DRAFT Version 1 for Field Testing

World Vision

Community Care Coalitions
A World Vision Project Model

GUIDANCE FOR INTEGRATED PROGRAMMING

World Vision is a Christian relief, development, and advocacy organisation dedicated to working with children, families, and communities to overcome poverty and injustice.

As followers of Jesus, World Vision is dedicated to working with the world's most vulnerable people. World Vision serves all people regardless of religion, race, ethnicity, or gender.

Contents

Overview

What is this model?

The *Community Care Coalition* (CCC) project model is the foundational community structure for supporting various possible types of programming to ensure sustained child well-being for the most vulnerable boys and girls at the local level.

The *CCC* project model, originally part of World Vision's Hope initiative, seeks to strengthen community-led care and support for orphans and vulnerable children (OVCs). *CCCs* are formed by joining key community stakeholders into a coalition to identify OVC-related issues within the community and to develop and prioritise action plans for responding to these issues. *CCCs* normally recruit and supervise home visitors (HVs), who are trained by WV staff, to make visits to the homes of OVC and to provide essential forms of care and support.

The *CCC* project model may work with community groups mobilised by World Vision as well as pre-existing groups that World Vision may work with and through.

The *CCC* model may be adopted as a foundation for other types of programming options. For example, *CCCs* could support a community health worker (CHW) project aimed at bringing Timed and Targeted Counselling (ttC) around health and nutrition messages into households.

What are the primary target groups for this model?

The primary target group for this project model are *CCC* members and home visitors. Secondary target groups are the OVC, between 0 and 18 years of age, and their families.

What are the expected benefits of this model?

The project model's goal is to achieve improved quality of life for the most vulnerable boys and girls in a community.

When should this project model be considered?

The *CCC* project model is flexible and can be implemented in various contexts, including both urban and rural communities. The model may not, however, be appropriate in a conflict setting, but may be useful in rebuilding communities in post-conflict settings.

What are the main elements of this model?

There are at least three aspects to the *Community Care Coalitions* project model:

1. Mobilising and strengthening of a community-led response to protect and care for the most vulnerable children and their families

2. Improving community capacity to secure resources for the care and support of OVC, and

3. Improving the coordination, collaboration, and advocacy of the community in which OVC live.

Executive Summary

The *Community Care Coalition* (CCC) project model was originally conceived and developed as part of an overall strategy within World Vision's Hope Initiative to strengthen community-led care and support for orphans and vulnerable children. In this context, *CCCs* were formed by joining key community stakeholders into a coalition to identify issues within the community related to orphans and vulnerable children (OVC), and to develop prioritized action plans for responding to these issues. Within the Hope Initiative, *CCCs* normally recruited and supervised home visitors. Home visitors were trained by World Vision (WV) staff to make visits to the homes of OVC to provide essential forms of care and support.

The *CCC* project model (including the home visits) formed the 'core' of Hope Initiative OVC programming. Along with this core, community-level programming was often supplemented within Hope Initiative projects by bringing in additional models aimed at the household level (i.e. life skills for children and youth) and creating an enabling environment level (i.e. capacity building for government). While these additional programming elements often formed part of OVC projects, they are supplemental to the *CCC* project model and are not discussed in this document.
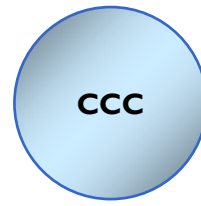
The *CCC* project model does, however, enable a widening of the range of activities carried out by the *CCC* beyond community mobilisation and the supervision of home visits, to include advocacy related work, or participation in a "Community Conversations" initiative. The application of advocacy components, specifically to the work of the *CCC* is included in this document, as the involvement of a *CCC* in advocacy efforts responds to the structural causes of the various types of vulnerabilities that *CCCs* seek to address. Although not all projects will incorporate an advocacy model within a *CCC* model, the projects that do (or those *CCCs* that engage in advocacy work) will be broadening the scope of their objectives and working with an set of objectives, outcomes, and indicators.

While World Vision has historically worked to mobilise and build the capacity of *CCCs* in high HIV and AIDS prevalent countries across east and southern Africa, the model is, in fact, appropriate for most contexts to stimulate community-led child care initiatives, with a focus on the most vulnerable children, in a sustainable way. The evolution of the *CCC* project model has been such that the *CCC* is now seen as the necessary prerequisite community structure needed to support various types of programming options. The *CCC* model can be more broadly defined as a community structure established for home visitation, meant to target vulnerable boys and girls, regardless of the nature of the vulnerability (thus including but moving beyond the HIV and AIDS context). As such, the *CCC* model can be used and integrated with other programming. For example, the *CCC* model could support a community health workers' project aimed at bringing Timed and Targeted Counselling (TTC) around health and nutrition messages into households.

