Evaluation as experience of knowledge
the OVC program in the Great Lake Region - Africa
All our knowledge, even the most simple, is always a minor miracle, since it can never be fully explained by the material instruments that we apply to it.

Caritas in Veritate, n.77
This document contains the synthesis of the final evaluation of the AVSI’s Program of Orphans and Vulnerable Children (OVC) conducted by the Foundation for Subsidiarity (Fondazione per la Sussidiarietà), an Italian cultural and research non-profit organization. The OVC Program has been implemented by AVSI Foundation in Uganda, Rwanda and Kenya, from 2005 to 2010, with the financial support of the U.S. Agency for International Development and AVSI itself.

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The first objective of this project, started in November 2009, is to improve the information network and the exchange of best practises of non governmental authorities and local authorities, involved in the AVSI network, also including the following European NGO: CESAL in Spain, VIDA in Portugal, AVSI POLASKA in Poland, FUNDATIA in Romania and SOTAS in Lithuania.

The opinions expressed in this document are of AVSI and do not necessarily reflect those of the European Union.
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Evaluation as Experience of Knowledge

AVSI's Program for Orphans and Vulnerable Children in the Great Lakes Region – East Africa
1

Background and Methodology of the OVC Program
Background and Methodology of the OVC Program
Children have been the main beneficiaries of AVSI’s activities since its arrival in Africa, 35 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 unrepeatable. 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. A child is looked upon as a member of a family and community and AVSI always engages parents or guardians directly to enhance their responsibility towards their children. 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 with the U.S. Agency for International Development GPO-A-00-05-0002000, AVSI started implementation of a 5-year project to expand its DSP intervention model across Uganda, Rwanda, and Kenya, later on to be extended to 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 that of 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’s 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 and in supporting families.
Geographical Areas of intervention
In Uganda
AVSI chose to implement the project largely through local partners, mainly in the northern, central and western regions. The partners are local NGOs, FBOs, CBOs and schools within target communities.

In Kenya
AVSI implemented the project in 10 districts spread across 5 provinces, namely Nyanza, Nairobi, Eastern, Central and Rift Valley provinces. Activities were carried out both directly with AVSI social workers and through local partners. The partners are local NGOs, FBOs, CBOs and schools within target communities.

In Rwanda
The project covered 4 districts in the Eastern and Southern provinces. While in the beginning AVSI mainly implemented directly with AVSI social workers, by the end of the project six local partners were involved in direct activity implementation. The partners are local NGOs, FBOs, CBOs and health centers within target communities.
2

Achievements
The project reached a high number of beneficiaries, exceeding original target:

<table>
<thead>
<tr>
<th>Description of beneficiaries</th>
<th>Uganda</th>
<th>Kenya</th>
<th>Rwanda</th>
<th>TOT</th>
</tr>
</thead>
<tbody>
<tr>
<td>partners built their capacity to offer quality and sustainable services to OVC and their families</td>
<td>41</td>
<td>20</td>
<td>6</td>
<td>67</td>
</tr>
<tr>
<td>OVC who have been served with a wide range of services;</td>
<td>12,390</td>
<td>16,596</td>
<td>4,553</td>
<td>33,539</td>
</tr>
<tr>
<td>households which have been strengthened economically to provide for their members;</td>
<td>4,223</td>
<td>5,233</td>
<td>1,316</td>
<td>9,456</td>
</tr>
<tr>
<td>caregivers (social workers, teachers, parents and student leaders) who have been trained to enhance their skills in OVC care and support</td>
<td>2,992</td>
<td>636</td>
<td>243</td>
<td>3,871</td>
</tr>
</tbody>
</table>

The basic or “core” needs of children and youth to which the project responded include: food and nutrition, shelter and care, protection, health care, psychosocial support, education and economic strengthening for families. Results in specific core program areas are described in the table below.

