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END OF PROGRAM EVALUATION FOR THE G.R.A.C.E. AFRICA (NPI PROGRAMME)

FINAL REPORT



January 11, 2012

EXECUTIVE SUMMARY

Grassroots Alliance for Community Education (G.R.A.C.E. Africa) program on “Engaging Indigenous Youth Groups and Community-Based Organizations to Support Orphans and Vulnerable Children” (OVC) was a three year program between 2008 and 2011. However, the actual implementation lasted only two years.

The program was funded through the President’s Emergency Plan for AID Relief (PEPFAR) and New Partners Initiative (NPI); it was implemented in three provinces (Nyanza, Central and Eastern) in partnership with 15 local Community Based Organizations (CBOs).

The goal of this program was to improve the quality of care not only of the OVC in the program areas but also the livelihood their families. The specific program objectives were to:

1. Provide educational opportunities and support to OVC
2. Provide leadership skills and training to OVC caregivers and community members
3. Develop capacity and strengthen the 15 partner organizations
4. Foster national forums and networks
5. Provide HIV Prevention messages to 20,000 caregivers and community members.

During the program implementation phase, G.R.A.C.E. Africa trained CBOs and other community leaders, equipping them with several professional skills, strengthening community networking among relevant stakeholders, and providing CBOs with grants to enable them implement agreed program activities.

In return, the CBOs mobilized community resources, provided direct support services to OVC and their caregivers as well as deploying Trainers of Trainers (ToTs) to conduct home-visits and provide required support to specific households. The range of services provided by CBOs included educational support to OVC aged 3-6 years, psychosocial support, food and nutritional support, child protection, income generating economic opportunities, health care services and prevention of HIV/AIDS through target specific messages.

By October, 2011, the program had achieved most of its targets; it had provided a minimum OVC package to 44,306 OVC, enrolled 2,176 OVC in community Early Childhood Development (ECD) schools, provided food and nutrition support to 11,315 beneficiaries, psychosocial support to 12,376 people and given referrals for health care to 3,018 people. Despite the program's successes, not all the beneficiaries' needs were met either due to limited financial and other resources or by virtue of program design. For instance, the program coverage did not include comprehensive package for OVC in primary and secondary schools and those below the age of three who were not attending ECD schools. Furthermore, the inadequate number of skilled counselors within the communities, limited accessibility to guidance and

counseling services amongst the OVC in need of sustained and specialized counseling services. There was also limited legal resolution of cases of rights violations against OVC.

Resource limitation was a particular challenge during program implementation and it was difficult to meet the overwhelming needs of the beneficiary households. Similarly, community expectation of direct material assistance posed quite a challenge to the ToTs counselors who only provided information and psychosocial support. Another challenge the program faced was the increased number of vulnerable children in the community who could not be admitted into the program. Lastly, the program faced the challenge of realizing the expectation of educational support to OVC in secondary and primary schools. Several CBO staff members noted that supporting OVC through ECD alone was not enough to ensure the child completes school.

G.R.A.C.E. Africa had many program innovations, the program successfully adapted interventions to the identified community needs. The program focused on encouraging CBOs to be self-sufficient through provision of training and direct grants. The training of community members including the formation of child rights clubs in schools increased the program reach and promoted local expertise within the community and sustainability chances of program activities. G.R.A.C.E. Africa assisted former OVC to be trained as ECD teachers and employed them as assistant teachers, giving them a chance to give back to their community. The program also supported and facilitated partnerships among local stakeholders like government ministries, health facilities, education institutions, religious institutions and other CBOs. These partnerships stimulated community-driven responses, leading to a wider referral network to serve the children and families in need, and ultimately assist CBOs access additional resources to support OVC.

ACKNOWLEDGEMENTS

We wish to express our sincere gratitude to staff from G.R.A.C.E. Africa and those from the partner CBOs visited and interviewed; Forum for Community Mobilization (FOFCOM), Kokech Jamii, Nyamira Adventist Medical Center, Mt. Kenya Animators & Puppeteers Youth Group, Embu Youth AIDS Advocates, Chuka Youth Information Center, and Isiolo Youth Against AIDS and Poverty for their support during the evaluation exercise. Our sincere gratitude to all the project staff for mobilizing various groups to be interviewed within a short notice, facilitating the information collection activities, planning field work and providing invaluable information and guidance with regard to project activities. Their efforts made this evaluation exercise a success.

We acknowledge the contribution of caregivers, Trainers of Trainers, ECD Teachers and various government officers who made invaluable contribution to the evaluation exercise through their active participation, willingness and openness in sharing information and their individual experiences. Many shared their unique and captivating stories, which immensely enriched the evaluation exercise. Group discussions and in-depth individual interviews provided a fitting opportunity to not only share experiences and knowledge, but more importantly, to also identify lessons learned during the implementation of project. The close interaction with these groups in the various project sites offered a good learning opportunity that vastly enriched our experience in OVC programming.

We highly appreciate the invaluable contributions and tireless work of the team from G.R.A.C.E. that supported the evaluation exercise. They worked for long hours to accomplish the planned field activities in the selected project focal areas. Credit is due to the logistics and administration support provided by G.R.A.C.E.

We acknowledge Ms. Janet Onyalo for her guidance and patience in explaining to us G.R.A.C.E. activities and enduring our many questions which to some people seemed obvious. Janet and Martin Okello also accompanied us in the field and ensured the team reached most of the sites identified for the evaluation exercise where we braved bad weather and muddy roads to reach our destinations. Their support was invaluable to the exercise.

We hope that the spirit of cooperation between G.R.A.C.E., the community based organizations and the beneficiary communities, which helped bring this exercise come to fruition, will continue. This heralds a positive participatory trend and partnerships for the future growth of the program and better support to the needy children of Kenya.

Finally, we thank the entire team of the NPI Program at G.R.A.C.E. Africa for the opportunity to serve and tap into their unique knowledge and experience. We hope this report adequately highlights the organization's achievements, promising practices and lessons learned in supporting orphaned and other vulnerable children.

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ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
APHIA	AIDS, Population and Health Integrated Assistance Program
BCC	Behaviour Change Communication
CBO	Community Based Organisation
CRS	Catholic Relief Services
CSI	Child Status Index
CSO	Civil Society Organisation
CLAN	Children’s Legal Action Network
ECE	Early Childhood Education
ECD	Early Childhood Development
G.R.A.C.E.	Grassroots Alliance for Community Education
GoK	Government of Kenya
FBO	Faith-based organization
HBC	Home Based Care
HIV	Human Immune-deficiency Virus
IGA	Income Generating Activities
IEC	Information Education Communication
JAPR	Joint HIV and AIDS Programme Review
KNASP	Kenya National Strategic Plan on HIV and AIDS
MFIs	Micro Finance Institutions
MOA	Ministry of Agriculture
MOE	Ministry of Education
MOPH	Ministry of Public Works
M & E	Monitoring and Evaluation
NACC	National Aids Control Council
NASCOP	National AIDS/STI Control Programme
NOPE	National Organizational of Peer Educators
NGO	Non Governmental Organization
NPI	New Partners Initiatives Technical Assistance Project
NUPITA	New Partners Initiative Technical Assistant Project
OCA	Organizational Capacity Assessment
ODP	Organizational Development Partners
OVC	Orphans and Vulnerable Children
PEPFAR	President’s Emergency Plan for AIDS Relief
PET	Participatory Educational Theatre
PLWHA	People Living with HIV and AIDS
PMTCT	Prevention of Mother to Child Transmission of HIV
PSI	Population Services International
RAAAPA	Rapid country Assessment, Analysis, and Action Planning Process
SPM	Selection Planning and Management
TICAH	Trust for Indigenous Culture and Health
ToT	Training of Trainers
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing

1.0 INTRODUCTION

The Grassroots Alliance for Community Education (G.R.A.C.E. Africa) Program on “*Engaging Indigenous Youth Groups and Community-Based Organizations to Support Orphans and Vulnerable Children in Nyanza, Central and Eastern Provinces*” was launched in 2008. The program was to run for three years with a total funding of \$2.7 million from the President’s Emergency Plan for AID Relief (PEPFAR) through the New Partners Initiative (NPI).

The program was implemented in partnership with fifteen community-based organizations (4 in Central Province, 5 in Eastern Province and 6 in Nyanza Province) supporting 2,176 OVC and 1,707 caregivers with the goal to improve the quality of care of the Orphans and Vulnerable Children and their families while the program objectives were to:

- Provide educational opportunities and support to OVC
- Provide leadership skills and training to OVC caregivers and communities
- Develop capacity and strengthen the 15 partner CBOs
- Foster national forums and networks
- Provide HIV Prevention messages to 20,000 caregivers, youths and community members.

At the end of the program, G.R.A.C.E. Africa commissioned a Kenyan Consultant to conduct the end of program evaluation. To carry out this mandate, the consultant assembled a team consisting of another consultant and four research assistants. The program evaluation was carried between 10th November to 9th December, 2011, with field visits taking place between the 10th and 25th November 2011.

G.R.A.C.E. Africa Implementing Partners

Nyanza Province

1. Kenya Society for People with AIDS
2. Kisumu Urban Apostolate Programme - Pandpieri
3. Kokech Jamii Tujiunge kwa Mapambano ya Ukimwi
4. St. Francis Hospice Kimosi
5. Nyamira Adventist Medical Centre (Matutu)
6. Victoria Agricultural and Environmental Conversation Organization (VIAGENCO)

Eastern Province

1. Pastoralist Women for Health and Education
2. Isiolo Youth against AIDS and Poverty (IYAP)
3. Maua Methodist Hospital
4. Chuka Youth Information Centre
5. Embu Youth Information Centre

Central Province

1. Youth For Change
2. Mt. Animators & Puppeteers Youth Group formerly known as ACK-Kerugoya
3. Kamahuha Anti AIDS Group

4. Forum for Community Mobilization (FOFCOM)

1.1 Terms of Reference

1.1.1 Summary

The Terms of Reference identified six objectives to be covered in this evaluation:

1. Assess the outputs and outcomes generated by the program in relation to the stated goal, objectives and desired results. In particular, the evaluation was to assess the effects of the program activities on the targeted beneficiaries including the OVC, their caregivers, partner CBOs and community members reached with the various services.
2. Assess whether the program interventions had met the needs of the beneficiaries; the appropriateness of results in relation to the needs of the communities, national policies and priorities.
3. Assess the extent to which program interventions achieved the desired outcomes, factoring in issues of program management including decision making processes, risk management, institutional arrangements and partnerships and their effect on the program results.
4. Assess the relationship between the quantity, quality, and timeliness of program inputs, including personnel, consultants, travel, training, office equipment and financial sub grants to partner CBOs. In addition, determine the quantity, quality, and timeliness of the outputs generated and whether the resources were spent as economically as possible.
5. Assess the readiness of partner CBOs and other stakeholders to sustain program interventions, in particular assess the infrastructure and systems of partner CBOs, resources available to sustain the activities and services, collaborative links and referral networks with other service providers, and the level of community ownership.
6. Identify and document key successes, best practices lessons learnt, implementation challenges, constraints, strengths and weaknesses and provide recommendations for possible scale up or replication of the program in totality or in part.

The evaluation methodology ensured participation and involvement of multiple groups of stakeholders including government and community leaders.

1.2 Program Description

1.2.1 G.R.A.C.E. Africa in Kenya

Grassroots Alliance for Community Education (G.R.A.C.E.) is a non-government organization registered in Kenya under the NGO act in 2001. The mission of the organization is to enhance the capacity of community based organizations for self-determination, high-impact and sustainable initiatives leading to better health and development. G.R.A.C.E. has over the years

established functional partnerships with 105 local organizations in Kenya, including CBOs, FBOs and youth groups. The organizations operate as part of a network through which G.R.A.C.E. provides capacity building support for communities in areas such as:

- Leadership and governance,
- Economic empowerment of poor and marginalized communities and groups,
- Youth empowerment,
- Child protection,
- HIV prevention care and treatment,
- Project design and management,
- Monitoring and evaluation.

In addition G.R.A.C.E. provided its local partners with financial grants to enable them improve the quality and scale up their work by applying the skills acquired in capacity building training workshops.

The organization has carved out a niche for itself and has a proven track record in working with and empowering grassroots organizations across the country.

In 2008, G.R.A.C.E. Africa received a \$2.7 million grant from USAID through Round 3 of the President Emergency Plan for AID Relief (PEPFAR), under the umbrella of the New Partners Initiative (NPI). This grant was to support Orphans and Vulnerable Children and their families in Nyanza, Central and Eastern regions.

1.2.2 Program Context

National HIV prevalence in Kenya has fallen from a peak of 10% in adults in the mid 1990s to the current estimate of 7.4 %; however this decline is not uniform throughout the country. Prevalence in some regions are higher than the national average Nyanza Province leads in HIV prevalence (15.4%) followed by Nairobi (9.0%)Coast (7.9%) and Rift Valley (7.0%). The lowest prevalence rates are found in Eastern (4.5%) and central (3.8%); North Eastern Province has the lowest prevalence rate at 1%¹ .

