CASE STUDY

IMPROVING CARE FOR VULNERABLE CHILDREN IN KENYA:
Results from Piloting Service Standards

This report was prepared by University Research Co., LLC (URC) for review by the United States Agency for International Development (USAID). It was authored by Dorcas Amolo, Roselyn Were, Stanley Masam, Robert Kyeyagali, Oscar Kedenge, and Kate Fatta of URC for the USAID Health Care Improvement Project (HCI). This work was made possible by the generous support of the American people through USAID and received funding support from the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR).
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# ABBREVIATIONS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>ANPPCAN</td>
<td>African Network for the Prevention and Protection of Child Abuse and Neglect</td>
</tr>
<tr>
<td>ART</td>
<td>Antiretroviral therapy</td>
</tr>
<tr>
<td>CBO</td>
<td>Community Based Organization</td>
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<tr>
<td>CLAN</td>
<td>Child Legal Action Network</td>
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<tr>
<td>CRS</td>
<td>Catholic Relief Services</td>
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<td>CSI</td>
<td>Child Status Index</td>
</tr>
<tr>
<td>DCS</td>
<td>Department of Children Services</td>
</tr>
<tr>
<td>FHI-360</td>
<td>Family Health International 360</td>
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<tr>
<td>GOK</td>
<td>Government of Kenya</td>
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<tr>
<td>HCI</td>
<td>USAID Health Care Improvement Project</td>
</tr>
<tr>
<td>IGA</td>
<td>Income Generating Activity</td>
</tr>
<tr>
<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
</tr>
<tr>
<td>MOH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>NAL</td>
<td>North Arid Lands</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-Governmental Organization</td>
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<tr>
<td>OVC</td>
<td>Orphans and Vulnerable Children</td>
</tr>
<tr>
<td>PEPFAR</td>
<td>The President’s Plan for Emergency AIDS Relief</td>
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<tr>
<td>PSS</td>
<td>Psycho-Social Support</td>
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<tr>
<td>QI</td>
<td>Quality Improvement</td>
</tr>
<tr>
<td>TWG</td>
<td>Technical Working Group</td>
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<td>URC</td>
<td>University Research Co., LLC</td>
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<td>USAID</td>
<td>United States Agency for International Development</td>
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I. INTRODUCTION

When the President’s Emergency Plan for AIDS Relief (PEPFAR) was launched in 2003, interventions to meet the needs of orphans and vulnerable children (OVC) were designed with a sense of urgency to help address the devastating effect of the epidemic on children. While much progress has been made since then, the “emergency response approach” is no longer adequate. Lessons learned from OVC programs have revealed the need to improve quality in OVC services and to strengthen harmonization across partners around the questions: How can our programs make a measurable difference in children’s well-being? What are the range of essential actions that we all agree need to be part of a service to best mitigate the impact of HIV and AIDS on children and families, in the pursuit of efficiency, effectiveness and sustainability?

Several countries in sub-Saharan Africa have joined together in the quest for improving quality of services, through the USAID-funded Care that Counts Initiative, implemented by the USAID Health Care Improvement Project (HCI). These countries are engaged in applying the “science of improvement” to OVC services by 1) defining quality using service standards; 2) organizing for improvement at the point of service delivery; and 3) gathering evidence on the application of service standards that can be shared across countries.

II. CURRENT SITUATION IN KENYA

In Kenya, out of the 18 million children in the country, it is estimated that 2.5 million are vulnerable children and half of them are due to HIV and AIDS.

In 2008 HCI was asked by the Government of Kenya (GOK) to assist them to address concerns about the quality of services provided to vulnerable children. At that point, donor agencies were providing funding for OVC programming, but there lacked a systematic process for measuring the effectiveness of those investments. A Technical Working Group (TWG) was formed within the Department of Children Services (DCS) of the Ministry of Gender, Children, and Social Development to serve as the focal point for the initiation of OVC improvement activities in Kenya. This TWG coordinates with the OVC Secretariat and consists of members from not only the DCS, but also HCI, HOPE Worldwide Kenya, Family Health International 360 (FHI-360), UNICEF, USAID, World Vision Kenya, Population Services International (PSI), Catholic Relief Services (CRS), and SOS Children’s Villages Kenya. The TWG meetings are chaired by the DCS which has also appointed a focal person for QI activities.

