in drawings or a diary.[10] However, most children do not like long talks. They just need to know you are there to listen and that they can come to you if they feel like talking. They may need a lot of reassurance, especially at night or if they are feeling sad or lonely.

## How to help a grieving child

The following suggestions should be followed cautiously. Some may not be accepted in all cultures, and they should be adapted to fit local customs.[11]

*Be honest with the child.* Relate what has happened in a way he or she can understand. Where possible, use the correct words, such as "died" and "death," not cover-up words like "gone to sleep." Some children will ask questions about the death. Never lie. If you do not know the answer, say so and do not try to make something up.

*Accept the child's feelings.* The child may behave in a way that you did not expect, but you must be prepared to accept this. Allow the child to cry. Do not be upset if the child is angry about the dead parent, and do not be surprised if the child behaves as though the parent were not dead.

*Reassure the child.* Find out what the child is thinking. Allow him or her to ask questions and talk about the future.

*Try to keep as many things as continuous and normal as possible.* Try to maintain day-to-day routines. The child will feel safer if other routines don't change, including where and with whom he or she is living.

*Talk about the deceased parent.* Remember happier times and enjoy good memories, but do not make the child talk about a deceased parent if he or she is not ready for it. Remember and talk about the deceased family member at special times, including traditional family celebrations and birthdays.

*Allow the child to take part in ceremonies.* Consider allowing the child to attend the funeral or join in other rituals normally attended by adults. If this is not possible, consider holding your own ceremony especially for the child.

*Allow the child to use something belonging to the deceased parent.* Something that a parent wore often reminds the child of their life together.

*Help child prepare a box or a scrapbook for small items of remembrance.* This process is called a memory box or a memory book. Some HIV/AIDS programs encourage sick parents to prepare these and discuss the items with their children to help them prepare for the future.

*Encourage the child to express feelings by writing or drawing.* Children may choose to write a letter to the deceased or draw a picture of the person.

*Tell or read a story from the Bible or Koran, or else share a parable or animal story about loss or death with the child.* This helps children understand that loss and death are a normal part of life and may help them to open up with questions or memories they want to share.

*Be patient with the child.* Remember that grief can take a long time to pass. Provide support when children feel sad and encouragement if they feel hopeless. Be prepared to repeat explanations and give information again and again. In time, they will find it easier to cope with their feelings.

## Supporting a child's ongoing emotional needs

Though some cultures discourage children from talking about their deceased relatives, this practice is not helpful. Children want to remember their loved ones and want others to remember them too. It is better to create an open atmosphere, where memories and feelings can be shared. For example, children may look at photographs or light a candle on holidays or on the deceased parent's birthday. When other relatives come to visit, children may need your support to ask them to tell stories about the person who has died.

You can't always protect children from feelings of sadness, loss, stigma, or anger, but you can help them to deal with their feelings and to cope the best they can. Children who have experienced grief and mourning offered these suggestions: "Listen to us and to our sisters and brothers;" "Accept us and accept our feelings;" "Be honest with us;" "Try to answer our questions clearly;" and "Be there when we need you."

In addition, you can encourage children and youth to pray, draw a picture of how they feel, or keep a diary. With your help and understanding, they will feel more positive and better able to solve the problems they face. There are many ways you can help, and table 3 summarizes some of them.

If children continue to feel very sad or angry over a long period of time, you should approach a school counsellor or an NGO that specializes in child development for assistance. You can also encourage the children to talk to others who they (and you) know to

be a good parent or caregiver. Ask for practical advice from that person about helpful ways to relate to a child or adolescent who is behaving badly, experiencing emotional problems, or doing poorly at school.

## Two exercises that may help

Two exercises that may be helpful are provided. The first is suitable for younger children and the second for older children:[12]

### 1. Create a "picture-friend" for comfort and support

- Imagine what your sadness or pain looks like. Imagine the form, the size, and the color, and draw it on a piece of blank paper. Think about how the pain or sadness sounds: the loudness, tone, and melody.

- On another piece of paper, draw an animal or cartoon that can give you support and comfort and help you with the pain or sadness. This is your "picture-friend," and the drawing can look like anything you want it to be.

- Think about how your picture-friend can help. How can it change the pain's form, size, and color? How can it change the tone or sound that the pain or sadness makes?

- On your first piece of paper, draw your pain or sadness the way it looks and sounds after your picture-friend has changed it. How is it different?

- Take your papers and put them under your bed or pillow. Take them out and look at them every day, whenever you can.

### 2. Create a mental shield against anger or rejection

- Think about some experience in the past where you stayed cool and calm despite another person's harsh words or anger. Dive once again into that memory. Feel for yourself how their anger or

**Table 3. How to help children and youth cope with a major loss**

| WHAT TO DO | HOW |
| --- | --- |
| **1. Reduce stressors** | Reduce the impact of present stressors for children but never lie or hide the truth. Lying or hiding the truth breaks trust and makes things more difficult in the long run. |
| | Offer to take some problems away from the child. This helps the child feel less responsible for solving problems alone. |
| | Help children make peace with the past and heal their emotional wounds. |
| **2. Strengthen children's use of existing protective factors— things that protect them from suffering** | Provide supportive counseling through good listening and responding skills and help children identify and name obstacles that stand in the way of their goals. |
| | Help family members fill caregiving gaps by calling on other relatives, caring neighbors, and volunteers. |
| | Identify community resources that can help, including friends and neighbors, support groups, youth clubs, religious congregations, and NGOs. |
| | Apply resilience-building tools for children offered by child-focused organizations such as the Regional Psychosocial Support Initiative (www.repssi.org) |
| **3. Broaden coping skills** | Facilitate the use of existing coping strategies. Find out what children are already doing to overcome their problems, then reinforce these actions. |
| | Assist children, youth, and caregivers to identify and try new coping skills, such as through training on basic listening-and-responding techniques, psychosocial support, and life skills. |
| **4. Build hope** | Help children and youth identify and keep alive their dreams for the future. If their hopes and dreams are not realistic for now, help them identify and pursue small goals that are achievable and build their self-confidence. |

unpleasantness bounced off you, like a ping-pong ball bounces off from a table or off a sheet of thick glass.

- Let the feeling grow that you know how to protect yourself by holding up an invisible shield that causes bad things to bounce off.

- Continue to imagine this shield—one through which you can see or hear everything. It is similar to thick glass at a bank counter. Think to yourself: I can build this protective shield in my mind any time and anywhere I want to.

- Think up a sentence or motto you can repeat to yourself when you hold up your invisible shield— something like, "That anger is just ping-pong balls that bounce off my shield;" or "That has nothing to do with me right now;" or simply "This doesn't hurt me."

- Imagine how you can stay friendly, calm, and cool behind this shield, even when you are with people who make your life difficult. What other people say to you can't affect you any more.

## Other forms of communication

Sometimes children find it difficult to talk about how they are feeling. They may be too young and not know what words to use, or they may simply prefer to express themselves in another way, such as by drawing pictures.

Ask grieving children if they would like to draw or paint a picture. When they finish, ask them to talk about their pictures. They may be able to use them to tell you what is troubling them. Don't make assumptions: ask why they made the drawing in a certain way and then listen carefully to their answers.

Older children may prefer to write poetry or a song. After you have read or listened to what they wrote, ask them some questions about the contents that can open the door into their feelings and concerns.

Younger children often show their feelings in play. They may have an easier time sharing their feelings with a puppet or a doll, rather than directly with an adult. When an adult talks to a child through a puppet

## FIG. 1. MAKE A PAPER-BAG BUNNY



**Time required:** 30 minutes to 1 hour

**Materials:** Two paper or plastic bags, one larger and one smaller; newspaper; glue; string; scissors; coloured markers; thin cardboard

### Method

Fill both bags with crumpled newspaper. Push the larger bag into the opening of the smaller bag and tie them together with string.

Make a collar from thin cardboard. Color it and glue around the neck of the bunny. Cut paper in the shape of the bunny's ears, feet, and other features. Color them in and glue these features to the bunny.

or doll, it seems to a child that it is the puppet or doll who is asking questions and responding, rather than the adult. If there isn't one available, you can make a home-made doll or puppet, such as a paper-bag bunny (fig. 1). [13]

## Recommended readings and toolkits

■ Lynne S. Dumas, *Talk With Your Kids About Tough Issues,* 2003.
This parent guide from the USA offers practical, concrete tips and techniques for talking easily and openly with children ages 8–12 about issues such as sex, HIV and AIDS, violence, and drugs and alcohol. www.comminit.com/en/node/176630

■ Sarah Frost, *HIV Positive: A Book for Caregivers,* 2002
A manual that includes games and activities to build children's self-confidence. In the Circle Game, for example, the facilitator asks children in a circle to say something good about themselves then something good about the child sitting next to them. www.popline.org/docs/1732/312554.html

■ Government of South Africa, Department of Social Development, and UNICEF, *Parental/Primary Caregiver Capacity Building Training Package. Low Literacy Version,* 2008.
This resource is useful in all settings. It is one of relatively few that is sensitive to the fact that some of the best caregivers in the community never had the opportunity to attend school and must rely on pictures and symbols rather than the written word. www.unicef.org/southafrica/SAF_resouces_parentallow1.pdf

■ Sr. Silke-Andrea Mallmann, *Building Resilience Among Children Affected by HIV/AIDS,* 2003.
This self-help manual is chock-full of counselling techniques, group activities, and program ideas. www.fhi.org/en/HIVAIDS/pub/guide/caacounseling.htm

■ Jonathan Morgan, *Memory/ Life Story Work Manual,* 2003.
http://web.uct.ac.za/depts/cgc/Jonathan/Life%20Story%20Manual.htm

■ Erika von Wietersheim with Lucy Y Steinitz, *Teachers' Manual. Window of Hope: Orange Double Power Window,* 2005.
www.hamu-nam.net/docs/unicef/orange.pdf

■ Mark Winiarski, *Community-based Counselling for People Who Are Affected by HIV/ AIDS,* 2004
www.comminit.com/en/node/188126/307

In addition to these resources, check out the websites listed in appendix 1, especially www.repssi.org; www.satregion.org; www.safaids.net; www.fhi.org; www.aidsalliance.org; www.eldis.org; www.humiliza.org; www.readytolearn.org; and www.unicef.org.

# 5. Children's Rights and Protection

Children are mentioned explicitly in many human rights instruments, the most prominent of which is the United Nations Convention on the Rights of the Child. Since its adoption in 1989 after more than 60 years of advocacy, this convention has been ratified more quickly than any other human-rights instrument and by more governments—every UN member except for Somalia and the United States.[14] It is also the only international human-rights treaty that expressly gives NGOs a role in monitoring its implementation. Governments must also report back regularly to the UN on the state of children's rights in their countries.

The UN Convention's basic premise is that all children—defined as persons age 18 and under—are born with the same fundamental freedoms and inherent rights as all human beings. The Convention sets out rights that must be realized for children to develop their full potential and be free from hunger, want, neglect, and abuse.

Human rights (including those of children) are enshrined in a set of internationally agreed upon legal and moral standards. These rights are universal and inalienable, and they come with responsibilities.

- *Universal rights* establish the basic civil, political, economic, social, and cultural entitlements and freedoms of every human being, anywhere in the world and at all times.

- *Inalienable rights* cannot be taken away or given up. Everyone is entitled to the same human rights from birth.

- *Rights with responsibilities* relate to the relationship between rights-holders and duty-bearers. States and other duty-bearers are responsible for ensuring that the rights of all people are equally respected, protected, and fulfilled; rights-holders are responsible for respecting and not violating the rights of others. Participation is a fundamental human right. Every child, woman, and man is entitled to demand her or his rights from duty-bearers.[15]

Human rights are also indivisible and interdependent, and they include the whole range of civil, political, social, economic, and cultural rights. The denial of certain rights undermines other rights. For example, governments that do not provide protection from domestic violence undermine the right to health of women and children.

**International human rights treaties relating to children signed by most countries**

- UN Convention on the Rights of the Child
- Optional protocol to the Convention on the Rights of the Child on the sale of children, child prostitution, and child pornography
- African Charter on the Rights and Welfare of the Child
- ILO Convention 138 on Minimum Age for Employment
- ILO Convention 182 on the Prohibition and Immediate Action for the Elimination of the Worst Forms of Child Labor
- UN Protocol to Prevent, Suppress, and Punish Trafficking in Persons, Especially Women and Children
- Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa
- Hague Convention on the Protection of Children and Cooperation in Respect of Intercountry Adoption
- Hague Convention on the Civil Aspects of International Child Abduction

## From abstract rights to reality

In industrialized and developing countries, millions of children continue to suffer from extreme poverty, homelessness, abuse, neglect, preventable diseases, unequal access to education, and justice systems that do not recognize their special needs. However, the near-universal ratification of the UN Convention on the Rights of the Child has obligated governments to amend and create laws and policies to fully implement the rights articulated and to ensure that all actions undertaken for and with children are in "the best interests of the child." That said, standards and principles only become a reality when they are respected and followed by everyone, including within the family, in schools and other community institutions, and by society at large.

The UN Convention refers to the family as the fundamental unit of society and the natural environment for the growth and wellbeing of its members, particularly for children. Ratifying the convention obliges governments to respect the primary responsibility of parents for providing care and guidance for their children. It also obliges governments to prevent children from

being separated from their families, unless it is in the child's best interests.

## Rights-based advocacy programming

All children have the same human rights. A rights-based approach promotes justice, equality, and freedom; it tackles power issues that lie at the root of poverty and exploitation. The approach requires awareness of how children are affected by poverty, discrimination, ignorance, child labor, exploitation, and life-threatening diseases. It also requires advocacy to persuade people in power to make decisions that support children's rights—for example by passing legislation that supports children's rights and then implementing that legislation in the way intended. Rights-based programming is not a one-time thing; it is an ongoing process that requires ongoing commitment and constant reinforcement.

Rights-based advocacy programming holds people in power accountable for fulfilling their responsibilities toward children and their families. It also supports children and families to demand their rights and supports their involvement in political, economic, and social decisions. Rights-based programming aims to increase impact and strengthen sustainability by working collaboratively with other stakeholders to address root causes of problems, change power relations, and bring about changes in policies and practices.

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**Articles in the UN Convention on the Rights of the Child**

4:  The state must do all it can to implement the rights recognized in the convention.

24:  The child has a right to the highest standard of health and health facilities attainable. No child should be deprived of access to health services.

26:  The child has the right to benefit from social security and to benefits that are applied for by the person responsible for his or her maintenance.

27:  Children have a right to an adequate standard of living. When parents are unable to provide this, the state shall take appropriate measures to assist parents and others responsible for the child to implement this right and shall, in case of need, provide material assistance and support programs, particularly with regard to nutrition, clothing, and housing.

28:  The child has a right to education, and states shall ensure that primary education is free and compulsory and that higher education is accessible to all on the basis of capacity by every appropriate means.

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> **When it comes to defending children's rights, you are never fully off-duty. This should be a personal commitment as well as a professional one.**
>
> Yolande Baker

No one organization can achieve these broad, ambitious, and long-term goals alone. When you work with children and their families, you need to prioritize actions based on what needs to be done locally to realize children's rights, in collaboration with others. After taking account of your expertise and skills, concentrate on the worst rights violations and the most vulnerable children and families. Work with other stakeholders to identify who are the most vulnerable and what needs to be done to ensure their rights are not overlooked.

Working with others, local organizations may engage in the following kinds of rights-based advocacy activities:

- Put pressure on decision-makers to change policies, laws, programs, and budget allocations in order to meet children's needs.

- Use the media to raise awareness and to report abuses of power and violations of rights.

- Establish and monitor standards and create systems of incentives and sanctions to enforce these standards.

- Audit the quality of government services.

- Monitor and report human rights violations.

- Work with watchdog organizations.

- Conduct education on human rights.

- Use the court system to achieve justice and equality.

The starting point in all rights-based, advocacy programming is a community's or district's assessment of their own situation and their analyses of rights violations and related problems. While it may be important to begin with some education or training on human-rights issues, your actions should be based on the views and decisions of community members. The process is as important as the outcome, since it builds the local commitment that is prerequisite for long-term enforcement of rights.

UNICEF promotes a seven-step process to human rights programming that begins with the underlying

**Table 4. UNICEF's human-rights approach to programming**

| SEVEN STEPS | QUESTIONS TO ASK |
|---|---|
| 1. Children's rights: minimum standards | What should be the situation of children? |
| 2. Assessment | What is the situation of children? |
| 3. Identification of priority problems | What rights are violated or at risk? |
| 4. Causality analysis | What are the causes of rights violations? |
| 5. Roles of duty-bearers | Who are the major duty-bearers and what are their obligations? |
| 6. Capacity and resource analysis | Do duty-bearers have the capacity to undertake their obligations? What current and potential resources do they have? |
| 7. Identification of goal, strategy, and actions | What needs be achieved? What actions must be undertaken, by whom, and how? |

concepts of children's rights and proceeds to the identification of problems and their causes; the roles of key actors (or duty-bearers); assessments of capabilities and available resources; and the development of goals, strategies, and actions (table 4).[16]

Many countries have adopted national plans of action and other policies that promote the wellbeing of vulnerable children and youth. All of these plans are based on conventions and laws that promote the rights of children, youth, families, and people living with HIV. You should familiarize yourself with the laws and conventions adopted in your host-country before undertaking program planning, since the activities you implement must reflect the rights, principles, standards, and guidelines contained in these documents.

### Child protection and child protection systems

UNICEF states that the term "child protection" refers to preventing and responding to violence, exploitation, and abuse against children. Child protection thus includes preventing and responding to commercial sexual exploitation; child trafficking; child labor; abuse in the home, school, and community; and harmful and abusive traditional practices such as female genital mutilation and child marriage.

UNICEF notes that violations of children's right to protection occur in every country and that these violations are massive, under-recognized, and under-reported barriers to child survival and development.[17] Children require special protection and care because of their physical and mental immaturity. All children need to be protected, but some need greater levels of protection, including orphans without adult care, children living in extreme poverty, disabled children,

and children affected by natural disaster and conflict. Cultural and social factors also often put girls at greater risk than boys.

Child protection systems comprise laws, policies, regulations, and services that support the prevention of violence, exploitation, and abuse directed at children, as well as remedies when children's rights

**Rights that may need special attention**

When programming for children, take note of rights that are often abused or overlooked. These include gender rights, since girls are often denied the same rights as boys, as well as the rights of children affected by illness or disability.

are violated. Child protection systems also serve a prevention function: they let adults know that abuse won't be tolerated and what the consequences are. An effective child protection system requires coordination and collaboration among government agencies at all levels and among civil society organizations and community groups.

The degree to which an organization gets involved in child protection will depend on its mission and the experiences and skills of its staff. That said, organizations working with children have some basic responsibilities in relation to child protection. Their staff should be familiar with the UN Convention and what constitutes a violation of a child's rights. They should also be familiar with specific child protection systems in the countries where they work, including laws, policies, services, and referral mechanisms. Staff should be trained in child protection issues. They should recognize when a child is in need of protection, and they should be able to link that child to appropriate protection services. Organizations should develop their own institutional guidelines on child protection, perhaps along the lines of guidance outlined in appendix 2, or by reviewing and applying child protection policies of other organizations.

## Recognizing child abuse

Child abuse has no boundaries. It affects all segments of society and takes many forms. Child abuse is any behavior by any adult that endangers a child's wellbeing and development. The most common types of child abuse are physical abuse, emotional abuse, sexual abuse, and neglect.

■ *Physical abuse* involves any action that brings physical pain or discomfort to a child, including slapping, pinching, punching, pushing, burning, or throwing objects with the intention of hurting or punishing the child. Often, there are external injuries (wounds or bruises), but the abuse may not always be detectable. Physical abuse is almost always accompanied by emotional abuse.

■ *Emotional abuse* wounds a child's emotions and spirit, leaving psychological marks that can last a lifetime. Children who experience emotional abuse are "hit" every day with words that demean, shame, threaten, blame, or intimidate them. Emotional abuse destroys children's self-confidence and self-esteem and results in a sense of worthlessness and inadequacy, especially when expressions of love, support, and reassurance are withheld.

■ *Sexual abuse* can entail genital or oral stimulation and fondling, sexual intercourse, or indecent exposure. It may also be violent, as in rape.

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**Some facts to note about child sexual abuse**

• Sexual abuse occurs in all countries. Both boys and girls are abused. Much sexual abuse is hidden, since people often don't talk about it.

• Most child abusers are men. Women can also be abusers, but this is far less frequent. Many abusers were victims of sexual abuse as children.

• Most of the time, the abuser is someone the child knows or trusts: a family member, relative, neighbor, or authority figure.

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Whether sexual abuse occurs once or many times, it damages children. One experience of indecent exposure may seem minor, but it may cause embarrassment, fear, confusion, guilt, anxiety, and a distrust of adults. Incest and rape have longer and deeper effects. Some children may try to block out the memory of this abuse.

■ *Neglect* is a form of abuse, since it results in children who lack adequate shelter, food, clothing, and medical care. Child neglect is also characterized by the lack of appropriate supervision and care for extended periods of time, especially for young children.

We need to recognize signs and symptoms of abuse so we can respond appropriately when we see or hear about a child who may have been abused. Symptoms listed in table 5 don't tell you specifically that abuse has happened, but they suggest that something is wrong and that immediate follow-up may be required. That "something" may be abuse. These signs may appear in combination. A child who is physically abused may also be emotionally abused, and a sexually abused child can also be neglected.[18]

Though perpetrators of physical and emotional abuse and neglect are usually parents or caregivers, those who sexually abuse children may be non-blood relatives, distant relatives, or frequent household visitors. A parent or caregiver may not be aware of the abuse, or they may know about it but do little or nothing to protect the child. It is important to help the parent or caregiver improve the situation, take constructive action, and better protect the child in the future.

## Responding to child abuse and neglect

### What to say to a child who discloses abuse

Immediately convey five important messages and follow up the last one.

**1.** I believe you.

**2.** I am glad you told me.

**Table 5. Signs and symptoms of child abuse**

|  | CHILD | SUSPECTED ABUSER |
|---|---|---|
| **PHYSICAL ABUSE** | • has unexplained injuries: burns, bites, bruises, broken bones, or black eyes<br>• seems frightened of the parent or caretaker<br>• reports being injured by a parent or another adult caregiver | • has no logical or convincing explanation for the child's injuries<br>• describes the child as "evil" or in another very negative way<br>• uses harsh physical discipline with the child<br>• was abused as a child |
| **EMOTIONAL ABUSE** | • engages in extreme behavior such as lying or stealing, or is overly aggressive and acts out inappropriately<br>• is defensive, shy, or overly dependent<br>• uses abusive and demeaning language<br>• is inappropriately adult (acts as the parent of other children)<br>• engages in inappropriately childish behavior, such as frequent rocking or head-banging<br>• is delayed in physical or emotional development<br>• has attempted suicide<br>• seems emotionally distant toward the parent or caregiver | • constantly blames, belittles, or berates the child<br>• does not show concern about the child and refuses to accept help for the child's problems.<br>• openly rejects the child |
| **SEXUAL ABUSE** | • has difficulty walking or sitting<br>• wets the bed or has nightmares<br>• has unusual or sophisticated sexual knowledge<br>• becomes pregnant or contracts a sexually transmitted infection, particularly if under age 14<br>• runs away<br>• reports sexual abuse by a parent or another adult caregiver | • is overly protective of the child or severely limits the child's contact with other children, especially those of the opposite sex<br>• is secretive and isolated<br>• is jealous or controlling with family members |
| **NEGLECT** | • is frequently absent from school<br>• begs or steals food or money<br>• lacks needed medical or dental care and immunizations<br>• is consistently dirty and has severe body odor<br>• lacks sufficient clothing for the weather<br>• abuses alcohol or other drugs<br>• says that there is no one at home to provide care | • seems to be indifferent to the child<br>• seems apathetic or depressed<br>• behaves irrationally<br>• abuses alcohol or other drugs |

**3.** I am sorry this has happened to you.

**4.** It is not your fault.

**5.** I need to speak to other adults in order to help you and to try to make sure this does not happen to you again.

If you suspect or know that a child is being abused or neglected, you should immediately take three important actions: 1) report the confirmed or suspected abuse, 2) provide counseling and emotional support, and 3) follow up with the child.

### Action 1: Report the abuse.

Reporting the known or alleged abuse can save a child's life. If possible, inform the child that you are going to report it and explain that you are doing so protect him or her. At the same time, you need to be sensitive to the possibility the child may feel even more vulnerable and exposed if others know, especially if the perpetrator has threatened harm or death if anyone finds out. You must respond to the child's fears, possibly taking special measures to ensure his or her safety after reporting the abuse.

If you are unsure how to handle the situation, contact the local child protection agency and/or law enforcement institution and ask a professional for advice. Keep in mind that legal action may be taken, since child abuse is illegal. A child protection unit or its equivalent can provide advice on the best way to proceed. Some countries also have legal aid societies or public-interest law firms that can help.

A child who has been physically or sexually abused will need a medical examination as soon as possible. If a child has been exposed to HIV infection, the window for post-exposure prophylaxis is only 48–72 hours, a treatment available in many countries at local hospitals or through child protection units. Other sexually transmitted infections require immediate testing and treatment, and female children may also need emergency contraception or pregnancy counseling.

Take the child to the nearest child protection unit or to a designated hospital or clinic, but first explain what will happen and why. Allow him or her to ask questions or offer additional information. A child under age 16 may need the consent of a parent or guardian for an exam, especially if sexual abuse is suspected. Specially trained doctors are desirable for this purpose; they know all the steps they should take, including retaining evidence such as stained underwear for forensic analysis. (However, a lack of visible signs of abuse does not mean the child is not telling the truth.)

### Action 2. Provide counseling and emotional support.

Counseling and emotional support that are critical to an abused child's recovery are needed immediately after the abuse is reported and at least periodically thereafter. If your organization has counselors who know how to respond to cases of child abuse, provide initial counseling until more professional assistance can be obtained through a national child protection system or another resource.

Counselors recognize that the perpetrator of abuse is almost always known to the child. Children often love the people who abuse them and simply want the abuse to stop. They may hesitate to talk if they have been threatened or if they don't want to get the perpetrator in trouble.

Children who start to talk about the abuse and receive negative or disbelieving responses may clam up and stop disclosing. This will increase their sense of isolation and shame and delay the help they need. It is important to let the child talk freely, sometimes interjecting open-ended questions that can be answered in the child's own words, but not simply by yes or

no. Express appreciation and support for the child's bravery in telling you what happened.

### Action 3. Follow up with the child.

Don't let the child feel that she or he is forgotten. After you report the abuse and take other initial actions, follow up to make sure the child is no longer at risk and has received appropriate assistance. Offer additional counseling and emotional support, if needed.

## The importance of prevention

Prevention is the best hope for reducing child abuse and neglect and improving the lives of children and families. Preventing child abuse requires a shared commitment by individuals and organizations in every community.

The first step—admittedly a difficult and lengthy one—is understanding and addressing factors that contribute to child abuse and neglect. Perpetrators were often abused as children and continue to suffer from the experience. Many adults don't understand basic child development concepts or what their children need to grow up healthy and strong. Many lack parenting skills and don't know how to guide or discipline children except by using abusive techniques. In addition, child abuse and neglect may result when parents and caregivers are affected by desperate poverty, depression, and substance abuse.

Although there is no quick recipe, some things can be done to prevent child abuse and neglect:

- ■ *Help children and youth improve their knowledge and skills for self-protection.* Children can play an active role in their own protection by learning about their rights, building their

confidence and self-esteem, and developing better interpersonal and self-care skills.

■ *Educate parents and caregivers.* To help parents and caregivers improve their child-rearing practices and reduce their own stress, educate them on good parenting, anger-management, alternatives to violence, child rights, and basic child development concepts.

■ *Develop a home-based care program.* Home-based care and home visitation programs allow local volunteers or community-based staff to assess the wellbeing of children living in the home and become more aware of the problems and struggles of local families. In response, they can build awareness, provide parenting education, offer supportive counseling, and make referrals to other services.

■ *Facilitate access to childcare opportunities.* Parents and caregivers stressed by constant child-care responsibilities often benefit from childcare or daycare programs. Childcare programs also provide opportunities for children to learn basic self-care skills and can be used to screen or protect children from abuse.

■ *Create community awareness.* Educational activities and campaigns create community awareness about child abuse and what individuals and communities can do to protect vulnerable children.

■ *Strengthen foster care and other alternative care systems by working with local authorities.* Children who cannot remain in their homes due to past or threatened abuse need alternative care.

■ *Start a support group.* Support groups can help people with similar histories or backgrounds cope with the stresses of daily life. They can be enormously helpful—for parents and caregivers and for children.

## Recommended readings and toolkits

■ Corinne Grainger, Douglas Webb, and Lyn Elliott, *Children Affected by HIV/AIDS: Rights and Responses in the Developing World*, 2001.
This working paper produced by Save the Children UK analyzes the responses in resource-poor countries to children affected by HIV and AIDS by households, communities, programming organizations, governments, and donors. www.ovcsupport.net/graphics/OVC/documents/0000066e00.pdf

■ International AIDS Alliance and PACT/Tanzania, *Understanding and Challenging HIV Stigma. Toolkit for Action. Module I: Children and Stigma*. 2007.
This training module explores the different ways in which children are stigmatized and looks at strategies to change attitudes and experiences. Exercises are designed for both children and adults. www.pactworld.org.

■ International AIDS Alliance and PACT/Tanzania, *Understanding and Challenging HIV Stigma. Toolkit for Action. Module J. Young People and Stigma,* 2007.
This training module provides exercises to help young people identify the stigma issues they face. It analyzes the causes and consequences of stigma; addresses the link between stigma, gender, and sexuality; and empowers young people with skills to cope with stigma and build strategies for change. www.pactworld.org

■ Rachel Sabates-Wheeler and Lissa Pelhan, *Social Protection: How Important Are the National Plans of Action for Orphans and Vulnerable Children?* 2006.
This briefing paper by the Institute of Development Studies analyzes how social protection issues have been incorporated into 14 national plans of action and action-planning work. It highlights areas where social protection activities may be needed. www.crin.org/docs/IDSReportforUNICEF_2.pdf

UNICEF, *Progress for Children: A World Fit for Children Statistical Review,* 2007.
Number 6 in the series, this document looks at UNICEF's global statistical report on progress toward reaching Millennium Development Goals and other key child-focused indicators. www.crin.org/docs/Progress_for_Children_No_6.pdf

In addition, check out the websites listed in appendix 1, especially www.crin.org/bcn, the website of the Children's Rights Information Network (CRIN), which lists over 16,000 resources.

# 6. Guidelines for Promoting Child and Youth Participation

Children undergoing critical life experiences have valuable information to share. They need opportunities to express themselves and want to feel that their opinions count. Just as the GIPA principle promotes greater involvement of people living with AIDS, programs that support children and youth need to be committed to and encourage child and youth participation. The right to child participation is built into the UN Convention on the Rights of the Child, the African Charter on the Rights and Welfare of the Child, and into other conventions and national plans of action for vulnerable children.

## Why promote child participation?

Not only is child participation a right, but children and youth have a lot to teach us. Hearing what they have to say often gives adults new understanding about their wishes and needs.[19] Who knows more than they do about what their lives are like? The greater public understanding that comes from listening to their voices can lead to constructive change for public policies and increased protection from stigma and discrimination. Involving children and youth builds their self-esteem and helps them find ways to support themselves and others. Giving them opportunities to share their thoughts and feelings can result in a better and more sustainable support plan and fewer violations of their inheritance rights.



> **Who benefits from children's participation?**
>
> Children's participation should first and foremost benefit the children who are involved. If others gain from what is shared (as they likely will), that is the bonus. But it is only a secondary goal.

When children and youth feel they are taken seriously and respected by others, they gain more control over their lives and develop hope for the future. This increases the likelihood that they will choose behaviors that help them to make good decisions, avoid HIV infection and other dangers, and influence the behavior of their peers and others in the community in positive ways.

## How are children selected to participate?

Programs that are already working directly with children and youth should provide opportunities for their participation and input—for example, within beneficiary families or at an after-school program. When planning a new program, seeking input for policy change, or conducting an evaluation, input may be sought from a representational sample of children and youth. The sample will usually be selected through community contacts, NGOs, schools, clinics, and so on.

To ensure maximum representation and participation, the selection should be as broad as possible. It should span different geographic regions and ethnic groups and include children with special needs and other subgroups. The selection should including children and youth who community leaders consider to be the most vulnerable, such as street children or members of child-headed households.

Children's input may be sought for the selection process. It must be made clear to all participants that their involvement is voluntary, informed, meaningful,

**If you have a problem, you must share it with someone else. Otherwise it will feel worse and worse.**

Matroos, 12, Namibia

**Award-winning and innovative work in children's participatory leadership**

Consol Homes, which works with over 20,000 children orphaned by AIDS in rural Malawi, won a Red Ribbon Award at the 17th International AIDS Conference in Mexico City in 2008. The organization encourages vulnerable children to form collectives that foster communities working together to address local problems.

Children created their own social clubs and built clubhouses that are used during off-hours as nursery schools and training centers. Club activities extend beyond ports and social activities. The children help elderly grandparents by fetching water, hoeing gardens, and doing other chores. Consol Homes teaches the youngsters agricultural skills and income-generating activities. It provides school-related support for two high school students per year in each of 250 villages who chosen by the young people.

This pivotal work demonstrates that vulnerable children can become key actors in a community's response to HIV and poverty.

respectful, and safe. You should explain these concepts, as follows:

- **Voluntary:** Children should not be forced to participate. If they don't want to, they don't have to answer any questions or join in any activities.

- **Informed:** Before they decide whether or not to participate, children and their caregivers should know the background, purpose, risks, and possible outcomes of their participation. This can be explained in written texts, tape recordings, visual media, posters, and presentations. A sample consent form is in appendix 3.

- **Meaningful:** Participation should have a realistic and constructive purpose that benefits vulnerable children.

- **Respectful:** Participating children should feel that their contributions are valued and their comments are listened to. This also means that the information they provide should be shared with other people only with the children's clear consent on how it is shared and with whom.

- **Safe:** The activities, venues, or methodologies used should not put children or adults at any risk of physical, psychological, or emotional harm.

## How should children give their input?

How children give input to programs designed for their benefit depends on their ages and the types of activity being considered. Very young children may not be able to express themselves in words, but they can show you which games and toys they prefer among those you put out.

Rather than answering questions about what they like and don't like, primary-school aged children may express themselves more easily by drawing pictures or taking photographs and then talking about their content. Children age 10 and up can provide input through role-plays and drama, drawings, small-group discussions, written surveys, radio call-in programs, cellphone text messages, videos, or films.

A model for thinking about child and youth participation is presented in figure 2, a ladder of participation developed by sociologist Roger Hart.[20] The three lower rungs represent involvement that is undesirable and not true participation.

**Children's participation: A caveat**

Never do anything to pressure a child, make him or her feel badly or manipulated, or feel more vulnerable than he or she did before participating.

## FIG. 2. LADDER OF CHILD AND YOUTH PARTICIPATION

TRUE PARTICIPATION

**8.** Child/youth-initiated, shared decision with adults

**7.** Child/youth-initiated and directed

**6.** Adult-initiated, shared decisions with children/youth

**5.** Consulted and informed

**4.** Assigned but informed

**3.** Tokenism

**2.** Decoration

**1.** Manipulation

UNDESIRABLE INVOLVEMENT
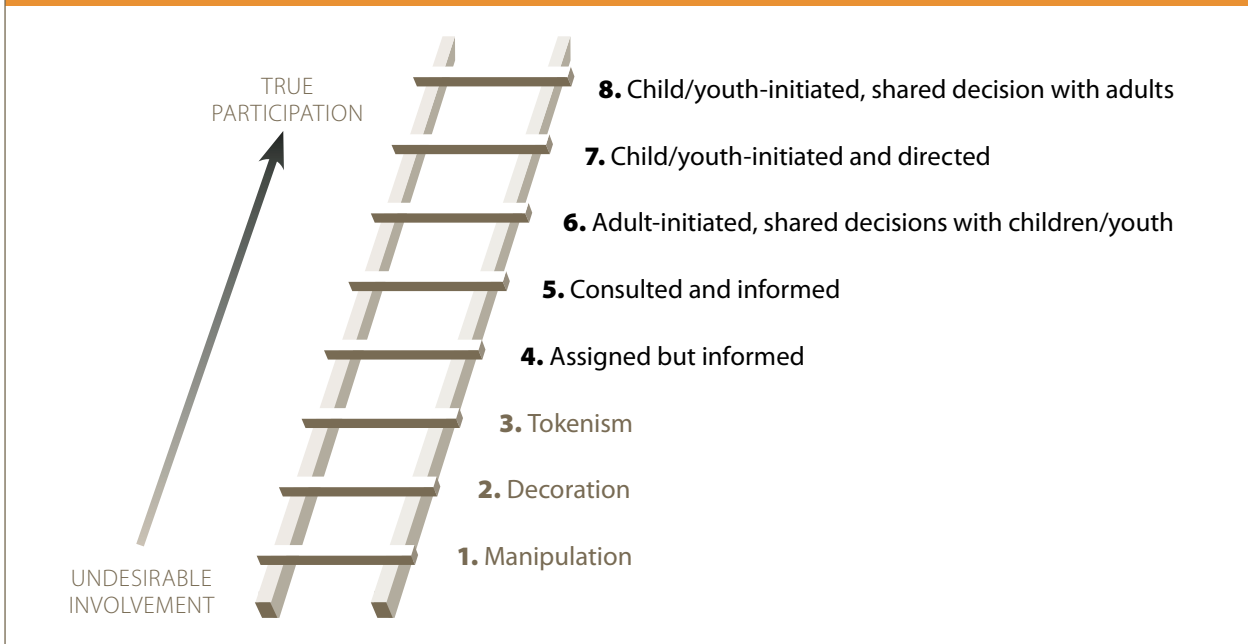
■ *Manipulation* means that children and youth involved in a project or activity don't understand it and its aims, such as when preschool children carry political placards or older children are involved in research that is never properly explained to them.

■ *Decoration* means that children are asked to perform at an event—sing, act, or recite poetry—but are not involved in the organization, told why the event is taking place, or given the opportunity to decline.

■ *Tokenism* means children and youth are only seemingly given a voice, such as by appearing on a conference panel where they basically echo what adults want them to say. They have little or no opportunity to formulate their own opinions and make no contribution to the substance or style of what they are communicating.[21]

Starting with the fourth rung of the ladder, child and youth involvement becomes more participatory. Participation is consultative and then shared. At the topmost rungs, children and youth initiate and direct their involvement, in partnership with the adults with whom they work.

■ *Assigned but informed* means that adults decide on the project and children volunteer to become involved. They understand the project—they know why they are involved and who decided to involve them—and they have a meaningful role for which they are respected.

■ *Consulted and informed* means that the project is still designed and run by adults, but with the full understanding and consent of children, whose input and opinions are taken seriously.

■ *Adult-initiated, shared decisions* means that the adults still have the initial idea for the project, but young people are involved in its planning and implementation. Their views are considered and they are involved in making the decisions.

■ *Child/youth-initiated and directed* means that young people have the initial idea for the project and decide how it is supposed to be implemented. Adults are available for support but do not take over.

■ *Child/youth-initiated, shared decisions with adults,* means that young people have ideas for the project and initiate it themselves. They may decide

**Be polite to visitors and clean up the house for them, but don't let them push you around. If you feel that someone wants to take away your rights, ask for help at the Women and Child Protection Unit or the Ministry of Gender Equality and Child Welfare.**

Armin, 17

to seek advice and support from adults, who offer expertise but do not impose their will.

## What preparation is required?

Children's participation requires good planning, and the best interest of the child should be the primary consideration at all times. Children must first voluntarily agree to participate, and they must know that they have the right to withdraw at all times. Efforts should be made to include all children equally in appropriate activities that will provide the desired program input. If children have input into the agenda, that is the best of all.

Program managers should ensure adherence during all activities with the country's laws concerning child protection and, if applicable, with NGO-approved child protection guidelines.[22] Child participation requires assessing participants' different stages of development, their emotional stability, levels of vulnerability, and the local support structures that may be available.

Staff at the activity should be trained to work with children and ensure a safe, child-friendly atmosphere. Venues should be clean and offer healthy meals. There should also be appropriate chaperones, including for travel to and from the venue, and first-aid kits and personnel trained in emergency care should be available for out-of-town events. Linkages should also be established with local health facilities in the event of an emergency, and counseling resources and specialized services should be available if children report experience with abuse.

The following are some other considerations:

- All participants should understand and be able to converse in the language used. If translations are needed, they should be well done so no child is at a disadvantage.

- Depending on the activity, children should be separated into groups with a three- to four-year age range (6–9, 10–13, 14–17, 18+).

- There should be between 8 and 15 children per facilitator.

- Gender sensitivity is essential. The opinions of girls and boys should be heard, respected, and considered equally. If barriers exist to boys' or girls' participation, appropriate interventions should address this imbalance, such as targeted outreach efforts to reach more girls, occasional separation of groups by gender, and careful use of language and illustrations that highlight gender sensitivity. Efforts should be made to ensure the participation of children from minority groups and children with special needs.

### Involving children in research

It is always important to maintain ethical standards when gathering information from people. Extra precautions are needed when working with children and youth, since they are especially vulnerable to exploitation, abuse, and other harmful outcomes.[24] Most countries and most donors require that organizations engaged in research activities establish or make use of an independent ethical review board (often known as an ethics committee) to review and approve all research plans or protocols.[25] While program monitoring and evaluation activities are not usually bound by the strict requirements of an ethical review board, program managers should strive to uphold similar ethical standards and supervision at all times.

The following are some key points to keep in mind:

- Select interviewers who have past working experience with children. Train them to respond to children's needs and to provide ongoing supervision and support.

- Train interviewers to recognize gender and cultural concerns (such as when it is appropriate to use interviewers who are the same sex as the children interviewed). Training should emphasize the importance of being sensitive to the potential emotional impact of some interview questions, including knowing when to stop asking questions and when and how to provide psychosocial support.

- Prepare a reaction plan that anticipates serious needs, including what to do if abuse is discovered. This means that there should be somebody on hand who can provide emotional support to children who react emotionally to the interview questions. Referral links should be in place, should additional support be required.

Save the Children UK developed a checklist of practice standards for children's participation:[23]

1. Ethical approaches are paramount at all times, including transparency, honesty, and accountability.

2. Children's participation is relevant and voluntary. Informed consent has been given.

3. Children's participation occurs in child-friendly, enabling environment.

4. Participation offers equality of opportunity, regardless of gender or other issues.

5. Staff are effective, experienced, and confident in their work with children.

**6.** Participation promotes the safety and protection of children at all times.

**7.** Children's participation always involves follow-up and evaluation.

### What about consent forms?

Consent forms are generally required for children's participation, in accordance with local laws and customs. If your organization is decentralized, keep one copy of the signed form in the local office and another in a central location. A sample form is reproduced in appendix 3.

The consent agreement may be adapted to local circumstances. It should be in the vernacular language and read aloud for those who are not literate. Permission needs to be acknowledged in writing or by a thumbprint. A child who is old enough to write should co-sign the form, as should his or her parent or guardian. Medical information and emergency contacts should also be added. If the event requires travel away from home, additional information should be added to the consent form, including a release of liability that states that the sponsoring organization is not responsible for accidents or lost property (such as clothing that gets left behind).

