

Increased Care and Support to Orphans and Vulnerable Children in the Great Lakes Region of East Africa

5 Years Program Achievements in Kenya (2005-2010)



L-R: Primary School, Mutuati, Kenya; the AVSI OVC Logo; the barber shop of Kevin, Soweto, Kibera, Nairobi

Background and Methodology

Children have been the main beneficiaries of AVSI activities since its arrival in Africa, 25 years ago. AVSI's concern is for the integral development of every child, with each one seen as being endowed with inestimable dignity and potential, each unique and unrepeatably. For many years, AVSI's Distance Support Program (DSP) had made it possible for thousands of children to attend school, have access to regular and emergency health care, and to know the care and concern of adults in their communities. Through the DSP, private donors are matched with a child who receives both direct and indirect support by AVSI and selected partner organizations in his/her home community. AVSI has traditionally focused on the most marginalized and vulnerable families and communities, with particular attention to those affected by the HIV/AIDS epidemic.

In April 2005, under the cooperative agreement GPO-A-00-05-0002000 – AVSI started the implementation of a 5-year project to expand its DSP intervention model across Uganda, Rwanda, Kenya, later on extended in Ivory Coast.

The overall goal of the project has been to improve the well-being and coping capacity of orphans and vulnerable children (OVC), as well as their families and communities. AVSI chose to work both directly and via sub-grants to local community-based organizations, together with capacity building and mentoring.

During the early stage of the program, AVSI decided to change the OVC acronym to reflect more accurately AVSI's view of the program purpose and vision; *Orphans and Vulnerable Children* was therefore replaced by ***Our Valuable Children***, thus emphasizing the positive resource inherent in every child, and the community responsibility in from of them and ownership over the program.

Since the onset the project, AVSI embraced a family-centered and community-based model of care and support for OVC that relies on each individual child as an entry point to a family. This approach recognizes that every child despite his/her condition is unique, valuable and with special needs; it recognizes that the family is very central for the growth, education and development of the child and that the community plays a vital role in nurturing the child.

Geographical Areas of intervention

In Kenya AVSI implemented the project in 10 districts spread in 5 provinces namely Nyanza, Nairobi, Eastern, Central and Rift Valley provinces, both directly with AVSI social workers and through local partners. The partners are local NGOs, FBOs, CBOs and schools within target communities. The districts involved were Nairobi, Kiambu, Nyandarua, Thika, Meru north, Baringo, Nandi north, Siaya, Kajiado and Narok

Achievements

During the 5 years of the project,

- **20 partners** built their capacity to offer quality and sustainable services to OVC and their families
- **16,596 OVC** have been served with a wide range of services;
- **5,233 households** have been strengthened economically to provide for their members;
- **636 caregivers** (social workers, teachers, parents and student leaders) have been trained to enhance their skills in OVC care and support.

Results in specific core program areas are described in the table below.

Project Evaluation

In the final year of the project, a longitudinal study of the beneficiaries and partner organizations was completed through the implementation of a final household and organizational survey. The survey data proved to be extremely rich in detail and information. The tools and processes were also useful to improve the capacity of AVSI and her partner organizations in each country to develop indicators, adapt evaluation instruments and ultimately to collect standardized data on the project's impact.

At the level of the child, most indicators related to education, psychosocial, health and nutrition all improved over the life of the project.

One important conclusion was the direct impact that guardians' health and economic stability has on the well-being of the child (considered holistically in terms of education, health and psycho-social indicators of well-being). In particular:

- Children who exhibit bad general health are often related to the guardians with bad health and to the outcome of poor performance at school;
- Children who report poor nutrition (less than 2 meals per day) are more likely to have guardians who are illiterate or affected by bad health conditions;
- Bad school performance is more common among children with illiterate guardians, those who live in "dirty" houses or those in rural areas;
- On the positive side, children who maintain regular school attendance are more likely to live in places that are less isolated, enjoy good health and nutrition, have a father as guardian, live with guardians in good health and enjoy positive relationships with the guardian.

The findings confirm that indeed a family centered approach is more effective in promoting a child's well-being as opposed to simply child centered interventions.

At the level of the partner organization, the results of the study show overall improvement in organizational structures and the awareness and skills related to quality service delivery to children

and families. Among the results, the following conclusions can be noted, and linked to the work of capacity building done by AVSI throughout the project.¹

- A general improvement of self awareness about the functions of the board and the different managerial styles;
- An improvement of the relationships with the families or caregivers of the children;
- An increase in the degree to which they value networking and sharing of experiences with other organizations and
- More attention given to sensitization activities.

