

OPERATIONALIZING GOVERNMENT GUIDELINES FOR ORPHANS AND VULNERABLE CHILDREN

OVC Call to Action

HIV/AIDS has had an enormous impact on Mozambique; in 2014, UNAIDS estimated that 610,000¹ children in Mozambique were orphaned because of the disease. A 2014 situation analysis conducted by UNICEF cited several challenges faced by Mozambique's orphans and vulnerable children (OVC) that increase their vulnerability—namely poverty, lack of household assets, lack of social protection, frequent natural disasters, and loss of parents through disease.² These challenges are exacerbated by long-term climate change and food deprivation. Other key factors influencing the well-being of children include gaps in local knowledge and the pervasiveness of certain attitudes and practices rooted in cultural traditions, including unequal gender relations.³

Overall vulnerability also creates conditions that increase children's own exposure to HIV—especially for young girls and young women. Children who have been left behind by parents who died from HIV may also be HIV-positive themselves. According to UNICEF, in 2013 only 37 percent of HIV positive children in Mozambique were receiving treatment.⁴ Those caring for these children need additional support so that these young people can live with HIV and grow into productive adults.

Empowering Communities to Care for OVC

In an attempt to improve the quality of care for OVC and to shift the approach from charity to empowerment, the Ministry of Children, Gender and Social Action articulated guidelines promoting minimum standards of care and a family-centered approach. However, implementation of these guidelines has been a challenge. CAP Mozambique worked with local CSOs to systematically apply the guidelines in a way that was relevant to and respectful of local communities.

¹ <http://www.unaids.org/en/regionscountries/countries/mozambique/>

² http://sitian.unicef.org.mz/english/files/UNICEF%20SitAn%20FULL%2014%20EN_WEB.pdf

³ Ibid.

⁴ http://www.unicef.org/about/annualreport/files/Mozambique_COAR_2013.pdf

To help address the critical needs of these children, the Ministry of Gender, Children, and Social Action (MGCAS) integrated three objectives in the National Strategic HIV and AIDS Response Plan, 2010–2014, specifically geared towards assisting OVC:

- create a protective environment that reduces the impact of HIV/AIDS on OVC
- strengthen the capacity of the Ministry and its partners to support OVC
- strengthen family and community capacity to care for and protect OVC

The United States President's Emergency Plan for AIDS Relief (PEPFAR) supported the Ministry in this endeavor by obligating funds for this agenda.⁵ The U.S. Agency for International Development (USAID)/Mozambique recognized the important role that local organizations—embedded in their communities and at times established by people living with HIV/AIDS (PLWHA)—could play in caring for OVC. With their knowledge of community dynamics, access to local resources, and, in some cases, their very personal connections to the impact of HIV on children and families, these civil society organizations (CSOs) have the potential to act as a powerful and sustainable force for change.

The Capable Partners Program (CAP) in Mozambique was designed to strengthen the capacity of leading Mozambican organizations and their networks in the fight against HIV/AIDS. Funded by USAID through PEPFAR, the project was implemented by FHI 360. CAP combined implementation grants with intensive, tailored capacity development to support local community-based organizations (CBOs) to play a bigger role in fighting HIV and promoting health in their communities. In addition to providing technical assistance, CAP supported core organizational systems—financial, human resources, accountability, and internal governance systems—to improve the sustainability and resilience of the organizations. CAP Mozambique developed and tested strategies and tools to manage a capacity development and grants project that support organizations (not just individuals) to identify the most promising partners; foster ownership and self-determination; and anticipate, prevent, and respond to challenges.

In December 2011, CAP Mozambique launched a competitive process in Manica, Nampula, Zambezia, and Maputo through which it identified local organizations with experience and interest in supporting OVC and their caregivers. Since 2012, CAP provided intensive capacity development support and sub-grants to these local NGOs to design and implement interventions to support OVC and their families affected by HIV.

This technical brief describes the support provided to these organizations and the results of their efforts. It also highlights success factors identified through interviews conducted with Partners.