# Children are the brightest moon.

Maasai proverb

A separate form is used to give permission to take photographs or videos of the children and use their quotes in publications. The form may include a description or checklist of how this material may and may not be used. Organizations sometimes make a distinction between materials produced for distribution inside the country and those produced solely for international consumption, since the risk of the child being recognized (and possibly stigmatized) by someone he or she knows is much lower if materials are only available outside the country.

The consent form should address the following questions:

- What is expected of the children in terms of commitment, time, and other inputs?

- What are the possible outcomes of their participation, positive and negative?

- What are the dates of the event and where is it being held?

- Where and when will activities take place and how will transport, chaperoning, and other logistical issues be handled?

- What kinds of material and financial support can participating children expect from the sponsoring organization or its partners, if any?

- How can the parent or guardian be contacted in the case of an emergency?

- Does the child have medical needs that the staff and chaperones should know about? If so, what are they?

### Evaluating children's participation

Always be sure to give children feedback by explaining how their participation and ideas were received and what will happen next. The following are some questions to ask some weeks after children have participated:

- Did you feel that you were listened to?

- Were there some processes or activities you would have liked to participate in but were not given the chance?

- Do you agree with the outcomes of actions and decisions? Why or why not?

- If suggestions or requests were not followed, did the adults explain why this happened? Do you understand those reasons?

- Has the process been respectful and supportive?

- Did you feel safe and protected at all times during their participation?

- How has your life changed since your participation? Are you now participating more in family and community life? Do you feel more self-confident?

- What recommendations do you have for future programs and activities? How can the process be improved?

Finally, the children can be asked for other comments and to offer their suggestions for other monitoring and evaluation questions. After all, even this exercise is a good opportunity to practice what we preach about children's participation!

### Recommended readings and toolkits

- REPSSI, Toolkits for Body Mapping and Hero Books. Among many psychosocial resources available by download on this site, these toolkits can be used by trained facilitators to enhance the personal development and resilience of children, youth, and adults. www.children-psychosocial-wellbeing.org/body-mapping.html www.children-psychosocial-wellbeing.org/hero-books.html

- In addition, check out websites listed in the appendix 1, including www.eldis.org, www.savethechildren.net, and www.worldvisionresources.com.

When parents become sick, they should start preparing their children for the future. They shouldn't wait until it's too late.
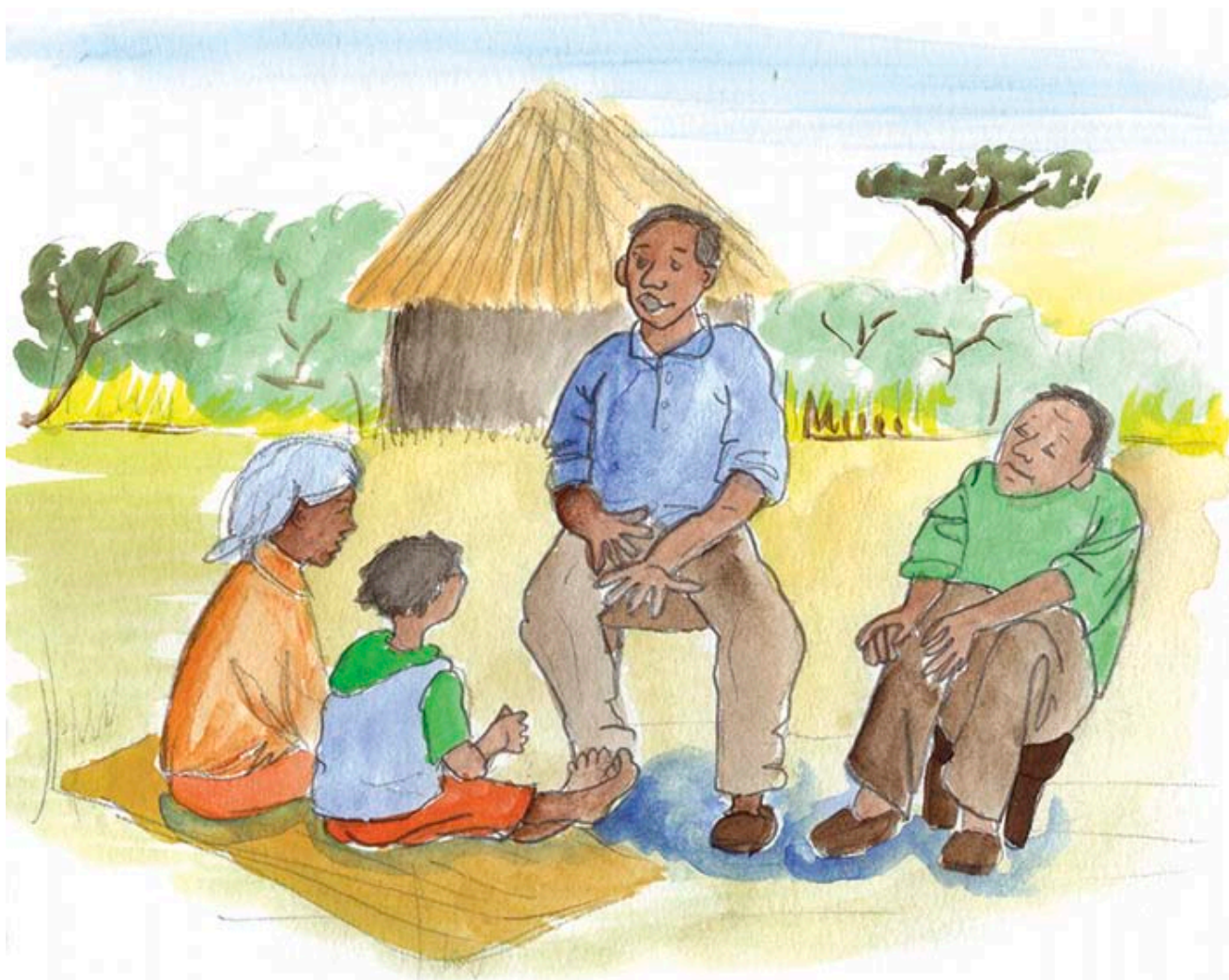
Toini, 19

# 1. Global Programming Principles and Strategies

All programs for vulnerable children and youth need to work together to incorporate interventions that improve the quality of life of families and communities and of the young people themselves. Interventions should respond to children's comprehensive needs, within the context of globally established guidelines and principles.

In planning, you should consider two types of interventions: direct and indirect. The first type provides services directly to children and families who are identified by your program. The second type—indirect interventions—strengthens the ability of government and community organizations to meet the needs of children, including by promoting and enforcing laws and policies that benefit and protect them.

Given the global HIV pandemic, one goal of programming for vulnerable children and youth is to mitigate the impact of HIV and AIDS on them, their families, and their communities. These mitigation efforts require the integration of prevention, care, and treatment strategies and a multisectoral approach that involves the government, the private sector, and all community stakeholders. By contrast, where extreme poverty, natural disaster, armed conflict, or other harmful influences play a bigger role in a child's life than HIV, the focus should be mitigating these factors to the extent possible, although an HIV focus may be added.

Overall, the main goal of all programming is to provide vulnerable children and youth with the same standard of care and opportunities in life that children and youth who are not vulnerable experience within their respective communities or countries.

## A conceptual framework

To shape the way we plan, we must look beneath the surface in communities where we work and learn to think conceptually. A good theory of social change will help us identify ways to assist individuals, families, communities, and organizations who are seeking to understand and shape their own futures.[1]

One place to begin is to consider ideas and values that underlie our view of how change occurs in a community. Most conventional theories of social change are linear in concept—that is, they are based on the notion that if you provide an intervention you can predict the improved outcome, even a year or two in advance. Let's say you teach members of a household with vulnerable children how to garden and then give them tools and vegetable seeds. Conventional linear thinking assumes that they will grow some food and their nutritional status will improve within a year.

Real life is not always so simple. Household members may be too ill to garden, or their plantings may be killed by drought. The family may sell off their crop to pay off an old debt or some other expense, with no benefit to their nutritional status. In conventional thinking, these outcomes would be considered failures, but that may be a shortsighted way of looking at the issue. If we look at each these unforeseen outcomes in a different way, we would see that good things could still result. For example, illness may cause local volunteers to emerge with offers to help—neighbor-to-neighbor or through relationships in a local religious congregation—which will strengthen the community network. Experience with drought may encourage people to consider and learn about planting drought-resistant crops. Selling produce instead of eating it may give the family access to credit for a small-business loan, help with paying school fees, or some other kind of assistance. The situation may not always work out this positively (often it doesn't), but the possibility increases if you are willing to learn from unexpected things that happen and then apply these lessons to your future work.

What does this example teach us? First, that simple cause-and-effect thinking is often misleading. Second, not all crises are failures; instead, they may be a prerequisite to transformative change. All of us

> ## Sometimes I felt embarrassed to ask for help from neighbors. They mocked me and laughed behind my back. But I kept looking until I found someone else who could help us.
>
> Raukha, 16

learn from experience—often more from our mistakes than our successes. For this learning to occur, we need to take a wide view, be flexible, and think out-of-the box. While maintaining our core values and goals, we should always be open to unanticipated opportunities for learning and positive social change.

Social change is cyclical. It involves a continuous (and sometimes messy) process of planning, action, reflection, learning, and then more planning (fig. 3).[2]

Sometimes social change occurs naturally, at other times unexpectedly, and still other times as part of a project or program. Inevitably, it involves ups and downs—a hodge-podge of setbacks, crises, steps forward, and unanticipated factors. Planning is an ongoing process, not something that occurs only at the beginning. The same is true of the actions, reflection (or monitoring), and learning as you go. The key is to always keep learning from the process. You then need to apply that learning to your work in the field—through more planning, action, and reflection—to improve what you are doing and foster positive social change.



**FIG. 3. ACTION LEARNING CYCLE**

Planning → Action → Reflection → Learning
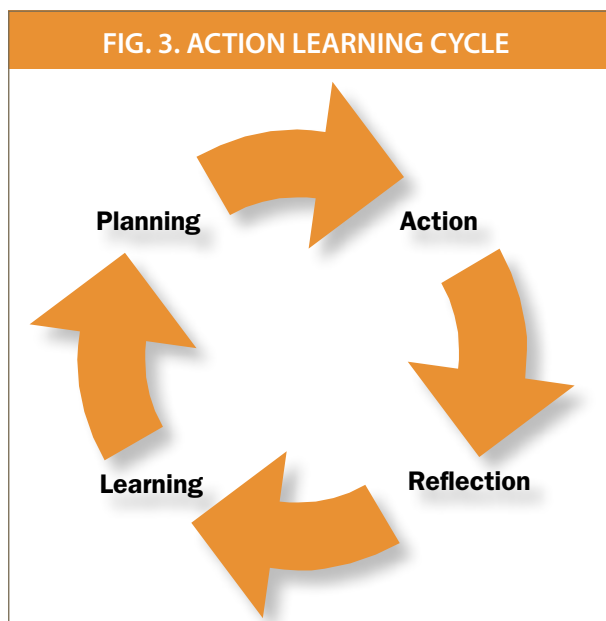
## A global strategic framework

Books about program planning and social change contain innumerable references to organizing principles, planning frameworks, guiding strategies, and the like. In 2004, UNICEF, UNAIDS, USAID, and other international organizations agreed on a global strategic framework to guide responses to issues facing orphans and other vulnerable children.[3] It highlights five key strategies to guide programmatic responses:

1. Strengthen the capacity of families to protect and care for orphans and vulnerable children by prolonging the lives of parents and providing economic, psychosocial, and other support.

2. Mobilize and support community-based responses.

3. Ensure access for orphans and vulnerable children to essential services, including education, healthcare, birth registration, and other services.

4. Ensure that governments protect the most vulnerable children through improved policy and legislation and by channeling resources to communities.

5. Raise awareness to create a supportive environment for children affected by HIV and AIDS.

Although these strategies were mainly intended for senior policymakers, they provide valuable guidance for you and others working more closely with vulnerable children and youth within organizations and in local communities.

### 1. Strengthen the capacity of families to protect and care for children.

Families living under very difficult circumstances are often unable to meet the basic needs of their children. They may need external support and additional resources to fulfill their responsibilities. The best way to help is to strengthen the capacities of parents, extended family members, and other caregivers to provide children with the care and support they need. Within the context of HIV and other life-threatening diseases, the best approach is to help keep parents alive and healthy and prevent children from becoming orphans.

Your child-focused work should involve advocacy and support for all family members to access HIV counseling, testing, and treatment; economic strengthening activities; and nutritional support, if needed. The integration of HIV-prevention education and support for all family members is also important, depending on their ages and situation. This support may include services to prevent mother-to-child transmission of HIV for those mothers at risk of giving birth to HIV-positive children, referrals for a test where HIV status is not known, and adherence counseling related to

**Help children by helping their families**

*Home Truths: Facing the Facts on Children, AIDS, and Poverty,*[4] an outstanding report released in 2009, contains three main policy recommendations:

- Support children by helping their immediate or extended families and by delivering integrated family-centered services.

- Strengthen community action to support families—for example, via a local children's committee or community care coalition whose volunteers provide outreach, referrals, guidance, and support.

- Address family poverty through a cash-transfer program or some other form of a bottom-line, basic, social safety net.

All three recommendations are AIDS-sensitive but not AIDS-directed.

The report concludes that prioritizing care and support for children who are orphaned is unhelpful, if not damaging. The fact is that 88 percent of children labeled in this way have one parent, and 95 percent live with extended families who are a strong source of continued material support, psychological care, and cultural identity. The report states that extreme poverty, not HIV infection, should be a criterion for support. It also states that supports through school systems often come too late.

antiretroviral treatment for HIV-positive family members.

Be sure to include children and all other family members in the planning process. This will help create a sense of ownership and ultimately enhance your program's sustainability. If you avoid contact with family members during the planning period, you may undermine what you are trying to achieve and set up a "we-versus-them" situation.

Assistance for children that does not include all family members may do more harm than good. It can create jealousies among siblings ("Why did my brother get help and not me?") as well as rejection by adults ("Since you got fed at the center, you can skip dinner at home"). Even without these problems, restricting support to children and then sending them back to families who are under-resourced or dysfunctional can only have limited effect. The approach may also create dependencies on outside support that are not sustainable.

By contrast, creating a partnership and working with family members makes it possible to introduce interventions with long-lasting impact. Everyone benefits if you strengthen the skills, knowledge, and capacity of caregivers. Collaboration with family members will help you to discover the children's most pressing needs and allow you to supplement what the family is able to provide. It is a holistic and cost-effective approach.

## 2. Mobilize and support community-based responses.

Vulnerable children and their families are often at a disadvantage when trying to access basic services, usually because of poverty, lack of formal education, and the frailty of many grandparent-guardians. Members of vulnerable families may not know what they are eligible for, and they are more likely to lack documents that prove their eligibility. They may also have difficulty navigating large bureaucracies and advocating for what is rightfully theirs.

To intervene, stakeholders, including traditional and religious leaders, elected officials, and community-based organizations, should mobilize support for needy children in their communities. Often, local resources exist, but residents need to be sensitized to challenges being faced by the neediest people in their communities. They can do a great deal to mitigate these challenges. For example, they can commit to regular visits with a few needy families and to spending time with children after school, encouraging them, offering homework support, and helping them to access local services. When embarking on this process, it may be best to start small, one community at a time. Once a children's support program gets underway, deeper, more meaningful support can be considered, along with expansion to additional geographic areas.

**Help community members realize the meaningful role they can play in the lives of children**

Community members—caring neighbors, local groups, community organizations, and so on—can provide care for children by taking on the roles of "auntie and uncle," counselor, friendly visitor, and educator. Community members can advocate for access to local schools, health clinics, and other resources. Those taking on these roles will come to realize that they have the skills and capacity to improve the lives of vulnerable children and that many needs can be met without money. To facilitate this process and mobilize communities to help children, the Regional Psycho-Social Support Initiative in South Africa developed *The Journey of Life,* excellent training materials for use with local groups, volunteers, and children.

> **Establish a children's rights committee in every village or neighborhood**
>
> One of the most effective ways to help children is by training local volunteers to serve as members of a children's rights committee or a similarly named group. Volunteers learn what children in their community are entitled to and they make sure that they get it. Following an initial training, committee members meet regularly to address problems and ensure that all families in their target area are reached.
>
> When forming a local children's rights committee, don't forget to involve children and youth or else train them in a parallel process to identify and assist their peers. Their involvement is invaluable because they have information about each other that otherwise never reaches adults.

### 3. Apply a child-rights and gender-sensitive perspective.

Every child has the right to have a name and birth registration, attend school, and receive healthcare services. However, access to these basic services may suffer when a child's parents are ill or have died, or when caregivers are overwhelmed with day-to-day survival tasks. Often, parental death certificates, children's birth certificates, and other documents are a prerequisite for receiving government entitlements, including food baskets, schooling, and welfare services. Obtaining these documents can be a daunting process that requires the help of someone who knows how to navigate the system.

Additional attention may be required for children with special needs—those who are HIV-positive, live with disabilities, or need protection from abuse or neglect. In addition, girls often need special attention to ensure they have equal opportunities to access education, community-based services, and safety. Girls and women may also need support so their voices can be heard and their decisions respected.

### 4. Provide support and capacity building at national and provincial levels.

Advocacy at community levels may not be sufficient. Often, systems must be changed at national and provincial levels and strong partnerships formed with governments, policymakers, and organizations at these levels to facilitate children's access to services and extra support. For example, problems with access to education could be addressed by a national policy that calls for elimination of all school fees.

Usually, systems change takes a protracted period of time and involves inter-organizational coalitions and advocacy efforts. Enforcement and monitoring

processes are also required to make a change on paper become real in a community. To ensure implementation, local representatives must be educated about the change and what it means to children in their area.

### 5. Raise awareness through advocacy and social mobilization.

Stigma and discrimination—and the rejection, hostility, isolation, and human-rights violations they generate—tend to occur when children and their families need a supportive environment the most. Affected family members may need one-on-one counseling, and they may need the assistance of support groups that allow them to share concerns, advocate for access to treatment and care, and develop income-generating schemes. To decrease or eliminate stigma and discrimination and create a supportive environment, individuals and groups can do the following things:

- Be sensitive to cultural norms, but work firmly toward behavior change.
- Challenge local myths that give rise to stigma and discrimination.
- Increase access to correct information about HIV and other sensitive issues.
- Develop and implement with local partners a communication plan that can foster a more supportive environment for children.

> **Ensure that all children attend school**
>
> Every child has a right to education. Most countries mandate schooling, at least through the primary grades, but obstacles inhibit the poorest-of-the-poor from attending school, even in countries that claim to offer free education. The most prominent obstacles are fees for registration, books, and exams, along with the requirement to wear a school uniform and buy personal school supplies. Families may also impose heavy chores on children that impede school attendance. More commonly, this affects girls, since some families believe their schooling is not important.
>
> Governments need to be encouraged to make school truly free of charge and accessible, providing school-feeding programs in areas with very poor nutrition and hostels for children who live far away. Where such governmental support is not possible, local community hostels and supplementary feeding programs could be substituted. Village child-rights committees or other volunteer groups should check on children who frequently miss school or come late for classes. They should then educate families on the importance of regular school attendance, emphasizing that it is the law in most countries.

## A self-help project by people living with HIV

When Kindlimuka (Wake Up) was registered in Mozambique in 1998, it was the first self-help group of people living with HIV (PLHIV) in the country.[5] Kindlimuka soon started income-generating activities with three sewing machines, producing domestic workers' clothing and accessories. In the face of inadequate demand for these products and many requests for assistance from members, the organization negotiated in 2000 a relationship with the multinational petroleum company TOTAL to produce uniforms for its staff at stations across the country. Later, Kindlimuka expanded its production to include school uniforms.

Kindlimuka contributed greatly toward reducing the stigma and discrimination associated with being HIV-positive. Earnings help its members support themselves and their children, ensuring that they have adequate nutrition, access to healthcare, and money to pay school expenses.

- Facilitate school-based youth clubs that campaign against all forms of stigma and discrimination in the school and community.

- Provide start-up assistance to local support groups for income-generating schemes that will benefit families.

Other child-friendly environments play an equally important role. These include local health clinics that make no judgments on reproductive health and other sensitive matters; outreach programs by the police and national ministries that combat domestic violence and child abuse; and schools that welcome children with special needs. Local advocacy efforts, support groups, and elected officials are well positioned to create and monitor child-friendly environments at local levels.

### Programming guidance from the global strategic framework

In addition to the five strategies, the global strategic framework offers seven elements of guidance for people who plan and work with local programs for vulnerable children.[6]

1. *Focus on the most vulnerable children and communities, not on children orphaned by AIDS.* Programs that target only children orphaned by AIDS may increase stigma and discrimination. Priority care and support should go to children in greatest need, regardless of the cause. These children are best identified by community stakeholders and local people who are in direct contact with lots of children. An assessment using the Child Status Index or a similar tool (III, chapter 3) can be used to confirm the selection. Alternatively, an entire community, school, or neighborhood can be targeted.

2. *Define community-specific problems and vulnerabilities at the outset and pursue locally determined intervention strategies.* Cookie-cutter approaches rarely work. By contrast, when a new program starts in a particular community, it should be adapted specifically to that location to meet the needs of vulnerable children and their families. This may involve a separate analysis at each site to prioritize local needs and resources, identify obstacles or gaps in service, and determine how to find the vulnerable children who are most in need of care and support. Community members—both adults and children—should play a central role throughout.

3. *Involve children and young people as active participants in the response.* Children and young people should not be seen as a passive, powerless group who need to be given help. They need to be allowed to actively participate in all aspects of activities that affect them (I, chapter 6).

4. *Address gender discrimination and give particular attention to the roles of boys and girls, men and boys, and women and men.* The burden of caring for vulnerable children and sick

## Always try to save some money for an emergency. You never know when you will need it.

Helvi, 21

**fhi** Family Health International

# FHI's Child Outreach Strategy

## Goal and Objectives

The overall goal is to improve the quality of lives of children and their families by mitigating the impact of HIV and AIDS through an integrated continuum of health and social support services that are accessible to families at scale, in partnership with government, civil society, the private sector, and children themselves.

Objectives are to increase

- access to and use of essential HIV prevention, care, treatment, and social sector support (impact mitigation) services

- coordination among community networks that provide linked HIV prevention, care, treatment, and social sector support services

- the capacity of health and social sector organizations and volunteer networks to provide essential quality services in an integrated continuum

- the participation of key stakeholders in the development of appropriate policies and legislation as a mechanism to increase access to healthcare and social sector support services

- the provision of quality strategic information that strengthens the evidence base on lessons learned from care and support models

## Ten Principles for Programming

- Families remain at the center of interventions, with efforts made to place a child in an environment that is as close to a familiar family structure as possible.

- Interventions are designed to focus on the best interest of the child, including and especially their right to protection from discrimination, stigma, exploitation, abuse, and neglect.

- Efforts are made to maximize support of a continuum of care for vulnerable children—from prevention, palliative care and treatment, to impact mitigation—utilizing a family-centered approach.

- Programs strive to be as comprehensive as possible by leveraging the provision of services through partnerships and networks of providers, while working with communities to ensure that vulnerable children have access to primary healthcare, adequate nutrition, and a basic education.

- Quality assurance tools and methods are made available or developed to ensure a high standard of quality of prevention, care, treatment, and impact mitigation services.

- Gender equity issues affecting the status of and relationships between girls and boys as well as women and men are taken into account and addressed in programs and policies.

- To leverage available community resources, community-based social mobilization strategies are utilized that involve key community leaders, families, and persons affected by HIV and AIDS.

- Reduction of stigma and the elimination of discrimination against children, adolescents, and families made vulnerable by HIV and AIDS are integral to the design of programs.

- Activities and interventions are designed to reflect the developmental levels, ages, and needs of children being served

- Children themselves—particularly adolescents—are involved in the design, implementation, and monitoring and evaluation of programs, where possible.

adults generally falls on females. Vulnerable girls are more likely to drop out of school, and they have fewer rights and less access to education and income-generating opportunities than boys. Females are also particularly vulnerable to HIV infection. Girls who are excluded from owning or inheriting land may be forced to work as servants or marry against their will. Though both sexes are subject to sexual abuse and child-trafficking, girls are more frequently victimized.

**5.** *Strengthen partnerships and mobilize collaborative action.* Working with other organizations can be a very good way of improving a program's activities. One way of doing this is to build or strengthen local community networks and referral systems that will ensure coordination and a seamless system of support for each child.

**6.** *Link disease-prevention activities and care and support for people living with that disease with care and support for their children.* Activities may include school-based, health education as well as home-based care for ill individuals and their family members. Creating linkages with poverty alleviation and development activities taking place in the community offers a holistic approach and addresses underlying risk factors to disease, such as poor nutrition, unclean water, sanitation problems, domestic violence, and lack of education. Because these approaches benefit a larger group of people, stigma and discrimination is minimized.

**7.** *Use external support to strengthen community initiative and motivation.* Funding and technical assistance from the outside the community should strengthen and build on existing community activities and projects. Wherever possible, collaborate with local leaders to strengthen local ownership and local capacity and contribute to sustainability. By contrast, great care should be taken to avoid undermining or replacing community initiatives—or even the perception thereof—as this may create resentment, destroy existing coping capacities, and result in a dependency syndrome, where people are always waiting for handouts from the outside.

## FHI's Child Outreach Strategy: A framework for programming

FHI has been a key player in the global response to the needs of orphans and vulnerable children. In 2007, FHI published *Child Outreach Strategy* to guide country offices on the design, implementation, monitoring, and evaluation of programs for orphans and vulnerable children.[7] The strategy is based on the UN Convention on the Rights of the Child, the goals and core indicators of the UN General Assembly Special Session on HIV, and the US Government's guidance for programs for vulnerable children. FHI advocates a child-focused, family-centered, and community-based approach. Though the focus is on children affected by HIV, the underlying principles are universal and apply to all vulnerable children.

Despite the strong foundation of core values and principles, FHI's *Child Outreach Strategy* acknowledges that there is no single model of service that is applicable in all contexts. Instead, it highlights key recommendations that can be adapted and applied differentially to help country offices and local program managers to design, implement, monitor, and evaluate their programs. Goals and objectives and 10 principles for programming from the strategy are reproduced on page 36 so you can make copies and post them on a board for easy reference.

## Recommended readings and toolkits

■ Family Health International, *Case Studies of Success in the SCOPE-OVC Project: A Guide to Assist OVC Programming*, 2004.
Case studies of successful outcomes for vulnerable households and the children who live in them.
www.ovcsupport.net/sw4325.asp

■ Guyana HIV/AIDS Reduction & Prevention (GHARP) Project, *Orphans & Vulnerable Children (OVC) Technical Manual, Working Document*, 2007.
A compilation of standards implicit in the project's technical assistance for civil society organizations and NGOs implementing programs to support children and their families living with or affected by HIV and AIDS in Guyana. www.fhi.org/en/HIVAIDS/pub/guide/res_GHARP_OVC_TM.htm

■ HelpAge International, *Forgotten Families: Older People as Carers of Orphans and Vulnerable Children*, 2003.
Many older people have been forced into caregiving roles for which they are ill-equipped, physically, emotionally, and economically. This document, along with others on the HelpAge International website, looks at the impact that the rising number of orphans are having on the elderly in the developing world.
http://ovcsupport.net/sw3244.asp

■ MEASURE Evaluation, *Evaluations of Five Programs for Orphans and Vulnerable Children in Kenya and Tanzania*, 2007.
An estimated 12 million children 17 or younger in sub-Saharan Africa have lost one or both parents to AIDS and many more live with one or more chronically ill parent. Despite the magnitude of this problem, there is little empirical evidence on what works to improve the wellbeing of children affected by HIV and AIDS.
www.cpc.unc.edu/measure/publications

■ Tonya Renee Thurman, Anna Hoffman, Minki Chatterji, and Lisanne Brown, *A Case Study: Kilifi Orphans and Vulnerable Children Project*, 2007.
The primary audience for this resource is program implementers in Africa and policymakers and funding agencies that address the needs of vulnerable children. www.cpc.unc.edu/measure/publications

■ UNAIDS, *Principles to Guide Programming for Orphans and Other Children Affected by HIV/AIDS*, 2002.
This document aims to build consensus on core guiding principles for an expanded response to children and adolescents affected by HIV and AIDS. It emphasizes human rights as a framework for analysis and response, a strategic approach to action, principles and approaches to guide programming, and collaboration and networking. www.harare.unesco.org/hivaids/view_abstract.asp?id=282

■ UNICEF, *Africa's Orphaned Generations,* 2003
A seminal study comparing different countries, but with common recommendations for policymakers, donors, and local organizations and communities. The statistics have largely gotten worse, but the issues have not changed. http://unicef.org/africas_orphans.pdf

In addition, check out the websites listed in appendix 1, especially www.helpage.org; www.kit.nl; www.ovcsupport.net; www.satregional.org; www.usaid.gov; and www.unicef.org

# 2. Models of Care and Support

To make a meaningful difference in the lives of children, you should make sure that they have access to the broad spectrum of coordinated services. This does not mean that your program has to provide all possible interventions, regardless of your funding capability or the availability of other implementing partners. The specific mix of services you provide will depend on these factors and will differ by location, current community resources, the capacity of the family and other stakeholders to provide support, and—above all—on the needs of the particular children you are helping.

At the point of service delivery, all good programs have these features in common: assessment, care management, and coordination and continuity of care. There is an initial assessment of the children served within their family or household settings to determine their needs and of the resources that are available to each child (III, chapter 4). The assessment is followed by a plan that is implemented to provide additional support, as needed. Coordination and continuity of care refers to follow-up services and linkages to other service providers. These help to minimize gaps, avoid duplication, and enable children receive the support they need, while empowering families to sustain the gains made and achieve improved wellbeing over time.

The whole family, not the individual child, should become the unit of care wherever possible. Recent publications suggest that extreme poverty and other measures of need should be the main criteria for selecting one family over another for assistance, rather than simply the child's status as an orphan or the presence of a specified disease.[8] Nevertheless, many donors follow their own criteria and target their funding accordingly. By far, the largest amount of international funding for children has been provided in response to the global HIV pandemic and targets orphans and other vulnerable children in high prevalence countries or within pockets of highly affected populations.

## Classification by HIV prevalence rates and population size

Most often, issues of poverty and HIV converge. The result is that it is very possible to reach the neediest children in a community within the confines of funding that targets HIV-affected families or those considered highly at risk. But this convergence also means that programs in high prevalence areas that do

not target HIV-affected families should nevertheless incorporate HIV prevention and care, integrating activities that promote healthy living, disease prevention, stigma reduction, and HIV-related assessments and referrals. "Knowing your epidemic"[9] also means that you have identified behaviors and conditions most associated with HIV transmission—those that undermine the ability of vulnerable children and youth to access and use HIV information and services.

Programs will differ, however, depending on whether they are implemented in countries with a generalized, concentrated, or low-level epidemic. At a 2008 worldwide gathering in South Africa, FHI staff outlined four program scenarios based on national differences in the HIV prevalence rate and the size of the country's population: 1) high prevalence and high population; 2) high prevalence and low population; 3) low prevalence and high population; and 4) low prevalence and low population.

### 1. High HIV prevalence and high population

In these settings, it can be argued that all children are HIV-affected, either directly or indirectly. Directly, they could be HIV-infected or they could be affected through family illness or death. Indirectly, they could be affected by unfavorable living conditions that result from high HIV prevalence in their communities, perhaps through increased levels of poverty, the deaths of teachers and other professionals on whom they rely, and the elevated risk of HIV transmission from future sexual relationships.

In high prevalence and high population settings, programs need to be broad-based and holistic. They should try to meet the needs of the whole child, within the family context, by combining services such as educational support, protection, and psychosocial assistance. Additionally, all programs should promote HIV testing and treatment and include activities that reduce stigma, emphasize mutual care and support, and teach about HIV prevention. Programs in these settings should also work with the government to guide monitoring and evaluation research, policy, and legislation on key public health issues.

### 2. High HIV prevalence and low population

In these settings, programs should target specific localities where people at risk of HIV gather, such as stops along truck-routes and at community centers and shopping areas. Similarly, programs should focus on children whose parents are in especially vulnerable

| **KENYA**<br>**High prevalence and high population** | **INDIA**<br>**Low prevalence and high population** |
|---|---|
| In Kenya, FHI has pioneered an innovative approach to serving children and families made vulnerable by HIV. Known as Nuru Ya Jamii (or light of the family in Swahili), the approach is family-centered and child-focused: all members of a household are targeted with a comprehensive package of prevention, treatment, care, and support services. The goal is to reduce vulnerability of household members to new HIV infections, maximize access to treatment, and prevent or delay the incidence of orphaning. One key challenge faced has been training and sustaining community volunteers to the point that they can offer comprehensive services to the entire household. | FHI/India's Balasahyoga Program aims to improve the quality of life of children and families infected and affected by HIV. Not all children are tested for HIV; a targeted approach is used. Entry points into the program include enrolment via self-referrals and through key community gatekeepers, community care centers, and centers that provide counseling and testing and antiretroviral treatment. At the same time, the program follows a holistic approach to child development, with comprehensive strategies on nutrition, education, food security, psychosocial wellbeing, and health. Trained community case managers and community assistants provide routine care for families and actively link them to social welfare and livelihood support services. |
| **NAMIBIA**<br>**High prevalence and low population** | **GUYANA**<br>**Low prevalence and low population** |
| With HIV prevalence rates among pregnant women hovering between 17 and 21 percent over the past six years (according to the Ministry of Health and Social Services), virtually all Namibian children are considered vulnerable to HIV. Most government programs focus on primary-school children, as they are the easiest to reach. Based on a long history of social action, however, Namibia's churches and faith-based organizations have come to play a huge role in community mobilization, prevention, and care, especially in mobilizing volunteers to help PLHIV in the community or care for orphans left behind. The majority of orphans are teenagers, and they are also the most at risk for new infections. Many church groups also spearhead HIV-related youth programs and prevention sessions. Not all clergy are committed, however, and the linkage between care, treatment, and prevention sometimes poses difficult theological challenges. | Prior to 2004, Guyana had no HIV-related program for orphans and vulnerable children. Since then, donor targets for reaching vulnerable children have been surpassed. Children are reached through sites that offer HIV counseling and testing and services to prevent mother-to-child transmission of HIV. Other vulnerable children are reached through door-to-door outreach campaigns, community home and palliative care services, and self-identification. The main challenge is stigma and discrimination: people don't want to be seen entering buildings associated with HIV services. The best approach has been for volunteers and others to go people's homes in unmarked clothing and unmarked vehicles. Retaining volunteers has been a challenge, especially for local NGOs. |

groups, such as commercial sex workers, refugees, or migrant workers. The same approach may be used as in a high prevalence and high population setting, though it may be easier to work more intensively with each child. Strategies should also focus on maximizing access to available government services, including healthcare, education, and social welfare benefits.

### 3. Low HIV prevalence and high population

In these settings, the key focus is to minimize the spread of HIV among populations who are currently vulnerable. HIV prevention education and stigma reduction should be mainstreamed into all care and support activities, and targeted assistance should be directed to children and families already infected or

affected by HIV. Supportive government policies are critical. These should address underlying conditions and concentrate on training, early identification of symptoms, and testing and treatment.

### 4. Low prevalence and low population

In these settings, most attention should be focused on broad public health issues, community education, and supportive public policies. The alternative is to target services very carefully to those already infected or affected and to others who are considered at greatest risk.

## Four models of care and support programming

FHI has identified four models of child care and support programming to may help you to focus on your target group and approach: 1) the family-centered care model; 2) the comprehensive, child-focused model; 3) the single-service model, and 4) the alternative-placement model.[10] Of these, the first and second are most often recommended, as children are best able to cope with their own vulnerabilities when parents or adult caregivers are healthy and able to support them and multiple needs are addressed simultaneously. Alternative placement is a model of last resort, when all the other options fail.

*1. The family-centered care model*, the most preferred option, targets the needs of both adults and children in a family and attempts to meet their other social care needs, either directly or through strategic partnerships. For example, families affected by HIV (or another disease) need a range of services and support: health, nutrition, education, legal, and child protection services, along with shelter and economic, psychosocial, and spiritual support for the household. Depending on the context, the term "family" may mean the child's birth-family, the household where the child currently lives, or the child's extended family.

*2. The comprehensive, child-focused model* addresses multiple needs among highly vulnerable children, and very few interventions, if any, directly address the needs of adult caregivers. School-based and community-center programs generally take this approach. However, regular contact with family members is still critical to determine the children's needs and for follow-up support. This model generally does not separate orphaned or HIV-affected children from others, which helps to reduce stigma and discrimination.

*3. The single-service model* targets a specific gap in capacity or in the services available for orphaned and vulnerable children. Their need for free education is one example. Single-service programs tend to make a broad impact among many children, but they may fall short if there are underlying issues, such as hunger or child exploitation in the home. Even if the program can't meet all the child's needs, it should incorporate wherever possible a home assessment to determine if referrals to other community providers are indicated, with subsequent follow-up.

*4. The alternative-placement model* targets children living outside family care. Although this model represents a last resort for children (after efforts are made to promote care by relatives and foster care), it can provide short-term placements for children who are abandoned, have experienced abuse, have no family left, or present very severe disabilities with which their families cannot cope. FHI programs have embraced a range of strategic solutions to transition residential care to a safe, temporary solution for a few, rather than a permanent solution for too many.

### Ensure that children are cared for in the least restrictive environment possible

In many countries, national plans of action for orphans and vulnerable children almost always state that the institutionalization of children in orphanages or residential care should be a last resort. Notwithstanding, new orphanages and group homes are mushrooming, and their quality of care varies widely, at best.

Technical assistance may be required to ensure that children are cared for in the least restrictive environment possible. Help should be offered to the relevant government ministry to develop recommendations, implement new policies and procedures that minimize the number of institutionalized children, and ensure proper standards are upheld in orphanages and group homes. This may include—but should not be limited to—new regulations to properly screen children before their admission to orphanages, policies on family reunification, a renewed focus on alternatives to institutional care (such as foster care) and requirements for staff training and other quality-of-care standards. Once regulations are in place, a rigorous process must be implemented to communicate, monitor, and enforce the new policies and procedures around the country.

**Table 6. Comparing family care with institutional care**

| ISSUE | FAMILY CARE, INCLUDING FOSTER CARE AND KINSHIP CARE WITH RELATIVES | INSTITUTIONAL CARE (ORPHANAGES OR RESIDENTIAL CARE) |
|---|---|---|
| COMMITMENT BY CAREGIVERS | Family caregivers have a long-term perspective on children in their care. Caregiving is part of a network of inter-relationships. | Paid child minders turn over frequently, so children can't bond with them long-term. Most paid staff see children only on a short-term basis (a few hours a day and possibly for just a few weeks or months), so they remain disconnected from the long-term issues in children's lives. |
| SENSE OF BELONGING | Children remain connected to extended kin and the community and are helped to maintain their lineage and inheritance. | Children have little or no connection with extended kin and the community except through school. They are likely to lose their individual identities and inheritance. |
| ROUTINES AND RITUALS | Family rituals and routines, where individuals have culturally demarcated roles and responsibilities, help children to participate meaningfully in the family and society. | The routines and rituals of institutions often serve the institutions rather than the children, making it more difficult for former residents to adjust to life outside the institution. |
| CHILD ABUSE | Though most family care is excellent, vulnerable children in poorly chosen family care may be physically and sexually exploited or abused. | In many institutions, children experience neglect, exploitation, and physical and sexual abuse. Children are especially vulnerable in institutions with very few staff or high staff turnover. |
| ENVIRONMENT | Children are connected to their extended families, communities, and culture and are more likely to maintain their lineage and inheritance. They are familiar with cultural rituals and routines. | Connections to the surrounding environment and culture are limited, and children are more likely to lose their identity and inheritance. Routines and rituals often serve the institutions rather than the needs of the children. |
| NUMBERS SUPPORTED | The great majority of HIV-affected children are cared for and supported by relatives. | Only a small number of vulnerable children can be accommodated in institutions. |
| COST OF CARE | Families provide care for children at relatively low cost; small amounts of income-support for these families benefit the children. | Consistently, institutional care is far more expensive than family care. |

Programs should also promote family reunification wherever possible.

## Family and community care, rather than institutional care

In the developing world, orphans were traditionally taken in and looked after by their extended families, but orphanages have become more commonplace in recent times, as the number of orphans has skyrocketed due to war, famine, and the HIV pandemic.

Children raised in orphanages—also known as residential or institutional care—are separated from their families and communities, and this often results in unhealthy child development. Studies show that

the long-term institutionalization of children is generally counterproductive and that it should only be a very last resort.[11] When orphanages have to be considered—preferably on a short-term basis—the settings should mimic a family arrangement as far as possible—for example, a small-group cottage with its own house parents.

Resources that pay for institutional care for a single child can assist scores of children, if used effectively to support a community-based initiative. Funds used to build and run an orphanage could be spent fostering children with grandparents or other relatives and paying allowances to these caregivers. If no family members are able to take on this role, children can be fostered with non-relatives, but still in a family

setting. If older orphans would do better in towns where they can learn a trade, other living arrangements in the community should be identified—for example, in hostels or with host families.

Community-based family care differs from institutional care. While some residential-care settings aim to blend the two by incorporating some family-like features (for example, by assigning several children as "siblings" under one set of house parents in a separate cottage on the institution's grounds), many distinctions remain, as table 6 shows.

Admittedly, institutional care may be preferable, at least on a short-term basis, when children are at risk of abuse or there is no caregiver at home to look after a severely ill child. Even in these situations, all other viable options should be explored first. If a child must be institutionalized, it is best to minimize the length of stay. If suitable family members can't be found to take in the child, a transfer should be made to alternative forms of care, such as foster care, adoption, or a small group home.

## Including children with special needs

Practitioners providing input for this manual highlighted three situations that often require special planning and additional support: 1) child-headed or youth-headed households; 2) children with disabilities and children living with HIV; and 3) children who have been recruited as a child soldiers or have experienced trafficking, forced migration, or abuse.

To ensure that these groups of children are not left out and not institutionalized unnecessarily, the practitioners recommended that supplemental efforts be undertaken to support children in these groups. Although their special challenges could require

### A Story by Cathy Majtenyi

It is lunchtime for the Kametis. Agnes Nzembi and her four grandchildren exchange stories of the day. They live in Nyumbani Village near the eastern Kenyan town of Kitui. But this is a different kind of village.

The Kametis and 28 other households are run by an elderly grandparent. The grandparent takes care of up to 11 children. Some of the youngsters are their biological grandchildren. The rest are children from other families. Kavata Kameti says she enjoys living with her grandmother, "She tells me about our forefathers and things that happened in the past. Also she tells me about how to live a good life," she said.

All the young people in the village have one thing in common. Their low-income parents died of HIV/AIDS, turning them destitute and into orphans.

Sister Mary Owens, co-founder of Nyumbani Village, says the village grew out of a concern for the welfare of AIDS orphans and their elderly caregivers.

"These are two lost generations, because the grandparents have been left behind by their children, and the children have been left behind by their parents," she said. "So there is a need to reach out to these grandparents. Secondly, this idea of trying to give these children as close experience of family as possible, we thought that the grandparents could do that, because they can hand out the values, they can share the culture, and they can guide."

During the day, the children attend primary school in the village. When they are not studying, they work in the garden, cook, and do other chores.Sister Owens says Nyumbani Village aims to be self-sustaining by growing its own food, cultivating income-generating plants such as castor and jatropha, creating its own water supply, and providing services to its residents.

