USAID ASSIST Project
Applying Science to Strengthen and Improve Systems

Improving the lives of vulnerable children in Kenya

Experiences from implementing quality service standards

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Cover photo: Okoka CBO, Kisumu County

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By

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September 2013

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List of acronyms

AACs	Area Advisory Councils
AIDS	Acquired Immune Deficiency Syndrome
ASSIST	USAID Applying Science to Strengthen and Improve Systems Project
AMPATH	Academic Model Providing Access to Healthcare
APHIA	AIDS Population and Health Integrated Assistance
CBO	Community Based Organization
CHW	Community Health Worker
CHV	Community Health Volunteer
CSI	Child Status Index
CSO	Civil Society Organization
CU	Community Unit
DCS	Department of Children Services
GOK	Government of Kenya
HCI	USAID Health Care Improvement Project
HIV	Human Immunodeficiency Virus
IGA	Income Generating Activity
KCPE	Kenya Certificate of Primary Education
MoA	Ministry of Agriculture
NGO	Non Governmental Organization
NSC	National Steering Committee
OVC	Orphans and Vulnerable Children
PDSA	Plan Do Study Act
PSS	Psychosocial Support
QI	Quality Improvement
QIT	Quality Improvement Teams
SILC	Saving and Internal Lending Communities
URC	University Research Company
USAID	United States Agency for International Development

Introduction

Quality Improvement in Programs for Vulnerable Children

The population of Orphans and Vulnerable Children (OVC) in Kenya is estimated to be 2.6 million and is set to increase due the rising poverty levels, high cost of living and children orphaned as a result of HIV and AIDS. Since 46% of Kenyans live on less than a dollar a day, most children lack access to basic needs and are prone to different forms of abuse and exploitation due to their vulnerable circumstances. To take care of this burden, ingenious ways must be designed to ensure that these children not only receive good interventions, but receive holistic support so that they grow to be well grounded adults.

In response to a 2009 study that revealed vulnerable children in Kenya mainly received unharmonised services, the Kenya Government together with other development partners developed the *Minimum Service Standards for Quality Improvement of Vulnerable Children Programmes in Kenya* that were launched in 2012. The standards were designed to harmonise interventions by stakeholders, encourage fair distribution of services and provide a framework for monitoring and evaluating the impact of the programs serving vulnerable children.

Since 2011, USAID through the Health Care Improvement Project(HCI) and later Applying Science to Strengthen and Improve Systems (ASSIST) Project has been helping implementing partners for vulnerable children programmes to mainstream Quality Improvement (QI) at the point of service delivery through institutionalizing the Minimum Standards for QI of vulnerable children programmes.

HCI and ASSIST work with the implementing mechanism for USAID – AIDS Population Health Integrated Assistance (APHIA) and AMPATH Plus in several counties as shown in the list and figure 1.

- APHIA Plus Western - Busia, Bungoma, Kakamega, Vihiga, Kisii, Nyamira, Kisumu, Homabay, Migori and Siaya Counties
- APHIA Plus Kamili, - Kiambu, Nyandarua,Nyeri,Kirinyaga, Murang'a, Embu, Meru ,Tharaka Nithi, Machakos, Kitui and Mwingi Counties.
- AMPATH – Academic Model Providing Access to Healthcare. – Uasin Gishu, Elgeyo Marakwet, Trans Nzoia and West Pokot Counties.
- APHIA Plus Nairobi Coast –Nairobi, Kilifi, Kwale, Lamu and Taita Taveta Counties
- APHIA Plus Nuru ya Bonde – Nakuru, Kajiado, Narok, Baringo, Laikipia and Nandi Counties

These partners have program components that provide care and support to orphans and vulnerable children in the areas they operate.

Figure 1: Administrative map of Kenya showing the 47 counties

In Kenya Civil Society Organizations (CSOs), comprising Faith Based Organizations (FBOs), Community Based Organizations (CBOs), Community Units (CUs) and Non Governmental Organizations (NGOs), are some of the grass root institutions that take up the responsibility of delivering quality care to vulnerable children in the community. Arguably, caring for vulnerable children under the community banner delivers better results than putting them in foster homes that are also not accessible to a majority of them. In addition, the breakdown of the once strong social fabric where children belonged to the community has led societies to design new ways of taking care of these children while ensuring that there are less child-headed families.

For a long time, the CSOs that worked with development partners to meet the needs of vulnerable children simply supplied the items they thought the children needed without assessing the needs of the vulnerable children. According to a situation analysis done in 2009, the focus was on high coverage and outputs with little attention paid to outcomes and service quality. In response to this, the Kenya government together with development partners developed the *Minimum Service Standards for Quality Improvement of Vulnerable Children Programmes in Kenya* to support and streamline the quality of vulnerable children care.

These case studies are aimed at those implementing programmes for orphaned and vulnerable children highlights the impact of implementing the Minimum Service Standards on the lives and wellbeing of vulnerable children and families in Kenya. A CSO has been selected from the regions above to show some of the results that have been achieved across the country.

Other resources (available on www.usaidassist.org) on quality improvement for OVC programming that may be helpful include:

- Change Package for Quality Improvement in Orphans and Vulnerable Children Programmes in Kenya
- Minimum Service Standards for Quality Improvement of Vulnerable Children Programmes in Kenya
- The Child Status Index tool
- Children's right to essential actions
- Job Aid for Community Volunteers

APHIA Plus Western

APHIA Plus Western Kenya project is a five-year cooperative agreement between USAID and PATH, and comprises four additional strategic partners: Elizabeth Glaser Pediatric AIDS Foundation (EGPAF), JHPIEGO, BroadReach and World Vision. The vulnerable children component is implemented by World Vision through the Social Determinants of Health (SDH) department. The SDH Component has staff and a vulnerable children QI coach in each of the 10 counties covered by the project. APHIA Plus Western works with CSOs such as Matunda Jua Kazi and Dago Dala Hera which in turn form QITs to meet the needs of vulnerable children in the community. So far the project is working with a total of 21 QITs.

Matunda Jua Kazi

With the support of the American people, Matunda Jua Kazi in a period of one year helped 854 vulnerable households in Lugari sub-county that were previously food insecure for five months every year to become food secure throughout the year.

Matunda Jua Kazi is a community-based organization (CBO) that works with APHIA Plus Western Kenya to improve service delivery to vulnerable children in Kakamega county, about 41km from Eldoret town. In June 2011, USAID HCI trained 2 coaches from the CBO on Quality Improvement (QI), and then the coaches had a step down training targeting 60 Community Health Volunteers (CHVs), whose role is to provide on-the-ground-support to vulnerable children and their households mostly through household visits. The trained CHVs and the coaches carried out community sensitisation on minimum service standards for vulnerable children programs.

During a meeting that brought together the CBO members, CHVs and the community, a District level QIT consisting of 16 members was constituted. To mainstream minimum standards at the point of service delivery, the team constituted locational QITs in Lukiyani, Sinoko, Nzoia and Kongoni , the four locations covered by the CBO. Each of the 4 QITs has 10-12 members.

The District level coordinates all the QI activities and the location level QITs help in data collection and execution of interventions that are agreed upon at the district level.

District Level Quality Improvement Team Composition

1. Spiritual leaders (2)
2. Agriculture Officer (1)
3. Administrators from 4 locations (4)
4. Home-based care representative (1)
5. Constituency Development Fund representative (1)
6. Area Advisory Council representative (1)
7. Household Economic Strengthening representative (1)
8. Community Health Volunteer representatives (2)
9. District Children Officer (1)
10. CBO representative (1)
11. VULNERABLE CHILDREN Desk Person (1)

Location Level Quality Improvement Team Composition

1. Spiritual leaders (2)
2. Caregivers (2)
3. VULNERABLE CHILDREN (2 – male & female)
4. Area Advisory Council representative (1)
5. Community Health Volunteers (3-5)

The assessment

Matunda Jua Kazi administered a self-assessment tool based on the standards to determine which essential actions were not being implemented well and food security emerged as the priority area that needed improvement. Further discussions with the community in public meetings confirmed the same.

Kakamega County is located in the Western highlands of Kenya where maize is the main food crop and thus it came as a surprise for the QIT to realize that food security was a pressing need among vulnerable children and households in the region despite the area being highly productive. The community had major challenges in ensuring access to adequate nutrition (good quality and correct quantity, up to three nutritious meals per day) despite the area being rich in food production. Most caregivers sold their food at throw-away prices immediately after harvesting, leaving their households vulnerable. Another problem was that maize took long (about six months) to mature and thus between May and July most households struggled to put food on the table. Despite being a highland region the period of December – February was characterized by a dry spell and households did not plant anything on their farms.

Change ideas

Food security

To increase food security in the area, the district and location level QITs came up with the following interventions:

- Approaching the Ministry of Agriculture (MoA) to provide support on other crops that can be planted in the region and offer training on the same to the community
- Sensitizing the community on food security, drought tolerant crops, multi cropping and irrigation through CHVs and MoA
- Encouraging caregivers to take up small stock (rabbit, goats, poultry, sheep) and other income generating activities
- Community support to the very vulnerable households through establishing a food bank
- Continuous follow-up by CHVs to ensure caregivers implemented what they learnt.

Implementation of the change ideas took place between January - December 2012 and targeted the 1436 households that Matunds Jua Kazi works with for both home-based care clients and orphans and vulnerable children. Through collaboration with MoA, representatives from 186 households were trained on food security and drought tolerant crops such as cassava, bananas, pumpkins and sweet potatoes. The MoA also supported the community in adopting kitchen gardens and multi cropping as opposed to mono cropping which was prevalent before the change ideas were introduced. As a result of the multiplication effect of caregivers sharing what they learnt with others within the community, 1386 households took up the drought tolerant crops.

In multi cropping caregivers were trained on how to plant crops that take a shorter time to mature (three months or less) and that would generate supplementary income for households such as traditional vegetables, irish potatoes, onions, carrots and tomatoes. A total of 1013 households planted the fast maturing crops and 854 of them actually practiced multi cropping thus becoming food secure throughout the year. Through constant sensitization meetings and follow-up by the QITs, the uptake of traditional vegetables and early maturing crops has improved resulting in increased access to nutritious food by the community and supplementary income for some households.

As a direct outcome of taking up drought tolerant and fast maturing crops 100 households were able to provide breakfast for their children before going to school and serve 3 meals per day. Previously many children did not take breakfast and often took one meal per day during the food insecure months.

