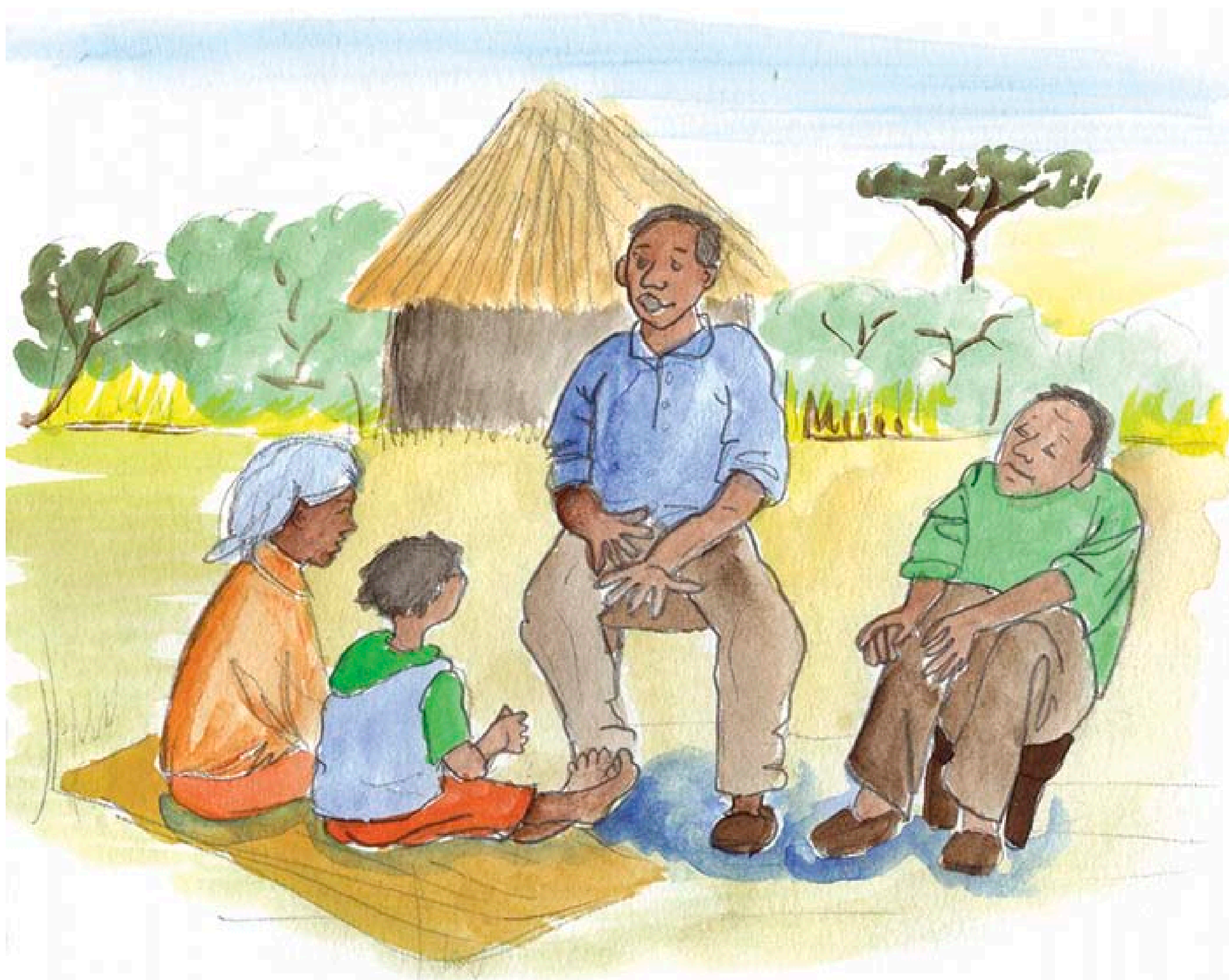
SECTION II

Planning



II. PLANNING 29

1. Global Programming Principles and Strategies 31

A conceptual framework 31

A global strategic framework 32

Programming guidance from the global strategic framework 35

FHI's Child Outreach Strategy: A framework for programming 37

Recommended readings and toolkits. 37

2. Models of Care and Support 39

Classification by HIV prevalence rates and population size. 39

Four models of care and support programming 41

Family and community care, rather than institutional care 42

Including children with special needs 43

Recommended readings and toolkits. 46

3. Core Services for Children and Families 47

PEPFAR's core service areas. 47

Addressing cross-cutting issues in program planning 50

Recommended readings and toolkits. 50

4. Laying the Groundwork 53

Conducting a situation analysis. 53

An organizational assessment 55

Making key programmatic decisions. 56

Recommended readings and toolkits. 57

When parents become sick, they should start preparing their children for the future. They shouldn't wait until it's too late.

Toini, 19

1. Global Programming Principles and Strategies

All programs for vulnerable children and youth need to work together to incorporate interventions that improve the quality of life of families and communities and of the young people themselves. Interventions should respond to children's comprehensive needs, within the context of globally established guidelines and principles.

In planning, you should consider two types of interventions: direct and indirect. The first type provides services directly to children and families who are identified by your program. The second type—indirect interventions—strengthens the ability of government and community organizations to meet the needs of children, including by promoting and enforcing laws and policies that benefit and protect them.

Given the global HIV pandemic, one goal of programming for vulnerable children and youth is to mitigate the impact of HIV and AIDS on them, their families, and their communities. These mitigation efforts require the integration of prevention, care, and treatment strategies and a multisectoral approach that involves the government, the private sector, and all community stakeholders. By contrast, where extreme poverty, natural disaster, armed conflict, or other harmful influences play a bigger role in a child's life than HIV, the focus should be mitigating these factors to the extent possible, although an HIV focus may be added.

Overall, the main goal of all programming is to provide vulnerable children and youth with the same standard of care and opportunities in life that children and youth who are not vulnerable experience within their respective communities or countries.

A conceptual framework

To shape the way we plan, we must look beneath the surface in communities where we work and learn to think conceptually. A good theory of social change will help us identify ways to assist individuals, families, communities, and organizations who are seeking to understand and shape their own futures.[1]

One place to begin is to consider ideas and values that underlie our view of how change occurs in a community. Most conventional theories of social change are linear in concept—that is, they are based on the notion that if you provide an intervention you can predict the improved outcome, even a year or two in advance. Let's say you teach members of a household with vulnerable children how to garden and then give them tools and vegetable seeds. Conventional linear thinking assumes that they will grow some food and their nutritional status will improve within a year.

Real life is not always so simple. Household members may be too ill to garden, or their plantings may be killed by drought. The family may sell off their crop to pay off an old debt or some other expense, with no benefit to their nutritional status. In conventional thinking, these outcomes would be considered failures, but that may be a shortsighted way of looking at the issue. If we look at each these unforeseen outcomes in a different way, we would see that good things could still result. For example, illness may cause local volunteers to emerge with offers to help—neighbor-to-neighbor or through relationships in a local religious congregation—which will strengthen the community network. Experience with drought may encourage people to consider and learn about planting drought-resistant crops. Selling produce instead of eating it may give the family access to credit for a small-business loan, help with paying school fees, or some other kind of assistance. The situation may not always work out this positively (often it doesn't), but the possibility increases if you are willing to learn from unexpected things that happen and then apply these lessons to your future work.

What does this example teach us? First, that simple cause-and-effect thinking is often misleading. Second, not all crises are failures; instead, they may be a prerequisite to transformative change. All of us

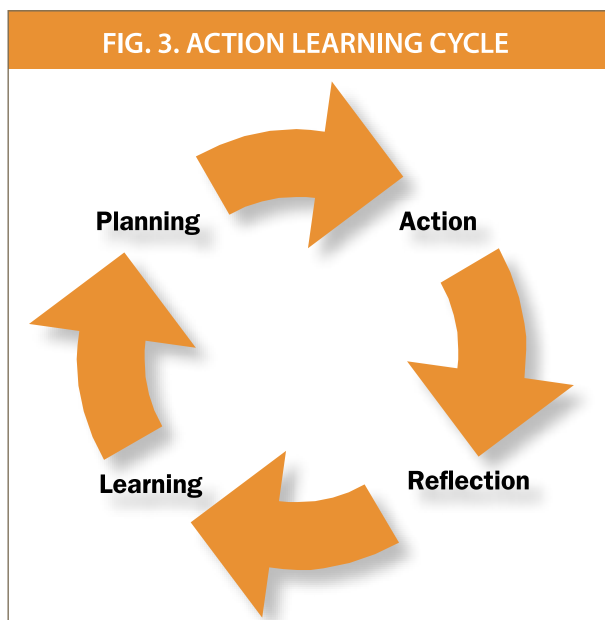
> **Sometimes I felt embarrassed to ask for help from neighbors. They mocked me and laughed behind my back. But I kept looking until I found someone else who could help us.**
>
> Raukha, 16

learn from experience—often more from our mistakes than our successes. For this learning to occur, we need to take a wide view, be flexible, and think out-of-the box. While maintaining our core values and goals, we should always be open to unanticipated opportunities for learning and positive social change.

Social change is cyclical. It involves a continuous (and sometimes messy) process of planning, action, reflection, learning, and then more planning (fig. 3).[2]

Sometimes social change occurs naturally, at other times unexpectedly, and still other times as part of a project or program. Inevitably, it involves ups and downs—a hodge-podge of setbacks, crises, steps forward, and unanticipated factors. Planning is an ongoing process, not something that occurs only at the beginning. The same is true of the actions, reflection (or monitoring), and learning as you go. The key is to always keep learning from the process. You then need to apply that learning to your work in the field—through more planning, action, and reflection—to improve what you are doing and foster positive social change.

FIG. 3. ACTION LEARNING CYCLE



A global strategic framework

Books about program planning and social change contain innumerable references to organizing principles, planning frameworks, guiding strategies, and the like. In 2004, UNICEF, UNAIDS, USAID, and other international organizations agreed on a global strategic framework to guide responses to issues facing orphans and other vulnerable children.[3] It highlights five key strategies to guide programmatic responses:

1. Strengthen the capacity of families to protect and care for orphans and vulnerable children by prolonging the lives of parents and providing economic, psychosocial, and other support.
2. Mobilize and support community-based responses.
3. Ensure access for orphans and vulnerable children to essential services, including education, healthcare, birth registration, and other services.
4. Ensure that governments protect the most vulnerable children through improved policy and legislation and by channeling resources to communities.
5. Raise awareness to create a supportive environment for children affected by HIV and AIDS.

Although these strategies were mainly intended for senior policymakers, they provide valuable guidance for you and others working more closely with vulnerable children and youth within organizations and in local communities.

1. Strengthen the capacity of families to protect and care for children.

Families living under very difficult circumstances are often unable to meet the basic needs of their children. They may need external support and additional resources to fulfill their responsibilities. The best way to help is to strengthen the capacities of parents, extended family members, and other caregivers to provide children with the care and support they need. Within the context of HIV and other life-threatening diseases, the best approach is to help keep parents alive and healthy and prevent children from becoming orphans.

