

Hope Implementation Guide

Community-led care for orphans and vulnerable children



HIV/AIDS Hope Initiative
Draft for Review, February 2005

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PREFACE TO THE HOPE IMPLEMENTATION GUIDE SERIES

World Vision's HIV/AIDS Hope Initiative has developed a series of Hope Implementation Guides to equip World Vision field staff to implement key elements of World Vision's HIV/AIDS response more easily and effectively. These guides are intended to complement the World Vision *ADP Toolkit for HIV/AIDS Programming*. While the toolkit focuses on design, monitoring, and evaluation of HIV/AIDS responses, the guides provide detailed guidance on implementation.

All implementation guides draw on the experience, learnings, and good practice of World Vision and other organizations. Each implementation guide is intended to cover programming inside World Vision Area Development Programs (ADPs) and outside ADPs.

One Hope Implementation Guide has been produced for each of the three core elements of WV's HIV/AIDS response:

1. Care for orphans and vulnerable children
2. HIV prevention for children aged 5-15
3. Partnering with churches and other faith-based organizations for HIV/AIDS response

Additional implementation guides will be developed in the future for other types of HIV/AIDS response prioritized by World Vision.

This initial draft has been developed for review at the WV Africa HIV/AIDS Capacity Building Workshop in September 2004. Your guidance is requested to ensure that the Hope Implementation Guides are as useful and user-friendly as possible. Please send feedback to mark_lorey@wvi.org.

1. The Situation of OVC

1.1 *The Impacts of HIV/AIDS*

The global community is increasingly recognizing the HIV/AIDS pandemic as an unprecedented crisis. It is fundamentally different from other crises in the past because of its:

- **Scale:** HIV/AIDS has affected millions more people than any previous crisis
- **Scope:** HIV/AIDS affects every *sector* of society, including public and private, health, education and agriculture, etc., and every *level* of society, from local through district/provincial to national.
- **Duration:** HIV/AIDS is a slow-onset, long term development catastrophe that will be widening and worsening for many years to come. Some high prevalence areas of the world are still in the early stages of its impact and the consequences are already devastating.

By the end of 2001, over 40 million people worldwide were living with HIV/AIDS, 95% of these in developing countries, according to UNAIDS statistics. In sub-Saharan Africa, the region most affected by the pandemic, HIV/AIDS is the leading cause of death, and average life expectancy has fallen to 47 years. Women account for 58% of the 26 million adults living with HIV/AIDS in the region.

Underlying the immediate causes of the HIV/AIDS crisis are poverty, conflicts, migration patterns, and cultural practices involving sexuality. Religious and ethnic discrimination, limitations to full political participation, and lack of access to basic education and health services are also contributing factors. In addition, gender inequity, manifested in many forms across heavily AIDS-affected areas, is a major contributor to the spread of HIV and the aggravation of its impacts.

HIV/AIDS substantially degrades the current and future livelihood security of families and communities. When a farmer or an individual from the educated workforce dies, expertise and productivity are lost along with the income s/he earned. Affected families are forced to sell productive assets and borrow money, diminishing their long-term economic potential. Their hardship is exacerbated in cultures where a deceased husband's family claims the property he leaves behind, leaving his widow and orphans destitute. The food consumption of all surviving family members frequently declines, resulting in malnutrition. Malnutrition, in turn, increases the likelihood of opportunistic infections associated with HIV/AIDS and hastens the onset of full-blown AIDS and ultimately death. When livelihood insecurity worsens, the risk of HIV transmission is likely to increase as households may be forced into riskier economic alternatives, including migration and transactional sex.

The impacts of the HIV/AIDS pandemic are exacerbated by the stigma and denial associated with the disease, which have until recently resulted in silence and inaction by governments, donors, and NGOs. This collective failure to respond in a timely manner commensurate with the magnitude of the challenge has allowed the disease to spread even more rapidly. In the most heavily affected areas, HIV threatens the stability and security of communities and countries.

1.2 Orphans and Vulnerable Children (OVC)

More than 14 million children under the age of 15, most of them in sub-Saharan Africa, have lost one or both parents to AIDS. This number is expected to increase to more than 25 million by the year 2010. In addition, there are millions more children who are highly vulnerable because their parents are suffering from AIDS or because their families are otherwise affected by the disease.

Definition of OVC

A child (age 18 and under) who:

- Has lost one or both parents from any cause
- Is HIV-positive
- Is living with a chronically-ill adult
- Is living in a family that has absorbed orphans

Community definitions of vulnerability are also accepted.

Children affected by HIV/AIDS are at high risk of being deprived of a full, healthy, productive life. The children left behind when parents die may not have acquired sufficient skills to perform essential agricultural and economic activities. This increases livelihood insecurity indefinitely. Concurrently, children are drawn increasingly into adult responsibilities by parents or guardians and may be taken out of school, with long-term negative impact on their ability to acquire literacy-based skills. In addition to the psychological distress of losing one or both parents, they may be required to care for chronically ill adults or younger siblings. Orphans and other children made vulnerable by HIV/AIDS often lack financial resources and go without even the most basic human rights, such as food, shelter, clothing, or health care. They may face social stigma, isolation, discrimination, abuse, or exploitation. Girls, in particular, are less likely to be immunized, more likely to be malnourished, less likely to go to school, and more vulnerable to abuse and exploitation. Deprived of parental guidance and protection, they may themselves become vulnerable to HIV/ infection.

As children grow up under these conditions, they are at risk of developing anti-social behavior and of becoming less productive members of society. The consequences for affected children and for society as a whole will be profound. It is, then, necessary to find ways to delay orphaning as long as possible through appropriate and compassionate care to chronically-ill parents, and to provide supplementary care to orphans and other children made vulnerable by the crisis. Unfortunately, in high prevalence contexts traditional ways of caring for orphans and vulnerable children, such as the extended family system, are coming under tremendous strain as more caregivers fall ill and die, and resources must be stretched more thinly among an increasing number of orphans.

The challenge now is to find new ways to help communities provide this necessary care for the unprecedented numbers of vulnerable children, focusing efforts on building the capacity of community structures to provide support in an ongoing way.

2. World Vision Strategy for OVC Response

2.1 Programming Principles

World Vision's programming in response to OVC needs following the guiding principles developed by UNICEF and other partners to protect and fulfill the rights of children and adolescents. They encourage actions that are child-centered and family and human rights based. Programming principles include:

- Strengthening the caring and economic *coping capacity of families* and secondary caregivers through *community based approaches*
- Enhance the capacity of families and communities to respond to the *psychosocial needs* of orphans, vulnerable children, and their caregivers.
- Strengthen the protection and care of orphans and vulnerable children within their *extended families and communities*
- Encourage approaches that allow children to *remain in communities* rather than being institutionalized.
- Foster linkages between HIV/AIDS prevention activities, home based care and efforts to support orphans and vulnerable children
- Target the most vulnerable children, not only orphans
- Ensure gender awareness in all activities.
- Encourage children and adolescents to participate in identifying solutions and making decisions that affect them
- Support schools and ensure access to education
- Reduce stigma and discrimination
- Accelerate learning and information sharing
- Strengthen partners and partnerships at all levels and build coalitions among key stakeholders
- Ensure that external support strengthens and does not undermine community initiative and motivation

2.2 Program Settings and Program Options

2.2.1 Program Settings

World Vision seeks to strengthen and extend the work communities are already undertaking to assist OVC. WV can work in two types of program settings, as follows:

- **Within ADPs:** Adding an OVC focus in communities where WV sponsors children.
- **Outside ADPs:** Initiating new OVC-focused programming in areas where WV is not yet operational.

2.2.2 Program Options

Projects may choose to implement *Core* OVC Programming, focusing on a community-level response, or if resources permit, implement *Comprehensive* OVC Programming, focusing on family, community and enabling environment-level responses.

- **Core Programming**
 - **Community-Level Response: (CCCs and HVs)**
 - Mobilization and Training
 - Support
- **Comprehensive Programming**
 - **Family-Level Response**
 - Life-Skills Training for Children and Youth
 - Livelihood Support for Families
 - **Community-Level Response: (CCCs and HVs)**
 - Mobilization and Training
 - Support
 - **Enabling Environment-Level Response**
 - Coordination and Collaboration
 - Government Capacity Building
 - Advocacy

Within ADPs, projects may have more resources to mobilize, train and support a CCC and HV-based community-led response, and to perhaps add components of comprehensive programming as well.

Outside ADPs, projects may not have the resources to *mobilize* CCCs and HVs and may rather choose to provide various forms of *training* and *support* to pre-existing community-based organizations responding to OVC needs, selecting from the options outlined in Section 4.

2.3 Outline of Possible Program Components

A. Goals and Objectives

See Section 4 for examples

B. Core Program: Community-Level Response

B1: Mobilization and Training

B 1.1 CCC Mobilization (core)

B 1.2 Home Visitor Training (core)

B 1.3 Organizational Capacity Building (optional)

B 1.4 Transformational Development Training (optional)

B 1.5 FBO Channels of Hope Training (optional)

B 1.6 Home Based Care Training (optional)

B2: Support

B 2.1 Materials and Incentives

B 2.2 Support Groups

B 2.3 Community Centers

B 2.4 GIK

B 2.5 Accredited Trainings

B 2.6 Transport

B 2.7 Social Worker

B 2.8 Links with Funding Sources

B 2.9 Small Grants

B 2.10 Links with ADP Programs

C. Comprehensive Program

*NB: These components are **in addition** to Core Components*

C1: Family Level Response

C 1.1 Life Skills Training For Children and Youth

C 1.2 Livelihood Strengthening for Families

C 1.2.1 Food Assistance

C 1.2.2 Material Support

C 1.2.3 Agriculture, Livestock & Business Inputs & Training

C 1.2.4 Links to Microfinance

C2: Enabling Environment Level Response

C 2.1 Coordination and Collaboration

C 2.2 Government Capacity Building

C 2.3 Advocacy

3. Partners in OVC Response

3.1 Local Level

The Partnership Inherent in the CCC Model

The importance of partnership is implicit in OVC program design at all levels. As explained in Section 4, CCCs draw their membership from all community stakeholders to ensure a holistic response to OVC needs. As such, the very model of the CCC implies a mutuality of effort.

WV Partnership with the CCC

WV in this way enters into direct partnership with the community, with the CCC taking on the front-line responsibility for implementation. WV's role in this partnership is to assist in mobilizing the CCC, to train the CCC and Home Visitors in technical HIV/AIDS and OVC programming, and to assist in the capacity building of the CCC, thereby helping to ensure its long-term viability.

WV Partnership with other Community Stakeholders

In addition, where possible WV prefers not to take on the role of mobilizing CCCs by itself, preferring instead to collaborate with other relevant local-level actors. WV seeks to engage all those who can contribute to the mobilization and capacity-building process in order both to access available technical resources in the area, and to build a sense of ownership among other community stakeholders. Potential partners in mobilization and capacity-building include:

- Relevant Government Departments (to include District Departments of Social Welfare, Community Development, Health, and other relevant sectors.)
- Multi-Sectoral Committees (to include District OVC Committees, District AIDS Task Forces and any OVC Subcommittees, and the like.)
- NGOs, churches and other FBOs
- Local businesses

Wider Linkages

To the extent that local/district-level coordinating structures exist in project areas, close collaboration and partnership with these are essential in order to build a harmonized response to OVC needs, as outlined in Section 4: C 2.1. (*Coordination and Collaboration*).

3.2 Provincial, Regional and National Levels

Coordination and Resource Mobilization

In the same way that WV builds linkages and fosters partnerships with all relevant stakeholders and coordinating bodies at local level, as these structures are replicated at provincial, regional and national levels WV must be equally active in linking with these. It is often the case that *decisions* for financial and material disbursements at local level are in fact taken at these higher levels. By seeking and maintaining such partnerships WV not only ensures more effective coordination at all levels, but can also work to mobilize additional resources to support the activities of the CCCs.

4. Program Description

A. Goals and Objectives

- **Core vs. Comprehensive Program:** Depending on available resources and decisions made at project level, OVC care programs may focus on the *core* response of *building community capacity*, or may choose to undertake a *comprehensive* program that focuses on the three levels of *family/child, community, and environment*.
- The **core** program works with *community care coalitions (CCCs)* and *home visitors (HVs)* to mobilize a community-led response to OVC care and support.
- The **comprehensive** program may add *livelihood* and *life-skills* interventions at the family/child level, and may add *coordination, government capacity building* and *advocacy* activities at the environment level. Projects must decide if they have the resources and/or mandate to take on these additional functions.
 - Core Program:
 - Community level response
 - Comprehensive Program:
 - Family/Child level response
 - Community level response
 - Enabling environment level response

Goals and Objectives: Core Program Examples

Goal: Improved Quality of Life of (*number*) Orphans and Vulnerable Children in (*project area*).

Objective 1: Mobilized and strengthened community-led response to protect and care for OVC and their families

Objective 2: Strengthened community capacity to secure external sources of OVC support

Goals and Objectives: Comprehensive Program Examples

Goal: Improved Quality of Life and Resilience of (*number*) Orphans and Vulnerable Children in (*project area*).

Objective 1: Enhanced resilience of OVC and households caring for OVC

Objective 2: Mobilized and strengthened community-led response to protect and care for OVC and their families.

Objective 3: Improved enabling environment at (*district, provincial, national*) levels that actively support care for OVC.

B. Core Program Implementation

Community Level Response

Community Care Coalitions and Home Visitors: The program to mobilize and strengthen a community-led response to OVC care works with a model of *Community Care Coalitions*, or *CCCs*, which in turn identify and work with *Home Visitors*, or *HVs*. World Vision carries out two primary functions within this model:

- Mobilize and Train
- Support

B1. Mobilize and Train: There are two **core** trainings and numerous **optional (additional)** trainings that a project can choose to carry out with CCCs and HVs.

- B 1.1** **CCC Mobilization**
- B 1.2** **Home Visitor Training**
- B 1.3 Organizational Capacity Building
- B 1.4 Transformational Development Training
- B 1.5 FBO Channels of Hope Training
- B 1.6 Home-Based Care Training

B2. Support: It is recognized that communities, while representing the best hope for a broad-based and sustainable response to HIV/AIDS, are themselves increasingly stretched and reeling from the effects of the crisis. As World Vision mobilizes and trains CCCs and HVs to take the lead in OVC care at local level, projects at the same time should identify and provide various forms of *support* to ensure that these already-strained communities are equipped to cope with their expanded responsibilities. A project may select, as relevant, from the possibilities listed below, or identify other forms of appropriate support.

- B 2.1 Incentives
- B 2.2 Support groups
- B 2.3 Community Centers
- B 2.4 GIK
- B 2.5 Accredited trainings
- B 2.6 Transport (for referrals)
- B 2.7 Placement of social worker
- B 2.8 Links with funding sources
- B 2.9 Small grants
- B 2.10 Links with ADP activities

B1: Mobilization and Training

B 1.1 CCC Mobilization

Introduction: WV's Models of Learning unit has developed a standardized manual to mobilize and train CCCs. Entitled *Mobilizing and Strengthening Community-Led Care for OVC*, the first unit of the manual provides step-by-step guidance on forming CCCs in project areas, as follows:

Mobilizing Community-Led Care for OVC	
Step 1: Preliminary Institutional Mapping	Step 6: Identifying Home Visitors
Step 2: Community Stakeholders Meeting	Step 7: Supporting Home Visitors
Step 3: Forming a CCC	Step 8: Monitoring and Evaluation
Step 4: Action Planning	Step 9: Training CCC Members
Step 5: Identifying OVC	Step 10: Training Home Visitors

CCC Models: The project, together with the communities, must select between one of two different CCC models to employ. The selection process is described in the manual, but project staff should be aware of the selection considerations prior to moving forward with mobilizing the CCCs.

CCC Model 1

In the first model, various organizations and individuals come together to form a *new* organization: one that has as its mission to respond to the needs of OVC in the community. Together they will come up with an action plan, and together they will decide how to implement the plan. This work is *in addition* to the regular work the members are already doing within their own organizations. The CCC will be a *new* organization, formed for the purpose of responding to the OVC crisis.