A caregivers' sensitization meeting in session

A caregiver practicing multi cropping

To increase the adoption of drought tolerant crops, the QIT encouraged the formation of Common Interest Groups (CIGs) at village level so that caregivers interested in taking up certain crops would come together not only to share seeds/seedlings but also to police one another so that everyone in the group planted at least one crop on his/her farm. A total of 5 groups representing 165 households were formed and incorporated Savings and Internal Lending Communities (SILC) as part of their activities.

To increase adoption of small stock (poultry, rabbits, goat and sheep), APHIA Plus Western donated one chicken to each of the 60 households who were able to breed and expand their flock. Some have sold a portion of the flock to buy sheep and goats. A total of 1350 households took up small stock.

By participating in SILC activities and starting income generating activities like poultry rearing, 62 households have access to supplementary income that is used to pay school fees.

One locational QIT also set up a food bank after they talked to caregivers on how they can support the very vulnerable among them. The caregivers donated four kilograms of dry maize each and a total of 200 kilograms of maize was collected. This was stored in the chief's office and distributed by the CHWs to 38 very vulnerable households during the dry season in February 2012.

The QIT also uses caregivers who have successfully implemented the change ideas to sensitize other caregivers in the community. This approach has been instrumental in increasing the uptake of drought tolerant crops and IGAs.

Other outcomes are better captured in the testimonies below.

Mr. Wafula became a widower in 2011 when his wife died and he was left with eight children. On the half an acre plot of land he had, he would plant maize that would take a gruelling 9 months from preparation to harvesting. His family often went without food and his children had dropped out of school for lack of school fees.

In March 2012, a CHV visiting his house invited him to a food security training organized by Matunda Jua Kazi CBO and facilitated by a representative from the Ministry of Agriculture. Something he learnt that he will never forget was to look at farming as a business and not 'a good thing to do'. During the training he learnt how to intercrop, do rotational farming and irrigate his farm. He also received some seedlings which he used to start off his farming business. He divided his farm into four portions and planted different fast-maturing crops in each, created a sessbania fence around his farm and set aside a portion to grow tree seedlings on his back yard. With a lot of follow-up from the location QIT, he now has an established farming business where he grows traditional vegetables, butternuts, arrowroots and tree seedlings for sale. With income generated from farming, he has reinstated his 8 children in school. The sessbania fence provides firewood for the household and at the same time acts as a windbreak.

Thanks to the training he received and his commitment to succeed, he has now become a community trainer and his farm is often used as a demonstration plot during caregivers' sensitization meetings. He also provides support to community members who are interested in taking up the fast maturing crops and is currently mentoring a self-help group in his village.

Mama Nafula is a widow who looks after her three grandchildren, whose mother died in 2009. She was on the verge of giving up on educating her grandchildren when a CHV visited her and on seeing the plight of the children, enrolled one to the APHIA Plus School Fees Program. But the other two children did not get that opportunity and the CHV had to do something to help Mama Nafula pay fees for them.

In May 2012 after the CHV had received QI training, she returned to Mama Nafula's home and invited her to participate in the food security training where she learnt post harvest handing of maize and how to grow drought tolerant crops such as cassava and sweet potatoes. On returning to her farm, she started growing the cassava and sweet potatoes and distributing seedlings to her neighbours. Eventually Mama Nafula brought together 12 other women to form a Savings and Internal Lending Community (SILC) group. She transferred the skills learnt on drought tolerant crops to these women and mentored them as they adopted cassava and sweet potato farming. Later APHIA Plus Western gave one chicken to each of the women for breeding. After the chicken had multiplied, Mama Nafula sold some and bought two sheep which she hopes to sell once they have multiplied and acquire a cow.

Thanks to these interventions, Mama Nafula has educated her grandchildren and one has completed university, the second is in his third year at the university while the youngest is in primary school. Mama Nafula is grateful to Matunda Jua Kazi QIT and APHIA Plus Western for improving her livelihood and thus enabling her to educate her grandchildren.

The swampy home of love - *Dago Dala Hera*

With support from the American people, Dago Dala Hera was able to assist 2880 vulnerable children in East Sakwa location to acquire birth certificates in six months.

Dago Dala Hera is a CBO based in Migori County, approximately 186km from Kisumu town. Dago Dala Hera CBO works with APHIA Plus Western Kenya to address the plight of orphans and vulnerable children in East Sakwa location. They are currently working with 3000 vulnerable children.

In January 2012, two QI coaches from Dago CBO were trained by the HCI project. Thereafter, they conveyed the QI message to the rest of the CBO members and together they convened a meeting where they invited the community together with nurses, provincial administration and paralegals. At the end of the meeting, A QIT consisting of 15 members was selected.

Quality Improvement Team Composition

1. Paralegals (2)
2. Village elder (1)
3. Orphans and Vulnerable Children (2)
4. Teacher (1)
5. Caregiver (1)
6. Community Health Volunteers (6)
7. Spiritual leader (1)
8. Nurse (1)

The assessment

In February 2012, The QIT conducted a CSI assessment on 300 (10%) of the total vulnerable children under their care from four sub-locations Kogelo, Oware East, Oware West and Oware South. Analysis of the CSI data and self assessment revealed that the education domain was performing badly. Further analysis revealed that education was affected by lack of school fees, scholastic materials, uniform and sanitary towels. Child labour was also rampant with many caregivers having a negative attitude towards education such that when children were sent home for school fees they would mostly engage in menial jobs in the sugar cane plantations for a fee. Another issue was peer influence that led many children to drop out of school and engage in the lucrative *boda boda* business (using motor cycles for public transport).

Change Ideas

Education

To address the problems identified, the QIT settled on the following interventions that were implemented between March and August 2012:

- Sensitizing caregivers on household economic strengthening so that they are able to pay school fees
- Sensitizing caregivers on the importance of education for their children
- Monitoring progress of those reinstated to school
- Engaging well wishers / sponsors to pay school fees

For sensitization, the chief called for a meeting where the QIT educated caregivers on the importance of education and household economic strengthening (HES) that would help them earn income and therefore pay school fees. Under HES, caregivers were introduced to kitchen gardens where they planted vegetables for consumption as well as selling. Dago Dala Hera works with 746 caregivers, of which 432 established kitchen gardens. This intervention has also positively affected the health domain whereby in July 2012, 238 caregivers started saving regularly to pay for their health premiums after they joined the National Hospital Insurance Fund and APHIA Plus paid the premiums for year one but they are now paying for themselves in year two.

The provincial administration was involved in addressing child labour through summoning caregivers whose children were involved in the vice and warning them of repercussions if their children did not resume school. Through this approach 15 children were reinstated in school.

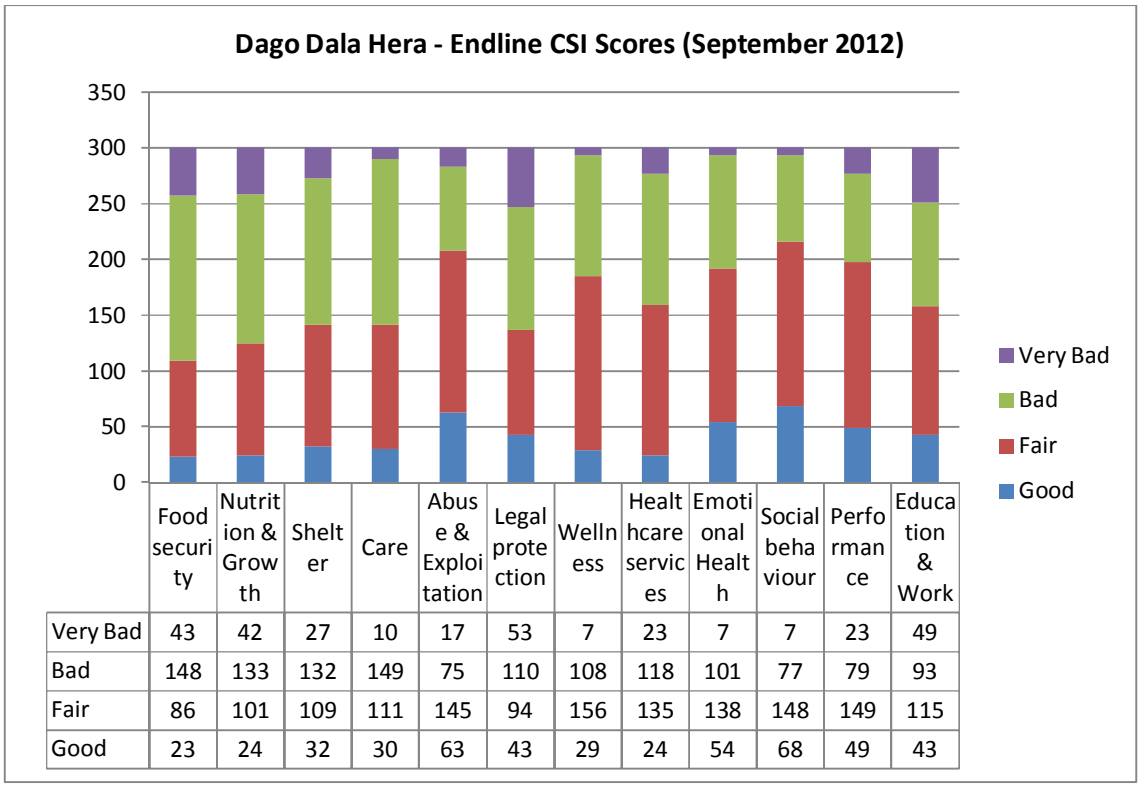
To ensure retention and completion, progress monitoring was done in conjunction with the school management committees, teachers and caregivers who ensured regular school attendance especially for reinstated children. Impromptu visits to the schools by the QIT made children remain in school throughout the day.

While the CSI was administered to a sample of the vulnerable children, the interventions focussed on the 3000 children under Dago. The end data compilation on school enrolment, retention and attendance done in September 2012 showed, 313 children were reinstated / enrolled in school, surpassing the target of 300. Eight completed secondary school in 2012 and 5 will be joining university while 3 will join tertiary colleges. In 2012, Dago Dala Hera also produced the top scoring girl who scored an A- in the Kenya Certificate of Primary Education (KCPE) in Migori County, who is now in secondary school under the sponsorship of the Equity Bank's *Wings to Fly* Program

10 caregivers are now able to contribute 10% of their children's' school fees as a long-term sustainability strategy where they will continue to increase this amount as their economic status improves.

