

*A Case Study*

# Kilifi Orphans and Vulnerable Children Project



MEASURE Evaluation  
&  
Catholic Relief Services



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# Kilifi Orphans and Vulnerable Children Project

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Cover photo by Felix Masi/Voiceless Children, courtesy of Photoshare.

## Acronyms

AIDS	acquired immune deficiency syndrome
APHIA II	AIDS, Population, and Health Integrated Assistance Program
CHW	community health worker
CRS	Catholic Relief Services
ECD	early childhood development
GOK	government of Kenya
HIV	human immunodeficiency virus
IGA	income generating activity
OVC	orphans and vulnerable children
PMC	parish management committee
SILC	savings and internal lending committee
UNICEF	United Nation's Children's Fund
USAID	U.S. Agency for International Development
VCT	voluntary counseling and testing
VMC	village management committee

# Executive Summary

An estimated 12 million children aged 17 or younger have lost one or both parents to AIDS in sub-Saharan Africa (UNICEF, 2006a). Despite the recognition of the magnitude and negative consequences of this problem, there is little evidence on “what works” to improve the well-being of children affected by HIV and AIDS. In an attempt to fill this knowledge gap, MEASURE Evaluation is conducting targeted evaluations of five orphans - and-vulnerable-children (OVC) programs in five unique settings — two in Kenya and three in Tanzania. Case studies are the first phase of MEASURE Evaluation’s targeted evaluations and begin the process of information sharing on lessons learned in OVC programming. Additional evaluation activities under the MEASURE Evaluation targeted evaluation activity include an impact assessment and costing activity of each of the five selected programs.

This case study was conducted to impart a thorough understanding of Catholic Relief Services’ (CRS) OVC program model in Kenya and to document lessons learned that could be applied to other OVC initiatives. This case study is based upon a program document review; program site visits, including discussions with local staff, volunteers, beneficiaries and community members; as well as observations of program activities. The primary audience for this case study includes OVC program implementers in Kenya and elsewhere in Africa, as well as relevant policy makers and funding agencies addressing OVC needs.

The Kilifi OVC project of CRS was selected as a priority program for the evaluation. Program goals are to:

1. increase the capacity of communities and families and orphans to respond to the needs of OVC; and
2. increase the institutional capacity of local partners to deliver high quality and sustainable interventions.

To accomplish these program goals, CRS collaborates with the Archdiocese of Mombasa by providing technical and financial support. In turn, the archdiocese ensures OVC receive needed services by employing community-based social workers, establishing partnerships with local institutions, and engaging community volunteers in OVC support. The project supports formation of village management committees (VMC) composed of volunteers responsible for identifying and prioritizing OVC for project services and engaging in independent efforts to support OVC. Home visits conducted by

community health workers (CHWs) are a major component of the project. These volunteers assess needs, provide social support and information, and facilitate OVC access to higher-level interventions during home visits.

OVC services are offered as a package; thus, every beneficiary receives at least four essential services. The four direct services delivered to all identified beneficiaries are psychosocial support, health care, HIV prevention education, and educational support in pre-primary and primary school. Some unmet needs remain, such as support in secondary school and health care for OVC guardians.

This case study identified several program challenges, many of which are related to limited resources. The project has found it difficult to meet the overwhelming needs of the OVC households in the community. In some cases, however, OVC households become dependent upon a particular service provided, such as food support. The project has also been challenged by limits on the target numbers of beneficiaries it can serve. One group of beneficiaries was identified at the outset and provided services throughout the life of the project. Due to limited resources, the project cannot accommodate new OVC or families whose situation has worsened. In addition, CRS has found it difficult to attract and retain volunteers when offering no remuneration. Other challenges concern enrollment and monitoring of OVC. Initial and ongoing assessment of OVC needs has been problematic due to lack of a user-friendly monitoring tool. High levels of HIV stigma makes it challenging to identify and enroll children whose parents are ill or have died due to an illness.

The CRS Kilifi OVC project has many program innovations and successes. The project has found that rehabilitating early childhood development centers and paying related expenses better prepares children for primary school. Another program innovation is conducting trainings locally for a large number of participants, rather than holding workshops in out-of-town hotels for smaller select group of participants. CRS has found this approach to be more cost-effective and participatory. The project has made a concerted effort to ensure transparency about project implementation, and these efforts have led to a high level of community trust. Information is disseminated at committee meetings, and VMC members then sensitize the community about the project. CRS has found it helpful to involve a wide variety of other actors in the identification of beneficiaries, as this strategy appears to

help increase community understanding as to why only some households benefit from the project. Another program success has been including OVC guardians as active participants on volunteer committees. Their participation has reportedly allowed this entity to understand and address beneficiary needs more accurately.

Since its inception in 2004, the project has supported 20,000 OVC within 7,480 households of Kilifi District. However, CRS estimates a total of 15,000 additional needy OVC in Kilifi who have yet to be reached by the program, including the 8,700 children identified in 2004 who remain on a waiting list for services. Therefore, expansion through 2009 within Coast Province aims to add 15,000 beneficiaries, for a total of 35,000 OVC.

To complement lessons learned through this case study, MEASURE Evaluation plans to conduct an impact assessment of the Kilifi OVC project during the spring of 2007. A cross-sectional post-test study design will be applied to gather immediate data concerning program impact. Focus groups among volunteers, children, and guardian beneficiaries will also be conducted to enhance understanding of program impacts that may not be evident from a standardized survey. The impact assessment presents opportunity to examine the extent to which the Kilifi OVC project improves OVC well-being.