Your child-focused work should involve advocacy and support for all family members to access HIV counseling, testing, and treatment; economic strengthening activities; and nutritional support, if needed. The integration of HIV-prevention education and support for all family members is also important, depending on their ages and situation. This support may include services to prevent mother-to-child transmission of HIV for those mothers at risk of giving birth to HIV-positive children, referrals for a test where HIV status is not known, and adherence counseling related to

Help children by helping their families

Home Truths: Facing the Facts on Children, AIDS, and Poverty,[4] an outstanding report released in 2009, contains three main policy recommendations:

- Support children by helping their immediate or extended families and by delivering integrated family-centered services.
- Strengthen community action to support families—for example, via a local children's committee or community care coalition whose volunteers provide outreach, referrals, guidance, and support.
- Address family poverty through a cash-transfer program or some other form of a bottom-line, basic, social safety net.

All three recommendations are AIDS-sensitive but not AIDS-directed.

The report concludes that prioritizing care and support for children who are orphaned is unhelpful, if not damaging. The fact is that 88 percent of children labeled in this way have one parent, and 95 percent live with extended families who are a strong source of continued material support, psychological care, and cultural identity. The report states that extreme poverty, not HIV infection, should be a criterion for support. It also states that supports through school systems often come too late.

antiretroviral treatment for HIV-positive family members.

Be sure to include children and all other family members in the planning process. This will help create a sense of ownership and ultimately enhance your program's sustainability. If you avoid contact with family members during the planning period, you may undermine what you are trying to achieve and set up a "we-versus-them" situation.

Assistance for children that does not include all family members may do more harm than good. It can create jealousies among siblings ("Why did my brother get help and not me?") as well as rejection by adults ("Since you got fed at the center, you can skip dinner at home"). Even without these problems, restricting support to children and then sending them back to families who are under-resourced or dysfunctional can only have limited effect. The approach may also create dependencies on outside support that are not sustainable.

By contrast, creating a partnership and working with family members makes it possible to introduce interventions with long-lasting impact. Everyone benefits if you strengthen the skills, knowledge, and capacity of caregivers. Collaboration with family members will help you to discover the children's most pressing needs and allow you to supplement what the family is able to provide. It is a holistic and cost-effective approach.

2. Mobilize and support community-based responses.

Vulnerable children and their families are often at a disadvantage when trying to access basic services, usually because of poverty, lack of formal education, and the frailty of many grandparent-guardians. Members of vulnerable families may not know what they are eligible for, and they are more likely to lack documents that prove their eligibility. They may also have difficulty navigating large bureaucracies and advocating for what is rightfully theirs.

To intervene, stakeholders, including traditional and religious leaders, elected officials, and community-based organizations, should mobilize support for needy children in their communities. Often, local resources exist, but residents need to be sensitized to challenges being faced by the neediest people in their communities. They can do a great deal to mitigate these challenges. For example, they can commit to regular visits with a few needy families and to spending time with children after school, encouraging them, offering homework support, and helping them to access local services. When embarking on this process, it may be best to start small, one community at a time. Once a children's support program gets underway, deeper, more meaningful support can be considered, along with expansion to additional geographic areas.

Help community members realize the meaningful role they can play in the lives of children

Community members—caring neighbors, local groups, community organizations, and so on—can provide care for children by taking on the roles of "auntie and uncle," counselor, friendly visitor, and educator. Community members can advocate for access to local schools, health clinics, and other resources. Those taking on these roles will come to realize that they have the skills and capacity to improve the lives of vulnerable children and that many needs can be met without money. To facilitate this process and mobilize communities to help children, the Regional Psycho-Social Support Initiative in South Africa developed *The Journey of Life,* excellent training materials for use with local groups, volunteers, and children.

Establish a children's rights committee in every village or neighborhood

One of the most effective ways to help children is by training local volunteers to serve as members of a children's rights committee or a similarly named group. Volunteers learn what children in their community are entitled to and they make sure that they get it. Following an initial training, committee members meet regularly to address problems and ensure that all families in their target area are reached.

When forming a local children's rights committee, don't forget to involve children and youth or else train them in a parallel process to identify and assist their peers. Their involvement is invaluable because they have information about each other that otherwise never reaches adults.

3. Apply a child-rights and gender-sensitive perspective.

Every child has the right to have a name and birth registration, attend school, and receive healthcare services. However, access to these basic services may suffer when a child's parents are ill or have died, or when caregivers are overwhelmed with day-to-day survival tasks. Often, parental death certificates, children's birth certificates, and other documents are a prerequisite for receiving government entitlements, including food baskets, schooling, and welfare services. Obtaining these documents can be a daunting process that requires the help of someone who knows how to navigate the system.

Additional attention may be required for children with special needs—those who are HIV-positive, live with disabilities, or need protection from abuse or neglect. In addition, girls often need special attention to ensure they have equal opportunities to access education, community-based services, and safety. Girls and women may also need support so their voices can be heard and their decisions respected.

4. Provide support and capacity building at national and provincial levels.

Advocacy at community levels may not be sufficient. Often, systems must be changed at national and provincial levels and strong partnerships formed with governments, policymakers, and organizations at these levels to facilitate children's access to services and extra support. For example, problems with access to education could be addressed by a national policy that calls for elimination of all school fees.

Usually, systems change takes a protracted period of time and involves inter-organizational coalitions and advocacy efforts. Enforcement and monitoring processes are also required to make a change on paper become real in a community. To ensure implementation, local representatives must be educated about the change and what it means to children in their area.

5. Raise awareness through advocacy and social mobilization.

Stigma and discrimination—and the rejection, hostility, isolation, and human-rights violations they generate—tend to occur when children and their families need a supportive environment the most. Affected family members may need one-on-one counseling, and they may need the assistance of support groups that allow them to share concerns, advocate for access to treatment and care, and develop income-generating schemes. To decrease or eliminate stigma and discrimination and create a supportive environment, individuals and groups can do the following things:

- Be sensitive to cultural norms, but work firmly toward behavior change.
- Challenge local myths that give rise to stigma and discrimination.
- Increase access to correct information about HIV and other sensitive issues.
- Develop and implement with local partners a communication plan that can foster a more supportive environment for children.

Ensure that all children attend school

Every child has a right to education. Most countries mandate schooling, at least through the primary grades, but obstacles inhibit the poorest-of-the-poor from attending school, even in countries that claim to offer free education. The most prominent obstacles are fees for registration, books, and exams, along with the requirement to wear a school uniform and buy personal school supplies. Families may also impose heavy chores on children that impede school attendance. More commonly, this affects girls, since some families believe their schooling is not important.

Governments need to be encouraged to make school truly free of charge and accessible, providing school-feeding programs in areas with very poor nutrition and hostels for children who live far away. Where such governmental support is not possible, local community hostels and supplementary feeding programs could be substituted. Village child-rights committees or other volunteer groups should check on children who frequently miss school or come late for classes. They should then educate families on the importance of regular school attendance, emphasizing that it is the law in most countries.

A self-help project by people living with HIV

When Kindlimuka (Wake Up) was registered in Mozambique in 1998, it was the first self-help group of people living with HIV (PLHIV) in the country.[5] Kindlimuka soon started income-generating activities with three sewing machines, producing domestic workers' clothing and accessories. In the face of inadequate demand for these products and many requests for assistance from members, the organization negotiated in 2000 a relationship with the multinational petroleum company TOTAL to produce uniforms for its staff at stations across the country. Later, Kindlimuka expanded its production to include school uniforms.

Kindlimuka contributed greatly toward reducing the stigma and discrimination associated with being HIV-positive. Earnings help its members support themselves and their children, ensuring that they have adequate nutrition, access to healthcare, and money to pay school expenses.

- Facilitate school-based youth clubs that campaign against all forms of stigma and discrimination in the school and community.
- Provide start-up assistance to local support groups for income-generating schemes that will benefit families.

Other child-friendly environments play an equally important role. These include local health clinics that make no judgments on reproductive health and other sensitive matters; outreach programs by the police and national ministries that combat domestic violence and child abuse; and schools that welcome children with special needs. Local advocacy efforts, support groups, and elected officials are well positioned to create and monitor child-friendly environments at local levels.

Programming guidance from the global strategic framework

In addition to the five strategies, the global strategic framework offers seven elements of guidance for people who plan and work with local programs for vulnerable children.[6]

1. ***Focus on the most vulnerable children and communities, not on children orphaned by AIDS.*** Programs that target only children orphaned by AIDS may increase stigma and discrimination. Priority care and support should go to children in greatest need, regardless of the cause. These children are best identified by community stakeholders and local people who are in direct contact with lots of children. An assessment using the Child Status Index or a similar tool (III, chapter 3) can be used to confirm the selection. Alternatively, an entire community, school, or neighborhood can be targeted.
2. ***Define community-specific problems and vulnerabilities at the outset and pursue locally determined intervention strategies.*** Cookie-cutter approaches rarely work. By contrast, when a new program starts in a particular community, it should be adapted specifically to that location to meet the needs of vulnerable children and their families. This may involve a separate analysis at each site to prioritize local needs and resources, identify obstacles or gaps in service, and determine how to find the vulnerable children who are most in need of care and support. Community members—both adults and children—should play a central role throughout.
3. ***Involve children and young people as active participants in the response.*** Children and young people should not be seen as a passive, powerless group who need to be given help. They need to be allowed to actively participate in all aspects of activities that affect them (I, chapter 6).
4. ***Address gender discrimination and give particular attention to the roles of boys and girls, men and boys, and women and men.*** The burden of caring for vulnerable children and sick

Always try to save some money for an emergency. You never know when you will need it.

Helvi, 21

FHI's Child Outreach Strategy

Goal and Objectives

The overall goal is to improve the quality of lives of children and their families by mitigating the impact of HIV and AIDS through an integrated continuum of health and social support services that are accessible to families at scale, in partnership with government, civil society, the private sector, and children themselves.

Objectives are to increase

- access to and use of essential HIV prevention, care, treatment, and social sector support (impact mitigation) services
- coordination among community networks that provide linked HIV prevention, care, treatment, and social sector support services
- the capacity of health and social sector organizations and volunteer networks to provide essential quality services in an integrated continuum
- the participation of key stakeholders in the development of appropriate policies and legislation as a mechanism to increase access to healthcare and social sector support services
- the provision of quality strategic information that strengthens the evidence base on lessons learned from care and support models

Ten Principles for Programming

- Families remain at the center of interventions, with efforts made to place a child in an environment that is as close to a familiar family structure as possible.
- Interventions are designed to focus on the best interest of the child, including and especially their right to protection from discrimination, stigma, exploitation, abuse, and neglect.
- Efforts are made to maximize support of a continuum of care for vulnerable children—from prevention, palliative care and treatment, to impact mitigation—utilizing a family-centered approach.
- Programs strive to be as comprehensive as possible by leveraging the provision of services through partnerships and networks of providers, while working with communities to ensure that vulnerable children have access to primary healthcare, adequate nutrition, and a basic education.
- Quality assurance tools and methods are made available or developed to ensure a high standard of quality of prevention, care, treatment, and impact mitigation services.
- Gender equity issues affecting the status of and relationships between girls and boys as well as women and men are taken into account and addressed in programs and policies.
- To leverage available community resources, community-based social mobilization strategies are utilized that involve key community leaders, families, and persons affected by HIV and AIDS.
- Reduction of stigma and the elimination of discrimination against children, adolescents, and families made vulnerable by HIV and AIDS are integral to the design of programs.
- Activities and interventions are designed to reflect the developmental levels, ages, and needs of children being served
- Children themselves—particularly adolescents—are involved in the design, implementation, and monitoring and evaluation of programs, where possible.

adults generally falls on females. Vulnerable girls are more likely to drop out of school, and they have fewer rights and less access to education and income-generating opportunities than boys. Females are also particularly vulnerable to HIV infection. Girls who are excluded from owning or inheriting land may be forced to work as servants or marry against their will. Though both sexes are subject to sexual abuse and child-trafficking, girls are more frequently victimized.