CCC Model 2

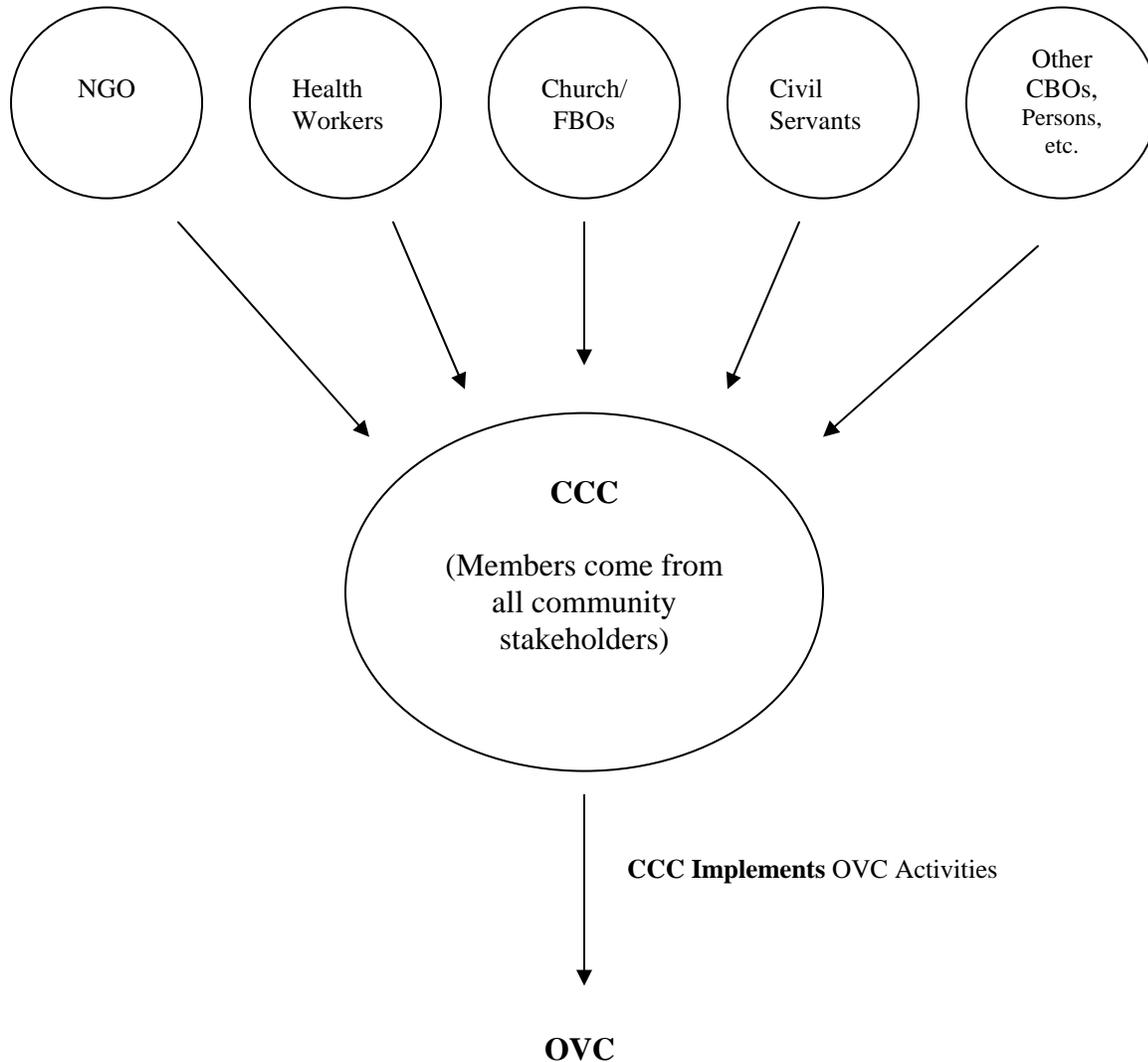
In the second model, the various organizations and individuals come together, but this time more for purposes of carrying out a *coordinating* function, rather than an implementing function. In this case, each member organization continues to work in accordance with its own internal mission, in recognition of the fact that many organizations are *already* working with OVC and that an effective response can be carried out *by* these organizations without needing to form a *new* implementing structure. In this model, the CCC exists more to understand what each stakeholder is doing to respond to OVC, and to help to coordinate the response. The member organizations can come together in the CCC to share experiences, to identify lessons learned, to share information about their activities so that complementarities may be gained. In some cases, if the CCC feels that there is an obvious gap that *no* member organization is filling, the CCC *may* choose to implement certain OVC-related activities itself.

Model 1: If there is very little current activity with respect to OVC and the participants feel that a new structure should be created to fill this gap and *implement* new activities.

Model 2: If there are already many stakeholders responding to the OVC situation and the participants feel that what is needed is more *coordination*, with limited CCC direct implementation.

B 1.1 CCC Mobilization (cont.)

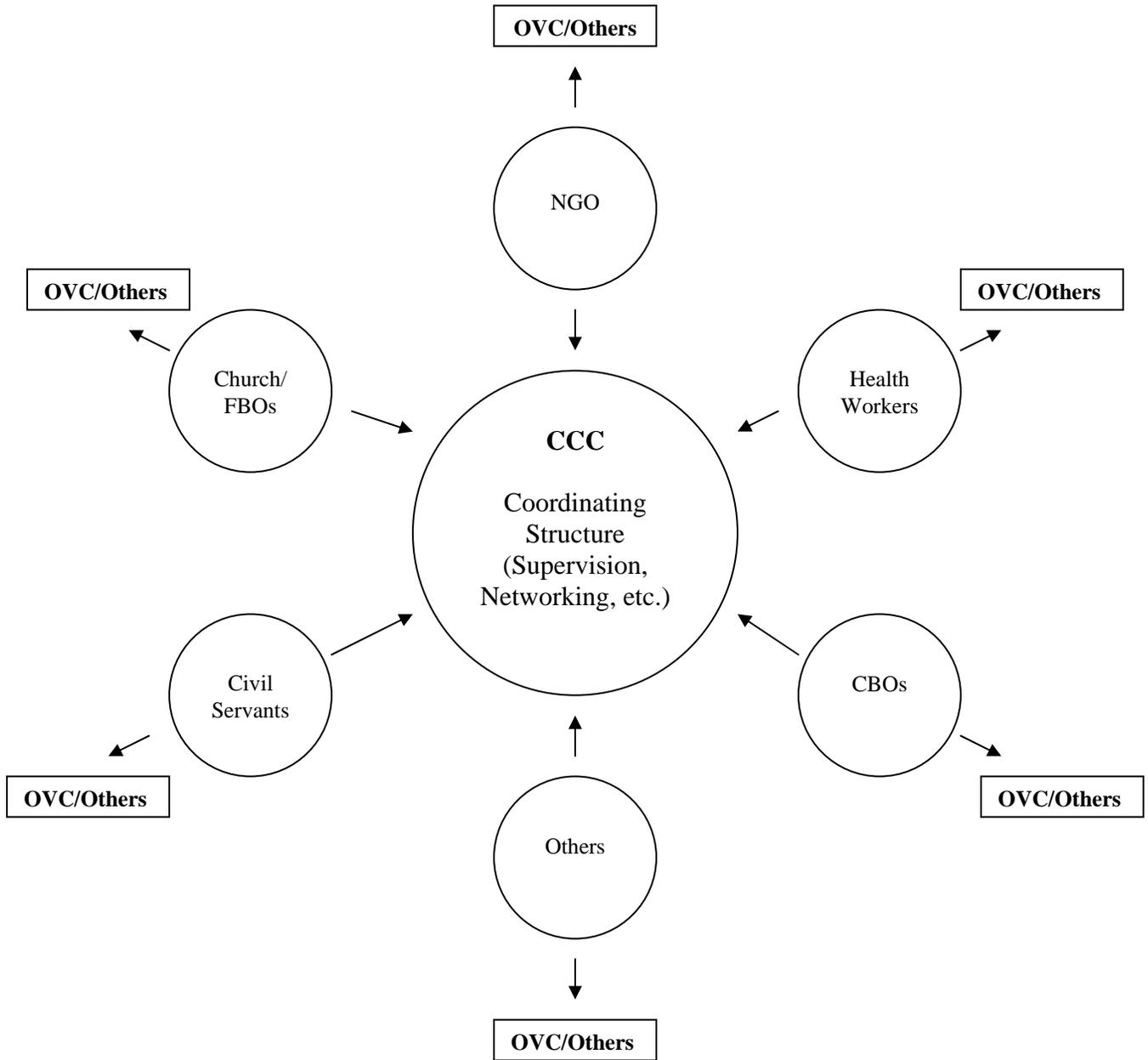
CCC Model 1: CCC as Implementing Body



In this model, key community stakeholders come together to *form* a new institutional structure, the CCC (community care coalition). The CCC will elect leaders and will develop an activity plan to respond to current gaps in OVC response. The CCC will oversee **implementation** of the activity plan, calling on the efforts of its members to take on various responsibilities. For CCC members, this work is *in addition* to whatever work they may be already doing as an individual or as an organization.

B 1.1 CCC Mobilization (cont.)

CCC Model 2: CCC as Coordinating Body



In this model, key community stakeholders come together to carry out a *coordinating* function in the form of a CCC, but the CCC itself does not *implement* community activities. Instead, each member organization or individual continues to carry out activities in accordance with its own internal mandate, perhaps adapting these as needed based on the CCC assessment of gaps in the overall response that need to be filled. In some cases the CCC may take on a type of supervisory role with respect to OVC, but most of the actual activity is handled by the member organizations.

B 1.1 CCC Mobilization (cont.)

- ***Implementing B1.1: CCC Mobilization***

- ❑ ADP HIV/AIDS Coordinator or Project Technical Advisor reviews CCC Mobilization curriculum and adapts as needed to local context.
- ❑ OVC Facilitators hired (see Section 5: Program Structure and Staffing).
- ❑ *Mobilizing Community-Led Care for OVC* training manuals duplicated for all project staff.
- ❑ Coordinator or Technical Advisor carries out five-day ToT with all OVC Facilitators (all training materials purchased and logistics arranged).
- ❑ Project reviews two CCC models and makes preliminary decision based on local context, to finalize during CCC formation phase.
- ❑ OVC Facilitators carry out CCC Mobilization in respective communities, CCCs mobilized and formed, develop activity plans.
- ❑ CCCs identify OVC in community.
- ❑ CCCs identify Home Visitors in preparation for Home Visitor training.
- ❑ OVC Facilitators assist in Monitoring and Evaluation.
- ❑ OVC Facilitators provide supervisory support to CCCs, based on example description of CCC responsibilities (will vary among CCCs):

- ***Example CCC Responsibilities***

- Carry out participatory community assessment to determine priority OVC needs
- Define criteria for assessing vulnerability; identify OVC in the community using these criteria
- Determine desired qualities for volunteer HVs and recruit from the community
- Identify households to receive emergency nutritional support when necessary
- Through school and teacher participation on the CCC, increase OVC access to education, and identify children needing school support
- Through primary health staff participation on the CCC, promote linkages between HVs and health centers, referring OVC to clinics when needed
- Assist with basic household tasks (fetching water, tending crops, etc.) when needed
- Organize community-managed day care for young children (under six years)
- Organize recreational activities for local children, including OVC (sports, games, singing, drama, other activities that promote integration and healthy socialization.)
- Advocate within the community in an attempt to reduce stigma and to promote child rights

B 1.2 Home Visitor Training

- **Introduction:** Following on from Unit 1 in the *Mobilizing and Strengthening Community-Led Care for OVC* manual, Unit 2 is focused on training and preparing volunteer home visitors to make visits to the homes of OVC. This section of the manual is divided into six modules, as follows:
 - Module 1: Training Facilitator’s Guidelines
 - Module 2: HIV/AIDS and the Situation of OVC
 - Module 3: Addressing Psychosocial Needs of OVC
 - Module 4: Addressing Physical Needs of OVC
 - Module 5: Equipping OVC for the Future
 - Module 6: From Training to Taking Action.
- The Home Visitor Training is geared primarily to the HVs. As the HVs go through the six modules they will compile their *own* manuals to serve as reference during home visits.
- CCC members should *also* participate in the Home Visitor Training, however. While there are many ways that HVs can assist OVC during individual visits, there are some OVC-related issues that are best taken up at the level of the community as a whole; i.e. at the level of the CCC. Such issues include OVC access to education, general community food security, OVC protection and legal processes, etc. CCCs will be better able to make decisions on these issues if they also participate in the Home Visitor Training.
- **Implementing B1.2: Home Visitor Training**
 - ❑ ADP HIV/AIDS Coordinator or Project Technical Advisor reviews Home Visitor training manual adapts as needed to local context.
 - ❑ *Strengthening Community-Led Care for OVC* training manuals duplicated for all project staff.
 - ❑ Coordinator or Technical Advisor carries out xx-day ToT with all OVC Facilitators (all training materials purchased and logistics arranged).
 - ❑ OVC Facilitators carry out Home Visitor training in all communities, with participation of both HVs and CCC members.
 - ❑ OVC Facilitators provide support to Home Visitors, including incentives and/or stipends, based on decisions made by project concerning HV support (see Section B2: Support).
 - ❑ OVC Facilitators provide supervisory support to HVs, based on description of HV responsibilities, as follows:

B 1.2 Home Visitor Training (cont.)

- ***Home Visitor Responsibilities***
 - Visit a set number of households per week to provide care and support to set number of OVC
 - Ensure that all family members have age appropriate information about HIV/AIDS
 - Train primary caregivers in universal precautions to protect them from contracting the virus
 - Train primary caregivers and chronically ill individuals in preventive health messages regarding routine and opportunistic infections
 - Train primary caregivers and OVC in appropriate hygiene and nutrition
 - Monitor OVC well-being, including health, education and psychosocial status
 - Protect against abuse and neglect of OVC, through prevention, advocacy and referrals
 - Build HIV awareness and prevention knowledge among OVC
 - Provide spiritual and psychosocial support for OVC and chronically ill patients through one-on-one counseling during home visits
 - Work with households on succession planning to include the development of memory books or memory boxes, the identification of standby guardians and the protection of inheritance rights
 - Submit monthly reports to CCC supervisors.

B 1.3 Organizational Capacity Building (Optional)

Introduction: A project may choose to supplement the training given to CCCs in technical HIV/AIDS and OVC issues with Organizational Capacity Building (OCB). This programming option focuses on strengthening the internal organizational capacity of the CCC leading to increased effectiveness and long-term viability. This type of OCB support may also help CCCs to *access outside sources of funding* in later years of the project.

MoL Programming: World Vision’s Models of Learning unit has developed a separate Hope Implementation Guide entitled *Organizational Capacity Building*. This guide assists projects to select appropriate assessment and training materials from a choice of three levels (beginner, intermediate and advanced), and to implement a program of capacity building with CCCs that incorporates organizational self-assessment, targeted trainings and tailored follow-up support. The text box below lists the types of topics or issues that OCB assessment, training and follow-up support may address.

Strategic Planning	Program Design
Vision	Community Assessment
Mission	Program Design
Goals, Objectives, etc.	Program Implementation
Organizational Structure	Monitoring and Evaluation
Governance	Monitoring
Leadership	Evaluation
Hierarchies, teams etc.	Reporting
Organizational Management	Financial Management
Human Resources	Budgeting
Policies and Procedures	Accounting
Stakeholder Participation	Bookkeeping

Alternative Curricula: Alternatively, a project may seek to outsource organizational capacity building to other in-country organizations with known track records and recognized reputations in the this area. Projects should look for any or all of the above topics when assessing outside syllabi.

- **Implementing B1.3: Organizational Development Training**
 - ❑ ADP HIV/AIDS Coordinator or Project Technical Advisor reviews MoL and/or alternative curricula for organizational development. Selects, and adapts as needed, based on local context.
 - ❑ If MoL curriculum selected, training manuals duplicated for all project staff.
 - ❑ If MoL curriculum selected, Coordinator or Technical Advisor carries out five-day ToT with project staff, identified to be OCB Facilitators (all training materials purchased and logistics arranged).
 - ❑ If training to be outsourced, organization and curriculum identified, contractual arrangements made.