Child protection

The end-line CSI conducted in September 2012 was also used as the base line to identify priority areas for the next phase. Child Protection and Food Security were identified as next priority areas that needed attention.



	Food security	Nutrition & Growth	Shelter	Care	Abuse & Exploitation	Legal protection	Wellness	Healthcare services	Emotional Health	Social behaviour	Performance	Education & Work
Very Bad	43	42	27	10	17	53	7	23	7	7	23	49
Bad	148	133	132	149	75	110	108	118	101	77	79	93
Fair	86	101	109	111	145	94	156	135	138	148	149	115
Good	23	24	32	30	63	43	29	24	54	68	49	43

Analysis of the end line CSI scores

In child protection the issues identified were; caregivers and children alike were ignorant of children rights, majority of the vulnerable children did not have birth certificates, child abuse and disinheritance were also rampant.

From March 2013 the following change ideas to improve child protection were carried out:

- Educate children and their caregivers on children rights
- Help caregivers acquire legal documents for vulnerable children
- Rescue children from child abuse and exploitation
- Promote succession planning and thus address disinheritance

Caregivers were initially sensitized on the importance of birth certificates after which they were mobilized to register their children. The QIT negotiated with the registrar's office and officials were sent to the community to do registration over a five-day period. Through this initiative 96% or 2880 vulnerable children now have birth certificates while 23% or 171 caregivers obtained national identity cards, which is a national requirement.

To address child abuse and exploitation caregivers and vulnerable children were taught on children rights. The QIT then embarked on rescuing children who were in early marriages and *boda boda* (using motorcycles for public transport) business and reinstated 5 vulnerable children back to school.

To promote succession planning and thus address disinheritance, the QIT sensitized 383 caregivers on the importance of writing wills during two meetings while children in primary school between the ages of 11-14 were also trained to write memory books. 34 memory

books have been created mostly during school holidays. In the book, children include details such as origin of their parents, uncles, aunts, siblings, history of any diseases, position in family, education history of the child, family photos among others.

Food security

The CSI revealed that 191 (63.7%) children from the 300 that were sampled scored poorly on food security.

Food insecurity was due to the large number of households that leased their farms for sugarcane farming leaving them with little or no land to plant food crops. Due to poverty, households sold almost all the produce soon after the harvest leaving them with no food to cushion them in the months ahead and thus most households would have a single meal per day. Cultural beliefs were also affecting what and when people planted their crops for instance a daughter in law could not plant until her mother-in-law had planted.

Food security was addressed through:

- Controlling land leasing for sugarcane farming
- Income Generating Activities (IGAs) for caregivers
- Sensitization on adequate nutrition, multiple cropping, kitchen gardens and drought tolerant crops

A sensitization meeting was organised to educate caregivers on the importance of adequate nutrition of at least two balanced meals per day for their households. Caregivers were educated on kitchen gardens, multiple cropping, drought tolerant crops and post harvest management. 54 caregivers organised themselves into two support groups and were provided with seeds / seedlings of sweet potatoes, banana and fruit trees, by APHIA Plus to start them off. 425 households have established kitchen gardens. So far 96% of vulnerable children have access to at least two meals per day as opposed to one as was the case before.

To rein in on households that were leasing out their entire land to sugarcane dealers, the community agreed to have all land leasing done through the chief's office to ensure that the leasing household is left with enough land to plant food crops. No household is allowed to lease their entire parcel of land.

Other caregivers formed support groups to engage in IGAs such as poultry keeping, goat rearing and fish ponds. All the 746 households are actively involved in this. Two fish ponds belonging to caregivers in support groups have also been established.

To address the cultural beliefs, CHVs together with the religious leaders enlightened the community on the retrogressive nature of the beliefs and the community is slowly abandoning some of the beliefs. In fact one CHV demonstrated that some of the beliefs are void when she planted maize despite the death of her husband and neighbours told her that the maize would not grow. After the maize had grown and she had a bumper harvest, neighbours again told her that if her children consumed the maize they would die, they consumed and they are still alive – a living testimony that the beliefs are empty and out to impoverish the community.

The impact of the Dago Dala Hera QIT is exceptional and they have become the custodians of discipline in the community. Often QIT members are called to deal with the errant children in the society, a sign of acceptance and respect from the community.

APHIA Plus Kamili

APHIA plus Kamili operates in Central and parts of Eastern Kenya. CSOs under Kamili, initially received QI training in May 2011 but it is only after a second training in February 2012 that they were able to start integrating the QI concepts in their work. APHIA Plus Kamili is currently working with 31 CSOs who have 123 QITs. The tremendous growth has been realized as a result of the project allocating 5% of its budget to QI and related activities. This money is used to help QI coaches move around and mentor CSOs. Each CSO has at least one officer who has been trained on QI and the officer gets back-up from either APHIA Plus or a government official. The CSOs started by rolling-out QI with one team then formed other groups resulting in remarkable growth in the number of QITs in the area covered by Kamili.

Society of Women Against AIDs in Kenya (SWAK)

With support from the American people, SWAK managed to reduce the number of children not attending school within the Kaindutu informal settlement, Embu County, from 40 to 11 within a period of six months.

Background

SWAK is aNon Governmental Organization (NGO) working with APHIA Plus Kamili in assisting vulnerable children in Embu County. In March 2012, USAID through the HCI Project trained coaches from selected CSOs working under the APHIA Plus Kamili, SWAK included, on the Quality Improvement methodology. The output of the training was a clear work plan stipulating steps of awareness creation on minimum standards and QI to the rest of the NGO members. The coach who received training from HCI eventually trained 15 members of SWAK on QI. Thereafter, the trained members formed a Quality Improvement Team (QIT) and the team conducted an assessment of 100 children using the CSI tool.

Quality Improvement Team Composition

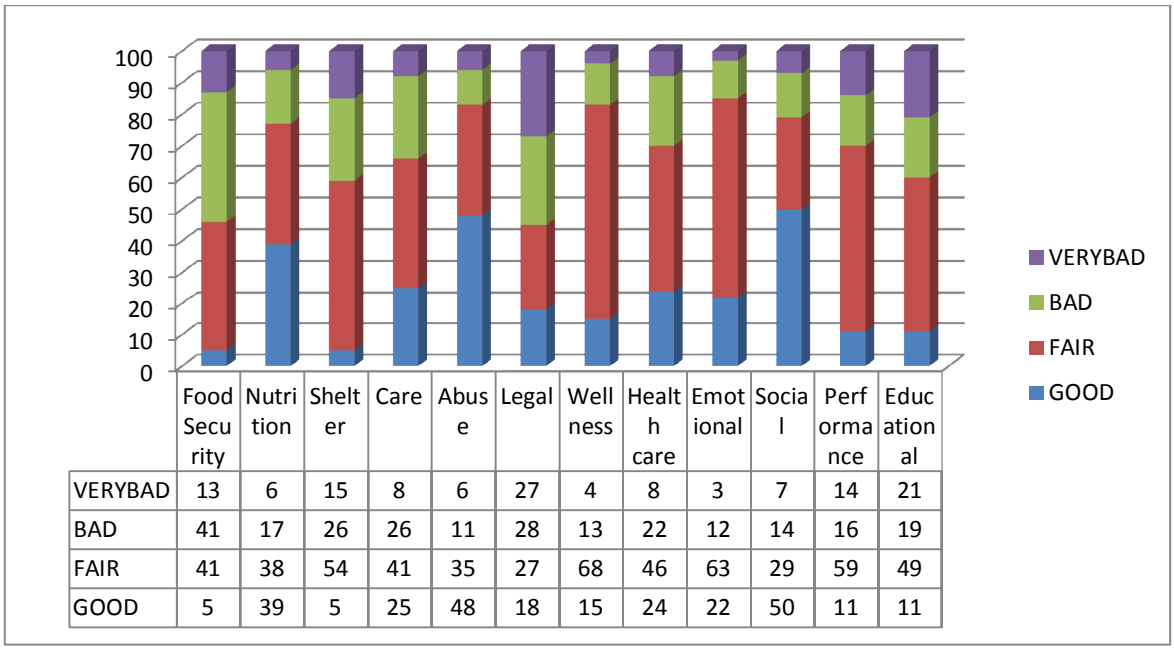
Community membership

1. Pastor / Spiritual leader
2. Peer Educator
3. Community Based Organisation representative
4. Female orphaned child
5. Male orphaned child
6. Community Health Workers (6)
7. Volunteer Children's Officer
8. Health Officer
9. Provincial administration
10. Teacher

The priority area

The team analyzed the data collected during the base line and conducting self assessment as a QIT, with education emerging as a priority area. The root cause analysis revealed that children were not attending school due to food insecurity, lack of legal documents and some caregivers had a negative attitude towards education. The team realised that to

fully address the education issues, they had to look into food security and legal protection. The results of the baseline CSI are captured in the graph below.



	Food Security	Nutrition	Shelter	Care	Abuse	Legal	Wellness	Health care	Emotional	Social	Performance	Educational
VERYBAD	13	6	15	8	6	27	4	8	3	7	14	21
BAD	41	17	26	26	11	28	13	22	12	14	16	19
FAIR	41	38	54	41	35	27	68	46	63	29	59	49
GOOD	5	39	5	25	48	18	15	24	22	50	11	11

Analysis of the baseline CSI scores

The interventions

To address the issues above the following change ideas were implemented between June and November 2012,

- Sensitization of caregivers on the importance of education
- Establishing kitchen gardens
- Facilitating the civil registration of children

Education

The QIT first sensitized caregivers and children on the importance of education. During the assessment, the QIT had noted that some caregivers lacked knowledge on the importance of education for their children. The caregivers reasoned that some of the successful businessmen in the community did not even complete primary education and thus there was no need for their children to go through formal education. Another intervention used by the QIT was sensitizing caregivers on child rights thus making them aware that children have a right to education.