## Introduction



A young girl who lost her parents to HIV/AIDS sits at the doorstep of her classroom at a rescue center for AIDS orphans in Kenya's largest slum Kibera. On her pair of socks she has an AIDS campaign logo which tells it all. The little girl is not only an orphan but also a crusader in the fight against the killer disease. 2005. Photo by Felix Masi/Voiceless Children, Courtesy of Photoshare.

Worldwide, the number of children under age 18 who have lost one or both parents to AIDS stands at more than 14.3 million (*UNAIDS, UNICEF & USAID, 2004*). Many more children live with one or more chronically-ill parent. The vast majority of these children live in sub-Saharan Africa. Despite the recognition of the magnitude and negative consequences of this problem, there is little evidence on “what works” to improve the well-being of children affected by HIV and AIDS. Given the lack of information on the impact of care and support strategies for orphans and vulnerable children (OVC), there is an

urgent need to learn more about how to improve the effectiveness, quality, and reach of these efforts. In an attempt to fill these knowledge gaps, MEASURE Evaluation is conducting targeted evaluations of five OVC programs in five unique settings, two in Kenya and three in Tanzania. The Kilifi OVC Project of Catholic Relief Services (CRS) was selected as a priority program for the evaluation.

The CRS Kilifi OVC project is supported with CRS funds, as well as U.S. President's Emergency Plan for AIDS Relief (Emergency Plan) funds provided through the U.S. Agency for International Development (USAID). The project focuses on ensuring OVC access to basic needs and essential services. In addition, the program encourages economic strengthening for OVC caregivers and engages community volunteers in support of OVC. As such, CRS strategies are in alignment with key Emergency Plan strategies, including those that ensure OVC access to essential services, strengthen the capacity of families to care for OVC, and mobilize and support community-based responses.

This case study was conducted to impart a thorough understanding of CRS' OVC program model and document lessons learned that can be applied to other OVC initiatives. The primary audience for this case study includes OVC

program implementers in Kenya and elsewhere in Africa, as well as policy makers and funding agencies addressing OVC needs. The case study is based upon program document review; program site visits, including discussions with local staff, volunteers, beneficiaries, and community members; and observations of program activities. The program model is described in-depth, including a description of key program activities, methods of beneficiary selection, services delivered, unmet needs, and approaches to working with the community. Program innovations and challenges are also detailed. It is our hope that this document may stimulate improved approaches in the effort to support OVC in resource constrained environments.

Case studies are the first activity of MEASURE Evaluation's targeted evaluations. Additional evaluation activities include an impact assessment and costing activity of each of the five selected programs, including the CRS' Kilifi OVC Project. Best practices relating to improving the effectiveness of OVC interventions will be identified and disseminated. This document seeks to support the process of information sharing on lessons learned in OVC programming.

## Orphans and Vulnerable Children in Kenya



Community children awaiting a project-sponsored local drama focusing on HIV and AIDS prevention, Chonyi Parish, 2006. Photo by Anna Hoffman.

HIV prevalence in Kenya has fallen from a peak of 10% among adults in the mid-1990s to the most currently available estimate (2006) of 6.1%. However, decline is not uniform throughout the country, and prevalence in some antenatal clinics falls between 14% and 30%. The Joint United Nations Programme on HIV/AIDS (UNAIDS) also estimates 1.1 million children living in Kenya have been orphaned by AIDS (UNAIDS, 2006). The percentage of children orphaned or otherwise considered vulnerable and in

need of assistance is estimated at approximately 60% (Kenya Central Bureau of Statistics, 1999).

Children affected by HIV and AIDS often live in households undergoing dramatic changes, such as intensified poverty; increased responsibilities placed on 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 parental death. These changes often result in reduced household capacity to meet children's basic needs. Orphaned children may undergo a transition to a new household or, in relatively few cases, be forced to head their own households. Orphans are more likely to live in households with higher dependency ratios, may experience property dispossession, often miss out on opportunities for education, may live in households experiencing food insecurity, and often experience decreased emotional and psychological well-being due to such dramatic life changes, challenges, and losses (UNICEF, 2006a).

Political will and donor support in Kenya have combined to intensify programmatic and policy responses to the HIV/AIDS epidemic and the increasing numbers of OVC. The Kenya Ministry of Health and the National AIDS and STD Control Programme (NASCOP) of Kenya undertook a rapid country assessment, analysis, and action planning process for OVC in 2004

(*Kenya Ministry of Health & NASCOP, 2004*). Based on results, a national plan of action and a national policy on OVC were developed. In 2006, the government also began developing a national OVC database to coordinate efforts of various agencies offering relevant interventions. Orphaned and vulnerable children in Kenya further benefit from government efforts to address the needs of all children, such as the provision of free health care for children under five years of age, free primary school education, and efforts to establish children's courts. With an emphasis on increasing OVC access to essential services, CRS expands on government services to vulnerable children by ensuring OVC in all age groups have access to basic needs.

## Methodology



Guardian attends caregiver support group meeting, Kikambala Parish, 2006. Photo by Anna Hoffman.

### Information Gathering

Case study activities were completed by August 2006 and included interviews and group discussions with headquarter and field staff, project social workers, priests, CHWs, and VMC members; program document review; and observations of program activities such as VMCs, caregiver support groups, and community meetings; as well as CHW and social worker home visits to project beneficiaries. CRS operates program activities at a parish level; a parish

is roughly equivalent in size to the nationally recognized geographical division boundary. The case study involved visits to four parishes within Kilifi District — Mariakani, Chonyi, Kilifi, and Kikambala.

