

Standard Service Delivery Guidelines **FOR ORPHANS AND VULNERABLE CHILDREN'S CARE AND SUPPORT PROGRAMS**

February 2010
Addis Ababa

FEDERAL DEMOCRATIC REPUBLIC OF ETHIOPIA



Ministry of Women's Affairs



Federal HIV/AIDS Prevention
And Control Office

List of Acronyms

ACRWC	African Charter on the Rights and Welfare of the Child
AIDS	Acquired Immune-deficiency Syndrome
ANC	Antenatal Care
ART	Anti-retroviral Therapy
BCC	Behavior Change Communications
CBO	Community-Based Organizations
CPU	Child Protection Unit
CRC	Convention on the Rights of the Child
EDHS	Ethiopia Demographic and Health Survey
FBO	Faith-based Organization
HAPCO	HIV/AIDS Prevention and Control Office
HBC	Home-based Care
HH	Household
HIV	Human Immune deficiency Virus
IEC	Information, Education and Communication
IGA	Income Generating Activities
KETB	<i>Kebele</i> Education and Training Board
MOH	Ministry of Health
NGOs	Non-Governmental Organizations
OVC	Orphans and other Vulnerable Children
PEPFAR	United States of America's President's Emergency Plan for AIDS Relief
PLHIV	People Living with HIV
PRA	Participatory Rapid Appraisal
PSS	Psychosocial Support Services
PTA	Parent-Teacher Association
QAI	Quality Assurance Indicator
QI	Quality Improvement
SA	Situational Analysis
USA	United States of America

Acknowledgements

The Ministry of Women's Affairs (MOWA) and the Federal HIV/AIDS Prevention and Control Office (FHAPCO) would like to express sincere appreciation to the United States Agency for International Development (USAID) and the President's Emergency Plan for AIDS Relief (PEPFAR) for funding and providing technical assistance for the development of the OVC Care and Support Standard Service Delivery Guidelines. We would also like to recognize Save the Children USA and OVC-PEPFAR partners for the development and piloting of the Standard Service Delivery Guidelines. Our special thanks is also extended to the community based organizations (CBOs), community members and the many orphans and other vulnerable children (OVC) who provided their thoughtful feedback and support during the piloting phase of this work. These important partnerships have allowed the important work being done for vulnerable Ethiopian children to be documented and it is our hope that the QI initiative serves as an impetus to continue this most valuable work for the most vulnerable of our society.

We would also like to extend our gratitude to the partners who directly or indirectly contributed to the development of this document as well as to the participants of the validation workshop held in Adama in April 2009. Last but not least, we would like to thank the National OVC Task Force, the Technical Working Group of the Task Force, and the Inter-Agency Technical Task Team for reviewing and finalizing this document.

The production of this document is made possible by the support of the American people through the United States Agency for International Development (USAID). The contents do not necessarily reflect the views of USAID or the United States Government.

Technical Assistance provided by Save the Children USA, Ethiopia Country Office

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SECTION I: OVERVIEW

Background

With a total population of over 73.9 million, Ethiopia is the second most populous country in Africa. More than half (55.5%) of the population is constituted by children below the age of 18 (CSA, 2007). Though the national prevalence of HIV in Ethiopia, estimated to be 2.3%, is considerably lower than rates in other sub-Saharan African countries, the number of people living with HIV and orphans continue to grow. As of 2009, Ethiopia is estimated to have 5,459,139 orphans of whom 855,720 are orphans due to HIV and AIDS (Single Point HIV Prevalence Estimate, MOH 2007), one of the largest populations of OVC in Africa. Given the context of Ethiopia, all OVC, directly or indirectly are vulnerable to HIV and AIDS and other health, socio-economic, psychological and legal problems. This vulnerability may be linked to extreme poverty, hunger, armed conflict and child labor practices, among other threats. All of these issues fuel and are fuelled by HIV and AIDS.

In response to the aforementioned situation, the government of Ethiopia has taken various measures to positively address the complex issues. The Federal Constitution has clearly articulated the rights of children in Article 36. Ethiopia has ratified both the UN Child Rights Convention (CRC) and the African Charter on Rights and Welfare of Child (ACRWC). The country has harmonized domestic laws and policies with the provisions of both conventions and which creates an enabling environment for improving the wellbeing of OVC. MOWA is the government ministry mandated to coordinate the issue of children including OVC. FHAPCO is charged with leading and coordinating the overall multi-sectoral response to HIV and AIDS, including the issue of care and support for OVC.

The legal and policy framework created by the government has enhanced the involvement of NGOs, UN agencies, INGOs, FBOs and CBOs in the provision of various care and support services to OVC. In spite of all the positive steps forward, there has still been a lack of standards and uniformity in the services and support offered to OVC and their caregivers. Despite all these efforts made so far, due to lack of standards and uniformity in the services the majority of the OVC are still facing the problems.

Therefore, to provide standardized service delivery to OVC and to enable key stakeholders to uniformly provide services to beneficiaries at varying levels the Ethiopian government has developed the Standard Service Delivery Guidelines with the hopes of maximizing quality and utilization of resource while simultaneously minimizing duplication.

Introduction

To date, the services offered to OVC by government, non-governmental and community-based organizations have not been standardized or made uniform in terms of quality and size. To address this issue, the Ministry of Women's Affairs (MoWA) and Federal HIV/AIDS Prevention and Control Office (FHAPCO) have developed the Standard Service Delivery Guidelines for Orphans and Vulnerable Children (OVC) Care and Support Programs (henceforth referred to as the Standard Service Delivery Guidelines). The Standard Service Delivery Guidelines have been pre-tested and piloted with specific emphasis on the basic principles of quality assurance and universal access.

The OVC Standard Service Delivery Guidelines document has three parts. The first part deals with the background, guiding principles, and implementation at different levels. The second part of Service Standard Service Delivery Guidelines addresses the service components and standards with their respective dimensions of quality as well as identifying the critical minimum and additional activities which should be implemented. Part three of the Standard Service Delivery Guidelines covers monitoring and evaluation. The document provides the latest approaches for implementing Standard Service Delivery Guidelines for OVC. The recommendations in the document are based on a pilot exercise conducted in selected sites in Ethiopia, which was designed to test the feasibility of the standards. It also provides further information on the dimensions of quality for each service area.

Goal

The overall goal of the Standard Service Delivery Guidelines is to standardize the implementation of OVC services in an effort to improve the general wellbeing of OVC. The objectives of the OVC Standard Service Delivery Guidelines include:

1. To provide key OVC stakeholders with Standard Service Delivery Guidelines and an implementation guide;
2. To harmonize OVC service delivery thereby increasing access to and quality of care and support; and
3. To contribute to an OVC data management system for OVC issues.

Need for Standard Service Delivery Guidelines

With an increased number of OVC and involved stakeholders working in the area of care and support, it is more important than ever to assess how well the needs of children are being met by those services. While each governmental, non-governmental or community-based organization has individually addressed monitoring and evaluation issues related to their work for and with OVC, there has not been a unified approach. This gap has made it difficult for programs to measure progress in achieving overall outcomes for children. The development of the Standard Service Delivery Guidelines and implementation manual sets a framework within which stakeholders involved in the area of OVC can operate to ensure that the desired outcomes are achieved.

Definition of Standard Service Delivery Guidelines

OVC services may be broadly defined as interventions that address the need to improve health, wellbeing and development of OVC. OVC service providers have a responsibility to assess, refer and potentially follow-up on cases that cannot be managed at community levels. As such, the Standard Service Delivery Guidelines deal with the community - level approaches to OVC services and support. The Standard Service Delivery Guidelines define the dimensions of care and outline the specific actions and steps that must be taken by OVC service providers to assure a systematic approach and effective delivery of services to children.

How Do We Define OVC?

In Ethiopia, it is commonly understood and legally defined that an orphan is defined as a child who is less than 18 years old and who has lost one or both parents, regardless of the cause of the loss. A vulnerable child is a child who is less than 18 years of age and whose survival, care, protection or development might have been jeopardized due to a particular condition, and who is found in a situation that precludes the fulfillment of his or her rights¹. However, for these standards a more inclusive definition is used which includes all of the following:

- A child who lost one or both parents;
- A child whose parent(s) is/are terminally ill and can no longer support the child;
- Children living on or in the streets;
- A child exposed to different forms of abuse, violence and/or exploitation;
- A child in conflict with the law;²
- A child who is sexually exploited;
- A child with disabilities;
- Unaccompanied children due to displacement ³

Who Should Use the Standard Service Delivery Guidelines

This document will be used by service providers, donors and community volunteers for program planning, service delivery, monitoring and evaluation to improve overall service delivery for OVC within their family. The Standard Service Guidelines serve as a tool for improvement of services and is recommended to be used by:

- Policy makers and Program Managers
- Stakeholders working on OVC programs at all levels
- Community members
- Beneficiaries

¹ Alternative Childcare Guidelines on Community-based Childcare, Reunification and Reintegration Program, Foster Care, Adoption and Institutional Care Services (2009). Ministry of Women's Affairs, Ethiopia

² A child in conflict with the law is a person who at the time of the commission of the offence is below age 18, but not less than nine years and one day old.

³ Comprehensive Community-Based Care and Support Guideline for PLHA, OVC and Affected Families, 2006 (FHAPCO).

Guiding Principles

Several key stakeholders have the responsibility for implementation of program level standards. It is not only the program itself that should monitor these standards but government, institutions and communities have a role to play as well. When implementing the Standard Service Delivery Guidelines, the following are key principles which should always be observed:

Target Focused: Program implementers should ensure that interventions are OVC-focused and age appropriate, with services tailored to the holistic needs of OVC.

Minimize Risk and Vulnerability: Provision of services to OVC should seek to prevent further vulnerability. Implementation of the Standards should minimize risks of harm and not exacerbate the already vulnerable status of program beneficiaries. Programs should strive for consistent application of the standards within agreed upon dimensions. In order to minimize risks, various strategies may be adopted such as, seeking community input when implementing programs and ensuring the consistent and continued participation of OVC, their caregivers and all other interested stakeholders.

