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Community-Based Social Services: Practical Advice Based upon Lessons from Outside the World Bank

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I. Introduction

There is now broad agreement that community-based social service interventions can have sustainable and effective outcomes.¹ Evidence also suggests that community-based projects are cost-effective, not least because they make maximum use of volunteerism and informal, community-based safety nets – resources that are hard to mobilize at the macro-level.²

While community-based care is commonplace in industrialized countries, the largest aid agencies have only recently begun to finance such projects in developing countries. However, World Bank lending in this area is growing quickly. To date, the Bank has provided more than \$1.4 billion of financing for community-based social services in over 110 projects around the world. This figure is set to increase as the Bank turns its attention to issues of risk and vulnerability; and as demand for social care services is fuelled by the increase in serious social problems such as elderly abandonment, drug abuse, and, especially, the social costs of the AIDS epidemic.

Recently, we researched Bank lending for community-based social services and drew initial lessons on project design.³ The purpose of this paper is to gather information outside of the Bank, in both developed and developing countries, on design and delivery of community-based social service initiatives. While the field is sufficiently new that “best practice” may not yet be fully identifiable,⁴ there are many initiatives funded by other governments, NGOs, and donor agencies, which taken along with acknowledged good practice from the

¹ See, for example, Karen Horsch, “Evaluating CBIs: Facing the Challenges and Improving Practice,” in The Evaluation Exchange Newsletter, Harvard University, Volume III, Number 3-4 1997, pp. 2-5.

² See, for example, Geoff Foster, “Responses in Zimbabwe to Children Affected by AIDS,” in SAfAIDS News Volume 8 No. 1, March 2000, available at www.safaids.org.zw/n127feat.html

³ Mcleod, Dinah and Maurizia Tovo, Social Services Delivery through Community-Based Projects (Washington, D.C.: Social Protection Discussion Paper, The World Bank, 2001).

⁴ Although new publications taking stock of Bank and other donors’ experience are now available. See, for example, K. Subbarao, K., Angel Mattimore, and Kathrin Plangemann, Social Protection of Africa’s Orphans and Vulnerable Children: Issues and Good Practices, Elena Volpi. Street Children: Promising Practices and Approaches, Amber Surrency, Guidelines for Supporting Early Child Development (ECD) in the Multi-Country HIV/AIDS Program (MAP) for Africa, and Louise Fox et al., toolkits on Improving Standards in Child Protection, Gate-Keeping Services for Vulnerable Children and Families, and Redirecting Resources to Community-Based Services, available at <http://www.eurochild.gla.ac.uk/changing/>.

industrialized world, can help task managers with the design of community-based social service projects.

Below is a brief summary of the key recommendations made.

The paper includes the following practical advice on project design.

- Demand-driven approaches allow for flexibility and leave the door open for new solutions.
- Community-based social services projects need to be guided by technical standards at the national level. Project design should incorporate measures to help update and develop useful technical standards.
- Social service projects are very different in nature than community-based infrastructure projects, therefore there is a need to have a specialized professional staff to manage this component of a project.
- Experiment with a pilot, before investing heavily.
- Community social service projects need to target a specific vulnerable group and define clear goals and indicators.
- NGOs play an important role in the delivery community social services. For success, it is important that there is a clear division of labor between the NGOs and government and that the NGOs are seen as legitimate in the eyes of the beneficiaries.
- In some ways, it is much more challenging to deliver a community social service than to build a community infrastructure. Therefore, it is important to build into the project design enough time and funding to allow for the necessary training of staff, NGO partners, and communities.
- The project design should include public awareness building as an eligible activity, since many vulnerable groups suffer from discrimination fueled by traditional taboos that need to be addressed.

Several specific recommendations are offered to enhance the Sub-Project cycle for Social Service-type projects.

- The geographic and poverty targeting approaches used by most social funds may not work for vulnerable groups, since they are often geographically scattered in low concentrations. Self-targeting mechanisms may be the most cost-effective alternative.
- Community involvement and ownership of the social service activities is essential given the on-going recurrent costs that they imply. For this reason, the project should promote participatory approaches and volunteerism at the community level.
- Involve other stakeholders such as local government, since they can make or break the project.
- Capacity-building should be present at each phase of the sub-project cycle and should involve the service providers, the communities, and the local government agencies responsible for monitoring and regulating the services.
- Sub-project proposals should be evaluated by a steering committee that includes at least two social service specialists and one NGO specialist. Applicants should be assessed based upon their cost-effectiveness, comparative advantage and organizational and mobilization capacity.
- The sub-project proposals must show how they intend to finance the recurrent costs of the social service. By involving local government, the service provider increases the chance that tax revenues may become available to finance a portion of the recurrent costs.
- Monitoring and evaluation should be kept simple; technical assistance should be available at all points during the sub-project cycle and evaluation should be built into the design the project. Participatory Monitoring and Evaluation is recommended as a technique that is well adapted to community-based social services.

II. Social *Care* Services: Different from Other Projects

Rather than reviewing the whole spectrum of community-based initiatives that might be described as “social services,” this paper instead focuses on social *care* services, defined in an earlier paper as *projects that supply services to vulnerable individuals and families to reduce or escape poverty and exclusion, and to lead a fuller and more satisfying lives, where most decisions on how to run a subproject and responsibility for its implementation rest at*

*the community level, either with local government or civil society.*⁵ Such community-based social care services might include home care services for the elderly and HIV affected individuals and households or rehabilitation services for the disabled, which may not be available from Government. These services fill gaps in the social protection network and do not include basic services such as primary education and health care services, which are generally the responsibility of the state to deliver.

Since community-based social care projects are new and quite different from traditional community-based social infrastructure investment projects, designing such projects entails more than simply providing financing for the activity itself. Often, for example, these are services in which governments have had little or no experience, and therefore the policy framework may not be developed or may require significant overhaul. Further, the method of implementation may be different than infrastructure projects, as NGOs, rather than communities, are often the implementing agencies, since they, rather than government or community-based organizations, usually have the greatest experience in providing such services. Service staff and project supervisors generally require much more training than in the more established social sectors such as health or education. Moreover, social services can take longer to implement, and their impacts harder to measure. Most expenditures in social service projects are recurrent, which means that post-investment funding strategies must be well thought-out part of subproject design.⁶

III. Why Are Community-based Social Care Services Important?

There are several reasons that the World Bank should finance community-based social care services⁷:

⁵McLeod and Tovo, p. 1.

⁶*Ibid.*, p. 1.

⁷*Ibid.*, pp. 15-16.

- **Good development outcomes.** While buildings and other infrastructure are important, focusing on the services provided within that infrastructure—and the quality of those

Box 1: Effectiveness of community-based health programs in Brazil and Benin

In Brazil, a WHO-sponsored community-based family health program led to a dramatic decrease in the infant death rate. Begun in 1994 (before which Brazil relied on an expensive, hospital-based system of care), the program financed community health workers to advise poor families on health issues, administer vaccinations, give nutrition advice, and treat diseases such as diarrhoea and malaria. In one city, the infant mortality rate dropped by 75% over a 6-year period. In others, the number of reported cases of diarrhoeal disease dropped by 50%. In other areas, the rates of mothers' attendance at antenatal clinics almost doubled.

In Benin, a UNICEF-financed community-based vaccination program adopted in 1985 led to a 20% drop in death rates among children under five. By 1998, immunization coverage increased to 80% of the population, and at least 65% of all women were using antenatal services.

-Source: WHO

services—are necessary to achieve lasting development outcomes (see Box 1).

- **Cost effectiveness.** The marginal cost of providing social services in a “traditional” way can be extremely high for the service provided. One World Bank study concluded that, for developing countries at average income levels, a large portion of under- five deaths could be averted with interventions costing between \$10 and \$1000, but that the real cost for each death averted through traditional public health channels averaged between \$50,000 and 100,000.⁸ Moreover, evidence is now showing that decentralizing responsibility to communities can be an effective way of delivering social services because the community resources that supplement the external resources help make the services more affordable. Community participation can also help reduce “leakages” and ensure more efficient use of resources. When a community is responsible for supporting a portion of the project costs, it is more likely to make sure that project investments from other sources are well managed. Community-based care services are also quicker to implement

⁸ Deon Filmer and Lant Pritchett. 1997 “Child Mortality and Public Spending on Health: How Much Does Money Matter?”, World Bank Policy Research Working Paper no. 1864, pp. 3-4.

than “traditional” forms of lending.⁹ The way in which a service is provided has a great influence over the price and impact of the service.¹⁰

- **Activities that fit the users.** A community-based approach to social services provision, in which communities are empowered to establish priorities and manage resources, helps to ensure that services are appropriate for the local context and suit local preferences.

- **Opening the door to include vulnerable groups.** Including social service components in community-based projects can help increase the likelihood of the project targeting poorest and most vulnerable groups *within* a community who may otherwise be hard to reach.

- **Growing demand.** Tragically, demand for social care services is being driven by growth in the number of people who need such services, particularly due to the ravages of AIDS. In 1990, in the 34 countries most affected by AIDS there were an estimated 22 million orphans aged less than 15; ten years later, that number was 35 million and projections put it at 44 million by 2010.¹¹ The African sub-continent will be particularly hard hit, with the number of orphans set to treble over the next ten years.¹² Effective social care for groups such as these will be a critical challenge for governments and donors.

IV. Focus on the Individuals, Not the Services

There are literally hundreds of potential community-based care services that a project might finance. Services might include daycare facilities for elderly people, foster care for AIDS-

⁹ Deepa Narayan, “Designing Community-Based Development,” Environment Department Dissemination Note no. 17, June 1995.

¹⁰ William Jack, “Social Investment Funds: An Organizational Approach to Improved Development Assistance,” World Bank mimeo, January, 2000, p. 1.

¹¹ Susan Hunter and John Williamson. 2000. *Children on the Brink*. Washington: USAID.

¹² Kalanidhi Subbarao, Angel Mattimore, and Kathrin Plangemann, “Social Protection of Africa’s Orphans and Vulnerable Children: Issues and Good Practice Program Options” (World Bank Africa Region Human Development Working Papers Series, 2001).

orphaned children, counseling for victims of domestic violence, drug and alcohol awareness programs for students, drop-in centers for street children, alternatives to residential institutions for physically disabled adults, or a host of others. It is beyond the scope of this paper to provide detailed project design suggestions on every type of service. Indeed, even if this were possible, many experts do not advocate taking such an approach; instead, they recommend focusing on the individuals to be reached.¹³ This is both because it is best to let “money follow the client” rather than being pre-allocated to any one activity, and because taking a “holistic” approach to care helps a service to address the complete needs of the client rather than just one small portion of them. Some of the major vulnerable groups to be targeted through a community-based project might include:

- Family members in female-headed households
- Victims of “new” social ills, such as prostitution, drug and alcohol abuse
- Women and children at risk of sexual abuse/violence
- People with disabilities and their families
- Street children and child laborers
- AIDS orphans and other AIDS victims
- The destitute elderly
- Members of a socially-marginalized group or ethnic minority
- Victims of war or trauma
- Other marginalized groups, according to country context

This paper adopts the target group- rather than service-based approach, providing general guidelines on community-based project design that task managers may adapt to individual projects rather than specific suggestions on types of social care.¹⁴ However, to give a flavor

¹³ See, for example, Mark Connolly, “Principles to Guide Programming for Orphans and Other Children Affected by HIV/AIDS,” available at www.unicef.org ; and Nishi Mitra, “Best Practices among Responses to Domestic Violence in Maharashtra and Madhya Pradesh,” in Domestic Violence in India: A Summary Report of Three Studies (Washington, DC: International Center for Research on Women, 1999), p. 26.

¹⁴ For more specific details on working with particular vulnerable groups, task managers will also want to refer to new publications of “promising practice” such as K. Subbarao et al., Social Protection of Africa’s Orphans

of the types of activities a service may provide, sample monitoring indicators for a range of different programs may be found in Annexes 1 through 9.

V. Suggestions on Overall Project Design

1. *Demand-driven or not?*

Creativity is important when financing community-based social services. In non-industrialized countries, there are often very few services being provided to vulnerable groups. Much remains to be explored, and lessons to copy from are relatively few. Encouraging innovation in the design of programs, while equipping project staff with appropriate skills and stimulating demand among beneficiaries for such services, is most likely to yield good results. Rather than allocating resources to already-existing community facilities or predetermining the social service to be provided, it is recommended to keep a flexible approach, based on the articulated needs of the clients. The World Bank has experimented with several such demand-driven projects; this approach is also used extensively in the developed world.

With a demand-driven project, proposals may be solicited either by inviting CBOs, NGOs, local governments or other service providers to submit proposals to deliver pre-selected services for selected groups, or by advertising in a more “open” way, notifying communities and interested bidders that funding is available for social services to be chosen by community groups themselves. The question then is how to structure the project financing menu. It has been noted that having a completely open menu of allowable subprojects rather than restricting choices to only a few types of services can provide “greater stimulus to innovation and creative problem solving,” allowing the true investment priorities of a community to be financed.¹⁵ For example, Thailand’s Social Investment Fund lists a series of subproject objectives, “capacity and learning development” and “immediate community welfare for the

and Vulnerable Children: Issues and Good Practices, and Elena Volpi, Street Children: Promising Practices and Approaches.

¹⁵ Weissman, p. 21.

needy,” which leaves much room for community-based organizations to design a custom-made service for their constituents. Similarly, the Palestinian NGO project provides block grants or service contract awards for priority issue areas, such as training and capacity building for service provision and poverty alleviation.¹⁶ However, this assumes that funding applicants have the technical capacity to design effective interventions, and/or that funding agencies have the capacity to assist them in designing effective services.

One other possibility is to take the group-based approach, whereby instead of predetermining the services to provide, a list is developed of the sorts of beneficiaries to be served, and weighting provided in the subproject evaluation process in favor of the projects reaching such groups. The decision over whether to have an open or closed menu should be decided given the country context and the level of development of social services within that country.

One note of caution, entirely open-menu, demand-driven approaches tend to cater to the interests of the vocal majority, not to the minorities or silent majorities, who might be most vulnerable and in most need of social care services. For this reason, some programs earmark a portion of sub-project funding for social services to benefit vulnerable groups and to fill gaps in a community’s social protection system.

Since resources are scarce, it may be most cost-effective to build on services that already exist and to expand the activities of present facilities, rather than reaching out to new social service providers. This may be problematic where existing facilities do not provide adequate forms of care for its clients. For example, in some developing countries, particularly the post-Soviet states, often the only form of social care is provided through residential facilities, which along with being very expensive compared to daycare facilities, are often in the long run harmful rather than helpful to residents.¹⁷ However, there have been documented successes in starting alternative forms of care that are run out of residential institutions. For example, a residential facility for children and orphans in Kyrgyzstan, with support and

¹⁶ Weissman, p. 22.

¹⁷ For more information, see David Tobis, Moving from Residential Institutions to Community-Based Services in Eastern Europe (Washington, D.C.: The World Bank, 1999).

technical assistance from international donors, began operating a daycare facility for children whose parents would otherwise be unable to go to work and support their families, and would have had to abandon their children in the orphanage. Providing this crèche has meant a decrease in the number of children abandoned by their parents, and an increase in the number of mothers able to work and to keep their children at home. Again, the key is flexibility and openness to new solutions.

2. *Developing Technical Standards and Facilitating National Policies*

However, demand-driven does not mean a free-for-all in which every service put forward by local groups can be funded. Just as one would not build a bridge without a technically sound blueprint and skilled workers, so one should not expect to run a social service without first knowing what the project is trying to achieve, ensuring that the methods proposed for running the facility are technically sound, and having well-equipped and trained staff.

Technical standards may come in the form of laws (e.g. the criminalization of domestic violence), public regulatory standards (e.g. maximum number of children per child care provider), or service delivery guidelines on quality (e.g. keep siblings together). Before developing any new technical standards, it is important to find out what laws, regulations, and guidelines already exist. Developing technical standards need not be difficult: while the outputs may be new, the method by which one develops a sound proposal is the same as in any other community-based project. Box 2 shows a suggested checklist of actions for planning and implementing a community-based social service.

Box 2: Planning, Implementation, and Assessment of Social Services

1. Define the problem to be solved.
2. List the assumptions, facts, beliefs, etc. about why the problems exist.
3. Describe the people to be helped.
4. List the assumptions, facts, beliefs, etc. about the people to be helped.
5. Define the solutions.
6. List the steps and actions required to obtain the solution.
7. Describe the ways the steps and actions are taken.
8. List the assumptions, facts, beliefs, etc. about the effectiveness and validity of the actions and the means identified.
9. State the staff roles, skills and abilities.
10. Define the staff selection process.
11. List the policies and procedures linking all of the components.
12. Describe the staff training and supervision process and content.
13. List the indicators of change or achievement of the solutions.
14. Outline the improvement and enhancement procedures.

Source: Christel Nichols, House of Ruth

Unfortunately, there are few developing countries – or, some might argue, even industrialized countries – with adequate social care policy frameworks that can serve as a baseline for community subprojects standards. A funding agency that finances community schools can usually draw on the Ministry of Education’s construction standards to ensure a minimum level of quality of the building and school curricula to guide teachers. Social services in developing countries rarely enjoy the same sets of technical standards governing care. In many countries, responsibility for social care is dispersed among many different agencies or the “forgotten cousin” of a larger line ministry (for example, a Ministry of Health and Social Welfare). Many social care services in developing countries are provided by locally-based international non-governmental organizations, and their working relationship with local and central governments on social policy issues may or may not be adequately developed to have begun a dialog on laws and standards of social care. Yet, laws and standards are the basis on which better service are built.

The development of laws governing social services can lead to more services being provided at the local level and greater attention paid to hitherto-ignored issues. In the provinces of Maharashtra and Madhya Pradesh, India, for example, the criminalization in 1997 of domestic violence and the passing of amendments addressing dowry death and dowry harassment went hand-in-hand with the development at the local government level of family courts, women’s police units, and community policing systems. Using the new laws, local NGOs providing legal services began to more actively target victims of domestic violence. In some cases, NGOs and local police units began for the first time joint activities, providing, for example, counseling services run in police stations.¹⁸

Standards and guidelines for implementation are also necessary to ensure quality of care across all regions. Without them, there will be confusion regarding overall responsibility for

¹⁸ Nishi Mitra, “Best Practices among Responses to Domestic Violence in Maharashtra and Madhya Pradesh,” in *Domestic Violence in India: Summary Report of Three Studies* (Washington, DC: International Center for Research on Women and the Centre for Development and Population Activities, 1999), pp. 19-20.

the services (for example, who controls the services? Clients? Local governments?), which body is to supervise social services (who ensures quality of care? Who monitors individual programs?), who is to provide training, where financial responsibility for the services lies, and who is able to implement programs (NGOs, local district authorities, or others).¹⁹

If standards are not available, the project should strive to contribute to their development. In the short term, if national standards are unavailable or inappropriate, UN or other donor standards of care may be adopted (as an illustration, see Boxes 3 and 4 on care standards for AIDS orphans and fostering programs) or project-specific standards developed, as discussed and agreed upon by government, social services experts, and the project team. Annexes 10 and 11 provide sample service standards for the national level. At the program level, in Annex 12, Elena Volpi provides a checklist of factors that should be included in any program for street children; while specific to that group, they may be adapted to other programs for vulnerable people.

Box 3: U.N. Principles to Guide Programming for Orphans and other Children Affected by HIV/AIDS

- Strengthen the protection and care of orphans and other vulnerable children within their extended families and communities
- Strengthen the economic coping capacities of families and communities
- Enhance the capacity of families and communities to respond to the psychosocial needs of orphans, vulnerable children, and their caregivers
- Link HIV/AIDS prevention activities, care and support for people living with HIV/AIDS and efforts to support orphans and other vulnerable children
- Focus on the most vulnerable children and communities, not only those orphaned by AIDS
- Give particular attention to the roles of boys and girls, men and women and address gender discrimination
- Ensure the full involvement of young people as part of the solution
- Strengthen schools and ensure access to education
- Reduce stigma and discrimination
- Accelerate learning and information exchange
- Strengthen partners and partnerships at all levels and build coalitions among key stakeholders
- Ensure that external support strengthens and does not undermine community initiative and motivation

From XII International AIDS Conference in South Africa in July 2000.

Box 4: World Vision’s Suggested Guidelines for Fostering Programs in Africa

- 19
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- Keep siblings together
 - Avoid stigma by targeting AIDS orphans
 - Provide foster families with access to health and HIV/AIDS education
 - Provide psychosocial counseling
 - Ensure livelihood of foster families and orphans through education, vocational training, and microenterprise development
 - Involve infected parents before their death, while they can still plan or provide for their families
- Quoted in Social Protection of Africa’s Orphans and Vulnerable Children: Issues and Good Practices

3. *Separate activities merit a separate component – and separate staff.*

In many Bank projects to date, social services have not been earmarked under a separate subcomponent but instead are listed on a large menu of allowable subprojects. As a result, services have tended to take a rather low priority for communities and project staff. In the case of communities, the needs of the majority will often take precedence over the needs of a specific vulnerable group. Although, there are cases in which a minority vulnerable group has a vocal group of advocates, such as the parents of disabled children, who will speak out on their behalf. In the case of the project staff, they find that social service sub-projects are relatively complex to implement, compared to infrastructure projects, and real impacts can take months or even years to be measured. For those few social services that are financed, results can be uneven: recurrent cost financing plans for social care projects are not generally well thought-out, local governments have seldom been consulted in the design process, and basic social care indicators for cost-benefit analysis, monitoring and evaluation have not been well developed.

If community-based social care services are to be part of a project that finances both services and infrastructure, a separate subcomponent should be developed for services. Unless funds are earmarked separately for services, the natural inclination will be to promote only infrastructure subprojects, which are quickly-implemented and have easily monitored results. A separate component is also merited because the subproject cycle of a community-based social services initiative is quite different from an infrastructure subproject, requiring, for example, greater attention to recurrent rather than upfront costs, greater public awareness activities and outreach/capacity building to potential clients and service providers, and use of NGOs or other intermediaries to deliver services.

Many Bank projects to date have shown that the professional background of staff members tend to influence the type of subprojects that the project finances (for example, engineers tend to promote infrastructure or other “hardware” projects). To avoid social care services

being an afterthought, it is advisable to ensure that at least one staff member with a professional background in social services is responsible for the social services component. This specialist should form a core part of the management staff rather than occupying a junior position. Further, appointing a services specialist to keep abreast of new developments in the field of social services and to disseminate good practice to subproject staff is one of the main ways of facilitating continuous learning for service providers.²⁰

4. Start Slowly with a Pilot Phase.

Because implementation of community-based services can be complicated and time-consuming, many donors suggest piloting one or more methods of intervention to learn lessons that may be incorporated into the main phase of the project. The experience of Save the Children UK, a UK-based international development organization, helps to illustrate the advantages of this approach. The organization developed two models for integrating children with learning disabilities into mainstream classrooms. The first model, based on adding a special class for disabled children to an existing school, was piloted in Thailand in 1989. Two schools tried the approach, with a full-time teacher running special classes while gradually integrating children with other pupils during lunch and playtime. Eventually the special needs children would participate in sports, music, art, and academic classes. The lessons learned from this phase convinced Save the Children that this approach was no different than segregated special education, in which the child, rather than the system, is regarded as a “problem” to be “solved.” It was also expensive.

Happily, the results of other pilot projects, the “full integration” model piloted in 1994 in Zanzibar and Kenya, and 1988 in Anhui province, China, had better results. In such programs, children with disabilities were immersed into mainstream classes. Volunteers or teachers were trained in basic disability management techniques and also conducted family support and awareness-raising activities. Once children were actually put into classrooms, attitudes and prejudices were found to change quickly, particularly with physically-disabled

²⁰ Christel Nichols, Presentation to the World Bank on The House of Ruth, July 2002.

children (rather than mentally-disabled) as school peers and teachers realized that children were “teachable”. There were, of course, many lessons learned, including the need for community-based activities to be accompanied by a country-wide and government-endorsed strategy of integration. The pilot results have led to widespread changes: in the China example, inclusive education for kindergarten-aged children is now the norm across the entire country.²¹

5. *Keep goals manageable and know what the project is trying to achieve.*

As with any other business initiative, social services can run into trouble if they do not adhere to sound project management practices. Many service providers feel that the greatest danger of social service delivery projects is that of overstretch, as services try to cater to too many constituents or fulfill too many mandates. “Eradicating homelessness,” for example, is not a sensible goal for any project, let alone a community-based one, to have. A service that aims to do so will quickly fail as the many roots of homelessness, from lack of housing stock to psychological problems of the individual, outpace the resources and skills of the facility. Rather than trying to provide all services to all people, it is best to know the project’s limit and to restrict activities to a well-defined target group, because “mission creep,” especially in a very small facility, can endanger the facility’s capacity to deal with core clients. If a service caters to victims of domestic violence, it should try only to work with those women and their children, rather than trying also to branch out into marriage counseling or alcohol abuse problems of the batterer.

Another danger occurs when goals are well-defined and suitable to the capacity of the project, but the exact methods by which services are to be provided are less clear: one knows what the goals are, but the solutions – what the achievement of those goals actually looks like, has not been defined. Money in the field of social services is often wasted because insufficient attention is paid to project follow-through and ensuring the linkages between

²¹ Sue Stubbs, “Promoting Opportunities for Disabled Children: Save the Children’s Experience of Inclusive Education,” mimeo, Sept. 1998, pp. 14-20.

project goals and implementation. Some argue that it is better not to have a service at all than to provide a poorly thought-out service or one in which workers are unsure of their work program.²²

6. *Build in sufficient time, and budget for more training.*

The need to build in adequate time to every stage of implementation cannot be overstressed. More time is needed for three reasons: (1) to adequately prepare stakeholders, including training project staff and service deliverers; (2) to ensure that stakeholders themselves have been adequately prepared and feel ready to take on such projects, to avoid “[subverting] local ownership and responsibilities,”²³ and, (3) to show results. Each type of social service will of course take a different length of time to implement. Providing laundry facilities for street children, for example, would require only the purchase of equipment and staffing the facility. Starting a shelter for victims of domestic violence, on the other hand, would require preparation time to train staff and develop impact indicators, as well as a long incubation period before seeing impacts (such as increase in client welfare or reduction in the rate of domestic abuse in the community). Along with greater time requirements, the additional costs of training and capacity building may lead to greater costs than those associated with infrastructure subprojects. Developing up-front cost guidelines for the type of service and the training to be provided, preferably using existing in-country interventions as benchmarks, should be part of the design phase. Similarly, developing realistic indicators of the time required to implement each stage of the service will save on frustration down the road.

Some donors have already begun to recognize the need for longer timelines for social service-related subprojects. For example, DANIDA, the Danish development agency, has developed a strategy for special needs education that assumes a 10- to 20-year program lifetime. In its special needs program in Nepal, for example, DANIDA agrees with the

²² Christel Nichols, personal conversation, July 2002.

²³ Jill Donahue and John Williamson, “Community Mobilization to Mitigate the Impacts of HIV/AIDS” (Publication city unknown, Displaced Children and Orphans Fund, September 1999), p. 3.

government on five-year implementation periods, each new period beginning with an appraisal of the previous phase and new targets for the upcoming phase.²⁴

7. *Who will reach them? Choosing the Agents to Deliver the Services*

Even before a request for proposals is published or any public awareness activities take place, there should be a good understanding among project staff about the types of agencies available to provide social services and the relative advantages and disadvantages of using each. Although non-government organizations have traditionally been at the forefront of community-based social service provision (see Box 5 for an example), encouraging a large

**Box 5: the importance of NGOs in policy development:
the African experience with orphaned children**

Orphaned children are often exploited because they lack the protection normally provided by parents. In such cases, the State has the responsibility to protect the children from neglect, abuse, or harmful labor. In practice, many governments lack the capacity, and sometimes the will, to fulfill these obligations. Some NGOs have encouraged the development of policy, strengthening the development of Child Welfare Forums and raising awareness of issues affecting orphaned children. Some programs have sought to build the capacity of social welfare departments, which have a statutory responsibility for child welfare.”

For example, in Manicaland, Zimbabwe, the NGO Family AIDs Caring Trust (FACT) began noticing a sharp rise in the number of orphans in Manicaland in the 1980s. The NGO decided to quantify the results through survey work in 1991 and 1992. This showed that fully 1 in 15 children under age 15 was orphaned. These studies, along with subsequent activities under an NGO developed specifically to deal with orphaned children, helped to shape the national policy dialogue in Zimbabwe and neighboring countries.

-- Source: Makufa, p. 1.

spectrum of potential service delivery agents, from local governments to community-based organizations and NGOs, to access project funding will likely increase the chances of achieving a good outcome. This includes making maximum use of non-governmental organizations, which traditionally have been the agents most involved in community-based social services in both developed and developing countries alike. It may be useful to structure RFPs to encourage partnerships and coalitions between different types of service providers with the aim of building capacity and sustainability.

²⁴ Birgit Dyssegaard and Bernadette Robinson, “Implementing Programmes for Special Needs Education: Lessons Learnt from Developing Countries,” in J. Lynch, C. Modgil, and S. Modgil (eds), Equity and Excellence in Education for Development (London: Cassell Educational), chapter 8, p. 5.

While using NGOs as intermediaries may lead to the most effective social service outcomes, there are three issues to be considered. The first is the importance of the local government or local authorities in the decision-making process. No matter what the intermediary chosen to deliver services, it is essential to begin by measuring the willingness and capacity of the local authorities to have such services in their community, since they might well be the determinants of project success. Support from local elders and other leaders can impart greater legitimacy to a social service initiative in the eyes of the larger communities, especially if the proposed service is controversial or culturally sensitive (for example, a program to help victims of sexual violence or a drug abuse/HIV awareness program). In some cases, local authorities might also be able to donate goods, such as property in which a service might be run, or a garden where produce can be sold to raise funds for recurrent costs. If the local government is not happy with NGOs delivering service, they might feel resentful or competitive, and work against rather than for the project.²⁵ As part of their fieldwork, then, project staff may often expect to become facilitators, communicating and improving relations between the NGO/CBO and government. In its research into partnering with NGOs, the ADB finds several features that are common to successful government/donor/NGO collaborations: joint ownership of NGO/CBO involvement (i.e. the government, especially the relevant line ministry, should want to work with NGOs); mutual trust between government and NGOs/CBOs; and capacity of the NGOs along with NGO involvement project concept and design stages and appraisal.²⁶

The Asian Development Bank provides a suggested checklist on facilitating smooth cooperation between local governments and NGOs:²⁷

²⁵ Operations Evaluation Office, Asian Development Bank: Special Evaluation Study of the Role of Nongovernment Organizations and Community-Based Organizations in Asian Development Bank Projects (Washington, DC: The Asian Development Bank, 1999), p. 40.

²⁶ Ibid., p. 46.

²⁷ Operations Evaluation Office, Asian Development Bank: Special Evaluation Study of the Role of Nongovernment Organizations and Community-Based Organizations in Asian Development Bank Projects (Washington, DC: The Asian Development Bank, 1999), p.57.

- Full ownership of NGO/CBO involvement should be secured from government and project beneficiaries, including an agreed rationale for NGO/CBO involvement, well-defined roles and responsibilities, and anticipated outputs and impact, at the project preparation stage.
- Appropriate NGOs/CBOs and civil society should be involved as early as possible, in project concept and design.
- Fair and transparent NGO/CBO screening and selection should be in place, based on systematic evidence of competence and cost-efficiency (where appropriate) using competitive tender processes.
- A clear definition of executing agency and NGO/CBO responsibilities for management, performance monitoring, reporting and accounting, should be prepared and included in the project or program implementation plan and project administration manual.

One might add a fifth point to this list, which is the importance of establishing a clear division of labor between government, NGOs and the community. During the sub-project start-up period, efforts should be made to build the capacity of the chosen government agency to perform its defined role.

The second issue is that of the legitimacy of the service provider in the eyes of beneficiaries. Some social service practitioners believe that NGOs are the *only* way to provide services in the developing world, because they are the only ones that very poor/marginalized people trust.²⁸ However, there are also risks in working with NGOs. Given the large numbers of such organizations that have sprung up in recent years in response to donor interest, careful scrutiny is needed to ensure that the NGOs chosen as service providers have the skills needed to do a good job. There have been cases where partner NGOs selected on the basis of a written application form, have turned out to be little more than self-employment schemes for entrepreneurial individuals. In other cases, NGOs may take a charitable approach to social

²⁸Pri Fernando of the IDSS, for example, cites the World Bank's *Voices of the Poor: Crying Out for Change* which said that overall, in poor people's judgment, 45% of important institutions in their lives are state institutions, but that 83% of ineffective institutions are state institutions. By contrast, civil society institutions make up almost 50% of important institutions but only 15% of ineffective institutions..

care – treating clients as victims – or may hold views on social care that are different, or even opposite, to what is considered best practice in the field of social care, or the objectives of the project. The only way to avoid poor selection is to keep in regular contact with the actual

**Box 6: Choose your intermediary wisely:
Excerpt from “Community Perceptions of Orphan Care in Malawi,” by Sandra Ali**

In 1997, donors and the Government of Malawi established a project to document the situation of AIDS orphans. Some of the community interviews done for the midterm assessment were particularly revealing: “...communities are tired of accommodating NGO and government personnel going in and registering orphans when no feedback and/or assistance (especially assistance) is offered to the communities. As a result, communities feel cheated and used,” one reviewer wrote. “Communities also feel that the existing structures in place are not doing much in addressing the plight of orphans. This is mainly due to distance, lack of feedback or emphasis on other programmes rather than orphans.” Author Sandra Ali summarizes community perceptions of each type of service provider:

| SUPPORT STRUCTURE | COMMUNITIES’ PERCEPTION OF EFFECTIVENESS |
|--|--|
| Government Extension Workers | Line agency #1: Somewhat effective because they focus more on developmental programmes than on orphans. Line agency #2: Not effective because they just register orphans but do nothing to help them. |
| District hospital, and Health facilities | Somewhat effective because some of the District hospitals offer wet feeding for orphans but not all and they are too far away. |
| Traditional Healers | Effective because they sometimes treat orphans for free and are nearby. They can also tell you who is bewitching you. |
| Church Committees | Not effective because they do not help with orphan care Effective because they help caring for the sick and say prayers for them. |
| NGOs | Effective because they bring development to the community Not effective because they do not help with orphans. "They just register and don't come back." |

From the table,” Ali writes, “it is evident that the community does not see much support for orphans coming from the NGO, government or the church. The traditional healer is most effective because of his proximity and generosity. What is important though is that they view these structures as resources even if presently they do not fully address orphan needs.”

Source: “Community Perceptions of Orphan Care in Malawi”

clients of the service, and those within the community. Box 6 shows the value of regularly measuring community perceptions of care.

The third issue is that of the skills levels of the provider, particularly if using a community-based organization. Depending on the complexity of service to be provided and general skills level of service providers within the country, much thought should be given to the type of intermediary to use. For fairly simple projects with limited goals (such as providing a soup kitchen or shelter for the homeless), community-based organizations (CBOs) may be perfectly suitable. For more complex projects – women’s empowerment or adult literacy, for example, there may be only a limited number of organizations able to provide the services. So, during an early phase, it may be necessary to have the support of an NGO to build local capacity and empower local organizations to deliver this type of service.

The differences may be compared to financing community-based rural water supply projects. If the clients’ needs may be met through a simple water pump easily installed by a local contractor, and where a water source is easily found, then the community implementation committee can probably undertake all stages of the subproject cycle, from proposal writing to contracting and maintenance. However, if the water project requires borehole drilling, for which there are usually only a few contractors with the machinery and expertise to drill, more supervision, technical inputs, and training by the project staff is required. Box 7 illustrates the different tradeoffs between using a community-based intermediary and using an NGO. Since social service provision often requires considerable skill, it is important not to overestimate the impacts that small local NGOs will have on entrenched social service problems, and to ensure that adequate attention is paid to capacity building of the social service provider (see below under “capacity building”).

Box 7: NGO or CBO? Choices, choices

Whether the decision is to have an “open” approach in which all types of service providers are eligible for funding, it is important to know the relative advantages of each type of service provider. Foster breaks them down as follows, in the context of NGOs and CBOs for orphans’ care:

NGOs:

- More likely to have more resources than CBOs
- Training coordinators and volunteers likely to be of higher quality
- Donor funding and other revenues are probably easier to obtain
- Monitoring and reporting systems are probably already in place

CBOs:

- Since most NGO programs for orphans concentrate on home care activities, those who do not receive home care may be overlooked. CBOs, who may be better aware of all members of the community, will be able to identify each eligible client
- Volunteers make the decisions about providing support, rather than program coordinators. These volunteers will be better aware of any other potential sources of support that the client may have, and may be better able to allocate funding.
- CBOs are owned and associated within the community, and so can mobilize community members, facilitate sustainability, and marshal volunteers more easily.