- Outside organization carries out ToT with project staff, if *project* will be carrying out the training. No ToT necessary if outside organization will be carrying out the training.
- Project staff, or staff of outside organization design a training schedule and carry out organizational development training with all CCCs
- Project designs set of indicators to measure organizational capacity and tracks progress of CCCs, to assist in linking with outside sources of funding, described in section B 2.8.

B 1.4 Transformational Development Training (Optional)

- **Introduction:** Transformational Development (TD) is based on the premise that *information* and *motivation*, while necessary, will not by themselves lead to behavior change in an individual if the *context* from which the individual operates is not supportive of that change. With respect to HIV/AIDS, TD works to transform the prevailing context of stigma and discrimination, helplessness and despair into a context where positive support, healthy living and risk-avoidance sexual behaviors become the accepted social norms. An OVC program that seeks to influence the *context* in which CCCs and HVs are operating, and to develop their ability to act as agents of change, may wish to include a TD component. In an initial phase, this would involve providing Transformational Development Training to CCCs.

NB: The TD process is a lengthy and conceptually sophisticated one, and projects should only include this component if they are willing to commit to a long-term (multi-year) process, and to invest in the necessary internal capacity-building. Projects may wish to begin with a TD pilot program before scaling up.

MoL does not have a set training curriculum for TD, but WV South Africa has successfully piloted TD in one ADP and can share references and resources. (See Sections 9 and 10: Resources, and Technical Resource People.)

- **Implementing B1.4: Transformational Development Training**
 - ❑ ADP HIV/AIDS Coordinator or Project Manager contacts WV South Africa for resources and references.
 - ❑ Coordinator or Project Manager identifies outside TD Consultant to provide xx training and mentoring days to project.
 - ❑ TD Consultant carries out xx-day ToT for project TD Facilitators.
 - ❑ TD Consultant carries out 5-day TD Basic Training Orientation for all project staff. (Not meant to *train* all staff *per se*, but to give staff an overview of the approach.)
 - ❑ TD Facilitators carry out 2-day TD Introductory Workshops in all communities, to introduce CCC members to the approach and garner interest in the program.
 - ❑ TD Facilitators carry out xx-day Transformational Leadership Basic Trainings with all CCCs.
 - ❑ CCCs design work plans to operationalize TD in their activities.
 - ❑ TD Facilitators provide follow up support and supervision to CCCs.
 - ❑ TD Consultant advises project on phasing in remaining stages of TD trainings (in subsequent years, i.e. after year 2.)

B 1.5 FBO Channels of Hope Training (Optional)

- ***Introduction:***

CCCs: Multi-Sectoral: The CCC structure is one that draws its membership from all sectors of the community, as described in section B 1.1. The CCC may take on either an implementing or a coordinating function, and is responsible for identifying Home Visitors to provide essential care and support to OVC.

Channels of Hope: FBOs: WV has also designed a specialized training entitled *Channels of Hope*, geared especially to churches and FBOs, that aims to mobilize a faith-based community response, drawing from Christian principles and focusing on messages of abstinence, fidelity and compassion for those living with the disease. The training is two-tiered, as follows:

- Phase 1 Training: Workshops for Pastors and Religious Leaders
- Phase 2 Training: Congregation Members Workshops

FBO Hope Teams: Following the trainings, the participants form “Hope Teams” to bring activities forward into their communities. Hope Teams may focus on Prevention, Care and/or Advocacy. Not all Hope Teams choose to implement OVC Care activities, but many do.

Hope Team Home Visitors: Those Hope Teams that choose OVC Care as their focus are then assisted by WV to identify Home Visitors, who will then receive the regular Home Visitor Training.

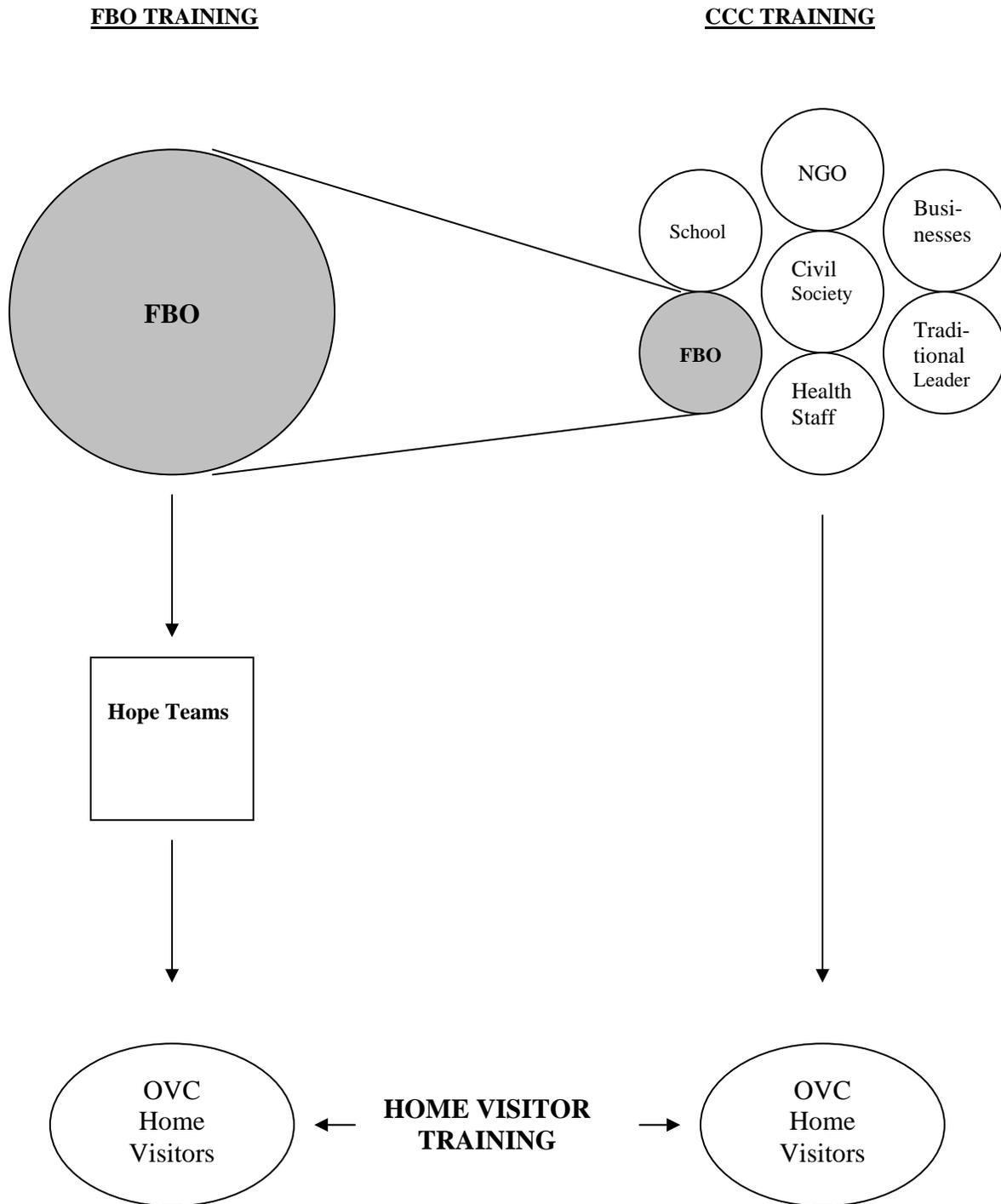
A project may wish to draw out those churches and FBOs in the communities to receive the specialized Channels of Hope training. This training in turn will lead to the identification of *some* Home Visitors for OVC care, who will enter into the regular track of Home Visitor Training and subsequent care activities.

See diagram on the following page for a representation of these two implementation tracks.

- ***Implementing B1.5: FBO Channels of Hope Training***

A separate Hope Implementation Guide has been developed describing the Channels of Hope program. See *Partnering with Churches/FBOs for HIV/AIDS Response*.

B 1.5 FBO Channels of Hope Training (Cont.)



B 1.6 Home Based Care Training (Optional)

- **Introduction:** Many HIV/AIDS projects provide care and support to *both* OVC and PLWHA, and it is often the *same* HVs who fulfill both functions. If the project decides to include a home based care component, HVs will need to receive a special Home Based Care Training.

*NB: This will have a bearing on the project objectives. A project may choose to **combine** both target groups under one objective, to read: “Mobilized and strengthened community-led response to care for OVC and PLWHA”, or may choose to break PLWHA out into a separate project objective.*

In many countries, the Ministry/Department of Health has strict guidelines for home-based care. Qualifications might include a specialized, accredited training, and regulations might stipulate the payment of a stipend. The project should research these requirements prior to beginning any home-based care program.

- **Implementing B 1.6: Home Based Care Training**
 - Gather information regarding country-specific requirements for home-based care.
 - Determine whether training may be carried out in-house or whether an outside organization or Department of Health must be contracted. Design training schedule.
 - In-house personnel or outside organization carries out ToT with identified project staff, if project staff will be carrying the training forward to Home Visitors.
 - Project staff or outside organization carries out Home-Based Care Training with all selected Home Visitors.
 - Home Visitors supplied with new Job Descriptions to include care for PLWHA in addition to existing OVC responsibilities.
 - Project provides Home Visitors with agreed-upon stipend and/or other forms of support, in accordance with country-specific guidelines and project decisions. This support may include packages of materials and drugs. (See Section B2: Support)
 - Provide supervisory support to Home Visitors, based on description of expanded Home Visitor responsibilities, as follows:
- **Home Visitor Expanded Responsibilities for Home Based Care: Examples**
 - Bathe patients and ensure comfort, administer approved drugs for treatment of pain and/or opportunistic infections, and ensure compliance with treatment regimes
 - Refer patients to health and/or treatment centers, as appropriate
 - Submit monthly reports to identified supervisor

B2: Support

B 2.1 Materials and Incentives

- **Introduction:** The project should carefully think through and determine what types of materials and incentives, if any, should be provided to CCC members and/or Home Visitors. Retention of experienced caregivers should be a key output of project design. It is inefficient, more costly and less beneficial to children to have constant turnover and training of new caregivers. At the same time, the Home Visitor program should not be dependent on World Vision support for its long-term success and sustainability. Pertinent considerations include:
 - Are there Government requirements stipulating the payment of a stipend to Home Visitors and/or Home Based Caregivers?
 - Is there a reasonable degree of “volunteer spirit” or a “culture of volunteering” in the country?
 - Can the project be built on an assumption of “volunteer spirit” or do additional mechanisms need to be put into place to ensure the long-term sustainability of the Home Visitor program?
 - Together with the CCCs, determine workload, hours per week, caregiver/child ratio for the Home Visitors. This may be standard or flexible.

The types of materials and incentive that a project may consider include:

- Bicycles, to enable HVs to visit children in good time
 - Raincoats, umbrellas and rain boots
 - Carrier bags for record keeping
 - Identifying T-shirts and hats
 - Basic palliative care kits
 - Basic home based care kits (ex: aprons, non-sterile gloves, thermometer, plaster, scissors, disinfectant, cotton, Gentian violet, bandages, non-sterile gauze, ORS, paracetamol, fluconazole, loperamide.)
- **Implementing B 2.1: Materials and Incentives**
 - ❑ Hold initial meetings in-house and with CCCs to discuss considerations relative to volunteers and the provision of materials and incentives.
 - ❑ Decide upon, and develop, incentives program, including criteria for awarding of incentives (i.e., bicycle becomes property of HV after 2 years of continuous service).
 - ❑ Draft an “Incentives Position Paper” for internal reference and clarification.
 - ❑ Purchase materials and distribute to HVs in accordance with defined criteria.

B 2.2 Support Groups

- **Introduction:** It may be the case that Home Visitors, over time, will experience sadness, stress and other forms of psychological burdens, as they work for prolonged periods in distressing environments. The project may choose to assist HVs to cope with these emotions by promoting the formation of support groups among HVs. Sharing experiences with others in similar circumstances can help HVs to relieve tension and to gain perspective on their work and their lives.

Support groups may take the form of periodic meetings among HVs with the purpose of coming together to share experiences. These meetings may be facilitated by a project staff member, who may or may not go through an introductory training. Support groups may also be organized in the form of periodic “retreats” for HVs, financed by the project and/or by the CCC.

- **Implementing B 2.2: Support Groups**
 - ❑ Hold initial meetings in-house and with CCC to discuss mechanisms for forming support groups among HVs. (i.e. how many HVs per support group, frequency of meetings and/or retreats, presence of outside facilitator, need for training).
 - ❑ Identify staff to organize and facilitate, as appropriate, the HV support groups.
 - ❑ Identified staff undergo training in simple psychological coping strategies and group facilitation, as appropriate. Project will need to determine where this training can be sourced.
 - ❑ HVs organized into support groups.
 - ❑ HV support groups hold periodic meetings and/or “retreats”, with or without WV or CCC facilitator.
 - ❑ WV provides necessary material and/or logistical support for retreats, as appropriate.

B 2.3 Community Centers

- **Introduction:** One of the suggested responsibilities of a CCC is to organize community day care and community-led recreation for local children. While this is an appropriate role for a CCC to play, it is often the case that the CCC lacks the necessary resources to open a suitable community center for these purposes. Assisting with a community center is, then, one form of support that the project can provide to communities.

Community centers are primarily conceived as a gathering place for children and youth. The centers may be manned one or more days per week by identified WV staff and/or by CCC members and HVs. The project and/or the CCC can use these opportunities to carry out such activities as life-skills training for children and youth, setting up Anti-AIDS Youth Clubs, and providing supervised recreation. Children and youth may play, draw, listen to music and engage in sport under the supervision of supportive and caring adults.

- **Implementing B 2.3: Community Centers**
 - ❑ Hold initial meetings in-house and with CCCs to decide on purpose of community center and the activities for which it will be put to use.
 - ❑ Meet with local authorities to identify suitable locale for community center, arrange for rent payment if required.
 - ❑ Identify project personnel and/or CCC members and HVs to staff the center during designated times, design work schedule and schedule of activities.
 - ❑ Promote community center among all local children and youth (do not single out OVC).
 - ❑ Purchase materials, or source GIK (see section B 2.4 below), as appropriate, for use in community centers.
 - ❑ Carry out community center activities based on WV and CCC agreed-upon schedule.

B 2.4 GIK

- ***Introduction:*** The provision of materials sourced as Gifts-in-Kind (GIK) is an appropriate form of support that the project can give to communities, so long as the materials in question do not undercut local initiatives. Possibilities for GIK contributions include:
 - Home Visitor Incentives
 - Bicycles
 - T-shirts and hats
 - Raincoats, umbrellas, boots
 - Carrier bags
 - Materials for Community Centers
 - Music equipment
 - Art supplies
 - Sports equipment
 - Books and other print material
 - Material Support for Vulnerable Families (see Section C)
 - Household Items: Beds, Mattresses, Blankets, Shoes
 - School Materials: Books, Bags, School Uniforms
 - “Ag Packs”: Seeds, Tools, Fertilizer
 - Home Based Care Kits
 - Bandages, gauze, gloves
 - Basic medications (government approved, country-specific)
- ***Implementing B 2.4: GIK***
 - Hold in-house meeting to determine types of material support to be provided as GIK, based on main project interventions.
 - Determine criteria for receiving GIK (in cases of vulnerable families, for example), and distribution mechanisms. Recommended to draft “GIK Position Paper” for internal reference and clarification.
 - Follow standard WV channels for sourcing GIK.
 - Receive GIK and distribute by agreed mechanisms. Record all distributions.

B 2.5 Accredited Trainings

- **Introduction:** In some cases, the experience that volunteers gain as Home Visitors may pave the way for their eventual entry into the formal job market. The project may choose to support HVs by offering financial assistance to attend accredited training courses as a way of upgrading their skills. This is conceived as an education benefit for the HVs, and one that may motivate them to gain as much experience as possible, first, as volunteers. Examples of the types of training courses that HVs may attend with WV support (accreditation will vary from country to country) include:
 - Home Based Care
 - VCT Lay Counselor
 - PMTCT Counselor

Alternatively, WV may attempt to approach national in-country Ministries/Departments of Health to explore the possibility of awarding HVs with a nationally-recognized credential upon completion of the Home Visitor Training and successful contribution of community service under the model.