5. ***Strengthen partnerships and mobilize collaborative action.*** Working with other organizations can be a very good way of improving a program's activities. One way of doing this is to build or strengthen local community networks and referral systems that will ensure coordination and a seamless system of support for each child.

6. ***Link disease-prevention activities and care and support for people living with that disease with care and support for their children.*** Activities may include school-based, health education as well as home-based care for ill individuals and their family members. Creating linkages with poverty alleviation and development activities taking place in the community offers a holistic approach and addresses underlying risk factors to disease, such as poor nutrition, unclean water, sanitation problems, domestic violence, and lack of education. Because these approaches benefit a larger group of people, stigma and discrimination is minimized.

7. ***Use external support to strengthen community initiative and motivation.*** Funding and technical assistance from the outside the community should strengthen and build on existing community activities and projects. Wherever possible, collaborate with local leaders to strengthen local ownership and local capacity and contribute to sustainability. By contrast, great care should be taken to avoid undermining or replacing community initiatives—or even the perception thereof—as this may create resentment, destroy existing coping capacities, and result in a dependency syndrome, where people are always waiting for handouts from the outside.

FHI's Child Outreach Strategy: A framework for programming

FHI has been a key player in the global response to the needs of orphans and vulnerable children. In 2007, FHI published *Child Outreach Strategy* to guide country offices on the design, implementation, monitoring, and evaluation of programs for orphans and vulnerable children.[7] The strategy is based on the UN Convention on the Rights of the Child, the goals and core indicators of the UN General Assembly Special Session on HIV, and the US Government's guidance for programs for vulnerable children. FHI advocates a child-focused, family-centered, and community-based approach. Though the focus is on children affected by HIV, the underlying principles are universal and apply to all vulnerable children.

Despite the strong foundation of core values and principles, FHI's *Child Outreach Strategy* acknowledges that there is no single model of service that is applicable in all contexts. Instead, it highlights key recommendations that can be adapted and applied differentially to help country offices and local program managers to design, implement, monitor, and evaluate their programs. Goals and objectives and 10 principles for programming from the strategy are reproduced on page 36 so you can make copies and post them on a board for easy reference.

Recommended readings and toolkits

- Family Health International, ***Case Studies of Success in the SCOPE-OVC Project: A Guide to Assist OVC Programming***, 2004.
  Case studies of successful outcomes for vulnerable households and the children who live in them.
  www.ovcsupport.net/sw4325.asp

- Guyana HIV/AIDS Reduction & Prevention (GHARP) Project, ***Orphans & Vulnerable Children (OVC) Technical Manual, Working Document***, 2007.
  A compilation of standards implicit in the project's technical assistance for civil society organizations and NGOs implementing programs to support children and their families living with or affected by HIV and AIDS in Guyana. www.fhi.org/en/HIVAIDS/pub/guide/res_GHARP_OVC_TM.htm

- HelpAge International, ***Forgotten Families: Older People as Carers of Orphans and Vulnerable Children***, 2003.
  Many older people have been forced into caregiving roles for which they are ill-equipped, physically, emotionally, and economically. This document, along with others on the HelpAge International website, looks at the impact that the rising number of orphans are having on the elderly in the developing world.
  http://ovcsupport.net/sw3244.asp

- MEASURE Evaluation, ***Evaluations of Five Programs for Orphans and Vulnerable Children in Kenya and Tanzania***, 2007.
  An estimated 12 million children 17 or younger in sub-Saharan Africa have lost one or both parents to AIDS and many more live with one or more chronically ill parent. Despite the magnitude of this problem, there is little empirical evidence on what works to improve the wellbeing of children affected by HIV and AIDS.
  www.cpc.unc.edu/measure/publications

- Tonya Renee Thurman, Anna Hoffman, Minki Chatterji, and Lisanne Brown, ***A Case Study: Kilifi Orphans and Vulnerable Children Project***, 2007.
The primary audience for this resource is program implementers in Africa and policymakers and funding agencies that address the needs of vulnerable children. www.cpc.unc.edu/measure/publications

- UNAIDS, ***Principles to Guide Programming for Orphans and Other Children Affected by HIV/AIDS***, 2002.
This document aims to build consensus on core guiding principles for an expanded response to children and adolescents affected by HIV and AIDS. It emphasizes human rights as a framework for analysis and response, a strategic approach to action, principles and approaches to guide programming, and collaboration and networking. www.harare.unesco.org/hivaids/view_abstract.asp?id=282

- UNICEF, *Africa's Orphaned Generations*, 2003
A seminal study comparing different countries, but with common recommendations for policymakers, donors, and local organizations and communities. The statistics have largely gotten worse, but the issues have not changed. http://unicef.org/africas_orphans.pdf

In addition, check out the websites listed in appendix 1, especially www.helpage.org; www.kit.nl; www.ovcsupport.net; www.satregional.org; www.usaid.gov; and www.unicef.org

2. Models of Care and Support

To make a meaningful difference in the lives of children, you should make sure that they have access to the broad spectrum of coordinated services. This does not mean that your program has to provide all possible interventions, regardless of your funding capability or the availability of other implementing partners. The specific mix of services you provide will depend on these factors and will differ by location, current community resources, the capacity of the family and other stakeholders to provide support, and—above all—on the needs of the particular children you are helping.

At the point of service delivery, all good programs have these features in common: assessment, care management, and coordination and continuity of care. There is an initial assessment of the children served within their family or household settings to determine their needs and of the resources that are available to each child (III, chapter 4). The assessment is followed by a plan that is implemented to provide additional support, as needed. Coordination and continuity of care refers to follow-up services and linkages to other service providers. These help to minimize gaps, avoid duplication, and enable children receive the support they need, while empowering families to sustain the gains made and achieve improved wellbeing over time.

The whole family, not the individual child, should become the unit of care wherever possible. Recent publications suggest that extreme poverty and other measures of need should be the main criteria for selecting one family over another for assistance, rather than simply the child's status as an orphan or the presence of a specified disease.[8] Nevertheless, many donors follow their own criteria and target their funding accordingly. By far, the largest amount of international funding for children has been provided in response to the global HIV pandemic and targets orphans and other vulnerable children in high prevalence countries or within pockets of highly affected populations.

Classification by HIV prevalence rates and population size

Most often, issues of poverty and HIV converge. The result is that it is very possible to reach the neediest children in a community within the confines of funding that targets HIV-affected families or those considered highly at risk. But this convergence also means that programs in high prevalence areas that do not target HIV-affected families should nevertheless incorporate HIV prevention and care, integrating activities that promote healthy living, disease prevention, stigma reduction, and HIV-related assessments and referrals. "Knowing your epidemic"[9] also means that you have identified behaviors and conditions most associated with HIV transmission—those that undermine the ability of vulnerable children and youth to access and use HIV information and services.

Programs will differ, however, depending on whether they are implemented in countries with a generalized, concentrated, or low-level epidemic. At a 2008 worldwide gathering in South Africa, FHI staff outlined four program scenarios based on national differences in the HIV prevalence rate and the size of the country's population: 1) high prevalence and high population; 2) high prevalence and low population; 3) low prevalence and high population; and 4) low prevalence and low population.

1. High HIV prevalence and high population

In these settings, it can be argued that all children are HIV-affected, either directly or indirectly. Directly, they could be HIV-infected or they could be affected through family illness or death. Indirectly, they could be affected by unfavorable living conditions that result from high HIV prevalence in their communities, perhaps through increased levels of poverty, the deaths of teachers and other professionals on whom they rely, and the elevated risk of HIV transmission from future sexual relationships.

In high prevalence and high population settings, programs need to be broad-based and holistic. They should try to meet the needs of the whole child, within the family context, by combining services such as educational support, protection, and psychosocial assistance. Additionally, all programs should promote HIV testing and treatment and include activities that reduce stigma, emphasize mutual care and support, and teach about HIV prevention. Programs in these settings should also work with the government to guide monitoring and evaluation research, policy, and legislation on key public health issues.

2. High HIV prevalence and low population

In these settings, programs should target specific localities where people at risk of HIV gather, such as stops along truck-routes and at community centers and shopping areas. Similarly, programs should focus on children whose parents are in especially vulnerable

KENYA High prevalence and high population	INDIA Low prevalence and high population
In Kenya, FHI has pioneered an innovative approach to serving children and families made vulnerable by HIV. Known as Nuru Ya Jamii (or light of the family in Swahili), the approach is family-centered and child-focused: all members of a household are targeted with a comprehensive package of prevention, treatment, care, and support services. The goal is to reduce vulnerability of household members to new HIV infections, maximize access to treatment, and prevent or delay the incidence of orphaning. One key challenge faced has been training and sustaining community volunteers to the point that they can offer comprehensive services to the entire household.	FHI/India's Balasahyoga Program aims to improve the quality of life of children and families infected and affected by HIV. Not all children are tested for HIV; a targeted approach is used. Entry points into the program include enrolment via self-referrals and through key community gatekeepers, community care centers, and centers that provide counseling and testing and antiretroviral treatment. At the same time, the program follows a holistic approach to child development, with comprehensive strategies on nutrition, education, food security, psychosocial wellbeing, and health. Trained community case managers and community assistants provide routine care for families and actively link them to social welfare and livelihood support services.
NAMIBIA High prevalence and low population	**GUYANA Low prevalence and low population**
With HIV prevalence rates among pregnant women hovering between 17 and 21 percent over the past six years (according to the Ministry of Health and Social Services), virtually all Namibian children are considered vulnerable to HIV. Most government programs focus on primary-school children, as they are the easiest to reach. Based on a long history of social action, however, Namibia's churches and faith-based organizations have come to play a huge role in community mobilization, prevention, and care, especially in mobilizing volunteers to help PLHIV in the community or care for orphans left behind. The majority of orphans are teenagers, and they are also the most at risk for new infections. Many church groups also spearhead HIV-related youth programs and prevention sessions. Not all clergy are committed, however, and the linkage between care, treatment, and prevention sometimes poses difficult theological challenges.	Prior to 2004, Guyana had no HIV-related program for orphans and vulnerable children. Since then, donor targets for reaching vulnerable children have been surpassed. Children are reached through sites that offer HIV counseling and testing and services to prevent mother-to-child transmission of HIV. Other vulnerable children are reached through door-to-door outreach campaigns, community home and palliative care services, and self-identification. The main challenge is stigma and discrimination: people don't want to be seen entering buildings associated with HIV services. The best approach has been for volunteers and others to go people's homes in unmarked clothing and unmarked vehicles. Retaining volunteers has been a challenge, especially for local NGOs.

groups, such as commercial sex workers, refugees, or migrant workers. The same approach may be used as in a high prevalence and high population setting, though it may be easier to work more intensively with each child. Strategies should also focus on maximizing access to available government services, including healthcare, education, and social welfare benefits.