Resulting from the analysis of indexes derived from both surveys (children and organizational partners), we gain the most interesting and impressive results:

- There is a strong correlation between the Well-being Status Index and the AVSI intervention with variables derived from the partners' survey like the "Planning and Sensitization Index" and the "Development Capabilities and Evaluation Index". The higher these characteristics are among partners, the higher the result on the main indexes of children status and the capability of intervention of AVSI partners
- Big partner organizations have better governance capabilities, as well as greater financial sustainability and structure, but not necessarily good results in the Well-being of the children or in the level of AVSI intervention. *The size of the partners doesn't play the main role in determining better results for the children. There is some indication that medium sized organizations (11-40 employees) managed to achieve better results on child well-being indicators and AVSI programming indicators.*
- The type of organization has an important role in the level of impact on child-wellbeing. The organizations with better scores in Well-being Status Index and with higher level in AVSI intervention are the education centers while NGOs are strong in governance capabilities and financial innovation and sustainability. The faith and charitable organizations are stronger in the governance capabilities and in structural complexity.

These findings confirm AVSI approach in identifying local partners organizations embedded in the communities with the main criteria of a common vision towards the good of the child. The capacity building of local partners is very effective in promoting a child's well-being and will remain one of the core interventions of AVSI OVC programming.

Future

AVSI is fully committed to ensuring that all children who have not completed their educational cycle will be enabled to do so. In large part this sustainability is made possible by the dedicated support of thousands of private donors in AVSI's Distance Support Program.

AVSI's interest in continuing supporting OVC is still high and for this reason is continuing to look for other forms of support for the expanded reach of the AVSI OVC/DSP program.

¹ See http://www.avsi.org/documenti/AVSIConceptPaperCapacityBuildingOVC_care.pdf

Table on Core Program Areas

Services/Indicator	Kenya	Comments/notes*
Food/nutritional support (no. children supported)	5,089	HIV positive children and those from food insecure holds were served with food.
Shelter and Care (no. households supported)	10,379	Children with no extended families and those with households with difficulties in meeting shelter needs
Protection (no. children supported)	5,490	Involves imparting of children rights messages to the community, birth registration, inheritance rights issues
Health Care (no. children who had access to health care)	8,212	Agreement with hospitals, health care centers and clinics, health insurance to provide health care to the supported children and their families
Sensitization (no. contacts)	75,544	Sensitization included topics on HIV prevention and behavior change
Psychosocial Support(no. children supported)	16,596	Psychosocial needs of children were addressed through follow up support visits by social workers and counseling to children and guardians
Counseling/communications(no. children supported)	5,693	
Recreational activities(no. children supported)	10,647	Recreational activities include educational tours, Christmas and birthday parties, sport competitions, music, dance and drama festivals, trips to recreational centers.
Education and Vocational Training (no. children supported)	8,047	Children received schools fees, uniforms, shoes, exercise and text books and transport to facilitate their learning.
Quality education (no. of schools supported)	71	Rehabilitation of classrooms, provision of desks, Maps and atlases, educational kit for nursery and primary schools, geometry kits for teachers, books for school library, school feeding program
Quality education (no. of pupils in supported schools)	26,102	
Quality education (no. of teachers in supported schools)	918	
Care and support (no. of caregivers teachers, social workers, trained)	636	Some of the training and workshops organized include Observation and The Helping Process of OVC; Planning, Reporting and Follow Up; Monitoring and Evaluation; HIV/AIDS Counseling and Testing; The Meaning and Scope of Education; The National OVC Policy and Quality Standards, Value of Life, Psychosocial Approach, Well being in class, Introduction to Play Therapy
Economic Opportunity/Strengthening (no. of families supported)	5,233	Socioeconomic interventions included training of caregivers in business skills , provision of start capitals and/or material (like seeds, animals), provision of start up kits after vocational courses (like tool boxes, sewing machines, saucepans etc)
Number of community projects	6	Extension of piped water to the communities that had no water for many years; renovations of houses for the needy and elderly members in the community; constructions of pit latrines for families, road repair, houses renovation, social halls renovations, toilets renovation, and office renovation.
Number of families benefiting from community projects	7,580	
Adult literacy (no. of adults)	778	

Interesting related documents

- <http://www.avsi-usa.org/docs/pdf/stories%20of%20hope.pdf>
- <http://www.avsi-usa.org/docs/pdf/FacesOfHope.pdf> .
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