"In a village, you have services, and we knew that if we could set up services like education and medical services at the clinic, and a polytechnic, then those services would be very accessible to the children," she said.

For grandmother Agnes Nzembi, living in Nyumbani is a dream come true. "Before this, we were living in poverty," she said. She says she is teaching her grandchildren to be responsible now so they will be responsible adults later.[12]

another manual, it needs to be emphasized that these children have the same rights and similar core needs, concerns, and dreams as every other child, and efforts should be undertaken to include them in your programming to the extent possible.

### Child- and youth-headed households

Only a few years ago, the term "child-headed household" was virtually unknown, but such households, headed by a child 18 and under, are now almost

## Child and youth-headed households

There are child-headed households in many parts of the world affected by disease or war. Sometimes, a household is child-headed because the adult in the house is frail, ill, or severely disabled. In these households, it is usually the eldest child (or the eldest girl-child) who takes on the responsibilities traditionally borne by parents. These households face a wide range of challenges related to poverty, education, and psychological distress. Foster care is often seen as a better alternative, but it should be pursued only if it is in the best interest of the children. Wherever possible, siblings should be kept together, not separated.

Many people feel that child-headed households are evidence that the extended family system is collapsing and failing to cope. While it is generally true that members of extended families are unable to take children into their own homes (most often because they are too poor themselves), most child-headed households continue to receive some support, albeit sporadically, from extended family members. Child and youth-headed households can also be assisted by a variety of other support mechanisms, including regular visits by community volunteers, modest levels of material support, assistance with health-related and educational needs (including with attending school), government cash-transfer grants, psychosocial support programs, and training in effective parenting.

commonplace in some communities. Even more prevalent are homes headed by youth ages 18–25 who shoulder such weighty responsibilities that they are unable to concentrate on their own lives and future plans. Coupled with extreme poverty and a lack of parental guidance, children living in child- and youth-headed households are at high risk of early pregnancy and marriage, sexually transmitted diseases including HIV, exploitation, juvenile delinquency, and other self-destructive behaviors.

One might then ask, "Wouldn't the children in these households be better off in an orphanage? For most, the answer is no. A study by Monica Ruiz-Casares found that most children without adult caregivers want to remain in their homes and in their communities, where their memories are intact.[13] Evidence that this is so was provided by a 14-year-old head of a household in rural Tanzania who asked Lucy Steinitz, "Do you want to meet my parents?" then took her to two graves at the back of the hut. The young woman explained, "I come here every day to visit. We spend time together and I talk to them."

Child- and youth-headed households rely heavily for guidance and support on their social networks—neighbors, distant relatives, caring community members, traditional and religious leaders, local volunteers, NGO representatives, and teachers.[14] To help, you can provide targeted training and follow-up support on how to manage a household and care for younger siblings and how to determine where and how to ask for outside assistance. This can make an enormous difference. But without this additional support, most child-headed households can't survive, and the children living in them are likely to end up exploited by others or living on the street.

### Children with disabilities

Children with disabilities (sometimes called children with special needs) are often forgotten or hidden from view, largely because of feelings of shame, mistaken beliefs that they are bewitched, or other superstitions. Disabilities vary in the degree to which they impede a child's normal functioning, if they do at all; they may be physical, developmental, psychological, or a combination thereof. In the developing world, children with learning disabilities and children who are slow learners or live with other more subtle forms of disability often get overlooked, given the prevalence of poverty, overcrowded classrooms, health constraints, shortages of experienced teachers, lack of teaching materials, and low school expectations.

All children with disabilities have one thing in common. Although the amount of additional care they require may vary, they all need more support than other children do, at least for some period in their lives. In addition to accepting and loving these children, family and community members should be trained on ways to build on their strengths and abilities—to focus on what they can do, rather than on what they can't.

Organizations that serve vulnerable children and youth—even if they don't themselves focus on disabilities—should be familiar with local services available for people with disabilities so they can link children to these services whenever the need arises.

## Input from children on a guide for child- and youth-headed households

In Namibia, during the planning process for a guide for child- and youth-headed households, children and youth suggested the following modules: Caring for Younger Siblings and Yourself; Being Smart about Money Matters and the Things You Own; and Building Helpful Community Relationships.[15]

## Some facts about children living with HIV

Many countries that had previously seen child survival rates rise as a result of improved healthcare are now seeing these rates fall due to HIV. Most children with HIV live in sub-Saharan Africa, but large numbers also live in the Caribbean, Latin America, and Asia. At the end of 2007, there were 2 million children living with HIV around the world.

An estimated 370,000 children became infected that year, most as a result of mother-to-child transmission. Children are also at risk for HIV through early unprotected sex, sexual abuse, and child prostitution. Every hour, at least 31 children die from AIDS-related illnesses.[16]

Working in collaboration with special schools, support groups, NGOs, and government ministries, individual family and community members can also be mobilized to participate in community action, support services, and advocacy for the rights of all children with special needs.

### Children living with HIV

HIV-positive children contend with all the stresses of children whose family member or close relative is living with HIV or has died of AIDS-related illnesses, as well as facing their own health-related issues, stigma, and psychosocial challenges.

The main way to stop children becoming infected is to prevent mother-to-child transmission. This is almost entirely avoidable by giving antiretroviral drugs to HIV-positive pregnant women and to their newborn babies and ensuring safe infant feeding. However, the services that prevent mother-to-child transmission reach only 33 percent of HIV-infected pregnant women in resource-poor countries.[17]

The integration of prevention education constitutes an important dimension of any program that provides care and assistance for vulnerable children and youth. To minimize new infections, children must also be protected from physical violence and child sexual abuse, from unsafe (unprotected) sex, and from intravenous drug use.

Death from AIDS-related illnesses among children can usually be prevented with proper care and antiretroviral treatment, but an estimated 90 percent of children who could benefit from this therapy are not yet receiving it.[18] As with other programs that aim to serve children, the whole family should be targeted for treatment and support to ensure success. Although there is a high risk of death in the first year of life for infants infected perinatally, be aware that

undiagnosed children may live with asymptomatic HIV infection for long periods. Even so, the World Health Organization recommends that all children with HIV should be placed on antiretroviral therapy as soon as possible after diagnosis. Because of this, counseling and testing for HIV are critical services for all children considered at risk for infection.

If your organization does not provide treatment services, you should establish linkages with counseling and testing centers and healthcare facilities to which you can refer children and family members. Local organizations can also collaborate with health facilities by implementing community-based interventions that promote health-seeking behaviors and adherence to treatment. This manual does not cover clinical treatment, but it lists several websites and other sources that provide more information.

Good literature can be found to help practitioners working on issues of disclosure, treatment, and support. Disclosure—explaining that the child or another family member is HIV-positive—is particularly sensitive but absolutely critical in order to maximize acceptance, adherence to treatment, and a healthy lifestyle. One useful resource is FHI/India's *Protocol for Child Counseling on HIV Testing, Disclosure and Support*.[19] Another is *Kids ART Education Series: The Children's Treatment*

## How you can assist children with disabilities

Providing training to family members and volunteers on the care and support of children with disabilities involves experiential exercises, the active participation of persons with disabilities, and references to relevant cultural or religious traditions that accord respect and acceptance to people with disabilities.

Children and youth with disabilities have the right to be educated and need to be treated in the same way as other children, although they may need some additional support to participate to their maximum ability. Special attention may also be required to identify and pursue vocational opportunities so that these children can become as independent and self-supporting as possible when they are adults.

To promote independence, encourage parents and caregivers to allow disabled children to learn to help themselves and struggle to do things, even if it would be faster for someone else to do them. Also encourage parents, caregivers, and siblings to allow disabled children to play with other children. They will benefit from learning about tolerance, helpfulness, and respect for others, as will neighbors and friends who help a disabled child by making aids such as crutches or special toys.

*Literacy Toolkit* from SAfAIDS,[20] which contains a board game and quiz sheets, an adherence calendar, advocacy stickers, information on TB co-infection, and informative and attractive booklets. The recommended reading list and appendix 1 contain references to additional information and training materials that address HIV-positive children and their caregivers.

## Recommended readings and toolkits

■  Family Health International/Cambodia, *Helping My Child Stay Healthy: For Carers of HIV Positive Children,* 2009.
This publication provides information on the special needs of HIV-positive children, suggests ways to involve them in their own care, and includes practical suggestions for health-facility and home-based care teams who work with children, regardless of HIV status. www.fhi.org/en/Topics/Orphans+and+Other+Vulnerable +Children+topic+page.htm

■  Family Health International/Cambodia, *Playgroup Resource Book*, 2009.
This publication provides guidance to implementing agencies and community care assistants on how to run playgroups for orphans and vulnerable children as well as other children. www.fhi.org/en/Topics/Orphans+and+ Other+Vulnerable+Children+topic+page.htm

■  Family Health International/Cambodia, *What Can I Do if I Think My Child Has HIV?,* 2009.
This publication provides suggestions about ways to talk to HIV-positive children about HIV and involve them in their own care. It also encourages parents to visit a voluntary counseling and testing clinic with their children. www.fhi.org/en/Topics/Orphans+and+Other+Vulnerable +Children+topic+page.htm

■  Family Health International/India, *Protocol for Child Counseling on HIV Testing, Disclosure and Support*, 2007.
This protocol was developed for 30 USAID-funded IMPACT projects in India to provide guidance on counseling children and their parents or guardians about HIV and AIDS. It embraces a holistic approach and considers the disease as one among many other issues in a child's life. www.fhi.org/en/CountryProfiles/India/ indiatools.htm

■  Guyana HIV/AIDS Reduction and Prevention (GHARP) Project. *Counseling Children Manual. Working Document,* 2008.
This manual developed by FHI in Guyana includes learning aids and guides facilitators of a one-week training program with five modules and 23 sessions. The training addresses the stages of personality and child development, including children's social/emotional, intellectual/cognitive, psychomotor, and spiritual development.

■  Aini N. Hoaeb and Aune S. Iiyambula with Lucy Y. Steinitz, *Our Home Is Where the Heart Is: A Young Homemakers' Guide,* 2008.
This resource targets child-headed and youth-headed households in Namibia. www.yelula.com/resources.htm

■  HelpAge International. *Salt, Soap and Shoes for School. Evaluation Summary: The Impact of Pensions on the Lives of Older People and Grandchildren in the KwaWazee Project in Tanzania's Kagera Region,* 2008.
This evaluation summary offers a detailed analysis of how the welfare of Africa's aged population is closely intertwined with the survival and wellbeing of vulnerable children and impoverished orphans and provides recommendations. www.helpage.org/Resources/ Policyreports#n54d

■  Horizons Project/ Population Council, *Psychosocial Benefits of a Mentoring Program for Youth-headed Households in Rwanda,* 2007.
This quasi-experimental study showed that mentoring from adults can measurably mitigate adverse psychosocial outcomes among youth-headed households. www.popcouncil.org/horizons/projects/Rwanda_ PsychOVC.htm

■  Vinod Mishra and Simona Bignami-Van Assche, *Orphans and Vulnerable Children in High HIV Prevalence Countries in sub-Saharan Africa,* 2008.
This source contains comparative data based on in-depth, in-country surveys. http://pdf.usaid.gov/ pdf_docs/PNADM647.pdf

■  Sara Liane Nam et al., "Discussing matters of sexual health with children: What issues relating to disclosure of parental HIV status reveal," *AIDS Care,* 2009. http://dx.doi.org/10.1080/09540120802270276

■  SAfAIDS, *Kids ART Education Series: The Children's Treatment Literacy Toolkit,* 2008.
A fantastic resource and a set of excellent tools, with practical exercises and activities for HIV-positive children and their caregivers. www.safaids.net/?q=node/520.

■  Southern Africa AIDS Trust, *Guidelines for Counselling Children Who Are Infected with HIV or Affected by HIV and AIDS,* 2003.
An excellent and very practical old standby. www.satregional.org/content/publications_en.html

# 3. Core Services for Children and Families

Now that you have taken into account a range of underlying principles and alternate models of care (II, chapters 1, 2), you need to begin to consider what types of services or core service areas you want to incorporate in the design of your programs for children and families. Several core service areas have been variously defined in legislation relating to the US President's Emergency Plan for AIDS Relief (PEPFAR) and by other entities.

PEPFAR outlines seven core services for children that, taken together, address all of a child's basic needs. However, don't get stuck on the number; other donors also configure the range of services somewhat differently. In addition, various countries have developed national plans of action for vulnerable children that combine two or more of these services, and some add an additional one, namely the "coordination of services." Also, don't get stuck on the fact that the descriptions related to these core service areas focus on HIV. Although PEPFAR promotes this focus, the service descriptions are applicable in other situations.

Although you should consider all of these service areas in designing your program, it isn't necessary that every organization or every program provide all or even most of these services on its own. You should try to develop a good referral network so that different organizations and providers can supplement each other's support, depending on a child's needs. In addition, interventions may occur directly with the child and that child's caregivers, or at a community or systems' level. This may require the promotion of additional support on a broader scale with provincial or national policymakers, perhaps via legislation or new regulations. Similarly, you can try to mobilize the private sector, faith-based organizations, or traditional leaders (and others) to increase their involvement and support for vulnerable children and their families.

## PEPFAR's core service areas

For the programs for orphans and vulnerable children that it funds, PEPFAR defines seven core service areas that take into account the needs of a whole child: 1) food and nutrition support; 2) shelter and care; 3) protection; 4) healthcare; 5) psychosocial support; 6) education and vocational training; and 7) economic strengthening. You can use these service areas as a guideline for planning and improving your programs. The services should be provided in accordance with



Education and Vocational Training

Protection

Shelter and Care

Healthcare

Food and Nutrition Support

Economic Strengthening

Psychosocial Support
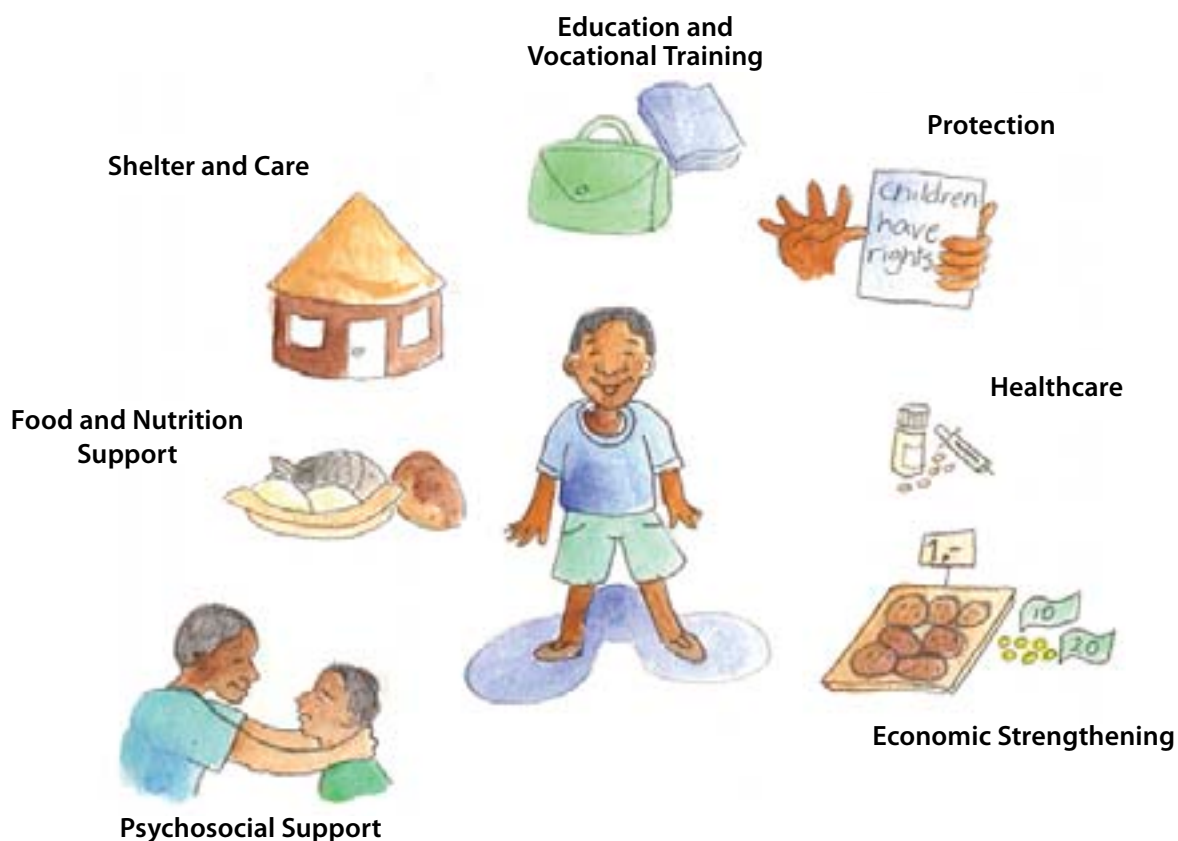
**Should your organization try to provide all seven core services?**

Your organization does not have to provide all seven core services. Rather, select one or more after you assess the services currently available in the community, the most urgent needs of vulnerable children, and your organization's strengths and capacity. Once you have assessed these factors and decided on the type and level of your interventions (whether through direct provision of care or referral and community mobilization), you should partner with other service providers to ensure that vulnerable children and their families have a network of comprehensive support. Chapter 5 in this section provides more information on conducting a community assessment and involving other key stakeholders.

the assessed needs of the child or children, within the context of their families and communities.

*1. Food and nutrition* services aim to ensure that vulnerable children have food resources and that their nutritional status is similar to that of other children in their communities. This should be conceived as a time-limited strategy, and your program should aim to leverage other partners and identify more sustainable solutions. The following range of services might be included at different levels:

- *child*—nutritional assessment and counseling; therapeutic and supplementary feeding; links to other health and nutrition interventions for treatment of moderate and acute malnutrition

- *caregiver/family*—assessment of nutritional status of adult PLHIV; therapeutic and supplemental feeding; training on nutrition, diet, and food preparation; food security interventions

- *community*—community-based food security and nutrition strategies to support vulnerable children, including gardens and feeding programs

- *system*—policy development; regional and national coordination; technical assistance to the food industry; availability and supply-chain management of ready-to-use therapeutic foods; advocacy

**Assistance for food-insecure families and malnourished children**

Some organizations partner with the World Food Programme to help deliver food packages to food-insecure households. Special ready-to-use foods (such as Plumpy'Nut) are used as treatment for moderate and severe malnutrition.

*2. Shelter and care* services have the desired outcomes of ensuring that no child goes without shelter, clothing, access to clean water and basic personal hygiene, and at least one adult who provides love and support. The following range of services might be included at different levels:

- *child*—identification of potential caregivers prior to the death of a parent; reintegration of children in institutional care; transitional care; support for child-headed households

- *caregiver/family*—assistance with reunification to take children off the street; referrals to programs that provide incentives for adoption; foster care

- *community*—support of family-based care with home visits and other strategies; development of innovative community alternatives when family-based care is not an option

- *system*—policy development; regional and national coordination; education; anti-stigma efforts; and monitoring of institutional care

*3. Protection* services have the desired outcomes of reducing stigma and social neglect, ensuring children have access to basic rights and services, and protecting them from abuse and exploitation. The following range of services might be included at different levels:

- *child*—assistance with birth registration and inheritance claims; prevention of sibling separations; removal of children from abusive situations and assistance to help them recover from abuse; prevention of forced migration and trafficking

- *caregiver/family*—support with parenting and caregiving responsibilities; assistance with access to services

- *community*—support for child protection committees; training of community members to identify and assist children who need assistance

**Organizational child-protection policies and activities**

Child protection has received insufficient attention from many organizations. Unwittingly, some programs may increase the risk of physical harm and abuse, such as when they require children to walk long distances to attend evening activities.

Organizations should be encouraged to consider adopting a policy that increases their own awareness of child protection and improves their support for it. The very practical system developed by FHI/Cambodia for preventing, monitoring, and responding to abuse is included among recommended resources at the end of this chapter.

**PEPFAR recommendations on key health interventions for vulnerable children**

In general, programs should facilitate access to primary healthcare for orphans and vulnerable children and take active measures to meet the general health needs of children of all ages. [21] Needs differ significantly at different stages of a child's development (I, chapter 3), and interventions must be tailored to the age of the child.

Provision of HIV-related healthcare for HIV-exposed or HIV-infected infants is a high priority because over 50 percent of children born HIV-positive die within the first two years if they do not obtain appropriate treatment. Programs should ensure timely access to appropriate ART through referrals to services that reduce mother-to-child transmission and services that provide pediatric ART and palliative care. Community volunteers and home-based care teams need to be trained to identify danger signs in HIV-exposed and HIV-positive children so they know when to make referrals. Home-based care teams should also be trained to reinforce correct infant feeding, provide home-based care for minor opportunistic infections, and support cotrimoxazole and ART adherence for children and adolescents.

Prevention of HIV is a priority intervention in regions where the risk of infection is high. Programs should provide age-appropriate prevention activities for children, including services that prevent mother-to-child transmission of HIV and behavior change communication that is targeted to appropriate age groups.

- *system*—legal and policy development; advocacy campaigns to support laws and values that protect children.

**4. Healthcare** services have the desired outcomes of meeting the health needs of HIV-negative as well as HIV-positive children and providing primary healthcare, immunization, treatment of illnesses, ongoing palliative care, and HIV prevention services. The following might be included at different levels:

- *child*—home visits; enrollment in HIV care and treatment services; access to integrated primary healthcare services

- *caregiver/family*—training of caregivers in preventing diseases, monitoring health, and seeking appropriate care; involvement of caretakers in HIV-prevention education

- *community*—training of HIV-care providers, including community volunteers and home-based care teams, in how to refer children for health and social services

- *system*—policy development to ensure access and a service delivery model that meets the needs of vulnerable children

**5. Psychosocial support** services include supporting the spiritual needs of children. Their desired outcomes include ensuring that children have the human attachments necessary for normal development and can participate cooperatively with other children and adults in all kinds of activities. The following range of services might be included at different levels:

- *child*—counseling; support in dealing with anxiety, grief, and trauma related to parental illness and death; services to prevent and treat alcohol and drug abuse and rehabilitation for children who abuse drugs and alcohol; activities that support life skills and self-esteem; activities that strengthen the connection between the child and traditional social networks

- *caregiver/family*—parenting and communication skills; support during illness, such as assistance with disclosure of information, grief management, succession planning, and preservation of memories; assistance for caregivers coping with stigma and discrimination

- *community*—services that increase community understanding of the psychosocial needs of vulnerable children; activities that lead to the reduction of stigma and discrimination

- *system*—support for laws and policies that lead to national social welfare and care management systems for vulnerable children, including trained child counselors; provision of trained counselors

within schools to identify at-risk children in need of psychosocial support

*6. Education and vocational training* services have the desired outcome of ensuring that vulnerable children receive educational and vocational opportunities that correspond with community norms and market-driven employment options. The following range of services might be included at different levels:

- *child*—school registration initiatives; direct assistance to subsidize school costs; creation of early childhood development programs; access to vocational training and employment;

- *caregiver/family*—training of health providers and caregivers to identify and refer children who are not in the educational system; anti-stigma campaigns

- *community*—community mobilization and advocacy related to increasing access and developing appropriate curricula (introduction of life skills and job skills)

- *system*—support services such as fee-waivers, referral to psychosocial support, and tutoring

*7. Livelihood or economic strengthening* services have the desired outcome that families are able meet their own material needs, in spite of changes in the family situation due to HIV. Such services can include helping families to obtain more efficient cooking stoves or improved water-collection devices that reduce the strain on children and caregivers, especially those who are elderly or frail. The following range of services might be included at different levels:

- *child and caregiver/family*—vocational training for caregivers; income-generating activities; labor-saving devices; access to credit

- *community*—community-based child care and asset-building

- *system*—government-supported guarantees for income-generating activities and microfinance institutions

Note that some analysts add coordination of care as an eighth service. Others say that activities related to prevention and sustainability—the empowerment of families to function without ongoing support—should be integrated with other services whenever opportunities arise.

## Addressing cross-cutting issues in program planning

Much has been learned worldwide on how best to structure and deliver essential services to children and families in need. While each context is unique,

programs can build upon common elements to ensure strong systems and high-quality services.

FHI's checklist of cross-cutting issues for all affiliated programs (table 7) may be helpful to organizations engaged in planning, training for field-visits, and in monitoring and evaluation. It supplements FHI's Standards of Care (III, chapter 5).

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**If there is no social worker in your village, find another grown-up who can help— maybe from the Village Welfare Committee or OVC Forum, or a teacher at your school.**

Petrina, 14

## Recommended readings and toolkits

- Lorraine Blank and Sudhanshu Handa, *Social Protection in Eastern and Southern Africa: A Framework and Strategy,* 2008.
A report for UNICEF that suggests that well designed and fairly distributed social-welfare protection schemes may make a positive difference on a broad scale. www.unicef.org/socialpolicy/index_45350.html

- Family Health International/Cambodia, *Child Protection Policy & Procedures,* 2007.
This detailed child protection policy outlines procedures for preventing and responding to child abuse, both within FHI/Cambodia and the communities with which it works. The policy is accompanied by a training manual and tools to guide implementation of the policy. www.fhi.org/en/HIVAIDS/pub/res_ChildProtectionPolicy.htm

- Geoff Foster, *Bottlenecks and Drip-feeds: Channeling Resources to Communities Responding to Orphans and Vulnerable Children in Southern Africa,* 2005.
This briefing document by Save the Children/UK identifies bottlenecks affecting the flow of funds to support community initiatives. It states that current mechanisms do not allow for resource flows to community-based organizations. Donors and governments do not take the provision of such resources seriously and are not held accountable for spending to support community initiatives. www.hsrc.ac.za/Document-2179.phtml

- International HIV Alliance, *Expanding Community-based Support for Orphans and Vulnerable Children,* 2002.
This publication includes case studies and addresses topics such as support for community-based

**Table 7. Checklist of cross-cutting issues for implementing partners working with children**

| SAFETY |
|---|
| • All new clients and staff are made aware of the child-protection policy and procedures of the organization or country. <br> • Areas used for project activities are safe for children and youth (non hazardous, well-lit, guarded). |

| PARTICIPATION |
|---|
| • Beneficiaries (PLHIV and/or vulnerable children and youth) are involved in the design and monitoring of activities that affect them. <br> • Children, youth, and their families are involved in decisions about their individual care to the greatest extent possible. |

| CONFIDENTIALITY |
|---|
| • The child's and family's right to privacy is protected. Appropriate confidentiality is maintained when information is released to others, especially relating (but not limited to) sensitive topics, including HIV status, sexuality, sexual orientation, and abuse. <br> • Documents containing information about health and HIV status are kept in a secure place in the organization's main office and are shared only to serve the best interests of the child. |

| EQUITY |
|---|
| • Girls served by the organization are ensured equal status with boys. <br> • The organization is responsive to the needs of children across the age span, including and especially those often missed by programs: the youngest (ages 0–5) and oldest (ages 14 and over). <br> • All children and youth within client households have the opportunity to benefit from the program according to need. |

| COMMUNITY OWNERSHIP |
|---|
| • Proposed interventions build on existing community structures, thereby enabling the community to benefit in the long-term, not just during the activity period. <br> • Community members are actively encouraged to share in planning and implementation. They have input in decisions about the organizations' services that provide care and support for vulnerable children and youth. |

| COST EFFICIENCY |
|---|
| • Costs are carefully monitored to ensure that the maximum number of children who are in need benefit from resources available, but within the context of quality standards. |

| CULTURAL SENSITIVITY |
|---|
| • Programs respect and are appropriate to the diverse social and cultural contexts of local communities. |

organizations and NGOs involved in community responses and the creation of an enabling environment for scale-up. www.ovcsupport.net/graphics/OVC/documents/cp/0000900e00.pdf

■ Florence Nyangara, Tonya R. Thurman, Paul Hutchinson, and Walter Obiero, *Effects of Programs Supporting Orphans and Vulnerable Children: Key Findings, Emerging Issues, and Future Directions from Evaluations of Four Projects in Kenya and Tanzania,* 2009.
This report summarizes key findings from a MEASURE evaluation of the results and cost-effectiveness of interventions in Kenya and Tanzania to improve the wellbeing of orphans and vulnerable children and their families. The study may have broad implications for the

quality of care for children in East Africa and beyond. www.cpc.unc.edu/measure/publications

■ UNICEF, *Africa's Orphaned Generations,* 2003
This seminal study compares different countries, but offers common recommendations for policymakers, donors, and local organizations and communities. The statistics have changed—largely they have gotten worse—but the issues have not. http://unicef.org/africas_orphans.pdf

■ UNICEF, *The Evidence Base for Programming for Children Affected by HIV/AIDS In Low Prevalence and Concentrated Epidemic Countries,* 2008.
The evidence-base is spotty for programming for HIV-affected children in countries with low prevalence and

concentrated epidemics. In general, stigma is greater in low-prevalence countries than in countries with high HIV prevalence. www.unicef.org/aids/files/OVC_final.pdf

■ UNICEF, *The Impact of Social Cash Transfers on Children Affected by HIV and AIDS: Evidence from Zambia, Malawi and South Africa*, 2007.
This detailed analysis demonstrates that appropriately designed, social cash-transfer schemes in low-income African countries with high HIV prevalence can reach approximately 80 per cent of HIV-affected households that urgently require social welfare interventions, even without using HIV and AIDS as targeting criteria. www.unicef.org/publications/index.html

■ World Health Organization and UNICEF, *Scale Up of HIV-related Prevention, Diagnosis, Care and Treatment for Infants and Children: A Programming Framework,* 2008.
Despite documented progress in the ability to deliver high-quality care to children living with HIV, national responses are limited in many resource-constrained settings. This working document identifies seven strategies that are key to scaling up national responses. www.unicef.org/aids/files/OMS_PAEDS_Programming_Frameworks_WEB.pdf

■ World Vision, *Research Results from Child-focused, Faith- and Community-based Responses to HIV*, 2008.
This report presents research findings from Uganda and Zambia on the operation of World Vision's main project models that respond to HIV and AIDS in higher prevalence contexts. It includes research abstracts on other innovative program approaches and World Vision research around the world. www.worldvision.org

■ Miriam Zoll, *Integrated Health Care Delivery Systems for Families and Children Impacted by HIV/ AIDS: Four Program Case Studies from Kenya and Rwanda,* 2008.
www.jlica.org/resources/publications.php

In addition, check out the websites listed in appendix 1, including www.aed.org; www.cabsa.org.za; www.pact-world.org; www.pronutrition.org; and www.taskforce.org

# 4. Laying the Groundwork



To determine the needs of vulnerable children and their families in a given geographic area and develop realistic, effective, and feasible interventions, begin with a situation analysis. This will give you a deeper understanding on where and how to focus your support and help you determine what other resources are available in the community that can supplement your efforts.

A situation analysis builds on what you already know and incorporates new information, stakeholder input, updated environmental trends, and additional issues relevant to the work you want to do. If a situational analysis was recently completed by your organization or a similar one, there is no need to repeat the process. Focus instead on important updates or gaps in knowledge.

Once you have identified unmet needs through your situation analysis, it may also be necessary to conduct an organizational assessment to determine the interventions that best fit your organization and the challenges it faces. These two processes—a situation analysis and an organizational assessment—are discussed in this chapter.

## Conducting a situation analysis

A situation analysis is a process of gathering and analyzing information to guide planning and mobilize action. In the context of children and families affected by HIV (or any other life-threatening condition), a situation analysis involves gathering information about the epidemic, its consequences, coping responses of households and communities, and relevant policies and programs.[22]

A situation analysis should be collaborative and engage all key stakeholders, including government ministries, NGOs, international aid organizations, faith-based organizations, the public and private sectors, community groups, families, and children. The results guide the identification of geographic and programmatic priorities, as well as the development of sound and shared recommendations.

### Sample questions to ask during a situation analysis

The following questions ask about the biggest unmet needs in a community and what might be done to improve the situation.[23] You can change these questions or add new ones.

1. What do you see as the biggest problem facing this community?
2. What do you think is the main cause of this problem?
3. As you see it, what effect has this problem had on the community?
4. Specifically, how does this problem affect you and your family?
5. To what extent, if any, do you think HIV and AIDS makes this problem worse?
6. What do you think a local NGO can do to improve this situation?
7. Can you make some suggestions about how this improvement should be done?
8. What more could you personally do to help your community deal with problems caused by HIV and AIDS?

| FIG. 4. ELEMENTS OF A SITUATION ANALYSIS | | | | |
|---|---|---|---|---|
| | | INFORMATION GATHERING | | |
| | PLANNING | National Level | Local Level | ANALYSIS |
| **ACTIVITIES** | • Engage all key actors<br>• Define<br> o objectives<br> o technical scope<br> o geographic coverage<br> o process and participation<br> o skills needed<br> o budget(s) | Collect and review existing<br>• reports and other documents<br>• statistics<br>• programs<br>• interviews of key informants | • Collect reports and statistical information.<br>• Carry out focus group discussions in priority areas.<br>• Interview key informants. | • Identify<br> o most urgent problems<br> o causes<br> o local responses, coping strategies, and capacities<br> o key aspects of context<br>• Identify potential intervention strategies and measures. |
| **OUTPUTS** | A written plan that includes responsibilities of each participating body, with a line item budget. | • A full overview of<br> o problems<br> o context of problems<br> o local responses, coping strategies, and capacities<br> o relevant laws and policies<br> o relevant services<br>• Initial mapping of<br> o most seriously affected populations<br> o service areas of existing programs | • In-depth understanding of<br> o problems<br> o context of problems<br> o coping strategies<br> o current and potential programmatic action<br> o relevant laws and policies<br> o services<br>• Refined information on coverage of existing services. | Report containing<br>• overview of problems<br>• identification of priority issues, capacities, and resources<br>• identification of key intervention points<br>• recommendations for action<br>• key information and sources for ongoing monitoring |

From J. Williamson, *What can we do to make a difference? Situation analysis concerning children and families affected by AIDS* (draft), Oct. 2008.

A situation analysis differs from other types of needs assessments. Generally, a needs assessment is narrower in scope; it focuses primarily on existing problems and what needs to be added or scaled up in order to address them. By contrast, a situation analysis identifies priority issues within the context of a complex environment. It also considers the underlying dynamics, with a broad view toward identifying potential points of intervention. Thus, with a situation analysis you are more likely to deal with the causes of current problems, not just immediate needs or symptoms. Additionally, a situation analysis focuses on capacities. It identifies not only current policies and relevant services, but also current and potential stakeholders.

A situation analysis can be undertaken at different levels: in a community, district, state, or province, or on a national or regional basis (fig. 4).

**What if the government doesn't want to cooperate or places restrictions on your activities?**

Sometimes in-country laws, policies, attitudes, and conflicts can make it difficult for civil society to foster a high level of collaboration and mutual support. In these cases, you must think creatively and do the best you can.

Work closely with other organizations that seem to have maintained good linkages. Be extra sensitive to local culture and protocol and build on existing relationships, wherever possible. Aim to find common values and issues of mutual interest. Reframe some of your terminology if needed, so long as you don't seriously compromise the integrity of your program. Never employ illegal methods or even leave the impression that you have done so. You could create lasting damage to your program and hurt the children you most want to help.

## An organizational assessment

While a situational analysis will give you a good picture of problems and opportunities in a community, province, or country, an organizational assessment will let you know how effectively you will be able respond to these problems and opportunities. The assessment will appraise the strengths and weaknesses within your organization, as well its resources and capabilities—the know-how and experience of the people involved in your organization or community. In-kind resources such as office space, transport, food, and volunteers' time are included in the assessment.

### A SWOT analysis

The most common way to conduct an organizational assessment is to undertake concurrently an analysis of *s*trengths, *w*eaknesses, *o*pportunities, and threats—a SWOT analysis—which looks at the external and internal issues that are affecting your organization. However, the discussion should remain focused on your organization, not on any other organization or the wider community.

One of the easiest ways to undertake a SWOT analysis is to ask your stakeholders to first identify the internal strengths and weaknesses of the organization, and then the external opportunities and threats that they see. The stakeholders you involve should be selected carefully. They can include (but need not be limited

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**Sample questions to ask during a situation analysis**

The following questions ask about the biggest unmet needs in a community and what might be done to improve the situation.[23] You can change these questions or add new ones.

- What do you see as the biggest problem facing this community?

- What do you think is the main cause of this problem?

- As you see it, what effect has this problem had on the community?

- Specifically, how does this problem affect you and your family?

- To what extent, if any, do you think HIV and AIDS makes this problem worse?

- What do you think a local NGO can do to improve this situation?

- Can you make some suggestions about how this improvement should be done?

- What more could you personally do to help your community deal with problems caused by HIV and AIDS?

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The following are important considerations for a situation analysis:

- ■ *Protect children:* When gathering information from children, be sure to uphold the ethical standards for the protection of a child's rights (I, chapter 5).

- ■ *Ensure a collaborative process:* Ensure that the process is broadly inclusive and highly participatory so as to promote stakeholder understanding and create a sense of ownership of the process and its results.

- ■ *Access existing knowledge and resources:* Capitalize on existing resources within the community before seeking additional resources. For example, make use of available data, reports, and mapping exercises.

- ■ *Take a multisectoral approach:* HIV affects all sectors in a society. It is therefore critical to involve key individuals from all sectors (including health, education, labor, social welfare, faith-based institutions, and business) to help determine a comprehensive response.

- ■ *Enhance capacity:* Use the process to build local capacity, including the knowledge and skills of the local people (IV, chapter 1).

- ■ *Maintain joint ownership:* Ensure that all stakeholders—including children—have an opportunity to participate in the process and share ownership

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**Involvement of key stakeholders**

For insight and long-term support, involve all key stakeholders in the community in your planning process. Consider putting some people directly onto your strategic planning team and involving others through background interviews, focus-group discussions, and house-to-house surveys. To make sure that you don't miss any critical input, you should involve a broad spectrum of community representatives. Sometimes you will want to include an elected official or an individual known to you, but it will be sufficient at other times to have group representatives.

Groups to consider include religious, political, cultural, and traditional leaders; NGO "gatekeepers" from other organizations; influential community members, such as musicians, athletes, spokespersons, business leaders, and media representatives; volunteers and staff of your organization; children and other beneficiaries (or potential beneficiaries); people living openly with HIV; and technical advisors and/or donor representatives.

**Organizational assessment tools**

In addition to the SWOT analysis, many more in-depth organizational assessment tools are also available, such as the Technical and Organizational Capacity Assessment Tool (TOCAT) developed by FHI and two publications by the International HIV/AIDS Alliance: *CBO Capacity Analysis: A Toolkit for Assessing and Building Capacities for High Quality Responses to HIV,* and *Intermediary Organisations Capacity Analysis: A Toolkit for Assessing and Building Capacities for High Quality Responses to HIV.*



to) selected community leaders, clients, constituents (including children), staff, volunteers, board members, and donors. Conducting a SWOT analysis may involve one or more community meetings, workshops, focus-group discussions, and/or interviews and questionnaires. Often, a SWOT analysis accompanies an organization's strategic planning process.

For a SWOT analysis, you can begin by asking participants to identify and write down on a piece of paper what they consider to be your organization's strengths, weaknesses, opportunities, and threats. You then group these responses in four boxes on a large chart, and participants review the chart together to determine patterns and areas of consensus.

| STRENGTHS | WEAKNESSES |
|---|---|
| OPPORTUNITIES | THREATS |

After some discussion, make another chart and ask participants to consider how you might develop your organization's strengths, make use of your opportunities, improve your weaknesses, and control threats. Insert new headings in the chart and ask participants to put their suggestions into appropriate boxes.

| DEVELOP STRENGTHS | IMPROVE WEAKNESSES |
|---|---|
| MAKE USE OF OPPORTUNITIES | CONTROL THREATS |

### How to analyze your results

Now ask participants to explain how they would summarize the different SWOT responses. Several responses may be similar, which means that people think that those issues are the most important. As the discussion continues, ask them what conclusions they can draw.

- If your SWOT chart shows exceptionally strong strengths and opportunities, then you are ready for growth, including a new project.

- If strengths and threats come out as the dominant features, you may want to apply some of your strengths to deal with the threats before embarking on any new initiatives.

- A combination of prominent weaknesses and opportunities might suggest that your organization should work in coalition with another organization, rather than alone.

- If weaknesses and threats emerge as the most dominant features, then you may be advised to put aside a new project for the time being or start something very small that will not further drain your organization's resources. Alternatively, you might decide to use all your resources to support a larger, well-established project run by another organization.

### Making key programmatic decisions

Once you have undertaken your situational analysis and the SWOT process, you are in a better position to decide who you want to serve and how. At this point, you will find it useful to formulate your program goals—the long-term aim of your program.

A crucial question must be answered early: Who is your target group? Together with your project committee, you must decide who you particularly want to reach— for example, children in extreme poverty; children with HIV; children attending primary school in a high prevalence area; or low-income families where at least one parent has died. These categories that can be further broken down to identify those in greatest need when you apply an individualized assessment tool such as the Child

for young orphans and vulnerable children.
www.ovcsupport.net/graphics/OVC/documents/
cp/0000895e00.pdf

■ Family Health International, *Conducting a Participatory Situation Analysis of Orphans and Vulnerable Children Affected by HIV/AIDS: Framework and Resource Guide,* 2005.
The guide serves as a tool for collecting and synthesizing in-country and sub-national information. It includes examples of situation analyses and related research. www.fhi.org/en/HIVAIDS/pub/guide/ovcguide.htm

■ Family Health International Asia Pacific Regional Office, *Scaling Up the Continuum of Care for People Living with HIV in Asia and the Pacific: A Toolkit for Implementers,* 2007.
This toolkit provides managers and implementers with a step-by-step guide in establishing active networks of care, treatment, support, and prevention services for people living with HIV and their families. While based on experience in the Asia-Pacific region, the information and resources are broadly applicable. www.fhi.org/en/HIVAIDS/pub/res_CoC_toolkit.htm

■ HelpAge International, *Strengthening your Organisation: Strategic Planning,* 2000.
Advice on carrying out a SWOT analysis is included this guide to the process of developing a strategic plan, including vision and mission statements. www.ngosupport.net/graphics/NGO/documents/english/181d_Strategic_planning.pdf

■ International HIV/AIDS Alliance, *CBO Capacity Analysis: A Toolkit for Assessing and Building Capacities for High Quality Responses to HIV,* 2007.
This capacity analysis toolkit was developed to enable community-based organizations (CBOs) to analyze levels of capacity in different organizational and technical areas, such as governance, finance, administration and human resources, project design and management, and so on. www.aidsalliance.org/custom_asp/publications/view.asp?publication_id=114&language=en

■ International HIV/AIDS Alliance, *Intermediary Organisations Capacity Analysis: A Toolkit for Assessing and Building Capacities for High Quality Responses to HIV,* 2008.
This toolkit provides a range of tools for analyzing the capacity of intermediary organizations—those that provide financial and/or technical support to grassroots HIV organizations. These may be national or regional NGOs or networks that support groups of NGOs and community-based organizations.
www.aidsalliance.org/custom_asp/publications/view.asp?publication_id=285&language=en

■ Janet Shapiro, *Strategic Planning Toolkit,* 2003.
This model and its useful tools and techniques can be used to take an organization through a strategic planning process. www.civicus.org/new/media/Strategic%20Planning.pdf

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**Key program-design questions**

*Steps in program planning*

- What aspects of the situation assessment can be improved? Select one for immediate action.
- Are key populations sufficiently involved in program planning?
- What aspects of program planning can be improved? Have priority actions, resources required, and expected outcomes been clearly identified?
- Are actions prioritized using different budget scenarios (such as high, medium, and low levels of funding)?