### Focal Site

The Kilifi OVC Project takes place within Kilifi District, located in Coast Province. With the exception of peri-urban Kilifi town, all areas within the district are classified as rural. There are approximately 744,010 households in Kilifi District (*Kenya Central Bureau of Statistics, 1999*). The United Nations Children's Fund (UNICEF) estimated the number of orphans in Kilifi District to be 20,009 in 2003, with a projected increase to 21,249 orphans by 2008 (UNICEF, 2006b). While Kilifi's HIV prevalence is relatively low at 2.5% (*Kenya Ministry of Health, 2005*), a large number of children are made vulnerable by food insecurity, poverty, and high illiteracy rates. Kilifi is the most impoverished district within Coast Province, and the second most impoverished district in Kenya, with 72% of residents living below the poverty line (*Kenya Central Bureau of Statistics, 2005*). Lack of adequate rainfall and rocky soil inhibit food production, contributing to high levels of poverty. There are few community drinking water systems and the majority of families rely on ponds and rainwater, resulting in high levels of diarrheal and water-borne diseases. Lack of water impedes subsistence farming productivity, the major economic activity in the area. Public health vulnerabilities are further increased by polygamy and early marriage, as well as the proximity of the district to the nearby Nairobi-Mombasa highway, where brothels serving truckers are located.

# Program Model



Audience members of a project-sponsored local drama focusing on HIV and AIDS stigma, Chonyi Parish. 2006. Photo by Anna Hoffman.

## Overview and Framework

*“Project activities are things that can be generated from the community.”*  
— A project staff member

Funded by the Emergency Plan and CRS from 2004 through 2009, the Kilifi OVC Project is currently implemented in all six parishes of Kilifi District in the Coast Province. The project seeks to improve quality of life for OVC and their families through access to essential services.

Program goals are to:

- increase the capacity of communities and families and orphans to respond to the needs of OVC; and
- increase the institutional capacity of local partners to deliver high quality and sustainable interventions.

To accomplish program goals, CRS collaborates with the Archdiocese of Mombasa. CRS provides the archdiocese with financial and technical support and, in turn, the archdiocese ensures OVC receive needed services by employing community-based social workers, establishing partnerships with local institutions, and engaging community volunteers in OVC support. Volunteers identify and provide ongoing support to OVC through Parish management committees (PMC), VMCs, and CHWs. These volunteers provide home-visits and engage in independent initiatives to support OVC, such as advocacy and soliciting community donations. OVC receive additional services through project supported health centers and educational institutions. In addition, the capacity of caregivers is enhanced through caregiver support groups linked with income-generating activities. Program activities aim to impact child well-being through activities that target OVC directly, as well as indirectly, through community- and family-level capacity-building. Intended outcomes at the individual OVC level are described in the framework shown on pages 18-19.

## Key Program Activities

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Key activities instrumental to accomplishing program goals center on ensuring provision of essential and quality services to OVC. Services are delivered through a network of community institutions and volunteers supported by project staff and resources. Volunteers serve on local committees concerned with OVC well-being and as community health workers providing home visits. Partnering community institutions include the archdiocese, health centers, and schools.

**Partnership with local institutions** — Rather than a direct service delivery approach, CRS supports other local entities to meet OVC needs. In Kilifi District, CRS developed the OVC project in partnership with the Archdiocese of Mombasa. CRS and the archdiocese collaborate in the development of program activities, and CRS provides financial backing to achieve these aims. CRS also provides archdiocese staff with training in project management, budgeting, program monitoring, and specific topic areas needed to support OVC and their families, such as children's rights and income generation. With these skills and support, the archdiocese oversees program implementation at the community level, responsible for hiring project staff and securing community networks.

To facilitate service delivery, the archdiocese creates partnerships with community facilities. The archdiocese, with support from CRS, currently partners with 11 health centers and 266 schools, including primary schools and early childhood development (ECD) centers. Health centers, for example, have agreed to provide OVC beneficiaries with immediate medical treatment as needed, and bill the project on a monthly basis for services rendered. Delayed payment is not common in Kenya. However, health facility confidence in receiving payment from the project enables them to attend to OVC needs in a timely manner and maintain a stocked supply of medicines. In turn, health-care centers support prevention initiatives by partnering with the archdiocese to perform health campaigns among beneficiaries, such as de-worming and vitamin distribution. Project activities and resources also concentrate on building stronger education infrastructure that benefits not only OVC, but all children in the community. In primary schools, teachers are trained in life skills education and are supported to develop and revitalize peer HIV education clubs for all students. The physical infrastructure of 53 ECD centers has also been renovated as part of project activities. Specifically, CRS funded a cement floor and tin roof, and additional inputs were provided

by funds raised in the community. Project resources also cover the ECD fees of many beneficiaries; for instance, enrollment fees were paid for 3,555 OVC from October 2005 to May 2006. School fee expenditures provide coverage for school staff salaries and finance facility expenses, such as books and furniture, which benefits all children in the community. Project collaboration with health centers, primary schools, and ECD centers builds the capacity of community institutions while ensuring that OVC basic needs are met.