The joint United Nations Programme on HIV/AIDS (UNAIDS) estimates that 1.1 million children living in Kenya have been orphaned by AIDS (UNAIDS, 2006) while is estimated that the percentage of children orphaned or otherwise considered “vulnerable” stands at to be 60% of all children (Kenya Central Bureau of Statistics, 2005).

¹ Kenya AIDS Indicator Survey 2007

Children affected by HIV/AIDS often live in households undergoing dramatic changes, such as extensive poverty; increased responsibilities being placed on the young members of the family; poor parental health that may increase emotional or physical neglect; stigma and discrimination from friends, community members or extended family and in extreme cases parental death.

These dire circumstances consequently result to reduced capacity of these households in meeting the children's basic needs. In most cases, the orphaned children undergo transition into a new household or in a few cases they are forced to head their own households.

Orphans are also more likely to live in households with higher dependency ratios; experience property dispossession; often miss out on opportunities for education; live in households experiencing food insecurity and often experience decreased emotional and psychological well being due to the dramatic life changes that they undergo, the challenges and losses (UNICEF, 2006).

The Government of Kenya with support from donors has intensified programmatic and policy responses to the HIV/AIDS epidemic and increasing numbers of orphans and vulnerable children (OVC).

In 2004, the Ministry of Home Affairs and United Nations Children's Fund (UNICEF) undertook a Rapid country Assessment, Analysis, and Action Planning Process (RAAAPP) for OVC. Based on RAAAPP results, a National Plan of Action and National Policy on OVC were developed. The government also developed a National Database of the OVC to coordinate the efforts of various agencies offering interventions for these children. Beyond national policies, coordination, and plans for action, OVC in Kenya benefit from government efforts to address the needs of all children through provision of free health care for those under the age of five, free primary school education, and establishment of a Children' Court. However, lack of school fees often prohibit OVC living in poor households from attending preschools during early childhood development and secondary schools.

At community level, despite of their limited manpower, financial and technical resources and managerial training; community based organizations (CBOs) are implementing programs aimed at meeting needs of OVC. These organizations often drawing on the dedication and commitment of community volunteers and have great potential to address the needs of OVC; however they require capacity building in terms of training, network strengthening and grants support.

It is against this background that G.R.A.C.E. Africa has built on government initiatives to support orphans, vulnerable children and their caregivers by focusing efforts towards building the capacity of CBOs at the community grassroots level.

2.0 METHODOLOGY AND LIMITATIONS

The study set out to evaluate the G.R.A.C.E. Africa program that was implemented by 15 CBOs spread across 3 provinces namely Nyanza, Central and Eastern.

2.1 Data collection techniques

The program evaluation was designed to employ a cross-section of data collection methods aimed at meeting the desired objectives. The data collection methods were:-

2.1.1. Document review

During the evaluation, several publications and other documents from G.R.A.C.E. were reviewed to gather critical information on the project, at the same time readily available data was collected from partner CBOs,

2.1.2. Structured interview questionnaires

These mainly targeted caregivers, teachers and the OVC. Due to the tender age of the OVC in this project (3-6 years), they could not be interviewed directly because of ethical issues around interviewing of minors; hence the caregiver answered questions on their behalf.

2.1.3. Interview guides

These were used for focus group discussions held with beneficiaries of the G.R.A.C.E. Program and for key informant interviews with program officers and other stakeholders.

2.1.4. Informal group meetings

Group meetings were conducted with child rights clubs formed in primary schools within the program execution areas,

2.1.5. Observation

Simple observation and logical inference was another data collection tool that was used during the program evaluation

The program evaluation team selected 6 partner organizations to be visited with the aim of familiarization with the G.R.A.C.E. Project, meeting of beneficiaries and other stakeholders, gathering of information on the successes, shortfalls and challenges faced both by the program implementers and beneficiaries.

2.2 The Sample

The sampling methodology used to select the partner organizations to be visited was based on both convenience and purpose. It was imperative for the evaluation team that the selected partner organizations not only be conveniently available but also be a representative sample of the whole

population totaling 15 partners. With these considerations in mind, 6 partner organizations were subsequently selected for field visits, they were:-

- Kokech Jamii Tujiunge Kwa Mapambano ya Ukimwi in Oyugis, Nyanza;
- Nyamira Adventist Medical Centre (Matutu) in Borabu ;
- Forum for Community Mobilization (FOFOCOM) in Kiambu, Central;
- Mt. Kenya Animators in Kerugoya, Central;
- Chuka Youth Information Centre (CIYC) in Chuka, Eastern and
- Isiolo Youth AIDS Program in Isiolo, Eastern.

2.3 Program evaluation respondents

During program evaluation, data was collected from a total of 200 people who were involved with the G.R.A.C.E. Project in one way or another. These were G.R.A.C.E. staff members, mainly the program managers and program officers, program beneficiaries and other stakeholders. Table 1 below gives a summary of the respondents interviewed during the program evaluation.

Table 1: Respondents Interviewed during evaluation

G.R.A.C.E. Staff	Chief Executive Officer, Director, Project Coordinator, Finance Officer, and 3 Program Officers
Partner CBO Staff	7 Program Officers, 6 Finance officers, 4 Field Officers, 4 Board Members
Early Childhood Development	32 ECD Teachers
Trainers of Trainers	34 ToTs
Caregivers	60 Caregivers who also provided information on behalf of 67 OVC under their care
Government Officials	3 Agricultural Extension Officers, 3 Ministry of Health Officers, 2 Children Officers, 4 Assistant Chiefs
Child Rights Clubs	3 Clubs

2.3.1 Characteristics of the Caregivers

This section presents a summary of the demographic characteristics of the 60 caregivers interviewed during the program evaluation period in terms of sex ratio, age, level of education, marital status and their relationship with the orphan or vulnerable child under their care during the G.R.A.C.E. program. This information is captured in Table 2.

Table 2: Characteristics of the Caregivers

Sex	Number	Percentage
Male	10	16.7
Female	50	83.3
Age Groups		
<31 years	15	25
31-40 years	19	31.7
41-50 years	17	28.3
51-60 years	7	11.7
61+ years	2	3.3
Education level		
No education/Nursery	15	25
Primary	29	48.3
Secondary/Higher	16	28.3
Marital Status		
Married	40	66.7
Widowed	13	21.7
Divorced/Separated	6	10
Single	1	1.7
Relationship to OVC		
Natural mother	19	31.7
Natural father	10	16.7
Natural grandmother	10	16.7
Natural grandfather	1	1.7
Aunt	8	13.3
Uncle	4	6.7
Older sister	4	6.7
Great grandmother	2	3.3
Other (Not related)	2	3.3
TOTAL	60	100

(a) Age

During the evaluation, more than half of the caregivers interviewed (57%) were below the age of 41 while only 2 were over 60 years old.

(b) Education

Over 72% of the caregivers interviewed had no formal education or had attained primary education as highest level of education.

(c) Marital Status

Of all the caregivers interviewed, two thirds (66.7%) were married, 21.7% were widowed and the remaining 10% were either divorced or separated. Only one had never been married.

(d) Relationship to the orphan or vulnerable child

Almost half (48.4%) of the caregivers interviewed were natural parents of the OVC whom they are responsible for. On the other hand, 18.4% were grandparents to the child and 20% were either an uncle or aunt to the child. Another 6.7% of the caregivers were an older sibling and 3.3% were great grandparents of the child. Only 2 of the caregivers were not related in any way to the child they were taking care of.

2.3.2 Characteristics of the OVC

During the evaluation, due to the tender ages of the OVC covered by the G.R.A.C.E. Program; their caregivers responded their proxies.

Sex – Out of the 67 OVC, 33 (49.3%) were male while 34 (50.7%) were female, The sample size is statistically representative of the total number of OVC covered by the program with 1147 (52.7%) male and 1029 (47.3%) female with a variation is less than 3%.

Primary Caregiver - Of the 67 OVC 55% had the mother as primary caregiver while 18% had the natural father as the primary caregiver. Another 20% had the grandparent as the caregiver and 6% had the aunt as primary caregiver. Only 1 child was cared for by someone not related to them.

Orphan hood status

Out of the 67 OVC, only 1 was determined to be completely orphaned 24 (35.8%) were partially orphaned with only one parent dead. On the other hand, 37 of the OVC (55.2%) had both parents alive; the orphan hood status of 5 OVC could not be established because the caregiver was not sure whether the father of the child was dead or alive.

Table 3: Orphan hood Status of the OVC

Status	Number	Percentage
Total orphans	1	1.5
Partial orphans	24	35.8
Both parents alive	37	55.2
Status undetermined	5	7.5
Total	67	100

2.4 Limitations

During the program evaluation, certain challenges and limitations were experienced by the evaluation team these were:-

i) Time constraints

The Team had only one day to meet all the respondents in each of the selected program implementation sites and conduct all the necessary interviews. This proved to be a challenge as not all the informants were available when the evaluation team was in those specific sites.

ii) Pre-selection of evaluation informants

The evaluation team could only interview pre-selected respondents whose names were provided to them by the G.R.A.C.E. Program partner organizations. This potentially compromised the validity of the information provided as a result of selection bias as the team could not establish the criteria that was used to select these respondents or if the selected sample was a statistical representation on the entire sample

iii) Unavailability of some key informants and other stakeholders for interview

In certain program evaluation areas, key respondents and stakeholders identified were unavailable for interview. In 2 CBOs, government officials were unavailable while in 1 CBO there were no caregivers to take part in the group discussions.

iv) Sampling

Due to the time constraints and limitations on availability of partners, the sampling technique used for selection was not based on probability therefore the resultant sample was not random.

v) Lack of program beneficiary control group

There was no control group identified at the beginning of the G.R.A.C.E. Program to determine the baseline status of the beneficiaries; consequently during the evaluation phase it was not easy to clearly separate and identify the specific program impacts on the beneficiaries as some of the impacts could also be easily be attributed to other similar programs in the areas of implementation or other external variables.

vi) *Limitations of due to proxy representation of OVC*

The under-age beneficiaries of the G.R.A.C.E. Program could not be directly interviewed and hence a proxy in the person of their caregivers was identified to represent them, in doing so, the evaluation ran the risk of not getting actual information from this group of beneficiaries.

3.0 FINDINGS AND OBSERVATIONS

3.1 Program Management Structures:

The program was managed through a two level organizational structure; G.R.A.C.E. Africa and the CBO levels. At G.R.A.C.E. Africa level, the overall policy direction was provided by the Board, Chief Executive Officer and the Director, while the day-to-day management of the program was conducted by the Program Coordinator/M&E Officer (see annex III for G.R.A.C.E. Organogram). Below the Program Coordinator were various Program Officers and Coordinators responsible for various themes mainly ECD, youth and OVC. The Program officers and Coordinators provided supportive supervision and technical assistant (TA) to CBOs. The Finance Department was headed by the Finance and Administration Officer with a Finance Officer being responsible for day-to-day transactions of the program. The financial, personnel, travel, procurement and management systems were evaluated and found to be adequate and comprehensive enough to meet all requirements of any donor.

At the CBO level, each project was headed by a Project officer who reported to the Board of Directors. Immediately below the Project Officers were an Accountant and a Field Officer. The Accountant was responsible for financial management, book keeping and financial reporting while the Field Officer was responsible for the program management.

ToTs were selected and trained by G.R.A.C.E. Africa to handle each of the six thematic areas; child protection, HIV prevention, nutrition and food security, health, economic empowerment and psycho-social support, G.R.A.C.E. Africa also employed ECD teachers for the 18 ECD schools. The day-to-day supervision of the ECD teachers was conducted by a head teacher who was appointed from among the six teachers in each ECD schools and was provided with technical assistance and supportive supervision by the Divisional ECD Officer from the local Ministry of Education. ECD teachers and the ToTs were directly in contact with the beneficiaries and were involved in the day-to-day implementation of the program.

Program data was captured at the community level by the ToTs and ECD teachers, who then forwarded to the field officer, doubling as the M&E Officer. The 15 partner CBOs were provided

with monthly financial sub grants to support their administrative costs and provision of services to OVCs at the ECD centers and the caregivers at household levels. They were spending the funds as per the approved budget and replenishing of these funds was only done when they had accounted for their monthly expenditures. G.R.A.C.E. Africa had provided all of them with financial and procurement policies and procedure manuals which they always utilized. The management system put in place both at the G.R.A.C.E. and the CBO levels worked very well and was able to deliver results.

3.2 Relationship between Inputs, Outputs and Outcomes vis-à-vis Program Goal, Objectives and Desired Results.

The goal of the program was to improve the quality of care of orphans and vulnerable children and their families. The objectives were stated as follows:

- provide educational opportunities and support to OVC;
- provide leadership skills and training to caregivers and communities;
- develop capacity and strengthen the 15 G.R.A.C.E. Program partner organizations;
- foster national forums and networks,
- Provide HIV messages to 20,000 caregivers, youths and community members.