3. Low HIV prevalence and high population

In these settings, the key focus is to minimize the spread of HIV among populations who are currently vulnerable. HIV prevention education and stigma reduction should be mainstreamed into all care and support activities, and targeted assistance should be directed to children and families already infected or affected by HIV. Supportive government policies are critical. These should address underlying conditions and concentrate on training, early identification of symptoms, and testing and treatment.

4. Low prevalence and low population

In these settings, most attention should be focused on broad public health issues, community education, and supportive public policies. The alternative is to target services very carefully to those already infected or affected and to others who are considered at greatest risk.

Four models of care and support programming

FHI has identified four models of child care and support programming to may help you to focus on your target group and approach: 1) the family-centered care model; 2) the comprehensive, child-focused model; 3) the single-service model, and 4) the alternative-placement model.[10] Of these, the first and second are most often recommended, as children are best able to cope with their own vulnerabilities when parents or adult caregivers are healthy and able to support them and multiple needs are addressed simultaneously. Alternative placement is a model of last resort, when all the other options fail.

1. The family-centered care model, the most preferred option, targets the needs of both adults and children in a family and attempts to meet their other social care needs, either directly or through strategic partnerships. For example, families affected by HIV (or another disease) need a range of services and support: health, nutrition, education, legal, and child protection services, along with shelter and economic, psychosocial, and spiritual support for the household. Depending on the context, the term "family" may mean the child's birth-family, the household where the child currently lives, or the child's extended family.

2. The comprehensive, child-focused model addresses multiple needs among highly vulnerable children, and very few interventions, if any, directly address the needs of adult caregivers. School-based and community-center programs generally take this approach. However, regular contact with family members is still critical to determine the children's needs and for follow-up support. This model generally does not separate orphaned or HIV-affected children from others, which helps to reduce stigma and discrimination.

3. The single-service model targets a specific gap in capacity or in the services available for orphaned and vulnerable children. Their need for free education is one example. Single-service programs tend to make a broad impact among many children, but they may fall short if there are underlying issues, such as hunger or child exploitation in the home. Even if the program can't meet all the child's needs, it should incorporate wherever possible a home assessment to determine if referrals to other community providers are indicated, with subsequent follow-up.

4. The alternative-placement model targets children living outside family care. Although this model represents a last resort for children (after efforts are made to promote care by relatives and foster care), it can provide short-term placements for children who are abandoned, have experienced abuse, have no family left, or present very severe disabilities with which their families cannot cope. FHI programs have embraced a range of strategic solutions to transition residential care to a safe, temporary solution for a few, rather than a permanent solution for too many.

Ensure that children are cared for in the least restrictive environment possible

In many countries, national plans of action for orphans and vulnerable children almost always state that the institutionalization of children in orphanages or residential care should be a last resort. Notwithstanding, new orphanages and group homes are mushrooming, and their quality of care varies widely, at best.

Technical assistance may be required to ensure that children are cared for in the least restrictive environment possible. Help should be offered to the relevant government ministry to develop recommendations, implement new policies and procedures that minimize the number of institutionalized children, and ensure proper standards are upheld in orphanages and group homes. This may include—but should not be limited to—new regulations to properly screen children before their admission to orphanages, policies on family reunification, a renewed focus on alternatives to institutional care (such as foster care) and requirements for staff training and other quality-of-care standards. Once regulations are in place, a rigorous process must be implemented to communicate, monitor, and enforce the new policies and procedures around the country.

Table 6. Comparing family care with institutional care

ISSUE	FAMILY CARE, INCLUDING FOSTER CARE AND KINSHIP CARE WITH RELATIVES	INSTITUTIONAL CARE (ORPHANAGES OR RESIDENTIAL CARE)
COMMITMENT BY CAREGIVERS	Family caregivers have a long-term perspective on children in their care. Caregiving is part of a network of inter-relationships.	Paid child minders turn over frequently, so children can't bond with them long-term. Most paid staff see children only on a short-term basis (a few hours a day and possibly for just a few weeks or months), so they remain disconnected from the long-term issues in children's lives.
SENSE OF BELONGING	Children remain connected to extended kin and the community and are helped to maintain their lineage and inheritance.	Children have little or no connection with extended kin and the community except through school. They are likely to lose their individual identities and inheritance.
ROUTINES AND RITUALS	Family rituals and routines, where individuals have culturally demarcated roles and responsibilities, help children to participate meaningfully in the family and society.	The routines and rituals of institutions often serve the institutions rather than the children, making it more difficult for former residents to adjust to life outside the institution.
CHILD ABUSE	Though most family care is excellent, vulnerable children in poorly chosen family care may be physically and sexually exploited or abused.	In many institutions, children experience neglect, exploitation, and physical and sexual abuse. Children are especially vulnerable in institutions with very few staff or high staff turnover.
ENVIRONMENT	Children are connected to their extended families, communities, and culture and are more likely to maintain their lineage and inheritance. They are familiar with cultural rituals and routines.	Connections to the surrounding environment and culture are limited, and children are more likely to lose their identity and inheritance. Routines and rituals often serve the institutions rather than the needs of the children.
NUMBERS SUPPORTED	The great majority of HIV-affected children are cared for and supported by relatives.	Only a small number of vulnerable children can be accommodated in institutions.
COST OF CARE	Families provide care for children at relatively low cost; small amounts of income-support for these families benefit the children.	Consistently, institutional care is far more expensive than family care.

Programs should also promote family reunification wherever possible.

Family and community care, rather than institutional care

In the developing world, orphans were traditionally taken in and looked after by their extended families, but orphanages have become more commonplace in recent times, as the number of orphans has skyrocketed due to war, famine, and the HIV pandemic.

Children raised in orphanages—also known as residential or institutional care—are separated from their families and communities, and this often results in unhealthy child development. Studies show that the long-term institutionalization of children is generally counterproductive and that it should only be a very last resort.[11] When orphanages have to be considered—preferably on a short-term basis—the settings should mimic a family arrangement as far as possible—for example, a small-group cottage with its own house parents.

Resources that pay for institutional care for a single child can assist scores of children, if used effectively to support a community-based initiative. Funds used to build and run an orphanage could be spent fostering children with grandparents or other relatives and paying allowances to these caregivers. If no family members are able to take on this role, children can be fostered with non-relatives, but still in a family

setting. If older orphans would do better in towns where they can learn a trade, other living arrangements in the community should be identified—for example, in hostels or with host families.

Community-based family care differs from institutional care. While some residential-care settings aim to blend the two by incorporating some family-like features (for example, by assigning several children as "siblings" under one set of house parents in a separate cottage on the institution's grounds), many distinctions remain, as table 6 shows.

Admittedly, institutional care may be preferable, at least on a short-term basis, when children are at risk of abuse or there is no caregiver at home to look after a severely ill child. Even in these situations, all other viable options should be explored first. If a child must be institutionalized, it is best to minimize the length of stay. If suitable family members can't be found to take in the child, a transfer should be made to alternative forms of care, such as foster care, adoption, or a small group home.

Including children with special needs

Practitioners providing input for this manual highlighted three situations that often require special planning and additional support: 1) child-headed or youth-headed households; 2) children with disabilities and children living with HIV; and 3) children who have been recruited as a child soldiers or have experienced trafficking, forced migration, or abuse.

To ensure that these groups of children are not left out and not institutionalized unnecessarily, the practitioners recommended that supplemental efforts be undertaken to support children in these groups. Although their special challenges could require another manual, it needs to be emphasized that these children have the same rights and similar core needs, concerns, and dreams as every other child, and efforts should be undertaken to include them in your programming to the extent possible.

A Story by Cathy Majtenyi

It is lunchtime for the Kametis. Agnes Nzembi and her four grandchildren exchange stories of the day. They live in Nyumbani Village near the eastern Kenyan town of Kitui. But this is a different kind of village.

The Kametis and 28 other households are run by an elderly grandparent. The grandparent takes care of up to 11 children. Some of the youngsters are their biological grandchildren. The rest are children from other families. Kavata Kameti says she enjoys living with her grandmother, "She tells me about our forefathers and things that happened in the past. Also she tells me about how to live a good life," she said.

All the young people in the village have one thing in common. Their low-income parents died of HIV/AIDS, turning them destitute and into orphans.

Sister Mary Owens, co-founder of Nyumbani Village, says the village grew out of a concern for the welfare of AIDS orphans and their elderly caregivers.

"These are two lost generations, because the grandparents have been left behind by their children, and the children have been left behind by their parents," she said. "So there is a need to reach out to these grandparents. Secondly, this idea of trying to give these children as close experience of family as possible, we thought that the grandparents could do that, because they can hand out the values, they can share the culture, and they can guide."

During the day, the children attend primary school in the village. When they are not studying, they work in the garden, cook, and do other chores.Sister Owens says Nyumbani Village aims to be self-sustaining by growing its own food, cultivating income-generating plants such as castor and jatropha, creating its own water supply, and providing services to its residents.

"In a village, you have services, and we knew that if we could set up services like education and medical services at the clinic, and a polytechnic, then those services would be very accessible to the children," she said.

For grandmother Agnes Nzembi, living in Nyumbani is a dream come true. "Before this, we were living in poverty," she said. She says she is teaching her grandchildren to be responsible now so they will be responsible adults later.[12]

Child- and youth-headed households

Only a few years ago, the term "child-headed household" was virtually unknown, but such households, headed by a child 18 and under, are now almost

Child and youth-headed households

There are child-headed households in many parts of the world affected by disease or war. Sometimes, a household is child-headed because the adult in the house is frail, ill, or severely disabled. In these households, it is usually the eldest child (or the eldest girl-child) who takes on the responsibilities traditionally borne by parents. These households face a wide range of challenges related to poverty, education, and psychological distress. Foster care is often seen as a better alternative, but it should be pursued only if it is in the best interest of the children. Wherever possible, siblings should be kept together, not separated.

Many people feel that child-headed households are evidence that the extended family system is collapsing and failing to cope. While it is generally true that members of extended families are unable to take children into their own homes (most often because they are too poor themselves), most child-headed households continue to receive some support, albeit sporadically, from extended family members. Child and youth-headed households can also be assisted by a variety of other support mechanisms, including regular visits by community volunteers, modest levels of material support, assistance with health-related and educational needs (including with attending school), government cash-transfer grants, psychosocial support programs, and training in effective parenting.

commonplace in some communities. Even more prevalent are homes headed by youth ages 18–25 who shoulder such weighty responsibilities that they are unable to concentrate on their own lives and future plans. Coupled with extreme poverty and a lack of parental guidance, children living in child- and youth-headed households are at high risk of early pregnancy and marriage, sexually transmitted diseases including HIV, exploitation, juvenile delinquency, and other self-destructive behaviors.