<table>
<thead>
<tr>
<th>Services/Indicator</th>
<th>Uganda</th>
<th>Kenya</th>
<th>Rwanda</th>
<th>TOT</th>
<th>Comments/notes*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Food/nutritional support (no. children supported)</td>
<td>3,974</td>
<td>5,089</td>
<td>692</td>
<td>9,755</td>
<td>HIV positive children and those from food insecure holds were served with food</td>
</tr>
<tr>
<td>Shelter and Care (no. households supported)</td>
<td>6,188</td>
<td>10,379</td>
<td>4,485</td>
<td>21,052</td>
<td>Children with no extended families and those with households with difficulties in meeting shelter needs</td>
</tr>
<tr>
<td>Protection (no. children supported)</td>
<td>12,390</td>
<td>5,490</td>
<td>3,642</td>
<td>21,522</td>
<td>Involves imparting of children rights messages to the community, birth registration, inheritance rights issues</td>
</tr>
<tr>
<td>Health Care (no. children who had access to health care)</td>
<td>10,353</td>
<td>8,212</td>
<td>4,428</td>
<td>22,993</td>
<td>Agreement with hospitals, health care centers and clinics, health insurance to provide heath care to the supported children and their families</td>
</tr>
<tr>
<td>Sensitization (no. contacts)</td>
<td>68,623</td>
<td>75,544</td>
<td>360,746</td>
<td>504,913</td>
<td>Sensitization included topics on HIV prevention and behavior change</td>
</tr>
<tr>
<td>Psychosocial Support (no. children supported)</td>
<td>12,390</td>
<td>16,596</td>
<td>4,553</td>
<td>33,539</td>
<td>Psychosocial needs of children were addressed through follow up support visits by social workers and counseling to children and guardians</td>
</tr>
<tr>
<td>Counseling/ communications (no. children supported)</td>
<td>12,390</td>
<td>5,693</td>
<td>3,292</td>
<td>21,375</td>
<td>Children and families with particular needs received individual or group counseling by trained social workers</td>
</tr>
</tbody>
</table>
| **Recreational activities (no. children supported)** | 10,843 | 10,647 | 43,290 | 64,780 | **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)** | 12,024 | 8,047 | 4,436 | 24,507 | **Children received schools fees, uniforms, shoes, exercise and text books and transport to facilitate their learning.**
| **Quality education (no. of schools supported)** | 66 | 71 | 53 | 190 | **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)** | 21,700 | 26,102 | 40,757 | 88,559 | **Training and workshops organized include: Observation and The Helping Process of OVC; Planning, Reporting and Follow Up; Monitoring and Evaluation; HIV/AIDS Prevention, Counseling and Testing; The Meaning and Scope of Education; The National OVC Policy and Quality Standards, Psychosocial Approach, Well being in class, Introduction to Play Therapy**
| **Quality education (no. of teachers in supported schools)** | 1,741 | 918 | 826 | 3,485 | **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)**
| **Care and support (no. of caregivers, teachers, social workers, trained)** | 2,992 | 636 | 243 | 3,871 | **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**
| **Economic Opportunity/ Strengthening (no. of families supported)** | 4,223 | 5,233 | 1,316 | 10,772 | **Adult literacy courses were organized for caregivers to improve their capacity to follow the children in their home works and to be more equipped to start a business**
| **Number of community projects** | 7 | 6 | 12 | 25 | **Adult literacy courses were organized for caregivers to improve their capacity to follow the children in their home works and to be more equipped to start a business**
| **Number of families benefiting from community projects** | 9,000 | 7,580 | 5,860 | 22,440 | **Adult literacy courses were organized for caregivers to improve their capacity to follow the children in their home works and to be more equipped to start a business**
| **Adult literacy (no. of adults)** | 760 | 778 |  |  | **Adult literacy courses were organized for caregivers to improve their capacity to follow the children in their home works and to be more equipped to start a business**
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3

Project Evaluation
**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.*

Statistical analysis of the interactions among variables led to useful findings. 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.

*A comprehensive summary of the evaluation done on children is in Annex 1.*

At the level of the partner organizations, 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:

- 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.