Participation: Programs should seek to enhance the participation of all beneficiaries and their caregivers. In the implementation and monitoring of the Standard Service Delivery Guidelines it is crucial to have active beneficiary feedback. This participation will enhance the quality of services and help to ensure that services are being provided according to the true needs and wants of the beneficiaries.

Evidence based: Interventions aimed to address the needs of OVC should be evidence-based. Programs should apply available evidence to tailor activities and services accordingly and place a particular focus on monitoring and data collection to generate the evidence for improving service delivery mechanisms.

Gender Equity: Ensuring gender equity in service provision for OVC is an important principle that these Standard Service Delivery Guidelines promote. Programs should ensure that interventions and services meet the special individual needs of both girls and boys, despite the difference in gender.

Confidentiality: To obtain the desired results, confidentiality should be observed by all aspects of the program. The Program and staff or volunteers with knowledge of information should make all efforts to ensure that information shared by children such as their personal history or HIV status are not disclosed unnecessarily without the child's and/or family's consent.

Respect: Service providers should treat beneficiaries with due respect

Result oriented: Focus on the anticipated outcomes of services and support for OVC should be a key priority of program implementers. Standard Service Delivery Guidelines enable programs to enhance their monitoring and evaluation systems. For example, programs should use these standards to ensure that their processes are leading to the intended outcome/impact.

Coordination: The needs of OVC may not be met by a single organization or an individual's support. In order to fulfill the vast needs of OVC all service providers should identify service gaps and fill the gaps by coordinating their effort.

Strategies

The following strategies should be used by program implementers to apply the OVC Standard Service Delivery Guidelines:

Capacity-building: All key stakeholders involved in providing service and support to OVC should ensure that users of the Standards, at all levels including federal, regional and local are trained in the application of the Guideline. The stakeholders should also ensure implementers have technical, financial and managerial capacities necessary to successfully utilize the Standard Service Delivery Guidelines.

Use Existing Coordinating Mechanisms at All Level: There are a number of existing structures that support OVC programs and services at the national, regional and community level. Programs should build upon these existing structures to promote the use of the standards rather than establish new ones.

Social Mobilization: Empowering communities to mobilize and utilize existing resources will help generate ownership and sustained action to support OVC. Programs should ensure that communities have the necessary support to take responsibility for addressing the needs of OVC. Such an approach will work towards ensuring ownership of the services by the community and hopefully enhancing the sustainability of services and support.

For appropriate use and application of the Standard Service Delivery Guidelines, programs need to invest in sensitizing key stakeholders and beneficiaries as to the importance of the document and advocate for its integration into the overall design and planning of programs for OVC. Advocacy efforts should focus on quality of services and support for all OVC programming efforts.

Partnerships: Partnering and collaborating with other actors involved should enhance the ability to apply the three-one principle, (one coordinating body; one agreed framework and one M & E system thus allowing the Standards to be utilized at greater scale and impact.,

Linkages and Integration: Programs should facilitate linkages and referrals with other services to fill gaps that may be identified. Service gaps can be overcome through referral linkages and integration.

Resource Mobilization: Short-term and long-term plans of actions for resource mobilization should be a part of every organization or group providing services and support for OVC. Resource mobilization may be done both domestically and internationally.

Sectoral Mainstreaming: Programs for OVC should advocate for mainstreaming of services in key sectors such as education, health and youth development to expand the scope for service delivery. Once mainstreaming is achieved, OVC stakeholders should ensure that Standard Service Delivery Guidelines are applied by actors in the aforementioned sectors to ensure quality of service delivery to vulnerable children.

Roles and Responsibilities of Stakeholder

The application of the Standard Service Delivery Guidelines will require concerted efforts by all stakeholders at various including the federal, regional and local levels. Specific roles and responsibilities for each level will include the following:

Federal Level

- Provide guidance and leadership;
- Create conducive environment for actors (including policies and strategies);
- Ensure necessary resource mobilization and allocation;
- Develop an overall program strategy for planning, resource mobilization and allocation, implementation, and monitoring and evaluation;
- Strengthen the legal framework and enforcement mechanisms for OVC support;
- Create partnership networks with and coordinate key partners and stakeholders;
- Protect the rights of beneficiaries through existing protection mechanisms;
- Ensure the provision of quality services to OVC through effective application of Standard Service Delivery Guidelines; and
- Monitor and evaluate overall service delivery.

Regional Level

- Provide guidance and leadership;
- Adapt relevant policies and strategies in relation to the regional context;
- Ensure resource mobilization and allocation;
- Create enabling working atmosphere for all stakeholders;
- Utilize the Service Standard Guideline as a planning and monitoring tool;
- Mobilize resources to support OVC activities;
- Ensure that the Standard Service Delivery Guidelines are in place to promote quality services;
- Provide capacity building programs to implementing partners;
- Build partnerships with all actors and coordinate OVC programs at the regional level;
- Ensure OVC programs provide quality services and produce the expected outcomes;
- Actively monitor and evaluate program implementation and service delivery; and
- Document and disseminate promising practices and lessons learned.

Woreda Level

- Build partnerships, coordinate and follow-up implementation of OVC programs;
- Create enabling environment for implementing partners;
- Mobilize community and resources to support OVC activities;
- Ensure that Standard Service Delivery Guidelines are available to all implementing partners to assure quality service delivery;
- Provide capacity building programs to implementing partners;
- Build partnerships with all actors and coordinate OVC programs;
- Actively monitor and evaluate program implementation and service delivery; and
- Document and disseminate promising practices and lessons learned.

Kebele Level

- Identify partners and support the application of Standard Service Delivery Guidelines;
- Lead the identification of OVC and organize a database which includes geographic coverage;
- Identify needy OVC in collaboration with key actors, mobilize community resources and coordinate the responses of various players;
- Promote and protect the human and legal rights of OVC including reduction of stigma and discrimination;
- Facilitate access to health care (issue IDs and recommendation letter for free services) and birth registration services for OVC;
- Facilitate the integration of OVC services with Kebele level services; and
- Participate in program planning, implementation, monitoring and evaluation and reporting on OVC activities.

Section II: Standard Service Delivery Guidelines and Dimensions

2.1 Dimensions of Quality

To provide quality services to OVC, all stakeholders and program implementers should adhere to and take into account the dimensions of quality described below.

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

2.2 Quality Dimensions and Core Service Components

The lessons learned from previous experiences indicate that support targeting OVC were not often standardized, comprehensive or sustainable. The need to standardize and provide the services in a uniform manner was a crucial reason for the development of the Service Standard Service Delivery Guidelines. The Standard Service Delivery Guidelines document contains seven core service areas which are considered critical components of a set of services for programming targeting vulnerable children. The seven service areas include the following:

- **Shelter and Care:** These services strive to prevent children from going without shelter and work to ensure sufficient clothing and access to clean safe water or basic personal hygiene. An additional focus is ensuring that vulnerable children have at least one adult who provides them with love and support.
- **Economic Strengthening:** These services seek to enable families to meet their own needs from an economic perspective regardless of changes in the family situation.
- **Legal Protection:** These services aim to reduce stigma, discrimination and social neglect while ensuring access to basic rights and services protecting children from violence, abuse and exploitation.
- **Health care:** These services include provision of primary care, immunization, treatment for ill children, ongoing treatment for HIV positive children and HIV prevention.
- **Psychosocial Support:** These services aim to provide OVC with the human relationships necessary for normal development. It also seeks to promote and support the acquirement of life skills that allow adolescents in particular to participate in activities such as school, recreation and work and eventually live independently.
- **Education:** These services seek to ensure that orphans and vulnerable children receive educational, vocational and occupational opportunities needed for them to be productive adults.
- **Food and Nutrition:** These services aim to ensure that vulnerable children have access to similar nutritional resources as other children in their communities.

Each of the seven core service areas highlighted in the Standard Service Delivery Guidelines is discussed with specific focus on the quality dimensions and quality characteristics. In addition to the seven service areas, coordination of care is also discussed from the same perspective as it is a critical component of any comprehensive care package for OVC.

2.2.1 Shelter and Care

<p>DESIRED OUTCOME: All OVC have adequate shelter, clothing, and personal hygiene and adult care giver in accordance with community norms</p>	
<p>DIMENSIONS OF QUALITY MATRIX: SHELTER AND CARE</p>	
<p>Dimensions of Quality</p>	<p>Quality Characteristics for Shelter and Care</p>
<p>Safety</p>	<ul style="list-style-type: none"> ▪ Ensure that shelter is safe i.e. has walls, a roof, widows, latrine and close to water source and is clean. ▪ Ensure the shelter is environmentally safe dry with ventilation, with materials such as clothing etc as described under the shelter critical minimum standards. ▪ Ensure children have appropriate adult supervision. ▪ Ensure shelter is free from risk of any abuse and violation of child's rights.
<p>Access</p>	<ul style="list-style-type: none"> ▪ Children will be able to stay in a safe shelter within their communities. ▪ Ensure shelter provides basic service facilities (i.e. toilet, water, etc.). ▪ Shelter provision by linking children with <i>Kebele</i> and sponsors/fosters, caretakers. ▪ Link children to community support services (counseling, day care). ▪ All children have access to shelter including temporary shelter in case of high vulnerability (i.e. children on the street, children abused).
<p>Effectiveness</p>	<ul style="list-style-type: none"> ▪ Shelters are safe, warm and dry with access to water and sanitation i.e. latrines. ▪ Children cared for by an adult who understands their shelter needs and has strong parenting skills.
<p>Technical Performance</p>	<ul style="list-style-type: none"> ▪ Build the capacity of stakeholders to network and advocate for children's right to decent shelter. ▪ Care is provided according to age appropriate needs of child. ▪ Care and shelter are in accordance with community standards.
<p>Efficiency</p>	<ul style="list-style-type: none"> ▪ Shelter services are provided to the ones who need it. ▪ Local community response for OVC needs (shelter) is enhanced by proper use of time and resources. ▪ Ensure optimization of resources does not lead to overcrowding ▪ Ensure that services provided are of minimum cost. ▪ Children are cared for by an adult with parenting skills. ▪ Linkages are made with other community-based shelter services.