One might then ask, “Wouldn’t the children in these households be better off in an orphanage? For most, the answer is no. A study by Monica Ruiz-Casares found that most children without adult caregivers want to remain in their homes and in their communities, where their memories are intact.[13] Evidence that this is so was provided by a 14-year-old head of a household in rural Tanzania who asked Lucy Steinitz, “Do you want to meet my parents?” then took her to two graves at the back of the hut. The young woman explained, “I come here every day to visit. We spend time together and I talk to them.”

Child- and youth-headed households rely heavily for guidance and support on their social networks—neighbors, distant relatives, caring community members, traditional and religious leaders, local volunteers, NGO representatives, and teachers.[14] To help, you can provide targeted training and follow-up support on how to manage a household and care for younger siblings and how to determine where and how to ask for outside assistance. This can make an enormous difference. But without this additional support, most child-headed households can’t survive, and the children living in them are likely to end up exploited by others or living on the street.

Children with disabilities

Children with disabilities (sometimes called children with special needs) are often forgotten or hidden from view, largely because of feelings of shame, mistaken beliefs that they are bewitched, or other superstitions. Disabilities vary in the degree to which they impede a child’s normal functioning, if they do at all; they may be physical, developmental, psychological, or a combination thereof. In the developing world, children with learning disabilities and children who are slow learners or live with other more subtle forms of disability often get overlooked, given the prevalence of poverty, overcrowded classrooms, health constraints, shortages of experienced teachers, lack of teaching materials, and low school expectations.

All children with disabilities have one thing in common. Although the amount of additional care they require may vary, they all need more support than other children do, at least for some period in their lives. In addition to accepting and loving these children, family and community members should be trained on ways to build on their strengths and abilities—to focus on what they can do, rather than on what they can’t.

Organizations that serve vulnerable children and youth—even if they don’t themselves focus on disabilities—should be familiar with local services available for people with disabilities so they can link children to these services whenever the need arises.

Input from children on a guide for child- and youth-headed households

In Namibia, during the planning process for a guide for child- and youth-headed households, children and youth suggested the following modules: Caring for Younger Siblings and Yourself; Being Smart about Money Matters and the Things You Own; and Building Helpful Community Relationships.[15]

Some facts about children living with HIV

Many countries that had previously seen child survival rates rise as a result of improved healthcare are now seeing these rates fall due to HIV. Most children with HIV live in sub-Saharan Africa, but large numbers also live in the Caribbean, Latin America, and Asia. At the end of 2007, there were 2 million children living with HIV around the world.

An estimated 370,000 children became infected that year, most as a result of mother-to-child transmission. Children are also at risk for HIV through early unprotected sex, sexual abuse, and child prostitution. Every hour, at least 31 children die from AIDS-related illnesses.[16]

Working in collaboration with special schools, support groups, NGOs, and government ministries, individual family and community members can also be mobilized to participate in community action, support services, and advocacy for the rights of all children with special needs.

Children living with HIV

HIV-positive children contend with all the stresses of children whose family member or close relative is living with HIV or has died of AIDS-related illnesses, as well as facing their own health-related issues, stigma, and psychosocial challenges.

The main way to stop children becoming infected is to prevent mother-to-child transmission. This is almost entirely avoidable by giving antiretroviral drugs to HIV-positive pregnant women and to their newborn babies and ensuring safe infant feeding. However, the services that prevent mother-to-child transmission reach only 33 percent of HIV-infected pregnant women in resource-poor countries.[17]

The integration of prevention education constitutes an important dimension of any program that provides care and assistance for vulnerable children and youth. To minimize new infections, children must also be protected from physical violence and child sexual abuse, from unsafe (unprotected) sex, and from intravenous drug use.

Death from AIDS-related illnesses among children can usually be prevented with proper care and antiretroviral treatment, but an estimated 90 percent of children who could benefit from this therapy are not yet receiving it.[18] As with other programs that aim to serve children, the whole family should be targeted for treatment and support to ensure success. Although there is a high risk of death in the first year of life for infants infected perinatally, be aware that undiagnosed children may live with asymptomatic HIV infection for long periods. Even so, the World Health Organization recommends that all children with HIV should be placed on antiretroviral therapy as soon as possible after diagnosis. Because of this, counseling and testing for HIV are critical services for all children considered at risk for infection.

If your organization does not provide treatment services, you should establish linkages with counseling and testing centers and healthcare facilities to which you can refer children and family members. Local organizations can also collaborate with health facilities by implementing community-based interventions that promote health-seeking behaviors and adherence to treatment. This manual does not cover clinical treatment, but it lists several websites and other sources that provide more information.

Good literature can be found to help practitioners working on issues of disclosure, treatment, and support. Disclosure—explaining that the child or another family member is HIV-positive—is particularly sensitive but absolutely critical in order to maximize acceptance, adherence to treatment, and a healthy lifestyle. One useful resource is FHI/India's *Protocol for Child Counseling on HIV Testing, Disclosure and Support.*[19] Another is *Kids ART Education Series: The Children's Treatment*

How you can assist children with disabilities

Providing training to family members and volunteers on the care and support of children with disabilities involves experiential exercises, the active participation of persons with disabilities, and references to relevant cultural or religious traditions that accord respect and acceptance to people with disabilities.

Children and youth with disabilities have the right to be educated and need to be treated in the same way as other children, although they may need some additional support to participate to their maximum ability. Special attention may also be required to identify and pursue vocational opportunities so that these children can become as independent and self-supporting as possible when they are adults.

To promote independence, encourage parents and caregivers to allow disabled children to learn to help themselves and struggle to do things, even if it would be faster for someone else to do them. Also encourage parents, caregivers, and siblings to allow disabled children to play with other children. They will benefit from learning about tolerance, helpfulness, and respect for others, as will neighbors and friends who help a disabled child by making aids such as crutches or special toys.

Literacy Toolkit from SAfAIDS,[20] which contains a board game and quiz sheets, an adherence calendar, advocacy stickers, information on TB co-infection, and informative and attractive booklets. The recommended reading list and appendix 1 contain references to additional information and training materials that address HIV-positive children and their caregivers.

Recommended readings and toolkits

- Family Health International/Cambodia, ***Helping My Child Stay Healthy: For Carers of HIV Positive Children***, 2009.
This publication provides information on the special needs of HIV-positive children, suggests ways to involve them in their own care, and includes practical suggestions for health-facility and home-based care teams who work with children, regardless of HIV status. www.fhi.org/en/Topics/Orphans+and+Other+Vulnerable+Children+topic+page.htm

- Family Health International/Cambodia, ***Playgroup Resource Book***, 2009.
This publication provides guidance to implementing agencies and community care assistants on how to run playgroups for orphans and vulnerable children as well as other children. www.fhi.org/en/Topics/Orphans+and+Other+Vulnerable+Children+topic+page.htm

- Family Health International/Cambodia, ***What Can I Do if I Think My Child Has HIV?***, 2009.
This publication provides suggestions about ways to talk to HIV-positive children about HIV and involve them in their own care. It also encourages parents to visit a voluntary counseling and testing clinic with their children. www.fhi.org/en/Topics/Orphans+and+Other+Vulnerable+Children+topic+page.htm

- Family Health International/India, ***Protocol for Child Counseling on HIV Testing, Disclosure and Support***, 2007.
This protocol was developed for 30 USAID-funded IMPACT projects in India to provide guidance on counseling children and their parents or guardians about HIV and AIDS. It embraces a holistic approach and considers the disease as one among many other issues in a child's life. www.fhi.org/en/CountryProfiles/India/indiatools.htm

- Guyana HIV/AIDS Reduction and Prevention (GHARP) Project. ***Counseling Children Manual. Working Document***, 2008.
This manual developed by FHI in Guyana includes learning aids and guides facilitators of a one-week training program with five modules and 23 sessions. The training addresses the stages of personality and child development, including children's social/emotional, intellectual/cognitive, psychomotor, and spiritual development.

- Aini N. Hoaeb and Aune S. Iiyambula with Lucy Y. Steinitz, ***Our Home Is Where the Heart Is: A Young Homemakers' Guide***, 2008.
This resource targets child-headed and youth-headed households in Namibia. www.yelula.com/resources.htm

- HelpAge International. ***Salt, Soap and Shoes for School. Evaluation Summary: The Impact of Pensions on the Lives of Older People and Grandchildren in the KwaWazee Project in Tanzania's Kagera Region***, 2008.
This evaluation summary offers a detailed analysis of how the welfare of Africa's aged population is closely intertwined with the survival and wellbeing of vulnerable children and impoverished orphans and provides recommendations. www.helpage.org/Resources/Policyreports#n54d

- Horizons Project/ Population Council, ***Psychosocial Benefits of a Mentoring Program for Youth-headed Households in Rwanda***, 2007.
This quasi-experimental study showed that mentoring from adults can measurably mitigate adverse psychosocial outcomes among youth-headed households. www.popcouncil.org/horizons/projects/Rwanda_PsychOVC.htm

- Vinod Mishra and Simona Bignami-Van Assche, ***Orphans and Vulnerable Children in High HIV Prevalence Countries in sub-Saharan Africa***, 2008.
This source contains comparative data based on in-depth, in-country surveys. http://pdf.usaid.gov/pdf_docs/PNADM647.pdf

- Sara Liane Nam et al., "Discussing matters of sexual health with children: What issues relating to disclosure of parental HIV status reveal," ***AIDS Care***, 2009. http://dx.doi.org/10.1080/09540120802270276

- SAfAIDS, ***Kids ART Education Series: The Children's Treatment Literacy Toolkit***, 2008.
A fantastic resource and a set of excellent tools, with practical exercises and activities for HIV-positive children and their caregivers. www.safaids.net/?q=node/520.