*A comprehensive summary of the evaluation done on partners is in Annex 2.*

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

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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 does not 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 on the Well-Being Status Index and with higher levels in AVSI Intervention are the educational 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’s 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.
Evaluation as Experience of Knowledge
AVSI’s Program for Orphans and Vulnerable Children in the Great Lakes Region – East Africa
Interesting related documents
Interesting related documents
Here below a list of links to download the documents produced during the life of the project, including the full report of the evaluation done on children and on partners.

http://www.avsi-usa.org/docs/pdf/stories%20of%20hope.pdf
http://www.avsi-usa.org/docs/pdf/FacesOfHope.pdf
http://www.avsi.org/documenti/AVSIEligibilityCriteria-ScoringForm.pdf
http://www.avsi.org/documenti/AVSIVulnerabilityChildForm.PDF
http://www.avsi.org/documenti/AVSIVulnerabilityFollowUpForm.pdf
http://www.avsi.org/documenti/OCV_partners_report_final_AVSI.pdf
Annex 1
Executive Summary – External Evaluation of Children’s Wellbeing, AVSI’s Program of Support for Orphans and Vulnerable Children in the Great Lakes Region - East Africa

October 2010

In 2005, AVSI Foundation embarked on the endeavor of scaling-up its existing system of support to the most vulnerable children and orphans in poor communities in Kenya, Uganda and Rwanda, all of which have been directly affected by the HIV epidemic. This scaling-up was made possible due to complementary financing from USAID through PEPFAR and was feasible because of AVSI’s established network of local partner organizations.

The main objective of the program has always been to increase the capacity of families and communities to care for the most vulnerable orphans and children in HIV/AIDS affected communities. In harmony with the expectations of USAID, AVSI sought to work towards this objective with a combined approach of direct provision of services to OVC and, indirectly, through a method and specific interventions designed to increase the capacity of families and communities to care for all vulnerable children. Therefore, AVSI utilized a set of objectives and corresponding indicators of outcome to guide the program along two parallel tracks: directly improving the well-being of children and increasing the capacity of families and communities to care for children.

In order to grasp the impact of its method on children’s well-being and on the organizational capacity building of its partners in the three countries of the program, and in concordance with USAID’s strong interest in evidenced-based programming, AVSI contracted the Foundation for Subsidiarity (Fondazione per la Sussidiarietà), an Italian cultural and research no-profit organization, to conduct an evaluation exercise. The research team combined expertise in sociology, statistics, and field based data collection. With input from the project team, the researchers designed two surveys, one directed towards the domain of children and the other at the domain of partner organizations. Two sets of evaluation reports resulted from this exercise.

Summary of Method

Throughout the AVSI OVC project (2005-2010), three surveys of a random sample of participating children were conducted by the external research firm together with AVSI staff based locally in Uganda, Rwanda and Kenya. The study utilized a longitudinal panel survey design with the intention of capturing change among a stable, representative, sample of participants over time. The three surveys were conducted in the spring months of 2006, 2007 and 2009. Interviews were directed towards guardians and social workers of children (ages 6-16 years) in the sample of 1,200 children, taken from the universe of children (2-18 years) enrolled in AVSI’s OVC program at the start in 2005.2

2 The researchers decided to focus on school-age children because of the program focus on education and educational outcomes. The age range was limited to those age 16 at the beginning of the program to allow for the follow-up surveys to be conducted with the same children. The program eventually assisted over 12,000 youth directly in the three countries.
This Concluding Report documents the changes observed between data from the 2006 baseline survey and the 2009 survey with the longitudinal approach. In this way, a dynamic profile of the changes occurred in each beneficiary of the OVC program can be obtained. It is divided into three parts: (1) Outputs of Longitudinal Analysis, (2) Outputs of Multivariate Analysis, and (3) Conclusions and Recommendations.