8. *Twinning Local Activities with Public Awareness*

Public outreach must be an integral part of project design in order to “challenge popular myths, stereotypes, and judgments that provide the ground upon which [social] stigma can grow.”²⁹ While public relations and outreach are key, comparatively little thought has usually been given to it: one 1997 study of major international donors’ community development projects reported that only 30% built in awareness raising and community development components. However, of the high success initiatives, 44% employed awareness raising strategies, contrasted with none of the low-success ventures.³⁰ The first reason for funding public outreach in community-based social services is to dispel the sometimes-heavy social taboos associated with the vulnerable groups to be reached. In Uganda, for example, children with even the mildest forms of epilepsy are prevented from attending school because they are considered to be cursed.³¹ Greater acceptance of “outsiders” by the public at large begins with providing information.³² See Annexes 13 and 14, which contain a description and evaluation of a national AIDS awareness campaign in Vietnam, describing how project staff involve constituents in the design of programs and to build in enough time to develop appropriate information, education and communication materials. Especially important, note other specialists, is the need to use local communications experts so that the campaigns are culturally appropriate. As one social worker in Kenya puts it, “We are like a musical instrument: the music is produced by touching the cords in a right way. The cords are there everywhere, but the way of touching them to produce a melody is specific to each culture.”³³ Many also recommend hiring a public relations firm, rather than delegating this to project staff who may not have the expertise to design effective communications interventions, or to have a communications specialist on staff to ensure that campaigns reach their intended audience.

²⁹ From HIV and AIDS-Related Stigmatization, Discrimination, and Denial: Forms, Contexts and Determinants

³⁰ Aldred Neufeldt and Alison Albright, eds., Disability and Self-directed Employment (North York: Captus University Publications, 1997), pp. 82-83.

³¹ Dyssegaard and Robinson, p. 2.

³² Ibid, p. 6.

³³ Fabio Dallape, An Experience with Street Children, (PUBLICATION NOTE, 1988), PAGE NUMBER

Box 8: Take a Lesson from the Nutrition Experts: Behaviour Change Programs Do Work

“In areas where nutrition practices are poor, teaching mothers better health practices can significantly improve health outcomes. It has been proven that educational interventions such as public awareness campaigns can result in better health practices and reduced disease rates. For example, it has been proven that feeding children solid food when they have diarrhoea is better for their health than stopping feeding. In the Gambia after a health education campaign on this subject, the number of mothers feeding their children solid food increased from 14% to 55%.

-- Source: Hill and Kirkwood, p. 42.

Communications involves changing the mentalities of the families of socially-excluded people as well as the community at large. For example, in Uganda, a recent study³⁴ into the stigmatization of people with AIDS noted that widows of AIDS victims face ostracism from their family. Their children may be taken away by other family members, or in-laws steal their money or property.³⁵ It is the responsibility of the project to ensure that projects targeted to such beneficiaries include work with, and education of, immediate family members.

Sometimes, an NGO intending to help clients may unwittingly contribute to social stigma, failing to demonstrate sufficient sensitivity to the delicate situations of their clients. The Uganda study noted that some clients were ambivalent about receiving support services from workers who arrived to help them in automobiles with “TASO” (“The Aids Support Organization”) written in large letters on the side. As one respondent noted, “I prefer to come to TASO but not TASO come to my home.”³⁶ It is important to bear in mind the sensitive nature of many social services intervention and to design outreach and communications interventions carefully.

³⁴ ---, HIV and AIDS-Related Stigmatization, Discrimination, and Denial: Forms, Contexts and Determinants, Research Studies from Uganda and India (Geneva: Joint United Nations Programme on HIV/AIDS, 2002).

³⁵ Ibid., p. 31.

³⁶ Ibid., pp. 31-32.

Box 9: Public Awareness-Raising in Lesotho: Integrating Disabled Children into Schools

In Lesotho, tradition has it that children born with a disability are disabled because of witchcraft, infidelity of the mother while pregnant, touching other people with disabilities and becoming “infected,” evil spirits, or insufficient respect for ancestors. Since the rate of physical impairment among children in Lesotho is estimated to be as high as 17% of all school-age children, the social and economic consequences of the stigma are considerable.

In 1990, the Ministry of Education began a strategy to integrate disabled children into the mainstream education system. One of the key implementation strategies was a public awareness campaign. This took place over six months and included the following actions:

- Workshops for the Special Education Curriculum Committee (central government office), district education officers, school principals, local chiefs, district administrators, and parents of children both with and without disabilities;
- Training workshops on special education for pilot schools
- A 45-minute radio program on special education, broadcast on the national radio channel;
- A conference with the National Teacher Training College staff to agree on curriculum changes to include special education in the training syllabus; and
- Video recording of seminars and workshops so that those unable to attend are able to learn more.

VI. Within the Subproject Cycle

This section does not provide a predetermined subproject cycle structure that can be adopted to all types of community-based social service projects. Indeed, most literature suggests developing a subproject cycle on a case-by-case basis in collaboration with project staff and government and client stakeholders. That way, the project may be tailored to country context and to the types of constituents each project wants to reach. Here instead are suggestions on community-based social service issues that will arise as part of that development process.

1. Targeting: Whom are you trying to reach?

Within the Bank, most community-based infrastructure subprojects target clients using some combination of geographic and poverty indicators. For community-based social services, however, targeting becomes more complicated. The groups to be reached can be found only at a sub-community level or even household level, sometimes areas that at the district level appear to be relatively well-off. For example, the most prosperous parts of a country are often the cities, which is where some of the most marginalized groups, such as street

children, may be found. On the other hand, people with disabilities may be dispersed throughout city and country. Traditional targeting formulas, therefore, must be supplemented by other data, including qualitative factors such as client questionnaires (see Box 10 for an example of this).

Box 10: India: Detective work to develop a baseline: How one researcher determined the extent of the domestic violence problem in Maharashtra

In 1997, Surinder Jaswal, researcher at the Tata Institute of Social Sciences in Mumbai, found that there was no reliable quantitative information on levels of domestic violence in the province Maharashtra. Her solution was to examine medical records from the major municipal hospital, the district's referral hospital, and community health centers in rural and urban centers searching for records of injuries that were attributed to domestic violence. Jaswal then conducted focus group discussions as well as in-depth interviews with service users and service providers. She was able to conclude that 53% of injuries requiring medical attention were caused by domestic violence.

Source: Domestic Violence in India, pp. 6-7.

Because traditional targeting strategies are so difficult to develop *a priori* for social services, many financing agencies opt not to develop a targeting strategy per se, but rather choose to concentrate on one or more vulnerable types of populations with a predetermined set of funding criteria that will help them to select appropriate projects.

The first priority is to determine which groups are most in need of services. This may be done through interviews, including a survey of the NGOs, local government leaders, prefects, and religious or charitable organizations currently providing social services. In cases where data is unavailable or unreliable, a more far-ranging qualitative and quantitative social assessment may be called for which will both provide information on the groups to be targeted and establish a baseline monitoring program. Annex 17 provide sample terms of reference for a national-level social assessment conducted in Albania.

Social care service projects also lend themselves to self-targeting more than other projects because they tend to finance services that would not be attractive to non-target population. Home care for AIDS patients is unlikely to be sought by people who do not suffer from AIDS, while trauma counseling for victims of domestic violence would not be sought by unaffected people. Because self-targeting is the cheapest targeting mechanism, it is generally

worth it to invest the time and creative energy to identify the services that would result in self-targeting.³⁷

2. *Building Initial Capacity of Potential Service Providers to Develop Proposals*

The likelihood of receiving a sufficient number of technically acceptable proposals depends on the level of expertise available at the community level. Requesting organizations should at the outset be able to conduct the following activities (taken from a UN module on developing street children assistance programs):

- Conduct a situation assessment deciding on the problems to be addressed.
- Develop a strategic plan the project goals and outlining required strategies, activities, required resources (human and financial), and implementation plan.

Later, the organization will require the skills to actually implement the project:

- Carry out the activities
- Monitoring and evaluation: continuous assessment of the project and measuring project impact at agreed time points
- Revising the strategic plan: rewriting the strategy incorporating lessons learned through monitoring and evaluation
- Disseminating project lessons to other interested parties.³⁸

As part of the evaluation process, field staff should be able to conduct a thorough site visit assessing the potential of the agency to deliver services. Annex 18 provides a step-by-step guide to field evaluation provides information, including qualitative and quantitative data to collect and how to collect it, using the example of a community-based street children project.

³⁷ McLeod and Tovo, p. 50.

³⁸ Taken from Module 5: Determining the Needs and Problems of Street Children, (Geneva: World Health Organization, 1999), available at http://www.who.int/substance_abuse/PDFfiles/module5.pdf.

As an initial capacity-building measure for potential service providers, many authorities suggest having the providers themselves, along with representatives of the community, conduct a detailed community needs assessment. Annex 19 provides suggestions on conducting such an assessment, taken from a health initiative for Canadian aboriginal communities. As is common with many examples from the developed world, the suggestions are most likely too expensive and technically demanding for many developing country contexts. However, if simplified, the suggestions may be valuable.

Advertising availability of funding: The request for proposals should be flexible enough to stimulate creativity in the type of service to be delivered, yet also provide enough guidance on the standards of service to be delivered. See Annex 30 for a sample Request for Proposals for community-based social service provision in the United States that may be modified and used in a development context.

3. Building Community Understanding and Ownership

Communities: You Need Them. Building ownership among community members at large is especially important for social services projects. One expert notes that “communities must be truly committed ... because the time required to overcome negative influences of disadvantaged [groups] is measured in years, not days or hours.”³⁹ In addition, a community that feels ownership of a program within their community will be much more likely to invest in that project, both in terms of time and volunteerism, and help to sustain activities after project funding ends. When conducting community outreach, officers should bear in mind these sorts of questions: Is the local government committed to helping the groups to be targeted? Are there advocates that are willing to support this issue? Is there any capacity or built-in mechanisms for service delivery? What are the services available at the moment provided by the Government and NGOs? Are there any possible allies? Can beneficiaries

³⁹ Bernard S. Arons, The CMHS Approach to Enhancing Youth Resilience and Preventing Youth Violence in Schools and Communities (Rockville, Md.: The Center for Mental Health Sciences, 2001), text at <http://www.samhsa.gov/grants/content/2002/YouthViolence/intervene.htm>

help themselves? Is the group socially stigmatized and if so, what are some community-level activities to begin combating those taboos?

Needs assessment and initial outreach: Another reason for more attention to community outreach programs in social care services is because of the difficulty that many communities have in formulating often complex social service proposals, and the need to create “informed demand” for social services. Without assistance, communities may not be able to articulate the social needs that they have, let alone develop a solution for them. For example, if communities note that their already-existing health clinic is not stocked with vaccinations or needs better-trained health care workers, their natural inclination might be simply to demand a new health clinic rather than to formulate a proposal to provide new services in the existing clinic (a canny move by communities if donors are known to finance only infrastructure!). This calls for intensive concentration on participatory approaches and other community-level interventions so that communities understand and can formulate their own social service needs.

Volunteerism: In the developed world, it is estimated that volunteers account for approximately 27% of all staff who work in social service fields.⁴⁰ Volunteerism is therefore a good way of stretching scarce project resources and encouraging sustainability of projects. In its five years of operation, for example, Zimbabwe’s FOCUS program, a community-based care program for orphaned children, had lost only one volunteer out of 138, who was quickly replaced by one of the many who offered to fill the vacancy. Part of the success of the program was due to the sense of community ownership and responsibility that the program volunteers felt, having been specially selected for the program by their community. In addition, the program provides a package of small but attractive bonuses, such as uniforms (skirt, shirt, and shoes), monthly bus fares to meetings, Christmas bonuses, monthly training,

⁴⁰ Lester Salamon et al, *Global Civil Society : Dimensions of the Nonprofit Sector, Volume II* (Baltimore: Johns Hopkins Comparative Nonprofit Sector Project, forthcoming), quoted in *Alliance Magazine*, Volume 7 No. 2, p. 3.

or exchange visits to other regional programs.⁴¹ Program officers should recognize the value of volunteerism and the project should give incentives to stimulate volunteerism.

However, experts caution that volunteers must be well-trained in order to provide an acceptable level of service, and that the role that they are expected to play must be well thought-out and explained clearly to the volunteers. It is a dispiriting experience for a volunteer not to be given explicit instructions on how to help. Further, no matter how good their intentions or deep their commitment, poorly-trained volunteers working with very vulnerable clients can lead to very bad results. Some specialists believe that it is better to have no volunteers at all than to have an unskilled or poorly-managed (albeit free of charge) workforce. Training volunteers working with clients is therefore essential, or else reserving their time for unskilled work (assisting in fundraising pledges or maintenance of the facility, for example).

Building links with other service providers: schools, community-centers, health clinics. The importance of getting many stakeholders involved in social service initiatives cannot be overstressed. Happily, it is often fairly easy to develop networks and communities of interest around an issue (see Box 11). For example, many projects involve getting teachers invested and involved in services for children (for example, recognizing signs of abuse and providing referral services), or getting clinic-based doctors and nurses involved in health initiatives that occur off-site (for example, having doctors visit battered women's shelters or providing free medical checkups for clients being fitted for prosthetic devices).

Box 11: Building the links between community, project, and government

Staff of Zambia's Project Concern International work closely with district social welfare agents employed by the Zambian government social services department. They, along with local NGOs, CBOs and church groups are the catalysts that mobilize neighborhood committees. They have assisted poor neighborhoods to gain Ministry of Education recognition for their community schools, approval for their syllabus and training for their volunteer teachers.

-- From Donahue and Williamson, p. 3.

⁴¹ Donahue and Williamson, p. 5.

The project can encourage these linkages by offering incentives to such volunteers, such as specialist training or participation in conferences. In addition to harnessing the resources of local professionals, social service providers may also develop links with public facilities. Box 12 on a street children’s project in Cambodia illustrates how a World Vision project, by moving operations from a special center for street children into a facility that also housed a library, school, and outreach services for poor people, was able to integrate street children into a larger community. Additionally, to maximize stakeholder involvement, each community-based care service might have its own steering committee, comprising clients, community members, and local authorities, to stimulate a broad base of “ownership” in the project.

Box 12: Phnom Penh Street Children Project, Cambodia, Sponsored by World Vision and AUSAID

Funding Source: AusAID and other donors in WVI
Project Timing: November 1993 – September 1999
Contract Value: \$ US 100,000 per annum

Project Goals:

- Operate a Street Children Centre; Reconcile street children with families of origin.
- Provide education, skills training, employment, sporting and craft and traditional dancing activities for the children who reside at the centre.
- Provide long-term foster care for street children for whom reconciliation with family of origin is not possible. Outreach on the street in late afternoon and late night to keep current on the issues facing children on the streets.
- Undertake advocacy on issues concerning children in Cambodia; cooperate with other agencies concerned for the rights and needs of children in especially difficult circumstances.
- Provide capacity building/training and development opportunities for project staff.
- Community development.

Project Target:

898 street children in Phnom Penh.

Project Description

The Bamboo Shoot Children’s centre provided short term accommodation for street children usually for about six months along with food, clean clothes, health care, counselling and basic education. As their basic needs were being met at the Centre, the children were enabled to see their life from a new perspective which might then include a future in a family environment with the chance to go to school and/ or to learn skills that will be useful in future employment. The reconciliation of street children with their families of origin was a process requiring painstaking discussion and negotiation. Material and psychological/ sociological support for the families was usually essential. This task also involved much travelling in difficult conditions as the children come to Phnom Penh from all the provinces of Cambodia. **(Box 12 continued below...)**

... Continuation Box 12

Many of the children have never been to school. The provision of education, skills training and employment opportunities acknowledges the children's rights and needs to go to school and to learn useful skills and to work. The opportunity to participate in sporting, craft and cultural pursuits exposes the children to "normal" children and provides a healthy exercise and builds co-operative team spirit. Advocacy in conjunction with other like-minded agencies is an important part of the project. Children in especially difficult circumstances are powerless to defend and speak out for themselves. By actively supporting the Child's Welfare Group, a coalition of agencies concerned for the needs and rights of children, the Project is supporting street children's rights and needs.

Successful Strategies

- The project led to the commencement of a related project to address the causes of children moving to the streets which focussed on some of the areas where children originated. Very poor households, many of which were female headed, were identified and given extra assistance to help them take up income generation activities. Programs addressing domestic violence were also started.
- A number of other community development projects grew out of the Street Children project including a project to address the needs of three slum communities in Phnom Penh; a project to rehabilitate former child sex workers and a project to train Khmer police in protection of children and enforcement of children's rights.
- The project managed to have a strong emphasis on advocacy and policy and had an influence through the production of a manual for managing fostering of children which was developed in the absence of any government policy or procedures for adoption or fostering.
- Research papers were produced that assisted in focussing attention of such areas as child labour, tourism and sex abuse and the child participation in project design and evaluation.
- The project was instrumental in developing networks with other NGOs and government agencies to advocate for the rights of children in line with the Convention on the Rights of the Child.

Lessons Learnt/Issues:

- The local community is impressed by project staff's daily demonstration that street children can be assisted to make positive changes in their attitude and behavior. This is particularly true in the Boeng Kok squatter area.
- Over time it was seen that the work could be more effective by greater integration with the community and as security improved in rural areas, addressing some of the causes of children leaving home to become street children. The education program was moved to the Boeng Kok Lake squatter community and an informal school and library started that integrated the street children with the children of the squatter community. This was the start of moving from a **Centre-Based-Programme to a Community-Based Programme**.

-- Source: World Vision

Local Government Involvement Securing buy-in from local authorities is essential. The best way of developing interest and involvement of local governments is the most obvious: through a series of meetings and workshops to explain the objectives and introduce (if necessary) local government officials to the potential providers of services, followed by training as appropriate on monitoring and supervision (if the local government will be responsible for this). Some donors have found it useful to develop a simple memorandum of understanding that describes the project and sets out project goals and responsibilities and which is signed with the central government and the local government. See Annex 31 for a sample memorandum of agreement from the European Children's Trust fostering project in Albania.

Box 13: Guidelines for Soliciting Community Involvement: Lessons from a Community-Based AIDS Orphans Initiative

The process of mobilization must start with a community identifying its own concerns... Community mobilization is a mechanism to define and put into action the collective will of the community. The following are some key guidelines for successful mobilization:

- Once mobilized, a grassroots group should try to engage the entire community in responding to its own shared concerns.
- Community mobilization should not be seen as a way for an outside agency to achieve community consensus around its goals.
- Outside support seeks to build capacity of communities, rather than delivering services themselves. The catalyst role is to sensitize, mobilize and build capacity....
- Let the process unfold according to an internally defined rhythm where the community is left to process at its own pace. Emphasis is on a process that is iterative and incremental. Taking time, as well as timing of outside support is crucial. Leading with outside resources before a community begins to take action through internally produced means is a sure way to subvert local ownership and responsibilities.
-- From Donohue and Williamson, pp. 3-4.

The elusive quest for beneficiary involvement: Perhaps the most important feedback to solicit is that of the potential service users, rather than simply intermediaries or the community at large.⁴² As a regular part of site visits and monitoring, project staff should talk with beneficiaries themselves, perhaps developing a regular cohort of interviewees who can give a “micro-beneficiary assessment.” In some projects, developing beneficiary involvement becomes the primary aim of the project, such as World Vision’s Myanmar Street Children project. In that program, the children themselves formed a beneficiary evaluation team to analyze the successes and challenges of the program. Such programs are also common in the developed world, such as the Youth Empowerment Evaluation program in San Francisco, California, whose aim is to increase youths’ inputs into the policies and programs serving them.⁴³

⁴² Weissman, p. 16.

⁴³ Kristen Zimmerman and Nancy Erbsstein, “Promising Practices: Youth Empowerment Evaluation,” in *The Evaluation Exchange*, Volume V, Number 1 (Boston Harvard University, 1999), p. 4.

A word about advocacy and empowerment. Many social development specialists emphasize strongly that social services alone will not reach the groups that are most in need of help without also helping to foster their empowerment. The notion of empowerment is one that the World Bank has been struggling with to define and quantify for several years, and perhaps for that reason, building specific “empowerment” components into projects has not

Box 14: Tingog sa Kabataan: A Radio Programme by Children for Children

ECPAT-Cebu is an extension office of ECPAT-Philippines, which is part of ECPAT International, a non-governmental organization. ECPAT-Philippines is committed to the elimination of child prostitution, child pornography, trafficking of children for sexual purposes, and other forms of commercial sexual exploitation of children. ECPAT-Cebu has been carrying out an aggressive public awareness campaign against child sexual abuse and exploitation of children in Cebu. It has carried out dialogue and training, community awareness sessions, and campaigns in private high schools. It has produced and disseminated brochures, newsletters, and posters on child sexual abuse and the commercial sexual exploitation of children, and has developed advocacy tools such as a children's mobile theatre and a video documentary on the trafficking of children.

ECPAT-Cebu has also launched a radio programme called Tingog sa Kabataan. Tingog sa Kabataan, which means 'Voice of the Children', is a 30-minute radio programme aired over a local AM band radio station every Sunday at 10:30 am. It is the first and only radio programme in Central Visayas which is by children for children. It is produced by 20 high school students from Cebu, all of whom have been assisted by various NGOs in Cebu, and all of whom have at one time been victims of abuse. Production is carried out on Saturday, to avoid interfering with the children's schooling. The children are given a modest stipend. The stipend was requested by the children to help pay the costs of their schooling. Since the radio programme is for children by children, a maximum age for participants has been set at 18 years.

The radio programme was first broadcast on October 1999 in celebration of Children's Month and the tenth anniversary of the adoption of the Convention on the Rights of the Child. It is now in its second year. Apart from the benefits the child producers themselves receive, The programme has exposed large numbers of people to information and advocacy concerning children's issues and rights. A December 1999 survey conducted by the Asia Research Organization found that Tingog sa Kabataan was the fifth most popular radio programme in Metro Cebu.

--From the ECPAT website

been as common as the academic literature suggests that it should be. However, many outside agencies firmly believe that without facilitating empowerment, the poorest of the poor will not be reached. For example, the UK Community Fund, which distributes money to domestic non-profit service groups, has recently changed its selection process so that, in order to ensure that the most disadvantaged groups have access to funding, it will fund only projects that include capacity building and influencing opinion, either stand-alone or as part of a larger service delivery project. Within the developing world, too, there are many examples of initiatives that, while not specifically social service-related, fit in with the

definition of community-based social care services; that is, they help vulnerable people to lead fuller and more satisfying lives. Pioneering work in this area is going on in the Philippines, where several projects have been developed to help street children become involved in the design and monitoring of programs targeted to them; see Box 14. In addition, work with rag picking community of Pune on empowerment issues has helped improve Oxfam's project outcomes there. See Annex 16 for more details.

4. *Evaluating Proposals*

The steering committee charged with reviewing proposals should comprise at least two social service specialists and, if applicable, an NGO specialist. Depending on the level of expertise available, it may be prudent to supplement the committee with an international social services consultant.

Assessments should be based on cost effectiveness (measured through analysis of several NGOs and alternative project implementation strategies), comparative advantage in the field of specialty (knowledge of beneficiaries, experience in delivering services), and organizational and mobilization capacity. At the simplest level is the following set of evaluation criteria, used in several ADB-financed projects that employ NGOs:

| | Max. | Min. |
|--|------|------------------|
| NGO/CBO experience (years of operation, relevant projects) | 13 | 32 |
| NGO/CBO organization (staff experience, coverage, gender) | 35 | 21 |
| Project management (no. of services, efficiency) | 15 | 5 |
| Annual budget (e.g., audit) | 3 | 3 |
| Approach/methodology | 15 | 8 |
| Total | 100 | 50 ⁴⁴ |

⁴⁴ *Ibid.*, p. 43.

However, social services require consideration of other factors that are not captured there. These include:

General linkages with other institutions Along with specifics of the service to be delivered (see below), programs should be evaluated in terms of their linkages with other institutions and services in the community. If it is a nutrition initiative, does it have links with the local health clinic? Are teachers in the community aware of the program and will they help publicize and monitor the program? How have local government officials or village elders been involved in the design of the program?

Specific social service indicators. There is no one set of indicators that will definitively separate good project proposals from bad ones. However, each project should have developed a set of group indicators for each type of client to be targeted by the project, so that specific service proposals may be evaluated in light of how they agree to those principles. Sample indicators may be found in annexes 1 through 10.

5. *Capacity building: of the service provider, the communities, and local governments*

Capacity building is a necessary – and expensive – input to a community-based social service project. As one specialist puts it, “You can have a terrific model and show that these skills lead to these results. But if you don’t have a skilled person who is able to implement this model, then you have a problem. Consistent, intensive, and ongoing training, supervision, and monitoring is crucial.”⁴⁵ More importantly, there can be literally life-or-death consequences of putting badly-skilled people in charge of treating psychologically damaged clients. A recent case in Washington, DC, in which homeless shelter staff mistakenly put a client on to the streets (leading to his death from hypothermia), illustrates this point.

Recognizing the need for adequate skills among social service staff, there are several donor-financed projects that do not actually finance social services per se, but rather build the

⁴⁵ Christel Nichols, personal conversation, July 2002.

capacity of NGOs to deliver services. For example, in Zimbabwe, there are several NGOs that exclusively help to develop the skills of smaller organizations. Their recommendations on the specialist service skills to be developed include the following:

- Stimulating volunteerism and training volunteers
- Community mobilization and development of training materials
- Teaching communities to monitor services
- Caregiver training
- Networking and fundraising
- “Scaling up” operations and replicating services in different communities
- Policy and advocacy
- Building local government capacity to monitor social service projects⁴⁶

Networking is cited by many specialists as an especially important capacity-building tool. For example, many funding agencies finance annual conferences in which caregivers may discuss standards, share experiences, and modify existing notions of best practice based on the previous year’s experience. Other projects fund study tours and in-country site visits, or facilitate twinning arrangements with social work schools in developed countries.

Along with the opportunity to participate in such training activities, each service provider should have an individualized capacity-building plan based on the type of organization and service to be provided, the skills level of staff, and the availability of local training resources. The skills to be developed include both generic ones, common to all community-based projects, and social service skills. Since it is time-consuming and expensive to conduct individual seminars for each social service provider, many projects conduct training “en masse”. The Stockholm School of Social Work, for example, was contracted by the Government of Lithuania to train several new community social service providers. The school was able to train 100 social workers over the course of nine months, in three separate training streams. All staff participated in a study tour to Sweden, an intensive course on

⁴⁶ Foster, pp. 6-7.

basic social work methodology, a series of on-site seminars at their own workplaces, where their particular social service skills are studied, and finally, on-the-job learning as they work day to day, which is monitored closely by instructors. Even though it is done “in bulk,” this form of in-depth training is still extremely expensive, costing approximately \$2 million of a \$16-million community social services project. However, the training has made a measurable difference to the quality of care available at the facilities as opposed to other forms of social care.⁴⁷

Social skills training need not be so intensive. At the House of Ruth, a battered women’s shelter in Washington, D.C., supervisors at the facility are responsible for training their employees. Working with nearby academic institutions and also keeping up to date with trade journals, the supervisors hold monthly two-hour training sessions (required attendance) in which the latest developments in the field are discussed. This has the added advantage of putting practitioners, who are familiar with the day-to-day challenges of the profession, in charge of the learning.⁴⁸ In the developing world it is not always as easy to keep informed of social service best practice, making it all the more important that the financing institution itself keeps a social service specialist on staff who can keep in contact on behalf of service providers and disseminate findings during site visits.

In addition to social service skills, service providers, as with any other small business, should have staff with basic business and project management skills. Pri Fernando of International Development Support Services suggests the following:

- Governance, strategic planning, mission, vision, participatory project planning, financial systems, IT.
- Improved service delivery: needs assessment, outreach management, peer education, gender training, monitoring and evaluation methodology, impact assessments.

⁴⁷ Stockholm University Department of Social Work and Vilnius University Department of Social Work, “Competence-Enhancing Activities: The Community Social Services Development Project Mid-Term Evaluation,” pp. 1-15.

⁴⁸ Christol Nichols, presentation to the World Bank on The House of Ruth, July 2002.

- Advocacy and networking: developing inter-agency forums, consultations and policy dialogue with government counterparts, advocacy to the general community, fundraising.
- Improved office systems and facilities: provision of upgraded equipment and other office hardware.
- Access to information resources and best practice documentation; regular distribution of key resources.

She suggests that the most effective training strategies are workshops, mentoring through every stage of the project cycle, and study tours.⁴⁹ See Annex 20 for terms of reference from a World Wildlife Fund institutional strengthening project in Cameroon, which gives a good outline of “generic” training activities. For a flavor of the type of capacity building seminars that are held with NGOs, refer to Annex 21 which describes the proceedings of such a workshop in East Timor.

Recently, USAID financed “Pact,” an NGO capacity building initiative in Ethiopia for NGOs dealing with orphans and street children. A total of \$1 million was set aside to strengthen the capacity of 25 NGOs at the national and local levels. The subproject cycle was as follows: first, PACT staff conducted an organizational capacity assessment of each NGO to help the NGO identify its own strengths and weaknesses and help the PACT staff determine its training needs. Then interventions begin, mostly structured training for a week with 3-4 weeks of subsequent mentoring by a PACT-appointed consultant focusing on strategic planning and management, domestic fundraising, project design, monitoring and evaluation, and financial management. After completion of the training activities, the NGO was eligible for further funding. Many of the program graduates increased their donor funding allocation

⁴⁹ Pri Fernando, presentation to the World Bank on effective social service delivery (unpublished presentation), May 2002.

and increased the number of children benefiting from their programs. Collectively, the NGOs' budgets grew by \$2.6 million over the life of the initiative, an increase of 121%.⁵⁰

Note that capacity building is not limited to developing skills. The capacity building measures suggested for a community-based project for battered women in the United States, for example, included the following:

- Providing staff with a living wage
- Supporting continued staff and volunteer development
- Addressing issues of secondary trauma and “burnout”
- Ensuring safe working conditions
- Ensuring that workers have access to specialized consultants, including legal, medical, and mental health specialists as necessary to meet community needs
- Increasing workers' the cultural sensitivity and language skills so that they can communicate effectively with clients⁵¹

The most effective form of training is often learning by doing. Many community-based social service authors advocate delegating responsibility for impact evaluation to the service provider itself, so that staff can learn as they prepare the evaluation. This of course depends on the size of the organization and the skills level of the staff; projects should not automatically delegate responsibilities to an already-understaffed and overworked facility. Annex 22 provides suggestions written by a social service NGO for use by others on how to conduct one's own impact evaluation. More may be found below under “Monitoring and evaluation.” Projects may also consider “farming out” such impact evaluation activities to local governments as a competence-enhancing activity.

⁵⁰ John Williamson, “Executive Summary, Assessment of the Street Children and Orphans Component of the Pact NGO Sector Enhancement Initiative in Ethiopia,” USAID publication, available at www.usaid.gov/pop_health/dcofwvf/reports/evals/dcethiopia00.html

⁵¹ The National Advisory Council on Violence Against Women and the Violence Against Women Office, Toolkit to End Violence Against Women, Chapter 1, “Strengthening Community-Based Services and Advocacy for Victims” More available at http://toolkit.ncjrs.org/vawo_1.html

Capacity building of the community is particularly important when community members are part of the potential client base. It also serves to help “invest” community members in a program so that they will be more likely to support it and to contribute time or resources to the project. For example, one of the main functions of a community-based AIDS prevention project is to teach people to recognize the toll that AIDS takes on their communities and to develop simple, monitorable activities to cope with AIDS once it strikes. For example, the COPE program in Malawi, sponsored by Save the Children, was developed expressly to help build the capacity of communities to address AIDS and to mitigate its impact on women and children. The program first appointed and train a village AIDS prevention and care committee, comprising coalitions of government officers, religious leaders, businesspersons, and other community leaders. One COPE fieldworker, whose job was to train the committee on developing a community needs assessment, was appointed for every nine villages in the pilot area. The fieldworker was not so much a trainer as a facilitator, helping communities to identify its own solutions. Each village organized a community workshop to discuss the impacts of HIV/AIDS and identify existing responses, and develop new ideas. Suggestions were highly original. Successful fundraising strategies developed included video shows, community gardens, working in farmer’s plots for cash and big walks, and services that were simple but effective and monitorable. Volunteers made regular home visits to monitor AIDS patients’ health and provide encouragement and occasional material help as needed. Other villages established youth clubs whose members delivered HIV prevention and care messages through drama, and song, while providing recreation for youngsters. Community-based childcare programs were also developed. The COPE staff’s role in all of this was not so much to lead the communities to any pre-determined forms of care but rather to facilitate the discussion and provide suggestions on implementation and resources as needed.⁵²

Local government and central government officials must also be able to monitor and regulate services; however, their administrative capacity is often limited. The first step is to develop

⁵² Tom Krift and Stanley Phiri, “Developing a Strategy to Strengthen Community Capacity to Assist HIV/AIDS-affected Children and Families: The COPE Program of Save the Children Federation in Malawi,” available at <http://www.togan.co.za/cindi/papers/paper7.htm>

awareness of standards, whether in the project or at the national level, and to secure officials' agreement to them. The PACT program of Ethiopia, for example, worked with the Ministry of Labor and Social Affairs to develop an information exchange network for local governments and other stakeholders that allowed more than three-quarters of the country's service providers to stay in regular contact. The network helped NGOs and government officials to exchange information and experience, find information resources, and organize site visits to 19 organizations dealing with vulnerable children. Exposure to other countries' experience with local government monitoring of social services is also important, whether taught through workshops or in the form of study tours.

6. *Financing recurrent costs and cost-effectiveness*

Recurrent Costs Securing agreement with local governments or other funding agencies at the outset of the project is essential. Community-based social service projects handle recurrent cost financing in different ways, depending on whether this responsibility rests with the local government or with NGOs and CBOs. In general, projects that deal with local governments find it easier to introduce plans for recurrent cost financing because local governments have the option of relying on any of the three traditional sources—they can use tax revenues, charge user fees and obtain donor money (the last option becoming easier to pursue because of the spread of decentralized cooperation approaches in Europe). However, there are potential pitfalls. Often, community-based projects that deliver social care services take place in a context of new fiscal decentralization, where local governments are taking on responsibility for services that they have never provided before. The project itself may be the first experience that these local governments have in delivering or monitoring these services. In these cases, it is essential to have adequate training on how to budget social care services according to the needs of their jurisdiction. For example, a review of the Philippines experience with fiscal decentralization of social services noted that several provincial governments responsible for social services for the first time allocated too little compared to the social need in their areas (as measured by the human development index). This suggested

that the link between social service expenditures and social development outcomes must be made explicit for local government officials.⁵³

In NGO or CBO-implemented projects, the tax option is not available and provisions must often be made to ensure that beneficiaries or users' associations pay for recurrent costs – a difficult prospect if the targeted group is extremely poor. One good feature is that, along with traditional sources of money for recurrent costs, community-based projects have an important advantage: they can harness in-kind community resources and volunteerism and develop alternative, more creative sources of financing. Communities in Malawi, for example, thought of video showings, growing vegetables, and holding discos as ways of financing the costs of AIDS orphans programs in their communities.⁵⁴ Training in fundraising techniques encourages this and helps service providers locate new sources of funding.⁵⁵ Including fundraising skills in the capacity-building activities financed by the project is a solution that has been used for years by the non-profit sector in the developed world, and this is now spreading to developing countries. The Soros Foundation, for example, funds recurrent costs for only three years, during which subprojects staff are trained extensively on outreach and fundraising techniques. Once funding is finished, Soros involvement finishes – without exception – and the subprojects are left to fend for themselves. While this policy carries a high risk that the subproject may fail, those subprojects that are able to continue will be much better-placed to finance recurrent costs. Some international NGOs may also finance the salary of a (future) professional fund-raiser on a sliding scale, or with the provision that the fund-raiser has to raise at least, say, three times his/her salary.⁵⁶

As with other community-based projects, timely disbursement of recurrent-cost financing is seen as key to ensuring project success. Without efficient and timely disbursements, the day-to-day operations of NGOs may be interrupted, which can compromise the organization and

⁵³ Manasan, Rosario G. Manasan, 1996, "Local Government Financing of Social Service Sectors in a Decentralized Regime: Special Focus on Provincial Governments in 1993 and 1994," mimeo, World Bank, 1996.

⁵⁴ Krift, and Phiri, available at <http://www.togan.co.za/cindi/papers/paper7.htm>

⁵⁵ McLeod and Tovo, p. 31.

⁵⁶ Ibid., p. 33.

damage their ability to meet client needs. The Asian Development Bank suggests that the ideal turnaround time, based on its experience in Bangladesh and the Philippines, is a 30-45 day payment process.⁵⁷

Auditing procedures should be simplified as much as possible so that the agency has time to concentrate on providing services rather than filling out paperwork. The World Bank has just released guidelines on fiduciary management that emphasizes the importance of simple accounting and record keeping for community-level projects. The guiding principles for a community accounting system should be:

- use of local language,
- all transactions (cash and bank) to be recorded in simple formats,
- keeping all relevant accounting documents, and
- using as few forms as possible to do the job, focusing instead on the needs of the community (including tracking use of funds and stores and community contributions when required).⁵⁸

Another basic practice that helps increase the probability of transparent financial management is ensuring that the person who keeps the accounts does not have access to the cash. Likewise, requiring that two people sign off on each transaction helps enhance transparency.