<p>Continuity</p>	<ul style="list-style-type: none"> ▪ Vulnerable children are cared for by members of their community. ▪ Reunification or reintegration of OVC with relatives is prioritized. ▪ Community mobilization of alternatives such as adoption, foster families, etc.. ▪ Awareness building and community awareness around eliminating stigma and discrimination occurs. ▪ Service provision is monitored. ▪ No gaps exist between needs assessment and actual provision of service. ▪ Children don't lose their right to inheritance, especially the home.
<p>Compassionate Relations</p>	<ul style="list-style-type: none"> ▪ Service does not increase stigma and discrimination. ▪ Selection criteria of OVC and households are well defined. ▪ Shelter is provided based on need and in accordance with community norms. ▪ Communities are involved in setting selection criteria and defining needs. ▪ Establishment of confident and responsive relation with caretaker. ▪ Creation of an environment where children live and express their feelings and ideas freely. ▪ Ensure positive caretaker-child relationships are established and supported.
<p>Appropriateness</p>	<ul style="list-style-type: none"> ▪ Adequate space for the child (in the case of institutional care, the dormitory should be divided by age; gender; equal conditions for all children, in accordance with the National Guidelines for Alternative Care). ▪ Gender sensitization and priority placed on the protection of female children. ▪ Responsive to the existing community norms and standards. ▪ Shelter services are provided based on need assessments and consent of OVC and/or caretaker.
<p>Participation</p>	<ul style="list-style-type: none"> ▪ Community involved in service provision. ▪ Activities implemented with consent and participation of OVC and their guardians and community members. ▪ Children, communities and key local stakeholders are involved in the decision-making process and service provision.
<p>Sustainability</p>	<ul style="list-style-type: none"> ▪ Biological and extended family relationships are strengthened. ▪ Advocacy and community mobilization is prioritized and supported. ▪ Communities and other stakeholders are involved in the provision and support of safe and environmentally-sound shelter to OVC. ▪ Family reunification is prioritized and supported.

2.2.2 Economic Strengthening

DESIRED OUTCOME: Households caring for vulnerable children have sufficient income to care for children	
DIMENSIONS OF QUALITY MATRIX: ECONOMIC STRENGTHENING	
Dimensions of Quality	Quality Characteristic of Economic Strengthening
Safety	<ul style="list-style-type: none"> ▪ Develop financial service delivery mechanism to reduce financial vulnerabilities (saving led financial services) of caregivers and OVC. ▪ Child labor exploitation is protected in accordance with the CRC. ▪ Employers are aware of requirements for a safe working environment. ▪ Income Generating Activities (IGA) which are deemed illegal or dangerous are avoided.
Access	<ul style="list-style-type: none"> ▪ Convenience to target group is considered when delivering services. ▪ All training materials are in accordance to and respectful of the local context. ▪ Geographical proximity to OVC should be considered when arranging service delivery. ▪ Selection criteria are transparent and prioritize the most vulnerable. ▪ Families should have access to financial resources.
Effectiveness	<ul style="list-style-type: none"> ▪ Income generated is used to care for children. ▪ Low capital or resource requirement of the scheme making it accessible to those in most need. ▪ Household assets (economic and social) are built to withstand shocks as result of HIV and AIDS. ▪ A financial service delivery mechanism is developed to reduce debt (savings led financial services). ▪ Household income source is sustained and diversified.
Technical Performance	<ul style="list-style-type: none"> ▪ Technical support considered critical in all circumstances. ▪ All activities and services are managed by the community. ▪ IGAs are environmentally sustainable. ▪ Families and caregivers know/are trained in how to manage financial resources. ▪ Services have established mechanisms to minimize risk (e.g. providing child friendly IGAs, follow-up to avoid possible risks, strengthening appropriate data management, confidentiality, etc.). ▪ IGAs are based on market assessments (supply/demand driven). ▪ Progress of beneficiaries is monitored and documented.

<p>Efficiency</p>	<ul style="list-style-type: none"> ▪ Service delivery strategy has a low operation cost. ▪ Leverage public and private sector resources. ▪ Service delivery strategies are consistent with community norms and values. ▪ IGA opportunities are diverse.
<p>Continuity</p>	<ul style="list-style-type: none"> ▪ Referral service is appropriately linked with other service providers. ▪ Service delivery strategy is managed by the community. ▪ Services are consistent with local laws and regulations. ▪ Services are built on indigenous community knowledge and tradition. ▪ Services are based on local resources and outlets. ▪ Trained participants are linked to potential employers. ▪ Communities are facilitated and encouraged to interact or build relationships with the private sector.
<p>Respectful Relations</p>	<ul style="list-style-type: none"> ▪ Service delivery is participatory. ▪ Service delivery is need based not supply driven. ▪ Services and products made should not be labeled to avoid stigma.
<p>Appropriateness</p>	<ul style="list-style-type: none"> ▪ HIV positive OVC and caregivers are not engaged in activities that are overly strenuous or put their health at risk. ▪ Service delivery is demand driven. ▪ Services are based on local tradition norms and values. ▪ Services are focused on primary needs of most vulnerable.
<p>Participation</p>	<ul style="list-style-type: none"> ▪ Caregivers and OVC participate in selection, planning and management of the activities. ▪ Flexibility of service delivery. ▪ Community convenience is considered in conducting activities. ▪ Selection of beneficiaries is transparent. ▪ Community is involved in decision making leading to empowerment.
<p>Sustainability</p>	<ul style="list-style-type: none"> ▪ Local laws and regulations maintained and recognition given to innovative service delivery mechanisms. ▪ The services provided are built on strengthening traditional coping mechanisms. ▪ Referral system is properly linked and maintained with safety-net programs such as urban gardening, WFP and others in the targeted areas. ▪ Resources are leveraged from communities, private and public sector. ▪ Beneficiaries are trained in business management, savings, and investment.

2.2.3 Legal Protection

DESIRED OUTCOME: OVC receive legal information and access to legal services as needed including birth registration and property inheritance plans. OVC are protected from all forms of abuses, violence and neglect.

DIMENSIONS OF QUALITY MATRIX: LEGAL PROTECTION

Dimensions of Quality	Quality Characteristics for Legal Protection
Safety	<ul style="list-style-type: none"> ▪ Reporting mechanism protects the identity of the person reporting (to reduce the chances of retribution). ▪ The records, information and files in the police station, public prosecutor office and the Court are confidential and the privacy of the child is protected by the media. ▪ Safe interrogation of children is enforced.
Access	<ul style="list-style-type: none"> ▪ Legal services are free for OVC. ▪ Strong referral networks are established between stakeholders. ▪ Services are child-friendly and information is easily understandable and accessible. ▪ Services are provided proactively to children instead of the child having to search for services. ▪ Current service mapping is available and identifies legal service providers. ▪ Information about services is available in a variety of media including electronic, print and public forums such as schools, <i>Kebele</i> offices, media etc.
Effectiveness	<ul style="list-style-type: none"> ▪ Information and advice is relevant and accurate. ▪ OVC have timely access to legal assistance (i.e. before the issue becomes too serious). ▪ OVC legal issues are followed-up to determine if more advice/assistance is needed. ▪ OVC- friendly courts are established. ▪ Legal issues are resolved according to the law and where the law does not protect OVC, change is advocated. ▪ OVC and caregivers learn or are trained to identify when they have a legal problem and how to access assistance.
Technical Performance	<ul style="list-style-type: none"> ▪ Service providers are sensitive to OVC legal rights and needs. ▪ Legal service is appropriate for the child or caregivers. ▪ Support on legal issues of OVC continues until successful resolution. ▪ Formal referral systems are established among the relevant legal institutions. ▪ Training is provided for legal bodies and service providers on different dimension (emotional, social impact and child development needs and stages).

<p>Efficiency</p>	<ul style="list-style-type: none"> ▪ Information is accessible and available to OVC. ▪ OVC and caregivers know when to access information or ask for legal help. ▪ OVC's legal problems are resolved quickly with appropriate follow-up. ▪ A comprehensive approach is taken so that legal needs are not addressed in isolation of other issues, and when other needs are discovered, children are appropriately referred to the services that they need. ▪ Referral, reporting systems and networks are established for easy acquisition of evidence for speedy trial. ▪ Continuity and stability in the provision of legal assistance and follow-up so that child is not passed from person to person and follow-up is documented and timely so that legal problems are resolved quickly.
<p>Continuity</p>	<ul style="list-style-type: none"> ▪ Education about law, standards, and reporting mechanisms are provided to OVC and caregivers.
<p>Compassionate Relations</p>	<ul style="list-style-type: none"> ▪ OVC are dealt with sensitively and are actively listened to by concerned stakeholders. ▪ OVC are represented in court or in negotiations. ▪ Child-friendly courts are established and/ or advocated for (especially for taking evidence in abuse cases).
<p>Appropriateness</p>	<ul style="list-style-type: none"> ▪ Information and services are child-friendly, appropriate and accessible by age, culture, educational level and especially for children with disability.
<p>Participation</p>	<ul style="list-style-type: none"> ▪ Children and their caregivers are listened to and involved in solving their legal problems. ▪ Through education about the law and legal system, children and their caregivers are empowered to identify when they have a legal issue and how it should be resolved and who to look to for assistance. ▪ Steps are taken to increase community participation in protecting children from abuse, reporting abuses, resolving issues out of court where appropriate and helping children to access legal help; ▪ Government is empowered to more actively participate in protecting children through Child Protection Units (CPU) and Child Rights Committees. ▪ Ensure political participation of children through programs such as the child parliament.
<p>Sustainability</p>	<ul style="list-style-type: none"> ▪ Community ownership and awareness about children's rights promoted. ▪ Strengthen Child Rights Clubs and Committees and CPUs. ▪ Establish and strengthen referral networks.