- **Implementing B 2.5: Accredited Trainings**
 - Inventory existing national-level accredited trainings.
 - Hold initial meetings in-house and with CCCs and/or HVs to determine training courses of most interest and relevance to HVs.
 - Determine criteria for selection of HV to participate in trainings. (i.e., 2 years of successful volunteer service, minimum (*grade*) education, etc.)
 - Contact training organizations/institutions to outsource the trainings, or to carry out ToTs with project staff.
 - If project staff to carry out trainings following ToT, training schedule designed, materials purchased and logistics arranged.
 - WV and/or CCCs select HVs to participate in trainings. WV carries out or finances the trainings.
 - Project staff approach national Ministries/Departments of Health; negotiate for HVs to receive nationally-recognized credential upon completion of WV Home Visitor Training and successful community service under the model. WV shares Home Visitor Training curriculum with Ministry/Department.
 - Project tracks employment record of HVs having received accredited trainings for (3 years) after separation from WV project?

B 2.6 Transport

- ***Introduction:*** The remote location of many project areas and the distances that HVs must travel to visit OVC or to attend monthly meetings, is often a limiting variable negatively impacting the effectiveness of a Home Visitor program. Remote locations, distance and lack of transport can also hinder the referrals of OVC or their chronically ill parents or guardians to local health or treatment centers. A project may choose to assist with transport as an appropriate form of support to communities. Assistance with transport may be used for the following purposes:
 - Transport of Home Visitors to monthly meetings with CCCs and/or project staff.
 - Transport of OVC to local health centers.
 - Transport of chronically ill parents or guardians to health or treatment centers.

WV may choose to make transport available on a monthly basis to facilitate supervisory meetings, or may go as far as making a weekly bus service available to allow patients to access ARV therapy in town locations, for example.

- ***Implementing B 2.6: Transport***
 - ❑ Hold initial meeting in-house and with CCCs and/or HVs to determine priority transport needs.
 - ❑ Develop a transport schedule for designated purposes and allocate and/or rent one or more vehicles and drivers. Make necessary adjustments to project fuel budget.
 - ❑ Design and work with a transport sign-up list, if appropriate.
 - ❑ Comply with all country-specific vehicle and passenger safety regulations. Review existing insurance policies and amend as necessary.
 - ❑ Carry out transport program on designated days, according to schedule.

B 2.7 Placement of Social Worker

- **Introduction:** While in most countries government benefits for OVC exist on paper, it is often the case that accessing these benefits in practice is extremely difficult, particularly in rural areas. In many cases existing government social workers face enormous backlogs and orphans may wait for as long as two or three years to receive the grants they are entitled to. As the number of orphans is only expected to increase in coming years, this situation is likely to worsen before it improves.

WV projects may choose to play a role in ensuring that Government benefits find their way down to those who are entitled to them; this being a special form of support that projects can provide to communities. By hiring a social worker in one or more project areas and making the services of the social worker available to local OVC, the channels for accessing entitlements can be smoothed. The types of processes for which the social worker can provide assistance include:

- Entitlements for orphans, including food and grants
 - Entitlements for PLWHA
 - The adoption process, for families wanting to foster orphans
 - Foster care placements and legal processes
 - Will writing
 - Inheritance rights
 - Taking abuse cases to court
- **Implementing B 2.7: Placement of Social Worker**
 - ❑ Review country-specific legislation for children and OVC; inventory existing benefits and entitlements.
 - ❑ Contact Department of Social Services or equivalent authority to discuss project plans and acquire support and buy-in. Gather statistical information on numbers of social workers, numbers of OVC, caseloads, etc.
 - ❑ Hire social worker; qualifications in line with national standards. Develop and review Job Description, determine geographic coverage of social worker.
 - ❑ Hold meeting, or organize special training with HVs to instruct them on their responsibilities for compiling necessary paperwork in families to pass along to social worker.
 - ❑ HVs refer OVC and/or family members to social worker.
 - ❑ Social worker takes on and follows up OVC cases, in accordance with job description and country-specific protocols.

B 2.8 Links with Funding Sources

- **Introduction:** All projects should be designed so as to ensure the sustainability of the CCCs in the long term. CCC participation in the CCC Mobilization, Home Visitor Training and Organizational Capacity Building will help to ensure that the CCCs are well-functioning community based organizations capable of carrying out their self-defined tasks.

In addition to training, however, the CCCs will need to access outside sources of funding to allow them to carry on with activities and to address other critical needs the HVs identify when visiting the homes of OVC. In addition to building the CCCs' capacity, projects can help to link the CCCs to these outside sources of support. A range of funders are increasingly seeking to channel funds to the community level for HIV/AIDS response, including OVC care. CCCs should prove excellent partners for this funding, as they will have both the experience and the organizational skills necessary to manage external resources effectively.

Potential funding sources include:

- The Global Fund to Fight AIDS, Tuberculosis and Malaria (small grants mechanism)
- The World Bank
- The European Union
- USAID
- Country-specific funding sources (i.e. CRAIDS and ZAMSIF in Zambia)

NB: While the Organizational Capacity Building programming component is listed in this manual as optional, if the project chooses to link CCCs to outside sources of funding, an OCB program should be considered a necessary prerequisite for preparing CCCs to effectively manage external resources.

- **Implementing B 2.8: Links with Funding Sources**
 - ❑ Ensure that all CCCs under consideration for linking with funding sources have received Organizational Development Training
 - ❑ Inventory potential country-specific funding sources for community based organizations responding to HIV/AIDS. Arrange meetings with any or all funders. Draft Memoranda of Understanding, or receive criteria and application procedures from each potential funder.
 - ❑ Review Organizational Development Training curricula and add units and/or adapt, based on specific funding application criteria and procedures.
 - ❑ Project staff or outside contracted organization trains CCCs in additional/adapted Organizational Development topics, with a view to funding applications.
 - ❑ Project staff develop list of indicators that CCC must demonstrate before being considered as candidates to apply for external funding. CCCs must achieve minimum standards of effective management, governance, financial control and operational proficiency.
 - ❑ WV staff assists qualifying CCCs in funding application process and accompanies CCC leaders to meetings with funders, as appropriate, in initial phase. In later stages CCCs will seek funding without WV assistance.

B 2.9 Small Grants

- ***Introduction:*** In some cases WV may choose to fund CCCs with small grants as a precursor to their accessing outside sources of funding in a subsequent stage. A small grants mechanism offered by the project will allow the CCCs to gain experience in managing funds before submitting to the rigorous application processes that outside funders normally require. A small grants program may operate in two phases, as follows:
 - Phase I: Cash Advance (USD \$2,000 and under)
CCCs request a cash advance for activity implementation and provide the project with receipts as expenditures are made. The project handles all accounting and record-keeping. This provides the CCC with an initial experience in money management and accountability.
 - Phase II: Grant (up to USD \$5,000)
Following successful management and accounting of cash advance, CCCs may submit proposals to receive grants from WV up to USD \$5,000. WV disburses funds on a competitive basis. Financial accounting and record-keeping is the responsibility of the CCC, but the project can ask for progress reports, and monitor activity implementation.

A CCC that has successfully competed for, received and put to use a WV grant should be well prepared to go on to access other outside sources of funding. The project can assist the CCC with linkages, as described in Section B 2.8.

- ***Implementing B 2.9: Small Grants***
 - ❑ Ensure that all CCCs under consideration for small grants program have received Organizational Development Training.
 - ❑ Develop list of indicators that CCC must demonstrate before being considered as candidates to apply for cash advances. CCCs must achieve minimum standards of effective management, governance, financial control and operational proficiency in order to be considered for the program.
 - ❑ CCC submits simple work plan for use of cash advance. Project disburses cash advance up to USD \$2,000. CCC implements activities and submits receipts as expenditures are made. Project incorporates into normal project accounting system.
 - ❑ CCC evaluated following receipt and use of cash advance. Project staff assists successful CCCs in drafting proposals for grants.
 - ❑ Project reviews proposals, awards grants up to USD \$5,000 on competitive basis.
 - ❑ Project staff monitors activity implementation of grant recipient CCCs; CCCs submit progress reports as agreed with project.

B 2.10 Links with Mutli-Sectoral ADP Programs

- **Introduction:** While OVC care programs are not always livelihood/development projects *per se*, given the need to focus on “emergency like” prevention and care efforts, it is nevertheless important to recognize that many of the *underlying contributors* to the HIV/AIDS crisis in fact relate to poverty, food and livelihood insecurity. With a view to the long-term, programs should consider linking communities to sources of livelihood support, moving beyond strict prevention and care interventions in order to address these underlying contributing factors.

Linking CCCs to ADP activities is one way in which a project can address the HIV/AIDS crisis in a more holistic and multi-sectoral fashion, as ADPs respond to a range of livelihood needs. While the CCCs will take the lead in responding to OVC needs within each of the various sectors (i.e. ensuring OVC remain in school, ensuring OVC access to health care, etc.), coordination and collaboration between the CCCs and ADP activities will result in more efficient programming and use of resources.

*NB: If a project chooses to carry out a **comprehensive** program, to include interventions at the family and environment levels (described in Section C), beyond the core interventions at the community level described in this Section B, the project will in fact incorporate **livelihood activities** as part of the design.*

*If a project chooses to go forward with only the **core** program, as described in this Section B, livelihood interventions, while not directly implemented, can nonetheless be fostered in this way, by linking CCCs to ADP projects.*

Possibilities for multi-sectoral assistance, to be coordinated between CCCs and ADPs, include:

Education

- School fees, books and uniforms
- Establishing community schools
- Negotiating with local school administrators to waive or reduce school fees for OVC
- Advocacy at national level for free universal primary education (in countries where not already available).
- Construction or rehabilitation of classrooms to increase space and enrollment in schools
- Provision of teaching and school materials
- Refresher courses for teachers
- Support for vocational skills in schools
- Support for vocational training for out-of-school OVC
- Help with household chores or farming/small business responsibilities
- Childcare or nursery school for pre-school age children
- Advocacy against the exclusion of children who are HIV positive or who have lost parents to AIDS from formal schools

B 2.10 Links with Multi-Sectoral ADP Programs (cont.)

Health Care

- Transport and fees for health checkups and consultations
- Ensuring access to full immunization coverage
- Provision of essential medicines and equipment to health units
- Training or refresher courses for health personnel, including birth attendants and community health workers, in OVC care, counseling, and home based care.
- Referrals to home based care and public sector agencies
- Provision of insecticide-treated bed nets
- Nutrition support/supplementary feeding
- Home based care kits for chronically ill children and adults
- Training for caregivers in basic health, hygiene and HIV/AIDS prevention messages
- Shelter, clothing and blankets (where available and necessary)

Water and Sanitation

- ADP program may be involved in a water development program, to include construction of wells and/or drilling of boreholes.
- CCCs should ensure that OVC are accessing clean water at the same standard of all children

Food Security (See also Section C: Comprehensive Programming)

- Assistance to community farms to enhance crop production, including provision of agricultural inputs and training, and introduction of low-labor methods and highly nutritious crops, such as backyard vegetable gardens
- Provision (loans or grants) of small animal breed stock (chickens, rabbits, honeybees, pigs, etc.) and training for families or groups in livestock management
- In-kind or cash loans for productive assets (dairy animals, oxen, maize mills, etc.)
- Provision of seed capital for development enterprises
- Training of households in various skills and microenterprise development
- Provision of nutritional supplements (food rations) through institutions or direct distribution. Such programs need to target children with severe food shortages and need to include provisions to avoid stigma and discrimination against enrolled children.

• *Implementing B 2.10: Links with Multi-Sectoral ADP Programs*

- ❑ Ensure that CCC members participate in the Home Visitor Training. During this training, participants will brainstorm the various forms of support to provide to OVC. CCCs will make decisions as to their response within each sector (i.e. education, health, etc.) at this time. Many of their decisions will reflect the bullets listed above.
- ❑ Following the CCC/Home Visitor Training, organize meetings between the CCC and ADP community committees. WV project staff should facilitate these meetings to help the two implementers share and compare activities.
- ❑ CCCs and ADPs design a plan to bring multi-sectoral support into the community, based on activities each has previously decided on. CCC and ADP agree on respective division of responsibilities.

C. Comprehensive Program Implementation

C1: Family Level Response

C2: Enabling Environment Level Response

*NB: These two components are **in addition to** Community Level Response described in Section B.*

C1: Family Level Response

A comprehensive program that seeks to supplement a community level response to support and care for orphans, may add interventions aimed at increasing the resilience of the OVC themselves, and their families, to look after their own needs. Interventions may include life skills training for children and youth, and livelihood strengthening for families.

C 1.1 Life Skills Training for Children and Youth

C 1.2 Livelihood Strengthening for Families

C 1.2.1 Food Support

C 1.2.2 Material Support

C 1.2.3 Agriculture, Livestock and Small Business Inputs and Training

C 1.2.4 Links to Microfinance

C2: Enabling Environment Level Response

Family and community efforts to spearhead OVC activities can be hampered if carried out in environments marked by lack of coordination and information, nonexistent or unfavorable policies and practices, and/or generalized negative attitudes directed towards those living with HIV/AIDS. A comprehensive program may include interventions aimed at promoting an enabling environment for OVC, focusing on coordination and collaboration, government capacity-building with a view to policy-making and advocacy for child rights and to reduce stigma and discrimination.

C 2.1 Coordination and Collaboration

C 2.2 Government Capacity Building

C 2.3 Advocacy

C1: Family Level Response

C 1.1 Life Skills Training for Children and Youth

- ***Introduction:*** Children between the ages of 5-15 represent a “window of hope” for HIV/AIDS prevention, as they are generally not yet sexually active and have among the lowest HIV prevalence rates in the overall population. The project may choose to supplement the Home Visitor program with special Life Skills Training for children and youth.

WV has an agreement with Scripture Union to use their curricula, entitled *Adventure Unlimited* for young children, and *Choose Freedom* for adolescents. The curricula work to promote self-confidence, healthy communication skills and responsible decision-making, giving children and youth the opportunity to develop healthy attitudes and behaviors before they are exposed to the sexual pressures of adolescence, and to lay the foundation for minimizing HIV risk in adulthood.

The project may offer a Life Skills ToT to various community members, to enable them to go on to train children and youth within their domain. The project should try to ensure that both in-school and out-of-school children are reached with Life Skills Training, and should not limit the training only to OVC. Possibilities for channels through which to promote Life Skills Training include:

- Teachers/Schools
 - Sunday school teachers
 - Health Workers
 - Church youth group leaders
 - Youth: peer educators
- ***Implementing C 1.1: Life Skills Training for Children and Youth***
 - ❑ Hold initial meetings in-house and with CCCs to introduce and discuss the Life Skills Training curricula. Decide, together with CCC, on appropriate community channels for the training (i.e. through the schools, the church, at the community center, etc.)
 - ❑ Project staff and CCC members review curricula and make any necessary modifications based on local context. (*NB: If other Life Skills curricula besides Scripture Union exist in country, project staff and CCC members may want to review these alternatives.*)
 - ❑ If Life Skills Training to be introduced in schools, meet with appropriate education authorities to review curricula and determine whether the curricula will be *incorporated* into existing lesson plans, or offered as an *additional*, perhaps after-school, option. Receive necessary authorization from school administrators/Department of Education.
 - ❑ Identify trainer/training organization to carry out ToT for selected project staff.

C 1.1 Life Skills Training for Children and Youth (cont.)