A major finding of the evaluation team was that by October 2011, the G.R.A.C.E. Program had achieved most of the its objectives; it had provided a minimum OVC package to 44,306 beneficiaries compared to the target of 10,200 OVC and their caregivers, thus, surpassing the target by 343%, enrolled 2,176 OVC compared to a set target of 1,800 OVC into ECD institutions surpassing the target by 120%., provided food and nutrition support to 11,315 clients (126%) and provided psychosocial support to 12,376 people (121% of the set target). Despite performing way above the program targets in these areas and the impressive achievements; the program performed below the set targets in health referrals (34%), HIV and AIDS messages (91%), and economic empowerment (67%). These achievements are summarized in Table 4 below.

Table 4: Program achievements against the set targets

Components	Targets	Achievements	(%) Achievements
HIV and AIDS Messages	20,000	18,344	91%
Minimum OVC package	10,200	44,306	343%
ECD enrollment	1,800	2,176	120%
Psycho-social support	10,200	12,376	121%
Economic empowerment	9,000	6,059	67%
Food and Nutrition	9,000	11,315	125%

Health Referrals	9,000	3,018	34%
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Source: G.R.A.C.E. MIS System

The under-achievement recorded in these areas could be attributed to the short duration of the program; from launch the program had less than two years of actual implementation and some aspects of the program required certain preparation and groundwork to be done before the takeoff. For example, the formation of SILC groups could not have been conducted before the identification and training of caregivers.

One of the objectives of the evaluation was to assess the relationship between the inputs, outputs and outcomes generated by the program against the initial goal, objective and desired results. This relationship is summarized in the table 5 below, which shows the correlation between program activities, CBO outputs and program outcomes. It also shows linkages and networks, which the program formed to assist in implementation.

Table 5: Relationship between program activities, CBOs outputs and outcomes of the program

Program Activities	Selected Program outputs	Selected Program Outcomes
<ul style="list-style-type: none"> • Trained board members from CBOs in resource mobilization and strategic planning. • Trained CBOs in child rights, psychosocial support, ECD management, Monitoring and Evaluation, Financial Management, paralegal advisors, educated caregivers, and mobilized communities around child rights • Sensitized community leaders on HIV impact and OVC needs • Trained CBO managers in OVC program management • Trained school teachers, ECD staff, other key adults in child counselling and support • Provided ongoing technical assistance and material 	<ul style="list-style-type: none"> • All 15 CBOs developed and submitted proposals to different donors. • 12,376 Children and Adults provided with psychosocial support services • 18,334 people reached with individual or small group level preventive interventions that are based on evidence • 2,176 children provided with ECD educational support. • 3,018 OVC received health care referrals. 	<ul style="list-style-type: none"> • <i>Nutrition, Health, and Prevention:</i> Increased food security; improved OVC and caregivers health; reduced HIV transmission • OVC graduated from ECD centres • <i>Community Support;</i> Strengthened CBO capacity to manage OVC activities; decreased community stigma; increased in kind contributions to OVC households • <i>Psychosocial & Child Protection:</i> Improved lives of OVC caregivers; resiliency among children & caregivers; enforcement of child-rights policies leading to legal action against perpetrators; reduced cases of child

<p>support to CBOs</p> <ul style="list-style-type: none"> • Provided training on SILC and SPM and funds for IGA to caregivers groups 		<p>abuse & disinheritance</p> <ul style="list-style-type: none"> • <i>Economic Security:</i> Increased household economic security and ability to meet basic needs
<p>Linkages and Networks</p> <ul style="list-style-type: none"> • Referral links with government health facilities ensured OVC access to health services • OVC & caregivers support linked with wider community support initiatives including support groups, VCT & PMTCT information & referral, income generating activities and food security programs • CBO staff attended various regional and international workshops for networking and disseminating best practices • CBO Staff held regular feedback meetings with stakeholders. 		

Fostering National Forums and Networks

G.R.A.C.E. Africa staff and CBO partners participated actively in numerous forums aimed at improving program performance. They attended regional workshops and sponsored CBOs to attend international workshop on OVC Care and Support. In addition, all the 15 CBO were actively involved in forums organized by various civil society organizations and the ministry of health, gender and children’s department in their localities.

At CBO level, all of them held regular feedback and information sharing meetings with community members in their respective sites. Members involved include caregivers, community leaders and issues discussed included program performance and sustainability strategies. G.R.A.C.E. Africa also held quarterly progress review meetings with all the CBOs where they discuss progress and raise issues pertaining to implementation. G.R.A.C.E. Africa also supported cross learning exchange visits among partner CBOs where they obtained valuable information and share best practices. The program also developed a directory of service providers in the three provinces and this information was being used by CBOs to refer clients. From our findings, we would say that G.R.A.C.E Africa satisfactorily implemented the program as per the stated goals and objectives.

3.3 Meeting the Needs of the Beneficiaries.

In the initial stages of the program rollout, all CBOs conducted community needs assessment through meetings where local leaders were informed on the purpose of the program, training and other services to be provided. During these meetings, CBOs addressed their expectations against their needs and the expected balance between the program contributions and contributions from the community. Community needs addressed by the program included:

a) Education support

The program facilitated access to Early Childhood Development (ECD) education by supporting 18 ECD centers and enrolling 2,176 OVC to the centers. 91 ECD teachers were employed out of whom 45 were fully trained ECD teachers while the other 46 were untrained youths. The untrained youths were employed as assistant teachers who were sponsored to attend government ECD colleges for certification. The OVC were provided with school uniforms and scholastic materials (76% of the caregivers indicated that the child under their care had received school materials including uniform in the last year from G.R.A.C.E. Africa). The Program further established play grounds with fixed play recreational facilities in all the 18 ECD centers that it supported. Since the program provided support to the OVC aged 3-6 years and attending ECD schools and their caregivers, those OVC attending primary and secondary schools did not benefit from the program.

“We are very happy about this free education, playing materials that were provided for free. Some poor parents whose children were not attending school were brought here and now are making good progress” a caregiver from Isiolo.

Initially, the program provided all the children in the ECD centers with breakfast of porridge and hot lunch in the afternoon. In an effort to enable the program CBO partners and the community members to gradually take over and sustain the feeding program; G.R.A.C.E. Africa gradually scaled down the support provided for the feeding program and by the time of the evaluation, its support had been completely phased out and caregivers had taken over the responsibility of contributing food in conjunction with some of the centers that were already benefiting from food donations from some faith-based organizations and government departments.

Through discussions between the evaluation team with teachers, community leaders and caregivers, it became apparent that providing meals in schools was an incentive for children to consistently attend school. Several respondents confirmed that school attendance was very good during the period when G.R.A.C.E. Africa was providing school meals. When asked the number of days OVC missed class in the week prior to the evaluation, 75 % had not missed school at all while 11% had missed school for 5 days.

b) Health Care

Due to the economic and social condition of communities that G.R.A.C.E. Africa was targeting, their health status was expected to be poor. This was confirmed by the field survey, when caregivers were asked about their health status, 37% indicated their health was either “poor or very poor” and when the same caregiver were asked about the health status of OVC, they indicated that 27% of the OVC’ had “poor or very poor” health status. Furthermore when asked

how easy it is to access health services when they are sick, 65% of the caregivers and OVC indicated it was not easy.

Since access to health care services was identified as one of the felt needs in all the communities, it was imperative that the program provide access to healthcare, hence the CBOs were expected to provide caregivers and OVC with healthcare referral forms to improve healthcare services.

Therefore, CBOs were expected to provide caregivers and OVC with health care referral forms to enable them access health services in program selected health facilities. These forms were to assist beneficiaries to access health care, medicine and referral from government health facilities. The partnering health centers had to agree to provide beneficiaries who presented a referral form with treatment and medication as needed and later bill the project or in case of children provide them with free services.

With the exception of one CBO (Nyamira Adventist Medical Center), there was little evidence that other CBOs had organized a collaborative arrangement with local health facilities and as the evaluation team found out, uptake of these free health services was low and achievement was only 34% of the target.

When questioned about the none use of health referrals during the focus group discussions; participants (caregivers, ToTs and ECD teachers) identified various barriers that included the long distance to the health facility, high transportation costs, long waiting time before getting medical attention, issues related to quality such as unkind treatment and discomfort in communicating with hospital staff. Some participants indicated that they were requested to queue while they expected the referral form to be a “pass” to see the clinician directly. Others indicated that they were told to pay for medication at private pharmacies as the medicine they required was out of stock.

Although the program could do little to address factors such as long distance to the health facility and long waiting time; G.R.A.C.E. Africa and the CBOs should attempt to increase the referral uptake by the program beneficiaries by addressing barriers pertaining to quality of health care.

Addressing service quality will require training health care providers on quality assurance and ensuring that guidelines and protocols are available and health workers are adhering to them. Further sensitization sessions designed to alter clinic staff attitude and treatment of vulnerable clients is needed.

Increasing utilization may also involve addressing other barriers specific to caregivers, such as empowering them to communicate with health care providers by providing forums for dialogue between them, and alleviating transport cost by including this in the CBO budget.

There were positive health outcomes as the program provided nutrition information to beneficiaries, assisted in developing 438 kitchen gardens and Savings and Internal Lending Communities (SILC) loans thus, enabling caregivers to provide balanced diet to their families and hence improved nutrition especially for the OVC. On a positive note, all CBOS held medical camps for ECD children and their caregivers at all the ECD centers. In addition, all the ECD centers were provided with safe water containers, water treatment packages and trained teachers and children in basic hygiene, thus, contributing to improved health care.

c) Nutrition and Food Security

Improving the nutritional status of OVC and caregivers through nutrition education and increased food security was a core component of the program. G.R.A.C.E. Africa worked with the Trust for Indigenous Culture and Health (TICAH) to train 75 ToTs in health and nutrition who in turn trained caregivers. The training of caregivers involved demonstrating best practices in the preparation of locally available foods with maximum retention of nutrients. Nutrition education included promotion of dietary diversification and growing techniques to increase the nutrient value of crops, food handling, preparation, processing, and storage techniques to minimize nutrient loss. They also provided nutritional counseling and incorporated nutrition messages into the community mobilization messages. During the interviews, 80% of caregivers indicated that they were educated on nutrition through the program.

Food Security: Majority of the districts in which the program was being implemented are classified by the government as food deficit districts. When caregivers were asked whether any of the family members ever slept without food in the last four weeks, 79% answered in the affirmative, asked how often this happened, 29% said very often (more than 10 times in a month).

Consequently, the program improved food security mostly among the caregivers by linking them to government agriculture extension workers of the Ministry of Agriculture (MOA) who trained them in bio-intensive gardening techniques to grow onions, tomatoes, cabbage, and other fruits and vegetables in their backyards.

Discussions with various program beneficiaries indicated that beyond improving family nutritional status, families had also benefitted from the kitchen gardens by selling any surplus produce hence increasing their household incomes.

Mr. Joseph Kamau is one of the five ToTs trained by G.R.A.C.E. Africa in nutrition and kitchen garden. "After the training I come back home to implement what I had learned" He started by purchasing and preparing the seed bed. Once the seedlings were ready, he transferred them to his small kitchen garden which was less than an eighth of an acre. Today Mr. Kamau has reached more than 300 community members with teaching on how to establish a kitchen garden. He also use his small farm for demonstration and has taught at least 30 caregivers on one to one on how to establish kitchen gardens.

d) HIV Prevention

HIV and AID prevention was a priority of the program, a total of 18,322 people were reached with prevention information focusing on behavior change. This was achieved through community based outreach activities implemented by ToTs. Community members were reached through small group discussions focusing on themes such as HIV transmission, behavior change, available services in relation to HIV, positive living with HIV infection, HIV prevention options including condom use, delaying sexual debut, sexual abstinence, VCT services, being faithful and correct and consistence use of condoms.

The program also partnered with the UZIMA foundation, a local capacity building organization, and the Population Services International (PSI) to build the capacity of CBOs in HIV prevention by providing assistance on message design and puppetry, a total of 32 ToTs were trained on puppetry while focus group discussions indicated an increase in the uptake of VCT services and condom use.

e) Psycho-social support

Psycho-social support was provided by all the CBOs to OVC and their caregivers; when caregivers were asked whether within the last year they had attended a support group, all (100%) answered in the affirmative and 65% had attended group meetings once a month.

ToTs were trained in basic counselling skills and assisted in resolving issues as they arose. To ensure provision of comprehensive psychosocial services, the program developed linkages among counsellors, ToTs, paralegals and child protection ToTs; these groups routinely referred children to each other according to the identified needs.

All CBOs provided additional psycho-social support through support groups. From the focus group discussions, it was confirmed that connection between caregivers goes beyond the regular meetings held weekly or monthly. Group members interviewed indicated that they often visited each other outside normal meeting sessions. Also, ToTs indicated that they made efforts to link families they visited by encouraging their children to play together. Support group members also assisted each other with food, pooled labor to prepare their fields and sometimes money for emergency conditions.