**Community-based social workers** — Eight social workers are employed by the archdiocese and stationed across the six parishes where the program operates (two parishes are assigned two social workers each, due to their large size and high number of OVC). Social workers support an average of 30 villages within each parish and visit each of these villages at least twice a month. Social workers have formal training in community assessment, counseling, nutrition, and casework. They secure and oversee partnerships with local institutions and utilize their professional training to support partners and community efforts. For instance, after-school peer education, life skills, and anti-AIDS clubs have been revived with additional training and support from social workers. They encourage primary school teachers with existing skills to offer group counseling and, at times, also facilitate these sessions alongside teachers. In addition, social workers conduct sensitization activities within the general community. At the outset of the project, social workers and the project coordinator hold “start-up workshops” at the village level to prepare the community for the services that will be provided to OVC, explain beneficiary selection, and stimulate interest among community members that subsequently become volunteers. They also conduct community workshops on HIV prevention, VCT, child rights, and stigma reduction. They promote guardian involvement in caregiver support groups and offer them training and support in income generating. Finally, they support and educate VMCs and CHWs, and help address issues facing OVC beyond the capacity of these volunteers.

**Committee formation** — In each village, a VMC comprised of 15 to 18 members is formed. Committee members include local and religious authorities, social workers, teachers, nurses, and OVC guardians. Composition of these committees is determined throughout the initial “start-up workshops,” led by the project coordinator and social workers. After learning about the project, community leaders nominate potential VMC members and other community members volunteer themselves. Final VMC members are

# Catholic Relief Services: Kilifi Orphan

Implemented in Kilifi District, Coast Province, Kenya by the Archdiocese of Mombasa to deliver services to Orphan and Vulnerable Children. Expansion throughout Coast Province.

## Program Objectives

1. Increase the capacity of communities, families and caregivers
2. Increase the institutional capacity of local partners

### CRS Activities

- Provide financial support to local archdiocese to support social workers and other project staff
- Conduct periodic supervisory visits
- Develop and support program plans and monitoring and evaluation (M&E) strategies
- Provide technical, financial and administrative support
- Train archdiocese staff in HBC, microfinance, gender, M&E, and financial management



### Archdiocese Activities

*Implemented through community groups, school and village committees, and local partners.*

- Facilitate free health care for OVC and provide positive OVC through partnerships
- Train teachers in life skills education
- Provide financial and infrastructure support for Childhood Development Centres
- Develop village and parish networks to identify, select and support OVC beneficiaries
- Train and support CHWs to provide home visits and provide psychosocial support
- Provide primary and pre-primary education and assistance
- Conduct community education on HIV prevention
- Provide OVC with vocational training
- Renovate shelters for needy OVC
- Engage OVC guardians in C&A and provide social support and monitoring

# ans and Vulnerable Children Project

East Province, CRS works through  
to 20,000 OVC and support 7,950 caregivers.  
Province will target 35,000 OVC.

## m Goals

es and orphans to respond to the needs of OVC  
to deliver high quality and sustainable interventions

*y-based social workers, parish  
l partner institutions*  
 OVC and ARVs for HIV  
 erships with health facilities  
 education and HIV prevention  
 structure support to Early  
 enters  
 management committees who  
 eeficiaries  
 o document household needs  
 port to OVC households  
 mary OVC with educational  
 ion and sensitization about  
 al training  
 st OVC households  
 Caregiver Support Groups to  
 microfinance opportunities

## Expected Outcomes among OVC

- *Education:* increased school attendance
- *Health and Prevention:* prompt health-seeking behavior leading to decreased morbidity and mortality among OVC and fewer cases of immunizable diseases; fewer pregnancies among adolescents; reduced HIV transmission
- *Economic Security:* increased ability of OVC households to meet basic needs
- *Psychosocial and Child Protection:* increased resilience and self-esteem
- *Community Support:* decreased community stigma and discrimination; increased community support for OVC and their caregivers

selected through a community election. VMC members serve as volunteers and are responsible for identifying and prioritizing OVC for project services and engage in independent efforts to support OVC, such as community sensitization and resource mobilization. VMC members identify all children in their community who have an ill or deceased parent, and through informal assessments and home-visits, prioritize OVC who are most in need of project services. In addition to beneficiary identification, social workers depend on VMC members to implement project activities successfully. For example, VMC members were instrumental in ensuring beneficiary participation and community acceptance of caregiver support groups and mass health initiatives (e.g., de-worming) sponsored by the project. Independent activities of VMC to support OVC include helping youth access funding for secondary school, and soliciting donations to assist families in dire circumstances with home refurbishment and food security. VMCs generally meet once a month to discuss OVC issues, liaison with the social worker, and try to find ways to address unmet needs of project beneficiaries.

PMCs are formed at the parish level and are comprised of 12 to 15 volunteers, including VMC representatives, the parish priest, and other community leaders. Each VMC nominates two current members to serve on the PMC; typically this includes the VMC chairperson. PMC members meet once a month and try to find resolution to issues facing VMCs at the village level. For example, such legal issues as child abuse or disinheritance may be brought to the PMC. The PMC also serves as a conduit of information from the VMC level to the parish priest and other local authorities, and provides guidance and input on programmatic decisions.

There are six PMCs (one in each parish) and 63 VMCs throughout Kilifi District. Committee members do not receive any formal training. During monthly meetings, however, social workers sensitize VMC members about the needs of OVC and specific topics, such as children's rights and HIV prevention.