Measuring Cost-effectiveness It is notoriously difficult to measure the costs of social service programs, particularly in developing countries. Subbarao et al point to three reasons: 1) paucity of data on interventions, since service providers do not report the time period, sample size, cost component breakdown, or total costs; 2) the data that is available comes from only a handful of countries that have been able to conduct research at all; and 3)

⁵⁷ Operations Evaluation Office, Asian Development Bank: Special Evaluation Study of the Role of Nongovernment Organizations and Community-Based Organizations in Asian Development Bank Projects (Washington, DC: The Asian Development Bank, 1999), p. 50.

⁵⁸ ---, Fiduciary Management for Community-Driven Development Projects: A Reference Guide (Washington, DC: The World Bank, 2002), p. 19.

interventions differ in scale, approach, and goals, which makes comparing them difficult even within the same country.⁵⁹

Many authorities also note the difficulties of articulating, and then measuring, desired outcomes and the ease with which more easily-measured outputs – “number of patients seen,” for example, can take the place of real impact measurements, such as “number of patients getting better.” Many managers “prefer to concentrate on outputs or process, or worker satisfaction, as surrogates of agency effectiveness. . . . much of the displacement of goals is traceable to agencies pursuing performance outcomes that have little to do with client benefit.”⁶⁰

Similarly, economic analysis is difficult. Analysis of community-based-projects delivering social care faces a double challenge, one due to the community approach and the other to the nature of the output sought. Because there tend to be hundreds of individual small projects, employing the same economic evaluation techniques as traditional investment projects (economic rate of return, net present value, and benefit-cost ratios) may be too expensive. In addition, since many impacts take a long time to accrue, social services subprojects tend to be measured only by their outputs (for example, the construction of a daycare facility) rather than their impacts (such as increased employment for parents or caregivers). Difficulties are compounded by the fact that benefits are harder to put a price tag on, because they consist almost exclusively of “software”: training or counseling sessions, or home visits, which are difficult to value.⁶¹

Along with the extended timescale needed to measure long-term benefits of social services, the subproject implementation cycle can take longer and cost more, for although social care projects are less capital intensive than infrastructure projects, they tend to be more expensive

⁵⁹ Subbarao, K., Angel Mattimore, and Kathrin Plangemann, Social Protection of Africa’s Orphans and Vulnerable Children: Issues and Good Practices (Washington, D.C.: Africa Region Human Development Working Paper Series, The World Bank, 2001), pp. 21-22.

⁶⁰ Lyn Gain and Laurie Young, Outcome Measurement in Child Protection: International Literature Review and Critical Analysis of Child Protection and Alternative Placement Outcome Measures (Report, Australian Commonwealth/State Service Provision, September 1998), p. 40.

⁶¹ McLeod and Tovo, p. 40.

in terms of community mobilization, training, and staffing costs. If implemented well, community-based social care services will enhance the ability of a community to address certain social needs over the long term, but changing the way people think, behave and care for each other is a slow process. To begin with, communities need to agree on what to do and how to do it, which may take several months –and therefore several months of facilitators’ salaries. Adhering to proper community participation techniques is another time and cost factor to be considered. Additionally, since capacity varies widely among beneficiary groups, some weighting may be required to ensure that the greater costs associated with training poorer or less cohesive groups are taken into account in the cost-benefit analysis.⁶²

Box 15: NGOs in Health Service Delivery in Cambodia: Keeping Costs in Focus

The Basic Health Services Project in Cambodia, funded by the Asian Development Bank, represents an innovative NGO approach. In 1998, NGOs and the private sector were invited to tender for contracting in/out health service delivery in four pilot districts. Three NGOs and one pharmaceutical firm were awarded contracts, based on capability statements and costs. Through MEDICAM, NGOs/CBOs worked along with the Ministry of Health in defining selection criteria and contracting arrangements, including adequate financing flows.

Two pilot approaches were adopted. In one case, NGOs/CBOs simply manage services, including Government-employed health staff. In the second case, health staff are contracted by the NGO/CBO on a leave of absence basis. Monitoring systems focusing on changes in health status in these districts have helped to compare these two pilot approaches with the unchanged arrangements in control districts.

The innovation deserves cautious applause. There appears to be significant disparities in the per capita spending on health between the pilot and control districts. The pilot district is being allocated anywhere from \$5 to \$6 per person per annum compared with less than \$1 per person in the control district. As a result, performance monitoring and evaluation will need to undertake careful analysis of cost-effectiveness to iron out these funding disparities.

--Source: The Asian Development Bank, p. 50.

There is abundant literature available on the subject of cost-effectiveness in community-based service projects. Overall, at least four options are open:

⁶² Ibid., p. 42.

a. **Cost-benefit analysis**, generally measured in dollar terms, which compares a program's benefits to a stakeholder versus its costs to that stakeholder. The advantages of cost-benefit analysis are that costs and benefits can easily be compared between programs, or contrasted within a single service. Cost-benefit can also demonstrate how program spending measures up against program benefits. The time required for program benefits to exceed program costs may also be measured in certain cost-benefit analyses. Cost-benefit figures are also easily understood. It is simple, for example, for a policy maker to understand the

**Box 16: Sometimes, Cost-Effective is Also Best for the Client:
The Orphans Reunification Program in Eritrea**

The Government of Eritrea's Ministry of Labour and Human Welfare established the Orphans Reunification Programme in 1994. Its goal is to address the issue of orphaned children, one of Eritrea's greatest social problems, by placing children with adoptive families and strengthening the economic resources available to those families. Families were helped in buying productive assets such as livestock and small consumer items. As of 2000, approximately 7,000 families and 14,000 children had been helped.

Participation both of direct beneficiaries and the community at large was encouraged through local workshops that were at every stage of the project cycle, particularly when decisions were to be made over what assets to buy.

The unit cost of the program per orphan was only US\$305, compared to a unit cost of US\$1350 for orphan placement into a residential institution. This cost does not reflect the long-term benefits, both to the child and for government expenditures, accrued from the probable better health and education improvements of the orphan.

Lessons learned included: a) the importance of including stakeholders at all stages of project implementation; b) working within the traditional safety nets of the country; c) the need for agreement on and transparency of resource allocation; d) the constraints inherent in trying to monitor a program with such long-term outcomes; e) the need to help families through coping and life skills training; and f) the need for effective training strategies for the social workers involved in project delivery.

Source: Social Protection of Africa's Orphans and Vulnerable Children: Issues and Good Practices

finding that for each dollar spent on a drug abuse program, an average of \$4.96 is saved by the taxpayer in terms of expenditures on jails or loss due to crime.⁶³ The disadvantage of this approach is that those benefits that cannot be measured in dollar terms cannot be captured, and may be tracked only through additional qualitative studies.⁶⁴ This makes it of only limited use in measuring community-based social service projects.

⁶³ Brian Yates, *Measuring and Improving Costs, Cost-Effectiveness, and Cost-Benefit for Substance Abuse Treatment Programs: A Manual* (Bethesda, Md: the National Institute on Drug Abuse, 1999), p. 8.

⁶⁴ Karoly et al., p. 11.

b. Cost-savings analysis. This may be used only to compare the costs and benefits realized by the government or by a funding agency as a whole. In cost-savings analysis, only the costs to the funding agency are taken into account, and the benefits measured only in terms of savings elsewhere in the agency's budget. Such analysis can be useful to see if a publicly provided program "pays for itself."⁶⁵ This may be useful for a borrowing government wishing to compare costs of community-based projects versus other, similar interventions it finances elsewhere. This requires considerable sophistication of cost data gathering mechanisms and may be of limited use in most developing country contexts.

c. Cost analysis. Cost analysis does not measure benefits, only inputs. It can be a good tool to measure, for example, the kinds of inputs that every community-based program for a certain group must include, in order to make decisions about program replication.⁶⁶ However, its limitations as a way of measuring true cost efficiency are self-evident.

d. Cost-effectiveness analysis. This looks at how much must be spent to produce a certain outcome or outcomes. In cost-effectiveness analysis, inputs to the program are tracked as dollars spent, while outcome is measured as "changes in patients' behaviors, thoughts, feelings, or biology." For example, the cost-effectiveness of a methadone treatment program might be measured as the cost of generating an drug-free month for the average patient. The term "cost-effective" is used in many different contexts, usually to mean that a "something probably costs less, or is more effective, than something else."⁶⁷ Cost-effectiveness can be hard to measure accurately because "indicators vary somewhat over time and over patients because of many factors, not all of which are controlled by the program. It is easy to find an apparent difference in the cost-effectiveness of different program components or different programs. It is harder to show that the difference is real -for example, that it occurs reliably over months and for most patients and therefore should be

⁶⁵ Ibid., p. 11.

⁶⁶ Ibid., p. 11.

⁶⁷ Yates, page available at <http://165.112.78.61/IMPCOST/IMPCOST9.html>

used in program management decisions.”⁶⁸ Nonetheless, because of its combination of trackable inputs (easy to monitor with a unit cost database) and measurable outcomes (possible to gauge with qualitative monitoring of beneficiaries), cost-effectiveness may be the most appropriate mechanism for measuring community-based social services.

Unfortunately, using any of these analyses in small programs requires time and money. Karoly et al. have suggestions of “proxy” analysis that takes less time to gather, most of which are rather unwieldy for community-level analysis, particularly in the developing world. The most appropriate advice they give for a developing country context is to outline a framework that, in general, measures as many benefits as possible, that can be expressed in dollar terms, and to compare them to program costs (including costs measured not only in budgetary terms but also in terms of social resources, such as the value of donated time or space) that could have been used for other purposes. At the community-level, cost-effectiveness comparisons should prevail; i.e. to determine one or two simple, measurable indicators of progress and programs, regardless of the intervention method chosen to reach clients, such as “increased school attendance by street children” or “decreased incidences of drug abuse in the community,” per dollar spent.⁶⁹ See Annexes 23-24 for a fuller discussion of measuring cost-effectiveness, including a sample timetable to developing cost, cost-effectiveness, and cost-benefit analysis of a community-based social service program.

7. *Monitoring and Evaluation*

The first rule of thumb is that monitoring should be kept as simple as possible. Project requirements for accounting and paperwork should be kept to the minimum that will still provide an acceptable level of oversight, services to be delivered should be well defined and manageable, and impact indicators clear and understood by all. At the same time, technical assistance should be readily available at all stages of the subproject cycle and site supervision visits frequent.⁷⁰ As one specialist puts it, “monitoring is not just submitting reports,” and

⁶⁸ Ibid.

⁶⁹ Ibid., pp. 16-19.

⁷⁰ McLeod and Tovo, p. 55.

the emphasis should remain on tracking the impact of the service being provided.⁷¹ A sample community-based monitoring program used in a child welfare project in the Philippines is found in Annex 25. A sample evaluation of a community-based initiative with people with disabilities, using statistical analysis, may be found in Annex 26.

The question of measuring over time becomes especially important when measuring social service impacts. For many social service interventions, program benefits will accrue in years rather than days. A study of cost-effectiveness of Early Childhood Development interventions in the United States, for example, noted that some preschool development projects took 14-20 years or longer (until the beneficiaries had reached adolescence or adulthood) before results began to show. The eventual benefits shown by the programs, however, as evidenced in educational performance and health and crime rates, were considerable.⁷²

Especially for small projects, some compromises must of course be made. The House of Ruth in Washington, D.C., for example, tracks individual cases only while their clients remain at the facility (average length of stay is two years). Monitoring clients during their stay, to see whether they stay drug-free or avoid returning to an abusive relationship, is obviously less desirable than tracking the client over time to monitor whether she develops new addictions or new abusive relationships. However, it is virtually impossible for the facility to do this. If a client chooses to lose touch with the service, there is no way to keep in contact with them involuntarily. It is also perhaps beyond the purview of the organization to “fix” a client for life. As the manager of the facility says, “we put the Band-Aids on the problem.” Longer-lasting solutions to the question of domestic abuse lies in larger, more powerful institutions working together to initiate society-wide change.⁷³ The trick is to strike a balance, monitoring clients while they are under one’s care, and monitoring only those

⁷¹ Christol Nichol, personal conversation, July 2002.

⁷² Lynn A. Karoly, M. Rebecca Kilburn, James H. Bigelow, Jonathan P. Caulkins, Jill S. Cannon, James Chiesa, Assessing Costs and Benefits of Early Childhood Intervention Programs: Overview and Application to the Starting Early Starting Smart Program (Santa Monica, Ca: The RAND Corporation, 2001), p. 1.)

⁷³ Christol Nichol, personal conversation, July 2002.

results that are within the reach of the service to achieve. After that, developing “proxy indicators” of longer-lasting change may be possible (see below).

It is helpful to build in evaluation from the very start, helping the service providers to understand and develop evaluation indicators. Writing of a California early childhood development initiative, social scientist Pablo Stansbury has the following suggestions, which are applicable to a developing country context (see Annex 27 for complete details):

- Ensure contractors fully understand how their project is linked to a common set of goals and objectives.
- Provide contractors with an overview of plausible evaluation methods.
- Assist contractors to select evaluation instruments and/or design an evaluation instrument. This helps to build ownership of the supervision process. instrument.
- Build on contractor’s knowledge of their targeted population. Typically contractors have experience working with their cultural community, and it is important to build this into the evaluation.⁷⁴

Monitoring plans should be developed in collaboration with the service providers, as a natural follow-on to participators’ appraisals and planning. There are as many approaches to monitoring and evaluation as there are experts in the field, but most agree on these points: 1) a plan should be developed according to pre-set criteria and indicators that have been developed in tandem with the subproject staff and stakeholders;⁷⁵ 2) it should be developed according to pre-set norms of social service care. For example, a homecare project might use quality, reliability, and timeliness of services;⁷⁶ and 3) beneficiaries should be directly asked their opinions on the services provided, in the form of regular questionnaires – or even

⁷⁴ Pablo Stansbury, “Promising Practices: Multi-Level Evaluation Design: California’s Proposition 10,” The Evaluation Exchange Newsletter Family Support Issue, Spring 2002.

⁷⁵ Anna Madison, “Demonstrating Performance and Accountability Through Mission-Based Evaluation” in The Nonprofit Quarterly, Exploring Evaluation: What We Measure and Why Volume 5, Issue 3 Fall/Winter 1998.

⁷⁶ ---, Inspection of Social Care Services for Older People (Medway, UK: The Medway Council, 2000), available at

[http://tap.ccta.gov.uk/doh/point.nsf/66b6f04bdca6defc0025693b0051ada0/1eda5dcdd25f13d300256b820033dac3/\\$FILE/Insp_medway.pdf](http://tap.ccta.gov.uk/doh/point.nsf/66b6f04bdca6defc0025693b0051ada0/1eda5dcdd25f13d300256b820033dac3/$FILE/Insp_medway.pdf)

employing clients as project monitors.⁷⁷ Many note that it is not necessarily the technical quality of care that matters so much as whether clients themselves feel they are being well-provided for. The technical quality of care, some suggest, may be inspected by performing anonymous quality assurance checks, for example, by hiring students to pose as clients to report back to the project on the level of service being provided. A “step by step guide” to social services program evaluation may be found in Annex 28.

Some social service and community-based specialists also argue that community-based monitoring depends on continued involvement of the community itself to ensure quality of care. This technique, known as “participatory monitoring and evaluation (PM&E), has four principles: a) it is participatory; that is, clients and other stakeholders are involved; b) agreement is required among stakeholders on what should be monitored, how and when to monitor, and action plans based on findings; c) the process depends on developing feedback to improve future activities; and d) taking into account the diverse contexts, skills levels, and numbers of the participants, the technique depends on flexibility.⁷⁸ The technique is particularly appropriate for community-based social services, since so many of them depend on qualitative monitoring. In simple terms, PM&E involves project staff becoming facilitators for monitoring, helping local people and clients develop a baseline against which to measure results, then help them to track those results. Progress can be monitored in many different ways, from individual diaries of progress to photographic evidence or questionnaires.

This monitoring method tends to be more qualitative in nature than traditional monitoring techniques, though it does not necessarily have to be. In a nutrition project in Uganda, for example, the community chose “number of households eating ‘beer bananas’ “ as an indicator of hunger, since this type of banana is eaten only during times of food storage.⁷⁹

⁷⁷ For example, one project in the Philippines (measuring impact of macro policies at the micro level; <http://www.panasia.org.sg/mimapph/publications/mrp15.pdf>) has a community-based child monitoring system in which children themselves are employed as monitors.

⁷⁸ Irene Guijt and John Gaventa, “Participatory Monitoring and Evaluation: Learning from Change,” briefing note (Sussex: the Institute of Development Studies, 1998), p. 2.

⁷⁹ Ibid., p. 5.

Nonetheless, such “intangibles” as “self-esteem” or “sense of identity with the community” are perfectly appropriate indicators that stakeholders themselves are best-placed to monitor, and which may be the most progress indicators to track.

This approach is recommended here for social service projects particularly, because of the general lack of experience within communities of implementing social services and the need to develop and share lessons in this area. This is also true because research has indicated that projects using PM&E techniques have better chances for sustainability. As proponents note, “with many governments and development agencies favoring devolution and decentralization, PM&E has an increasing role to play. If responsibility is to become more localized, and based on the diverse needs and priorities of local communities, progress can no longer be measured using standardized top-down indicators. New, more versatile, and more devolved processes are required to track and assess change.”⁸⁰

In certain cases, participatory monitoring and evaluation can become the purpose of the service itself. A useful model from the nutrition sector is the Honduras “Atencion Integral a la Ninez Comunitario” program, and holds lessons for those designing social services that require continuous monitoring.⁸¹ See Box 17 for details.

⁸⁰ Ibid., p. 5.

⁸¹ Judy Mcguire, “AIN-C Integrated Child Care: Improving Health and Nutrition at the Community Level,” available at [http://wbln0023.worldbank.org/_8a9imeqbfdppi09h08dnnarjke9kmaso_/LAC/LACInfoClient.nsf/4f1b144aaa9938338525664c00017fdb/773d30d04a460616852568cb0068213d/\\$FILE/HONDURAS%20engl.pdf](http://wbln0023.worldbank.org/_8a9imeqbfdppi09h08dnnarjke9kmaso_/LAC/LACInfoClient.nsf/4f1b144aaa9938338525664c00017fdb/773d30d04a460616852568cb0068213d/$FILE/HONDURAS%20engl.pdf)

Box 17: Community-Based Monitoring

Atencion Integral a la Niñez Comunitario (AIN-C), a community-based nutrition monitoring program, was established in 1994. The purpose of the AIN-C was to train community volunteers to monitor the growth of children under two in their village, to help target counseling to mothers, especially those of children who were not gaining weight. The program was redesigned in 1997 with the concepts of client orientation at the forefront. A program overhaul in 1997 led to the development of training materials and tools that the community volunteers (the “monitoras”) would use in their work. These included counseling cards, a simple information and feedback method, hands-on training, and a supportive supervision system. In each community, the village itself voted on the volunteers (at least three required) that would run the program.

Program goals were described to stakeholders in a basic and realistic way with a manual that was simple to use. For every 25 children under the age of two, the program required one monitora. The timetable for monitoring activities were designed as flexibly as possible to take into account the monitoras’ personal schedules, and monitoring activities were kept simple.

The monitoras’ activities were to: a) Get to understand the community (number and location of children under two, health issues, and local nutrition practices); b) Run monthly workshops on child development and growth with the families of children under two; c) Follow up on the negotiated nutrition actions taken for children who were not growing; and d) Help resolve problems by involving the community, and liaise with the local health center, especially about detected diseases.

Training of the monitoras was practical and task-based, rather than theoretical. National trainers and community health workers were included as formal trainers; the volunteers’ manual formed the basis of the training. Training was kept hands-on, with much of it based on working in the community.

Several aspects of the program were highly standardized across regions, such as training, monitoring indicators, counseling, and the monitoras’ job description. However, local flexibility was allowed, such as division of labor between monitoras, and scheduling.

Each monitora was provided a manual that gave tips on all aspects of the job she was to perform. This included monitoring indicators, tables of desirable weight gain, examples of the use of counseling cards (containing key messages based on the specific child’s age, health, etc.). The monitoras gathered information on the total number of children, those attending monthly sessions, the number gaining or failing to gain adequate weight, and the special “problem cases” of those children who had not gained weight for two months.

By 1999, evaluation results were monitored. The results were substantial: malnutrition had been cut to less than 10% in most participating communities:

- 1/3 of the population had been covered;
- 2 million people, including 57,000 children under two, lived in the program area;
- Health personnel in 192 health centers in 9 areas were trained; and
- 583 monitoras from 179 communities were selected, trained, and on the job.

-- Source: Judy McGuire, “AIN-C Integrated Child Care”

Just
as

national service standards help to set standards of care at individual sites, it is easier to develop evaluation plans if there are nationally agreed-upon evaluation criteria by which to measure projects. Annex 29 gives an example of the United Kingdom’s national social services performance assessment framework.

Many specialists agree that impact indicators for each project should be developed at the outset of a project, in collaboration with the project staff and a group of key stakeholders

including people outside the project with some knowledge of the subject and/or background in the community (eg. police, healthcare workers, local government officials, member of the group to be reached, teachers). The group begins with a brainstorming session to develop a list of possible indicators of community impacts caused by the problem. A key feature of the session is for all suggestions to merit equal consideration, regardless of their “quality,” and that thoughts are recording immediately. The goal is to define as many existing information sources as possible while also developing thoughts on information that would also be valuable to have, whether or not available. Then, the group must round out the field. Once the list is prepared, the group winnows ideas down and identifies gaps.⁸²

Others suggest a deeper process of consultation with the project staff. Karen Horsch, a research specialist with the Harvard Family Research Project, suggests the following criteria should be used when evaluating community-based interventions:

What outcomes are reasonable to expect?

- Evaluators note that the most important part of evaluation is to be realistic about what sort of outcomes to achieve and the timeframe in which to achieve them. There are three ranks of outcome: a) those that are directly related to the program activities; b) the extent to which the program activities are helping to change the social service delivery system; and c) the community-level ramifications (the latter being very hard to measure and time-consuming).

What processes can be used to identify outcomes?

- The first step is to find out from all stakeholders what they expect the project to achieve, and how they plan to evaluate it. The evaluator should facilitate this discussion.

⁸² Roy M. Gabriel and Charles Brinkerhoff, Developing a Community Profile: A Handbook for Using Pre-existing Data in Prevention Planning (Portland, Oregon: Northwest Regional Educational Laboratory, 1993), pp. 7-12

- Next is to determine how well the project was designed, and what the original goals were. It is essential to find out how clearly the goals were defined, how realistic they were, and whether stakeholders understood all practical ramifications. If this has not been done properly, expectations need to be revisited. The goal is to “have a broad framework of outcomes to garner interest and focus subsequent discussions about outcomes.”
- Then, begin articulating intermediate goals. The short-term and long-term goals are usually well-understood by stakeholders, but medium-term achievements are the milestones by which progress to the final goal may be measured.
- Make sure that what the initiative is producing is actually tied to what the project was financed to achieve.
- Don’t take too long about it. Try to find shortcuts, such as evaluators’ past experiences or best practices from other communities, to find and agree on outcomes. You do not want to test the energies and commitment of the stakeholders to the fullest, merely in the process of identifying outcomes.⁸³

In addition--and this is particularly true in a developing country context--it may be appropriate to build in evidence of a community’s past performance with project financing as a predictor of the success for the current initiative.⁸⁴

Many specialists recommend dividing the outcomes to be measured into short-term and longer-term items to be measured. For example, in writing of evaluating services for battered women, social scientist Cris Sullivan offers the following outcome categories:

Short-term outcomes:

- survivors’ immediate physical safety and that of their children (for shelter programs)
- clients’ increased knowledge about domestic violence issues

⁸³ Karen Horsch, “Evaluating CBIs: Facing the Challenges and Improving Practice,” in *The Evaluation Exchange*, Volume III, Number 3-4, 1997 (Boston: Harvard Family Research Project), pp. 2-3.

⁸⁴ *Ibid.*, p. 2.

- clients' increased awareness of sources of help and future choices
- diminution in survivors' sense of isolation;
- better community response to victims of domestic violence; and/or
- increased public awareness about domestic violence.

Longer-term outcomes:

- increased survivor safety in the longer term and improved quality of life;
- reduced incidence of abuse measured in the community; and/or
- reduced murder rate in the community.⁸⁵

Sullivan also notes the difficulty of measuring long-term results, for reasons of time and money constraints. Proxy indicators must be developed that can substitute for measurement years down the road, based first on qualitative measurements such as beneficiary assessments and questionnaires. Proxy questions should answer: a) how effective did clients find the program; b) how satisfied they were; and c) if the service was supposed to result in an immediate, measurable change in the clients' lives, whether this change occurred.

Depending on the type of service, specific indicators may then be developed. For example, for a hospital-based program for battered women, proximal change indicators might be that the hospital staff identify more battered women; that more women receive information about the program; and that hospital staff demonstrate greater sensitivity toward battered women. These changes might in turn be expected to lead to an increase in the number of women in general seeking help, which in the long term would lead to reduced violence and better quality of life. The proxy indicators could be measured by: (1) the number of women correctly identified in the hospital as survivors of domestic abuse; (2) survivors' perceptions of the effectiveness of the intervention in meeting their needs (including receiving

⁸⁵ Cris Sullivan, Evaluating the Outcomes of Domestic Violence Service Programs: Some Practical Considerations and Strategies (no publication city: Applied Research Forum, National Electronic Network on Violence Against Women, pp. 2-3.

information and support they perceived to be helpful); and (3) hospital personnel's attitudes toward survivors of domestic violence.⁸⁶

VII. Conclusion

The issue of community-level social services provision is one that is still in its infancy at the Bank, though the area holds tremendous promise as a way of reaching extremely vulnerable groups. However, while research into community-based care is only beginning, task managers can still tackle social services projects with reasonable confidence by using principles that are common to all community-level lending. Developing technical standards need not be difficult, since while the outputs may be new, the method by which one develops a sound proposal is the same as in any other community-based project. Sound practices include:

- Defining target beneficiary groups at the outset of the project
- Knowing the goals to be achieved and the methods by which to achieve them
- Developing sound technical standards, preferably based on national policies
- Training project staff well and ensuring they know how to train service providers
- Keeping accounting and business requirements simple yet transparent, so that service providers can concentrate on helping clients
- Keeping goals manageable

In addition, the following considerations are especially important when implementing community-based social service projects:

- Encourage flexibility in subproject design

⁸⁶ Ibid, pp. 2-3.

- Factor in more time for impacts to be seen, and develop realistic estimates of the implementation periods required for social services
- Know the limitations of the project as a whole and of each individual service provider
- Have a recurrent cost and financing plan thought out at project inception
- Ensure that public awareness and community outreach is properly budgeted for
- Keep all stakeholders, from service providers to local authorities to beneficiaries and the community at large, involved in all stages of the subproject cycle. If at all possible, they should help to design project goals, training plans, and monitoring and evaluation indicators.

These principles will no doubt be refined as the Bank continues to lend for community social services. In the meantime, provided that services are well-designed, tailored to the capacity of the implementing agency, follow international standards of good practice, and allow for recurrent costs, task managers will be well-positioned to design projects that can have a real impact on vulnerable people.

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Annex 1: Sample impact indicators for services for older people

Standard 1: Effectiveness of Service Delivery and Outcomes

Older people receive responsive social services which promote independence and support them to make the most of their own capacity and potential. This standard looks at whether:

- a. users and carers were satisfied with services;
- b. services were good enough; i.e. they:
 - actively promote independence and seek to reduce dependency;
 - respond to service users' identified needs and achieve agreed outcomes;
 - seek to maintain the dignity of service users;
 - are reliable, timely, flexible, accessible, non-intrusive, supportive of informal arrangements and adaptable to changing need
- c. the range of services was broad and varied enough, measured by:
 - relevant specialist focus (for example, mental health, physical disability and sensory impairment);
 - availability outside office hours;
 - preventive services (particularly prevention of avoidable hospital, residential and nursing home admission);
 - rehabilitation (particularly following a stay in hospital).
- d. users were well safeguarded against abuse, neglect or poor treatment whilst receiving social care;
- e. social services worked collaboratively with health, housing and other parts of the local authority and other agencies to provide services; and
- f. providers monitored their services to ensure that they are of good quality, responsive to need and promote independence.

Standard 2: Quality of Services for Users and Carers – Information and Care Management

Older people and carers benefit from convenient and person centred care management arrangements. Criteria include:

- The public benefits from information that helps them to know how to go
- about getting social services.
- Referral and initial response systems are convenient and consumer friendly for service users and carers.

Assessment and care planning arrangements should:

- promote independence and choice,
- be needs-led and timely,
- prevent avoidable hospital admission and facilitate timely hospital discharge and rehabilitation;
- operate out of office hours for emergencies;
- involve other professionals;
- be multi-disciplinary when they should be;
- offer opportunities for health and other agencies to play a role in care management;
- involve users and carers as active participants and contributors;
- include risk assessment and planning; and
- address the full range of the social care needs of the local population of older people, including mental health needs, physical disability and sensory impairment.

Care plans are:

- comprehensive and address strengths as well as needs;
- given to service users and carers;
- in accessible formats; and
- reviewed systematically to see whether users' individual needs have changed and whether services are providing the best outcomes.

Standard 3: Fair Access

a. Social services acts fairly and with consistency about who gets what social care services, and how charging works. Eligibility criteria:

- inform existing and potential service users and carers about what
- sorts of people with what kinds of needs qualify for what types of
- services;
- help fieldworkers to carry out effective assessments and then
- match services to assessed needs;
- result in everyone being treated fairly.

b. Regardless of where they live, people have fair and equal access to services and those with similar needs are assured of similar access and outcomes (consistency).

c. Social service is proactive about preventing exclusion from service because a person is from a minority ethnic group.

d. Specific social care needs that arise from older people and carers' cultures and lifestyles are respected and responded to.

e. The system for charging is transparent, fair and consistent.

f. When service users or carers want to comment about their services there is an effective mechanism for listening to them and the complaints system works well for users and carers.

Standard 4: Cost and Efficiency

Social services commissions and delivers services to clear standards, covering both quality and costs, by the most effective, economic and efficient means available (Best Value).

Criteria:

a) There is clear management accountability for budgets, with financial and managerial responsibility aligned as closely as practicable and supported by robust systems.

b) Social services has in place the key elements for good commissioning –needs analysis, strategic planning, contract setting and market management, and contract monitoring.

c) Social services knows the unit costs of all its services (whether provided in-house or contracted out to the voluntary or private sector) and uses this information to manage efficiently and to encourage competition in the provision of good quality responsive services.

d) The council collaborates with health to consider the potential for joint financial arrangements, including pooled budgets, lead commissioning and integrated provision.

e) The council has established local objectives and performance measures for social services for older people and they reflect national objectives and priorities.

f) The council has a programme of Best Value Reviews set out in a local performance plan and it includes social services for older people – and the review of these services has a clear way of determining Best Value which includes comparison with others and challenge to the status quo.

g) Where a council has undertaken a Best Value Review of social services for older people this has resulted in the setting of performance and efficiency targets for these services, publishing information about what the targets are and how well they are met in the local performance plan, and using this information to address any shortcomings.

Standard 5: Organization and Management Arrangements

Social services has management and accountability structures that commission and provide effective services. Criteria:

- a) Social services has a clear strategy for responding to the national objectives for social services and the national priorities guidance (so far as they concern older people and carers) and is implementing this strategy.
- b) Social services plans social care services for older people:
- involving and consulting with users and carers;
 - in collaboration with health (including through Primary Care Groups/Trusts), other parts of the local authority and other agencies; and
 - through an appropriate range of opportunities [the community care plan (CCP), the better services for vulnerable people (BSVP) initiative, the Health Improvement Programme (HImP), the Joint Investment Plan (JIP), a local carers' strategy etc].
- c) Elected members have clear responsibilities for social services for older people and their carers, including arrangements for the review of policy and strong scrutiny arrangements for performance.
- d) Social services has ensured appropriate organisational and management arrangements are in place for services for older people and their carers.
- e) Organisation and management are supported and informed by management information and policies and procedures for staff.
- f) Social services ensures that social care workers are appropriately skilled, trained and qualified, and promotes the uptake of training at all levels.
- g) Social services monitors the composition of its workforce as part of an equal opportunities strategy to ensure that the workforce profile reflects the composition of the local community.

Taken from "Inspection of Social Care Services for Older People, Medway Council," October 2000. Available at [http://tap.ccta.gov.uk/doh/point.nsf/66b6f04bdca6defc0025693b0051ada0/1eda5dcdd25f13d300256b820033dac3/\\$FILE/Insp_medway.pdf](http://tap.ccta.gov.uk/doh/point.nsf/66b6f04bdca6defc0025693b0051ada0/1eda5dcdd25f13d300256b820033dac3/$FILE/Insp_medway.pdf)

Annex 2: Sample impact indicators for Early Childhood Development interventions

Table: Early Childhood Intervention Program Benefit Domains and Illustrative Measures

| Benefit Domain | Illustrative Measures for: | |
|--|---|---|
| | Child | Parent/Caregiver |
| Emotional and cognitive development | Socioemotional and behavior scores IQ test scores Teacher's ratings | Quality of parent-child relationship Quality of home environment |
| Education | Achievement test scores Grades <i>Grade progression (repetition)</i> <i>Participation in special education</i> <i>Educational attainment</i> | |
| Public assistance receipt, income, crime | <i>Receipt of public assistance</i> <i>Employment</i> <i>Earnings/income</i> <i>Criminal activity</i> <i>Contact with criminal justice system</i> | <i>Receipt of public assistance</i> <i>Employment</i> <i>Earnings/income</i> <i>Criminal activity</i> <i>Contact with criminal justice system</i> |
| Health | Physical and mental health status <i>Child abuse and neglect</i> Substance abuse Fertility control <i>Emergency room visits</i> <i>Other health care use</i> | Physical and mental health status Family violence Substance abuse Fertility control |
| | Note: <i>Italics</i> indicate measures more easily expressed in dollar terms. | |

Reprinted from "Assessing Costs and Benefits of Early Childhood Interventions," in Karoly et al.

Annex 3: Monitoring participation by socially excluded groups and monitoring the extent of increased community involvement in programs

Outcome 1: The program/service is accessible to children and families.

| Type of Indicator | System Level Indicators | | | |
|-------------------|--|---|--|---------|
| | Child | Family | Community | Society |
| Quantitative | Increase in number of children entering the program from previous year Reduced waiting list | Increase in number of families applying to the program from the previous year | Number of referrals made by other organizations | |
| Qualitative | | Parents perceive the application procedure to enter the program is inclusive and easy to follow | Community demonstrates support for the program (for example, recommends, cofinances, and/or otherwise promotes it) | |

Outcome 2: The program meets the needs of diverse communities.

| Type of Indicator | System Level Indicators | | | |
|-------------------|---|--|--|--|
| | Child | Family | Community | Society |
| Quantitative | Number of children from families of ethnic minorities/socially excluded groups participating in the program | | Number of ethnic minorities/socially excluded groups consulted in planning the program | |
| Qualitative | Children from families of ethnic minorities/socially excluded groups feel a sense of belonging | Family members feel that their cultural values are respected and incorporated into the services they receive | | Social policy reflects the program needs of ethnic minorities/socially excluded families |

Outcome 3: The program builds community capacity through participation.

| Type of Indicator | System Level Indicators | | | |
|-------------------|---|---|--|---------|
| | Child | Family | Community | Society |
| Quantitative | Number of children more engaged in the community as a result of the program | Number of parents participating in the program's decision-making process, e.g. volunteering | Number of community members volunteering or hired in the administration of | |

| | | | | |
|-------------|--|--|--|--|
| | | | the program | |
| Qualitative | Children feel they have choices, abilities, skills as a result of participating in the program | Parents believe that they have the opportunities to provide input and effect in the program planning | Extent to which local organizations are aware of the program | Social policy incorporates community directives in program planning and evaluation |

Adapted from the Social Planning Council of Winnipeg: A Model for Third Party Monitoring of the Early Childhood Development Initiative in the Manitoba Region.

Annex 4 Sample evaluation indicators for a youth outreach project

Positive Youth Development Constructs

The first task is to establish operational definitions or criteria for positive youth development through a literature review, consultation with project officers, and a consensus meeting of the project advisory board. Positive youth development programs are approaches that seek to achieve one or more of the following objectives:

1. Promotes bonding
2. Fosters resilience
3. Promotes social competence
4. Promotes emotional competence
5. Promotes cognitive competence
6. Promotes behavioral competence
7. Promotes moral competence
8. Fosters self-determination
9. Fosters spirituality
10. Fosters self-efficacy
11. Fosters clear and positive identity
12. Fosters belief in the future
13. Provides recognition for positive behavior
14. Provides opportunities for prosocial involvement
15. Fosters prosocial norms.