The *CCC* structure is intended to be flexible and adaptable to local contexts. On the ground, the *CCC* has taken a variety of forms, and *CCC* activities have been carried out in a variety of ways. In addition to *CCCs* that are mobilised and trained by World Vision, there has been an increasing emphasis on working with, and through, pre-existing community groups, councils, and committees as appropriate for the type of project being carried out, as opposed to mobilising a new group. The name *CCC*, then, may be applied both to those community groups mobilised by World Vision, as well as the pre-existing groups that projects choose to work with and through.

The figure below illustrates the role of *CCCs* to ensure sustained, local, community responses for the protection, care and support of the most vulnerable children at the community level. This figure shows the links between the *CCC* and key stakeholders, including government and other local partners.

Structure

CCC

Programming

| Home visits for OVC (HIV and AIDS projects) | Home visits for most vulnerable boys and girls | Timed and Targeted Counseling thru CHWs (H/N projects) |
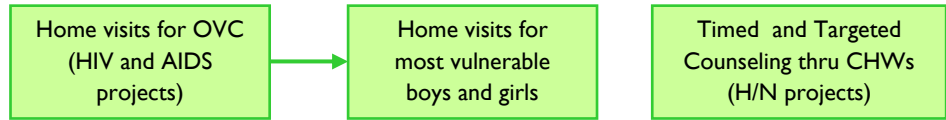
Acronyms

ADP	Area Development Programme
AIDS	Acquired Immune Deficiency Syndrome
CBO	Community-based Organisation
CHAT	Congregational Hope Action Teams
CHW	Community Health Worker
CoH	Channels of Hope project model
CWBO	Child Well-being Outcomes
FBO	Faith-based Organisation
GIK	Gifts-in-kind
HIV	Human Immunodeficiency Virus
HV	Home visitors
IPM	Integrated Programming Model
NGO	Non-Governmental Organisation
OCB	Organisational Capacity Building
OVC	Orphans and Vulnerable Children
PLWHA	People Living With HIV and AIDS
TTC	Timed and targeted counseling project model
UNICEF	United Nations Children's Fund
WV	World Vision
WVI	World Vision International
VCT	Voluntary Counselling and Testing

Community Care Coalitions project model

1. Specific child well-being outcomes to which the model contributes

The *Community Care Coalitions* project model is the foundational community structure for supporting various types of programming to ensure sustained child well-being for the most vulnerable boys and girls at the local level. Depending on the nature of the programming that *CCCs* are organising and overseeing, the work of the *CCC* may contribute to any, or all, of the four child well-being outcomes (CWBO). The work of a *CCC* overseeing the timed and targeted counseling by community health workers project model, for example, will contribute, most specifically, to the child well-being outcomes under the impact area, 'Children Enjoy Good Health'. On the other hand, a *CCC* that recruits and supervises volunteers to make visits to the homes of vulnerable boys and girls, according to the home visitor training developed within the Hope Initiative, seeks to provide essential care and support to these children in a multi-sectoral and holistic way and, so may impact all of the child well-being outcomes. The table below aligns community health worker and home visitor activities to the four impact areas of the CWBO. The *CCC* project model thus potentially contributes directly to all four impact areas.

TABLE 1: Project model contributions to the child well-being outcomes		
Outcome	**Contributions**	*Community Care Coalitions*
Children enjoy good health	• Timed and Targeted Counseling • Child monitoring: health and nutrition • Access to health services • Access to social grants	• Community health worker • Community health worker / home visit • Community health worker / home visit • Home visit
Children are educated for life	• Child monitoring: education • Access to education • Access to vocational education	• Home visit • Home visit • Home visit
Children love God and their neighbors	• Psychosocial support	• Home visit
Children are cared for, protected and participate	• Birth registration • Inheritance rights • Protection from abuse	• Child health worker / home visit • Home visit • Home visit

2. Context characteristics in which the model *should* and *should not* be considered

The *CCC* project model is flexible and can be implemented in various contexts, including both urban and rural communities. The model may not, however, be appropriate in a conflict setting, but may be useful in rebuilding communities in post-conflict settings.