*Participation in program planning*

- What strategies have been used for action planning, and what information is needed to improve these efforts?
- Have systems and structures been established to expand community-based action planning? Do staff members have the competencies to support these efforts?
- Are key populations involved in program planning?

*Assessment of the context*

- Does the county have an approved national OVC plan of action into which your program fits?
- Do sectoral strategic plans exist? Are they implemented?
- Have districts developed HIV/AIDS action plans or OVC plans of action?
- Is community-based strategic planning underway relating to PLHIV and/or vulnerable children?[24]

Status Index (III, chapter 2.) The activities you undertake and methodologies you use will depend on your choice of target group.

Section III of the manual will give you ideas about how you can formulate your program objectives and activities and develop a plan on how to achieve them.

## Recommended readings and toolkits

■ Academy for Educational Development, *Speak for the Child: A Program Guide with Tools Supporting Families and Communities to Improve the Care and Development of Young Orphans and Vulnerable Children,* 2003.
This guide is intended to assist program managers in planning, designing, implementing, and monitoring and evaluating community-based programs to improve care

■ Camilla Symes, *The New Toolbox: A Handbook for Community Based Organisations. Volume 2: Vision Building, Planning and Evaluation,* 2002.
A superb how-to guide for managers of small organizations. www.barnabastrust.co.za/toolbox.php

■ World Bank, *The OVC Toolkit: A Toolkit on How to Support Orphans and Other Vulnerable Children in Sub-Saharan Africa,* 2005.
The tips and resources in this toolkit also address street children, children living with a disability, children affected by armed conflict, and children in hazardous labor. www.worldbank.org/ovctoolkit

■ World Vision International, *Development of Child-Focused, Evidence-based, and Context- adaptable Project Models to Respond to HIV and AIDS in Low-prevalence Contexts, Including Organizational Learning in Practice,* 2008.
www.wvi.org/

■ World Vision International, *Guide to Mobilising and Strengthening Community-led Care for Orphans and Vulnerable Children,* 2005.
This guide is intended to provide useful tools for individuals and organizations seeking to mobilize and strengthen community-led care for orphans and vulnerable children. www.crin.org/docs/ovc%20care%20guide.pdf

In addition, check out websites listed in appendix 1, especially www.fhi.org; www.msh.org; www. networklearning.org; www.ngoconnect.net; www. ngosupport.net; and www.worldbank.org/children.

**Now elders appear more willing to talk to each other; that somehow makes me feel better.**

Jyothi, 13

# 1. Outlining Your Implementation Plans

Once you have chosen your program's focus and general approach, you need to identify your goal and target group. Your goal—the end-result you want to achieve—should be consistent with your organization's mission statement and reflect one or more recommendations from your organization's strategic plan, if you have one. Your goal should also be in line with the goals of your host-government's planning processes, as expressed in its national plan of action or national vision document. To ensure that your program is feasible to implement and will meet community needs, your goal should also be consistent with the situational analysis and the SWOT analysis you conducted (II, chapter 4).

Sometimes donors also put forth goals and identify target groups in their requests for proposals. Goals usually represent the big picture: your goal may be to reduce the number of new infections among youth ages 15–19 or to improve the quality of life of impoverished families that include orphans. By contrast, your target population refers to the people or organizations you want to help. Here it becomes important to get more specific. Otherwise, you may find yourself wasting money and effort by going from one group to another.

Even with a clear goal and target population, it can be very challenging to determine exactly what you want to do and how you are going to do it. Your chances of success will increase to the extent that you base your program design on your situational analysis and SWOT analysis and on lessons learned from existing programs and program models.

To research program models you might follow, identify similar programs that demonstrate best practices in the field. It may be a good idea try to arrange a visit to see one or more of them in action or talk with someone with direct experience who can guide you on the do's and don'ts. To obtain more information, use the internet, ask questions of technical experts at FHI or at another international organization, consult representatives within the UN system, and meet with key government leaders

The saying "the devil is in the details" reminds us that a program can sound grand when you describe the big picture, but problems may emerge when you get down to the details of exactly what you plan to do. It is best to anticipate these problems and resolve them before they interfere with what you are trying to achieve.

Where possible, stay in touch with a technical advisor or your best-practice representative as you design your program's day-to-day work. Doing this involves the following steps: 1) identifying program objectives and activities; 2) creating a logical framework, workplan, and timeline—also called a Gantt chart; 3) developing a monitoring and evaluation plan; 4) crafting and reaching agreement on a budget; and 5) documenting your program design.

### Identifying program objectives and activities

Based on your situation analysis and organizational assessment, you should have a clear understanding of where you want to put your emphasis, who you want to help, and what you want to achieve in the long-term. Based on this information, you now need to decide on specific objectives and the activities that your program will implement, including when and how it will do so.

Clear objectives are crucial because they help define what outcomes or results you want to achieve and how you can evaluate your progress. This will allow you look back at your program in six months or a year and say, "Yes, we accomplished what we intended," or "No, we fell short of our desired results." However, setting good objectives can sometimes be difficult.

#### SMART objectives

A good objective is SMART:

- **S***imple*—easy to understand and specifically related to the problem
- **M***easurable*—possible to know whether you have succeeded or failed by using indicators that can be counted
- **A***chievable*—not too easy, but easy enough for you to have a good hope of success
- **R***elevant*—really important to your organization and community
- **T***imely*—given a date by which your objectives should be met

Remember that activities are only a vehicle for your objectives and you must try to identify and implement those that are most likely to give you the outcomes you want. Posing the following list of questions may help you and other key stakeholders decide which activities you should implement and which you should not:

- What should the activity achieve?
- How will you know that it has been successful?
- How many people should it serve?
- When should it take place?
- Where should it take place?
- Who should be involved?
- Who is the person in charge?
- How much will it cost?
- Over what period of time should the activity take place?

### Creating a logical framework, workplan, and timeline

Some donor organizations may ask you to provide a logical framework (also known as a logframe) or a workplan, a timeline (sometimes referred to as a Gantt chart,) or some combination thereof that outlines your activities, expected results, and timeline. Using these tools helps you to plan ahead and thoughtfully determine which program activities will lead to desired outcomes. To keep things as simple as possible, consider using the logframe and a workplan that includes a timeline.[1]

#### A logframe and why is it useful

Using a logical framework or logframe will help programmers to logically consider the program's overall goals and objectives and the activities needed to achieve them. The logframe is the overarching program roadmap. It helps staff and volunteers to see the "forest," or the goal of the program, as well as the "trees," the smaller parts needed to achieve the goal. Using a logframe will help you to avoid feeling so harried to report achievements that your project becomes a long list of activities, instead of an account of what is needed to effect the change we want to see. As with all other aspects of program planning and implementation, involve as many stakeholders as possible in deciding how to compile your logframe, then ensure everyone has a copy of it.

Table 8 presents a partially completed logframe. You start by filling in the left-hand column and then fill in the others. After completing the template, you will have a constant reminder of how you want to implement your project and how you will be able to measure its success or failure.

Of course, things change, and a logframe developed at the beginning of a project may need to be adjusted. A better way of achieving the goal might have been identified, or barriers that prevent the implementation of a given activity might require a modified approach. Whatever the reason, an updated logframe that reflects the real situation is infinitely more useful than an unchanged plan. Depending on the magnitude of the changes, you may need to inform your donors and get their approval before implementing the change.

#### How a workplan differs from a logframe

While the logframe outlines the project, the workplan is the day-to-day tool that guides its implementation: a detailed plan that helps staff, volunteers, and other stakeholders be clear on what needs to be done, when, by whom, how much it will cost, and outputs expected (table 9). Some projects also develop a separate timeline. To make things easier, the timeline can be integrated into the workplan.

**Table 8. A partially completed sample logframe**

| BRIGHTER DAY PROJECT | | | | |
|---|---|---|---|---|
| **PROGRAM GOAL:** Improve the psychosocial wellbeing of vulnerable children and their caregivers | | | | |
| | **Indicators of achievement** *(what you expect to accomplish)* | **Sources and means of verification** *(how you will be able to demonstrate what you have accomplished)* | **Timing** *(by when you expect you achieve this)* | **Assumptions and risks** *(what you have to rely on outside the project to succeed and dangers that could make you fail)* |
| **PROGRAM OBJECTIVE 1:** Increase access to and use of counseling services for children and caregivers | | | | |
| ACTIVITIES THAT WILL LEAD TO ACHIEVING THE OBJECTIVE | 1 Recruit 28 counselors | Short-term staff contracts | Month 1 | Individuals who are suitable for the job are available and apply |
| | 2 Train counselors in two modules of one week each, plus practical field experience | Graduation certificates | Month 2 | A suitable trainer and curriculum can be found for the dates and funds available |
| | 3 Advertise counseling service in the community via radio spots, brochures, and posters | Number of modes of advertisement | Months 2–12 | Avenues for advertisement are available |
| | 4 Enroll children and caregivers in counseling services | Number of children who enroll; number of caregivers who enroll | Months 3–12 | Children and families are willing to enroll in the program; services are perceived to be of quality |
| | 5 Provide quality counseling to children and caregivers | Client files; supervisor reports; QA assessment | Months 3–12 | Counselors are able to provide counseling services of quality |
| | 6 Mentor and supervise counselors in their role | Completed supervision forms | Months 3–12 | Supervisors are able to spend adequate time mentoring counselors |
| | 7 Evaluate outcomes of counseling service | Child and family evaluation of counselor-performance through questionnaires; file review to determine changes in child and caregiver wellbeing over time. | Month 12 | Children and families are willing to provide feedback on the program |
| **PROGRAM OBJECTIVE 2:** *[In a real-life situation, this would also be completed.]* | | | | |
| | 1 | | | |
| | 2 | | | |
| | 3 | | | |
| | 4 | | | |

**Table 9. Example of a workplan**

| PROJECT NAME | WHO IS RESPONSIBLE | BY WHEN (M=MONTH) | | | | | | BUDGET | EXPECTED OUTPUT |
|---|---|---|---|---|---|---|---|---|---|
| | | M1 | M2 | M3 | M4 | M5 | M6 | | |
| **OBJECTIVE 1:** Increase access to and use of counseling services for children and caregivers | | | | | | | | | |
| *Activity 1.1* Recruit 28 counselors | Project manager | X | | | | | | $100 | 28 qualified counselors hired |
| *Activity 1.2* Train counselors in two modules of one week each, plus practical field experience | Project manager/ training officer | | X | | | | | $10,000 | 28 counselors fully trained |
| *Activity 1.2.1* Identify time and location of training | | X | | | | | | | Letter of invitation to trainees |
| *Activity 1.2.2* Select trainers | | X | | | | | | | Roster of trainees |
| *Activity 1.2.3* Prepare training logistics | | | X | | | | | | Agenda |
| *Activity 1.3* | | | | X | | | | | |
| *Activity 1.4* | | | | X | X | X | X | | |
| **OBJECTIVE 2:** [In a real-life situation, this would also be completed.] | | | | | | | | | |
| *Activity 2.1* | | | | X | | | | | |
| *Activity 2.2* | | | | X | | | | | |

The level of detail required for a workplan depends on what the project team might need. Further detail can be provided by breaking activities down into sub-activities that state what needs to happen. For larger projects that operate in different geographic areas, site-level workplans should supplement an overall program workplan.

The project workplan can be hung on the wall so all are clear about what is expected. In addition, a weekly workplan can be produced, perhaps on a white board, butcher paper, or chalk board. Computerized calendars are also very helpful.

## Crafting a budget

A budget is a detailed plan of the allocation of the program's financial resources, and it includes an estimate of the total cost of implementation. Many program planners express concern that they don't know how to make a budget and aren't very good with numbers. In fact, making a good budget is not very difficult. Many donors have pre-set formats, with step-by-step instructions you can follow. Accountants and other specialists at FHI and other large organizations can help you, and many self-help tools are available for organizations that don't have

that support. One of the most accessible is the Excel spreadsheet on most computers.

Your organization's reputation depends, in part, on your ability to stick within the boundaries of the budget you make. Thus, the first priority is to ensure that it is realistic. Once approved by your donors and the board of trustees (or whoever has that authority within your organization), you should aim for little or no variance between how much you forecast spending on a particular item and how much you do spend.

Always check the rules your donor attaches to the use of funds and any fiscal changes made after the program is underway. If an unexpected expense or budget variance arises or if you want to make a change midway during the funding cycle, the golden rule is to consult your donor first. Explain the reasons why you want to make the change and ensure that you are completely transparent in the way that you apply and report on your program spending.

Every month, your organization should post a financial report that indicates how much was spent during the previous month and how that compares with what was projected. Quarterly financial reports serve as an additional summary, and these should be carefully reviewed by the board of trustees. An audit should be

done promptly after the end of the fiscal year (or as agreed-upon with donors). Most organizations issue their annual financial reports only after an audit has occurred, with copies to donors. Sometimes audited financial reports are also shared with the country's regulatory authorities, key stakeholders, and members of the general public.

If you need more information or self-guided training on basic financial management, go to www.mango.org.uk, a website that offers a wide range of online resources in finance and administration to help aid agencies and NGOs work more effectively. The organization can also provide sample financial policy and procedure manuals and offers training courses in different locations all over the world.

## Documenting your program design

By the time you finish your planning, you should have a lot of information that can be included in your final report. Sometimes, mid-project reports are also required. Your reports should include most, if not all, of the following information:

- your organization's vision and mission statements

- a summary of the situation analysis and organizational (SWOT) analysis

- priority area(s) for your activities, including target populations and the focus of your work

- clear objectives for each priority area

- major actions to address these objectives

- the logical framework and/or workplan

- indicators that can be measured to demonstrate whether or not you have succeeded

- identification of planning partners and their roles

- definitions of everyone's roles and involvement, including the role of children

- estimates of program cost (budget)

- proposed timeline

## Recommended readings and toolkits

- Fadumo Alin, Sjaak de Ber, Gordon Greer et al., *How to Build a Good Small NGO*, 2008.
This is a marvelous, down-to-earth, one-stop manual that is also available in French, Arabic, and Vietnamese. If all 79 pages aren't needed, the manual can be downloaded in modules and by topic. www.networklearning.org

- Andrew A. Fisher and James R. Foreit with John Laing, John Stoeckel, and John Townsend, *Designing HIV/AIDS Intervention Studies: An Operations Research Handbook,* 2002.
A useful tool when planning research related to vulnerable children and their families. www.popcouncil.org/pdfs/horizons/orhivaidshndbk.pdf

- CORE Initiative, *CBO/FBO Capacity Analysis: A Tool for Assessing and Building Capacities for High Quality Responses to HIV/AIDS,* 2005.
This toolkit was developed to enable community-based organizations to analyze levels of capacity in different organizational and technical areas. www.ngosupport.net

- CTC Research and Development Programme, *Community-based Therapeutic Care (CTC) Field Manual,* 2007.
This manual addresses issues of acute malnutrition. Other useful publications are downloadable from the Save the Children website. www.savethechildren.org.

In addition, check out the websites listed in appendix 1, particularly www.eldis.org; www.cabsa.co.za; www.mango.org.uk ; and www.ovcsupport.net.

# 2. The Moment You've Been Waiting For: Doing It!

After you have identified the community's needs (through the situation analysis), determined how your organization can help (by means of your organization assessment), identified your priorities, and designed your program, it is time to implement your plans.

As you do this, proceed cautiously and work closely with all key stakeholders, who should retain an active role during every stage of planning and implementation (II, chapter 4). If local stakeholders have been involved as true partners since the beginning, they are likely to develop feelings of ownership toward the program, especially if you can build on initiatives that are already in place in the community. These feelings of ownership help as the program transitions from paper (the planning stages) into reality (implementation). Stakeholders who feel good about your program and are committed to it can become critical advocates on your behalf. They are also likely to contribute time and resources, provide you with important contacts, and offer their support, especially when the inevitable rough spots occur. Their support and commitment may also determine your program's long-term outcome or sustainability.

By contrast, if stakeholders feel ignored or negative about what you are doing, they can set up some formidable obstacles. You will probably find that some local stakeholders have particular interests in selected activities and want to be more involved in certain areas. You should be flexible, possibly by providing them with a choice of involvement opportunities—perhaps as direct-care volunteers, members of an advisory committee, or recipients of regular communication on policy and coordination. You may also find that new groups and individuals who were not

### The importance of clear and regular communication

The implementation process allows you to strengthen existing relationships and initiate new ones. Regular communication keeps all key stakeholders aware of what you are doing and gives them opportunities to provide input on their own roles, linkages to people in power, and new concerns. The form of your communications with stakeholders will depend on who you want to reach and the type of information you want to share. To ensure maximum effectiveness, some organizations develop a communication plan that mimics the workplan (III, chapter 1) but is exclusively concerned with communication issues.

part of your planning process may want to be involved in implementing your program.

The implementation phase includes creating or reinforcing partnerships and referral networks, mobilizing the community, and identifying and selecting the children and families who will be beneficiaries. Each of these topics is discussed in greater depth, then particular attention is paid to the issue of creating a community care coalition as a way of bringing key stakeholders together to foster program goals and meet the needs of vulnerable children. Chapter 3 in this section addresses care management issues, beginning with an assessment of current or prospective beneficiaries.

## Creating or reinforcing partnerships and referral networks

For your program to be effective and sustainable, linkages with other organizations, institutions, and government departments are crucial. Through such cooperative relationships and inter-organizational partnerships, you can increase the scope, reach, and impact of your work.

By working together, local partners can also advocate for broad social change, something that you cannot do alone. These linkages will also help you to increase knowledge and build skills among leaders, volunteers, and beneficiary groups in your community. These efforts will also help you to identify funding or additional support to benefit your program or individuals and families in need. Creating these linkages will also help the local community groups

**Table 10. Building partnerships**

| NAME OF PARTNER | CURRENT SITUATION WITH PARTNER | WHAT WE WANT TO DO WITH PARTNER | WHO WILL APPROACH THE PARTNER AND HOW |
|---|---|---|---|
| 1 | | | |
| 2 | | | |
| 3 | | | |
| 4 | | | |

you are supporting to function more independently from your organization.

Your program's goals and objectives and your situational analysis and assessment of the strengths and weaknesses of your organization (II, chapter 4) will help to determine your choice of partners. Partnerships work best when they are mutually beneficial. Once you know what you can give to another group or organization and what you might need from them, see if there are any other local organizations with whom a partnership would be beneficial. Don't forget to consider government institutions (schools, clinics, or ministries), religious institutions (churches, mosques, temples, and faith-based organizations), traditional authorities, and businesses. Filling in table 10 might assist you as you go about building partnerships. In discussions with a potential partner, ask what kind of compensation, if any, it might require to assist or partner with you. Entering into an exchange may mean that you help that partner in one way and the partner helps you in another.

You may further increase the capacity of your program by establishing, linking with, or strengthening partnerships between several different service providers as part of a network that has common interests or goals. Partnerships and networks allow you to share information and resources and increase your impact, particularly when advocating for change or additional resources at local and national levels.

### Working with the government

For any program working with children and families to succeed long-term, it must cooperate with in-country governments. The level of cooperation will depend on many things. Your work with the government may concern the rights of children and families, as guaranteed by the country's constitution and laws and the international conventions that it signed. You may also be concerned with governmental regulations and policies and access to specific services. The mandate provided in a national plan of action or long-term vision documents may also come into play, along with

the degree to which the government is open to input from organizations and groups like your own.

Your work with the government may also depend on the benefits you and the government foresee as

### The role of faith-based organizations and institutions

Spirituality is very important to the people you are trying to reach, and you should build into your project cooperation with faith-based organizations and institutions. During project planning and implementation, churches, mosques, and temples can be a critical resource. Faith-based organizations

- usually have strong leadership who get their messages across to audiences who are seen every week or more often
- are found everywhere, in every village and neighborhood
- maintain moral authority and espouse values of compassion, care, and outreach to youth
- possess a reservoir of committed members and important community stakeholders
- have existing groups, implement youth activities, and possess other resources you can tap into when recruiting volunteers and implementing home-based care and youth education
- offer existing leadership, education, and outreach onto which family-centered and children's programs can be integrated for rapid scale-up
- often have a strong history of cross-denominational cooperation and are respected by governments and civil society
- fill gaps left by governments and other institutions
- can often respond faster and more effectively than government institutions, especially to local conditions
- are there for the long haul and do not depend on donor and program funding

deriving from the interaction, whether a relationship of mutual trust exists, and your organization's past experiences working with the government—perhaps including those of key individuals on both sides.

Before approaching the government, be clear about what you realistically want. You should also know your rights and those of your constituents or beneficiaries. Become familiar with government documents that address the concerns of your organization. If access to a government office you want to visit is not readily available, think of someone you know who can open the door for you and try to pique that person's interest in making the introduction.

### Partnering with religious institutions and faith-based organizations

Though religious institutions and faith-based organizations play a great role in helping vulnerable children and families, it is important to determine whether your values are in synch before involving such organizations in your program. You may not agree on every point, but there must be enough commonality and mutual respect for the partnership to be meaningful. Again, you should think clearly about whether you need a personal introduction to this potential new partner, as well as who can provide you with the best access.

### Partnering with businesses and the corporate sector

Many people think that the for-profit mentality of businesses is incompatible with the goals of local non-profit organizations and community groups. In reality, both businesses and NGOs seek a well-functioning, healthy community, and both depend on building and maintaining a good reputation within these communities. Increasingly, large businesses set aside corporate development funds or run charitable, give-back events that can benefit your program. Businesses may be able to provide discounts, eliminate bank charges, donate food or second-hand furniture, run clothing drives, and offer free transport.

When approaching a business, be sure to let them know why you think it is in their interest to help your organization or group, and don't be shy. It never hurts to ask, and you may be pleasantly surprised.

### Mobilizing the community

Involving local stakeholders and potential beneficiaries in the implementation of your activities is critical to your program's success. Presumably, you have already consulted these individuals in your planning process; now you are continuing the partnership. Community mobilization for implementation must be characterized by respect for the community and

its needs. It entails a deliberate, participatory process to involve local institutions and leaders, community groups, and community members to organize for collective action toward a common purpose. Community mobilization may result in the establishment of a community care coalition or in the integration of your work within an existing community care coalition. The formation and work of this kind of body—an ongoing group of community watchdogs and activists who are concerned with the care and support of vulnerable children and youth in their communities—is addressed later in this chapter.

### Involving and empowering local stakeholders and potential beneficiaries

People are usually more committed to projects that are based on their own ideas and needs. They also tend to be happier with decisions that they were able to make themselves and that address situations over which they seem to have some control. This is especially important when problems seem overwhelming, such as losses due to HIV, armed conflict, or extreme poverty.

**Effective mobilization is based on the community's ownership of the problem and a sense of responsibility to address it. It is not a matter of convincing people to take action by giving them resources or to work for free in someone else's program.**

John Williamson

By bringing together the people most affected by the problems you are focusing on and helping them to make their own decisions—and then take the leadership in implementing those decisions—you are helping them to regain hope and a sense of control over their own lives. They are the ones who will have to live with the consequences of decisions that are made, while you might move on to another job or community.

Generally, the more local stakeholders you can involve as consultants in your planning and decision-making the better. Those you involve should be broadly representative: they should include community leaders as well as people directly affected by the issues on which you focus. As you promote community mobilization and involvement, you may want to consult *Journey of Life,* an excellent tool that is applicable for children as well as adults.[2]

To the extent that certain constituencies or groups are under-represented, you may also need to undertake additional outreach efforts to get them involved. Some groups may also benefit from awareness-building activities so they understand why it is in their interest to get involved in the first place. If all key stakeholders can't come together, it may also be necessary to conduct some interviews, focus-group discussions, or some other kind of information-gathering to ensure their input.

You must make every effort to involve potential beneficiaries and people whose lives will be affected by the decisions. UNAIDS and many organizations promote the GIPA Principle—greater involvement of people living with AIDS—in relation to programs designed for their benefit. With family members and children, you can apply the GICA principle: greater involvement of children who are affected (I, chapter 5).

### Keeping a consultative process going

Some organizations fall into the trap of involving local stakeholders in their planning process and dropping them after implementation begins. This is a mistake. Once all key stakeholders come together or are otherwise involved, you must make it clear that everyone is welcome to contribute his or her own experience and perspective on an ongoing basis. As implementation unfolds, be sure to ask what kind of role local stakeholders would like to maintain. This becomes especially important if you are offering skills-training and other forms of capacity building to develop leadership and prepare for future challenges. These local stakeholders will also be important for your monitoring and evaluation process (III, chapter 4).

It can sometimes be tricky to figure out what role the people you want to involve should play. Some

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**Facilitating a group discussion**

*What if some people dominate the discussion?*

The facilitator should give positive feedback and involve other participants in responding to the dominant participant. For example, the facilitator may say, "Thank you for that interesting viewpoint. What do other people think about this?" The facilitator could also speak privately to dominant participants during a break and ask them to allow others more time to speak.

*What if there are quiet participants?*

Sometimes people who feel that their opinions are not valued sit silently through meetings. This is especially true of women, children, and others who have not had much experience in making decisions. In this situation, the facilitator might suggest that people work in small groups, since these may make it easier for quiet participants to express themselves. Use activities that request a small contribution from everyone—for example, one that goes around the room or asks each person to draw their ideas on paper. In group discussions, facilitators should give preference to participants who have not yet spoken, then offer positive feedback by reinforcing what they just said.

*What if participants don't get along?*

It is best to anticipate this problem by agreeing on certain ground rules at the beginning of the session, such as "Don't interrupt when another person is speaking," or "Don't say anything disrespectful about anybody else." When a participant starts digressing, it may be necessary to refocus the discussion. If serious differences emerge, however, the facilitator may have to speak to each person separately, possibly during a break.

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constituency groups or special-interest groups may want to send representatives to communicate their wishes during part of the implementation process. So long as everyone maintains the same goals and objectives, you can periodically liaise back with them so they can play an ongoing role.

As soon as an organization or community group wants to be involved, it is important to find out the issues about which everyone feels most strongly. Remember that the problems you feel are the most important may not be seen as such by local people who are directly affected. It is important to listen and learn. It is also important to build confidence that the group can and should take the leadership in addressing the problems that they face.

Meetings and other forms of communication with key stakeholders should occur regularly. To reach decisions that are agreeable to all on an unanticipated

problem or concern, several supplemental meetings may be necessary. The first may be needed to understand the problem and outline some responses. Additional meetings may produce agreement on a specific approach and action plan. However, you may need to be careful that your process is not co-opted to serve another set of interests that could defeat or undermine your program's success. If you sense this may happen, try to arrange a separate meeting to mediate differences and come to an agreement.

The facilitator for any problem-solving process should be neutral, with no personal stake in the outcome. While this person does not need to be a technical expert on the subject under discussion, it is helpful if he or she has some knowledge of the issues and resources available. In addition, the facilitator should be a good listener and a clear communicator, respectful of the local culture, sensitive to issues of gender and the needs of children, a good time-keeper, self-aware, and encouraging of others.

### Identifying and selecting beneficiaries

The degree to which your results are meaningful will depend on whom you are serving. Resources are always limited, so you should generally strive to serve the neediest children or the neediest households first. But how can you determine who fits into these categories?

In some cases, donors place restrictions on whom they will fund—perhaps only orphans, or only children affected by HIV and AIDS. Where you feel these distinctions are stigmatizing or not in the best interest of children, try to reason with the donor's representative in your country. You can also ask to broaden the categories, perhaps suggesting a focus on children who are affected by HIV and other serious diseases or on children not yet affected but whose living environments make them more vulnerable to disease.

In some communities, local committees or local government offices register and keep lists of children who meet certain criteria, such as those who are double-orphans, have a serious disability, or are known to have dropped out of school. Even without documentation, local volunteers and community representatives in some neighborhoods or rural villages can often tell you who the neediest children and families are.

But it is always a good idea to go out into communities and make your own assessments—not only to determine the range of needs and existing resources or strengths, but also whether parents or guardians would welcome assistance from your organization. When you make these assessments, be sure to let families know that you can't promise that their

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**Who gets left out?**

Programs for orphans and vulnerable children disproportionately target primary school-age children. They are relatively easy to reach and easier to communicate with than adolescents, who may exhibit troubled or antisocial behaviors. Children of primary school age are also easier to reach than very young children who have not yet started school. But leaving out young children and older adolescents is a big mistake. It is important to aim as much as possible for where the need is, rather than what is most convenient to implement.

It is important to reach very young children because early childhood programs help build a foundation for later life. Those who may need assistance the most may be children and youth who exhibit troubled or antisocial behaviors or drop out of school. Programs for older children and youth can easily combine issues of healthy lifestyle (such as disease-prevention) with vocational training and/or parenting skills. All such programs can have a lifelong impact.

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children will be served, but you will be glad to refer them to other locally available service providers and resources, such as a schools, health clinics, or community care coalitions.

### Creating a community care coalition

Establishing a community care coalition is good way to mobilize people to take ongoing responsibility for vulnerable children and families in their midst.[3] This kind of body has been called a children's welfare forum, an OVC community taskforce, a stakeholders' committee, or a continuum-of-care coordination committee, but the goal is the same: to bring together active and caring people who are willing to invest time and work together to help needy children and families in their communities. If community care coalition or a similar group already exists, or there is a local community-based organization that provides this function, aim to work with that group and possibly expand its role rather than start a new stakeholders' group.

To establish and support a community care coalition, begin by gathering together a group of local stakeholders who want to make a positive difference in the lives of families and children. Where it is not possible to engage the people whose involvement you think is critical, be sure to consult with these individuals periodically, through one-on-one meetings or in other ways. After you gather the group, take the following steps.

### 1. Hold a meeting with community stakeholders.

This meeting should take place after you have informed yourself about issues facing orphans and vulnerable children in the community and possible responses that could improve the situation. That learning process might involve a situational analysis, interviews, and/or workshops that include some of the people you want to involve. Be sure to have a good mix: appointed and elected government officials, traditional leaders, social workers, community activists, and representatives of local NGOs, faith-based organizations, and constituency groups, PLHIV support groups, youth groups and affected teenagers, and local schools and businesses.

### 2. Form the community care coalition

At the end of the meeting or series of meetings, your stakeholders' group should agree on the next steps. At this point, many communities choose to form some sort of community care coalition (not necessarily with that name) that begins to implement activities decided upon. Otherwise, it helps to plan other activities, including supporting and monitoring the wellbeing of specific children. Other key activities of the coalition may include the following:[4]

- developing assessment criteria to identify the most needy vulnerable children and youth in the community

- organizing a program of home visits to child-headed and other priority households

- advocating for support for vulnerable children, their families, and caregivers from local institutions, government, and businesses

- creating a child-rights subcommittee composed of people who can effectively address situations where a child's rights might have been compromised

### 3. Define roles and responsibilities

The community care coalition should develop its own job description and determine how it will operate, when it should meet, and what role each person in it should play. Even if certain key people in the community are not regular members, their insights and information should be sought. Children's voices should also be included. If children and youth are not coalition members, they should be included as presenters, though interviews or focus-group discussions.

### 4. Plan action steps

The community care coalition should agree on a series of actions that can help vulnerable children and youth and their families. For example, they could undertake activities to help curb violence against women and

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**The role of community care coalitions**

Community care coalitions can influence public opinion and decision-makers and make a big difference in the fight against stigma and discrimination. Though their contacts and advocacy, they can help needy children and families benefit from donations; access public services such as antiretroviral treatment; and stand up for rights, including the right to access education.

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children, increase access to public benefits, provide regular visits to child-headed households, and/or identify plots of land to be allocated for gardens whose produce benefits vulnerable children and youth and their families. After one course of action is agreed upon and implemented, the coalition may decide to do more. A comprehensive and holistic planning process can help the work to evolve.

If coalition members agree, they may also serve as an oversight or advisory body for your program. This works best if your planning process had already included coalition representatives or the whole coalition.

It is important that the coalition's planning process be as clear and specific as possible, mimicking the planning process used to design and implement your organization's program. Thus, the coalition should develop and use a simple workplan that includes agreed-upon timelines and states who is responsible for each step. This is needed to ensure that the group's momentum does not fizzle away.

Encourage the coalition to continue meeting periodically—or, failing that, to elect a small executive committee that meets on a regular basis. Holding regular meetings will reinforce the coalition's resolve, help to address unanticipated problems that might arise, and track that decisions are implemented as planned.

### 5. Train coalition members

Depending on the actions being considered or agreed upon, coalition members may need to learn some skills to carry out their responsibilities. Perhaps organizations nearby that community members can identify can help provide this training; alternatively, other resources may have to be brought in.

If it appears that the coalition's leadership does not have prior knowledge or experience in their new roles, you or your organization may also consider offering some technical support or one-on-one coaching. Otherwise, you may suggest that coalition leaders visit another group doing similar work in another community (IV, chapter 3). If leaders are unsure of

themselves, be sure to start small, with modest goals. One success—even a tiny one—builds confidence and more success in the future.

### 6. Identify beneficiaries

It is important to target services to the children, youth, and families who need them most. To do this, a process of identification and assessment has to be agreed upon. During this process, be careful not to stigmatize children by publicly identifying them as "OVC" or as children infected by HIV or affected by AIDS.

This balancing act can be tricky. Wherever possible, it is best to serve all children in a very needy catchment area, school, or community, rather than label some children as different from or more needy than their peers (II, chapter 2). If only a limited number of children can be served in a particular setting, a referral process or an individualized assessment is needed.

In small communities, some of the most vulnerable children and families will already be known to key stakeholders, coalition members, government social workers, healthcare personnel, or the staff or volunteers of other organizations. Wherever possible, try to get a holistic understanding of the child's or children's situation through a home visit, preferably using an assessment scale such as the Child Status Index (III, chapter 3).

Your group may also want to highlight certain types of interventions that would first require a community-awareness and outreach campaign. Among such campaigns are those that raise awareness of child-headed or youth-headed families and of issues that affect children with serious developmental or physical disabilities.

### 7. Implement and monitor

As with any program, real impact only occurs when the activities of a community care coalition are implemented regularly and monitored accordingly. Even when local stakeholders and coalition members work as volunteers, implementation and monitoring may require some financial support. This, in turn, requires a short proposal budget that includes all identified sources of funding or in-kind support.

To the extent that the community care coalition is able to rely on income-generating projects and/or local donations, its activities will be more sustainable over the long run. On the other hand, even when the work is not completely self-reliant, a properly monitored and accountable set of activities can be seen as an investment in the children the coalition serves. This outcome may be helpful in securing additional funds in the future.

# 3. Care Management for Children and Families

To make a difference in the lives of vulnerable children and their families, programs must be able to assess the needs of beneficiaries and provide care over time. Ongoing relationships—between program staff, volunteer lay social workers or home-based care teams, and children—will lay the foundation for improvements in future planning and in the wellbeing of vulnerable children, youth, and families. Studies show that ongoing, routine support can make a significant difference in the health and emotional, social, and cognitive wellbeing of vulnerable children and families. Care management is at the heart of these efforts.

Previous chapters highlighted how children's needs change as they grow and develop. But children and youth living in difficult circumstances may face multiple challenges that affect their ability to achieve the levels of development and wellbeing of their non-vulnerable peers. A care management system can help along the way, from the time vulnerable children and youth are enrolled in services to the time they can stand on their own or age-out of programs. Care management is a process of initial and ongoing holistic assessment of the real needs of children, youth, and families, as well as an assessment of the support that meets those needs.

Many organizations are already implementing variations of care-management focused programs. At Family Health International, these include Balasahyoga in India; the Family-Centered Care Program in Viet Nam; Living with Hope in Cambodia; Nuru ya Jamii in Kenya; and variations of the Star Model in Namibia, Botswana, and Ethiopia. Resources developed by some of these FHI country offices can be used in developing your own variation.

## The care management process

Care management starts with the enrollment of children and families in the program and an initial needs assessment that helps identify their priority needs among seven core services: food and nutrition, shelter and care, protection, healthcare, psychosocial support, education and vocation training, and economic support and livelihoods.

Based on priority needs, a care plan is developed with families and they receive help to implement it. On routine follow-up visits, progress made in the care plan is reviewed, needs are reassessed, the care plan is updated, and implementation support is provided. This cycle continues on each visit. Over time, some children and families will reach a point when they no longer need support and can be discharged from the program.

The care management process involves a cycle with four main steps: 1) enrollment of eligible children, youth, and families into the program; 2) a baseline assessment and care planning; 3) routine follow-up visits or assessments; and 4) discharge of families when they are ready.

Steps two and three have four sub-steps. For step two, a baseline assessment and care planning, the sub-steps are

- an assessment of child and family needs
- assistance to children and families to prioritize their most important needs
- preparation of a child and family care plan
- support for families to implement their care plan through direct service provision or referrals

There are four sub-steps attached to step three—routine follow-up visits or assessments:

- a review of the previous care plan
- assessment of new needs

## FIG. 5. STANDARD OPERATING PROCEDURES FOR THE CARE MANAGEMENT PROCESS

**1. Enrollment**
- Client register
- Family file preparation

**2. Needs assesment/first visit**
- Family needs assessment form
- OVC needs assessment form
- Child Status Index (CSI)
  ○ *If child is HIV-positive: CHBC form*
- Family care plan
- Monthly service register

**3. Follow-up visits**
- Family care plan
  ○ *If child is HIV-positive: CHBC form*
  ○ *Every three months: CSI*
- Monthly service register

**4. Discharge**
- Discharge form
  *only if family no longer needs services*

- an update of the careplan
- support to implement the careplan

Although the same cycle is used for each child and family, the needs identified and services provided will differ. The length of time each family will need support will also vary.

The care management cycle is illustrated in figure 5, FHI/Viet Nam's standard operating procedures for the care management process. The diagram refers to forms used during each phase, including forms for community- and home-based care (CHBC).

### Where is care management offered?

In community programs, care management usually centers on assessing needs and providing care through routine home visits and on supporting children and families to access the services. Some programs also conduct baseline and follow-up needs assessments and care management in drop-in-centers, NGO offices, or government social work departments. Others use a combination of locations to provide maximum options for families, particularly for those who do not prefer home visits due to concerns about stigma and discrimination.

### How do care management services for vulnerable children interact with community and home-based care services?

Each program is different, but integrating services for vulnerable children and community- and home-based care is a successful approach to delivering more comprehensive care to families. By doing this, the whole family—including adults and children living with HIV—are assessed and receive care and basic services from the same people, instead of from separate teams. This approach promotes a family-centered care approach, which is more cost efficient and often preferred by families.

### Does care management mean we have to provide all services?

Each program needs to determine which direct services it can provide to clients and which need to be referred. However, care management does mean that assessments should be made of all seven core needs (fig. 6) and a plan put in place for how best to meet them over time.

For example, your program might be able to offer direct provision of psychosocial support, basic healthcare and palliative care, nutrition counseling, and support for school enrollment and future planning, but may need to refer children and families to other organizations for facility-based healthcare, professional psychological services, economic strengthening, vocational training, and enforcement of protection laws.

## Developing a care management system

To set up a care management system, the program team responsible for care services will need to put in place clear steps that detail which services are included and how they will be provided or accessed. The team also needs to develop forms needed to support the program. It will also need to train, mentor, and supervise those responsible for providing routine care to children and families.

The program-planning steps outlined in section II should help you determine what services are needed and which children are in most need of care (II, chapter 4). Once service-planning activities are complete,

## FIG. 6. CARE MANAGEMENT OF CORE SERVICES

Key Questions to Ask

- Of the seven core services, which ones are currently available in your community?
- Which services are not available?
- Among the providers of service, what are their strengths and capacity and ability to serve additional children?
- What assistance is required to insure that all seven services are avilable and accessible for those children who need them?

**CORE SERVICES**
1. Food and nutrition
2. Shelter and care
3. Protection
4. Education and vocation
5. Healthcare
6. Psychosocial support
7. Economic strengthening

FAMILY

CHILD

COMMUNITY    SYSTEMS
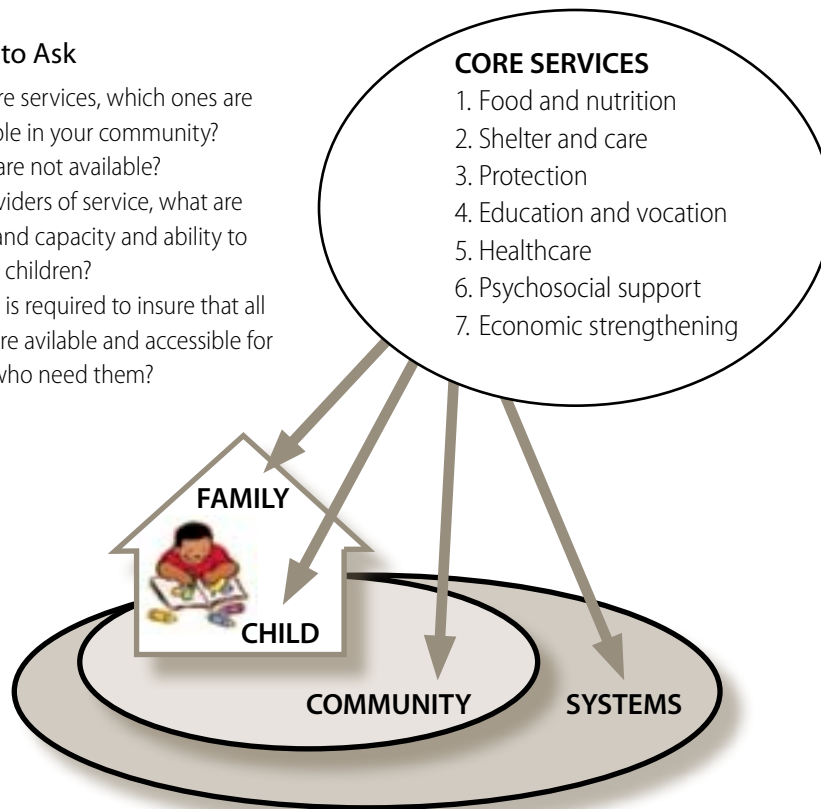
four steps can be taken, though not necessarily all of them or in the order listed.

### Step 1. Develop a program-enrollment and client-monitoring system for children and families.

To provide better care and be able to track children and families who are enrolled, programs should have a system in place for coding, registering, and maintaining important information about these clients. This step should entail the following actions:

■ *Use client coding.*
Each client enrolled in the program can be allocated a unique code or identifier that is used in the place of a name to protect confidentiality. To reinforce the orientation to family-centered care, a code could be given to a family and each child and adult within it assigned a sub-code.

■ *Create a program register.*
The program register can be developed in a large book, with a corresponding computerized version, such as Microsoft Access or Excel. An example of a program register can be found in appendix 4. The register's several columns could include the codes assigned to families and individuals and each individual's address, age, gender, HIV status, and school enrollment. Other columns would indicate

whether a client is still in the program or has been discharged, moved, lost to follow-up, or died. Registers that include names of clients need to be kept in a secure location.

■ *Establish a child or family file.*
Some organizations prefer to establish one case file per family or household (with sub-files for each child), while others prefer to have a separate file for each child, albeit including information about the family or household. If each file has a code number, these can be organized in a logical sequence and confidentiality maintained.