*“To assess what people need, you have to go into a house and see what is there.” — A community health worker*

**Home visiting** — CHWs were introduced into the project in the beginning of 2005, when staff recognized the need for ongoing support and monitoring of OVC households. CHWs are volunteers who conduct home visits to assess

needs, provide social support and information, and facilitate OVC access to higher-level interventions. Each CHW is responsible for making home visits to an average of 10 households; caseloads may vary since they are assigned households near their personal residence. The distribution of CHWs to OVC households ensures coverage of all project-supported households. On average, households receive two visits per month from a CHW that range from 30 minutes to two hours long. Household circumstances and CHW availability affect visit frequency and duration. OVC households do not typically receive material support during home visits. Instead, they receive education (e.g. household cleanliness, HIV prevention, OVC care), counseling, and assistance with basic household upkeep. CHWs also provide OVC with official health care referrals necessary to access free medical treatment. Other major needs identified on visits are reported to social workers and VMC as appropriate for follow up and for making arrangements to address identified needs. For example, if a child is suspected to be HIV positive, the CHW will liaise with the VMC and social worker to facilitate follow-up support such as counseling and transport to the District capital city for testing and treatment. In addition to assistance for families in dire circumstances, VMC members conduct home-visits to inform beneficiaries of services available and to screen beneficiaries for services available to only a limited number of households. VMC members are also tasked with making random household visits, visiting at least five households each month.

A total of 700 CHW volunteers participate in the project. CHWs are selected by OVC guardians, who nominate supportive individuals from within their neighborhoods to undertake this responsibility. VMCs and social workers verify the appropriateness of these selections and invite nominees to serve as CHWs. Those individuals who agree to participate receive two-day training from social workers covering basic skills in needs assessment, home-based care, and counseling. CHWs are supervised by the social worker and meet on a monthly basis within their respective communities as a group and with the social worker to discuss issues facing the homes they serve.

## **Beneficiaries**

There are 20,000 OVC beneficiaries in Kilifi District (12,000 females and 8,000 males) from a total of 7,480 households. Most OVC beneficiaries are under age 18 and the majority (approximately 75%) are under age 15. Beneficiary identification was completed at project outset; new beneficiaries were not added during the first two years. OVC beneficiaries were identified

by the VMCs; however, more OVC were identified than the project had the capacity to serve. VMC members then prioritized children who were “most needy,” including OVC living in child-headed homes, with an elderly caregiver, or with an ill guardian. For instance, while 5,210 OVC were initially identified in one of the six parishes, only 3,210 were enrolled. Each VMC established its own criteria to prioritize OVC, utilizing information from initial assessment forms and the knowledge acquired during home visits.

In addition to identified OVC counted as “beneficiaries,” many other children in the community benefit from the stronger education infrastructure built by the project. For example, renovation of ECD centers and encouragement of group counseling and youth clubs in primary schools supports many youth in the community.

## Services Provided

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Services are offered to OVC as a package; thus, every beneficiary receives at least four essential services. Direct services delivered to all identified beneficiaries include psychosocial support, health care, HIV prevention education, and educational support in pre-primary and primary school. Many beneficiaries are also reached by child protection initiatives. Prior to June 2006, each OVC household also benefited from nutritional support. Though all beneficiaries typically receive the same package of basic services, services such as vocational training and shelter renovation are targeted based on eligibility, need and available resources. In general, services are consistent across parishes.

**Food and nutritional support** — The OVC project partnered with another USAID-funded CRS program, Leadership in Fighting an Epidemic (LIFE), to distribute corn-soya blend flour and vegetable oil to beneficiary households. This initiative ended in June 2006; however, to address the end of this service, the project currently provides nutrition education and promotes growing indigenous vegetables with high vitamin and mineral content.

**Shelter and care** — Select OVC households in need receive metal roofing sheets for shelter renovation. The household and community contribute local building materials and labor. These materials were distributed to the neediest 250 households in Kilifi District. Recipients are selected through a collaborative agreement between the entire VMC and eligibility is confirmed by the social worker.

**Child protection** — Education for primary school children about their rights is conducted by social workers on an annual basis through after-school HIV clubs. Social workers further educate guardians and community members about children’s rights during caregiver support groups and community meetings.

**Health care** — Health care is provided through referral to nine government-run and two Catholic-run health facilities. CHWs and social workers provide formal referral forms to OVC in need to facilitate their access to free care at health facilities. Through an agreement with the project, cost of treatment is paid by the project at the end of each month. Though transportation is not typically paid for, families living far away from the referral facility and unable to afford travel costs may be assisted through project funds provided by the social workers or parish priests. The project also supports periodic health campaigns with participation from local health center staff for de-worming, bilharzia (schistosomiasis) treatment, and vitamin A distribution.

To promote HIV education in schools, social workers train primary school teachers in life skills education and encourage them to lead after-school HIV prevention clubs. These clubs serve as a forum to disseminate health information, implement group counseling and facilitate skills development relating to self-esteem and risk reduction. Teachers selected for life skills training are typically guidance counselors or Girl Guide/Boy Scout leaders, and therefore have previous background in counseling.

**Psychosocial support** — Social workers and parish priests offer formal counseling to OVC. Another main conduit for psychosocial support is through primary school group counseling sessions during after-school HIV prevention clubs facilitated by teachers with counseling backgrounds or, at times, project social workers. Home-visits also serve as another forum for psychosocial support, though CHWs may concentrate attention on the needs of guardians during these visits.

**Education and vocational training** — ECD centers are renovated by the project and school fees paid directly to the school for all pre-primary age OVC enrolled in the project. At these centers, Social Workers distribute exercise books and uniforms to beneficiaries and monitor their provision. At the primary school level, the project distributes uniforms and stationery to beneficiaries in a similar manner. The project also supports payment of

vocational training fees at local polytechnic schools for 250 OVC who have completed primary school. The parish social worker and VMC determine the beneficiaries selected for this service, considering family needs, youth commitment and successful completion of the primary school graduation exam.