Context	Yes/No
Rural	Yes
Urban	Yes
Conflict	No
Post-Conflict	Yes

3. Advocacy component(s)

An advocacy component may be incorporated within a *CCC* model, so that *CCCs* broaden the scope of their objectives and work with an additional set of objectives, outcomes and indicators. While core *CCC* programming involves community mobilisation and engagement in issues related to the most vulnerable boys and girls, it will frequently be the case that the impact of the *CCCs'* activities can only be maintained if efforts are made to address the underlying causes of the vulnerabilities that *CCCs* seek to address. This is the purpose of advocacy-related work, and it is therefore recommended that *CCCs* add advocacy to their overall responsibilities as soon as they have the capacity.

Local level, child-focused, advocacy can be an important role of the *CCC*. In the context of social protection, for example, the role of *CCCs* in the area of advocating for access to local services. *CCCs* can ensure that child protection is effective at local level and that advocacy issues are linked with other *CCCs* up to district and national levels.

The ***Organisational Capacity Building*** guide, that was developed to strengthen *CCC's* capacity, includes one section on networking and advocacy in order to strengthen this important area of *CCC* operations.

Key considerations for WV local level staff when bringing an advocacy component into *CCC* programming:
- o Training of WV staff and *CCC* members in advocacy, including child protection
- o Assisting *CCCs* with accessing the key information they need to enable them to advocate effectively (i.e. government policies, local statistics, etc.)
- o Assist in ensuring linkages of key local advocacy issues to district, provincial, and national level.

4. Recommended partners

TABLE 3: Recommended key partners	
Partner	**Key partnership roles**
Community level	• All the various stakeholders (individuals or institutions) directly or indirectly involved in caring and supporting children, (e.g. traditional leadership, government extension workers, CBOs, schools, health institutions, women's groups, business communities, FBOs, etc.) • Children of various ages, youth • Households impacted by vulnerability factors
District level	• Offices of associations coordinating activities that affect the lives of children • District authorities – local government and other relevant authorities • FBO district offices, NGOs, district business associations, other relevant bodies that exist at the district
National level	• Government ministries • Multilateral organisations such as UNICEF, • FBO mother bodies • International NGOs

5. How will the model include/impact the most vulnerable?

The model has been designed so that the participation of the most vulnerable, in other words, the participation of those who will be the primary beneficiaries of the project, takes place at various stages.

Participation of vulnerable groups:

- o The "Guide for Mobilising Community Led Care of Orphans and Vulnerable Children" (the manual to guide staff in mobilising a *CCC*) includes various methods and activities for child participation and for targeting the most vulnerable (e.g. child walkabout, community activity wheel, etc.).

- o Membership and leadership of the *CCC* is made up of various stakeholders including youth and representatives of vulnerable groups (i.e. HIV-positive individuals, orphaned or disabled children, widows, etc.).

Definition of 'most vulnerable':

- o The definition of "the most vulnerable" is contextualised. Certain vulnerable groups such as double orphans and disabled children are clearly singled out in the definition process to enable the facilitator to guide the community. But the ultimate definition is determined during a stakeholders meeting where a broad range of community members participate.

Clearly defined criteria and process for identifying the most vulnerable:

- o Identification criteria of the most vulnerable is agreed upon by the community and later documented for wider sharing within the community through churches, other FBOs, and community gatherings.

- o A simple monitoring system, with easy to use forms for the various stages of the process, has been developed. These will help collect data that will inform the *CCC* as to who is participating.

- o Regular feedback is given to the *CCC* by home visitors to ensure the most vulnerable are benefiting.

Home visitors caring and supporting the most vulnerable:

- o The model is based on community volunteers. Home visitors who volunteer to identify and visit the most vulnerable live within the community, enabling accurate identification of the most vulnerable:

Capacity building of various stakeholders:

- o Capacity building in the form of training, mentoring, field visits, and some provision of resources is carried out with the relevant stakeholders in the community.

- o When capacity is built, the stakeholders, including the vulnerable, will be able to advocate for services and support.

6. How does the model promote gender equity?

Gender has been mainstreamed in leadership, home visitor identification, home visits, *CCCs* and home visitor curriculum. It is a topic included under *CCC* mobilisation.

7. How does the model promote empowerment and sustainability?

Focus on well-being of children and families in the community:

- o The *Community Care Coalitions* project model primary objective is to improve the well-being of children and families in the community. From assessment, to the formation of the *CCC*, the process places the children as the central focus. This is reinforced by the key role of the *CCC* which is monitoring the well-being of children and their families.