Case files should contain a record of all essential information, including a cover page with the names of children and adult family members and the code numbers assigned. Case files generally contain first-assessment forms, follow-up forms, care plans, Child Status Index results or the results of a similar assessment, referral records, and other important information. Files can be reviewed before a family is visited and then updated after the visit to keep them as current as possible.

The more that can be computerized the better. FHI/India developed a management information system (MIS) whereby information on baseline needs assessments and follow-up visits is entered

### A case record makes the child feel special

Maintaining a case record on each child or household is not only good practice, it can also make children feel special. That is especially true if your case record contains photographs, copies of school reports, or examples of the child's drawings or writings. Be sure to ask children for permission to keep examples of their creative work, let them know that these items are being saved, and allow them to look at them as often as they want. When children age out of the program or the program ends, return these items. They will seem like rare treasures and as evidence of the child's uniqueness, thoughts, and experiences during his or her early years.

into a data base. Implementing partners are supported to use the data to analyze the coverage and quality of their programs—for example, to track over time improvements in enrollment of HIV-positive children in clinical care services.

Many programs also store in the child or family file original examples or photocopies of children's drawings and creative writing, photographs, and end-of-term reports. These contribute to a qualitative analysis of how well the child is developing over time (III, chapter 5).

### Step 2. Establish a process for first and follow-up assessments and care planning.

The baseline and follow-up assessment process is the crux of the care management program. To support comprehensive assessments of children's and family's needs, programs should consider the following steps and tools:

■ *Determine client limit and frequency of visits.*
   To ensure staff and volunteers have the time to provide adequate attention to the children they care for, calculate how many can be reasonably reached in a given day, week, or month. How often children and families are visited and supported by program staff and volunteers may be related to the quality of the program. When families are only visited a few times a year, the impact will likely be limited. More frequent visits—for example, once a month—will generally contribute to better outcomes.

   It is also important to determine what types of households will need more intensive follow-up. A child whose parent is very ill or has recently died may need more frequent visits and support— perhaps a few times a week—than a child in need of economic support who is living in a stable household and doing relatively well in most areas.

■ *Conduct first-visit baseline and follow-up assessments.*
   The baseline needs assessment is conducted to help staff and volunteers gather information about the wellbeing and most pressing needs of vulnerable children and their families. It offers an opportunity for children and family members to get to know program workers and to begin to develop a relationship of trust. It is important that staff and volunteers not let information-gathering dominate communication. They should spend time listening to the children and family and facilitate a process that will help them to identify and prioritize their own needs. As children, families, and care managers come to better understand the situation together, they can initiate a plan that begins to address these needs.

   Many programs develop their own forms to better document the situation of families and capture program-level data that describe the quality of care. These forms can be short, yet contain essential information and adequate detail about the backgrounds and needs of children and families. Some programs use two sets of assessment forms, one for the family and one for each child. Additionally, many governments have started to require service providers to submit an official "OVC registration form" for each vulnerable child served. A copy of that form can double as the background sheet or can be added to your case record.

   Follow-up visits provide opportunities to review the care plan from the previous visit and reassess the needs of the household. A simple form can be used to document these visits. It should provide space for the care management worker to write in new needs identified, care and support or other services provided, and next steps. Some programs use the Child Status Index (CSI) and/or family care plans as their main tools during follow-up visits.

■ *Use the Child Status Index as part of baseline and follow-up assessments.*
   The CSI, initiated in 2006 by the Office of the U.S. Government's Global AIDS Coordinator, can be used to track the wellbeing of each child in your program in each service area. It can be employed during the baseline and follow-up needs assessments and then periodically over time. Although the CSI is still being pilot-tested, it is already an excellent tool for assessing a child in a family setting. It can also be used in a community assessment to identify the neediest children in the area.[5] The CSI is also useful in quality improvement (QI) activities (III, chapter 5) and in research to measure changes over time in the wellbeing of children after interventions have been introduced.

The CSI is based on the core service areas used by PEFPAR. Four-point scales measure the degree to which 12 different domains meet particular goals—such as "The child is healthy" or "The child is safe from abuse, neglect, or exploitation." The lower the score in each domain, the needier the child. The care worker or a trained volunteer visits the household, talks with both the caregiver and the children, and then completes the CSI form by entering a number from 1 to 4 and adding comments for follow-up, as needed (appendix 5). Some practitioners use the CSI every month, others every three or every six months. This does not mean that follow-up visits occur only every three or six months, but that the CSI is conducted at this interval to detect change over time in the child's wellbeing.

CSI scores can also be used during your program's selection process, as they give you a good basis of comparison from one household to the next. The process allows for an objective analysis to guide decisions on children who should be given the first priority: those who are neediest and have the lowest scores. Once you review all the assessments, you can determine which children or families you will be able to serve, given limited resources.

You can download the CSI field guide, a pictorial version of it, translations into other languages, and related documents, including a form for follow-up field visits at www.cpc.unc.edu/measure. Spin-off tools developed in several countries to further

refine or adapt the CSI to local needs are available at www.ovcsupport.net. A low-literacy Parenting Map by Project Hope is another variant that can be downloaded (appendix 6).[6]

The CSI has been further adapted by several FHI country offices and in other locations. It is used as part of local organizations' routine care management to develop care plans and track changes in the wellbeing of enrolled children. A low-literacy version has been produced by FHI/Cambodia and in South Africa. FHI made the scale more developmentally sensitive by adapting indicators for different age groups: 0–2, 3–5, 6–11, and 12–18. Additional questions are also being asked of main caregivers to get a family-wide perspective.

■ *Make a family care plan.*
Once you collect background information and assess needs, a family care plan is a great way to help a family prioritize their most pressing needs and identify steps that your program, family members, and others can take to address these needs. Programs use family care plans to help focus the care management team on what needs to be done. Such plans are used to empower and support children and families to problem-solve, plan, and take action.

Family care plans build accountability between care managers and children and families. They allow programs to track over time the changing needs of clients and what has been done to address

**Table 11. Sample guidebook-listing of forms used by a program**

| FORM | FIRST VISIT | | | FOLLOW-UP VISIT | | | EVERY QUARTER |
|---|---|---|---|---|---|---|---|
| | All children | Children with HIV | Family | All children | Children with HIV | Family | All Children |
| 1. Child baseline needs-assessment form | ■ | ■ | | | | | |
| 2. Volunteer or worker's first-visit form for children with HIV | | ■ | | | | | |
| 3. Volunteer or worker's follow-up form for children with HIV | | | | | ■ | | |
| 4. Family baseline needs-assessment form | | | ■ | | | | |
| 5. Family/child care plan | ■ | ■ | ■ | ■ | ■ | ■ | |
| 6. Child Status Index | ■ | ■ | | | | | ■ |
| 7. Referral form | ■ | ■ | ■ | ■ | ■ | ■ | |

those needs. Care plans need not be done only for families; they can also be done for individual children in a family.

### Step 3. Take action to help respond to the needs of children and families.

Once a system is in place to help assess the needs of families and develop a plan to address these needs, programs should determine how services will be provided. Short and specific program guidelines or standard operating procedures are needed, along with training and mentoring for program staff and volunteers, the use of job aids, and the establishment of a referral system.

■ *Produce program guidelines or standard operating procedures.*
A very useful tool used by some programs is a guidebook or a set of standard operating procedures that outlines the roles and responsibilities of staff and volunteers and the steps they must take to do their jobs effectively. The guidebook can address the types of care provided in the home—such as counseling, basic healthcare, help with disclosure, and future planning—along with tasks that staff and volunteers perform within

a community, such as running a playgroup or a hero-book session. The guidebook should also list all the forms and tools used by the program (with samples, as needed). These include the baseline needs assessment form, the CSI (or another such tool), family care plans, registers, report forms, and job descriptions. A description of the forms to be completed for baseline and follow-up visits can also be added (table 11).

■ *Train and mentor program staff and volunteers.*
Programs can make an immediate contribution to improving the quality of their services by providing clear, hands-on training to build the core competencies of staff and volunteers. Good training helps care providers to feel clear and comfortable in the services they provide for families and children.

After program guidance or standard operating procedures are developed, staff and volunteers are trained in the details of care management, the services included, and competencies needed. This training may include information about child development and child rights, skills-building in child and adult communication, and instruction on conducting baseline and follow-up home visits.

Training curricula developed by FHI and others that aim to equip care managers to make a difference in the lives of children are listed at the end of this chapter.

There is a wise saying, "Training is often essential but rarely sufficient." Once trained, staff and volunteers need mentoring to help them feel more confident in their work (IV, chapter 1). Supervisors or more experienced providers mentor and coach new trainees to help them become more skillful. Mentoring is crucial to the ability of programs to offer quality services. There are many ways to do it, and a number of useful mentoring resources are available on www.go2itech.org, the website of the International Training and Education Center on HIV.

■ *Use job aids.*
Job aids can help staff and volunteers build their skills and knowledge in different areas, especially in assessing and providing care for children and families. For example, a program in India uses a checklist that care managers bring with them during home visits to help them remember all the steps they should follow. In Namibia, many NGOs use laminated cards with question-prompts for each service area, in accordance with national standards for care and support of children (III, chapter 5). A program in Viet Nam developed a job aid to help teams better assess how well children were developing, physically, cognitively, and socially.

■ *Develop a referral system.*
A clear referral system can be challenging to develop, but it is a prerequisite for ensuring that children and families have access to as many services as they need. Staff and volunteers may need guidance and tools to help them manage referrals, and these can be outlined in program guidelines or standard operating procedures.

## Step 4. Define and implement the discharge process

At some point, children and families receiving services may need less intensive support from the program or be ready to stand on their own. Discharge processes are important. They help the program to be more focused on developing longer-term economic security and on fostering the independence of families, ensuring efficient use of scarce resources for those most in need.

Discharge planning consists of a joint decision of the care manager, children, and family that the intensity and frequency of support can be gradually reduced and that the family and children are more and more able to address their own needs. Support

from the program might taper off to a semi-annual visit and an eventual exit when the family is ready.

The following steps must be taken to define and implement the discharge process:

■ *Develop discharge criteria.*
Children may age-out of programs; this may happen when they reach age 18 in some programs and at age 25 in others. If possible, allow for some extensions, especially if children are still attending school full-time. It is preferable to develop criteria for discharge-readiness that outline when a child or family needs less support. A holistic determination should be made that includes economic, physical, psychosocial, and protection criteria. What is essential is that these criteria be developed in a transparent way, with participation from children and families.

■ *Plan for the future.*
To help children and families aim for greater independence, programs can emphasize activities that enable the poor to become less poor and more self-reliant. These include economic strengthening activities (such as job training and placement and microcredit schemes), as well as the implementation of cash transfers, other social welfare schemes, and food security assistance. Programs can also focus on the emotional and social wellbeing of children and families to build independence. The process described in step 2 can be used to help families take concrete steps toward greater economic security and a better future.

## Step 5. Develop a management information system (MIS)

Many programs and national governments use client-MIS systems to improve the accountability of programs and more accurate reporting. These systems assess the coverage and quality of services with data collected though baseline and follow-up assessments, the CSI, referral records, and client registers.

Computer packages such as Oracle Express and Microsoft Access can facilitate the setting up of a program database or an MIS that is developed in conjunction with partner organizations. However, it is essential to control confidential information and use coded case-identifiers, instead of children's names.

Depending on how your database is structured, you may be able to extract data to give you the kind of summary information contained in table 12, which is very useful for monitoring and evaluation and for improving and developing new services. Note that both numbers and percentages are used to give a sense of magnitude and comparison, and that some children receive more than one service.

**Table 12. Services provided for sample subgroups of children by three cooperating NGOs**

| SUBGROUPS | NO. OF CHILDREN | FOOD AND NUTRITION | PSYCHOSOCIAL SUPPORT | SHELTER AND CARE | EDUCATION | PROTECTION | HEALTH | ECONOMIC STRENGTHENING |
|---|---|---|---|---|---|---|---|---|
| Children less than age 6 | 1,200 | 300 (25%) | 600 (50%) | | 400 (33%) | 60 (5%) | 120 (10%) | |
| Children with disabilities | 200 | | | 100 (50%) | | | 200 (100%) | |
| Child soldiers | 300 | | 200 (66%) | | 100 (33%) | 294 (98%) | | |
| Married children | 100 | | | | 50 (50%) | | | 75 (75%) |
| Girl children | 2,000 | | 500 (25%) | | 1300 (65%) | | | |
| Child household heads | 250 | 200 (80%) | 225 (90%) | 25 (10%) | 100 (40%) | 50 (20%) | | 50 (20%) |
| Child survivors of violence | 200 | | 200 (100%) | | | 180 (90%) | 160 (80%) | |

## The Star Model of care for vulnerable children and their families

The Star Model (fig. 7), used by some FHI programs in Africa, is a care-management schematic that expresses a holistic approach to caring for children, youth, and families.[7] Designed to explain an integrated system of care, support, and prevention for vulnerable children and youth within the context of their families, the schematic helps staff and volunteers visualize how the different aspects of their work fit together. It also reminds them to consider all areas of a child's needs and to follow up, when required. You should not think of this as something brand-new or contrary to other care-management approaches, but rather as a new visual construct that aims to bring together current best practices in the field, including assessment, service coordination, healthy living (disease prevention), economic empowerment, capacity building, and direct support.

The Star Model highlights the coordination of care and seeks to ensure that children receive support in all service areas, as needed, whether this support is provided directly by one organization or program or through other resources in the community. The Star Model also emphasizes that services and support for children should go to and through their families to build self-reliance and sustainability. Finally, the model highlights the importance of promoting strategies designed to prevent the spread of disease and high-risk behaviors.

In the Star Model, six areas of focus surround a child and his or her family. These incorporate the PEPFAR core service areas: food and nutritional support, shelter and care, protection, healthcare, psychosocial support, education and vocational training. Economic strengthening is an overarching approach, as are life-promoting activities such as those related to disease prevention and treatment.

1. **Household wellbeing** corresponds to *shelter and care* (shelter: the condition of the place where the child sleeps and lives; care: basic material needs)[8]

2. **Physical wellbeing** corresponds to *health* (wellness and healthcare services)

3. **Nutritional wellbeing** corresponds to *food and nutritional support* (food security and nutrition and growth)

4. **Cognitive wellbeing** corresponds to *education and vocational training* (performance and education or work)

5. **Emotional wellbeing** corresponds to *psychosocial support* (emotional health and social wellbeing and spiritual support)

6. **Security and protection** corresponds with *protection* (abuse and exploitation and legal protection)

The six points of the star represent these service areas, albeit with the recognition that many programs cross over several of its points. For example, a child who attends an after-school program may receive

## FIG. 7. THE STAR MODEL



**Applying the Star Model**

As in most care management programs, the Star Model relies on trained volunteers or staff members to make the initial assessment, be in frequent in-person contact with the child and family, and provide support for them. It also relies on volunteers and staff to conduct periodic monitoring visits, ensure ongoing care coordination, and verify that all services to which children and families are referred are being provided. Training of volunteers or staff should initially focus on home-visit skills, listening and responding, the assessment and reassessment process (using the Child Status Index or a similar tool), and on how to make a referral and follow up—basic care-coordination skills. Special attention may be needed during the training on how to communicate directly with children and on understanding developmental changes among children and youth. Follow-up training can be more specialized, perhaps in one or more area in the schematic.

While the Star Model emphasizes the support that children receive with and through their own family members, support can also come from a combination of teachers, neighbors, community members, peers, paraprofessional childcare workers, and trained volunteers (also called family advocates, aunties and uncles, home-care supporters, and so on). Although one child may be the primary focus of the assessment and care, other children in the household should also be considered and assisted, as needed.

In addition to care and support, issues of disease-prevention and economic strengthening should be integrated for sustainability, wherever feasible. Thus, the Star Model suggests that one of the most effective ways that your organization can assist children is by strengthening the capacity of parents, guardians, volunteers, or other *caregiving* adults and youth to better care for themselves and the children with whom they have contact. [9]

food (nutritional wellbeing), homework support and supplementary education (cognitive wellbeing), and group psychosocial support or individual counseling (emotional wellbeing).

When assessing or referring a child to services across these points of the star, be sure to check that the services are developmentally correct for that child. The very young child may require regular health check-ups and need to attend a crèche or nursery school, while older children or youth would benefit from training on nutrition and gardening and from a workshop on reproductive health.

Too often, programs that focus on care and support services overlook opportunities to promote disease-prevention and healthy decision-making, including the reinforcement of positive behaviors, behavior change communication, and adherence to treatment. Programs may also overlook opportunities to promote self-reliance and sustainability by encouraging personal empowerment and economic strengthening. These are crucially important because the best way to break the cycle of vulnerability is by promoting life-sustaining, poverty-reduction approaches. The crescents above and below the Star Model constantly remind local implementers to integrate these two components. Integration can be achieved by fostering discussion on these issues, providing technical assistance, encouraging add-on or wrap-around services (linked to activities already in place), and connecting beneficiaries with relevant programs or activities in the community.

## Recommended readings and toolkits

■ Catholic Relief Services, *OVC Wellbeing Tool*, 2008. A self-administered tool that is suitable for children age 13 and older. It can serve as a substitute for the CSI in some settings. www.crs.org/publications/ovc-wellbeing-tool.

■ Communities Responding to the HIV/AIDS Epidemic (CORE) Initiative. Multiple resources on project design, technical support, capacity and credibility assessments, proposal writing, and strategic planning. www.coreinitiative.org/

■ MEASURE Evaluation, *Child Status Index*, 2009 The field guide and related documents can be downloaded, including a pictorial version, translations into other languages, and a form for follow-up field visits. www.cpc.unc.edu/measure/tools/child-health/child-status-index

■ Project Hope, *Parenting Map*, 2009 The website provides more information on Project Hope's Parenting Map and related materials, such as a training guide and score card. www.projecthope.org/technicalsite/innovations.asp

■ Save the Children UK, *Children at the Centre: A Guide to Supporting Community Groups Caring for Vulnerable Children*, 2007. www.ovcsupport.net/graphics/OVC/documents/Jay/0000924e00.pdf

In addition, check out websites listed in the appendix 1, particularly www.cpc.unc.edu/measure; www.eldis.org; www.fhi.org; www.go2itech.org, and www.ovcsupport.net.

# **4.** Monitoring and Evaluation



Monitoring and evaluation (M&E) are processes that help track the progress and measure the effects of a program's work against agreed-upon plans, objectives, or indicators of success, and they generate learning about how well our interventions are achieving their desired results. Both quantitative and qualitative approaches can be used to collect information. The processes range from routine collection of information on a set of pre-determined indicators to complex, in-depth survey evaluations that use rigorous study design and data analysis methods.

## Monitoring versus evaluation

Although we tend to use the terms monitoring and evaluation together, they have different definitions. *Monitoring* refers to the ongoing effort of collecting data that tell you how well your project is moving toward the objectives you have set. The actual counting and recording of the information can be done on

a regular basis, perhaps every week or month. The process of consolidating, analyzing, and reporting these data may take place a little less frequently, depending on donor requirements.

*Evaluation* refers to assessments of how well the program met the expectations you had during the planning process and whether your interventions achieved the objectives you outlined prior to implementation. Evaluations may occur at pre-determined points during the project or at the end of a particular activity, such as a training workshop (III, chapter 1). Note that there are different types of evaluations, including process evaluations, outcome evaluations, and impact evaluations. Process evaluations can usually be done in-house, based on data already collected and an examination of program records that contain information about activities. Outcome and impact evaluations usually require special studies beyond routine monitoring of activities and results.

M&E processes provide information or evidence that enable program implementers, service providers, and donors to

- identify intervention strengths, weaknesses, and gaps

- support partners whose programs and organizations need to be strengthened

- stay at the cutting-edge of issues (such as HIV-related care for children) and learn which interventions are working and not working

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### How monitoring and evaluation differ

Program monitoring is concerned with routine reporting and/or tracking of inputs, processes, and outputs of programs. It tracks numbers and/or assesses the quality of outputs.

Evaluation is concerned with the program's outcomes and impacts. It often involves population-based and other special studies.

## Designing your M&E plan

Before you start implementing your project, it is important to know how you are going to monitor and evaluate it. Here are some examples of process indicators you can track to help you monitor what your project is doing on a monthly basis:

- No. of people served during a set time period (male/female; adults/children)
- No. of home-based care visits made (and by whom)
- No. of blankets (or food parcels or other items) that were provided
- No. of support sessions held (and where and with whom)
- No. of children attending a vocational skills course
- No. of public-service announcements on a new children's law
- No. of people trained in new knowledge and skills
- No. of volunteers involved in the program

If you are using the Child Status Index (CSI) or a similar case assessment tool, you already have a head start in the monitoring process. The measures you are already collecting will provide you with excellent monitoring information. If the scores are already entered in a database, so much the better. If not, individual scores must be tallied and compared over time, after each reassessment, to form an overall picture of what your program has achieved.

In addition to the numerical data you collect, you can also ask program beneficiaries for comments on how they experience the program and document their answers. Case vignettes, success stories, or "most significant change stories"[10] add depth and understanding. You can also ask key informants—such as teachers, volunteers, and village elders—for their input.

Here are some sample questions for you to consider:

- How well did the program achieve what was expected?
- Where did it do better than expected or worse than expected? Why?
- What was the best thing about this activity (or workshop or program)?
- What was the most disappointing thing about this activity (or workshop or program)?
- What did you learn as a result of this activity (or workshop or program)?
- What changes, if any, do you observe among the children who have been assisted by the program?
- Do you think this program changed the way you think or act on certain issues? If so, how?
- How can the program or activity be improved in the future?

Among the most important measurements in M&E are those that relate to the program's outcome and impact. Where feasible, it is always worth making the effort to get this information. Again, if you have reliable data from the CSI or similar tool, you are way ahead of the game.

Here are some examples of questions that may not be very difficult to answer:

- How many more children have started ART since your program began?
- What percentage of orphans who are eligible to be enrolled in school are now attending school regularly, compared to a year ago?
- How many more families are adequately fed, thanks to your program's food distribution?
- Two years later, what do young people who went through your church life-skills program say about the way it still affects them?

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- improve the planning and program implementation of governments and NGOs
- use evidence of what approaches work to mobilize additional resources and/or advocate for legislative and policy changes
- track how changes—perhaps to policies or funding—are affecting local partners and take appropriate advocacy action

M&E activities can enhance the accountability of your organization's work and assess how well it is achieving desired results or moving toward its goal and objectives at any point in time.

## Components of an M&E system

There are five components in a program's M&E system:

1. *Inputs*—resources used to conduct and carry out the program, including staff, finance, materials, and time

2. *Process*—a set of activities, such as workshops and trainings, where you apply your resources to achieve the objectives of your program

3. *Outputs*—the immediate results of the activities, such as number of staff trained or people served

4. *Outcomes*—changes at the population level, some or all of which may be the result of your program or intervention

5. *Impact*—the difference or changes your program interventions make in people's lives

The information you collect via ongoing monitoring activities becomes the basis for your process evaluation. Thus an effective monitoring activity can serve as an early warning system. It helps you to notice and analyze problems early and correct them before they start to hold back your work.

Of all the evaluation criteria you have, those that can measure outcomes—the final results of your project—are the most important. Unfortunately, resource constrains do not always make it possible to measure outcomes. In any case, outcome measurement should not be confused with impact assessments, which usually require special studies.

"If it's not written down, it hasn't happened." How many times have you heard that phrase? The findings of your M&E activities should always be documented in reports so you have a record you can check or share with donors and others. These reports are generally compiled on a monthly, quarterly, and/or six-monthly basis, and they include both program M&E and financial information. Back-up documents (field reports, forms, case files, receipts, and so on) should also be saved until well after the program is closed—generally for several years, depending on the donor's stipulation. Additionally, most donors require an annual report with M&E data.

Try to include photographs with your reports. Though these visuals do not replace the factual information you need to provide, they add punch and interest. Donor organizations appreciate them and may ask to use them in their own publications. (Be sure to get permission from people you photograph before sharing their pictures with a wider audience. See appendix 3 for a sample permission form that can be adapted for photos of adults.)

## Developing an M&E plan and selecting appropriate indicators

Ideally, the development of your M&E plan is part of your program design, which means that intended beneficiaries and other stakeholders are engaged in the process of designing your M&E activities from the beginning of the planning process (III, chapter 1). At the very least, a broad consensus should be sought from all stakeholders on program goals, objectives, activities, and M&E indicators.

An M&E plan usually consists of a framework that describes how you will design, conduct, and use



### Challenges for programs serving vulnerable children

M&E challenges for programs serving children, youth, and families include double-counting, data quality, and the quality of community-based information systems. In addition, data must be captured that go beyond health-related indicators, since these programs are multisectoral.

your monitoring system to track results. Your logical framework and workplan (III, chapter 1) are valuable tools that should guide the development of your M&E plan and may already include some of its elements. The draft formats outlined are also well suited to M&E planning. Note, however, that M&E indicators should be measurable and very specific. Your plan should also describe the M&E methodology; it should state who is responsible for collecting the information and outline the frequency of data collection. The act of putting this in writing should help you think through challenges you may not have anticipated.

Indicators are conditions that can be measured. They are used to track your project's progress toward its desired results. There are two main types of indicators, quantitative and qualitative.

■ *Quantitative indicators* are usually written as numbers or percentages. For example, instead of stating that linkages will be strengthened with local HIV-testing centers and healthcare providers, you state numerical targets: the number of community events you will hold to promote HIV testing and treatment and the number (or percent) of children

**Table 13. Sample objectives, results, and performance indicators**

| PROGRAM LEVEL | OBJECTIVES AND RESULTS | SAMPLE PERFORMANCE INDICATORS |
|---|---|---|
| *National and/or long-term goal* to which your program is contributing: All children should live within a stable family setting | Children live with a parent or legal guardian and have access to their rights, including inheritance | No. of children cared for by their legal guardians in the country<br><br>No. of children known to be living on the streets |
| *Main, medium-term, program goal* for your program, achievable within 2–5 years. | Increased number of orphaned and vulnerable children are cared for by a legal guardian within program target areas | No. of children cared for by their legal guardian in program target areas<br><br>No. of foster-care cases approved by the courts in target areas |
| *Short-term results:* Two to four expected results that contribute to your medium-term result | PLHIV signed wills before they died in the target area<br><br>Increased level of community awareness on children's rights | No. of PLHIV who have signed wills in target areas<br><br>Percentage of PLHIV in the caseload who have signed wills<br><br>No. of volunteers who offered advice in will-writing to PLHIV<br><br>Level of satisfaction among PLHIV with advice from volunteers<br><br>No. of community gatherings that offered at least a one-hour training session on children's rights |
| *Activities* | Training volunteers<br><br>Training PLHIV<br><br>Organizing media campaigns<br><br>Running advice sessions | No. of home-based care volunteers trained in will-writing<br><br>No. of PLHIV receiving advice in will-writing<br><br>No. of draft will formats distributed<br><br>No. of children referred to social welfare services for foster care |

served who, at a minimum, will be actively referred by your program for this purpose.

- ■ *Qualitative indicators* track results that are not easily documented by using numbers, though they often provide insight into the quality of services received. Qualitative indicators may involve use of checklists. They may be in the form of statements (such as "standard operating procedures have been developed for X service: yes/no") or they may be expressed as the level of satisfaction with the counselling or support received or the way a project is run. Such indicators can be expressed as high, medium, or low levels of satisfaction or the level of knowledge gained. To be useful, these levels must be clearly defined.

Both quantitative and qualitative indicators must be clearly defined and measurable. At the same time,

indicators should not drive program planning. This may seem obvious, but unfortunately this kind of "backward" thinking happens a lot, along with an unwillingness to track certain kinds of data because it isn't a donor requirement.

Just because you may be able to more easily measure something does not mean that this should determine what you do. At the same time, if certain data are important for your planning and care management (for example, data on household size or ratio of volunteers to clients), then you should track this information even if no one is asking for it. In sum, your M&E program design should not be driven by not by whatever is easiest to measure, but by your desire to meet your goals with indicators that measure the achievement of your objectives, provide information for future planning, and document the progress of your program's implementation (table 13). Before starting your program,

**Table 14. Examples of indicators**

| PERFORMANCE INDICATOR | BASELINE AND TARGETS AT THE END OF ONE YEAR | DATA SOURCES | COLLECTION METHODS | FREQUENCY OF DATA COLLECTION | ROLE AND RESPONSIBILITY |
|---|---|---|---|---|---|
| No. of volunteers who have offered PLHIV advice in will-writing | Target: 100%, 25 of 25 volunteers | Volunteers, PLHIV | Interviews and monthly reports | Every three months | Regional coordinator and volunteer supervisor |
| Level of satisfaction among PLHIV with advice (on a 5-point scale) | Baseline: Not applicable at start. Target: 80% are very satisfied (4 on the scale) | PLHIV | Interviews | Annual | Regional coordinator |

remember to first measure your indicators as a baseline, which will allow for a comparison later on.

The appropriateness of your indicators depends largely on how your program goals and objectives are defined. If possible, these and your key results should be stated in a client-focused way, meaning that they should relate to your beneficiaries. However, donors or governments sometimes determine some or all indicators that you must incorporate into your M&E plan. If you feel the need to substitute a given indicator with a different one or make any other alterations, be sure to check with your donor representative or government liaison before you take any action.

Like your objectives, your indicators should be SMART: specific, measurable, achievable, relevant (or realistic), and timely (III, chapter 1). This means that you should only choose indicators that relate directly to your program's objectives and that rely on information that you know you can obtain fairly easily. Don't choose indicators that depend on data that is difficult or expensive to get or that won't tell you anything about what your interventions have achieved.

Indicators also need to be valid, reliable, and sensitive to the outputs, status, or outcomes of interest to your program:

- *Valid* means that the indicator is a valid or true measure of the behaviors, status, knowledge, attitudes, or other features that it is supposed to measure.

- *Reliable* means that if you measure the same thing more than once using the same indicator and the same methods, tools, or instruments, you will get the same response every time.

- *Sensitive* means that the measure is responsive to changes in the outcomes, status, or behaviors of interest.

Table 14 offers additional information about these indicators, including details about how they will be collected.

## Implementing your M&E plan

As you implement your M&E plan, remember that not all methods involve collecting numbers. Be sure to gather people's stories about how your program might have changed their lives and their views on how the program is run: what worked and what was not so good. These testimonies can help you improve the quality of your program. Include the gathering of these testimonies in your planning process as you answer the following questions about the implementation of your M&E plan:

- *Who should be involved?* Especially if you are going to rely on volunteers and grassroots workers to collect data, it is best to get them involved in designing your indicators and data-collection tools. Getting children's input is also useful, especially if you decide to interview them or meet with some of them in a focus group as part of your monitoring process (I, chapter 5). If your project is part of a larger inter-agency or national initiative, try to establish a collaborative, team approach. For example, you can form an M&E group that comprises project and partner-organization staff and detail their responsibilities.

- *What training is required?* You cannot expect program staff and volunteers to adopt monitoring as an extra task without some training. Additional training will be required for those with specific responsibilities. Training community volunteers is time-consuming, and changing the indicators

**How to involve the community in
M&E activities**

*Get information from community members*—
Let community members know that your program
is evaluated and monitored and that you want their
input. For example, you can interview them to find out
how their knowledge and skills have changed since the
program started.

*Collect data*—Train community members to
use simple data collection instruments, such as
short surveys.

*Analyze the data and decide what it means*—
Some community groups can collect data on their own.
Later, with guidance from your organization, discuss
their findings and decide what the information tells
them about their situation.

*Provide feedback*—Share information by holding
meetings and giving short reports to local groups on
what your organization has learned about issues facing
the community, priority needs, program achievements,
and areas needing more effort.

or the monitoring or reporting forms will require
extra training and supervision. Remember that
changing indicators also means that you cannot
compare the values over time.

Monitoring is often understood negatively, as a
means to judge staff or volunteer performance.
Obviously, this perception must be changed if you
want to ensure timely, reliable data. The goal is to
make staff and volunteers become an active part
of the process; you need to provide input, informa-
tion, and feedback as they go about their daily
business and participate in M&E activities. Both
staff and volunteers should be involved in annual
program reviews that offer opportunities to reach
consensus on the purpose, aims, and methods of an
organization's monitoring plan.

■ *What funding is available?* The level of resources
available will greatly affect your plan for monitor-
ing. Program managers should consider M&E
as an integral aspect of budgeting and program
management, not as a separate or additional
activity. Programs that are up and running without
M&E systems may find it more difficult to obtain
additional funds to establish one. Some donors
recognise that M&E often consumes between 5 to
10 percent of a project's budget.

■ *How many indicators need to be monitored,
and for how many children?* If you are dealing
with large numbers of children or volunteers, it

may be too expensive to monitor every indicator
for every child touched by the program. In these
situations, you should design a sampling system.
Some donors may allow you to take a representa-
tive sample, which means that you would get
detailed information on only every third or every
fifth child. Be careful, however; decisions must
be carefully considered ahead of time. Sampling
for quantitative indicators with the aim of general-
izing the findings to the entire population can
get quite complicated. For more guidance, refer
to documents in the reference section or talk to a
sampling expert.

■ *Where will you monitor and who will be in
charge?* You should consider logistics and
practical issues. For example, will you cover
both urban and rural areas and include all major
ethnic groups? Where are volunteers based, and
what is the distance between children's homes?
You will also need to identify who on your staff
will be responsible for plan implementation and
administrative tasks. Volunteers are often relied
on to collect data, but unless they have a stake in
the results and receive regular communication
about the monitoring, they may not pay sufficient
attention to the process. For large amounts of data
collection and entry, you may need to employ
temporary staff or involve an outside organization
to help implement your M&E plan.

■ *What is the timing and frequency of monitor-
ing?* Where possible, determine up-front the
best time of year to monitor each of your chosen
indicators and how often they should be monitored.
Often, there is limited flexibility, since donors may
require reports every three or six months. When
you can, take other considerations into account,
such as the need to work around harvest time or
avoid the worst of the rainy season. Once you have
a schedule, however, stick to it. Late reporting
weakens the validity of your data.

■ *What about qualitative indicators?* Often we get
so caught up in numbers that we forget the value
of qualitative information. The intention is not to
generalize the findings to a larger group, but rather
to get in-depth information that is hard to obtain
through structured questionnaires and statistics.
How you gather qualitative information depends
on what you want to find out, why you want to find
it out, how you intend to use the findings, and—
probably most importantly—what resources you
have for this kind of monitoring.

Common qualitative methods are focus-group dis-
cussions (open-ended questions posed to a group),
one-on-one interviews with selected beneficiaries,
case studies (sometimes called success stories or

most significant change stories), and direct observations about the program. Depending on the type of program, you may be also able to use a "mystery client"—a staff member or volunteer who poses as a client, perhaps at a voluntary counselling and testing centre, and then reports on his or her experience. Alternatively, you may make use a questionnaire that is answered by key stakeholders, such as teachers or family members.

Before data collection begins, make decisions on data entry, editing, validation (checking the quality of your data), and on how data will be stored and archived. Microsoft Excel and Microsoft Access are useful tools for quantitative data management and analysis. Databases have many uses, and they can store lots of information about each child's needs and the type of assistance provided (III, chapter 3).

To some extent, the level of your analysis will depend on resources available. Ideally, the analysis of routine monitoring data can be carried out by a staff member without the use of a specialized computer program (though software programs do ease the burden of computing and consolidating data). Analyzing questionnaires and surveys does take time; in some cases, running the analysis may require a more sophisticated software package.

## A final word: M&E never stops

Effective monitoring is not a one-time event. It is an ongoing process of planning, implementation, communication, and follow-up. But just monitoring indicators is not enough. Blips or changes in indicators are a signal that field work is needed to find out what is going on. This ongoing work should be planned and responsibilities assigned before monitoring begins.

You also need to decide how results will be presented and summarized, how monitoring will be used, and what potential trigger-points will cause re-examination of the monitoring plan and/or management activity. You may also want to discuss these questions with your donors, especially if their continued funding is tied to your M&E results. Inform them ahead of time about management actions you will take if your monitoring data meet or exceed targets or indicate undesirable trends.

M&E should not be a secret. Be sure to communicate regularly with all key stakeholders, staff, volunteers, and beneficiaries about the process and ask for their input if unexpected results appear. This increases local ownership and commitment. If something appears to go wrong, it is better for you to initiate this discussion than to have someone else ask about it and put you on the defensive.

## Recommended readings and toolkits

■ Catholic Relief Services, *OVC Wellbeing Tool*, 2008. Following careful research and pretesting in four countries, this tool was released for use as a self-report measure for children ages 13–18. Note how the scoring works. www.crs.org/publications/ovc-wellbeing-tool/

■ Andrew Dawes, Amelia Merwe, Rene Brandt, and Rachel Bray, *Core Indicators for Monitoring Child Wellbeing,* 2007.
This resource provides a set of core indicators for monitoring orphans and children made vulnerable by HIV and AIDS. www.ovcsupport.net/graphics/OVC/documents/Jay/0000921e00.pdf

■ Joan Duncan and Laura Arntson, *Children in Crisis: Good Practices in Evaluating Psychosocial Programming*, 2004.
Guidance on the concepts, methods, and tools that can be used in evaluating psychosocial programming with children. www.ovcsupport.net/graphics/OVC/documents/0000822e00.pdf

■ Clare Feinstein and Claire O'Kane, *The Spider Tool: A Self Assessment and Planning Tool for Child Led Initiatives and Organisations*, 2005.
The Spider Tool aims to help child-led initiatives and organizations to assess what are trying to achieve, what they feel they are good at, and areas they feel should be improved. It also enables them to reflect on the learning process and plan changes and actions to improve their organizations. www.ovcsupport.net/graphics/OVC/documents/0000816e01.pdf

■ Anastasia J. Gage, Disha Ali, and Chiho Suzuki, *A Guide for Monitoring and Evaluating Child Health Programs*, 2005.
This guide seeks to compile indicators judged to be most useful in monitoring child health and encourage the use of standardized indicators and terminology across the child health community. It also aims to serve as a central source of obtaining measures of process and output that can be reasonably linked to program activities, promoting M&E of child health programs by making indicators better known and easier to use. www.cpc.unc.edu/measure/publications/pdf/ms-05-15.pdf

■ Thomas Rehle, Tobi Saidel, Stephen Mills, and Robert Magnani, *Evaluating Programs for HIV/AIDS Prevention and Care in Developing Countries: A Handbook for Program Managers and Decision-Makers*, 2006.
www.fhi.org/en/HIVAIDS/pub/Archive/evalchap/index.htm

■ Bandana Shrestha and Glenda Giron, *Regional Capacity Building Workshop on Monitoring and Evaluation Tools and Mechanisms,* 2006.
This workshop report summarizes discussions on building capacity and strategic development in the area of child rights and M&E mechanisms and tools across the South and Central Asia region.
www.ovcsupport.net/graphics/OVC/documents/0000827e00.pdf

■ Marco Segone, ed. *Country-led Monitoring and Evaluation Systems: Better Evidence, Better Policies, Better Development Results,* 2009.
M&E works best if everyone works together, consistently applying country-wide indicators toward agreed-upon outcomes. This tool provides do's and don'ts and examples of best practices.
www.comminit.com/en/node/284462/36

■ Camilla Symes, *The New Toolbox: A Handbook for Community Based Organisations, Vol. 2, Vision Building, Planning and Evaluation,* 2002.
Superb, how-to guide for managers of small organizations. www.barnabastrust.co.za/toolbox.php

■ UNICEF, *M&E Training Modules,* 2003.
This resource includes modules on macro planning, design and management, conceptual frameworks, data gathering, data analysis, and data sharing.
www.ceecis.org/remf/Service3/unicef_eng/index.html

■ UNICEF and UNAIDS, *Guide to Monitoring and Evaluation of the National Response for Children made Vulnerable by HIV/AIDS,* 2005.
This document provides guidance to governments, international organizations, and NGOs. www.ovcsupport.net/graphics/OVC/documents/0000300e00.pdf

An upcoming FHI publication, *A Guide to Monitoring and Evaluating Program-Level Activities for Children Affected by HIV/AIDS*, projected for 2010, deals exclusively with this issue.

In addition, you may want to check out websites in appendix 1, particularly www.cpc.unc.edu/measure; www.eldis.org; www.fhi.org; and www.ovcsupport.net, and explore resources available at www.globalhivmeinfo.org/Pages/HomePage.aspx, a collaborative effort led by the US Government and UNAIDS that provides a one-stop shop for global HIV and AIDS M&E-related information.

# 5. Quality Assurance and Quality Improvement

Ask yourself if giving a child a pencil for school is sufficient to be called an educational service. Probably you will say, "No, not by itself, because it is not enough to make a meaningful difference in a child's life." Assuming the outcome you want is for the child to regularly attend school, how much must you give before your interventions achieve that outcome and meaningfully improve his or her quality of life? How about three pencils and a couple of notebooks each term? Or school fees, educational supplies, and a voucher for a school uniform, but no direct contact with the child? Or a homework-support program three days a week, combined with a nutritious meal in an after-school center?

How much you need to give depends on the child's context or setting in the family and community and on his or her particular needs. It also depends on the availability of other resources in the community that can be called upon to help. All these factors must be considered if services rendered are to achieve the desired outcome and thus be considered a quality service.

To determine whether your interventions can make a meaningful difference in a child's life, you must know what outcome you want to achieve and identify the evidence that tells you that you are succeeding in helping the child to reach this outcome. A simple example: If you want all children in your community to eat at least two nutritious meals a day, then you must know what activities must take place and who needs to do them before this outcome becomes a reality.

Quality assurance and quality improvement (QA/QI) is a continuous process that addresses the quality of services provided and the performance of the organizations or systems that deliver these services. QA/QI focuses on making changes in systems and processes to achieve quality and on measuring the effects of these changes.

To do this, QA/QI starts with the development or endorsement of key setting and implementing of standards is just called QA. The process continues, however, as stakeholders prioritize important areas and continuously aim to improve the care provided and ensure maximum, long-lasting impact (or QI). (Some organizations prefer to bundle both aspects under the single acronym QI. At FHI, however, we tend to use both standards of care.) QA and QI have common features, but there are also differences between them (fig. 8).