From “Positive Youth Development in the United States: Defining and Evaluating Positive Youth Development <http://aspe.hhs.gov/hsp/PositiveYouthDev99/chapter2.htm>

Annex 5: Sample impact indicators for drug/alcohol abuse programs

| Category | Examples of potential indicators | | |
|------------------|---|--|---|
| Health | Overdose deaths | Drug-affected births | Alcohol/drug-related hospital cases |
| Education | Drug-related suspensions | Alcohol/drug use survey findings | Student hours in prevention curriculum |
| Families | Alcohol/drug-related foster care placements | Parent training events provided | Alcohol/drug-related family problems tied to unemployment |
| Safety | Alcohol/drug-related traffic injuries and death | Alcohol/drug-related drownings and other accidents | Discarded syringes etc. In parks and playgrounds |
| Business | Alcohol/drug-related sick leave | Productivity and product quality deficiencies | |
| Other | Community improvements deferred due to alcohol/drug-related impacts | | Adverse media exposure affecting community reputation |

Adapted from Roy M. Gabriel and Charles Brinkerhoff, Developing a Community Profile: A Handbook for Using Pre-existing Data in Prevention Planning

Annex 6: Evaluation Indicators for a Youth Mentoring Program

Evaluation is an essential component of all successful programs. Evaluations help a program to know whether it has met its objectives and served the needs of the participants, and provide critical feedback that can be used for program revision and improvement. Data collected for evaluations can also be used as positive reinforcement for mentors and can alert program directors and program staff to any problems with program implementation. The best evaluations are ongoing and continuous.

Evaluation plans should be designed at the very beginning of program development. Incorporating evaluation plans into the program design causes planners to think about proposed activities and the ways in which these activities could be assessed as successful or not. Program staff should also be involved in the planning phases of evaluation, so that evaluation is not perceived as threatening, but as an opportunity to further the goals of the program. Staff can also play a vital role in interpreting the findings, as staff will be the most knowledgeable about the actual day-to-day operation of the program.

In general, evaluations use two types of information--"process" and "outcome"--to decide whether a program is successful. **Process** information lets the program planners know whether the program is being implemented as it was intended to be, and whether changes or mid-course adjustments are needed. It includes answers to the following questions:

- How many mentors and students were matched?
- For how long were they paired?
- Was student attendance adequate? Was mentor attendance adequate?
- What was the length of each meeting? Were adequate facilities always available for meeting?
- How many mentors left before the program ended? How many students left before the program ended?
- What kind of activities did mentors and students participate in?
- What types of relationships formed between the mentors and students?

Taken from Yes, You Can: A Guide for Establishing Mentoring Programs to Prepare Youth for College

Annex 7: Sample impact indicators for child and youth protection initiatives

Overriding goals:

- To protect children and young people at risk of harm within their family or in circumstances in which the family of the child or young person does not have the capacity to protect them.
- To assist families to protect children and young people.

Broad Goal: Safety

The child will be safe from immediate physical, sexual, emotional abuse or neglect

- Ratio of children investigated for abuse to number reported at risk
- Abuse or neglect while active case
- Decrease in number of subsequent confirmed cases of open cases
- % of children re-abused
- Numbers of substantiated maltreatment incidents on active family preservation cases
- % of cases reported and assessed as founded for an abuse or neglect report and which were provided protective services after the assessment, represent cases which were
- previously assessed for abuse and neglect while services were still being provided

The child will become/remain safe from any/further physical, sexual, emotional abuse or neglect/Children will be safe from maltreatment

- Abuse or neglect recidivism after case is closed
- Abuse or neglect after return home
- Confirmed abuse cases
- Decrease the number of subsequent confirmed reports of unsubstantiated cases of abuse or neglect
- Death
- What percentage of cases reported and assessed as founded for an abuse or neglect report within a given time period represent cases which were previously assessed for abuse and neglect?
- What percentage of cases reported and assessed as founded for an abuse or neglect report within a given time period, and which were closed at the end of the assessment, represent cases which were previously assessed for abuse and neglect?
- Which of the cases were reported and assessed as founded after services had been terminated?
- What percentage of cases reported and assessed for abuse or neglect are subsequently reported and assessed as founded within 12 months of the earlier report?
- Decrease in number of subsequent confirmed case within a specified time
- % of children needing protection who get services beyond investigation

- % of children for whom no incident of determined abuse occurred during reporting period
- 80% of families successfully completing the program (no child removed from home) will have no confirmed reports of abuse or neglect within six months of case closure
- Percentage of child welfare cases with a subsequent substantiated report of CA/N for any child in the home: (a) within a given time frame following the initial substantiated report, (b) while open for child welfare services, (c) for families involved in prior unsubstantiated cases, (d) within a specified period of time following case closure.
- Child's sense of safety and security
- Increase by 20% the number of families closed in the Department with no subsequent abuse and neglect after initiation of services
- Increase by 50% the number of families with no subsequent substantiated abuse and neglect within 12 months after case closure
- Decrease by 20% the duration of open cases
- Decrease the number of preventable injuries/deaths resulting from abuse or neglect
- Reduce propensity for/risk of, future abuse and neglect
- Potential for future abuse (measured by worker rating of risk variables)
- Reduction in following risk factors: medically diagnosed injuries, lack of physical necessities (clothing, food); punishment (excessive; bizarre); lack of supervision; parental behaviour toward child (parent ignoring child, antagonistic)
- Percentage of children whose cases were opened due at least in part to living conditions, e.g., housing quality and cleanliness, stability of income, etc., live in improved conditions when services are terminated?)
- Safety of children and communities will improve
- Improved child safety through improved child and family functioning measured by a standardised instrument such as:

(a) Child Wellbeing Scales, which quantify 43 different dimensions of the physical, psychological and social needs of children including items for "physical health care, nutrition, clothing, household furnishings, overcrowding, sanitation, parental supervision of young children, consistency of discipline, abusive discipline, deprivation of food/water, and measures of child behavior such as academic performance, school attendance, and misconduct.

(b) The Family Risk Scales. 26 items including habitability of the family residence, suitability of living conditions, financial problems, social support, parental health, parental mental health, parental substance abuse, child's health, delinquency, child's home related behaviour.

- Increase by 30% the community services families utilise while their cases are open
- Increase in families' knowledge of available resources
- Decrease by 25% the average length of time a case is in court under a Dependency and Neglect Petition
- Decrease by 30% the number of police contacts a family's children experience while

- their case is open
- Increase in use of appropriate discipline
- Improved level of parental knowledge re physical and developmental needs of children
- Increased reports from community
- Increased availability and adequacy of an array of services
- Decrease in rate of juvenile delinquency
- Decrease in rate of criminal arrests or charges for child welfare cases
- Decrease the factors that put adolescents at risk of perpetrating violence or becoming a victim of violence
- Higher rates of service provision for newly opened services (especially in parenting skills training, family counselling and mental health services)

Broad Goal: Permanency and Stability

The child will have a permanent home/Children are in a permanent home.

- Number or percent of confirmed child protection cases where children remain in own home without further support
- Number or percent of confirmed child protection cases where children remain in own home with support services
- Reunification with birth families or original caretakers
- No. or % returned home after entry to foster or residential care

The child will have continuity of care.

- Number of different people who have acted as the child's main carer since s/he was a baby
- Number of returns to parents after first separation
- Number or % of child protection cases where children re-enter substitute care after reunification

The child will have a safe and permanent home.

- Children will live in safe, permanent homes reflective and respectful of the child's cultural, ethnic, racial, and kinship identity.

Broad Goal: Child Wellbeing/Children Are On the Right Track

The child's wellbeing will improve/be maintained on a number of dimensions/The child is receiving the care expected by the community that would be provided by a "reasonable parent". This will result in maintained/improved wellbeing on a number of dimensions/Children will be assisted to become caring and productive adults.

Health/Mental Health Dimension

- The child is normally well, i.e., unwell for 1 week or less in the last 6 months
- The child is thriving (satisfactory growth and development)
- All preventive health measures, including appropriate immunisations, are being taken
- Percent of children with current immunisations.
- Inadequate immunisations
- Percent of children who received a yearly medical examination
- Percent of children who received a yearly dental examination
- All ongoing health conditions and disabilities, including developmental delays, are being addressed as soon as recognised
- The child is reasonably protected against common accidents, environment is safe (carer(s) are aware of common hazards and take adequate precautions): receipt of pre-natal care, normal births, adequate birthweight, insured children
- Percentage of children whose cases were opened due at least in part to diagnosed mental conditions who have an improved diagnosis at the termination of services
- Eliminate the use of alcohol and smoking during pregnancy

Education Dimension

- Percent attending school x% of the time scheduled
- Percent graduating from school
- Graduation rates
- Percent who complete high school
- Youth prepared for university admission
- Improved school attendance and/or performance for children within a specified time following service
- School performance and educational progress
- Reduction in truancy/increase in the number of days a child attends school)
- Child at age appropriate school grade level at entry

Identity Dimension

- The carer(s) are responsive to and encourage the baby's emerging individuality
- The young person has a positive view of him/herself and his/her abilities (generally confident in new situations, takes on challenges & expects to succeed, enjoys meeting new people, expects to be liked)
- The young person can relate to his/her racial or ethnic background

Social and Family Relationships Dimension

- The child/young person's contacts with his or her birth family strengthen his/her relationship with them
- The baby is definitely attached to at least one caregiver

- The young person is able to make friendships with others of the same age
- The young person has a relationship with a person who is prepared to help him/her in times of need
- Child's connection to family and community

Social Presentation Dimension

- The young person can communicate easily with others
- The young person's appearance is acceptable to young people and adults
- The baby gives every appearance of being well cared for

Emotional and Behavioral Development Dimension

- The baby/child/young person is free of serious emotional and behavioural problems
- The baby/child/young person is receiving effective treatment for all persistent serious emotional and behavioural problems
- Percentage of children whose cases were opened at least in part due to their own behavior who have become more able to control their behavior in appropriate ways by the time of termination of services?
- Improved behavior within a specified time following service
- Increased availability and affordability of child care options
- Bedwetting

Self Care Dimension

- The young person can function independently at a level appropriate to his/her age and ability
- The child is learning simple self-care skills for coping with early independence

Employment and Training Dimension

- Increase in number of adolescents successfully involved in education or vocational activities

Law and Order Dimension

- Adjudicated delinquency rates for youth receiving child welfare services
- % not in juvenile corrections system
- % of youth returning to community from youth centers who re-offend within 6 and 12 months of release
- Improve or maintain functioning of child

Relationships with Parents

- Decrease in child's fear toward parent
- Improvement in quality of child parent interactions
- Improved effective communication and non abusive techniques to resolve family conflict
- Improved sense of cohesion
- Improved parental care-giving capacity (care, nutrition, hygiene, supervision)
- Increased community recreation services and community support
- Family Relative contact - contact with biological mother, father, siblings, extended family, foster care family or group home family

Other Indicators

- % not in juvenile corrections system
- % not having children out of wedlock
- % not active in social service caseload
- % of youth returning to community from youth centers who re-offend within 6 and 12 months

Broad goal: Family Wellbeing/Strengthened Capacity for Child Rearing

Improve or maintain functioning of caretaker.

- Improved parental ability to access and use formal and informal community resources
- Improved parent and family members' awareness of how their behavior impact the child
- Improved parental ability to identify child's needs
- Increased time spent by workers with families
- Increased % of families actively involved in decisionmaking about their children

Goal: Family Preservation

- Number of days children are in placement during family preservation services
- Children's residence at the end of family preservation services
- Increase in children placed with family or kinship relations
- Increase in number of families providing regular contact
- Improved quality of parent/child interaction and satisfaction with the relationship for those reunified
- Increase in culturally and ethnically appropriate adoptive and foster homes
- Fewer children will enter foster care

Broad Goal: Consumer Satisfaction

Users of services will be satisfied with services received.

Increase by 30% families' expressed satisfaction with Department services while cases are open

Increase by 20% the families who report a helpfulness of services on a scale of 1 to 5

-- Taken from Child Protection Outcome Measurement - Final Report, Young & Gain Consultants

Annex 8: Sample impact indicators for child and youth placement programs

The objective of supported placement services is to care for children and young people aged 18 years who cannot live with their parents for reasons of safety or family crisis

Broad Goal: Safety

- The child will be free of physical, sexual, emotional abuse or neglect whilst in out-of-home placement
- Decrease in number of subsequent confirmed cases in out-of home placements

Broad Goal: Permanency/Stability

- Length of time in a non permanent placement will be minimized
- Length of time in a non permanent placement will be minimized
- % of children for whom permanency plan was achieved within 24 months
- Length of time for child in out of home care to achieve permanent plan
- Length of time to finalize an adoption once parental rights terminated
- Permanency plan will be achieved
- The child will be re-united with birth family, original caretakers
- The child will be placed in kinship care with transferred guardianship
- The child will be adopted
- Number of children not moving to permanency plan
- Increase the success rate of reunification
- Children who return home after a supported placement will remain at home
- More children who return home from foster care will remain at home
- Number of children who re-enter substitute care following reunification with birth family), expressed as percentage of children in care
- Frequency of parental visits when in foster care as a predictor of reuniting
- Improve the stability of children's living arrangements
- Children in placement will experience fewer moves
- Maintain sibling groups wherever possible and appropriate
- Increase the number of local community placements for out of home care
- Increased % of children with planned discharges from residential treatment
- Movement to less restrictive environment when a child's placement with the provider facility is terminated
- Moving from group home to foster care (measure of success)
- Child running away or going to another equally or more restrictive measure (measure of lack of success)

Broad Goal : Child Wellbeing

The wellbeing of children in supported placements improve/be maintained

on a number of dimensions/ children in supported placements will receive a similar standard of care to that which would have been provided by a "reasonable parent."

Measures set out under this goal in the Child Protection objectives section (in previous annex) are also relevant, so long as child is in supported placement.

Health Dimension

What percentage of children in substitute care who have physical health problems experience improvements in their physical functioning while in substitute care?

Education Dimension

What percentage of children in substitute care who are performing below grade level when they enter substitute care experience improvement in their performance during their stay?

School performance assessed through grades, citizenship and attendance

Emotional & Behavioural Dimension

Percent of children in substitute care who always feel loved by their caretakers

Percent of children in substitute care who feel safe

General

% of children who received purchased supportive/rehab services in substitute care

-- Taken from Child Protection Outcome Measurement - Final Report, Young & Gain Consultants

Annex 9: Sample Indicators for Services for People with Disabilities

Community-based services for people with disabilities may include:

- residential (including halfway houses, group homes and individual apartments);
- mobile outreach services;
- assistance with independent living activities;
- attendant care;
- crisis and case management;
- day treatment;
- income maintenance;
- vocational rehabilitation and employment assistance;
- transportation;
- recreation;
- counseling;
- special assistance; and
- medication maintenance.

A community-based safety net should ensure:

- Availability of services
Ensuring that all in a community who need the service have access to it.
- Continuity and quality care
A stable, experienced and trained workforce who are remunerated appropriately and with good working conditions.
- Cost effectiveness
As compared to other programs in the community, and also measured against the number of people with mental illness who are incarcerated (since often they are in jail because of their illness and lack of any other place to go, rather than any criminality)
- Accountability
Including financial propriety, transparent reporting methods and adequate business supervision.

Taken from <http://afscme.org/pol-leg/opens02.htm> The American Federation of State County and Municipal Employees, “Opening New Doors: The Transition from Institutional to Community-Based Care”

Annex 10: General Social Service Standards, the United Kingdom

”The Government of the United Kingdom has developed a National Priorities Guidance framework that sets out the key social service priorities for 1999/00 - 2001/02. Priorities not only include benchmarks for standards of care, but also indicate how sharing arrangements will be handled between line ministries.

| National priorities for health and social care 1999/2000 - 2001/02 | | |
|--|---|---|
| Ministry of social services takes the lead in: Children's welfare Inter-agency working Regulation | Shared lead Cutting health inequalities Mental health Promoting independence | The National Health Service takes the lead in: Waiting lists/times Primary care Coronary heart disease Cancer |

National objectives for social services

Children's services

- to ensure that children are securely attached to carers capable of providing safe and effective care for the duration of childhood
- to ensure that children are protected from emotional, physical, sexual abuse and neglect (significant harm)
- to ensure that children in need gain maximum life chance benefits from educational opportunities, health care and social care
- to ensure that children looked after gain maximum life chance benefits from educational opportunities, health care and social care
- to ensure that young people leaving care, as they enter adulthood, are not isolated and participate socially and economically as citizens
- to ensure that children with specific social needs arising out of disability or a health condition are living in families or other appropriate settings in the community where their assessed needs are adequately met and reviewed
- to ensure that referral and assessment processes discriminate effectively between different types and levels of need and produce a timely service response.

Adult services

- to promote the independence of adults assessed as needing social care support arranged by the local authority, respecting their dignity and furthering their social and economic participation
- to enable adults assessed as needing social care support to live as safe, full and as normal a life as possible, in their own home wherever feasible
- to ensure that people of working age who have been assessed as requiring community care services, are provided with these services in ways which take account of and, as far as

possible, maximise their and their carers' capacity to take up, remain in or return to employment

- to work with the NHS, users, carers and other agencies to avoid unnecessary admission to hospital, and inappropriate placement on leaving hospital; and to maximise the health status and thus independence of those they support
- to enable informal carers to care or continue to care for as long as they and the service user wish
- to plan, commission, purchase and monitor an adequate supply of appropriate, cost-effective and safe social care provision for those eligible for local authority support to identify individuals with social care needs who are eligible for public support, to assess those needs accurately and consistently, and to review care packages as necessary to ensure that they continue to be appropriate and effective.

Common objectives

- to actively involve users and carers in planning services and in tailoring individual packages of care; and to ensure effective mechanisms are in place to handle complaints
- to ensure through regulatory powers and duties that adults and children in regulated services are protected from harm and poor care standards
- to ensure that social care workers are appropriately skilled, trained and qualified, and to promote the uptake of training at all levels
- to maximise the benefit to service users for the resources available, and to demonstrate the effectiveness and value for money of the care and support provided, and allow for choice and different responses for different needs and circumstances. For adult services, to operate a charging regime which is transparent, consistent and equitable; and which maximises revenue while not providing distortions or disincentives which would affect the outcomes of care for individuals.

Source: UK Government website

Annex 11: Specific standards for social services for older people (may be adapted to all vulnerable groups)

The following national services standards have been developed specifically for services for the elderly. However, they may be modified for other services.

Standard 1: Effectiveness of service delivery and outcomes

Older people receive responsive social services which promote independence and support them to make the most of their own capacity and potential. This standard looks at whether:

- users and carers were satisfied with services;
- services were good enough;
- the range of services was broad and varied enough;
- users were well safeguarded;
- social services worked collaboratively; and
- providers monitored their services.

Standard 2: Quality of services for users and carers: Information and care management

Older people and carers benefit from convenient and person centred care management arrangements. This standard looks at whether:

- information about getting social services was well publicised;
- a consumer friendly response was given to users and carers;
- assessment and care planning worked well; and
- care plans played an important part.

Standard 3: Fair Access

Social services acts fairly and with consistency about who gets what social care services, and how charging works. This standard looks at whether:

- eligibility criteria helped create fair access;
- social services aimed to prevent exclusion of people from minority ethnic groups;
- cultural needs were respected and responded to;
- the charging system was fair; and
- the complaints system worked.

Standard 4: Cost and Efficiency

Social services commissions and delivers services to clear standards, covering both quality and costs, by the most effective, economic and efficient means available (Best Value). This standard looks at whether:

financial management was effective;
the key elements for commissioning were in place;
the council had considered with the NHS the options for joint financial arrangements;
and
social care services for older people were included in the council's Best Value performance management framework – and users and carers benefited from resulting improvements.

Standard 5: Organization and Management Arrangements

Social services has management and accountability structures that commission and provide effective services. This standard looks at whether:

social services acted strategically and planned well;
elected members had clear responsibilities;
organisation and management arrangements were effective;
management information, and staff policies and procedures contributed to the work management;
training and qualification was given importance; and
there was ethnic monitoring of the workforce.

Source: UK Government Website

Annex 12: Factors Important for Project Success, Street Children Initiatives

The following suggestions, taken from Street Children: Promising Practices and Approaches⁸⁷ by Elena Volpi, are for programs for street children. However, they may be adapted to many different types of social services. Volpi writes that the following factors are essential for a program for children's services:

Trained professionals. Goodwill alone cannot generate a sound program. The input of experts from different sectors is vital, and resources must go toward the training and retraining of their volunteers.

Focus on integration into the family, school, and labor market. Charity-oriented programs help perpetuate the street children problem by making street life easier and strengthening children's dependence on service providers. By contrast, development-oriented activities enable children to express their potential and to function effectively in both the family and society. [Similarly, charity-oriented programs for other marginalized groups, such as people with disabilities, emphasize the separate nature and present situation of the marginalized group, without redirecting efforts toward integrating those people into mainstream society.]

Reaching children where they are. Children cannot be forced to leave the street. Several established programs that have had a positive impact begin with a phased-in transition to allow children to gradually change their lifestyle if they wish.

Individualized attention and tailor-made services. Time and multidisciplinary expertise need to be invested in assessing the situation of each participant and in designing tailor-made life plans and services.

Children's participation. It is important to design program activities with children, and not only for them. Children can be involved as peer counselors and facilitator. Their special life experience makes them potential leaders and advocates of development in their communities.

Physical and mental health care. Programs must also pay close attention to physical and mental health needs. Public health staff need to be sensitized to the specific needs of street children.

Involving family and community. The situation of street children reflects the vulnerability of their social environment. It is therefore important to strengthen the capacity of the family and community (including the school) to receive and take care of their young members.

⁸⁷ Volpi, Elena. Street Children: Promising Practices and Approaches (Washington, D.C.: The World Bank Institute, The World Bank, 2002).

Lobbying and advocacy efforts. By becoming involved in lobbying and advocacy, NGOs can instigate changes in the legal and political environment that affects children and thereby increase the impact of more typical services.

Integration of services. The health, education, survival, and emotional needs of street children should be addressed as an integrated system with the child's well-being at the center.

Networking and institutional cooperation. NGO programs alone are not enough to significantly reduce the number of children in the street, nor are they expected to do so. It is far more effective for NGOs to network and cooperate among themselves and with local governments if they hope to increase the long-term impact and sustainability of interventions in this area.

Link to programs at the first and second level of risk. *When street children activities are integrated into community development programs, it becomes easier to tackle the multiple causes of child and youth distress, and to prepare a favorable environment for children who decide to leave the street.*⁸⁸

⁸⁸ Volpi, p. vii-viii.

Annex 13: “Stopping AIDS in its Tracks”: The Role of Public Relations

The Australian aid program's objectives in the area of HIV/AIDS are to help:

- prevent the spread of HIV
- reduce the impact of HIV/AIDS on individuals and society
- address the social and economic needs created by HIV/AIDS

Many countries in Africa, as well as India and Thailand have found that major transmission of HIV first occurred along transport routes before spreading throughout the country. This is because truck-drivers, away from their families for long periods, are likely to have multiple sex partners at different truck stops along the highway. Poor women (and young girls) living near truck stops resort to commercial sex for income and are therefore vulnerable to HIV infection. In turn the infection spreads to the families of both drivers and sex workers.

The *spatial association* between truck routes and HIV infection has led to the National Highway One Project in Vietnam, funded by the Australian Government's overseas aid program and implemented by World Vision. The project aims to prevent the spread of infection by increasing awareness of HIV infection and prevention among truck drivers and communities and by encouraging a change in behaviour. Due to the nature of their work, mobile groups such as truck drivers have limited access to health services and to health care information and this make them a vulnerable risk group for HIV/AIDS infection.

National Highway One is the main channel for movement of both goods and people between north and south Vietnam. Importantly it is also linked to cross-border traffic with China, Cambodia, Laos and Thailand. The project involved prevention activities at nine locations along 300 kilometres of road in four provinces.

Community members, such as restaurant workers and other service workers who are in frequent contact with truck drivers, were trained to distribute information and educational materials (including leaflets, key-rings, and audio-cassettes containing songs interspersed with conversations between truck-drivers) and supply condoms. The aim was to convince drivers to change their sexual behavior in order to reduce the risk of HIV infection.



The spare tyre-carrying condom appears in eye-catching statues beside Highway One, reminding drivers to carry two kinds of "rubbers". The text says "Safe sex helps people stay healthy".

Choosing to contact the drivers at small truck stops meant there was more opportunity for conversation, without the distractions provided by larger towns. Young men and women in roadside locations took part in education sessions and produced colourful murals and billboards which reinforced the message that HIV/AIDS threatens everyone, not just 'high-risk groups'. By educating the wider community, and urging sex workers to insist on the use of condoms and to seek treatment for STDs, the project aimed to create an environment that would encourage a change in behaviour.



Murals painted by community members helped to remind everyone that "Condoms help to prevent HIV/AIDS."

A survey of truck drivers passing through the project locations found that the educational materials have been distributed as far away as Ho Chi Minh City and Hanoi. The demand for condoms is increasing and condoms are becoming more available and more acceptable locally. One villager commented, "Sex without condoms is like walking barefoot."

Since this project began in 1998, interest in the link between HIV and mobility has increased and other projects are being implemented within Vietnam and in the greater Mekong region.

From "Facing the Global Challenges of HIV/AIDS, AusAid, available at <http://globaled.usaid.gov.au/secondary/casestud/vietnam/1/hiv-aids.html>

Annex 14: Focus on Outreach: Analysis of the World Vision National Highway One Project, Developing Community Responses to HIV/AIDS in Vietnam

| | |
|------------------------|---|
| Funding Source: | AusAID |
| Project Timing: | 1 September 1997 – 30 August 2000 |
| Contract Value: | \$ A 304,370 |
| Project Site/s: | Central Vietnam: Danang City, Quang Nam, Quang Tri, & Thua Tien Hue provinces |

Project Goal:

To reduce HIV transmission and to increase acceptance and the capacity for care of those infected with HIV in the target locations.

Project Purpose:

To increase the capacity of Truck Drivers and selected communities, particularly women, to effectively respond to HIV and AIDS.

Project Target: Long and short haul truck drivers and women living in selected communes along the highway

Project Description:

The project was to conduct participatory research, develop a model for an appropriate HIV/AIDS Behaviour Change Communication (BCC) strategy for truck drivers and women based on the research, implement the models on a pilot basis and evaluate them with a view to promoting them as appropriate for replication in Vietnam. The project was a strategic response in that it sought to develop an effective model for HIV/AIDS prevention for particularly vulnerable groups in the context of future HIV/AIDS transmission. This model is strategic in that it can be incorporated into an existing structure with potential to reach large numbers of people at the grassroots level throughout Vietnam.

The major project outputs:

- 1) Operational research using PLA methodology conducted and appropriate BCC models for HIV/AIDS developed for truck drivers and women.
- 2) A BCC program implemented for truck drivers in selected districts along National Highway One in Danang city and the three provinces.
- 3) A BCC program implemented incorporating appropriate care strategies among poor women in selected districts along the highway.
- 4) Improved capacity of the DOH and Women's Union in research, management and training.

Successful strategies and reasons for their success:

Participatory learning and action (PLA) research provided an opportunity to make contact with truck drivers and to collect data on their work pattern and social behaviour that informed the development of an appropriate BCC strategy. This was successful because it

involved the truck drivers from the start and it was the first time such research was conducted among truck drivers in Vietnam.

Truck drivers participated in the development of the IEC materials which meant that they were acceptable to the truck drivers and there was a sense of ownership as they had being involved in the testing and development of the materials. By the end of the project the truck driver specific IEC materials was of UNAIDS best practice standards and was approved by the National AIDS Committee who sought more funding to print materials for national distribution. The materials were later used in another AusAID funded mobility project in the north of Vietnam for truck drivers and modified for other mobile groups.

As truck drivers are constantly on the move working it was not feasible to develop a peer education group. Instead key stopping points along the highway were identified and individuals such as restaurant owners, waitresses, pharmacists, petrol pump attendants and toll gate operators were recruited as “Frontline social networkers (FSNs)” whose job it was to advise the truck drivers about STI/HIV, provide IEC materials and answer their questions. This strategy worked because the project staff were able to train the FSN, provide them with materials and provide regular support for the group at each location. The truck drivers became familiar with the FSNs and would seek them out to get condoms and IEC materials, and to ask questions relating to HIV.

Participatory research among the women and youth in the communes along the highway indicated that there was a need for a poverty alleviation program as well as for an education program on HIV prevention. Initially the project planned to develop an income generation program but the research findings indicated that many young girls dropped out of school and did not have the skills to get a job. An alternative strategy of school scholarships was developed to allow young teenage girls to complete their schooling and older girls were provided with scholarships to learning skills such as typing, computing and English. This provided many of them with opportunities to get employment in nearby towns.

Another innovative strategy used in the development of the BCC strategy among the youth in the commune was the use of an artist who taught the youth how to draw and paint. The youth then painted murals with a HIV prevention theme, on the side of key buildings in their villages. This had many positive effects such as giving the youth confidence, while adults were proud of their children’s achievements. Because the murals were painted by their own youth the community had ownership of them and took time to look and discuss the message in the painting.

Strategies that failed and reasons why

The project planning to develop a strategy for caring for people with HIV/AIDS but this did not happen as it was not easy to identify those that were HIV+ either among the truck drivers or in the selected communities along the highway. At this time in Vietnam people that were HIV+ were mainly IDUs and sex workers and the general public did not think they were at risk. Counselling and testing was not available to all and confidentiality was not assured. As

this was the first HIV prevention project among truck drivers in Vietnam it was too ambitious to expect that a care program could be developed at the same time as increasing awareness of the epidemic and its modes of transmission.

Overall Lessons

Inclusion of the target group (truck drivers/women and youth) in the development of HIV prevention strategies was the key to the development of appropriate and acceptable IEC materials.

HIV/AIDS prevention must be incorporated into development programs as the alleviation of poverty is an important strategy in preventing the spread of HIV.

By including operational research in a project the outcomes are appropriate for the local situation and sustainability is more achievable.

The development of good IEC materials takes much time and resources if fieldtesting is done correctly, donors and project designers need to take this into consideration when designing projects.

Central Vietnam HIV/AIDS projects 1992 – 1998

Two AusAID funded projects were implemented in Quang Nam Danang province during this period. The goal of the first project was to equip the DOH, Preventative Medicine Centre to provide testing and counselling for HIV and to train staff and peer educators in prevention strategies.

The second focused on providing HIV education and awareness to youth and continued to support the peer education program for IDU and sex workers.

Successful strategies in these two projects and reasons for their success:

Peer educators were given official identity badges so that they were not arrested by police during raids on brothels or bars.

A small loan scheme was set up for peer educators which enabled them to start small income generation projects so that they were not completely dependant on the allowance they got from the DOH.

The use of PLA among school children assisted in the development of an appropriate curriculum on HIV prevention for youth in school. By using the research finding and by partnering with the Departmentt of Education as well as DOH the curriculum was approved by the Provincial Education Authority for use in all secondary schools. It was later approved for use nationwide.

Annex 15: Sample Terms of Reference for a Social Assessment

ALBANIA SOCIAL SERVICE DELIVERY PROJECT (SSDP)

Terms of Reference Vulnerability Needs and Institutional Capability Assessment (VNICA)

Background for the Assessment

The Government of Albania and the World Bank have agreed to proceed with the preparation of the Social Services Delivery Project (SSDP). The SSDP's major function will be to help build skills and capacities of local governments, local NGOs and local communities through implementation of community-based social service delivery sub-projects targeted to vulnerable and marginalized population groups, and through training and technical assistance. Communities will be given the chance to organize, select their own priorities for services to vulnerable groups, and take primary responsibility for implementing their own small sub-projects.

The SSDP immediate objectives are: (i) development of policy and institutional framework for community based social services; (ii) development of the capacities of central and local governments in provision of social services; (iii) promotion of new forms and initiatives in the area of provision of social services and improved variety and quality of social services; and (iv) increased involvement of local communities and civil society in supporting vulnerable and marginalized population groups.

In Albania, large demographic and social changes arising from mass migration and fast, uncontrolled urbanization have increased already existing social problems (child abandonment, youth prostitution, children, youth and women trafficking and other social problems) and exacerbated overall vulnerability, particularly of children, youth, the elderly, and women. These have presented overwhelmingly difficult challenges to the currently weak system of social protection, particularly to the General Administration of Social Services (GASS), which is charged with the delivery of social assistance, including services.

In the absence of a strong public system of social assistance, the traditional family-based informal safety net has become the main coping mechanism for individuals and households. This informal system works well for socially integrated groups with large extended families and strong community ties. However, it often leaves out less protected and marginalized groups such as single parent families with women head of households, destitute children, abandoned elderly, unemployed youth and new migrants in urban/peri/urban areas.⁸⁹

1. Objectives

The objectives of proposed Vulnerability Needs and Institutional Capabilities Assessment are:

⁸⁹ For a review of the various social assessments carried out recently in Albania see: Gloria La Cava, "Addressing the Needs of Vulnerable Groups and Promoting Social Inclusion: Options for a Community-based Project in Albania", October 1998, mimeo. Specific studies include (i) *Albania: Filling the Vulnerability Gap* (World Bank, 1999); (ii) *Albania Human Development Report* (UNDP, 1998); (iii) *Children and Women's Rights in Albania: Situation Analysis* (UNICEF, 1998).

- (i) better understanding of the needs for social care services, including a better understanding of urgent needs and priorities in communities and possible typology of potential SSDP sub-projects;
- (ii) better understanding of urban and rural differences;
- (iii) better understanding of the mechanisms for identification and implementation of community-based social services;
- (iv) to inform the design of the proposed SSD project overall and its specific components;
- (v) to provide detailed and comprehensive mapping of vulnerable groups in order to prepared the proposed SSD project targeting matrix;

The Vulnerability Needs and Institutional Capability Assessment will provide inputs to the four components of the SSDP as follows:

Component 1. Policy Development

- evaluate overall legal framework and identify areas for its improvements;
- map and provide information on volume and type of currently provided social care services;
- using data from the vulnerability assessment, provide inputs for the SSDP public information and communication campaign;

Component 2. Capacity Building

- evaluate the current social care services system in Albania and assess institutional capacity at all government levels;

Component 3. Fund to Support Community-based Social Services

- develop measurable indicators of vulnerability and, as explained in the following section, rank vulnerability and institutional capability;
- provide the basic indicators for the development of a targeting/resource allocation matrix to be used under the SSDP *Fund to Support Community-based Social Services*;

Component 4. Project Management

- set up a baseline data set for the SSDP to be periodically updated during SSDP implementation (social and institutional impact monitoring) and to be used as the basis for project monitoring and evaluation.

2. Scope of Work

The proposed scope of work for the Needs and Institutional Capability Assessment (VNICA) would include the following three main components:

Component 1: Policy and legal assessment

Component 2: Institutional assessment with two sub-components: (i) institutional capacity assessment; and (ii) assessment of the social care services system and services provided

Component 3: Needs and vulnerability assessment with two sub-components: (i) qualitative vulnerability assessment; and (ii) data collecting system.

The VNICA will be carried out by a team of experts that will be responsible for each of the above components of the study. An Italian consultant recruited under the Italian TF will be responsible for overall coordination and supervision of the study in the field.

3. Methodology

The Vulnerability Needs and Institutional Capability Assessment will include different desk reviews, surveys of available data, in-depth interviews and focus group discussions. In order to ensure continuous social and institutional impact monitoring, the data should be updated on a yearly basis. INSTAT and UNICEF data should be incorporated, and their substantive and methodological inputs should be taken into account. Consultation on type of data required and methodology should also be pursued with the most active agencies addressing the needs of vulnerable groups in Albania (for example, Handicap International). The research outputs should include:

- Review of existing public (i.e., INSTAT) and non public data on vulnerability needs at central and local level to establish ratios and rankings, on the basis of relevant demographic data;
- Qualitative beneficiary needs assessment with semi-structured interviews and focus group discussions with different categories of vulnerable groups in selected locations of Albania, and, if needed, Italy and Greece; topical studies on particularly problematic vulnerable groups, i.e. young prostitutes, youth gangs, should be pursued;
- Qualitative institutional capability assessment with semi-structured interviews with public officials, local NGOs and informal citizens' groups at district level;
- Stocktaking of information on Albanian vulnerable groups currently residing in Italy and Greece either voluntarily or under coercion, their areas of origin, areas of major concentration in countries of destination, role of their families and communities, number and type of governmental and non governmental institutions which are currently delivering services to them, willingness and possible arrangement to return. This will be carried out through a thorough review of existing NGO and official sources (i.e. police records, special reports by municipalities, Ministry of Interior and Department of Social Affairs) and interviews with key informants. If necessary, direct consultation with vulnerable individuals residing in these countries may be considered.

4. Study Areas

At the initial stage, the assessment will take place in the four districts selected for the pilot phase of the SSDP: Tirana, Vlora, Shkodra, and Durrës. It will continuously feed information into the different phases of the project cycle. Sources and methods of data gathering and evaluation will be discussed, updated and agreed with counterparts. The results of the assessment will serve and feed data for the installation of a Geographic Information System that will be part of the Management Information System (MIS) for mapping of vulnerability and project data management.