Children empowered as agents of change:

- o Child participation is key in the process of implementing the *CCC* model. Using the tools included in the "The Guide for Mobilising Community Led Care for OVC," the facilitator is given methods to enable the participation of children. Capacity building activities are also tailored to suit the children's needs and skills.

Transformed relationships:

- o The *Community Care Coalitions* project model transforms relationships by bringing the community to a place where they start talking about issues around children. Both those directly, and indirectly, involved come together to care for the children. The improved well-being of children brings them greater dignity, which is a platform for improved relationships based on equal access and love.

Interdependent and empowered communities

- o The *CCC* project model emphasises building both the technical and organisational capacities of the various stakeholders in the community. This capacity building process is a strong citizen empowerment process.
- o A multi-sectoral approach is taken to assess the needs of the children and to respond to the inter-linked needs. The *CCC* creates a cycle of linkages in which many types of stakeholders play a role.

Transformed systems and structures

- o The *CCCs* that engage in advocacy related activities will be working at the level of the systems and structures that form the underlying causes of the vulnerabilities experienced by children and families in the communities. Advocacy victories are meant to transform these systems and structures so as to minimize or do away with these root causes.

8. Recommended project timeline

The *CCC* project model has a number of stages as summarised in the table below. It is important to note that while the each activity represented in the table is necessary, while ongoing staff mentoring of the *CCC* members is equally important.

TABLE 4: Recommended project timeline			
Activity	**Time**	**Facilitators**	**Comments**
CCC training for staff (Focus on CCC mobilisation)	5 days	Africa HIV and AIDS Team	Training has two parts: • Mobilising *CCC* • Strengthening *CCC* in technical capacities
Staff mentoring in CCC mobilisation	3 days	Africa HIV and AIDS Team	• Staff are mentored in the field by a trained trainer. After mentoring, staff start mobilisation and strengthening *CCC*
Staff conduct preliminary institutional mapping	Up to 1 month	Trained ADP staff	• This is partner identification and partnership building time at district and community level
Community stakeholders meetings	Up to 3 months	Trained ADP staff	• Very critical moment of assessing the problem as it is perceived by the community. Children participate. Facilitator helps community see the need to find solutions and systems to respond to the problems affecting most vulnerable boys and girls
CCC formation	2 days	Trained ADP staff	• Community facilitated to develop systems and structure that will enable community to coordinate care and support of most vulnerable children and their families. *CCC* develops an action plan and identifies interim leadership
Technical capacity building of CCC	1-3 days (One training per quarter, ongoing)	Trained ADP staff, or partners with expertise in the technical area(s)	• Technical capacities that enable the *CCC* model to provide care and support to most vulnerable boys and girls. • (e.g. identification of home visitors, vulnerable children and households, psychosocial support, health and nutrition, etc.)

Organisational Capacity Building (OCB): staff training	8 days	Africa HIV and AIDS team	2 parts of training: • Organisational self-assessment, • Organisational capacity building • Staff field mentoring in OCB
Organisational Capacity Building with CCCs: Organisational self-assessment	3 days	ADP staff trained in OCB	• A series of OCB self-assessments are conducted for each CCC • An improvement plan is developed at the end of the self-assessment.
Reviews and ongoing mentoring of CCC	2 days	ADP staff trained in OCB	• CCC reviews the progress on improvement plans • ADP staff provide ongoing mentoring of the CCC in both technical and organisational capacity.

9. Potential roles for WV at different periods in the project timeline

TABLE 5: Role of World Vision staff	
Activity	**World Vision Role**
CCC training for staff (focus on CCC mobilisation)	• Participants in the CCC training
Staff mentoring in CCC mobilisation	• Recipients of the mentoring
Staff conduct preliminary institutional mapping	• WV staff facilitate the process
Community stakeholders meetings	• WV staff facilitate the process
CCC formation	• WV staff facilitate the process
Technical capacity building of CCC	• WV staff facilitate the process • Provision of minor resources to support home visitors
Organisational Capacity Building (OCB): staff training	• WV are both participants and trainers
Organisational capacity building with CCC Organisational self-assessment	• WV facilitates • Provision of minor resources to support CCC mentoring process
Reviews and ongoing mentoring of CCC	• WV staff mentor the CCC
Staff conduct preliminary institutional mapping	• Participants in the CCC training

10. Guidelines for adaptation of the model to the local situation

What TO do:

o Conduct a one day orientation of senior staff at the national office.
o Build a capacity building team at the national level.
o Conduct training and mentoring of staff in CCC mobilisation and strengthening in the respective national offices before rolling out.
o Deal with cultural and structural issues related to the model during staff capacity building.
o Conduct institutional mapping of relevant individuals and institutions.
o Develop messages for awareness raising among identified key stakeholders.
o Raise the key stakeholder's awareness about the CCC project model at the national and district level.
o Conduct a staff review meeting to identify possible entry points into the community. Draw on information gathered during mapping exercises and meetings with key stakeholders.