FIG. 8. LINKING QUALITY ASSURANCE AND QUALITY IMPROVEMENT
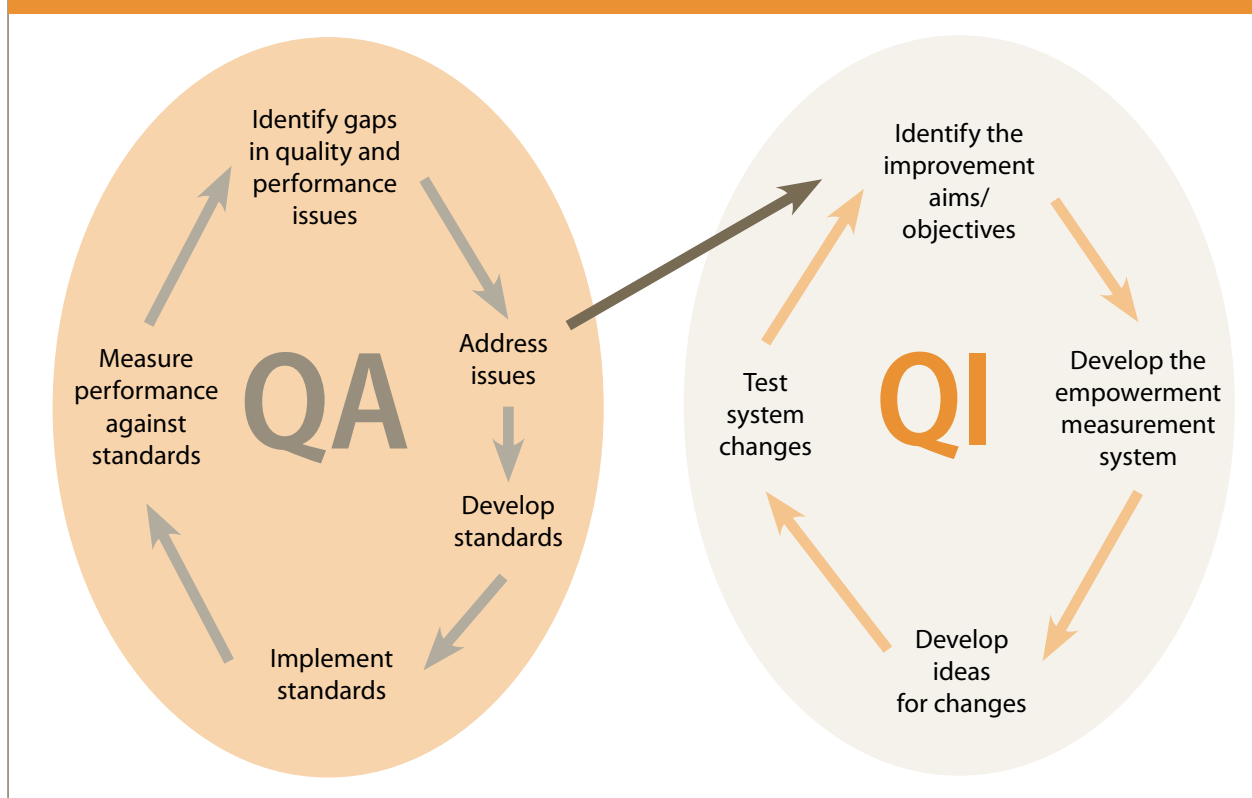
**Table 15. Dimensions of quality for activities involving children, families, and community members**

| | |
|---|---|
| **SAFETY** | The degree to which risks related to care are minimized. Do no harm. |
| **ACCESS** | The extent to which barriers to services are absent, whether these barriers are geographic, economic, social, cultural, organizational, or linguistic. |
| **EFFECTIVENESS** | The degree to which desired results or outcomes are achieved. |
| **TECHNICAL PERFORMANCE** | The degree to which tasks are carried out in accordance with program standards and current professional practice. |
| **EFFICIENCY** | The extent to which the cost of achieving the desired results is minimized so that the reach and impact of programs can be maximized. |
| **CONTINUITY** | The delivery of care by the same person and timely referral, and effective communication between providers when multiple providers are necessary. |
| **COMPASSIONATE RELATIONS** | The establishment of trust, respect, confidentiality, and responsiveness achieved through ethical practice, effective communication, and appropriate interactions. |
| **APPROPRIATENESS** | The adaptation of services and overall care to needs or circumstances, based on gender, age, disability, culture, or socioeconomic factors. |
| **PARTICIPATION** | The participation of caregivers, communities, and the children themselves in the design and delivery of services and in decision-making regarding their own care. |
| **SUSTAINABILITY** | Services designed so they could be maintained, directed, and managed at the community level in the foreseeable future and resources procured. |

QA aims at ensuring compliance with standards of care (the way care should be delivered) by removing the causes that limit their implementation. QI aims at making changes in a system in order to achieve improvement objectives and levels of performance that may not be defined by standards; it is a change-management process that fosters the discovery of new systems. QA and QI meet when the improvement objective is stated in terms of improving compliance with standards. A QI effort may focus on making system changes to allow for implementation of standards (a connection highlighted in fig. 8), but it does always begin with explicit standards that are a program's improvement objectives.

 For example, a program's QA process may note a standard that child growth is monitored during each clinic visit, but may find that only 60 percent of children are weighed systematically. This discrepancy may be the starting point for investigating the cause and addressing the problem. If there is only one weighing scale in working order, used by three health workers in the facility, the problem may be solved by providing additional scales or having children weighed by a nurse while they wait to see

a physician. The expected result is that standards are met—for example, 95 percent of children are weighed—and there are health benefits—for example, children found to be malnourished are referred to nutritional rehabilitation.

 A QA process may target an objective that is not defined by standards—for example, a reduction in the malnourishment rate among vulnerable children from 30 percent to 5 percent within 12 months. System changes that may help to achieve this objective will be tested on a small scale and progress monitored and measured. New recipes may be taught and dietary changes effected for a number of families. At the same time, the program may identify volunteers who will monitor children and ensure that a nurse makes weekly home visits until malnourished children achieve full recovery. Changes found to be most effective—best practices—will be institutionalized and scaled up. That is to say, if teaching new recipes produces health benefits, these will be taught to all vulnerable families. The QI process encourages the discovery of better systems and dynamic change. It fosters innovations and creativity, whereas rigid enforcement of standards may stifle innovations.

## Defining quality

Though quality can be defined as "a degree or grade of excellence or worth," many people are likely to define "excellence" and "worth" very differently. It may be helpful to think of various dimensions of quality[11] (table 15), these use these as a checklist for services or programs that you are designing, implementing, or supporting.

One goal of virtually all programs for vulnerable children and youth is to strengthen the capacity of families and communities to meet their needs as much as possible. A related goal is that all interventions should use existing safety nets and social structures, including extended-family support, government entitlements, informal community groups, community care coalitions, and faith-based organizations and NGOs that successfully reach vulnerable children and youth. Interventions that undermine these pre-existing supports should be avoided at all costs.

The following are among the additional goals articulated by QA/QI advocates for care and support programs for children:

■ The basic human rights of all children are addressed.

■ Vulnerable children and youth have the same opportunities in their communities as young people who are not vulnerable.

■ Services provided to children and youth make a meaningful, positive difference in their lives.

■ Partners work together toward the same QA/QI outcomes.

## Quality goals and standards of care

A QA/QI process begins with agreement on standards of care and measurable outcomes for children's services so that goals can be achieved. A standard can be defined as a statement of what is expected. Standard of care refers to a comprehensive description of the content of care. These are used as a guide for service delivery and as a basis for the training and supervision of service providers.

By describing your desired outcome (what you want to achieve), standards of care set the bar against which you can assess the quality of your program's services at a national, provincial, or local level. Standards also include activities (sometimes called inputs), processes, and outcomes. These define a minimum package of services and help you answer the following questions:

■ Are your program's activities contributing significantly to desired outcomes that benefit vulnerable children?

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**Quality care for orphans and other vulnerable children: "The degree to which the cluster of services provided to children, families, and communities maximizes benefits and minimizes risks, so that children may grow and develop in a manner that is appropriate to the norms in their community and cultural context..."**

Lori DiPrete Brown

Are these children approaching or surpassing the outcomes you want to achieve in each of the service areas—education, health, shelter and care, and so on?

■ Are your interventions in keeping with the essential actions that define the service? For example, if an essential action is to identify barriers to education, are your programs doing that? If not, why not, and what can you do differently?

■ Are you identifying best practices you can put into place and recommend to others that will help to operationalize the standards?

Many countries have established national quality standards of care for services reaching vulnerable children, usually as part of a national outreach and consensus-building process that involves input from a wide range of stakeholders. These national standards help you improve your support for children and their families because they help you to focus your activities and identify gaps in your current programming. These standards also guide the M&E process. Thus, if your monitoring indicates that your interventions are not meeting the standard, you are probably not helping the children you seek to reach and you should consider redesigning or changing your approach.

All activities that are part of setting quality standards should reflect the wisdom of community stakeholders, incorporate children's input (I, chapter 5), and be based on evidence of what works in the field. In 2008, FHI developed its own quality guidelines for programs that support orphans and other vulnerable

## FIG. 9. THE FHI QUALITY IMPROVEMENT MODEL



What are we trying to accomplish?

How will we know a change is an improvement?

What change can we make that will result in improvement?

Act | Plan | Study | Do

I. Identify the improvement aim/objectives

II. Develop the improvement measurement system

III. Generate ideas for changes

IV. Test/implement system changes

V. Sustain and spread the new system

fhi Family Health International

Source: G. Langley, KM Nolan, TW Nolan, CL Norman, and LP Provost, *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance* (San Francisco: Jossey-Bass, 1996).

children that can be used to complement national standards of care.[12] However, if there are differences between them, government-approved standards in your country will always supersede.

The FHI guidelines should be especially useful in countries that don't yet have their own national standards. Within the context of specific programs, you can also use the Child Status Index and similar care assessment tools to support the QA/QI process, since the service goals listed in these tools constitute a quality standard for measuring the wellbeing of individual children and their families over time (III, chapter 3).

National quality standards of care for services for orphans and vulnerable children often leave a lot of room open for additional objectives, guidelines, and program standards. All additions to the national framework should be specific, though they may span several service areas and refer to a subset of services, programs, or settings. For example, several organizations may get together and create specific standards for home-based family care or for the training of caregivers in psychosocial and nutritional support, within the broader context of the country's national quality standards.

Remember that setting and implementing quality standards of care does not imply that a service should

be perfect; rather, it should be sufficiently effective so that it can improve a child's life. Because the QA/QI process is continuous, however, new standards of care can always be introduced and new improvements made. Once your goal is reached in a particular service area, your program should aim to go further: either trying to help more children achieve this standard or aiming to set the bar higher toward a more advanced standard. Alternatively, if you don't achieve the standard right away, you need to keep trying to get closer and closer.

Always look for ways to coordinate services and achieve sustainability. For example, you can aim to access government assistance and find opportunities for the child's family to increase its income or benefit from your organization's support, rather than just providing services to the individual child.

### The FHI Quality Improvement Model

What are we trying to accomplish?" is the first question in the FHI Quality Improvement Model (fig. 9). All quality standards start with a desired outcome or goal, and should contain information that is clear, measurable, evidence-based, valid, and reliable (III, chapter 4).

Here is one example: "Children and youth have the human attachments necessary for normal development and participate cooperatively in school, recreation, and work with other children, peers, and adults." Another might be: "All children receive

### The importance of a participatory approach

A participatory and broadly inclusive approach is critical throughout the QA/QI process. Involving key stakeholders in developing, piloting and implementing draft service standards

- determines the extent to which the service standards are understandable and doable at the field level

- identifies what organizations need to do or change to be able to implement (follow) the standards—best practices that facilitate the ability to meet the standards

- helps stakeholders ascertain whether following the standards improves the quality of programming and services delivered, as articulated in the dimensions of quality outlined during the standards-development process

- allows stakeholders to investigate whether implementation of standards leads to a measurable difference for children (adequacy and effectiveness of the standards)

enough healthy food to ensure adequate nutrition for growth and development and an active and productive life." Thus, your goal should be specific and targeted to a specific client population. It helps to ask the following questions:

- *What are we trying to accomplish?* (Example: Reach 95 percent enrollment of vulnerable children in school.)

- *How will we know that a change is an improvement?* (Example: Increase in the number [percentage] of school-age children in XX program enrolled in school.)

- *What changes can we make that will result in an improvement?* (Example: Develop a system of case management to promote follow-up on the behalf of children and families in addressing barriers to school enrollment.)

The FHI Quality Improvement Model follows the Plan–Do–Study–Act cycle, adapted from www.hivguidelines.org. This is shorthand for testing a change in a real work environment, trying it, observing what happens, and acting on what has been learned. Applying this cycle helps you transform a standard on paper to activities that improve the lives of vulnerable children and their families in the community.

*PLAN:* Plan or test the observation. State the objectives of the test and make these objectives address what will happen and why. Develop a plan to test the changes. (Who will do it? Where? When? What data will need to be collected?)

*DO:* Once a change has been selected, carry out a test on a small scale and document problems and unexpected observations.

*STUDY:* Set aside time to study the data. Compare the data to your predictions and summarize and reflect on what was learned. If the pilot does not work, determine the modifications to be made.

*ACT:* If the change is feasible and it produced the desired effect, then the change can be adopted more widely. If the change was not successful, then another one can be chosen and tested. The cycle is repeated.

## Partnering for QA/QI

QA/QI involves working in concert with other stakeholders (including the government, other NGOs, traditional leaders, and groups of representative children and relatives) to define standards of care, communicate these standards, implement them, and encourage people to always look for new opportunities to meet or even exceed the agreed-upon standards. It is also important to regularly communicate both your standards and your QA/QI efforts to build consensus with beneficiaries and other providers about what you are doing and why.

The following actions are recommended to get as many people as possible to buy into the QA/QI process:

- Make use of short training sessions and easy-to-use tools that will help implement quality standards.

- Create QI checklists or other simple job aids—perhaps as pictograms or in the vernacular language—that volunteers, paid staff, and other service providers can use, including at the point of contact with children.

- Build commitment through peer-learning or an improvement collaborative, where people learn from each other by sharing changes that have worked, identify remaining challenges, and develop proposed solutions to test again. Essentially, this involves bringing together field workers or supervisors from different organizations or sites that provide similar services and asking them to form a team that reviews each other's programs and offers encouragement and ideas about how to improve the work.

- Check back regularly to see how well the recommendations have been implemented and determine what additional follow-up is needed.

## Implementing the QA/QI process

Remember that QA refers to the setting of quality standards and efforts to achieve standards. QI is the ongoing process using the plan-do-study-act cycle to test a hypothesis for improving the quality of services. It involves testing new approaches to promote improvement and then studying whether or not the new approaches were effective in changing quality.

The existence of good standards is critical but not sufficient to ensure quality service delivery. Local organizations and practitioners should be aware of the standards, agree with them (or better yet, play a role

in developing them), and have the skills to implement them and put them into practice.

Ongoing monitoring and feedback are part of the process. This provides opportunities for the standards to be reviewed, altered or expanded, and then reapplied. It is through this continuous process that organizations effectively operationalize QA standards and understand what they need to change in the service delivery system to make a measurable and positive difference in the lives of children and youth. With implementation, your focus is on the community or point of contact with children, rather than on the national level.

Most people find it easier to develop QA standards than to implement them. A new guide, *Road Map for Quality Improvement for OVC Programs*, may assist you, since it describes essential steps and is based on implementers' field experiences.[13] FHI is also developing a self-assessment manual to assist with the implementation of standards through a continuous process of QI. Additional tools, including the SALT approach, can be applied or adapted from www.aidscompetence.org.[14]

In local communities, the central idea for QA/QI is to build constituencies and commitment for quality care for vulnerable children and youth, initially on a pilot basis and then more broadly. You start by involving local people—a group of prospective beneficiaries and

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### The SALT approach

**S** —support, stimulate
**A**—appreciate, analyze
**L**—listen, learn, and link
**T**—transfer

The SALT approach encourages community-based innovation and QI; it is a personalized, bottom-up way of thinking and doing. SALT encourages communities or groups of people to develop their own standards, rather than applying those developed externally. The measure of success is the response of the people and by the people, who are self-measuring because they want to do the best possible job they can.

# No one can whistle a symphony. It takes an orchestra to play it.

H.E. Luccock

other stakeholders—to define what quality means to them. Then you work with the group to establish consensus about the standards they want to see for each area of service in their organization or community. If your country has national standards, these should be used as an overall framework or set of desired outcomes for your service areas. But this leaves lots of room for local standards and local improvements for a particular program or community.

Next, the group determines what interventions or activities may be needed to achieve these standards at the point of contact in the field, not just on paper or in some technical document. This is important because QA/QI must happen with children and their families in their own homes and communities for the process to be meaningful.

Once an intervention and activity is implemented and measured, the process can start over. Note that you may also take stock and restart in any point where your assessment tells you that some additional focus is needed. The dimensions of quality (table 14) can be used as a checklist to ensure that all key concerns are addressed.

The *Road Map* referenced on page 96 lists nine steps you should take in developing and implementing a QA/QI process:

1. Build constituencies and commitment for QA/QI.

2. Establish consensus on draft service standards— the standards of care that prospective beneficiaries and other stakeholders want.

3. Pilot the draft service standards.

4. Finalize and validate the draft service standards with evidence (M&E).

5. Disseminate agreed-upon service standards.

6. Disseminate lessons learned from the piloting.

7. Create a commitment to engage in ongoing QA/QI with many organizations.

8. Build local capacity in QA/QI to build communities of learning.

9. Institutionalize communities of learning to build on past knowledge with new initiatives for ongoing QA/QI.

Other QA/QI frameworks condense these steps, but the essential ingredients are the same. Start with a consensus-building process to draft standards you want to achieve for each service area or build upon or adapt standards that are already developed in your country.

The process of developing and implementing quality standards generally spans several years. It involves many consultative workshops or other avenues for input, including one or more workshops with children, local assessments, and peer-review sessions. A piloting stage follows, when standards are field-tested and a formal review based on the piloting experience occurs. As a result, modifications may be made to the standards and to the way services are provided in the community. The overall QA/QI process includes ongoing efforts to improve the way services are delivered.

## Pilot testing

One of the guiding principles of QA/QI is to gather evidence in the field that is based on draft standards or procedures before a final endorsement or mass rollout, whether on a national level or for a local organization or community. This step is often forgotten, or stakeholders may gloss over the need to gather evidence on the preliminary or draft standards initially agreed upon.

Pilot testing these draft standards will help you determine whether they are realistic and feasible at the point of contact with children. The process will also help you determine whether the standards are making a measurable difference in the children's wellbeing and whether actions being undertaken are good enough to meet the desired outcomes. The importance of first engaging in pilot testing applies equally to new procedures and other interventions being considered.

Pilot testing has at least two spin-off benefits. It helps you identify some of the best practices that improve the quality of programs serving vulnerable children, and it gathers buy-in from organizations and other stakeholders in communities where the programs are based. Be sure to include all feedback when evaluating your pilot and keep everyone informed about any changes made that resulted from their involvement.

Only after new standards and procedures are piloted and (if necessary) modified should they be adopted as final. Afterward, you should continue with your dissemination and implementation and with the ongoing QA/QI cycle.

## QA/QI as an internal process

A commitment to QA/QI requires you to look inward, into your own organization, as well as outward, to the community and to the services that you and others provide.

Regardless of size or type, every organization can implement a variety of interventions that help to assure or improve its own internal systems, structures, operations, programs, activities, and services. Ideally, everyone in the organization should desire continuous learning and want to participate in the process, and the organization's leadership should welcome this involvement.

Internal QA/QI occurs in different ways. System improvements can result from one person's experience and knowledge, scientific advancement, experimentation, or trial and error.

To illustrate, here are some examples:

- A staff member might observe a crowded waiting room and alter the flow by reorganizing the appointment system, based on his or her common sense or experience in a previous facility.
- The discovery and use of a new and more effective pediatric drug may improve the quality of care and children's lives.
- Structured research design and experimentation may result in improved ways of purchasing and distributing supplies.
- Improved immunization rates at a local health centre may result from trial and error, including sending reminders to mothers and changing the day that immunizations are offered.

Address the following issues to ensure success for your internal QA/QI process:

- *Ensure sufficient resources* including human resources, equipment, supplies, drugs, and physical space.

- *Provide ongoing training and education to staff and volunteers* so they have the knowledge and skills they need to perform their work, make good decisions, take leadership where indicated, respond to changing conditions, and pursue the organization's goals and objectives (IV, chapter 1).

- *Adopt state-of-the-art organizational standards, methods, and systems* by keeping up-to-date and following or adapting best practices in the field.

- *Employ quality supervision* that brings out the best in people and encourages continuous learning and improvement, in accordance with established guidance and procedures. The focus should be on recognizing what is being done well, helping staff and volunteer to identify and solve problems, and improving skills to perform more efficiently and effectively in the future (IV, chapter 1).

- *Link incentives to performance for staff and volunteers* meeting pre-established quality criteria or targets, including public recognition, pay increments, training opportunities, and/or attendance at out-of-town conferences.

## Recommended readings and toolkits

- Save the Children UK, *Raising the Standards: Quality Childcare Provision in East and Central Africa*, 2005.
This document provides a set of standards to guide quality childcare provision. www.ovcsupport.net/graphics/OVC/documents/cp/0000875e00.pdf

- FHI/Namibia, *Standards-Based Quality Improvement: A Process Report from Organisations Working with Orphans and Vulnerable Children in Namibia,* 2007.
A good description of the process and outcomes in setting QA standards for Namibia, including work with community stakeholders, NGOs, government, and directly with children. www.ovcsupport.net

- In addition, check out the following websites in the appendix 1 for more information on QA/QI: www.aidscompetence.org; www.cpc.unc.edu/measure; www.hciproject.org; and www.ovcsupport.net.

If you think you are too small to make a difference, try sleeping in a closed room with a mosquito.

African proverb

# 1. Build the Capacity of Implementing Organizations

Increasingly, large donors require that international partners such as Family Health International build the capacity of local implementing organizations so they can function without relying on external technical support and resources. Most local organizations want to develop their strengths for the same reasons; moreover, they want to grow in influence, maximize the quality of their work, and feel confident that they will be able to keep functioning until their mission is fulfilled. They also realize that money and technology alone are not enough to solve the problems they face, and they recognize that they must build their own ability to identify and respond to needs in their own communities.

Capacity building thus refers to a range of activities by which individuals, groups, and organizations improve their knowledge, skills, and ability to provide quality services, function effectively and efficiently, and achieve sustainability in their work. These activities draw on the organizations' own strengths and internal resources, as well as on the strengths, technical assistance, and resources of others in the community and beyond, such as FHI and other partner-organizations. A successful capacity-building process involves broad participation by all stakeholders in the organization to increase motivation, commitment, skills, knowledge, and confidence; achieve goals; and enhance the ability to manage work challenges and adapt to change.

Capacity building promotes and sustains the programs and activities of an organization or community group. It starts with the desire to improve the effectiveness, quality, or efficiency of the work the organization or group is undertaking. Partners like FHI can try to stimulate this desire, but the organization or group must own it. For capacity building to succeed, groups and organizations must want to learn what they can do to bring about these improvements.

Once underway, capacity building employs a variety of methods to strengthen skills, establish internal organizational systems, improve infrastructure, and increase the ability of people within the organization or group to identify their goals and objectives and then achieve them. Training is a particular set of methodologies, one that uses teaching, apprenticeship, one-on-one coaching, peer-learning, and specific print and electronic media to foster the acquisition of knowledge, skills, and competencies. Other methods include guided implementation (where people are closely advised or mentored); exchange programs

(where key people visit another organization to see how it addresses challenges); and job aids (where small booklets, templates, cell-phone reminders, and other support materials are used to guide the day-to-day work).

Through the provision of training and other learning opportunities, capacity building strengthens an organization's staff and volunteers and provides opportunities for their knowledge, skills, and attitudes to develop and grow. As their competence grows, the expectation is that the children, youth, and families they assist will receive better and more holistic services.

For local organizations engaged in caring for vulnerable children and families, capacity building can

- add value to staff and volunteers; increase their motivation, productivity, and commitment; and improve individual, team, and organizational performance

- ensure that staff and volunteers who take on new roles become fully competent as soon as possible and help them become up-to-date with new technology, systems, and methods of practice

- maximize local involvement and ownership of the organization's work in the community

**FIG. 10. THE CAPACITY-BUILDING PROCESS**
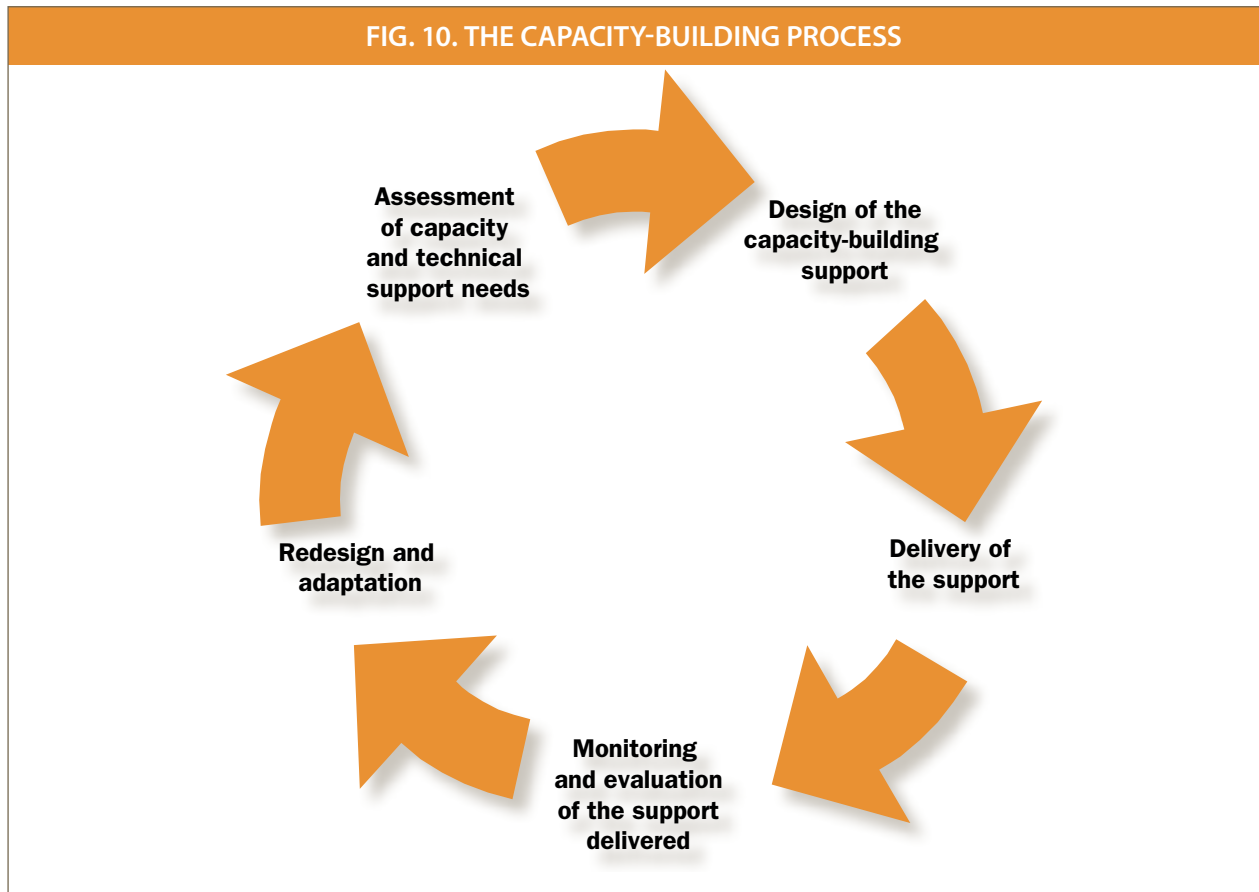
- enhance the quality of care, responsiveness, and range of services available for children, youth, and their families

- help to apply new policies and best practices in relation to the prevention, treatment, and care of HIV and AIDS and other diseases or to other social concerns.

- provide knowledge, tools, and techniques that enable an organization to rely on itself, rather than on outside organizations for ongoing guidance and support

Capacity building is a cyclical process (fig. 10). It starts with an assessment of an organization or group's current capacity or strengths and then determines what gaps need to be filled (II, chapter 4). Once the key people involved agree on an approach to fill those gaps, they may designate certain staff and volunteers whose personal capacity—that is, whose own knowledge and skills—should be increased to best help the organization meet its goals. Other approaches may involve developing new organizational policies and procedures, establishing stronger linkages with other local organizations and community groups, and listening to the voices of children.

### Assessing capacity and technical support needs

To know where you are going, you must first know where you are. Capacity building usually begins

when an organization's leadership undertakes an assessment to identify the type of capacity building needed to meet current demands and improve the organization's functioning. Alternatively, the organization may undertake a bottom-up approach, in which staff and volunteers identify key learning needs for themselves that fit within the organization's priorities. In both situations, the needs and interest in capacity building must be matched with opportunities that arise for additional learning, in conjunction with available resources. A combination of both approaches is also possible.

### Designing and delivering capacity building

Once capacity-building needs have been identified and priorities set, various implementation options are available. These include distance learning over the internet, study groups within the organization, shared learning with other organizations, mentoring by more experienced staff or technical advisors, and exchange visits to other organizations doing similar work.

Many organizations have relied disproportionately on training workshops, but one of the problems is that the learning often ends when the workshop is over, and what gets implemented in the field (if anything) is a watered-down version of what was taught. Workshops can also be very expensive, especially when transport, accommodation, and facilitation fees are taken into account.

As in other areas, you should begin with a planning process that lays out the capacity-building activities that should take place during a particular time span—usually one year. The choice of activities should be based on the desired learning objectives, on the methods you want to use, and on the availability of the people—staff or volunteers—who you want to involve. You also need to consider logistical issues related to timing, costs, and location. Often, two or more organizations can join forces to access training or skills-building activities, thereby saving money and strengthening inter-organizational bonds upon which future cooperative ventures may be established.

After your organization's decision-makers and/or donors approve your capacity-building plan, the next step is to implement it, preferably with attention given to issues deemed the most urgent. Be aware, however, that unanticipated needs and new opportunities for capacity building often arise mid-year. Be sure to look around for short courses and other training opportunities in the community that are offered by other organizations in which you and other members of your organization could participate.

Sometimes capacity building leads to unexpected outcomes, such as new staff policies and procedures; new computer software or new programmatic emphases; changes relating to service delivery, communications, or accountability; or even staff restructuring. Thus, organizations involved in capacity building should commit themselves to remaining flexible and open to new ideas, engaging in a constant process of learning and sharing and involving as many people as possible.

### Monitoring, evaluation, redesign, and adaptation

Outcomes of capacity-building activities must be evaluated immediately after they occur as well as some months later. Questions to be asked during an ongoing M&E process should include the following:

- Do staff remember what they learned through the capacity-building activity?

- Are staff implementing this learning by applying new skills and procedures?

- What difference is this making to the children and families who are targeted?

- Are there additional issues or unanswered questions that require additional capacity building?

Inevitably, the need for learning is ongoing, and one cycle of capacity building leads to another. New issues are selected for support, and recently acquired skills and knowledge are adapted to other areas or the organization.

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**How NGOs can conduct capacity building and training**

There are many ways to conduct training and capacity building. Not all of them cost a lot of money or require large chunks of time away from the job.

Here are some creative methods you can consider:

- Collaborate with other NGOs to share training. For example, your organization might offer training on basic counseling techniques with children and another organization might offer training on financial management or monitoring and evaluation.

- Structure peer learning and/or learning opportunities at lunchtime. Staff can take turns reading articles, newsletters, and book chapters and then report on what they learn.

- Arrange to visit other organizations doing similar work. Ask about lessons learned and how they could be applied to your work. To maximize the impact, always debrief.

- Bring in local guest speakers from stakeholder groups and line ministries, show topical films, or take an online course.

- Assign a junior staff member or volunteer to be coached by someone who is more experienced in the same job.

- Work in small teams so different skills can be brought together.

- After the training, build in a practical component with some supervision and evaluate the skills learned.

## When capacity building involves training

People learn differently: some prefer listening and others prefer reading. Generally, however, the best approach during capacity building activities is to combine auditory and visual techniques and apply them experientially, via a field assignment or internship—or, if that is not possible, through an experiential exercise or role-play.

People learn most effectively when they can see that what they learn is valuable. It is thus important to make the content of the capacity-building training as practical as possible and prove to participants that they can benefit from it. The training also needs to articulate clear goals that participants share. As with all planning and implementation cycles discussed in this manual, training follows a similar pattern. The training is designed, prepared for, conducted, and evaluated. The evaluation should involve a pre- and

post-test, as well as a follow-up six months or a year after to determine the value of the training and whether some reinforcement or a short refresher is needed.

Start by finding out what potential participants already know and build from there, connecting new knowledge and skills to the body of knowledge that already exists. It is helpful if participants can relate to the learning in a personal way and if it resonates in their own lives.

Learning is also most effective when participants feel respected and listened to and when their knowledge is valued and drawn upon. Trainers or facilitators should give direct and frequent feedback—especially positive feedback, where applicable—and participants should be given a say in how teaching and learning happen. At all times, trainers and facilitators must be sensitive to the differences in the culture and experiences of participants. They should also allow time for reflection, and they should summarize what was learned.

## Preparations for a training workshop

Needs and objectives (that is, desired results) must be identified for the training as part of your planning, along with the selection of a training environment that has the right atmosphere for learning. For example, training on child abuse may arouse strong feelings and painful memories, whether from participants' own lives or their professional work. You thus need to integrate opportunities for personal reflection and for peer support or counseling, and you need to ensure the venue is conducive to these activities.

Good training often includes both a classroom component—a workshop where participants gain information, discuss issues, and participate in small-group exercises and possibly some field trips—and a practical component. During the practical component, participants are urged to implement what they have learned via an assignment or internship (perhaps by being attached to another program or coached by a more senior practitioner). They then report, either in writing or orally, on their experiences and lessons learned. To maximize learning, the schedule and logistics must be prepared ahead of time, along with the training outline or curriculum.

### *Trainers and translators*

If training lasts more than one day, it is good to have two or more trainers—for variety's sake and to help everyone stay energetic and upbeat. At least one trainer should have a strong content-knowledge and at least one should have direct experience and knowledge of how your organization works in the field. If you are using several trainers or translators, come to

### Training on children's issues

When training on topics related to the care and support of children, it is always helpful to build on participants' existing knowledge and past experiences. Our own life-stories may not be the same as those of the children who our programs serve, but we can still relate at some fundamental level to many feelings and challenges that vulnerable young people face today and remember the joy, frustrations, and feelings of powerlessness that come with being a child. Many participants are also parents, and this gives them another set of useful experiences upon which to draw. Aim to touch the child within each adult during role-plays and other training exercises. Field visits and film clips of real-life situations help to crystallize lessons learned during training. If it is possible to have children or youth participate in part or all of the training and willingly share their own experiences, this often provides the most powerful part of the learning experience (I, chapter 5).

an agreement ahead of time on who does what, when, and how. You need to assign specific tasks, and you need to discuss communication issues and how to deal with any difficulties that may arise.

Trainers need to present their information clearly and use a variety of methods. They must encourage active learning by involving participants in experiential exercises, role-plays, break-out groups, inclusive discussions, and educational games. Where people are shy about speaking in large groups or are not very comfortable with the main language of instruction, small-group work helps maximize everyone's participation and active learning. Attractive PowerPoint slides can supplement a trainer's presentation, but these should never substitute for active discussion or participant involvement. A back-up plan is always needed for electricity outages and equipment failures, as technical glitches have a habit of happening at the most inopportune moments.

Trainers need to check frequently to make sure that participants understand the content being presented. They also need to encourage participants to reflect on what they are taught and on how they can apply it to their work. When questions arise, trainers are not expected to have all the answers; they may need to call on specialists for help or get back to the participants after the training is over.

Trainers must model good listening skills and allow time for participants to share information and ask questions. During discussion and feedback sessions, trainers should ensure equal input from both genders and that views expressed span all ethnic and age groups. Trainers who are not locally based should also

try to find out from local staff and translators what is and is not culturally acceptable during the training process and in relation to the issues under discussion.

Good translators are often an essential part of a successful training. They need to be culturally sensitive as well as language-sensitive: they should know when a literal translation may not be properly understood or, worse, be heard as offensive. To keep things lively, try to involve more than one translator. Breakout groups can be language-specific, unless you intentionally want to mix people from different regions or ethnic groups. If possible, communicate with translators beforehand to make sure that they have been briefed properly and are familiar with the content of the training. If necessary, translate all handouts ahead of time. When making up the schedule, you need to remember that activities always take longer if everyone in the group does not share the same language.

### A conducive and accessible environment

The choice of venue is very important, since people learn more easily when they are comfortable. Consider all aspects, including childcare arrangements, how long it might take participants to travel to and from the venue, whether an urban or rural setting is preferable, and whether the venue easily facilitates built-in breaks that enhance the absorption of new information. Set up training areas to maximize participation by having participants sit in a horseshoe or a circle and face each other and the trainer.

Take account of cultural and religious festivals and holidays when you choose training dates. And think about accessibility issues. Investigate whether participants (or trainers) have any hearing, visual, or mobility impairments and make arrangements for hearing loops, large-print handouts, or other kinds of accommodations that will make the training sessions accessible to all.

The internet and video-conferencing have enabled many training programs and refresher courses to become "virtual." Keep in mind that all participants don't have to be in the same place for a session to occur.

### The training agenda

A training schedule should have a detailed outline. The agenda should be provided to participants before the training, if possible, again on the first day, and reviewed with participants to ensure that topics meet their needs and expectations.

Keep the training practical—for example, by focusing on skills and competencies that participants can apply in their communities and that will improve the quality of life of vulnerable children and youth. Rather than

# Instead of constantly adapting to change, why not change to be adaptive?

Merrelyn Emery

giving lots of information that will be difficult to remember, focus on key concepts and methodologies, building on participants' own personal experiences and backgrounds.

Take into account that some people might not be familiar with certain modes of learning and that it will take time to explain the training process and methods. Use ice-breakers and warm-up exercises to get participants into the right mood; incorporate energizing exercises to keep them alert and interested throughout.

Participants should be asked early on the first day about their personal goals for the training. They should also be asked to suggest ground rules they think should be established. Make sure that these rules address punctuality and attendance, mutual respect, use of cellphones, and confidentiality. Distribute short evaluations at the end of every day, as well as pre-and post-test evaluations before and after the entire workshop. The responses provided will help to keep the training relevant and at appropriate levels for participants.

As issues or questions that can't be answered come up during the training, put them in a "parking lot" and try to get back to them. If you can't address them before the end of the training, make a plan for follow-up, perhaps during a refresher-session or a subsequent training.

### Applying what is learned

If not applied soon after, a lot of what is learned may get lost. Those applying this new learning in practical ways—whether they are interns, volunteers, or staff members—should be closely supervised. The supervision might involve written assignments, onsite observation, or debriefing. Exchange visits could be also arranged to facilitate peer-learning and feedback.

To demonstrate that the theoretical and practical parts of the training are equally important, you can withhold your end-of-training certificate until both components are completed. After the training is over, follow-up refresher sessions can be held to address questions, concerns, and inconsistencies that emerge

during the practical application. Sometimes these sessions are conducted in conjunction with group-supervision meetings that reinforce the training's key points and offer updates.

### Training evaluation

The training must be evaluated to see how effective it is. There are three types of evaluations: 1) pre- and post-tests to measure changes in knowledge and attitude; 2) ongoing evaluations during the course of the training (for example, at the end of every day) that allow mid-course adjustments to be made, if needed; and 3) a follow-up evaluation at the end of the training or possibly six months or a year later that provides a sense of how the training will affect (or has started to affect) practice in the field.

For an evaluation questionnaire, it is best to use a combination of open-ended questions and questions that ask participants to rate their answers on a numerical scale—perhaps in a 1-to-5 range or a range of 1 to 10. Your ongoing evaluation may be short; it essentially asks participants to review what they learned during the day and relate what is still not clear to them.

To measure how much knowledge has been acquired and attitude shifts (such as a shift related to gender stereotyping), use the same questionnaire at the beginning and at end of the training and ask participants to fill it in anonymously. You may also ask about their level of confidence in relation to the knowledge and skills addressed in the training, comparing the first day to the last (using a rating scale of 1 to 5 or 1 to 10). These evaluations are your pre- and post-tests.

As you draft questions for a follow-up evaluation at the end of a training or 6 to 12 months later, you may want to draw on the following list. Be sure to add other questions that relate specifically to your work, its setting, and the areas you address.

### Immediately after the training:

- What went well? (You may choose to list the training topics or presentations and ask participants to rate their assessment on a scale of 1 to 5 or 1 to 10.)
- What could have been done differently or better?
- How effective were the trainers, rated on a scale of 1 to 5 or 1 to 10?
- Were training materials relevant to your work? What was most relevant?
- Were any further training needs identified?
- Was the training inclusive? Did it involve a good mix or participants and allow everyone to participate in a meaningful way? If not, why not?

- Were the environment and facilities satisfactory (venue location, comfort, and refreshments)?

### Some time later or immediately after the training:

- What do you feel you learned from the training that is still useful to you?
- How have you applied or will you apply the learning?
- Did you acquire different knowledge, attitudes, and skills in relation to your work? (List areas of potential impact or ask for specific examples.)
- How well did the training achieve its aims and objectives, using a rating scale of 1 to 5 or 1 to 10?

A follow-up evaluation can also be conducted six months or a year later with beneficiaries or with community stakeholders. They can be asked to identify any changes or improvements they observed that are related to the issues covered by the training.

## Training new staff, community caregivers, and volunteers

New staff and volunteers must have basic competency in working with vulnerable children and youth. When home visits constitute the core for all the other services (as in the Star Model, III, chapter 3), it is advisable that all childcare workers and volunteers be first trained in home visitation and communication skills. Knowledge of the assessment and referral process is also critical, since it enables staff and volunteers to develop a care plan and connect the child or family members to needed services in the community. Training of new staff

and volunteers also involves mentoring wherever possible, pairing them up with others doing similar work who have a lot of experience.

In short, every person who makes a home visit needs to master basic care management, develop support skills, make good referrals, follow up with clients, and maintain up-to-date client records. To fill knowledge gaps, staff and volunteers need to ask questions of each other and refer to other resources in the community so that all areas of need can be addressed in accordance with national standards and quality improvement principles (III, chapter 5).

If the country where you are working has established national standards for the care and support of vulnerable children (III, chapter 5), your training program for community health workers should follow these guidelines and make use of any pre-approved curricula. This will ensure that local staff and volunteers achieve nationally recognized competencies.

Specialized skills may be learned by only a few (III, chapter 3), but some staff and volunteers may begin to specialize after they have finished their core training. They may be trained in such topics home-based healthcare, entrepreneurship and household economic strengthening, psychosocial support, early childhood education, nutrition and gardening, reproductive health, and disease prevention (appendix 7). Most of these focus areas are addressed in this manual. Staff and volunteers should master one or more, and supervisor-specialists should be trained in several areas.

## Recommended readings and toolkits

■  R.M. Cook, *Starting from Strengths: Community Care for Orphaned Children in Malawi: A Training Manual Supporting the Community Care of Vulnerable Orphans,* 1998.
A detailed and practical training manual produced through the Starting from Strengths project in Malawi. www.ovcsupport.net/graphics/OVC/documents/0000053e01.pdf

■  Uganda Ministry of Gender, Labour and Social Development, *Integrated Care for Orphans & Other Vulnerable Children: A Toolkit for Community Service Providers,* 2006, pp. 115–121.
A first-class document by the Ugandan government. www.worlded.org/docs/Publications/training/integrated_care_for_ovc_toolkit.pdf

■  Carol Vita and Cory Fleming, *Building Capacity in Non-Profit Organizations,* 2001.
This document examines capacity building as it relates to the overall quality of life in the communities that nonprofit organizations serve. www.urban.org/UploadedPDF/building_capacity.PDF

■  In addition, check out the websites listed in appendix 1, especially www.aidsalliance.org; www.aidscompetence.org; www.eldis.org; www.networklearning.org; www.stratshope.org; and www.youthwg.org.

# 2. Manage and Mobilize Local Support

Often, small organizations that may be providing excellent service are a one-man or a one-woman show. Everything hangs on what that one person does, and administrative procedures (so to speak) operate out of that person's back pocket. But what happens if that person can no longer perform these duties, or if he or she is accused of wrongdoing?

Large organizations are no less vulnerable to these threats, and financial mismanagement and interpersonal conflicts are major causes of failure among NGOs. Without proper checks and balances, documentation, and good teamwork, there can be no accountability and long-term continuity.

