
**Orphans and Vulnerable Children Comprehensive
Action Research (OVC-CARE) Task Order**

Final Report

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OVC-CARE Final Report

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List of Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
AVSI	The AVSI Foundation Network
BIDII	Benevolent Institute of Development Initiatives
BPE	Basic Program Evaluation
BU	Boston University
CABA	Children Affected by HIV/AIDS
CESTRE	Center for Strategic Research and Development
CGHD	Center for Global Health and Development
CBCO	Community-based Care for OVC
CBO	Community based organization
CSO	Civil service organization
CDI	Child Depression Inventory
CSI	Child Status Index
COTR	Contracting Officer's Technical Representative
EoPE	End of Project Evaluation
ECR	Expanded Church Response, Zambia
FABRIC	Community Faith Based Initiative for OVC
FBO	Faith-based organization
FHI	Family Health International
HES	Household Economic Strengthening
ICOBI	Integrated Community Based Initiatives
IDCCS	Inter Diocesan Christian Community Service
IQC	Indefinite Quantity Contract
IRB	Institutional Review Board
MARP	Most at Risk Population
MGECW	Ministry of Gender Equity and Child Welfare
MMAS	Ministry of Women and Social Action
M&E	Monitoring and Evaluation
MOH	Ministry of Health
NGO	Non-Governmental Organization
OHA	Office of HIV/AIDS
OVC	Orphans and Vulnerable Children
OVC-CARE	Orphans and Vulnerable Children Comprehensive Action Research
PEPFAR	US President's Emergency Plan for AIDS Relief
PHE	Public Health Evaluation
PLHA	People living with HIV/AIDS
PV	Positive Vibes, Namibia
SEARCH	Supporting Evaluation and Research to Combat HIV/AIDS
SES	Socio-economic Status
SLA	Savings and Loan Association
SR	Sub recipient
TO	Task Order
TOCAT	Technical and Organizational Capacity Assessment Tool
TWG	Technical Work Group
UNAIDS	Joint United Nations Programme on HIV/AIDS

UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USG	United States Government

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Center for Global Health and Development (CGHD)



The Center for Global Health & Development (CGHD) is a multidisciplinary applied research center that addresses the immediate and future challenges in global health and development. Our mission is to find simple and relevant solutions by conducting high-quality applied research that will strengthen program effectiveness and enhance policy locally and globally. Our guiding principle is that health is the necessary foundation for human development.

WHO WE ARE

Led by Dr. Jonathon Simon, the CGHD's team consists of clinicians, infectious disease and pediatric specialists, epidemiologists, demographers, engineers, social scientists, health economists, program managers, and policy analysts from across BU's schools and colleges who collaborate with researchers and universities around the globe.

WHERE WE WORK

The CGHD maintains partnerships and professional networks in a broad range of low- and middle-income countries across Africa, Asia, the Americas and Eurasia. A central part of our mission is to work with low- and middle-income country scientists to carry out research on vital issues in their countries, helping local stakeholders use the information generated to improve the health and well-being of their populations.

OUR APPROACH

To achieve our mission, CGHD researchers work to fill critical gaps in global health knowledge and understanding through:

- Generating policy and program relevant evidence using a range of qualitative and quantitative methodologies including community-based clinical trials, impact evaluations, costing studies, etc.;
- Determining which strategies, interventions and service delivery models are most effective and cost effective in different settings;
- Publishing and presenting the findings and lessons learned to decision makers, who can use the information to change policies and practices;
- Strengthening capacity of local stakeholders to develop, conduct, disseminate and utilize research; and
- Providing assistance with the implementation of new programs and policies that have come about as a result of our research.

I. Executive Summary



In July 2008, the United States Agency for International Development (USAID) awarded the Orphans and Vulnerable Children Comprehensive Action Research Project (OVC-CARE) to Boston University's (BU) Center for Global Health and Development (CGHD). The Project was designed to achieve three main objectives: Fill critical gaps in the OVC research evidence base in order to guide cost-effective programming of OVC resources; guide alignment of OVC programs to complement national-level responses, frameworks and plans of action for OVC; and, identify strategies and approaches that can improve the coverage, quality, effectiveness, and impact of OVC programming.

During the Project's four years of implementation, 24 research studies were conducted evaluating the impact of programs funded by the President's Emergency Program for AIDS Relief (PEPFAR) in all of the so-called 6+1 OVC technical areas (food and nutrition, health support, educational support and vocational training, psychosocial support, shelter and care, child protection, and household economic strengthening). The different stages of development of programming, local country characteristics, and decisions made at program design, necessitated a variety of research designs with a strong focus on mixed qualitative and quantitative methodologies.

The Project's progression during its four-year period began with an examination of the larger global issues facing OVC programming. This included the challenges of costing services and identifying those populations most marginalized and as-yet poorly served by programs. We attempted to validate the most commonly used instrument for assessing OVC status. Finally, the Project conducted in-depth analyses of national research priorities and capabilities to address these priorities in both Africa and South Asia.

Based on the knowledge gained in the first year of operation, the Project undertook a series of studies to answer key questions related to global OVC programming raised from the literature reviews and country analyses. This included studying educational programming, costing of services, household economic strengthening, serving children of commercial sex workers and injecting drug users, and faith-based programming. Finally, as the Project matured, the focus narrowed to evaluating local level programming in Mozambique, India, Namibia, and Ethiopia. This provided important opportunities to establish baseline data sets for future longitudinal evaluative research, but also to explore in-depth such complex issues as capacity-building of organizations providing services to OVC, disclosure of HIV status to OVC, innovations in expanding access to services for OVC, and ways to reach marginalized children through alternative approaches to care.

The Project faced significant methodological challenges resulting from the nature of the emergency response. These included a lack of baseline data; poor quality data from routine sources; a paucity of guidance on what constitutes a positive outcome or impact of OVC programming; and, frequent contamination of study sites because multiple actors (in addition to PEPFAR) provide services to OVC. Finally, because programming was underway, it was impossible to conduct randomized controlled trials, necessitating the construction of complex counterfactuals, while facing multiple sources of bias. Each study report referenced in this document raises these issues and how they were addressed.

The Project's results have been well received in the research community, and have made significant contributions to the knowledge base about OVC programming. Nine studies were presented at international conferences, including the Global AIDS conference in 2010 and 2012, the OVC Africa conference in South Africa in 2010, and the American Public Health Association in 2011 and 2012. Eight peer reviewed journal articles have been published and another dozen manuscripts are still in various stages of development and submission. This is important, because the multidimensional nature of programs serving OVC requires long timelines and covers multiple outcomes. This fact makes evaluating such programs substantially more complex than evaluating other targeted HIV/AIDS programs such as the provision of antiretroviral therapy. This difference is reflected in the relative paucity of peer-reviewed literature on the evaluation of orphans and vulnerable children.

In addition to improving the knowledge base, this Project was able to influence many aspects of OVC programming at both global and local levels. Project studies contributed to both the HES and educational recommendations in the Guidance for Orphans and Vulnerable Children Programming published by PEPFAR in July 2012. The Project was also a contributor to the new OVC evaluation framework following our work with the CSI. At the local level, individual country programs have been modified on the basis of Project findings, notably in Ethiopia, India, Kenya, Mozambique, Namibia, Nigeria, Tanzania, Uganda, Vietnam, and Zambia.

In this report, only brief summaries of each research study are presented, with key findings highlighted. References are provided to link the reader to the full study description, including the protocol and report.



II. OVC-CARE Project

The Orphans and Vulnerable Children Comprehensive Action Research Project (OVC-CARE) was designed in 2008 as USAID's primary instrument to bridge the gaps in our experience and knowledge about how to scale up services to the 145 million children around the world who have lost one or both parents to HIV/AIDS or other causes. Awarded to Boston University's (BU) Center for Global Health and Development (CGHD) in August 2008, the project's strategic objective was to improve coverage and quality of OVC program services in developing countries through applied OVC program research. In the process of achieving this objective, the project worked towards achieving three main goals: 1) fill critical gaps in the OVC research evidence base in order to guide cost-effective programming of OVC resources; 2) guide alignment of OVC programs to complement national-level responses, frameworks, and Plans of Action for OVC; and 3) identify strategies and approaches that will improve the coverage, quality, effectiveness, and impact of OVC programs.

At the time of this award, the emergency response to the OVC crisis launched in the early part of the decade was transitioning to a longer-term approach of supporting and sustaining OVC. During the emergency phase of the response, programs and interventions were introduced on the basis of observed need, with the focus on providing services to the maximum number of OVC possible. Lack of existing programs and the paucity of the evidence-base meant that many programs were introduced using



approaches that were not adequately tested or validated, and those programs were often focused on numbers of children served with less emphasis on quality of services provided or outcomes achieved. In addition, effective measures of quality or outcome were not always systematically built into OVC programs making impact evaluation of the investments difficult.



OVC-CARE was designed to guide future programming of PEPFAR and other resources to achieve optimum impact on the health and welfare of OVC and document what has been done, what has been effective, what outcomes have been achieved, and what are the associated costs. Because of the lack of systematic data collection noted above, the OVC-CARE Project had to use cross-sectional studies to look at the impact of selected existing programs funded under PEPFAR I as very little opportunity offered itself for longitudinal studies. Through these studies, the Project was able to identify solutions to the causes of programming bottlenecks, produce evidence needed to develop good policies for OVC, and make recommendations about the most cost effective

approaches to achieve real outcomes for OVC health and social wellbeing.

During the first year of the OVC-CARE Project, a series of critical review studies were conducted on alternative care programs, children of Most at Risk Populations (MARPs), and costing and outcomes of OVC services. In addition, OVC research situation analyses were also completed in Nigeria, Zambia, Kenya, Namibia, and Vietnam. The second year of the Project moved to examining aspects of program effectiveness and impact. Areas of focus included: costing of services, evaluating OVC wellbeing, capacity building of service delivery organizations at the community level, capacity building of research institutions, and program evaluation. Year three of the Project saw three core-funded studies and ten field-funded studies. The fourth year of the Project, a no-cost extension was granted to continue field activities and enable final data collection and analysis.

A complete list of Project activities is presented in Annex 1: List of OVC-CARE Studies. Brief summaries and findings of individual studies are presented in this section of the report. The geographical focus along with the key OVC technical areas are highlighted for each study. URLs are provided for full reports and supporting documentation.



III. Research Projects



The project used a collaborative process with the Technical Working Group (TWG) for Orphans and Vulnerable Children and the Office of HIV/AIDS. The TWG chose the programs and projects to be evaluated and developed priority research questions in consultation with the project research teams. These questions were refined following literature reviews and the identification of suitable research sites.

Data and analysis

We collected data using quantitative household surveys; qualitative interviews and focus groups; record reviews; and, mixed methodology quantitative and qualitative approaches. We used cross-sectional, prospective, and retrospective designs. Comparison community groups and counterfactuals were (where possible) identified by matching people randomly selected from within the same communities with program participants according to household characteristics, age range, and sex.

Data were stratified as appropriate. For qualitative data, statistical analysis was conducted using domain analysis. For quantitative data, we used bivariate models, single and double difference approaches, ordinary least squares regression, cross tabulations, and logistic regression models.

Limitations of the project's studies

Individual study limitations are listed in each study report (see references in the main body of text). However, several broader issues limited our ability to draw conclusions. The most noteworthy were:

- We were unable to conduct randomized controlled trials because programs were already being implemented. This necessitated the construction of complex counterfactuals. At the same time, there was a risk of potential confounding factors causing bias. Details of specific counterfactuals and confounders are presented in each report.
- It was impossible to discern the effects of PEPFAR-funded programs alone because the intervention sites were in effect “contaminated” by programs and activities of other funding agencies. By design, some PEPFAR-supported children receive services from multiple sources. This overlap, combined with a lack of

Box 1: OVC Technical Areas (6+1 Domains)

- Food and nutrition
- Health support
- Educational support and vocational training
- Psychosocial support
- Shelter and care
- Child protection
- Household economic strengthening

population denominators, makes it difficult to attribute impacts to PEPFAR's programs, as opposed to those of other donors, with any degree of confidence.

- The programs and the evaluation study samples we examined may not have been representative of all of the programs in each country. PEPFAR's encouragement of the use of locally appropriate solutions has resulted in a plethora of approaches and an uneven distribution of services. We attempted to select countries, regions, and organizations that could be representative of overall programming for orphans and vulnerable children. However, caution is needed when drawing conclusions from a single program overseen by one nongovernmental organization and implemented by multiple community-based organizations.

Classification of OVC research studies in the project

Where possible, the project reported according to the formal OVC technical areas (Box 1). In the report that follows, we have presented the work by type of study: Literature Reviews; Needs Assessments; Costing Studies; Qualitative Studies; and Mixed Methods Studies

A. Literature Reviews

1. Costs, Outcomes, and Cost-Effectiveness of OVC Intervention

Countries: Global

OVC Technical Areas: N/A (literature review)

Link: <http://www.bu.edu/cghd/files/2009/12/Costs-Outcomes-and-Cost-Effectiveness-of-OVC-Interventions-Full-Report-02.11.10.pdf>

Given the past and continuing magnitude of the U.S. public's investment in PEPFAR-funded OVC programs, this project reviewed existing literature addressing the costs, the impacts/outcomes, and cost-effectiveness of OVC programs and interventions.

