# BREAKING BARRIERS PROJECT: KENYA, UGANDA AND ZAMBIA

# END-TERM EVALUATION REPORT

MAY 2010

UPWARD BOUND COMPANY LIMITED
Marist Road, Karen, P.O. Box 79747, Nairobi Tel 254 20 3594276
email:enquiries@upwardboundkenya.org

# TABLE OF CONTENTS

## LIST OF BOXES



## LIST OF FIGURES



## LIST OF TABLES

# ACKNOWLEDGEMENT

This end-tem evaluation was commissioned by Plan International Kenya to Upward Bound Company Ltd, a firm of professional consultants and researchers based in Nairobi. Many individuals, children and institutions greatly benefited the evaluation by setting aside time to share their perspectives. Were it not for their participation and sacrifice, this report would not have been possible. Upward Bound Company Ltd. therefore wishes to acknowledge their support and input.

We thank Breaking Barriers Regional Manager, Bwibo Adieri, Plan USA Technical Advisor in-charge of the Breaking Barriers project, Laban Tsuma, and the Breaking Barriers team in Kenya, Uganda and Zambia for the administrative and technical support they offered during the course of the evaluation. We also thank the Strategic Program Support Manager, Samual Musyoki, Corporate Planning Monitoring and Evaluation Manager, Benson King'oo, and Corporate Evaluation and Monitoring Coordinator, Stephen Okoth, all of Plan International Kenya. We are especially indebted to them for sharing an overview of the project and for offering invaluable insights. We are also indebted to the current and former staff of Plan in Kenya, Uganda and Zambia; Save the Children in Uganda; Inter-Religious Council of Kenya; Inter-Religious Council of Uganda; St. Johns' Community Centre; Kisumu Urban Apostolic Program (KUAP), Rang'ala; USAID in Kenya, Uganda and Zambia; ZINGO; and a host of Breaking Barriers partners.

We also acknowledge the cooperation and views:

Government officials serving in the areas we visited who went out of their way to avail useful data and perspectives;

Community Based Organizations' leaders and their members who discussed with us their experiences of working with the BB project;

Community leaders, men and women, the youth, people living with disabilities as well as members of other disadvantaged groups who provided information that enriched this evaluation report;

The children who volunteered to share with the evaluators on the work done by the Breaking Barriers project and its impact on their lives;

Many others who, though not mentioned here by name, contributed to the success of this evaluation.

Last, and by no means least, we thank Daniel Masyuki, Florence Juma, Jeremiah Mbewe, Lydia Amoit, Zipporah Mashini and Munaweza Muleji, the team of consultants who were entrusted with this evaluation by Upward Bound Company Ltd.

UPWARD BOUND
May, 2010

## ABBREVIATIONS

| | |
|---|---|
| AIDS | Acquired Immuno-deficiency Syndrome |
| ARVs | Anti-Retroviral medicines |
| BB | Breaking Barriers |
| CBCs | Community Based Caregivers |
| CBO(s) | Community Based Organization(s) |
| CHANCE | Child-centered Alternatives for Non-formal Community-based Education |
| COPRS | Country Operational Plan and Reporting Systems |
| COPs | Country Operational Plans |
| CPO | Country Program Outline |
| CTO | Cognizant Technical Officer (USAID) |
| DOVCC | District Orphans and Vulnerable Children Coordination Committee |
| ECCD | Early Childhood Care and Development |
| FBO(s) | Faith Based Organization(s) |
| FCC | Family and Children Court |
| FPU | Family Protection Unit |
| HACI | Hope for African Child Initiative |
| HBC | Home Based Care |
| HIV | Human Immune-deficiency Virus |
| IGA | Income Generating Activity |
| IR | Intermediate Result |
| IRCK | Inter-Religious Council of Kenya |

| | |
|---|---|
| IRCU | Inter-Religious Council of Uganda |
| KUAP | Kisumu Urban Apostolate Programme |
| LOA | Letter of Agreement |
| M&E | Monitoring and Evaluation |
| MDGs | Millennium Development Goals |
| MIFUMI | An organization for Protection of Women and Children against Violence in Uganda |
| MoUs | Memorandum of Understanding |
| NAC(s) | National AIDS Commission(s) |
| NCC | National Council for Children |
| NCCK | National Council of Churches of Kenya |
| NFE | Non-Formal Education |
| NGO(s) | Non-Governmental Organization(s) |
| NPI | New Partners Initiative |
| NSC | National Steering Committee |
| OCA | Organizational Capacity Assessment |
| OSAWE | Own Saving for Assets and Wealth Creation |
| OVC | Orphaned and other Vulnerable Children |
| PEPFAR | President's Emergency Plan for AIDS Relief |
| PLWHA(s) | Person(s) Living With HIV and AIDS |
| PM&E | Participatory Monitoring and Evaluation |
| POVCC | Parish OVC Coordination Committee |
| PSS | Psycho-Social Support |

| | |
|---|---|
| PWD(s) | Person(s) with Disability(ies) |
| REPPSI | Regional Psychosocial Support Initiative |
| RFDP | Rang'ala Family Development Program |
| RHE(s) | Reproductive Health Educator(s) (Uganda) |
| SDA | Seventh Day Adventist |
| SDD | Stigma Denial and Discrimination |
| SOVCC | Sub-County OVC Coordination Committee |
| UN | United Nations |
| UNAIDS | Joint United Nations AIDS Program |
| UNGASS | United Nations General Assembly Special Session |
| UNICEF | United Nations Children Fund |
| UNPAC | Uganda National Program of Actions for Children |
| UPE | Universal Primary Education |
| USA | United States of America |
| USAID | United States Agency for International Development |
| USG | United States Government |
| VIP | Ventilated Improved Pit latrine |
| VSLA | Village Savings and Loan Associations |
| WCRP | World Council of Religions for Peace |
| ZINGO | Zambia Interfaith Network Group |

## DEFINITIONS

The working definitions for this report are as follows:

### Child
Any human being whose age is less than 18 years

### Duty bearer
Any person or institution, including the State, with responsibility for the welfare of a child

### Orphan
A child who has lost one or both parents

### Psychosocial support
Counseling and emotional support for a child after a difficult or traumatizing experience

### Served OVC
An orphan or vulnerable child who has received a minimum of one of BB services

### Vulnerable Child
A child who is living in circumstances with high risks and whose prospects for continued growth and development are seriously threatened.

In other words, a vulnerable child is a child whose safety, wellbeing and development are, for various reasons, threatened. This is often a child whose parents or guardians are not able to administer proper care and protection; it is frequently a child living in a household where one or both parents/guardians is/are chronically ill or a child who is being looked after by a grandparent.

This report is alive to the fact that developing and implementing policies has to take into account local variations regarding factors that cause or constitute vulnerability and no single prescriptive notion will be appropriate in all circumstances.

### Sustainability
The ability to meet current needs without compromising the ability to do so in the future.

# EXECUTIVE SUMMARY

Millions of children are living with sick and dying parents or in poor households that take in orphans. Their communities have been weakened by HIV and AIDS as have their schools, health care delivery systems and other social support networks. By 2010, the number of children in sub-Saharan Africa who have lost both parents from AIDS will rise to 8 million, up from 5.5 million in 2001, according to estimates[1]. This means that by 2010 nearly a third of such children worldwide will be in sub-Saharan Africa. In response to this challenge, the mandate of the President's Emergency Plan for AIDS Relief (PEPFAR) is to bring compassionate relief and support to countries, communities, families, and children affected by the HIV and AIDS epidemic.

## Breaking Barriers

Breaking Barriers Project (BB) is a US$ 11,500,000 program implemented over five years in Kenya, Uganda and Zambia. It is funded by United States Agency for International Development (USAID), Cooperative Agreement No GPO-A-00-05-00017-00, through the President's Emergency Plan for AIDS Relief (PEPFAR). The BB project began on April 4, 2005 and is expected to end on June 30, 2010 as the result of a 15-month extension. BB seeks to increase orphan and other vulnerable children (OVC) access to (a) education, (b) psychosocial support (PSS) and (c) home-based care (HBC) by strengthening existing educational and religious institutions, resources, and infrastructures. The primary Emergency Plan strategy is a community-based response to these needs that preserves and supports families as much as possible.

The Strategic Objective of the Breaking Barriers project is: *To expand sustainable, effective, quality OVC programs in education, psychosocial support and community-based care for children and families affected by HIV and AIDS, using an extensive network of schools (both formal and informal) and religious institutions as a coordinated platform for rapid scale up and scale out.* The main strategies employed to deliver this strategic objective includes (1) Direct service delivery of essential services to OVC, (2) Capacity building for families, children and communities to care for OVC, (3) Advocacy for protection of the OVC; and (4) Economic empowerment of the community to support the OVC in their midst.

## Methodology

The methodology employed included (i) secondary data collection (ii) administration of questionnaires (iii) key informant interviews (iv) focus group discussions (v) most significant change stories and (vi) validation workshop. There was collection of quantitative primary data from 1,200 respondents. The sample size of respondents for each partner was based on each partner's number of targeted beneficiaries and funding portfolio. OVC constituted 60% of the sample since they were the primary beneficiaries of BB. Quantitative data was screened, coded, categorized, cleaned and analyzed. Qualitative data was collated and where necessity verified in order for inferences, judgments and conclusions made to be as accurate as possible.

[1] *The Framework for the Protection, Care and support of Orphans and Vulnerable Children Living in a World with HIV and AIDS*, 2004

### Alignment to Global and National Government Policies

BB is in compliance with the UN Convention on the Rights of the Child (CRC) (1989), UNGASS and the Millennium Development Goals (MDGs). BB was aligned with Government policies on universal primary education (UPE), child abuse and child protection. The socio-economic interventions and food security work, health care and support were all in alignment with government policies in all the three countries. In addition BB has been working with probation officers, nurses, security personnel, teachers and other government officials.

### Addressing structural causes of poverty

The structural causes of poverty, - illiteracy, limitation of access to resources, poor infrastructure, inequity, injustice and cultural practices have been addressed in a number of ways. BB addressed illiteracy by supporting children who would not have otherwise accessed education. Pass-on-the-gift, an intervention aimed at addressing household income, availed goats in Uganda and Zambia; and banana suckers in Rang'ala, Kenya.

### Entry and identification

There were commendable efforts made to introduce the project to beneficiary communities. This was complemented by a clear and transparent beneficiary identification process which involved local government officials, religious and local leaders. At the local level there was involvement of community volunteers to identify sites and beneficiaries. Overall, these processes were in line with country OVC policies.

### Efficiency

Though the project was hampered in its initial stages by the collapse of HACI, Plan and the implementing partners were able to re-organize the delivery structure. As a result BB project was able to recover remarkably well and has been able to secure timely delivery of outputs. The operationalization of the project structure, especially in the initial stages, was focused on meeting the requirements of the USAID Washington reporting relationship, to the detriment of strong working relationship with the USAID offices in the project implementing countries. However, this has been addressed and there is strong liaison between BB officers in the implementing countries and respective USAID interlocutors. Delivery of expenditure fluctuated below and above budget and is expected to be on target by end of the project. There was a 15-month extension following a mid-term evaluation that pointed out the need to focus on advocacy and economic empowerment in order to bolster sustainability.

### Effectiveness

BB has been effective, it Improved access to quality education, psychosocial support, and community-based care for children and families affected by HIV and AIDS. BB also increased capacity of OVC, families and communities to mobilize and manage internal and external resources needed for quality care and support for children and families affected by HIV and AIDS. Besides, BB worked to create a supportive environment in which children, families and communities engaged with government, community-based organizations (CBOs), faith-based

organizations (FBOs) and civil society to advocate for the provision of essential services, and reduce stigma and discrimination related to HIV and AIDS.

| Reporting Period (February 2004 or date of signed agreement – March 31, 2010) | Country KENYA– Planned for LOA | Country KENYA – Achieved to Date | Country UGANDA –Planned for LOA | Country UGANDA – Achieved to Date | Country ZAMBIA – Planned for LOA | Country ZAMBIA – Achieved to Date | Totals (A+B+…n)- Planned for LOA | Totals (A+B+…n)- Achieved to Date |
|---|---|---|---|---|---|---|---|---|
| Number OVC served by an OVC program | 67,672 | 79,831 | 142,090 | 188,674 | 24,000 | 27,464 | 233,762 | 295,969 |
| Care takers trained | 3,000 | 6,532 | 4,500 | 6,802 | 200 | 942 | 7,700 | 14,276 |

*Source: Breaking Barriers Project Progress Reports*

### Partnerships

A key factor of the success of BB has been the synergy that was developed between, on one hand, BB interventions and, on the other hand, the structures and other programs of the implementing partners. Schools were an excellent focal point for all the actors. The use of partners brought together a variety of complementary competencies, which enabled OVC access a wrap-around of important interventions. It also helped strengthen the implementation of BB by taking advantage of each partner's comparative strength. Partnership thus enabled BB to triangulate its interventions.

However, there were challenges that arose from little or no formal capacity assessment of BB partners by Plan in Zambia; inadequate legal and operational environmental scanning which led to operational hitches in Uganda that hampered original wrap-around approach; lack of a baseline survey accompanied by support mapping and determination of commensurate financial requirements and as a result, for instance, IRCU and IRCK felt that the budgets allocated for implementation of their activities were too little compared to their workload.