5. Implementation Arrangements

The assessment will be conducted by a team of international and local consultants specialized in social assessment techniques with expertise in demography, statistics and institutional assessment, under World Bank (Gloria La Cava) and GASS (Zamira Sinomeiri) coordination.

The overall policy development component of the assessment will be supervised by Aleksandra Posarac from the World Bank and her counterpart in GASS, Frida Hysi.

The Institutional Capability Assessment will be conducted by an international and a local consultants.

An international social scientist, together with a statistician to be appointed by INSTAT, will carry out the Vulnerability Needs Assessment.

6. Timing of the Assessment and Reporting/Outputs

The overall assessment should be completed over a four month period. Consultants should provide:

- An Inception Report, with a detailed research strategy (including sample strategy, number of interviews and focus group discussion per type of respondent, interview guides, role of participating institutions);
- An Interim Report with key findings and recommendations;
- A Final Report summarizing the findings of the different outputs/sections indicated in the methodology section and presenting in annex each output, within 120 days; and
- Background reports (papers) for each component of the study.

Detailed TORs and outputs for each component of the study is presented below.

7. Stakeholder Consultation and Dissemination Workshops

In some selected communities the research team should carry out a participatory discussion of the findings of the study. Community members should be encouraged to lead discussions while the research team should acts more as facilitator and provider of needed technical information. The objective of such an exercise would be to help the community reach a rational assessment of their problems and possible solutions, and to rank them according to their feasibility of success. During this process, new information can be included and corrections made to the team's findings. Based on the data collection and community-wide meeting, a report will prepared synthesizing the major issues relevant to the study.

At the end of the study the researchers should organize stakeholder workshops for discussions of findings and dissemination of results for each of four pilot targeted regions.

A national stakeholder workshop will be organized in order to include broader public into the decision making and participation in project design.

8. Budget and schedule

Overall budget available US\$80,000, including \$50,000 from the PHRD and \$30,000 from Italian grant for pilot project. In addition an Italian social scientist will be hired under the Italian TF for the supervision and coordination of the field work. Detailed estimated budget and schedule for each component of the study is presented below.

TORs for VNICA Components

These TOR are comprehensive of the four components of the study:

- 1) Component 1: Policy development and legal assessment
- 2) Component 2: Institutional assessment. Sub-components: (i) institutional capacity assessment and (ii) assessment of the social care services system and services provided
- 3) Component 3: Needs and vulnerability assessment. Sub-components: (i) qualitative vulnerability assessment and (ii) data collecting system.

Component 1: Legal Assessment

1.1 Objectives. The policy and legal assessment is a desk review exercise aiming at analyzing and evaluating the overall legal framework in relation to the juridical framework for social services provision and identifying areas for improvements. This component is a thorough and comprehensive review of all legal documents providing a framework for social care services provision to vulnerable and marginalized groups. In addition to reviewing the legislation and regulations, this component should provide an analysis and evaluation of the legislation to assess whether it provides a solid foundation for efficient and effective delivery of social care services. It should identify its weaknesses and gaps in regulations, and propose appropriate changes.

1.2 The review should include:

- laws such as the Family Code, Law on Social Welfare, Law on NGOs, Law on Adoption, relevant parts of the Constitution and the Criminal Code, Law/regulation no. 510, etc.;
- decisions of the Council of Ministers regulating implementation of legislation related to provision of social care services and social protection of the vulnerable;
- manuals, procedures, guidelines and other documents of the Ministry of Labor and Social Affairs and GAAS at all government levels and Judiciary;
- legislation and regulations, which are currently being developed, such as Law on Foster Care, etc.
- existing NGO legislation
- all other related legislated currently under development.

1.3 This review will serve also as a key input for the Institutional Assessment of the VNICA (Component 2 of the study), and specifically for this purpose, current public system of social care services will be review and evaluate in terms of :

- (a) procedures according to which an individual is placed in a residential institution;
- (b) manuals, guidelines, procedures;
- (c) legislation concerning residential care institutions financing with sources of financing (GASS, local governments, donors), and expenditures by different categories (salaries/wages, taxes, utilities, food, other current expenditures; capital maintenance, investment)
- (d) a review of GASS contracts with NGOs;
- (e) NGOs compliance with existing regulatory framework.

1.4 Methodology. The assessment will be carried out as a desk review of relevant legislation, including regulations, manual of procedures and contractual regulations directly linked to social services provision. The review will include relevant studies already available (i.e., UNICEF: “Children’s and women ‘s rights in Albania”; UNDP “ National Human Development” on migration,etc.).

1.5 Output. The final report will include analysis of the legislation and regulations with the consultants' conclusions on: (i) whether the current legislation provides a solid foundation for efficient and effective delivery of social care services; (ii) how selected groups of vulnerable people perceive and relate to the law and the justice system; (ii) whether the system provides a sense of protection; (iii) which are the major gaps in the legislation from the point of view of the beneficiaries; (iv) who are the groups that feels the least protected by the present legislation; (v) identify weaknesses and gaps in regulations; and (vi) propose appropriate changes.

1.6 Staffing. The assessment will be carried out by two senior legal expert with direct experience with social legislation and a part-time junior legal expert. The senior legal experts will be coordinating and supervising all activities and will be responsible for the final report.

1.7 Timing. The consultants will work both for approximately three months, starting from mid January 2000. The senior consultants are expected to prepare a methodology proposal and to submit a draft report to the Government and the World Bank for comments by end of March 2000. The final report is expected by mid April, 2000.

1.8 Budget. The estimated budget for this component is US\$ 8,000 which includes:

| | Total |
|---|----------------|
| 2 Senior legal experts (*) 4 months – lumpsum – \$ 3,400 | \$6,800 |
| One junior legal expert for 1 month (**) | \$300 |
| 2 Field trip per diem (2) at \$50/day x 3 days | \$300 |
| Travelling expenses: 1 car x 3 days | \$300 |
| Miscellanea | \$300 |
| | \$8,000 |

Component 2: Institutional Capacity Assessment

1.1 **Objectives.** This component, composed of two sub-components described below, aims at: (i) evaluating the current social care services system in Albania, (ii) assess institutional capacity at all government and non-governmental levels, (iii) evaluate the potential for local public administration involvement; and (iv) finally map and provide information on volume, type, quality and impact of currently provided social care services.

1.2 This assessment include the following two sub-components:

1.2.1 (a) **Institutional capacity assessment.** This sub-component aims at assessing the capacity to design, monitor, evaluate, analyze, and implement social care policies in all relevant government agencies, particularly the Ministry of Labor and Social Affairs and GASS at all government level, including municipal and local community levels. This component is crucial in assessing administrative capability required for efficient and effective administration and implementation of social care services policies.

More specifically under this sub-component the consultants should carry out:

- (i) functional review of all public institutions dealing with social care services policies, including inter-institutional links and focus on who is accountable for what and to whom;
- (ii) organizational capability assessment – horizontal and vertical organization of MOLSA and GASS at all public administration levels, including municipal and local community levels;
- (iii) coordination, monitoring and evaluation mechanisms, and reporting;
- (iv) staffing: number of employees by institutions, government levels, departmental levels, qualifications and skills, information on training, etc.). Short description of tasks performed by social administrators/ social workers and social inspectors;
- (v) evaluation of work procedures and practices;
- (vi) premises and equipment;
- (vii) information management system evaluation;
- (viii) manuals, guidelines and procedures;
- (ix) assessment of existing social workers and their role in the PA.
- (x) social services specialist training institutions, programs, including line-ministries, universities, NGOs etc.

1.2.2 (b) **Assessment of the current social care services system and services provided**

This sub-component aims at reviewing and evaluating current public system of social care services including:

- (i) types of services provided to different vulnerable groups;
- (ii) public (state) residential care institutions: number, types of services by each institution, number of beneficiaries by each institution (with as much information as available about their social background and reasons for institutionalization); number of people on a waiting list for each institution, number of care providers with detailed information about their tasks and qualifications, provision of training, etc.
- (iii) management of residential institutions, decision-making processes, monitoring and control mechanisms;
- (iv) procedures according to which an individual is placed in a residential institution

- (v) premises and equipment;
- (vi) manuals, guidelines, procedures;
- (vii) residential care institutions financing with sources of financing (GASS, local governments, donors), and expenditures by different categories (salaries/wages, taxes, utilities, food, other current expenditures; capital maintenance, investment);
- (viii) an assessment of the quality of services provided by each institution, with identification of major issues to be addressed;
- (ix) residential care services adjustment and improvements.

This sub-component: (b) should also provide a comprehensive review on social care services provided by NGOs, with at least the following information:

- (a) information on NGO – local, foreign, cooperation;
- (b) short history of the program;
- (c) programs and services provided (description);
- (d) number and categories of beneficiaries;
- (e) partnership and participation of local community;
- (f) relationship between NGOs and GASS;
- (g) services (care) providers;
- (h) funds (revenues by sources and expenditures by categories);
- (i) an assessment of the quality of services provided by each NGO/institution;
- (j) assessment of sustainability of the program;

1.3 The Institutional Capacity Assessment component will also provide information on: (i) amount and level of community/local participation in the management of social services; (ii) quality of and potentials for local government participation

1.4 Coordination. The consultant is expected to work in liaison with all VNICA components and especially the Legal and the Needs and Vulnerability Qualitative Assessment team, in order to present a clear picture on supply and demand of social services and combine relevant recommendations. She/he will therefore coordinate and help the formulation of operational recommendations in regards to: (a) level of satisfaction with social care service of users, their families and neighboring community (as explained in the last paragraph of section one); (b) the integration of vulnerable groups into the mainstream of society; and (c) level of public knowledge of available services for vulnerable groups.

1.5 Methodology. This component will be carried out as a qualitative institutional capacity assessment and will include: collecting relevant literature and information; desk review of relevant information and semi-structured interviews with public officials, local NGOs and informal citizens' groups at central (Tirana) and district level (Tirana, Vlora, Durrës and Shkodra). More specifically, the assessment will include: (i) interviews and meetings with major government representatives (Ministry of Social Affairs, Labor, Finance, Health, etc...), relevant public agencies and institutions, local administration officers and non-governmental organizations representatives and functionaries in the relevant fields, social workers in selected institutions and key informants; (ii) collect relevant literature and data and desk review of all available data and information; of organizational charts and list of professionals for each relevant institutions, etc.; (iii) consultations with international NGOs and the most active national and international agencies addressing the needs of vulnerable groups in Albania.

1.6 In view of the need to have an assessment of supply and demand of social services to better match gaps and needs under the project, the consultant will work in close liaison with the other teams and will share final outputs with the VNICA team leaders.

1.7 Outputs. The overall research outputs should include:

- (i) Review of existing public and non public information on vulnerability needs at central and local level;
- (ii) Review of topical studies on particularly problematic vulnerable groups, i.e. young prostitutes, youth gangs, should be pursued;
- (iii) Capacity and institutional assessment of categories of: central and local government institutions; international and national NGOs providing social services to vulnerable groups in selected locations of Albania; social workers and responsible staff at public and private level, etc.
- (iv) Recommendations. The assessment will include conclusions and a set of operational and strategic recommendations both from the side of the supply and demand of social services.

1.8 Staffing. This component will be carried out by a senior local institutional expert who has in-depth knowledge of the institutional setting and the arena of social service providers in Albania.

1.9 Timing. The overall assessment will start in January, 2000 and will be carried out within 3 months from the beginning of the assignment. More specifically: (i) a research proposal, work plan (including field work) and a methodology with questionnaire guidelines will be presented for comments after 2 weeks from the beginning of the contract; (ii) a draft and work-in-progress report will be sent to the Government and the World Bank for comments, after completion of the institutional survey and analysis of major findings for each of the sub-components; a final analytical report which includes a set of operational and strategic recommendations will be ready by the end of contract and will be submitted to the Government and the World Bank for comments.

1.10 Budget. The estimated budget for this component is US\$ 6,200 which includes:

| | |
|------------------------------------|----------------|
| 1 institutional expert 3 months | \$3,000 |
| 1 assistant 6 weeks (*) | \$500 |
| 2 Per diem 50/day for 12 days | \$1,200 |
| Car | \$1,200 |
| Miscellanea | \$300 |
| | \$6,200 |

Component 3: Needs and Vulnerability assessment

1.1 Scope of work. There is a need to systematically identify, observe and to the extent possible quantify all major vulnerable groups – potential social care services beneficiaries at district level - in order to adequately target SSDP resources on a territorial basis. This component should evaluate and estimate vulnerability needs both in urban/suburban and rural/rural-mountains settings and provide the qualitative information and basic indicators for the development of targeting/resource allocation matrix to be used under the SSDP *Fund to Support Community-based Social Services*.

This review will also serve as a key input for the Policy Development Component of the SSDP.

1.2 Target groups. The following categories of vulnerable groups and sub-categories have been identified through previous studies and researches and their needs and preferences should be assessed from a qualitative point view:

- ***disabled (mentally and physically) children, adults and the elderly*** - their number, by gender, by age, by type of disability (mental, physical, etc...), etc.;
- ***children at risk*** (biological and social orphans, single-parent families, children living with grandparents, children with one or both parents living/working abroad, children suffering from abuse, etc, street children; children – beggars, children not attending school or at risk of dropping out, etc.
- ***youth at risk*** – youth with criminal behavior record, youth not attending school, alcoholic and drug addicted youth, unemployed youth, etc.
- ***women and families at risk*** – women undergoing divorce, single parent female headed families (categories by reason – widows, divorced, never married, husband is working abroad), abused women, families with violence record, prostitutes, etc.
- ***elderly at risk*** – elderly (single or couples) living alone without income or insufficient income, able – not able to take care of themselves, etc.

1.3 These are not rigid categories and if at any moment during the study, it is perceived the need to enlarge the target population, including in the same categories of vulnerable groups, sub-categories of marginalized groups, this should be taken into account. In fact, there are populated sub-groups (i.e., internal migrants from the north squatting in peri-urban areas - non registered within the commune -, gypsy, “hev”, etc..), whose risk of exclusion from the fabric of the Albanian society as well as from the governmental and non governmental support is even higher as well as it is higher the risk of vulnerability.

This component is divided into the following two sub-components: (i) data collecting system; and (ii) qualitative vulnerability needs assessment.

Sub-Component 1: Data Collecting System

1.1 Objectives. Through this task, the assessment aims at developing measurable and observable indicators of vulnerability and set up a baseline data set for the SSDP to be periodically updated during the project implementation (social and institutional impact monitoring). In addition this data collecting and elaboration system will be used as the basis for project monitoring and evaluation.

1.2 The level of vulnerability in each district will be mapped, measured and ranked on the basis of a few quantifiable indicators. Whenever data are not available, on-site observation would be used as research and data collecting tool. This ranking will then guide the design of the targeting matrix. The indicators and the methodology for the ranking will be finalized and agreed upon with the Albanian counterparts during the completion of this assessment.

1.3 Possible indicators to be used for the vulnerability ranking of districts maybe the following:

- Demographic indicators (district population by gender, age, education level, residence within urban/suburban - rural/rural-mountains; average family size; etc.),
- Estimated number of the above listed vulnerable groups (by specific type and by age and gender) in need of social services;
- Number of applicants for institutions such as: elderly institutions, shelters for abused women, orphanages, shelters and day care facilities for handicaps, centers for alcoholic and /or drug addicted youth, and other institutions per each district; etc.

1.4 Listed below are a number of contextual elements which are directly indicative of the level of social risk in a given district:

- Level of unemployment, and particularly youth and female unemployment
- Incidence of internal and external migration
- Number of drug addicted youth in high school and universities
- Number of alcoholic youth in high school and universities
- Number of estimated sexually abused children and/or victims of domestic violence
- Number of illegally working children
- Number of abused women seeking shelter and counseling
- Ratio of individuals estimated to be involved in or victims of prostitution or “human trade”
- Number of estimated drug traffickers/dealers
- Estimated number of blood feuds
- Number of divorces with the number of children involved
- Estimated number of single mother-headed household in urban/rural areas in each district
- Primary and secondary education drop outs
- Primary and secondary education completion ratios and education gross enrollment ratios.

1.5 *Methodology.* This experimental approach for Albania, where little public data is available, aims at the creation of a data base system for monitoring of vulnerability at regional level, which would then manage a monitoring indicator system, based on standardization and correlation of indicators of non-homogeneous data. Sources for gathering information, extract data and/or for estimating the order of magnitude of the above-mentioned indicators and risk-elements may be the following:

- (a) INSTAT data, including that from the latest household income survey sponsored by the European Union.
- (b) official and public records such as those of the statistical departments of the Prefectures’ Development and Coordination Offices, of the inspectors for social assistance, social issues and educational and health problems, of GASS regional, and municipal offices and the Police Office for the Citizens’ Relations;
- (c) consultation with specialized national and international NGOs, advocacy groups and UN agencies collecting data on targeted vulnerable groups at national and local level;
- (d) consultation with specialized local social service delivery institutions;

(d) direct on-site observation and survey

1.6 Activities will be carried out in the following order:

- 1) identify and familiarize with the institutional and non-institutional structure related to social service delivery and identify the national staff (if exists) in the district level structure who work closely with data of the study target groups;
- 2) collect and organize data on the basis of existing sources and official records;
- 3) collect data and useful information from non-public sources (specialized NGOs and UN agencies collecting data on vulnerable groups at national and local level);
- 4) screen collected data from both public and non public, check reliability, and discuss methodology for data standardization;
- 5) plan survey activity where data are not available. Analyze and process data, organize information for vulnerability ranking and vulnerability mapping;
- 6) design of sample of qualitative needs assessment.

1.7 Finally, this sub-component will necessarily inter-link and benefit the Qualitative Assessment by attempting to rank and map vulnerability in the selected districts and by providing a representative sample for vulnerable groups. The qualitative needs assessment will, on the other hand, provide qualitative perceptions and indications of needs, through semi-structured questionnaires, in-depth interviews and group discussions carried out in the different selected areas. The qualitative analysis will be carried on the same sample designed for the database collection system and interviews will be carried out after vulnerability ranking and mapping is completed. If a survey is required in order to gather additional data (after review of public and non public data) to finalize ranking and mapping of vulnerability, the qualitative survey will be done simultaneously.

1.8 As part of the experimental approach, the specialized team, will share information with the project MIS experts, advice and give operational directions for the data update on an ongoing basis, or at least periodically, depending on policy and SSDP requirements.

1.9 Outputs. The consultant(s) is required to:

- (i) build a vulnerability ranking system;
- (ii) design a vulnerability map ;
- (iii) design a (representative) sample;
- (iii) contribute to the creation of a data management system and
- (iv) discuss inputs and coordination with the Management Information System (MIS) to be developed for SSD project and how the database prepared as a result of the study can fit into the MIS.

The vulnerability (i) ranking and (ii) map will guide the design of a targeting matrix, which will become an essential tool for project implementation in the pilot areas and at the national level as a reference. The MIS system will help periodically monitor vulnerability and therefore, the consultant(s) should prepare a detailed research plan specifying the updating frequency for each type of data sets. Recommendations should be formulated as to (i) the type of database to be set up at national and local level for the mapping of vulnerable groups and available resources to address their needs, (ii) human, technical and financial resources required to set up and update the database over time, (iii) possible institutional framework for the management of the database at central and local level, with particular reference at the role of INSTAT and GASS offices at central and district level. The consultants are expected to regularly report to the Government and the World Bank for each phase of their assignment.

1.10 Staffing. The data collecting system sub-component, requires a team of four people, of which 1 statistician and supervisor and 3 statisticians/data analyst and 2 survey specialists. The assignment is estimated to be of 4 man-months for the supervisor and 3 man months for the 3 statisticians. The survey specialists will be working for one month during the survey/field work phase.

1.11 Timing. The exercise will be carried out, starting in mid January 2000, in approximately four months. The data collection phase will be carried out in approximately 1 month, during which basic information and data are collected in the four designated districts. After 2 weeks of data processing and elaboration and preparation of survey questionnaires, the field work-survey phase will begin and will take about 20 days to over 30 clusters in the 4 designated districts. A draft report inclusive of major findings, a methodology plan, data results and operational recommendation, is expected by end of March and a final report will be submitted at the Government and the World Bank for comments by the end of April, 2000.

1.10 Budget. The estimated budget is USD 27,900 which includes:

| | Total |
|---|------------------|
| 1 Statistician-supervisor (*) \$1000/Month x 4 months | \$4,000 |
| 3 Statisticians- survey and data experts (**) lumpsum 1800/x 3 months x 3 people | \$5,400 |
| 2 interviewers x 1 month | \$600 |
| Data collecting phase (1): perdiem = \$50/person x 4 persons x 12 days | \$2,400 |
| Data collecting phase: 2 Cars x 3 weeks , 100\$/day | \$4,200 |
| Survey (2) perdiem: 6 x \$50/day x 15 days | \$4,500 |
| Survey Cars: 3 cars x 20 days x \$100/day | \$6,000 |
| Miscellanea | \$800 |
| | \$ 27,900 |

Sub-component 2: Qualitative Vulnerability Needs Assessment

1.1 Objectives. Vulnerable groups' major problems, needs, preferences for social care (i.e., in institutions, direct assistance at home) type of service and assistant staff which could better fulfill people's needs, opinions on quality of services and expectations for change will be qualitatively assessed, through consultations with the pre-identified groups at risk or vulnerable population, both in urban and rural areas. The assessment should also analyze situations of exclusion and what causes them, both in urban and rural areas. Situations where needs were met and/or positive changes were introduced with time, should also be reported in order to learn lessons and track down areas for improvement.

1.2 Different care providers will also be consulted in order to (i) be familiar with the already available services, (ii) have a better understanding of the categories of people that are or are not covered by their services and the reasons, and (iii) get support for the design of the sample.

1.3 Methodology. The qualitative need assessment will be designed in close coordination with the data collection (sub-component 1) survey team. The latter will provide all important socio-demographic information and will support the qualitative needs assessment team in sample design. The analysis will indeed be carried on a sample derived from the database collection system survey and results (weights and concentration of vulnerability, representative by areas). Interviews – through semi-structured questionnaires and in-depth interviews – will be carried out after vulnerability ranking and mapping is completed. The needs assessment methodology includes semi-structured questionnaires, shaped on each vulnerable group category.

1.4 Focus group discussions will be carried out among:

- (i) selected groups, representative of gender, age, vulnerability area, currently beneficiaries (or their immediate relatives or tutors) of social services;
- (ii) groups (in the same number of the pre-identified categories of vulnerability) of vulnerable people, in need of and not presently benefiting of any social service;
- (iii) public local administration official (representatives of the districts and communes).

1.5 Semi-structured questionnaires and focus-groups guidelines will be customized and shaped accordingly to the survey and sample needs and will inquire on:

A. The context of vulnerability and social exclusion: main causes of vulnerability, the current social and economic situation, the family composition, the relationship and interaction with family members and the relationship of dependence with/to other persons, etc, the interaction or the sense of exclusion in the community, their perception (i.e., sense of neglect or protection) of the role of the public institutions and administration, and suggestions for change, etc.

B. The specific needs of vulnerable groups in relation to social services: i.e., the assessment will inquire on (a) elderly preferences for either residential care or home base services, (b) institutionalized children's preference (and /or their parents'/tutors') for either smaller institutions or day care centers as alternatives to current arrangements; (c) children at risk preference over, for example, day care centers or institutionalized solutions, (d) women and families at risk on what kind of services have been/could be most helpful to them, i.e. family counseling; etc...

Different care service providers will be used as key informants and will help designing a sample with the above categories (current, potential and excluded beneficiaries).

1.6 Staffing. The Italian consultant will be responsible for this component and it will be carried out under her direct supervision. The assessment will be carried out by a team of 2 junior social scientists, under the leadership of a senior social scientist. The junior social scientists, will have specific experience for each of the main areas of vulnerability (handicaps, women at risk, children, youth and elderly). The senior social scientist will be responsible for (i) the organization and coordination of field work and survey activities, (ii) the supervision and harmonization of the specific questionnaires (thematic areas), in-depth interviews and focus groups guidelines; (iii) coordination with the "database system" (*sub-comp. i*) supervisor for survey data processing; (iv) data analysis and (vi) preparation of final report for the qualitative needs assessment.

The team members will have in-depth knowledge of the Albanian social fabric and will have worked with national or international NGOs in the specific sectors. Experience with survey methodologies is highly desirable. The team is required to keep close relationship with all other VNICA team members and report to the Government and the World Bank .

1.7 Output. The team is responsible to carry out a need assessment, under the supervision of the World Bank. Each of the team members will:

- (i) participate in the formulation of the methodology tools such as the semi-structured questionnaires and the in-depth interviews and focus-groups guidelines. Each contribution of the members will take advantage of the specific professional experience with the target groups;
- (ii) carry out the survey, in-depth interviews and focus groups, according to the work plan and survey calendar;
- (iii) analyze a portion of the questionnaires, according to specific knowledge of geographic areas and thematic specialization and write draft analytical report. The draft report of each of the members of the team will be done on the basis of the outline of the final report that will be decided together with the World Bank consultant.
- (iv) draft a final report: this will be of the responsibility of the supervisor with the consultation of the other members of the team. The draft report will be submitted to the Government and the World Bank for comments.

1.8 Timing. The assessment will be carried out in 12 week, after vulnerability mapping and ranking is completed. A work proposal, including methodology tools and sample design will be presented after 3/4 weeks from the beginning of the beginning of the study. Methodology tools include: questionnaires for survey and in-depth interviews and focus groups guidelines. A draft report will be presented at the Government and the World Bank for comments, two weeks after the end of the field work. The final report should be presented at the Government and the World Bank by end of April, 2000.

1.9 Budget. The estimated budget for this component is US\$ 15,250 which includes:

| | Total |
|--|------------------|
| 1 International Supervisor (*) | Italian TF |
| 1 Senior survey and field coordinator (**) 3 months – lumpsum | \$2,400 |
| 2 Social Workers (***): 3 months – lumpsum 1,800 | \$3,600 |
| Interviewers: 4 x 30\$ day x 20 days | \$2,400 |
| Survey Cars: 2 cars x 20 days – 100\$/day | \$4,000 |
| Survey: per diem \$50/day 15 days x 3 persons | \$2,250 |
| Miscellanea (photocopies, disquettes, etc..) | \$600 |
| | |
| | \$ 15,250 |

Annex 16: Determining the Needs and Problems of Street Children: How to Conduct a Street Assessment

1.1. Assessment helps in understanding the needs and problems of street children. It also provides an idea about their environment. Adequate assessment is essential before any intervention is attempted. Similarly, assessments may be carried out later to monitor the progress and success of the programme. Modification in intervention may be made on the basis of information obtained from the assessment.

Example: India.

Focus group discussions held by a project in India revealed that many street youths were engaging in sexual practices which put them at risk of becoming infected with HIV and other sexually transmitted diseases. The discussions helped identify a need for basic sexual and reproductive health education and also a need to work more with the families of the street children.

1.2 The goal of the assessment.

Two questions define the goals of an assessment. These are:

- What specific problems should the assessment address?
- What is the purpose of collecting the information?

There is a danger of collecting information that is of no use to street children if these fundamental questions are not clarified before the assessment begins. The purpose of the initial assessment may be the determination of problems and needs, while the purpose of ongoing assessment may be to provide feedback on the success of the programme. The information gathered should be closely linked to the specific issues to be addressed. In this module you will be thinking more about information related to substance use.

1.3 Possible sources of information.

Information can be obtained from primary and secondary sources. Street children and their families, health care and other service providers are primary sources of information. The common secondary sources of information are:

- Official documents such as surveys, policy statements, professional guidelines, registers and court proceedings on street children.
- Unofficial materials from government or medical institutions and private individuals, e.g. television and radio programmes, evaluation reports on street children, books, newspapers and magazine reports and copies of presentations at professional and community forums can add to the resource materials.

Secondary sources provide the background for designing assessment procedures. Usually they do not provide sufficient information for a complete understanding of the situation of

street children. Information should be gathered from primary sources to supplement secondary information. Primary information also gives you qualitative data (feelings, views, beliefs and aspirations).

1.4 Importance of service providers as a source of information.

Service providers can be an important source because they can provide information on:

- the economic, social and political conditions of the community.
- community attitudes towards street children, substance use, sexual and reproductive health.
- services available in the area, particularly those accessible to street children, potential barriers to their use by street children, and how to overcome such barriers.
- what interventions have worked, or failed (this information is critical for designing interventions).

Secondary sources of information usually do not provide all the information required.

1.5 Basic steps to be followed.

After deciding on the goals of the assessment, the following steps should be followed:

1. Make a plan regarding the method for obtaining information (when, where, how and by whom).
2. Collect the information.
3. Organize the information.
4. Analyze the information.
5. Make conclusions.
6. Use the information.

1.6 Important considerations during collection of information.

The following issues should be kept in mind during the assessment of substance use and sexual and reproductive health problems among street children.

- Informed consent.

The street child should agree to participate. To get valid consent, inform the child about the goals and method of the assessment, what they would gain or lose if they participate and also that they are free to refuse to participate.

- Confidentiality.

All assessment information should be kept confidential, unless you have the street child's consent to give information to others. Talk to the street child away from peers, family and others. Their presence may compromise confidentiality. Similarly, the confidentiality of the informants is extremely important. In some countries, children and other informants have been murdered for providing information.

- Rapport.

The process of assessment is not just the collection of information as it can be an opportunity to engage the street child in a respectful and trusting relationship. The assessment could provide an opportunity for street children to ask questions and get information if they choose to do so.

1.7 Suggested areas for assessment and use of the Modified Social Stress Model for collecting information

Information should be obtained in the following areas:

- Background: age, gender, religion, cultural background.
- Substance use.
- Sexual and reproductive health.
- Physical health and injuries.
- Mental health and psychological trauma.
- Family and social.
- School and vocation.
- Unlawful behaviour.
- Recreational and cultural activities.

Taken from MODULE 5 Determining the Needs and Problems of Street Children, (Geneva: World Health Organization, 1999), available at http://www.who.int/substance_abuse/PDFfiles/module5.pdf

Annex 17: Suggestions on Conducting a Community-based Needs Assessment

Through its community health needs assessment (CHNA), the community looks at:

- physical health status including illnesses and physical impairments
- mental and social problems of individuals and groups and
- environmental problems which may affect community health or social welfare.

The CHNA usually includes analyses of statistics collected routinely by nursing stations, hospitals, and other facilities to establish levels of various health and social problems. However, the most important aspect of the CHNA is obtaining information and views from community members themselves. This involves surveying a certain percentage of the community to find out which health problems are most prevalent. The survey also explores the factors which will affect the design of programs and services to effectively address these health problems.

Communities have learned the importance of involving their members in the planning of programs and the need for good communication throughout all phases of the planning process. Community involvement during the health needs assessment can create and maintain the support of key community members which is necessary for successful programs.

Funding and support for the Community Health Needs Assessment

Communities planning for Transfer have access to one-time funds for conducting the initial CHNA. The funding is based on the community population approved by FNIHB. The amount ranges from \$38,000 to \$96,000 per Transfer project. The time frame for conducting the CHNA ranges from five to nine months.

Getting Started

Set up a planning and management committee

The health authority in your community should form a committee to plan and manage the CHNA. The first task of this committee is to develop and obtain approval for its own terms of reference: what is the committee's role, who is responsible to whom, how often will they meet, etc.

Terms of reference should specify what the committee's responsibilities are for:

- the study timeframe
- the survey questions
- the methods for collecting information
- hiring members of the research team
- attending selected community meetings

- reviewing the findings of the study and
- making recommendations to the community's leadership.

Decide if you have the skills to carry out the work

If your community has members with the skills to carry out the work, review this Guide and select and adapt the methods which are best for your community. Use the Guide to help develop your workplan for carrying out the needs assessment, setting reasonable timelines for each activity.

If your community does not have the necessary skills to carry out the needs assessment, you may want to consider:

- partnering with another community, region or Band skilled in needs assessments. This could involve:
 - sending a staff member from your community to participate in another community's needs assessment to learn from a skilled staff member doing the assessment; or
 - arrange with another community or region or Band for a skilled staff member to come to your community so that he or she can work together with your staff to do the assessment and report.
 - contracting with a research consultant to discuss the objectives of the needs assessment and the type of data you want to collect. The consultant may then either carry out the work or provide technical support and training needed for the community to carry out the needs assessment.

An experienced community-based researcher can give you advice and support on key aspects of the needs assessment such as agreeing on manageable objectives, designing effective research tools, developing a reasonable workplan, training interviewers, analyzing data, and reaching conclusions.

If the decision is to contract a consultant, it is important to try to find one who is experienced in involving community members and training them to conduct the work of the needs assessment. In this way, the process of conducting the needs assessment will enhance community skills and knowledge. When the study is completed and the consultant leaves, the new skills and knowledge gained will remain in the community to support program planning and other community research.

Coordinate your needs assessment with other community research

Generally speaking, people in your community will appreciate not being asked the same kinds of questions repeatedly. Find out about previous or planned community-based research and coordinate with them.

Designing and Carrying Out Your Needs Assessment

Decide on the type of information you want

Your planning and management committee and research team may want to brainstorm the type of information you want to gather in your needs assessment. Examples of data collected in community health needs assessments conducted in other communities include:

- general background information on the community including a description of the population, location, community health programs and services and staff, other relevant services (e.g., social services, environmental programs, housing programs, economic development initiatives, crime prevention), and access to off-reserve health facilities and services, and
- descriptions of priority health needs, gaps in services, barriers to access, and training needs.

Decide on the data collection methods you will use

The study can include several methods to obtain different kinds of information from different perspectives such as a review of documents, interviews with health care and other staff, a survey of community members, and focus group discussions with various groups of community members or service providers.

Document review

A document review collects relevant information about the community, health status, where health services are obtained, other related services, and gaps in services. This information may be found in reports and records of facilities such as the following:

- data from facilities, i.e., hospitals, nursing stations, clinics, etc., and government records for the past ten years on population numbers each year for the whole community, by age groups, and by sex.
- reports from earlier needs assessments conducted for health, environment, social services, economic development, crime prevention, etc.
- community planning documents in similar areas
- environment reports, e.g., the results of monitoring of water, air or soil conditions for the purposes of waste management
- regular reports or special analyses of data on use of health services by various age groups to determine information about rates and causes of death, acute illnesses or injuries (e.g., respiratory infections, broken arm), chronic diseases (e.g., asthma, diabetes, arthritis, cancer), disabilities, use of prenatal services, pregnancy outcomes, use of dental services, use of substance abuse services, use of prescription drugs, etc.
- reports about specific health programs or services
- reports on culture and recreation, children's services, police services (e.g., accident reports).

Interviews with key individuals

The document review will give demographic information and an idea of the prominent health concerns, gaps in services, and any other community issues related to health. Interviews can then be conducted with key individuals if more information is needed to help the researchers to identify unique characteristics of the community as well as potential health problems. Who is interviewed will vary depending on the community and the information required. You may want to interview staff of facilities, members of community organizations, elders, community leaders, health professionals, health care workers, informal caregivers, child and family services workers, police, providers of transportation, etc. These people could offer their perspective on the health problems and gaps in services in the community.

Survey of community members

A survey involves asking a set of questions of a number of people in the entire community. Face-to-face interviews by trained interviewers often work best for community health needs assessments. Enough people must be surveyed to allow you to make general statements about the health concerns of community members. For example, about 30% of everyone 14 years of age or older could be surveyed. People should be selected randomly so that they represent a good cross-section of opinions. An experienced researcher knows how to ensure that you involve a representative sample of your community so the survey results are meaningful and useful.

Focus groups

A survey of the community is often followed by interviews or focus groups with people who can provide greater insights into the key issues which the survey identified. For example, if results of a survey suggested that home and community care services were lacking for many community members, you could learn more about the specific needs, gaps in services, and barriers to access by talking to possible users of the services and to key people knowledgeable about the issues. Focus groups might include elders, people with chronic illnesses or disabilities, family service workers, community health representatives (CHRs), family members, other informal caregivers, and so on.

Focus groups pull together a number of people to discuss concerns they have in common. Organizing focus groups on the basis of similarity of people's situations is a good approach to take. For example, related to home and community care, the needs of younger adults with disabilities are usually quite different from those of children or elders so separate focus groups might be needed for each if numbers permit. An additional focus group made up of health care and social service providers may also be helpful.

It is recommended that a focus group session have no more than 12 participants to ensure that everyone has a better chance of expressing their views. An experienced researcher knows about the other important considerations for how to organize and conduct a focus group, and how to record the information the focus group participants provide.

Develop or adapt data collection tools

Regardless of which data collection methods you use, the quality of the information you get will depend on what you ask and how you ask it. Data collection tools (e.g., survey questionnaires, interview forms, questions for focus groups) are necessary for consistency in what is asked. In addition, they must be worded carefully so that it is easy for the person being interviewed to give the information you need.