While information on the number of OVC reached by programs and by core program areas are included in global PEPFAR reporting requirements, such information is not adequate for evaluating costs of program service delivery to OVC. The current PEPFAR global reporting requirements also do not identify adequate outcome measures or requirements for measuring impacts. Substantially more and better information is needed on program activities, number and characteristics of OVC served, program costs, intended program outcomes, and estimated impacts. The Reauthorization Act of 2008 specifically calls for such analysis as part of impact evaluation research, operations research, and program monitoring. Given that OVC programs are multiple-input, multiple-output activities, evaluation of such programs should focus on reporting costs and program impacts across multiple dimensions (cost-outcomes analysis). In the absence of one aggregate OVC outcome indicator, cost-effectiveness analysis of OVC programs is not possible.

In summary, the findings indicate that relatively little information exists to:

- Document the costs of OVC program implementation.
- Identify the specific outcomes the programs are designed to improve upon (measures or indicators of child wellbeing).
- Measure the impacts of the programs in terms of outcomes achieved by delivering the OVC program services.

2. Children of Female Sex Workers and Drug Users: A Review of Vulnerability, Resilience, and Family-Centered Models of Care

Countries: Global

OVC Technical Areas: N/A (literature review)

Link: <http://www.bu.edu/cghd/files/2009/12/Children-of-female-sex-workers-and-injection-drug-users-Full-Report-3.2.10.pdf>

Female sex workers (FSWs) and injection drug users (IDUs) are often categorized as two of the four populations “most-at-risk” for becoming infected with HIV due to behaviors that heighten their vulnerability to the virus. According to UNAIDS, the term “most-at-risk populations” refers to men who have sex with men, injection drug users, and sex workers and their clients. Injecting drugs with non-sterile needles and unsafe sex between male couples and sex workers and clients are believed to drive the HIV epidemics in Western countries, former Soviet republics, and Asia. Interventions for most-at-risk populations tend to focus on the needs of adults with the objective of reducing their risk for HIV through prevention and behavior-change education and risk-reduction strategies. But, to date, little attention has been paid in the published literature to the vulnerabilities faced by their children or to interventions focused on keeping these potentially vulnerable families together, improving the wellbeing of both parents and children, and reducing the risk of both generations for becoming infected with or transmitting HIV.

Eight key findings summarize this review of the vulnerabilities faced by children of IDUs and FSWs, their sources of resilience, and promising models of care:

1. Many drug users and sex workers are parents.
2. Their children can face a variety of vulnerabilities as a result of their parents' addiction or profession.
3. Potential vulnerability can be mediated by numerous potential sources of resilience connected to support networks, parent health, parent-child bonding, education, economic situation, and other environmental factors.
4. Because their parents' drug use or sex work is often illegal and hidden, identifying these children can be difficult and even increase their vulnerability and marginalization.
5. Measuring the magnitude of child vulnerability derived from parental sex work or drug use is difficult and, in some instances, likely not possible.
6. Interventions tend to focus on the needs of at-risk adults without addressing their families, particularly their children.
7. Some interventions have been implemented in low and middle-income countries to assist these families, but they tend to be small, piecemeal, and struggling to meet demand.
8. Most interventions have not been evaluated for short-term effectiveness or long-term impact.

3. The Scale, Scope, and Impact of Alternative Care for OVC in Developing Countries

Countries: Global

OVC Technical Areas: N/A (literature review)

Over 145 million children worldwide have lost one or both parents due to various causes, 15 million of these are due to AIDS and many more have been made vulnerable due to other causes. The global community has responded by putting in place various care arrangements for these children. However, the scale, scope and impact of these alternative care approaches have not been well summarized. The aim of this literature review was to synthesize and analyze available data on alternative care placements and their impact on the lives of orphans and other vulnerable children (OVC). Both the short-term and long term wellbeing of a child depends a lot on where they live and the care they receive in those settings.

Alternative Care is defined as all residential care (either formal or informal) provided outside of the parental home. Such alternatives include: the extended family, foster families, group homes, orphanages, and community-based care. Family-centered care initiatives include programs focused on preserving or strengthening the ability of extended or foster families to absorb and effectively care for OVC without compromising the economic viability of the household and the health and wellbeing of other resident family members. Community-based care refers to a variety of community initiated and/or community led interventions, including family-strengthening, psychosocial support, empowerment, economic development, cash assistance; all provided within child's own community and within a family or family-like setting.

What We Do Know:

- Extended families are shouldering the burden of care: Ninety percent of children in developing countries separated from their parents by reason of death or other causes are living under the care of the extended family.
- The extended family system has been severely overburdened to the point of failure to cope: Increasing numbers of OVC, high dependency ratios, poverty and HIV/AIDS have put increased socio-economic strain on households that have absorbed OVC. This strain is manifested as reduced per capita income, reduced per capita consumption, reduced household investments, and negative impacts on both the OVC taken in and the caretaker's biological children.
- Long term care of young children in large orphanages is associated with attachment disorders and developmental delays in social, behavioral and cognitive functions.

What We Do Not Know:

- Magnitude of the OVC crisis.
- Number of children in residential care.
- Short-term effectiveness of community-based care.
- Short term effectiveness of child-centered group homes.
- Long-term impact of various forms of Alternative Care.

B. Needs Assessments

4. Research Situation Analysis on OVC

Countries: Kenya, Namibia, Nigeria, Zambia, Vietnam

OVC Technical Areas: N/A (needs assessment)

Link: <http://www.bu.edu/cghd/files/2009/12/Kenya-Research-Situation-Analysis-Country-Brief.pdf>

<http://www.bu.edu/cghd/files/2009/12/Namibia-Research-Situation-Analysis-Country-Brief.pdf>

<http://www.bu.edu/cghd/files/2009/12/Nigeria-Research-Situation-Analysis-Country-Brief.pdf>

<http://www.bu.edu/cghd/files/2009/12/Zambia-Research-Situation-Analysis-Country-Brief.pdf>

<http://www.bu.edu/cghd/files/2009/12/Vietnam-Research-Situation-Analysis-Country-Brief.pdf>

Research Situation Analyses were conducted in Kenya, Namibia, Nigeria, Zambia, and Vietnam. They involved both an extensive literature review and primary data collection. The latter involved administration of a survey questionnaire and key informant interviews with organizations providing OVC care and support. The country specific situation analysis reports indicated that while some valuable research has been conducted on OVC, overall there is very limited rigorous research evidence and data on OVC and interventions to inform policies and programs. This lack of information is hindering policy makers and program leaders from making well-informed decisions about the path forward. However, with limited resources available to divide between programming and research, a reasonable balance should be found to answer key questions without sacrificing support for critical services.

The following program-relevant research priority areas were identified:

- OVC survey to accurately determine the magnitude and characterization of OVC population in terms of total number of OVC by province and district, and categories of OVC by sex, age, and needs.
- Identification of drivers of children's vulnerability and evaluation of interventions to prevent and reduce vulnerability.
- Evaluation of the effectiveness and impact of various OVC interventions and models of care.
- Determination of cost and cost-effectiveness of OVC interventions.

Recommended supportive actions for OVC research included:

- Develop national OVC research agenda with implementation strategy, backed by resources.
- Commission national longitudinal cohort to evaluate over time the effectiveness and impact of interventions on OVC.
- Provide funding mechanism for OVC research by setting up an OVC research fund or allocating at least 10% of OVC budgets to research.
- Develop a robust monitoring and evaluation plan to capture all the data gaps identified in this study.
- Set up a central OVC database to capture among other essential data, information on all OVC service organizations by geographical and service coverage, and numbers of OVC by gender, age, and geographic area.

C. Costing Studies

5. Costing of OVC Services

Countries: Zambia, South Africa

OVC Technical Areas: N/A (costing analysis)

Link: <http://www.bu.edu/cghd/files/2010/10/Full-costing-report-Sept-2010.pdf>

The objective of the costing component of the Faith Based Regional Initiative for OVC (FABRIC) End of Project Evaluation (EoPE) was to estimate the full cost of inputs (goods and services) used to implement the FABRIC program at the level of FABRIC sub-recipient partner faith-based organizations (FBOs) in Zambia and South Africa for 2009. OVC programs or projects are similar to other types of projects, thus standard program costing methods were followed for this analysis. Data for the analysis were based on a review of program financial records, equipment inventories, and interviews with program staff. The purpose was to obtain information to estimate the full costs of goods and services used to implement the programs from the FBO's perspective. The study did not attempt to capture the costs of FHI, USAID or others organizations above the FBO/community level.

Key points from completed FBO cost profiles are highlighted below:

- In 2009, the average total FBO cost per child (USD) in Zambia ranged from \$26-\$45 and in South Africa from \$47-\$643. The sites in the cost analysis involved a range of locations, program structures, and different cost profiles.
- All FBOs rely on volunteer labor for program administration and implementation. The imputed value of volunteer time, based on a modest daily wage rate, increases the full program costs between 28-47%.
- Office administration, utilities, and annualized value of equipment/assets were a relatively small share of overall program costs.
- Expenditures on project staff training in each year were a relatively large share of program costs.
- Within the materials category, key sub-categories varied somewhat across FBOs. Some FBOs allocated more resources towards food and nutrition while others spent it on educational assistance or medical costs. Needs of OVC can dictate the types of services provided and the overall program costs.

6. A Costing Analysis of Household Economic Strengthening Program for Households Caring for OVC

Countries: Kenya

OVC Technical Areas: Economic strengthening

Link: <http://www.bu.edu/cghd/files/2011/01/HES-Costing-Analysis-Final-Report.pdf>

Christian Aid, through funding from PEPFAR and its own resources, implemented the Community-Based Care for OVC (CBCO) program from 2005-2010. The CBCO program was designed to improve household economic strengthening (HES) through the development and support of village savings and loan associations (SLAs) for caregivers of OVC. In Kenya, the CBCO Program was implemented through two partner NGOs: the Benevolent Institute of Development Initiatives (BIDI) based in Machakos and the Inter Diocesan Christian Community Services (IDCCS) based in Kisumu. In 2009, the program was providing support to 108 SLAs, which included over 3000 SLA members who were caring for over 7000 OVC. These SLA members are typically women who are also household heads or main sources of household economic support. A costing analysis of implementing the CBCO program was conducted in FY2010 focusing on costs from the perspective of the local organizations (BIDI and IDCCS) directly implementing the program on the ground.

Major findings:

- The direct financial cost of implementing this program for BIDI/IDCCS was \$49/57 per SLA member and \$21/25 per OVC per year.
- Financial costs do not account for the fundamental role of volunteers, who were responsible for implementing key components of the program. The two key categories of volunteers were 'facilitators' who supported SLAs or school-based programs and 'mentors' who served essentially as social workers for OVC and their guardians.
- Each NGO marshaled an estimated 14,000-15,000 days of volunteer or semi-volunteer time for program implementation.
- The imputed opportunity cost of this time was \$47/household for BIDI and \$35/household for IDCCS, so that the estimated total cost of the program was \$101/household for BIDI and \$98/household for IDCCS.

From the different OVC costing studies implemented by BU, a methodology for evaluating the costs of implementing OVC support programs was developed*:

Prerequisite – Develop clear definition of NGO's OVC program

Step 1. Access and organize NGO's annual financial report.

Step 2. Link financial report sub-categories from Step 1 into input cost categories and create financial cost profile.

Step 3. Estimate the annual equivalent payment for program equipment.

Step 4. Document donations to the NGO for program implementation.

Step 5. Include a portion of NGO organizational costs not attributed to specific programs.

Step 6. Include the results of Steps 3-5 into an expanded cost profile.

**Larson BA, Wambua. How to calculate the annual costs of NGO-implemented programmes to support orphans and vulnerable children: a six-step approach. J Int AIDS Soc. 2011; 14: 59.*

D. Qualitative Studies

7. Documentation of Three Programs Providing Family-Centered Support to Most-at-Risk Populations (MARP) and their Children

Countries: Zambia, Viet Nam, Ukraine

OVC Technical Areas: Shelter and care, child protection

Link: http://www.bu.edu/cghd/files/2011/12/Children-of-MARP-Program-Documentation_Sept-1-Final.pdf

Few data exist on the number of children of MARP, and very little evidence (beyond anecdotes) is available describing their needs and the programs that have begun to assist them with various services. To help address this gap, we partnered with three organizations providing services to injection drug users (IDU) and sex workers and their children, documenting their program history and current challenges and successes: Tasintha (a grassroots organization in Zambia providing services to sex workers and their children), HealthRight International Ukraine's MAMA+ for IDU, and Family Health International Viet Nam (both large international NGOs working with local partners to provide services to drug users and their children). In-country program site visits and staff interviews were conducted. We found that although each of the three partner organizations was unique in terms of approach, assistance offered, and populations served, there were a number of common challenges they were confronting as they sought to provide services to MARP and their children.

Common challenges identified:

Funding - While the programs vary in the degree to which they have enjoyed a stable and predictable funding source, all the programs are limited in what they can do for children due to financial constraints.