The local resources of your organization—financial, human, and physical—are the inputs that make your programs possible. Inputs also include in-kind resources, such as donated office space, volunteer time, seconded staff, or partner participation at board meetings. Your most important resource is likely to be the people with whom you work—staff, volunteers, and community stakeholders—whose level of skill and commitment can make or break even the best-designed programs.

When you engage in resource mobilization, you pull together the resources you need for your program. The process may be simple or complicated. The resources in question include your organization's own financial resources and its external support from donors; exchange programs you have with partner organizations (for example, for training); self-generated income (from, say, a fundraising activity or a community garden); and your in-kind resources. Resources also include community contacts that can facilitate your organization's outreach, communication, networking, and advocacy. Above all, your most precious resources are your people—staff, board members, volunteers, beneficiaries, local stakeholders, and community leaders. Find out why these people are involved and what you can do to strengthen their self-sufficiency, involvement, and contributions to others. It's often not money that they seek, but recognition and the feeling that they are valued. Many also seek

## When spider webs unite, they can catch a lion.

Ethiopian proverb

training and input into some of the organization's decision-making.

Good resource management and resource mobilization will allow you to

- conduct your program activities as planned
- maximize sound management and the effective allocation of resources
- promote collaboration and communication among all stakeholders and partners
- empower local communities and groups to become proactive in meeting their own needs
- strengthen partner capacity and support new ideas

The most important components in these endeavors are financial management, volunteer recruitment and support, collaboration, and advocacy.

### Financial management

Initially, you may have considered finance and administration issues to be somewhat removed from direct provision of services to children and their families. But the bottom line is that everything else depends on dealing effectively with finance and administration. Managers cannot afford to overlook these areas, even if they are outside their expertise. All organizational and program leaders should know something about the finances and budgets for which they are responsible.

Financial mobilization and financial management encompass all processes that govern accessing, recording, and using funds. This includes (but is not limited to) policies and procedures on fund-raising, budgeting and the allocation of income, the crediting and debiting of accounts, regular financial reporting, and regulations governing the use of an organization's property. Additionally, financial management includes processes to ensure that funds are used for their intended purpose and in accordance with donor expectations. If funds accumulate over time, the management of a cash and investment portfolio must be added to the list.

Good financial mobilization and management generally calls for people with specialized training. If you need information on how to establish internal organizational policies and procedures on financial matters, check out the free resources offered by Management Accounting for Non-Governmental Organizations at www.mango.org.uk. International donors and

international NGOs such as FHI also have sample manuals that you can adapt to your own situation. Before asking your organization's board of trustees to approve your new policies and procedures, it is a good idea to request a legal review to ensure they comply with in-country laws and practices.

### A financial mobilization and management strategy

The creation of a financial mobilization and management strategy should be the first step. (The pattern you should follow should be quite clear by now. You always begin a new set of administrative or community-based activities with a planning process.) The strategy includes the following steps:

- identifying potential sources of funds
- actively soliciting opportunities and pledges for support and following up on these pledges
- properly depositing and/or investing funds
- accurately recording all transactions and any restrictions on their use

These processes are usually reinforced by legal agreements and the legally binding policies and procedures adopted by your organization.

### Financial administrative systems

All organizations need to establish proper administrative and financial systems to ensure that they achieve their goals and objectives effectively and efficiently in the short term and, in the long term, that they develop sustainable programs. Strengths and weaknesses in these areas should come to light when you undertake an initial organizational assessment (II, chapter 4).

Your financial responsibilities include ensuring your program's strategic aims, objectives, and activities are properly reflected in your organization's budget. If you make a grant to another organization, you must ensure that your grant agreement includes detailed budget and reporting requirements. You must also ensure that all donor requirements are met, resources are used effectively and efficiently in accordance with the budget, and nothing is misused. As program manager, you must also ensure that roles and responsibilities are clearly allocated for all implementation tasks and a clear framework is in place for day-to-day management.

If you don't feel well trained in these issues, you should work with someone who has an accounting or administrative background. At all times, however, you should rigorously maintain oversight on your program's finances—a task you share with your organization's senior management and board of trustees. Resources that can help you to perform these duties

are available at www.mango.org.uk; www.aidsalliance.org; www.networklearning.org; and other websites listed in appendix 1.

### Fundraising for small programs

Eventually, any discussion about program planning and implementation comes down to raising funds. Even the most competent, highly motivated, and self-reliant organization or group serving vulnerable children and youth needs some financial resources and outside support to meet its goals. In-kind support may help, such as free office space, the work of unpaid volunteers, and donated transportation.

Small-scale support can come via exchanges with other organizations, through household-based, income-generating activities and from community savings clubs. Before embarking on these kinds of activities, it may be wise to establish a fundraising committee and develop a fundraising strategy to guide the effort.

You can also explore community-based, income-generating projects (such as the sale of food from a community garden), but undertake them only after a feasibility and market study, and after agreement is reached on a set of rules that state who does what and how much of any profit will be used for the program. Perhaps most importantly, you need to involve someone who is trustworthy and can manage the finances and account books.[1]

Sometimes, however, there is no alternative to raising some cash for an organization or program, and this is frequently a job in itself that may include organizing community fundraisers and soliciting donations and sponsorships, including from local businessmen, board members, and well-wishers. Raising funds can also entail online and community networking and writing proposals for small, one-time grants.

### Grant-making

International organizations such as FHI often function as a conduit for funding provided by large bilateral or multilateral donors to relatively small NGOs who are in-country implementing partners. In this arrangement, FHI identifies the organizations to develop and/or implement community-level services, then provides them with support and technical assistance so they can function as well and independently as possible. The grants can vary considerably in size, duration, restrictions, and requirements. Sometimes the contracted organizations make subgrants to smaller community-based groups, perhaps a church organization or an early childhood development center.

Grant-making requires a lot of monitoring and follow-up to ensure that implementing partners receive

timely technical assistance and the money they need. Monitoring and follow-up are also required to ensure that the funds that are allocated actually reach communities and are used in accordance with approved budgets and agreements. All financial and work arrangements must be handled transparently, based on agreed-upon criteria and processes.

It is essential that organizations receiving funds are accountable to communities, other partners, and donors. Usually, recipient organizations must report monthly on what they received and how they spent it, in line with their budgets. They also need to provide, either monthly or quarterly, back-up documentation, receipts, and statistical and narrative information about their programs. Donors usually have strict rules about grant-making (including sub-grants), and these must be followed carefully.

## Volunteer recruitment and support

Many programs working with vulnerable children and youth rely heavily on the support of community-based volunteers—people who know their communities well and are personally committed to the care and support of children and their families. Sometimes called home-based care givers, community health outreach workers, or a similar term, most of these volunteers are unpaid. They may be provided with bicycles and some other small incentive, or they may be reimbursed for transportation, lunches, or wear-and-tear on their clothing and equipment.

Your organization's volunteers are not just free or low-cost labor, and they should never be exploited. Though their roles and their relationship with your organization differ from those of paid staff, they require good supervision, training, and support. Be sure to check current labor laws and make sure that your use of

### Why do people volunteer?

Many volunteers of Catholic AIDS Action in Namibia were asked why they volunteer. Their answers included, "My neighbor needs me;" "This is what I believe God (or Jesus) wants me to do;" and "I may need the same help some day in the future." Other organizations have found that people volunteer because they develop skills and receive training; they appreciate the acknowledgement given to them by others; and they like the status their knowledge and volunteer role gives them in the community. Others see volunteering as a stepping-stone to a paid job. This is fine if it is acknowledged up-front, and if the volunteer fulfills whatever commitment she or he has made to provide a specific level of service for a specified length of time after receiving training or another type of support.

volunteers is not misunderstood as hiring staff below the minimum wage.

Trained community volunteers have important roles in baseline assessments and care management. They also provide referrals and advocate for needed services in the community. Volunteers can be wonderful role models for children, and their services are useful and varied.

They provide

- practical support—when they make home visits; help with planting and child-minding; and advise on water, sanitation, and other public health matters

- emotional support—when they listen sympathetically to difficulties and offer counseling or mentoring

- educational support—when they assist with homework and vocational training

- material support—when they serve as conduits for food assistance and school uniforms

- recreational and psychosocial support—when they tell stories and participate in art, drama, and sports

- legal support—when they share information about inheritance procedures, will-making, and guardianship

- cultural and religious support—when they help children and families learn more about their own cultures or obtain spiritual comfort

**Ten things you can do to honor and support your volunteers**

1. Listen to the views of volunteers who are experts about what is happening in their villages or neighborhoods. Provide feedback and support to improve work being done.

2. Ask volunteers what they need to do their work well. As much as possible, give them the tools they need, such as home-based care supplies, access to bicycles, and some options for material support in emergency situations.

3. Define the volunteer's job responsibilities and requirements so as not to take away from their main source of livelihood. Volunteer tasks should involve only a few hours a week or be otherwise structured to be manageable over the long term.

4. Invest in volunteer training and support. Just like paid staff, volunteers should receive training, coaching, and supervision.

5. As opportunities arise, consider transferring volunteers to paid positions. Many hope they will be offered paid employment at some point and may become disillusioned when this does not happen, especially if they learn that someone recently hired has similar competencies.

6. Consider motivational incentives that fit the style and budget of your organization, including award ceremonies and other forms of public recognition, spiritual retreats, credits to qualify for free healthcare, or an income-generating fund for a group project or savings club.

7. Over time, consider designating some volunteers as specialists, perhaps in monitoring and evaluation or as support-group leaders. Tailor incentives accordingly.

8. Work with government to ensure clear, appropriate guidelines that define volunteers' roles and offer them protection from potentially dangerous or harmful situations.

9. Develop your own policies to address the recruitment and roles of volunteers, guidelines for supervision, financial and material reimbursements, incentives, and volunteer access to keys and other property.

10. Maintain volunteer registration cards that include full names, contact details, areas of interest, and skills. This will make it easier for you to find appropriate work and training opportunities for them.

## *Recruiting, screening, and retaining volunteers*

Being a volunteer can be hard work, but it should also be considered an honor. Many organizations ask existing community groups (such as religious congregations, women's groups, and youth clubs) to identify individuals who could be recruited as volunteers for their projects. Requests can also be made from the pulpit, at community meetings, or via local newspapers and radio. Sometimes, volunteers come forward on their own or because of a personal recommendation, perhaps from a traditional or spiritual leader.

**How to motivate volunteers**

Involve them in program design, implementation, and decisions about monitoring and evaluation.

Report back to them on the successes of their combined efforts—for example, how many more people are being reached with their help.

Provide training and public recognition.

Offer a career path that has increasing responsibilities. For example, peer educators can be offered opportunities to become group leaders of peer educators, then coordinators of peer-education activities.

Don't overwork them, and give them sufficient time off to perform livelihood and household functions.

Sometimes certain qualifications are sought that are related to previous experience, literacy levels, and so on. Above all, however, volunteers should love children and have a burning desire to make a positive difference in their communities.

Before volunteers start work, be sure to screen them. You need to interview them and obtain recommendations or references from people you know and trust. You must also make sure that no one is accepted who has a criminal record or any history of involvement in the abuse of children. All volunteers should sign a code of conduct and a confidentiality pledge. If you are developing a code of conduct, you may wish to include excerpts from a statement of principles and guidance on the protection of children in appendix 2 (I, chapter 5).

Like paid staff, volunteers need to know what is expected of them and what they can expect in return. Some may want to know what training and incentives are in store, or if volunteering will put them in a good position for a paid job in the future. When you answer these questions, do not make promises you may not be able to keep. Many organizations have found it is best to put this kind of information in written contract that is signed by the volunteer and by a representative of your organization.

To retain volunteers, you should be careful not to overload them. Try to maintain a reasonable workload

of carefully defined duties that take just a few hours a week. Your contract with the volunteer should be reviewed in light of the actual work being performed, perhaps quarterly at first and then once a year. Like other staff members, volunteers need support and encouragement, including feedback, acknowledgement, and a sense of trust and belonging.

### *Supporting your volunteers*

From a community's perspective, volunteers who have hands-on responsibilities with children and families are the most important people in your organization, and you should treat them the same way. Find out why people volunteer and what motivates them, and build on this to generate long-term involvement and improve service quality.

## Collaboration and networking for sustainability

Organizations delivering programs that serve vulnerable children and their families maximize their sustainability when they network and partner with other service providers and stakeholders. To ensure extensive local support, program managers need to reach out to and collaborate with grassroots NGOs and community- and faith-based organizations. The networks established are useful for sharing ideas, planning, ensuring service coordination, minimizing overlap, and learning about participatory community activities that are occurring.

Collaboration is also important because civil society organizations can respond relatively quickly in an emergency. They are also generally flexible, often provide essential services not otherwise available to people in need, and advocate on behalf of particularly vulnerable groups. Grassroots organizations may be the first to identify gaps in service and try new service-delivery approaches. In large part, the wellbeing of a society can be measured by the level of engagement of these organizations and the rest of civil society—the extent to which neighbors, family members, and friends offer helping hands.

FHI's commitment to a holistic approach for children and their families relies heavily on good cooperation among all service providers in the community and on the broad integration of care, treatment, and prevention services. Working toward this goal ensures that you are in the best possible position to find community resources, if your organization can't provide a particular service needed by children or families.

The networks include government ministries, local NGOs, community-based groups, traditional authorities, business representatives, youth organizations, and so on. By working with all these partners, you can reduce overlap and identify gaps where few services exist and where you and your partners should place more attention. Also, different organizations and stakeholder groups within a network can help each other by sharing transport costs and training.

Ensuring timely and smooth delivery of needed services and maximizing service collaboration requires you to develop a good referral network. Although your checklist of the local stakeholders who could become network partners will vary, it will generally include some or all of the following:

- national and local government representatives and key personnel from ministries of health, education, gender, and/or social welfare

- persons who can liaise with local hospitals, clinics providing antiretroviral treatment, and primary and/or secondary schools

- local religious leaders and traditional authorities

- representatives from. NGOs, community- and faith-based organizations, support groups, and youth groups

- local business leaders

- beneficiary representatives, especially children and caregivers

Just as you make referrals to other providers, other organizations will also want to make referrals to you. You should also be aware that government ministries and civil society organizations will be much more willing to collaborate with you if they have had input into your program's development or expansion and are informed about your objectives. Ongoing communications—personal contact, short news briefs, consultative visits, and inter-organizational committee work—go a long way toward building mutual respect and opening doors that contribute to the wellbeing of your program's beneficiaries.

## Advocacy for social change

For organizations that support vulnerable children and their families, advocacy for social change is the systematic and organized effort to change unhelpful laws, policies, practices, or behavior. It is about pleading for the creation of an environment where specific goals can be achieved. Advocacy may aim to obtain additional resources and/or increase the access of vulnerable children and youth to local services and support.

Advocacy occurs through education and awareness-raising, behavior change communication, and active lobbying or targeted actions that bring attention to something you believe is wrong and must be changed for the better. Almost always, successful advocacy depends on broad partnerships across organizations and local groups. Advocates often speak out on behalf of the powerless or vulnerable, but the best approach is to find safe avenues that help those who are most affected to find their own voice and advocate for the change they want.

Advocacy for social change can take many forms, including quiet persuasion in private settings, community education, outreach, training, and social mobilization that encourages people to speak out or act differently. This can be accomplished through media campaigns, discussion groups, community gatherings, street dramas, workshops, and new curricula in schools or after-school centers. However, representatives of international organizations should never engage in partisan politics—or even give the impression of doing so—or take part in confrontations that call attention to issues in a dramatic way.

### How to conduct an advocacy campaign

It is always best to join forces with other organizations to ensure greater impact. But before you do so and get involved in an advocacy campaign, check with your organization's senior management and board of trustees to ensure that issues you want to address and networking partnerships you propose are consonant with your organization's current values and priorities.

If you have already mobilized the community as part of your core activities—that is, if you have opened up channels of communication and already work closely with several local groups and organizations—it becomes relatively easy to use these same channels for advocacy or an community-awareness campaign.[2] But first you must get consensus among your program's stakeholders on your messages and scope of action. If you overlook this step, you may find that you or your program will become victimized by a backlash campaign and future collaborations will be more difficult.

Also, be sure to focus on issues where you are confident there is widespread agreement with your partners and that you have the skills and resources you need to be successful. In talking with key stakeholders (including the people you want to influence but aren't sure how they will react), consider what their interests are and aim to build consensus. But don't expect change to occur overnight or on your first attempt. Achieving positive social change is a process, and it takes time.

### Recommended readings and toolkits

- Academy for Educational Development and USAID, *Speak for the Child. Case Study: Kenya,* 2003.
A detailed case study of work carried out in Western Kenya. www.ovcsupport.net/graphics/OVC/documents/0000512e.pdf

- Academy for Educational Development and USAID, *Speak for the Child. Case Study: Kenya. Annex E: Mentor Training Manual,* 2003
This document, based on experience of a pilot project in Western Kenya, is intended to be used by other organizations to train mentors and volunteers.
www.ovcsupport.net/graphics/OVC/documents/0000154e06.pdf

■ Fadumo Alin, Sjaak de Ber, Gordon Greer, et al., *How to Build a Good Small NGO,* 2006.
A marvelous, one-stop, down-to-earth manual that also available in French, Arabic, and Vietnamese. If you don't need the whole manual (79 pages), it can be downloaded in modules by topic. www.networklearning.org,

■ Marion and Les Derbyshire, *Friends in Need: A Handbook for the Care of Orphans in the Community,* 2003.
This detailed, well-presented, practical, and personal handbook is aimed at people who want to set up and run programs for orphans and vulnerable children. www.ovcsupport.net/graphics/OVC/documents/0000244e00.pdf

■ Firelight Foundation, American Jewish World Service, Bernard van Leer Foundation, and Pan African Children's Fund, *The Promise of a Future: Strengthening Family and Community Care for Orphans and Vulnerable Children in Sub-Saharan Africa*, 2005.
This publication highlights programs and strategies that help ensure that children remain in family care and within their communities by reducing discrimination, ensuring access to education, generating income, and providing direct support. www.ovcsupport.net/graphics/OVC/documents/0000838e00.pdf

■ Mary Harber, *Developing a Community-based AIDS Orphan Project: A South African Case Study,* 2003.
A case study involving the Thandanani Association in South Africa's efforts to establish a community-based program of care and support for orphans and other vulnerable children. www.ovcsupport.net/graphics/OVC/documents/0000083e00.pdf (accessed July 22, 2008)

■ Vasavya Mahila Mandali and the International HIV/AIDS Alliance, *Moving Forward. A Report on Pioneering Responses to Children Affected by HIV/AIDS in Andhra Pradesh, India,* 2004.
A report on a pioneering program of home and community-based care and support for vulnerable children and their families. It identifies gaps in existing services and effective initiatives and policies and examples of good practice for dealing with the issues that children face when they are affected by HIV and AIDS. www.hivpolicy.org/Library/HPP000599.pdf

■ UNDP and South Asia HIV Development Project, *Our Families, Our Friends, An Action Guide. Mobilize Your Community for HIV/AIDS Prevention and Care,* 2001.
Based on the experience of Mae-Chan community in Chiang Rai, Thailand, this document explains how a community can establish a program that responds to HIV and AIDS. www.ovcsupport.net/graphics/OVC/documents/0000150e00.pdf

■ World Vision International, *Guide to Mobilising and Strengthening Community-Led Care for Orphans and Vulnerable Children,* 2005.
This guide aims to provide useful tools for individuals and organizations seeking to mobilize and strengthen community-led care for orphans and vulnerable children. www.crin.org/docs/ovc%20care%20guide.pdf

■ In addition, check out websites listed in appendix 1, particularly www.aidsalliance.org; www.aidscompetence.org; www.eldis.org; www.networklearning.org; www.ngosupport.net; and www.mango.org.uk. Resource mobilization is not covered in depth in this manual, so you may want to look at www.sangonet.org.za; www.barnabastrust.co.za/toolbox.php; and www.aidsalliance.org

# 3. Lead with Super-VISION



Great leadership is not about being a smart politician or a brave hero. It is about the ability to mobilize people to tap into their own strengths and collective resources as they respond to the daily challenges of moving an organization or an idea forward. Developing leadership and supervisory skills always requires helping others to do the same.

At the core of great leadership in an organization lies great supervision. Emphasizing the last two syllables—Super-VISION—highlights the common purpose or vision that unites a supervisory relationship and builds on an organization's long-term strategic goals. Supervision helps staff and volunteers better understand the issues they face, brings competing viewpoints into play, and creates a safe and effective team atmosphere, where everyone can explore ways to overcome challenges.

Supervision must be experienced, though it can be taught. It is an art more than a science; a "feel" more than a formula. It is premised on the fact that every organization is different and dynamic, but all undergo constant change and need to be adaptable and flexible.

Supervision requires good communication and mutual respect. It begins with good listening and responding skills, and it requires a common understanding of the organization's role or mission in the community and where each individual staff person and volunteer fits into it. Supervision involves mastering duties and fostering good teamwork among an organization's employees, volunteers, and stakeholders. Through supervision, staff and volunteers

**People will forget what you said and people will forget what you did, but people will never forget how you made them feel.**

Bonnie Jean Wasmund

come to understand that the key to their own success is found by working with others on behalf of their organization and its programs. In this environment, effective communication, improved competence, and accountability flow naturally.

### Managing and leading—not the same thing

Many people think that managing an organization, a project, or a team is the same as leading it. This is not true, though both leading and managing are important and good.

You are *managing* when you ensure that processes, procedures, and resources (including human resources) are used efficiently and effectively. You manage as you develop operations within your organization that help staff and other stakeholders to reach shared goals. A well-managed organization is characterized by three core components: a supportive work climate, effective management systems, and skills in change-management.

### Core components of a well-managed organization

*A supportive work climate:* Managers contribute to a supportive work climate when they are good role models who "walk the talk" and practice what they preach; offer regular feedback and appraisal; treat people equitably and fairly; and ensure frequent opportunities for learning and self-improvement. Clear, regular, and respectful communication is essential. Managers consider input from all stakeholders before making decisions and explain the reasons for making them. If needed, they pay special attention to fostering good working relationships among people from diverse backgrounds.

*Management systems:* Managers develop structures, processes, and procedures to facilitate work. For these systems to work well, staff need to understand their own responsibilities and how their jobs fit in with others. Effective management systems involve good teamwork, clear communication, and participatory decision-making and planning.

*Skills in change-management:* The capacity of staff and volunteers to respond to change is critical, especially in organizations that work under difficult circumstances. ("Adapt or die" is often the message.) A successful response to change relies on the resilience, sense of organizational mission, and personal empowerment of everyone involved, along with optimism, openness to learning, creativity, and teamwork.

You are *leading* when you enable others to find or hone their own strengths and capabilities while they are overcoming challenges that stand in the way of desired results. Leading is particularly important in times of crisis. It encourages and empowers people to move forward and take on increased responsibilities, despite the obstacles in the way.

Providing leadership thus means more than being in charge or making good decisions. It also has to do with being a good listener and a good role model, supervisor, teacher, supporter, and facilitator of opportunities for others. Good leaders help to create the good team atmosphere that allows programs to grow and flourish.

Table 16 presents eight activities and organizational outcomes associated with leading and managing.[3] It also shows the value and expected result of integrating these eight practices into a program manager's daily work and applying them consistently.

### Delegating and sharing tasks

You may feel overwhelmed by the number of activities and responsibilities in table 16, but no one person can reasonably be expected to take them on alone. Good teamwork often comes down to effective delegation—sharing tasks with staff or colleagues and checking periodically to see if the activity is going well and if questions or problems have arisen. To help ensure the long-term functioning of a team, seek opportunities for staff and volunteers to engage in peer-learning and task-sharing. In the main, people work best in a supportive environment that encourages everyone to learn new skills and feel valued for their work.

When delegating or sharing tasks, consider the range of talents, skills, and personality types of the people in your organization. (For example, some may love detail-work; others may like working with numbers or take pride in being peacemakers.) Encourage staff and volunteers to bring their whole selves to the work and try new things. With ongoing encouragement and support, and with allowances for some mistakes during the trial phase, your team will grow stronger, more unified, and more successful.

Supervision helps people tap their individual and collective resources to respond to daily challenges and move an organization toward its mission. Good supervision is evidenced by the ability to get people to see the issues they face and bring competing viewpoints into play. It is also about the creation of a safe and effective team atmosphere, where staff and volunteers understand that their own success can be found in achieving the goals of their organization. In this environment, effective communication, improved competency, and accountability flow naturally.

### Supervision communication

Supervision involves being affirmative or supportive and communicating clearly. It requires that supervisors set aside regular times for meetings; make themselves available for consultation; and are accessible in

### Delegating tasks

Before delegating, ensure that all staff clearly understand the tasks they will undertake and be responsible for. One approach is to ask them to explain the steps involved in their own words; another is to prepare a short work plan together.

- Always make sure the deadline is agreed upon.

- Reiterate that each person may communicate with you (or to some you designate) in the interim, if questions or problems arise.

- Delegation works best when there is regular, one-on-one communication. Write down agreed action-points from these interactions so that they can be referred to later.

**Table 16. Leading and managing: What's the difference?**

| LEADING | MANAGING |
|---|---|
| Activity: **SCANNING**<br>Identify client and stakeholder needs and priorities.<br>Recognize trends, opportunities, and risks that affect the organization.<br>Look for best practices.<br>Identify staff capacities and constraints.<br>Know yourself, your staff, and your organization's values, strengths, and weaknesses. | Activity: **PLANNING**<br>Set short-term organizational goals and performance objectives.<br>Develop multi-year and annual plans.<br>Allocate adequate resources (money, people, and materials).<br>Anticipate and reduce risks. |
| OUTCOMES<br>Managers have up-to-date, valid knowledge of their clients, the organization, and its context; they know how their behavior affects others. | OUTCOMES<br>Organization has defined results, assigned resources, and an operational plan. |
| Activity: **FOCUSING**<br>Articulate the organization's mission and strategy.<br>Identify critical challenges.<br>Link goals with the overall organizational strategy.<br>Determine key priorities for action.<br>Create a common picture of desired results. | Activity: **ORGANIZING**<br>Ensure a structure that provides accountability and delineates authority.<br>Ensure that systems for human resources management, finance, logistics, quality assurance, operations, information, and marketing effectively support the plan.<br>Strengthen work processes to implement the plan.<br>Align staff capacities with planned activities. |
| OUTCOMES<br>Organization's work is directed toward well-defined mission, strategy, and priorities | OUTCOMES<br>Organization has functional structures, systems, and processes for efficient operations. Staff are aware of job responsibilities and expectations. |
| Activity: **ALIGNING AND MOBILIZING**<br>Ensure congruence of values, mission, strategy, structure, systems, and daily actions.<br>Facilitate teamwork.<br>Unite key stakeholders around an inspiring vision.<br>Link goals with rewards and recognition.<br>Enlist stakeholders to commit resources. | Activity: **IMPLEMENTING**<br>Integrate systems and coordinate work flow.<br>Balance competing demands.<br>Routinely use data for decision-making.<br>Coordinate activities with other programs and sectors.<br>Adjust plans and resources as circumstances change. |
| OUTCOMES<br>Internal and external stakeholders understand and support the organization's goals and mobilize resources to reach these goals. | OUTCOMES<br>Activities are carried out efficiently, effectively, and responsively. |
| Activity: **INSPIRING**<br>Match deeds to words.<br>Demonstrate honesty in interactions.<br>Show trust and confidence in staff.<br>Acknowledge the contributions of others.<br>Provide staff with challenges, feedback, and support.<br>Be a model of creativity, innovation, and learning. | Activity: **MONITORING AND EVALUATING**<br>Monitor and reflect on progress against plans.<br>Provide feedback.<br>Identify needed changes.<br>Improve work processes, procedures, and tools. |
| OUTCOMES<br>Organization displays a climate of continuous learning and staff show commitment, even when setbacks occur. | OUTCOMES<br>Organization continuously updates information about the status of achievements and results and applies ongoing learning and knowledge. |

the event of an emergency, whether by e-mail, phone, or in person. A back-up system should be in place if the supervisor is not available.

You know you are a good supervisor when staff and volunteers identify and understand the issues they face, can express different points of view without anyone getting angry, feel comfortable bringing up difficult or sensitive problems, and talk about and act on their commitment to quality assurance and quality improvement (III, chapter 5) and to your organization's goals and objectives.

The communication that lies at the heart of supervision may occur through written reports and in-person contacts, but increasingly it happens electronically, via telephone, e-mail, videoconferencing, and web-based chat rooms. In some settings, in-person meetings may be difficult and expensive to arrange, but they should occur periodically because they often lead to understanding and support.

In all communication, active listening and responding skills are essential. To listen actively means that we give another person our complete, undivided attention. It requires taking an interest in what the other person is saying, indicating we are following what they are saying and providing provide periodic affirmations such as "uh-huh" and "I understand." It requires using all our senses to pick up on non-verbal as well as verbal communication.

When a staff member or volunteer initiates a discussion, a good supervisor should try to express empathy and understanding, reflecting back what has been said and asking open-ended questions that allow a conversation to flow. If the discussion is about an issue that requires a decision, it is important to get all needed information and understand the other person's feelings and thoughts. Only then should the decision be made.

### Supervision meetings and group supervision

Supervision meetings require preparation. They reflect the manager's interest in the staff person or volunteer, and they provide the support that allows him or her to perform better or excel. The preparation may include analyzing the person's output, such as M&E data or reports or the way he or she greets guests. However, managers should not fall into the trap of setting the entire agenda; there must be enough time for the other person to bring in his or her own topics and questions. It is particularly important to be sensitive to what younger, shy, or less assertive staff and volunteers may want to bring to the discussion.

During supervision meetings, managers should make notes on anything they find remarkable—good things as well as areas that need improvement. If conveying

these observations, allow enough space and time for staff or volunteers to respond.

Group supervision occurs when the supervisor meets face-to-face with a group of employees or volunteers. Group meetings may supplement one-to-one meetings or they may be an alternative to them, especially in the case of volunteers. Usually a supervisor chairs such a meeting, although rotating this function may be preferred.

Though the agenda items may include information from a regional office, refresher-training on a particular topic, or data gathered since the last meeting, in each and every case it must also involve listening carefully to group members' concerns. Participants should be encouraged to share ideas about how a particular difficulty can be overcome, and they should be provided with support and follow-up after the meeting is over.

Though group supervision is an effective way to share information with a lot of people, there must always be opportunities for one-to-one communication, especially around sensitive or confidential issues. After a group meeting, a staff member or volunteer may indicate a desire to meet with the supervisor away

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**Three ways to help a new worker get started**

New staff members usually need a lot of direction. Consider the following three approaches to help orient and train them during their first few weeks on the job:

*Shadowing:* A new worker shadows or follows around someone with experience in similar work who is assigned to teach him or her how things are done. The person being shadowed may not be the official supervisor. Formal guidelines are set on where and for how long the exercise will occur and how much the new worker is expected to learn. At the end, a written report highlights areas where the new worker is still unsure and makes recommendations for additional support.

*A buddy system:* A buddy experienced in similar work is assigned to be the person the new worker can call upon informally for advice or support. This arrangement works well when two people with similar positions are in the same office or when volunteers are doing work in the field.

*Extra instruction:* The supervisor provides extra readings and explains things in considerable detail. As the new worker demonstrates proficiency, contact is less frequent but may increase again as new tasks or special assignments are given.

## SKILLS AND TIPS FOR PRACTICE

### Leadership Skills
- Inspire, focus, mobilize, support.
- Be a role model: lead by example.
- Establish trust and competence.
- Be fair and true to your words.
- Know yourself and your own style.
- Keep learning.
- Develop a plan to improve yourself.
- Ask for feedback.
- Apologize when you make a mistake.

### Conflict-Management Skills
- Assess the root cause of the conflict, such as differences in training or personality styles or experiences that resulted in jealousy, fear, or feelings of inadequacy.
- Delegate assignments fully and clearly to all involved.
- Be fair and impartial.
- Listen and do not judge.
- Bring the parties together to resolve the conflict.
- Mediate and let those affected try to find the solution.

### Problem-Solving Skills
- Use good listening and responding skills.
- Be focused and give clear feedback as soon after the event as possible.
- Be fair, just, and honest to all.
- Look for something positive to say and say it.
- Be timely; don't wait until the problem gets worse.
- Realize that everyone makes mistakes and can learn from them.
- Help workers affected by a problem to come up with their own solutions.
- Give feedback regularly and follow up in writing.

### Time-Management Skills
- Remember that the urgent is not necessarily the important.
- Set priorities. Decide what are you going to stop doing and assess the worst thing that will happen if you stop doing it. Determine when being a perfectionist is counterproductive.
- Reassess your work focus on a regular basis.
- Organize a workplan, but be open to change.
- Identify deliverables and tasks you must do.
- Delegate.
- Leave time for emergencies.
- Leave yourself time to reflect and plan.

### Diplomacy Skills
- Read the situation and other people with sensitivity.
- Carefully choose your language (words) and tone of voice.
- Never publicly embarrass anyone.
- Never allow a personal relationship with someone to influence your work relationship.
- Avoid supervising a relative or close friend.

### Communication Skills
- Use good listening and responding skills.
- Remember that people may respond even more to your body language than to your tone of voice and words.
- Be sensitive to culture, gender, and age.

### Negotiating Skills
- Read the situation with sensitivity.
- Identify all interests of all parties involved, including your own.
- Identify win-win situations.
- Break out of hardened positions, appeal to the needs behind the positions, and creatively look for solutions.

### Hiring Skills
- Take time interviewing and do not hire someone you are not sure of.
- Promote from within if possible, including available volunteers.
- Assess personality fit and motivation.
- Assess gaps in your team and fill those first.
- Remember that skill-building is possible and attitude adjustment often isn't.

### Skills In Handling Difficult People
- Avoid getting personal.
- Be flexible, except when it comes to the organization's rules of good and moral behavior.
- Keep focused on the work goals and mission.
- Speak to the person in private and try to get that person to agree on key ground rules for behavior in the workplace
- Provide coaching, but refer the counseling elsewhere
- Focus on facts (not assumptions or impressions) as you move toward a shared goal, a decision on how to achieve it, and the step-by-step approach required.
- Keep evaluations up to date; avoiding them because they are difficult will only make things worse.
- Use feedback as a warning system, in line with your organization's disciplinary code.

### Stress-Management Skills
- Identify what is bothering you and get rid of as many stressors as possible.
- Cut out extraneous information and focus on the most important issues.
- Avoid a concentration on history; what is past is past.
- Exercise, meditate, and pray to relieve stress.
- Take some time off.
- Do something else for a while and rotate your activities.
- Be easy on yourself; nobody is perfect.
- Find peace and calm in yourself before facing a difficult situation.

## FIG. 11. LEADERSHIP AND SUPERVISORY STYLES
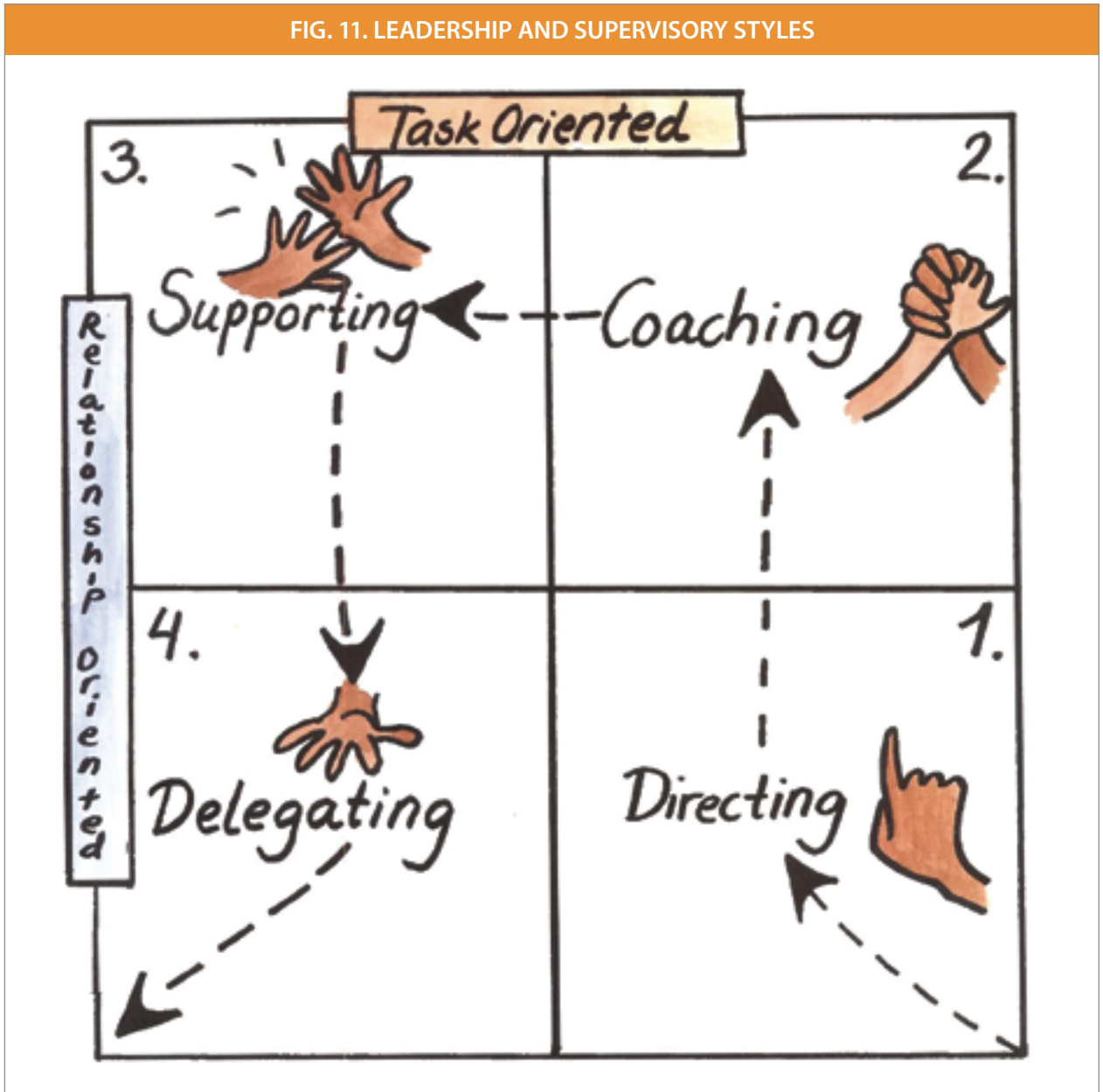


from everyone else. If a private discussion does not allow enough time to address or solve the problem, some follow-up arrangement should be made.

### Supervision frequency

How often supervision takes place depends on the kind of issues faced, the personalities involved, and the physical logistics or practicalities of communication. In general, supervision should be frequent—maybe even daily—when someone is new to a job or to a particular task or is facing a sensitive or difficult situation.

When routines are established and there are fewer problems to deal with, supervision may be less frequent, with less face-to-face contact and more telephone calls and e-mails. Still, regular communication is essential, including periodic in-person meetings where possible.

Other factors to consider when scheduling supervision include how much the person knows about the work, whether he or she has been trained, and how much confidence he or she has. A need for a lot more on-the-job training should trigger more frequent supervisory contact. The frequency also depends on practical issues, such as how far away the person is and whether he or she has access to a telephone or e-mail.

A written performance review should occur annually, and it should involve both a self-assessment and a supervisory evaluation. During the review, new goals with indicators are set for the year ahead. Supervisors may request confidential input from co-workers that feeds into the review. Most often, the job description of the staff member and the goals from the previous year are used as the baseline to determine whether work performance is satisfactory or has improved. If

there seems to have been no improvement or a slide backward, reasons for saying so should be explained.

## Styles of supervisory leadership

Good supervisors need to individualize their approach. They should not treat everyone the same way or on the basis of their educational backgrounds or positions. The approach with the same person may also vary, as old challenges are mastered and new ones emerge. In applying different styles of supervisory leadership, the work context needs to be considered: the kind of organization it is; how this affects the way that staff and volunteers function; a supervisor's work style or strengths; the preferred work styles of staff and volunteers; and how well everyone understands and performs required tasks.

Ken Blanchard and Paul Hersey created a useful model that allows managers to analyze situations and adopt the most appropriate leadership or supervisory style.[4] Figure 11 adapts these authors' simple grid, based on a leader's directive or supportive behavior.

A manager's supervisory style should vary across these four boxes, depending on the situation or tasks at hand and on the developmental levels of the people supervised:

- *Directing (sometimes called telling):* Supervisors define the roles and tasks of the people they supervise, supervise them closely, and make and announce decisions. Communication is largely one-way.

- *Coaching (sometimes called selling):* Supervisors still define roles and tasks, but seek ideas and suggestions from the people they supervise. Decisions remain the supervisor's prerogative, but communication is much more two-way.

- *Supporting (sometimes called consulting):* Supervisors pass day-to-day decisions such as task allocation and processes to the people they supervise. Supervisors facilitate and take part in decisions made by the people they supervise.

- *Delegating:* Supervisors are still involved in decisions and problem-solving, but control is with the people they supervise, who decide when and how supervisors will be involved.

There is no one right style. Effective supervisors are versatile; they move around the grid according to the situation. However, we all tend to have a preferred style, and it is helpful to know which comes most naturally.

Being a good supervisor is an all-around job, as it requires you to draw on the leadership, management, and good communication skills used by counselors and community activists. Above all, always aim to be a good role model, as people learn much more from what you do than from what you say.

## Recommended readings and toolkits

- Fadumo Alin, Sjaak de Ber, Gordon Greer, et al., *How to Build a Good Small NGO,* 2006.
A marvelous, one-stop, down-to-earth manual that also available in French, Arabic, and Vietnamese. If you don't need the whole manual (79 pages), it can be downloaded in modules by topic. www.networklearning.org,

- Carl D. Glickman, Stephen P. Gordon, and Jovita M. Ross-Gordon, *Supervision and Instructional Leadership: A Developmental Approach,* 7th ed., 2006.
A classic used in many universities and business schools

- International HIV/AIDS Alliance, *NGO Support Toolkit,* Version 3, 2008.
This toolkit is an amazing resource. Available as a series of seven manuals and on a CD ROM, it addresses a wide range of issues, including institutional change. www.aidsalliance.org/custom_asp/publications/view. asp?publication_id=112

Bryan Walker, *How to Succeed in Your Work: A Tool Kit,* 2nd ed., 2008.
This manual is designed to help build a career and improve work, management, and supervisory styles. www.networklearning.org

- In addition, check out the websites listed in appendix 1, particularly www.aidsalliance.org; www.eldis.org; www.networklearning.org; and www.ngoconnect.org.

# 4. Care for Yourself So You Can Care for Others

People who work with and care for children in difficult circumstances— supervisors, paid employees, volunteers, and family members—are particularly vulnerable to stress. The work involves giving of ourselves to others—our attention, caring, emotional support, and love. If we don't get some of this back or find opportunities for personal renewal and replenishment, we will eventually feel emotionally exhausted and empty inside.

The point at which we just want to give up or run away is called burnout. If not managed correctly, too much stress can also lead to health-related problems and declining work quality. It is important that you take care of yourself so you can take care of others. If you don't, you will not be of much use to anyone.

## Stress and burnout

Burnout is a state of emotional and physical exhaustion caused by excessive and prolonged stress. It can occur when you feel overwhelmed and unable to meet constant demands. As the stress continues, you begin to lose interest or motivation.