- Define the most vulnerable boys and girls according to the local context.
- Form *CCCs* and build capacity of *CCC* members, as outlined in the table in section 4.

What NOT to do:
- Implement the *CCC* model without ensuring national office understanding and buy-in.
- Implement the *CCC* model without involving other key stakeholders at local and district levels.
- WV staff determines the type of *CCC* structure for the community.
- Build capacity of project staff without orienting national office and programme staff.
- Provide services without building the capacity of *CCC* members and other stakeholders.
- WV staff defines OVC or vulnerability.
- Increase or initiate stigmatising of vulnerable groups by singling these groups out in ways that cause embarrassment or discomfort.
- Train staff and *CCC* members without follow-up mentoring.
- Form too many *CCCs* at once.

11. Recommended objectives and indicators (for both monitoring and evaluation)

Although it is possible to track input and activity indicators, this can result in a burden of paperwork. It is normally sufficient to track output, outcome and goal indicators.

- **Output and outcome level:** The formation of the *CCC* and the building of the capacity of the *CCC* to oversee home visitor programmes (or CHWs programmes in cases where *CCCs* are involved in health and nutrition programming) will result in outputs and outcomes. This is because a *CCC* is a necessary prerequisite structure in order to oversee programming that will lead to ultimate impact.
- **Home visitors and community health workers impact level:** The impact of the *CCC* model is realised through home visitations and outreachs that the *CCC* oversees; namely the home visitations that provide care and support for the most vulnerable boys and girls, or the CHW programmes aimed at providing timed and targeted counseling around health and nutrition in households.

12. A sample logframe for WV's contribution to this model

TABLE 5: Project model logframe		
Objective	**Indicator**	**Data source**

Goal: Improved quality of life of orphans and vulnerable children in the project area	Standard Outcome Indicator
	 • Number of OVC reached through project interventions
	 • Number and percent of identified OVC that have:
	   • **Education**: In school or appropriate vocational education
	   • **Nutrition**: Adequate nutrition according to national standards, or at least as much food as normal for children in the community
	   • **Care**: Are being visited regularly by caring community member who monitors and assists child and family
		• Baseline/Midterm/
		 • Final Surveys
		 • HV Records
		 • *CCC* Records
		 • OVC Registers

Objective 1: Mobilized, strengthened and supported community-led response to	• Number of CCCs formed and functioning • Number of home visitors trained • Number of home visitors that received home-based	• WV training records • *CCC* meeting reports/minutes

protect and care for the most vulnerable boys and girls and their families	care training	*CCC records*
	• Percent of CCCs that receive material support	• *CCC work plans*
	• Percent of home visitors who receive material support	• *OVC registers compiled by CCCs and home visits*
	• Number of home visitor support groups formed	• *Home visit records*
	• Number of meetings of home visitor support groups	• *CCC meeting reports/ minutes*
	• Percent of home visitors who report they are coping well with psychosocial effects of work	• *CCC records*
	• Number of community centers formed	• *CCC work plans*
	• Number of organized events at community centers	• *OVC registers compiled by CCCs and home visitors*
	• Value of GIK received	• *Home visit records*
	• Number of beneficiaries receiving GIK	• *Procurement records*
	• Percent of home visitors who participate in additional accredited trainings	• *Distribution tracking system*
	• Percent of home visitors who receive nationally-recognized credential	• *Social worker work plans*
	• Percent of home visitors who enter salaried workforce	• *Social worker reports*
	• Number of beneficiaries who use WV transport to access treatment	
	• Number of OVC cases handled by a social worker	
	• Number of home visitors providing continuous service to OVC	
	• Number of OVC visited by home visitors	
	• Percent of home visitors who demonstrate knowledge of key OVC needs	
	• Number of home visitors providing continuous service to PLWHA	
	• Percent of home visitors who demonstrate quality care giving skills	
	• Number of children and youth participants at community center events	
	• Number OVC accessing entitlements through a social worker	
Objective 2: Strengthened community capacity to secure outside sources of funding for the care and support of most vulnerable boys and girls	• Percent of *CCCs* who receive WV cash advance for OVC activities	• WV training records
	• Percent of cash advances *CCC* recipients successfully manage	• WV accounting records
	• Percent of *CCCs* who submit proposals for small WV grants	• *CCC proposals*
	• Percent of *CCCs* who receive small WV grants	
	• Percent of small grants *CCC* recipients successfully manage	
	• Percent of *CCCs* who meet and collaborate with ADP committees	
	• Number of *CCCs* participating in organisational capacity building	
	• Percent of *CCCs* accessing outside funding for OVC care/support	
Objective 3: Improved enabling environment that actively supports care for the most vulnerable boys and girls and their families (at the local, district and national levels)	• Number of coordination meetings at local (community) level	• Minutes of meetings
	• Number of government-linked district/municipal/provincial coordinating committees formed and/or strengthened with project support	• CCC records/reports
	• Percent of CCCs sending representatives to district/municipal/ provincial coordinating meetings	• WV training records
		• "Coordinating structure" reports and minutes
		• Project advocacy plans and records