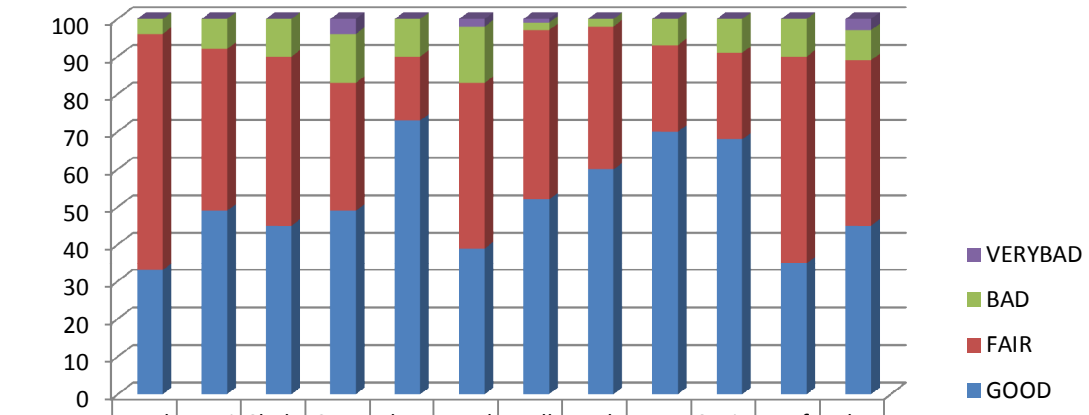
Food security

During the root cause analysis, the QIT discovered that some children did not go to school because during the day as they were busy looking for vegetables. It is interesting to note that these children were not looking for carbohydrates or cereals such as maize and beans but were particularly interested in vegetables as their daily diet had very little vegetables, if any. To address this issue, the QIT employed the change idea of establishing vegetable kitchen and multi-storey gardens where the affected households would plant potatoes, onions, kales and cabbages. In one particular area, the QIT realized that the caregivers were not keen on establishing the kitchen gardens on their farms and had to re-strategize on how to make caregivers interested in the gardens. To tackle this challenge, one CHW set up a demonstration kitchen garden on her farm and volunteered to help interested caregivers in setting up similar units on their farms. This led to an increase in the number of kitchen gardens set up within that area from 2 in one month to 15 the following month.

Legal protection services

In Kenya, it is a requirement for children joining transiting from pre-school to primary school to have birth certificates. In the area covered by SWAK, some children had migrated from other counties after the death of their parents and had come without birth certificates; others had been born there but did not have the certificates. To enable them enrol in school, the QIT liaised with the office of the registrar who accepted to come to the community and was able to assist 38 children to get birth certificates against a target of 55. For this to be successful, the team involved religious leaders and the provincial administration (sub-chief) who would verify that they knew the children and that the children belong to that community.

Below is the end line CSI score that shows the improvement achieved in each of the domains.



	Food Security	Nutrition	Shelter	Care	Abuse	Legal	Wellness	Health care	Emotional	Social	Performance	Educational
VERYBAD	0	0	0	4	0	2	1	0	0	0	0	3
BAD	4	8	10	13	10	15	2	2	7	9	10	8
FAIR	63	43	45	34	17	44	45	38	23	23	55	44
GOOD	33	49	45	49	73	39	52	60	70	68	35	45

Improved outcomes

A comparison of the baseline and endline CSI data shows that there was marked improvement in the three services areas the QIT addressed as shown in the table below.

Service area	Baseline (Bad & Very bad)	Endline (Bad & very Bad)
Food security	54	14
Legal protection	55	17
Education	40	11

AMPATH Plus

With support from the American people, the Kapsoya quality improvement team trained 1535 vulnerable children on their rights which resulted in 57 child abuse cases being reported within a period of six months in Kapsoya, Eldoret County.

Academic Model Providing Access to Healthcare(AMPATH) were among the first groups to adopt QI in their work as some of their staff were involved in developing the minimum standards for quality improvement of orphaned and vulnerable children in 2009-2012. They do not work with CBOs but directly interact with the vulnerable children and their households. The project has 7 QITs spread across the upper Rift Valley region.

In 2009, AMPATH modified their child assessment form so as to align with the Child Status Index tool. In October 2011, they formed their first QI team in Kapsoya, Eldoret, by reviving the Local Area Advisory Council and adding other members of the community that were working with children to form a team of 18.

To determine their priority area, the Kapsoya QIT first administered the self assessment tool based on the standards at team level and identified child protection as the priority area.

Quality Improvement Team Composition

1. Provincial administration representative – area chief
2. Village elders (3)
3. Police Caregivers (2)
4. Children (2)
5. Religious leaders (2)
6. Community Health Workers (2)
7. Education zonal inspector
8. District Children Officer
9. Representative from SOS
10. Representative from local health centre
11. Representative from rehabilitation centre for street children
12. Representative from AMPATH

Child protection

The QIT conducted an assessment with children to establish issues that undermined their protection and identify areas where abuse happened. The children identified video dens, pool table joints and their homes as being the most risky places for them to be. They also mentioned scrap metal dealers as exploiting them through child labour since most of them skipped school to look for scrap metals that were sold to the dealers hence did not go to school as expected.

To address the above issues, the QIT first did a sensitization meeting where caregivers were given the statistics of what was happening mostly without their knowledge. They were then educated on child rights and the dangers of involving children in the sale of alcohol (local brews), how the scrap metal business was affecting households and the kind of movies children were watching in the video dens. Through the chief, the QIT invited the proprietors of the video dens, local brews and scrap metal business to a meeting and educated them on the dangers of involving children in the kind

of business they were doing. The proprietors then signed an agreement committing not to involve children anymore, and this led to the closure of the scrap metal shops in the area.

The QIT has also been rescuing defiled and physically abused children and sending them to rescue centres. So far more than 20 cases are being investigated by the police and 15 children have been taken to rescue centres. This improvement has been realized because caregivers now know that they need to report defilement cases to the police. By involving police in the QIT, CHWs have been trained by policemen on how to preserve evidence and thus file strong cases that are not likely to collapse.

To make child abuse cases move fast, the QIT has police officers and when the police officers do not attend several meetings and there are defilement or physical abuse cases that need follow-up, the QIT uses the police station as a venue for their meetings making it inevitable for the policemen to attend. As a result, defilement cases in Kapsoya do not drag on forever as is the case in most parts of the country and the community now knows that no one can get away with child abuse which was quite rampant before the QIT was formed. Currently AMPATH directly and indirectly assists 158 and 2000 children up from 49 and 301 directly and indirectly assisted children respectively, in August 2012.

Education

In a bid to deal with child protection, the QIT visited schools to sensitize children on their rights and on how to protect themselves from abuse. Through this the team got to know other issues that were affecting children especially in school. So far the team has visited four schools and the results are tremendous with the area now showing increased enrolment in schools. For instance Koibara primary school saw its enrolment increase from 250 to 400 between July 2012 and July 2013. This was after the QIT visited the school and after talking to the students realized there were issues like teachers, boys and girls using the same toilets, and drug abuse in the school compound which needed to be sorted out. On raising the issues with the school administration, the school organised for a meeting with parents and teachers, increased the number of teachers from 5 (all female) to 10 (3 male, 7 female), built separate toilets for teachers, boys and girls (previously teachers and students shared the same toilet) and the teachers started monitoring students during play time to ensure they were not engaging in drug abuse. On recommendation from the QIT, schools in the region are now involving volunteer counsellors to address the psychosocial issues the QIT identified, setting up counselling departments in schools and are exploring the possibility of employing a guidance and counselling person who is not part of the school administration as the QIT visits revealed that children share more with outsiders as opposed to members of the school administration.

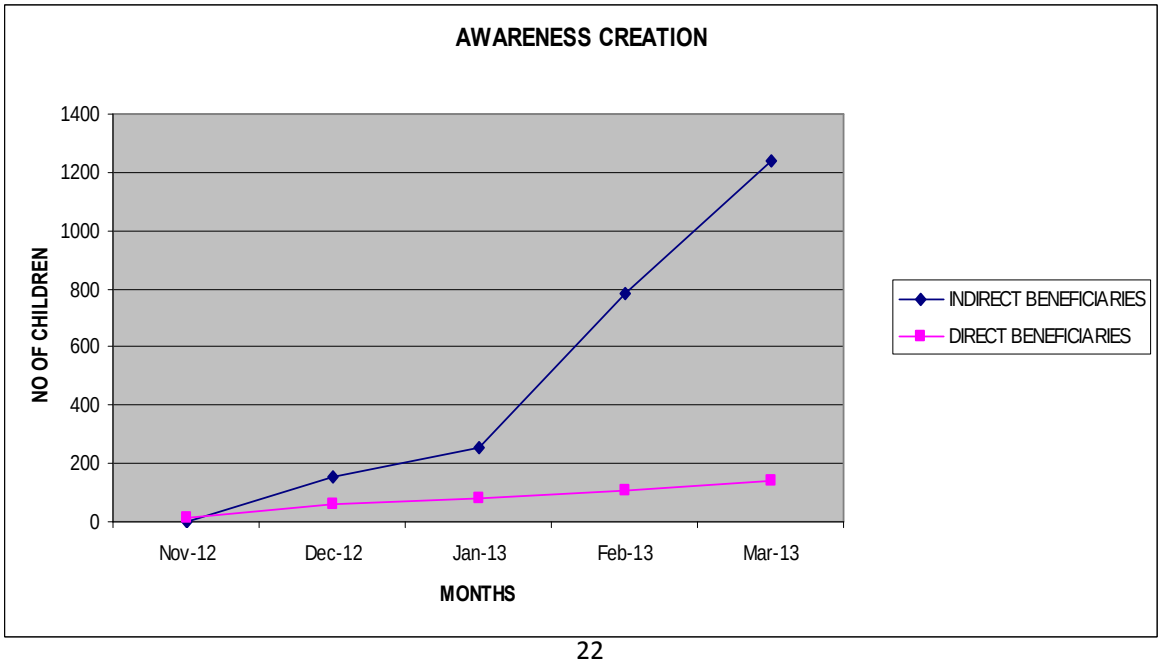
Remarkable improvement has been evident in the other schools visited by the QIT and other schools within the area are now requesting the QIT to visit them.

Due to the sensitization meetings with caregivers and through household visits, the community is on high alert and self policing within the community is taking place. Neighbours report children who do not attend school to the chief while children also report to members of the QIT when their counterparts miss school. In addressing child protection, the Kapsoya QIT has been able to positively impact education.

Activity	Cumulative figures									outcome
Awareness creation meetings on children rights/responsibilities for indirect beneficiaries	158	278	460	560	560	723	793	881	1383	Nine meetings were held in comm.
Awareness creation meetings on rights, responsibilities, abuse and neglect for direct beneficiaries	20	30	106	0	0	106	126	137	152	Numbers were less than target
Report all cases of abuse from indirect beneficiaries	3	3	5	9	12	14	16	19	24	14 cases are active
Report all cases of abuse for direct beneficiaries	1	3	3	7	9	13	23	31	33	All cases were reported

Number of people reached with the child protection interventions between November 2012 and March 2013

The impact of the QIT in reforming the Kapsoya community has been so high, such that



representatives of two neighbouring locations have come to study how the QIT operates to replicate the same their areas.