- Southern Africa AIDS Trust, ***Guidelines for Counselling Children Who Are Infected with HIV or Affected by HIV and AIDS***, 2003.
An excellent and very practical old standby. www.satregional.org/content/publications_en.html

3. Core Services for Children and Families

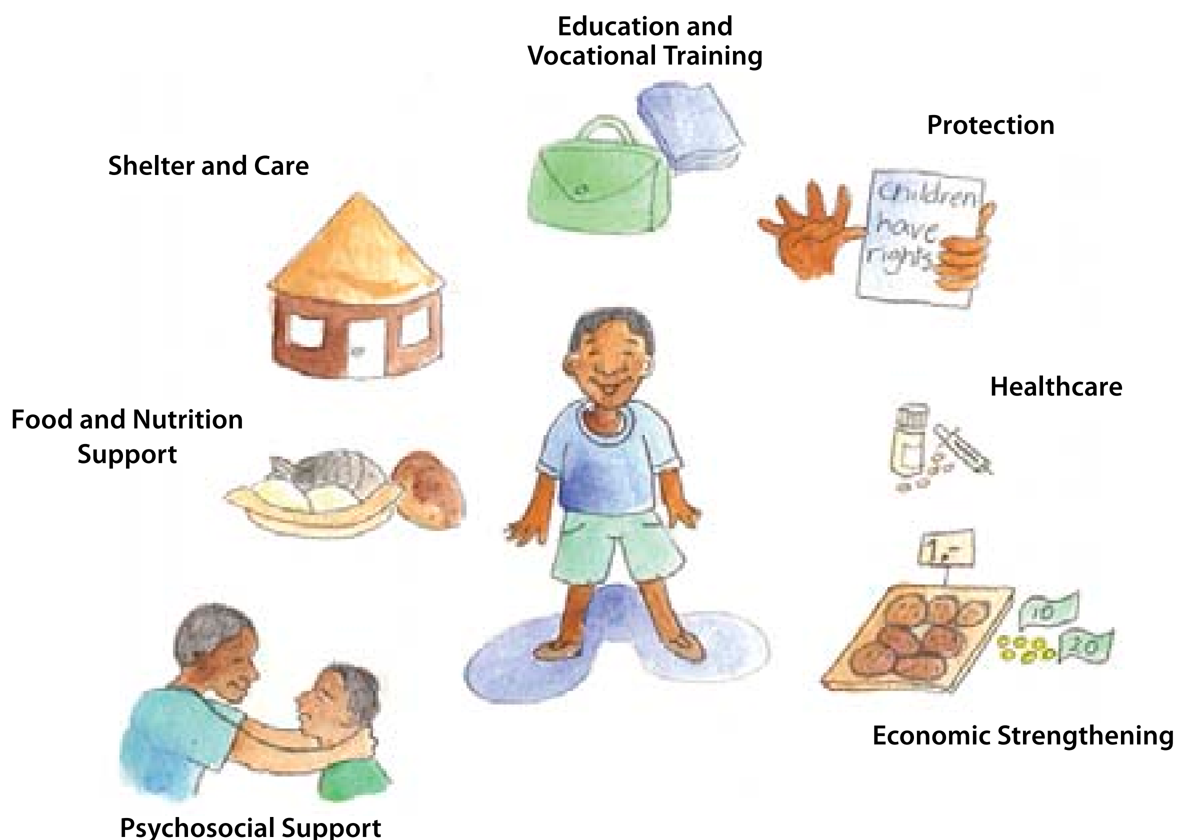
Now that you have taken into account a range of underlying principles and alternate models of care (II, chapters 1, 2), you need to begin to consider what types of services or core service areas you want to incorporate in the design of your programs for children and families. Several core service areas have been variously defined in legislation relating to the US President's Emergency Plan for AIDS Relief (PEPFAR) and by other entities.

PEPFAR outlines seven core services for children that, taken together, address all of a child's basic needs. However, don't get stuck on the number; other donors also configure the range of services somewhat differently. In addition, various countries have developed national plans of action for vulnerable children that combine two or more of these services, and some add an additional one, namely the "coordination of services." Also, don't get stuck on the fact that the descriptions related to these core service areas focus on HIV. Although PEPFAR promotes this focus, the service descriptions are applicable in other situations.

Although you should consider all of these service areas in designing your program, it isn't necessary that every organization or every program provide all or even most of these services on its own. You should try to develop a good referral network so that different organizations and providers can supplement each other's support, depending on a child's needs. In addition, interventions may occur directly with the child and that child's caregivers, or at a community or systems' level. This may require the promotion of additional support on a broader scale with provincial or national policymakers, perhaps via legislation or new regulations. Similarly, you can try to mobilize the private sector, faith-based organizations, or traditional leaders (and others) to increase their involvement and support for vulnerable children and their families.

PEPFAR's core service areas

For the programs for orphans and vulnerable children that it funds, PEPFAR defines seven core service areas that take into account the needs of a whole child: 1) food and nutrition support; 2) shelter and care; 3) protection; 4) healthcare; 5) psychosocial support; 6) education and vocational training; and 7) economic strengthening. You can use these service areas as a guideline for planning and improving your programs. The services should be provided in accordance with



Should your organization try to provide all seven core services?

Your organization does not have to provide all seven core services. Rather, select one or more after you assess the services currently available in the community, the most urgent needs of vulnerable children, and your organization's strengths and capacity. Once you have assessed these factors and decided on the type and level of your interventions (whether through direct provision of care or referral and community mobilization), you should partner with other service providers to ensure that vulnerable children and their families have a network of comprehensive support. Chapter 5 in this section provides more information on conducting a community assessment and involving other key stakeholders.

the assessed needs of the child or children, within the context of their families and communities.

1. Food and nutrition services aim to ensure that vulnerable children have food resources and that their nutritional status is similar to that of other children in their communities. This should be conceived as a time-limited strategy, and your program should aim to leverage other partners and identify more sustainable solutions. The following range of services might be included at different levels:

- *child*—nutritional assessment and counseling; therapeutic and supplementary feeding; links to other health and nutrition interventions for treatment of moderate and acute malnutrition
- *caregiver/family*—assessment of nutritional status of adult PLHIV; therapeutic and supplemental feeding; training on nutrition, diet, and food preparation; food security interventions
- *community*—community-based food security and nutrition strategies to support vulnerable children, including gardens and feeding programs
- *system*—policy development; regional and national coordination; technical assistance to the food industry; availability and supply-chain management of ready-to-use therapeutic foods; advocacy

Assistance for food-insecure families and malnourished children

Some organizations partner with the World Food Programme to help deliver food packages to food-insecure households. Special ready-to-use foods (such as Plumpy'Nut) are used as treatment for moderate and severe malnutrition.

2. Shelter and care services have the desired outcomes of ensuring that no child goes without shelter, clothing, access to clean water and basic personal hygiene, and at least one adult who provides love and support. The following range of services might be included at different levels:

- *child*—identification of potential caregivers prior to the death of a parent; reintegration of children in institutional care; transitional care; support for child-headed households
- *caregiver/family*—assistance with reunification to take children off the street; referrals to programs that provide incentives for adoption; foster care
- *community*—support of family-based care with home visits and other strategies; development of innovative community alternatives when family-based care is not an option
- *system*—policy development; regional and national coordination; education; anti-stigma efforts; and monitoring of institutional care

3. Protection services have the desired outcomes of reducing stigma and social neglect, ensuring children have access to basic rights and services, and protecting them from abuse and exploitation. The following range of services might be included at different levels:

- *child*—assistance with birth registration and inheritance claims; prevention of sibling separations; removal of children from abusive situations and assistance to help them recover from abuse; prevention of forced migration and trafficking
- *caregiver/family*—support with parenting and caregiving responsibilities; assistance with access to services
- *community*—support for child protection committees; training of community members to identify and assist children who need assistance

Organizational child-protection policies and activities

Child protection has received insufficient attention from many organizations. Unwittingly, some programs may increase the risk of physical harm and abuse, such as when they require children to walk long distances to attend evening activities.

Organizations should be encouraged to consider adopting a policy that increases their own awareness of child protection and improves their support for it. The very practical system developed by FHI/Cambodia for preventing, monitoring, and responding to abuse is included among recommended resources at the end of this chapter.

- *system*—legal and policy development; advocacy campaigns to support laws and values that protect children.

4. Healthcare services have the desired outcomes of meeting the health needs of HIV-negative as well as HIV-positive children and providing primary healthcare, immunization, treatment of illnesses, ongoing palliative care, and HIV prevention services. The following might be included at different levels:

- *child*—home visits; enrollment in HIV care and treatment services; access to integrated primary healthcare services
- *caregiver/family*—training of caregivers in preventing diseases, monitoring health, and seeking appropriate care; involvement of caretakers in HIV-prevention education
- *community*—training of HIV-care providers, including community volunteers and home-based care teams, in how to refer children for health and social services
- *system*—policy development to ensure access and a service delivery model that meets the needs of vulnerable children

5. Psychosocial support services include supporting the spiritual needs of children. Their desired outcomes include ensuring that children have the human attachments necessary for normal development and can participate cooperatively with other children and adults in all kinds of activities. The following range of services might be included at different levels:

PEPFAR recommendations on key health interventions for vulnerable children

In general, programs should facilitate access to primary healthcare for orphans and vulnerable children and take active measures to meet the general health needs of children of all ages.[21] Needs differ significantly at different stages of a child's development (I, chapter 3), and interventions must be tailored to the age of the child.

Provision of HIV-related healthcare for HIV-exposed or HIV-infected infants is a high priority because over 50 percent of children born HIV-positive die within the first two years if they do not obtain appropriate treatment. Programs should ensure timely access to appropriate ART through referrals to services that reduce mother-to-child transmission and services that provide pediatric ART and palliative care. Community volunteers and home-based care teams need to be trained to identify danger signs in HIV-exposed and HIV-positive children so they know when to make referrals. Home-based care teams should also be trained to reinforce correct infant feeding, provide home-based care for minor opportunistic infections, and support cotrimoxazole and ART adherence for children and adolescents.

Prevention of HIV is a priority intervention in regions where the risk of infection is high. Programs should provide age-appropriate prevention activities for children, including services that prevent mother-to-child transmission of HIV and behavior change communication that is targeted to appropriate age groups.

- *child*—counseling; support in dealing with anxiety, grief, and trauma related to parental illness and death; services to prevent and treat alcohol and drug abuse and rehabilitation for children who abuse drugs and alcohol; activities that support life skills and self-esteem; activities that strengthen the connection between the child and traditional social networks
- *caregiver/family*—parenting and communication skills; support during illness, such as assistance with disclosure of information, grief management, succession planning, and preservation of memories; assistance for caregivers coping with stigma and discrimination
- *community*—services that increase community understanding of the psychosocial needs of vulnerable children; activities that lead to the reduction of stigma and discrimination
- *system*—support for laws and policies that lead to national social welfare and care management systems for vulnerable children, including trained child counselors; provision of trained counselors

within schools to identify at-risk children in need of psychosocial support

6. Education and vocational training services have the desired outcome of ensuring that vulnerable children receive educational and vocational opportunities that correspond with community norms and market-driven employment options. The following range of services might be included at different levels:

- *child*—school registration initiatives; direct assistance to subsidize school costs; creation of early childhood development programs; access to vocational training and employment;
- *caregiver/family*—training of health providers and caregivers to identify and refer children who are not in the educational system; anti-stigma campaigns
- *community*—community mobilization and advocacy related to increasing access and developing appropriate curricula (introduction of life skills and job skills)
- *system*—support services such as fee-waivers, referral to psychosocial support, and tutoring

7. Livelihood or economic strengthening services have the desired outcome that families are able meet their own material needs, in spite of changes in the family situation due to HIV. Such services can include helping families to obtain more efficient cooking stoves or improved water-collection devices that reduce the strain on children and caregivers, especially those who are elderly or frail. The following range of services might be included at different levels:

- *child and caregiver/family*—vocational training for caregivers; income-generating activities; labor-saving devices; access to credit
- *community*—community-based child care and asset-building
- *system*—government-supported guarantees for income-generating activities and microfinance institutions

Note that some analysts add coordination of care as an eighth service. Others say that activities related to prevention and sustainability—the empowerment of families to function without ongoing support—should be integrated with other services whenever opportunities arise.

