SECTION III

Implementation

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 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

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.

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 nonprofit 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 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

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.

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 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.

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.

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 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

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.

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.

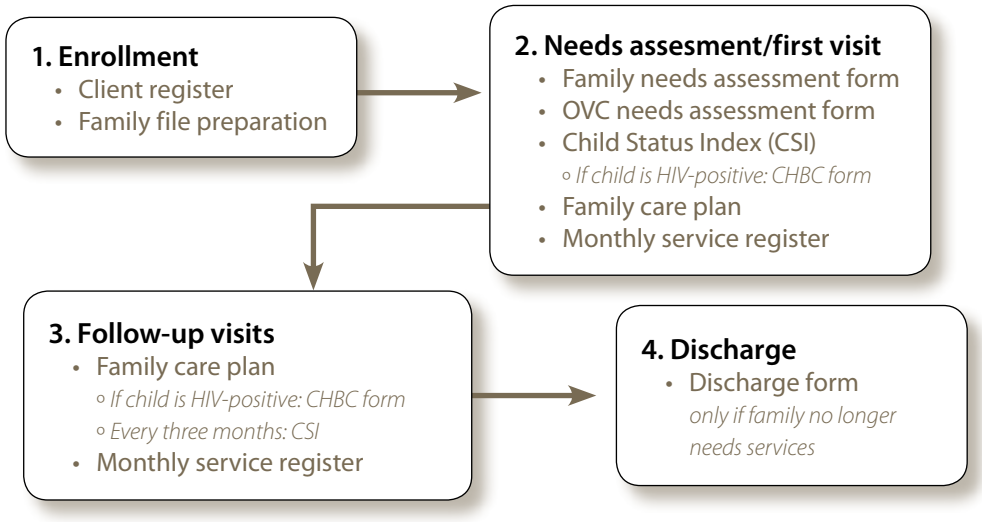
Steps two and three have four sub-steps. For step two, a baseline assessment and care planning, the sub-steps are

- 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



- 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

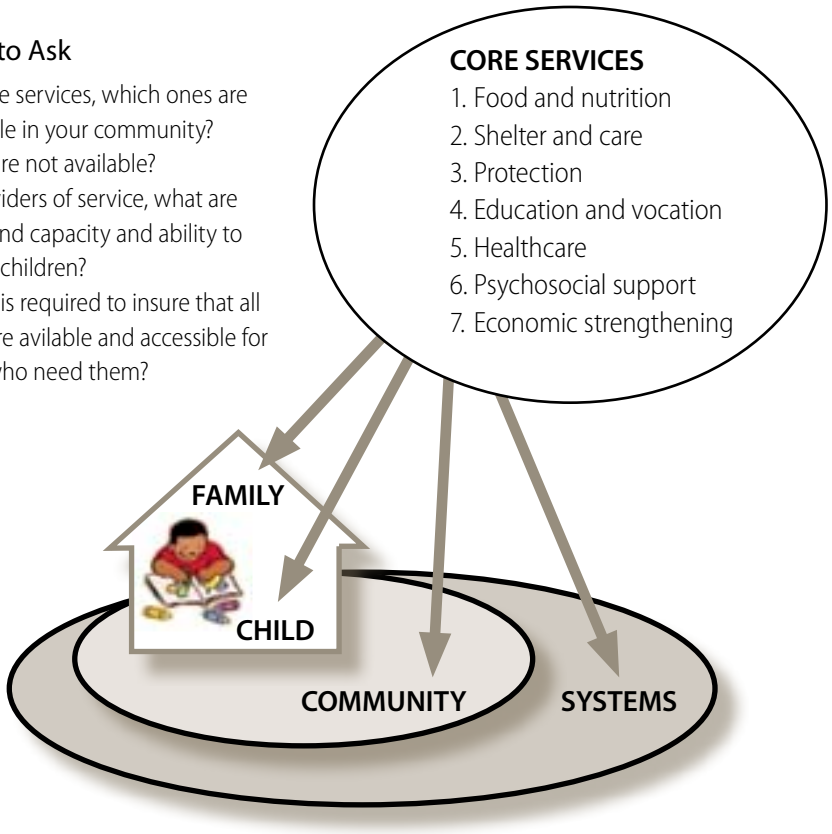
To set up a care management system, the program team responsible for care services will need to put in place clear steps that detail which services are included and how they will be provided or accessed. The team also needs to develop forms needed to support the program. It will also need to train, mentor,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



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.