2.2.4 Health Care

<p>DESIRED OUTCOME: Child has access to health services, including HIV and AIDS prevention, care and treatment</p>	
<p>DIMENSIONS OF QUALITY MATRIX: HEALTH CARE</p>	
<p>Dimensions of Quality</p>	<p>Quality Characteristics for Health Care</p>
<p>Safety</p>	<ul style="list-style-type: none"> ▪ Services are provided in a confidential manner (in accordance with the do no harm principle) by skilled professionals. ▪ Referrals are made to skilled professionals and on the basis of need. ▪ Health services are provided safely (according to recognized standards) and in appropriate settings with appropriate equipment and supplies.
<p>Access/Reach</p>	<ul style="list-style-type: none"> ▪ Existence of a referral network of local services. ▪ Community-based services are strengthened. ▪ Services are provided locally (either in the community by community based workers or at local health facilities or service providers). ▪ Barriers to health care services are assessed and addressed (i.e. transportation, fee waivers). ▪ On-going access to treatment (including ART) is ensured. ▪ Services are child-friendly.
<p>Effectiveness</p>	<ul style="list-style-type: none"> ▪ Prevention measures and preventive health care is promoted. ▪ Preventative health -seeking behaviors increased. ▪ Child receives appropriate care for the identified needs. ▪ Activities to promote health seeking (well being) behaviors are implemented. ▪ Referrals are acted upon and followed-up.
<p>Technical Performance</p>	<ul style="list-style-type: none"> ▪ Service providers are sensitized to children’s needs and holistic approach is promoted. ▪ Children receive age appropriate services. ▪ Children recover from illness. ▪ Effective referral systems in place including counter-referrals. ▪ Home-based care providers are trained to recognize needs of children.

Efficiency	<ul style="list-style-type: none"> ▪ Comprehensive services are provided in one location. ▪ Caregivers identify problems in a timely manner and through regular interaction at household level. Basic routine health screening is provided to identify problems (i.e. community case finding for OVC). ▪ Continuous access to necessary drugs, care (i.e. home based care) and care provider.
Continuity	<ul style="list-style-type: none"> ▪ Recipients are encouraged to complete the full course of medication. ▪ HIV prevention messages are continuous. ▪ Ensure ongoing access to treatment (including ART) and adherence for HIV positive OVC and caregivers. ▪ Referrals are followed-up in a timely manner.
Compassionate Relations	<ul style="list-style-type: none"> ▪ Service provision is done in a child-friendly manner. ▪ Ensure ability of caregivers and providers to listen and recognize needs. ▪ Health care is provided with dignity and respect.
Appropriateness (Relevance)	<ul style="list-style-type: none"> ▪ Health care and medication are age-appropriate (including ARSH for adolescents and immunizations for children under five). ▪ Services are relevant and based upon need (on the basis of diagnosis).
Participation	<ul style="list-style-type: none"> ▪ Health care workers listen to and observe the child in the provision of care. ▪ Caregivers, CBOs, and children are actively involved in their treatment, health education and other health care activities.
Sustainability	<ul style="list-style-type: none"> ▪ Community ownership and health education is promoted. Caregivers are encouraged and supported to seek health services. ▪ Civil society and private health facilities are involved in an effort to improve the quality of health care. ▪ The community has knowledge of health issues and the ability to relay this information. ▪ Prevention activities and referral linkages are in place, strengthened and well functioning. ▪ Increased government resources for system strengthening and coverage to improve access and quality of services.

2.2.5 Psychosocial Support

DESIRED OUTCOME: OVC cope with losses and other trauma and has improved self-esteem and self-efficiency.	
DIMENSIONS OF QUALITY MATRIX: PSYCHOSOCIAL SUPPORT	
Dimensions of Quality	Quality Characteristics for Psychosocial Support
Safety	<ul style="list-style-type: none"> ▪ Programs are conducted in physically safe environments. ▪ OVC are protected from harsh punishments, stigma and labeling. ▪ OVC are protected from all types of abuses (child labor exploitation, emotional abuse such as insulting, warning, belittling, bullying, teasing etc.), especially when they report cases of abuse. ▪ OVC have the ability (knowledge, skill, emotional strength) to say NO to dangerous situations. ▪ A stable and predictable environment exists for the OVC to find support within. ▪ Children cognizant that their right to inheritance and other rights will be protected. ▪ Caregivers and those working with children are not known or suspected child abusers. ▪ Confidentiality of information related to counseling, testing and treatment is protected. ▪ Children equally participate in different activities. ▪ Ensure that BCC and IEC materials are tailor made. ▪ Facilities and environments are child friendly. ▪ Group dynamics are maintained by age, religion, etc.
Access	<ul style="list-style-type: none"> ▪ Children have access to play materials and environment. ▪ Training and other service areas are convenient. ▪ Materials and services are in accordance with beneficiaries’ cultural and linguistic settings. ▪ Every child has access to counseling – with para-professional or laypersons, and with professionals if needed or requested. ▪ All services in community are accessible regardless of gender, disability, etc. ▪ Every child/caregiver has information about where and how to access resources/services. ▪ Environment and participation are free from stigma and discrimination. ▪ All community services are child- friendly. ▪ HIV-related counseling, testing, and treatment is confidential and of high quality. ▪ Children have access to guidance and therapy as needed.

<p>Effectiveness</p>	<ul style="list-style-type: none"> ▪ Children are happy participating in activities and not isolated. ▪ Children are interactive, confident and empowered to be decision-makers. ▪ Children are protected from HIV and AIDS and other reproductive health associated problems. ▪ Programs and services actively promote self-confidence, nurture hope, and facilitate happiness in children. ▪ OVC has opportunities to fulfill his/her potentials – e.g. talents, skills, and interests (to pursue his /her dreams). ▪ OVC have opportunity for fun and laughter. ▪ The environment is open, supportive, nurturing, accepting of children and promotes opportunities for a child to meet needs and fulfill dreams. ▪ Children learn leadership and life-skills. ▪ Caregivers have knowledge about parenting, positive discipline techniques, communication and children’s needs. ▪ Adults in community are competent to deal with trauma, grief, bereavement, inheritance and capable of providing emotional and spiritual supports.
<p>Technical Performance</p>	<ul style="list-style-type: none"> ▪ Every child has one competent adult with whom there is regular and genuine contact, to whom he/she can go for guidance, encouragement, and problem-solving support. ▪ Parents disclose their health status and make the necessary succession planning for children together with them. ▪ Emotional wellbeing of child is monitored. ▪ Peer-groups and youth clubs are formed and children are encouraged and supported to consistently attend regular activities. ▪ Service providers are role models: ethical, passionate, caring, open-minded, and trustworthy. ▪ Confidentiality is respected by community members. ▪ Participating community members have assessment and referral skills (and conduct follow-up). ▪ Life-skills trainers have capacity and ability to ensure activities. ▪ IEC and BCC materials should contain appropriate information.

<p>Efficiency</p>	<ul style="list-style-type: none"> ▪ Volunteers provide services sufficiently. ▪ Referral linkages are utilized for professional counseling, play materials and trainings. ▪ Children are fully integrated into family and community life – there is normalcy in their lives and they do not feel isolated. ▪ All OVC programs and services include psycho-social support (PSS).
<p>Continuity</p>	<ul style="list-style-type: none"> ▪ Clubs for children and caregivers are established. ▪ Service providers are motivated. ▪ Referral systems for professional counseling, spiritual support, life skills training and other activities are promoted and supported. ▪ PSS competence is achieved by actors at community level, so that it is ongoing and sustainable. This means that there should be basic training/knowledge in active listening and responding skills, child development, referral (coordination of care). ▪ Community should provide support for the caregivers. ▪ Children are encouraged and/or supported to have an ongoing spiritual life (religious affiliation and relationship).
<p>Compassionate Relations</p>	<ul style="list-style-type: none"> ▪ Children are treated equally, but not the same, by caregivers, service providers, trainers and community. ▪ Both OVC and non-OVC participate in services in an effort to avoid stigma and discrimination. ▪ Children are not neglected. ▪ Every child is able to express feelings and concerns without fear of punishment. ▪ All services are provided with dignity, respect, and care. ▪ All adults in community positively acknowledge and engage children.
<p>Appropriateness</p>	<ul style="list-style-type: none"> ▪ Services are culturally and age appropriate. ▪ Materials developed are sensitive to respective cultural and religious contexts. ▪ Services and programs are individualized meaning that they should recognize the uniqueness of each child and be tailored to the relevant aspects of the child's own needs and situation. ▪ Services are gender and age specific (sensitive).

<p>Participation</p>	<ul style="list-style-type: none"> ▪ Children participate equally and voluntarily in different games and activities. ▪ Children and caregivers actively participate in the decision-making process regarding types of services, where and when to get services, selecting their leaders in clubs and peer-groups. ▪ Children participate in providing, monitoring, and evaluating services. ▪ OVC have feedback loops (to evaluate their services, situation). ▪ Children participate in setting rules and regulations in their clubs and peer- groups and in selecting their caregivers. ▪ OVC are given the opportunity and support to succeed in something that is meaningful to them (e.g. engage in self-expression, explore talents, and fulfill dreams). ▪ OVC encouraged/ trained in good communication skills. ▪ Community and systems-level should encourage active child participation although this requires an attitude shift/change. ▪ OVC have the right to design and choose services, activities, affiliations, and adult linkages.
<p>Sustainability</p>	<ul style="list-style-type: none"> ▪ Advocacy efforts focus on PSS and LS in primary school and community set-up.(e.g. Curriculum and play ground.) ▪ Personal history of parents kept/documented for children (i.e. memory work) ▪ Community involvement in providing support is promoted. ▪ Formal referral linkages between community and service providers are established. ▪ Locally available, child-friendly and culturally sound materials are utilized. ▪ PSS is integrated into <i>Idirs</i> (traditional burial societies - local CBO) activities. ▪ Community leaders are trained and encouraged to promote PSS activities. ▪ Youth are empowered to become leaders (peer supports and youth-models). ▪ Child rights approach is applied for systems and attitudinal change.

2.2.6 Education

DESIRED OUTCOME: OVC is enrolled, regularly attend school and completes a minimum of TVET and preparatory education.