Other things that the QIT has addressed include:

- They have eliminated the duplication that used to happen when all the partners were working separately and thus two or more partners would be assisting the same household in the same service area without knowing.
- Some caregivers were ignorant on their responsibilities to children in relation to education, health, food and nutrition and child protection. They have now been enlightened and they are now keen on protecting their children and ensuring they have access to education, balanced and regular meals, and healthcare.
- The networking that has come about as a result of involving partners in the QIT has been very beneficial especially in managing referrals and linking up children to the support they need. The chief is now able to tackle children's issues that were previously a challenge for him as he just talks the relevant partner whenever a case arises.
- The team has come to appreciate the power of documentation whereby when they encounter issues that are beyond their jurisdiction, they have been able to document the problem, append their signatures on the document and send it to the relevant authority through the district children's office. For instance the QIT noted some children would miss school to hang around the Dola Flour Mills to collect spilled maize and sometimes steal some maize for sale. The money obtained would be used as admission fee for the video dens. The QIT wrote a letter to the county government through the district children's officer and had it signed by the entire team. In response to the letter, the governor of Eldoret County ordered policemen to arrest the children involved in the vice and were also tasked with the responsibility of ensuring no children were found near the Dola factory in the future. The arrested children were either sent to juvenile homes, or had their caregivers put on probation so that they would regularly report on the progress of their children, while others were repatriated back to their counties through the help of the county and district children officers.

APHIA Plus Nairobi Coast

APHIA Plus Nairobi Coast arose from an emergency response to APHIA 2 and operates in Nairobi and Coast as a consortium that brings together Pathfinder, Child Fund, Population Services International, Cooperative League of USA and NARESA. The orphaned and vulnerable children component is implemented under Child Fund since 2008. APHIA Plus Nairobi Coast (Nairobi) works with 58 CSOs under which 24 QITS have been formed, supporting 80,000 vulnerable children in Nairobi County. The project operates at two levels through direct support to the vulnerable children and through indirect supplementary services offered through CSOs. In Nairobi, the organization works closely with the Ministry of Health (department of health coordination), district nutrition officers, Nairobi City Council (quality assurance department), Ministry of Education (department of quality assurance)and the Ministry of Labour and Social Services (department of children services).

'QI is self-sustaining; it requires minimal financial resources to implement' Dennis Okello, Head of OVC APHIA Plus Nairobi Coast (Nairobi)

With the Ministry of Education, APHIA Plus Nairobi Coast (Nairobi) has been able to set up child friendly spaces in schools including health clubs – where basic hygiene issues are taught, financial literacy clubs designed to create a culture of saving in children and children's rights clubs. They also distribute child friendly spaces learning materials to the schools they work with and train teachers on how to use the materials.

With the Department of Children Services and Nairobi City Council, APHIA has trained Voluntary Children Officers, Area Advisory Councils, and children officers from the city council and the central government as QI coaches.

Other achievements of the CSOs under APHIA include; small poultry farming in urban slum setting, incorporating the government cash transfer programme in QIT work, having a pool of QI coaches from CSOs and growth monitoring out posts at community level.

Shangia

With support from the American people, Shangia Community Unit has been able to economically empower 191 caregivers and reinstate 49 vulnerable children back to school in Mariakani sub-county within a period of one year.

Shangia is a Community Unit (CU) in Mariakani, 34 km northwest of Mombasa that works with APHIA Plus Nairobi Coast in assisting 1225 orphaned and vulnerable children. In May 2012, a member of Shangia was trained on Quality Improvement (QI) as a coach. Thereafter Shangia communicated the minimum service standards for orphans and vulnerable children first to its members and together they selected the QIT of 15 members that was named *'Jicho Pevu' (Swahili for the investigative eye).* The QIT was trained on QI and the team members communicated the standards to the 8 villages covered by Shangia through collaboration with the village elders and chiefs.

Assessment

The QIT together with members of the CU then conducted a self assessment and identified education and food security as the priority areas. Using the quality improvement approach of root cause analysis, it was discovered that the poor school enrolment was due to inadequate food in households which forced children to get involved in small businesses such as hawking porridge to truck drivers so as to get food. Other children engaged in child labour and would fetch water for their neighbours at a fee while others were employed as farm hands. Another major issue was the sale of the local beer from homes and beer customers would lure children into relationships that saw them drop out of school.

Quality Improvement Team Composition

1. CBO Contact person (1)
2. Community Health Extension Worker / Nurse (1)
3. Community Health Worker (2)
4. Spiritual leaders (2 – Pastor & Imam)
5. Business person (1)
6. Caregivers (2)
7. Village Elder (1)
8. Orphaned & Vulnerable Children (2)
9. Representatives from the Local Area Advisory Committee (2)
10. Early Childhood Education representative (1)

The food insecurity in the area was largely due to Mariakani being semi-arid and therefore not very productive. The community was also not getting adequate nutrition in terms of a balanced diet.

Change ideas

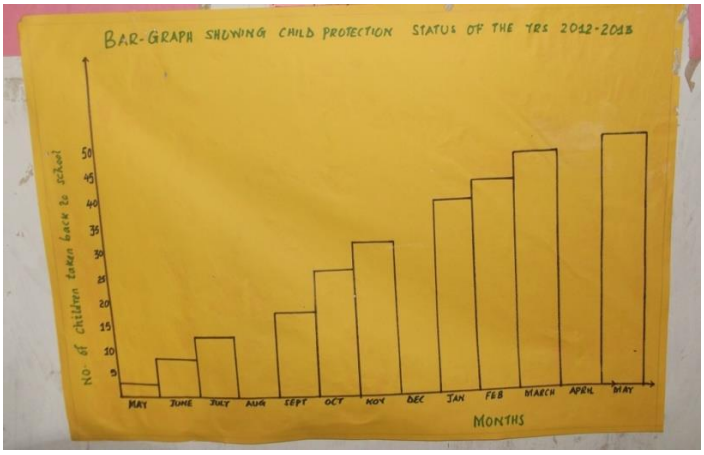
Education

The QIT then used quality improvement methodology to address the education domain they came up with change ideas that would help them restore 50 children to school between May 2012 and May 2013. The change ideas included:

- Sensitizing the community on the importance of education for children
- Enlightening the community on the negative effects of involving children in small businesses
- Following-up on the children that were involved in child labour
- Finding an alternative to selling local beer from homes

After enlightening truck drivers, policemen and the community on the adverse effects of small businesses on children, a decree was made by the area chief that children would no longer be allowed to engage in small businesses and those found would be arrested and their caregivers summoned to the police station to answer to child labour charges. The QIT then mobilized caregivers involved in selling the local brew to convene and they agreed on a central location, away from their homes, where they would conduct their business. These caregivers also set up rules of engagement agreeing that no children would be allowed within the vicinity of the new business premises, not even to collect money needed for food or any other urgent need.

The QIT also followed-up on children who had dropped out of school and were able to rescue 8 girls from early marriages and reinstate them in school. One such girl scored 340 marks out of 500 in the 2012 Kenya Certificate of Primary Education (KCPE) examination and is now in secondary school. Thanks to the household economic strengthening activities her caregiver was involved in, her mother was able to buy her school uniform, a mattress and other provisions she needed to start her secondary school education. Thanks to the follow-up efforts of the QIT, another 9 children also scored above 300 marks in the same examination, something that has never happened before in the location. As a result of such interventions the QIT has enrolled/ reinstated a total of 49 children against a target of 50 between May 2012 and May 2013.



Monthly tracking of school enrolment and retention by Shangia CU, May 2012 – May 2013

Food & Nutrition

With the aim of achieving food security and balanced diets for the vulnerable children and households, the food and nutrition domain was addressed through:

- sensitization of caregivers and children on the importance of a balanced diet
- adoption of irrigated farming
- Empowering caregivers so that they would be able to adequately feed their families and also earn income.

Caregivers were formed groups and together with well wishers dug dams for rain water harvesting to support irrigation activities in their farms. They initially constructed two dams but now five dams spread over 5 villages. Shangia now has five groups each having a dam and a farm where they engage in group farming. Caregivers were also sensitized on Savings

and Internal Lending Communities (SILC) and revived their SILC activities so that the five farming groups also double up as SILC groups. The groups were revived in May 2012 after the caregivers' sensitization meeting on economic empowerment and their contributions as at August 2013 are as shown in the table below.

Group name	No. of caregivers	Contribution May 2012 – May 2013 (Ksh)	Income Generating Activities
Vuma	32	310,245	Farming, soap making, ploughing oxen for hire, selling clothes
Amkeni	60	118,000	Farming, ploughing oxen for hire, selling dry fish, rearing goats
Shauri Moyo	35	60,000	Farming, ploughing oxen for hire
Twaweza	37	120,000	Farming, poultry keeping
Furaha	27	122,050	Farming, selling clothes
Total	191	730, 295	

Group farming by one of the SILC groups

A SILC group in session

Five caregivers, one from each group were trained by a representative from World Vision on good farming practices for crops that do well in the Mariakani area and they taught this to the other caregivers. The groups farm okra, greengrams, cow peas, tomatoes, maize and rice. Proceeds from the group farming activities are saved in the SILC group for onward lending to members who in turn use the borrowed money as capital for other Income Generating Activities (IGAs) such as sale of 'omena' (small fish), charcoal and paraffin. They also use the proceeds to buy chemicals for spraying crops and water for irrigating crops when the dams dry out during prolonged dry seasons. It is interesting to note that even members buy the produce harvested from the group farming activities which boosts their savings.

Improving outcomes for children

Jicho Pevu's interventions in education have resulted in 49 vulnerable children being enrolled and retained in school and their progress monitored by both their caregivers and the QIT. They have also established Children Learning Actively in Supportive School Environment (CLASSE) groups in three primary schools in the area and a youth group that encourages

children to diligently pursue education. CLASSE equips the teachers and children with knowledge on how to create an environment where children know their rights and teachers provide the support that children need to develop socially, emotionally, spiritually and academically.