From October through November 2009, a situational analysis was conducted to better understand the current quality and effectiveness of OVC services in five areas of the country: Meru North, Garissa, Homa Bay, Migori, and Nairobi in Westlands and in Kasarani. The results of this situational analysis identified the following issues:

- Efforts to provide services for OVC had expanded rapidly as the numbers of children affected by HIV and AIDS grew;
- There had been a rapid increase in funding for OVC care;
- Emphasis was on high coverage and outputs with little attention paid to outcomes;
- There was no evidence of effectiveness, efficiency, or equity in the services provided;
- Services offered to children were not coordinated;
- There was need to have children, families, and communities play a role in determining the services needed.

These findings helped stakeholders to realize that attention needed to be focused on how services were making a difference in children’s lives and achieving desired outcomes for children, spurring stakeholders to draft service standards of care for OVC.
III. DRAFTING THE STANDARDS

The draft quality service standards for OVC service delivery were developed at a workshop in Naivasha, Kenya in December 2009. At that workshop, 48 individuals, representing 28 organizations, both governmental and non-governmental, including the Ministry of Gender, Children and Social Development; the Ministry of Education, Science and Technology; USAID and other civil society organizations, contributed to standards in seven service areas: food and nutrition, education, health, psychosocial support, shelter and care, child protection, and household economic strengthening.

These seven service areas were prioritized in Kenya due to their predominance in current OVC programs and to the opinions of children canvassed during the situational analysis. An additional eighth standard of coordination of care was included after the workshop in Naivasha because it was found to be a crucial element for improving the quality of OVC service delivery.

The participants worked in groups divided by service area and drafted definitions, dimensions of quality, essential actions, and guidelines for each service based on their own local knowledge and expertise, other standards, and nationally and internationally known best practices (see Figure 1). These were shared in plenary with comments and revisions incorporated. Feedback on the initial draft of the standards was provided by the Quality Initiative Core Group, which was a group specifically created to review the draft standards, and other stakeholders.

In order to include the input of the children receiving these services, a two-day workshop was held in April 2010 with children currently receiving services from OVC implementing partners. The OVC secretariat through the provincial directors of children services helped to identify OVC from all the provinces in Kenya. The children were guided through sessions to understand what quality services constitute. From this, they shared their understanding of what a quality service means to them and shared their experiences as recipients as well as their personal hopes and aspirations for the future. The children’s views were incorporated into the draft standards.

Each standard addresses the following dimensions of quality: access; safety; effectiveness; technical performance; efficiency; continuity; sustainability; compassionate relationships; participation; and appropriateness. These standards can inform efforts to measure the outcome of services and detect gaps between current practice and desired outcomes. The use of these quality standards takes into consideration the principle of gender mainstreaming in the provision of OVC services as well as encourages active stakeholder participation by engaging children, their families, and communities in assessing the gaps between the existing practice and the desired outcomes as a means of improving the quality of OVC services. This would be achieved through regular monitoring and evaluation (M&E) of the existing programs.

A review meeting with partners was convened by the government in May 2010 to consolidate inputs from the regions into the draft service standards. In June 2010, a team of M&E specialists identified indicators for the desired outcomes and the essential actions. These indicators were consolidated into the draft service standards. A meeting by the TWG in June 2010 endorsed the draft standards for piloting (see Table 1).

The TWG meetings were critical for defining the direction of implementation and lobbying government and other partners’ support in assisting the QI process in Kenya. As a result of their engagement in the TWG, different partners have joined HCI staff in visiting the non-performing sites as part of supportive supervision. The TWG also lobbied for the inclusion of other line ministries including the Ministries of Health and Education, as they both play a critical role in OVC programming.
Table 1: Excerpt of Draft Minimum Standard for Food and Nutrition

<table>
<thead>
<tr>
<th>Service Area</th>
<th>Desired Outcome</th>
<th>Outcome Indicator</th>
<th>Essential Actions</th>
<th>Guidelines for Implementation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Food and Nutrition</td>
<td>The OVC and their households are food secure and they enjoy good and regular nutrition for normal growth and development</td>
<td>Proportion of OVC households with sufficient food year-round Percentage of OVC with the right weight and height for their age</td>
<td>Conduct a community food and nutrition needs assessment</td>
<td>Mobilize and sensitize the community on food and nutrition Organize forums to gauge community needs on food and nutrition Establish feedback mechanisms</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Mapping out stakeholders and resources available for food and nutrition support services</td>
<td>Facilitate gathering of information on stakeholders and resources available on food and nutrition Create food and nutrition networks and essential relations for quality programming Establish effective referral and linkage networks within the community</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Institute effective referral and linkage services with organizations involved in food and nutrition support activities</td>
<td>Utilize the existing networks and linkages to provide OVC with appropriate referrals for food and nutrition support</td>
</tr>
</tbody>
</table>

IV. PILOTING THE STANDARDS

The draft standards could not be made final until sound evidence showed that service providers would achieve improvements in overall service delivery and, ultimately, child well-being. As a result, project managers agreed on the need to gather evidence before disseminating the standards. Three questions guided the piloting of draft service standards:

1. Are the service standards understandable and “do-able” at the point of service delivery?
2. What are the best practices that facilitate the ability of implementing organizations to meet the service standards?
3. Do the service standards (when implemented) lead to measurable improvements in the quality of services and programming and the lives of children?

