Case Study

Communities in Action:

Improving Quality in Service Delivery for Enhanced Wellbeing of Children in Ethiopia

October 2009

Save the Children.

ProPride

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COMMUNITIES IN ACTION

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Acknowledgements

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This case study highlights the key findings and lessons learned from the Quality Improvement pilot project. A companion case study, *Applying the Science of Improvement to Achieving Quality Care for Vulnerable Children in Ethiopia*, was prepared by the USAID Health Care Improvement Project and Save the Children and is available at http://www.hciproject.org.

For more information regarding the project, please contact Save the Children's HIV/AIDS Office at 2000 L Street, NW, Suite 500, Washington, DC 20036.

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Table of Contents

Acronyms

CBOs	Community-Based Organizations
CMAs	Critical Minimum Activities
CSI	Child Status Index
FHAPCO	Federal HIV/AIDS Prevention and Control Office
LNGOs	Local Non-Governmental Organizations
OVC	Orphans and Vulnerable Children
PC3	Positive Change: Children, Communities, and Care Program
PEPFAR	President's Emergency Plan for AIDS Relief
PSS	Psychosocial Care and Support
QI	Quality Improvement
SC	Save the Children
URC	University Research Co., LLC
USAID	United States Agency for International Development

Introduction

While communities are best placed to deliver care and protection services to children, many lack the mechanisms and systems to ensure coordination and quality of services. With increased resources being funneled to community-based initiatives, there is an emerging need to develop systems to support larger scale programs while at the same time ensuring consistency and quality in meeting children's basic needs. Several models exist, but the evidence is still evolving on how resources are being effectively used to improve the wellbeing of orphans and vulnerable children (OVC).

Save the Children (SC) has been implementing OVC programs at scale in Ethiopia through the Positive Change: Children, Communities, and Care Program (PC3), funded by the President's Emergency Plan for AIDS Relief (PEPFAR). This program was designed to reach approximately 500,000 children with a comprehensive range of services through large-scale capacity-building efforts targeting local non-governmental organizations (LNGOs) and community-based organizations (CBOs). During the program's implementation, key questions arose regarding the ability of these organizations to not only deliver comprehensive services but also ensure they were of high quality. Until this point, there was a lack of standardization in the provision of services to children in need, a process that often failed to lead to measurable improvements in child wellbeing. Furthermore, there was a recognition that community groups needed to be fully engaged in the process of defining quality and making changes to improve service provision at the point of service delivery. Therefore, in order to understand whether groups at the point of service delivery could engage in a process of quality improvement in order to improve the lives of children, SC and University Research Co., LLC (URC), in collaboration with a number of international and local partners, developed a pilot program which was implemented from February 2008 to March 2009.

Background

SC became the lead organization for the PC3 program in 2004, and it has since become one of the largest US Government investments at scale for OVC, targeting service delivery to 500,000 OVC over a five-year period. Part of PC3's mandate is national level capacity-building and the implementation of quality programs for children affected by HIV and AIDS. This program works through 5 international partners, 34 national level NGOs, and almost 600 local CBOs. During implementation, program partners met to explore the possibility of setting quality standards for OVC; the process ultimately led to the development of draft standards. Program partners organized numerous workshops for local stakeholders to acquaint them with the standards. The push to standardize service delivery came from the realization that partners were offering varying levels of services within a standard package of care, including health, education, protection, and economic strengthening, among others. Furthermore, donor reporting mechanisms were not clear on what constituted a 'service,' and specific guidelines were lacking to support meaningful conclusions about improvements in children's wellbeing.

A wide range of implementers in Ethiopia and the National OVC Task Force participated in the development of the draft service standards in 2006. These standards provided guidance for implementing organizations but did not generate evidence that they actually improved OVC's wellbeing. Also unknown was whether the standards were practical and do-able at the point of service delivery. Furthermore, a process was needed to ensure that organizations at the point of service delivery could improve their services to achieve desired outcomes. PC3, as the largest program with the broadest reach for OVC, offered an ideal laboratory to test the standards and gather evidence on whether the services were sufficiently effective to warrant national level programming.

The pilot was designed to answer four questions:

1) Are the service standards understandable and "do-able" at the point of service delivery?

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

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

4) Do the service standards (when implemented) lead to measurable improvements in the lives of children?