- ❑ Acquire necessary quantities of *Adventure Unlimited* and *Choose Freedom* training materials.
- ❑ Selected project staff carry out ToT for selected community members, according to decisions made in initial meetings. ToTs may be carried out with teachers, health workers, Sunday school teachers, church leaders or lay ministers, youth group leaders, youth peer educators, or other appropriate individuals.
- ❑ Following ToT, project staff work with selected community members to design training schedule; in schools, in churches, at community center, during youth club meetings, etc.
- ❑ Life Skills Training carried out by selected community members, reaching local children and youth (not only OVC).
- ❑ Project staff provide supervisory support to community members carrying out Life Skills Training. Staff may observe trainings, co-facilitate and/or mentor the trainers.
- ❑ Community trainers provide basic information on numbers of trainings held and numbers of children and youth participants for project monitoring.

NB: A separate Hope Implementation Guide has been developed entitled “HIV Prevention for Children aged 5-15” with more detailed information on this intervention.

C 1.2 Livelihood Strengthening for Families

The participatory assessment carried out by the CCC at the beginning of project activities (during the CCC Mobilization training) will help to identify the major livelihood issues and constraints faced by vulnerable households in the community. It is expected that in most communities there will be a continuum of needs and, therefore, a continuum of appropriate livelihood support activities that a project may choose to carry out, as follows:

- C 1.2.1 Food Assistance
- C 1.2.2 Material Support
- C 1.2.3 Agriculture, Livestock and Small Business Inputs and Training
- C 1.2.4 Links to Microfinance

C 1.2.1 Food Assistance

- ***Introduction:*** This intervention should be aimed at the *most vulnerable* households; those too far back along the relief-to-development continuum to be able to participate in the other types of livelihood activities outlined in the sections to follow. In some cases, chronically ill adults will be too weak to farm, to attend to livestock or to engage in small business activities. With a priority of keeping children in school (as opposed to relying on these young members to carry the burden of household support), a project may choose to support these households with food assistance in order to stabilize their livelihoods in the short-term.
- ***Implementing C 1.2.1: Food Assistance***
 - ❑ Hold initial meetings with CCCs and local authorities to determine the need for a relief-type food assistance intervention. Discuss targeting mechanisms.
 - ❑ Through discussions with national and regional WV offices, project donor or donors, and relevant organizations at national level such as WFP, C-SAFE and others, determine *source* of food commodities.
 - ❑ Project staff and CCC members determine qualifying criteria and register vulnerable families qualifying for food assistance.
 - ❑ Determine ration amounts per family, total quantities required and schedule for distributions,
 - ❑ Locate and purchase or hire appropriate warehousing facilities.
 - ❑ Call-forward food commodities through sourcing organization based on scheduled required quantities.
 - ❑ Develop in-house commodity tracking information system, or install and train staff in WV CTS software.
 - ❑ Receive food commodities, record incoming quantities, warehouse, distribute food to qualifying families as per distribution schedule. Record outgoing quantities.

C 1.2.2 Material Support

- **Introduction:** The project may choose to support households with OVC and PLWHA through material assistance, which may be purchased or sourced as GIK. (This is different from material incentives provided to Home Visitors aimed at ensuring their ongoing participation in the Home Visitor program. Material assistance to households is aimed at strengthening the resilience of OVC and their families.)

Possibilities for material support include:

- Household Items
 - Beds
 - Mattresses
 - Blankets
 - Shoes
- School Materials
 - Books
 - Bags
 - School Uniforms
 - Pens, pencils, etc.
- **Implementing C 1.2.2: Material Support**
 - Hold initial meetings with CCCs and local authorities to discuss the pros and cons of free material distribution to vulnerable families. Discuss targeting mechanisms.
 - Project staff and CCC members determine qualifying criteria and register vulnerable families qualifying for material support.
 - Follow standard WV channels for sourcing GIK, if material is to be acquired in this way.
 - Purchase materials if not possible to source as GIK
 - Receive material and distribute by agreed mechanisms. (Distributions may be made by project staff or by the CCCs.) Record all distributions.

C 1.2.3 Agriculture, Livestock and Small Business Inputs and Training

- ***Introduction:*** Projects may choose to provide selected inputs to families to assist them in expanding their livelihood options. The types of inputs selected should be determined by the types of livelihoods most appropriate to the project area in question. Possibilities include:
 - **Agriculture Inputs:** These may be “ag-packs” containing items such as basic crop seeds, seeds of soil improving species (agroforestry or green manures), fertilizer, agricultural tools.
 - **Livestock Inputs:** Projects may explore the possibility of providing families with a male/female pair of cattle, goats or chickens, as appropriate to the area, under a revolving loan scheme whereby one female offspring will later be returned to the project for distribution to another family.
 - **Small Business Inputs:** Items such as sewing machines, saws and other tools for carpentry, scales and adding machines for retail sales, etc., may be provided to families as a form of initiating small businesses as a livelihood option.

These inputs, in most cases, should be accompanied by appropriate trainings in agriculture and/or livestock husbandry practices, and/or small business skills. The project should determine if these trainings will be carried out by project staff, by Home Visitors, through links to other programs, or by outsourcing to an outside organization.

- ***Implementing C 1.2.3: Agriculture, Livestock and Small Business Inputs and Training***
 - ❑ As part of CCC Mobilization training, a participatory community assessment should be carried out to determine main livelihood priorities and possibilities appropriate to the local context.
 - ❑ Project staff with CCC to decide on livelihood interventions, qualifying criteria for families, and targeting mechanisms. CCC identifies and registers families to receive livelihood assistance.
 - ❑ Project staff with CCC determine what trainings to accompany provision of inputs. Identify trainers. (Project staff, Home Visitors, outside organization, etc.)
 - ❑ Project sources all necessary inputs; purchasing or acquiring as GIK as appropriate.
 - ❑ Project identifies Trainers of Trainers. ToT carried out for all trainers, as required. (Trainers in labor-saving agriculture practices, livestock husbandry, small business skills, as required.) Trainers design training schedules/work plans.
 - ❑ Inputs distributed to qualifying families. Project records all distributions.
 - ❑ Follow-up trainings provided to all families receiving inputs, according to previously-defined training schedule/work plan.
 - ❑ Project links families to agriculture extension programs working in area, where possible.

C 1.2.4 Links to Microfinance

- **Introduction:** All families, from the most vulnerable to the more economically-active, can benefit from appropriate financial services. It is normally the case that the financial sector in most developing countries does not extend far into remote or isolated areas and that, therefore, the types of financial services that these families need are generally not available.

Nevertheless, microfinance programs have begun to fill this gap and may be able to extend certain financial products to families in project areas. The type of financial product appropriate to each family will depend largely on the degree of vulnerability of the family. While conditions and qualifying criteria are generally determined by the microfinance institution (rather than the project), possibilities include:

- Most Vulnerable Families: **Insurance** (Adult caregivers too ill to work or engage in productive activities)
- More Vulnerable Families: **Savings** (Adult caregiver still active, but with no productive economic activity such as a small business)
- Less Vulnerable Families: **Credit** (Adult caregiver, or perhaps family youth, engaged in small business or other productive economic activity)

In instances where microfinance institutions (MFIs) are active in project areas, the project may wish to promote links between project families and these institutions. In most cases the MFI will have pre-defined financial products to offer, which may or may not be suited to the project families in question. Project staff with experience in microfinance should inventory the financial products available and determine the suitability of linking families with the institution. If the project has a microfinance specialist on staff, and if the MFI is open to innovation, the project may choose to *assist* the MFI in *developing* appropriate financial products for project families.

- **Implementing C 1.2.4: Links to Microfinance**
 - ❑ Project staff inventory existing MFIs in project areas. Arrange meetings to review financial products offered by the MFIs, and to discuss potential collaboration.
 - ❑ Project staff (microfinance specialist) reviews financial products offered by MFIs, determines suitability for project families, from most vulnerable to least vulnerable.
 - ❑ Meet with CCC to introduce microfinance possibilities. (A workshop may be needed to explain microfinance concepts to CCC members). CCC assists in identifying families to be targeted with this intervention.
 - ❑ Identified families linked with identified MFIs. Appropriate financial services extended by MFIs to project families.
 - ❑ *Alternatively*, project explores possibility of providing sub-grant to MFI to enable them to *develop* new financial products appropriate to target group. The steps for this are not detailed here.

C2: Enabling Environment Level Response

C 2.1 Coordination and Collaboration

- ***Introduction:*** The need for coordination and collaboration in OVC response is clear. Without coordination of efforts at all levels, the response to HIV/AIDS in general, and to OVC needs in particular, will remain fragmented, with organizations working in isolation, often unaware of the activities of others and unable to capitalize on potential complementarities, or to identify gaps in the response that might need filling.

Projects should certainly work to ensure coordination of efforts among all stakeholders operating in the same communities as the project; that is to say, at *local* level. In addition, projects may wish to play a role in promoting effective coordination at *district, regional, and/or national* levels as well.

- **Local Level:** CCCs draw their membership from all stakeholders in the community. Mobilizing efforts at the beginning of project activities should ensure that all potential stakeholders are informed and invited to participate as members of the CCC.
- **Municipal/District/Regional Level:** Projects may have a role to play in sending CCC representatives to municipal and/or district-level coordination meetings, or in helping to set up such coordinating bodies where none as yet exist. In many cases, where these coordinating bodies do exist, they are nascent and/or poorly-functioning. The project may choose to assist in building their capacity and linking them to outside sources of funding. The identification of the relevant coordinating structures will vary from country to country.

See diagram on following page illustrating the structures in South Africa and Zambia as examples. In both countries, WV is assisting in building the capacity of the municipal and district-level coordinating bodies.

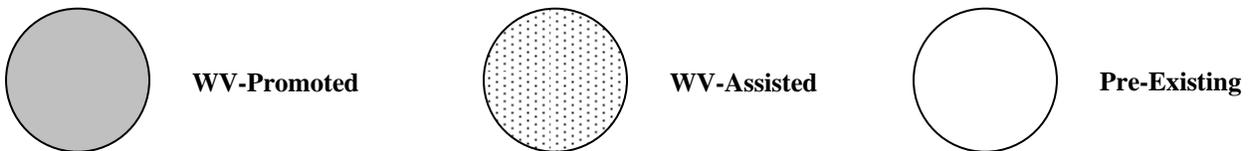
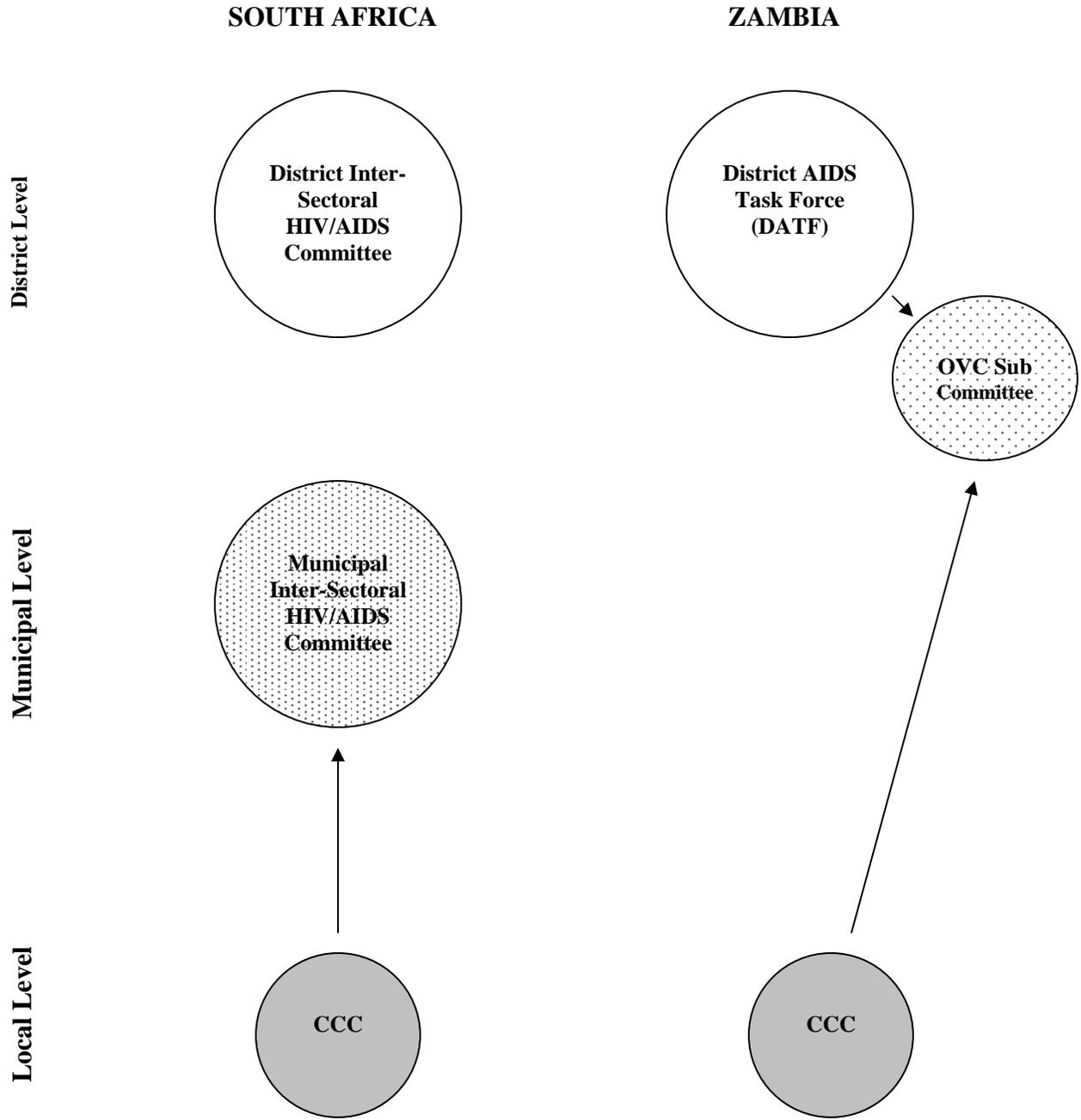
- **National Level:** Where feasible, head office project staff should attend meetings of relevant national-level coordinating organizations. These organizations will vary from country to country. Illustrative examples from Zambia include:
 - National AIDS Council
 - National Steering Committee on OVC
 - Ministry of Sport, Youth and Child Development
 - Ministry of Community Development and Social Welfare
 - Ministry of Health
 - Ministry of Education

C 2.1 Coordination and Collaboration (Cont.)

• *Implementing C 2.1: Coordination and Collaboration*

- ❑ Project staff inventory all stakeholders at local level during CCC mobilization process to ensure inclusion of all, and effective coordination and collaboration.
- ❑ Project staff participate in local-level stakeholder meetings.
- ❑ Project staff inventory existing coordinating structures at district and/or municipal level. Where these exist, arrange for CCC leader participation/representation in district or municipal-level coordination meetings.
- ❑ Where district and/or municipal level coordinating structures do not exist, meet with relevant authorities at *national* level to discuss mechanisms for promoting such structures, working within whatever Government frameworks and plans for such structures as might exist.
- ❑ Inventory all stakeholders at district/municipal level in preparation for formation of coordinating structure. Approach all stakeholders to invite participation.
- ❑ Organize first meeting of district/municipal-level coordinating structure, with participation of all interested stakeholders. At meeting discuss the form that the structure will take. One multi-sectoral committee? An OVC Sub-Committee? Etc. Ensure links to existing Government structures, as relevant and appropriate.
- ❑ Arrange for election of leaders to committees so that the project may hand over responsibility as soon as feasibly possible.
- ❑ Where district/municipal-level coordinating structures exist but are nascent and/or poorly functioning, arrange meeting with leadership to discuss desire for capacity building assistance.
- ❑ Project staff carry out needs assessment for capacity building. Training schedule designed, trainers identified, ToT carried out if necessary.
- ❑ Training of district/municipal-level coordinating structure carried out in accordance with needs assessment and training schedule.
- ❑ Project staff inventory potential sources of outside funding for CBOs. Links made between coordinating structure and funders. (*NB: See Section B 2.8 for further information on Links with Funding.*)
- ❑ Head office staff participate in meetings of national-level coordinating organizations.

C 2.1 Coordination and Collaboration (Cont.)