Before developing or adapting your data collection tools, you need to decide whether you will analyze the data you collect manually (with pencil and paper) or by computer. Your choice for analyzing the data influences the design of the tools. Your choice will be affected by the size of your community, the length of the questionnaire, and your access to computers and data analysis software. The larger the number of respondents and the longer the questionnaire, the more difficult it is to analyze the data manually.

Once you have made the decisions about the research methodology and how you will analyze the data, you need to develop or adapt the tools for data collection for each method. Try to use existing questions which have been tested in similar communities and are known to obtain the information you need. Whether you use existing questions or develop your own, the questions should be pre-tested before they are used for the needs assessment. The pre-test helps to find problem questions before you go out into the community, such as questions that people find confusing because the wording is unclear or refuse to answer because the wording is insensitive to their situation.

To find sample questionnaires that you can adapt to your needs, ask the director of your health authority or the Regional Offices of FNIHB for information about planned or completed surveys. The First Nations and Inuit Regional Health Survey developed a questionnaire for use in interviews with community members. You could adapt the Regional Health Survey questionnaire or a similar one so that it is customized for your community. For example, you may want to add specific health or environmental issues which are not included but which are of concern in your community.

Review the process with community leadership

It is important to ensure that the community leadership is kept informed about the plans for the community health needs assessment. This is a good time to go back to the community leadership to ensure that they support and approve the needs assessment process. Present to them the objectives of the needs assessment, the type of data you plan to collect, and the methods you propose to use.

Organize and carry out the data collection

Organize and carry out the data collection by deciding who will be responsible for each component of the work and setting reasonable timelines.

Analyzing the Information You Collected

Analyzing all the data you collected is an important part of your needs assessment process. The analyses you select will help to highlight your conclusions about the needs and assets of the community in the final needs assessment report. An experienced researcher has simple tools and techniques for analyzing and interpreting your data for your report.

Preparing and Sharing Your Report

Prepare your needs assessment report by summarizing the information you collected and your conclusions about the community's needs. Use a draft as the basis for reviewing the information with the community leadership to ensure that they understand and agree with the findings. In the CHNA report you should:

Describe the needs assessment process

- Identify the purpose of this needs assessment.
- Explain the methods used and how they were carried out.
- Describe who participated.
- Include the tools used for collecting the information.
- Note any limitations in the process or with the tools used.

Describe the community and its health resources

- Describe the community and demographics.
- Summarize the community-based and other resources including local facilities, staff, and visiting health professionals, as well as other locations where community members receive health and other related services.

Summarize the information collected

Source: Health Canada; full document available at

http://www.hc-sc.gc.ca/fnihb/pptsp/hfa/transfer_publications/community_needs_assessment.htm

**Annex 18: Sample Request for Proposals for Delivering Community-Based Service,
Department of Health and Human Services Administration for Children and Families**

Program Announcement

Announcement of the Availability of Financial Assistance and Request for Applications to Support Adoption Opportunities Demonstration Projects, the Abandoned Infants Assistance Resource Center, Migrant and Tribal Community-Based Family Resource and Support Programs, and a Community-Based Family Resource and Support Resource Center.

Funding Agency: Children's Bureau, Administration on Children, Youth and Families

Action: Announcement of availability of financial assistance and request for applications to support projects under the Adoption Opportunities Program (federal funding program)

Summary: The Children's Bureau (CB) within the Administration on Children, Youth and Families (ACYF), Administration for Children and Families (ACF) announces the availability of fiscal year (FY) 2002 funds for competing new Adoption Opportunities Program and Abandoned Infants Assistance. Funds from the Adoption Opportunities Program are designed to provide support for demonstration projects that facilitate the elimination of barriers to adoption and provide permanent loving homes for children who would benefit from adoption, particularly children with special needs. The Center provides State and local, private, non-profit agencies and organizations with access to information, methods, techniques and strategies for establishing an effective, coordinated range of comprehensive social and health care services to infants and young children and their families impacted by substance abuse and/or HIV infection.

Closing Time and Date: The closing time and date for RECEIPT of applications is 4:30 p.m. (Eastern Time Zone) on May 30, 2002..

Deadline: Mailed applications shall be considered as meeting an announced deadline if they are received on or before the deadline time and date at: (address supplied)

For Further Information Contact: (contact name here).

PART III: GENERAL EVALUATION CRITERIA

- A. [CRITERION 1: Objectives and need for Assistance](#)
- B. [CRITERION 2: Approach](#)
- C. [CRITERION 3: Organizational Profiles](#)
- D. [CRITERION 4: Budget and Budget Justification](#)

In evaluating each application reviewers will take into consideration the extent to which the application fully addresses each of the following four general evaluation criteria and each of the important components specified in the priority area.

CRITERION 1: OBJECTIVES AND NEED FOR ASSISTANCE (20 points)

Clearly identify the physical, economic, social, financial, institutional, and/or other problem(s) requiring a solution. The need for assistance must be demonstrated and the principal and subordinate objectives of the project must be clearly stated; supporting documentation, such as letters of support and testimonials from concerned interests other than the applicant, may be included. Any relevant data based on planning studies should be included or referred to in the endnotes/footnotes. Incorporate demographic data and participant/beneficiary information, as needed, if possible to collect. In developing the project description, the applicant may volunteer or be requested to provide information on the total range of projects currently being conducted and supported (or to be initiated), some of which may be outside the scope of the program announcement.

The following are specific criteria:

Context. Describe the context of the proposed project, including the geographic location, characteristics of the community, magnitude and severity of the problem and the needs to be addressed.

Target population. Describe characteristics of the target population. The description should include key socioeconomic and demographic information on the target population and the anticipated number of clients to be served by the proposed project.

Present a vision of the service systems you anticipate developing. Describe the objectives and discuss contextual factors that will facilitate or impede the implementation of their project. Tell us how the components are linked together and form a coherent approach. Why do you believe that what you want to do will achieve the goals you have set?

Explain how the proposed project is innovative and will contribute to increased knowledge of the problems, issues, and effective strategies and practices in the field. This section is an overview. The detailed information should be provided in the Approach section that follows.

CRITERION 2: APPROACH (50 points)

Outline a plan of action, which describes the scope, and detail of how the proposed work will be accomplished. Account for all functions or activities identified in the application. Cite factors, which might accelerate or decelerate the work and state your reason for taking the proposed approach rather than others. Describe any unusual features of the project such as design or technological innovations, reductions in cost or time, or extraordinary social and community involvement.

Provide quantitative monthly or quarterly projections of the accomplishments to be achieved for each function or activity in such terms as the number of people to be served and the number of program activities to be held, or appropriate measurable outcomes. When accomplishments cannot be quantified by activity or function, list them in chronological order to show the schedule of accomplishments and their target dates.

List organizations, cooperating entities, consultants, or other key individuals whom will work on the project along with a short description of the nature of their effort or contribution.

The Approach section pertains to information you must provide about program design, project services, project evaluation and product development and dissemination.

Present a plan that: (1) reflects an understanding of the characteristics, needs, and services currently available to the target population; (2) is based on current theory, research, evaluation or best practice knowledge; (3) is appropriate and feasible; (4) can be reliably evaluated; (5) could be replicated, if successful; and (6) if successful, can be sustained after funding has ceased.

Define goals and specific, measurable objectives for the project. Goals are end product of an effective project. Objectives are measurable steps for reaching goals.

Describe an appropriate, feasible plan of action pertaining to the scope of the project and provide details on how the proposed project will be accomplished.

Present a project design that includes detailed procedures for documenting project activities and results, including the development of a data collection process that can support an appropriate evaluation.

Provide a narrative addressing how the results of the project and the conduct of the project will be evaluated. In addressing the evaluation of results, state how you will determined the extent to which the project has achieved its stated objectives and the extent to which the accomplishment of objectives can be attributed to the project. Discuss the criteria to be used to evaluate results, and explain the methodology that will be used to determine if the needs identified and discussed are being met and if the project results and benefits are being achieved. With respect to the conduct of the project, define the procedures to be employed to determine whether the project is being conducted in a manner consistent with the work plan presented and discuss the impact of the project's various activities on the project's effectiveness.

If an evaluation is required, the following is applicable. The evaluation should include a process component that describes the activities of the project, how the project operates, how well the design was followed, and the extent to which it produced the expected results for each task or activity. It should also contain an outcome component with output and outcome measures. Output measures are tools, or indicators to count the services and goods produced by the project. These may include the number of people participating in a program or

receiving a service, the number of services delivered, the number of responses to an outreach program, etc. Outcome measures are indicators of the actual impact or effect a program's activities have on the problem or situation. For example, what benefits did children waiting for derive from this activity? How did the activities help the child welfare agency?

The evaluation design should include strategies for periodic assessment of program performance.

Present a dissemination plan specifying the venues for conveying information about the project and discuss the intended audiences (eg. Community, parents, local governments, other stakeholders). One of your final products will be the required final report. Describe how you will make the contents of your final report useful to donors, other NGOs, and other stakeholders. Your evaluation and final report must provide enough detail so that others could replicate your project, including detailed information about successful strategies as well as barriers, hurdles, and pitfalls you can help them avoid.

CRITERION 3: ORGANIZATION PROFILES (20 points)

Provide information on the applicant organization(s) and cooperating partners such as organizational charts, financial statements, audit reports or statements from contact persons and telephone numbers, child care licenses and other documentation of professional accreditation, information on compliance with Federal/State/local government standards, if applicable, documentation of experience in the program area, and other pertinent information. Any non-profit organization submitting an application must submit proof of its non-profit status in its application at the time of submission.

This criterion consists of three broad topics: (1) management plan, (2) staff qualifications, and (3) organizational capacity and resources.

Organizational capacity. Demonstrate that you have the capacity to implement the proposed project. Capacity includes: (1) experience with similar projects; (2) experience with target population; (3) qualifications and experience of the project leadership; (4) commitment to developing and sustaining working relationships among key stakeholders; (5) experience and commitment of any consultants and subcontractors; and (6) appropriateness of the organizational structure, including the management information system, to carry out the project.

Management plan. Present a sound and feasible management plan for implementing the proposed project. Detail how the project will be structured and managed, how the timeliness of activities will be ensured, how quality control will be maintained, and how costs will be controlled. If appropriate, discuss the management and coordination of activities carried out by any partners, subcontractors, and consultants.

Timeline. Produce a timeline that presents a reasonable schedule of target dates, accomplishment, and deliverables. The timeline should include the sequence and timing of

the major tasks and subtasks, important milestones, reports, and completion dates. Discuss factors that may affect project implementation or the outcomes and present realistic strategies for resolution of these difficulties. Additionally, if appropriate, present a plan for training project staff as well as staff of cooperating organizations.

Staff qualifications and job descriptions. Provide brief resumes of current and proposed staff, as well as job descriptions. Resumes must indicate the position that the individual will fill, and each position description must specifically describe the job as it relates to the proposed project.

Suggested addition here: If capacity does not currently exist, describe technical assistance needs for staff.

Capability statements and commitment of partners, subcontractors, and consultants. You must show that they have the organizational capacity and resources to successfully carry out the project on time and to a high standard of quality, including the capacity to resolve a variety of technical and management problems that may occur. If the application involves partnering and/or subcontracting with other organizations, the application should include an organizational capability statement for each participating organization documenting the ability of the partners and/or subcontractors to fulfill their assigned roles and functions. The applicant is also required to submit letters of commitment describing in detail the services that will be provided by partners, consultants, and subcontractors.

CRITERION 4: BUDGET AND BUDGET JUSTIFICATION (10 points)

The following guidelines are for preparing the budget and budget justification.

The applicant must demonstrate that the project costs and budget information are reasonable and justified in terms of the proposed tasks and the anticipated results and benefits. In addition describe the fiscal control and accounting procedures that will be used to ensure prudent use, proper and timely disbursement, and accurate accounting of funds received under this program announcement.

The budget must include 15 percent for the evaluation. Evaluation budgets must be appropriate to sustain the proposed evaluation activities. Agencies that do not have the in-house capacity to conduct an objective, comprehensive evaluation of the project are advised to contract with a third-party evaluator specializing in social science or evaluation, or a university or college to conduct the evaluation. Applicants are expected to allocate sufficient funds in the budget to provide for the project director and the evaluator to attend an annual 3-5 day grantees' conference (to be determined by the Children's Bureau) in Washington, D.C. Attendance at this conference is a grant requirement.

Adapted from <http://www.acf.dhhs.gov/programs/cb/funding/cb2002/cb2002.htm>

Annex 19: Sample Memorandum of Agreement between Government and Donor on Social Services: the European Children’s Trust and the Government of Albania

**AGREEMENT BETWEEN THE MINISTRY OF LABOR AND SOCIAL AFFAIRS
OF THE GOVERNMENT OF ALBANIA
AND
THE EUROPEAN CHILDREN’S TRUST**

PREAMBLE

- Social welfare is not well developed in Albania, in terms of both practice and legislation. There is only limited support available to vulnerable children and families, who are exposed to a number of pressures, including poverty, the risk of abandonment, abuse and maltreatment.
- The Government has ratified the Preamble to the UN Convention on the Rights of the Child, which states that “the child for the full and harmonious development of hi or her personality, should grow up in a family environment, in an atmosphere of happiness, love and understanding.”
Article 20 of the Convention states that “A child temporarily or permanently deprived of his/her family... Shall be entitled to special protection... provided by the state. Such care could include, inter alia, foster placement, adoption, or if necessary placement in suitable institutions for the care of children.”
Article 21 and the Hague Convention both state that fostering and adoption within the country of birth/origin is preferable to inter country (international) adoption.
- The Government of Albania has ratified the UN Convention and is now taking steps to comply with its provisions. This agreement recognizes that every effort should be made to ensure that children are brought up in a family environment. Wherever possible, children should live with their birth family, where this is not possible, whether temporarily or permanently, the State should give priority to finding family alternatives, rather than placing children in institutions.
- The parties to this agreement therefore intend to carry out a pilot project to develop the capacity of the Ministry of Labour and Social Affairs to operate professional foster care programmes in Albania. A national foster care service will require a framework of appropriate legislation; a staff of appropriately qualified social workers, financial support from the national budget and written methodologies for social work to enable Albanian specialists to move forward at the earliest opportunity. It is the intention of both parties that the programme should be entirely owned and operated by Albanian authorities once the project phase has been completed.

PROJECT SUMMARY

Guiding Principle.

The pilot project will provide the Albanian Government with the information and experience necessary to meet its commitment to the UN Convention on the Rights of the Child. It is therefore essential that any developments are sustainable in the long term and that authorities at national, regional and local levels take full responsibility for any reforms introduced.

Programme Objectives

1.1. To develop a system of foster care and supporting legislation.

- To place up to 20 children who are currently in institutional care, or who could be placed in institutional care, with Albanian foster families.
- To develop a sustainable model of fostering which can be implemented nationally.
- To develop national fostering legislation.

1.2. To enhance the support available to families in order to strengthen their ability to care for their children.

- To train at least 4 Albanian family support workers capable of:
 - Providing counseling and advice to children and families
 - Training additional family support workers
 - Implementing an effective fostering scheme which meets the needs of children
- To create self-sustaining family support departments at municipality (Bashki) and regional (Prefecture) levels, which will promote family-based care for children.

1.3. To improve the quality of care for children who cannot be placed in family care.

- To create a small group home in the pilot region as a model for national development.
- To provide training to orphanage staff in order to improve the quality of child care.

AGREEMENT

This agreement between the European Children's Trust and the Ministry of Labour and Social Affairs (hereafter called 'The Parties') is based on the UN Convention on the Rights of the Child and law nr 7710 dated 18 May 1993 "For Social Assistance and Welfare". The Parties agree:

1. The Objective of the Agreement

To implement a pilot project for foster care in the Tirana Prefecture.

2. Parties to the Agreement

- 2.1** The European Children's trust (hereafter referred to as ECT), 64 Queen Street, London, EC4R 1HA, a non-profit making and humanitarian NGO registered by the

Certificate of Incorporation dated 14th November 1997 as Company Nr 2485690. ECT is represented by Mr. Trefor Williams.

2.2 The Ministry of Labor and Social Affairs (hereafter referred to as the Ministry), rr Kavaja, Tirana, Albania, represented by the Minister Kadri Rapi.

3. Subject of the Agreement

3.1 The European Children's Trust Agrees:

- To recruit, train, and provide salaries for 4 specialist social workers for a period of 2 years.
- To provide training for the 4 social workers to enable them to implement a fostering scheme with a view to placing up to 20 children with foster families.
- To provide a specialist to work closely with a named person from the Ministry in order to assist in drafting Albanian foster care legislation. This specialist will be a part time appointment, visiting Albania on a consultancy basis as decided by the ECT Programme Manager.
- To provide a manager to manage the project. The programme Manager will not be permanently based in Albania, but he will visit the project on a regular basis.
- To provide a vehicle for use by the specialist social workers for the duration of the project.
- To provide administrative support to ECT staff, including provision of computer, paper, accommodation, and interpreting.
- To provide a project coordinator for up to 2 years to oversee the project in Albania.
- To provide funds for payment of fostering allowances to foster families up to a maximum of 20 children.

3.2. The Ministry of Labor and Social Affairs Agrees:

- Nominate a representative in the Ministry/GASS to work with the programme at no cost to the programme. This individual must have a sound knowledge of Albania social work policy and procedures, together with an understanding of current developments in this field.
- Participate in the planning and implementation of the pilot project and agree and promote all components of the programme.
- Ensure that all parties cooperate fully with the project.
- Ensure that all equipment, funds and other resources provided by ECT are used exclusively for fulfilling the aims and objectives of this project.
- Where family support departments are established within municipalities, the accommodation for these departments will be provided at no cost to the project. The accommodation will be sufficient to provide an office with telephone and working space for at least 4 people; access to a training room capable of seating 10-15 people, and access to an interview room for private interviews with families.
- To take on the full running costs of all reforms at the end of the pilot period (2 years from the signing of this Agreement), including the salaries of the family support social

workers; the cost of any payments made to foster families and the running costs of any additional premises.

- To provide the ECT specialist with a chair and desk in the General Administration of Social Services.
- To agree to the attached project proposal and create the necessary conditions for its implementation.

4. General Provisions

- Both parties agree to carry out an evaluation of the project at 2 monthly intervals to monitor progress and to keep each other informed of emerging problems which might influence the achievement of the objectives agreed.
- The project will be implemented in accordance with the attached document.
- This Protocol comes into force on the date when it is signed by the parties; this also represents the start date of the pilot project. The Agreement and the project will come to an end one year after the start date.
- This protocol can only be modified with the agreement of both parties.
- In the event of non-compliance with the provisions of this Protocol by the parties, either party may withdraw their agreement by giving one month's notice in writing.
- The timetable for implementation of the pilot project will be agreed by the signatories within one month of the Protocol being signed.

5. Documents Associated with this Agreement

- a. Memorandum of Association of ECT (the statute).
- b. Certificate of Incorporation of ECT (court registration)
- c. Project description
- d. Official Request to the Ministry to implement the foster care pilot

RATIFICATION

This Protocol is hereby signed and agreed in 4 copies, each in Albanian and English and each having equal legal force

Signed
Minister
The Ministry of Labor, Social Affairs and Women
The Government of Albania

s
Signed
T G Williams
Programme Manager
European Children's Trust

Annex 20: The Rag Pickers of Pune: Oxfam Programme for the Empowerment of Women Waste-pickers July 2001 – June 2003

- 1. Name of the Project:** Programme for the Empowerment of Women Waste-pickers
- 2. Legal Project Holder:** Department of Adult and Continuing Education and Extension Work (Pune Sub-centre)
SNDT Women's University
Karve Road
Pune 411038.

Introduction to the Implementing Organisation

The SNDT Women's University was started in 1916 with the objective of providing access to higher education for girls. It is registered as a Public Trust and Society and is governed by the Maharashtra Non-Agricultural Universities Act, 1994. It is recognised by the University Grants Commission.

The Pune sub-centre of the Department of Continuing and Adult Education and Extension Work was started in September 1984. It was the outcome of an attempt by the University Grants Commission to build bridges between institutions of higher learning and social realities through the provision of Extension and Outreach Services by University Departments specially set up for the purpose. Extension was promoted as the third dimension of the University system, in addition to teaching and research.

Child waste-pickers used to attend the adult education centres conducted by the sub-centre in a city slum. The interaction with waste-pickers led to a large, long term Programme for the Empowerment of Women Waste-pickers which commenced in 1990-91.

3.0.0 Description of the Project

3.1.0 General Situation in the Project Area

Pune city is located at the head of the Deccan Plateau in Western Maharashtra about 170 km from Bombay. It is a rapidly growing city with large industrial belts around it. It has a population of about 2.5 million, 40 per cent of which resides in slums. There are 420 declared slums within the city which has seen unprecedented growth in the last ten years.

3.1.1 The Participant Group

Scrap collection is undertaken by two groups, waste-pickers and itinerant buyers. They belong almost exclusively to the Scheduled Castes. They rank the lowest within the urban occupational hierarchy even within the urban informal sector. The total population of such workers in Pune city is estimated to be 7,000, of which waste-pickers constitute 85 per cent and itinerant buyers, 15 per cent. Waste-pickers retrieve metal, glass, paper and plastic scrap from garbage bins and dumps. Over 90 per cent of waste-pickers are women. They leave their homes at sunrise and return at sunset after a 10-12 hour working day. Their average daily earning is about Rs.50. Contrary to popular belief these forays do not take place at random. They have specific beats and establish territorial rights over bins and dumps.

Itinerant buyers purchase small quantities of scrap from residential areas and commercial establishments. Over 90 per cent of them are women. They access small amounts of capital from the scrap traders which is deducted from their earnings at the end of the day. The push carts which the men use are provided by the traders who charge a fee of Rs.5 per day. The items collected by the itinerant buyers are of relatively better value than those collected by waste-pickers. These include unbroken bottles, metal scrap, newspaper, plastic cans and tins. Their earnings average at Rs.70-80 per day. Women itinerant buyers also barter peanuts in exchange for scrap.

The scrap thus collected is sold to scrap traders by weight, after rudimentary sorting into about 13 categories of plastic, glass, paper and metal. It is further sorted and graded, as it moves progressively through various trade channels until it reaches the reprocessor or end user.

The scrap trade is closely held and controlled by the trading castes and communities. The scrap market is subject to seasonal fluctuations. It is also influenced by the imports of scrap from developed countries.

3.1.2 Contribution of Waste-pickers to Solid Waste Management

The generation of garbage has increased in direct proportion to the growth of cities and urban centres. About 75 per cent of the total garbage generated (1000 tons per day in Pune and its suburbs) is organic garbage that decomposes. The cost incurred by the municipalities per tonne of garbage for collection and disposal is Rs.300 (PMC, 1998). The other 25 per cent is recyclable scrap such as paper, plastic, metal and glass that constitutes the raw material for the recycling industry. Itinerant buyers purchase about 10 per cent of the scrap, the other 90 per cent is collected by waste-pickers from garbage bins and dumping yards. This amounts to almost 225 tonnes per day.

The civic bodies in these cities are mandated by the Bombay Municipal Corporations Act, 1949 to provide for public receptacles for garbage, its transport and final disposal. Citizens are required to deposit the garbage in containers provided by the municipalities. The most

common form of disposal is the sanitary landfill method (composting through dumping at sites reserved for the purpose).

The project is premised upon the fact that waste-pickers are engaged in socially useful, economically productive and environmentally beneficial work.

Unlike in most Western countries, segregation of garbage at source into organic (biodegradable) and recyclable (non-biodegradable), is not mandatory in India. The municipalities themselves do not undertake segregation. It is the waste-pickers who perform this task, thereby earning their livelihood. The quantification of their work indicates its magnitude, even at conservative estimates indicates its magnitude.(the estimates have been computed on the basis of the data generated by the cooperative store run by the Scrap Collectors Association).

- Collectively, waste-pickers salvage about 150 tonnes of recyclable scrap prior to its transportation, thereby saving the municipalities the sum of Rs.1.5 crores per annum. By implication, each waste-picker contributes Rs.246 worth of unpaid labour per month to the municipality.
- Each waste-picker and itinerant buyer, average earnings of Rs.50 and 75 per day, respectively. At conservative estimates, this amounts to Rs.3,75,000 per day, in the primary transaction that takes place between the scrap collector and the local scrap store, Further value addition takes place as the scrap is sorted, graded and traded.
- The environmental benefits that are derived from the work done by waste-pickers would be difficult to quantify in economic terms.

3.1.3 Conditions of Work

Occupational health

Waste-pickers are subject to a number of health hazards because they rummage through putrefying garbage including toxic medical waste using bare hands. Tuberculosis, scabies, asthma and other respiratory infections, cuts and injuries are common. As are animal bites from the pigs, dogs and rodents that they have to contend with.

Legitimacy, social security and worker benefits

Waste-pickers and itinerant buyers are considered to be self employed. There exists no legally established tenable employer-employee relationship between the scrap trader and the scrap collector even though they frequent the same store for decades. Consequently they do not come within the purview of any labour legislation that could entitle them to contributory provident fund, gratuity, insurance, paid leave, minimum returns for labour or any other social security. Scrap collection is not recognised as gainful work. Scrap collectors are variously subjected to abuse, unwarranted suspicion and harassment from the public, police and municipal workers.

Exploitation by scrap traders

The relationship between the scrap traders and scrap collectors is exploitative and paternalistic in nature. Underweighing of scrap, random cutting of weights, price fixation and abuse are some of the common exploitative practices.

Threat to livelihood

The increasing dissatisfaction with garbage clearance by the civic bodies has created a lobby for the privatisation of garbage collection. Experience shows that such private collection by contractors has a direct negative impact on the livelihoods of waste-pickers. This gives rise to questions about the waste-pickers' 'customary rights' to garbage.

Social aspects of marginalisation

Most waste-pickers being women have to cope with domestic, social and work obligations. A significant proportion belong to women headed households or are de facto heads of households. Over 97 per cent of waste-pickers are illiterate. Child marriage is the norm. Child labour is widely prevalent in the sector. Marital discord, desertion, domestic violence and alcoholism are common, as are certain caste linked social practices.

3.1.4 Present Status of the Project

The initiative of the sub-centre led to the formation of an independently registered association of scrap collectors in 1993, with the support of other like minded people. The Kagad Kach Patra Kashtakari Panchayat (waste-pickers association) has with the assistance of the sub-centre and others, managed to establish itself as the platform for articulating the concerns of waste-pickers. Some of the key achievements and programmes are detailed below.

- Endorsement of identity cards by the Pune and Pimpri Chinchwad Municipal Corporations:

Each member of the association has been issued an photo-identity card by the municipality. These cards were officially endorsed by the municipalities in recognition of the waste-pickers' contribution to the management of urban solid waste. The card authorises members to collect recyclable scrap from across the city.

- Redressal of complaints by waste-pickers:

This concerns recovery of bribes taken by the police, recovery of compensation for physical abuse and accident claims, domestic violence and desertion and other similar cases.

- Savings linked credit cooperative (Kagad Kach Patra Kashtakari Nagri Sahakari Pat Sanstha)

This is a registered credit cooperative. Each member saves a sum of Rs.50 per month and is entitled to loans of upto three times the amount saved after a period of six months, at an

interest rate of 1.5 per cent per month and a social security surcharge of 0.5 per cent per month. The total share capital was about Rs.6,00,000 and the total loan disbursal was about Rs.9,00,000. This has reduced the members dependence on usurious informal channels of credit at interest rates of 10-30 per cent per month.

- Co-operative scrap store (Kashtachi Kamai).

The store is conducted in 2000 sq.ft. of space provided free of cost by the Pimpri Chichwad Municipal Corporation. About 30 women sell their scrap at the store everyday and are entitled to a share of the profits generated. The store started in February 1998 with working capital of Rs.50,000. All the costs of labour etc. are met through the income generated. In January 1999 a bonus was distributed at the rate of 5 per cent of the total material sold at the shop by each waste-picker during the year. This amounted to almost Rs.10,000 and was disbursed from the net profit.

- Group Insurance Scheme.

A group insurance scheme was introduced in November 1998 in collaboration with the Life Insurance Corporation of India. For a premium of Rs.25 per annum, members are insured against death (natural death, Rs.5000 and accidental death Rs.25,000) and disability (Rs. 12500). have been disbursed since the commencement of the scheme.

The association has commenced negotiations with the General Insurance Company for medical insurance for waste-pickers.

Child Labor.

The sub-centre conducted non-formal education classes for child waste-pickers from 1991-1996. Since then the focus has been on school enrolment and retention. Educational incentives in the form of exercise books and scholarships to meritorious students are provided at the beginning of each academic year. Destitute children and those from single parent families (unable to cope) are enrolled at three residential educational institutions.

Certain deterrent measures have also been initiated alongside. The identity card carries the proviso that children below the age of 18 years cannot engage in wastepicking. Periodic drives are organised with the help of the police and municipality to pick up child waste-pickers and to encourage their parents to send them to school.

Garbage recycling and segregation programme.

About 300 waste-pickers are engaged in the doorstep collection of segregated garbage at source from 30000 households and commercial establishments. This programme is now being actively promoted as official policy by the Pune and Pimpri Chinchwad Municipalities. Recently, the PMC has instructed all medical establishments to segregate waste at source and hand it to authorised waste-pickers. Almost 550 establishments will be covered. The sub-

centre as well as the association are represented on the Apex Sanitation Committee of the Pane Municipal Corporation.

Platforms for social and cultural renewal

The association has consciously created spaces for alternate social and cultural practices. Traditional forms of cultural expression have been used to promote messages of change. The Samajik Jagran Gondhal, Kashtakaryanchi Lok Adalat (peoples court), Samudayik Vivah Solah (community marriage celebration) and street plays have been the means used to address social practices like child marriage, dedication of girl children to dieties and caste related ritual begging which are widely prevalent amongst waste-pickers.

Legislative Protection.

As mentioned earlier, waste-pickers are not covered under any labour legislation. The most appropriate Act suitable for this group seems to be the Maharashtra Hamal Mathadi and other Unprotected Workers (Regulation of Employment and Welfare) Act, 1969. The Act provides for compulsory registration of employers and workers with a Statutory Board. The constituents of the tripartite board include representatives of the employers, trade associations, trade unions of workers and the state. The costs of administering the board are defrayed through a levy payable by the employers. Wages are deposited with the Board by the employers along with the levy which includes contribution towards provident fund and other statutory benefits. The Board deducts the workers contribution and makes the wage payment to the workers. The Act allows for multiple employers and payment at piece rate. The Act applies to a list of scheduled employments specified in the Act.

The Act has been very beneficial to the workers covered under it, in the three decades since its enactment. Its efficacy has been directly proportional to the strength of the workers trade unions in different districts of the state.

The Kagad Kach Patra Kashtakari Panchayat raised the demand for inclusion of waste-pickers under the Act in 1998. Since then attempts have been made to initiate similar organised efforts in other parts of the state. Some work has commenced in Ahmednagar, Sangli, Kolhapur, Bombay and Aurangabad, although those organisations have yet to be formally registered. State wide Convention of waste-pickers was organised at Pane on 25 March 1999 and 5 May 2001. The most recent was attended by over 6000 waste-pickers from Pane and 5 other cities.

In 1998, the Supreme Court of India set up an Expert Committee on Solid Waste Management in response to Writ Petition no.888 of 1996 filed by Almitra Patel and others. The association was asked to send recommendations to the Committee, which it did. These have been incorporated in the final report of the Committee.

Building Strategic Alliances

While the association limits itself to waste-pickers as a constituency, it recognises that social realities and change involve a complex interplay of social, economic, political and cultural factors. Consequently, there is a need to link up with similar groups and movements. The association is part of several fora such as the Angamehnti Kashtakari Kruti Samiti (action committee of unorganised labour), Stree Mukti Andolan Sampark Samiti (womens organisations), Action for the Rights of the Child, Campaign against Child Labour and environmental groups. Contact has also been established with organisations working with waste-pickers in Bangalore, Ahmedabad, Indore, Rajkot and New Delhi.

Research and documentation

A team of three researchers from the SNTD has recently (2000) completed a “Study of Scrap Collectors, Scrap Traders and Recycling Enterprises in Pune city” for the International Labour Organisation.

3.2.0 The Aims of the Project

Since its inception core support for the project has been provided by Community Aid Abroad (Australia). Core support has almost exclusively been towards personnel costs. The third and final phase for core support will commence in July 2001. The projected period for the third phase is three years. The attempt has been towards setting up various self supporting institutional mechanisms in order to ensure long term sustainability, even after the withdrawal of the sub-centre.

Programme Expenditure has been met through annual membership fees which the waste-pickers pay to the association and small local activity specific donations. This application is being made specifically for a Campaign for the Rights of Unprotected Scrap Collectors (waste-pickers).

There are estimated to be between 50-75000 waste-pickers in the state of Maharashtra. A fact finding tour across the state has revealed that the conditions are more or less similar across the state, with some variations in Bombay which is a large metropolitan city. Populations of waste-pickers are higher in cities which have flourishing markets or well developed industrial zones and a sizeable proportion of prosperous middle and upper income group residents.

The project aims to work towards,

1. Legislative protection for waste-pickers i.e. Application of the Maharashtra Hamal Mathadi and Other Unprotected Workers (Regulation of Employment and Welfare) Act, 1969, to scrap collectors.
2. Formal integration of waste-pickers into urban solid waste management through compulsory segregation of garbage at source, and its doorstep collection by waste-pickers.

3. Assertion of the waste-pickers right over recyclable scrap
4. Elimination of child labour in scrap collection
5. Development of institutional mechanisms for social security for waste-pickers
6. Research and documentation to support institutional and advocacy initiatives

3.3.0 Planned measures

The key thrust during Phase III will be towards,

1. Promoting associations/ organisations of waste-pickers across the state of Maharashtra
 - More specifically this would involve touring across the state of Maharashtra to identify and establish contact with local organisers and organisations. Such groups have already been identified in Ahmednagar, Sangli, Kolhapur, Satara, Solapur and Bombay.
 - Capacity building of organisers from the above areas
 - Facilitating interaction between the various groups from different cities
2. Lobbying with the government (legislature and bureaucracy)
 - Provision of issue related information kits to Municipal Councillors and State Legislators
 - Strategic events to focus public attention on issues related to waste-pickers
 - Workshop / seminar for Municipal Commissioners / health department officials
 - Interaction with legislators and bureaucrats
3. Media relations
 - Provision of regular inflow of information to print and visual media
 - Interaction with journalists
4. Interaction and exchange of information with similar initiatives in other cities
5. Data collection, research, documentation, information dissemination and publication of materials on issues related to occupational health, law, social security measures, scrap trade, solid waste management and other relevant topics, to aid lobbying efforts. Eg. Search and documentation of the case laws related to challenges to the Mathadi Act in the Supreme Court.

Annex 21: Sample institutional strengthening activities for NGOs

Though funded by the World Wildlife Fund, their Institutional Strengthening and Capacity Building Project in Cameroon helped, among other NGOs, those targeted to disadvantaged social groups (women, disabled, children, etc). More information is available at <http://www.wwfcameroon.org/cpoprojects/institustrength.htm>.

The project undertakes:

-
- Facilitation of access of CBOs, NGOs and CBO/NGO-networks to meet operational needs (Finance, logistics, information etc.)
- Analysis of socio-cultural and economic environment in view of developing instruments and approaches for the promotion of community conservation including education.
- Development/Dissemination of training and Information, Education and Communication (IEC) materials in support of capacity building of collaborating partners.

Training for skills and knowledge enhancement in sustainable natural resource utilisation and management.

This component of the project has two main foci: *Organisational capacity building* which focuses on upgrading professional, technical and management skills with the overall purpose of improving the operational capacities of CBOs, NGOs and NGO-networks. *Institutional development, which addresses focuses on the promotion of creative relations among conservation partners.* It also seeks to encourage partners to work collectively to improve institutional frameworks for the implementation of biodiversity conservation site actions.

Organizational Capacity Building.

Developing individual capacities through skill sharing. The main areas of concern here include:

- operational methodologies, approaches, working tools, etc
- integration of related concepts into conservation service delivery
- assistance in the development of project proposals
- development of training and dissemination materials

Supporting the design of appropriate operational mechanisms for partner organizations

- workshop facilitation
- refining and redesigning organizational visions, missions, goals and objectives

Institutional Development.

Supporting alliances and networks

Workshops/seminars to develop common understanding on related conservation concepts

Facilitating and participating in workshops with other partners to improve understanding and knowledge on related policy issue
Network development.

Facilitating Access of National NGOs, CBOs and CBO/NGO networks to Information, Financial Resources and Operational Logistics, including:

The WWF-CPO Resource Centre: the focus here is the facilitation of access to information to partners on the status, value and management of species and ecosystems. The WWF-CPO Resource Centre is one of the sites for the experimentation of an electronic-based information and knowledge sharing mechanism for *Capacity Building*; a collaborative venture with WWF-UK.

Development/Dissemination of Training and IEC Materials in Support of Project Capacity Enhancement Interventions.