The Longitudinal Analysis provided an in-depth profile of the children and families who were selected for and participated in the project. The profile is dynamic, showing indications of change over the period of project intervention and study. The resulting data, focused on univariate statistical analysis disaggregated where relevant by country and sex, has been captured in five different areas:
- Child situation (orphanhood) and vulnerabilities
- Guardian Characteristics and Vulnerabilities
- Household Characteristics
- School Attendance and Performance
- AVSI Support Provided

For each of these areas, the data was synthesized into indexes which allow for quick comparison of related data points according to the main programmatic objectives.\(^3\)

The indexes were:
- Orphanhood Index
- Child Nutritional Index
- Child Health Index
- Guardian Health Index
- Care Giving Index
- Property Index
- Social Risk Index
- School Performance Index

The Multivariate Analysis involved the application of some advanced statistical tools to analyze the relationships among multiple variables and build composite indicators. The goals were also to identify segments of the population with similar characteristics, which would be applicable for the adaptation of program interventions for particular sub-target groups, and to understand the mechanisms of impact for prediction and planning purposes. The tools utilized and reported upon in this report include the following:
- Factorial Analysis
- Cluster Analysis
- Children Profiling
- Structural Equation Modeling

The final model approach allows for an estimation of the causal relationship between the so-called manifest, or observed, variables collected through the survey and the latent variables in order to identify the drivers of change that have greater effect on the status and evolution of children. The analysis was guided by an interest in providing data useful for the management and design of program interventions.

**Summary of Findings**
Overall, the research has provided an in-depth understanding of the children within this program.

**By Longitudinal Analysis**

Starting from children vulnerability
The Orphanhood Index shows that 20% of the children have had a worsening of their situation due to the loss of a parent; more children are orphans (partial and total) than in 2006. Among 6% of children, the index has improved, meaning that absent parents have returned to the family unit.

To improve Health Care and Health Conditions
The Child Health Index shows that health conditions have remained bad or very bad or have worsened for more than half of the children. At the same time, health conditions are improving for 38% of the children (see Figures 6, 7). Results were slightly worse in Rwanda and better in Kenya. Among the children, 61% have never been tested for HIV/AIDS, although this level is significantly lower in Rwanda where only 25% have never been tested. Overall, 3.8% of the tested children are HIV positive: 5.6% in Uganda, 2.1% in Kenya, and 1.2% in Rwanda (see Table 5). Guardians’ health performance also continued to be very bad during the period and worsening for the same percentage of guardians as those whose health is improving (see Figures 18-20). The rate of HIV/AIDS infection among guardians has increased from 14.9% in 2006 to 16.7% in 2009, while Uganda continues to suffer from the highest infection rate of adults, at 24% in 2009 (see Table 12). Rates of HIV testing are significantly higher among guardians than among children, around 65% compared to 33%. Guardian’s poor health is increasingly affecting their capacity for work (see Tables 14, 15).

To improve Access to Food and Nutrition
The Child Nutritional Index has clearly improved, with slightly better results for the children in the urban areas. Rwanda continues to be the country with relatively worse nutrition; 2009 data were collected during a period of drought conditions (see Figures 2-5). The generally positive trends in the nutritional data lead to a preliminary conclusion that AVSI’s intervention helped to mitigate the impact of the food crisis on the participating OVC.
To improve Shelter and Care
The data reflect slight improvements in shelter conditions and living density of the OVC in the program. For example, the percentage of families living in single-room homes has reduced slightly from 28% in 2006 to 24.5% in 2009. Indicators of house building materials and access to water and sanitation continue to show a mixed situation, with only slight improvements. The Social Risk Index captures indicators related to the living conditions and environment of the child's home; in 27% of the cases the risk factors have decreased and for 35% they have remained low (see Figure 29). The most critical situation is found in the urban slums where risks have increased more than the average (see Figure 31).

To improve Protection
Children's involvement in work/labor is more widespread and frequent than in 2006; 90% of children work at some time, mostly in housework and digging, with rates highest in Rwanda where 87% work every day. This output may be related to the fact that children have grown older, and confirms that according to tradition all family members are supposed to contribute to household well-being. It has been important for AVSI to note with concern that children belonging to households that received IGA support do work more than the average. Work, however, does not seem to have an impact on children's personality or school performance (see Figure 35); instead it has a negative influence on the relationship between the child and his/her guardian, possibly due to the amount of time spent together.