C 2.2 Government Capacity Building

- ***Introduction:*** Projects may choose to work directly with the Department or Ministry responsible for child rights, and those responsible for Health and Education, to help build the capacity of these policy-makers. In many cases these Departments/Ministries can benefit from assistance to help them put into place systems, policies and protocols to guide and coordinate OVC activities throughout the country. The following examples are illustrative:
 - In Mozambique, WV has a MOU with the Ministry of Women and Social Action Coordination (MMCAS) to support coordinating efforts in the area of OVC. WV will carry out a training needs assessment with MMCAS and a curriculum will be designed based on these needs. WV together with MMCAS will map out existing community and institutional OVC efforts in project areas and organize district and provincial-level multi-agency coordination meetings. During the second year, WV will assist MMCAS in developing a coordinated action plan for OVC.
 - In Zambia, WV has hired a Technical Advisor to be seconded to the Ministry of Sport, Youth and Child Development (MSYCD). WV will pay the salary of this individual but he will work directly within the Department of Child Development in this Ministry. The Technical Advisor will work with the Ministry on a range of OVC issues to include:
 - OVC Policy
 - National OVC Database
 - Provincial OVC Situation Analysis
 - National OVC Consultative Meetings
- ***Implementing C 2.2: Government Capacity Building***
 - Identify Departments/Ministries influencing child and OVC rights and policies. Approach in order to determine need for assistance in capacity building.
 - Hold negotiations to determine specific form that capacity-building assistance will take; i.e. training support, seconded staff, technical assistance, etc. Identify main goals and activities.
 - Hire technical assistant(s) and/or identify trainers as needed. Draft Job Descriptions together with relevant Departments/Ministries, reflective of agreements on types of assistance to be provided.
 - Technical assistants/trainers carry out work plans with identified Departments/Ministries.

C 2.3 Advocacy

- **Introduction:** Advocacy activities may take many forms and may be carried out at various levels. The following examples are illustrative, but not exhaustive:
 - **Local Level Activities:**
 - **CCCs and HVs:** Project builds capacity of CCCs and Home Visitors to protect the rights of children, with an emphasis on preventing stigma, discrimination and property grabbing.
 - **FBO Channels of Hope:** If project carries out FBO Channels of Hope Training, FBOs will be uniquely suited to work to break down stigma and discrimination in their congregations and communities.
 - **Transformational Development:** If project carries out Transformational Development program, changes in the current context with respect to stigma and discrimination can be expected.
 - **Social Worker:** If project hires social worker, OVC better able to access entitlements, to receive inheritances and to be protected from abuse.
 - **District/Municipal Level Activities:**
 - **Coordination:** Efforts to support coordinating structures at district/municipal level assist in giving greater weight to OVC rights, and promote efficiency of response.
 - **Child Parliaments:** Project may support and/or mobilize Child Parliaments to bring forward the voices of OVC and promote linkages between the Parliaments and the relevant Departments of Health, Education and Social Services
 - **National Level Activities:**
 - **Government Capacity Building:** Government capacity building activities can help to ensure that systems and policies are put into place to ensure and protect the rights of OVC throughout the country.
 - **Lobbying:** Project may lobby at national level for legislation concerning OVC.
- **Implementing C 2.3: Advocacy**
 - Hold initial in-house meetings to design advocacy strategy. Project may select from any or all of the above possibilities.
 - Refer to relevant sections in this Guide for steps in implementing each of the selections.

D. Project Checklist *Select those components that your project will implement*

B. Core Program

B1: Mobilization and Training

- CCC Mobilization
- Home Visitor Training
- Organizational Capacity Building
- Transformational Development Training
- FBO Channels of Hope Training
- Home Based Care Training

B2: Support

- Materials and Incentives
- Support Groups
- Community Centers
- GIK
- Accredited Trainings
- Transport
- Social Worker
- Links with Funding Sources
- Small Grants
- Links with ADP Programs

C. Comprehensive Program

C1: Family Level Response

- Life Skills Training For Children and Youth
- Livelihood Strengthening for Families
 - Food Assistance
 - Material Support
 - Agriculture, Livestock and Small Business Inputs and Training
 - Links to Microfinance

C2: Enabling Environment Level Response

- Coordination and Collaboration
- Government Capacity Building
- Advocacy

5. Program Staffing

5.1 Stand-Alone Projects (Outside ADPs)

5.1.1 Core Staff

The following core staff is needed to launch a new stand-alone OVC care program:

- **National Project Manager:** In charge of overall project management. The Project Manager will liaise closely with the donor and with all major stakeholders and partners and will supervise national-office OVC program staff
- **OVC Technical Specialist:** May be based in the national office or in an identified key project province/district. Responsible for reviewing all training curricula and adapting as needed and for providing key inputs into the design and implementation of OVC response. Supports OVC Supervisors and OVC Facilitators. Areas of specialization can include child development, education, psychosocial support, livelihoods, HIV/AIDS prevention, care and health, community/church/FBO mobilization, and/or local organizational development.
- **Monitoring and Evaluation Officer:** May be based in the National Office or in an identified key project province/district. Responsible for managing the overall M&E system including data compilation, data analysis and reports preparation.
- **Grant Accountant:** A certified public accountant responsible for managing all of the finances of the project and compiling the financial reports for the donor. The project may also choose to hire a **Bookkeeper** for each project province where applicable, to be supervised by the Grant Accountant.
- **District OVC Supervisor:** (One per project district) Reports to the National Project Manager and supervises the OVC Facilitators. Responsible for overseeing project activities at district/community level and for collaborating with district-level structures and agencies.
- **OVC Facilitators:** Numbers of facilitators hired will depend on project geography and targets. On average, one OVC Facilitator can mobilize and support 10-15 CCCs and their respective Home Visitors. OVC Facilitators responsible for the field-level work of mobilizing, training and supporting the community-led response for OVC care, based on selected project components. Responsible for the following trainings:
 - CCC Mobilization
 - Home Visitor Training
 - Organizational Capacity Building (where applicable)

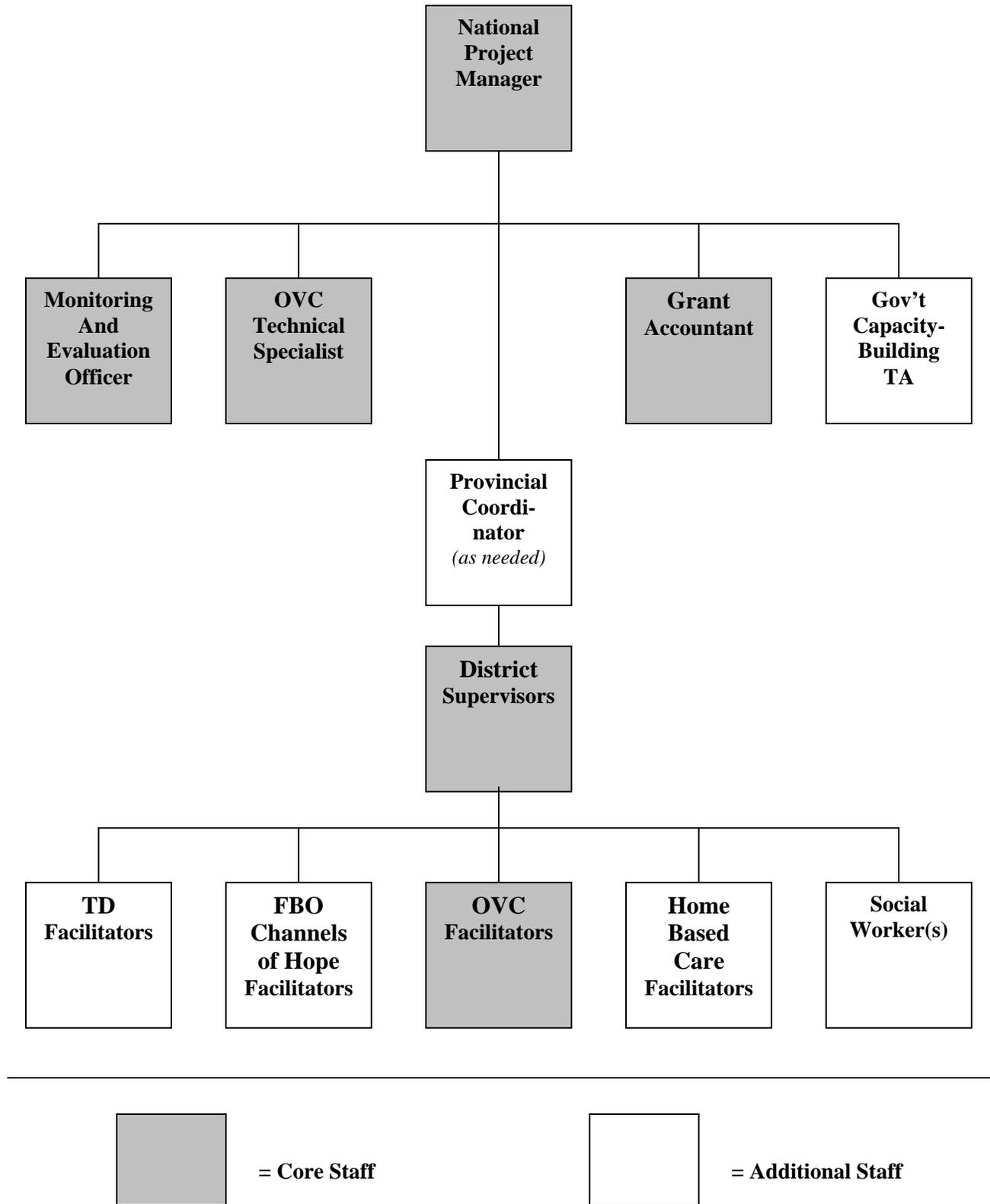
5.1.2 Additional Staff

Additional staff will need to be hired if projects select from among the programming options, as follows:

- ***Transformational Development Facilitators:*** *(where applicable)*. A separate training team should be hired to carry out a TD program if the project selects this intervention. Numbers of facilitators hired will depend on project geography and targets. (Project may contact WVSA for guidance). TD Facilitators responsible for all aspects of TD program.
- ***FBO Channels of Hope Facilitators:*** *(where applicable)*. A separate training team should be hired to carry out the FBO Channels of Hope training program. Numbers of facilitators hired will depend on project geography and targets
- ***Home Based Care Facilitators:*** *(where applicable)*. A project may choose to hire Home Based Care Facilitators separate from OVC Facilitators if the home based care intervention is to involve health-related protocols and the administration of drugs. Health skills are desired for this position.
- ***Social Worker(s):*** *(where applicable)*. Projects choosing to provide this form of support to communities should hire one or more social workers in compliance with nationally recognized standards. The Social Worker(s) will be responsible for taking on and following up OVC cases involving entitlements, protection and/or fostering, among other possibilities.
- ***Government Capacity-Building Technical Assistant (TA):*** *(where applicable)*. This individual will be seconded to the identified government ministry or department to provide capacity-building support, as per agreements made between the project and the relevant government body.

See Sample Organization Chart on next page.

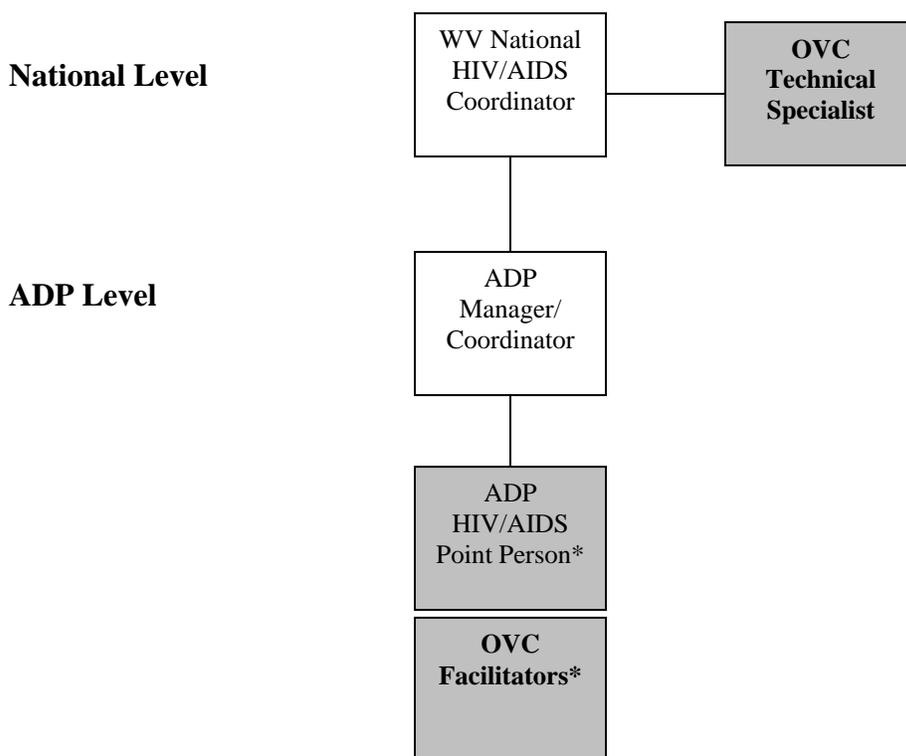
Sample Organization Chart: Stand-Alone Program (Outside ADPs)



5.2 Within ADPs

ADPs generally have pre-existing staffing structures, although these may vary across programs. For purposes of HIV/AIDS response, each ADP should already be staffed with an HIV/AIDS Point Person, reporting to the ADP Manager. Where resources permit, it is recommended that each ADP also have at least one staff member focused primarily on OVC programming. In ADPs where resources are constrained it may be necessary to merge the responsibilities of this person into those of the HIV/AIDS Point Person. This is illustrated in the diagram below.

- HIV/AIDS Point Person/OVC Facilitator:** Provide technical support in facilitating community-led care for OVC and their families in ADP; in facilitating life-skills training for children aged 5-15 and, where applicable, in the mobilization and support of church/FBO Channels of Hope programming. Engage with existing HIV/AIDS and/or OVC-related networks and stakeholders at community, district and zonal levels for improved practices, resource base and policies. Spearhead HIV/AIDS prevention and care interventions among staff.
- OVC Technical Specialist:** Where possible, it is also recommended that there be an OVC Technical Specialist at the national level to support ADPs in enhancing expanded OVC programming.



**The positioning of these two boxes indicates that in some instances these responsibilities may be shared by one person, effectively collapsing the two levels into one.*

6. Sample Project Start-up Work Plans

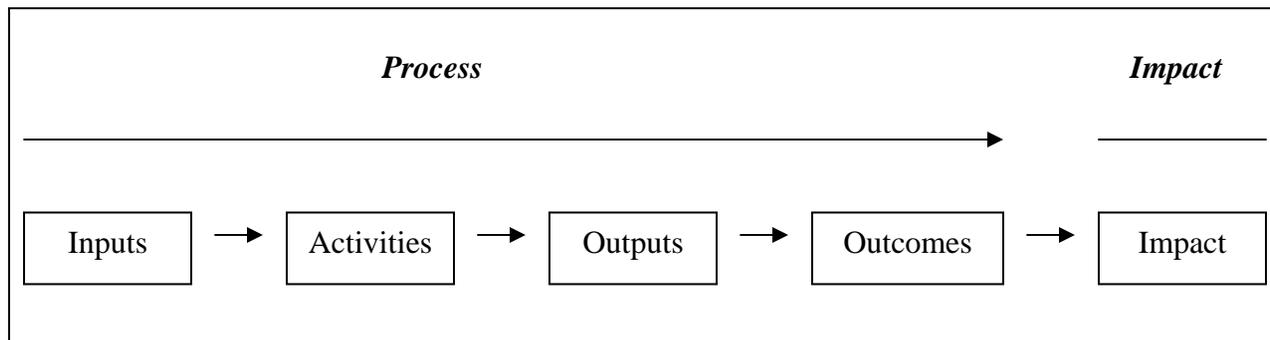
See tables on following pages for Core and Comprehensive Programming

7. Monitoring and Evaluation

7.1 Conceptual Framework

While slightly different from the framework set out in *The Monitoring and Evaluation Framework for World Vision's HIV/AIDS Response in Area Development Programs*, the following conceptual structure may be useful in designing M&E systems for OVC Care programming.