### Learning, Innovation, Upscaling and Replication

The evaluation captured a number of innovations and key lessons for scale up and replication in future OVC interventions. These lessons included the realization that developing shared strategies and tools is useful in ensuring delivery coherence in advocacy; community participation is essential for the success of child-centered development approaches because it enhances effectiveness and sustainability in building a strong circle of hope around OVC; targeting and involving institutional leadership is essential for success of interventions; building shared understanding among the implementers through joint formulation of monitoring and evaluation framework including agreement on outputs and the development of indicators is vital; and that interventions that address pressing community needs such as OVC draw broad participation including public-private partnerships which work well in delivering benefits to OVC.

### Accountability

Under BB there have been efforts to ensure community representation during performance reviews to strengthen accountability. In terms of upward accountability, there have been regular and timely reports to the funding partner; there have also been reports by the implementing partners, on their overall work including BB, to local government regulatory organs in the three countries. However, downward accountability has been relatively weaker.

### Sustainability

In all the three countries evaluated, there were signs of program sustainability beyond BB project period owing to the existence of strong community structures on the ground. For instance, in Zambia, there were strong participatory monitoring and evaluation (PM&E) groups. In Uganda, a strong district child protection structure exists and in Kenya vocational training of beneficiaries helps substantially raise income levels. There were a number of challenges to sustainability, notably, that BB, as part of the emergency intervention under PEPFAR, was service oriented. However, the shift of focus towards advocacy ad economic empowerment over the 15-month extension has done much to address this weakness and build project sustainability.

### Program quality

BB, as a PEPFAR project, is expected to adhere to a number of principles and best practices which it ably did. A multi-sectoral approach, such as the one adopted by BB, is needed to address the diverse and often complex needs of orphans and other vulnerable children. Core interventions children need for their well-being and future development are (1) food/nutrition, (2) shelter, (3) protection, (4) health care, (5) psychosocial support, and (6) education. The interventions under BB addressed all these core interventions.

### Factors of success

The structure of the BB project at local level; an integration approach that implementing partners adopted; the involvement of government officials; usage of a complementary partnership model; a multi-sectoral approach; and the space to learn and innovate have all contributed to the success of BB project. Plan's ability to be flexible and accommodate change also played a role in ensuring the success of BB. The political climate has been largely stable in the project countries, which greatly helped create an environment that enabled BB to be a success. A key factor of the success of BB has been the synergy that was developed between BB interventions and the structures and other programs of the implementing partners. An aspect of note has been that schools were an excellent focal point that brought together all the actors. In addition, the use of partners introduced a variety of complementary competencies that helped to strengthen the implementation of BB.

BB enjoyed a variety of beneficial partnerships at both international and country level. At the international level, the partners included Plan USA, Save the Children USA and the World Council of Religions for Peace (WCRP). Country-level partners included the Inter-Religious Council of Kenya, Inter-Religious Council of Uganda, Save the Children in Uganda, St. Johns' Community Centre, Kisumu Urban Apostolic Program (KUAP)/Pandpieri, Rang'ala Family Development Program (RFDP); Zambia Interfaith Network Group (ZINGO), Family Trust; and a host of Breaking

Barriers partners. BB also interacted with the USAID country missions in Kenya, Uganda and Zambia.

## Challenges

The collapse of HACI at the initial stages led to loss of time and goodwill from potential implementing partners. Even after the transition to BB format, project management was a challenge with for instance, no clear person in charge of BB project in Uganda and Zambia for almost two years. Though progress has since been made, monitoring and evaluation was perceived to be inadequate with no central database and no effective means of tracking changes in status of beneficiaries. In some cases communities were not well sensitized and did not give BB adequate support. There were policy inadequacies in all the three countries; concomitantly there has been less than desirable prosecution of child offenders. For instance, in eastern Uganda, orphans have been targeted for human sacrifices by their communities. The use of project volunteers is a challenge. For instance, some of the caregivers were being discouraged by their spouses from participating in the project because of perceived low benefits. In the reporting cycle, USAID country offices were often been excluded from the communication loop which was confined to Plan, Save the Children and World Council of Religions for Peace (WCRP) offices in the USA, on one hand, and the implementing partner country offices in Kenya, Uganda and Zambia, on the other hand.

## Recommendations

1. During formalization of partnerships, there is need for all implementing partners to agree on an Organizational Capacity Assessment (OCA) framework to be employed in capacity assessment. Early efforts should be made to address identified capacity gaps.

2. Plan should improve its Monitoring and Evaluation system to enable the capturing of data that can be disaggregated into sponsorship and grant-funded children, with ability to track changes in the lives of the beneficiaries as a result of interventions

3. To strengthen legal redress mechanisms in the three countries, an intervention akin to BB should prioritize collaboration with national authorities and other development institutions to develop tools and policies that cultivate strong political will and strengthen legal systems to address violation of child rights.

4. Through interviews it clear that BB has increased women's participation, however they are not empowered enough to make crucial decisions at the house hold level. In subsequent projects USAID should work with development institutions such as the BB implementing partners to challenge and change power relationship that are the root cause of gender inequality which impacts negatively on children, particularly OVC.

5. Unsustainable interventions such as direct material support which often take form of the relief services should be minimized since they cannot be effectively, regularly and consistently delivered; besides they tend to create dependency. Such interventions, should, right from commencement, be combined with strong household income and advocacy efforts. In subsequent phases of the project, the latter should be emphasized as direct material support tapers off in order to minimize dependency of OVC and their families on the project(s).

6. Advocacy work across multiple countries and a host of partners needs to be guided by an agreed, over-arching advocacy strategy to maximize its impact. Were the BB project to be extended in the present or modified form, the development of such a strategy would be essential.

7. USAID support for BB should be continued long enough to entrench sustainability, which in our estimate will take three years. This would also advance the advocacy agenda in support of OVC in the three countries of Kenya, Uganda and Zambia. In pursuing this, implementing partners should pay keen attention to the need to continue with a regional program vis-à-vis adhering to the 'Three Ones' principle.

## Conclusion

Overall, the BB project was successful in reducing vulnerability and improving the well-being of OVC. BB has also made significant steps to ensure the sustainability of its interventions. Furthermore, BB complied with USAID, national and local government requirements, the UN Convention on the Rights of the Child (CRC) (1989), UNGASS and MDGs and did much in contributing to the fulfillment the objectives of PEPFAR.

BB was able to register success despite a number of challenges, notably the collapse of HACI, at the initial stages, which led to loss of time and goodwill. Key factors of the success of BB have been the synergy among BB implementers, local structures and integration with other programs.

BB achieved the following intermediate results:

1. BB tackled the structural causes of poverty which, among other things, were a barrier to OVC access to education. BB worked to improved access to quality education, psychosocial support, and community-based care for children and families affected by HIV and AIDS.

2. Through a variety of interventions BB has increased capacity of vulnerable children, families and communities to mobilize and manage internal and external resources needed for quality care and support for children and families affected by HIV and AIDS.

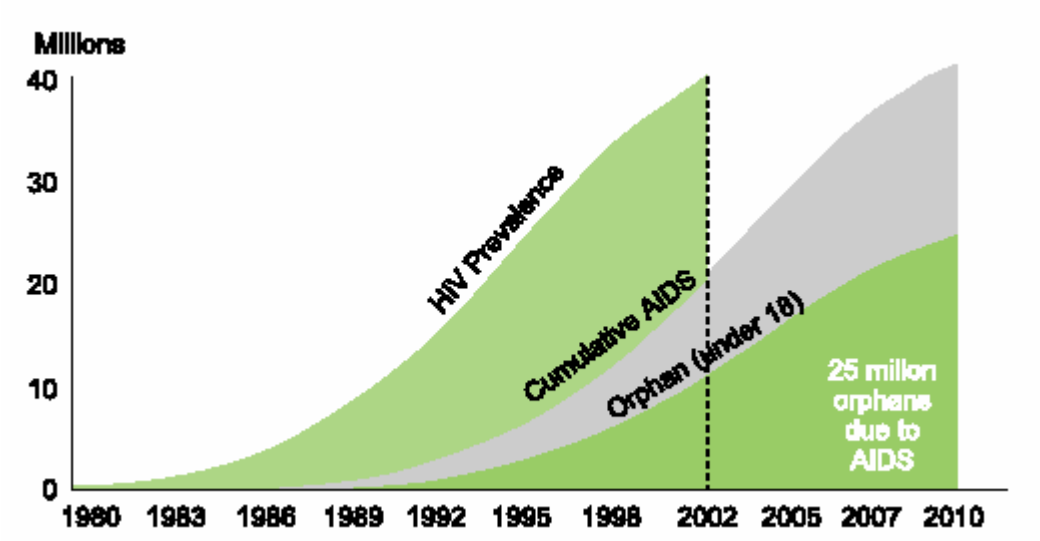
3. BB implementing partners have worked to create a supportive environment in which children, families and communities engage with government, community-based organizations (CBOs), faith-based organizations (FBOs) and civil society to advocate for the provision of essential services, and reduce stigma and discrimination related to HIV and AIDS.

After a mid-term review, BB focused on economic empowerment and advocacy in order to address sustainability. Much has been achieved although a lot more still needs to be addressed. It would be prudent for the implementing partners to seek and secure further PEPFAR funding to further strengthen advocacy and entrench sustainability in Kenya, Uganda and Zambia.

# 1.0 BACKGROUND

A large number of children have been made vulnerable by the impact of HIV and AIDS. This vulnerability is due to poverty, hunger, armed conflict and harmful child labor practices, among other threats, all of which fuel and are fuelled by the epidemic. In the countries affected most, parents, adult relatives, teachers, health care workers and others essential to the survival, development and protection of children are dying in unprecedented numbers. Millions of children are living with sick and dying parents or in poor households that take in orphans. Their communities have been weakened by HIV and AIDS as have their schools, health care delivery systems and other social support networks. By 2010, the number of children in sub-Saharan Africa who have lost both parents from AIDS will rise to 8 million, up m 5.5 million in 2001, according to estimates[2]. This means that by 2010 nearly a third of such children worldwide will be in sub-Saharan Africa.

Figure 1: Epidemic curves for HIV, AIDS and Orphans




*Source*: UNAIDS/UNICEF, 2003 Adapted from Whiteside, A. and Sunter, C. 2000.

## 1.1 BREAKING BARRIERS PROJECT

Breaking Barriers Project (BB) is a US$ 11.5 million program being implemented over four years in Kenya, Uganda and Zambia. It is funded by United States Agency for International Development (USAID), Cooperative Agreement No GPO-A-00-05-00017-00, through the President's Emergency Plan for AIDS Relief (PEPFAR). The matching fund requirement was US$5.5 million. The BB project began on April 4, 2005, and is expected to end on June 30, 2010, after a 15-month extension.

---

[2] *The Framework for the Protection, Care and support of Orphans and Vulnerable Children Living in a World with HIV and AIDS*, 2004

BB seeks to increase orphans and other vulnerable children (OVC) access to (a) education, (b) psychosocial support (PSS) and (c) home-based care (HBC) by strengthening existing educational and religious institutions, resources, and infrastructures. The project builds on the

(i) expertise of implementing partners,
(ii) investment of host country governments in school infrastructure, and
(iii) resources of religious/ faith based organizations

– all of which are uniquely positioned to make effective and lasting change for OVC within their communities.

The Strategic Objective of the Breaking Barriers project is:
*To expand sustainable, effective, quality OVC programs in education, psychosocial support and community-based care for children and families affected by HIV and AIDS, using an extensive network of schools, both formal and informal; and religious institutions as a coordinated platform for rapid scale up and scale out.*

The main strategies employed to deliver this strategic objective include

1. Direct service delivery of essential services to OVC;
2. Capacity building for families, children and communities to care for OVC;
3. Advocacy for protection of OVC; and
4. Economic empowerment of the community to support OVC in their midst.

## Intermediate Results

The three Intermediate Results of the Breaking Barriers project were:

IR #1: Improved access to quality education, psychosocial support, and community-based care for children and families affected by HIV and AIDS.

IR #2: Increased capacity of vulnerable children, families and communities to mobilize and manage internal and external resources needed for quality care and support for children and families affected by HIV and AIDS.

IR#3: Supportive environment created in which children, families and communities working with government, community-based organizations (CBOs), faith-based organizations (FBOs) and civil society advocate for the provision of essential services, and reduce stigma and discrimination related to HIV and AIDS.

## Approach

BB sought to address access to education as an essential service to be increased both directly, by eliminating common barriers keeping OVC from school, and indirectly, by addressing the psychosocial and physical health needs of OVC and their families, and by addressing HIV and AIDS-related stigma.

### Coverage

During the life of the project, BB aimed reach at least 150,000 OVC in Kenya, Uganda and Zambia combined, with one or more of its services.

### Timeline

| | |
|---|---|
| 2001 | HACI formed by seven organizations in response to UNGASS and the threat posed by HIV and AIDS in Sub-Saharan Africa |
| 2004 | Concept paper on ensuring future of the child submitted to USAID |
| 2005 | USAID approves proposal based on the concept paper and implementation commences in Uganda and Zambia |
| 2006 | Implementation commences in Kenya |
| 2007 | HACI collapses in June |
| 2008 | BB Regional Manager leaves |
| | Regional management role merged with co-ordination of Kenya program |
| | Mid-term evaluation carried out - it recommends focus on household income and advocacy to bolster sustainability |
| 2009 | Cost extension approved up to June 2010<br>BB Technical manager based in the USA leaves and is replaced |
| 2010 | End-term evaluation |

## 1.2 PEPFAR

The mandate of the President's Emergency Plan for AIDS Relief (PEPFAR) is to bring compassionate relief and support to countries, communities, families, and children affected by the HIV and AIDS epidemic. The Emergency Plan uses a three-pronged strategy of (a) prevention, (b) treatment, and (c) care interventions to accomplish this goal, and OVC programs are among the HIV and AIDS care interventions it supports. Usually, the U.S. Government country teams make programming decisions for PEPFAR, and thus for OVC programs, which receive approval in Washington through the Country Operational Plan and Reporting Systems (COPRS) process. It is a requirement that OVC in-country programs need to be fully integrated into host national strategies, as well as function within the context of Emergency Plan policy with harmonized planning, operations and reporting systems.