Poverty - The grinding poverty that affects so many families, in addition to HIV infection, presents enormous challenges due to the complex web of issues that affect very poor client households. Program staff in all the programs mentioned being able to provide treatment for specific ailments, and to help cheer up children for a day with something special such as an outing, a meal, or a gift, but not being in a position to address the fundamental and enduring problem of experiencing HIV and other health issues in the face of extreme poverty. However, program staff are often able to link clients with various government programs and services, which can play an important role in alleviating some of the worst poverty.

HIV-related stigma and discrimination - Stigma poses a major challenge in adequately and efficiently providing services to both adults and children. Fundamentally, the programs cannot remove stigma, but rather continually cope with it and try to overcome it as it relates to their clients.

Serving MARP clients - all the programs face inherent difficulties due to the high-risk behaviors of so many of their clients. For the programs serving large numbers of IDU, the main challenge identified by staff is dealing with clients who in some cases have disabling addictions and/or priorities other than their own health needs and the needs of their children.

8. Committed Communities Development Trust (CCDT): Integrating Home Based and Residential Care and Support in Mumbai

Countries: India

OVC Technical Areas: Shelter and care, child protection

Link: <http://www.bu.edu/cghd/files/2012/02/IndiaOVCreport-100212-copy1.pdf>

Maharashtra is one of the Indian states hit hardest by the HIV/AIDS epidemic. There are no official national or state estimates of the number of children orphaned by HIV or the number of children infected or affected; however, UNICEF has estimated that 4 million children in India (concentrated in high burden states) are affected by HIV. In response to this crisis, Committed Communities Development Trust (CCDT) has been providing care and support to families and children affected by or at risk for HIV/AIDS in Mumbai since 1995. Their approach is multi-faceted and community-based: focused in equal parts on filling health and social services gaps, stigma reduction, community development, and advocacy within some of Mumbai's most vulnerable communities. This study documented the care provided to vulnerable children living in CCDT's 4 residential crisis intervention centers (CICs): Ashray, Aakaar, Ankur-Asmita, and Umang.

The particular strengths of CCDT's Crisis Intervention Centre (CIC) model include:

- Continually evolving commitment and approach to child rights.
- Multi-faceted method of filling urgent needs within vulnerable communities while simultaneously building community capacity for self-efficacy and advocacy.
- Established reputation at the city, state, and (increasingly) national level for providing leadership, monitoring, and training for other leadership and staff running other special homes for children (both public and private).
- Ongoing collaborations with civil society, service providers, and government to improve care and support for vulnerable families and children.
- Conscious self-positioning to offer their home-based care CIC support as a practical, experience-based strategy.

Challenges to Providing Residential and Community-based Care to Children Affected by HIV/AIDS

- Complexity of reintegration for children into families.
- Difficulties faced by young adults in transitioning into independent community life after growing up in residential care.
- Barriers to finding appropriate schooling due to frequent sub-standard quality of education in the public school system and stigma within private schools barring entrance for HIV-positive children.
- Lack of government entitlements to health and food security.
- Lack of a government sponsored foster care system.
- Few residential vocational placements for slow learners who are HIV-positive.
- Few suitable residential placements for boys age 12 and over.
- Need for greater government attention to and funding for care and support programming for families and children affected by HIV/AIDS.
- Unsubsidized second-line ART for HIV+ children.

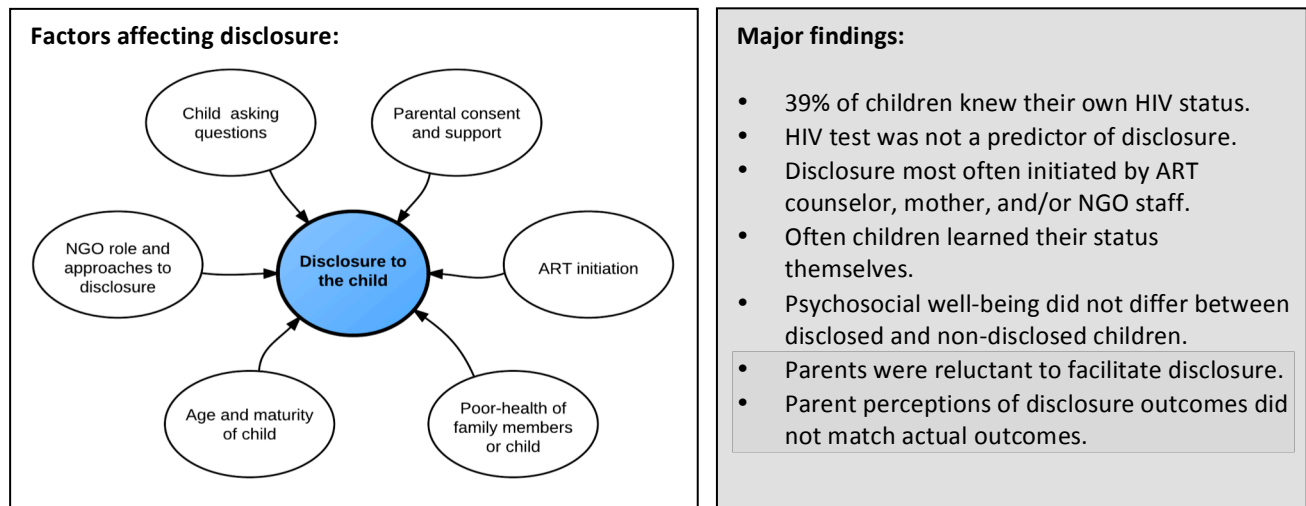
9. Disclosure of Children’s HIV Status in Four High Prevalence States in India

Countries: India

OVC Technical Areas: Health support, child protection

Link: <http://www.bu.edu/cghd/files/2012/02/IndiaOVCreport-100212-copy1.pdf>

Telling a child they are HIV positive, answering their questions about medicines and visits to the hospital, and talking about their future is a challenging and sensitive issue for parents, health care workers and HIV counseling and testing centers. This study responded to the scarcity of research and programmatic knowledge on disclosure of HIV status to children in India. The study was conducted with four NGOs which have developed resources, models and expertise to facilitate disclosure to OVC and their families in Bangalore, Chennai, Delhi and Mumbai.



Major conclusions:

- Parents should be the lead actors in disclosure, guided by the child’s maturity, and supported by a health care worker.
- Need for national guidelines and a toolkit on pediatric disclosure.
- ART centers should provide appropriate counseling.

10. An Evaluation of the Karnataka Cash Transfer Program

Countries: India

OVC Technical Areas: Food and nutrition, educational support, psychosocial support, health support, shelter and care

Link: <http://www.bu.edu/cghd/publication/phase-iii-report-early-impacts-of-the-karnataka-cash-transfer-on-children-and-families/>

Karnataka is one of the five states in India most affected by HIV. In 2009, HIV prevalence was 1%-1.9% across the 30 districts. In Karnataka, most orphans and vulnerable children (OVC) do not receive support, despite their needs. As a result, the Karnataka Cash Transfer was designed with a community-based targeting process. Transfers are targeted to poor households with children aged 0 to 18 years of age who are infected or affected by HIV/AIDS and are in need of food, medicine, healthcare, and/or support for education. In addition to Karnataka, similar cash transfer programs for children affected by HIV/AIDS have also been launched in Delhi and Tamil Nadu. In this study, we conducted qualitative in-depth interviews (IDIs) with families receiving the transfer (intervention group) and those not selected to receive the transfer (comparison group) to examine the impact of the cash transfers on children's health, access to medical care, and education.

Major findings:

- Overall, we found that most of the study respondents were facing serious health and economic problems. Many respondents, and/or their children, required ART along with frequent hospital and clinic visits, given their serious and reoccurring health problems. Also, because of weakened immunity and being on ART, respondents required adequate amounts of nutrient rich foods.
- Adult respondents were often too ill to work regularly or they struggled to find jobs that did not require difficult manual labor. Some families had exorbitant debts, were forced to relocate after the death of a family member, and faced other stressful economic challenges. Many youth and adult respondents had serious mental health issues as they were plagued with worry, sadness and fear of the future.
- Among the intervention group receiving the cash transfer, the majority of youth and adults reported spending priorities in line with the purpose and intent of the cash transfer, which was to meet the needs of HIV positive children and their families. Households generally prioritized transfers for food, medical care expenses, educational materials, and to purchase basic needs for the children and the household. The spending priorities appear appropriate in nearly all households.
- While the transfer enabled many households to meet their basic needs, some families still needed additional support for food, medical care and/or housing. Additionally, some families were in need of social services, home based care and mental health counseling and support.

E. Mixed Methods Studies

11. Exploring the Impact of the Community-Based Care Program for OVC (CBCO) Program

Countries: Kenya

OVC Technical Areas: Economic strengthening

Link: <http://www.bu.edu/cghd/files/2012/07/CBCO-Impact-Eval-Final-Report-6.13.12.pdf>

The Community Based Care for Orphans and Vulnerable Children (CBCO) program operated from 2006-2011 in Nyanza Province and portions of Eastern Province. Christian Aid partnered with two NGOs, the Benevolent Institute for Development Initiatives (BIDII) in Eastern Province and Anglican Development Services (ADS, formerly known as Inter Diocesan Christian Community Services) in Nyanza Province, to implement the program. The central component of the CBCO program was to support household economic strengthening through the development of village “saving and loan associations” (SLAs), which for the CBCO program consisted of a group of approximately 30 OVC caregivers. The SLA was an institution through which members could mobilize local resources to improve access to credit, to support group-based income generating activities, and to provide a conduit through which other CBCO program services could be provided to OVC. The overall objective of this study was to investigate the impacts of the CBCO program on various development outcomes associated with household economic strength and child-welfare. The study was a retrospective cohort study of CBCO program participants (the intervention group) and other households living in sub-locations where the program was implemented and in nearby communities (adjacent sub-locations) where the CBCO program did not operate. The survey was implemented in Eastern (n=1,429) and Nyanza (n=1,361) Provinces in the same districts included in the CBCO program.

Major findings:

- Throughout the analysis of all outcomes (household- and child-level), a simple comparison of the CBCO and the group of households in adjacent communities showed varying levels of differences. Sometimes CBCO had better outcomes, sometimes not, sometimes statistically significant at the 5% level, and sometimes not.
- The magnitude of the intervention is probably an issue. The cost of implementing the CBCO program at the level of implementers in each province was \$49-\$57 per household per year (\$21-\$25 per child) as of 2009. The program relied on large quantities of volunteer labor, which if valued at reasonable local wages, might increase these costs by 100%.
- The results of this study clearly suggest that a low-cost and low-input SLA model is not adequate to generate significant additional impacts on household welfare.
- If all the households in the SLA are essentially caught in a poverty-trap, pooling resources within such households is unlikely to push them out of poverty. An SLA model within an OVC support program may make sense as a foundation for a program, but additional poverty alleviation activities (e.g. direct cash transfers, direct transfers of agricultural inputs, new jobs, etc.) is still needed.
- This conclusion does not imply that the program did not provide useful benefits to the households or the OVC living in the households. While not an “OVC outcome”, SLAs as an institution are likely to provide useful non-financial social support to their members. For example, an SLA member who is severely food insecure may find significant emotional support from other SLA members, even if such support has no impact on food security.

12. End-of-Project Evaluation: Faith-Based Regional Initiative for OVC

Countries: Zambia, South Africa, Namibia

OVC Technical Areas: Food and nutrition, educational support, psychosocial support, health support, shelter and care

Link: <http://www.bu.edu/cghd/files/2010/10/FABRIC-EoPE-Final-Report.pdf>

In 2005, FHI received a five-year grant from PEPFAR for a regional comprehensive care and support program for OVC in Namibia, South Africa and Zambia. The program, entitled the Community Faith-Based Regional Initiative for Vulnerable Children (FABRIC), aimed to improve the quality of life for OVC in these program countries by developing the capacity of implementing partners to effectively allocate resources and ensure essential services reached OVC. An End of Project Evaluation (EoPE) of the FABRIC program was conducted in March 2010 by comparing FABRIC-supported OVC (n=263) to non-supported OVC within the community (n=525).

Major findings:

- The FABRIC beneficiaries appear to be vulnerable children. Though the specific targeting approaches were not well documented and are unknown to the current FHI project staff, every indication we could measure leads us to conclude the beneficiaries are children in need and that the targeting was successful.
- Given the high rates of vulnerability in these communities, it is hard for the evaluation to show statistically significant differences between the FABRIC and community samples. If we make the assumption (which we believe is reasonable, though not provable) that the initial FABRIC beneficiaries were children from households in greatest need, then the lack of difference in many of the wellbeing domains could be interpreted as the FABRIC project interventions bringing the served population up to, or maintaining them at, the levels of need and vulnerability of the general population.
- Related to the high levels of needs discussed above, our evaluation reports relatively low rates of service uptake reported by FABRIC beneficiaries in all age groups, particularly in Zambia. Some of this is related to our use of a twelve-month recall period for many services which we used to minimize recall bias, but a larger component of this low and limited intensity coverage is a result of financial constraints, variable annual budgets that made planning extremely difficult, and the dependence on volunteer labor.
- The dependence on unpaid volunteer labor as the key labor force for provision of services is problematic. Attrition and turnover rates were high at every level of the FABRIC operation. This has profound effects on the quality of services and limits the impacts of the training and other capacity strengthening investments.