G.R.A.C.E. Africa also trained 32 CBO representatives as ToTs on Memory Work Development. The training focused on memory books and other tools that were to facilitate dialogue on issues of HIV and AIDS, disclosure and acceptance of the loss of loved ones among caregivers and OVC. The ToTs subsequently trained 980 caregivers and out of these 420 trained caregivers developed memory work items that included baskets, blankets, pottery items and books. Focus group discussions confirmed that after the training in memory work, many caregivers found it easier to discuss their past with children and relatives as well as accept loss of loved ones. ECD Teachers were also trained on art therapy and the subsequent application of the skills to facilitate art therapy sessions with children at the centers.

f) Child Protection

Child protection was integrated as one of the key components in the program activities. The program ensured that children were protected from different types of abuse including sexual abuse and child labor.

In all CBOs, the program trained ToTs and ECD teachers continuously creating awareness to caregivers and members of the community on rights of a child and human rights in general through community meetings, children's Area Advisory Committees (AAC) at all levels and other stakeholder forums. Parents, caregivers and members of the community were repeatedly advised to report cases of child abuse to the District Children Officer or the local administration officials where follow-up was done. Some of the ToTs were trained as paralegals and routinely advised abused children on legal matters.

When caregivers were asked whether there were authorities in their community to whom they could turn to for protection, 93% strongly agreed that there were, this was an indication that they had confidence in government child protection programs partly promoted by this program.

The program also ensured that beneficiaries were aware of the importance attached to birth registrations and identification of children which is a prerequisite for long-term access to education, health care and other social services, to this end, 679 children were assisted to obtain birth certificates. During field interviews, caregivers confirmed that 54% of the OVC had birth certificates.

g) Economic Empowerment

The evaluation confirmed that many of the OVC and caregivers lived in extreme poverty and were struggling to afford basic necessities such as food, clothing, school fees, medical bills and decent shelter. With little or no money and often living in remote areas, many of the program beneficiaries were unable to access credit facilities that could help them engage in income generating activities that could help them improve their livelihoods. To address this issue the G.R.A.C.E. Program came up with the Savings and Internal Lending Communities (SILC) where caregivers participated in community based loan schemes that enabled them to borrow and lend money to each other.

Mildred Akoth is one of the success stories G.R.A.C.E. has seen since the beginning of the OVC project funded by USAID. Popularly known as Mama Veronica she is 26 years old with 3 children aged between 3 and 10 years. The third born Veronica is almost 5 years and is a beneficiary of the OVC support program.

“To be honest life was not easy and I struggled with my children and lived from hand to mouth. Although I was already a tailor, money was not easy to come by. I have come from far and owe this to the support that I have received”.

Today Mama Veronica moved to a permanent house and uses the money she borrows from her group to scale up her business. She can now afford to travel to Nairobi to buy second hand clothes to sell in Embu.

The SILC Program was started in 2010 by G.R.A.C.E. Africa where they partnered with the Catholic Relief Services (CRS) and trained 30 ToTs (two from each CBO) on SILC methodology. The ToTs then cascaded the training to caregivers, during the evaluation the team determined that 93% of respondents were members of a SILC group.

SILC is a community managed savings and loaning model where caregivers come together to form a group of between 10-13 people with the specific objective of saving money.

By the time of the evaluation exercise G.R.A.C.E. Africa had assisted the formation of 67 SILC groups with 975 active members. The groups were trained by the ToTs on how to manage their own transactions and were left to make their own rules and regulations. As part of these rules, the group sets the amount of contribution each member has to make, when they are to remit their contributions, the size and duration of loans borrowed and frequency of group meetings. In most of the places visited, SILC groups were meeting once a month as they felt that monthly meetings were more effective for building their savings and creating group cohesion.

Table 6: Funding for IGA activities received by CBO

	PARTNER	IGA funds
1	Forum for Community Mobilization (FOFCOM)	275,700
2	Kokech Jamii	172,500
3	Matutu SDA Dispensary (MEDRA)	1,166,500
4	Pandpieri	677,605
5	Mt Kenya Animators	170,160
6	Kenya Society for People with AIDS (KESPA)	720,350
7	Embu Youth	552,000
8	Victoria Agric & Environmental Conservation Org. (VIAGENCO)	781,450
9	St Francis Kimosi	221,400
10	Maua Methodist Hospital	318,000
11	Isiolo Youth	701,200
12	Chuka Youth info Centre	444,250
13	Pastoralist women	230,400
14	Kamahuha Anti-AIDS Project	693,000
15	Youth for Change	496,000

The SILC groups were also responsible for managing themselves; each group selected a leadership committee to oversee the transactions of the group. The committee maintained the group's records in a central ledger book and completed transactions in the passbooks of individual members. The committee also accurately recorded savings payments and tracked

loans using basic accounting procedures, while keeping the social fund and other group resources distinct from individual contributions.

The SILC group saved small sums on a regular basis and then lent their pooled funds to group members. The cycle of savings and lending was specifically time-bound and members agreed to save and borrow as they wished from their accumulated savings for a limited period of time (between 6 and 12 months). At the end of the period; the accumulated savings, interest earned, and income from other economic activities undertaken by the SILC group is shared in proportion to the amount saved during the cycle.

Apart from the savings, groups also operated a social fund account where members agreed to make a fixed monthly contribution to a social fund (10-20 shillings a month) to cater for other social needs identified by the group, such as caring for the sick in their community and meeting burial expenses.

After establishing SILC groups, G.R.A.C.E. went further and trained the groups in Selection, Planning and Management (SPM) of Income Generating Activities (IGAs) where group members were equipped with knowledge on how to make informed decisions in selecting income generating activities. After the trainings, groups were requested to write proposals and submit them to G.R.A.C.E. for funding (See table 6). Each group was supposed to identify a project for IGA whereby they agreed to support the ECD schools with 30% of their profit.

Discussions with various CBO Officers revealed that caregivers who were involved in SILC were increasingly focusing on income generation activities as opposed to being dependent on other sources for financial support. Quite a number of SILC groups and individuals were engaged in income generation activities and constantly were seeking new opportunities to generate more income. Those who had borrowed money from SILC groups had used their loans to start small scale businesses such as mat-making, trading in second hand clothes, vegetables kiosks and firewood businesses while others had restocked their small businesses. A few SILC members used their loans to buy farm inputs, pay for farm labor or buy seeds for planting, while others used the money to educate their children. However, although SILC was effective in meeting the economic needs of caregivers, there were gaps as the program did not include mature orphans who otherwise could have benefited from the loan scheme.

3.4 Desired Program Outcomes:

Some of the program desired outcomes included:

Supportive Environment for OVC: From the initial stages of the program rollout, all CBOs, conducted community meetings informing local leaders on the purpose of the program, services

to be provided and expectation of the community members. During these meetings and thereafter, CBOs addressed the expected balance between their contributions and contributions from the community. CBO management continuously reiterated any additional services for OVC would be provided through community efforts. These efforts created a supportive environment in that communities started contributing time and resources to support the program. For example, in the initial stages, the program provided OVC in the ECD center with breakfast of porridge and hot lunch through G.R.A.C.E. Africa support. However, the support was scaled down and CBO and community members took over the feeding program and by the time of the evaluation, the support had completely been phased out and community members had taken over the responsibility to contribute food items for the feeding program. Communities also provided the free space for ECD centers which is a good indication of community ownership.

Strengthened CBOs Capacity for quality Programming: G.R.A.C.E Africa built the capacity of the local CBOs by provided training and technical assistant including project management, resource mobilization, strategic planning, and financial management. For example, through NuPITA, G.R.A.C.E trained 30 CBO Board Representatives on resource mobilization and strategic planning and five of the six CBOs visited indicated that they are in the process of reviewing their strategic plans or are exploring new ways of resource mobilization for program sustainability. Project staffs, particularly ToTs were also trained in technical HIV and AIDS and other OVC related topical issues like psychosocial support (39), Nutrition (75), HIV and AID prevention (90), Child protection (91) and Savings and Internal Lending Committee (43) enabling them provide high quality services. Through these efforts, the program was able to strengthen the CBOs' capacity to better manage OVC programming.

Improved Nutrition and Food Security: Another major outcome produced by the program was improved food security in communities and particularly among caregivers. This was done by linking caregivers and other community members to government agriculture extension workers of the Ministry of Agriculture (MOA) who trained them in bio-intensive gardening techniques to grow onions, tomatoes, cabbage, and other fruits and vegetables in their backyards. Consequently, 483 kitchen gardens were started within the two year period and discussions with various program beneficiaries indicated that beyond improving family nutritional status, families also benefitted from the kitchen gardens by selling any surplus produce hence increasing their household incomes.

Increased Access to ECD Schools: The program facilitated access to Early Childhood Development (ECD) education by supporting 18 ECD centers and enrolling 2,176 OVC to these centers. 91 ECD teachers were employed out of whom 45 were fully trained ECD teachers while the other 46 were untrained youths. The untrained youths were employed as assistant teachers who were sponsored to attend government ECD colleges for certification. The OVC were provided with school uniforms and scholastic materials. The Program further established play grounds with fixed play recreational facilities in all the 18 ECD centers that it supported.

Improved Knowledge of HIV and AIDS and Risk Management Among Youth and Community Members to Reduce HI Transmission

HIV and AID prevention was a priority of the program, a total of 18,322 people were reached with prevention information focusing on behavior change. This was achieved through community based outreach activities implemented by ToTs. Community members were reached through small group discussions focusing on themes such as HIV transmission, behavior change, available services in relation to HIV, positive living with HIV infection, HIV prevention options including condom use, delaying sexual debut, sexual abstinence, VCT services, being faithful and correct and consistence use of condoms.

Improved Access to Social and Legal Protection: The program targeted communities, schools, local health center staff, children's officers and other government officials with sensitization campaigns on the rights of children. After sensitization and trainings, government officials worked hand in hand with CBO staff to improve the status of children in their communities. For example, in Nyamira Adventist Medical Center, two assistant chiefs were trained as Child Right ToTs and paralegals and were busy conducting *barazas* on child rights in their communities and provided paralegal services to OVC and other members of the community. Also, sensitization sessions provided by CBOs to primary schools stimulated leniency within these institutions when it come to OVC enrollment and some even started child rights clubs.

The program also emphasized on the importance attached to birth registrations and identification of children as a prerequisite for long-term access to education, health care and other social services, to this end, 679 children were assisted to obtain birth certificates. During field interviews, caregivers confirmed that 54% of the OVC had birth certificates.

Improved Health Status: Although CBOs were expected to facilitate caregivers and OVC access health care by providing them with referral forms to enable them seek health services in program selected health facilities. However, this aspect of the program did not work very well and with the exception of one CBO (Nyamira Adventist Medical Center), there was little evidence that other CBOs had organized a collaborative arrangement with local health facilities and as the evaluation team found out, uptake of health services was low and achievement was below target.

There were some positive health outcomes including the fact that families who were members of the SILC group reported improved eating habits and offered better foods at home. Also, all CBOS held medical camps for ECD children and their caregivers at all the ECD centers. In addition, all the ECD centers were provided with safe water containers, water treatment packages and teachers and children were trained in basic hygiene, thus, contributing to improved health status.

Improved Household Incomes; Since majority of the OVC and caregivers live in extreme poverty and were struggling to afford basic necessities such as food, clothing, school fees, medical bills and decent shelter, the Program came up with the Savings and Internal Lending

Communities (SILC) where caregivers participated in community based loan schemes that enabled them to borrow and lend money to each other. The program assisted in the formation of 67 SILC groups with 975 active members. After establishing SILC groups, G.R.A.C.E. went further and trained the groups in selection, planning and management (SPM) of Income Generating Activities (IGAs) where group members were equipped with knowledge on how to make informed decisions in selecting income generating activities.

The evaluation team found that caregivers who were involved in SILC were increasingly focusing on income generation activities as opposed to being dependent on other sources for financial support. Quite a number of SILC groups and individuals were engaged in income generation activities and constantly were seeking new opportunities to generate more income. Those who had borrowed money from SILC groups had used their loans to start small scale businesses such as mat-making, trading in second hand clothes, vegetables kiosks and firewood businesses while others had restocked their small businesses. A few SILC members used their loans to buy farm inputs, pay for farm labor or buy seeds for planting, while others used the money to educate their children.

3.5 Relationship between the Quantity, Quality and Timeliness of Program Inputs.

To be able to achieve the program's objectives, G.R.A.C.E provided inputs in the form of finance, personnel, office equipment and technical support to the CBO staff and ToTs who in turn trained and supported caregivers and other community leaders in a number of skills. G.R.A.C.E also strengthened local networking among other relevant stakeholders. The implementing partner CBOs also helped in community mobilization through the field officers, setting up and management of the 18 ECD centres. They also helped in the management of the financial sub grants provided by G.R.A.C.E in the payment of the ECD teachers, ToTs and provision of the capital to caregivers for their I.G.A projects, SILC groups and setting up kitchen gardens.