Specifically, Emergency Plan programs need to be planned in accordance with "The Three Ones" principle for HIV and AIDS assistance. "The Three Ones" principle is promoted by the Joint United Nations Programme on HIV and AIDS and co-sponsored by the U.S. Government. It seeks to promote harmonized programs by ensuring that all international partners agree to support:

1. one national action framework;
2. one national AIDS coordinating authority; and
3. one agreed-upon, country-level monitoring-and evaluation system.

The *U.S. Emergency Plan Five Year Global HIV and AIDS Strategy* identifies several goals for developing OVC programs: to rapidly scale up compassionate care for OVC; to build capacity for long-term sustainability of care; to advance policy initiatives with direct outcomes that support care for OVC; and to collect strategic information to monitor and evaluate progress and ensure compliance with Emergency Plan policies and strategies.

The primary Emergency Plan strategy is a community-based response to these needs, one that preserves and supports families as much as possible.

## 2.0 METHODOLOGY

Methodology approaches for the assignment utilised:

1. Primary data collection
    a. Questionnaires
    b. Key informant interviews
    c. Focus groups discussions
    d. Workshop
    e. Most significant change stories
2. Secondary data collection (Desk review)

This was designed to triangulate our findings and enhance the robustness of this report, its conclusions and recommendations.

### 2.1 Primary data collection and sampling methods

Key informants were identified through a mapping process and individuals to be interviewed were selected by purposive sampling. Quantitative primary data was collected from 1,200 respondents.

Table 1: Distribution of respondents

| Partner | Respondents | % Distribution |
|---|---|---|
| 1.PLAN UGANDA | 300 | Uganda 50% |
| 2.SAVE THE CHILDREN IN UGANDA | 200 | |
| 3.INTERRELIGIOUS COUNCIL OF UGANDA | 100 | |
| 4. RANG'ALA KENYA | 100 | Kenya 25% |
| 5.PANDPIERI KENYA | 150 | |
| 6.INTER-RELIGIOUS COUNCIL OF KENYA | 50 | |
| 7. ST. JOHN COMMUNITY CENTRE KENYA | 100 | Zambia 25% |
| 8. PLAN ZAMBIA | 200 | |
| Total | 1,200 | |

The sample size of respondents for each partner was based on each partner's number of targeted beneficiaries and funding portfolio. Half of the respondents were from Uganda and 25% from each of Kenya and Zambia. At each site there was stratified, purposive sampling of the respondents. OVC constituted 60% of the sample since they were the primary beneficiaries of BB. Of the OVC interviewed, girls constituted 58% and boys 42%.

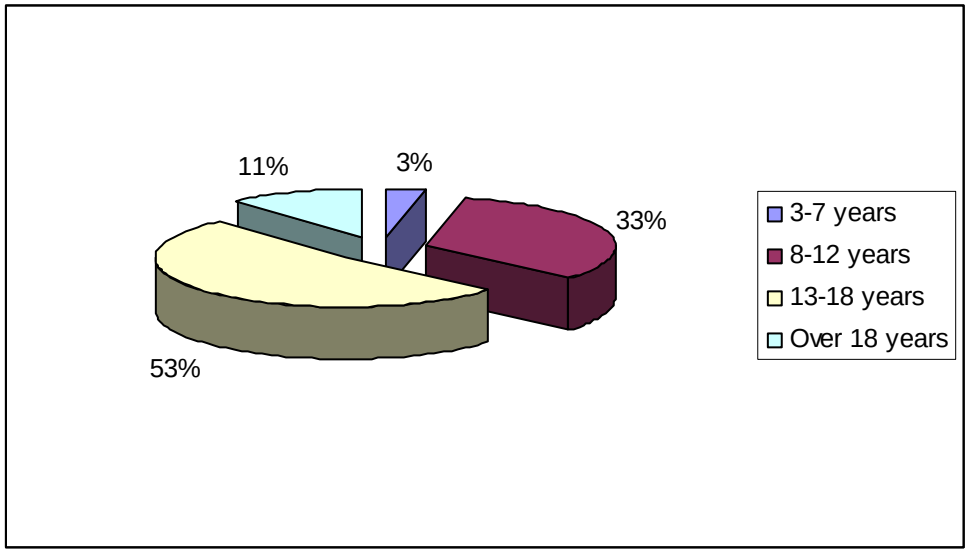
Table 2: Breakdown of served OVC by age

| Age | Under 2 | 2-4 | 5-11 | 12-17 | 18-20 | Total |
|---|---|---|---|---|---|---|
| Number of orphans and vulnerable children served by age group | 8,151 | 32,557 | 115,901 | 126,511 | 12,849 | 295,969 |
| Percentage | 3% | 11% | 39% | 43% | 4% | 100% |

*Source: Breaking Barriers Project Progress Reports*

Of the OVC interviewed, 52% were between 13 and 18 years of age while 11% were over 18 years. This distribution was broadly in line with that of the ages of the OVC served by BB.

Figure 2: Age distribution of OVC interviewed




## 2.2 Data collection tools

Data collection tools included questionnaires and interview guides. The questions were a mix of close-ended and open-ended questions. The interview schedule was used to guide the conversations towards issues on which feedback was sought. Data collection instruments were aimed at obtaining, among other things, data on targets based on indicators as documented in the project proposal and the performance monitoring and evaluation framework.

Table 3: Utilization of data collection tools

| Tool | Target groups |
|---|---|
| Questionnaire | OVC |
| Children Discussion Guide | Children |
| Key Informant Interview Schedule | Project staff, implementing partners' staff, government officials, funding partner staff |
| Focus Group Discussion Guide | Community level groups, PLWHA, implementing partners' staff |
| Validation workshop | Implementing partners' staff |
| Most Significant Change Story Guide | Community leaders and members, children |

## 2.3 Data collection procedures

Multiple tools and techniques were used to gather specific information from different target groups and to gain a better understanding of the issues in question. This included using photographic and

audio recording. Face-to-face interviews were conducted with the respondents and, where distance was a challenge, telephone interviews were carried out. The questionnaires were administered in person by the evaluation team members.

## 2.4 Secondary data collection (Desk Review)

We reviewed relevant material which included:
(1) documents from the government and its agencies, at both local and national levels;
(2) documents from implementing organizations and from other Civil Society organizations;
(3) documents relating to respective national political environment and policy imperatives; and to national and global development goals and instruments, in particular the Convention on the Rights of the Child, UNGASS and the MDGs
(4) documents relating to best practice in civil society and specifically international NGO delivery of interventions for OVC.

## 2.5 Key Informant Interviews

The key informants included:

1. Representatives of CBOs
2. Community opinion leaders
3. Relevant Government officials
4. Children
5. Teachers in schools where BB has specific intervention
6. School management committee members where BB has specific interventions
7. Representatives of Faith-Based Organizations where BB has specific interventions
8. Staff members of implementing partners

## 2.6 Validation Workshop

A validation workshop was held at the regional level, convening representatives of implementing partners from the Kenya and Uganda to debrief on findings and subject the draft report to constructive comments. The Plan USA Technical Advisor in charge of BB was in attendance. Comments were received from Plan Zambia. A subsequent workshop, which reviewed the report, was held in which all implementing partners from all the countries were represented.

## 2.7 Most significant change stories

Significant stories in the communities that encapsulate the challenges, processes, changes, failure and success of Breaking Barriers project, were captured from a variety of informants.

## 2.8 Data Handling and Management

The data collected was both quantitative and qualitative. Quantitative data was screened, coded, categorized, cleaned and analyzed. Data analysis involved dis-aggregation of information by age, gender and geographic location to ensure non-discrimination and eliminate bias. Qualitative data was collated and where necessity verified in order for inferences, judgments and conclusions made to be as accurate as possible.


COMMUNITY BASED
CARE GIVER
USAID
Plan

# 3.0 FINDINGS AND DISCUSSION

## 3.1 ALIGNMENT TO GLOBAL DEVELOPMENT GOALS

BB is in compliance with the UN Convention on the Rights of the Child (CRC) (1989), which is a framework that guides programs for all children, including OVC. BB adheres to the principles of the CRC which are:

(i) The right to survival, development and protection from abuse and neglect – Article 6;
(ii) Non-discrimination – Article 2;
(iii) The right to have a voice and be listened to – Article 12; and
(iv) That the best interests of the child should be of primary consideration – Article 3.

The Millennium Summit in September 2000, identified 8 Millennium Development Goals (MDGs), three of which are relevant to the rights of all children, including OVC. These are "To achieve universal primary education" (Goal 2); "To promote gender equality and empower women" (Goal 3); and "To combat HIV and AIDS, malaria and other diseases" (Goal 6). The strategic goals of BB include providing direct service delivery of essential services to OVC and to building the capacity for families, children and communities to care for OVC. In pursuing its strategic goals, BB fulfilled MDG 6. BB sought to achieve improved access to quality education, psychosocial support, and community-based care for children and families affected by HIV and AIDS under its first intermediate result - which addressed MDG 2. In working to improve access to education, attention was paid to factors that hindered school attendance by girls and, for instance, a number of BB implementing partners were involved in provision of sanitary towels, this addressed MDG 3. In addition, by working on economic empowerment BB joined forces against extreme poverty and hunger.

BB was well aligned with other global development goals. For instance, its interventions are in line with the UN General Assembly Special Session on HIV and AIDS (UNGASS) held in 2001, which adopted a Declaration of Commitment that set specific targets for all signatory nations. BB compliance is particularly in line with article 65, 66 and 67. Article 67 urges "…*the international community, particularly donor countries, civil society, as well as the private sector, to complement effectively national programmes to support programmes for children orphaned or made vulnerable by HIV and AIDS in affected regions and in countries at high risk and to direct special assistance to sub-Saharan Africa."*

## 3.2 ALIGNMENT TO NATIONAL GOVERNMENT POLICIES

BB was aligned with government policies on UPE, child abuse and on child protection. The socio-economic interventions and food security, health care and support were in alignment with government policies in all the three countries. In addition, BB worked with probation officers, nurses, security personnel, teachers and other government officials.

Kenya, as a signatory to the Declaration adopted at UNGASS, is committed to developing and adopting a national policy on orphans and vulnerable children. Kenya ratified the Convention on the Rights of the Child (CRC) on July 31, 1990. The enactment of the Children's Act no. 8 of 2001 provides wide ranging safeguards for the rights and welfare of the child and gave effect to the obligations of Kenya under the CRC and the African Children's Charter. Since its ratification, Kenya has been working to implement CRC provisions in domestic legislation concerning childcare and protection. HIV and AIDS were declared a national disaster by the President of the Republic of Kenya on 25 November 1999. Led by the National AIDS Control Council, the Kenya National HIV and AIDS Strategic Plan (2005/6-2009/10) (KNASP) emphasizes a multi-sectoral response to the epidemic and the targeting of vulnerable groups, including orphans and vulnerable children (OVC). Guided by the National Steering Committee (NSC) on OVC, a draft OVC policy has been developed. The interventions of BB in Kenya were in compliance with the Children's Act and the draft OVC policy.

In Zambia, BB is in compliance with government policies and plans. Zambia adopted and launched the Fifth National Development Plan (2006-2011) to guide Zambia's national development priorities and translate national policies into action. Among a host of issues, the Zambian Plan specifically seeks to promote the rights of the child and youths to enhance their survival, protection, and development. In this regard, the key strategies identified include: protection of the girl child from all forms of exploitation and abuse; provision of full access to education to female youths and girls within the Rights-Based Approach; establishment of safety and rehabilitation centers for abused females, youths and children. It also includes the development and implementation of a Gender Communication Strategy which will be utilized to address the negative cultural and traditional practices which perpetuate stereotyping, abuse and degradation of girls.

In Uganda Plan International facilitated the development of district level OVC strategic plans which were aligned to the National OVC policy. BB implementing partners used government officers to train teachers and community volunteers, non-formal school facilitators, community committees in charge of CHANCE schools.

Furthermore, in Uganda, there are coordinating organs up to local levels from District (DOVCC), Sub-county OVC Coordination Committee (SOVCC), Parish OVC Committee Coordination Committee (POVCC) and the community level. At the various levels, the Deputy Chair person is charged with the responsibility of child protection.

Box 1: Law and Policies: The Uganda Experience

To address the issues outlined in the Convention on the Rights of the Child (CRC), Uganda created the Uganda National Program of Actions for Children (UNPAC) in 1992/1993. UNPAC's main objectives included protecting women and children, ensuring children are not abused or neglected, and establishing survival and development goals related to children and women by improving key indicators of infant and child mortality, access to primary health care services, water and sanitation, and primary education. One of the main strategies UNPAC used to achieve its goals was decentralization, which ensured local government involvement and emphasis on community-based care. In addition to setting national goals for children and women, UNPAC provided a framework for legal reform to ensure better conditions for them (NCC, UNICEF 2001).

The Uganda Children Statute, formulated and ratified in 1996, provides a comprehensive legal instrument to address the rights of children and the obligations of children to society. To make UNPAC operational and ensure implementation of the Children Statute, the government established the National Council for Children (NCC) on an interim basis in 1993 and permanently by statute in 1996.