Methods/Design

To test the standards, SC chose a partner that had successfully delivered services to children affected by HIV and AIDS under the PC3 program. ProPride, based in Dire Dawa, had been recognized for its efforts at the community level and had sufficient capacity to implement the pilot. The pilot focused on groups' ability to implement the Critical Minimum Activities (CMAs) within the following service components: economic strengthening, education, psychosocial support, legal protection, food and nutrition, health services, and coordinated care. However, shelter and care was excluded as a service component because organizations recognized the difficulty in meeting the CMAs given the high costs. Six CBOs under ProPride were selected to pilot the services.

The CMAs were piloted from September 2008 to February 2009 using the "improvement collaborative" approach. This approach "is a shared learning system that brings together a large number of teams to work together to rapidly achieve significant improvements in processes, quality, and efficiency of a specific topic area, with intentions of spreading these methods to other sites."[1] In addition, the improvement collaborative fosters learning opportunities among participating organizations through forums, such as learning sessions, where representatives of all participating organizations come together to share their successes and challenges as well as work together on common objectives/ indicators and best practices. The PC3 program served as an excellent entry point given the program's tiered structure. At national level, the work with the National OVC Task Force also helped facilitate shared learning between the national and local levels, including government. Table 1 shows the different levels of stakeholders involved in the pilot.

The pilot began with an orientation and several trainings on quality improvement (QI) to all key stakeholders. These activities were followed by a baseline survey of participating CBOs enabling them to assess their current level and quality of service delivery. The assessment surveyed 543 children and 89 caregivers. Gaps in the provision of services and barriers were identified using an assessment checklist administered by Tier I and II coaches. Tier III organizations then identified improvement objectives that corresponded to the CMAs and worked in QI Teams to implement the standards. The Teams were monitored monthly by Tier I and II coaches to determine how closely Teams adhered to the CMAs as articulated in the draft service standards and whether the Teams were meeting their improvement objectives. Additionally, each Team documented its successes and challenges in a scrapbook which was used by the CBOs to advocate for resources and monitor progress in the implementation of the standards as well as track indicators of wellbeing for children. The use of the scrapbooks helped to build ownership as the data collected were locally relevant and determined by the groups themselves. Learning sessions allowed partners to discuss and share best practices, successes, and barriers in implementing the standards. The Teams used the Child Status Index[2] tool to systematically capture the impact of the changes to understand whether children were faring better.

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1 "The HCI Project: USAID's Resource for Health Care Improvement", USAID Health Care Improvement Project, University Research Co., LLC, May 2008.

2 MEASURE Evaluation developed the Child Status Index (CSI, available at http://www.cpc.unc.edu/measure/tools/child-health/child-status-index) with PEPFAR support. It can be used as a case management tool for volunteers during home visits and helps to coordinate care for a child and household and enables volunteers to assess progress over time. It was translated in Ethiopia into Amharic to facilitate understanding by the volunteers and CBOs.

Table 1: Stakeholders and Roles

Organization	Roles and Responsibilities
Ministry of Women's Affairs	1. Involve the Government of Ethiopia in the QI Initiative 2. Chair and prepare national plans for the Task Force 3. Mobilize resources
Federal HIV/AIDS Prevention and Control Office (FHAPCO)	1. Co-chair the Task Force 2. Build continued commitment toward quality improvement for OVC programs 3. Assist in soliciting funds
The Regional HAPCO office in Dire Dawa	1. Oversee the HIV/AIDS care and support services in the surrounding region 2. Assist LNGOs with their specific programs 3. Fund the HIV/AIDS facilitators at the Kebele level 4. Participate in planning and implementing change
International Non-governmental Organizations (Tier I)	1. Provide technical assistance and mentoring to their Tier II and Tier III partners 2. Assign component-specific coaches to assist their Tier II partners on the service standards, improvement objectives, and CMAs 3. Provide training by using a training of trainers (TOT) approach to their Tier II partners to ensure that the proper information will be given to the CBOs to help build their capacity 4. Develop and execute monitoring tools
LNGOs (Tier II)	1. Act as a bridge between the Tier I and Tier III partners 2. Provide direct mentoring to the CBOs on the service standards, assistance with gap analysis, support in data collection, and implementation of the CMAs 3. Work closely with Tier I partners to assess the effectiveness of Tier III partners in delivering services according to standards
CBOs (Tier III)	1. Pilot the draft service standards and CMAs
Quality Improvement Team: A QI Team comprises a member from the CBO's executive committee, two from the CBO's subcommittee in the service area being piloted, one guardian, 2 OVCs (older children), a member from another NGO working in the Kebele, and a member from HAPCO at the Kebele level	1. Select, implement, and study changes to improve quality of service delivery 2. Collect and analyze monthly data on compliance 3. Participate in learning sessions to share experiences and results