CAP Mozambique OVC Implementing Partners

Umbrella organization Partner:

- Hope for the African Child Initiative (HACI) managed nine local partners

Direct implementing Partners:

- Associação Niiwanane Wamphula (Niiwanane)
- Associação Ecluménica Cristã (Kubatsirana)
- Associação Nacional para o Desenvolvimento Auto-sustentado (ANDA)
- Organização de Desenvolvimento Rural (Kukumbi)
- Liga dos direitos da Criança da Zambezia (LDC)*

*LDC ended in 2014 and did not complete the program.

⁵ <http://www.bu.edu/cghd/files/2012/05/Mozambique-OVC-Evaluation-Project-FINAL.pdf>

Operationalization of MGCAS Minimum Standards for OVC Care

Guidelines and tools

In July 2013, MGCAS, which is responsible for OVC support, approved guidelines on a minimum package of OVC care and a needs assessment tool—the Child Status Index (CSI). (Measure Evaluation, a USAID-funded project, developed the CSI in 2009 to support improved OVC case management.⁶) The guidelines outline seven areas of support: nutrition, health, psycho-social support, education, shelter, legal and social protection, and economic strengthening. For each area, MGCAS stipulated essential actions and activities. CSOs working with OVC were required to ensure that their beneficiaries had access to all seven services. MGCAS required service providers to conduct an individual needs assessment for each OVC using the CSI, develop a care plan following the approved MGCAS guidelines, and respond accordingly. OVC service providers were not expected to provide all seven services. They could provide quality services in one or two key area/s but were required to make sure other needs were addressed through referrals to other governmental and non-governmental services providers. In addition, MGCAS increasingly advocated for a family-centered approach. It supported the premise that children cannot be viewed in isolation from their caregivers; assisting children without addressing the needs of caregivers cannot generate the desired outcomes.



MAURO VOMBE | FHI 360

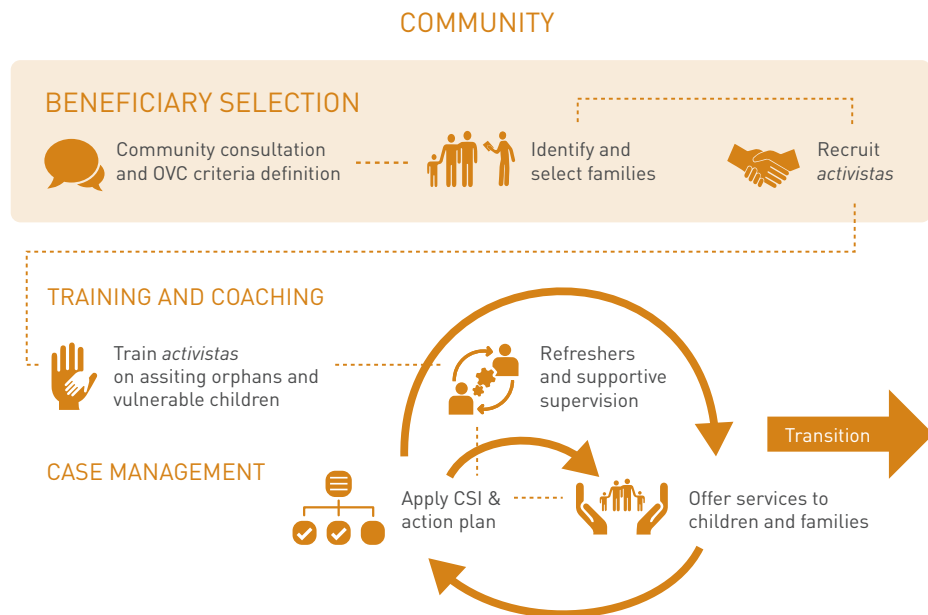
Putting the MGCAS minimum OVC care standards into practice and focusing on family-centered care represented a shift for CAP Mozambique's Partners, who mostly worked in one particular area of support and tended to be charity focused—providing short-term benefits. For example, CSOs might provide school uniforms and supplies for OVC, but did not identify and address barriers to doing homework or encourage parental involvement in the school life of the children.

The case management process

Case management is an iterative process of assessing and addressing needs and analyzing change (see Figure 1). The process starts with CBO Partners and local leaders identifying beneficiaries. Once beneficiaries are identified, community health workers are chosen (based on their proximity to beneficiaries, knowledge of a community's needs, language/s spoken, and capacity for interpersonal dialogue) and trained. Community health workers, under strict supervision, conduct the CSI and develop a care plan. With the care plan in place, community health workers conduct bi-weekly household visits to beneficiaries to provide services, or make referrals, accordingly. Six months after a CSI is conducted and a care plan developed, a re-assessment follows and the care plan is adjusted. Once the OVC and the family have progressed sufficiently, the OVC transitions, and the intensity of the support decreases.