This body has been crucial in upholding laws and guidelines pertaining to the rights and protection of children and orphans. In addition to creating laws and policies to protect the most vulnerable members of society, government sectors in Uganda have begun taking steps to ensure the enforcement of these laws. The Administrator General's Office in the Ministry of Justice and Constitution oversees the concerns of widows and children and ensures flexibility in the legal system for defending their inheritance and property rights. The Association of Uganda Women Lawyers, a voluntary NGO, was established to help women and children, especially widows and orphans, obtain effective protection under the law. Likewise, Public Welfare Assistants have been appointed at the district and community levels to promote and supervise implementation of the Children Statute. In keeping with recommendations of the CRC, the Uganda government has revitalized the birth and death registry, recording a name for and the parentage of every child. These are essential for protecting children and preserving their identity. To strengthen district administration and the work of NGOs focusing on children, the government established a Family Protection Unit (FPU) in the Uganda police force, Social Welfare Public Assistants, and the Secretary for Children's Affairs. In addition, Uganda measures adherence to the Children Statute by monitoring implementation, coordination, communication, advocacy, and resource mobilization for child rights at the national, district, and community levels.

### 3.3 ADDRESSING STRUCTURAL CAUSES OF POVERTY

The structural causes of poverty, - illiteracy, limitations on access to resources, poor infrastructure, inequity, injustice and cultural practices were impacted by interventions under BB.

Schools supported by BB provided a better learning environment which enticed the children to go to school and, because of the targeting, marginalized children were afforded an opportunity to attend school. As a result, BB addressed illiteracy by supporting children who would not have otherwise accessed education. There was increase in enrollment, because of the availability of scholastic materials and uniforms. In the non-formal schools, uniforms were not a barrier and so such schools served to capture children that would not have otherwise accessed school. Such schools, therefore, acted as a bridge between the out-of-school and the formal education systems. Generally, the provision of girl-friendly VIP toilets contributed to addressing retention in schools. For instance, in schools visited in Uganda where VIP toilets were constructed, teachers reported a reduction in non-attendance of girls throughout the term. Teachers who were Reproductive Health Educators (RHEs) reported that they used the opportunity presented by the facility to train girls on proper use of the reusable sanitary towels and on proper use of the VIP toilets for personal hygiene. This aptly demonstrates the work done by BB in sensitizing duty bearers, including parents and government officials, on the need to address barriers in accessing education.

Pass-on-the-gift, an intervention aimed at addressing household income, availed goats in Uganda and Zambia; and banana suckers in Rang'ala, Kenya. BB encouraged table banking, for communities to pool their resources and granted technical support. There was training in Uganda on village banking and on OSAWE in Zambia. This has been a platform that mobilizes externally-sourced resources and enables the release of the resources within communities. There was been training in use of organic fertilizers and in varieties of crops. In assisting the beneficiaries, BB provided actual capital - seeds, livestock, poultry and heifers. Most of the caregivers and the targeted communities started small scale businesses such vegetable vending, dealing in grains and other small-scale and micro-sale businesses.

There was a combined approach in ensuring financial resources were available to communities; on one hand communities were encouraged to pool resources; while on the other hand, there was provision of grants. For instance, under IRCK, PLWHAs in Ongata Rongai in Kenya were given training in business management and in honey processing, which was done in conjunction with Ministry of Agriculture of the GoK. The groups of PLWHA were also given grants of KShs.13,000, KShs.8,000 or KShs.5,000 depending on their capability.

BB made efforts to rehabilitate schools. For instance in Mututu Basic School in Kabwe, Chibombo, Plan Zambia under BB renovated VIP toilets, refurbished a library and as a result enrolment increased and teachers consider it a preferred posting.

BB has contributed to reduction of stigma at community level. In all three countries sensitization on stigmatization has been done and focus group discussions indicate that stigmatization has reduced.

Box 2: Stigma and discrimination associated with HIV and AIDS

A woman who used to work with a Seventh Day Adventist (SDA) Church, Kibera, in Nairobi was dismissed when discovered to be HIV positive. When IRCK trained leaders on stigma, denial and discrimination (SDD), stigmatization reduced and the woman rehabilitated. The woman was later trained in income generating activities and is currently in a group of PLWHA, running a small-scale poultry business. Through her example many persons have come to appreciate the need to find out about their status and PLWHAs have been encouraged to live positively.

Before BB project, key informants in Kenya observed, some school teachers could not allow child living with HIV and AIDS to play with others. In contrast, such mixing is now allowed, as a result of the work of BB. Such reduction of stigma was also cited, for instance, among Christian leaders in Kalanamu, in Uganda, and the Muslim leaders in Umoja Mosque in Nairobi, Kenya. At the Umoja mosque, it was reported that the local Islamic community members had become more willing to support OVC. Street boys around the mosque had been reintegrated in schools. In Rongai, at Evangelizing Sisters of Mary facility, and Rang'ala, Kenya, community members opted to contribute towards the support of OVC in 2009 after Plan reported that food available could not support all the numbers of OVC in the area at that time. The Evangelizing Sisters of Mary, a partner of IRCK, developed best practice remedial approach to children's needs so as to individually address their needs while helping them realize their potential.

BB has done some work with the persons with disabilities, for instance, 25 PWDs have been taken to school, provided with wheelchairs through support of NCCK and PWDs have been included in NCCK Board. In overall terms, however, BB's work with persons with disabilities has been feeble.

## 3.4 ADDRESSING GENDER INEQUALITY

In dealing with gender relations, BB provided a forum for men and women to combine efforts in dealing with OVC. For instance, the community OVC selection committees comprised of both men and women. School enrollment of both boys and girls has increased due to sensitization on child rights. In Tororo, Uganda, sensitization of communities on children rights increased the number of both boys and girls attending school. Similarly, through CHANCE schools, both boys and girls enjoyed equal opportunities to access foundation education. In Umoja Mosque, in Nairobi, Kenya, for instance, girls were also attended to under an OVC project. Key informants reported that the girls had regained a sense of dignity and belonging. They were able to access education and therefore address cultural barriers that stood in the way of their advancement. Furthermore, BB enabled socialization between boys and girls to normalize which helped minimize sexual violence.

BB has enabled men and women to participate in joint training sessions and to work together in accessing resources. For instance in all the countries both men and women have been trained in home-based care. However, men's participation is still low compared to that of women. For example, at the time of the interview, St. John Community Centre had ten HBC providers of whom only two were men.

It is remarkable that BB has encouraged men – although limited in number – to get involved in the triple roles that usually fall on women (community work, reproductive and productive roles). Through capacity building, women gained economic empowerment by building skills to increase access to resources and enhanced participation in decision making at household level. However, their participation in crucial decision making in both public and domestic spheres is still limited

Men in Uganda now appreciate their children better and support their education. It was indicated that boys who used to remain at home to take care of livestock are now being sent to school. BB has also facilitated the discussion of sexuality among the youth. With the help of RHEs in Uganda and PSS teachers in Kenya (Pandpieri & Rang'ala), boys and girls sit to discuss sexuality in a focused and factual manner. Gender based violence was reported to be reducing in BB project areas in all the three countries. Participatory discussions by men and women on issues associated with HIV and AIDS such as OVC care and support, counseling, violence against OVC, among others, were reported to have contributed to reduced stigma and discrimination with increased understanding of gender dynamics around HIV and AIDS. For instance, key informants reported that through NCCK's work, the self-esteem of women living positively has been boosted and they can now have children and breast feed with dignity. NCCK reported to have supported 160 men through training which led to improved marital relationships.

## 3.5 ENTRY AND IDENTIFICATION PROCESS

There were commendable efforts made to introduce the project to beneficiary communities. This was complemented by a clear and transparent beneficiary identification process. The process of identification of OVC included local government officials, religious leaders and other local leaders. At the district level the officers involved included the, for example, the District Education Officers and district level officers handling children affairs – for instance, the Probation and Social Welfare Officer (in Uganda). At the local level there was involvement of community volunteers to identify the sites and beneficiaries. Overall, BB's entry and identification process was in line with national OVC policies.

There were efforts by religious leaders, notably in Uganda, to involve communities in the verification of beneficiary OVC by making public the names of the selected beneficiaries. However, not all the implementing partners adequately involved community members in verifying whether the volunteers and the headmen had adhered faithfully to the selection criteria. Indeed, it was reported across the three countries, that there were a few instances in which some of the selected children were not perceived to be deserving beneficiaries. In Zambia, some key informants noted that there were cases in which the community came to learn of the BB project once it was underway. It is clear that the involvement of communities during entry could have been carried out much better. In Uganda and Kenya local structures were used in identifying OVC. There were community meetings that were used to identify OVC in both countries. In Luwero, Uganda, large numbers of children were covered by the project because of the high levels of vulnerability. In some parts in Uganda, such as Tororo, Plan could have benefited much from taking advantage of government surveys and OVC mapping reports. BB implementing agencies have however, been deliberate in seeking the involvement of government officials.

### 3.6 EFFICIENCY

The structure of HACI, though workable, was constrained by implementation challenges and conflicting partner priorities. Though the project was hampered in its initial stages by the collapse of HACI, Plan and the implementing partners were able to re-organize the delivery structure and as result, BB project was able to recover remarkably well and has been able to secure timely delivery of outputs. Over the review period Plan had an efficient community level structure which informed BB implementation. Plan also had efficient inter-country structure that enabled the regional aspects of the HACI project to be retained. Intra-country, Plan had excellent linkages between Development Areas and the Country offices. Therefore, Plan with its efficient structure was able to offer direction and support in developing a successor arrangement for delivery of the strong objectives of HACI.

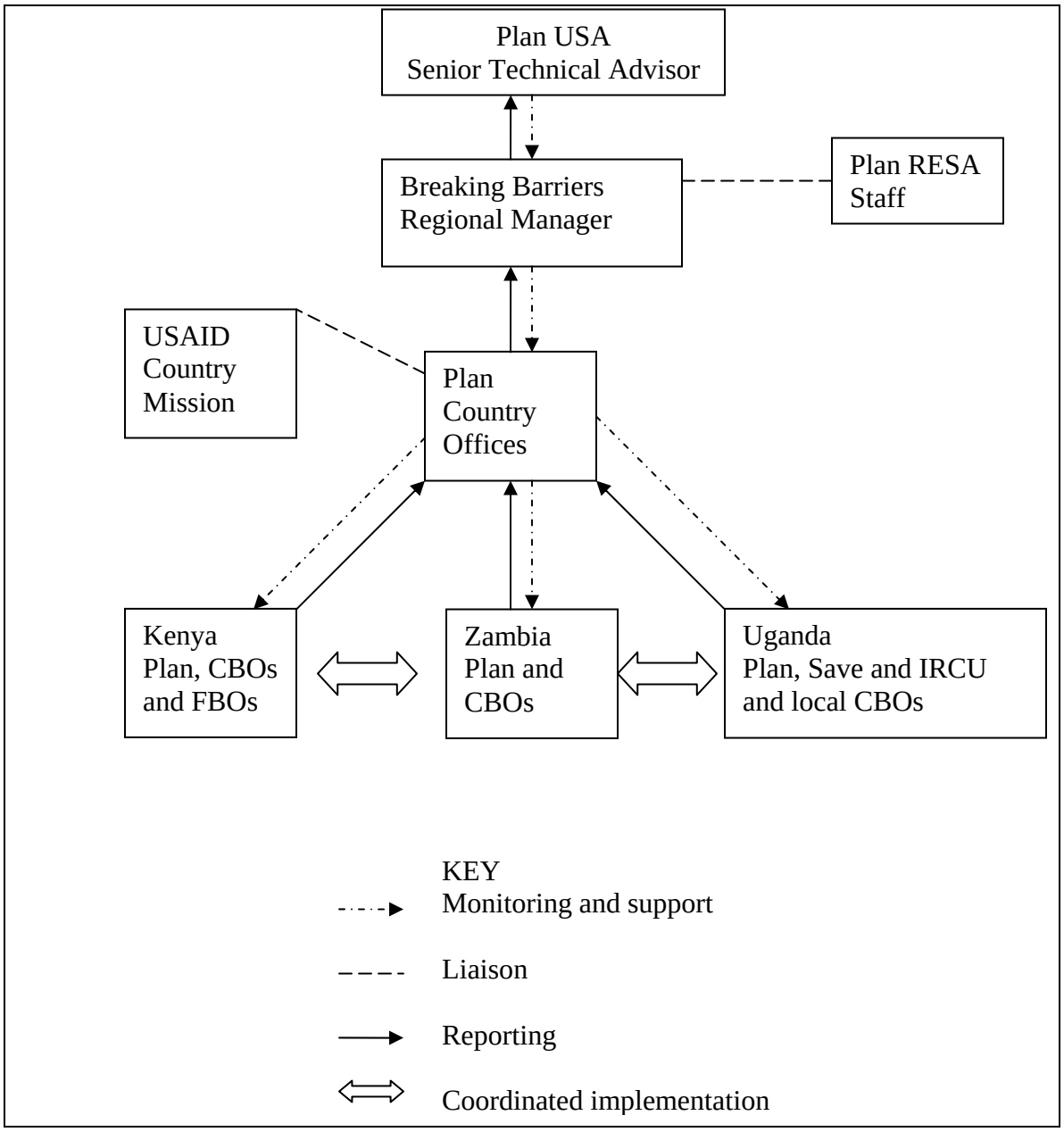
The operationalization of the structure of the project, especially in at the beginning, was focused on meeting the requirements of the USAID Washington reporting relationship, to the detriment of strong working relationship with the USAID offices in the project implementing countries. However, this was addressed and a strong liaison between BB officers, in the implementing countries, and respective USAID interlocutors- the Cognizant Technical Officers (CTOs) was developed.