Following the approach adopted by UNAIDS and many governments, donor agencies and NGOs, indicators may be divided into two broad categories; namely *process* indicators and *impact* indicators. "Process" follows a continuum from Inputs to Activities to Outputs to Outcomes, all of which finally lead to Impact.



- Inputs:** Inputs are the *materials* and *staff* that World Vision uses to carry out its various activities.
- Activities:** Activities are the *mobilization, training* and *support* responsibilities that WV carries out.
- Outputs:** Outputs are the *CCCs formed, HVs trained*, etc.; achieved as a result of WV activities.
- Outcomes:** Outcomes are the *OVC reached*, normally *via* the CCCs and HVs, rather than directly via World Vision.
- Impact:** Impact is the improvement in the *Quality of Life of OVC* resulting from the CCC and HV interventions.

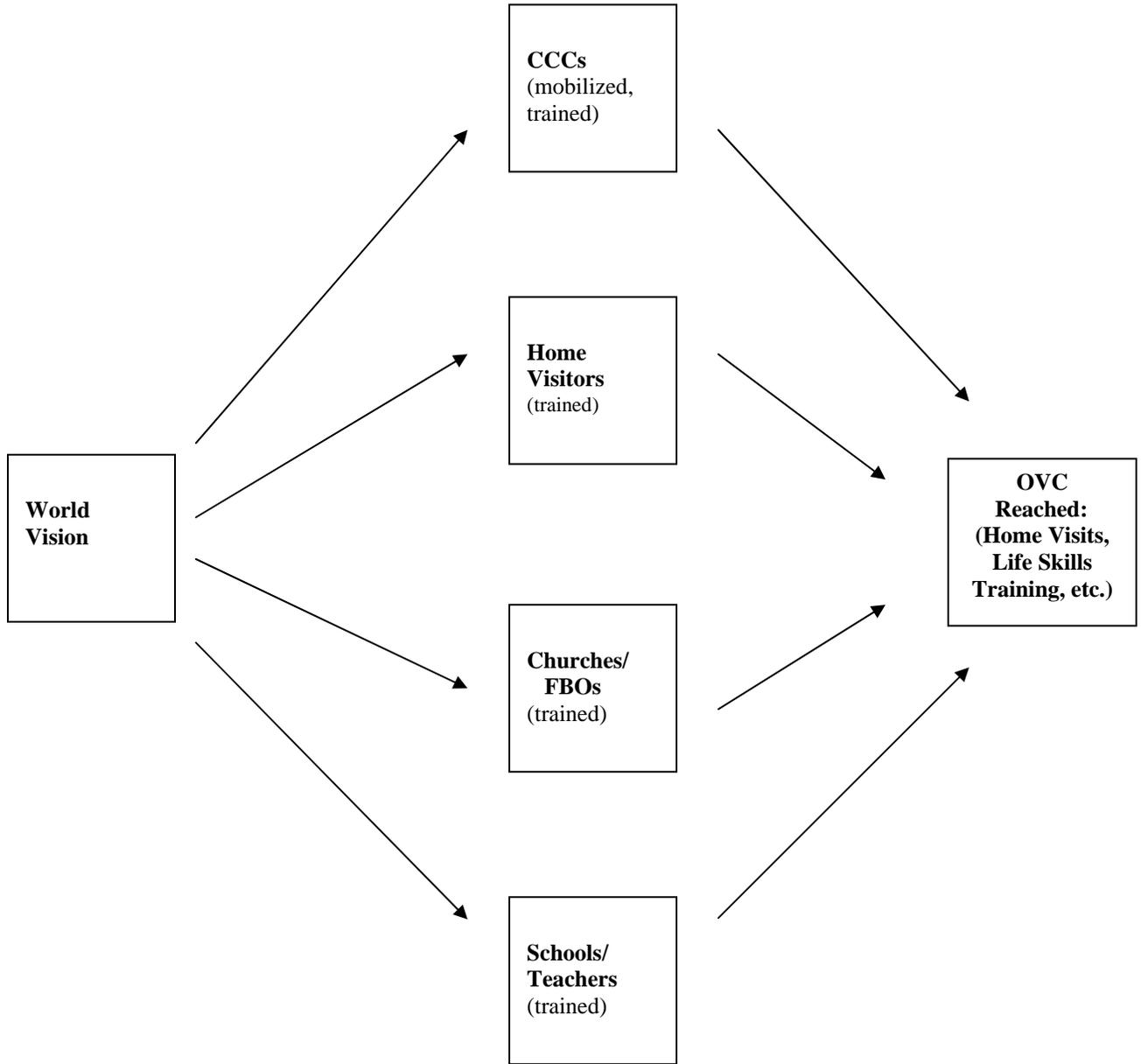
See Diagram on following page.

INPUTS
(materials, etc.)

ACTIVITIES
(training, support, etc.)

OUTPUTS
(CCCs, HVs trained, etc.)

OUTCOMES
(OVC reached)



IMPACT = IMPROVED QUALITY OF LIFE OF OVC

7.2 Key Indicators

7.2.1 Core Indicators

Although it is possible to track *input* and *activity* indicators, this can result in a heavy burden of paperwork. It is normally sufficient to track **output**, **outcome** and **impact** indicators.

World Vision’s Monitoring and Evaluation Framework outlines the **core** output, outcome and impact indicators, as follows:

- **Core Output Indicators:** # of CCCs formed and/or strengthened
of HVs trained
- **Core Outcome Indicators:** # of OVC identified by the CCCs
and % of identified OVC reached (receiving some type of care/assistance from the CCC)
- **Core Impact Indicators:** # and % of identified OVC that have:
 - Education: in school or appropriate vocational training
 - Nutrition: *Either:*
 - Adequate nutrition according to national standards
 - At least as much food as the norm for children in community
 - Care: are being visited regularly by caring community member who assists child and family
 - All of the above

All ADPs and projects are required to report on these indicators, using standard forms designed by World Vision’s *Core HIV/AIDS Response Monitoring System (CHARMS)*. Data for this reporting may be collected from the following sources:

- WV training records
- CCC records and minutes
- CCC OVC registers
- HV records
- OVC surveys

Examples of the forms developed by CHARMS and required by World Vision can be found in Section 11.

7.2.2 Additional Indicators

Projects may wish to design a logical framework (“logframe”) and track additional indicators corresponding to specific project interventions. Sample indicators are given for all project components for both core and comprehensive programs in section 11.

7.3 Program Monitoring

7.3.1 Monitoring by World Vision

Once the project has determined the indicators to be tracked (these may be only the core indicators required by CHARMS, or a more complete set of indicators aimed at providing a more thorough picture of project performance), a system should be designed to ensure the regular collection of the necessary data. Project *monitoring* is normally limited to the tracking of *output* and *outcome* indicators.

The *output indicators* (e.g. number of CCCs formed/trained, number of HVs trained, etc.) measure the direct results of project activities for which managers are accountable, and are used to ensure that managers are on track with their mandate. Field-level staff should report on this data to their supervisors on a monthly basis.

The *outcome indicators* (e.g. number of OVC reached by home visitors, number of OVC participating in life skills training, etc.) are used to measure the extent to which project objectives are being achieved. This data may be used for strategic planning, for redesign if needed, and for generation of lessons learned. Projects should determine the periodicity of outcome indicator reporting.

7.3.2 Monitoring by CCCs

It is in fact the CCCs and respective HVs who take on the front-line responsibility for achieving outcomes (i.e. for reaching OVC with care and support). This means that the data needed for tracking outcome indicators must originate with the CCCs and HVs. The project should assist the CCCs and HVs in setting up their *own* monitoring and evaluation system to ensure that this monitoring is as participatory as possible.

The training manual for mobilizing CCCs, “Mobilizing and Strengthening Community-Led Care for OVC Care” provides guidance on how to assist CCCs in setting up a monitoring system.

Monitoring of OVC status and well-being can be done directly by the HVs and reported using a simple, standardized, user-friendly form. The reports on OVC status should be turned in monthly to identified supervisors within the CCC. It may be helpful for groups of volunteers who live near each other to meet on a regular basis with their supervisors to discuss their reports and their clients, in order to obtain advice and assistance with problems, and to share ideas about how to help the children.

Samples of forms that CCCs and HVs can use to assist them in monitoring and evaluation can be found in Section 11.

7.4 Program Evaluation

7.4.1 Evaluation by World Vision

Program evaluation can be both quantitative and qualitative.

Quantitative Evaluation: Quantitative evaluation normally seeks to measure change at the *impact* level, tracking the indicators selected to measure impact. The core impact indicators are:

- **Core Impact Indicators:** # and % of identified OVC that have:
 - Education: in school or in appropriate vocational education
 - Nutrition: *Either:*
 - Adequate nutrition according to national standards
 - At least as much food as the norm for children in community
 - Care: visited regularly by caring community member who assists child and family
 - All of the above
- **Data Sources:** Data to measure these indicators may be collected either through:
 - Program surveys (baseline, midterm, final)
 - Home Visitor records
- **Steps for Surveys:** If projects decide to carry out quantitative baseline, midterm and/or final surveys, the following steps should be taken:
 - Survey design (ensure all necessary information captured by questions)
 - Training of survey enumerators
 - Sample size and sample population determined
 - Survey interviews carried out
 - Data entry
 - Data cleaning
 - Report

Qualitative Evaluation: Programs may choose to hire outside consultants to carry out a program evaluation. A Scope of Work should be drafted, and the consultant instructed to use any or all of the following evaluation tools:

- Quantitative survey information
- Focus group interviews
- Key informant interviews (CCC members, HVs, OVC, etc.)
- Review of WV and implementing partners' records

The consultant should submit a report of the evaluation and hold a workshop with project staff and other key stakeholders to discuss findings and lessons learned.

7.4.2 Evaluation by CCCs and HVs

The training manual for mobilizing CCCs, “Mobilizing and Strengthening Community-Led Care for OVC” provides guidance on how to assist CCCs in evaluating their programs.

Collaborative evaluation between WV and the CCCs should be done in a participatory manner and can be handled through community meetings, visits to OVC households, meetings with the children themselves, and reports from the CCCs. Feedback meetings are very important. These should be agreed upon and planned for by the community at the project launch. These meetings will help the community review what has happened since the last meeting, including what has succeeded and what has failed, why interventions have succeeded or failed, lessons learned, and issues that need further resolution.

8. Budgeting

Activity	Frequency /#	Est. Cost: USD
1. Core Program		
1.1 CCC Mobilization		
1.1.1 ADP staff training in community-led OVC programming	Five days	\$100 per person
1.1.2 Stakeholder meetings	Two days	\$50 per person
1.1.3 Community Fund for Child Development Support <ul style="list-style-type: none"> • Education support • Health care • Basic needs; Food, shelter and clothing • Psycho social support 	Annually	\$50/child per year
1.2 Home Visitor Training		
1.2.1 Training workshops in comprehensive OVC care	Twenty days	\$300 per person
1.3 Organizational Capacity Building (OCB)		
1.3.1 Organizational Self-Assessment Workshop	Five days	\$100 per person
1.3.2 Follow up capacity-building training	Variable	\$20/person/day
1.3.3 Follow up workshops (mentoring/process assessment)	Variable	\$20/person/day
1.4 Transformational Development Training		
1.4.1 Workshops for CCCs in TD	Program-specific	Program-specific
1.5 FBO Channels of Hope Training		
<i>See Separate Implementation Guide for details</i>		
1.6 Home Based Care Training		
1.6.1 Workshops for home visitors in Home Based Care	Five days	\$50 per person
2. Comprehensive Program		
2.1 Family Level Response		
2.1.1 Life Skills Training for children and youths	10 sessions (10 hours) per class	\$50 per class
2.1.2 Livelihood Strengthening for Families <ul style="list-style-type: none"> • Food Assistance • Material Support • Agriculture; Livestock and crops • Business Inputs and Training • Links to Micro-finance 	Annually	\$50 per household
2.2 Enabling Environment Level Response		
2.3.1 Coordination and Collaboration	Annually	\$200 per year
2.3.2 Government / Institutional Capacity Building	Annually	\$200 per year
2.3.3 Advocacy: <ul style="list-style-type: none"> General Peace building and reconciliation training 	Annually 3 days	\$500 per year \$60 per person

9. References and Resources

9.1 World Vision Publications

1. ADP Toolkit for HIV/AIDS Programming

The Toolkit provides ADP Managers with guidelines for designing, monitoring and evaluating HIV/AIDS response within ADP programs. Guidance is provided for programming for different categories of response, to include:

- HIV Prevention for Children Aged 5-15
- Prevention of Mother-to-Child Transmission of HIV
- HIV Prevention for High Risk Groups
- Care for Orphans and Vulnerable Children
- Home Based Care for the Chronically Ill
- Psychosocial Support for HIV/AIDS-Affected Communities
- Advocacy
- Partnering with Churches and Other FBOs to Fight HIV/AIDS
- Integrating HIV/AIDS Response in Ongoing Development and Relief Interventions

Available through Models of Learning: email: models_of_learning@wvi.org, or on the Hope Initiative's online HIV/AIDS resource database (www.worldvision.org/help/aids-lib.nsf)

2. Hope in Action: Summaries of World Vision's Strategies for HIV/AIDS Response

This booklet summarizes the Hope Initiative strategies for the nine key areas of HIV/AIDS response on which World Vision focuses (listed above under *ADP Toolkit for HIV/AIDS Programming*). It is intended to be of use to partners interested in learning about WV's HIV/AIDS programming, including NGOs, churches and other FBOs, donors and policymakers.

Available through Models of Learning: email: models_of_learning@wvi.org, or on the Hope Initiative's online HIV/AIDS resource database (www.worldvision.org/help/aids-lib.nsf)

3. Mobilizing Community-Led Care for OVC

This training manual provides instructions for mobilizing and forming Community Care Coalitions (CCCs) as part of a core program of OVC response. The manual assists facilitators and communities to go through an assessment process, to identify needs, current response, and gaps in the current response. Building from this, key stakeholders will come together to form a CCC and develop action plans to provide essential care and support to community OVC

Available through Models of Learning: email: models_of_learning@wvi.org.

4. Strengthening Community-Led Care for OVC

This training manual is aimed at preparing volunteer Home Visitors to make visits to the homes of OVC and provide essential forms of care and support. The manual is divided into a Facilitator's Guide with detailed instructions for training Home Visitors in a participatory manner, and into Handouts that Home Visitors will collect in order to compile their own reference manual for use during home visits. The training manual is divided into four modules, as follows:

- Module 1: HIV/AIDS and the Situation of OVC
- Module 2: Addressing Psychosocial Needs of OVC
- Module 3: Addressing Physical Needs of OVC
- Module 4: Equipping OVC for the Future

Available through Models of Learning: email: models_of_learning@wvi.org.

5. Monitoring and Evaluation Framework for World Vision's HIV/AIDS Response in Area Development Programs

This document describes the monitoring and evaluation (M&E) framework for World Vision's HIV/AIDS Response in ADPs. The document serves several purposes. It is intended to be of use to ADPs, strengthening their capacity to assess the progress and results of their HIV/AIDS responses and to adjust strategy and operations to enhance performance. It is also intended to facilitate and tracking and reporting on progress towards achieving WV HIV/AIDS goals at national, regional and global levels, and to generate information that can be used as an evidence base for resource mobilization, advocacy and communications.

The framework is guided by and, where appropriate, aligned with state-of-the-art M&E approaches used by other partners, including:

- The 2001 UNGASS HIV/AIDS goals and related indicators
- The UNAIDS framework for M&E of HIV/AIDS responses
- The M&E system for USAID's Expanded Response to HIV/AIDS
- The Hope for African Children Initiative's M&E Framework

Available through Models of Learning: email: models_of_learning@wvi.org.

9.2 Other Publications

1. UNAIDS 2004 Report on the Global AIDS Epidemic, UNAIDS, 2004.

This report warns that the number of people living with HIV, the virus that causes AIDS, has risen in every region of the world during 2003 and last year five million people became newly infected with HIV -- more people than any previous year.