Through targeted sensitization meetings with the community, Jicho Pevu has promoted knowledge on nutrition to caregivers and the community, increased access to nutritious food through the group farms and established a linkage service with World Vision, who continue to provide support on good farming methods to the community. Previously the common diet in the area of ugali and omena (stiff porridge and small fish) lacked vegetables and the consumption of fruits was low. Today, the same diet now consists of a variety vegetables harvested from the group farms and fruits.

In addressing education and food security, Jicho Pevu engaged caregivers in household economic strengthening through training of caregivers on SILC and IGAs. A total of 191 vulnerable children households are in SILC groups where they are also doing IGAs. Through this approach, the households have graduated from high vulnerability to medium vulnerability as they are no longer dependent on well wishers for every day survival as was the case before the economic strengthening activities were introduced. Today, these caregivers are able to pay school levies (even vocational training), buy school uniforms and books for their children, pay hospital bills, feed their families on a balanced diet, repair and build new houses and meet other basic household needs. In fact, more children now have access to education.

Conclusion

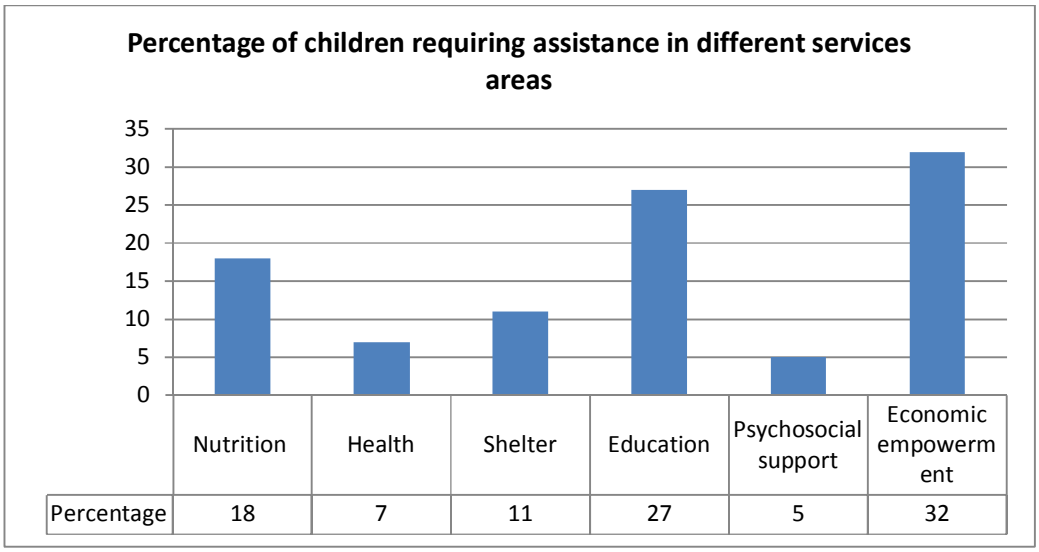
The impact of *Jicho Pevu* in the community has been profound. Education has become a community affair and parents no longer keep their children at home either for lack of school fees or cultural beliefs such as it is better to educate a boy than a girl. For a long time, the area chief and district commissioner had been unable to tame the child labour menace but now through the intervention of *Jicho Pevu,* this has been solved and caregivers no longer engage children in small businesses to generate income. In recognition of the work done by *Jicho Pevu* in reforming the community, a *Jicho Pevu* member now sits in the administrative meetings held at the district commissioner's office. Jicho Pevu also has an outreach group that educates the community on social ills in society using skits that are staged at market centres in Mariakani. Caregivers in the community are proud of their improved livelihoods and attribute this to the change ideas implemented by the *Jicho Pevu* QIT.

Neighbouring locations also noticed the transformation of the Mariakani community since Jicho Pevu was formed and demanded to be empowered so as to transform their communities. As a result, 3 more QITs have been formed in the larger Kaloleni Sub County thanks to Jicho Pevu's commitment to spreading the good news of quality improvement.

Kenya Network of Women with AIDs (KENWA)

With support from the American people, a community in the Kasarani sub-county of Kenya managed to enrol 150 children, of school going age previously not attending school, and enrolled 181 caregivers in 6 internal savings and lending groups with a total networth of Ksh. 300,000, within one year.

The Kenya Network of Women with AIDs (KENWA) is an NGO that has a presence in most of the informal settlements in Nairobi County. A representative from KENWA Korogocho was trained on QI in June 2011 and thereafter she enlightened the other KENWA members on the minimum service standards for quality improvement and use of the Child Status Index (CSI) tool. Later APHIA Plus Nairobi Coast trained KENWA members on QI in November 2011, after which they formed a QIT and since then 2 more teams have been formed. KENWA Korogocho is now in the second phase of QI that started in July 2012 and is scheduled to end in August 2013. In July 2012, KENWA did a CSI assessment on 560 vulnerable children, followed by a self assessment that identified education and economic empowerment as the priority areas. As shown in the graph below, 150 (27%) and 179 (32%) children needed assistance on education and economic empowerment respectively.



KENWA set their targets as 55 children attending school regularly and 60 caregivers taught on savings and internal lending to start small businesses so as to boost their economic well being.

Education

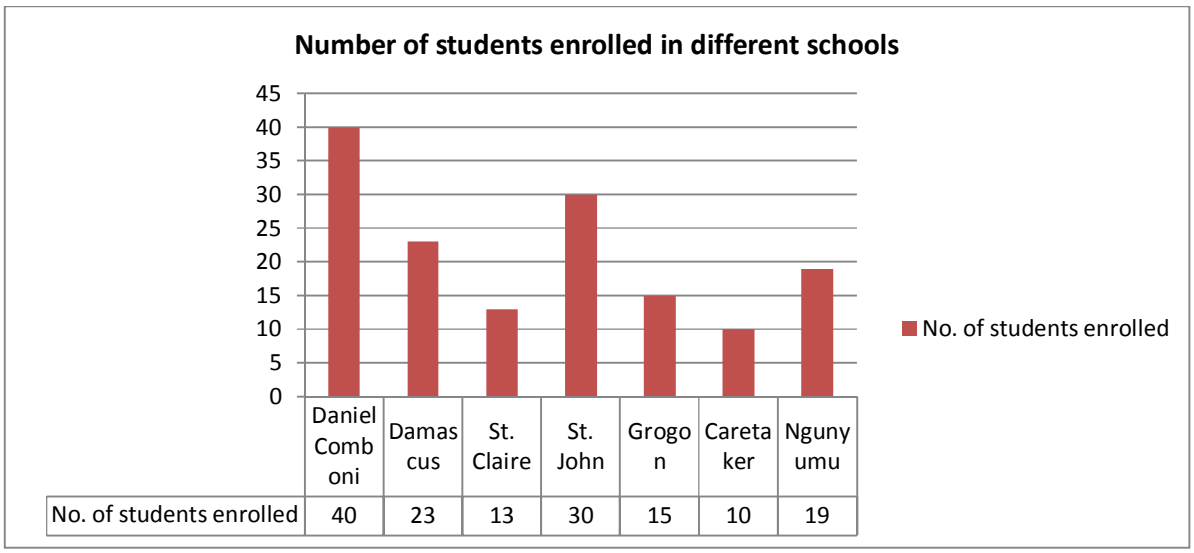
The root cause analysis revealed that the irregular school attendance was due to child labour, lack of school uniforms, and insufficient food. To address these issues, the QIT designed several interventions:

- Sensitizing caregivers on the importance of regular school attendance
- Negotiating with the school administration to allow vulnerable children to attend school while their caregivers pay the required levies in instalments
- Monitoring school performance of the reinstated children

QI Team Composition

1. KENWA staff (2)
2. Community health worker (2)
3. Caregivers (2),
4. Vulnerable children (2)
5. Teacher (1),
6. Health centre representative (1)
7. Community radio representative (1)

The QIT sensitized caregivers on the importance of regular school attendance. Initially, the QIT tasked caregivers with the responsibility of negotiating with the school administration so that their children would be allowed to attend school without school uniforms and money for lunch would be paid in instalments, but this failed and the QIT had to re-strategize. In the new strategy the QIT nominated some members who approached the various schools around Korogocho and this time round, they were successful and children were admitted to various schools. The caregivers were then tasked with the responsibility of following up on the performance and school attendance of the children through impromptu visits to the school and checking their school report cards. As a result of these interventions, school enrolment increased as 150 children were enrolled in different schools as shown in the figure below.



The QIT was also able to mobilise five sponsors from the community to pay school fees for some of the vulnerable children.

Economic empowerment

The interventions on economic empowerment were;

- Train caregivers on Savings and Internal Lending Communities (SILC)
- Support caregivers to start Income Generating Activities (IGAs)

Before QI was introduced KENWA already had support groups for caregivers who were living with HIV but the support groups was just that – a place for the women to encourage one another. Today the group speaks of a different story. When you sit down with them, they are all bubbly and happy. Happy because they are economically empowered and thus no longer dependent on well wishers and handouts, thanks to a change idea that was introduced after the QIT did the CSI assessment. The caregivers were trained on SILC and formed groups to put theory into practice. KENWA now has 6 SILC groups with a total membership of 181 caregivers assisting 93 vulnerable children who are now able to get a balanced diet, access medical services and attend school regularly due to the income generated by their parents.

Caregivers making candles at the KENWA Korogocho offices

Besides the children, caregivers have a lot to say about the SILC groups. Today they command respect within the community thanks to QI and SILC groups, and their livelihoods have improved. Previously they were stigmatised and looked down upon because they had little or nothing to offer. They literally depended on handouts and begging to survive. Most of their children were not in school because they were also involved in the begging business. They could not afford a decent meal, medical care and good clothing. But today all this has changed and they are even furnishing their houses and empowering younger women on how to live harmoniously with their husbands. Some of their testimonials are captured below.

'Previously, I would go to bed thinking where I will send my three children to go beg for food, while I searched the streets for someone to give me a handout. It never crossed my mind that I would be able to generate my own income and earn a living. But today I am a happy mother who is able to take care of my needs and send my three children to school, thanks to my 'githeri' (a mixture of boiled maize and beans) business.'

'My neighbours knew me as the woman with one dress because I only had one outfit. These days I have put on some weight, I dress smartly and am able to make my hair with the income I generate from my 'omena '(small fish) business. Besides, I am no longer stigmatised by me neighbours as was the case before. '

'Our friends living with HIV ask whether they can be picking their ARVs from the KENWA office as opposed to the local health centre because all the women living with HIV from KENWA are healthy and happy .... they do not look sick. '

'Before the SILC group, I could not stand before people to talk. But due to a lot of encouragement and advice since I joined the SILC group, I can now address a group of people. Am also credit worthy and my friends lend me money knowing that I have a small business that will enable me to repay, unlike before when no one would lend me money because they did not know where I would get money to repay.'