The originally conceived 'wrap-around' model ran into practical challenges in Uganda due to government regulations which discourage what is perceived as duplication of efforts. Alternative approaches were developed in order to secure intended benefits to OVC. An example was the triangulation model proposed and used by IRCU which involved Plan, IRCU and the communities working through schools.

In addition, the monitoring and evaluation requirements of BB were initially not well handled by Plan's M&E system which meant that it was not easy to obtain some of the information required by USAID. However, there were efforts by Plan and other implementing partners to address these shortcomings.

There was an extension of the project period for 15 months so that BB ends June 2010. The extension arose out of a need to address gaps that were highlighted by a mid-term review especially in the areas of advocacy and livelihoods to promote project sustainability.

Figure 3: Breaking Barriers Project Organizational Structure




BB total budget was US$11.5 million with a matching fund requirement of US$5,529,057. The project spent modest amounts on travel, equipment, supplies, contractual and other expenses; 15% of the expenditure was on personnel costs and fringe benefits while 54% was spent directly on program costs.

Table 4: Breaking Barriers expenditure

| Budget Categories | Spend up to 2009 | 2010 Budget | Total Budget (US$) |
|---|---|---|---|
| | US$ | US$ | |
| A. Personnel | | | |
| PLAN USA HQ | 149,555 | 27,054 | 176,608 |
| PLAN Intl. Regional Office | 196,061 | 21,065 | 217,126 |
| PLAN Kenya | 161,317 | 44,745 | 206,062 |
| PLAN Zambia | 66,987 | 63,785 | 130,772 |
| PLAN Uganda | 745,568 | 108,911 | 854,479 |
| | | | |
| Subtotal Personnel | 1,319,488 | 265,558 | 1,585,046 |
| | | | |
| B. Fringe Benefits | | | |
| PLAN USA HQ | 572 | 6,763 | 7,335 |
| PLAN Intl. Regional Office | 7,606 | 2,106 | 9,712 |
| PLAN Kenya | 0 | 2,389 | 2,389 |
| PLAN Zambia | 0 | 0 | 0 |
| PLAN Uganda | 19,178 | 52,313 | 71,491 |
| Subtotal Fringe Benefits | 27,356 | 63,571 | 90,927 |
| | | | |
| C. Travel | | | |
| PLAN USA HQ | 95,668 | 12,600 | 108,268 |
| PLAN Intl. Regional Office | 44,023 | 11,300 | 55,323 |
| PLAN Kenya | 53,659 | 11,170 | 64,829 |
| PLAN Zambia | 7,547 | 16,841 | 24,388 |
| PLAN Uganda | 75,240 | 44,182 | 119,422 |
| Subtotal Travel | 276,137 | 96,092 | 372,229 |
| | | | |
| D. Equipment | | | |
| PLAN USA HQ | 0 | 0 | 0 |
| PLAN Intl. Regional Office | 0 | 0 | 0 |
| PLAN Kenya | 8,645 | 0 | 8,645 |
| PLAN Zambia | 18,782 | 0 | 18,782 |
| PLAN Uganda | 107,041 | 4,678 | 111,719 |
| Subtotal Equipment | 134,468 | 4,678 | 139,146 |
| | | | |

| Budget Categories | Spend up to 2009 US$ | 2010 Budget US$ | Total Budget (US$) |
|---|---|---|---|
| E. Supplies | | | |
| PLAN USA HQ | 0 | 0 | 0 |
| PLAN Intl. Regional Office | 14,217 | 0 | 14,217 |
| PLAN Kenya | 8,339 | 0 | 8,339 |
| PLAN Zambia | 0 | 0 | 0 |
| PLAN Uganda | 550,482 | 1,500 | 551,982 |
| Subtotal Supplies | 573,038 | 1,500 | 574,538 |
| | | | |
| F. Contractual Services | | | |
| PLAN USA HQ | 573 | 0 | 573 |
| PLAN Intl. Regional Office | 7,060 | 51,725 | 58,785 |
| PLAN Kenya | 101 | 0 | 101 |
| PLAN Zambia | -13,263 | 0 | -13,263 |
| PLAN Uganda | 520,420 | 0 | 520,420 |
| Subtotal Contractual Services | 514,891 | 51,725 | 566,616 |
| | | | |
| G. Program Costs | | | |
| PLAN USA HQ | 0 | 0 | 0 |
| PLAN Intl. Regional Office | 268,123 | 0 | 268,123 |
| PLAN Kenya | 1,386,536 | 269,970 | 1,656,506 |
| PLAN Zambia | 1,261,751 | 247,452 | 1,509,203 |
| PLAN Uganda | 1,746,046 | 1,054,106 | 2,800,152 |
| Subtotal Program Costs | 4,662,456 | 1,571,528 | 6,233,984 |
| | | | |
| H. Other Expenses | | | |
| PLAN USA HQ | 160 | 0 | 160 |
| PLAN Intl. Regional Office | 75,519 | 600 | 76,119 |
| PLAN Kenya | 27,377 | 21,846 | 49,223 |
| PLAN Zambia | 0 | 0 | 0 |
| PLAN Uganda | 651,127 | 118,484 | 769,611 |
| Subtotal Other Expenses | 754,183 | 140,929 | 895,112 |
| | | | |

| Budget Categories | Spend up to 2009 | 2010 Budget | Total Budget (US$) |
|---|---|---|---|
| | US$ | US$ | |
| Total Direct Costs | 8,262,016 | 2,195,583 | 10,457,599 |
| | | | |
| NICRA @ 9.99679% (expenses) | 823,289 | 218,853 | 1,042,401 |
| | | | |
| GRAND TOTAL | 9,085,305 | 2,414,436 | 11,500,000 |

*Source: Breaking Barriers Project Progress Reports*

(Note: The amounts shown above include monies for all implementing partners in Kenya, Uganda and Zambia.)

In a prudent use of funds for such a project, out of a total of US$11.5 million, BB invested USD139,146 in equipment while US$11,360,854 was used to meet fixed and variable costs associated with serving OVC.

Table 5: Breaking Barriers financial cost per OVC served

| Cost classification | Types of expenditure | Amount (US$) | Cost/OVC served (US$) |
|---|---|---|---|
| Investment Costs | Equipment | 139,146 | N/A |
| Fixed Costs | Personnel | 1,585,046 | |
| | Fringe | 90,927 | |
| | Supplies | 574,538 | |
| | Contractual services | 566,616 | |
| | Other expenses | 895,112 | |
| | NICRA | 1,042,401 | |
| | Total Fixed Costs | 4,754,640 | 16.06 |
| Variable Costs | Travel | 372,229 | |
| | Program | 6,233,984 | |
| | Total Variable Costs | 6,606,214 | 22.32 |
| Fixed + Variable Costs | | 11,360,854 | 38.38 |
| Overall Costs | | 11,500,000 | 38.85 |

*Source: Breaking Barriers Project Progress Reports*. (Computations done by the Evaluation team.)

Based on its financial statements, BB utilized an average of US$38.38 to serve each OVC. BB fixed costs were markedly lower than variable cots, which is in keeping with best practice, in order to facilitate the rapid scaling-up and scaling-down in accordance with the size of the beneficiary population. While diverse approaches and services render comparability difficult, it is noteworthy that the costs for BB were lower than home-based care delivery costs of US$86 per OVC estimated by Desmond and Gow (2001)[3]. The lower costs arise from the fact that a significant proportion of the services rendered under BB did not carry high financial costs; and the marginal costs were low.

An analysis of the pattern of expenditure shows general under-spending with spurts of over-spending against budget. The implementing team demonstrated significant efforts aimed at meeting project goals and fully utilizing the funding available before the project comes to an end.

Table 6: Breaking Barriers expenditure variances

| Quarter | Jan-March 2010 (US$) | Oct-Dec 2009 (US$) | July-Sept 2009 (US$) | April-June 2009 (US$) | Jan-March 2009 (US$) | Oct-Dec 2008 (US$) | July-Sept 2008 (US$) |
|---|---|---|---|---|---|---|---|
| Planned | 804,897 | 842,247 | 432,604 | 800,000 | 700,000 | 600,000 | 400,000 |
| Actual | 958,122 | 663,332 | 366,445 | 721,168 | 484,101 | 842,287 | 432,604 |
| Variance | (153,225) | 178,915 | 66,159 | 78,832 | 215,899 | (242,287) | (32,604) |

## 3.7 PARTNERSHIPS

A key factor of the success of BB has been the synergy that was developed between, on one hand, BB interventions and, on the other hand, the structures and other programs of implementing partners. The schools were an excellent focal point for all the actors. The use of partners brought together a variety of complementary competencies, which enabled OVC access a wrap-around of important interventions. Partnership also helped strengthen the implementation of BB by taking advantage of each partner's comparative strength. Overall, partnership enabled BB to triangulate its interventions.

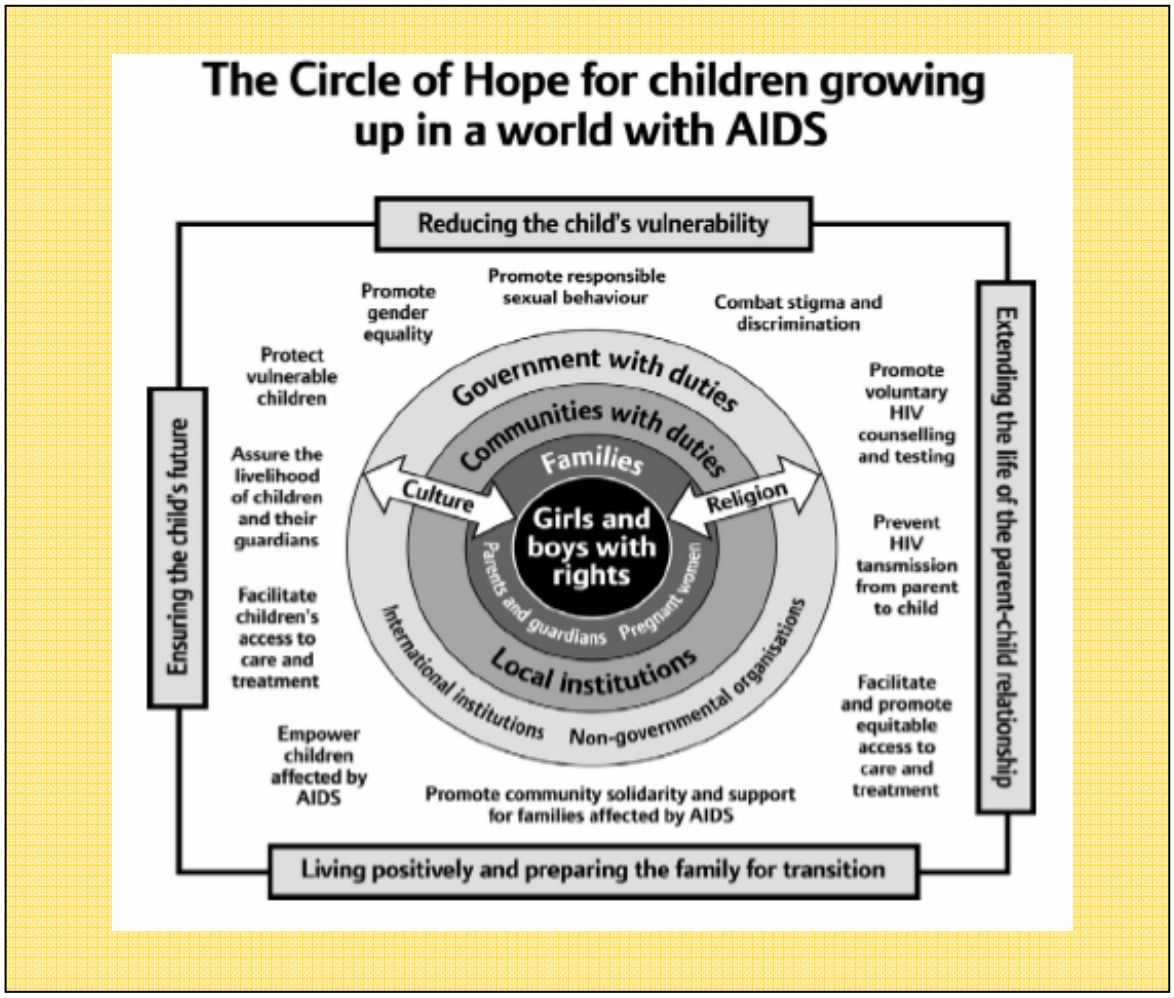
Through partnerships, different implementers contributed resources to support the formation and operationalization of DOVCCs and SOVCCs in Uganda as an avenue for improving co-ordination mechanisms and strengthening district level referral networks among OVC service providers. For

[3] Desmond, C. and Gow, J. (2001). *The Cost Effectiveness of Six Models of Care for Orphan and Vulnerable Children in South Africa*. Durban: Health Economics and HIV AND AIDS Research Division, University of Natal.

example, during the setting up of a Family & Child Protection Police Unit in Tororo, BB purchased a motorcycle for the police to help hasten response to child violation cases, MIFUMI constructed a permanent building to house the unit and helped set up a database. On the operational side, the District Probation Officer tracks progress on prosecutions at the Family & Children Court (FCC). In Mazabuka, Zambia, BB partnered with World Vision and a number of other child-centered organizations to implement a child protection project in which a project vehicle is used to pick child survivors of violence for urgent medical attention, and also used by police to arrest the offenders. The project provides for transport and accommodation of the victim and, should the need arise, an accompanying adult.