13. The Well-Being of OVC and Their Households in Four Districts of Mozambique

Countries: Mozambique

OVC Technical Areas: Food and nutrition, educational support, psychosocial support, health support, shelter and care

Link: <http://www.bu.edu/cghd/files/2012/08/Mozambique-OVC-Evaluation-Project-Final-Report-7.26.121.pdf>

A mixed method study of OVC and their households was conducted in the districts of Marracuene, Katembe, Dondo, and the administrative post of Naticire in Mozambique. Both quantitative and qualitative methods were utilized to measure outcomes and gain rich insights into child and household experiences and the processes by which OVC organizations provide support. A quantitative household survey was first conducted among 1,759 households with 5,726 children aged 0-17 years. Next, a qualitative data collection was conducted including focus group discussions (FGDs) with caregivers of OVC; in depth interviews with local key informants such as village chiefs and community leaders; and in-depth interviews with children and their caregivers. Shelter and care, nutrition, health, education, child protection, and psychosocial outcomes among children were measured based on household food security, households' poverty status, and whether they care for OVC. The receipt of support services, the types and frequency of services received, and how organizations implemented OVC programs were examined as part of this study.

Major findings:

- Results reveal disparities in outcomes in food security, nutritional status, shelter, health, psychological wellbeing, and education based on both poverty and OVC status. For example, among children under five years old, poor OVC households were more than twice as likely to have a child go hungry a day and night compared to poor non-OVC households. These children were twice more likely to go to bed hungry and more than twice as likely to go to school hungry compared to poor non-OVC respectively.
- Among 5-11 year olds, poor OVC were more likely to be behind in grade-for-age compared to poor non-OVC and more than twice as likely compared to non-poor, non-OVC.
- In logistic regression models, poor OVC were 2.7 times more likely to be out of school compared to non-poor, non-OVC.
- With the exception of households that received support for birth registration, less than 10% of needy households received any support during the twelve months preceding the survey.
- Support did not seem to target the children and households in the worst circumstances. Interviews and focus group discussions with caregivers and community members revealed that few children and households receive any type of support.
- While there are OVC support services, the organizations generally provide services to a small number of children and families on a regular basis. Interviews with OVC service providers revealed low levels of program and M&E knowledge.

14. A Baseline Evaluation of the Yekokeb Berhan Project

Countries: Ethiopia

OVC Technical Areas: Food and nutrition, educational support, psychosocial support, health support, shelter and care, child protection

Link: Not Yet Released for Public Review by USAID

The evaluation is a prospective, observational, mixed methods approach to follow children and households, measuring vulnerability and outcomes based on the receipt of care and support services over time. Additionally, the design calls for observation of program implementation and documentation of key aspects of the intervention (i.e. services provided because of Yekokeb Berhan). The evaluation study was conducted in 130 kebeles (municipalities) across 111 woredas (districts) throughout the 11 regions of Ethiopia with a study sample (n= 3,445) that is representative of the areas where Pact and Yekokeb Berhan are operational. This national study will allow us to describe the situation of children and households throughout the country. Results from the statistical models at baseline (first round of data collection for this longitudinal cohort) are briefly summarized below.

At the child level, findings suggest:

- Poor children, regardless of vulnerability, had lower odds of having adequate care. The only support associated with better health care was receiving a referral for PMTCT services.
- Amidst poverty and vulnerability based school enrolment disparities, the only support associated with being enrolled in school was free tuition.
- Poor children were least likely to have adequate food. The supports for children associated with adequate food were supplemental feeding, optimal feeding advice and free school feeding.
- Given the poverty and vulnerability based disparities in the number of absences per month, the only educational support that was associated with reduced absences was free tuition.

At the household level, findings suggest:

- While poor households had dramatically higher odds of insufficient food diversity, the only support that was associated with reduced odds of having inadequate food diversity was receiving food rations. No other supports were associated with food insecurity.
- Poor households had weekly expenditures that were approximately \$4.30 lower than the expenditures in non-poor and non-vulnerable households. The only support that was associated with increased food expenditures—by \$0.90 per capita per week—was receiving cash assistance. However, few households received this assistance.

15. Evaluating the Effectiveness of Educational Support to OVC

Countries: Tanzania, Uganda

OVC Technical Areas: Educational support, psychosocial support

Link: <http://www.bu.edu/cghd/files/2011/12/Block-Grant-Final-Report-9.30.11-Full-Report.pdf>

An evaluation study to determine the effectiveness and cost of different approaches to providing educational support to OVC at secondary schools was conducted in Tanzania and Uganda. Four NGOs funded by PEPFAR were studied, two used block grants as a means to support OVC in secondary school (Africare and ICOBI), while two used scholarship approaches (AVSI and CRS). One NGO providing block grants operated in both countries (Africare). Each of the five NGO programs studied was distinct in its characteristics, administration, and adaptations to the local environment. The study was a retrospective record review (n=5,738) and used a mixed methods design adopting both qualitative and quantitative approaches to research.

Comparison of Effectiveness of Different Approaches to Providing Support to OVC				
UGANDA				
	Cost per child per year	Attendance	Drop out	Academic Achievements
Block Grants	\$324	Significantly Improved	No difference	No difference to non OVC
Scholarship	\$412	Significantly Improved	Significantly improved	No difference to non OVC
TANZANIA				
Block Grants	\$293	No difference	Significantly higher rates	Notably better performance (not significant)
Scholarship	\$356	No difference	No difference	No difference to non OVC

Major findings:

- We can conclude from our study that providing support to children to attend secondary school can be successful whether through block grants or scholarships, and that in general, supported performed as well as their non-OVC peers and sometimes better.
- Comparing the two approaches (block grant and scholarship), block grants are simpler to administer, require less administrative costs and oversight to ensure that students receive the benefits, and are more cost effective than scholarships per student.
- We did observe that block grants become less effective with smaller numbers of students enrolled as not only are there losses in economies of scale, the leverage on the school is much reduced when only small amounts are provided. We were unable to determine the exact point at which block grants become most efficient.
- It was clear throughout our observations that provision of free access to schools alone is insufficient to ensure that OVC attend regularly or perform well. Additional support was required that addressed physical health, nutrition, social setting, economic well-being, and other aspects of the child's overall well-being.

16. Evaluation of the Child Status Index Tool: A Validation Study in Malawi

Countries: Malawi

OVC Technical Areas: Food and nutrition, educational support, psychosocial support, health support, shelter and care

Link: <http://www.bu.edu/cghd/files/2011/10/Child-Status-Index.-Final-Report.-December-2010.pdf>

The Child Status Index (CSI) tool was developed by MEASURE Evaluation at the Carolina Population Center at the University of North Carolina as part of ongoing efforts by US government agencies to improve the systematic assessment of the needs of children and their households. The CSI tool was first made public in 2008 with the Manual and Field User's Guide appearing in July 2009. The CSI was designed as a simple, economical, yet comprehensive tool, organized around six dimensions pertaining to child welfare which could be used by low literacy staff. The CSI is a high-inference tool which has a rating system that requires an observer to make inferences on a composite construct from their observations. It was made available to community-based organizations (CBOs) in various countries. CBO staff use the CSI tool to assess the children they serve so that organizations can prioritize assistance and activities. An instrument must be valid in order to yield accurate information and inform decision making. As a recently developed instrument, to date there has been limited rigorous evaluation of the CSI's ability to generate valid information regarding the type and degree of vulnerability that children face.

To validate the CSI tool, two age-specific instruments, comprised of previously validated tools and indicators commonly considered best practice, were administered to children aged 5-10 years (n=102) and children aged 11-17 years (n=100) in Mchinji, Malawi. Respondents were randomly sampled from a roster of children recently scored with the CSI. For each of the CSI's 12 subdomains, we assessed construct validity using Spearman Rank correlation coefficients. We also calculated cross tabulations to explain the resulting correlation coefficients.

Major findings:

- No relationships exceeded the standard for high construct validity (≥ 0.7). Only 2 were moderate (0.3-0.7), both for the younger age group: food security (0.4) and wellness (0.36). All other relationships were weak or negative.
- In most subcategories, a substantial proportion of surveyed children indicated distress that was not evident from CSI scores. In the abuse and exploitation subdomain, all children were rated as "good" or "fair" by the CSI, but among surveyed children aged 11-17, 20% or more reported being beaten, kicked, locked out of the house, threatened with abandonment, cursed, and made to feel ashamed.
- In this rural Malawi population, we were not able to validate the CSI as a tool for assessing the vulnerabilities of orphaned and vulnerable children.
- We recommend caution in interpreting CSI scores and revisions to the tool before global scale-up in its use.

17. Impact of Mobile Primary Care Clinics on Health Status of OVC in Namibia: A Preliminary Evaluation of the “Mister Sister” Program

Countries: Namibia

OVC Technical Areas: health support

Link: <http://www.bu.edu/cghd/files/2012/08/OVC-Namibia-Preliminary-Evaluation1.pdf>

In October and November 2010, a mobile primary clinic operated by Pharmaccess Namibia first visited isolated farms, schools and encampments in Otjozondjupa Region of Namibia. From July 2011 to January 2012, the clinic, named Mister Sister, provided a regular monthly service in the same region. Part of the costs for this pilot program were paid by farmers, who subscribed N\$417 per farm per month to have the clinic make monthly stops to treat their farm workers and dependents. For the six month period, USAID provided funding for Mister Sister to serve all orphans and vulnerable children (OVC) along this route, including those at Otjozundu primary school, as well as Five Rand Camp and the Ileni Tulikwafeni nutrition program located there. This study evaluated the impact of mobile primary care services on health utilization and health status of OVC (n=1,210) along this route.

Study results				
Percent of Total Costs Covered by Employer/Employee Fees				
11.5%				
Drug Costs Per Patient	Private Market	Cost to MOHSS	Cost to Mister Sister	Saving
	N\$ 41	N\$15	0	\$N26 \$N41
Transport Costs Per Patient		Patient to MOHSS	Cost to Mister Sister	Saving
		N\$ 141	N\$57	N\$84
Outcome Measures (Longitudinal Cohort)	November 2010	July 2011 - August 2011	December 2011 - January 2012	Change
Immunization Rate	84%	97.2%	99.1%	+15.1%*
Worm Infection (Skin)		15.6%	0%	-15.6%*
Worm Infection (Intestine)		1.4%	0.2%	-1.2%*
Anemia		1.9%	0%	-1.9%*
* statistically significant (P<0.05)				

Major findings:

- Study findings suggest that the Mister Sister partnership captured revenue from the private sector, reduced its costs through receipt of essential drugs from MOHSS, lowered transport costs per patient substantially, and produced statistically significant improvements in immunization rates, worm infections and anemia.
- Mobile primary care clinics staffed by nurse practitioners -- the model tested by the Mister Sister program in Namibia -- appear an effective way to improve health status of OVC in widely dispersed populations.
- While program costs can be partially covered by fees for serving employment sites and workers, continued subsidy will be necessary to reach OVC concentrations.

18. Children Affected by AIDS Pilot Scheme: Organization Network Analysis in Five Districts

Countries: India

OVC Technical Areas: Child protection

Link: <http://www.bu.edu/cghd/files/2012/02/IndiaOVCreport-100212-copy1.pdf>

The National Aids Control Organization (NACO) of the Government of India launched the Children Affected by AIDS (CABA) Pilot Scheme, in May 2010 to “ensure that all children exposed to and affected by HIV/AIDS are identified and linked to early diagnosis and treatment services, along with development, protection and welfare services on a need basis.” Utilizing the methodology of Organizational Network Analysis (ONA), the research team set out to identify and understand the most effective pathways for coordination and linkages of multi-sectoral government departments and non-governmental organizations resulting in needed services for CABA. The effect of the CABA Pilot Scheme is analyzed by applying ONA methods to assess inter-organizational relationships before the CABA Pilot Scheme was implemented (Period 1) and one-year after implementation (Period 2). This study was conducted in 5 districts with the support of the accompanying District Coordination Action Agencies (DCAAs): Karnataka (Karnataka Health Promotion Trust – KHPT) in Belgaum and Bagalkot; Andhra Pradesh: Krishna (India HIV AIDS Alliance and Vasavya Mahila Mandali - VMM) and East Godavari (FHI 360); and North East Delhi (FHI 360 and WAG-CHELSEA).

Network definitions:

The following Organizational Network Analysis (ONA) measures were assessed:

- Multiplexity: multiple relationships among the same set organizations.
- Intensity: level of interaction between different organizations or nodes (no interaction; at least once a year; quarterly, at least 3-4 times a year and monthly or more frequently).
- Density: sum of the ties divided by the number of possible ties.

Major findings:

- Overall Belgaum has the highest densities for both time periods demonstrating that this district is a highly connected network. East Godavari and NE Delhi have the lowest densities. The density measures did not change significantly after implementation of the CABA Pilot Scheme.
- A robust organizational network will consist of multiplex relationships. This study requested departments to report on 4 key activities that informed the CABA Pilot Scheme implementation: joint planning, sharing information, referrals, and training. Bagalkot had a highly robust multiplex network (majority of ties represent participation in all 3-4 activities) while Krishna showed limited multiplexity.
- The weakest organizational linkages were with non-health departments.
- The CABA Pilot Scheme has brought attention to the needs of children but the levels of coordination did not change with the program.
- Increasing the coordination of referral networks and by working across HIV/AIDS, health and non-health departments can lead to improvement in access to social schemes and services.