It was determined that the OVC service providers that would pilot these quality standards would come from the same districts that were included in the situational analysis. Organizations were chosen to participate in the piloting of the OVC QI standards based on the commitment expressed by the organizations to participate in the process to completion. Some requested to be part of the piloting, while others were invited by the government. The DCS assessed the potential partners in these districts and the TWG selected the final eight partners:

- Speak for the Child Program, implemented by FHI-360, in Nyando in Nyanza Province
- Lea Toto, implemented by Children of God Relief Institute, in Westlands in Nairobi
- Catholic Relief Services in Homa Bay district (Magina and Aluor) in Nyanza Province
- Maua Methodist Hospital in Meru North in Eastern Province
- APHIA Plus North Arid Lands (NAL) with SIMAHO non-governmental organization (NGO) in Garissa in North Eastern Province
- APHIA Plus NAL through Al Farouk Islamic Center in Garissa in North Eastern Province
- The DCS’ Kasarani OVC Cash Transfer Project in Kasarani in Nairobi
- HOPE Worldwide Kenya in Starehe district Nairobi
Improving Care for Vulnerable Children in Kenya

Through the piloting, 23,000 children were reached. At each participating site, quality improvement (QI) coaches were identified and included representatives from international non-governmental organizations, implementing partners, and DCS. These QI coaches were essential in providing ongoing support and mentoring to the teams piloting the standards. The QI coaches received their own training in overall QI concepts; measuring for QI with a focus on outcomes and making use of the Child Status Index (CSI) previously developed by Measure Evaluation; implementing OVC activities; and use of the standards. Further support was provided by the DCS, TWG, and HCI personnel through supportive supervision and review of activities. In addition, HCI personnel, together with the DCS, made regular coaching visits to mentor the piloting sites. The coaches spent time working with the implementing partners, sensitizing them on QI and introducing the standards, assessment tools, and QI journals. The implementing partners were supported to develop work plans. Please see Figure 2 for a tieline of key activities.

Throughout the piloting phase, regional meetings were coordinated and held by the provincial Directors of Children Services with support from HCI and the OVC Secretariat. At the regional level, piloting QI teams shared their experiences with both government representatives and implementers from civil society organizations.

Each of the implementing partners formed their own QI teams to oversee the piloting process. Overall, QI team members were made up of representatives of community based organizations (CBOs), vulnerable children, village chiefs, community health workers, caregivers, church members, members of Area Advisory Councils, counselors, social workers, and other community members. Implementing partner Speak for the Child developed criteria for QI team members, such as resident of the area and a supporter of children’s affairs, and formed two teams of 12 members from different local groups. Catholic Relief Services (CRS) identified two sites in which to pilot the standards and formed two QI teams composed of 15 members each. Lea Toto first trained their staff, held meetings to receive feedback from community health workers, and then formed their QI team. Maua Methodist Hospital formed their QI team following a sharing session with their management and staff and created a QI team which included staff and beneficiaries. APHIA-Plus and SIMAHO NGO formed their QI team which planned the roll-out of the piloting. The Kasarani OVC Cash Transfer Project formed a QI team of 18 members.

Figure 2. Timeline of key activities in the development and piloting of quality services standards

2008 GOK requested TA from HCI to address quality of services for vulnerable children
2009 October – November: Situational analysis conducted
December: Draft standards developed
2010 April: Children’s Workshop held
June: Indicators identified and TWG endorsed the standards. Piloting begins
November: District learning sessions in the piloting sites
April – May: Regional learning sessions and validation meetings
July: National Learning Session, during which the standards were endorsed for finalizing and national use

I joined the QI team because of the way I was participating in the CBO, so they were seeing that I could be an example for the other OVCs. Most of the things they were discussing, I was going through. What I have learned here, I will also teach the others so they can also learn. So we can take care of this idea that if we are OVC there are things we aren’t supposed to do, so we can remove those barriers.