The inputs and services provided by G.R.A.C.E varied greatly due to individual CBO characteristics, geographical area of operation and local resources available. As such the amount of inputs and services were not uniform.

a) Financial Inputs

The financial sub grants provided by G.R.A.C.E, took care of

- Physical improvement of dilapidated ECD structures and Teachers salaries,
- Tuition fees for training 3 ECD assistant teachers from every ECD centre,
- Allowances for ToTs,
- Staff salaries for the 3 persons at the CBO office,
- Rent for office space and office furniture for some CBOs,
- Capital to start some of the IGAs,

- Money to buy food for the OVC at the ECD centres,
- Money to buy uniform and furniture for ECD centres,
- Reading and Writing materials for children and teachers at the ECD centres and
- Play ground equipment for the ECD centres.

There were recurrent costs like salaries, rent for the office and other recurrent administrative costs which were given monthly to the CBO and were always on time as reported by the teachers. There were “one off” financial payments for office equipment, playground equipment; school uniform and capital for setting up IGAs and kitchen gardens. Funds provided for the office equipment and playground materials was adequate but the school uniform was not adequate as it was only provided once at the beginning of the program, hence some of the new OVC joining in year two did not get uniform.

The other type of financial input was dependent on feedback reports from ToTs; this was the allowances paid to ToTs based on the activities undertaken in the communities for a specified period of time mostly a month. The evaluation team got information from ToTs that there were long delays between the time the reports are sent to G.R.A.C.E. and the time the allowances were paid. The reason for the delays by the implementing CBO was that sometimes money received from G.R.A.C.E. had not sent a break down for its use and the receiving CBO had to request for the breakdown sometimes taking more than two weeks. Another reason given by the ToTs was that many times they gave reports but it took a long time before the reports were sent to G.R.A.C.E by the CBO office. This gave an indication of possible breakdown in communication between the CBO and G.R.A.C.E.

Whether by program design or otherwise, financial inputs to some of the program areas was gradually phased out and eventually came to an end before the end of the program. Some of the inputs provided initially like the feeding program for the ECD centres were slowly phased out. In all the ECD centres visited, the teachers said the feeding program stopped in July and in most of the program sites visited, the community had taken over the feeding program.

Hence, clearly the funds available for the program was not sufficient to run all the planned activities for the duration of the program and due to occasional breakdown in communication between G.R.A.C.E and its partners on the ground there were delays in disbursement of funds to the people who implemented the activities. This could have dampened the moral of those implementing the program activities.

b) Technical assistance

G.R.A.C.E with the assistance of partners like UZIMA Foundation and Population Services International (PSI) who provided training and technical assistance on HIV Prevention, Children's Legal Action Network (CLAN) who provided training on Child protection, Catholic Relief Services (CRS) who provided training on economic strengthening while Trust for Indigenous Culture and Health provided training on health, nutrition and the establishment of kitchen

gardens was able to impart skills and knowledge to the CBO staff and ToTs who in turn passed it on to the beneficiaries. Private consultants were also used to provide capacity in specific areas of specialization relevant to the program. G.R.A.C.E. staff learned at the same time with the CBO staff, sometimes making it difficult for them to provide quality technical assistance including supportive supervision

We have learnt a lot in HIV, PSS, Child protection and Nutrition as a result of the training we got from G.R.A.C.E. Can stand in front of anyone and talk about these things. ToT in Chuka.

The cost of implementing the project could have been significantly reduced if G.R.A.C.E had more in house skills and could have relied less on the external technical assistance from partners and private consultants. This could have diverted most of the funds used to pay for external assistance to be used to improve the coverage of the program and probably enable the limited funds available to stretch to the end of the program.

The team found that the number of trainings conducted which were providing capacity building for the ToTs were both adequate in number and in quality. The participants of these training workshops were also well facilitated to attend them by provision of transport and accommodation during the workshops conducted away from the program sites.

From the interviews with the partner CBO staff and with group discussions with ToTs, all were confident they had learnt enough in their specific areas as a result of the trainings that they had received from the several workshops they had attended. The trainings were adequate because according to the quarterly Newsletter *Mashinani (January – March, 2011)*, by march 2011, 90 ToT had been trained on HIV prevention, 75 had been trained on Nutrition, 91 on child protection, 39 on Psychosocial support and 43 on Savings & Internal Lending Communities as shown in detail in the table 7 below.

Table 7: Persons reached through NPI Project

Components	Trained ToTs	No. of individuals reached per service		Total
		Male	Female	
HIV & AIDS Messages	90	11226	7118	18344
Psycho-social support	39	7364	5012	12376
Economic empowerment	48	3733	2326	6059
Food and Nutrition	75	6468	4747	11215
Child protection	91	9166	6597	15763
Savings & Internal lending Communities	43	1441	2244	3685

ECD Management (CBO staff trained)	-	13	18	33
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Source: Mashinani, May – July, 2011

In a Partners review meeting in February 2011, partners reported improved service delivery as a result of ToTs “good work” resulting from trainings got from workshops attended. The CBOs program officers reported improved resource mobilization for sustainability as result of training they got on resource mobilisation. They also reported improved M&E knowledge among partners and timelines were better adhered to. This technical assistance led to general improvement of efficiency in the delivery of services provided by both G.R.A.C.E. and that by the partner CBOs to the caregivers; hence they could better care for the OVC. Hence, the training conducted was adequate quantity and quality and timely. The input on training was adequate in both and was provided in a timely manner.

c) Resource Utilization

The three year program had a total budget of 2.7 million US dollars for the three years it was implemented. With the Kenya shilling exchanging rate at an average of 85 to a dollar between 2009 and 2011, this translated to approximately Kenya Shillings 230 million as the total budget. Out of this total budget, the amount disbursed to implementing CBOs was Kenya shillings 43,656,694 meaning that program support was 81% of the total budget. Table 8 below shows details amount of money disbursed to implementing partner CBOs and various unit costs.

Table 8: Financial resources disbursed to the Implementing partners

Implementing Partner	Expenditure as 8/30/11	No. of OVC	No. of Caregivers	No. of TOT	Cost /OVC	Cost/ Caregiver	OVC/ Caregiver	OVC/TOT	Caregiver/ TOT
FOFCOM	2,917,479	125	115	12	23,340	25,369	1.09	10.42	9.58
Kokech Jamii	3,368,769	149	120	11	22,609	28,073	1.24	13.55	10.91
Matutu SDA (MEDRA)	3,983,088	319	265	18	12,486	15,031	1.20	17.72	14.72
Pandipieri	2,774,803	107	97	8	25,933	28,606	1.10	13.38	12.13
Mt Kenya Animators	3,517,248	126	89	10	27,915	39,520	1.42	12.60	8.90
KESPA	3,153,428	120	108	12	26,279	29,198	1.11	10.00	9.00
Embu Youth	3,166,706	122	97	12	25,957	32,646	1.26	10.17	8.08
VIAGENCO	3,721,897	113	103	11	32,937	36,135	1.10	10.27	9.36
Kimosi	1,480,654	129	75	10	11,478	19,742	1.72	12.90	7.50
Maua Methodist Hospital	2,540,623	128	116	11	19,849	21,902	1.10	11.64	10.55
Isiolo Youth	2,491,878	103	89	12	24,193	27,999	1.16	8.58	7.42
Chuka Youth info Centre (CYIC)	2,963,189	212	86	13	13,977	34,456	2.47	16.31	6.62
Pastoralist women	2,529,157	109	80	7	23,203	31,614	1.36	15.57	11.43

Kamahuha Anti AIDS Project	3,509,469	227	193	12	15,460	18,184	1.18	18.92	16.08
Youth for Change	1,538,306	87	74	8	17,682	20,788	1.18	10.88	9.25
TOTAL	43,656,694	2,176	1,707	167	20,063	25,575	1.27	13.03	10.22

Source: G.R.A.C.E MIS System

Using the direct disbursements to the implementing CBOs, the average unit cost of training an OVC who was the direct beneficiary in the program was approximately Kenya shillings 20,063. However, this unit cost varied greatly from CBO to the other. VIAGENCO incurred the highest cost to train an OVC at Kenya shillings 32,937 per OVC while Kimosi incurred Kenya shillings 11,478 per OVC.

Despite the difference in needs of beneficiaries in different project areas, there was a very big variation between the unit cost used in the different program areas. Although the other supporting administration and programming costs are also as important as the actual a program activities, the proportion of financial resources used to directly fund the activities of the program was very little.

3.6 Program Sustainability

a) Capacity of CBOs

G.R.A.C.E. Africa has built the capacity of the local CBOs by providing training and technical assistance including project management, resource mobilization, strategic planning, and financial management; for example, through NuPITA, 30 CBO Board Representatives were trained on resource mobilization and strategic planning. Five of the six CBOs visited indicated that they are in the process of reviewing their strategic plans or were exploring new ways of resource mobilization for program sustainability.

Project staff specifically the ToTs were trained in HIV and AIDS Prevention (90), ECD Management (33), and other OVC related topical issues like psychosocial support (39), Nutrition (75), Child protection (91) and Savings and Internal Lending Committees (43); all these trainings provided by the G.R.A.C.E. Program enabled the beneficiaries to provide high quality services to their communities including managing ECD centers which were the entry to this project. Since the knowledge and skills provided by the program will remain with the CBO staff, we can conclude that they will continue to use it to manage any community based program including OVC support beyond the current program.

b) Assessment of partner CBOs to sustain program intervention

In assessing the readiness of G.R.A.C.E. Program partner CBOs to sustain program intervention, several key factors were evaluated, these were:

i) Leadership and Governance

Most of the CBOs had a management board whose members were either appointed by the founder(s) or were modeled along the structure of the sponsoring organization G.R.A.C.E. Africa.

Nyamira Adventist Medical Center had a board of directors directly elected through the SDA Church while at Kokech Jamii and Isiolo Youth, Boards were selected by the founder members and in both instances persons appointed were prominent members of their community. The SDA method of election of board members' ensured openness and accountability to communities they were serving. However, for those CBOs where founder members appointed the board it was apparent that their loyalty was more to the appointing authority rather than the community that they were to serve. Hence, all organizations were left with good leadership to take the program to the next levels.

ii) Administration and Human Resource Management

G.R.A.C.E. Africa had assisted all the CBOs develop clear organizational structures and systems with clear delineation of responsibility and tasks for each worker, whether paid or volunteers, the process systems were clearly indicative of what needed to be done, when it was supposed to be done and what standards were to be applied to any task.

Policies and procedures applied in dealing with all staff were in place providing guidance on how performance problems with workers or volunteers would be identified, acknowledged and discussed with a view to resolving them. This capacity will be useful in the next level where these CBO will be sourcing funds from different organizations.

iii) Financial sustainability

All the CBOs had identified other sources of funding including APHIA Plus and some had initiated discussions for continuity. Others had identified alternative funding sources including available government decentralized funding at community levels in particular NACC's/World Bank funding, the Global Fund and Constituency Development Funds (CDF). All partner CBOs had developed online websites which they were key fund raising tools. Hence, majority of the organizations will be able to attract funding from other sources including APHIA plus.

iv) Organizational Sustainability

All the CBOs had clearly stated *vision* and mission, their acquired expertise from G.R.A.C.E. Program enabled them to interact with other partners in the community and also with community members. The CBOs were shared OVC information with the government through the COBPAP, and hence there was wider information sharing with other implementers and networks resulting to full participation in various forums within their respective districts of operation, at the same time, some were members of various task forces regarding OVC gaining a good Visibility on the programs that they were involved in. All CBO indicated that they will continue participating in all the meetings involving OVC.

v) Collaborative Links and Referral Networks with other service providers

The program conducted sensitization campaigns and information sharing with community leaders, schools, local health center staff, children's officers and other government staff. Government representatives contributed to program development as officials from the ministries of health, gender and social services, provincial administration and education worked hand in hand with CBO staff in project implementation and in return the government supported the efforts of the CBOs. For example, in Nyamira Adventist Medical Center, two assistant chiefs were trained as Child Right TOTs and paralegals and were busy promoting children's rights and providing paralegal services. Also sensitization sessions provided by CBOs to primary schools stimulated leniency among these institutions when it came to OVC enrollment and some had even started child rights clubs.

vi) Community Ownership

G.R.A.C.E. Africa together with CBOs built the capacity of the communities by selecting and training 348 Trainers of Trainers (ToTs) who were members of the community, resided in particular community and were willing to continue providing care and support to OVC within the particular community. The CBOs also assisted in the formation of various support groups providing psychosocial support to OVC and their caregivers while championing the creation of SILC, an important vehicle for economic empowerment and sustainability within communities.