To improve Psychosocial Support and Wellbeing
Indicators of psychosocial wellbeing included child personality and relationships with guardians, adults and peers. A significant percentage of children who were shy or aggressive in 2006 are now reported to be sociable and better adapted; this result is likely due in part to personal growth and AVSI intervention. The relationships of children with adults in their families have clearly improved, while the trend in terms of relationships with peers is less clear, with some 23% of children reporting worsening relationships (see Tables 7,8 and Figures 12-14).

The Care Giving Index shows very good results in 2009 and clear improvement from 2006 with respect to the quality and quantity of time that children and guardians spend together (see Figures 23-25).

To improve Education
Considering school attendance and performance of the children in the sample, very encouraging results emerge. Although the children are delayed on their school path, they have not accumulated any more delay during the time that they have spent in the OVC program. Over 90% of the children attended school regularly throughout the life of the project. The School Performance Index shows a generally positive trend;
children scoring badly disappear while 30% have improved and 36% have maintained fair or high performance. Downward shifts in performance were mostly among those children who transitioned from primary to secondary school (see Figures 37-39).

Certain deficiencies persist in terms of access to education and quality; children walk long distances and classrooms are often overcrowded. A difference is noted between the average number of hours children spend in school and the availability of extra-curricular activities in Rwanda (where these indicators are lower) and Kenya and Uganda (see Tables 53-55). The comparison of class ranking of the children considered by country shows very positive results for the Rwandan school children despite the quality indicators (see Table 65). At the same time, Rwandan students also demonstrate the highest number of poor-performers (see Table 66).

**To improve Economic Strength of Families**

Most families of OVC are involved in agriculture, casual labor, petty trade and services; Uganda has the highest number of adults engaged in more formal capacities as civil servants, clerks or teachers. The sources of income for OVC families did not change. The Property Index shows improvement overall, though with notable distinctions by country. The most positive results come from Rwanda. It should be noted that the survey questions related to household properties were weighted towards agricultural assets and livestock, and therefore the relatively urban households in Kenya and Uganda may have found less applicability in these questions.

The Property Index produced better results for those households which received AVSI support for an IGA in 2006 (see Table 24). There has been an increase in household debt levels over time, with households participating in IGAs also showing greater relevance of household debt (see Table 27). Whether the debt-related indicators reflect positive or negative impact on overall household economic security, the data cannot provide conclusive evidence at this point.

**By Advanced Statistical Techniques**

*Factorial and Cluster Analysis*

This analysis allowed for the identification of the factors affecting the survey results and AVSI action as well as homogenous sub-groups of children within the sample based on similar characteristics (Multiple Correspondence Analysis). These factors can mainly be re-conducted to the living and economic condition of the families. Seven internally homogenous sub-groups emerged through the cluster analysis (see Part II, Figure 3)\(^4\).

The cluster analysis confirms that children and their situation are really quite different based on their place of origin and habitat (urban/rural). This conclusion suggests that

\(^4\) Table and figure references in this section “Advanced Statistical Techniques” refer to those in Part II of the corresponding report, related to Outputs of Multivariate Analysis.
in order to improve outcomes, AVSI should differentiate its interventions according to conditions specifically related to each area and sub-group of children. More detailed results by country and habitat can be found in Section 8.3 of the report.

Children Profiling
By looking carefully at the statistical profile of some critical categories of children, significant associations among variables emerge. These relationships could be utilized when targeting certain impact outcomes and designing future interventions. Below are some examples.

- **Children with HIV/AIDS** are more often related with the following variables: maternal orphan, Uganda, habitat with high criminality, large families.
- **Children with bad general health** are more often related with the following variables: guardian bad health, large families, grandmother as guardian.
- **Children who ate fewer than 2 meals a day** are more often related with the following variables: dirty housing areas, illiterate guardians, guardian bad health, and Rwanda.
- **Children with bad school performance** are more often related with the following variables: dirty house areas, houses without toilet, illiterate guardians, and rural areas.
- **Children with unstable personalities** are more often related with the following variables: bad hygiene, bad health, older guardians, areas of high criminality, and Rwanda.
- **Children with aggressive personalities** are more often related with the following variables: paternal orphans, urban slums, guardian bad health, and Uganda.
- **Children with shy personalities** are more often related with the following variables: females, under 13 years old, bad nutrition, and receive fewer visits from social workers.