OVIC REPRESENTATIVE, NYANDO DISTRICT
Table 2. Improvements in Food Security and Nutrition

Percent of children scoring “fair” or “good” in the CSI

<table>
<thead>
<tr>
<th>Implementing Partner</th>
<th>Food Security</th>
<th>Nutrition &amp; Growth</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Baseline</td>
<td>Endline</td>
</tr>
<tr>
<td>Maua Methodist Hospital</td>
<td>42%</td>
<td>100%</td>
</tr>
<tr>
<td>Catholic Relief Services</td>
<td>51%</td>
<td>92%</td>
</tr>
</tbody>
</table>

V. RESULTS

Each partner piloting the standards gathered baseline information to better understand the needs of the population they are serving. From this information, the piloting organizations were able to prioritize the service areas they focused on during the piloting phase. Not every partner piloted every standard, and instead piloted the standards for the areas where they found the greatest need for improvement. Implementing partners used the CSI to assess children’s well-being at baseline, at intervals during piloting, and at the end of the piloting phase. The CSI has six domains (food and nutrition, shelter and care, protection, health, psychosocial, and education and skills training) with two measures for each domain. The CSI places children in one of four categories: very bad, bad, fair, and good well-being. Fair is considered to be the minimally acceptable level of well-being for a child.

A. FOOD AND NUTRITION

For the service area of food and nutrition, implementing partner CRS sensitized households on the importance of food security and facilitated the sharing of information on locally available food resources. Changes they implemented included linking households to stakeholders’ agricultural technical personnel for specialized support and creating awareness among households on improved food production and storage. CRS also raised awareness on an improved diet based on locally available food resources and developed linkages with relevant GOK ministries for immunizations, growth monitoring, and micronutrient supplementation. By the end of piloting, CRS had sensitized 100% of the households they serve; scaled up cassava production; trained 30 households on poultry rearing; developed linkages with the Ministry of Health (MOH) for increased information sharing and service provision for households; and provided other direct support to households to improve food security.

Implementing partners found new ways to address food and nutrition needs, such as engaging the Ministry of Agriculture to teach communities about food security. (Photo: Allan Gichigi and Elijah Kanyi, Afroshok Media)

Prior to the piloting, Maua Methodist Hospital had interventions around promotion of food security but these were mainly focused on provision of handouts to deserving households. In order to ensure each child has regular access to food, they decided to adapt their interventions to promote better short-term food supply and enhance the households’ capacity to produce and access food with minimal external support. They provided training to children and caregivers on food and nutrition, established kitchen gardens, provided fertilizer to guardians to enhance crop production, and supported children and guardians with planting seeds. Please see Table 2 for results achieved by Maua Methodist Hospital and CRS.

B. HEALTH

The Speak for the Child program found during their baseline assessment that they were facing challenges related to local culture and religion that were affecting health-seeking behavior in their population. They also found that patients were experiencing difficulties in continuing antiretroviral treatment (ART). They set out to sensitize all of the households they were serving on appropriate health-seeking behavior and to obtain hospital fee waivers for vulnerable children in order to increase access to care. To this end, they conducted 12 targeted sensitizations at households, churches, and barazas, or outdoor meetings, and included role models to share their stories. Engaging the MOH, they conducted mobile clinics with them on a quarterly basis, leading them to reach all households with education on appropriate health-seeking behaviors and
reducing the number of patients who had lapsed in taking ART. Furthermore, they were able to receive waivers from health facilities for four of the 13 children they were serving. The APHIA Plus NAL Garissa, working with SIMAHO NGO, found services for health to be weak, so they developed a plan to address this gap. The action plan involved holding monthly meetings to discuss issues encountered, conducting field/home visits, brainstorming on best practices, and holding learning sessions with other stakeholders dealing with vulnerable children so as to get their thoughts on the QI standards. Changes they made included the introduction of a waiver system for most vulnerable children, providing them with health care free of charge; introduction of waiver cards to ease identification of vulnerable children once they are seeking services; recruitment of vulnerable children through the food by prescription program; linking families with the Red Cross to receive food; monthly health talks; and introduction of income-generating activities, such as poultry keeping. Please see Table 3 for results achieved in health care by Speak for the Child and APHIA Plus and SIMAHO.