**Economic strengthening** — Income generation activities are promoted among OVC guardians and OVC age 15 and older involved in associations and caregiver support groups. Initially, participants were encouraged to generate an informal rotating savings and loans system. However, CRS recently began to offer formal training in savings and internal lending committees (SILC). As of September 2006, 111 caregiver support groups, with an average of 25 members each, were trained in the SILC strategy; reaching over one-third of OVC guardians in the project. Start-up money is not provided; although SILCs offer group-generated funds that can be loaned to members through a monitored savings and credit system. In addition, groups are encouraged to maintain a separate pool of money that is not loaned to members, but used as a social fund in case of sickness or family need.

**Family services** — The project encourages OVC guardians to participate in caregiver support groups that provide social support and are often linked to income generating activities. At times, social workers facilitate group therapy during these meetings. Guardians are further provided with general household support during CHW home visits including basic counseling and help with household chores.

## Unmet Needs

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**Support for secondary school** — Although there is some provision for vocational training, the project does not provide secondary school fees. Vocational training is not necessarily an appropriate option for students who have excelled in primary school and desire opportunities to advance academically and intellectually. Project staff, VMC members, and PMC members try to link qualified OVC with scholarships, bursaries, and private sources of funding for secondary school; however, these resources are not consistently available and may not cover full tuition. Lack of support for promising youth in furthering their education limits career and economic prospects.

**Health care for OVC guardians** — While OVC have access to free health care, their guardians do not. As a result, ill guardians may be less able to care and support children in their household. Guardians may also resent the fact that their children’s medical needs are given priority over their own needs. In recognition of this issue, in September 2006 CRS began to provide health care support for guardians of project beneficiaries on a limited basis.

## **Community Ownership**

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*“We live with the OVC, so we feel that by helping them we are helping our own people.” — A parish management committee member*

The Kilifi OVC project began with the primary objective of delivering direct services to OVC in partnership with the archdiocese. A direct-service delivery approach made it difficult to engender community ownership and the project was perceived by some to be a Catholic Church initiative, rather than a community-led initiative. To facilitate a greater sense of community ownership, the project has evolved to facilitate more opportunities for community leadership. Key strategies adopted by the program to engender community ownership are described below.

**Involvement of community leaders** — VMC and PMC consist of community leaders such as retired social workers, teachers, nurses and religious authorities, including those from other religious denominations, such as Muslim and protestant denomination leaders. The committees serve as one of the main contacts between project staff and the community, and are instrumental in communicating new project strategies. Committee members select and prioritize OVC beneficiaries, represent the project during community meetings, and conduct home visits to beneficiary households to inform them of changes in the project and provide social support.

**OVC identified by local definitions of vulnerability** — VMC have responsibility for developing the beneficiary list and prioritizing OVC in need of project support. Committee members identify beneficiaries based on their experiences, observations and visits to the home. Collaboratively, they consider and determine agreed upon markers of vulnerability to narrow initial lists to meet target numbers outlined by the project. Following initial beneficiary

identification, committee members guide social workers in determining the neediest OVC households for distribution of limited resources, such as vocational training and shelter renovation. Their involvement in beneficiary selection increases their awareness of the problems that OVC face and has stimulated independent efforts to support OVC.

**Incorporating local input** — The project has adapted over time based on community-identified needs. For example, CHWs stressed how transportation barriers limited their ability to make regular home visits and bring sick children to medical facilities. To address this problem, CRS purchased bicycles in August 2006 for active CHWs. Bicycles will help address the problem of transportation as well as provide an incentive for CHWs who volunteer for the project without any material recognition.

**Leadership role of OVC guardians** — CHW selection is informed by consultation with OVC guardians. Guardians choose a member of their neighborhood to conduct volunteer home visits and provide support. In addition, a number of OVC guardians are members of VMCs and also serve as CHWs; thereby conveying pride in their work and helping to ensure the project addresses priority needs.

John Williamson, a senior technical advisor to USAID's Displaced Children and Orphans Fund, describes a typology of interventions for OVC that categorizes programs as direct service delivery; service delivery through community participation; or community owned, led, and managed activities (*Williamson, 2003*). CRS's Kilifi OVC Project represents a gradual transformation from direct service delivery to service delivery through community participation. While initially the project did not utilize a large volunteer cadre, volunteer participation has increased over time and has played a greater role in delivery of services, such as the provision of psychosocial support during home visits and resource mobilization by VMC. In addition, as the project scales up, more emphasis is expected to be placed on interventions that encourage a higher level of community independence, such as income generating activities.

## Resources



Children providing a local performance concerning HIV and AIDS prevention, Chonyi Parish. 2006.  
Photo by Anna Hoffman.

### Donors

The Kilifi OVC Project has been funded since 2004 by the Emergency Plan, with matching resources from CRS private funds. CRS further donates administrative and financial management resources to the project from its head office in Nairobi. The majority of project resources are provided directly to the archdiocese. The archdiocese utilizes funding to support indirect services, such as operational expenses; project staff salaries and travel support; and training for archdiocese staff, community health

workers, teachers, and OVC guardians. The remaining archdiocese budget is allocated towards direct services for OVC, such as health care, uniforms, and ECD fees. Initially, two-thirds of the project budget was directed towards capacity enhancement in mobilizing and training project staff and volunteers. However, in 2006 almost half of the budget was allocated towards direct resources to youth.