Further analysis and examples of this profiling approach can be found in Section 8.4 of the report.

Structural Equation Modeling
This technique offers a measure of impact of AVSI's intervention on the children's well-being status and improvement, also taking into account the family environment and habitat. Two sets of outcomes were synthesized from the data, a “Wellbeing Status Index” and a “Wellbeing Improvement Index”.

When compared to the previous year's report, the Wellbeing Improvement Index was more influenced by AVSI's direct interventions. However when looking at the Wellbeing Status Index, it is almost equally dependent on AVSI interventions as on the Family Environment Index. This highlights the importance of factors such as guardian's health and home environment for the wellbeing of children.

The modeling exercise allowed for the creation of a Decision Support Matrix (see Figure 8) which visually categorizes interventions into four quadrants: Area to Maintain, Area to Improve, Area to Monitor, and Area for Immediate Intervention. The
model highlights the importance for AVSI to maintain the level of services reached in recent years given that results demonstrate high impact on both Wellbeing Status and Improvement as measured by the respective path coefficients in the structural equation models estimated in this report. The set of Family Environment factors were the only to fall into the category of “Area for Immediate Intervention”, thus highlighting the conclusion that household and family conditions have a very significant impact on the wellbeing of children (see Figures 9, 10). This conclusion is very important to drive a family centered approach intervention.

Summary of Conclusions and Lessons Learned

Program evaluations can be important opportunities for learning and capacity building of implementers.

The results represented and discussed in this report were made possible due to a number of converging factors which facilitated the survey implementation. Among these were:

- The commitment of the AVSI program and staff to the evaluation, including the pre-planning necessary for a baseline survey.
- The programmatic context of having a large number of children in a “homogenous” situation of need and vulnerability.
- The presence of a reliable on-the-ground network of people capable of data collection through semi-structured interviews.

The research team took the decision to work closely with AVSI staff and collaborators both in the design of the instruments and the actual implementation of the surveys. The research team believed that the advantages of this choice outweighed the potential risk of positive prejudice towards the project and conditioning of interviews, as it ensured the involvement of highly motivated people with an existing relationship with the children and families being interviewed, capable of understanding the responses received and therefore ensuring higher quality and reliability of data collected. The evaluation process turned into real action research which resulted in a significant, positive impact on the capacity of AVSI and partner organizations. Among the gains were: increased self-awareness of tasks and responsibilities, increase appreciation for monitoring and data collection, more attentive observations of individual and collective needs and greater commitment to finding effective solutions.

Program evaluations can and should produce data that is useful for management decisions to enhance programmatic impact.

The survey process during the life of the project allowed for program management to make important changes in the focus of the project. These included increased focus on HIV testing and increased attention to guardian health and family responsibility including economic capacity. Severe food and nutrition needs were identified early and addressed.
The longitudinal survey design allowed for conclusions that are generalizable across the program population as well as for customized evaluations of each single case. The evaluation design served many purposes, one of which was to know the living conditions and changes of a sub-set of the population in much greater detail. The dynamic features of this design present an alternative to the use of a control group with each wave of data representing a term of comparison for the previous and subsequent wave.

The family-centered approach is absolutely essential for having a direct and long-term impact on children’s well-being and on specific desired outcomes. Much of the data converged upon the conclusion that direct support given to a child is only part of the solution, and the family environment and relationships must be addressed in order to help the child to flourish. The results demonstrate the multiple linkages among the five strategic objectives of the OVC program: education, health, food security and nutrition, psychosocial support and economic security. For greatest impact, programs of this kind must be allowed to run for multiple years in order to see the fruits of the intervention and to allow for capacities to be built and relationships to blossom.
Annex 2
In 2005, AVSI Foundation embarked on the endeavor of scaling-up its existing system of support to the most vulnerable children and orphans in poor communities in Kenya and Uganda, all of which have been directly affected by the HIV epidemic. This scaling-up was made possible due to complementary financing from USAID through PEPFAR and was feasible because of AVSI's established network of local partner organizations.

The main objective of the program has always been to increase the capacity of families and communities to care for the most vulnerable orphans and children in HIV/AIDS affected communities.