Stress can be good when it leads to excitement, stimulation, success, achievement, increased productivity, and creativity. However, if good stress goes on too long without a break, it can also lead to exhaustion and negative consequences.

Bad stress results from boredom, frustration, work and family pressures, a lack of teamwork or support, and poor performance or decreased productivity. Possible consequences include headaches, indigestion, sleeplessness, and a predisposition to illness, as well as unhappy relationships and a sense of failure.

### The longer you hold on to it, the heavier a burden becomes

A lecturer on stress management raised a glass of water and asked how heavy it was. He went on to explain that this depends on how long it's held. Holding the glass for an hour will cause the arm to ache; holding it up for a day could put the holder in hospital. The longer the glass is held, the heavier it becomes. That's the way it is with stress, he continued. If we always carry our burdens, sooner or later they become increasingly heavy and we won't be able to carry on. He advised listeners not to carry the burden of work home, but pick it up the next day.

Ugly stress results from the build up of too much bad stress and has even more serious consequences. Burnout may set in, accompanied by a significant drop in performance and emotional and physical well-being. Possible results include ulcers, heart attacks, sleep disorders, depression, and even suicide. The best thing you can do to remain emotionally strong is to maximize your own ability to take advantage of good stress while on the job, reduce bad stress, and avoid ugly stress and burnout.

If you are also experiencing a lot of bad or ugly stress in your personal life, then reducing your work-related stress is even more important. Burnout does not appear suddenly. You need to recognize some important physical and emotional symptoms:

- continual exhaustion; elevated pulse; forgetfulness
- impatience and irritability
- feelings of inadequacy, helplessness, and guilt
- loss of confidence and self-esteem; withdrawal from social contacts
- neglect of duties and reduced work performance

## Strategies to manage stress and prevent burnout

Don't carry all the burden of your work alone. If you are facing pressures you can't deal with, consider asking for help. Feelings of distress are legitimate, not signs of personal weakness or lack of professionalism. It's important that you find ways to manage your own stress, and also help others in your organization— both staff and volunteers—to do the same.

**A test to help you determine if you are burning out**

Use this checklist[5] before and after you take steps to reduce your bad or ugly stress. Answer the questions with a number from 1 to 5.

If you have not yet taken steps to reduce stress, 1 means *"No, this does not apply,"* and 5 means *"Yes, this is true."*

If you have taken steps to reduce stress or are retaking the test, 1 means *"There has been a great deal of positive change over time"* and 5 means "*There has been no improvement or very little improvement over time."*

____ Do you tire easily? Do you feel fatigued, rather than energetic?

____ Are people annoying you by saying "You don't look so good lately?"

____ Are you working harder and harder and accomplishing less and less?

____ Are you increasingly cynical and disenchanted?

____ Do you often feel sad but can't explain why?

____ Do you forget lots of things (such as appointments, deadlines, and personal possessions)?

____ Are you increasingly short-tempered and disappointed in the people around you?

____ Are you seeing close friends and family members less frequently?

____ Are you too busy to do even the routine things that you used to do?

____ Do you suffer from physical complaints (such as aches and pains, headaches, lingering colds)?

____ Do you feel disoriented when the day's activity comes to a halt?

____ Are you having difficulty experiencing joy?

____ Are you unable to laugh at a joke about yourself?

____ Does spending an evening with a friend or loved one feel like it is more trouble than it is worth?

____ Do you have very little say to people?

_____ **TOTAL**

Don't let a high score alarm you, but pay attention to it! Burnout is reversible, no matter how far along it is. The sooner you start being kinder to yourself the better.

Just as there are many sources of stress, so there are many ways to manage stress. Following the steps below will assist you.

### Step 1: Identify the problem.

- Ask yourself what is causing your stress.

### Step 2: Explore solutions and recognize what you can change

- Find out how you can handle and manage stress

- Ask yourself if you can change your stress by avoiding it, eliminating it, or taking a break to shorten periods of exposure to it.

- Recognize your limitations. Learn to say no to what you cannot or can no longer handle.

### Step 3: Reduce the intensity of your emotional reactions to stress.

- Ask yourself if you are expecting to please everyone.

- Try to temper excess emotions and put the situation in perspective. Do not focus on negative aspects. Try to see the stress as something you can cope with, rather than something that overpowers you.

- Ask yourself if you overreacting and viewing things as absolutely critical and urgent. If so, work at adopting some more moderate views.

- Expect some frustrations, failures, and sorrows. Seek professional counseling, if needed.

### Step 4: Learn to moderate your physical reactions to stress.

- Find a physical way of relaxing that works for you. If doing exercises helps, find time to do some.

- Try slow, deep breathing to normalize your heart rate and respiration. Try some relaxation techniques to reduce muscle tension.

- Consult a physician if you think you need medication. This can help in the short term, but it is not the long-term answer.

### Step 5: Build your physical reserves and embrace a healthy lifestyle

- Avoid nicotine, excessive caffeine, and other stimulants.

- Eat well-balanced, nutritious meals and maintain your ideal weight. If you drink alcohol, do so only in moderation.

- Mix leisure with work. Take breaks and get away when you can.

- Three to four times a week, engage in moderate, prolonged, rhythmic exercise, such as walking, swimming, cycling, or jogging.

- Get enough sleep and maintain a consistent sleep schedule as much as possible.

### Step 6: Maintain your emotional reserves

- Set your own boundaries.

- Expect some frustrations, failures, and sorrows.

- Pursue realistic goals that are meaningful to you, rather than goals that others have set that you do not share.

- Be kind and gentle with yourself and be your own best friend.

- Pray, sing, dance, create art, and play music.

### Step 7. Support each other

- Develop mutually supportive friendships and relationships. Meet regularly with staff or volunteers to debrief and share experiences.

- Consider a ritual or commemoration that marks the good things happening through your work as well as the sad events.

- Start the day or week with a short period of silent reflection or group prayer.

It is not necessary to do all these things at once. Pick one that feels right and start with that. When you feel less stressed, choose an additional strategy. Remember that we have to take care of ourselves in order to also take care of others.

# Endnotes

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## Section 4

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# Appendices

**Appendices**

# 1. Recommended Websites

The websites listed provide practical tools and information concerning vulnerable children, youth, and their families. Favorites are marked with an asterisk. New websites come online every day, so keep looking and you may find some great new treasures!

**www.adeanet.org**
Website of the Association for the Development of Education in Africa, which features articles, booklets, databases, and reports.

**www.aecf.org**
The US-focused Annie E. Casey Foundation aims to help vulnerable children and their families succeed by building supportive communities, reforming public systems, gathering and evaluating data, and promoting equity. The website highlights the foundation's work in child welfare, permanency planning, community change, health, education, and economic security.

**www.aed.org**
The website of the Academy for Educational Development provides information on education, health, civil society, and economic development. Of special interest is the project on Africa's Health in 2010, which lists a wide range of resources on health and nutritional issues. (www.aed.org/Projects/africa2010.cfm)

**\*www.aidsalliance.org**
The website of the International HIV/AIDS Alliance is a treasure-trove of toolkits and other good, practical information for use in training workshops and program implementation.

**www.aidscompetence.org**
This website aims to facilitate local ownership of responses to the HIV pandemic by linking people and organizations and encouraging local people to act from strength, build their capacity, provide support, reduce vulnerability and risks, learn and share with others, and live their lives to their full potential.

**www.aim.jsi.com**
The website of the USAID-funded Uganda AIDS/HIV Integrated Model District Programme allows for an in-depth view into one country and provides information on supporting and strengthening district HIV/AIDS and TB and community services. Many documents are available for download.

**www.basics.org**
The mission of BASICS is to help ministries of health and their partners implement large-scale interventions that have been proven effective in preventing and treating the major causes of newborn and childhood death. The website includes an online publication and resource center.

**www.bernardvanleer.org**
The Bernard van Leer Foundation funds and shares knowledge about work in early childhood development and child rights and promotes innovative and holistic approaches in education, health and nutrition. Publications are available for download. You can browse projects for disadvantaged young children supported by the foundation through partner organizations around the world.

**www.cabsa.co.za**
This website contains many excellent resources from a Christian perspective, including a sermon database, generic information (such as tools for project management), and the Prisma Capacity Building Program. The focus is on southern Africa, but many documents have broader appeal.

**www.clintonfoundation.org**
The William J. Clinton Foundation aims to strengthen the capacity of people around the world to meet the challenges of global interdependence. Of special interest is the pioneering work by the Clinton HIV/AIDS Initiative on the care and treatment of children living with HIV.

**www.comminit.com**
This excellent website is driven by the belief that communication and media are central to social and economic development. Of particular interest is *Drum Beat*, an e-magazine on communication and the media that addresses HIV and AIDS, reproductive health, and life skills for youth. Manuals, guides, and toolkits can be downloaded from the website and CDs, videos, posters, comics, and other reference materials can be ordered.

**www.cpc.unc.edu/measure**
This website highlights MEASURE Evaluation's work to help programs monitor and evaluate their progress in confronting disease, population changes, and poverty. Many publications related to quality improvement of services for vulnerable children are available, including case studies, the mapping of OVC services, and guides to the Child Status Index.

**www.crs.org**
The website of Catholic Relief Services spans a wide range of issues related to alleviating suffering in a hurting world. Of particular interest is the *OVC Wellness Tool and Scoring Sheet*, available to non-commercial organizations free of charge.

**www.crin.org**
The Children's Rights Information Network empowers the global child-rights community through the exchange of information and the promotion of children's rights. The network's websites contain over 16,000 resources as well as links directly to their Better Care Network and

their NGO Group for the Convention on the Rights of the Child (www.childrightsnet.org)

## www.crin.org/bcn

The Better Care Network brings together organizations and individuals concerned about children without adequate family care. The website provides valuable information from research studies, toolkits, examples of best practices, and advocacy issues. Information is updated on the Better Care Network listserv, which can be accessed from this site.

## www.ecdgroup.com

The website of the Consultative Group on Early Childhood Care and Development features news, upcoming events, and publications on early childhood, such as Coordinators' Notebook: A Global Call to Action for Early Childhood.

## * www.eldis.org

This website aims to share the best in development policy, practice, and research. Readers can browse through and download free of charge more than 26,000 summarized documents from over 7,500 development organizations. The website is easy to navigate and focuses on all vulnerable groups, including refugees, people affected by war and conflict, children and families in disease-burdened communities, and the very poor.

## * www.fhi.org

The homepage of Family Health International leads you to many excellent publications related to children, program management, and HIV. Many of the resources are referenced in this manual, but there are lots more!

## www.firelightfoundation.org

The Firelight Foundation supports and advocates for the needs and rights of children orphaned or affected by HIV and AIDS in sub-Saharan Africa. In a section of the website called Children and AIDS, issues are discussed and links made available to related publications.

## www.hciproject.org

This is the website of the USAID Health Care Improvement Project, which focuses on QA/QI.

## www.helpage.org

Increasingly, grandmothers and other older carers are taking on parenting roles. The website of HelpAge International focuses on the impact this has on the elderly and on policy, psychosocial, and economic issues. Research reports and some training materials are available.

## www.humantrafficking.org

This website is an excellent, non-partisan source of resources and links related to child protection, trafficking, and labor in the Asia-Pacific Region and, to a lesser extent, in other regions.

## www.humiliza.org

This is an excellent website on psychosocial counseling and teacher education on building the coping skills of children who have experienced loss. It sees children as part of the solution, rather than the problem.

## www.ilo.org

Through this website, the UN International Labor Organization brings together governments, employers, and workers in member states in common action to promote decent work for all, including a focus on child-labor issues.

## www.jlica.org

The Joint Leadership Initiative on Children and HIV/AIDS works "to make children visible in the AIDS response" by engaging practitioners, policymakers, and scholars in collaborative problem-solving, research, and analysis. Through their interdisciplinary learning groups, JLICA provides provocative research and policy papers on a family-focused response to the needs of children affected by the HIV pandemic.

## www.kit.nl

This website of the Royal Tropical Institute in the Netherlands references books and toolkits on NGO governance, gender, health, HIV/AIDS, sustainable economic development, and other issues.

## www.mango.org.uk

Management Accounting for Non-Governmental Organizations exists to help aid agencies and NGOs work more effectively, particularly in financial management, through training, consultancies, and free publications.

## www.msh.org

The website of Management Sciences for Health offers the Health Managers' Toolkit as part of the organization's electronic resource center. This material makes the important distinction between facilitating a planning process and managing a young organization or project.

## www.networklearning.org

This website makes resources available free of charge to NGOs working in development or humanitarian fields. Resources are in French, Somali, and Arabic. Materials for NGOs include advice on how to run a workshop, a guide to fundraising, and manuals on management skills, gender, the project management cycle, and microfinance.

## www.ngoconnect.net

This website is an interactive portal dedicated to connecting and strengthening NGOs, networks, and NGO-support organizations worldwide. It provides tools, theoretical frameworks, innovations, and lessons learned offered by the NGO community, donors, and support organizations.

## www.ngosupport.net

The International HIV/AIDS Alliance's website offers support to NGOs and community-and faith-based organizations by providing a wide range of practical information. In particular, the NGO toolkit has seven sections, including strategic planning, partner and

project selection, technical support, institutional change, monitoring and evaluation, and day-to-day management skills.

## www.ovcsupport.net

This website, jointly sponsored by FHI and the International HIV and AIDS Alliance, emphasizes program design, training, and QA/QI. If you could only access one website on issues related to vulnerable children, this one is probably your best bet.

## www.panos.org.uk

This website aims to promote dialogue, debate, and change by reporting on research and helping to apply it through the participation of poor and marginalized people at the community-level. Some of the research relates directly to children's issues.

## www.pedaids.org

The Elizabeth Glaser Foundation is dedicated to identifying, funding, and conducting research on pediatric HIV and AIDS and other life-threatening diseases that children face. Its website includes descriptions of research projects and grant-application information.

## www.popcouncil.org

The Population Council seeks to improve the wellbeing and reproductive health of current and future generations around the world and help achieve a humane, equitable, and sustainable balance between people and resources. Its website offers books, peer-reviewed journals, working papers, newsletters, and reports highlighting the council's research activities.

## www.pronutrition.org

This website cosponsored by Satellife and the Academy for Educational Development provides resources, practical knowledge, and decision-making tools on health and nutrition for healthcare providers, community health workers, policymakers, and program managers. Some subtopics focus on children and on maternal and child health.

## www.readytolearn.aed.org

The Academy for Educational Development's online Ready-to-Learn Center focuses on the widespread problem of inadequate care and education for children ages 0 to 8 in developing countries, providing advocacy information and relevant publications and presentations.

## * www.repssi.org

The Regional Psychosocial Support Initiative provides some of the best training material available on psychosocial care and support for children and youth in communities affected by HIV and AIDS, poverty, and conflict. REPSSI also provides training workshops, mentorships, experiential programs, and technical assistance to ensure that all children receive affectionate care and support to enhance their psychosocial wellbeing.

## www.safaids.net

This is a well-structured, coordinated network of information resource centers and "kiosks" established by SAfAIDS (the Southern Africa AIDS Information and Dissemination Service), in partnership with national networks of AIDS service organizations in Southern Africa. Much of the information has a broad, global focus.

## www.savethechildren.net

The International Save the Children Alliance comprises 27 national organizations in more than 110 countries and works with children to find long-term solutions to the problems they face. Publications can be found on all major Save the Children websites, such as www.savethechildren.org, the website of Save the Children in the United States.

## www.stratshope.org

The Strategies for Hope Trust has produced 16 case study books, five videos, a new series called "Called to Care" (directed to faith-based organizations), and the Stepping Stones training package on community-based responses to HIV and AIDS in sub-Saharan Africa. NGO representatives in developing countries are usually able to order publications from the website at no cost.

## www.satregional.org

This website gives you access to top-quality, user-friendly, training materials produced by the Southern African AIDS Trust for NGOs and community-based organizations on community-based approaches to HIV and AIDS care, advocacy, prevention, and other topics.

## www.streetchildren.org.uk

The Consortium for Street Children is a worldwide network that works to help street children. This website is dedicated to the welfare and rights of children who work and live on the street and of children at risk of taking to street life. It contains a wide range of publications on street children and related issues.

## www.taskforce.org

The website of Task Force for Child Survival and Development includes information on child health and development; infectious diseases such as polio, malaria, river blindness, tuberculosis, and HIV; and a special section related to orphans and other vulnerable children.

## www.terredeshommes.org

Terres des Hommes is an international federation of 11 national organizations working for the rights of children and to promote equitable development without racial, religious, political, cultural, or gender-based discrimination. From the website, you can connect to resources and links.

## www.unaids.org and www.unicef.org

These two United Nations websites contain much background data about HIV and AIDS and the condition, needs, and rights of children. Much of the information is provided country-by-country. In addition, you can find research studies, advocacy papers, training materials, and best-practice documents to help inform your work. Of particular interest when working with faith-based organizations is *Scaling Up Effective Partnerships: A Guide to Working with Faith-based Organizations in*

*Response to HIV and AIDS.* Also, check out www.unicef.org/eapro for resources related to child development, health, and protection in the Asia-Pacific Region.

### www.usaid.gov

The website of the United States Agency for International Development includes information about its work around the world and its partnership with the US President's Emergency Plan for AIDS Relief (PEPFAR). See also www.pepfar.gov.

### www.womenchildrenhiv.org

This website has a large library related to the prevention and treatment of HIV infection in women and children. It is targeted to health workers, program managers, and policymakers in resource-limited settings.

### www.worldbank.org/children

This site, which includes a resource library, is designed to assist policymakers, program managers, and practitioners in their efforts to promote the healthy growth and development of children and youth.

### www.worldvisionresources.com

This website contains many online resources—most of them available free of charge—related to theological issues and the welfare of children and families in the developing world.

### www.youthwg.org

This website is part of the work of the Interagency Youth Working Group based at FHI. It is a one-stop electronic source for publications and information on youth reproductive health and HIV prevention, includes tools, curricula, program reports, and previously unpublished research findings. The website is also reachable through www.infoforhealth/ythwg and www.fhi.org./en/Youth/YouthNet

# 2. Guidance on Screening Staff, Volunteers, and Board Members to Ensure the Protection of Children

The organization will make known that abuse of children is not tolerated and that protection of children from harm and abuse is a guiding principle. It is committed to screening all staff, interns, volunteers, consultants, board members, and others who may interact directly with children in the course of organizational activities.

Human resources personnel will coordinate this screening process, which includes obtaining personal information, including home locations for at least the past five years; a chronicle of all experiences working with children, whether as volunteer or employee; and a list of people who can provide references about this work. The screening will include a background check that determines whether misconduct with a child caused a paid or volunteer position to be terminated and any criminal offense histories, including type, date, location, and disposition.

When applicable, each individual will complete a form that provides written authorization for the organization to initiate the background check and contact references. Failure to complete the screening process or failure to provide written authorization for the background check will constitute grounds for non-selection.

No one with a history of criminal activity, especially any activity that involves children in crimes or activities that abuse, harm, or threaten them, will be considered for any position within the organization if there is any chance that the individual will have direct contact with children in the organization's programs.

The organization will ensure that implementing agencies funded through subgrants will similarly screen all individuals who stand to occupy positions where they have direct interaction with children.

# **3.** Sample Consent Form

*All consent forms should be translated into the vernacular and, if need be, adapted to local circumstances. Consent forms should be signed by children who are old enough to do so, as well as by their parents or guardians. One copy of the signed form should be kept in the local office of the implementing NGO and another copy maintained in the head office.*

*Medications that the organization's staff need to administer to a child during a sponsored event must be supplied, along with clear, written instructions on how much to give, when, and possible side effects. A written statement must also be provided if the child is authorized by the parent or guardian to self-medicate.*

## Consent form for children's participation

Sponsoring Organization/s _____

To Whom It May Concern:

We, _____ [print name of parent or guardian and name of child], give permission to _____ [sponsoring organization/s] for _____ [name of child] to fully participate in the _____ [name of activity or event] on _____ [date] at _____ [location].

Restrictions on participation, if any _____

Name and contact information for emergency contact _____

In the event of an illness, accident, or other emergency involving _____ [name of child], we authorize the staff of the sponsoring organization and the medical staff they select to take any action they consider appropriate.

Medical condition, medications, allergies, or restrictions: _____

None ____

We agree that the organizations involved and their staff, interns, and volunteers are not responsible for any unanticipated losses, damage, accidents, illness, or injuries that may occur during the activity or event.

**AGREED TO BY**

_____        _____
Signature of parent/guardian                    Signature of witness

_____        _____
Print name                                              Print name

_____        _____
Date                                                    Date


_____
Signature of child

_____
Print name

_____
Date

# Consent for use of quotes, photographs, and videotaped images

Except for the restrictions listed below, we give permission to the sponsoring organization/s to use my child's photograph, videotaped images, and quotes or information gathered during the activity or event in documents, published materials, and electronic presentations that may help improve the quality of services to vulnerable children:

Printed, audio, electronic, and internet-based materials produced by the sponsoring organization/s for documentation and awareness-raising during the activity or event

___/yes ___/no

Printed, audio, electronic, and internet-based materials produced by other organizations who may be present at the activity or event

___/yes ___/no

Printed, audio, electronic, and internet-based materials produced by newspapers, television, radio, and other public media
___/yes ___/no

Use the real names of the child and the parent or guardian in materials produced

Child: ___/yes ___/no

Parent or guardian: ___/yes ___/no

**AGREED TO BY**

_____
Signature of parent/guardian

_____
Print name

_____
Date

_____
Signature of child

_____
Print name

_____
Date

_____
Signature of witness

_____
Print name

_____
Date

# **4.** Intake Form Developed by FHI/Botswana

*Note that a child wellbeing assessment is also conducted with all children enrolled* in FHI's BONEPWA/Basha Lesedi Project, *with regular follow-ups. Copies of related documents are maintained in the client record, including referrals and information on other actions taken.*

**BASHA LESEDI PROJECT**
**BONEPWA CLIENT CARD — INITIAL INTAKE FORM**
*CONFIDENTIAL*

| Household Number: | Date of Registration: | |
|---|---|---|
| **PERSONAL DETAILS** | | |
| Client Name: | | Sex: M / F |
| Date of Birth: | | Age: |
| Place of Birth: | | |
| Residential Address: | | |
| Landmark: | | |
| **SCHOOL** | | |
| In School ☐ Yes  ☐ No | If no, reason: ☐ Dropped out ☐ Failed ☐ Other (specify) | |
| Grade in School: | | |
| Name of School: | | |
| **PARENTS' DETAILS** | | |
| Mother's Name: | | |
| Living:  ☐ Yes  ☐ No | Living but Absent::  ☐ Yes  ☐ No | |
| Cause of Death (if deceased and applicable): | | |
| How Long Ago She Died:  ☐ <1 year  ☐ 2–3 years  ☐ >3 years | | |
| Number of Children Mother Had at Death: | | |
| Age of Target Child When Mother Died: | | |
| Father's Name: | | |
| Living:  ☐ Yes  ☐ No | Living but Absent:  ☐ Yes  ☐ No | |
| Cause of Death (if deceased and applicable): | | |
| How Long Ago He Died:  ☐ <1 year  ☐ 2–3 years  ☐ >3 years | | |
| Number of Children Father Had at Death: | | |
| Age of Target Child When Father Died: | | |
| **PRIMARY CAREGIVER** *(if not one of the parents)* | | |
| Name: | | Sex: M / F |
| Age: | | |
| Relationship to the Child: | | |
| Reason for Living with the Child: | | |
| Number of Years Living with the Child: | | |

| EMPLOYMENT STATUS OF PRIMARY CAREGIVER | |
|---|---|
| Employed (*please specify*): | ☐ Yes (formal) <br> ☐ Yes (non-formal) |
| | ☐ No (please specify): <br> ☐ Disability <br> ☐ Pension <br> ☐ Other (please specify): |

**ADDITIONAL INFORMATION**

Other Children in the Household (<10 years):

| Name | Date of Birth | Sex | Relationship to Target Child | Grade in School | Out of School (Y) |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

Other Adults in the Household

| Name | Age | Sex | Relationship to Child | Occupation |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**HIV STATUS OF HOUSEHOLD MEMBERS**

Has anyone in the household ever tested for HIV?     ☐ Yes     ☐ No

Has anyone in the household disclosed their HIV status?     ☐ Yes     ☐ No

Is there anyone in the household who is on ARVs?     ☐ Yes     ☐ No

**COMMENTS**

**AVAILABILITY FOR SESSIONS**

| Day of week | Date | Time | Name |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

| | | | |
|---|---|---|---|
| Name of Field Worker: | Signature: | | Date: |
| Name of Supervisor: | Signature: | | Date: |

# *Instructions for completing the BONEPWA Intake Form*

*This form is to be filled by the "aunty" or "uncle" during his/her first visit to the household. The term "target child" or "client" refers to a vulnerable child between age 10 and 17 living within the household. If there is more than one target child or client, a separate client card should be completed for each. In other words, a client card should be completed for every vulnerable child between age 10 and 17 in every household.*

### Definition of Orphan and Vulnerable Child
An orphan is a child under age 18 who has lost one or both parents. A vulnerable child may or may not be an orphan, and is a child under age 18 who lives in (a) an abusive environment, or (b) in a poverty-stricken family where he or she is not able to access basic needs, or (c) a child-headed household.

### Household Number
Household numbers are unique identifiers used to distinguish households from each other. In the space provided, fill in the household number allocated to each household by the BONEPWA project officer.

### Date of Registration
Indicate the date when the first visit was conducted and/or when the client card was completed in the following format: DD/MM/YY (for example, 13/08/09).

### Personal Details for Target Child or Client
*Name:* Enter the full names (first, last) of the target child in the space provided.

*Age:* Indicate the age of the client (e.g., 17 if the participant is 17 years old).

*Date of Birth:* Enter the full date of the birth of the client using the following format: DD/MM/YY

*Sex:* Indicate the sex of the client in the space provided by writing (M) for male or (F) for female.

*Place of Birth:* Enter the client's place of birth. Enter both the name of the village or town and the name of the hospital, if known (e.g., Francistown, Nyangagwe hospital).

*Residential Address:* Enter the client's residential address (the name of the *kgotla* or a plot number, if one exists).

*Landmark:* Enter anything that can used to identify the location of the target household, such as next to the clinic or the school; plot has a big morula tree, etc.

*School:* Indicate whether the client is in or out-of-school by ticking (√) Yes or No.
If in school, write the grade that the child is in and the name of the school attended in the spaces provided.
If not in school, tick (√) the reason (dropped out, failed, other). If "other" is selected, please write in the reason.

### Personal Details for Parents
*Mother's Name:* Enter in full the name of the target child's biological mother (first, middle, last names).

*Living:* Tick the appropriate box (Yes or No) to indicate if the mother is living or not.

*Living but Absent:* Tick the appropriate box (Yes or No) to indicate if the mother is living but absent or not absent.

*Number of Children at Death:* If the mother is deceased, enter the total number of children she had before she died.

*Age of Target Child at the Time of Mother's Death:* If the mother is deceased, enter the age of the target child when his or her mother died.

*Father's Name:* Enter in full the name of the target child's biological father (first, middle, last names).

*Living:* Tick the appropriate box (Yes or No) to indicate if the father is living or not.

*Living but Absent:* Tick the appropriate box (Yes or No) to indicate if the father is living but absent or not absent.

*Number of Children at Death:* If the father is deceased, enter the total number of children he had before he died.

*Age of Target Child at the Time of Father's Death:* If the father is deceased, enter the age of the target child when his or her father died.

### Personal Details for Primary Caregiver
The primary caregiver is the adult that lives with and cares for the target child. He or she can either be a legal guardian or a relative (e.g., a grandparent, uncle, aunt, or sister).

*Name:* Enter in full the name of the primary caregiver (first, middle, last names).

Sex: Indicate the sex of the primary caregiver in the space provided. Write (M) for male and (F) for female.

*Age:* Enter the age of the primary caregiver.

*Relationship to the Child:* Indicate how the primary caregiver is related to the target child (e.g., sister, aunt, uncle). If not related, write "not a relative".

*Reasons for Living with the Child:* Enter the reasons why the target child is living with the caregiver (e.g., adopted; parents absent or deceased).

*Number of Years Living with the Child:* Enter the number of years the primary caregiver has been living with or caring for the child (e.g., 2 years)

*Employment Status of Primary Caregiver* (If parent is living, complete this section for the parent.)
Indicate the employment status of the primary caregiver or parent by ticking the appropriate box:

☐ Yes, employed in the formal sector         ☐ Yes, employed in the non-formal sector
☐ No (unemployed)         ☐ Pension         ☐ Disability         ☐ Other

For "employed" and "other", please specify (write in) the situation in the space provided.

**Additional Information**
**_Personal Details for Other Children in the Household_**
Fill in the details for all children under age 10 who are living in same household as the target child. Children visiting the household when this form is being completed should not be included.

*Name:* Enter the full name of each child (first, last) in the space provided.

*Date of Birth:* Enter the date of birth for each child living in the same household as the target child. Use the following format: DD/MM/YY.

*Sex:* Indicate the sex of the child in the space provided by writing (M) for male or (F) for female.

*Relationship to the Target Child:* Indicate how the child is related to the target child (e.g., first cousin, sister, brother).

*Grade in School:* Indicate the year the child is in school, if attending school. If out of school, leave this column blank.

*Out of School:* If the child is out of school, write Y for Yes.

**_Personal Details for Other Adults in the Household_**
In this section, fill in the details for all people over age 18 who are living in same household as the target child. Adults visiting the household when this form is being completed should not be included.

*Name:* Enter the full name of each adult (first, last) in the space provided.

*Age*: Enter the age of each adult living in the same household as the target child.

*Sex:* Indicate the sex of the adult in the space provided by writing (M) for male or (F) for female.

*Relationship to the Target Child*: Indicate how the adult is related to the target child (e.g., aunt, brother).

*Occupation:* Indicate in the space provided the occupation (e.g., teacher, cook, unemployed) of the adult.

**_HIV Status of Household Members_**
Indicate whether anyone in the household has ever tested for HIV by ticking either the Yes or the No box.

Indicate whether anyone in the household has ever disclosed his or her HIV status (either negative or positive) by ticking either the Yes or No Box.

Indicate whether there is anyone in the house who is taking antiretroviral drugs (ARVs) by ticking either the Yes or the No box.

**_Comments_**
Write in any comments or behavioral observations in the space provided.

**_Availability for Sessions_**
For each target child or client in the household, indicate his or her availability for sessions with the aunty or the uncle. Fill in the day of the week (e.g. Monday, Tuesday), the date and time, and the client's name.

*Once this form is completed it is to be signed and dated by the aunty or the uncle and submitted to the field supervisor. Field supervisors should sign and indicate the date the form has been reviewed and approved. Once these steps are complete, the supervisor keeps these forms in a locked cabinet.*

# 5. Child Status Index

Developed by MEASURE Evaluation. This document can be downloaded at
www.cpc.unc.edu/measure/tools/child-health/child-status-index/CSI%20Index-Jan-09-beta.pdf

| DOMAIN | FOOD AND NUTRITION | | SHELTER AND CARE | | PROTECTION | |
|---|---|---|---|---|---|---|
| | **1. Food Security** | **2. Nutrition & Growth*** | **3. Shelter** | **4. Care** | **5. Abuse and Exploitation** | **6. Legal Protection** |
| **GOAL** | *Child has sufficient food to eat at all times of the year.* | *Child is growing well compared to others of his/her age.* | *Child has stable shelter that is adequate, dry, safe, and lives like others in household.* | *Child has at least one adult (age 18 or over) who provides consistent love and support.* | *Child is safe from abuse, neglect, or exploitation.* | *Child is protected legally and has access to legal support when needed.* |
| **Good = 0** | 0 Child is well fed, eats regularly. | 0 Child is well grown with good height, weight, and energy level for his/her age. | 0 Child lives in a place that is safe, adequate, dry, and lives like others in household. | 0 Child has a primary adult caregiver who is involved in his/her life, and who protects and nurtures him. | 0 Child does not seem to be abused, neglected, do inappropriate work, or be exploited in other ways. | 0 Child is fully protected legally (e.g., has necessary documents and access to legal support). |
| **Fair = 1** | 1 Child has enough to eat some of the time, depending on season or food supply. | 1 Child looks slightly thin and less energetic compared to others of the same age. | 1 Child lives in a place that needs some repairs but is fairly adequate, and child lives like others in household. | 1 Child has an adult who provides care but who is limited by illness, work, other children, or seems indifferent to child. | 1 Child is sometimes neglected, overworked, or not treated well or there is suspicion of maltreatment. | 1 Child has civil registration but is not fully protected legally in other ways, although there is no current need. |
| **Bad = 2** | 2 Child frequently has less food to eat than needed, complains of hunger. | 2 Child is smaller in weight or height compared to others of the same age. | 2 Where child lives is not adequate, needs major repairs, is overcrowded, does not protect from weather, and/or lives in a way inferior to others in the household. | 2 There is no consistent adult who provides love and support. | 2 Child may be frequently neglected or given inappropriate work for his or her age. | 2 Child does not have civil registration, is not fully protected legally, and is at risk of being exploited and/or abused in a way that could be alleviated through legal protection. |
| **Very Bad = 3** | 3 Child rarely has enough to eat and goes to bed hungry most nights. | 3 Child is malnourished, significantly shorter (stunted) or thinner (wasted) than others of the same age. | 3 Child has no stable place to live. | 3 Child is completely without the care of an adult and must fend for him- or herself. | 3 Child is abused, sexually or physically, and/or is being subjected to child labor or otherwise exploited. | 3 Child is being exploited in a way that demands an urgent legal response. |

| DOMAIN | HEALTH | | PSYCHOSOCIAL | | EDUCATION AND WORK | |
|---|---|---|---|---|---|---|
| | **7. Wellness** | **8. Health Care Services** | **9. Emotional Health** | **10. Social Behavior** | **11. Performance** | **12. Education/Work** |
| **GOAL** | *Child is healthy.* | *Child receives health care services, including medical treatment when ill and preventative care (e.g., health education, immunizations).* | *Child is happy and content with a generally positive mood and hopeful outlook.* | *Child is cooperative and enjoys participating in activities with adults and other children.* | *Child is progressing well in acquiring knowledge and skills at home, school, job training, or an age-appropriate productive activity.* | *Child is enrolled and attends school or skills training, or is engaged in an age-appropriate activity or job. Infant or preschooler is stimulated by play.* |
| **Good = 0** | 0 In past month, child has been healthy and active, with no fever, diarrhea, or other illnesses. | 0 Child has received all or almost all necessary health care treatment and preventative services. | 0 Child seems happy, hopeful, and content. | 0 Child likes to play with peers and participates in group or family activities. Infant enjoys playing with adults. | 0 Child is learning well, gaining life skills, and progressing as expected by caregivers, teachers, or other leaders. | 0 Child enrolled in and attending school regularly. Infants or preschoolers play with caregiver. Older child has age-appropriate activities or job. |
| **Fair = 1** | 1 In past month, child was ill and less active for a few days (1 to 3 days) but she/he participated in some activities. | 1 Child received medical treatment when ill but some health care services (e.g. preventative care) are not received. | 1 Child is sometimes happy and sometimes unhappy. Infant may be crying, irritable, or not sleeping well some of the time. | 1 Child has minor problems getting along with others and argues, or gets into fights sometimes. | 1 Child is learning well and gaining life skills moderately well, but caregivers, teachers, or other leaders have a few concerns about progress. | 1 Child enrolled in school but attends irregularly or shows up inconsistently for productive activity/job. Younger child played with sometimes but not daily. |
| **Bad = 2** | 2 In past month, child was often (more than 3 days) too ill for school, work, or play. | 2 Child sometimes or inconsistently receives needed health care services (treatment or preventative). | 2 Child is often unhappy or sad. Infant may cry frequently or often be inactive. | 2 Child is more disobedient to adults than others of same age and frequently does not interact well with peers, guardian, or others at home or school. | 2 Child is learning and gaining poorly or is falling behind. Infant or preschool child is gaining skills more slowly than their peers are. | 2 Child enrolled in school or productive activity (work) but rarely attends. Infant or preschool child is rarely stimulated by play. |
| **Very Bad = 3** | 3 In past month, child has been ill most of the time (chronically ill). | 3 Child rarely or never receives the necessary health care services. | 3 Child seems hopeless, sad, withdrawn, or wants to be left alone. Infant may refuse to eat, sleep poorly, or cry a lot. | 3 Child has behavioral problems, including stealing, early sexual activity, and/or other risky or disruptive behavior. | 3 Child has serious problems with learning and gaining skills. | 3 Child not enrolled or not attending school and not involved in age-appropriate productive activity or job. Infant or preschooler is not being stimulated by play. |

# 6. Project Hope's Parenting Map

This Project Hope parenting map can be downloaded at
www.projecthope.org/media/pdf/Project%20HOPE%20Parenting%20Map%20-%20April%202009.pdf



Parenting Map

| Category | Items |
|---|---|
| Health | 1 Went to health facility last 3 times needed; 2 Diarrhea in last 2 weeks; 3 Fever in last 2 weeks; 4 Fully immunized (DTP1, DTP3, Measles, BCG, Vit A); 5 Received HIV education (over 8 years) |
| Nutrition and Development | 6 Received 4 meals last 2 days; 7 Eaten foods from all 3 food groups in the last 2 days; 8 Appears to be same height & weight as others his/her age (growth monitoring < 5); 9 Does what other children same age do; 10 Drinks clean water |
| Shelter/Care | 11 Safe living conditions (strong walls and roof); 12 Sleeps under mosquito net; 13 Sleeps in same type bed as others; 14 Has 2 sets of clothes; 15 Has 1 pair of shoes |
| Education | 16 Enrolled in school; 17 Was in school every day last week; 18 Has school uniform/waiver & supplies (i.e. pencil or notebook); 19 Able to read & write (over 7 years); 20 Does well on exams |
| Protection | 21 Has birth certificate or applied for one; 22 Has succession plan (will or death certificate); 23 Treated same as other children; 24 Unexplained bruises or injuries; 25 Does same work in the house as other children |
| Psycho-Social | 26 Unexplained crying; 27 Obeys adults similar to other children (not defy or rebel); 28 Has a memory book; 29 Attends religious services; 30 Has one good friend or talks to you about problems |

# 7. Training Modules and Suggested Topics

| MODULES | TOPICS |
|---|---|
| **Community mobilization**<br>Introduces the community to the needs of orphans and vulnerable children and empowers them to get involved and make a positive change | • Identification of challenges affecting children and resources in the community<br>• Action planning for follow-up, such as a community care coalition |
| **Core foundation**<br>Introduces childcare workers and volunteers to the program and to what is involved in caring for children within family and community contexts; also focuses on the central tasks of assessment, referral, and follow-up | • Family-centered care management, including the Star Model<br>• The role of childcare workers and volunteers<br>• Identification of stakeholders and beneficiaries (children and families)<br>• Characteristics of a good community caregiver<br>• Child rights and other cross-cutting issues<br>• How to make an assessment, including use of the Child Status Index<br>• How to make a referral and follow up<br>• Listening and responding skills |
| **Household wellbeing**<br>Helps childcare workers and volunteers to understand and respond to basic household and material needs<br><br>*Possible specialized areas*<br>Home repair; water and sanitation | • Home visit steps: protocol, content, follow-up<br>• General household conditions; equipment and bedding (standards, assessment, follow-up)<br>• Environmental health and basic hygiene<br>• Water usage (access to clean water)<br>• Extended family and community support for child-headed and youth-headed households |
| **Physical wellbeing**<br>Addresses the basic physical health of children and families<br><br>*Possible specialized areas*<br>First aid; DOTS (directly observed treatment, short-course for TB); pre- and post-test HIV voluntary counseling | • Child and family health (general), including access to healthcare<br>• Maternal health and immunizations<br>• Personal and sexual hygiene<br>• Counseling and testing for HIV and other major illnesses<br>• Adherence to drug regimens for TB, HIV, and other illnesses<br>• Use of illegal drugs and alcohol by children and in households<br>• HIV prevention and reproductive health (basic levels)<br>• Home remedies for basic ailments |
| **Nutritional wellbeing**<br>Covers the basics of good nutrition and food preparation<br><br>*Possible specialized areas*<br>Nutritional gardening; food preparation | • Food security<br>• Good nutrition for children and adults<br>• Food hygiene (storage and preparation)<br>• Special dietary considerations based on health and HIV status<br>• Nutritional gardening and kitchen gardens<br>• Small livestock (rural areas)<br>• Home economics: what is cheaper and just as healthy<br>• Nutrition and a child's physical development (weight, height) by age |
| **Emotional wellbeing**<br>Assists staff and volunteers to form open relationships with children and equips them to respond to their emotional needs<br><br>*Possible specialized areas*<br>Counseling and support-group facilitation; psychosocial experiential camps; memory books and memory boxes, body mapping, hero books | • Establishing rapport<br>• Basic child development and resilience-building<br>• Understanding children's emotions<br>• Understanding grief and mourning in children<br>• Basic counseling techniques<br>• Spiritual needs<br>• Finding a balance between traditional and modern life<br>• Family-focused psychosocial support<br>• How to start and manage a support group |

| MODULES | TOPICS |
|---------|--------|
| **Cognitive wellbeing**<br>Focuses on children's learning in and out of school and empowers staff and volunteers to facilitate a child's educational development<br><br>*Possible specialized areas*<br>Early learning center teaching; after-school support programs | • How children learn<br>• Children's cognitive development<br>• The importance of school preparedness and early childhood development<br>• Role of formal schooling and vocational education<br>• How to start and run an early childhood learning center<br>• How to start and run an after-school support program<br>• Home-based learning and other forms of learning |
| **Security and protection**<br>Deals with children's safety and protecting them from exploitation and abuse; legal protection and advocacy<br><br>*Possible specialized areas*<br>Paralegal support; child advocates | • Signs, symptoms, treatment, and prevention of violence and child abuse<br>• Child labor and exploitation<br>• Legal protections and support<br>• Access to appropriate documentation<br>• Advocacy skills on behalf of individuals and families |
| **Strategic information**<br>Addresses how to document and measure services being provided and the difference they are making<br><br>*Possible specialized areas:*<br>Computer literacy and data entry; basic interviewing techniques | • M&E (data collection and recording) at community levels<br>• How to maintain client records<br>• Data analysis and report writing |
| **Organizational development**<br>Deals with the organization as the client, rather than with families and children<br><br>*Possible specialized areas:*<br>Finance and administration; human resource management; strategic planning | • Board governance and oversight<br>• Budgeting and planning<br>• Resource development<br>• Super-VISION |

# THE WAY WE CARE
## A Guide for Managers of Programs Serving Vulnerable Children and Youth

*The Way We Care* was written by FHI staff for all readers, including those for whom English is a second language. The manual aims to improve the knowledge and skills of people who implement or support services for vulnerable children, youth, and families affected by disease, poverty, and trauma. It outlines child-focused, family-centered activities; promotes the integration of care, prevention, and treatment; and offers practical information on program design and project management. It can be used as a personal guide, a resource for collaborative learning, or a source of handouts for workshops or courses on performance management or capacity building.

For easy reference, the manual is divided into four parts:

1. **Foundations:** Cross-cutting concepts; a child-development primer; a guide to child-participation and psychosocial support; key background information

2. **Planning:** Service delivery issues; strategic planning; basic project management

3. **Implementation:** Community mobilization; monitoring and evaluation; care management; quality improvement.

4. **Sustainability:** Resource development; community ownership; volunteer and staff recruitment, supervision, and retention.

**fhi** Family Health International