⁶ For more information see: <http://www.cpc.unc.edu/measure/resources/tools/child-health/child-status-index>.

FIGURE 1: CASE MANAGEMENT PROCESS



Implementation strategies that improved outcomes

CAP Mozambique identified the following key implementation strategies that led to improved outcomes:

CAP Training and Coaching for Partners

Training

- Community consultation process
- Establishing and maintaining networks
- MGCAS guidelines
- Case management
- CSI application
- Household visit techniques
- Essential OVC services:
 - HIV care and treatment
 - household economic strengthening
 - psycho-social support
 - early childhood development

Coaching

- Bi-monthly monitoring site visits
- Data quality verification
- OVC database management

Involving the community in beneficiary selection. Local organizations know the importance of involving communities. CAP strengthened Partners' abilities to involve communities more effectively for longer-term benefit. CAP developed and trained Partners in an approach to facilitate community involvement in the selection of beneficiaries. The previous process (of asking leaders to identify OVC without first establishing eligibility criteria) did not always lead to the neediest beneficiaries being supported. CAP helped OVC Partners work closely with community leaders to define community-specific eligibility criteria to complement standardized criteria suggested by MGCAS's definition of OVC. Communities tended to define OVC differently; it might be a child who only takes one meal per day, who has no shoes, or who is not attending school. Establishing clear criteria provided legitimacy, transparency, and community ownership to the entire process.

The process of defining community-specific eligibility criteria also provided Partners with an opportunity to explain the minimum guidelines for OVC care and raise awareness about OVC needs and mitigating actions. The community understood that eligibility criteria were partly defined by them and not solely imposed by the Ministry or the CBO. Each Partner worked with community leaders to form a selection committee of two to three people who then made house calls to children identified by leaders as OVC. The committee decided jointly if the OVC fit the eligibility criteria.

Engaging community leaders early on in the process meant that: 1) the project reached the OVC most in need of support; and 2) leaders became more aware of and sensitized to the plight of the OVC and felt ownership over the process and a greater responsibility for helping the children.

Conducting case management with a holistic, family-centered approach. Case management starts with a solid needs assessment. To guide OVC needs assessments, MGCAS adapted the Child Status Index (CSI) tool to the Mozambique context and approved its use in 2013. Individual care plans were developed based on CSI assessments. Community *activistas* negotiated with caregivers to set priorities and determine the various stakeholders' roles and responsibilities (including those of the caregivers themselves) to meet children's needs. Discussion of the CSI and subsequent negotiations of priorities also provided an opportunity to raise awareness about OVC needs and rights.

Activistas conducted bi-weekly visits to families and provided services directly or made referrals to other services. For example, an *activista* might provide psycho-social support to a child who has lost a parent, discuss personal hygiene and sanitation, talk about the importance of education, find resources to assist a child with homework, give basic nutritional advice, and share information on child rights. Referrals might also be made to other services if required, such as birth registration, HIV testing, care and treatment, and family planning. An *activista* might support a caregiver to negotiate a child's re-entry into school. Each *activista* kept careful records of progress made towards beneficiary care plan goals.

CAP Mozambique provided Partners an initial five-day training on MGCAS guidelines and the CSI, followed by annual refresher trainings prior to CSI re-application. CAP also provided frequent on-the-job technical assistance both during CSI application and household visits, particularly in the first two years of the project. In addition, CAP supported Partners to analyse their staffing structures. CSI application and care plan development and implementation are complex processes that need to be strictly guided and supervised. Over the years, as Partner staff and community health workers gained experience and confidence with case management, CAP's technical assistance shifted from case management to specific technical areas—such as mobilization for HIV testing, psycho-social support, household economic strengthening, and early childhood development. CAP provided training and on-the-job coaching in each of these areas.

Community health workers identified two key benefits of the structured needs assessment process. First, it helped them focus on long-term needs rather than only those that can be addressed immediately. The CSI allowed them to identify and respond to more complex underlying issues that require a long-term perspective. A second important benefit was the opportunity to re-apply the CSI over time and help them see the changes in children's lives as a result of their efforts.