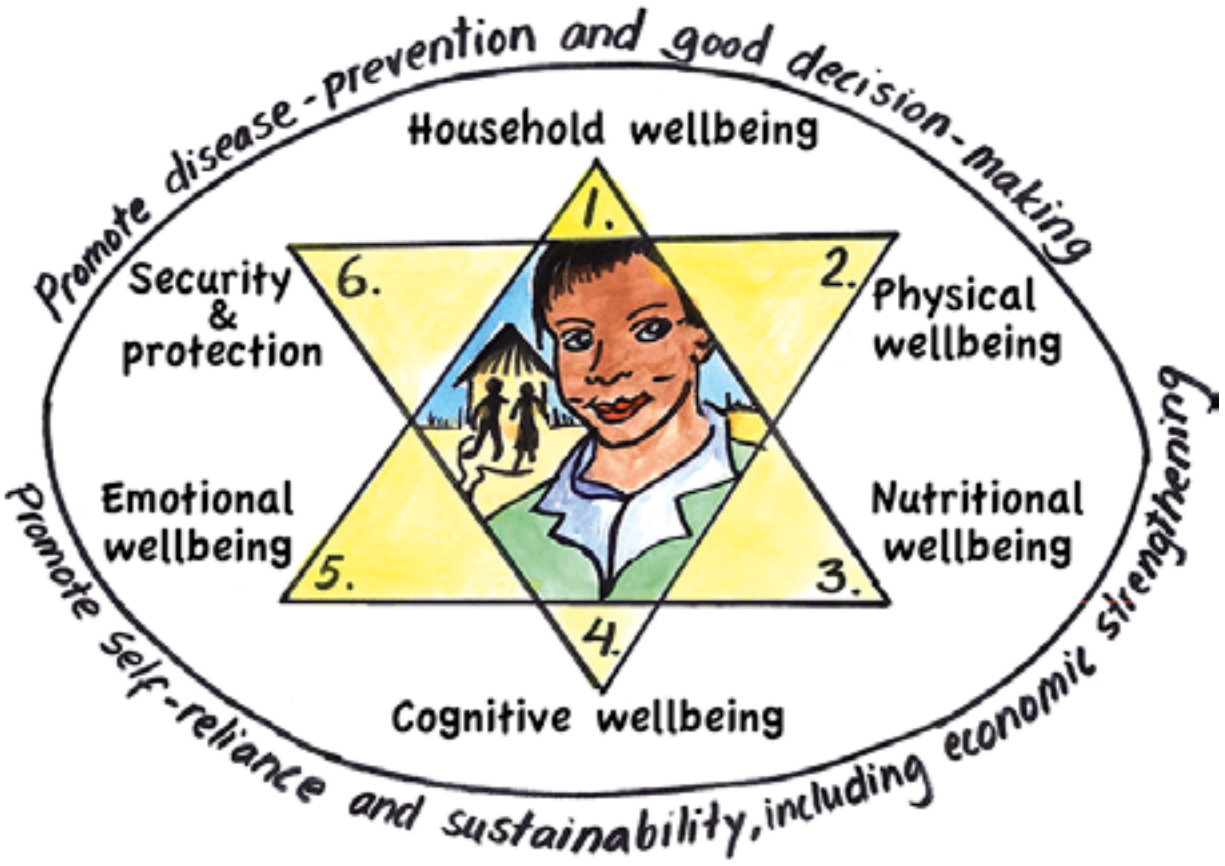
The Star Model highlights the coordination of care and seeks to ensure that children receive support in all service areas, as needed, whether this support is provided directly by one organization or program or through other resources in the community. The Star Model also emphasizes that services and 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 support-ers, 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

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?

- 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 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.

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.

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 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 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 Increased level of community awareness on children's rights	No. of PLHIV who have signed wills in target areas Percentage of PLHIV in the caseload who have signed wills No. of volunteers who offered advice in will-writing to PLHIV Level of satisfaction among PLHIV with advice from volunteers No. of community gatherings that offered at least a one-hour training session on children's rights
Activities	Training volunteers Training PLHIV Organizing media campaigns Running advice sessions	No. of home-based care volunteers trained in will-writing No. of PLHIV receiving advice in will-writing No. of draft will formats distributed 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, information, 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 monitoring. 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 representative 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 generalizing 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 monitoring?*** 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 discussions (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