3.7 Challenges, Lessons Learned and Best Practices

3.7.1 Programme Challenges

Some of the program challenges that were identified were:-

i) Inadequate resources

In any program area, the available resources addressing community needs are generally limited creating challenges for all involved. In the G.R.A.C.E. Program, the beneficiaries - the OVC households were generally poor with very limited resources. Each CBO provided direct material assistance to the extent that it was able to do, however, in spite of grant funding and community mobilization strategies, the CBOs felt that they were unable to provide enough assistance to meet the many needs of OVC households. Due to this several CBO staff members interviewed for this report felt that their contribution could have been better if they had additional resources.

ii) Community expectations

The Program beneficiaries expected tangible material support during home visits and for the ECD centres consequently, many community members felt that CBOs were not providing sufficient assistance. This expectation was initially created by the periodic distribution of material assistance .e.g. school uniforms for the OVC, once families had received some form of

material assistance; they then had the expectation that the program would provide them with some form of assistance either every year or during every home visit. Despite the provision of psychosocial support during home visits, the lack of tangible material support meant that neither the community nor the ToTs viewed this as a ‘service’.

iii) Unmet Needs

All the CBOs concentrated on providing support to the OVC aged 3-6 years who were attending ECD schools and their caregivers. However, the OVC attending primary and secondary schools were not getting any support in this program neither were their needs addressed in this program. Furthermore, mature OVC who could have benefited from SILC and IGAs were not included under the program. Opportunities for income generation were not directly available to these OVC or to households headed by children.

What motivates me is helping someone to move from where I was to the level I am now” –untrained ECD assistant teacher

iv) Insufficient number of ToT counsellors

CBO staff felt that the project had not trained enough ToT counsellors to deal with the many psychosocial needs of the OVC and their caregivers. Although ToTs had basic counselling skills, they were limited in their ability to address the major psychological issues facing OVC, caregivers and their families. They also did not know where to refer the complicated cases. Moreover, as many of the ToT counsellors were ECD teachers, they had to balance their academic responsibilities with counselling.

v) Limited legal resolution of child rights violations

While G.R.A.C.E. Africa trained paralegals within their program coverage areas, the judicial system in Kenya requires that litigation be handled in the courts by trained lawyers. When there was a need to go to court to seek redress in cases of child abuse or disinheritance that cannot be addressed through local leaders; there were few lawyers available to provide pro bono representation for the OVC under the program. Thus, many cases that should have been taken to court were never resolved through the legal process.

vi) Limited Male Participation

Very few men were involved in direct program implementation and even those who were directly working in program were performing managerial jobs like program coordination, accountancy and field work. This was in part contributed to by the cultural practice in many societies where the program was being implemented that views child care as the preserve of women.

vii) Short program duration

Discussions held with stakeholders indicated that the period of program implementation was too short and should have been not less than five years in order to make proper impact within the communities. The first year was spent on program preparation in terms of creating of a work

plan for approval (this took more than six months), therefore actual implementation and provision of services started in year two, thus, G.R.A.C.E. Africa and its partners had only two years to focus on implementation, expand coverage, apply the skills obtained in capacity building workshops while at the same time solidify the already enhanced institutional systems and structures.

vii) Inadequate coordination and cooperation by the donor

Although G.R.A.C.E. Africa Program was approved and funded in 2008; the work plan took more than 6 months to be get approved, this was partly because the reviewer was doing piece meal work and sending disjointed communication to G.R.A.C.E. Africa which was time consuming and frustrating considering the program execution timelines. Furthermore, the oversight of the activities by the Kenya USAID mission was inadequate and consultation was inadequate.

3.7.2 Lessons Learned and Best Practices

i) Adapting interventions to community identified needs

G.R.A.C.E. Africa consulted community and CBO leaders during the program design and implementation of program activities therefore the program was responsive to the local input and ingenuity. Program staff liaised with CBOs and other community members to determine needs and adjusted program work plans and budget accordingly.

For example, when volunteers highlighted the ongoing challenges in attending to the OVC's psychosocial issues, G.R.A.C.E. Africa brought in consultants who trained CBO members on memory work development and 420 caregivers were able to develop memory work items including books, baskets and boxes. G.R.A.C.E. Africa's willingness to adapt program activities to community needs encouraged a strong sense of program ownership among CBOs and the community.

ii) Encouraging CBOs to be self-sufficient

G.R.A.C.E. Africa provided limited direct resources to CBOs to address basic needs of the OVC. As a result CBOs did not rely exclusively on G.R.A.C.E. Africa but pursued additional sources of funding and support. CBOs had become skilled in resource mobilization and successfully garnered donations from local government, the private sector, and the general community. They were also able to prove receipt of in-kind contributions which included donated space, food, supplies, and technical support. Their success in mobilizing community resources assisted them to expand services for OVC as well as increase the sense of responsibility towards OVC in the community.

iii) Partnering with community stakeholders

The G.R.A.C.E. Africa program strived to capitalize on existing resources and expertise within the community. Both CBOs and G.R.A.C.E. Africa formulated partnerships with local stakeholders, including government ministries, health facilities, educational institutions, businesses, and other CBOs. G.R.A.C.E. Africa and CBOs evidenced these relationships through a number of strategies, including initial consultation, ongoing sensitization, and technical training and support. They also facilitated leadership roles for a number of local actors, meaningfully engaging them in the initiative.

Networking among CBOs and community resource persons was also encouraged through regular meetings and forums, supporting the exchange of lessons learned and reducing duplication of services. By engaging a certain cadre of community stakeholders in the program and promoting linkages among them, G.R.A.C.E. Africa facilitated a wide referral network to serve OVC, motivate community-driven responses, and ultimately helped CBOs access additional resources to support OVC.

iv) Mature OVC as active program participants

The G.R.A.C.E. Program employed mature OVC as untrained ECD teachers who were then enrolled in government colleges for training in education. We also found PLWHAs and other mature OVC included by several CBOs as TOTs, paralegals, and counsellors. CBO staff and beneficiaries reported that including PLWHAs and OVC as program volunteers creates a feeling of empowerment to OVC and PLWHAs who can then “give back” to the community by supporting others. In addition, this cadre of trained beneficiaries are more effective at empathizing with the problems that other OVC and PLWHAs face while engaging in independent efforts to support others in their situation.

4.0 CONCLUSIONS AND RECOMMENDATIONS

4.1 Conclusions

Lessons learned from the G.R.A.C.E. Africa program in Central, Eastern and Nyanza provinces offers a blueprint that can be followed by other programs aimed at ensuring that orphans and other vulnerable children and their families receive quality services that mitigate the multi-sectoral impacts of HIV and AIDS.

At the core of such effort is the need to strengthen CBO’s capacity. Local capacity exists in every individual, family, household, village, community, and country, no matter how desperately poor the situation may appear to be. Local capacity is contained in informal CBOs, FBOs, and NGOs that require organizational, financial, and technical strengthening from the grassroots up to the top.

Capacity building by formal CBOs that work to reach vulnerable populations may be in terms of the need for training, resources, and expertise to get them to the next level of sustained growth

and effectiveness. They may also need a vision, a strategy, or volunteers and staff who are members of affected communities and can re-awaken their mission and expand access to vulnerable children and families. Local capacity exists at all levels within communities and structures that support OVC. These structures need to work together and coordinate seamlessly to support communities and individuals to cope with the effects of HIV and AIDS.

Programs in collaboration with partners need to identify populations that are most vulnerable, assess their needs, and articulate plans to meet those needs. In addition, national frameworks, policies, plans and guidelines for vulnerable children and families also need to be implemented.

The process begins with an assessment of the OVC situation and the involvement of key stakeholders, in particular affected individuals, the community, and the national government. Throughout the duration of an OVC program, it is vital to strengthen the organizational capacity of local indigenous groups, coalitions, and networks so they can sustain the response.

The strengthening of collaborative networks and linkages is also important, since no single organization or service provider can meet all the needs of orphans and other vulnerable children. Establishing links with local and national organizations is crucial.

A common understanding of the fundamental role of childhood, child rights and basic child development are critical to good programs and should not be assumed. Basic education and training on these should be a standard part of any OVC program. Teachers, parents and volunteers can be trained to recognize and respond supportively when children show warning signs, such as becoming withdrawn, disruptive, or when academic performance declines. Basic training in psychosocial support can help to increase the chance that children who are compromised do not go unnoticed and receive the care and attention they need.

4.2 Recommendations.

- It is important to develop systems and mechanisms that help identifying and ensure that all those who are deemed to be most vulnerable receive support.
- Strengthen collaborative networks and linkages as this will help meet children's needs better as more resources are leveraged through partnerships.
- Any activities implemented by G.R.A.C.E. Africa in the future should be preceded by a baseline survey.
- As the government community strategy calls for a comprehensive integrated community owned resource persons, the cadre which fits this definition and description was the ToT whose training and job description was limited to one or 2 components of the OVC package. Therefore for a household to get a comprehensive package 1 or 2 or 3 ToT had to visit a home which was not only time consuming but confusing. Hence, we are recommending that G.R.A.C.E. Africa should adapt a comprehensive integrated approached in training ToTs who can adapt the government strategy.

ANNEXES

ANNEX I: PERSONS CONTACTED

Grassroots Alliance for Community Education Head Office

1. Natasha Martin – C.E.O., G.R.A.C.E. Africa
2. Pascal Masila Mailu - Director
3. Janet Onyalo – Project Coordinator and M&E officer
4. Martin Okelo –Food security and Nutrition Project assistant
5. Patricia Sewe- Communication Officer
6. Mwendu Karutu –Youth and Economic Empowerment Officer
7. Nasalan Kikaya –Finance Officer

Forum for Community Mobilization (FOFCOM)

1. Stephen Nga'ng'a- Project Coordinator
2. John O. Wanjir- Project Finance Officer
3. Francis Gitau-TOT for SILC
4. Mr. Joseph Kimanga-Divisional Agricultural Office
5. Mr. Mekenye Kebati-Children's Officer, Kiambu District
6. Jennifer Wangari-Children's Office, Kiambu West District
7. Ms. Jane Njuguna –Assistant Chief, Ndumberi Location

Also held separate focus group discussions with 5 Caregivers, 5 ECD teachers and 3 ToTs

Mt. Kenya Animators and Puppeteers Youth Group

1. Peter Muriithi –Project Coordinator
2. Samuel Gatere-Finance Officer
3. Edith Karemi-TOT (Nutrition)
4. George Maina –Field Officer
5. Anastasia Thuku – Head ECD centre/ToT
6. Jeff Mugo- TOT/ECD Teacher
7. Alice Karatu –TOT/ECD Teacher
8. Ruth Warioko-TOT/ECD Teacher

Kokech Jamii Tunjipange Kwa Mapambano ya Ukimwi

1. Martin Wasonga – Chairman Board of Directors
2. Ms. Mary Obiero- Vice chair of the Board
3. Josephine Akinyi –Project Coordinator
4. Churchill Owino Onono – Agricultural Extension Officer. Ministry of Agriculture
5. Elizabeth Ongallo – Nurse, Ministry of Health

6. Dorcas Omollo - ECD Teacher and TOT for PSS
7. Alice Odero - ECD Head teacher and ToT for PSS
8. Janet Atieno-ECD teacher and ToT for Child Protection
9. Vida Akinyi – ECD teacher
10. Joseph Laja – Assistant ECD teacher

Also held separate focus group discussion with 12 caregivers

Nyamira Adventist Medical Center (Matutu)

1. Daniel Musomi-Chairman
2. Samson Mukaba- Board Member
3. David Omare-Project Coordinator
4. George Muraru- Finance Officer
5. Edina Keruba Oguduora- Field Officer
6. Davis Ogega - Assistant Chief, Mweguri Sub-location
7. Samson Nyakiwa – Assistant Chief, Matutu sub-location
8. Franco Sowela - Headmaster, Mbalabu Primary School
9. Robinson Ondiek – Deputy Headmaster Matutu complex
10. Ms. Mary Omeri- Public Health Nurse, Ministry of Health
11. Trufosa B. Kaoka – Head Teacher/ ToT, Borabu ECD Centre
12. Nancy Oseko – ECD teachers/Borabu ECD Centre
13. Esther Gesare – ECD teachers/ToT
14. Fannis Onderi – Assistant ECD teacher
15. Flora Obara – Volunteer ECDvteacher
16. Stella Ondimu – Head teacher ECD, Matutu Complex
17. Sarah Kwamboka – Assistant ECD teacher/ToT
18. Stella Mochere – ECD teacher
19. Cecilia Osiemo – Assistant ECD teacher
20. Cyrus Nyangweso – Assistant ECD teacher

Also held separate focus group discussions with 19 caregivers and 9 ECD teachers and

Embu Youth AIDS Advocates (EYAA)

1. Martin Wachira - Project Coordinator

Chuka Youth Information Centre

1. Mike Kinyua Njeru - Project Coordinator
2. Loise Kanini- Finance Officer
3. Mr. M'Kenya Muriuki –Field l- Officer
4. Lucy Kanini – Agricultural Extension Officer
5. Charles Njagi – Assistant Chief, Ndagani
6. Lillian Gakii – ECD teacher, ToT for PSS/HIV
7. Anne Kangai – ECD teacher, ToT for HIV/CSI
8. Zainabu Mukami – ECD teacher, ToT for Child Protection

9. Faith Gasheri – ToT for Psycho Social Support

Also had separate focus group discussions with 12 Caregivers, 3 ECD teachers and with 3 ToTs

Isiolo Youth Against AIDS Program (IYAP)

1. Wario Kassim - Project Coordinator
2. Hassan Boru - Finance Office
3. Abdi Dida - ToT for Child Protection
4. Hashim Abdul - ToT for HIV prevention
5. Munir Jilo – Teacher and ToT for HIV
6. Hussien Ali – ECD head teacher and ToT for HIV
7. Hadija Hassan – Teacher and ToT for PSS
8. Ralia Boru – Teacher and ToT for PSS
9. Jamila Ibrahim – Teacher and ToT for Child Protection

Also held separate focus group discussions with 9 caregivers and Teachers/ToTs.