### Program Staff

Project staff members are employed through the archdiocese with funding and technical support from CRS. Eight social workers work within the six project parishes (roughly equivalent in size to the nationally recognized division); two sizable parishes are split among four social workers. They are provided with motorbikes so they can regularly visit the villages within their respective parish. The project coordinator based in Mombasa supervises social workers and visits them at their posts at least once every two weeks to provide support and assist them with project activities, such as training CHWs and facilitating caregiver support groups. Social workers also meet monthly in Mombasa as a group with the project coordinator to share experiences and ideas. A project accountant is responsible for tracking OVC project expenses and liaising with the CRS accounting department. Although parish priests are not employed under the OVC project, they are considered “custodians” of the project at the parish level, and serve as resources, particularly in emergency situations and with the neediest OVC cases. The CRS HIV and AIDS project officer travels

from Nairobi to Mombasa at least once a month to provide oversight, build staff capacity, and plan for future activities.

## **Volunteers**

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Volunteers include VMC and PMC members, as well as CHWs. Initial community volunteer participation in project service provision was limited to committee work. However, when staff identified a need for more monitoring and household level support, activities were modified to include home visiting by volunteer CHWs. Social workers and community leaders recruited committee members from community groups and religious institutions, while CHWs were principally recruited through nominations from OVC guardians. Recruitment for each volunteer cadre took nearly three months and required constant sensitization about the aims of the project and the voluntary nature of the work. Neither CHWs nor VMC members receive allowances for their time; however, due to the far distance they must travel to attend meetings, members of the PMCs receive a small amount of remuneration (100 Kenya shillings, or about U.S. \$1.50). The 400 longstanding CHWs in the project were also recently provided with bicycles to enable more and easier home-visits; the remaining 300 CHWs who are newly enrolled in the project will receive bicycles after a year of service. CHWs are expected to serve five to 10 hours per week; the majority of that time is spent on home visits. While VMC members are principally responsible for attending monthly meetings, they typically also contribute several hours of volunteer time per week, often making home visits themselves.

## **Community In-Kind Contributions**

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Community contributions are limited; however, some VMCs have begun to mobilize community resources. For example, one VMC sporadically solicits food donations for OVC households, as well as collects monetary contributions from the community to purchase roofing sheets for OVC households that have collapsed or are in disrepair. In addition, VMCs have also mobilized local resources and labor to support the refurbishment of ECD centers. The town parish offices are also able to regularly garner food and clothing donations from the community and distribute them to OVC and their families in need.

## Lessons Learned



Community health worker conducting a home visit, 2006. Photo by Anna Hoffman.

### Program Challenges

**Addressing the many needs of OVC households** — Although the project addresses many key needs of OVC with direct service provision and information education, it is a challenge to meet all OVC needs. Without food supplementation, nutrition education may not lead to better nutritional status among OVC. Without provision of clothing, OVC beneficiaries often wear school uniforms all the time because they do not own additional

clothing. Even with the level of material support provided, OVC needs are not completely met. In addition, the capacity of caregivers to support OVC may be limited and the project has only just begun to introduce efforts, such as caregiver support groups, for emotional and economic support of guardians.

**Fostering independence** — Project staff members observe that OVC households may become dependent on a particular service provided. For example, food subsidies were intended to supplement household food supply; however, some households relied exclusively on food subsidies. When this benefit ended in June 2006, some households were unprepared to cope with the cessation of food supplementation. The project faces challenges in ensuring that basic needs of OVC beneficiaries are met, while simultaneously discouraging dependency.

**Identification of vulnerable children in communities with high levels of HIV stigma** — Identifying and enrolling children whose parents are ill or have died due to an illness has been a challenge. When VMC members approached households presumed vulnerable due to the presence of orphans or an ill guardian, they found that some households refused program enrollment due to HIV stigma. Families were reluctant to participate in a program they felt may label them or the child under their care as being HIV-infected.

**Inflexible target numbers of beneficiaries** — Only one round of beneficiary identification was conducted, and these initial beneficiaries are

supported with available resources for the life of the project. Enrolling a group of beneficiaries for the life of the project means that the project cannot accommodate new OVC or families whose situation has worsened. Ideally, conditions for individual OVC served would improve and they would no longer be in need of program services, though this type of “graduation” has not occurred to date.

**Attracting and retaining volunteers with no remuneration** — While volunteers want to contribute to their community, they highlight the need for some type of incentive to sustain their efforts. Although bicycles have been provided to CHWs, this occurred only recently and only to those CHWs with longstanding service. Bicycles were not distributed to VMC members. The problem of retaining volunteers is compounded by the presence of other nongovernmental organizations operating in Kilifi District that may offer a more appealing remuneration to community volunteers for meeting attendance or participation in training.

**Monitoring OVC status and services provided** — Staff and volunteers reportedly desire a user-friendly monitoring tool to enroll OVC and provide ongoing assessment of their needs. Currently, the project promotes use of a comprehensive OVC registration tool; however, volunteers are not consistent in completing these forms. The length and complication of the present form is considered too cumbersome to complete for all 20,000 beneficiaries. Volunteers further lack a mechanism to document emerging needs and changing circumstances of OVC. Thus, project staff members face challenges when determining allocation of limited resources, relying only on anecdotal information provided by community volunteers, many of whom may feel the families they support are particularly needy. Staff and volunteers desire an easier method to enroll and monitor OVC supported by the project.

## **Program Innovations and Successes**

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**Building the capacity of educational institutions** — Project staff report that rehabilitating ECD centers and paying related expenses increases child participation in this educational opportunity and better prepares children for primary school. Although primary schools are free in Kenya, children that lack minimum competencies may be initially refused entry due to overcrowding. Community members have begun to recognize the value of these centers and support their existence and strengthening. For example, several communities mobilized resources to build walls and provide educational materials at the

centers. In addition, by training primary school teachers and revitalizing after-school HIV prevention clubs, skills of negotiation, self-confidence, and healthy behaviors are fostered among many community youth.