Addressing cross-cutting issues in program planning

Much has been learned worldwide on how best to structure and deliver essential services to children and families in need. While each context is unique, programs can build upon common elements to ensure strong systems and high-quality services.

FHI's checklist of cross-cutting issues for all affiliated programs (table 7) may be helpful to organizations engaged in planning, training for field-visits, and in monitoring and evaluation. It supplements FHI's Standards of Care (III, chapter 5).

If there is no social worker in your village, find another grown-up who can help—maybe from the Village Welfare Committee or OVC Forum, or a teacher at your school.

Petrina, 14

Recommended readings and toolkits

- Lorraine Blank and Sudhanshu Handa, ***Social Protection in Eastern and Southern Africa: A Framework and Strategy***, 2008.
A report for UNICEF that suggests that well designed and fairly distributed social-welfare protection schemes may make a positive difference on a broad scale.
www.unicef.org/socialpolicy/index_45350.html

- Family Health International/Cambodia, ***Child Protection Policy & Procedures***, 2007.
This detailed child protection policy outlines procedures for preventing and responding to child abuse, both within FHI/Cambodia and the communities with which it works. The policy is accompanied by a training manual and tools to guide implementation of the policy. www.fhi.org/en/HIVAIDS/pub/res_ChildProtectionPolicy.htm

- Geoff Foster, ***Bottlenecks and Drip-feeds: Channeling Resources to Communities Responding to Orphans and Vulnerable Children in Southern Africa***, 2005.
This briefing document by Save the Children/UK identifies bottlenecks affecting the flow of funds to support community initiatives. It states that current mechanisms do not allow for resource flows to community-based organizations. Donors and governments do not take the provision of such resources seriously and are not held accountable for spending to support community initiatives. www.hsrc.ac.za/Document-2179.phtml

- International HIV Alliance, *Expanding Community-based Support for Orphans and Vulnerable Children*, 2002.
This publication includes case studies and addresses topics such as support for community-based

Table 7. Checklist of cross-cutting issues for implementing partners working with children

SAFETY
• All new clients and staff are made aware of the child-protection policy and procedures of the organization or country. • Areas used for project activities are safe for children and youth (non hazardous, well-lit, guarded).
PARTICIPATION
• Beneficiaries (PLHIV and/or vulnerable children and youth) are involved in the design and monitoring of activities that affect them. • Children, youth, and their families are involved in decisions about their individual care to the greatest extent possible.
CONFIDENTIALITY
• The child's and family's right to privacy is protected. Appropriate confidentiality is maintained when information is released to others, especially relating (but not limited to) sensitive topics, including HIV status, sexuality, sexual orientation, and abuse. • Documents containing information about health and HIV status are kept in a secure place in the organization's main office and are shared only to serve the best interests of the child.
EQUITY
• Girls served by the organization are ensured equal status with boys. • The organization is responsive to the needs of children across the age span, including and especially those often missed by programs: the youngest (ages 0–5) and oldest (ages 14 and over). • All children and youth within client households have the opportunity to benefit from the program according to need.
COMMUNITY OWNERSHIP
• Proposed interventions build on existing community structures, thereby enabling the community to benefit in the long-term, not just during the activity period. • Community members are actively encouraged to share in planning and implementation. They have input in decisions about the organizations' services that provide care and support for vulnerable children and youth.
COST EFFICIENCY
• Costs are carefully monitored to ensure that the maximum number of children who are in need benefit from resources available, but within the context of quality standards.
CULTURAL SENSITIVITY
• Programs respect and are appropriate to the diverse social and cultural contexts of local communities.

organizations and NGOs involved in community responses and the creation of an enabling environment for scale-up. www.ovcsupport.net/graphics/OVC/documents/cp/0000900e00.pdf

■ Florence Nyangara, Tonya R. Thurman, Paul Hutchinson, and Walter Obiero, ***Effects of Programs Supporting Orphans and Vulnerable Children: Key Findings, Emerging Issues, and Future Directions from Evaluations of Four Projects in Kenya and Tanzania***, 2009.
This report summarizes key findings from a MEASURE evaluation of the results and cost-effectiveness of interventions in Kenya and Tanzania to improve the wellbeing of orphans and vulnerable children and their families. The study may have broad implications for the quality of care for children in East Africa and beyond. www.cpc.unc.edu/measure/publications

■ UNICEF, ***Africa's Orphaned Generations***, 2003
This seminal study compares different countries, but offers common recommendations for policymakers, donors, and local organizations and communities. The statistics have changed—largely they have gotten worse—but the issues have not. http://unicef.org/africas_orphans.pdf

■ UNICEF, ***The Evidence Base for Programming for Children Affected by HIV/AIDS In Low Prevalence and Concentrated Epidemic Countries***, 2008.
The evidence-base is spotty for programming for HIV-affected children in countries with low prevalence and

concentrated epidemics. In general, stigma is greater in low-prevalence countries than in countries with high HIV prevalence. www.unicef.org/aids/files/OVC_final.pdf

- UNICEF, ***The Impact of Social Cash Transfers on Children Affected by HIV and AIDS: Evidence from Zambia, Malawi and South Africa***, 2007.
This detailed analysis demonstrates that appropriately designed, social cash-transfer schemes in low-income African countries with high HIV prevalence can reach approximately 80 per cent of HIV-affected households that urgently require social welfare interventions, even without using HIV and AIDS as targeting criteria.
www.unicef.org/publications/index.html

- World Health Organization and UNICEF, ***Scale Up of HIV-related Prevention, Diagnosis, Care and Treatment for Infants and Children: A Programming Framework***, 2008.
Despite documented progress in the ability to deliver high-quality care to children living with HIV, national responses are limited in many resource-constrained settings. This working document identifies seven strategies that are key to scaling up national responses.
www.unicef.org/aids/files/OMS_PAEDS_Programming_Frameworks_WEB.pdf

- World Vision, ***Research Results from Child-focused, Faith- and Community-based Responses to HIV***, 2008.
This report presents research findings from Uganda and Zambia on the operation of World Vision's main project models that respond to HIV and AIDS in higher prevalence contexts. It includes research abstracts on other innovative program approaches and World Vision research around the world. www.worldvision.org

- Miriam Zoll, ***Integrated Health Care Delivery Systems for Families and Children Impacted by HIV/AIDS: Four Program Case Studies from Kenya and Rwanda***, 2008.
www.jlica.org/resources/publications.php

In addition, check out the websites listed in appendix 1, including www.aed.org; www.cabsa.org.za; www.pact-world.org; www.pronutrition.org; and www.taskforce.org

4. Laying the Groundwork

To determine the needs of vulnerable children and their families in a given geographic area and develop realistic, effective, and feasible interventions, begin with a situation analysis. This will give you a deeper understanding on where and how to focus your support and help you determine what other resources are available in the community that can supplement your efforts.

A situation analysis builds on what you already know and incorporates new information, stakeholder input, updated environmental trends, and additional issues relevant to the work you want to do. If a situational analysis was recently completed by your organization or a similar one, there is no need to repeat the process. Focus instead on important updates or gaps in knowledge.

Once you have identified unmet needs through your situation analysis, it may also be necessary to conduct an organizational assessment to determine the interventions that best fit your organization and the challenges it faces. These two processes—a situation analysis and an organizational assessment—are discussed in this chapter.

Conducting a situation analysis

A situation analysis is a process of gathering and analyzing information to guide planning and mobilize action. In the context of children and families affected by HIV (or any other life-threatening condition), a situation analysis involves gathering information about the epidemic, its consequences, coping responses of households and communities, and relevant policies and programs.[22]

A situation analysis should be collaborative and engage all key stakeholders, including government ministries, NGOs, international aid organizations, faith-based organizations, the public and private sectors, community groups, families, and children. The results guide the identification of geographic and programmatic priorities, as well as the development of sound and shared recommendations.

Sample questions to ask during a situation analysis

The following questions ask about the biggest unmet needs in a community and what might be done to improve the situation.[23] You can change these questions or add new ones.

1. What do you see as the biggest problem facing this community?
2. What do you think is the main cause of this problem?
3. As you see it, what effect has this problem had on the community?
4. Specifically, how does this problem affect you and your family?
5. To what extent, if any, do you think HIV and AIDS makes this problem worse?
6. What do you think a local NGO can do to improve this situation?
7. Can you make some suggestions about how this improvement should be done?
8. What more could you personally do to help your community deal with problems caused by HIV and AIDS?

FIG. 4. ELEMENTS OF A SITUATION ANALYSIS

	PLANNING	INFORMATION GATHERING		ANALYSIS
		National Level	Local Level	

ACTIVITIES	• Engage all key actors
	• Define
	  ◦ objectives
	  ◦ technical scope
	  ◦ geographic coverage
	  ◦ process and participation
	  ◦ skills needed
	  ◦ budget(s)
		Collect and review existing
		• reports and other documents
		• statistics
		• programs
		• interviews of key informants
			• Collect reports and statistical information.
			• Carry out focus group discussions in priority areas.
			• Interview key informants.
				• Identify
				  ◦ most urgent problems
				  ◦ causes
				  ◦ local responses, coping strategies, and capacities
				  ◦ key aspects of context
				• Identify potential intervention strategies and measures.

OUTPUTS	A written plan that includes responsibilities of each participating body, with a line item budget.	• A full overview of
		  ◦ problems
		  ◦ context of problems
		  ◦ local responses, coping strategies, and capacities
		  ◦ relevant laws and policies
		  ◦ relevant services
		• Initial mapping of
		  ◦ most seriously affected populations
		  ◦ service areas of existing programs
			• In-depth understanding of
			  ◦ problems
			  ◦ context of problems
			  ◦ coping strategies
			  ◦ current and potential programmatic action
			  ◦ relevant laws and policies
			  ◦ services
			• Refined information on coverage of existing services.
				Report containing
				• overview of problems
				• identification of priority issues, capacities, and resources
				• identification of key intervention points
				• recommendations for action
				• key information and sources for ongoing monitoring

From J. Williamson, *What can we do to make a difference? Situation analysis concerning children and families affected by AIDS* (draft), Oct. 2008.

A situation analysis differs from other types of needs assessments. Generally, a needs assessment is narrower in scope; it focuses primarily on existing problems and what needs to be added or scaled up in order to address them. By contrast, a situation analysis identifies priority issues within the context of a complex environment. It also considers the underlying dynamics, with a broad view toward identifying potential points of intervention. Thus, with a situation analysis you are more likely to deal with the causes of current problems, not just immediate needs or symptoms. Additionally, a situation analysis focuses on capacities. It identifies not only current policies and relevant services, but also current and potential stakeholders.

A situation analysis can be undertaken at different levels: in a community, district, state, or province, or on a national or regional basis (fig. 4).

What if the government doesn't want to cooperate or places restrictions on your activities?

Sometimes in-country laws, policies, attitudes, and conflicts can make it difficult for civil society to foster a high level of collaboration and mutual support. In these cases, you must think creatively and do the best you can.

Work closely with other organizations that seem to have maintained good linkages. Be extra sensitive to local culture and protocol and build on existing relationships, wherever possible. Aim to find common values and issues of mutual interest. Reframe some of your terminology if needed, so long as you don't seriously compromise the integrity of your program. Never employ illegal methods or even leave the impression that you have done so. You could create lasting damage to your program and hurt the children you most want to help.