Results

The pilot study gathered data on the changes which groups made to improve service delivery and tracked indicators related to their improvement objectives collected at the beginning and end of the pilot to assess changes in child wellbeing. For the most part, groups were able to meet or exceed their objectives. Moreover, all of the groups revealed changes in organizational practices which allowed them to better organize for quality. Key results are indicated below by service component.

Coordinated Care

Although coordinated care was originally seen as its own service component, the pilot showed that rather than being a service, coordinated care should serve as an overarching principle for the delivery of all services. Volunteers visited OVC regularly and had the primary responsibility of coordinating their care. While a volunteer may be trained in one technical area, he or she should also have the skills to recognize the needs of the entire child and refer, if necessary, to additional services.

The pilot indicated that the Coordinated Care QI Team actually delivered the best and most comprehensive range of services. This Team made several changes to achieve its desired outcomes. At the pilot's conclusion, noticeable changes were apparent in this QI Team's ability to assess, refer, and follow-up on children receiving support. The Team emphasized not only assessing the child(ren) but also the household situation, enabling more holistic care and support to families. In addition, volunteers were given clear job descriptions, allowing for better understanding of their roles and responsibilities. At the end of the pilot, the volunteers noted that they now understood better the concept of delivering a "service" (i.e. from simply providing material support to providing services based on needs). The other QI Teams also exhibited greater coordination across stakeholders. For example, there was evidence of increased linkages at the community level between service providers, such as the local Kebele government, which greatly enhanced the referral system. Furthermore, all QI Teams established regular, more thorough follow-up systems to children and households to ensure receipt of services to which they had been referred.

Education

The Education QI Team implemented major changes in the way its members delivered an education service. Before the pilot, children who dropped out of school received no follow-up as to the specific cause of their absenteeism. However, after the establishment of the Education QI Team, volunteers started to follow-up and refer children to tutorial services and food support, for example, depending on the child's need. It should be noted that a major barrier to school attendance was lack of food. Once the group understood this, they began to link children to food support which has helped to increase enrollment and retention rates. The Team linked 231 children out of 395 (58%) to food support through the World Food Program and other local organizations. They also eliminated other barriers to education, including the lack of education materials and the need for tutoring. The volunteers now visit the schools to determine whether the children are actually attending. Better follow-up over a 6-month period brought the number of dropouts down from 27 to 0.

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3 A Kebele is the lowest administrative unit in Ethiopia.

Table 2: Progress against Improvement Objectives for Education, Sept. 2008 to Feb. 2009

Improvement Objective	% Achieved
Provide food support for 25% of OVC who are in need	231/395 = 58%
Provide 80% of OVC in the area with scholastic materials and uniforms	598/598 = 100%
Increase the number of OVC receiving tutorial support to 70% by the end of 2008	130/310 = 42%
Assess 100% of OVC who dropped out or are frequently absent through home visits	100% as there were no dropouts to assess

Health and Nutrition

Health care was a major concern for children being served in the program because of the inability to pay for medication and the lack of access to affordable medical care. The Health QI Team improved the number of referrals made for health care through increased follow-up and a strong partnership with the local government, which issued fee waivers for children in need. In addition, the Team helped to improve care-seeking behavior by eliminating barriers to care. The Team reported that because they were able to facilitate the fee waivers, children were no longer waiting for long periods (on average eight days) before seeking medical care.

Table 3: Progress against Improvement Objectives for Health and Nutrition, Sept. 2008 to Feb. 2009

Improvement Objective	% Achieved
100% of OVC referred by caregivers to health facilities receive medical treatment within 3 days	40/40 = 100%
Implement a functional referral system	Achieved
10 volunteers trained to identify children with malnutrition or food insecurity	36 were trained

Economic Strengthening

The CBO that piloted the standards for economic strengthening also achieved noteworthy improvements. Before the QI process began, this CBO was not linking older OVC with income-generating activities according to the child's interests, thus children were not attending/completing the organized trainings. After the QI process, the Team worked to link each older OVC with a training of interest. The Team did this by collaborating with the business community, which provides both the training and employment opportunities for the older OVC and caregivers. Furthermore, this Team mobilized additional resources to support the training.