Strengthening connections for additional resources. The needs of OVC are many and complex. CSOs do not have the resources to provide all the services that OVC require—and neither should they. The government provides basic social services such as healthcare, education, birth registration, and social grants. Communities are also willing to help, and CSOs within a community may have different areas of focus. OVC and their caregivers,

"At first the activists thought that the CSI was a mandatory rapid survey. Once they applied the CSI for the second time, they realized it allowed them to assess the impact of their work and be more accurate about the support they provide."

—OVC officer, Kubatsirana

however, often face myriad obstacles to accessing government services as well as community-based support. CAP Mozambique assisted Partners to create access to existing services by identifying service providers, establishing relationships, and expanding referral networks. Partners mapped potential referral partners, and where possible, formalized relationships by signing memoranda of understanding. Through a combination of direct service delivery and referrals, they managed to provide a full package of OVC services.

With CAP Mozambique support, Partners improved their capacity to advocate for and negotiate access to services for OVC and caregivers and to mobilize community support. For example, Partners were able to successfully advocate with health facilities to provide HIV testing and counseling services within the community rather than only through health facilities. They negotiated with school management and school committees to eliminate registration and matriculation fees for OVC. They mobilized authorities to collectively register OVC who did not have identification papers. They mobilized local leaders to issue poverty statements through which OVC gained access to free health consultations and basic medication. And they organized community members to contribute materials and labor to improve housing for OVC families.

Capitalizing on opportunities for sustainability. CAP Mozambique tried to place knowledge and skills in the hands of both organizations and people so they in turn could channel good intentions into effective action and assume increased responsibility for the children under their care. Although financial resources are critical, improved knowledge, skills, and solid relationships have a chance of remaining in a community long after a project ends.

Example of psycho-social support from Kubatsirana

A child whose caregiver could not afford to contribute to building funds for the school bore the brunt of his teacher's anger when the teacher castigated him in front of his peers. The child was embarrassed, opted out of school, and started to live on the street. However, the *activista* worked with the child and his friends to return the child to school and re-socialize with other students.

CAP Mozambique pursued a dual approach of both training and follow-up coaching. CAP provided significant technical assistance in terms of initial training to staff and *activistas* on the MGCAS guidelines and case management. As the years progressed and *activistas* grew increasingly comfortable with case management and the family-centered approach, CAP helped Partners improve the quality and depth of their service offerings. Partners increased their knowledge and skills in household economic strengthening and introduced village savings and loan (VSL) groups; OVC participation in these groups led to tangible improvements in housing and nutrition. CAP invested considerable resources in strengthening the capacity of community health workers to provide much needed psycho-social support, using the respected methodologies of Regional Psycho-Socio Support Initiative's (REPSSI).⁷ Community health workers learned to apply the methodologies and reported improved communication between children and elderly caregivers, retention of OVC (previously stigmatized) in school, and helping children cope with the death of caregivers and friends. CAP helped Partners to overcome community health workers' reluctance to talk about HIV testing and counseling—resulting in more OVC and caregivers getting tested and gaining access to care. Whenever community health workers noticed that fear of stigma and discrimination continued to prevent beneficiaries from seeking HIV services, *activistas* devised

⁷ REPSSI is a non-profit organization that aims to lessen the social and emotional (psychosocial) impact of HIV and AIDS, poverty, and conflict on children and youth by building capacity to provide psychosocial care. The organization works with (I)NGOs and governments across East and Southern Africa.

alternative strategies to create access and support and advocate for retention in care. Finally, CAP introduced Partners to the importance of early childhood development, providing community health workers with the ability to engage their youngest beneficiaries in stimulating activities and teach caregivers to do the same.

CAP conducted frequent on-the-job coaching visits to support Partners and *activistas* in improving the quality of their work. Without such visits, CAP Mozambique and its Partners would not have achieved the same implementation quality.

The Results—More and Better Services for OVC

In fiscal year 2015, OVC Partners reached 10,189 OVC and caregivers. More than half (55 percent) of beneficiaries were under 15 years of age; about one third (32 percent) were older than 18 years. Partners provided 36,244 discrete services to OVC that year (see figure 2), with an average of 3.6 services provided to each OVC. In addition, Partners initiated 4,786 referrals to other service providers (primarily associated with health care, birth registration, and education) and verified that the vast majority of these referrals (72 percent) were completed (i.e., OVC accessed the services).