**Offering training in a community setting** — Rather than holding workshops in hotels for a select group of participants over an extended period of time, flexible training schedules conducted locally is thought to be most successful. Training programs are conducted over a period of several weeks at a village level to ensure that participants can balance training attendance with daily activities. Community-based training appears to allow for greater participation, as well as be more cost effective by reducing expenses related to travel, per diem, and food.

**Transparency about project implementation** — There is a concerted effort to ensure that community members and beneficiaries are aware of project activities, available resources, and constraints. Prior to beginning the OVC project, the archdiocese held start-up workshops in each parish to explain project aims to local leaders. Following an initial workshop, social workers conducted community sensitizations at the village level throughout all parishes. To ensure ongoing community trust, the project arranges community meetings when CRS or USAID representatives visit an area. Community members have an opportunity to hear from these representatives exactly how much funding is directed to project activities. These meetings prepared the community for services that would be provided to OVC, explained criteria for beneficiary selection, and stimulated interest among community members that subsequently became involved as volunteers. Sensitization of local leaders also provided a framework for partnerships within schools, health centers, ECD centers, and religious institutions.

**Disseminating information at committee meetings** — Social workers participate in VMC and PMC meetings and inform members of program activities including new or discontinuing services who, in turn, inform the larger community and beneficiary households. For instance, social workers share information on upcoming services, such as food distribution and bilharzia treatment, and committee members transmit this information to OVC beneficiaries and their families. Furthermore, project staff members have learned that VMC members can be very constructive in sensitizing the community about the project. As trusted and respected leaders within their communities, committee volunteers lend credibility to the project, and can

help to assuage distrust and counter unrealistic community expectations. Using committee meetings to disseminate project-related information increases meeting attendance and helps to ensure information is effectively and efficiently transmitted to beneficiaries and the general community.

**Including OVC guardians as active participants** — OVC guardians have had increasing leadership roles in the project, participating in volunteer committees and identifying and serving as CHWs. Their participation as committee members has reportedly allowed this entity to more accurately understand and address beneficiary needs. Similarly, OVC guardian nomination of CHWs ensures that a trusted individual undertakes this responsibility and enhances pride and commitment of these volunteers. In addition, OVC guardians may be less likely to request additional remuneration and be especially supportive of the project due to personal experience with its implementation. OVC guardians' active role in the project strengthens their leadership skills, and through the networking afforded in committees, increases their ability to recognize and access available community resources.

**Involving a variety of actors in the identification of beneficiaries** — Relying upon a variety of community perspectives helps to ensure an accurate beneficiary list of most needy OVC. Community selection of beneficiaries capitalizes on local knowledge of vulnerability and promotes community ownership. Community-led identification is also more expedient than if project staff were to undertake this task and decreases the possibility of deception by ineligible households wanting to benefit from project resources. Furthermore, having many people engaged in beneficiary identification appears to help increase community understanding as to why only some households benefit from the project.

## The Way Forward



Teachers educated in Catholic Relief Service's life skills training program, 2006. Photo by Anna Hoffman.

The Kilifi OVC Project is currently implemented in all parishes of Kilifi District in Coast Province. Since 2004, the project has supported 20,000 OVC within 7,480 households. However, CRS estimates a total of 15,000 additional needy OVC in the district who have yet to be reached by the program, including the 8,700 children identified in 2004 remaining on a waiting list for services. Therefore, expansion through 2009 within Coast Province aims

to add 15,000 beneficiaries for a total of 35,000 OVC served.

As the project continues and scale-up proceeds, CRS and the archdiocese are complementing present activities with additional initiatives to support OVC and their caregivers. They intend to increase vocational training and provision of secondary school fees among OVC, providing an opportunity for the project to reach and support more adolescents. In addition, though the project began by focusing primarily on the well-being of OVC themselves, the project will intensify efforts to build the capacity of guardians, expanding SILC training among caregiver support groups. They will also recruit additional CHWs, with the hope that each household has access to CHWs of both genders.

There may be additional changes in the project with advent of the province-wide AIDS, Population and Health Integrated Assistance II (APHIA II) project funded by USAID and the Emergency Plan in late 2006. APHIA II is a collaborative initiative among several program agencies that seeks to improve health in Kenya through facility and community-based interventions focusing on the prevention, care and treatment of HIV. CRS is an APHIA II partner in Coast Province, and will focus mainly on supporting OVC through expansion of the Kilifi program model across the coastal region. However, through APHIA II partnerships, services available to OVC are accentuated as APHIA II includes initiatives designed to improve and expand facility and community-based HIV and AIDS, reproductive health, and selected maternal and child health services. APHIA II is funded for three years, with an optional two-year extension.

Lastly, to complement lessons learned through this case study, MEASURE Evaluation plans to conduct an impact assessment of the Kilifi OVC project during the spring of 2007. A cross-sectional post-test study design will be applied, to gather immediate data concerning program impact. Surveys measuring a variety of aspects of OVC and guardian well-being are planned, to be conducted among intervention and comparison groups drawn from two parishes visited as part of this case study (Kikambala and Mariankani parishes). The intervention group consists of OVC and their caregivers who have received program services since 2004. The comparison group consists of OVC and their caregivers within these same two parishes slated to receive program services. Focus groups among volunteers, children, and guardian beneficiaries will also be conducted to enhance understanding of program impacts that may not be evident from a standardized survey. The impact assessment presents an opportunity to examine the extent to which the Kilifi OVC Project improves OVC well-being.

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