DIMENSIONS OF QUALITY MATRIX: EDUCATION

Dimensions of Quality	Quality Characteristics for Education Services
<p>Safety</p>	<ul style="list-style-type: none"> ▪ Children are secure from abduction, rape and harassment when they walk to or from school. ▪ Services provided to OVC are the same or similar to those provided to other students (<i>i.e.</i> no special uniforms for OVC or made from more expensive or different materials) so reducing the possibility of stigma and discrimination. ▪ HIV status of OVC remains confidential to reduce stigma which may lead to isolation, bullying, and other forms of harassment and psychological abuse. ▪ Protect children from abuse (physical and emotional) from teachers other students, caregivers or community members. ▪ Promote permanency for OVC and ensure they have a secure home-base rather than living on the street or in a temporary structure. ▪ Promote a safe environment for the child at school, at home and in the community.
<p>Access/Reach</p>	<ul style="list-style-type: none"> ▪ Eliminate school charges or fees (<i>.e.g.</i> primary school attendance is free but there are other school costs that may hinder enrollment and attendance). ▪ Encourage government and community to build additional schools as distance and lack of security may keep OVC out of school. ▪ Encourage government and community to increase the availability of early childhood education (<i>i.e.</i> pre-schools) especially in rural areas. ▪ Ensure enrollment of all children seven years of age in grade one. ▪ Promote gender equity by encouraging parents to send their daughters to school rather than having girls remain home to perform household chores or perform other work. ▪ Provide sufficient school materials, supplies and uniforms to encourage OVC school retention. ▪ Organize a school, community or home-based feeding program to ensure that hunger does not prevent OVC from attending school. ▪ Address child labor exploitation issues so that OVC are not denied educational opportunities because of the need to sustain them.

<p>Effectiveness</p>	<ul style="list-style-type: none"> ▪ Advocate and bring OVC issues to the forefront of community concerns. ▪ Empower community bodies such as Parent-Teacher Associations (PTA) or <i>Iddirs</i> to support OVC needs. ▪ Increase promotion rates among OVC through tutorial classes, summer programs and other supplementary educational support. ▪ Enhance OVC performance at school through improvements in the quality of learning through facilitating tutorial services, improving class attendance, student/book ratio...etc. ▪ Increase community and OVC understanding the rights-based protection policy. ▪ Promote more effective school supervision through increased parental involvement in school affairs and more intense supervision by <i>Woreda</i> educational officials.
<p>Technical Performance</p>	<ul style="list-style-type: none"> ▪ Increase capacity building for PTA and teachers through better planning, provision of tutorials and other methods to support OVC in school. ▪ Use school-based data to assist schools and communities make more informed decisions. ▪ Mobilize local resources and government and NGO support. ▪ Develop more effective communication channels between school and home (<i>i.e.</i> caregivers) for OVC.
<p>Efficiency</p>	<ul style="list-style-type: none"> ▪ Improve enrollment rates, class promotion rates, and retention, and reduce drop-outs. ▪ Prioritize school and individual needs. ▪ Target the neediest. ▪ Leverage local resources.
<p>Continuity</p>	<ul style="list-style-type: none"> ▪ Assist OVC with making the transition from primary to vocational school or promote other economic opportunities. ▪ Strengthen livelihood activities for families to ensure they have resources to pay for educational materials after end of project. ▪ Encourage and mobilize community to continue support for OVC after external projects end.

<p>Compassionate Relations</p>	<ul style="list-style-type: none"> ▪ Train para-professional counselors from the community to mentor and encourage OVC on a regular basis. ▪ Promote nurturing relationships and communication between teachers and students. ▪ Ensure confidentiality of OVC. ▪ Respect, trust, value, and recognize OVC as individuals rather than as a group. ▪ Provide services with dignity and in a respectable manner without stigmatizing OVC.
<p>Appropriateness (Relevance)</p>	<ul style="list-style-type: none"> ▪ Provide needs-based support. ▪ Match services with need, gender and age. ▪ Provide tutorial and supplementary assistance to all academically challenged children in school to reduce stigma and discrimination. However, the majority of participants should be OVC. Programs should be scheduled when OVC are available and able to participate. ▪ Develop health care referral system for OVC in-school.
<p>Participation</p>	<ul style="list-style-type: none"> ▪ Encourage age-appropriate OVC involvement in planning, implementation and monitoring of programs. ▪ Facilitate active participation of beneficiaries and caregivers in decision-making processes.
<p>Sustainability</p>	<ul style="list-style-type: none"> ▪ Promote sense of community ownership for OVC support by involving all stakeholders in programs (e.g. PTA, KETB, caregivers, Woreda Education Officers, community members, OVC). ▪ Generate long-term commitment from community. ▪ Develop a broad community vision beyond a short-term focus on OVC needs. ▪ Develop a resource generation focus that is multi-sectoral and not only targeting community or government (synergy of resources).

2.2.7 Food and Nutrition

DESIRED OUTCOME FOR FOOD AND NUTRITION: Balanced food is available for OVC and in accordance with their age and need	
DIMENSIONS OF QUALITY MATRIX: FOOD AND NUTRITION	
Dimensions of Quality	Quality Characteristics for Food and Nutrition Services
Safety	<ul style="list-style-type: none"> ▪ Ensure child has food on a regular and consistent basis. ▪ Ensure child has fresh and nutritious food to meet the requirements for his/her healthy development. Potable water is free from chemicals (no pesticides used). ▪ Avoid child labor exploitation during food collection (<i>e.g.</i> expecting children to travel long distance to get food aid and carry the food to home). ▪ Promote better food handling practices such as using good sanitation (<i>e.g.</i> hand wash exercise before and after meal) and safe food preparation and handling by OVC and caretakers. ▪ Promote healthy food preservation. ▪ PMTCT and PCR are available for pregnant women and newborns. ▪ Therapeutic feeding for malnourished children is available and accessible (<i>e.g.</i> community-based initiatives).
Access/Reach	<ul style="list-style-type: none"> ▪ Local availability of food for OVC is ensured throughout the year. ▪ Exclusive breast feeding (up to six month) is encouraged and safe complementary feeding practices are also promoted. ▪ Devise coping mechanisms during “shocks” such as eating unusual food such as rice during disaster time rather than expecting standard food products and distribution of available food. ▪ Improve transportation and infrastructure facilities to improve availability of potable water within a short distance. ▪ Encourage caretakers to practice good food sharing practices.
Effectiveness	<ul style="list-style-type: none"> ▪ Increase awareness and practice of a balanced and nutritious diet for OVC and caregivers. ▪ Develop skills in food production, preparation and handling. ▪ Ensure that OVC have access to food (<i>i.e.</i> change traditional customs of children eating after adults).
Technical Performance	<ul style="list-style-type: none"> ▪ Promote awareness of community members regarding supplementary feeding programs and identification of cases for referral to feeding programs. ▪ Develop criteria for how and where the community refers children. ▪ Innovate and learn from best practices. ▪ Build capacity of service providers related to nutrition provision. ▪ Mobilize local resources. ▪ Create opportunities for capacity building throughout the year.
Efficiency	<ul style="list-style-type: none"> ▪ Enhance local agricultural production knowledge; maximize local markets and mainstream food and nutrition aspect in all service areas. ▪ Proper food management and storage is promoted. ▪ Caregivers sensitive to the food need of children/OVC. ▪ Food distributed fairly (OVC have to come first). ▪ Prioritization of neediest OVC.

Continuity	<ul style="list-style-type: none"> ▪ Families encouraged to produce twice in a year using alternative agricultural technology (like irrigation) to ensure availability of food throughout the year. ▪ Promote diversification of food sources. ▪ Integrate food production with other income generating activities so that OVC/ caregivers have enough income to purchase food. ▪ Ensure steady food supply throughout the year by promoting storage by households. ▪ Train OVC on food production and preparation, so they can take care of themselves in the absence of the caregivers. ▪ Build resilience of the caregivers against hunger and disaster.
Compassionate Relations	<ul style="list-style-type: none"> ▪ Promote informed community decision making in meeting the nutritional needs of OVC so as to minimize disturbances to the normal life of the community. ▪ Design programs to prevent stigma while providing food and nutrition services for OVC, ▪ Provide food with respect, dignity and care. ▪ Design programs that are responsive to culture (<i>i.e.</i> should be accepted in the community). ▪ Encourage community members to care for OVC with love and respect.
Appropriateness (Relevance)	<ul style="list-style-type: none"> ▪ Services are provided at the household level. ▪ Services and education are age and need specific. ▪ Services discourage dependency. ▪ Services are culturally sensitive and responsive. ▪ Training is given in the primary language of the household.
Participation	<ul style="list-style-type: none"> ▪ OVC and caregivers participate in decisions that affect their lives. ▪ Stakeholders participate at all levels of program planning and implementation. ▪ Distribution of food is based on the actual need of OVC in the home.
Sustainability	<ul style="list-style-type: none"> ▪ Planning and implementation is linked with other stakeholders, economic sectors and government systems. ▪ Programs are integrated into school system (<i>e.g.</i> vegetable production at school compound and nutrition education). ▪ Promote school attendance through food supply. ▪ IGA and community initiatives to create access to food for the OVC. ▪ Mobilize sustainable food/nutrition supply (long term not only immediate support). ▪ Best practices of agricultural production in the community are identified and shared. ▪ Promote healthy cultural nutritional practices while encouraging a change in attitude against those that affect health in local communities (<i>e.g.</i> some groups will not eat seafood during fasting times, which is essential for child health development). ▪ Promote community ownership and participation in operating and financing the program including contribution of cash or commodities.

2.3 Coordination of Care

Coordination of care can be defined as a child-focused process that augments and coordinates existing services and manages child-wellness through advocacy, communication, education, identification of needs and referral to services. This involves planning care for a child or family, monitoring that care, and making adjustment to the combination of services when needed. Coordinated care requires linkages with all sectors to ensure the appropriate mix of services for program beneficiaries.⁴

Coordinated Care is selected to be the overall guiding principle through which services would be delivered in an integrated manner so as to reduce duplication, fill service gaps and increase service coverage and increase program efficiency and effectiveness. In order to deliver quality services to OVC, coordination should occur at all levels, not just at service delivery point. Coordination of care is the critical integrative activity that assures that services have the desired impact.

Coordinated care does not mean that programs should provide all the services. However, in order to ensure quality service provision, partners should be able to monitor children's/households' receipt of necessary services through linkages and referrals. Moreover, it has to be noted that coordination of care is overarching to the other service areas & also needs strong information sharing mechanism, good level of cooperation, collective vision & long-term commitment.