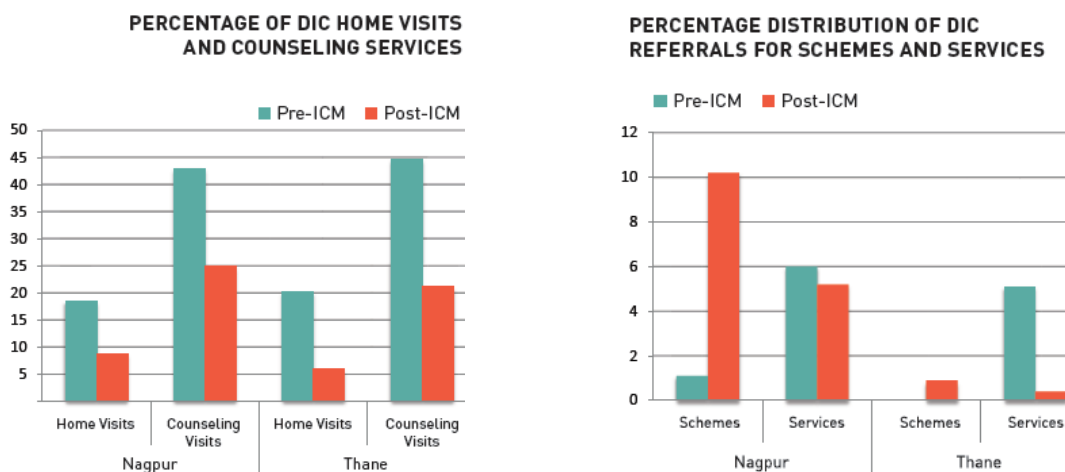
19. The Effectiveness of an Integrated Care Model Drop-in Center in Improving Access to Services and Selected Health Outcomes of OVC in Maharashtra

Countries: India

OVC Technical Areas: Shelter and care, health support

Link: <http://www.bu.edu/cghd/files/2012/02/IndiaOVCreport-100212-copy1.pdf>

The Avert Society, operating in Maharashtra in a partnership with the Maharashtra State AIDS Control Society (MSACS) and USAID, began supporting the implementation of the Drop-in Center concept in 7 districts through 7 different community-based organizations (CBO) in 2003. In April 2009, they added an Integrated Care Model (ICM) approach to increase coverage and expand linkages with schemes and services with a major focus on care and support for OVC. The goal of this study was to: (a) understand the network structure of organizations and departments at the district level and assess the mechanisms for linking children to schemes and services, and (b) to determine the effect of the ICM approach on selected DIC service delivery and referral indicators as well as available health outcome information one year before the DIC-ICM was implemented (Period 1) and one year after implementation (Period 2).



Major findings:

- The organizational network analysis (ONA) density measures were both low before and one-year after the implementation of the integrated care model Drop in Center (DIC).
- The DIC did not emerge as a key player, where there were very few direct relationships with other Government of India departments and organizations.
- The integrated care model (ICM) is performing at a very low level of service delivery consisting of home visits and counseling and the referrals to schemes and services to departments outside the DIC (refer to figures above).
- Of the children enrolled in the DIC, ART status revealed that 54% of children were on ART in Nagpur as opposed to 30% in Thane. If receiving ART, 94.2% of the children in Nagpur visited the ART Center at least once in Period 1 and this increased to 98.5% in Period 2. In Thane, only 16% of the children had at least one visit to the ART center in Period 1 and this did not change significantly in Period 2 (18.8%).
- Screening for health risks in HIV positive children is an important preventative health activity. In Nagpur, 50% of the children in the program were screened for TB while only 6% were screened in Thane.
- The high expectations coupled with inadequate level of resources and limited capacity building, have detracted the DICs from achieving access to schemes and services for HIV/AIDS orphans and vulnerable children.

20. Evaluating the Organizational Capacity of Three NGOs

Countries: India

OVC Technical Areas: Child protection

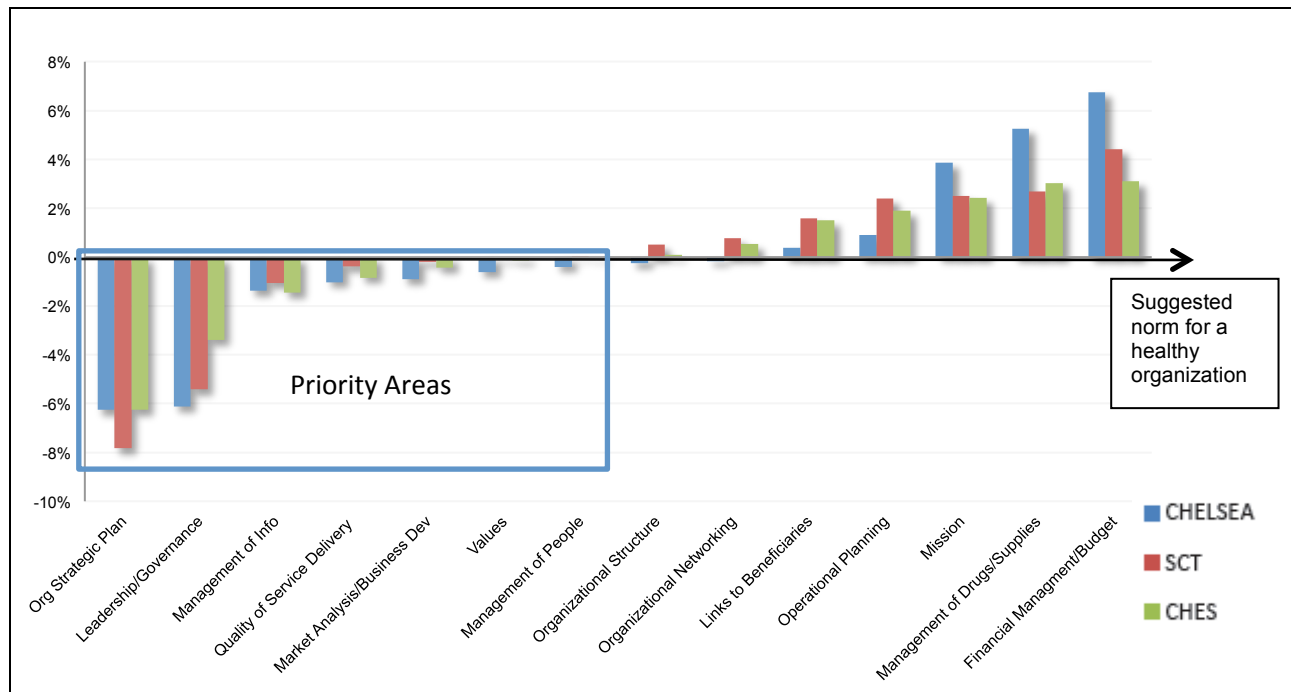
<http://www.bu.edu/cghd/files/2012/02/IndiaOVCreport-100212-copy1.pdf>

Government of India policy recognizes the central importance of civil society groups, NGOs and the private sector, in coordination with government structures, to serve children affected by AIDS. USAID/India has been a catalyst, advocate, and supporter of the Government of India’s vision and policies. They have provided innovative OVC program funding to strengthen NGOs, work directly with National AIDS Control Organization (NACO), and forge new public-private partnerships. As funding of the current USAID portfolio of projects draws to a close, there is a “graduation” of supported local NGOs to independent funding and “sustainability”. However, there are gaps in the knowledge base to determine when an organization is ready to graduate or achieve sustainability. Three NGOs providing community based/residential care to OVC in India were studied.

Major findings:

- The organizational capacity profiles generated were those of well-managed but unsustainable organizations.
- Financial and pharmaceutical management scored highly, while governance structures and strategic and business planning were weak (refer to Figure 1).
- The quantitative instrument is the first tool enabling consistent, repeated assessments on the organizational capacities of NGOs providing HIV services. It guides donors on which NGOs to invest in and which capacities to build. It also enables donors to rigorously evaluate capacity building efforts of international organizations and hold them accountable.

Organizational Deviation from the Norm and Priority Areas for Capacity Building



IV. Project Impact



During the life of this Project, a body of new OVC research work has been disseminated as part of the OVC-CARE Project (refer to Annex 1: List of OVC-CARE studies).

OVC-CARE researchers have been active in attending key technical meetings and workshops:

- March 2009: In preparation of the CSI validation study, Bram Brooks participated in the Child Status Index Regional Conference held in Rwanda.
- March 2010: Jonathon Simon participated in an USAID technical meeting on OVC costing in Washington DC.
- June 2010: Bruce Larson, Malcolm Bryant, and Jonathon Simon convened a meeting between USAID, PEPFAR, UNAIDS, UNICEF, and the World Bank to assess the state of the art for OVC costing and develop a multi-agency agenda going forward.
- August 2010: Jonathon Simon and Nancy Scott presented results of the FABRIC Evaluation to key stakeholders in Zambia.
- October 2010: Godfrey Biemba and Candace Miller conducted a five day Monitoring and Evaluation (M&E) workshop for OVC focal points and M&E officers from the Ministry of Women and Social Action (MMAS) and several NGOs in Mozambique.
- April 2011: Bruce Larson conducted a briefing for USAID staff by teleconference on the six step costing approach that has been developed by the OVC-CARE project.
- April 2011: Candace Miller and Lora Sabin participated in a technical consultation in Washington DC on the Child Status Index (CSI) and the future of the instrument based on the findings of the Malawi study.
- June 2011: Jonathon Simon, Malcolm Bryant, Bruce Larson, Jenny Ruducha, Jen Beard, Mary Shann, and Bram Brooks took part in a one day pre-dissemination workshop in Washington DC to present preliminary findings of Core-funded activities to USAID staff. Formal presentations were made for the educational block grant evaluation, HES impact study, and the MARP documentation project.
- July 2011: Malcolm Bryant and Mary Shann presented results for the block grant evaluation to key stakeholders in Tanzania and Uganda.
- July 2011: Bruce Larson had a technical meeting with USAID in Kenya to discuss the results of the HES impact study.
- October 2011: Malcolm Bryant, Candace Miller, Nancy Scott, and Nafisa Halim conducted a five day OVC evaluation workshop in Ethiopia in preparation for the baseline evaluation of Pact's Yekoheb Behan Project.

- November 2011: Godfrey Biemba presented the findings from the OVC Mozambique baseline evaluation to key stakeholders in Mozambique.
- January 2012: Jonathon Simon, Malcolm Bryant, Jenny Ruducha, and Katherine Semrau conducted a three-day workshop designed for managers, monitoring and evaluation staff, and researchers at government agencies, donors, and NGOs working with orphans and vulnerable children in India.
- January 2012: Jonathon Simon, Malcolm Bryant, Jenny Ruducha, Jen Beard, and Katherine Semrau presented findings from the various OVC India projects to key stakeholders in India.
- February 2012: Rich Feeley had a technical meeting with USAID in Namibia to discuss the results of the OVC Namibia study.

Presentation and manuscripts for peer-review publications are in various stages of preparation for activities that have already been completed by the Project. At this point the following presentations and manuscripts have been published or submitted for publication:

Presentations at international conferences

- A poster presentation on the CSI evaluation at the International HIV/AIDS conference in Vienna in July 2010.
- A poster presentation on the children of MARP at the International HIV/AIDS conference in Vienna in July 2010.
- An oral presentation on the children of MARP at the OVC Africa conference in South Africa in November 2010.
- A special panel on the OVC-CARE Project findings was held at the American Public Health Association conference in Washington DC in November 2011. Specific abstracts on the CSI study, FABRIC evaluation, costing methodology, and CABA Organizational Network Analysis (ONA) were formally presented.
- A poster presentation on the MARP program documentation study at the International AIDS conference in Washington DC in July 2012.
- A poster presentation on the OVC India HIV Disclosure study at the International AIDS conference in Washington DC in July 2012.
- A poster presentation on the OVC India Organizational Network Analysis at the International AIDS conference in Washington DC in July 2012.
- A poster presentation on the OVC India Integrated Care study at the International AIDS conference in Washington DC in July 2012.
- An oral presentation on the OVC India NGO organizational capacity study at the International AIDS conference in Washington DC in July 2012.

Peer Reviewed journal articles

- Beard J, Biemba G, Brooks MI, Costello J, Ommerborn M, Bresnahan M, Flynn D, Simon J. Children of female sex workers and drug users: a review of vulnerability, resilience and family centered models of care. *Journal of the International AIDS Society* 2010, 13(Suppl 2):S6.
- Sabin L, Tsoka M, Brooks MI, Miller C. Measuring vulnerability among orphans and vulnerable children in rural Malawi: Validation study of the Child Status Index tool. *Journal of Acquired Immune Deficiency Syndrome* 2011 Sep 1;58(1):e1-10.
- Larson BA, Wambua N. How to calculate the annual costs of NGO-implemented programmes to support orphans and vulnerable children: a six-step approach. *Journal of the International AIDS Society* 2011 Dec 19;14:59.