In all three countries, BB partnered with the Ministry of Education to train Early Childhood and Care Development facilitators and reproductive health educators. In Tororo, Uganda, the District Education Office and BB conducted a joint awareness campaign to demystify disability and facilitate children with disabilities to access education.

Figure 4: Breaking Barriers project and the Circle of Hope



The partnership approach under BB mobilized families, schools and other institutions, faith-based organizations and government to address the issues affecting OVC in a protective circle that supported relevant interventions to deliver essential services, meet the needs of children and protect their rights. BB thus enabled children, their families and communities to participate in their own development.

However, there were challenges that arose from four key limitations:

1. There was little or no formal capacity assessment of BB partners by Plan in Zambia although there was a due diligence procedure for assessing partners in place. By proceeding on assumed capacity the project created a situation where partners, such as ZINGO, felt that there were being called upon to deliver work in excess of their capacity. In other cases, it appeared that operational and governance shortcomings with some of the implementing partners would have been ironed out much earlier had a formal capacity assessment been done.

2. There was no adequate legal and operational environmental scanning that would have pointed out possible operational hitches. For instances, it was realized, well into the project implementation period, that the proposed 'wrap-around' could not be implemented in Uganda as envisaged because of local legal restrictions.

3. Since there was no baseline survey, there was no support mapping to identify the specific support expected from each partner and commensurate financial requirements across the implementation sites. For instance, IRCU was of the opinion that the resources allocated to them were far less than commensurate with BB project outputs. Indeed, the IRCU focal point persons at District level cited lack of adequate resources and organizational support to implement the project.

4. Arising from the foregoing, there was evidence that the financial resources were not allocated to each partners was not commensurate with 'workload'. For instance, IRCU and IRCK felt that the budgets allocated for implementation of their activities were too little compared to their workload. On the other hand, it is worthy of note that WCRP retained a notable amount of funds, as it channeled resources from USAID to IRCU.

## 3.8 EFFECTIVENESS AND OUTCOMES

In all the three countries BB was effective in addressing the needs of OVC. Generally, community level structures were formed, their capacities built, referrals mechanisms strengthened and formalized; and OVC served.

Table 7: OVC served per category of service

| Services / Indicator | Actual Served | Comments / notes |
|---|---|---|
| Food and Nutritional Support | 28,346 | Household food security through seed distribution. ECCD Centre based feeding through wrap around. |
| Shelter and Care | 2,345 | ECCD Shelters |
| Protection | 52,125 | Child protection and learning without fear |
| Health Care (General Health Needs of OVC, Health Care for HIV+ Children, Prevention of HIV/AIDS) | 142,126 | Peer counseling, Health education and Formation of health clubs, child to child campaign |
| Psychosocial Support | 295,969 | Child Counselors monthly meeting |
| Education and Vocational Training | 295,969 | Improved learning environment in ECCD centers and training of care givers and teachers |
| Economic Opportunity /Strengthening | 81,362 | Business skills training and goat provision. Income generating activities and food production. Seeds and tools purchase for household, community or individual garden |

*Source: Breaking Barriers Project Progress Reports*

The following were some of the outcomes under the three Intermediate Result areas of the Breaking Barriers project:

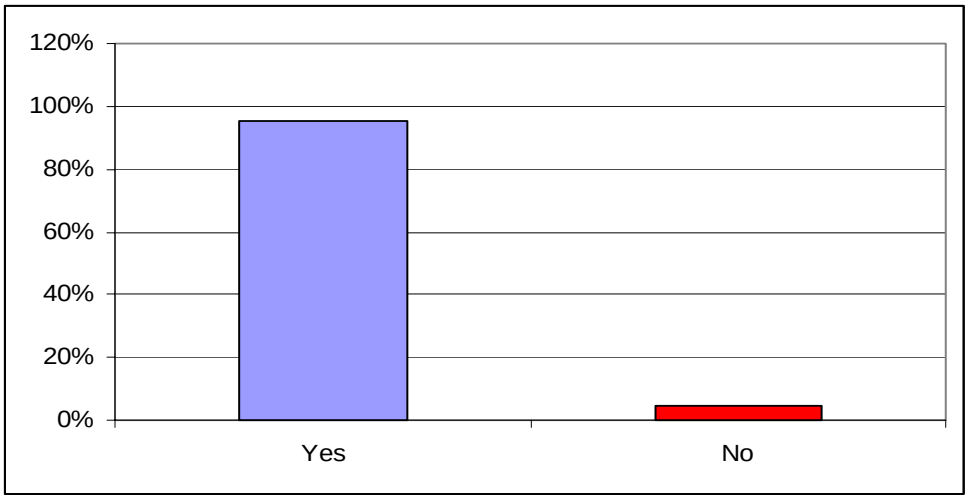
Intermediate Result # 1: Improved access to quality education, psychosocial support, and community-based care for children and families affected by HIV and AIDS.

At St. John's Community Centre, in Nairobi, for instance, orphans interviewed acknowledged that they had received food, uniforms, study materials, tuition fees and had been able to attend school. Their case was one of many examples, across the three countries, that illustrated the work done under BB to improve access to quality education, psychosocial support and community-based care for OVC.

1. Plan in Zambia, and a number of child-focused organizations, cooperated with the Police to handle child abuse cases. In Mazabuka, specific doctors in referral hospitals have been designated to support such cases. At the local level there were structures, run by youth and paralegals, to arrest offenders and hand them over to the police in districts where the implementing partners operate.

2. Under BB, support of OVC was based on the school and household as an entry and delivery platform. Of the OVC interviewed 95% were attending school and 5% were not doing so.

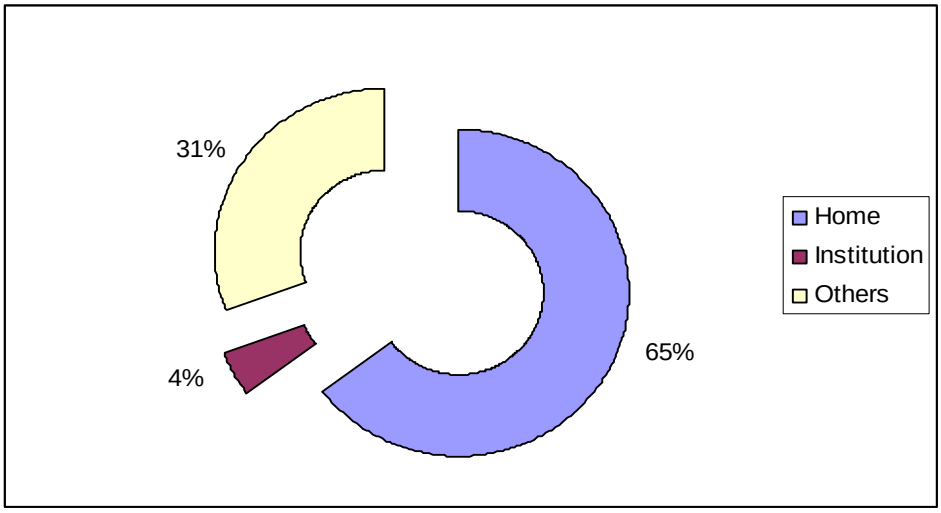
Figure 5: Percentage of OVC attending school




3. Save the Children in Uganda carried out exemplary work with ECCD and NFE. The CHANCE schools generated competitive graduands; were nearer than the government schools and therefore more accessible; and the children could start school earlier than would have been the case if only government schools were relied upon.

4. A key aspect of the work of BB has been the reinforcement of the shift from institutional towards community support and reintegration in the handling of OVC. As shown in the graph below, only 4% of the BB supported OVC interviewed are living in institutions.

Figure 6: Percentage of OVC living in institutions




5. The result of the rehabilitation work done under the psycho-social component of BB was a reduction of deviancy, truancy and vagabond behaviour among OVC. Key informants also pointed out the there has been reduction in the age of sexual debut for girls and of early pregnancy among girls.

Intermediate Result #2: Increased capacity of vulnerable children, families and communities to mobilize and manage internal and external resources needed for quality care and support for children and families affected by HIV and AIDS.

1. Through community based care providers, OVC were monitored closely and their concerns addressed at family and community level. This approach required that the capacity of OVC families be built to address OVC issues from an informed perspective, with complex issues escalated through the referral mechanisms. For instance, Pandpieri has resident child counselors and volunteers who work closely with the PSS teachers in handling referrals.

2. OVC received a host of services that translated to better care. Furthermore, there additional benefits, for instance, nutritional care and health service provision was reported to have led to better adherence to treatment regimes. Overall BB interventions were reported to have boosted the hope of OVC and PLWHAs. For example, in Mazabuka,

Zambia, a PLWHA who had given up on life after learning her of HIV-positive status contemplated suicide. CBCs referred her for counseling, she gained a positive outlook and later formed a PLWHAs support group which has transformed the lives of other PLWHAs in her locality.

3. There has been extensive capacity building including training on memory book, will writing and business skills. The business skills have translated to effective succession planning, income generation and better support for OVC and the households they belong to.

4. At St. John's Community Centre, Nairobi, support for families with OVC was addressed in order to buttress access to education. The centre works with a variety of health providers, and provides transport for the children to go for health services should the need arise. Similarly, in Tororo, Uganda, sick children were given support to travel to secure health services.

5. HBC givers were trained and supplied with kits to support the sick in all the three countries. In Uganda and Zambia, bicycles were provided to Home Based Caregivers thus facilitating health service provision.

6. In Zambia, herbal gardens run by beneficiaries provided affordable medical support. Besides, there were interventions to provide nutritional food to OVC including the provision of livestock.

7. There was vocational training which helped address poverty among the beneficiary communities. For instance, as a result of vocational training, one of the participants in Murukatipe in Tororo, Uganda had made become a banker. A similar case was reported as a result of the work of Pandpieri in Kisumu, Kenya.

8. There were village savings and loan associations (VSLA); and table banking in all the three countries which served to boost household incomes. For instance, in Zambia, beneficiaries cited that as a result of these interventions, they could take three meals a day.

Intermediate Result #3: Supportive environment created in which children, families and communities working with government, community-based organizations (CBOs), faith-based organizations (FBOs) and civil society, advocate for the provision of essential services, and reduce stigma and discrimination related to HIV and AIDS.

1. Key to the effectiveness of the work of BB was catalyzing duty bearers to meet the needs of OVC. For instance children from St. John's Community Centre, as the children's parliament, have interacted with duty bearers on various issues affecting their lives. In Tororo, the intervention of BB facilitated the establishment and operationalization of various OVC protection structures at various levels. These included orphan coordination committees at the District (DOVCC), County, Sub-county and Parish levels.

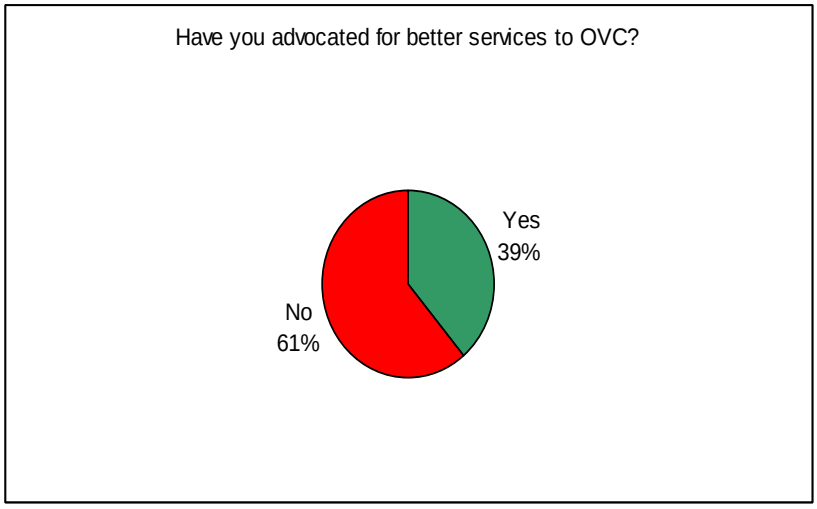
2. In all the three countries PSS providers were trained, counseling and guidance in school and at community level was carried out; and structured play for children facilitated.

3. Implementing partners in all three countries embraced advocacy. The advocacy agenda was however not harmonized. This was mainly due to the differences in understanding and capacity of implementing partners to undertake advocacy, and the levels and diversity of advocacy needs in the three countries. It was also apparent that there was no overarching advocacy strategy for BB.

4. In all three countries radio was used, with various levels of effectiveness, for policy advocacy and for expanding awareness on the rights of children. In Kenya access to ARVs has been discussed on radio. In Zambia and in Uganda, radio is used to disseminate awareness on HIV and AIDS, rights and responsibilities of the child, OVC policies and OVC care. Communities considered the radio programs successful and suggested that they should include active participation of OVC.

5. Respondent OVC indicated that advocacy action, either by themselves or by members of their family was at a fairly low level. This highlights the untapped potential that could be used to improve the advocacy aspect of BB interventions.

Figure 7: Advocacy efforts by OVC for better services




6. While OVC' access to basic education has markedly improved, in some of the sites it was clear that there is need for further sensitization on the importance of education. This is because OVC were assigned domestic duties that conflict with attendance in schools. For instance child labor is still a challenge for children in the Tororo area where children reported that they are expected to put in contractual manual farm labor to supplement family income, an enterprise that is often at the expense of school attendance.