	• Number of trainings carried out with district/municipal/provincial coordinating committees • Percent of identified district/municipal/provincial coordinating committees accessing outside funding for OVC activities • Number of coordination meetings at national level attended by WV staff • Number of community structures (*CCCs*, CHATs, children's clubs) that have identified an advocacy issue (dealing with systems, structures, policies, cultures or practices) and are discussing these issues with local authorities, local leadership, service providers, or the general community through different forums like meetings, presentations etc. • Qualitative description of policy or advocacy issues identified, action taken by the various community groups, or involvement of community groups in any outcomes	15

13. Critical success factors for the model

- o Buy in of senior management team at the national office
- o There should be a capacity building team at the national level with a point person.
- o The programme team should be oriented to this model. ADP managers are important to the success of the *CCC* project model, so they need a thorough orientation.
- o Train facilitators in mobilisation and strengthening of the *CCC* project model.
- o Service provision should come later in the *CCC* project timeline. Providing services at the beginning destroys the element of ownership.
- o Organisational and technical capacity should start at the beginning of the programme. These should be part of the design.
- o Partnerships are important in the capacity building of *CCC*. Develop partners at community, district, and national levels.
- o The district should be in the coordination role from the beginning.

14. Risks to consider during project implementation

Donor demands:

- o The *Community Care Coalitions* project model takes time to implement effectively. This may be an issue if the programme is donor funded, and the donor wants to see results within a short period of time. If this happens, programme staff may try to use short-cuts to meet donor demands.

Meeting urgent needs of children:

- o Due to the emergency-like situation of many of the most vulnerable boys and girls, programme staff and donors may rush to provide services instead of empowering the community to do things on its own.

Perception of *CCC* as an HIV and AIDS model:

- o The *CCC* project model may be perceived as an HIV and AIDS model, resulting in lack of interest and perceived relevanceby staff from other sectors.

Moving staff to other departments and staff turnover:

- o As the organisation grows, staff are moved from one position to another and some may leave the organisation. This turnover creates gaps in trained personnel at the programme and national levels.

15. Summary of implementation methodology

The *CCC* project model is implemented using a participatory approach. World Vision staff play a facilitation role. The methodology has a number of activities and stages which includes:

o Employ qualified staff for the national office and programme level.

o Train staff:

   ▪ The staff employed will first be trained in *CCC* mobilisation and *CCC* technical capacity building, focused on the care and support of the most vulnerable boys and girls. This will be followed by training in the organisational capacity building of the *CCC*.

   ▪ Staff will be trained as facilitators within their countries. During this training, two or three individuals are selected depending on their performance and ability to train others. Later, they are trained and mentored as Trainers of Trainers by regional technical advisors. Once the mentoring is completed, the Trainers of Trainers supports training and mentoring of facilitators in their respective countries. This also improves the quality of facilitation at the programme level. The technical advisor, together with the trainer develops a mentoring plan which is reviewed annually.

o Conduct *CCC* capacity building strategy for the national office:

   ▪ With the trained team of trainers and facilitators, the national office leadership develops a capacity building strategic plan. This activity is best done after the staff have understood the *CCC* concept and the process of *CCC* capacity building.

   ▪ Develop roll-out plans.

o Mobilising *Community Care Coalitions*: This is the first stage in mobilising community-led care for the most vulnerable boys and girls. It is made up of five steps.