- Bryant M, Beard J, Sabin L, Brooks MI, Scott N, Larson BA, Biemba G, Miller C, Simon J. PEPFAR's Support For Orphans And Vulnerable Children: Some Beneficial Effects, But Too Little Data, And Programs Spread Thin. *Health Affairs* 2012 Jul;31(7):1508-18.
- Larson B, Wambua N, Masila J, Wangai S, Rohr J, Brooks M, Bryant M. Exploring impacts of Multi-Year, Community-Based Care Programs for Orphans and Vulnerable Children: A Case study from Kenya. (Accepted by *AIDS Care*)
- Shann M, Bryant M, Brooks MI, Bukuluki P, Muhangi D, Lugalla J, Kwesigabo G. Evaluation of Educational Support to Orphans and Vulnerable Children in Uganda and Tanzania. (Accepted *ISRN Public Health*)
- Brooks MI, Bryant M, Shann M, Bukuluki P, Muhangi D, Lugalla J, Kwesigabo G. Are educational support programs for OVC helping girls in secondary school? Gender analysis of educational support programs in Uganda and Tanzania. (Submitted to *Vulnerable Children and Youth Studies*)
- Aneni EC, de Beer IH, Hanson L, Rijnen B, Brenan AT, Feeley FG. The Impact of Mobile Primary Health Care Services on the Health of Rural Namibian Children. (Submitted to *Rural and Remote Health*)

Results from research conducted in the early part of the Project have begun to influence the policy and programming of services. The evaluation of the Child Status Index (CSI) that was conducted in Malawi in 2009 contributed to a technical meeting in the early part of 2010, held to examine the redevelopment of the CSI in light of the findings. Project researchers were present at that meeting. The evaluation's findings have also contributed to the new OVC monitoring and evaluation framework developed by USAID. The costing studies conducted in Zambia, South Africa, and Kenya have resulted in the development in a new, simple, six-step costing process which was shared with USAID health officers and Washington-based personnel in a teleconference led by a Project researcher. It is expected that the work will ultimately lead to changes in the way NGOs report on financial data to facilitate more readily available costing data. Results from the study of household economic strengthening in Kenya, and the education studies in Uganda and Tanzania resulted in changes in policy recommendations in the *Guidance for Orphans and Vulnerable Children Programming* by PEPFAR in July 2012.



The Project has also been able to leverage funding from new sources to build on its work. Notably, the FABRIC study in Zambia received funding from FHI 360 to conduct a longitudinal study of OVC for a year following the end of the FABRIC project. This study was the first to look at a cohort of children following the end of support and examine whether perceived improvements in their wellbeing were maintained.

UNICEF co-funded a two-day workshop with the Project, to seek a consensus on costing of OVC services. Participants came from around the world representing organizations including: UNICEF, USAID, PEPFAR, UNAIDS, The World Bank, and WHO. Following this workshop, the project received funding from the World Bank to conduct further costing studies on OVC.

In late 2011, we received funding from the Legatum Foundation, through Geneva Global to scale up the small study examining organizational capacity in 3 NGOs, to 50 organizations in Ethiopia and link the results to child wellbeing. This will be further scaled to four countries in Africa in 2014.

Effective working partnerships were established with other global USAID projects, for example with AIDSTAR II where collaboration took place on the development of organizational capacity building tools; and the Health Care Improvement Project, with joint work on developing quality standards for OVC services.

LESSONS LEARNED AND WAYS TO RESOLVE CONSTRAINTS



The studies performed under this project achieved the goals of increasing knowledge about key interventions aimed at supporting OVC, as well as setting new directions for research. It also revealed that a number of specific PEPFAR-funded interventions, such as paying school fees and using girls' clubs to improve psychosocial health for teenagers, have had a beneficial impact on indicators of well-being for orphans and vulnerable children. However, because of significant methodological challenges (outlined in each study), the majority of the interventions could not be demonstrated to be effective. This does not mean that the investments have been ineffective, simply that the design of projects, the lack of

baseline data, and the poorly formulated OVC indicators at the outset of programming, make it impossible to demonstrate effectiveness.

The results of the studies conducted in this project however, confirm findings previously available only in project reports. For example, the education study confirms reports by Africare and Catholic Relief Services that educational support improves educational outcomes, and that block grants are the most efficient approach. Similarly, the high rates of food insecurity and poor nutrition in young girls that we identified in Zambia are consistent with findings from a World Vision project in the same country. On the other hand, our findings from Kenya differ from other findings that increasing household income leads to improved outcomes for orphans and vulnerable children.

IMPACT AND OUTCOME EVALUATION

As PEPFAR's programming for OVC move into the structural integration stage, evaluation approaches need to quickly catch up with the shift in programming. In January 2011 USAID issued a clear mandate for rigorous evaluation of all of its health and development initiatives, including PEPFAR-funded activities implemented by the agency. This is an important step, and the evaluation of the Yekokeb Berhan project is one of the first major prospective evaluations to be started under this policy.



Baselines established by this project in Mozambique, Zambia, and Kenya could also be used as the basis for prospective evaluations. Below we make some recommendations based on this Project's experience that will better inform future evaluative and applied research into OVC.

Baseline Data Collection

The projects we evaluated were never asked to collect baseline data at inception, despite the fact that such data are a critical precondition for drawing reliable conclusions about a program's impact. Throughout this project (with the exception of the evaluation of Yekokeb Berhan in Ethiopia), we were able to create intervention and comparison groups only after the programs' implementation and to assess the programs' impact by comparing data on indicators of well-being between the groups. Our results tended to show little difference between the groups.



One way to interpret these results is to assume that orphans and vulnerable children in intervention groups entered PEPFAR programs with lower levels of nutrition, education, shelter, legal protection, health care, and psychosocial support than the children in comparison groups had, and to conjecture that PEPFAR support allowed beneficiaries to improve to the same status as the children in comparison groups. This is reasonable, given the many studies demonstrating that orphans and vulnerable children tend to have less food security, lower

nutritional status, and lower rates of school attendance than children in comparison groups. However, the status of orphans and vulnerable children varies considerably both between countries and within regions of the same country.

We also cannot say for sure what the relative status of orphans and vulnerable children was across different indicators prior to the programs' implementation. Thus, a second reasonable interpretation of the results is that it is impossible to determine with confidence what impact programs serving orphans and vulnerable children have had.

We are left with the question "Why were baseline data not collected, given the large sums of money spent on programs for orphans and vulnerable children and the need to evaluate the programs' impact?" While visiting the field sites for all of our studies, we asked program implementers about this. The common reply was that the emergency response made providing services a priority over establishing baselines.

We already see that this situation is changing, as the evaluation policy of January 2011 articulates the need for rigorous impact evaluations of large programs, using external evaluators and established counterfactuals. We must hope that the lessons learned of the programming from PEPFAR 1, mean that future implementation of programs for orphans and vulnerable children will involve baseline data being collected, as well as subsequent



rigorous assessments of program effectiveness taking place.

Routine Program Data Collection

Our evaluations of educational grants were designed to utilize retrospective program monitoring data to determine the effect of block grants on educational outcomes for orphans and vulnerable children. However, these data were so poor that we had to drop the retrospective component of the study, limiting our analysis to cross-sectional data. Similarly, studies in India (Organizational Capacity and Karnataka Cash Transfer), were designed on the basis that routine data had been collected over several years of programming, only to find that the data was of insufficient quality to be able to measure child health improvements.



PEPFAR program monitoring relies heavily on routine data collection, often using elaborate systems to complete counts for PEPFAR reports. At best, these numbers say little about actual impact on child well-being. Based on our experience examining routine program data and finding numerous problems with completeness, accuracy, and quality, we believe that many PEPFAR reports contain numbers of questionable value and utility. This creates questions about the conclusions that may have been drawn from program evaluations

using routine data, and then used as the basis for new program design.

The Population To Be Served

PEPFAR programs count children served, often without calculating the total number in need. We found that several nongovernmental organizations were successful in meeting numeric targets but failed to provide services to 50 percent or more of eligible children. Counting services in this way, without a denominator, provides little program information and no guidance on coverage.

There are few estimations of service coverage rates for orphans and vulnerable children because of the lack of denominators in most monitoring indicators. Indeed, many of the programs that were the focus of our research were spread so thin across a vulnerable population that little, in the way of services, actually reached beneficiaries. Targeting and prioritization would be much more effective if the size of the population to be served was known.

Protocols To Prioritize Services

One possible explanation for the lack of demonstrated impact that our studies found might be related to our observation of low coverage of services. For example, in Zambia, only 24–52% of those eligible for services actually received them. The efforts of thousands of professionals and volunteers frequently could not overcome the combined difficulties of inadequate funding, weak capacity, and overwhelming need with the limited resources at their disposal. Thus, it is



important to ask whether available PEPFAR funds are sufficient to meet the needs of the five million orphans and vulnerable children for whom it aims to deliver services by 2014, or if PEPFAR is attempting to do too much with too few resources.

Effective Approaches

Only household wealth, or lack thereof, has been consistently shown to predict children's vulnerability (Akwara et al. 2010. Who is the Vulnerable Child? Using survey data to identify children at risk in the era of HIV and AIDS. AIDS Care Vol.22, No.9. 1066-1085). Although the majority of orphans and vulnerable children live in conditions of household hardship, poverty is not exclusive to children affected by HIV/AIDS. Our findings clearly demonstrated that poor children fare worse than non-poor children. Most notably, poor HIV-affected children fare much worse than all other children. Any programmatic approach that increases household wealth of HIV-affected children could therefore be expected to have a positive impact on orphans and vulnerable children.

With regard to anti-poverty programs, PEPFAR's movement to increasingly focus on cash transfers and not solely on increasing household wealth by linking households to programs that provide economic opportunities, including income-generating activities and microfinance is clearly demonstrated to be the right approach from our work.



CONCLUSION

The multidimensional nature of programs serving orphans and vulnerable children requires long timelines and covers multiple outcomes. This fact makes evaluating such programs substantially more complex than evaluating other targeted HIV/AIDS programs, such as the provision of antiretroviral therapy. This difference is reflected in the relative paucity of peer-reviewed literature on the evaluation of programs for orphans and vulnerable children. This project has contributed significantly to both the knowledge base around OVC programming and the peer-reviewed literature. It has also been able to provide clear guidance for further policy and programming, as well as proposing further research agendas in various areas of OVC programming.

It is very unfortunate, that despite the rigorous designs used in this project, the limitations of no baselines, poor indicator design, and challenges in creating counterfactuals, mean that seven years after

PEPFAR began large-scale implementation of programs for OVC we have been unable to demonstrate clear outcomes and impacts.

We do however, draw encouragement from several major steps forward, to which this project has been able to contribute or participate:

1. The introduction of the 2011 USAID Policy on Evaluation.
2. The publication by UNICEF of a document entitled "Taking Evidence to Impact" which provides clarity on measures of outcome and impact, and on how to establish data collection systems.
3. The soon-to-be-published revised indicators for evaluating programming for OVC which will have a focus on measuring outcomes.

V. Appendix

Annex 1: List of OVC-CARE Studies

Country and Title of Study	Type of Study and Methods	Services Evaluated	Summary of Results
Literature Review			
1. Costs, Outcomes, and Cost-Effectiveness of OVC Interventions^a <u>Countries:</u> Global	Literature review	Costing of services, measurement of outcomes	Decades into the AIDS pandemic and after five years of PEPFAR funding, relatively little information exists to: 1. Document the costs of OVC program implementation; 2. Identify the specific outcomes that programs are designed to improve upon (measures or indicators of child wellbeing); and 3. Measure the impacts of the programs in terms of outcomes achieved by delivering the OVC program services.
2. Children of Female Sex Workers and Drug Users: a Review of Vulnerability, Resilience, and Family-Centered Models of Care^b <u>Countries:</u> Global	Literature review	Children of MARP	A large literature assessing the vulnerability and resilience of children of drug users and alcoholics in developed countries was found. Research on the situation of the children of sex workers is extremely limited. Children of drug users and sex workers can face unique risks, stigma and discrimination, but both child vulnerability and resilience are associated in the drug use literature with the physical and mental health of parents and family context. Family-centered interventions have been implemented in low- and middle-income contexts, but they tend to be small, piecemeal and struggling to meet demand; they are poorly documented, and most have not been formally evaluated.
3. The Scale, Scope and Impact of Alternative Care for OVC in Developing Countries^c <u>Countries:</u> Global	Literature review	Education, psychosocial wellbeing, food and nutrition, healthcare, child protection and legal aid, shelter and care (including residential care)	This review has shown that the extended family system, currently taking care of the majority of OVC is under extreme pressure, and unless governments and international development partners redouble their current efforts to increase the capacity of the families to cope, the quality of lives of foster OVC and all children in vulnerable households remain in danger. Interventions aimed at preventing and reducing child vulnerability and those that aim to reduce household poverty and increase household investments will go a long way in reducing the numbers of vulnerable children. The