CBOs and NGOs do not only have a strong need for up-to-date technical information on species and ecosystem conservation but also for the expression of such information in a language they can understand and use. The presentation of government policies to grassroots communities in a language they can understand and use also presents the same challenge. A proper understanding of government policies, for example, is indispensable for urging institutional and policy reforms. Similarly, providing support to natural resource management networks and environmental action groups in accessing available technical information is an important aspect of information dissemination and networking. Providing information support to the CBOs and national NGOs could promote/maintain interactions, avoids semantic confusion and promote the culture required to institutionalise participatory approaches and methodologies. The servicing of these information needs is considered have been cardinal aspects of the project. In this connection, the project uses existing and emerging information and results of researches to develop awareness raising, information packs and training materials for use by project partners and the public at large.

Studies and Professional Support to WWF-Cameroon Field Projects.

Professional social science support to WWF-Cameroon has also been an important capacity enhancement activity of the project. Among the studies already carried out by the project are: socio-economic surveys required for the development of a management plan for the Korup National Park, a land tenure and resource access study in the Southeast, Kupe and Korup project sites and a nation-wide gender study.

The WWF-Cameroon Office and field projects also receive professional support related to the organisation of workshop/seminars, the development of terms of reference for sociological and economic studies, etc.

Production of Information and Dissemination Materials.

Brochures in French and English presenting the WWF-Cameroon Programme, her donors and field interventions sites in Cameroon have been produced and distributed.

Flyers outlining the procedures and guidelines for the WWF-CPO small grants initiative in support of biodiversity conservation was developed and are being distributed to potential beneficiaries particularly NGOs and CBOs within the conservation sites supported by WWF-Cameroon.

An analysis of the implementation hurdles and opportunities of the 1994 Forestry Law and Decree of Application has been developed and submitted for production into brochures in both English and French.

Annex 22: Proceedings from an NGO capacity building project, East Timor

The objectives of the UNDP East Timor NGO Capacity Building Project were to hold immediate training to assist local NGOs:

1. to deepen their understanding of development issues (including human rights, gender, environment, sustainability and problem solving) and project management and
2. to strengthen the managerial and organisational capacity of local NGOs.

Main training program

(a) Venue and catering All the main training was conducted at the Don Bosco Centre, Comoro. ..The Don Bosco Centre turned out well. The space is roomy, has a white board (a prized luxury in devastated Dili) and a garden setting. Taking people out of Dili lessened distractions. Participants were paid a subsidy of Rp10,000 a day to help with transport costs. Catering: Rp35,000 per person per day (substantial lunch, morning and afternoon snacks).

(b) Participants The training was offered to all East Timorese NGOs, with places limited to 2 per organisation and encouragement given for participation by women and NGOs from outside Dili. Numbers per session averaged 40 plus. Retention rates were very good with most staying the distance. A total of 60 NGOs were represented at the training, a majority of East Timor's operational NGOs. Most participants were young male university students from new, Dili based NGOs. Over the various sessions, NGOs from outside Dili came from Atauro, Maliana, Manatuto, Baucau, Los Palos and Viqueque. A number of International NGOs sought places in the training for local staff. As the training was intended to strengthen local capacity and it was assumed that INGOs had adequate capacity, these requests were generally turned down with the exception of local staff from three international organisations (Care, Asia Pacific Support Collective and Timor Aid - the latter two transitioning to become Timorese organisations) who attended the repeat training. The second training on organisational/project management and proposal preparation was heavily over-subscribed. A repeat training was offered after Easter to accommodate those who missed out. Because most of the participants were NGO volunteers and had no personal or organisational funds, the Project provided the following support: ·

Dili travel subsidy for all participants: Rp10,000 per day

Travel subsidy for district participants: Rp50,000 each way

Accommodation subsidy for district participants: Rp20,000 per day.

Note books and biros for each participant.

(c) The training program

Following consultation with the NGO Forum, local NGOs and others, it was agreed to pitch the training at an introductory level with the aim of raising the awareness of 9 new NGOs (including new staff of old NGOs) about the nature of development and organisational basics. Two other considerations were given priority: preference was given to trainers who could present in one of the locally used languages (usually Indonesian), and where possible we tried to utilise local NGO presenters. In each case, local presenters were given pre-

presentation coaching and guidance on content and methodology. We had only limited success with the latter. The experience points up the importance of a ‘train the trainers’ program to develop a pool of local trainers who can teach in their own language using images, references and case studies particular to East Timor.

The main training was provided in three parts.

(d) Module One (22-31 March 2000)

This comprised a series of 7 seminars/workshops on basic concepts of development. The aim of the module was to make participants aware of the complexity of development and the essentials of good development.

1. *Community development: principles and techniques*
2. *The nature and role of NGOs*
3. *History and politics of international development*
4. *Human rights and development*
5. *What is gender and why it matters in development*
6. *Environment and development*
7. *Post-conflict development: the role of NGOs in promoting reconciliation and psycho-social recovery*

(e) Module Two (3-19 April) and Repeat Module 2 (15-26 May)

This module provided training in three areas (a) organisational capacity (b) project management and (c) proposal preparation. The repeat training was compressed into fewer days by starting earlier each day.

The content of the module is available in UNDP in both Indonesian and English. It is planned to develop this material further, in collaboration with others, into a userfriendly manual for local NGOs.

The chief instructor was Frans Tugimin from the Yogyakarta chapter of Unity Service Cooperation (USC) Foundation. USC is a Canadian supported organization which specialises in capacity building and has chapters in a number of countries.

Daily session on human rights

Pat Walsh managed the module and provided a daily session on human rights. This was done to place the more technical focus of Module II in the wider context of a human rights approach to development and to remind participants that efficient organization is not an end in itself but a tool to fulfil human rights. Development is about promoting, fulfilling and protecting the full spectrum of human rights, especially for vulnerable groups. Human rights places people and their rights at the centre of the development process. Participants were

supplied with Tetum translations of the *Universal Declaration of Human Rights* and an Indonesian language version of the *Declaration on the Right to Development*.

Content

Session One

- Introduction to course, participants and their fears and expectations
- Study contract
- Basics of organisation
- Mandate and role of NGOs
- Institutional characteristics of NGOs
- The life cycle and stages of development of an NGO
- Statutes and networking
- NGO structures, transparency and accountability
- Leadership and decision making
- Conflict resolution in an organisation
- Motivation: blockages and personal development
- Effective communication
- Managing human resources
- Running effective meetings
- Project and meeting report writing
- Strategic planning

Session Two

- Basics of community development
- Approaches to community development
- Managing the project cycle
- Participation
- Project identification and problem identification
- Project objectives
- Target groups
- Strategic planning
- Implementation
- Monitoring and evaluation

Session Three

- Proposal writing

Three forums involving outside speakers were organised during the training on burning issues for local NGOs:

5 into 2 won't go: office space in Dili for NGOs Discussion with Declan O'Leary (Land and Property Unit, UNTAET Dili District Administration). This session was triggered by a discussion about the right to property in the UDHR. Most NGOs do not have an office and operate from someone's usually destroyed house. On the other hand, UNTAET is running out of properties in Dili and there is stiff competition for those that are left.

Let's hear what the donors think

Panel discussion with representatives from AusAID, CRS, Oxfam, Portuguese Mission, US AID. This was to supplement training on proposal writing. Points made included the importance of NGOs meeting with donors before they submit - one, to ensure they know the donor and their criteria and limitations; and two, to develop their idea together with the donor. NGOs were also encouraged to start small and to demonstrate they were active, instead of just planning for big projects and waiting for funds.

Herding the cats

Discussion with Pat Walsh and later Aleixo da Cruz on the East Timor NGO Forum and its role as a coordinating body. Most of the participants did not know of the Forum but strongly supported the concept. Those who were aware of the Forum associated it with old NGOs and wanted it to be more pro-active. The training course was an excellent opportunity for the Forum leadership to get to know the new NGOs and build support for the Forum. Two members of the Forum Board gave brief presentations (including Aleixo da Cruz, Forum Chair, who handed out certificates with Finn Reske Nielsen). But due to other pressing commitments it was not possible to utilise the training as an opportunity to show case the Forum. On a more positive note, however, it should be observed that the Project Training Assistant Arsenio Bano, who has just been appointed Forum Director, was able to spend many hours with the trainees, an association which will enhance Forum-NGO relations.

The sessions also generated the stimulating proposal that a Parliament of NGOs be organised by the Forum later this year to debate NGO policy on the most appropriate development model for East Timor.

Interviews with participants

Pat Walsh and Arsenio Bano interviewed each of the participants from the repeat training. This was done to obtain more exact information on NGO structures and activities. More research is required, however, to complete the picture and provide a fully informed assessment of individual NGO capacity, needs and level of donor support. Plans by the Donor Civil Society Working Group to prepare a map of which NGOs are receiving what from donors will also contribute to this research. See recommendations later.

6.2 Supplementary training programs

The Project organised extra training in two critical areas: (a) financial management and (b) proposal preparation. The Project also organised a (c) pilot NGO field visit to Manatuto and assisted with the organisation of several other capacity building initiatives.

(a) Financial management

10 hours of instruction were provided in the Quicken computer financial management program. The program is designed to assist budgeting and bookkeeping for home and small business use. It is user-friendly and assists in organising accounts, presenting budgets, keeping track of income and expenditure and transparency and accountability. The Project purchased two copies of the Quicken Program. These are available from the East Timor NGO Forum. It is suggested that the Forum contact the Quicken company in Australia and request the free use of 20 or so licenses for East Timorese NGOs.

The training was provided by Chris Gibbings (Edmund Rice Community) with a short follow up session presented by Edward Hammond (UNTAET Trust Fund Officer). Spaces were available for only 8 NGOs because of difficulty in providing sufficient computers. Four of these NGOs were given extra tuition because of their facility with English and computers. This was done on condition that they agreed to offer training to other East Timorese NGOs.

(b) Proposal preparation (10-20 April)

A major factor in the survival of many NGOs will be their capacity to present themselves to funding bodies as efficient organisations with a meaningful contribution to make. It should be emphasised, however, that proposal writing is more than grantseeking. It is also a powerful planning and organising tool with potential to strengthen a wide range of skills in an organisation. Training and support in this area therefore makes a substantial contribution to capacity building. The Project organised 10 days of training in proposal writing. This comprised a total of 19 outreach sessions conducted on a one-to-one on-site basis in Dili. Training was provided gratis by Genevieve Timmons, Executive Officer of the Lance Reichstein Foundation in Melbourne, Australia, an experienced adviser and trainer on grantseeking. Costs for travel between Darwin and Dili, accommodation and transport in Dili were met from the Project funds. The experience demonstrated the effectiveness of direct mentoring and the merits of the proposal that the East Timor NGO Forum facilitate the establishment of a Mobile Rapid Skills Training Team who could provide one-to-one on-site training oncall. (See *'New NGOs for a New East Timor'*, discussion paper on the role of the East Timor NGO Forum, Pat Walsh, p.12)

Recommendation

It is strongly recommended that donors review their relationships with local NGOs and adopt a capacity building approach to grantmaking. Some donors appear to act like bankers whose role is limited to dispensing or denying funds. In a number of cases NGOs complain that their submissions have failed and that they either discover this on enquiry (sometimes after a long wait) or through receipt of a letter. Is it beyond the capacity of donors to develop a helping relationship with NGOs, particularly in East Timor's current circumstances where so many new NGOs are newcomers to development and the intricacies of donor processes?

(c) Dialogue with the districts: NGO field visit to Manatuto

The Project organised a field visit to Manatuto to provide 12 Dili based trainees with an insight into development issues outside Dili. Called *'Dialogue with the Districts'*, the visitors undertook a short exposure tour of Manatuto, including visits to 4 local women's projects (buffalo farm, tais weaving, pottery, basket making) then spent the afternoon listening to members of the local community speak about their concerns and how the community/local NGOs were responding. The visit was also an opportunity for Dili NGOs to explain how they got started and operate - with a view to stimulating local community initiative. The emphasis was deliberately focussed on what the community, not CNRT or UNTAET, can do to help itself and stress was laid on the independent, community facilitation/empowering role of NGOs. The visit was very stimulating to both groups and established excellent links, plus some practical ways of continuing the relationship and support. The Project was also

instrumental in directing AU\$3000 from the Jesse Street Trust in Sydney, Australia, to assist the capacity building of OMT, the women's organisation in Manatuto.

6.3 Assistance with other capacity building initiatives

The Project assisted with a number of other capacity building initiatives by providing support or advice. These were:

(a) *Environment NGOs*: helping with capacity building of the two local environmental NGOs by (a) linking them to the UNTAET environmental unit (b) linking them to the Australian Conservation Foundation (c) helping organise a funding submission to Care International for a visit to East Timor by Yogya Sofyar, an experienced Indonesian environmentalist based in Australia, to assist with program development and planning.

(b) *CNRT*: advising UNICEF (Greg Fernandes) on a suitable trainer (David Shires, Capacity International) to provide training for CNRT and liaising with David on content and training approaches.

(c) *Geneva, UNCHR*: liaison with International Service for Human Rights in Geneva and assisting with the selection of two East Timorese women NGOs (Ubalda Alves/Fokupers and Rosa Garcia/CDHTL) to participate in ISHR Training Course in International Human Rights Law and Diplomacy, 13 March – 28 April 2000, Geneva including participation in the 2000 session of UN-CHR.

(d) *Human rights workshop in Bangkok*: advice and assistance to UNDP on selection of NGO (Aderito de Jesus Soares/SA'HE) to attend UNDP workshop on human rights in Asia, along with CNRT leader Mari Alkatiri.

(e) *NGO exposure visits*: assistance to NGO Forum and Oxfam in organising visits for local NGOs to (a) Cambodia : 5-16 July (b) Australia: 24 –31 July (c) Indonesia – TBC. Also advice to US Embassy officials on NGO exchange visits to the United States (US Embassy contact: Greta Morris, Jakarta handphone: 0811 993 242)

6.4 What results were produced?

- Awareness raised on development and organisational issues, including challenge to the top-down, infrastructure model of development inherited from Indonesia
- Awareness raised about civil society and the importance of a civil society that is independent and facilitates/empowers communities as its main role
- Draft of a first training manual specifically for East Timorese NGOs
- Raising of UNPD's profile amongst local NGOs and expectations of continuing UNDP support for civil society
- Demand for more training
- Building of networks amongst new NGOs and the possibility of mergers and rationalisation of numbers
- Insights into East Timorese preferences for teaching methodology
- Better understanding of the many new East Timorese NGOs and their capacity needs
- Identification of potential candidates for a 'train the trainers' program
- Improved understanding of donor requirements and the importance of dialogue with donors

- Contact with NGOs from the districts and an opportunity, especially through the field visit to Manatuto, to promote a sense of national NGO consciousness
- Awareness of the NGO Forum and its role.

6.5 Consultations on capacity building

The Project Manager was consulted on capacity building by the following agencies:
... (24 NGOs and donors named here)

These discussions generated three key recommendations:

- (a) International NGOs and UN Agencies utilising East Timorese staff as employees or volunteers should provide systematic training opportunities for staff, including in development issues;
- (b) donors should integrate capacity building into their partnership with East Timorese NGOs and e.g. utilise grant making to assist the organisation's capacity in accountability;
- (c) a focal point and mechanism of coordination is needed in East Timor on civil society building, including the promotion of exchange and dialogue within CNRT and East Timorese society generally on the concept and role of civil society. The Civil Society Working Group which involves a small number of donors and meets weekly, is a step in this direction.

Consultation with Community Empowerment and Governance Project (CEP)

The CEP has established a national team of four trainers who have run training workshops for CEP community facilitators over the same period as the UNDP training. The team comprises: Reynaldo Borges, Rosa Vong, Alvaro Ribeiro and Kieran Dwyer. The CEP training differs from the UNDP training in that it is specifically designed to equip facilitators to implement the CEP program and is not concerned with institution building. It also did not include NGOs. In other ways, however, the two courses have a lot in common particularly in relation to community development, project management, conflict resolution, participative processes and human rights. Both are medium to long-term programs and have much to offer each other.

It is recommended that UNDP and CEP continue to consult on their two programs and, where possible, collaborate particularly in relation to NGO involvement in the CEP (including the East Timor NGO Forum), train the trainers issues, the production of training materials, the utilisation of the excellent CEP community development graphics, lessons learned from both experiences, and assessment of on-going training needs. Based on its experience of direct community development, the CEP has a lot to offer NGOs. For their part, NGOs have skills, commitment and networks which will assist the CEP.

Taken from Pat Walsh, "All the King's Horses and All the King's Men: Report on UNDP East Timor NGO Capacity Building Project, June 2000, pp. 7-17.

Annex 23: Suggestions from a local NGO on how to develop self-reporting/impact evaluation techniques

“Know-How: Measuring the impact of your organization and the programs on the community”

We (NGOs) exist to make a difference. This is our prime goal. NGOs provide services in order for something to change for better, for something unpleasant to be stopped or reduced. But what difference have we made? How to measure this difference? Some of the organizations can give the answer right away, some can't. But this is the question that every NGO should have a clear and exact answer to.

Identifying the outcomes of services

First of all, you need to decide how wide you are going to take the outcomes. Are you concerned just with what has happened to the main user, or also to their friends and family? Are you interested in the way people use other services and what has then happened to the other services? The organization must be clear what they are measuring their achievements against. This means the project has to have clear aims and objectives, stated in terms that are achievable and measurable. Other organizations with whom the project works must also be clear about the expectations they have of the project.

The outcomes should be expressed in numbers, such as:

- a percentage
- a rate
- a ratio

Indicators that are useful in measuring the evaluation and outcomes:

- Indicators of availability – to show whether something exists and whether it is available
- Indicators of relevance – to show how relevant or appropriate something is
- Indicators of accessibility – to show whether what exists is actually within reach of those who need it.
- Indicators of utilization – to show to what extent something that has been made available is being used for that purpose
- Indicators of coverage – to show what proportion of those who need something are receiving it
- Indicators of quality – to show the quality or standard of something
- Indicators of effort – to show how much and what is being invested in order to achieve the objectives
- Indicators of efficiency – to show whether resources and activities are being put to the best possible use to achieve the objectives
- Indicators of impact – to show if what you are doing is really making any difference

The first problem associated with describing outcomes is that no one can be absolutely certain that one particular thing - in this case the project's services – actually caused another – the changes that happen to users. While the project is providing its services lots of other things will be happening in the lives of its users. For example, everyone might agree that a frail older lady is now more settled and happier than she was when she first came to the day center six months ago. However, this could be as much because her family has moved closer, or she has got a cat, as it is because of the practical help and support she is getting at the day center. The likely explanation is that it is a combination of things, which are often reinforcing other changes if the experience is bad or mixed. What this means is that a project cannot claim that it and it alone caused the outcomes, which are identified for its users. It can however say that these outcomes happened, and that these are associated with people's use of the service.

Outputs, outcomes, impact of project activities... Oh those complex words!!!!

We often talk about expected, actual results of the project, impact the project has on the community. Donor organization ask NGOs to establish criteria for their measurement, but do we really understand what is the difference between all these terms and why it is so important to show the impact and effect of all activities? The evidence suggests that NGOs in general are stronger on issues such as effort and activities, but less strong when it comes to determining what have been the result (**effect**) and the influence (**impact**) of the entire attempt. The intended **impact** of a program or a project is often taken to mean the longer-term, sustainable changes, which are hoped the program or project will contribute to bringing about. These may be unexpected or unintended changes; both positive and negative, arising from the project and these also should properly be described as its impact.

Let's see on the example how outputs, outcomes and impact can be measured and what indicators can be used.

Objective: Organizational development at the community level

Output indicators:

- . organization formation
- . capacity building related to organizational growth
- . type and frequency of organization activities
- . actions planned and executed

Outcome indicators:

- . emergence and strengthening of community level
- . growing involvement of the organization in local development issues

Impact indicator:

- . local organizations unite to become involved in local development issues

A project may have been effective in the way it has been able to organize its inputs, deliver an appropriate service or bring about a certain change in existing practice or attitudes, but it is still necessary to understand what has been the effect of all these effective activities.

To achieve effectiveness in our activities all important reports should be done in a written form.

How to demonstrate an impact of your activities... What the report needs to contain:

Front cover

- Title, name, and location of program
- Names of those who carried out the evaluation
- Names of those with whom the program is linked, such as ministries, agencies, etc
- Period covered by the report
- Date report completed

Summary

A brief one- or two-page overview of the report is useful for busy readers and those who wish to study it in more detail. Write the summary last. A “question-and-answer” style, or a specially designed diagram or table of the information, may be useful.

List of contents

Background information. Why and how the program began, which were the priority objectives, main activities and resources.

Purpose of evaluation and methods chosen

Explain the purpose of the evaluation and state the intended audiences. Be clear about what it is **not** intended to do. Include samples of methods used where necessary (for example, questionnaires in the appendix).

Outcomes of using the methods

Where and how were the evaluation methods developed and tested before use?
How was the information collected and how reliable and valid did the methods prove to be?
Include any timetable or evaluation schedule in an appendix. Include information about how staff and participants were trained to use the methods. Also mention unintended results, if appropriate.

Results of data collection and analysis

After analysis of the facts, prepare and include figures and information collected, tables, graphs, test results, etc. You may also include tape recordings, illustrations or photographs.

Conclusions

To what extent have program objectives been achieved? Which aspects of the program (such as planning, management, monitoring training, field activities, etc) are strong, and which need to be strengthened? Have human and material program resources been used efficiently? How has the program changed with time? What are its financial costs and benefits? What predictions can be made for the short-/long-term future of the program? Most important of all, what effect or impact is the program having?

Recommendations

On the basis of your conclusions what course(s) of action are proposed? How are these to be implemented, by whom and when? List your recommendations. This may be the part of the report, which some people read first. It may be the only part, which they read. Identify the priority recommendations. Take time to evaluate your own evaluation. Evaluation is hard and often painful work. This is because it requires those who are associated with a particular program to be very honest with themselves and with each other. Be critical of your own evaluation, methods and results. In this way, not only can you improve your own evaluation abilities but, by sharing your experience with others, they can learn from them too.

From S.Belushkina and P.Nesterenko in Counterpart Alliance for Partnership, "Cap Novosti" bulletin, Issue #8, September 2001, pp. 6-8.

Annex 24: Measuring Cost-Benefit

There are several ways to report the relationships between costs and benefits:

- The *net benefit* of a program can be shown by subtracting the costs of a program from its benefits. For example, if a substance abuse treatment program cost \$100,000 per year but generated in the same year \$500,000 in increased patient income, increased tax payments by patients, and reduced expenditures for social and criminal justice services, the net benefit of the program would be \$500,000 minus \$100,000, or \$400,000, for that year.
- The *ratio* of benefits to costs is found by dividing total program benefits by total program costs. For example, dividing the \$500,000 benefit of the program by its \$100,000 costs yields a cost-benefit ratio of 5:1.
- Because neither net benefits nor cost-benefit ratios indicate the size of the cost (*initial investment*) required for treatment to yield the observed benefits, it is important to report this as well. We cannot assume that the same exact relationships between costs and benefits will exist at different levels of investment. Sometimes an increase in cost allows new, more productive procedures to be used for treatment, increasing benefits dramatically. For example, increasing a program budget to allow hiring of a community liaison, vocational counselor, or physician might dramatically increase patient outcome. Therefore, it often is best to report the initial investment, the net benefit, and the cost-benefit ratio.
- The *time to return on investment* (the time it takes for program benefits to equal program costs) is yet another indicator used in cost-benefit analysis. For programs, benefits and costs occur at the same time, or at least in the same year. For individual patients, however, the investment in treatment may pay off substantially only after several months or years. Costs usually occur up front, but program benefits may take time to reach the point where they exceed costs.
- The decreasing value of benefits attained in the distant future can be calculated as the *present value* of benefits. When most of the cost of treatment occurs in the first year of treatment but most benefits occur only several years after treatment, the value of those delayed benefits needs to be adjusted (decreased) to reflect the delay.

Analyses of cost, cost-effectiveness, and cost-benefit relationships can provide valuable insights into how a program operates and how its operations could be improved to serve more people better for less. Analyses of costs, cost-effectiveness, and cost-benefit also show funders that program managers are aware of the importance of accountability -accountability for how funds are used and what they are used to achieve.

Annex 25. Sample timetable for cost, cost-effectiveness, and cost-benefit analysis of a substance abuse treatment program

| Steps | Weeks | | | | | | | | | | | | | | |
|--|-------|---|---|---|---|---|---|---|---|----|----|----|----|----|----|
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 |
| 1. Identify key players interest groups and a coordinator | █ | | | | | | | | | | | | | | |
| 2. Assign responsibilities for each step | █ | | | | | | | | | | | | | | |
| 3. Tailor this timetable to your program | █ | | | | | | | | | | | | | | |
| 4. Develop or refine a reporting plan | █ | | | | | | | | | | | | | | |
| 5. Describe program components and desired outcomes | | █ | | | | | | | | | | | | | |
| 6. Choose and test cost measures | | | █ | | | | | | | | | | | | |
| 7. Develop and test effectiveness measures | | | | █ | █ | | | | | | | | | | |
| 8. Choose and test benefit measures | | | | | | █ | | | | | | | | | |
| 9. Implement regular collection and reporting of cost measures | | | | | | | █ | █ | █ | █ | █ | █ | █ | █ | █ |
| 10. Regularly collect and report effectiveness measures | | | | | | | | █ | █ | █ | █ | █ | █ | █ | █ |
| 11. Regularly collect and report benefit measures | | | | | | | | | █ | █ | █ | █ | █ | █ | █ |
| 12. Perform first cost analysis | | | | | | | | | | █ | | | | | |
| 13. Perform first effectiveness analysis | | | | | | | | | | | █ | | | | |
| 14. Perform first benefit analysis | | | | | | | | | | | | █ | | | |
| 15. Perform first cost-effectiveness analysis | | | | | | | | | | | | | █ | | |
| 16. Perform first cost-benefit analysis | | | | | | | | | | | | | | █ | |

| | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| 17. Perform monthly analyses of cost cost-effectiveness and cost-benefit | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|

From Measuring and Improving Costs, Cost-Effectiveness, and Cost-Benefit for Substance Abuse Treatment Programs: A Manual by Brian Yates, p. 8.

Annex 26: Sample community monitoring program from the Philippines: Review of the Barangay Integrated Development Approach for Nutrition Improvement of the Rural Poor (BIDANI)

Objectives:

- (a) establish practical models of improving nutrition of the rural poor at the local level;
- (b) develop practical training courses for barangay (community) leaders and trainers;
- (c) develop packages of participatory services at the village level;
- (d) institutionalize the models for speedy, sustained and wider implementation at the municipal and barangay levels; and
- (e) sustain the implementation of BIDANI through assistance of state colleges and universities (SCUs) in the Philippines as a complementary effort to an associated program run by the National Nutrition Council.

Coverage:

The BIDANI Program (established in 1978) focused on model development and testing in its first few years. Six pilot barangays were initially chosen based on the type of agricultural pursuit. Over the years, BIDANI has expanded as it covered more barangays. Currently, it consists of a network of BIDANI model projects in seven Regions spearheaded by key regional SCUs. University of the Philippines at Los Banos serves as the trainer and overall coordinator of the Program. In the next five years, the BIDANI Network is envisioned to be expanded and institutionalized to cover 683 villages in 75 municipalities in seven regions.

Indicators.

Although BIDANI focuses on health and nutrition, it also touches on other areas of concern such as food production and utilization, income generation and employment, infrastructure development, education and training, institutional support development, sports development, peace and order, and spiritual development. The basic tool used in identifying and selecting relevant indicators is the Hypothetical-Input-Process-Output –Outcome (HIPPOPOC) table. This table particularly enables one to isolate output from outcome. An examination of the indicator system devised for the municipality of Tanauan, Batangas used for the evaluation of its Integrated Development Plan in 1990 shows that its indicators on health, nutrition and sanitation closely correspond to the Minimum Basic Needs (MBN) indicators. The other BIDANI indicators, however, basically monitor the effectivity of development programs and projects. (Specific indicators available under <http://www.panasia.org.sg/mimapph/publications/mrp15.pdf>, page 61).

Monitoring System.

The BIDANI approach involves the formulation of the Barangay Integrated Development Plan (BIDP) designed by the community members themselves. This BIDP embodies the situational analysis or the socio-economic profile of the community, the prioritized needs and problems, and the operational plan for the projects and activities of the barangay. The situational analysis is based on a survey conducted by the Barangay Nutrition Scholar-Development Worker (BNS-DW). Thus, relevant data are collected on an annual basis as inputs to the development planning process at the barangay level. Moreover, these data are used in monitoring and evaluating the development program. Evaluation, both internal and external, normally consists of process and impact assessment.

The BNS-DW plays a very important role as the monitor at the barangay level. Among his responsibilities are to:

- (a) gather program related data in the barangay;
- (b) plan, implement and evaluate the BIDP together with the Planning and Implementing Committee (PPIC);
- (c) act as liaison officer between barangay people and other entities;
- (d) act as trainer at the local level;
- (e) serve as member of the technical staff of the Barangay Captain, Barangay Development Council, and the PPIC; and
- (f) Act as a Barangay Action Officer.

In every barangay, the residents and the barangay officials select and recommend a potential BNS-DW based on the following criteria:

- (a) at least a high school graduate;
- (b) preferably 25 years old or older;
- (c) possesses leadership qualities or is a recognized/respectable person;
- (d) shows deep concern for the welfare of the barangay;
- (e) has more or less established credibility in the barangay;
- (f) available and willing to perform the task assigned to him/her; and
- (g) preferably a current indigenous local agency worker; e.g., BNS, Barangay Service Point Officer, Barangay Health Worker (BHW).

A major step in the evaluation stage of the Development Plan is the installation and maintenance of a data bank at the municipal level. Data collected by the BNS-DW are submitted to the Supervisory Team consisting of field technicians for validation. The Supervisory Teams provide copies of the reports to the Management Staff composed of the heads of various line agencies for further appraisal of data quality. Reports are then forwarded to the City/Municipal Planning and Development Coordinator (C/MPDC) or the City/Municipal Nutrition Action Officer (C/MNAO). The C/MPDC or the C/MNAO cooperates with NGOs in sharing information. Reports from the Management Staff/NGOs are coded and organized. These reports serve as inputs in the evaluation and reprogramming of the City/Municipal Integrated Development Plan (CMIDP). For a summary of duties and

responsibilities of persons/groups involved in the installation and maintenance of the data bank, see <http://www.panasia.org.sg/mimapph/publications/mrp15.pdf> page 68.

Evaluation.

The BIDANI approach provides evidence that a community-based monitoring system is viable. The system demonstrates that with adequate training, the barangay councils can generate enough information necessary to formulate a basic development plan. Among its strengths are: (a) implementation and sustainability of the Program on a wider scale is facilitated through institutionalization at the municipal/city level; (b) puts to practice the local government code of decentralization; (c) provides academic institutions an important role in the technical aspect of the Program such as training and research; and (d) provides linkages among the local government, NGOs, academic institutions, and community organizations.

Despite its success, there are still some aspects that could be improved. Currently, there are only approximately 14,500 BNS out of 45,000 barangays due to the slow pace of implementation of the BNS Project. In addition, too many BNS are supervised by only one C/MPDC. Furthermore, a core set of indicators that would facilitate monitoring across time and across barangays has not been identified.

Moreover, based on the information gathered by the MIMAP Project Management Office during a visit to a BIDANI municipality in Laguna, data files are not properly stored in the barangay. Thus, no time series of the data collected exists. The BNS practically “owns” the data files and disposes of them whenever and however they want to. It appears, too, that the information submitted to the municipal level are usually lost and on the other hand, processed information at the municipal level are not fed back to the barangay.

Taken from Celia M. Reyes and Isabelita Alba, Assessment of Community-Based Systems Monitoring Household Welfare (Manila: MIMAP Project Policy Development Foundation, 1994), pp. 4-8.

Annex 27: Sample Evaluation from the Developed World: The Special Vision Program

Because of the wide range of programs for people with disabilities, there are numerous ways one can measure project outcomes. Below is an example of a project for people with disabilities and a discussion of the evaluation techniques it uses. The evaluation comprises program use and impact on quality of life, as well as level of satisfaction by program beneficiaries. More information is available at http://www.chp.edu/spclvsn/01aa2_technical.html#techmeasures

Special Vision is a three-year demonstration project funded in part by the Technology Opportunities Program, National Telecommunications and Information Administration, U.S. Department of Commerce with matching funds guaranteed by Children's Hospital of Pittsburgh. It will give families and health care providers of CWSN secure Internet access to current and dynamic Patients' Private Web Sites (PPWS). This intervention is intended to improve communication and information exchange among end-users, resulting in improved health care delivery characteristics, quality of life dimensions and functional health measures for a select group of CWSN and their families.

Notes on evaluation:

Quality impact, quality of life for children and families, and functional outcomes (e.g., improvements in integrated interdisciplinary treatment planning and service delivery evaluation will be used not only to appraise the achievement of the major outcomes or missions of Special Vision, but also to continuously provide feedback data to the project designers to be used to improve the quality of the project.

The summative evaluation, focusing on program utilization and impact, will consist of broad-spectrum, longitudinal appraisal outcomes for children, families and health care providers over the three-year duration of the project. The program evaluation will consist of norm-based, curriculum-based, judgment-based, and ecological measures.

The Center for Mental Health Services Knowledge Exchange Network also provides guidance on measuring community-based care programs. It, too, used a combination of qualitative and outcome measures to measure the effectiveness of the Comprehensive Community Mental Health Services for Children and Their Families Program. The following is an excerpt from its Report to Congress on the Evaluation of the Comprehensive Community Mental Health Services for Children and Their Families Program, published August 1998. More may be obtained from <http://www.mentalhealth.org/publications/allpubs/CB-E198/chp3.asp>

Methods for the Descriptive and Outcome Studies

Descriptive Study Sample

Sites collected descriptive data on all children receiving services through the system-of-care initiative, including demographic information, diagnostic status, functional characteristics, and service histories. Data from this component of the evaluation is referred to in the remainder of this report as the *descriptive study sample*. The original intent of this part of the evaluation was to collect information that was fully representative of all children and families who entered systems of care. To date (August 31, 1998), demographic and diagnostic information has been reported on 34,377 children who have entered systems of care.

The intended target population for this initiative was children ages 5 to 18 with serious emotional disturbance. Between 15 and 20 percent of all children across the nation may be diagnosed with a mental disorder. However, it is generally recognized that a smaller subgroup, 6 to 8 percent of all children, present with a serious emotional disturbance and display significant functional impairment, as demonstrated by a decreased ability to meet the challenges presented by day-to-day settings and interactions (in the school, the home, and the community).

There was some variability across sites in how the target population was defined. The geographic areas in which the programs were situated varied substantially; some programs extended across an entire State or a large number of counties within a State, while others focused their efforts on single counties/cities or a circumscribed urban area. Additional variability in the definition of target populations occurred across sites as different subgroups of children were identified to receive care, and different agencies took the lead in the development of programs. For example, some sites had a strong focus on children who were referred through the juvenile justice system, while others were primarily oriented toward enhancing mental health-school liaison relationships. Target populations also changed significantly across time at individual sites. Services were in a constant state of development, with relationships between agencies continually cultivated and new service delivery options implemented as systems of care matured.

All 22 sites contributed some data for the descriptive study sample, although sites varied in the number of families participating due to differences in the number served. The most complete information obtained was for child age, child gender, racial/ethnic status, and diagnostic status.

Outcome Study Sample

Outcomes were evaluated through a simple pretest/post-test replacement design that requested sites to evaluate more fully a selected group of children at intake, at 6 months, at 1 year, and annually thereafter for as long as they remained in services. When children and families exited the evaluation or were lost to follow-up, they were replaced with a new family who had just entered system-of-care services. Sites were also requested to collect outcomes data from children and families when they exited services. This design allowed for tracking of children and examination of participation outcomes, although it did not provide a controlled test of the system-of-care approach versus other approaches or no services at all. Child and family outcome data included the child's clinical and social functioning,

educational performance, restrictiveness of child's placement, and child and family satisfaction collected with standardized instruments that are common to the field of children's mental health services.

The outcome evaluation design requested that grantees serving fewer than 400 children include all children and families who consented to participate. For those grantees serving between 400 and 4,000 children, a sample of 400 children was drawn. For those grantees serving over 4,000 children, a 10 percent sample was drawn. Sites were asked to report the specific reasons why children left services at exit. Data from this part of the evaluation is referred to in the remainder of this report as the *outcome study sample*.

Of the 22 programs, 20 provided data for the outcome study sample. In most sites, however, enrollment was not based on a systematic random sampling scheme. The number of children in the outcome study as a percentage of the descriptive study sample varied across the sites (i.e., 40 to 95.2 percent). Only two sites failed to enroll 70 percent of the children in the descriptive sample. The average percentage of children enrolled in the outcome study sample was 79.5 percent ($SD = 13.4\%$) of those in the descriptive study sample representing a relatively high rate of children and families who participated in both substudies. Some missing outcome data at intake can be attributed to families declining participation or insufficient support for data collection.