⁴ Toolkit for Positive Change: Providing Family-focused, Results –driven and Cost-effective Programming for Orphans and Vulnerable Children. Radeny, S. and Bunkers K.; Save the Children Federation, Inc. 2009.

The following table illustrates & summarizes the major issues related to coordination of care in light of the quality dimensions & characteristics:

DESIRED OUTCOME for Coordination of Care provided in Ethiopia: Child's needs are assessed and met in a coordinated way.	
DIMENSIONS OF QUALITY MATRIX: COORDINATION OF CARE	
Dimensions of Quality	Quality Characteristics for Coordinated Care
Safety	<ul style="list-style-type: none"> ▪ Ensure confidentiality; child-sensitive assessments; prevention of stigma, and transparency in network practices. ▪ Provide a watch-dog function to verify safety and quality across groups in the coordinated care mechanism.
Access	<ul style="list-style-type: none"> ▪ Engage government resources (money, physical, human). ▪ Undertake service mapping. ▪ Enhance availability of capacity for coordinated care to meet demand. ▪ Ensure information is available on where and how to access services (child friendly). ▪ Service access mechanisms are established and functioning.
Effectiveness	<ul style="list-style-type: none"> ▪ Ensure services responsive to needs of the whole child. ▪ Stakeholders are involved in planning for OVC. ▪ Established objectives that are being met.
Technical Performance	<ul style="list-style-type: none"> ▪ Problems of double counting resolved. ▪ Promising practices are identified, disseminated and applied. ▪ Monitoring and evaluation procedures in place across all participating partners. ▪ Procedures established to monitor capacity to avoid over extension. ▪ Ensure that joint planning is dynamic not static. ▪ Train staff regarding child-centered assessment so that services are based on need and not organizational offerings.

Efficiency	<ul style="list-style-type: none"> ▪ No duplication of effort. ▪ Resource utilization is transparent and mobilized. ▪ Lead responsibility honored without competition. ▪ National or regional level coordination is in dialogue with local level to increase service assess.
Continuity	<ul style="list-style-type: none"> ▪ Coordination is a long-term commitment. ▪ Networking is established, nurtured, and functional. ▪ Unified push for a long-term perspective from donors. ▪ Systems are formed and functioning across stakeholders. ▪ Care plans for individual children are completed and followed.
Compassionate Relations	<ul style="list-style-type: none"> ▪ Collaborative atmosphere is fostered. ▪ Child-friendly coordination mechanisms are practiced.
Appropriateness	<ul style="list-style-type: none"> ▪ Child-friendly services ensured. ▪ Services are responsive to gender, age, and special needs of children.
Participation	<ul style="list-style-type: none"> ▪ Child input informs needs assessment as age appropriate. ▪ Procedures are in place for the children to provide feedback on service provision.
Sustainability	<ul style="list-style-type: none"> ▪ Existing community structures are used. ▪ Shared ownership of care provision is fostered. ▪ Plan developed for reduction in external resources. ▪ A range of multi-sector stakeholders are engaged in planning, implementation and monitoring. ▪ Capacity building for coordination of care is a priority.
Innovation	<ul style="list-style-type: none"> ▪ Creative use of resources is fostered. ▪ Approach to coordination is flexible and responsive to community changes. ▪ Forums are conducted periodically to stimulate and encourage new ways to coordinated is in place.

Section III- Critical Minimum and Additional Activities

Critical minimum activities are activities that must be done by all partners implementing services for OVC. These activities form the basis of a quality service and represent what is doable by all service partners irrespective of financial and human resources. Additional activities are activities that will enhance the organization's ability to achieve measurable improvements in the lives of children being served by their program but they are not mandatory actions. These often rely on additional financial and human resources.

Service Area	Critical Minimum Activities	Additional Activities
<p>Shelter and Care</p> <p>Desired Outcome: All OVC have shelter clothing, personal hygiene and adult caregiver which is the same as or similar to the non-OVC in community.</p>	<ul style="list-style-type: none"> ▪ Regularly assess the needs of OVC for shelter. ▪ Identify and mobilize community resources to construct, improve and renovate shelter for OVC. ▪ Advocate for the provision of alternative options to housing children such as daycare, temporary shelter, etc. ▪ Link and advocate with stakeholders (legal services, <i>Kebeles</i>, others) ▪ Regularly assess the shelter and care needs of OVC. ▪ Ensure that an adult/foster caregiver visits the child at home and provides appropriate support. ▪ Refer children without adequate support to other services including temporary shelter. ▪ Sensitize community, line government offices and other stakeholders to monitor progress of the children (status of shelter and care) ▪ Recruitment, training and assignment of an adult/foster care giver or adoptive parents for OVC based on consent from OVC and caregiver. Includes training and provision of continuous support to caregivers to provide PSS to OVC 	<ul style="list-style-type: none"> ▪ Provide short-term shelter for abandoned and other needy children (<i>e.g.</i> legal protection). ▪ Make sanitary facilities (water and toilets) and materials accessible to OVC. ▪ Link with <i>Kebele</i> administration to secure home which is warm, safe and meets the local standards for OVC and their caretakers. ▪ Link with legal institution to ensure inheritance rights especially to the home for OVC. ▪ Educate OVC on hygienic Practices (personal, home and environmental). ▪ Provide clothing to OVC. ▪ Provide child reunification and family reintegration as needed. ▪ Ensure day-care services are available and accessible to OVC.

<p>Economic Strengthening</p> <p>Desired Outcome: Households caring for OVC have additional and diversified source of income to care for family.</p>	<ul style="list-style-type: none"> ▪ Assess household situation in which OVC live and determine if there is income to support needs of children. ▪ Refer caregivers to IGA opportunities (savings groups, etc). ▪ Map service providers and leverage resources from the private sector for training and future employment of those trained. ▪ Conduct market analysis for business viability before training. ▪ Help households caring for OVC to get financial resources. ▪ Provide training on how to generate and manage income. ▪ Provide materials, financial, and job opportunities. ▪ Monitor/document progress of beneficiaries through an assessment checklist. 	
<p>Legal Protection</p> <p>Desired Outcome: Child receives legal information and access to legal services as needed, including birth registration, will writing, property inheritance and is protected from all forms of abuse and violence</p>	<ul style="list-style-type: none"> ▪ Assess legal needs of children (<i>i.e.</i> birth certificates, wills and other issues such as rape, abuse, etc). ▪ Refer OVC to legal protection services. ▪ Conduct mapping of legal services available in the community, including Child Rights Committees, NGOs, Child Protection Units, etc. ▪ Conduct community education and awareness-raising on child-related laws and rights. ▪ Identify vulnerable children and their caregivers and make regular visits. ▪ Monitor protection needs of vulnerable children and caregivers. ▪ Sensitize the media to inform the public about the rights and needs of OVC. ▪ Promote birth registration. ▪ Establish and strengthen networking systems with other service providers such as shelter, medical care and psychosocial support. 	<ul style="list-style-type: none"> ▪ If a CPU does not exist, advocate for the establishment and strengthening of one. ▪ Raise community awareness within the community, in the schools, about child-related laws, self protection skills, timely reporting of cases, and child participation and child rights through child friendly and culturally appropriate material. ▪ Information (for example in brochures and newsletters) regarding common legal issues are widely distributed. ▪ Advocate and network with Government and other key stakeholders for change in laws that are not fair to children or for the enforcement of laws that protect children. ▪ Capacity building of stakeholders, particularly sensitizing police, judges Child Rights Clubs and Child Rights Committees to the needs of children and how to compassionately assist them.

<p>Health Services</p> <p>Desired Outcome: Child has access to health services, including HIV and AIDS prevention, care and treatment.</p>	<ul style="list-style-type: none"> ■ Assess and monitor the health status of OVC through household visits. ■ Refer OVC to health services based on need. ■ Follow up to ensure receipt of health services and identify whether child is better ■ Conduct mapping of health services in the community with participation of key stakeholders. ■ Ensure formal referral systems exist. ■ Provide basic age-appropriate health education and ensure that children receive HIV and AIDS education either directly from the CBO or through another partner, church, or community. ■ Train care givers/volunteers on a comprehensive range of health issues: hygiene, ART issues, IMAI, nutrition. ■ Make referrals for rape/child abuse/emotional problems, holistic care and follow up. 	<ul style="list-style-type: none"> ■ Cover fees, drugs, transportation, facilitating free medication papers. ■ Train caregivers and volunteers on basic health care, hygiene, VCT, ART adherence. HIV and AIDS prevention education and referral as needed to children and community members. ■ Provide water and sanitation services to OVC. ■ Provide health education to volunteers regarding HIV and AIDS, personal hygiene, water and sanitation, and other health care issues including Sexual and Reproductive Health (SRH) for youth aged 14 and up. ■ Conduct activities to sensitize the community on health issue-MCH, STI, OVC, HIV and AIDS. ■ Mobilize community resources.
<p>Psychosocial Care and Support</p> <p>Desired Outcome: OVC develop personal strengths and skills to become self-confident, happy, hopeful, and able to cope with life's challenges.</p>	<ul style="list-style-type: none"> ■ Assess psychosocial needs of children. ■ Identify and address barriers to PSS for children. ■ Follow up regularly to monitor child's status. ■ Mapping of PSS services including (child friendly centers, religious leaders). ■ Train volunteers in recognition of PSS needs and counseling. ■ Provide re-integration services are provided for children who have lived outside of family care. ■ Establish support groups (children and guardian support groups and clubs) to counsel/support caregivers/ children. ■ Develop safe spaces for children to engage in play. ■ Increase awareness amongst caregivers and community on parenting, positive disciplining, communication, open dialogue with children on RH and HIV and AIDS issues etc. ■ Provide life skills training through peer groups. 	<ul style="list-style-type: none"> ■ Assist /support caregiver with disclosure of HIV status. ■ Assist in succession planning (wills). ■ Assist families in creating memory books. ■ Provide counseling services with respect to grief and HIV disclosure. ■ Educate youth about the dangers of drugs and alcohol. Ask if drugs and alcohol are abused by adults in the household. Screen for signs of drug or alcohol use and refer any household member for treatment as needed. ■ Ensure that the child is living a normal life in terms of school, recreation and links to community. ■ Ensure that children are enrolled in school, attending school, and that the child does not feel isolated or stigmatized at school. ■ Monitor household dynamics vis-à-vis caregiver and siblings. ■ Establish mechanism to address burnout of caregivers such as support groups to counsel/support caregivers to protect caregivers from burnouts and enable them to cope. ■ Assist and counsel children who have lived outside of family care. ■ Implement a Role Modeling program where renowned people can be invited to share their experience and success.