ANNEX II. QUESTIONNAIRES

Focus Group Guide – Caregivers

Challenges facing caregivers and Program Impact [20 minutes]

1. What are the challenges that **ADULTS** who care for orphans and vulnerable children in this community face?
Follow-up: How do these problems affect ADULT CARE PROVIDERS?
Follow-up: How do these problems affect OVCs under their care?
2. What are the challenges that adults with HIV/AIDS in this community face?
Follow-up: How do these problems affect adult care providers?
Follow-up: How do these problems affect OVCs under their care?
3. Specifically, explain the influence, if any, that the program has had on these challenges:
Probe: How has the program helped to reduce [*reiterate mentioned challenges*]?
4. Specifically, how has the program affected, if at all, the following:
 - Caregivers health
 - Caregivers psychological wellbeing
 - Relationships with household members—adults and OVCs
 - Caregivers ability to care for OVCs in their household
 - Protection of the rights of household members—adults and OVCs
 - Experiences of stigma or discrimination
 - Other impacts?

Challenges facing OVC and Program Impact [15 minutes]

5. What are the challenges that orphans and vulnerable children in this community face?
Follow-up: How do these problems affect OVCs?
6. Specifically, explain the influence, if any, that the program has had on these challenges:
Probe: How has the program helped to reduce [*reiterate mentioned challenges*]?

Specific Program Components [20 minutes]

Trainers of Trainers

7. What do Trainer of Trainers do for the households they serve?
Follow-up: Specifically explain the influence, if any, that this assistance has on the physical or psychosocial well-being of household members both OVCs and adults.
8. What is the relationship between caregivers and ToTs?
Probe: What aspects of the relationship with the ToTs are most useful or valuable?

Probe: What, if any, problems are there with ToTs?
Probe: How could be this relationship be improved?
9. What is the relationship between the ToTs and OVCs?
Probe: What aspects of the relationship between ToTs and OVCs are most useful or valuable?
Probe: What, if any, problems are there between ToTs and OVCs?
Probe: How could be this relationship be improved?

Income Generating Activities (Savings and Internal Lending Committees (SILC) or (IGA) Groups.

10. Specifically explain the influence, if any, that IGA Groups/SILC have on the ability of caregivers to support themselves and their household.
11. What aspects of the IGA Groups/SILC are most useful or valuable?
12. How could these income generating activities be improved?

Community Meetings

13. What, if any, differences have community meetings had on the lives of vulnerable caregivers and OVCs?

Probe: What do they accomplish? What changes have resulted from these discussions?

Program Strengths and Weaknesses [20 minutes]

14. What is the most useful thing that the program provides?
Probe: What aspects of the program have made the most difference for OVCs and/or caregivers? Why?
15. What could the program be doing that it is not doing?
Probe: What would make the program better?
16. Does the program work better for some participants than others? If yes, explain why?
17. How does the program affect caregivers and OVCs differently?
Probe: Do both caregivers and OVCs receive equal benefits? Explain.
18. What aspects of the program work well? What is liked most about the program?
19. What aspects of the program do not work well? What is disliked about the program?
Probe: What problems are there with the program?
Probe: If you could, what would you change about the program?

Community Attitudes & Role of the Community in OVC Care [15 minutes]

20. How are adults served by the program, perceived and treated in the community?
21. How are OVCs served by the program perceived and treated in the community?
22. What do other adults and OVCs in the community think of the program?
23. What does the community do to help OVCs and families in need?
Probe: What types of support or assistance does the community provide for OVCs and families in need?

Follow-up: Do they help as much as they are able? Why or why not?

Follow-up: What more could they be doing to help?

Conclusion [5 minutes]

24. Is there anything else I have not asked you that you think is important to share?

Focus Group Guide – ToTs

Introduction [10 minutes]

Welcome to everyone, and thank you for being here with us today. My name is _____ and I am from Nairobi. Everyone in this group today is a ToT for the GRACE OVC program. I'll be asking you some questions about your role as a community health worker and your experiences and opinions of the GRACE (CBO affiliated to GRACE) Program. I will also ask about the challenges orphans and vulnerable children and their families face. We want to hear your opinions about the ways the program impacts your own life, as well as the life of adults and OVCs in the program, and your suggestions for improving the program.

We want this group to be a safe place for you to be honest. Everything that is said in this group today is confidential. That means that the things you share with us will not be shared with anyone and your name will never be used. We will be conducting several other groups like this in the community and will only reference comments by saying "a ToT said this." We will be taping our discussion so that we won't miss any of the important ideas and opinions you share with us today. The tapes will be kept safe and confidential and only heard by us, and when we are finished with them for our research, we will erase them.

We'll be spending about 2 hours together today. During that time, we want to be respectful of each other. Some of the rules we want to set for our discussion are:

1. One voice at a time.
2. Don't interrupt others.
3. Everyone's opinions are important. Be careful not to criticize anyone.
4. Confidentiality: what is shared in the meeting today should not be shared with other people.

Are there any other rules you can think of that are important?

You can answer the questions based on your own experience or what you understand are the experiences of other youth in the program.

Before we begin, let's all get to know each other. We'll go around the circle and each person tell the group something about you, such as your age, and the size of your family.

Focus Group Guide – ToTs

Role of ToTs [approx 20 minutes]

1. What do Trainer of Trainers do for the households they serve?
Follow-up: What do you think is the most useful or valuable aspect of the services ToTs provide for beneficiaries?
Follow-up: Specifically explain the influence, if any, that this assistance has on the physical or psychosocial well-being of household members—OVCs and adults.
2. What is the relationship like between caregivers and ToTs?
Probe: What aspects of the relationship with the ToTs are most useful or valuable?
Probe: What, if any, problems are there in these relationships?
Probe: How could these relationships be improved?
3. What is the relationship like between the ToTs and OVCs?
Probe: What aspects of the relationship with the ToTs are most useful or valuable?
Probe: What, if any, problems are there in these relationships?

Impact of the program on ToTs and their needs [20 minutes]

4. What impact has being a ToT had on your own life?
Probe: What have been the positive aspects of being a ToT?
Probe: What challenges have you encountered in your own life due to your work as a ToT?
5. What keeps you motivated to be a ToT?
Follow-up: What makes it difficult to keep your enthusiasm for the program?
6. What challenges have you faced in your work?
Probe: In which areas do you feel you need additional support?
Follow-up: What type of support, training or other resources would be helpful in addressing these challenges?
7. How could the program best recruit and keep good ToTs?
8. Would you recommend to your friends that they serve as ToTs? Why or why not?
Would adults in this program continue to visit these households if the formal home-visiting program was to end? Why or why not?
Follow-up: What, if anything, can be done to encourage this?

Challenges facing caregivers & OVC and Program Impact [20 minutes]

9. What are the challenges that adults who care for orphans and vulnerable children in this community face?
Follow-up: How do these problems affect adult care providers?
Follow-up: How do these problems affect OVCs under their care?
10. What are the challenges that adults with HIV/AIDS in this community face?
Follow-up: How do these problems affect adult care providers?
Follow-up: How do these problems affect OVCs under their care?
11. What are the challenges that orphans and vulnerable children in this community face?
Follow-up: How do these problems affect children?
12. Specifically, explain the influence, if any, that the program has had on these challenges:
Probe: How has the program helped to reduce [reiterate mentioned challenges]?

Follow-up: Specifically, explain the how ToTs workers help to address these needs, stresses and challenges?

13. What other needs, stresses and challenges of beneficiaries do you feel remain that are not addressed by GRACE/CBO affiliated to GRACE?

Probe: Among children?

Probe: Among adults?

Probe: Within the wider community?

Follow-up: How do you propose these outstanding needs could be addressed?

Program Strengths and Weaknesses [20 minutes]

14. What is the most useful thing that the program provides for beneficiaries?

Probe: What aspects of the program have made the most difference for children and/or caregivers? Why?

15. What could the program be doing that it is not doing?

Probe: What would make the program better?

16. Does the program work better for some participants than others? If yes, explain why?

17. How does the program affect caregivers and children differently?

Probe: Do both caregivers and children receive equal benefits? Explain.

18. What aspects of the program work well? What do beneficiaries like most about the program?

19. What aspects of the program do not work well? What do beneficiaries dislike about the program?

Probe: What problems are there with the program?

Probe: If you could, what would you change about the program?

Community Attitudes & Role of the Community in OVC Care [15 minutes]

20. How are adults served by the program, perceived and treated in the community?

21. How are children served by the program perceived and treated in the community?

22. What do other adults and children in the community think of the program?

23. What does the community do to help children and families in need?

Probe: What types of support or assistance does the community provide for children and families in need?

Follow-up: Do they help as much as they are able? Why or why not?

Follow-up: What more could they be doing to help?

24. What can be done to help encourage more adults in the community to support orphans and vulnerable children and families in need? (either through the home-visiting program or in other ways)

25. Is there anything else I have not asked you that you think is important to share?

G.R.A.C.E. EVALUATION Caregiver Questionnaire

MODULE A : DEMOGRAPHICS

Now, I am going to ask a little about you and your living situation. Remember that your answers will not be shared with anyone else.

A1.	Record Sex of Respondent	Male 1 Female..... 2	
A2.	How old were you at your last birthday?	Age in completed years [] []	
A3.	What is the highest level of school you attended: nursery, primary, secondary, or higher?	NONE 0 NURSERY 1 PRIMARY 2 SECONDARY..... 3 HIGHER 4	
A4.	Marital status?	Widowed 1 Divorced 2 Separated 3 Single..... 4	

MODULE B: HEALTH

Now I'm going to ask you some questions about your health and daily activity.

No.	Question	Response	
B1.	In general, how is your health? <i>READ ALL, CIRCLE ONE</i>	VERY GOOD 1 GOOD 2 NEITHER GOOD NOR POOR..... 3 POOR 4 VERY POOR 5	
B2.	In the past year, have you had an illness for 3 months in a row or longer?	Yes..... 1 No..... 0	
B3.	How many adults that live in this household fell sick?	[] [] IF 00 Adults SKIP to B5	
B4.	For each of the adults who fell ill, what is there relationship to the OVC you care for? <i>CIRCLE ONE</i> <i>IF OTHER, PLEASE SPECIFY</i>	Natural mother 1 Natural father 2 Natural grandmother 3 Natural grandfather 4 Aunt 5 Uncle 6 Older brother..... 7 Older sister 8 Other (specify) 88	

B5.	How easily are you able to get good medical care? <i>READ ALL, CIRCLE ONE</i>	NOT AT ALL1 SLIGHTLY.....2 MODERATELY3 VERY4 EXTREMELY.....5
B6.	How easy is it for the person you care for to get good medical care? <i>READ ALL, CIRCLE ONE</i>	NOT AT ALL1 SLIGHTLY.....2 MODERATELY3 VERY4 EXTREMELY.....5
B7.	Have you identified someone who would care for the child you care for if something should happen to you and you couldn't take care of him/her?	Yes..... 1 No..... 0

MODULE C: FOOD AND NUTRITION

Now I would like to ask you some questions about food used in your household, and the ways in which you are managing your needs for food. Please respond according to your situation in the past 4 weeks.

C1.	In the last 4 weeks, did you worry that your household would not have enough food?	Yes 1 No 0	IF NO SKIP TO C4
C2.	In the last 4 weeks, was there ever no food at all in your household because there were no resources?	Yes 1 No 0	
C3.	How often did this happen? <i>READ ALL</i>	RARELY (once or twice)..... 1 SOMETIMES (3 to 10 times) 2 OFTEN (more than 10 times)..... 3	
C4.	In the last 4 weeks, did you or any household member go to sleep at night hungry because there was not enough food?	Yes 1 No 0	IF NO SKIP TO D1
C5.	How often did this happen? <i>READ ALL</i>	RARELY (once or twice)..... 1 SOMETIMES (3 to 10 times) 2 OFTEN (more than 10 times)..... 3	

MODULE D: COMMUNITY SUPPORT

The next few questions are about help, you or your household might have received in the past 6 months. I am interested in whether you or your household have received money, food, clothing, help with education or educational expenses, childcare, transportation, medical care, or some other type of help.