In harmony with the expectations of USAID, AVSI sought to work towards this objective with a combined approach of direct provision of services to OVC and, indirectly, through a method and specific interventions designed to increase the capacity of families and communities to care for all vulnerable children. Drawing on its years of experience in the specific region and around the world, AVSI has understood that capacity building will never be achieved through a series of one-off interventions such as training sessions or assessments, even with the best materials and trainers. Capacity building happens through a combination of the practical aspects of working together on project management and administration, training on specific sets of skills, instilling the desire for improvement and growth, and education to the deepest levels of meaning for this particular work. Capacity building must begin from a starting point of respect and mutual trust, recognizing the local organizations for what they are: expressions of the society from which they come and formed by individuals with certain values, knowledge, experiences, goals, and patterns of working.

In order to grasp the impact of AVSI's method towards capacity building, AVSI contracted the Foundation for Subsidiarity (Fondazione per la Sussidiarietà), an Italian cultural and research no-profit organization, to conduct an evaluation of the capacity of AVSI's organizational partners in Uganda and Kenya. The research team combined expertise in sociology, statistics, and field based data collection. With input from the project team, the researchers designed a survey which was aimed at the partner organizations with a space reserved for input by AVSI staff who had been working directly with each partner organization. The project began in April 2005, and the “Partner Surveys” were conducted in February 2006 and May 2009 among 48 partner organizations in Uganda and Kenya.⁶

⁶ Note that in 2006, partners in Rwanda were also surveyed. The conclusion from the initial data analysis was that the context of AVSI’s work in Rwanda and the characteristics of the local partners there differed so much from those features in Uganda and Kenya to make comparisons difficult and irrelevant.
This report presents the data, analysis and preliminary conclusions from the evaluation. It is divided into three parts: Outputs of Cross Sectional Analysis, Outputs of Multivariate Analysis, and Conclusions and Recommendations.

**Characteristics of Partner Organizations**

This first part presents an analysis of who the partner organizations are and the main features of their history and structure. What emerges is that the experience of AVSI in each country as well as the contours of civil society therein has had significant influence on the shape of the organizations which became AVSI’s partners on this project. For example, AVSI has had longer partnerships in Uganda and there is a wider range of typologies of organizations, reflective of AVSI’s long history in the country and the vibrant civil society. In Kenya, the partnerships are younger and more partners are faith based and specifically religious congregations.

Over the life of the project, the majority of partner organizations have demonstrated growth in terms of staff and volunteers. Considering the total outreach of the partners, an average of 24% of their beneficiaries are supported through this project (Uganda 31%, Kenya 13%). These findings are one indication of increasing capacity and organizational stability.

The partners all provide a holistic package of services to children, consistent with AVSI’s method and the project objectives; see Table 6. Education, health and psychosocial support are the primary elements across the board. An interesting increase over the life of the project in the provision of economic strengthening activities to families and counseling and sensitization to families has been noted in the data; see Table 8.

The staff of the partner organizations is relatively highly skilled; in Kenya 65.4% and in Uganda 66.8% of employees have college or university level education. The segregation of roles and division of duties with the organizations depends on the size and type of organization overall. The extent to which the board members and key staff share in the values and missions of the organizations is relatively high; this commitment among volunteers is less strong, but has increased over the life of the project. Specifically the partner organizations in Kenya demonstrated extremely high levels of personal commitment to the purpose of the organization; 90% expressed strong “sharing of values” in 2009, compared with 75% in 2006; see Table 19.

**Program Management by Partners**

The evaluation focused on a few proxy indicators to gauge commitment to the work of serving OVC and the effectiveness of AVSI’s communication of methodology and quality service delivery. Among these indicators were the following:

- Type and prevalence of services delivered; *consistency is noted with the AVSI method and priority placed on education, health and psychosocial support followed by outreach to families in both countries.*
Attention to the child through:

• Frequency and location of visits, see Table 21; Kenyan partners are able to reach children more frequently at their homes than in Uganda, where visits are frequent but occur most at school and at the office.
• Planning and decision making of visits, see Table 20; conclusions are mixed, but planning of child visits seems to follow urgency of situation and a balance of timing and geographic considerations.