Education

Desired Outcome:

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

- Regularly assess educational needs of OVC (enrollment, retention, promotion).
- Identify and address barriers to education on an individualized basis for each OVC in collaboration with key stakeholders.
- Conduct resource mapping for educational services.
- Refer OVC to educational resources for tutoring, school materials (uniforms, etc).
- Regularly follow up on children's status.
- Identify and engage all stakeholders, including *Kebele* Education and Training Board, PTAs and CBOs, etc.
- Build capacity to support OVC among PTA, teachers, community representatives and local government officials.
- Support life skills and livelihood opportunities as an integral part of the education program.

- Strengthen and empower PTA and teachers through training, especially on PSS.
- Mobilize community such as PTAs and others to conduct regular community sensitization and meetings.
- Plan for local resources mobilization on regular basis including income generation activities (IGA).
- Develop school and community action plans for OVC support.
- Initiate/implement OVC policy and programs at different educational system levels.
- Develop tracking, monitoring and feedback mechanisms with educational program referral services and community.

Food and Nutrition

Desired Outcome:

Adequate food is available for the child to eat regularly throughout the year for healthy and active life.

- Assess food and nutritional needs of children.
- Refer malnourished or food insecure children and families to food sources.
- Follow up to ensure that children have received food or other rehabilitative/therapeutic service and monitor their status.
- Identify (through mapping) and engage other stakeholders to strengthen linkages and referral systems for food.
- Encouraging exclusive breast feeding and safe complementary feeding practices.
- Provide food to household on temporary basis.
- Train households on nutrition (balanced diet, food preparation, preservation, handling and exclusive breast feeding).
- Train community health agents/volunteers on basics of malnutrition diagnosis and referral system.
- Conduct training for these OVC and their caregivers on sanitation, food production, preparation and preservation.
- Training on food production (livestock and crop production) and input provision.
- Identify potential feeding centers and create referral systems with these emergency feeding centers.

Section IV: Application of the Standard Service Delivery Guidelines

The application of the standard needs the involvement and support different actors or stakeholders at all levels who are responding to the needs of OVC. In order to pave the ways for appropriate and necessary involvement, clear identification of the roles and responsibilities needs to be developed. The following is a description of the responsibilities of each key stakeholder at different levels for each key service area.

- 1. Food and nutrition:** Depending upon the context, the range of services to be provided include the following:
 - Child level: nutritional assessment and counseling, supplementary feeding, and links to other health and nutrition interventions;
 - Caregiver/family level: training on nutrition, diet, and food preparation.;
 - Community level: community-based strategies to support vulnerable children, including gardens and feeding programs; and
 - Systems level: policy development, regional and national coordination, technical assistance to the service providers, and advocacy.

- 2. Shelter:** Depending upon the context, services might include:
 - Child level: identifying potential caregivers prior to parent death, alternative care placement of child in institutional care, transitional care, or supported child-headed household.
 - Caregiver/family level: assisting with reunification for children without parental care and referral to programs that provide incentives for adoption, and foster care;
 - Community level: support of family-based care with home visits and other strategies, development of innovative community alternatives when family-based care is not an option; and
 - System level: policy development, regional and national coordination, education, mobilization of local resource, and monitoring of institutional care when needed.

- 3. Legal Protection:** Depending upon the context, the range of services might include:
 - Child level: assisting with birth registration and inheritance claims, preventing sibling separations, removing children from abusive situations;
 - Caregiver/family level: support with parenting and care-giving responsibilities, assistance with access to available services;
 - Community level: support for Child Protection Committees, training members of the community to identify and assist children needing assistance; and
 - Systems level: legal and policy development, social mobilization, strengthening of social capital.

- 4. Health Care:** Depending upon the context, the range of services might include:
 - Child level: assist children in receiving health services through referral and orientation towards preventive health seeking behavior;

- Caregiver/family level: train caregivers on a comprehensive range of health issues to effectively monitor health and seek care appropriately, refer OVC to health services;
- Community: conduct mapping of health services, mobilize and coordinate community volunteers; and
- Systems level: policy development to ensure access and a service delivery model that meets the needs of vulnerable children.

5. Psychosocial support: Depending upon the context, services might include:

- Child level: assess psycho-social needs of children, activities that support life skills including peer teaching, individual and group counseling (including spiritual) for children, rehabilitation for children who might be abused or neglected;
- Caregiver/family level: follow-up to monitor children's status, parenting and communication skills for caregivers, support during illness (assist with disclosure of information, grief management, succession planning, preserving memories, etc.);
- Community level: establish support groups, identify and address barriers for psychosocial support, increasing community understanding of psychosocial needs of vulnerable children; and
- System level: provide trained counselors within school systems and develop safe spaces for children to engage in play.

6. Education: Services with regard to this component might include:

- Child level: school registration initiatives, direct assistance to subsidize school costs;
- Caregiver level: assessment of educational needs of OVC and identify and address barriers to education, train health providers and caregivers to identify and refer children who are not in the education system;
- Community level: conduct resource mapping for education, community mobilization and advocacy related to increasing access and developing appropriate curricula and tutorial support; and
- Systems level: build capacity to support OVC among Parent-Teacher Association (PTA), teachers and community representatives and support services like Lifeskills and livelihood opportunities as an integral part of the education program.

7. Economic strengthening: Depending upon the context, services could include:

- Child/caregiver/family level: assess household situation in which OVC live and determine whether there is income to support needs of children, vocational training for caregivers, income-generating activities involving small business, urban/rural agriculture, and access to credit;
- Community level: mapping of related service providers in the community, community-based asset building; and
- Systems level: policy development, advocacy and creation of an enabling environment to have access to financial institutions.

Coordination of care is a critical integrative activity and approach which helps in ensuring that services have the desired impact on OVC. While it is critical that care is coordinated for each child, there are many activities that must be implemented at the community, regional, and systemic level. The following addresses what has to be considered at what level when coordinating care at the point of service delivery.

Coordination of Care at the Point of Service Delivery

At the child/household level, coordination of care involves assessing needs, planning care for a child or family, monitoring care, and making adjustments to the combination of services when needed. Coordinators of care will usually provide both **direct care** and **referral for services**. Ideally, coordination of care involves a home visit so that all the relevant aspects of the child's situation may be reviewed, but tools and approaches can be modified so that this individual assessment can take place in a group setting, such as a school, feeding program, or youth group. Regardless of whether the needed service is directly provided or arranged through referral, the home visitor/coordinator should monitor all the services that the child is receiving on an ongoing basis.

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

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

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

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

Section V: Monitoring and Evaluation of the Quality Standards

The existing national monitoring and evaluation system captures data on routine OVC services delivered at different levels. This data informs program managers and donors about the number of children served and allows them to estimate how well the needs of the community is met or where the gaps are. However, the existing OVC service indicators utilized to date have not sufficiently captured the quality of those services or whether or not it made a difference for the children served. Integrating concepts from QI into routine monitoring will complement information about the number of services delivered or children served to better demonstrate that the care provided was up to the standard depending on the local context.

Routinely monitoring quality is a powerful way to assure that stakeholders are meeting objectives in providing quality service to children. It will be necessary to collect information on a routine basis to ensure that guidelines are implemented correctly and to provide a knowledge base for periodic program evaluation. Use of standard checklists by all stakeholders to monitor quality of service ensures that all indicators are covered and will assist in documenting comprehensive and comparable data on provision of services over time. These checklists will aid in conducting organized monitoring of implementation of the standard and developing corrective actions in order to achieve desired outcomes. A generic checklist to be used to collect data on service quality is attached in the annex of this document; which users might modify this depending on their local context while maintaining the minimum activities.

Some of the critical considerations in monitoring standards are:

Effective monitoring system and clear procedures must exist or be established to ensure that programmes protect the confidentiality of any information regarding the identification by name, place of residence, and or HIV or AIDS status of any orphan or vulnerable child or household being assisted through programmes

Careful advance planning is crucial for data collection from children. Data collectors need to think through the consequences, both intentional and unintentional, of the information gathering activity on children and their households. If appropriate safeguards cannot be put in place, the activity should not proceed.

Monitoring the Implementation of the Standards

Monitoring of quality should be done at various levels. Communities have a role to play as they are closest to the beneficiaries; program implementers and coordinators as facilitators of many of the services also must have a role to play in monitoring quality. Internal monitoring of day to day activities comparing with the quality standard has to be done routinely by all level implementers to ensure provision of quality service. Joint schedule for monitoring should also be established by program coordinators and managers at various levels to minimize the burden on providers. However, as quality improvement is an interactive process, joint monitoring supervision should be

conducted regularly at least on bi-annual basis so as to modify the process of implementation. The details of care would be monitored by the provider, who also collects the indicator data and part of that data will be transferred to the next level structure; data flow for this reports needs to follow the mechanism established by OVC service coordinating bodies at each level. Recording and reporting tools will be annexed in this document to address standardization of the reporting system it self.

How to Measure the impact of the Standard Service Delivery Guidelines

The OVC programs will be monitored and evaluated based on the national indicators; in addition, assessing the performance in line with the standards will help to look achievement of the intended outcomes in children. Monitoring systems have to be designed so that data are collected and compiled at various levels in a pyramid structure. Possible modalities for monitoring and evaluation of OVC programs include:

- Service coverage specifically data on output level indicators will be captured through the routine M&E system;
- Outcome level indicators are monitored from large scale surveys like the welfare survey, EDHS and others;
- Evaluation studies (process and outcome evaluation) will also be conducted to gain detailed information on the extent of implementation of quality service in line with all quality dimensions and to explore the why and how part of program implementation; and
- Conducting regular supervision to ensure and monitor implementation of the standard and identify challenges faced in the implementation process is also needed.