The report highlights the latest global trends and, for the first time, features revised HIV prevalence rates for previous years, allowing for a better understanding of how the epidemic is spreading. It compares new estimates for 2003 with revised estimates for 2001 based on improved methodologies. The report also offers new estimates on resources needed to effectively combat the epidemic in the developing world, finding that current funding levels are less than half of what is needed. The report also identifies a series of major constraints to better treatment and prevention.

Available online at www.eldis.org/hiv aids/

2. Children on the Brink 2004, UNAIDS, UNICEF and USAID, 2004.

This report, produced jointly by UNICEF, UNAIDS and USAID, presents statistics on historical, current and projected numbers of children under 18 who have been orphaned by AIDS and other causes. Unlike the 2003 report, which provided data on children up to 15, the inclusion of data on children up to 18 recognises those affected are not only young children and that problems can extend well beyond the age of 15. The report also examines the changing developmental needs of orphans and other vulnerable children as they progress through childhood and adolescence.

The second section of the report provides an overview of the Framework for the Protection, Care and Support of Orphans and Vulnerable Children Living in a World with HIV and AIDS. The five key strategies of the Framework are summarised and include: strengthening the capacity of families to protect and care for orphans and vulnerable children; mobilising and supporting community-based responses to assist vulnerable households; ensuring access for orphans and children to essential services; ensuring government protection through improved policy and legislation; and raising awareness to create a supportive environment for affected children.
[adapted from author]

Available online at www.eldis.org/hiv aids/OVCindex.htm

3. Sub-National Distribution and Situation of Orphans: An Analysis of the President's Emergency AIDS Relief for Focus Countries, USAID, Bureau for Africa, Office of Sustainable Development and Population Health and Nutrition Information Project, March 2004.

This study utilized available Demographic and Health Surveys and Multiple Indicator Cluster Surveys (MICS) household survey data to analyze the sub-national geographical distribution and living situations of orphans in the African and Caribbean countries identified for special assistance by President Bush's Emergency Plan for AIDS Relief. The analysis provides information about the communities where orphaned children reside within countries and these children's living situations, which is necessary for national and targeted policies to care for orphans and other vulnerable children.

Available from the PHNI project (info@phni.com) or online at <http://sara.aed.org/sara-ovc.htm>.

4. Framework for Protection, Care and Support of OVC Living in a World with HIV and AIDS, UNICEF and UNAIDS, 2004.

The purpose of this framework is to provide an agreed-upon agenda for mounting an adequate and effective response to one of the most devastating and difficult challenges of the HIV/AIDS pandemic- the vast and growing number of orphans and vulnerable children being left behind. This framework has evolved directly from a process started in 2000 and is based on the cumulative experience of many years of work in support of orphans and vulnerable children. It has been developed and refined through regional and global consultations with practitioners and policymakers and feedback from key experts. Ultimately, the framework presented here reflects an evolution of the strategies and principles presented in these documents and a broader consensus on a common agenda.

Available online at <http://sara.aed.org/sara-ovc.htm>.

5. Africa's Orphaned Generations, UNICEF and UNAIDS, 2003.

The HIV/AIDS epidemic in sub-Saharan Africa has already orphaned a generation of children and now seems set to orphan generations more. Tragically, the number of orphans in sub-Saharan Africa will continue to rise in the years ahead, due to the high proportion of sub-Saharan adults already living with HIV/AIDS and the continuing difficulties in expanding access to life-prolonging antiretroviral treatment. But these children should not be left to suffer twice: denied their rights because they are orphaned. *Africa's Orphaned Generations* reports on the life circumstances of today's orphans with new data and fresh analyses. It presents the possibility of change – for those already orphaned and for the generation to come – if certain things are done now. *Africa's Orphaned Generations* presents a strategy for ensuring that all of Africa's orphaned children have a safe, healthy and well-educated childhood, establishing the foundation for a productive adult life.

Available online at www.unicef.org/media/files/orphans.pdf or <http://sara.aed.org/sara-ovc.htm>.

6. Conducting a Situation Analysis of Orphans and Vulnerable Children Affected by HIV/AIDS, USAID, Bureau for Africa, Office of Sustainable Development and Population Health and Nutrition Information Project, 2004.

This framework and resource guide is intended to help people involved in programs assisting orphans and vulnerable children conduct a situation analysis to:

- Develop stronger programs to meet the needs of orphans and vulnerable children, families and communities.
- Develop relevant and appropriate policies that protect the rights of children and ensure their care
- Mobilize financial resources and other forms of support for action
- Generate social mobilization
- Create a monitoring and evaluation framework for continued assessment of the situation of orphans and vulnerable children.

The framework covers information on planning a situation analysis, gathering and analyzing information, and reporting and communicating findings. The document provides examples of situation analyses and related research to highlight the approaches that communities and institutions have undertaken to assess a particular situation. An extensive resource list of existing and relevant research is also included.

Available from the PHNI project (info@phnip.com) or online <http://sara.aed.org/sara-ovc.htm>.

7. Building Blocks: Africa-Wide Briefing Notes, USAID, Bureau for Africa, Office of Sustainable Development and International HIV/AIDS Alliance, 2003.

These briefing notes are intended to help governments and non-governmental and religious organizations to meet the severity of the OVC challenge by providing effective, holistic support to children within their families and communities. The Overview section of the briefing notes outlines important issues involved in working with OVC and summarizes principles for programming support for them. The set includes briefing notes on:

- Education
- Health and Nutrition
- Psychosocial support
- Social inclusion
- Economic strengthening
- Elderly caregivers (currently being developed)

Each briefing note provides issues and principles for guiding strategy, while drawing on best practices from program experiences. Each can be used with a Participatory Adaptation Guide (under preparation and expected in 2004) which will help organizations and community members, including children, to adapt these principles and strategies to their own local contexts.

Available online at www.aidsalliance.org or <http://sara.aed.org/sara-ovc.htm>

9.3 Websites

1. www.aidsalliance.org
2. <http://sara.aed.org>
3. www.eldis.org/hivaids/OVCindex.htm
4. www.unaids.org
5. www.unicef.org

10. Technical Resource Contact Persons

Department/Technical Category	Name	Contact
WVUS Head Office HIV/AIDS Support Staff	Mark Vander Vort	mvandervort@worldvision.org
	Fe Garcia	fgarcia@worldvision.org
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	Boniface Maket	boniface_maket@wvi.org
Models of Learning	Mark Lorey	mark_lorey@wvi.org
	Faith Ngoma	faith_ngoma@wvi.org
	Grace Mayanja	grace_mayanja@wvi.org
Church/FBO Partnerships	Christo Greyling	christo_greyling@wvi.org
	Gideon Byamugisha	gideon_byamugisha@wvi.org
Transformational Development	Monika Holst	monika_holst@wvi.org

11. Sample Forms

11.1 SAMPLE OVC REGISTER FOR CCCs

Name of Child: _____

Assigned Home Visitor: _____

Sex: _____ **Date of Birth (if known)** _____

Approximate age as of (today's date) _____

Parental Status: _____

Head of household (circle one)

- Mother
- Father
- Other female adult _____
- Other male adult _____
- Grandparent or other elderly adult
- Sibling (over 18)
- Sibling (under 18)
- Self
- Other _____

Number of persons living in home _____

Number of children living in home _____

Child in school? Yes/No _____ **Grade** _____

General Observations _____

11.2 SAMPLE HOME VISIT RECORD FOR HOME VISITORS/CCCs

Name of Home Visitor _____ **Date:** _____

Family Name of Household Visited _____

Names and Status of Household OVC Visited (healthy, ill, upset, etc.)

Name: _____ **Status:** _____

Name: _____ **Status:** _____

Name: _____ **Status:** _____

Name: _____ **Status:** _____

Services Required by OVC in household _____

Assistance Provided/Description of Visit _____

Signature: _____

11.3 SAMPLE MONITORING AND EVALUATION TRACKING FORM FOR CCCs

Indicator	Source of Data	Jan.	Feb.	March	April	May	June	July	Aug.	Sept.	Oct.	Nov.	Dec.
Primary													
Existence of OVC Registers (yes/no)	OVC Register												
Existence of leadership structure (yes/no)	CCC Records												
Number of meetings/month	CCC Records												
Amount of funds raised during month	CCC Records												
Secondary													
Number of OVC Registered	OVC Register	58	112	130	153	155	160	160	169	177	207	222	250
Number of Home Visitors trained	CCC / WV Records												
Number of OVC visited regularly	Home Visit Records												
Tertiary													
Number and percent of OVC in school	Home Visit Records												
Number/percent OVC with birth record	Notary Records												
Number/percent OVC with home gardens	Home Visit Records												

11.4 SAMPLE LOGICAL FRAMEWORK AND ADDITIONAL INDICATORS

Item	Project Component	Indicators	Data Source
Goal: Impact			
Improved Quality of Life (and Resilience) of xx Orphans and Vulnerable Children in (project area)	Core Program (Comprehensive Program)	<p>Standard Outcome Indicator</p> <ul style="list-style-type: none"> • # OVC reached through project interventions <p>Core WV Impact Indicators: # and % identified OVC that have:</p> <ul style="list-style-type: none"> • Education: In school or appropriate vocational education • Nutrition: <ul style="list-style-type: none"> • Adequate nutrition according to national standards, <i>or</i> • At least as much food as norm for children in community • Care: Are being visited regularly by caring community member who monitors and assists child and family • All of the above 	<ul style="list-style-type: none"> • Baseline/Midterm/Final Surveys • HV Records • CCC Records • OVC Registers
Objectives: Outputs and Outcomes (<i>Outcomes indicated in bold font</i>)			
Objective 1 (Comprehensive:Family Level) Enhanced resilience of OVC and Households Caring for OVC			
Life Skills Training Children/Youth	C 1.1	# teachers trained in life-skills curricula	<ul style="list-style-type: none"> • WV training records
	C 1.1	# schools incorporate life-skills training in curricula	<ul style="list-style-type: none"> • School records
	C 1.1	# schools hold after-school life skills training	<ul style="list-style-type: none"> • CCC records
	C 1.1	# church leaders trained in life-skills curricula	<ul style="list-style-type: none"> • OVC surveys
	C 1.1	# peer educators trained in life-skills curricula	<ul style="list-style-type: none"> • Procurement records
	C 1.1	# other community members trained in life-skills curricula	<ul style="list-style-type: none"> • Waybills
	C 1.1	# children and youth receive life-skills training	<ul style="list-style-type: none"> • Distribution tracking system
	C 1.1	# children respond successfully to life-skills training identified questions (<i>need to develop</i>)	<ul style="list-style-type: none"> • HV Home Visit records • MFI records

Livelihood Strengthening Families	C 1.2.1	Quantity of food rations received by WV (<i>specify</i>)	
	C 1.2.1	# OVC households receive standard food ration (<i>specify</i>)	
	C 1.2.2	# OVC households receive school and/or household material	
	C 1.2.3	# OVC households receive livelihood inputs	
	C 1.2.3	# OVC households receive livelihood training	
	C 1.2.3	# OVC households linked to agriculture extension programs	
	C 1.2.4	# OVC households linked to microfinance programs	
Objective 2: Core (Community-Level) Mobilized and Strengthened Community-Led Response to Protect and Care for OVC and their Families			
Mobilization and Training	B 1.1	# CCCs formed and functioning	<ul style="list-style-type: none"> • WV Training records
	B 1.2	# HVs trained	<ul style="list-style-type: none"> • CCC meeting reports/minutes
	B 1.2	# HVs providing continuous service to OVC	<ul style="list-style-type: none"> • CCC records
	B 1.2	# OVC visited by HVs	<ul style="list-style-type: none"> • CCC work plans
	B 1.2	# and % HVs demonstrate knowledge of key OVC needs	<ul style="list-style-type: none"> • OVC registers compiled by CCCs and HVs
	B 1.3	# CCCs participating in Organizational Capacity Building	<ul style="list-style-type: none"> • HV home visit records
	B 1.3	# & % CCCs accessing outside funding for OVC care/support	<ul style="list-style-type: none"> • HV monthly reports
	B 1.4	# CCCs trained in Transformational Development	<ul style="list-style-type: none"> • HV surveys/questionnaires
	B 1.4	# and % CCCs with work plans to operationalize TD	
	B 1.5	# FBOs receive Channels of Hope training	
	B 1.5	# FBO Hope Teams formed to provide care to OVC	
	B 1.5	# FBO Hope Team Home Visitors trained	
	B 1.5	# FBO Hope Team HVs providing continuous service to OVC	
	B 1.5	# OVC visited by FBO Hope Team HVs	

	B 1.6	# HVs receive Home Based Care training	
	B 1.6	# HVs providing continuous service to PLWHA	
	B 1.6	# and % HVs demonstrate quality caregiving skills	

<p>Objective 2 (Cont)</p> <p>Support</p>	<p>B 2.1</p> <p>B 2.1</p> <p>B 2.2</p> <p>B 2.2</p> <p>B 2.2</p> <p>B 2.3</p> <p>B 2.3</p> <p>B 2.3</p> <p>B 2.4</p> <p>B 2.4</p> <p>B 2.5</p> <p>B 2.5</p> <p>B 2.5</p> <p>B 2.6</p> <p>B 2.7</p> <p>B 2.7</p> <p>B 2.8</p> <p>B 2.9</p> <p>B 2.9</p> <p>B 2.9</p>	<p># and % of CCCs receive material support</p> <p># and % of HVs receive material support</p> <p># of HV support groups formed</p> <p># of meetings of HV support groups</p> <p># & % HVs report coping well with psycholog. effects of work</p> <p># of community centers formed</p> <p># of organized events at community centers</p> <p># child and youth participants at community center events</p> <p>value of GIK received</p> <p># of beneficiaries receiving GIK</p> <p># and % HVs participate in additional accredited trainings</p> <p># and % HVs receive nationally-recognized credential</p> <p># and % HVs enter salaried workforce</p> <p># beneficiaries use WV transport to access treatment</p> <p># OVC cases handled by Social Worker</p> <p># OVC accessing entitlements through Social Worker</p> <p># and % CCCs accessing outside funding for OVC care (repeat)</p> <p># and % CCCs receive WV cash advance for OVC activities</p> <p># and % cash advance CCC recipients successfully manage cash</p> <p># and % CCCs submit proposal for WV small grant</p>	<ul style="list-style-type: none"> • Procurement records • Distribution tracking system • HV records • CCC records • HV surveys/questionnaires • WV training records • Social Worker work plans • Social Worker reports • WV accounting records • CCC proposals • ADP records
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Objective 2 (Cont.)	B 2.9	# and % CCCs receive WV small grant	
Support	B 2.9	# & % small grant CCC recipients successfully manage grant	
	B 2.10	# and % CCCs meet and collaborate with ADP committees	
Objective 3: Comprehensive (Environment Level) Improved Enabling Environments at (district, provincial, national) levels that actively supports OVC care			
Coordination and Collaboration	C 2.1	# of coordination meetings at <i>local</i> (community) level	<ul style="list-style-type: none"> • Minutes of meetings • CCC records/reports • WV training records • “Coordinating structure” reports and minutes
	C 2.1	# of <i>district/municipal/provincial</i> coordinating committees formed and/or strengthened with project support	
	C 2.1	# and % of CCCs sending representatives to <i>district/municipal/provincial</i> coordinating meetings	
	C 2.1	# of trainings carried out with <i>district/municipal/provincial</i> coordinating committees	
	C2.1	# and % of identified <i>district/municipal/provincial</i> coordinating committees accessing outside funding for OVC activities	
	C 2.1	# of coordination meetings at <i>national</i> level attended by WV staff	
Government Capacity Building	C 2.2	# of trainings carried out with (<i>identified Ministry/Department</i>)	<ul style="list-style-type: none"> • WV training records • Ministry/Department records and reports
	C 2.2	<ul style="list-style-type: none"> • (<i>additional indicators relating to the types of outputs coming from the identified relationship, i.e. OVC Policy, OVC Database, OVC Situation Analysis, etc.</i>) 	
Advocacy	C 2.3	<ul style="list-style-type: none"> • Indicators will depend on advocacy strategy selected and may borrow from indicators identified in various categories of activities listed herein. 	<ul style="list-style-type: none"> • Project advocacy strategy