'Before the SILC group, nearly every end month, I would run to the KENWA office to ask for money to pay rent least we are kicked out of our house. Other days I was here begging for relief food. This has since changed because even when we have no money to pay for rent, I borrow from the SILC and then repay slowly from my income generating activity (IGA). The IGA has also enabled me to afford a balanced diet in my home.'

How CSOs' operate has changed!

Below are lessons CSOs have learnt in the process of using the quality improvement approach to deliver services to vulnerable children:

Communities have solutions: Before the introduction of quality improvement most CSOs and development partners thought that they had the best solutions to the challenges communities were facing especially in the eight domain areas. The solutions usually required lots of money as they were input-oriented and often times died a natural death as soon as the CSO/development partner exited. Things have now changed with representatives from the community forming a QIT and sitting together to develop solutions, communities are coming up with innovative ways of addressing challenges that require little or minimum financial resources and are based more on the resources readily available within the community. A good example is the multi storey gardens set up in informal settlements where overcrowding is common. Out of these gardens, caregivers are now able to provide nutritious meals to their households and use the monies saved and sometimes earned from selling vegetables to meet other household expenses.

Community-led improvements are sustainable: Involving the community in developing interventions leads to community ownership and eventually sustainability as communities are likely to continue with the interventions even in the absence of the CSO. The QI approach ultimately benefits the entire community and not just those on the vulnerable children programmes as seen from the case studies documented here. Most education, food security and legal services interventions have led to the transformation of the community.

Inclusion of different professionals in the QIT improves team efficiency: QITs are by design supposed to include key people in the society that have skills required to address the eight domains. The inclusion of teachers, nurses, provincial administration, children officers, agricultural officers and other professions has been very instrumental in helping teams implement their change ideas faster as they leverage on the specialised skills of the professionals.

Child participation in the QIT improves decision making: Previously most of the CSOs operated without involving children in decision making. With the quality improvement approach, children are represented in the QIT and get their voices heard and their needs met in the most appropriate way. Children who sit in the QIT also act as mentors to other vulnerable children in the community and are especially helpful in advising on how best to deliver a certain service.

Right services not just good services –The earlier approach of supplying vulnerable children with what CSOs thought was needed usually addressed just some of the problems children faced. The quality improvement approach is able to capture a holistic picture of what is ailing a child and thus interventions are designed to deliver holistic service that yields better outcomes as opposed to just outputs. In the words of one QIT member 'We are now able to provide the right mix of services to our vulnerable children.'

QI requires strong leadership and passion: For the quality improvement approach to succeed, it requires strong leadership and sometimes QIT member have to volunteer their time and

resources for the good of the vulnerable children. The joy of seeing lives transformed has given QIT members the impetus to keep doing what they have done even when financial resources were needed but not forthcoming. Apart from APHIA plus Kamili, the other APHIA projects did not have a budget allocation for facilitating QITs but through commitment and team members focusing on the bigger picture of sustainability, teams have been able to transform communities. Other communities can nurture the passion and leadership by identifying champions within the community who have a passion for working with vulnerable children and then build their capacity in child protection, communication, advocacy, and leadership, before linking them with key leaders within the community & government.

Some of the stories shared here show that teams that stand out, like Shangia, are eventually co-opted in decision making at sub-county or county levels and become the voice of vulnerable children at that level. Once they have attained this status, such teams are able to convince government authorities to allocate more resources for vulnerable children and their households for instance allocation of bursary funds to those who are genuinely in need of such support.

The power of measurement and documentation: Measuring and documenting the problems and improvements helps teams to identify the change ideas that work for a particular problem and those that do not or those that need modification for them to work. Documentation has also been used by one team to lobby government to address issues that are beyond what the QIT can handle. In one instance, AMPATH Kapsoya team wrote a letter to the county government explaining that children were not attending school because they preferred loitering near the flour mill so that they would collect spilled maize for sale. After passing that letter through the chief and appending their signatures on it, it was forwarded to the governor and the problem was solved by the Eldoret county government.

APPENDIX I: CHILD STATUS INDEX

CHILD STATUS INDEX (CSI)

DOMAIN	*1 — FOOD AND NUTRITION*		*2 — SHELTER AND CARE*		*3 — PROTECTION*	
	1A. Food Security	**1B. Nutrition and Growth**	**2A. Shelter**	**2B. Care**	**3A. Abuse and Exploitation**	**3B. Legal Protection**
GOAL	Child has sufficient food to eat at all times of the year.	*Child is growing well compared to others of his/her age in the community.*	*Child has stable shelter that is adequate, dry, and safe.*	*Child has at least one adult (age 18 or over) who provides consistent care, attention, and support.*	*Child is safe from any abuse, neglect, or exploitation.*	*Child has access to legal protection services as needed.*
Good = 4	Child is well fed, eats regularly.	Child is well grown with good height, weight, and energy level for his/her age.	Child lives in a place that is adequate, dry, and safe.	Child has a primary adult caregiver who is involved in his/her life and who protects and nurtures him/her.	Child does not seem to be abused, neglected, do inappropriate work, or be exploited in other ways.	Child has access to legal protection as needed.
Fair = 3	Child has enough to eat some of the time, depending on season or food supply.	Child seems to be growing well but is less active compared to others of same age in community.	Child lives in a place that needs some repairs but is fairly adequate, dry, and safe.	Child has an adult who provides care but who is limited by illness, age, or seems indifferent to this child.	There is some suspicion that child may be neglected, over-worked, not treated well, or otherwise maltreated.	Child has no access to legal protection services, but no protection is needed at this time.
Bad = 2	Child frequently has less food to eat than needed, complains of hunger.	Child has lower weight, looks shorter and/or is less energetic compared to others of same age in community.	Child lives in a place that needs major repairs, is overcrowded, inadequate and/or does not protect him/her from weather.	Child has no consistent adult in his/her life that provides love, attention, and support.	Child is neglected, given inappropriate work for his or her age, or is clearly not treated well in household or institution.	Child has no access to any legal protection services and may be at risk of exploitation.
Very Bad = 1	Child rarely has food to eat and goes to bed hungry most nights.	Child has very low weight (wasted) or is too short (stunted) for his/her age (malnourished).	Child has no stable, adequate, or safe place to live.	Child is completely without the care of an adult and must fend for him or herself or lives in child-headed household.	Child is abused, sexually or physically, and/or is being subjected to child labor or otherwise exploited.	Child has no access to any legal protection services and is being legally exploited.

DOMAIN	*4 — HEALTH*		*5 — PSYCHOSOCIAL*		*6 — EDUCATION AND SKILLS TRAINING*	
	4A. Wellness	**4B. Health Care Services**	**5A. Emotional Health**	**5B. Social Behavior**	**6A. Performance**	**6B. Education and Work**
GOAL	*Child is physically healthy.*	*Child can access health care services, including medical treatment when ill and preventive care.*	*Child is happy and content with a generally positive mood and hopeful outlook.*	*Child is cooperative and enjoys participating in activities with adults and other children.*	*Child is progressing well in acquiring knowledge and life skills at home, school, job training, or an age-appropriate productive activity.*	*Child is enrolled and attends school or skills training or is engaged in age-appropriate play, learning activity, or job.*
Good = 4	In past month, child has been healthy and active, with no fever, diarrhea, or other illnesses.	Child has received all or almost all necessary health care treatment and preventive services.	Child seems happy, hopeful, and content.	Child likes to play with peers and participates in group or family activities.	Child is learning well, developing life skills, and progressing as expected by caregivers, teachers, or other leaders.	Child is enrolled in and attending school/training regularly. Infants or preschoolers play with caregiver. Older child has appropriate job.
Fair = 3	In past month, child was ill and less active for a few days (1 to 3 days), but he/she participated in some activities.	Child received medical treatment when ill, but some health care services (e.g. immunizations) are not received.	Child is mostly happy but occasionally he/she is anxious, or withdrawn. Infant may be crying, irritable, or not sleeping well some of the time.	Child has minor problems getting along with others and argues or gets into fights sometimes.	Child is learning well and developing life skills moderately well, but caregivers, teachers, or other leaders have some concerns about progress.	Child enrolled in school/training but attends irregularly or shows up inconsistently for productive activity/job. Younger child played with sometimes but not daily.
Bad = 2	In past month, child was often (more than 3 days) too ill for school, work, or play.	Child only sometimes or inconsistently receives needed health care services (treatment or preventive).	Child is often withdrawn, irritable, anxious, unhappy, or sad. Infant may cry frequently or often be inactive.	Child is disobedient to adults and frequently does not interact well with peers, guardian, or others at home or school.	Child is learning and gaining skills poorly or is falling behind. Infant or preschool child is gaining skills more slowly than peers.	Child enrolled in school or has a job but he/she rarely attends. Infant or preschool child is rarely played with.
Very Bad = 1	In past month, child has been ill most of the time (chronically ill).	Child rarely or never receives the necessary health care services.	Child seems hopeless, sad, withdrawn, wishes could die, or wants to be left alone. Infant may refuse to eat, sleep poorly, or cry a lot.	Child has behavioral problems, including stealing, early sexual activity, and/or other risky or disruptive behavior.	Child has serious problems with learning and performing in life or developmental skills.	Child is not enrolled, not attending training, or not involved in age-appropriate productive activity or job. Infant or preschooler is not played with.