The effectiveness of BB is best illustrated by the number of OVC served who were 295,969, a level nearly double the original project target of 150,000 served. When it is considered that BB has kept its expenses within budget, the cost-effectiveness of BB is even more striking.

Table 8: Progress tracking table for OVC served

| Reporting Period (February 2004 ,date of signed agreement – March 31, 2010) | Country KENYA– Planned for LOA | Country KENYA – Achieved to Date | Country UGANDA –Planned for LOA | Country UGANDA –Achieved to Date | Country ZAMBIA – Planned for LOA | Country ZAMBIA – Achieved to Date | Totals (A+B+…n) - Planned for LOA | Totals (A+B+…n) - Achieved to Date |
|---|---|---|---|---|---|---|---|---|
| Number of OVC served by an OVC program | 67,672 | 79,831 | 142,090 | 188,674 | 24,000 | 27,464 | 233,762 | 295,969 |
| Care takers trained | 3,000 | 6,532 | 4,500 | 6,802 | 200 | 942 | 7,700 | 14,276 |

*Source: Breaking Barriers Project Progress Reports*

Box 3: Changed lives

To Alfred Odwar, a second born in a family of five, dropping from and rejoining school was the norm. After he lost both parents, he stayed at his maternal grandmother's home as he supported his siblings. As a result, he repeated several classes in primary school.

Later, he took up casual jobs to support himself and could only raise KShs.300 (US$4) per month which he would send back home to support his siblings. He worked for one-and-a-half years then went to Kisumu. After a while, a family friend helped him get back to school and he sat for exams in 2003. He performed well but could not join secondary school. Fortunately for him a paternal aunt took him to secondary school in Kisumu and supported his schooling with income from her micro-enterprise. He benefited from bursaries a few times but had arrears for school fees, which kept him in and out of school. Nonetheless, he maintained good performance. However, danger loomed at his aunt's house and fearing assault by the husband to his aunt, he fled and went to leave on his own. One of his teachers stepped in and offered to pay rent for his accommodation until he completed secondary education in December 2006. Friends helped him with household items and Pandpieri gave him foodstuff and other support.

Meanwhile, Odwar's brother got BB sponsorship to take vocational training in Automotive Mechanics for one year in Kisumu. During the year, he volunteered at KUAP/Pandpieri and in December 2007, he was recruited by the church to visit Netherlands on an exchange program. He even volunteered for Plan Kenya unaware that the BB support he had received for his training had been through Plan Kenya.

Odwar passed his secondary school examinations and was hired as cleaner at a college. KUAP/Pandpieri, under BB, supported him for two-year college diploma course in Sales and Marketing. He completed his studies in 2009 and took an additional Certificate course in Computer studies. He passed well in both courses.

He then moved to work with a company dealing with projectors and computers. At the time of the evaluation he was working with a bank, heading a loans team. Odwar was in a position to meet his living expenses and also pay fees for his siblings' secondary education and vocational training. He had been nominated to attend a self-sponsored one-year course towards which he had already made savings of some KShs.25,000 (US$330).

## 3.9 LEARNING, INNOVATION, UP SCALING AND REPLICATION

The evaluation captured a number of innovations and key lessons for scale-up and replication in future OVC interventions, as outlined below:

1. Unless the key leadership is targeted and involved in interventions, implementation will be faced with challenges. For example, training of PSS teachers and PSS Assistants in the initial stages of BB, without involving the Head teachers, led to lack of support for the program by the school administration who neither understood the project nor the role of PSS teachers and PSS Assistants. To the credit of BB implementing agencies, this omission was quickly corrected and workshops were held to train head teachers.

2. To share implementation approaches and for coherence and effectiveness of project delivery, it is imperative that all players involved in OVC interventions develop shared strategies and tools. In particular, such an approach would have helped the further advance BB advocacy

3. Use of media with a wide reach such as radio can be successfully used to advance the OVC advocacy agenda, as for instance, IRCK was able to do.

4. A successful child counseling and resource centre should have trained counselors and be strongly linked to a referral system. Such was the approach that established Pandpieri's centre in Kenya as a model psychosocial support intervention that could be replicated.

5. Community participation is essential for the success of child-centered development approaches since it enhances effectiveness and sustainability of intervention and building a strong circle of hope as was the case with BB.

6. Interventions that address pressing community needs such as OVC draw broad participation including public-private partnerships which work well in delivering the benefits to OVC. This is even more effective when the family is made the first line of defense/entry.

7. For greater accountability amongst duty bearers, designation of clear mandates to specific offices and officials is an effective mechanism to secure active participation. For instance, under BB, the Tororo District child protection structure involves the District Health Officer, District Grade II Court Magistrate and the District Police Officer among other key actors, all with specific and clear roles for child protection.

8. OVC services should embrace an approach that will limit competition with and discrimination from other children. For example, to minimize competition generated by provision of scholastic material support to only targeted OVC Rang'ala begun giving gifts, such as desks, which were more likely to be seen as benefiting all children.

9. Exposure and exchange programs are among the strongest tools for experiential learning. Through cross-partner exchange and exposure programs, stakeholders adopted new innovations within BB. For instance, Rang'ala learnt about banana suckers from Zambia's pass-on-the-gift; St. John's Community Centre in Kenya started making reusable sanitary towels in order to address barriers to girl child education, an intervention that was replicated by Rang'ala.

10. Sustainability requires more than community participation, it requires capacity building, skills development and economic empowerment. The table banking and village saving of Uganda and OSAWE in Zambia have been effective in building sustainability in addressing OVC issues.

11. BB has demonstrated that a holistic approach to complex issues should adopt community organization processes alongside right based approach (RBA). BB required extensive community organization and largely a service delivery program which included aspects of advocacy. However, the implementing agencies, notably Plan, were carrying out their work in an RBA context. BB demonstrated that capacities of communities should be built to address structural issues to facilitate realization of sustainable benefits to children. This is similar to findings of a UNICEF (1991) study in Kenya.[4]

12. On cross-cutting issues such as HIV and AIDS, education and structures to support OVC, it is possible to break religious and other barriers and develop broad-based project ownership by the community.

13. Gender inequality issues require vigilant implementation where they are part of broad interventions of a project such a BB.

14. Building shared understanding among the implementers through joint formulation of monitoring and evaluation framework including agreement on outputs and the development of indicators are vital. For example, in BB, there were diverse perspectives on advocacy and sometimes weak adherence to the demands of PEPFAR reporting.

15. Partnerships as vehicles that enable efforts of each partner to be leveraged on the strengths and interventions of other partners are particularly effective in delivering programs that cover a wide area or are geographically dispersed. When managed effectively, they build a strong set of stakeholders keen on achieving program outcomes.

[4] UNICEF (1991): study on street children in Kenya highly recommended community organization process as a holistic approach to address issues of children in especially difficult circumstances (CEDC)

## 3.10 ACCOUNTABILITY

There have been regular and timely reports to the funding partner; there have also been reports by the implementing partner to local government regulatory organs. Overall, BB has been very strong in its accountability upward.

On the other hand, although there have been efforts to ensure community representation during performance reviews. There are regular monitoring and evaluation meetings with beneficiaries which have enhanced accountability of the project. In all the three countries, there were cases in which the community members met among themselves to address BB and other community initiatives. These and other measures addressed downward BB accountability. In Zambia stakeholders are required to take oath to protect children and not harm them; and there were PM&E groups to follow-up on the beneficiaries as an accountability measure. An example of strong downward accountability that should have been evident across the project was the Children's parliament at St. John's Community Centre. Overall, BB downward accountability was relatively weaker.

## 3.11 SUSTAINABILITY

In all the three countries, there were signs of program sustainability beyond the BB project period owing to existence of strong community structures on the ground. For instance, in Zambia, there are strong PM&E groups. In Uganda, a strong district child protection structure exists and in Kenya vocational training of beneficiaries helps substantially raise income levels.

To strengthen sustainability, various mechanisms have been adopted in the three countries. These include:

1. Capacity building for OVC, their households and other support structures. For instance psychosocial support is provided to OVC by the PSS Teachers and Assistants, who have been specially trained to render the service. Other training has included memory book, will writing and business skills.

2. Institutional capacity building. An apt demonstration of institutional capacity building carried out under BB is the fact that St. John's Community Centre was been able to access additional USG funding through the New Partners Initiative (NPI). In Rang'ala, PSS teachers have registered a CBO to mobilize resources with a view to continue supporting the OVC benefiting from BB.

3. Strengthening issue-based structures and committees at community level. For instance PM&E, CBCs and OSAWE groups have provided a platform for consolidation of effective community structures likely to outlive BB.

4. Economic empowerment, livelihood support for households and other BB interventions have reduced stress, denial, stigma and discrimination, hence improved self-reliance and community support for OVC. For instance, it was evident in discussions with key informants that IRCK was particularly effective with its work on SDD whose results will outlive the BB project.

5. BB facilitated the establishment, strengthening and formalization of referral systems. For instance, Plan Zambia worked in collaboration with the police and a number of child-focused organizations. At community level there are structures, run by youth and paralegals, to arrest offenders and hand them over to the police.

6. In Kenya, the establishment of child counseling and resource centers, such the ones at Pandpieri and St. John's Community Centre, provide a pool of support to OVC that is so entrenched and structured, as to outlive the BB project.

7. Recognition of and support from government for BB initiatives greatly boosted their sustainability. For instance some CHANCE schools have received teachers posted by the government of Uganda.

### Challenges to sustainability

There have been a number of challenges to sustainability, notably, that BB, as part of the emergency intervention under PEPFAR, was service oriented. However, the shift of focus towards advocacy and economic empowerment over the 15-month extension did much to address this weakness and build project sustainability.

## 3.12 PROGRAM QUALITY

A multi-sectoral approach is needed to address the diverse and often complex needs of orphans and other vulnerable children. Core interventions children need for their well-being and future development are (1) food/nutrition, (2) shelter, (3) protection, (4) health care, (5) psychosocial support, and (6) education. BB interventions addressed all these core interventions.

### Socio-economic impact

BB was designed and implemented in a particularly effective way to address the socioeconomic impact of HIV and AIDS. A glance at the table below shows that BB interventions addressed both the short-term and long-term impact of HIV and AIDS for the orphans, families and communities and illustrates the ultimate value of BB to the beneficiaries. For example, BB indirectly supported the integration of OVC into supportive households and lowered the levels of stigma associated with HIV and orphaned child status – in line with global OVC care best practice. With training on memory book and writing of wills, promotion of school attendance and tackling stigmatization at community level, BB mitigated the short-term socioeconomic impact on OVC.

With its interventions to increase household income and the establishment of community support networks, BB tackled the long-term socio-economic impact of HIV and AIDS on OVC.

Table 9: Framework for analyzing the socioeconomic impact of HIV and AIDS on orphans

| Level | Potential Socio-economic Impact | | Mitigating/Aggravating Factors |
|---|---|---|---|
| | Short Term | Long Term | |
| Orphan | • Loss of inheritance<br>• Reduced health, nutrition<br>• Reduced school attendance<br>• Increased labor<br>• Increased social isolation, vulnerability, and abuse<br>• Increased homelessness | • Reduced productivity<br>•Reduced socialization | • Parental cause of death<br>• Family or non-family living arrangement<br>• Head of household<br>• Personal characteristics (age, health, sex)<br>• Family, community factors |
| Family | • Increased dependency ratio<br>• Increased poverty<br>• Increased workload<br>• Reduced per person food consumption<br>• Reduced use of services such as education and health | • Entrenched poverty<br>• Genderization of poverty<br>• Further breakdown of traditional extended family structures | • Previous family income and assets<br>• Number, age, health of orphans<br>• Parental cause of death<br>• Head of household<br>• Availability of aid |
| Community | • Increased poverty<br>• Reduced child health, school enrollment<br>• Increased inequalities<br>• Increased crime, homelessness<br>• Increased social instability<br>• Changes in cultural practices<br>• Diversion of resources for orphan care | • Reduced quality of human capital<br>• Entrenched poverty<br>• Increased inequalities<br>• Reduced economic growth, development<br>• Increased social, political instability<br>• Diversion of resources for orphan care | • Historical economic strength<br>• Access to services<br>• Availability of assistance<br>• Effective anti-poverty programs<br>• Effective programs for Orphans |

*Source:* Adapted from Wakhweya A, et al. 2002. *Situation analysis of orphans in Uganda: Orphans and their households, caring for the future today.* Boston: Applied Research on Child Health (ARCH) Project, Boston University and Makerere University.

Box 4: Economic challenges and coping strategies

A study of HIV and AIDS and the economic crisis in Uganda and Kenya commissioned by MicroSave-Africa provides insights into the economic challenges faced by families affected by HIV and AIDS and the coping strategies they use in response.

The purpose of the study was to shed light on trends in economic coping mechanisms relied upon by microfinance clients. The study examined the nature of the economic impact of HIV and AIDS on clients; clients' economic strategies to cope with HIV and AIDS-related crises; the role of microfinance services in meeting clients' coping needs; and improvements to microfinance services that would strengthen clients' economic coping strategies.