Table 4: Progress against Improvement Objectives for Economic Strengthening, Sept. 2008 to Feb. 2009

Improvement Objective	% Achieved
10% of OVC over 15 attend vocational training	5/25 = 20%
Another 30% of OVC households are organized in solidarity groups (Savings groups)	6/15 = 40%
80% of OVC households organized in solidarity groups have access to financing and are engaged in business	6/7 = 86%

"Last year the community was expecting something from us but this year the attitude has changed and everyone wants to contribute to the children. For instance, this year the contribution has doubled and they have developed trust in what we are doing."

Home-based care provider

Psychosocial Care and Support

Before the pilot, the CBO admittedly did not provide a comprehensive range of services for psychosocial care and support (PSS). For instance, other than linking children to religious or spiritual community leaders, this CBO was not equipped to address children's PSS issues, such as the need for grief and trauma counseling. Through the QI process, this CBO has adopted a process standard that articulates how to identify children who need counseling or special attention and refer accordingly. Additionally, the Team also made a concerted effort to identify and better train volunteers.

Legal Support

One of the main goals of the Legal QI Team was to increase the number of children with birth registrations to 100% by the pilot's end, a significant target as birth registration is a critical service and gives children access to a range of services, including health care and education. However, even though this goal was not achieved during the pilot, significant steps were made by including the Bureau of Women's Affairs in the process and raising awareness in the community of the significance of birth registration for all children. The QI Team hopes to achieve this goal by the end of 2009. In addition, the CBO also focused on following up on abuse cases in the court system. The CBO had much difficulty with the prosecution of abuse cases before the pilot due to lack of coordination among law enforcement bodies as well as the need for evidence. However, this process was streamlined by involving a wide range of stakeholders from the community on the Legal Support QI Team (i.e. lawyers, police, volunteers, OVC, CBO volunteers). This Team addressed nine cases, of which four were resolved in the court system, three via alternative dispute resolution, and two are still being litigated. A key area of improvement for this Team was the development of a list of all relevant law enforcement bodies with phone numbers and addresses which was shared with the volunteers. As such, volunteers understood whom they could refer children to in the case of abuse.

Discussion

Achieving Quality through Essential Actions: Making Standards Understandable and Doable at the Point of Service Delivery

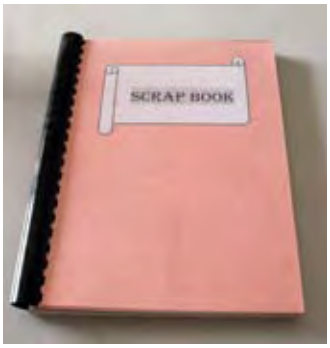
The data collected in the six-month period provided evidence on the ability of local groups to internalize quality and make changes to improve children's overall wellbeing. For example, the pilot showed that the CBOs can comply with several of the CMAs articulated in each service standard. However, a few gaps remain that the CBOs must still address. Progress and momentum generated during the pilot suggest that will happen in time and that most CBOs will be able to implement all CMAs. With a process in place to assess and address barriers as well as learn and share experiences with other service providers, the groups will be able to more readily devise solutions to current challenges. While it is too early to suggest that all CMAs are feasible, the results are extremely positive, indicating that compliance with the standards is certainly do-able.

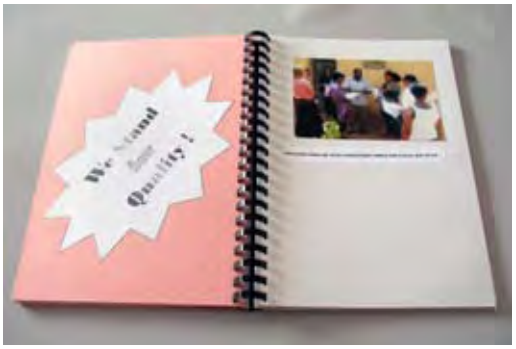
An important pilot revelation was that irrespective of the services being provided, three elements stood out as absolutely necessary: assessment, referral, and follow-up. The CBOs forged critical linkages with other service providers within their community and with the local Kebele administration, which aided in the facilitation of referrals for OVC. This process of engagement enhanced the volunteers' ability to quickly and appropriately respond to children's needs. Moreover, a regular and more thorough follow-up system was implemented by all CBOs. Volunteers are now responsible for conducting regular home visits to provide follow-up support and ensure children actually received the services. Regular follow-up has shown very positive results and led to quicker resolution of problems, especially in the contexts of abuse and health care.