   Step One: Conduct a situational analysis to:

   • Understand how HIV and AIDS, and other vulnerability factors have impacted the children and the community

   • Identify responses currently being implemented, and

   • Identify key stakeholders at the district and community levels who may be potential partners, provide technical support, advocacy, referral and other social linkages.

   ▪ Preliminary institutional mapping is conducted at this stage and takes one to three months.

   This process starts at the district level and continues to the community level. A mix of participatory methods is used.

   ▪ **Child Participation**: The process engages children from the beginning by using methods such as "Community Walkabouts".

   ▪ **Conduct stakeholders meetings:** This may take several hours or one to three days.

   The facilitator meets with community stakeholders to assess the situation of the most vulnerable boys and girls in the community. These meeting are held according to sectors and categories of stakeholders to ensure maximum participation. The obvious vulnerable groups (families of the sick, OVC, disabled, the old, child-headed households, and some women) are key informant groups during the stakeholder's meeting. Children are also involved by using various participatory methods. As vulnerable groups are often not involved in the decisions that affect them, stakeholder meetings aim to ensure that all affected groups participate. Examples of stakeholders invited to the meetings include:

   • Local business people

   • Support groups

   • Government representatives

   • Most vulnerable boys and girls

   • Parents/guardians of the most vulnerable boys and girls

- Youth groups
- Association members (i.e. women groups)
- Traditional leaders, and
- Faith based organisations.

The realisation of the magnitude of the problem often results in a strong felt need by the stakeholders to take action. The desire to respond is not a response to WV programming but a genuine need to care and support the children that have been impacted by a multitude of vulnerability factors.

Step Two: Designing a structure and systems to coordinate and implement *CCC:*

- At the community meeting, the members agree on a structure and systems that will be used to coordinate the care and support of the most vulnerable boys and girls in their community. These decisions depend on information collected and analysed during the stakeholder meetings and build on existing structures in the community. This is the point when the *CCC* is formed or when an existing structure is adopted to coordinate the care and support process. The structure is identified strictly by the community.

- The facilitator ensures the new structure has interim leadership to carry on the new coordination tasks until the *CCC* holds democratic elections to choose leaders.

Step Three: Developing criteria for identifying home visitors and vulnerable boys and girls:

- World Vision facilitates a process of identifying and registering home visitors and vulnerable boys and girls. This stage starts with community identification of vulnerable boys and girls, and later defining home visitors. The community then identifies criteria for selection and registration. The *CCC* uses monitoring forms designed by WV. The facilitators helps *CCC* members understand the forms, how to collect information, and how to use the information from the forms.

- This meeting ends with the *CCC* members developing an improvement plan. WV may support some activities in the plan and refer some to other stakeholders at the community and district level.

Step Four: Building capacity of the *CCC:*

The *CCC* goes through training and long-term mentoring by WV facilitators.

- **Building technical capacity of the CCC, home visitors, OVC, and their families:** The training mainly focuses on the skills of the *CCC* and home visitors, so they are able to provide care and support to the most vulnerable boys and girls (e.g. psychosocial support, home-based care, child protection, gender, and HIV and AIDS).

- **Facilitating the CCC to do its own organisational self-assessment:** This is conducted a year into the *CCC* project. The process takes three to five days. The self-assessment ends with a revised improvement plan.

- **Conducting training and mentoring of the CCC in module training:** Module training is one of the follow-up actions to the organisational self-assessment improvement plan. In line with the theories of adult learning, the facilitator provides ongoing mentoring to the *CCC*.

- **Provision of minimal resources to the CCC:** After the *CCC* has been trained in certain organisational capacity building modules, minimal financial resources for ongoing capacity building may be given. These resources will be used by the *CCC* to implement some tasks from the organisational capacity training. The amounts may increase over time provided there is accountability on how the funds are used.

- **WV staff start handing over responsibilities to the CCC:** Many tasks and responsibilities handled by the facilitators are gradually handed over to the *CCC*. By the end of year five the *CCC* should be able to operate on its own with little support from WV.

- **Conduct an organisational self-assessment:** A self-assessment will be conducted after a year to review the *CCC*'s progress and contribution to the most vulnerable boys' and girls' well-being.

16. Guidelines for staffing

The *CCC* project model requires an investment in staff capacity. Some of the key staff positions include:

- National office point person for OVC
- National office capacity building team (two to three staff)
- Two facilitators for the *CCC* in each ADP, and
- *CCC* volunteers to reach the most vulnerable boys and girls in their homes.