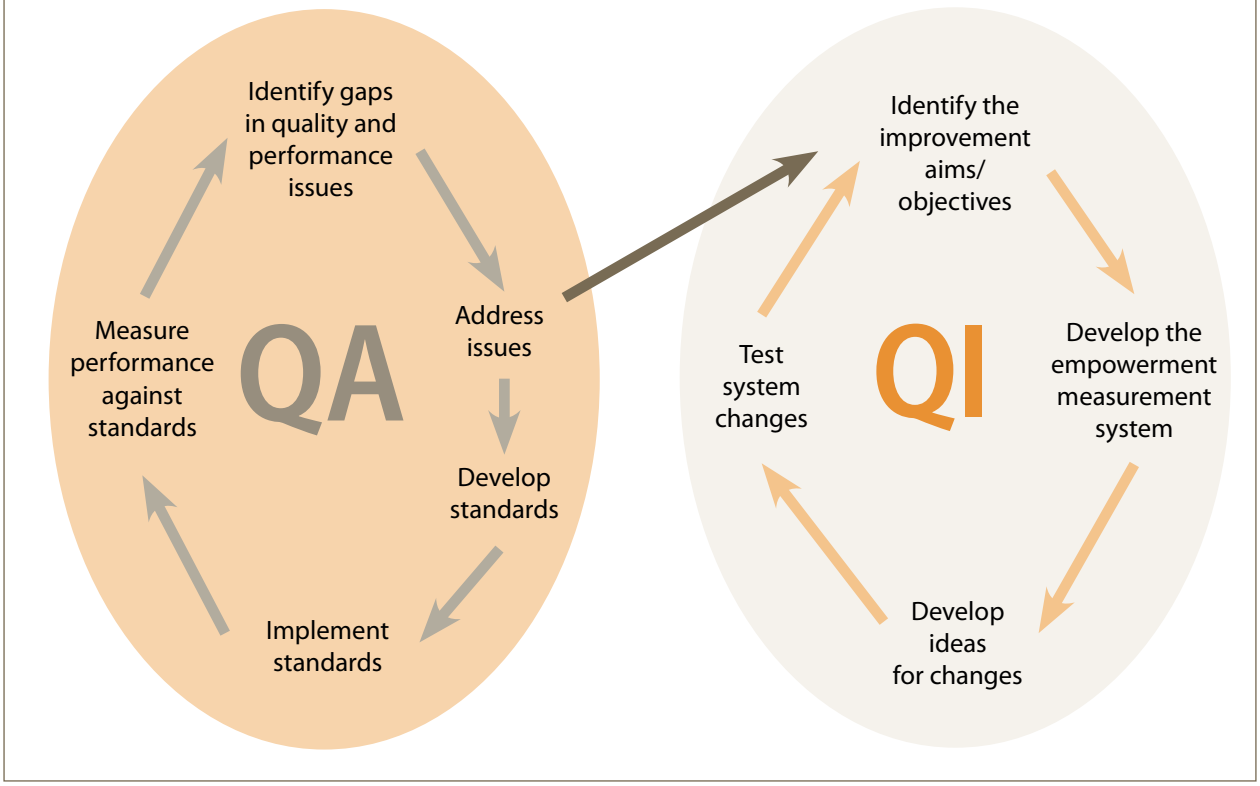


Table 15. Dimensions of quality for activities involving children, families, and community members

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?

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..."

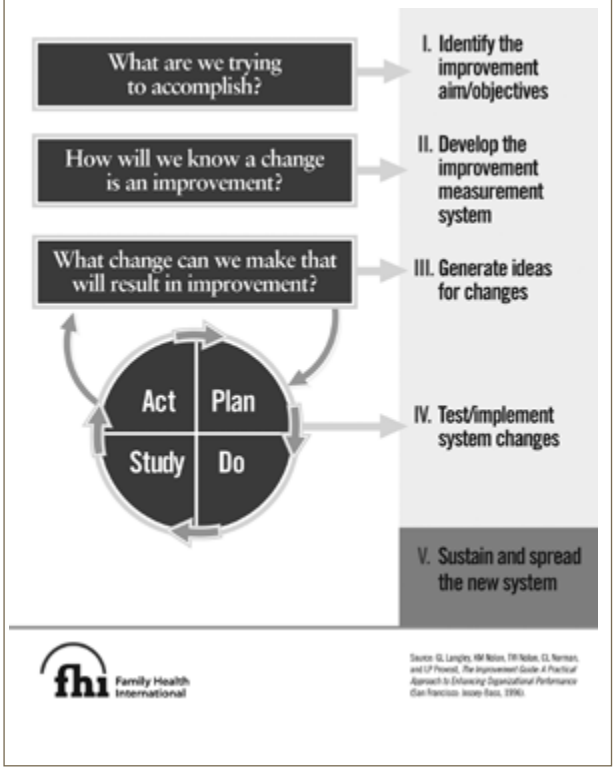
Lori DiPrete Brown

  - 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



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.

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.

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

> **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.