### C. PSYCHOSOCIAL SUPPORT

HOPE Worldwide Kenya identified psychosocial support (PSS) as a major challenge facing children in the urban slums of Nairobi. They targeted children through clubs and caregivers through homes. Children were matched with peers who would help them address their PSS related issues and provided them with a forum to share their challenges. Caregiver support groups were developed to provide a forum for them to address issues affecting their children and define solutions that were responsive to specific households. At the program level, the home visits were redesigned to be more inclusive of children and responsive to children’s PSS needs.

The Lea Toto program targets HIV-positive children in Nairobi informal settlement. During the piloting, special efforts were made to address PSS issues for individual children and the project counselor was assigned cases that needed special attention. Lea Toto also hosted children’s support groups which became more responsive to each child’s individual needs. Please see Table 4 for results achieved in PSS by HOPE Worldwide Kenya and Lea Toto.

### D. SHELTER AND CARE

Shelter and care interventions were cross cutting across different implementing partners during the piloting.
Major achievements include fund-raising initiatives to help renovate and build housing for vulnerable children who needed shelter.

Implementing partner Lea Toto addressed shelter related issues on a case by case basis by mobilizing resources to address rent issues faced by vulnerable households and linking households to economic strengthening activities for sustained livelihood. HOPE Worldwide Kenya engaged caregivers on parenting skills as part of PSS which also addressed the care needs of vulnerable children.

Speak for the Child determined at the onset of piloting that availability of birth certificates needed to be improved as they are a basic right as well as a requirement for children to enroll in school and take exams. During the piloting, the caregivers were engaged to mobilize late registration funds and documents through support groups. Required documentation was obtained and organized through the local CBO Okoka, who streamlined the process and removed the barrier of transport costs for caregivers by delivering the collected forms all at once. These changes resulted in 1,007 children receiving their birth certificates.

E. EDUCATION

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F. CHILD PROTECTION

During the collection of baseline CSI data and self-assessment conducted by the QI team at the Maua Methodist Hospital, child protection was discovered to be a major challenge. Many children did not have access to legal protection documents like birth certificates, parent’s death certificate, and property access documents. The team teased out essential actions they were not implementing and focused on them. Their key strength was enhancing child participation through school-based children’s clubs and working with the provincial administration, the civil registrar, and the DCS to ensure that children and their households had access to legal registration documents and legal protection.

For CRS, abuse and exploitation and legal protection were recognized as areas of need for their population. During the piloting, CRS began raising awareness on abuse and exploitation issues they had found to be rampant in the area, including child labor and sexual abuse. CRS also began referring cases identified and following up on the referred cases. They held regular meetings for review and update by the QI teams and lobbied for the formation of Area Advisory Councils. As a result of these efforts, local and divisional Area Advisory Councils were formed, launched, and trained by the District Children’s Office. Identified cases of abuse were referred to the Area Advisory Councils. In one case, a child labor situation that was preventing the child from attending school was identified.
Figure 3. Improvements seen in the percentage of children scoring “fair” or “good” on the Child Status Index among implementing partners.
G. HOUSEHOLD ECONOMIC STRENGTHENING

In the initial assessment phase, implementing partner Speak for the Child found that household economic strengthening was a cross-cutting issue and needed to be addressed as a way to improve most of the other outcomes for the children. They began by conducting a rapid income-generating activity (IGA) assessment and followed it with refresher training on IGA selection planning and management along with agribusiness training. They also provided continuous need-based business development skills while actively monitoring Table Banking, a savings and loan methodology focused on improving the skills of people to save money with weekly meetings. By the end of piloting, they found that each of the four support groups they worked with on this had better IGAs which included poultry, greenhouses, sugar selling, animal raising, and rice growing.

H. COORDINATION OF CARE

Many of the changes made by the implementing partners to address the other service areas also increased coordination of care because of its cross-cutting nature. At Maua Methodist Hospital, the team engaged the Ministry of Agriculture in order to increase local understanding of food security.

The Kasarani OVC Cash Transfer Project found that mapping stakeholders was not only a useful exercise which increased their understanding of what was locally available, but was also a necessary one as they needed to engage other groups in order to implement needed changes.

During their baseline assessment, Lea Toto found that there was need for increased child protection, but this was not an area they work in specifically. To address this gap, they developed linkages with the Ministry of Gender, Children and Social Development, DCS at the divisional level, where...
they work in order to increase the children’s access to appropriate child protection services. They also identified other partners to link with in order to provide protection services, including the Child Legal Action Network (CLAN), which provides pro-bono legal services and professional legal protection for children, and the African Network for the Prevention and Protection of Child Abuse and Neglect (ANPPCAN).