The pilot also indicated how important volunteers are to the QI process. Volunteers are uniquely positioned to help identify needs through assessment of children during home visits, referral to additional services based on need, and follow-up to ensure that those children and households receive the services. Establishing functional referral mechanisms and training of volunteers were extremely important. Indeed, these actions proved to be more significant than many of the other CMAs articulated in the original standards document. The ability to provide services and create linkages based on need is critically important in delivering quality services. Once CBOs become accustomed to providing services based on need, they may be able to improve efficiency in the use of resources. Other changes in the CMAs proved necessary as well. For example, under the service area shelter and care, CBOs had difficulty providing shelter because of the costs which were oftentimes prohibitive. Other CMAs that proved difficult had to do with limited financial resources on the part of the CBOs as well as cultural or political barriers. For instance, most CBOs expressed the need for additional resources for trainings, stationary materials, and transportation. Thus, increased fundraising within the local community or budgeting in a program's monitoring and evaluation budget is recommended.

Organizing for Quality: Practices that Facilitate the Ability of Organizations to Meet the Standards

The pilot captured several best practices that facilitated the ability of implementing organizations to meet the CMAs. The pilot's results have far-reaching implications for the way groups organize themselves to deliver OVC services. A key component of the QI process was that CBOs could make small changes in the way they deliver services, which led to much larger impacts on the children being served. Of note was the implementation of a coordinated care model that enabled the CBOs to assess the needs of the OVC and refer and follow-up as necessary. Additionally, other best practices include increased documentation; reorganization of how the CBOs carried out their work; and increased





Each QI Team has their own scrapbook which is used for documentation purposes. This tool is extremely significant as it has not only taught the community how to document their work but also has allowed them to keep the data they have collected within the community for future use, i.e. advocacy and fundraising.

advocacy and awareness within the community, which reduced stigma around OVCs and increased community ownership. Furthermore, significant improvements were made in volunteer management, with CBOs recruiting and training additional volunteers so as to decrease the care burden and ultimately provide better services.

The QI process also enabled CBOs to recognize that not all children's needs could or should be addressed by spending money. Many of the changes that the CBOs made had to do with the way they were organized to deliver services. For example, before QI, many CBOs reported that more than one volunteer would visit a household to check on a child. For instance, the psychosocial volunteer would address psychosocial needs and the health volunteer, health needs. During the pilot, all volunteers learned to assess a child's needs and refer him or her to community-based services. This coordinated-care approached enabled CBOs to optimize volunteers and also recognize cost savings.

Making Measurable Improvements in the Quality of Service and Programming

The QI process led to measurable improvements in the quality of the services provided to OVC and how groups organize themselves to provide the services. The results from the pilot show that the CBOs are now using a coordinated care approach that assesses a child's needs before providing a service, refers the child to other service providers if the organization itself does not provide it, and, lastly, follows up with the child after delivering the service in order to confirm such delivery and monitor improvements in the child's wellbeing. These improvements were directly related to the QI Teams' ability to link with a broad range of service providers and the local government to provide more referrals to other services and increase the effectiveness of such referrals. These linkages enhance the organizations' ability to address issues they identify during home visits.

The QI pilot has made great strides showing what can be accomplished at the community level. Significant changes have occurred within CBOs, and enthusiasm has grown around the concept of incorporating quality improvement methods within all service components. The CBOs have greater understanding of the QI process and have fully begun to integrate it into the way they work, but they still need further technical support and coaching in the area of monitoring progress and documenting results. Furthermore, more cross-learning between the CBOs would more rapidly disseminate best practices and ultimately enable scale-up of best practices across many organizations. Cross-learning was vital among the six CBOs, as each piloted only one service component. Knowledge and experience need to be shared to boost effectiveness. Overall, CBOs reported that the QI process was useful and built their capacity to advocate for additional services from their local government, as they better understood their challenges. Also, the CBOs were quite innovative in using their data to enhance their capacity to raise money from community members and local businesses. This will eventually lead to decreased dependency on external/donor resources as communities understand the challenges and rise to meet them.