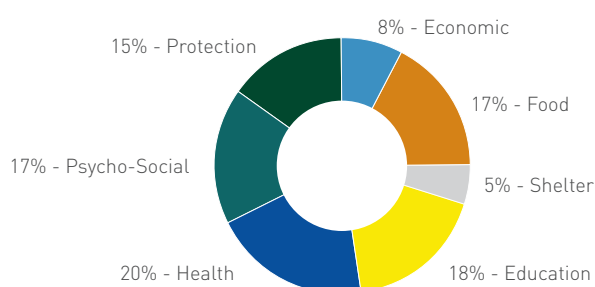
OVC now have access to more services and opportunities to enrich their lives as a result of CAP Mozambique's efforts. Children have improved access to school, health facilities, and personalized attention. Their own community leaders are more aware of their needs and advocate on their behalves. Specialized support for the families, such as VSLA and nutrition training, also helps to ensure that children benefit over the longer term.

"Before the training we provided care mainly to OVC of 5-18 years of age. We did not know what to do with younger children. Now we learned what to do and the activists are enthusiastic. Caregivers thank them for teaching them things that are so important for the development of their infants."

— Project officer for
Associação Kurera
Wana Gondola
(HACI sub-partner)

FIGURE 2: SERVICES PROVIDED TO OVC IN FISCAL YEAR 2015

Total = 36,244 services provided



Lessons Learned

CAP Mozambique Partners helped change the way communities think about and respond to OVC. They have seen many caregivers assume responsibility for their own lives and those of their children, and they have given them knowledge and means to sustain these changes. Asked what key factors they believe contributed to this success, the Partners identified the following:

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- **Early commitment by the village elders is critical**—The elders of Mozambican communities are highly trusted individuals. Gaining the confidence of these leaders is vital to the acceptance of any program that aims to support the community. The elders bring critical information about the families and their dynamics. They can facilitate access to services, influence barriers to services, and can point community health workers to the appropriate resources. If CBOs work with community elders early in their programs by including them in decision making, program implementation will ultimately be more acceptable, successful, and sustainable.
- **The CSI tool is very useful for case management but complex to master**—The CSI is an essential first step in the case management process. However, it is a complex tool to use, particularly in resource-poor settings, and requires extensive and continuous training and rigorous and supportive supervision and coaching. CAP Mozambique supported Partners during application of the CSI as well as in the development and implementation of action plans. Role plays and joint applications are effective ways to establish consensus on scoring.
- **CSI assessments and action planning should take place every six months**—The CSI is designed to be applied every three months. Three months of data, however, are not sufficient to measure change in a child's well-being. A period of at least six months is needed to gain an accurate snapshot of the change that is occurring or to begin planning for the next cycle. Bi-weekly household visits ensure that critical situations do not go unattended. CSI applications and re-applications must be meticulously planned in order to avoid spending excessive time conducting the assessments at the expense of service delivery.
- **Empower caregivers**—Negotiations with caregivers during CSI application and conversations during household visits foster greater awareness about parental/caregiver responsibilities. These interactions help improve caregiver knowledge and ability to support a child, thereby reducing dependence on the Partner CBO.
- **CBOs cannot tackle OVC issues alone**—No single entity has the resources to provide all services needed by OVC. Building and maintaining support networks is therefore critical. CBOs can help families to access resources through the formal system and identify and mobilize informal resources in the community. These efforts also foster a sense of community in support of OVC. It is not possible for all support to be provided by a single entity. The community must come together in support of its OVC and their families.
- **Continuous training and coaching for *activistas* and project managers is key for quality services**—Case management is not learned overnight, but rather through continuous application and supportive supervision. As required services become more complex and varied, training and coaching for those providing services is essential.

CAP Mozambique was able to operationalize the MCGAS guidelines because the Government of Mozambique had the vision to create necessary guidance on OVC care. CAP Mozambique and its Partners were thus able to develop a framework on which to create comprehensive family-centered interventions to support OVC who are healthy and able to give back to their communities.