Country and Title of Study	Type of Study and Methods	Services Evaluated	Summary of Results
			current research evidence is limited to cross-sectional designs and the few longitudinal studies that are limited in length of follow up and age coverage for robust evaluation of long term impact of OVC interventions. Longitudinal cohort studies that measure various OVC outcome variables over time, and provide a continuous set of reliable evidence for improving the scale and effectiveness of OVC interventions are therefore needed.
Needs Assessments			
<p>4. Research Situation Analysis on OVC: Kenya^d, Namibia^e, Nigeria^f, Viet Nam^g, and Zambia^h.</p> <p>Countries: Kenya, Namibia, Nigeria, Zambia, Viet Nam</p>	Mixed methods – literature review, key stakeholder interviews.	Research capacity, national policy, resource distribution, program effectiveness	While some valuable research has been conducted on OVC, overall there is very limited rigorous research evidence and data on OVC and interventions to inform policies and programs. This lack of information is hindering policy makers and program leaders from making well-informed decisions about the path forward. However, with limited resources available to divide between programming and research, a reasonable balance should be found to answer key questions without sacrificing support for critical services. In the short term, the greatest impact of research will come from filling the most fundamental gaps in information: How big is the problem and who does it affect? Are current programs working, and if not, what will? What will it cost to have a positive impact?
Costing Studies			
<p>5. Costing of OVC Service Deliveryⁱ</p> <p>Countries: Zambia, South Africa</p>	Quantitative methods – cost analysis	Costing of education, psychosocial wellbeing, food and nutrition, healthcare, child protection and legal aid, shelter and care	The full cost of inputs (goods and services) used to implement the FABRIC program at the level of sub-recipient partner organization was calculated. In 2009, the average total cost per child (USD) in Zambia ranged from \$26-\$42 and in South Africa from \$47-\$643. The sites in the cost analysis involved a range of locations, program structures, and different cost profiles. All organizations relied on volunteer labor; the imputed value of volunteer time, based on a modest daily wage rate, increases the full program costs by about 28-47%.
<p>6. A Costing Analysis of a Household Economic Strengthening (HES) Program</p>	Quantitative methods – cost analysis	Costing of household economic strengthening	The cost of implementing the HES program from the perspective of the local organizations (BIDI/IDCCS) was

Country and Title of Study	Type of Study and Methods	Services Evaluated	Summary of Results
<p>for Households Caring for Orphans and Vulnerable Children^j</p> <p>Country: Kenya</p>			<p>calculated. The program aimed to improve HES through the development and support of village savings and loan associations (SLAs) for caregivers of OVC. The direct financial cost of implementing this program for BIDII/IDCCS was \$49/57 per SLA member and \$21/25 per OVC per year. Financial costs do not account for the fundamental role of volunteers, who were responsible for implementing key components of the program.</p>
Qualitative Studies			
<p>7. Documentation of Three Programs Providing Family-Centered Support to Most-at-Risk Populations (MARP) and their Children^k</p> <p>Countries: Ukraine, Zambia, Vietnam</p>	<p>Qualitative methods – Program documentation</p>	<p>MARP, children of MARP, organizational capacity</p>	<p>Though each of the three organizations that were documented were unique in terms of approach, assistance offered, and populations served, there are a number of common challenges with which they are confronted as they seek to provide services to MARP and their children, including: financial constraints, the difficulties associated with poverty, HIV-related stigma and discrimination, and inherent difficulties due to the high-risk behaviors of many of their clients (especially injecting drug users).</p>
<p>8. Committed Communities Development Trust (CCDT): Integrating Home Based and Residential Care and Support in Mumbai^l</p> <p>Country: India</p>	<p>Qualitative methods – Process evaluation, narrative analysis</p>	<p>Children of MARP, shelter and care (including residential care)</p>	<p>The particular strengths of CCDT's Crisis Intervention Centre (CIC) model include: (1) Continually evolving commitment and approach to child rights; (2) Multi-faceted method of filling urgent needs within vulnerable communities while simultaneously building community capacity for self efficacy and advocacy; (3) Established reputation at the city, state, and (increasingly) national level for providing leadership, monitoring, and training for other leadership and staff running other special homes for children (both public and private); (4) Ongoing collaborations with civil society, service providers, and government to improve care and support for vulnerable families and children; (5) Conscious self-positioning to offer their home-based care CIC support as a practical, experience-based strategy.</p>
<p>9. Disclosure of Children's HIV Status in Four High Prevalence States in India^l</p>	<p>Qualitative methods – Cross-sectional</p>	<p>Psychosocial wellbeing, shelter and care (including residential care)</p>	<p>Parental guilt, shame, and worry strongly affected parents' ability to inform their child of his/her HIV status. When disclosure occurred it</p>

Country and Title of Study	Type of Study and Methods	Services Evaluated	Summary of Results
<p>Country: India</p>			<p>was most often initiated by the mother, ART counselor, and/or NGO staff person. While many factors influence disclosure, ART initiation was the strongest predictor of disclosure. Other predictors varied by NGO related to their programmatic focus. The public health significance of disclosure increases as more HIV+ children are living into adulthood. Findings suggest that while NGOs play a crucial role in facilitating disclosure, ART centers need to provide appropriate counseling to mothers and children on disclosure as ART initiation is a turning point for disclosure. Child-centered approaches are crucial as other children are key in the disclosure process.</p>
Mixed Methods Studies			
<p>10. Exploring the Impact of the Community-Based Care for Orphans and Vulnerable Children (CBCO) Program ^m</p> <p>Country: Kenya</p>	<p>Mixed methods – Cross-sectional household survey</p>	<p>Household economic strengthening, education, food security, psychosocial wellbeing</p>	<p>Throughout the analysis of all outcomes, a simple comparison of the CBCO group and the group of households in adjacent communities meeting eligibility requirements showed varying levels of differences (sometimes CBCO somewhat better, sometimes not, sometimes statistically significant at the 5% level, and sometimes not). The results of this study suggest that a low-cost and low-input SLA model is not adequate to generate significant additional impacts on household welfare.</p>
<p>11. End-of-Project Evaluation: Faith-based Regional Initiative For Orphans and Vulnerable Children (FABRIC) ⁿ</p> <p>Countries: Zambia, South Africa, Namibia</p>	<p>Mixed methods – Cross-sectional household survey</p>	<p>Education, psychosocial wellbeing, food and nutrition, healthcare, child protection and legal aid, shelter and care, organizational development.</p>	<p>Findings suggest the FABRIC recruitment and targeting strategies were successful as the FABRIC sample is generally worse off than the community comparison sample. At the end of the project, disparities between the two groups seem to be less widespread. We can reasonably assume, though cannot prove, that the initial FABRIC beneficiaries were from households in greatest need. The lack of differences in many of the wellbeing indicators measured by this end-of-project evaluation could be interpreted as the FABRIC project interventions bringing its beneficiaries up to, or maintaining them at, the levels of need and vulnerability of the general population.</p>

Country and Title of Study	Type of Study and Methods	Services Evaluated	Summary of Results
12. The wellbeing of OVC and their households in four districts of Mozambique ^o <u>Country:</u> Mozambique	Mixed methods – Cross-sectional household survey	Education, psychosocial wellbeing, food and nutrition, healthcare, child protection and legal aid, shelter and care, organizational development	Results reveal that orphans and vulnerable children living in poor households have worse outcomes in food security, nutritional status, shelter, health, psychological wellbeing, and education compared to non-OVC and children living in non-poor households.
13. A Baseline Study of the Yekokeb Berhan Project <u>Country:</u> Ethiopia	Mixed methods – Cross-sectional household survey	Education, psychosocial wellbeing, food and nutrition, healthcare, child protection and legal aid, shelter and care, organizational development	<i>Study currently under way.</i>
14. An Evaluation of The Karnataka Cash Transfer Program <u>Country:</u> India	Mixed methods – Cross-sectional household survey	Education, psychosocial wellbeing, food and nutrition, healthcare, child protection and legal aid, shelter and care, household economic strengthening	<i>Study currently under way.</i>
15. Evaluating the Effectiveness of Educational Support to OVC ^q <u>Countries:</u> Tanzania and Uganda	Mixed methods – Retrospective educational indicator survey	Education, psychosocial wellbeing	Providing support to children to attend secondary school can be successful whether through block grants or scholarships, and that in general, supported performed as well as their non-OVC peers and sometimes better. Of the two approaches, block grants are simpler to administer, require less administrative costs and oversight to ensure that students receive the benefits, and are more cost effective than scholarships per student. Provision of free access to schools alone is insufficient to ensure that OVC attend regularly or perform well. Additional support was required that addressed physical health, nutrition, social setting, economic well-being, and other aspects of the child's overall well-being.
16. Evaluation of the Child Status Index (CSI) Tool: A Validation Study in Malawi ^r <u>Country:</u> Malawi	Mixed methods – validation study	Education, psychosocial wellbeing, food and nutrition, healthcare, child protection and legal aid, shelter and care	No relationships exceeded the standard for high construct validity between the CSI tool and age-specific instruments comprised of previously validated tools and indicators commonly considered best practice. In this rural Malawi population, we were not able to validate the CSI as a tool for assessing the vulnerabilities of orphaned and vulnerable children.
17. Impact of Mobile Primary	Quantitative methods –	Education,	From the beginning to the end of the

Country and Title of Study	Type of Study and Methods	Services Evaluated	Summary of Results
<p>Care Clinics on Health Status of Orphans and Vulnerable Children in Namibia: A Preliminary Evaluation of the “Mister Sister” Program^s</p> <p>Country: Namibia</p>	<p>Longitudinal health survey</p>	<p>psychosocial wellbeing, food and nutrition, healthcare, child protection and legal aid, shelter and care, costing of services.</p> <p>Public Private Partnerships</p>	<p>6 month mobile clinic program, the Mister Sister program clearly improved vaccination rates and helped to control anemia and worm infections among OVC. By bringing the services to the people, the program facilitated regular primary care visits, even for this vulnerable population. Over the 6 month trial period, Mister Sister had 4,630 patient visits and incurred N\$934,684 in costs, for a per visit cost of N\$201.88.</p>
<p>18. The Effectiveness of an Integrated Care Model Drop-in Center (DIC) in Improving Access to Services and Selected Social and Health Outcomes of Orphans and Vulnerable Children in Maharashtra¹</p> <p>Country: India</p>	<p>Mixed methods – Organizational network analysis</p>	<p>Organizational capacity, access to care, food and nutrition</p>	<p>The study was conducted in 3 districts of Maharashtra: Nagpur, Thane and Satara. The organizational network analysis (ONA) density measures were both low before and one-year after the implementation of the integrated care model Drop in Center (DIC). The DIC did not emerge as a key player, where there were very few direct relationships with other Government of India departments and organizations. The integrated care model is performing at a very low level of service delivery consisting of home visits and counseling and the referrals to schemes and services to departments outside the DIC. The high expectations coupled with inadequate level of resources and limited capacity building, have detracted the DICs from achieving access to schemes and services for HIV/AIDS orphans and vulnerable children.</p>
<p>19. Children Affected by AIDS Pilot Scheme: Organizational Network Analysis in Five Districts¹</p> <p>Country: India</p>	<p>Qualitative methods – Organizational network analysis</p>	<p>Organizational capacity</p>	<p>The study was conducted in 3 states and 5 districts: Karnataka: Belgaum and Bagalkot; Andhra Pradesh: Krishna and East Godavari; and North East Delhi. Organizational network analysis (ONA) measures of density and multiplexity were assessed. The density measures did not change significantly after implementation of the CABA Pilot Scheme. The weakest linkages were with non-health departments. The CABA Pilot Scheme has brought attention to the needs of children but the levels of coordination did not change with the program. Increasing the coordination of referral networks and by working across HIV/AIDS, health and non-</p>

Country and Title of Study	Type of Study and Methods	Services Evaluated	Summary of Results
			health departments can lead to improvement in access to social schemes and services.
<p>20. Evaluating the Organizational Capacity of 3 NGOs¹</p> <p>Country: India</p>	Mixed methods – Historical documentation, cross-sectional study	Organizational capacity, food and nutrition, psychosocial wellbeing, shelter and care (including residential care)	Three NGOs providing community based/residential care to OVC in India was studied. The profiles generated were those of well-managed but unsustainable organizations. Financial and pharmaceutical management scored highly, while governance structures and strategic and business planning were weak. The quantitative instrument is the first tool enabling consistent, repeated assessments on the organizational capacities of NGOs providing HIV services. It guides donors on which NGOs to invest in and which capacities to build. It also enables donors to rigorously evaluate capacity building efforts of international organizations and hold them accountable.