Sample questions to ask during a situation analysis

The following questions ask about the biggest unmet needs in a community and what might be done to improve the situation.[23] You can change these questions or add new ones.

- What do you see as the biggest problem facing this community?
- What do you think is the main cause of this problem?
- As you see it, what effect has this problem had on the community?
- Specifically, how does this problem affect you and your family?
- To what extent, if any, do you think HIV and AIDS makes this problem worse?
- What do you think a local NGO can do to improve this situation?
- Can you make some suggestions about how this improvement should be done?
- What more could you personally do to help your community deal with problems caused by HIV and AIDS?

The following are important considerations for a situation analysis:

- ***Protect children:*** When gathering information from children, be sure to uphold the ethical standards for the protection of a child's rights (I, chapter 5).
- ***Ensure a collaborative process:*** Ensure that the process is broadly inclusive and highly participatory so as to promote stakeholder understanding and create a sense of ownership of the process and its results.
- ***Access existing knowledge and resources:*** Capitalize on existing resources within the community before seeking additional resources. For example, make use of available data, reports, and mapping exercises.
- ***Take a multisectoral approach:*** HIV affects all sectors in a society. It is therefore critical to involve key individuals from all sectors (including health, education, labor, social welfare, faith-based institutions, and business) to help determine a comprehensive response.
- ***Enhance capacity:*** Use the process to build local capacity, including the knowledge and skills of the local people (IV, chapter 1).
- ***Maintain joint ownership:*** Ensure that all stakeholders—including children—have an opportunity to participate in the process and share ownership of the final analysis, including its findings and recommendations (I, chapter 5).

An organizational assessment

While a situational analysis will give you a good picture of problems and opportunities in a community, province, or country, an organizational assessment will let you know how effectively you will be able respond to these problems and opportunities. The assessment will appraise the strengths and weaknesses within your organization, as well its resources and capabilities—the know-how and experience of the people involved in your organization or community. In-kind resources such as office space, transport, food, and volunteers' time are included in the assessment.

A SWOT analysis

The most common way to conduct an organizational assessment is to undertake concurrently an analysis of *s*trengths, *w*eaknesses, opportunities, and threats—a SWOT analysis—which looks at the external and internal issues that are affecting your organization. However, the discussion should remain focused on your organization, not on any other organization or the wider community.

One of the easiest ways to undertake a SWOT analysis is to ask your stakeholders to first identify the internal strengths and weaknesses of the organization, and then the external opportunities and threats that they see. The stakeholders you involve should be selected carefully. They can include (but need not be limited

Involvement of key stakeholders

For insight and long-term support, involve all key stakeholders in the community in your planning process. Consider putting some people directly onto your strategic planning team and involving others through background interviews, focus-group discussions, and house-to-house surveys. To make sure that you don't miss any critical input, you should involve a broad spectrum of community representatives. Sometimes you will want to include an elected official or an individual known to you, but it will be sufficient at other times to have group representatives.

Groups to consider include religious, political, cultural, and traditional leaders; NGO "gatekeepers" from other organizations; influential community members, such as musicians, athletes, spokespersons, business leaders, and media representatives; volunteers and staff of your organization; children and other beneficiaries (or potential beneficiaries); people living openly with HIV; and technical advisors and/or donor representatives.

> **Organizational assessment tools**
>
> In addition to the SWOT analysis, many more in-depth organizational assessment tools are also available, such as the Technical and Organizational Capacity Assessment Tool (TOCAT) developed by FHI and two publications by the International HIV/AIDS Alliance: *CBO Capacity Analysis: A Toolkit for Assessing and Building Capacities for High Quality Responses to HIV*, and *Intermediary Organisations Capacity Analysis: A Toolkit for Assessing and Building Capacities for High Quality Responses to HIV.*

to) selected community leaders, clients, constituents (including children), staff, volunteers, board members, and donors. Conducting a SWOT analysis may involve one or more community meetings, workshops, focus-group discussions, and/or interviews and questionnaires. Often, a SWOT analysis accompanies an organization's strategic planning process.

For a SWOT analysis, you can begin by asking participants to identify and write down on a piece of paper what they consider to be your organization's strengths, weaknesses, opportunities, and threats. You then group these responses in four boxes on a large chart, and participants review the chart together to determine patterns and areas of consensus.

STRENGTHS	WEAKNESSES
OPPORTUNITIES	THREATS

After some discussion, make another chart and ask participants to consider how you might develop your organization's strengths, make use of your opportunities, improve your weaknesses, and control threats. Insert new headings in the chart and ask participants to put their suggestions into appropriate boxes.

DEVELOP STRENGTHS	IMPROVE WEAKNESSES
MAKE USE OF OPPORTUNITIES	CONTROL THREATS

How to analyze your results

Now ask participants to explain how they would summarize the different SWOT responses. Several responses may be similar, which means that people think that those issues are the most important. As the discussion continues, ask them what conclusions they can draw.

- If your SWOT chart shows exceptionally strong strengths and opportunities, then you are ready for growth, including a new project.
- If strengths and threats come out as the dominant features, you may want to apply some of your strengths to deal with the threats before embarking on any new initiatives.
- A combination of prominent weaknesses and opportunities might suggest that your organization should work in coalition with another organization, rather than alone.
- If weaknesses and threats emerge as the most dominant features, then you may be advised to put aside a new project for the time being or start something very small that will not further drain your organization's resources. Alternatively, you might decide to use all your resources to support a larger, well-established project run by another organization.

Making key programmatic decisions

Once you have undertaken your situational analysis and the SWOT process, you are in a better position to decide who you want to serve and how. At this point, you will find it useful to formulate your program goals—the long-term aim of your program.

A crucial question must be answered early: Who is your target group? Together with your project committee, you must decide who you particularly want to reach— for example, children in extreme poverty; children with HIV; children attending primary school in a high prevalence area; or low-income families where at least one parent has died. These categories that can be further broken down to identify those in greatest need when you apply an individualized assessment tool such as the Child

Key program-design questions

Steps in program planning

- What aspects of the situation assessment can be improved? Select one for immediate action.
- Are key populations sufficiently involved in program planning?
- What aspects of program planning can be improved? Have priority actions, resources required, and expected outcomes been clearly identified?
- Are actions prioritized using different budget scenarios (such as high, medium, and low levels of funding)?

Participation in program planning

- What strategies have been used for action planning, and what information is needed to improve these efforts?
- Have systems and structures been established to expand community-based action planning? Do staff members have the competencies to support these efforts?
- Are key populations involved in program planning?

Assessment of the context

- Does the county have an approved national OVC plan of action into which your program fits?
- Do sectoral strategic plans exist? Are they implemented?
- Have districts developed HIV/AIDS action plans or OVC plans of action?
- Is community-based strategic planning underway relating to PLHIV and/or vulnerable children?[24]

Status Index (III, chapter 2.) The activities you undertake and methodologies you use will depend on your choice of target group.

Section III of the manual will give you ideas about how you can formulate your program objectives and activities and develop a plan on how to achieve them.

Recommended readings and toolkits

■ Academy for Educational Development, ***Speak for the Child: A Program Guide with Tools Supporting Families and Communities to Improve the Care and Development of Young Orphans and Vulnerable Children***, 2003.
This guide is intended to assist program managers in planning, designing, implementing, and monitoring and evaluating community-based programs to improve care for young orphans and vulnerable children.
www.ovcsupport.net/graphics/OVC/documents/cp/0000895e00.pdf

■ Family Health International, ***Conducting a Participatory Situation Analysis of Orphans and Vulnerable Children Affected by HIV/AIDS: Framework and Resource Guide***, 2005.
The guide serves as a tool for collecting and synthesizing in-country and sub-national information. It includes examples of situation analyses and related research.
www.fhi.org/en/HIVAIDS/pub/guide/ovcguide.htm

■ Family Health International Asia Pacific Regional Office, ***Scaling Up the Continuum of Care for People Living with HIV in Asia and the Pacific: A Toolkit for Implementers***, 2007.
This toolkit provides managers and implementers with a step-by-step guide in establishing active networks of care, treatment, support, and prevention services for people living with HIV and their families. While based on experience in the Asia-Pacific region, the information and resources are broadly applicable. www.fhi.org/en/HIVAIDS/pub/res_CoC_toolkit.htm

■ HelpAge International, ***Strengthening your Organisation: Strategic Planning***, 2000.
Advice on carrying out a SWOT analysis is included this guide to the process of developing a strategic plan, including vision and mission statements.
www.ngosupport.net/graphics/NGO/documents/english/181d_Strategic_planning.pdf

■ International HIV/AIDS Alliance, ***CBO Capacity Analysis: A Toolkit for Assessing and Building Capacities for High Quality Responses to HIV***, 2007.
This capacity analysis toolkit was developed to enable community-based organizations (CBOs) to analyze levels of capacity in different organizational and technical areas, such as governance, finance, administration and human resources, project design and management, and so on. www.aidsalliance.org/custom_asp/publications/view.asp?publication_id=114&language=en

■ International HIV/AIDS Alliance, ***Intermediary Organisations Capacity Analysis: A Toolkit for Assessing and Building Capacities for High Quality Responses to HIV***, 2008.
This toolkit provides a range of tools for analyzing the capacity of intermediary organizations—those that provide financial and/or technical support to grassroots HIV organizations. These may be national or regional NGOs or networks that support groups of NGOs and community-based organizations.
www.aidsalliance.org/custom_asp/publications/view.asp?publication_id=285&language=en

■ Janet Shapiro, ***Strategic Planning Toolkit***, 2003.
This model and its useful tools and techniques can be used to take an organization through a strategic planning process. www.civicus.org/new/media/Strategic%20Planning.pdf

- Camilla Symes, ***The New Toolbox: A Handbook for Community Based Organisations. Volume 2: Vision Building, Planning and Evaluation***, 2002.
A superb how-to guide for managers of small organizations. www.barnabastrust.co.za/toolbox.php

- World Bank, ***The OVC Toolkit: A Toolkit on How to Support Orphans and Other Vulnerable Children in Sub-Saharan Africa***, 2005.
The tips and resources in this toolkit also address street children, children living with a disability, children affected by armed conflict, and children in hazardous labor. www.worldbank.org/ovctoolkit

- World Vision International, ***Development of Child-Focused, Evidence-based, and Context- adaptable Project Models to Respond to HIV and AIDS in Low-prevalence Contexts, Including Organizational Learning in Practice***, 2008.
www.wvi.org/

- World Vision International, ***Guide to Mobilising and Strengthening Community-led Care for Orphans and Vulnerable Children***, 2005.
This guide is intended to provide useful tools for individuals and organizations seeking to mobilize and strengthen community-led care for orphans and vulnerable children. www.crin.org/docs/ovc%20care%20guide.pdf

In addition, check out websites listed in appendix 1, especially www.fhi.org; www.msh.org; www.networklearning.org; www.ngoconnect.net; www.ngosupport.net; and www.worldbank.org/children.