17. Guidelines for optimal types and levels of resources needed for project implementation

Facilitator training (local and external resources):

- Transport money to the training venue for the facilitators
- Food and accommodation for participants during training
- Printing of training materials, and
- Travel and accommodation for trainers.

Training of trainers (Local and external resources):

- Air travel for the participants to attend a training event
- Food and accommodation during training, and
- Printing of training materials.

CCC training, home visitor training (local resources):

- Food for lunch during *CCC* training with the community. The meeting is held in the community and the food is prepared by community members.

Small amounts of cash given to the *CCC* for capacity building, depending on the context.

18. Recommended capacity building

TABLE 8: Training system structures			
	Training	**Days**	**Target Audience**
Year One: 1st Quarter	Orientation in *CCC* mobilisation and strengthening	2	• Senior management team
	Orientation in *CCC* mobilisation and strengthening	2	• ADP managers
	Training in *CCC* mobilisation and Strengthening	5	• National office OVC point person • Capacity building team • ADP facilitators
	Mentoring in *CCC* mobilisation and Strengthening	2	• National office OVC point person • Capacity building team • ADP facilitators
Year One: 2nd and 3rd Quarters	There is no training. Staff form *CCCs* and conduct technical capacity building of *CCCs*		

Year One: 4th Quarter	Training in organisational capacity building, organisational self-assessment and capacity modules	7	• National office OVC point person Capacity building team • ADP facilitators
	Mentoring in organisational capacity building, organisational self-assessment	3	• National office OVC Point Person Capacity Building Team • ADP Facilitators
Year Two: 1st Quarter	• Training of Trainers, *CCC* mobilisation and organisational capacity building	7	• Selected national officestaff from national office training and mentoring
	Scaled up training and mentoring in organisational capacity building at ADP level	3	• ADP facilitators and *CCC* members

When the *CCC* project model was rolled out across Africa, it became evident that there is an enormous need to support *CCCs* with organisational capacity building. WV developed a comprehensive guide to support organisational capacity building. The guide became available online in October 2008.

19. Technical interventions and/or technical assistance needed

The *CCC* project model requires technical assistance from:

o Hope team regional advisors, and
o Partners within the respective countries hired as consultants.

20. Guidelines for project management

o A five year national office strategy for implementing the *CCC* project model
o A detailed action plan for the *CCC* (i.e improvement plans with targets and time frame)
o Clear documented monitoring system from household to district levels,using participatory monitoring
o Programme consolidated annual plans, developed from the *CCC* improvement plans. Plans become a monitoring mechanism for improvement plans.
o Review meetings at regional, national, programme and *CCC* level, and
o Documenting stories and lessons learned.

21. Any necessary tools

The following three tools are needed for mobilising and building the capacity of the *CCC*:

o "Guide for Mobilising Community Led Care for Orphans and Vulnerable Children"
o "Manual for Organisational Self Assessment"
o "Training Modules for Organisational Capacity Building"

22. Linkages to other project models for integration

The *Community Coalition Care* project model is a foundational community structure, and other models will build on this structure. There is a strong link with the *Channels of Hope* (CoH) project model through the CHATs which are potentially part of the *CCC*. The model is integrated with other sectors at the programme and community level (e.g. food security, education, child protection, and psychosocial support).

23. Guidelines on transition

Transitioning the *Community Care Coalitions* project model starts at the beginning of the mobilisation process. The mapping process and the involvement of other stakeholders is key to transitioning the *CCC*. The following guidelines will aid the transition.

- o Prepare staff:
    - ▪ Train staff in *CCC* mobilisation and organisational capacity building.
    - ▪ Clearly define the role of WV staff, making sure they understand that they are just facilitators, not implementers of the *CCC* process.
- o Mobilisation:
    - ▪ The design and ownership of the *CCC* structure should suit the existing legal and community structures.
    - ▪ Building partnerships during mobilisation, both at the community and district level, is important for transitioning.
    - ▪ *CCCs* should be linked to district government structures and other relevant organisations.
    - ▪ Handover some activities to the district authorities from the beginning.
- o Capacity building of *CCCs*
    - ▪ To prepare for transitioning the *CCC*, train members from the beginning. The focus should be on both technical capacity and organisational capacity, with strong mentoring. WV should gradually transition responsibilities to the *CCC*, including financial responsibilities.

Table of Annexes