Making Measurable Improvements in the Lives of Children

The evidence from this pilot is limited, but the results suggest that the standards have led to measurable improvements in children's lives. For instance, the Education QI Team documented increased school attendance; fewer dropouts; and more links with tutorial and food support. Furthermore, the Health and Nutrition QI Team reduced the period from requesting health care to receiving it from an average of five to eight days to three days for OVC and their families. These beneficiaries are also now receiving a waiver from the Kebele to receive free health care services.

In order to track these improvements, the CBOs utilized a number of tools that assisted them to monitor their progress, document their work, and continuously identify their barriers and successes. These tools included a learning session guide, documentation journal, assessment checklists, and a scrapbook. All of the tools were used to guide the CBOs through the QI process, allowing them to document their achievements over time. At the end of the pilot, the groups seemed to favor the scrapbook because it was held at the CBO level and could be used for advocacy and fundraising efforts, as it highlighted anecdotes from children served and contained personal stories. Additionally, a simpler data capture tool allowed groups to more rigorously document changes in children over time. In the future, it will be important to limit the number of tools and allow flexibility for groups to document the information they deem necessary in order to sustain their documentation efforts.

Why Was this Pilot Successful in Ethiopia?

Ethiopia's Tradition of Community Organization

Within Ethiopia, there has been a long history of communities helping one another. Community-based organizations known as *Idirs* were first established to assist families during the time of grieving and to help cover funeral costs. These organizations had very established governing structures including a chairperson, vice-chair, secretary, accountant, and home-based care providers. As HIV/AIDS became an increasing problem in the communities, the *Idirs* essentially transformed themselves, focusing more on mitigating the impact of the disease on children. The CBOs were therefore developed from a long-standing tradition of giving and mobilizing community efforts to address problems. In Dire Dawa, where the pilot was carried out, there was also a long history of groups programming to meet the needs of orphans. This history meant that they were very familiar with the challenges they faced in the delivery of quality programs for OVC. Their ability to understand the barriers also enabled them to devise innovative solutions to address them.

Community Action/Mobilization

The pilot also resulted in increased efforts to raise community awareness of OVC issues and ultimately through this awareness, led to greater commitment to assist OVC in their community. This commitment and ownership is demonstrated through the increase in the number of volunteers, the amount of money donated directly to CBOs by the community, the increase in funding to CBOs by the local government, as well as the number of children who now have access to the services (i.e., scholastic materials, health services, food support, etc.) compared with before.

Government Buy-in

In order for programs to be successful in the long-term, there needs to be a strong link with both national and local government agencies. In Dire Dawa there is close collaboration between CBOs and LNGOs and the local government. In addition, by including so many different actors on the QI Teams (i.e., one member from the CBO's executive committee, two members from the CBO's subcommittee in the service area being piloted, one guardian, two OVCs (older children), one member from another NGO working in the Kebele, and one member from HAPCO at the Kebele level) it provided a forum for both CBO and local government representatives to discuss issues on a monthly basis and come up with joint solutions—fee waivers for OVC to receive free health services, lessening the time for prosecuting abuse cases, and assisting in helping OVC to recover homes that were lost to relatives or the community.

Is this Replicable?

The quality improvement approach and methodology that the CBOs used to improve the quality of their programs and comply with the service standards is transferable across organizations and across countries. By integrating the process into their normal work, the QI teams showed that quality improvement can be done. However, there were some context-specific factors (program structure, community action/mobilization and government buy-in) that may not be transferable or replicable across organizations and regions. What this highlighted, though, was the need to have wide stakeholder engagement throughout the process in order to sustain efforts and reach quality.

Lessons Learned from the Pilot Design

Ethiopia is the first country to embark on piloting draft service standards at the point of service delivery for OVC. As such, it has provided important lessons on both the strengths and weaknesses in the actual design of the pilot and on what worked/did not work well during the implementation of the pilot. These lessons provide valuable insights for future efforts to gather evidence on standards.

Strengths of the Pilot Design

One of the main strengths of the design was the tiered structure of the PC3 program under which the standards were piloted. This structure was conducive to supporting the overall process for QI. At the Tier I level, coaches were assigned to provide technical support and mentoring to Tier II partners, who were then able to provide support and mentoring to the Tier III partners within the community. The structure itself allowed for the standards to be piloted at the point of service delivery and created an overarching structure within which to build capacity in QI. While the pilot was meant to be conducted by two other LNGOs and their partners, Save/US was still able to take the lessons it learned in Dire Dawa at the community level and share them across all partners in the PC3 program, as well as at the national level through the OVC Task Force.