VI. NATIONAL LEARNING SESSION

The year of piloting was concluded with the convening of the piloting teams in a national meeting, organized by the TWG and coordinated by HCI and the OVC Secretariat. The national learning session, held in Nairobi in July 2011, brought together over 100 implementers from across the country and was officially opened by the Secretary of the DCS. The government reiterated its commitment to serving vulnerable children across the country and belief that the standards will help improve the quality of OVC care.

The evidence gathered during the learning session helped inform the finalization process for the standards. What arose from the piloting was that the standards have helped improve the quality of care by:

- Enhancing community responses to household needs,
- Promoting referrals and linkages across the board, thus improving the leveraging of resources among partners
- Promoting effective service delivery

From the piloting, it was also evident that achievement of desired outcomes varied per service based on the socio-cultural environment. This information was critical in informing the implementation strategy for scale up of the standards among OVC service providers across the country.

VII. KEY LEARNING

1. Are the service standards understandable and “do-able” at the point of service delivery?

All of the implementing partners found that they were able to implement the standards and that they can be used in all organizations and at all levels, from local CBOs up to the national level. The standards were “workable and provided needed direction” to the implementing partners. At the onset of piloting, there was an extra burden on staff but this diminished as implementation led to more focused service delivery.

2. What are the best practices that facilitate the ability of implementing organizations to meet the service standards?

The implementing partners determined that community-driven initiatives are the most sustainable approaches and that an empowered community is necessary to own the projects in their area. Another key learning was that participation and involvement of the caregivers and the children themselves in all aspects of program design and implementation is crucial since they know their needs best. Some of the ways this can be done are through the development of social gatherings and fora where children can talk and share their views, building capacity of caregivers, and visiting schools to meet with teachers. The importance of providing feedback and soliciting the opinions of the beneficiaries cannot be overstated. Furthermore, the service standards can be used by the community to ensure their participation for ownership and sustainability.

3. Do the service standards (when implemented) lead to measurable improvements in the quality of services and programming and the lives of children?

The standards were found to be a very effective method to ensuring professionalism and uniformity across the program and among the beneficiaries. Using the standards offered possibilities of engaging all stakeholders to appreciate
Using QI has helped us reorganize what we are doing as we can now see the gaps. We also recognize the strengths that are in the families and we have the ability to forecast needs. Before we didn’t know how many children benefitted from the services we provided, now we read beyond the numbers.

Representative from Lea Toto

the goal and plan they have for every client. Using the standards allowed implementing partners to first gain a better understanding of their clients’ varying needs and to examine what they were doing that worked, what did not work, and what else was needed, thereby allowing for needs-based service provision as opposed to packaged services. The implementing partners noted that QI provides the opportunity to the organization to reflect on what has not worked and what has worked, thus informing the redesign of existing programs and the design of new programs. Overall, the implementing partners also noted that implementing QI and the standards did not require extra resources.

Some of the implementing partners were unable to see measurable improvements in children’s well-being due to situations beyond their control. For example, during the year of piloting, Kenya was affected by famine and subsequent inflation, increasing food prices dramatically and thereby affecting some implementing partners’ ability to see improvement in food and nutrition among their population. Also, some of the challenges implementing partners were trying to address, such as exploitation and abuse, have deeply embedded cultural ties which partners were unable to change over the course of just one year.

Overall, the implementing partners were able to address gaps in new ways and maximize resources, through mapping stakeholders and creating linkages with other service providers, engaging households in IGA instead of just providing food donations, reorganizing processes, and making use of other locally available resources.

Through the use of QI and the standards, the implementing partners were able to make measurable improvements in the well-being of the children they are serving.

VIII. WAY FORWARD

Based on the evidence shared during the National Learning Session and from feedback gained throughout the piloting period, the Ministry of Gender, Children and Social Development plan to finalize the OVC quality standards to serve as National Minimum Service Standards for QI in OVC Care in Kenya.

Implementing partners noted the need for a national database for OVC service providers to improve data management and coordination among partners.

The Ministry is developing job aids, including posters and handbooks, which will be used to educate and enable communities, households, and volunteers to use the service standards. In addition, HCI is working with all APHIA Plus partners, which cover the entire country, to introduce the QI methodology and standards to be used in their work with vulnerable children.

HCI will continue supporting implementing partners and the GOK to institutionalize QI in their daily work. This will spread the use of QI to continue to improve the well-being of vulnerable children throughout Kenya.

To hear more about implementing partners’ and beneficiaries’ experiences, please see our video on this work at: www.vimeo.com/improvinghealthcare/care-that-counts-kenya
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