Completion rates were calculated separately for the three major clinical outcome measures: the Child and Adolescent Functional Assessment Scale (CAFAS), the Child Behavior Checklist (CBCL), and the Youth Self-Report (YSR). Due to the replacement sampling design, data completion rates were based on a formula which limited the total number of potential respondents at each assessment interval to those children and families who could be reliably identified as continuing to participate in services rather than the total number of participants who were initially enrolled in the longitudinal outcome study. Data completion rates at 6 months averaged 64.5 percent ($SD = 21.0\%$) for the CAFAS, 53.6 percent ($SD = 20.7\%$) for the CBCL, and 46.4 percent ($SD = 19.6\%$) for the YSR. Data completion rates at 1 year averaged 43.5 percent ($SD = 25.5\%$) for the CAFAS, 36.5 percent ($SD = 23.3\%$) for the CBCL, and 28.5 percent ($SD = 22.1\%$) for the YSR. The generally low level and high variability in completion rates are due to a number of factors, many of which occurred across sites and many that are specific to individual sites. These include the use of a replacement sampling design, inconsistencies in implementation and use of tracking and tickler systems, and variable allocation of evaluation personnel at each site. Another factor to consider is that children and families may have exited systems of care before the 6-month and 1-year evaluation points due to either improvement or deterioration in their emotional disorders. Due to site variability in the collection of exit data, it is not possible to reliably determine whether improvement had occurred before exit for individual cases who left the program. Therefore, caution is recommended in interpreting the implications of the longitudinal outcome data.

For reporting and analysis purposes, data was aggregated across sites for the outcome study sample. Extensive information at intake is based upon a sample of 6,668 children. Smaller

samples were available for analyses for subsequent outcomes at 6 months ($N = 3,195$) and 1 year ($N = 1,729$). The outcome study sample differed from the descriptive study sample in the following ways: slightly more males participated in the outcome study at intake (66 percent), at 6 months (65 percent), and at 1 year (67 percent) than in the larger descriptive study sample (62 percent); the average age was lower and decreased across time from 11.6 years at intake and 6 months to 11.1 years at 1 year; a relatively higher proportion of African American children was involved in the outcome study at intake (21 percent), at 6 months (22 percent), and at 1 year (23 percent) than in the descriptive study sample (17 percent); there was a corresponding lower percentage of Hispanic children at intake (12 percent), at 6 months (10 percent), and at 1 year (7 percent) than in the descriptive study sample (24 percent). The sites that were included in the descriptive study sample but did not contribute data to the outcome study sample had higher rates of Hispanic children in their systems of care. Minimal differences existed in household composition and family income across the demographic study sample and three outcome study data collection points. In general, the demographic characteristics of the children and families who participated in the outcome study at different evaluation points were similar to the descriptive study sample despite lower numbers of children participating at the 6-month and 1-year follow-up data collection points.

Analyses were also computed to compare intake scores on the major clinical measures for the subsamples of children who completed these measures again at 6 months and 1 year. The same average scores on the CAFAS at intake were obtained for children with complete 6-month ($M = 62.6$; $SD = 27.5$) and 1-year ($M = 62.6$; $SD = 27.2$) outcome data. These scores were slightly higher than the average for all children at intake ($M = 61.7$; $SD = 27.8$). A similar pattern was observed with the CBCL. Average scores on the CBCL at intake were nearly equivalent for children with complete 6-month ($M = 68.3$; $SD = 10.5$) and 1-year outcome data ($M = 68.6$; $SD = 10.6$). These scores were slightly higher than the average for all children at intake ($M = 67.9$; $SD = 10.7$). Clinical status at entry into the evaluation was not substantially different for those who completed the evaluation at 6 months and 1 year when compared to all children who completed intake clinical measures. The subsamples providing outcome data at 6 months and 1 year appear to be representative of the clinical status of all children as they enter system-of-care services.

The following information in the remainder of this report regarding longitudinal outcomes should be interpreted with cautions. First, a control group was not included in the initial program evaluation design. To rectify this, evaluations are currently underway in three funded sites and their matched comparisons that will yield useful comparison information in the future. Second, completion rates for longitudinal data collection were lower than optimal across sites. This suggests that the generalizability of the current outcome analyses may be limited to a select group of children with serious emotional disorders who remain in services in systems of care. More complete evaluation information will provide better outcome data for determining the relative success of system-of-care interventions for children with serious emotional disorders.

ANNEX 28: Building in Evaluation from the Start: Excerpt from “Promising Practices: Multi-Level Evaluation Design: California’s Proposition 10”

In November 1998, California voters approved the Children and Families Act, commonly known as Proposition 10, creating a new challenge for us as evaluators in California. The Act imposes a 50¢ surcharge tax on cigarettes and tobacco with the revenues earmarked for early childhood education programs. Proposition 10 funds are given to each of the 58 counties in California, based on the number of annual live births. Because funding is flexible, many new programs have emerged to meet the growing demand for early childhood services.

Proposition 10 requires each county, through a governing commission, to demonstrate results-based accountability. Counties must provide data indicating that the money spent to support programs has indeed had an impact on young children and their families. To document the change resulting from their funded programs, many county commissions have contracted with professional evaluation consultants for data collection and synthesis.

Designed in response to the growing literature documenting early brain development and the infant’s capacity to interpret and categorize the earliest experiences, Proposition 10 has generated considerable excitement for new programs focusing on expectant mothers and children up to age 5. Funded programs work to: 1) improve children’s health, 2) increase parent education and support services, 3) enhance child development and school readiness, and 4) improve systems that will support services for young children. Most counties have funded 10-30 diverse programs across these four program areas.

This diverse set of programs means that evaluation consultants confront the task of developing an evaluation plan that documents the impact of Proposition 10 funding at multiple levels:

- *Contractor level.* Each contracted agency (service provider) that receives county funds must document the impact of its unique service. Proposition 10 funds programs over a three-year period, and contractors must be able to demonstrate the value of their projects in order to secure continued or additional funding from other sources.
- *County level.* County commissions have a broader view of the programs they fund and seek an evaluation design that collapses the diverse programs into a common aggregate framework. The county must address long-range countywide objectives and answer aggregate questions concerning the development of children.
- *State level.* California has developed a statewide evaluation design to which counties must provide required information.

Evaluators are charged to develop an evaluation design that meets multiple evaluation protocols while being neither cumbersome nor duplicative. Our approach has been to build the evaluation design from the ground up as opposed to the top down. We work with each contracted agency to co-develop an evaluation design that responds to its unique program. This grassroots approach consists of the following components:

1. *Ensure contractors fully understand how their project is linked to a common set of goals and objectives.* Many agencies hire professional grant writers to develop a proposal and have limited understanding of how the program is connected to goals and objectives. We spend considerable time working with the staffs of contractors to increase their understanding of evaluation and to raise their capacity to conduct future evaluations.
2. *Provide contractors with an overview of plausible evaluation methods.* This information allows them to select the evaluation method they feel will most likely result in valid data.
3. *Assist contractors to select evaluation instruments and/or design an instrument.* We introduce agencies to standardized instruments and/or tools that are used in similar programs. In many other instances, we work with the contractors to develop an assessment instrument that they feel adequately measures the effectiveness of their program. In either case, contractors tend to assume ownership of their evaluation process, become proficient in evaluation implementation, and enhance data integrity.
4. *Build on contractor’s knowledge of their targeted population.* Typically contractors have experience working with their cultural community. We co-construct the evaluation design with contractors, using their cultural competency and sensitivity. Many excellent programs have been developed to enhance the lives of young children, but have met limited success when replicated outside the original context. Much like strategic planning and program development, the evaluation component must also reflect the ecological reality of the target community.

Building an evaluation design from disparate programs also challenges the evaluator to develop a common framework for county commissions. One approach is to retrofit the multiple contractor evaluations to a common scale. We aim to reconfigure each contractors’ evaluation tools into a 10-point scale. For example, a parent questionnaire with a value of 0-50 is weighted in a 10-point scale, as is a child development assessment that is normally scored on a 0-100 scale. [Table 1](#) exemplifies how we collapse the divergent assessments into a common scoring system for a countywide assessment. Although each program may employ different assessments with different scoring systems, this method enables us to look at the overall effect of all programs. It also allows us to collapse programs based on target population (e.g. Latino/Hispanic community, first time mothers), target geographic area (e.g. zip code), or target service delivery mechanism (e.g. home visitation programs).

| | Common Scale Scoring System | | | | | | | | | |
|--|------------------------------------|-------|-------|-------|-------|-------|-------|-------|-------|--------|
| Contractor Assessment | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Child Assessment (Max Score 50) | 0-4 | 5-9 | 10-14 | 15-19 | 20-24 | 25-29 | 30-34 | 35-39 | 40-44 | 45-50 |
| Parent Assessment (Max Score 100) | 0-9 | 10-19 | 20-29 | 30-39 | 40-49 | 50-59 | 60-69 | 70-79 | 80-89 | 90-100 |

The purpose of a grassroots evaluation design is to include service providers and community members in the evaluation process. By incorporating these key players in the evaluation design, we raise evaluation capacity at the local contractor level, cultivate a new interest in evaluation by local contractors, and redefine evaluation from an obligation to a valued

method for improving service delivery. Although this approach can be labor-intensive and time-consuming, it responds to the multiple levels of evaluation required in Proposition 10, and builds local evaluation capacity, which remains long after we depart.

From Pablo Stansbury, The Evaluation Exchange Newsletter Family Support Issue, Spring 2002.

Annex 29: A Step-by-Step Approach to Programme Evaluation

The process of evaluation may be divided into steps, as follows:

Step 1 • Find out who wants the evaluation done, why, and in what form. Conduct a series of interviews, first with the requester and then with others involved. Identify evaluation priorities. Do not proceed until sufficient agreement is reached among those most responsible.

Step 2 • Determine what are the objectives of the programme. Ask involved persons and analyse programme documents. Do not proceed until sufficient agreement is reached among those most responsible.

Step 3 • Describe the programme at a general level and identify specific activities. Ask the programme director (individually) and a few staff (in group format) who actually deliver services to identify:

- a . the target population;
- b. specific activities;
- c. the process by which persons enter and participate in the programme;
- d . the forms users complete and the materials they have access to;
- e. the methods of storing data on programme users;
- f. the specific programme responsibility of each staff member; outcomes that would serve as evidence the programme's objective had been achieved . Select or design instruments to measure the outcomes.

Step 4 • Select a data-gathering design based upon the purposes or the evaluation and the type of data sought. Consider such factors as time needed, resources, availability and willingness of staff to provide data, and political forces that might affect the evaluation effort.

Step 5 • Develop and implement a plan for collecting and storing the evaluation data . This should specify:

- what data are to be collected;
- how the data are to be collected;
- who is to collect data ;
- when the data are to be collected, *and*
- where the data will be sorted .

Step 6 • Determine if the data collection methods are working as planned. Periodically check data as they come in to ensure that the evaluation procedures are being followed properly. Conduct statistical analyses as needed to determine the extent to which each programme objective was achieved.

Step 7 • Organize evaluation results in a way that will facilitate decision-making related to the valuation. The report may be divided as follows:

- I. Executive Summary (1-2 page s)*
- II. Purpose of the Evaluation (1 page)*
- III. Methods of the Evaluation (2 page s)*
- IV. Results of the Evaluation (6-12 page s)*
- V. Conclusions (1 page)*
- VI. Recommendations (1-2 page s)*

Step 9 • Develop and implement a plan to act on the results of the evaluation . Meet with those who requested the evaluation and discuss how the results can be disseminated to facilitate programme-related decision-making. The discussion should focus on:

- a . what decisions can be made by each of the interested persons?*
- b. how should the evaluation results be presented to each person so that the decision making will be facilitated ?*
- c. how should the results be released to the public, if at all?*
- d . who is responsible for presenting the results to each of the interested parties ?*

Taken from “Some methods: A Step-by-Step Approach to Programme Evaluation,”
Evaluation Newsletter:No 11, September 1990, pp. 1-2.

More details may be found at <http://www.unicef.org/reseval/pdfs/evnews11.pdf>

ANNEX 30: the Government of the United Kingdom's Performance Assessment Framework for Social Services

It is much easier to measure performance if it is part of a national framework of standards. The Government of the United Kingdom's "Performance Evaluation Framework" gives a nice framework for the government to use (from Para 7.17 of *Modernising Social Services*):

Best Value will introduce new performance management arrangements into local government to ensure that best value is achieved. The Department of Health is reorganising its approach to performance management so that it is aligned with and builds upon the local Best Value arrangements. The main elements of local and national performance management activity to be introduced for social services are outlined below:

- local authorities will establish **authority wide objectives** and performance measures. Local objectives for social services will need to reflect the national objectives and the need to meet any Government-prescribed national standards or targets, such as those in the National Priorities Guidance (NPG)
- local authorities will carry out **fundamental performance reviews** of all their services over a five year cycle; the outcomes of these service specific reviews will inform the preparation of local performance plans, and be assessed as part of Joint Reviews
- the local planning process will be supported by information from a new statistical **performance assessment framework**. This will draw together the key statistical information on the performance of social services. The Best Value National Performance Indicators will be central in this framework, supplemented by a number of further performance indicators to give a more rounded and in-depth assessment of performance. The performance assessment framework will provide a basis for a common understanding between central and local government on performance, value for money and resourcing issues in social services, both at overall programme level and in terms of individual local authorities. The performance indicators from the framework will allow authorities to compare their performance on a consistent basis. A similar framework is being developed for the NHS. Taken together, the two frameworks will enable the performance of local and health authorities at this vital interface to be examined, and key issues identified for action. It will be important for social services to have sound and effective information systems in place, in order to have a good understanding of how well they are performing against national indicators and against their own indicators
- **local performance plans** will provide a clear practical expression of an authority's performance. The plans will identify targets for annual improvements against locally defined performance indicators and the National Best Value Performance Indicators reflecting the quality and effectiveness of social services. In those areas where it is judged necessary the Government will also set performance standards which all authorities will be expected to meet

' common understanding between central and local government on performance'

- the Department of Health through the Social Care Regional Offices, with appropriate contributions from the NHS Regional Offices, will carry out **annual reviews** of the social services aspects **of the local performance plan**. These reviews will also provide an opportunity to discuss the delivery of specific policy initiatives, to assess with the NHS Executive local joint working with the NHS, and to pick up any issues from recent SSI inspections and Joint Reviews. We will strengthen the Social Care Regional Offices to enable them to take a more active role in monitoring and reviewing social services performance
- **independent inspection** by the SSI both of individual authorities and on thematic issues across sample authorities will continue, the overall programme being discussed annually with the Local Government Association and the Association of Directors of Social Services. Methodologies for these inspections will increasingly be informed and underpinned by the data in the performance assessment framework
- **joint Reviews** of every authority: the resourcing of the Joint Review programme will be expanded to enable each of the 150 local authorities to be reviewed every five years, rather than every seven years as at present, consistent with the five year cycle of the Best Value regime.

| Social services performance assessment framework | |
|--|--|
| The areas of performance to be covered by the performance assessment framework are shown in the table alongside the definitions for the areas and some example performance indicators. We will consult shortly on the details of the performance assessment framework. | |
| Area of performance: national priorities and strategic objectives | |
| Definition | Examples of possible performance indicators |
| <ul style="list-style-type: none"> • the extent to which local social services authorities (LSSAs) are delivering the national priorities for social care (as set out in the NPG), the national objectives and their own local strategic objectives | <ul style="list-style-type: none"> • the proportion of children looked after who have 3 or more placements in one year • emergency admissions to hospital of people aged over 75 |
| Area of performance: cost and efficiency | |
| <ul style="list-style-type: none"> • the extent to which LSSAs provide cost effective and efficient services | <ul style="list-style-type: none"> • unit costs, composite measures for adult and children's services |

| | |
|---|--|
| Area of performance: effectiveness of service delivery and outcomes | |
| <ul style="list-style-type: none"> the extent to which services are appropriate to need; in line with best practice; to agreed standards; timely; and delivered by appropriately trained staff and LSSA success in using its resources to increase self sufficiency and social and economic participation; to increase life chances of looked after children; to provide safe | <ul style="list-style-type: none"> emergency psychiatric readmissions the proportion of children who were looked after at age 16 still in touch with social services at age 19 the number of households receiving intensive home care per 1,000 households headed by someone aged 75 or over, adjusted by SSA the percentage of inspections of residential homes for adults which should have been carried out that were carried out |
| Area of performance: quality of services for users and carers | |
| <ul style="list-style-type: none"> user/carer perceptions and experiences of services; responsiveness of services to individual needs; continuity of provision; involvement of users/carers in assessment and review | <ul style="list-style-type: none"> delayed discharge from hospital proportion of residents provided with single rooms user and carer satisfaction surveys |
| Area of performance: fair access | |
| <ul style="list-style-type: none"> the fairness of provision in relation to need, the existence of clear eligibility criteria, the provision of accessible information about the provision of services | <ul style="list-style-type: none"> people aged 65+ helped to live at home daycare provision for adults per head of population, adjusted by SSA children looked after per 1,000 population, adjusted by SSA |

Annex 31: Case Study- Community Care of Orphans in Zimbabwe: The Farm Orphans Support Trust (FOST)

by Dr Sue Parry

full text available on website: <http://www.togan.co.za/cindi/papers/paper5.htm>

Introduction

Zimbabwe is a country where for many years the presence of HIV/AIDS as a threat in the country was not only not openly acknowledged, but also was actually strongly denied. The concept of orphans was not an alarming spectre because of the belief that (1) the extended family is always there and that there is no such thing as a real orphan in Africa, and (2) if there ever did exist a problem, the Government would resolve it with orphanages. Now that AIDS is openly acknowledged, the country lacks the resources to deal with what appears to be a runaway situation.

The Programme

The Farm Orphan Support Trust of Zimbabwe (FOST) is a state registered Private Voluntary Organisation. It is a national programme which solicits and facilitates support for children in especially difficult circumstances, particularly orphans, on commercial farms in Zimbabwe. It seeks to avoid costly and culturally undesirable institutional care, by keeping children in their communities of origin.

The overall aim is to proactively increase the capacities of the farming communities to respond to the impending orphan crisis and ensure that systems are in place to protect and care for the most vulnerable individuals. It is not yet a well-established model, with hundreds of foster homes to view and evaluate, though eventually it will become that.

The programme is based on the belief that orphaned children have the best opportunity for development within a family, remaining in their family groups without sibling separation, in an environment that is familiar and where they have opportunity to learn their culture first hand.

To date, FOST has concentrated its efforts in this area by:

- ✚ Researching the problem of orphans on commercial farms
- ✚ Creating awareness at all levels of the magnitude of the coming crisis
- ✚ Enlightening communities of the unrealistic expectations that Govt. could provide orphanages
- ✚ Encouraging communities to identify their problems and possible coping solutions
- ✚ Setting the wheels in motion, networking with other organisations, to develop a national programme of community based care for these children.

Changing attitudes is a lengthy process, particularly in a climate of prolonged denial. For many the idea of fostering non-related children requires a paradigm shift, but we have seen, and are seeing, that it is possible. Cultural sensitivity, open dialogue including dialogue with traditional leaders, community problem solving and most of all, examples of "success stories" of childcare make this paradigm shift possible.

It takes time, and lots of effort, but we believe it is an essential background to the implementation of any such programme.

Furthermore, there is the danger of glibly talking about 'community', but what really is a 'community?' Unless it is inclusive, unless there is cohesion and acceptance and above all a

sense of commitment the one to the other, I do not believe we really have "a community." Community building is another pre-requisite to any successful "community based child care scheme."

If we do not put a lot of effort into these areas, both initially and ongoing, there can only be sporadic success stories and, should external support become limited, the programme runs the risk of failure. Childcare requires long term commitment. There are no easy solutions and certainly no 'blue-print' to adopt, the world has never faced AIDS before.

How serious is the problem in Zimbabwe?

Zimbabwe has a population of approximately 11 million, 47% of whom are 15 years old or younger. An estimated 35% of urban adults and 20% of rural adults, or 1.2 million people, have HIV. Masvingo is most affected, with over 50% of antenatal patients HIV-positive. An estimated 200 000 Zimbabweans have developed AIDS and 90 000 have died from AIDS. It is not yet evident when or at what infection level the epidemic will plateau.

"This is an exceedingly high level and indicates that Zimbabwe is undergoing one of the worst HIV/AIDS epidemics in the entire world. It means that, among those Zimbabweans now over the age of 15 years, more than 1 out of 5 will probably die from this disease and most over the next 10 years." (National AIDS Co-Ordination Programme - NACP).

Numbers of orphans are rising alarmingly. The NACP estimates the orphan population to be growing by 60 000 children per year. By the year 2000, the total number of orphans will have risen to 670 000. By that time 1 in 6 children may be an orphan.

The proportion of orphans in Zimbabwe may peak between the year 2000 and 2005 when it may reach 1.1 million or 1/3 of all children under 15 years of age.

Options for Care

By 1994, 38 registered Institutes in Zimbabwe, operating at a capacity of up to 126%, were catering for 2 794 children. If only 10% of the anticipated number of orphans require institutional care, it would involve some 60 000 children. If one assumes an average of 50 children per institute, Zimbabwe would have to construct over 100 institutes per month for the next year just to cater for those 10%, and the number of orphans is rising yearly.

Formal adoption is not readily accepted because of the cultural beliefs, which mitigate against taking unrelated children into the family. The fear of invoking 'ngozi' or avenging spirits is very prevalent and the highest number of adoptions in any one year in Zimbabwe was 45.

Formal fostering is more acceptable, although it is not common practice to foster non-relations for the same reasons. In total there are approximately 755 formal foster parents caring for just over 1000 children.

The numbers of children traditionally absorbed into extended families, without the involvement of external agencies, is unknown.

The last year has seen much social upheaval in the country. Conditions of poverty, unemployment and illness in Zimbabwe are rising rapidly. A number of factors are contributing to this situation including the effects of the structural adjustment policies, the fall in the value of the dollar, lack of investment, the escalating cost of living, the effects of severe droughts and the emergence of HIV/AIDS. The AIDS crisis has hit at a time when

public resources are at their lowest and per capita expenditure on welfare programmes is declining.

The Agriculture Sector

The economy of Zimbabwe is largely based on Agriculture, Mining and Manufacturing. It has a relatively well-developed infrastructure. Extensive road networks and an effective public transport system contribute to a highly mobile population. Over 50% of the population live in communal lands, 17% in large-scale commercial farms and 3% in resettlement areas. Some 80% of the total population presently derive their livelihood either directly or indirectly from agriculture. In terms of employment, the large –scale commercial farming sector is the largest single employer of labour (currently 340 000 workers) which result in some 2 million people living on farms.

Historically many farm workers (over 30%) are from neighbouring countries, predominantly Malawi and Mozambique, and have married locally, raised families. Second, third and even fourth generations now exist on some farms. For many of them, the links with their country of origin and, in particular, their extended families left behind are very tenuous or non-existent. Furthermore, few have formalised their status and, together with their children, remain "foreigners" – both in the eyes of Government and their peers. The present Land Reform policies are as yet unclear with regard to the status of farm workers and their future. Government expenditure has largely by-passed the farm worker. Provision of facilities for their welfare, accommodation, water, sanitation, health, education and recreational facilities has, for the most part, been left to the responsibility of the individual farm employers. The economic viability of the farming enterprise, as well as the goodwill and motivation of the farmer to provide, has determined what resources are available for development. Consequently, some farming areas are very developed in terms of social amenities and others are appalling.

Farming enterprises are, for the most part, labour intensive and the number of employees on farms, particularly in the cropping areas, tend to be very high.

Farm villages usually comprise a core of permanent workers, many of whom may have been born on the farm and lived there all their lives. The numbers of inhabitants may swell at peak times, when the demand for seasonal labour increases and many of the casual labourers are single women. These women are more often than not from broken marriages, widows, and single mothers, whose circumstances have forced them onto the job market as the sole breadwinner. They move from farm to farm, district to district, in search of employment, supplementing income whenever and however, even through casual sex and with no lack of men prepared to capitalise on their misfortune.

Farm communities often lack cohesion and though the individual families may befriend each other and work together, they seldom function as an interdependent group and initiate community projects themselves.

Accommodation is usually tied to their employment and this contributes to their apparent lack of motivation in community issues.

In the rural communal areas, there exists a well- established system of community leaders with Chiefs, Sub-Chiefs, Elders and Ward Leaders who have varying degrees of familial

relationship with their communities. This is lacking on farms. Instead there exists a work-related hierarchy of managers, foremen, supervisors, clerks and the workers.

Traditional elders play a pivotal role in the Shona culture in terms of negotiation for marriage, arbitration in disputes, moral guidance and cultural heritage. Where there is no reference back to these elders, as on farms, marriages are often not formalised and are loose unions easily dissolved, with abdicated responsibility and occasional abandonment of children.

The absence of these community leaders on farms is being addressed by the introduction of "Farm Development Committees" (FADCO's). These committees are comprised of key permanent members, such as pre-school teachers, farm health workers and community elected members, together with either the farmer or his wife.

FADCO's are tasked to motivate and involve people in their own social programmes such as women's clubs, pre-schools, adult literacy groups, nutrition programmes and to liaise between the people and farm management on farm social and amenity development issues.

These groups will also form the core of Child Care Committees on farms as HIV/AIDS erodes families.

Children of the farm worker, whether they are of permanent workers or of single mothers, are particularly at risk. Absence of traceable extended families, dislocation from familial totem groups, marginalisation from society and of multi-ethnic backgrounds increase their vulnerability.

The formation of FOST was instigated by the plight of one family in precisely the circumstances already alluded to.

Case Study

About five years ago an elderly man with a young woman and four children came looking for work. The man was too old for normal work and was assigned light duties as a "special" worker. The woman was free to work with the other women on the farm. This she did from time to time but she shortly left the farm and was not seen again. All efforts to trace her failed.

It emerged that she was a Zimbabwean who had married a Mozambican who had been repatriated leaving her with four boys. The eldest child, aged seven, was followed by twins of four and a toddler of two years. The woman's association with the old man was simply one of convenience and had no formal status. After she disappeared, he soon left, abandoning the four boys. The farmer sought assistance from the Department of Social Welfare and it appeared that only three options of care were possible:

Institutionalisation of the children. Sibling separation would be entailed as the institutions were at capacity and one child, a twin, was disabled and required special care. This seemed a harsh option for the children.

The farmer could formally foster the children but as Zimbabwean law only permits the fostering of four children, what would become of the many others in similar circumstances when the full impact of AIDS was felt on the farm?

The farmer could build an institute with all the prerequisites to be fulfilled for such care. None of these options seemed appropriate. Another solution had to be found. Eventually the farm health worker and her husband agreed to take in the children on conditions the farmer

provided the shelter, food and clothing and met any other expenses. The children were thus informally fostered and are now well adjusted and integrated into the family with a chance in the future.

The Search for a Solution

The plight of these children and the difficulty in finding a solution, and concern over the coming orphan crisis, prompted us to instigate research into the situation of orphans on farms, current coping mechanisms and attitudes towards foster care.

In August 1995 a national seminar was held to present the findings. The research had shown that an intervention was not only necessary but also feasible. Though there were many cultural problems to be overcome, there was an encouraging expression of support among the national sample of farmers and a high degree of acceptance of the concept of fostering among farmers, key workers, general workers and among the children themselves.

A Steering Committee was elected to carry forward the recommendations for a national intervention and an organization, the Farm Orphan Support Trust (FOST) was constituted. FOST was formally launched in March 1996 with the support of the Ministry of Social Welfare who tasked FOST to work with the Ministry in developing a farm model of community care. In April 1997, FOST received official registration as a Private Voluntary Organization.

The Committee has representation from farmers, the Agricultural Labour Bureau, the General Agriculture and Plantation Workers' Union, a Social Worker from SAfAIDS, the Department of Community Medicine of the University and two NGO's, one of whom is the Farm Worker Programme Manager. It is supported by influential Trustees and has the mandate to co-opt Consultants. The Director of the Dept. of Social Welfare is invited to all meetings.

The Commercial Farmers Union provides accountancy backup, an office at the Headquarters, and access, through its extensive network and infra structure, to all districts nationwide through the offices of the Regional Executives and Farmers' Associations to the farmers and farm workers.

Aims and Objectives were decided on and methods of implementation were explored. These objectives included the following:

ESTABLISH AN INTEGRATED NATIONAL PROGRAMME To support and advocate for orphans and children in need on commercial farms. This involves networking with all the relevant players in this field.

SENSITIZATION AND AWARENESS CREATION amongst farmers, farmers' wives, farm worker communities, policy makers and traditional leaders stressing the extent of the crisis and the necessity for all to respond.

RESEARCH to ensure appropriate intervention.

FACILITATE THE ESTABLISHMENT OF FOSTER CARE SCHEMES ON FARMS.

This involves identifying the need; using existing farm structures such as the farm development committees to facilitate awareness creation amongst the communities and in selection of Child Care Committees; training caregivers, establishing monitoring channels; promoting "community projects" and

disseminating information re: models of care to farmers and farming communities.

REGISTRATION OF ORPHANED CHILDREN.

Registration is essential to identify, amongst other things, the size of the problem, areas of need, levels of support necessary and assistance with relative tracing.

TRAINING PROGRAMMES

It is the intention that FOST will facilitate the training of:

- ✚ Caregivers in aspects of child care and HIV/AIDS education
- ✚ Parents in legal education, inheritance law and writing of wills
- ✚ Community members involved in child care, in laws affecting children, child rights, gender specific programming and resource mobilisation
- ✚ Youth in HIV/AIDS education, vocational and life skills so that they can become economically self reliant
- ✚ Monitors in legal administrative and welfare requirements.

MONITORING

Monitoring will involve community members in Child- Care Committees, representatives of existing services in the area, and the Dept. of Social Welfare or their designate.

FUND RAISING AND DISBURSEMENT

The strategy is to target both national and international donors as well as to identify sources of income and support within the farming communities.

EVALUATION AND DISSEMINATION OF INFORMATION

Where are we now?

Whilst the first two objectives were being developed, and training programmes with the Farm Development Committees initiated, FOST undertook to tackle the research component as a priority. The initial research was replicated in another larger Province of Zimbabwe. It was further decided to deepen the scope of the research and to undertake socio-economic profiles of families already fostering children, to explore further the farm workers' traditional and current attitudes toward fostering, particularly non-related children, to hold consultative meetings with traditional leaders and to talk more to the children themselves.

An enumeration study was also undertaken, together with the Dept. of Social Welfare in selected areas in the Mashonaland Central Province.

Not only did these studies entirely validate the original findings but also many other interesting and useful observations emerged. Most of all the studies demonstrated the willingness of families to care for children, given some support. This willingness is there in spite of cultural fears. However, to overcome these fears and concerns of destabilizing the sanctity and unity of their own extended families, potential caregivers have indicated their preference for informal fostering arrangements. The children would still be incorporated into their homes, or overseen within their original homes, cared for and protected but would not become official members of the family.

The magnitude of the coming orphan crisis in Zimbabwe is such that all forms of acceptable caring community responses must be considered, and legislation will need to address the question of "guardianship." In the situation of informal fostering, who becomes the "Legal Guardian?" Is it the caregiver, or the Department of Social Welfare or its designate? On the farms, is it the caregiver, the community or the farmer?

Should the terminology be reduced to "Guardian" when the situation arises requiring signatories for documents, indemnity forms for school trips etc?

Legal provisions need to be considered to safeguard the rights of the child and the caregiver. For children on the farms without identifiable relatives to assume responsibility for them, very few options exist for orphans at this time.

Models of Care

Based on the research a five-tier response is envisaged for the farming community, in line with the following principles:

- ✚ The voluntary aspect must be emphasized at all times and at all levels. No farmer, farming community or caregiver should be forced or coerced into response.
- ✚ Motivation must be genuine because childcare is a long-term response. No person must seek financial reward for his or her efforts.
- ✚ Children should be reunited with their own family members wherever possible.
- ✚ There should be minimal disruption for the children and no sibling separation.
- ✚ Vulnerable children to be absorbed into known family units with preservation of culture and identity.
- ✚ Community involvement and participation is essential at every level from planning to monitoring.
- ✚ Monitoring is an essential component and should involve sensitized committed people from community level to dept. of Social Welfare personnel or their designate.

Five Levels of Priority Care

LEVEL 1: The Extended Family

This is the preferred strategy of care for orphaned children and every reasonable attempt must be made to trace relatives.

The extended family on the farms however needs support and must be included in any intervention to assist orphans and children in need.

Furthermore it must be borne in mind that children may be absorbed into HIV positive households, given the high sero-prevalence in existence, and the children may be subject to repeated grief and uncertainty. By including them in support programmes some of these problems may be partially alleviated.

LEVEL 2 : Substitute or Foster care families.

Vulnerable children, particularly those without traceable extended family, are absorbed into known, non-relative family units after careful caregiver selection.

Fostercare will be on an informal basis, taking cognisance of traditional norms, and ensuring the children are appropriately cared for, protected, supported and monitored.

LEVEL 3 : Family Type Group.

This level of care consists of paid foster mothers living together with small groups of orphans within the community: quasi-substitute family.

LEVEL 4 : Child-Headed Households.

This level consists of adolescents caring for younger siblings, preferably within the family home, with the support of the community.

LEVEL 5 : Orphanages.

As a last resort, when all other options are inappropriate, there is a place for orphanages.

The situation of babies and very young children needing care may fall into this category of care until alternative solutions can be found for them.

All levels must be adaptable to the needs and resources of the farm, farmer, community and geographical region, as well as the level of commitment of the communities involved.

By linking into already established infrastructure, the programme can be cost effective and sustainable. The wider the awareness, the greater will be the reservoir for response.

Registration

The next priority that the FOST Committee tackled was registration. It was felt that it is necessary to establish the extent of the problem and to map out areas of most need in order to allocate resources appropriately.

Orphan registration is only beneficial and efficient if the data is timely and accurately collected, updated and monitored with minimal cost and total commitment. To this end FOST developed a system whereby each individual farm has its own registration book on site, one page per orphan, so that minimal delays occur between orphanhood and registration. Minimum cost is involved in data collection – an envelope and stamp with the enclosed registration form from the farm- and up to date information should be available at all times. The information is being data banked at the CFU Headquarters on a special computer programme designed for this purpose. To date 43% of all farms in Zimbabwe have received a registration book and training on data collection is ongoing.

The Way Forward

Since its inception, FOST has been run on an entirely voluntary bases. However the programme is growing daily as the needs arise and the problem of orphans continue to emerge. FOST has largely concentrated on a facilitatory role in putting in place a mechanism of support for orphans. There also remains the question of the huge welfare support needed. General community mobilisation and development issues are important, but they take time, whereas orphans' needs are often immediate and the actual support given must be sufficient to make a difference for them. By simply being included as "orphans" in overall community development programmes, the orphaned children run the risk of being sidelined. Their needs are specific and require special care and attention. But how best to sustainably meet these needs and by which route of service delivery?

Thus in March 1998, a further seminar was convened to plan a way forward.

Consensus was reached that there is now need for programme expansion, with the employment of full time staff, to investigate these issues through different models of care and service provision. This would be achieved through linking into different organizations; already operational within the farming community and with whom FOST is already cooperating, and being flexible and adaptable to the differing needs and resources of the various areas. The aim is long term sustainability, local ownership and reduced dependency on external personnel and funding.

It was decided to employ a Coordinating Director and Field Officers to work intensively in three of the eight Provinces where the Farm Worker Programmes are most advanced, and where there is the highest concentration of farm workers. The modus operandi of service delivery will be different in each province and will be constantly evaluated and documented over the next three years. This could provide the information, appropriate models and experience needed for ultimate development in the remaining five provinces of Zimbabwe. Innovative forms of funding from Industry and Commerce are being explored. The identification of potential areas of indirect Government support, such as free education and healthcare for orphans, and the introduction of tax credits, are other areas to be pursued. Local initiative is also being widely encouraged. Competition for international resources will increasingly outstrip the supply as the impact of AIDS escalates worldwide.

Summary

The FOST programme can thus be summarized as having four aspects:

- ✚ The Structural: this is a skeletal organization with a largely facilitatory role in awareness creation, networking, and in developing community care for orphans, and children in need, on commercial farms
- ✚ The Farm Worker Community who will continue to care for their children and will, in innovative ways, contribute to their corporate upbringing
- ✚ The Farmers who can provide many of the necessary resources essential to the well-being of children
- ✚ The Agricultural Industry and the Society at large who have a corporate responsibility to assist in meeting the cost of raising the orphan generation. It is everyone's responsibility.

Conclusion

The problems of orphans and children in need are there and will escalate. The children deserve a chance, if only an equal chance to that of their non-affected peers. Not only do they deserve a chance but we must do all we can to ensure that the crisis which occasioned their orphanhood is not repeated in the next generation.

There is no doubt that both in human development and financial terms, the cost of care now will be less than the price society will ultimately pay for the neglect of these children to the streets, the bush or their life in institutions.

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