Secondly, it is important to highlight that the way the pilot was designed, allowed for the process to be essentially integrated into the already existing structures of the organizations. For example, the QI teams continued to meet during their regularly scheduled bi-weekly meetings, rather than having additional meetings. The Tier II coaches already had scheduled visits to the Tier III partners, and thus used these visits to discuss QI teams' progress and provide coaching. This design allowed for QI to essentially be integrated into the work of the CBOs, instead of being seen as a separate task and a burden.

Weaknesses of the Pilot Design

Each CBO was assigned one component area to pilot test, even though all of them provide more than one service to OVC. At the end of the pilot, many CBOs noted that they would use the process in other areas of work. In the future, it would be important to emphasize the integrated nature of OVC programming as such groups would pilot all areas using a coordinated care approach.

At the Tier I level, six external coaches were selected to provide mentoring/coaching support to Tier II partners. Each of the six coaches possessed an expertise in one service area and had also been trained in QI. However, each of the coaches that were selected already had other full-time responsibilities under the PC3 program and thus was not able to dedicate the needed time to coaching the Tier II partners.

The QI teams were introduced to various documentation tools at the beginning of the pilot. The first was a checklist that allowed them to assess their current performance against the standards in order to understand where they still have gaps. The second was a scrapbook where the QI team was to document the process and changes that they had implemented and their results. Lastly, a journal was developed to help QI teams synthesize their results; describe their gaps/barriers; their proposed solutions; and their quantitative results. An attempt was made at the beginning of the pilot to apply the Child Status Index tool to measure outcomes per service, but due to the volunteers' lack of familiarity with this method for assessing child wellbeing, these results did not provide a reliable baseline. At the end of the pilot a simpler monitoring tool that captured data on the outcomes of their improvements was introduced. This tool would have been more useful to introduce at the beginning of the pilot, so that the teams could have tracked the outcomes of their improvements over the duration of the pilot.

Lastly, the pilot carried out by Save/US and its local partners Mekdim and ProPride, was not allocated any additional resources in order to carry out the project. However, it was clear that there were certain costs associated with the pilot. The main costs were related to the baseline and endline survey; the learning sessions, which involved bringing all the partners together to discuss their best practices, results and remaining challenges; and for development of tools and job aides on the standards. There were no additional resources needed for bringing the QI teams together to meet or to have coaching visits, as they were integrated into their already existing meeting schedules.

Conclusion

Good Enough versus Gold Standards

The process for developing service standards involves bringing key OVC stakeholders together, and through a consensus-building process defining what constitutes a quality service for each of the component areas. The critical minimum activities outlined in the standards serve to define what all OVC stakeholders believe to be "good enough" care for OVC and are the minimum requirements for providing a quality service. The major activities and quality characteristics that also comprise the service standards (often a much longer list of activities that largely depended on availability of resources) serve to define what Ethiopia believes to be the "gold" standard of care and what service providers should strive to achieve. Thus, "good enough" care is really defined by what we believe to be the minimum requirements necessary to make a measurable improvement in children's well-being, while the "gold" standard of care is fulfilling all the activities and addressing all the quality dimensions as defined with the standards.

It is important however, to be aware that these standards were developed based on the current context in Ethiopia and will not necessarily hold constant over time. As the HIV/AIDS epidemic evolves, so shall our response. Thus, what defines "good enough" care and the "gold" standard of care need to be revisited by the stakeholders in Ethiopia and redefined based on what is appropriate within the contextual realities of that time.

Nevertheless, the pilot indicated that CBOs at the point of service delivery have the capacity and willingness to internalize quality improvement processes and make the necessary changes to overcome the barriers that hinder program implementation. Their ability to recognize and effectively address key barriers will ultimately lead to even more improvements in how they are organized to deliver services as well as improvements in the wellbeing of the children they serve. Child wellbeing assessments indicated improvements in many areas, including health (improved care seeking), economic strengthening, education (increased enrollment, retention and improved performance), and legal protection (increased number of cases resolved through the courts or through alternative dispute mechanisms). Going forward, these CBOs should integrate QI in all the services they provide. Their ability to coordinate care for children will be critically important and will lead to major improvements in the quality of programs targeted to OVC.