Management of phase-out of children from the project; data show that a much higher percentage (10%) of children in the project had been phased out over the previous year in Kenya compared to Uganda (1.4%). Most often partners selected “other” as the reason for phase-out, presumably as a means of capturing a wide variety of reasons based on each case.

Vulnerability criteria guiding selection of children for project participation, see Figure 6; consistency is noted with the AVSI method since the top criteria used be partners were the following, listed in order of importance:

• Single/total orphan
• Poverty
• HIV+ parent
• HIV+ parent

Partner Outreach to Parents and Communities

A specific section of the survey looked into the relationship of the partner organization with the parents and the community, including the community of local service providers. The intention was to go beyond the capacities internal to each organization to explore the external links which are essential for effective service of OVC in a long-term perspective.

Overall, the data show a high level of trust of parents with the partner organization; 80.6% in Uganda and 54.5% in Kenya. Yet, most partners expressed concern that a high level of parents may have stopped or reduced their commitment to care for their children after receiving support from AVSI; see Table 23. Most partners estimated that 20% of parents or guardians fall into this category.

AVSI’s partner organizations seem to have gained from the experience of being linked to one another within the framework of this project. The partners expressed an increase in the degree to which they value networking and sharing of experiences with other organizations. This opinion was also confirmed in the data showing that 56.5% of organizations have plans to continue these linkages over the next six months while 22% are already doing so.

The partners reflect the capacity to self-identify organizational weaknesses and to formulate plans to address these weaknesses. The main developments either underway or in planning are the following, listed in order of importance:

• Search for other financial resources and donors
• Manage transition of children leaving project
Increase cooperation with other organizations and stakeholders
Increase relationship with local government
Increase sensitization work with families

AVSI Staff Evaluation of Partners
Overall, AVSI’s staff gave a positive assessment to the capacity of partner organizations and their improvement over the life of the project in terms of administrative capacity and responsiveness.

A Multidimensional Data Analysis and Conclusions
In this part, the report details the statistical methods which were utilized to analyze the data from the Partner Survey, summarized into five area indicators (see Table 32), and compared with the results from the Children Survey. In doing so, the researchers attempted to account for project results in terms of child well-being according to implementing organizations. The Children Survey offered data around child well-being, improvement of child well-being and strength of AVSI intervention, as captured in the three indices, Well-Being Status Index, Well-Being Improvement Index, and AVSI Intervention Composite Index respectively.

Secondly, a Principal Component Analysis resulted in factorial maps which allowed for a visual presentation of the data indicating direction and strength of relationships among data points.

Thirdly, Cluster Analysis looked at the programmatic outcomes by partner organizations after these were disaggregated according to the most essential characteristics grouped into clusters of similar organizations. This method divided the 48 partner organizations into four clusters as follows:

- **Smaller partner organizations**: these were found to be less complex in terms of governance and structure but still producing results of child well-being consistent with the mean values.
- **Main Ugandan partner organizations**: these had outcomes higher than the mean for the Well-Being Status Index and the AVSI Intervention Index, and lower than average outcomes on Well-Being Improvement.
- **Big NGOs and FBOs**: these larger organizations had very high governance and structure results and high results on the AVSI Intervention Index, but lower outcomes on the Well-Being Status and Improvement Indices.
- **Big Kenyan Partners**: these were relatively younger partners but older organizations, with a high number of faith-based groups represented. Their results were very high on structure, governance and financial management, and outcomes were very high on Well-Being Improvement, though less high on Well-Being Status.

In summary, multiple indicators reveal important progress in terms of capacity of these partner organizations to serve their communities and in particular the most vulnerable
children and orphans. There does not emerge one type of organization or one size which is best suited or most capable of ensuring improved well-being of children. It does emerge that size of organization doesn’t play the main role in determining programmatic results. The type of organization is also not clearly or exclusively related to desired outcomes.

These findings confirm AVSI’s approach in identifying local partners organizations embedded in the communities with the main criteria of a common vision towards the good of the child.
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