D1.	In the past 6 months, did your household receive help from friends, relatives, or neighbors?	Yes..... 1 No..... 0	IF NO SKIP TO D3
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D2	<p>What type of help did your household receive from friends, relatives or neighbors?</p> <p><i>READ CHOICES & CIRCLE ALL THAT APPLY</i></p> <p><i>IF OTHER, PLEASE SPECIFY</i></p>	<p>FOOD1</p> <p>CLOTHING2</p> <p>EDUCATION OR EDUCATION EXPENSES3</p> <p>MONEY4</p> <p>CHILDCARE.....5</p> <p>COUNSELING/EMOTIONAL SUPPORT6</p> <p>MEDICAL CARE/MEDICINE7</p> <p>TRANSPORTATION8</p> <p>OTHER (SPECIFY)9</p>	
D3	<p>In this community, who is PRIMARILY responsible for caring for orphans and families affected by HIV/AIDS</p> <p><i>READ CHOICES</i></p> <p><i>IF OTHER, PLEASE SPECIFY</i></p>	<p>EXTENDED FAMILY1</p> <p>COMMUNITY2</p> <p>GOVERNMENT3</p> <p>NGOs.....4</p> <p>OTHER (SPECIFY)5</p> <p>DON'T KNOW.....6</p>	

	NGO SUPPORT	STRONGLY AGREE	AGREE	<i>DISAGREE</i>	STRONGLY DISAGREE
E1.	People are jealous of the services given to orphans and families affected by HIV/AIDS	1	2	3	4
E2.	The only people who care about your family are NGOs.	1	2	3	4

MODULE F: PROTECTION AND SUPPORT

Now, I am going to read a list of statements. Please tell me if you “STRONGLY AGREE,” “AGREE,” “DISAGREE” or “STRONGLY DISAGREE” with the statements.

No.	Question	Responses			
		STRONGLY AGREE	AGREE	DISAGREE	STRONGLY DISAGREE
F1.	There are authorities or leaders in this community you could go to if you were being hurt or treated unfairly.	1	2	3	4
F2.	You trust that, authorities in the community would look out for your best interests if you went to them with a problem.	1	2	3	4

MODULE G: HIV/AIDS PREVENTION

Now I have two questions for you about HIV and AIDS.

G1.	I don't want to know the results, but have you ever been tested for HIV and AIDS?	Yes 1 No 0 Refused to answer.....77
G2.	Has anyone close to you such as a relative or close friend of the family been infected with HIV or died of AIDS?	Yes 1 No 0 Refused to answer..... 77 Don't know 98

Now, I am going to ask you about possible services you may have received from the GRACE OVC project. Remember, I am only asking about services provided by that group, and not services you may have received from other CBOs or NGOs in the community.

K1	Has anyone from the GRACE (CBO affiliated to Grace) OVC project, such as a ToT or social worker, ever taught you about importance of taking your children to school ?	Yes.....1 No.....0	
K2	Has anyone from the GRACE or (CBO affiliated to Grace) OVC project, such as a ToT or social worker, ever referred you to a health care facility to get treatment for yourself?	Yes.....1 No.....0	If NO SKIP to K7
K3	How often did you actually utilize the referral at the suggested health facility? READ ALL	NEVER.....1 SOMETIMES.....2 ALWAYS.....3	
K4	Has anyone from the GRACE, such as a ToT or social worker, ever referred you for any other services?	Yes.....1 No.....0	
K5	If yes, what services? READ CHOICES AND CIRCLE ALL THAT APPLY IF OTHER, PLEASE SPECIFY _____	VOLUNTARY COUNSELING AND TESTING FOR HIV (VCT).....A ONE ON ONE COUNSELLING PSYCHO SOCIAL SUPPORTB GROUP COUNSELING.....C INCOME GENERATING ACTIVITYD ANY OTHER SERVICES? (SPECIFY).....O	

Now I am going to ask you about possible services you may have received from the GRACE or (CBO affiliated to GRACE) OVC Project within the last year. By last year, I am referring to the last 12 months. Remember, I am only asking about services provided by the GRACE (CBO affiliated to GRACE) OVC Project within the last year, and not services you may have received from other CBOs or NGOs in the community.

K6	Within the last year, has your household ever received flour, oil or food from the GRACE or (CBO affiliated with GRACE) OVC project?	Yes.....1 No.....0	
K7	Within the last year, have you attended an OVC Guardian Support Group meeting?	Yes.....1 No.....0	IF NO SKIP TO K12
K8	How often do you usually attend these group meetings? <i>READ CHOICES</i> <i>IF OTHER, PLEASE SPECIFY</i>	ONCE A WEEK.....1 ONCE PER TWO WEEKS.....2 ONCE A MONTH.....3 ONCE PER TWO MONTHS.....4 A FEW TIMES A YEAR.....5 ONLY VISITED ONCE.....6 OTHER RESPONSE8 (Specify)	
K9	Does your group do the following activities: <i>READ CHOICES & CIRCLE ALL THAT APPLY</i> <i>IF OTHER, PLEASE SPECIFY</i>	INCOME GENERATING ACTIVITIES SUCH AS PRODUCING GOODS FOR SALE.....A MERRY GO ROUND.....B LOAN MONEY TO MEMBERS.....C GIVE MONEY TO MEMBERS IN TIMES OF FAMILY ILLNESS OR NEED.....D TALK ABOUT PROBLEMS.....E VISIT ONE ANOTHER.....F ANY OTHER ACTIVITIES? (SPECIFY).....O NONE.....X	
K10	Did your Guardian Support Group receive training in SILC or Savings and Internal Lending?	Yes.....1 No.....0	
K11	Within the last year, have you received a loan, been given money or both from your Support Group?	Yes Loan.....1 Yes Given money.....2 Yes Loan & Given money.....3 No.....0	
<i>I'm going to ask you questions about Community Health Worker volunteers specifically. Volunteers are those people from GRACE or (GRACE affiliated CBO) OVC Project who visit your home.</i>			
K12	Has a ToT from the GRACE or (GRACE affiliated CBO) OVC project ever visited your household?	Yes.....1 No.....0	IF NO SKIP TO K17
K13	In the last year, how often did a community health worker visit your home? <i>READ ALL, CIRCLE ONE</i>	MORE THAN ONCE A WEEK.....1 ONCE A WEEK.....2 ONCE PER TWO WEEKS.....3 ONCE A MONTH.....4 ONCE PER TWO MONTHS.....5 A FEW TIMES A YEAR.....6 ONLY EVER VISITED ONCE.....7	

K14	On a home visit, how long does the community health worker usually stay at your house?	<input type="text"/> <input type="text"/> <input type="text"/> minutes <i>(1 hour = 060 minutes)</i> <i>(2 hours = 120 minutes)</i>	
K15	How satisfied are you with the things CBO Health Worker or (GRACE affiliated CBO) volunteer does for you and your household? <i>READ CHOICES</i>	VERY UNSATISFIED.....1 UNSATISFIED.....2 SATISFIED.....3 VERY SATISFIED.....4	

PLEASE RECORD ANY COMMENTS OR OBSERVATIONS THAT YOU FEEL ARE NECESSARY TO UNDERSTAND THE CIRCUMSTANCES IN WHICH YOU CONDUCTED THIS INTERVIEW.

QUESTIONNAIRE RESPONDEND BY THE GUARDIAN ON BEHALF OF THE OVC.

<i>Now I am going to ask you questions about NAME.</i>			
No.	Question	Responses	Skip
IN1	What is the name of the CHILD that you care for?	<hr/> Enter NAME of Child	
IN2	How old is the CHILD that you care for? ENTER AGE IN COMPLETED YEARS	Age [] []	
IN3	What is Sex of the child that you care for	Male 1 Female..... 2	
A1.	What is your relation to NAME? <i>CIRCLE ONE</i> <i>IF OTHER, PLEASE SPECIFY</i> <hr/>	Natural mother 1 Natural father 2 Natural grandmother 3 Natural grandfather 4 Aunt..... 5 Uncle 6 Older brother..... 7 Older sister 8 Other (specify) 88	IF NATURAL MOTHER SKIP TO A5
A2.	Is NAME's natural mother still alive?	Yes..... 1 No 0 Don't know.....98	IF YES GOTO A4
A3.	How old was NAME when his/her mother died? <i>RECORD AGE IN YEARS; IF DIED AT BIRTH WRITE 00</i>	Age [] []	ALL RESPONSES GOTO A5
A4.	In the past year, has NAME'S mother had an illness for 3 months period in a row or longer?	Yes..... 1 No 0 Don't know 98	

A5.	Is NAME's natural father still alive?	Yes..... 1 No..... 0 Don't know.....98	IF YES GOTO A7
A6.	How old was NAME when his father died? <i>RECORD AGE IN YEARS; IF SINCE BIRTH PLACE 00</i>	Age [] []	ALL RESPONSES GOTO A12
A7.	In the past year, has NAME'S father had an illness for 3 months in a row or longer?	Yes.....1 No0 Don't know.....98	
A8.	Does NAME's father live in this household?	Yes.....1 No0	IF YES GOTO A12
A9.	How old was NAME when his/her father left? <i>RECORD AGE IN YEARS; IF SINCE BIRTH OR LESS THAN ONE YEAR PLACE 00</i>	Age [] [] Parent still in contact with NAME.....88	
A10.	In the past year, have any adults in the household including yourself had an illness for 3 months in a row or longer?	Yes.....1 No0	if NO GOTO B1
A11.	How many adults that live in this household fell sick?	[] [] Number of sick adults	
A12.	For each of those who fell sick, what is their relationship to NAME? <i>CIRCLE ALL THAT APPLY</i> <i>IF OTHER, PLEASE SPECIFY</i> _____	Natural Mother.....A Natural Father.....B Natural Grandmother.....C Natural Grandfather.....D Aunt.....E Uncle.....F Brother.....G Sister.....H Cousin.....I Other (specify)O	

MODULE B: REGISTRATION AND CARE		
No.	Question	Response
B1.	Does NAME have a birth certificate or other proof of identity?	Yes.....1 No.....0 Don't know.....98
B2.	Have you identified someone to care for NAME if something happens to you and you couldn't take care ?	Yes.....1 No.....0 No Response.....98

MODULE C: CHILD SCHOOL ATTENDANCE

No.	Question	Response	
C1.	Has NAME ever attended school?	Yes.....1 No.....0	IF NO SKIP TO D1
C2.	Is NAME currently enrolled in school?	Yes.....1 No.....0	IF NO SKIP TO D1
C3.	How many school days are there per week?	[] Days	
C4.	How many days of school did NAME miss last week?	[] Days	0⇒D1

C5.	<p>What is the primary reason that NAME did not attend school for the normal days last week?</p> <p><i>IF OTHER, PLEASE SPECIFY</i></p> <p>_____</p>	<p>NAME was ill1</p> <p>Caring for sick family member2</p> <p>Working at home3</p> <p>Holidays.....4</p> <p>Funeral5</p> <p>Non-payment of fees6</p> <p>Teacher absent7</p> <p>Other88</p>	
C6.	How many days were school holidays in the last week?	[] Days	
C7.	Was NAME enrolled in school last term?	Yes.....1 No.....0	

MODULE D: CHILD HEALTH

No.	Question	Response	Skip
D1.	<p>In general, how is NAME's health?</p> <p><i>READ CHOICES</i></p>	<p>VERY GOOD1</p> <p>GOOD.....2</p> <p>NEITHER GOOD NOR POOR.....3</p> <p>POOR4</p> <p>VERY POOR5</p>	
D2	Does NAME need any health services he/she is not receiving?	<p>Yes1</p> <p>No0</p> <p>Don't know.....98</p>	
D3	<p>How easy is it for NAME to get good medical care?</p> <p><i>READ ALL, CIRCLE ONE</i></p>	<p>NOT AT ALL1</p> <p>SLIGHTLY2</p> <p>MODERATELY3</p> <p>VERY4</p> <p>EXTREMELY5</p>	

Module E: Program Exposure

Now I would like to ask you a few more questions about your experiences with particular services offered in your community. Remember these questions are not meant to determine the eligibility of NAME for services. Any information that you share with me will not affect NAME's eligibility for services.

No	Question		SKIP
E1	Within the last year, has NAME CHILD ever received any services or support from the GRACE OVC project?	Yes.....1 No.....0 Don't Know.....98	
E2	Within the last year, has NAME received school materials such as an exercise book, desk, stationary or uniform from the GRACE OVC project?	Yes.....1 No.....0 Don't Know.....98	
E3	Has a GRACE OVC project volunteer ever referred you to a healthcare facility to get treatment for NAME?	Yes.....1 No.....0	If no thank respondent and end Interview
E4	How often did you actually utilize the referral at the suggested health facility? <i>READ ALL</i>	NEVER.....1 SOMETIMES.....2 ALWAYS.....3	