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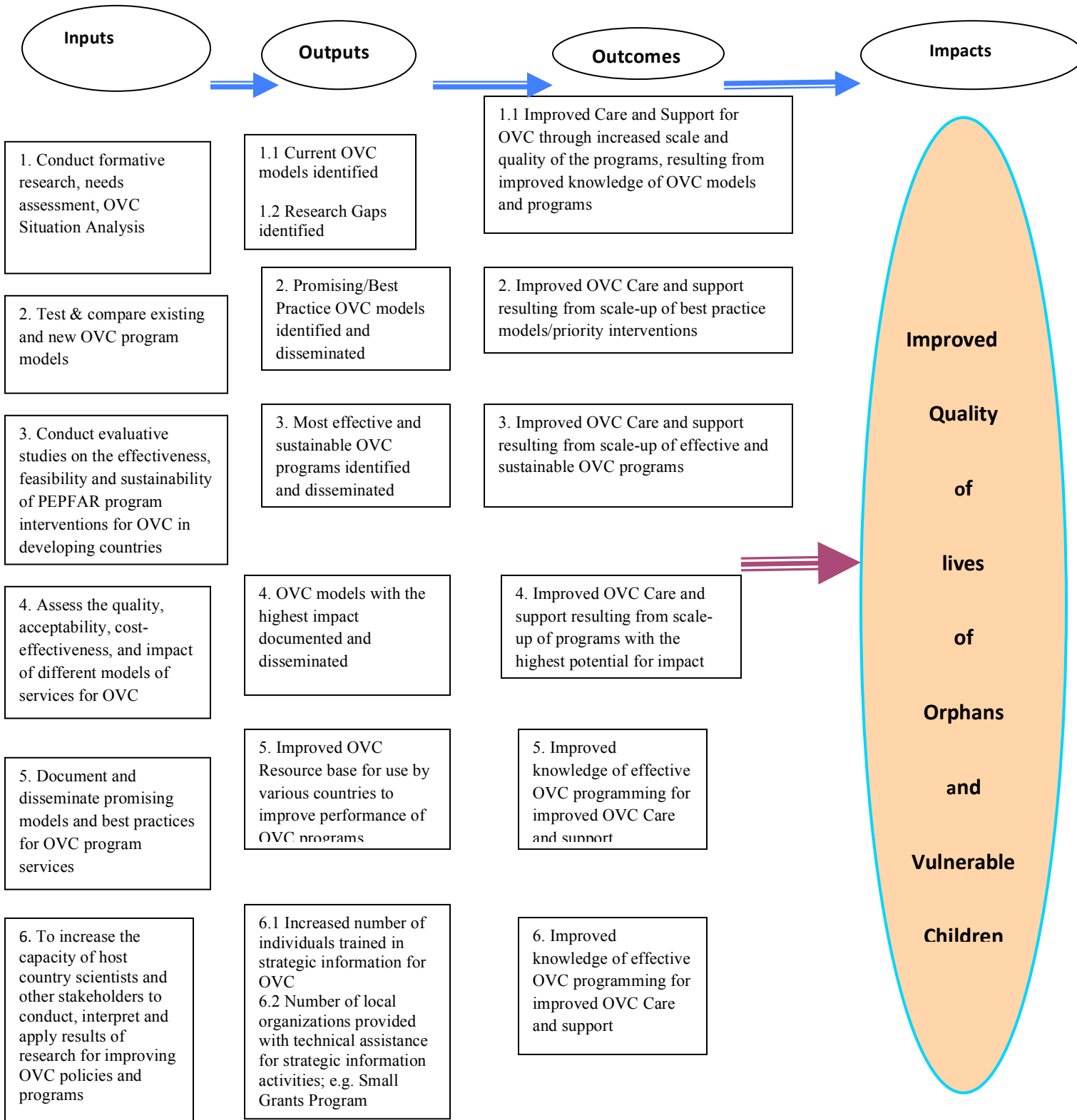
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Annex 2: List of OVC-CARE Deliverables

Year	Deliverables	Type
YR 1	OVC Research Situation Analyses - Kenya	Situation Analysis Paper
YR 1	OVC Research Situation Analyses - Nigeria	Situation Analysis Paper
YR 1	OVC Research Situation Analyses - Namibia	Situation Analysis Paper
YR 1	OVC Research Situation Analyses - Vietnam	Situation Analysis Paper
YR 1	OVC Research Situation Analyses - Zambia	Situation Analysis Paper
YR 1	Critical Review Papers - Alternative Care	Review Paper
YR 1	Critical Review Papers - MARP	Review Paper
YR 1	Critical Review Papers - Costing of OVC Interventions	Review Paper
YR 1	YR 1 Mid-term Report	Project Report
YR 1	YR 1 Annual Report	Project Report
YR 2	FABRIC End of Project Evaluation Report	Research Study
YR 2	FABRIC Evaluation Costing Report	Research Study
YR 2	FABRIC Stakeholder Meeting in Zambia	Consultation/Meeting
YR 2	HES Costing Study in Kenya	Research Study
YR 2	CSI Validation Study	Research Study
YR 2	OVC Costing Consultation	Consultation/Meeting
YR 2	Mozambique OVC Capacity Building Workshop	Capacity Building
YR 2	YR 2 Mid-term Report	Project Report
YR 2	YR 2 Annual Report	Project Report
YR 3	OVC Block Grant Evaluation Report	Research Study
YR 3	OVC Block Grant Stakeholder Meeting in Uganda and Tanzania	Consultation/Meeting
YR 3	HES Evaluation Report	Research Study
YR 3	HES Technical Meeting in Kenya	Consultation/Meeting
YR 3	MARPS Documentation Project	Research Study
YR 3	OVC Costing Technical Meeting	Consultation/Meeting
YR 3	CSI Technical Consultation	Consultation/Meeting
YR 3	OVC-CARE Pre-Dissemination Workshop	Consultation/Meeting
YR 3	YR 3 Mid-term Report	Project Report
YR 3	YR 3 Annual Report	Project Report
YR 4	APHA OVC Panel	Consultation/Meeting
YR 4	Mozambique OVC Study	Research Study
YR 4	OVC Stakeholder Meeting in Mozambique	Consultation/Meeting
YR 4	Namibia OVC Study	Research Study
YR 4	OVC Stakeholder Meeting in Namibia	Consultation/Meeting
YR 4	Ethiopia OVC Baseline Study	Research Study
YR 4	Ethiopia 5-year impact study design	Research Study
YR 4	OVC Stakeholder Meeting in Ethiopia	Consultation/Meeting
YR 4	India OVC Study - Organizational Network Analysis	Research Study

YR 4	India OVC Study - Drop-in-Center Evaluation	Research Study
YR 4	India OVC Study - 3 NGO Study	Research Study
YR 4	India OVC Study - Disclosure Study	Research Study
YR 4	India OVC Study - Cash Transfer Study	Research Study
YR 4	India OVC Study - CCDT Evaluation	Research Study
YR 4	India OVC Capacity Building Workshop	Capacity Building
YR 4	India OVC Dissemination Meeting	Consultation/Meeting
YR 4	OVC-CARE Final Report	Final Report
YR 4	YR 4 Mid-term Report	Project Report
YR 4	YR 4 Final Report	Project Report

Annex 3: Performance Monitoring Plan – Theoretical Framework



Annex 4: Performance Monitoring Plan – Evaluation Matrix

Performance Monitoring Plan Results	Indicators¹	Definition of Indicator	Base	Target	Achieved	Comments
Project Objective 1: To conduct formative research, needs assessment, and data analysis in order to inform OVC strategies and programming	1.1 Number of Country needs assessments / Situation Analyses conducted to develop research priorities.	1.1 Total number of country situation analyses/needs assessments conducted over the life of the project	0	5 by end Q4	5	- Nigeria - Vietnam - Zambia - Kenya - Namibia
	1.2 Number of Literature Reviews done to inform OVC programs and strategies	1.2 Total number of Review Papers on priority OVC topics produced over the life of the project	0	3 by end Q6	3	- Costing of OVC Services - Alternative Models of Care - Children of MARPS
	1.3 Number and topics of other formative research studies conducted, including qualitative studies	1.3 Total number of formative research studies conducted over three years	0	3 by end Q11	3	- Three country MARPS study - India MARPS study - India disclosure study
Project Objective 2: To test and compare existing and new OVC program models and service delivery approaches to identify promising practices for adaptation and scale up in resource poor settings	2.1 Number of promising program models and approaches reviewed and evaluated for scale-up potential	2.1 Total number of promising program models reviewed and evaluated	0	1 by end Q12	1	Mister Sister Operations Research Project in Namibia

¹ While some indicators relate to more than one objective, indicators are presented here in line with the most relevant Objective.

Performance Monitoring Plan Results	Indicators ¹	Definition of Indicator	Base	Target	Achieved	Comments
Project Objective 3: To conduct evaluative studies on the effectiveness, feasibility and sustainability of PEPFAR program interventions for OVC in developing countries	3.1 Number of effectiveness, feasibility and sustainability evaluation protocols completed	3.1 Total number of Protocols developed and completed	0	4 by end Q8	8	Protocols developed and IRB approval obtained: - CSI Study - FABRIC Evaluation - Education Block Grants - Mozambique - India ONA - India DIC - India 3 NGO - Ethiopia
	3.2 Number of Evaluative Studies developed and conducted	3.2 Total number of Evaluative studies conducted	0	4 by end Q 11	8	Studies completed: - CSI Study - FABRIC Evaluation - Education Block Grants - Mozambique - India ONA - India DIC - India 3 NGO - Ethiopia
	3.3 Number of articles published in Peer Review Journals	3.3 Number of manuscripts submitted for publication	0	2 by end Q 12	4	- CSI Paper - Educational Block Grants x2 - India 3 NGO
Project Objective 4: To assess the quality, acceptability, cost-effectiveness, and impact of different models of services for OVC programs	4.1 Number of Protocols on the quality, cost-effectiveness and impact of OVC models developed.	4.1 Total number of Protocols developed	0	4 by end Q8	4	Protocols developed and IRB approval obtained: - FABRIC costing study - Kenya costing study - Kenya HES study - India cash transfer (Karnataka)
	4.2 Number of studies conducted on the quality, cost-effectiveness and impact of OVC	4.2 Total number of Studies conducted and completed	0	4 by end Q11	4	Studies completed: - FABRIC costing study - Kenya costing study - Kenya HES study - India cash transfer (Karnataka)

Performance Monitoring Plan Results	Indicators ¹	Definition of Indicator	Base	Target	Achieved	Comments
		4.3 Total number of manuscripts submitted for publication	0	2 by end Q12	2	<ul style="list-style-type: none"> - Costing paper - Kenya HES paper
Project Objective 5: To document and disseminate promising models and best practices (knowledge management) for OVC program services and promote utilization of results in resource poor settings	5.1 Number of dissemination events to promote Project findings	5.1 Total number of meetings or conferences held to present research findings	0	5 by end Q12	11	<ul style="list-style-type: none"> - High-level meeting on costing of OVC services June 2010 - CSI meeting in Washington, DC - June 2010 - APHA Conference Panel (4 papers) - Nov. 2011 - Global AIDS conference Disclosure Poster - July 2012 - Global AIDS conference MARPS poster - July 2012 - Global AIDS conference 3 NGO oral presentation - July 2012 - Dissemination meeting with USAID in Washington, DC - June 2011 - Dissemination meeting of Education study in Uganda - July 2011 - Dissemination meeting of Education study in Tanzania - July 2011 - Dissemination meeting of HES study in Kenya July 2011 - Dissemination meeting in Delhi - Jan 2012

Performance Monitoring Plan Results	Indicators ¹	Definition of Indicator	Base	Target	Achieved	Comments
<p>Cross-Cutting Objective 6: To increase the capacity of host country scientists and other stakeholders to conduct, interpret and apply results of research for improving OVC policies and programs</p>	<p>6.1 Number of local investigators trained to conduct, interpret, and apply results for improving OVC programs</p>	<p>6.1 Total no. of local (non-US) investigators trained by end of year 3</p>	<p>0</p>	<p>15 by end Q12</p>	<p>78</p>	<ul style="list-style-type: none"> - 43 trained in Mozambique - 35 trained in India
<p>Cross Cutting Objective 7: To conduct all Project activities in a professional, efficient and effective manner that reflects well on USAID; complies with relevant USG regulations; and is rated highly by key stakeholders and developing country partners.</p>	<p>7.1 Proportion of requested work plans submitted on time</p>	<p>7.1a No. of work plans submitted within 60 days of being requested x 100 No. of work plans requested</p>	<p>0</p>	<p>100%</p>	<p>100%</p>	<ul style="list-style-type: none"> - 4 Core Budget Annual Plans - Mozambique workplan - Namibia Workplan - Ethiopia Workplan - India Workplan - All submitted on-time
	<p>7.2 Proportion of USAID requests for technical assistance on design/adaptation of methodologies, indicators, and tools met within 90 days.</p>	<p>7.2 No. of USAID requests for TA met within 90 days of being requested x 100 Total No. of USAID requests</p>	<p>0</p>	<p>100%</p>	<p>N/A</p>	<p>There have been no requests for technical assistance.</p>

Performance Monitoring Plan Results	Indicators ¹	Definition of Indicator	Base	Target	Achieved	Comments
	7.3 Proportion of on-time compliance with USAID reporting requirements and guidelines, including deliverables	7.3 Total No. of reports submitted on time (according to each reporting schedule) $\times 100$ $\frac{\text{Total No. of Reports over the life of the project}}{\text{Total No. of Reports over the life of the project}}$	0	100%	98%	<ul style="list-style-type: none"> - 3 annual reports - 1 Final Report - 4 semi-annual reports - 4 annual workplans - 1 PMP - 1 small grants plan - 1 Branding and Marking plan - 24 approved research reports - 1 research report submitted but not yet approved - 42 individual international trip reports
	7.4 Performance rating on quality and impact of capacity strengthening activities	7.4 Composite scores from USAID independent external evaluation among collaborating partners and stakeholders	0	80%	N/A	This has not happened yet
	7.5 Performance rating on quality and impact of research and evaluation activities	7.5 Composite scores from USAID independent external evaluation among collaborating partners and stakeholders	0	80%	N/A	This has not happened yet

Performance Monitoring Plan Results	Indicators ¹	Definition of Indicator	Base	Target	Achieved	Comments
	7.6 Performance rating on quality and impact of knowledge management and dissemination activities	7.6 Composite scores from USAID independent external evaluation among collaborating partners and stakeholders	0	80%	N/A	This has not happened yet