NB: In conducting such Monitoring and Evaluation activities we have to remember Quality of Care must be seen within the framework of the local context.

Annexes

Supervision Checklists for Standard Service Delivery Guidelines for Orphans and Vulnerable Children’s Care and Support Programs

Preparatory Activities before the Field Visit

- Review the QAI Standards for OVC Programs before visit
- Read program reports and documents
- Carry the checklists, pencils and board
- Inform partner of visit

Name and title of supervisory officer(s)	
<i>Kebele:</i>	
Woreda:	
Period under review	
Date of visit	
Purpose of visit	
General comments/additions from reading reports before visit	(attach documents if needed)

What are the standard service components offered by the Program?

	Yes	No	Comments
1. Food and nutrition			
2. Shelter and Care			
3. Legal Protection			
4. Health Care			
5. Psychosocial support			
6. Educational			
7. Economic Strengthening			
8. Coordinated care			

What are the activities implemented under each Standard Service Components offered by the program

Note: Please assess only for the services offered by the partner or program

Verify the response for each of the service areas from records, minutes and by communicating with beneficiaries and community stakeholders.

N ^o	Questions: Shelter and Care	Yes	No	Evidence/Comments
	Is the program collaborating with the community to regularly assess and identify the shelter and care needs of OVC?	1	0	
	Is the program collaborating with the community to improve shelter and care according to the standards, including access to sanitary facilities (safe water and latrines)?	1	0	
	Is the program mobilizing community resources (including labor, materials) to improve shelter and care for OVC in the community?	1	0	
	Does program link OVC to resources for temporary alternatives for shelter and care?	1	0	
	Is the program linking with the community legal institutions such as the <i>Kebele</i> Administration, Child Protection Unit, and Women's Groups etc... to ensure Shelter and Care services for OVC?	1	0	
	Does the legal protection component include protecting children's rights to assets (shelter and others)?	1	0	
	Does the program have mechanisms in place to promote child reunification with family members if needed (is the program reintegrating children in transitional care)?	1	0	
	Is the program engaging communities in identifying potential caregivers (adults) who can visit the home of the child regularly prior to and after parent's death?	1	0	
	Does the program support families with home visits?	1	0	
Total Score for Shelter and Care				

N ^o	Questions: Economic Strengthening	Y	N	Evidence/Comments
	Is the program identifying older OVC and guardians who are in need of economic strengthening activities?	1	0	
	Is the program engaging communities in defining criteria to identify OVC in need of economic strengthening services?	1	0	
	Does the program map community resources to promote economic strengthening activities for OVC and guardians?	1	0	
	Does the program conduct a market analysis to identify opportunities for economic strengthening activities?	1	0	
	Does the program inform the first point of contact (caregiver/volunteer) of children about the results of community mapping?	1	0	

	Does the program train caregivers in assessing economic needs of OVC and their caregivers?	1	0	
	Does program link caregivers to appropriate IGA based on market demand, interest and skill level of caregiver?	1	0	
	Does the program provide training to OVC and guardians in economic strengthening activities to help them increase their economic assets?	1	0	
	Does program include volunteer caregivers in economic strengthening activities (access training for their own livelihood)?	1	2	
	Does program link OVC to vocational training opportunities?	1	0	
	Does program link caregivers to small loans/credit?	1	0	
	Is the program linking with private sector to promote employment opportunities for OVC and guardians?	1	0	
Total Score for Economic Strengthening				

N ^o	Questions: Legal Protection Service	Yes	No	Evidence/Comments
	Does the program conduct a community mapping to identify existing legal structures to protect children?	1	0	
	Does the program share findings of community mapping with caregivers and community leaders? To help strengthen linkages with appropriate legal services when required?	1	0	
	Does program link OVC and guardians to legal services (identified in mapping exercise) and follow up on identified cases?			
	Does the program have a monitoring system to keep track of children identified with legal needs and their referrals?	1	0	
	Is the program linking with <i>Kebele</i> administration for birth registration?	1	0	
	Does the program sensitize/inform communities about the legal rights of children?	1	0	
	Is the program providing technical assistance and support to guardians to prepare for succession planning?	1	0	
	Is the program assisting with inheritance claims, activities to safeguard assets of children after parent's death?	1	0	
	Is the program linking with appropriate child protection bodies for legal protection of children (e.g. Child Protection Unit)?	1	0	
Total Score for Legal Protection:				

N ^o	Questions: Health Care Service	Yes	No	Evidence/Comments
	Does the program conduct a mapping exercise to identify health services available in the community (including treatment)?	1	0	
	Does the program share the findings with the community?	1	0	
	Has program negotiated access to health services with different levels of service providers			
	Is the program assisting with access to poverty certificates (card that allows children to have access to health services at the health post and health center) linked to the <i>Kebele</i> ?	1	0	
	Does the program facilitate free access to health services for OVC and guardians?	1	0	
	Does the program conduct regular (once a month) home visits to assess health status of the child?	1	0	
	Is the program training caregivers to monitor health status and refer children for health services when needed?	1	0	
	Does the program provide training to caregivers on the importance of immunization, malaria prevention, ORT, hygiene and sanitation, optimal nutrition (<i>e.g.</i> : exclusive breast feeding, introduction of complementary feeding after 6 months, recuperative feeding after illness, food preparation and storage, recognition of danger signs, and need to adhere to ART treatment)?			
Total score for health care service:				

N ^o	Questions: PSS	Yes	No	Evidence and Comments
	Is the organization implementing programs to raise community members' awareness including caregivers of PSS needs for OVC and their families?	1	0	
	Is the organization implementing programs to develop psychosocial support groups to provide support to OVC and caregivers, youth clubs, mentoring groups, grieving groups)?	1	0	
	Is the organization implementing programs that strengthen connections between children and traditional social networks (religious leaders)?	1	0	
	Is the organization providing regular training, including on counseling skills on psychosocial support for OVC to its "care givers," people who have direct contact with child?	1	0	

	Is the organization implementing programs to mobilize community resources, including schools, clinics, <i>Kebele</i> to meet OVC PSS needs?	1	0	
	Is the organization implementing programs that promote life skills and inform about reproductive health in schools and clinics and other community structures such as youth clubs?	1	0	
	Is the organization implementing programs that provide counseling to children and caregivers regarding their HIV status?	1	0	
	Is the organization providing rehabilitation services for children who abuse alcohol and drugs?	1	0	
	Is the organization implementing programs that promote reunification of OVC with extended families?	1	0	
Total score for PSS service:				

N ^o	Questions: Education	Yes	No	Evidence/ Comments
	Is the program identifying and promoting educational opportunities for OVC?	1	0	
	Is the program providing training to PTA, teachers, and other community members regarding OVC needs and supporting referrals to other services (nutrition, health, PSS, shelter and care, legal protection)?	1	0	
	Is the program engaging communities in identifying OVC in need of educational support?	1	0	
	Is the program sharing community based mapping of educational services with people who are in contact with children (volunteers, clinicians, religious leaders)?	1	0	
	Is the program conducting situation analysis to identify barriers to education for OVC?	1	0	
	Is the program designing interventions to promote OVC education services based on findings of situation analysis?	1	0	
	Is the program monitoring attendance of OVC already enrolled in school?	1	0	
	Is the program monitoring OVC school performance?	1	0	
	Is the program training caregivers (volunteers) to identify and refer OVC who are not enrolled in school?	1	0	
	Is the program introducing life skills activities in schools, community groups (youth clubs)?	1	0	
	Does program have school based strategies to increase ability of school to support OVC (<i>e.g.</i> IGA)?	1	0	
Total score for education service:				

N ^o	Questions: Food and Nutrition	Yes	No	Evidence/ Comments
	Does the program train caregivers on nutrition including optimal infant young child feeding practices (exclusive breast feeding, appropriate introduction of complementary foods after 6 months, recuperative feeding after illness)	1	0	
	Does the program train caregivers on appropriate food handling practices (food preparation and safe storage)?	1	0	
	Does the program conduct a situation/community mapping analysis to identify other nutrition services (food distribution sites, agricultural programs, safety net programs)?	1	0	
	Does the program share the findings of situational analysis with the community and volunteer caregivers so that they are informed of other nutrition services in the community?	1	0	
	Does the program have links to other services (<i>e.g.</i> health: immunization, de-worming; access to clean and safe water)?	1	0	
	Does the program train caregivers to conduct individualized assessment to identify OVC in needs of nutrition services?	1	0	
	Does the program train caregivers on recognition of signs of malnutrition?	1	0	
	Does the program have linkages with health services and other nutrition intervention such as Community Management of Acute Malnutrition for severely malnourished children to receive therapeutic feeding services?	1	0	
	Does the program include a tracking mechanisms to ensure that children identified as needing food aid receive and consume food supplements appropriately?	1	0	
	Does the program use community based strategies to increase OVC and their guardians' access to food (<i>e.g.</i> school feeding programs, community gardens, seeds, community kitchens)?			
Total score for Food and Nutrition Service				

N ^o	Questions: Coordinated Care	Yes	No	Evidence/ Comments
	Have you identified someone to supervise Volunteer Caregivers	1	0	
	Do you have a strategy in place to organize Volunteer Caregivers according to number of children to be reached	1	0	
	Have you identified capacity building needs of Volunteer Caregivers and links them to appropriate resources	1	0	
	Do you have mechanism to track activities of Caregivers	1	0	
	Do you use information gathered from monitoring activities to improve interventions for OVC	1	0	
	Do you orient Volunteer Caregivers on available services and has provided copies of referral forms to them	1	0	
	Have you established network for coordinated service delivery	1	0	
	Do you assess holistic needs of children served in program	1	0	
	Do you negotiate with network of service providers for OVC care and support services	1	0	
Total Score for CBO coordinated Care				

Comment (insert below each question)

Could you please describe some of the major challenges you face when providing this service?

What kind of help do you need to help provide this service to OVC in your community?

What best practices have you observed?

Other comments you would like to share:

Comments from supervisor:

Do you think the minimum activities are implemented?

If no, what are the gaps?

Recommendations:

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