Public Domain: Developed by the support from the U.S. President's Emergency Fund for AIDS Relief through USAID to Measure Evaluation & Duke University.
O'Donnell K., Nyangara F., Murphy R., & Nyberg B., 2008

Child Status Record

Child's Name: _____ Age in years: _____ Gender: F/M ___ Child ID: _____
Location: District _____ Ward/Division: _____ Village/Neighborhood: _____
Caregiver's Name: _____ **Relationship to Child:** _____

I. CSI SCORES:	**Date:**	**Evaluator's Name or ID:**
Domains	***Scores*** *(Circle One)*	**Action taken today:**
1 — FOOD AND NUTRITION		
1A. Food Security	**4 3 2 1**	
1B. Nutrition and Growth	**4 3 2 1**	
2 — SHELTER AND CARE		
2A. Shelter	**4 3 2 1**	
2B. Care	**4 3 2 1**	
3 — CHILD PROTECTION		
3A. Abuse and Exploitation	**4 3 2 1**	
3B. Legal Protection	**4 3 2 1**	
4 — HEALTH		
4A. Wellness	**4 3 2 1**	
4B. Health Care Services	**4 3 2 1**	
5 — PSYCHOSOCIAL		
5A. Emotional Health	**4 3 2 1**	
5B. Social Behavior	**4 3 2 1**	
6 — EDUCATION AND SKILLS TRAINING		
6A. Performance	**4 3 2 1**	
6B. Education and Work	**4 3 2 1**	
Source(s) of information: *(Circle all that apply)*	Child, Parent/Caregiver, Relative, Neighbor, Teacher, Family Friend, Community Worker, Other *(Specify)* : _____	

II. IMPORTANT EVENTS: *(Check any events that have happened since the last CSI assessment if applicable.)*	___ Child left program __Child pregnant ___ Child died ___ Parent ill ___Parent/guardian died (specify who) _____ ___ Other (Specify) _____	__ Family member died __ Change in caregiver/adoption ___ Change in living location ___ Community trauma (violence, famine, floods, etc)	**Comment(s)** *if necessary:*

III. TYPES OF SUPPORT/SERVICES PROVIDED *(at present):*	**What was provided?**	**Who provided services?** (e.g., NGO, neighbor, teacher, church, or other)
A. Food and nutrition support (such as food rations, supplemental foods)		
B. Shelter and other material support (such as house repair, clothes, bedding)		
C. Care (caregiver received training or support, child placed with family)		
D. Protection from abuse (education on abuse provided to child or caregiver)		
E. Legal support (birth certificate, legal services, succession plans prepared)		
F. Health care services (such as vaccinations, medicine, ARV, fees waived, HIV/AIDS education)		
G. Psychosocial support (clubs, group support, individual counseling)		
H. Educational support (fees waived; provision of uniforms, school supplies, tutorials,		
I. Livelihood support (vocational training, micro-finance opportunities for family, etc.)		
J. Other:		
Suggestions for other resources or services needed:		

APPENDIX 2: SELF ASSESSMENT TOOL

SELF-ASSESSMENT OF IMPLEMENTATION OF OVC STANDARDS

Service: FOOD AND NUTRITION SUPPORT

How are we doing with this service?

DESIRED OUTCOME: Children and their households are food secure, and they enjoy good and regular nutrition for normal growth and development.

ESSENTIAL ACTIONS	How are we doing? Mark the box that best reflects how we are implementing each essential action now.		
	Not well	Fair	Good
Conduct a community food and nutrition needs assessment			
Map out stakeholders and resources available for food and nutrition support services			
Institute effective referral and linkage services with organisations involved in food and nutrition support activities			
Ensure increased food access by OVC and their households			
Promote knowledge on nutrition to OVC, their households and community			
Provide targeted food and nutrition intervention for OVC and households			
Advocate with stakeholders to ensure that OVC receive regular and adequate food and nutrition			

What essential actions are you implementing well?	What do you do to provide this service for vulnerable children and their families?
What essential actions are not being implemented now or not done well?	Why not? What are the challenges you face when providing this service?

SELF-ASSESSMENT OF IMPLEMENTATION OF OVC STANDARDS

Service: EDUCATION

How are we doing with this service?

DESIRED OUTCOME: Children within a caring environment are enrolled, retained and progress through education and/or training institutions by receiving appropriate and quality education to enable them to become a responsible and contributing member of the society.

ESSENTIAL ACTIONS	How are we doing? Mark the box that best reflects how we are implementing each essential action now.		
	Not well	Fair	Good
Sensitise and mobilise community members and key stakeholders in the support of education and training for OVC			
Identify community resource base to support education and training			
Design and deliver education and training which is appropriate according to age and gender in order to address gender disparities in education			
Develop and implement appropriate mechanisms that can enable OVC to continuously attend school by designing guidelines to address barriers at household level and how to overcome them			
Engage in policy advocacy to ensure regular and consistent reforms in the education sector which support needs/aspirations of OVC			

What essential actions are you implementing well?	What do you do to provide this service for vulnerable children and their families?
What essential actions are not being implemented now or not done well?	Why not? What are the challenges you face when providing this service?

SELF-ASSESSMENT OF IMPLEMENTATION OF OVC STANDARDS

Service: HEALTH

How are we doing with this service?

DESIRED OUTCOME: Improved access to quality health care for all vulnerable children and their households.

ESSENTIAL ACTIONS	How are we doing? Mark the box that best reflects how we are implementing each essential action now.		
	Not well	Fair	Good
Assess health needs, services and costs for OVC and their households			
Prevent common illnesses in OVC of different care cohorts, i.e., 0-2 weeks, 2 weeks-5 years, and 5 -18 years			
Enhance access to HIV prevention, treatment, care and support for OVC			
Ensure access to appropriate curative services for OVC and their households			
Promote safe water, hygiene and sanitation practices			
Advocate to service providers and the government to enhance access to quality health services for OVC and their households			

What essential actions are you implementing well?	What do you do to provide this service for vulnerable children and their families?
What essential actions are not being implemented now or not done well?	Why not? What are the challenges you face when providing this service?

SELF-ASSESSMENT OF IMPLEMENTATION OF OVC STANDARDS

Service: PSYCHSOCIAL SUPPORT

How are we doing with this service?

DESIRED OUTCOME: A vulnerable child who is happy; self-confident; expressive; hopeful for the future; interactive; participative; relates well with peers and adults; and aware of the community supportive systems and structures that can support the child at household and community levels.

ESSENTIAL ACTIONS	How are we doing? Mark the box that best reflects how we are implementing each essential action now.		
	Not well	Fair	Good
Conduct community mobilisation and sensitisation to create awareness of psychosocial needs for OVC and their caregivers			
Promote safe platforms for OVC to express their needs for responses and actions			
Strengthen community and household capacities to provide psychosocial support to OVC and caregivers			
Establish and strengthen effective referral systems and linkages between service providers, OVC and their caregivers			
Advocate for the provision of quality psychosocial support to OVC at all levels			

What essential actions are you implementing well?	What do you do to provide this service for vulnerable children and their families?
What essential actions are not being implemented now or not done well?	Why not? What are the challenges you face when providing this service?

SELF-ASSESSMENT OF IMPLEMENTATION OF OVC STANDARDS

Service: SHELTER AND CARE

How are we doing with this service?

DESIRED OUTCOME: A vulnerable child who develops within a caring family or alternative care arrangement that ensures adult care, shelter, and other basic necessities.

ESSENTIAL ACTIONS	How are we doing? Mark the box that best reflects how we are implementing each essential action now.		
	Not well	Fair	Good
Mobilise/sensitise the community to provide shelter and care			
Support appropriate community shelter and care through household needs assessment			
Map and create linkages among stakeholders who will support OVC shelter and care			
Support community and stakeholder initiatives to provide shelter and care to targeted OVC			
Advocate with service providers and stakeholders to ensure that provision of shelter to the OVC is appropriate to the local conditions			

What essential actions are you implementing well?	What do you do to provide this service for vulnerable children and their families?
What essential actions are not being implemented now or not done well?	Why not? What are the challenges you face when providing this service?

SELF-ASSESSMENT OF IMPLEMENTATION OF OVC STANDARDS

Service: CHILD PROTECTION

How are we doing with this service?

DESIRED OUTCOME: Vulnerable children with access to social and legal protection that guarantees a safe and secure environment for growth and development.

ESSENTIAL ACTIONS	How are we doing? Mark the box that best reflects how we are implementing each essential action now.		
	Not well	Fair	Good
Assess OVC protection needs, resources and structures available			
Sensitise communities on child rights, responsibilities and child protection			
Build and strengthen capacity of households and local community structures to enhance OVC protection and maximise utilisation of available resources			
Promote OVC participation to enable them contribute to matters impacting their lives			
Improve partnerships with social protection and law enforcement to ensure appropriate referrals and monitor follow-up actions			
Establish or strengthen data collection and documentation mechanisms			
Advocate for the social protection of vulnerable children at all levels			

What essential actions are you implementing well?	What do you do to provide this service for vulnerable children and their families?
What essential actions are not being implemented now or not done well?	Why not? What are the challenges you face when providing this service?

SELF-ASSESSMENT OF IMPLEMENTATION OF OVC STANDARDS

Service: HOUSEHOLD ECONOMIC STRENGTHENING

How are we doing with this service?

DESIRED OUTCOME: Households have improved and sustainable income to meet their basic needs and ensure the wellbeing of vulnerable children.

ESSENTIAL ACTIONS	How are we doing? Mark the box that best reflects how we are implementing each essential action now.		
	Not well	Fair	Good
Conduct economic needs and baseline assessment for target OVC households			
Map out available resources in the community for economic strengthening of OVC households			
Initiate economic strengthening activities: income generating activities, seed money, revolving funds, providing assets to the households, and providing direct cash transfer to the households			
Link with other existing community structures to ensure continuity and sustainability in meeting basic needs of OVC and other members of the household			
Advocate to ensure that all service providers prioritise the economic strengthening of OVC households			

What essential actions are you implementing well?	What do you do to provide this service for vulnerable children and their families?
What essential actions are not being implemented now or not done well?	Why not? What are the challenges you face when providing this service?

SELF-ASSESSMENT OF IMPLEMENTATION OF OVC STANDARDS

Service: COORDINATION OF CARE

How are we doing with this service?

DESIRED OUTCOME: Harmonised and coordinated approaches for effective and sustainable service delivery for improved well-being of vulnerable children; children's needs are met and communities are at the forefront of addressing OVC issues.

ESSENTIAL ACTIONS	How are we doing? Mark the box that best reflects how we are implementing each essential action now.		
	Not well	Fair	Good
Establish a national directory of service providers who care for OVC at all levels			
Develop effective referral mechanism to meet children's needs			
Strengthen/establish new co-ordination units to integrate and harmonise OVC service provision at all levels to avoid duplication and ensure prudent utilisation of resources			
Advocate to the government and service providers to ensure that mechanisms for co-ordination are put in place for the improvement of service delivery to the OVC			

What essential actions are you implementing well?	What do you do to provide this service for vulnerable children and their families?
What essential actions are not being implemented now or not done well?	Why not? What are the challenges you face when providing this service?