In both Kenya and Uganda, participants identified the following as helping to improve coping strategies:

1. Access to microfinance to start, improve, or diversify their business activities
2. Better money management skills and savings discipline
3. More and better-organized informal support groups where members pool savings against future emergencies
4. More readily available information for their communities about treatment for family members with AIDS, which enables caregivers to manage their family member's AIDS-related illnesses more rationally. This also aids in encouraging openness and reducing stigma and psychosocial burdens
5. Increased reliance on informal support mechanisms such as rotating savings and credit associations and accumulating savings and credit associations

*Source:* Adapted from HIV and AIDS*: Responding to a Silent Economic Crisis Among Microfinance Clients in Kenya and Uganda*. Jill Donahue, Kamau Kabbucho and Sylvia Osinde. MicroSave-Africa, 2001.

The interventions of BB in addressing household income compare well with recognized best practice. BB has imparted money management skills and promoted a savings discipline by encouraging table-banking. By doing so, BB has also facilitated the emergence of better organized informal groups where members pool resources and therefore build resilience against the impact of HIV and AIDS including their capacity to better support OVC.

### Psychosocial support

Provision of PSS support involved structured recreation and play besides counseling. This support improved enrolment, retention and transition of children in school. Through PSS, children were able to address domestic matters affecting them. The involvement of community level structures had similar impact and improved a sense of responsibility on the part of the households with OVC.

About two-thirds (67%) of the respondent OVC reported that they had received counseling and guidance support under BB which demonstrates that PSS were a successful intervention. On reflection, two outstanding features underlie this success:

a) a deliberate focus on a holistic approach that included psychosocial support besides material, spiritual and household income support; and

b) a focus on children as individuals while considering their families and the place of children in the wider community.

There are different forms of psychosocial support (PSS) which may be offered at different levels to support children, families and communities. The model below has been used to consider the various levels at which psychosocial support in BB has been structured.

Box 5: Levels of Psychosocial Support

1. Advocacy:
Influencing policy and changes to the social conditions that affect the wellbeing of millions of children.

2. Provision of Basic Services:
Shelter, food, health & education, into which PSS needs to be mainstreamed, in order to reach many children and support ways of coping.

3. Family and Community Support:
Everyday care and support provided by caregivers, friends and community members.

4. Focused Support:
Additional, non-specialized support for children who are not coping and who are showing signs of distress.

5. Specialized Mental Health Services:
Psychiatric, clinical psychological, specialized traditional healer services for the few children with more severe responses.

*Source*: Adapted from REPPSI (2008) *Psychosocial Care and Support Mainstreaming Guidelines*

Focus on the first two levels shown in the table above leads to more impact on more children. A recent survey by REPSSI and UNICEF[5] showed that many organizations specializing in

[5] Brakarsh, J, *What has Love Got To Do With IT*, the State of the Response: Psychosocial Support Programming for Children in the Context of HIV and AIDS in the Eastern and Southern African Region, Draft 2008

psychosocial support are focusing their work on levels 3–5. The survey pointed out that it is good practice to focus on advocacy and provision of basic services; and to mainstream psychosocial support into schools, clinics, feeding programs and various government policies in order to reach more children.

Under BB, there was joint advocacy work to address the wider policy matters affecting OVC. BB clearly promoted PSS and at programming level, BB interventions were largely in congruence with PSS interventions principles. On the other hand, the PSS methods and tools used needed frequent and systematic updating. There was little evidence of the use of, for instance, body maps and journey of life tools. Nonetheless, there was systematic training on PSS under the BB project.

Box 6: Psychosocial support principles

1. Attitudes
Promoting respectful ways of interacting with children, families and communities so as to building a sense of dignity which is important in developing a sense of wellbeing.

2. Participation
Consulting children and families about what types of support would be appropriate and helpful, and how they could be involved.

3. Social Support
Drawing on and enhance existing constructive cultural, social and spiritual ways of coping and developing.

4. Family Support
Drawing on and enhance existing connections and relationships that the child has with trusted caregivers.

Promoting within the child and family, a sense of control (versus helplessness), during times of difficulty.

5. Emotional Support
Promoting stability and routine in the child's life, especially during difficult times
Promoting safe spaces for reflection on past experiences as a way of learning while seeking to improve as a result of the experiences.

*Source*: Adapted from REPPSI (2008) *Psychosocial Care and Support Mainstreaming Guidelines*

PEPFAR best practice

BB, as a PEPFAR project, is expected to adhere to a number of principles and best practices. The project design and implementation have complied as outlined below. In addition, implementing partners largely adhered to the BB proposal to USAID.

Table 10: Evaluating BB against PEPFAR best practice

| Principle/ Best Practice | Level of BB compliance | BB intervention |
|---|---|---|
| 1. Focus on the Best Interests of the Child and His or Her Family<br><br>Focusing interventions on the family unit and the community – and not only on the affected child—is usually the best way to promote the best interest of the child. | High | BB focused on schools and entire households as the entry points. Under IR#2, BB built resilient family support mechanisms in households in favor of orphan support. |
| 2. Prioritize Family/Household Care<br><br>The family is generally the optimal environment for a child to develop and it is important to encourage and maintain strong links with extended families, the reintegration of children back into the community, and the securing of a stable, family-based placement. | High | |
| 3. Bolster Families and Communities<br><br>Families and communities have important roles to play in raising children. Interventions need to strengthen the capacities of families and communities to make informed decisions regarding who needs what care and how best to provide it, especially for the long term. | High | BB recognized the role of family as the first line of defense in OVC support and laid much emphasis on supportive family structures. By training community volunteers and CBCs, BB ensured that OVC have crucial support easily available. |
| 4. Nurture Meaningful Participation of Children<br><br>Children and their families should participate, to the fullest extent of their capacities, through the entire project cycle of planning, implementing, monitoring, and evaluating | Medium | Child participation was evident through children parliament's endeavor to influence policy decisions. However, not many children knew about BB or had a chance to inform decision making. Downward accountability to children was wanting. |

| Principle/ Best Practice | Level of BB compliance | BB intervention |
|---|---|---|
| 5. Promote Action on Gender Disparities<br><br>Careful attention should be paid to conceptualizing and implementing OVC activities to ensure that differing needs of boys and girls are identified and addressed appropriate to their developmental stage. | Medium | This project took into consideration the different needs of both gender in education and addressed them. However, there was scope for more robust action on gender issues. |
| 6. Respond to Country Context<br><br>Activities also must be mindful and respectful of local, cultural, and religious values, and should seek to reinforce or include community norms that bolster the establishment of safe, loving, and secure environments for children, while attempting to change beliefs and practices that can cause harm to children. | Medium | BB interventions were alive to local, district, national, international and cultural values. Partners sought to ensure that interventions are implemented in the cultural context. The child protection interventions under BB have been evident in addressing this aspect. However, there were some initial difficulties in liaising effectively with Cognizant Technical Officers in USAID country missions. |
| 7. Strengthen Networks and Systems; Leverage Wrap-Around Programs<br><br>Networks and systems within communities offer opportunities for referral mechanisms and case management in delivering comprehensive support to children. Identifying and coordinating multi-sectoral responses is important to maximize benefit to children. | High | One of the strengths of BB was the establishment and strengthening of community and referral structures for improved services to OVC. BB also contributed significantly to the identification and delivery of multi-sectoral responses beneficial to OVC. |
| 8. Link HIV and AIDS Prevention, Treatment, and Care Programs<br><br>Functioning referral systems are essential for proper linkage of care treatment and prevention interventions. Prevention is critical because OVC are particularly vulnerable to sexual exploitation and trafficking and thus risk becoming HIV infected. | High | BB established a functional referral system and linkages with other actors. Actors, providing prevention, treatment and care programs and interventions, formed a circle of hope around OVC. |

| Principle/ Best Practice | Level of BB compliance | BB intervention |
|---|---|---|
| Support Capacity of Host-Country Structures<br><br>Provide technical assistance and investment in systems that strengthen provincial, district and national authorities along with NGOs, FBOs and CBOs. In addition, PEPFAR OVC programs must be part and parcel of national HIV and AIDS strategies and plans, and OVC national plans of action, as well as have the active support and engagement of local and national Governments, and multilateral organizations and institutions. | High | BB built the capacity of implementing partners and fell within the Country Operating Plans (COPs) and national OVC intervention instruments and guidelines. |

*Source*: Adapted from USAID (2006) *Orphans and Other Vulnerable Children Programming Guidance for United States Government In-Country Staff and Implementing Partners*

Compliance scoring key: (developed by the Evaluation team)

| | | |
|---|---|---|
| Very High | - | fully complied with best practice |
| High | - | complied with best practice |
| Medium | - | complied to best practice with notable deviations |
| Low | - | significantly deviated from best practice |
| Very Low | - | violated best practice |

## 3.13 FACTORS CONTRIBUTING TO BB SUCCESS

### 1. Structure of the project at local level

BB succeeded because of structures that eased communication, helped with identification of OVC, and facilitated access and support to OVC. These were:

a. Organizational structures: Community Development Facilitators, Program Officers, Project Coordinators, Regional Project Manager
b. District Point Persons, Program Officers and Project Coordinators
c. School Committees, RHE, children clubs in schools
d. Local church leaders and opinion leaders
e. Other community level structures such as HBC, PSS and CBCs.

### 2. Integration approach

The ability of the implementing partners to integrate BB with other projects helped to hasten the implementation of BB and offered a wider range of services than those supported by BB. For instance, Plan, Pandpieri, IRCU and IRCK were implementing BB in an integrated manner. Beneficiaries, therefore, received support from various projects, enjoyed stronger linkages and referral mechanisms and thereby received more services.

Another illustration of the integrated approach is that of religious leaders working with BB, who have integrated OVC care activities into their routine pastoral care activities. Indeed, they carry a home care kit to enable them carry out multiple care activities during home visits

### 3. Involvement of government officials

Recognition and involvement of government officials made it possible for the implementing agencies to tap into the technical skills of government officials. It also widened the circle of stakeholders and built ownership of the project on the part of government officials as duty bearers. In Tororo, Uganda, for instance, BB received support from the district offices in outreaches, monitoring and child protection services, among others.

### 4. Partnership model

BB used the partnership model to assemble a number of organizations that added value to the project. Save the Children in Uganda used CHANCE schools, in the areas it worked, to add value to the project in the increasing access to education. On the other hand, IRCK and IRCU brought on board the unique strengths, linkages and influence of religious leaders in mobilizing communities in tackling the impact of HIV and AIDS on OVC. In all the three countries BB was credited with having partners who had strong local legitimacy and credibility.

### 5. Multi-sectoral approach

The involvement of actors from a multiplicity of sectors to handle the OVC challenge helped to ensure the success of BB. This alliance included communities, implementing organizations, government departments and officials.

6. Space to learn and innovate

There was an effective feedback and reporting mechanism. There was been a clear ability to learn from implementation. For instance there have been new interventions as a result of the mid-term evaluation pointing out the need to strengthen advocacy and embrace economic empowerment.

7. Project design

The project design addressed community needs regarding OVC, took into account best practice; and built monitoring and evaluation into implementation. There was also transparency, involvement of various actors and the community in selection of beneficiaries. The BB project would have further benefited from stronger input from the community level at the design stage.

8. Plan as lead implementer

Plan was flexible and accommodating to changes aimed at improving project efficiency and effectiveness. Plan also had the capacity to provide funding to ensure timely implementation. Plan empowered its partners to implement their interventions using their approaches – as long as there was no overall contradiction with child programming guidelines. Plan facilitated its partners to understand BB project objectives prior to implementation and valued the participation of the community, and the children. This led to communities mobilizing resources towards OVC, for example, in Rang'ala, the community contributed food items to help keep OVC on a feeding program in school.

9. Enabling environment

The project addressed felt needs of communities and its interventions were valued by the beneficiaries. The policy environment was largely supportive. For instance, in Uganda, the country has a clear national policy on OVC and each district prepares a District OVC strategic plan. Over the project period, the political climate was for the most part stable in the three countries.

## 3.14 CHALLENGES

BB project faced a number of challenges during implementation, which were:

### 1. Project management

There was no clear person in charge of BB project in Uganda and Zambia for almost two years after the collapse of HACI. Clarity of roles was a challenge over a substantial length of time and in a number of cases, internal support in the implementing organizations was weak and poorly structured. Where no specific staff was identified to take charge of BB, there was an added burden to assigned staff and less than optimal support as competition from other duties limited the time staff could allot to BB. Attrition of staff serving BB project was also a challenge that affected project performance.

### 2. Reporting

Detailed reporting was required quarterly which consumed a substantial amount of time. In addition, training on USG guidelines and financial management was done but did not adequately permeate downwards. Furthermore, there was one too many upgrading/innovations of the program by USAID which were not matched with timely training of implementers. Several generations of PEPFAR indicators coupled with data and reporting demands from in-country National AIDS Commissions (NACs) contributed to hampering smooth delivery.

### 3. Monitoring & Evaluation

Monitoring and evaluation, especially at the beginning of the project, had challenges responding to USAID requirements. With no baseline data and no central database of OVC served, the tracking of changes in status of OVC was difficult. There was no budget allocated to monitoring and evaluation which meant that harmonization between the BB monitoring and evaluation framework and those of the implementing partners was slow. However, commendable efforts were made in an attempt to address these shortcomings.

### 4. Policy and legal inadequacies

There were policy inadequacies on OVC issues in all the three countries. A strong policy environment would have amplified impact of the work of BB at the national level. On the other hand, the lack of a strong advocacy component at the start of BB hindered the project from playing a role in addressing these policy handicaps. However, in all the three countries BB, and other intervening organizations have developed excellent district-level mechanisms that address OVC and, generally, children issues at the local level.

### 5. Collapse of HACI

The collapse of HACI led to loss of time and good-will in implementation of the project and led to significant changes of the implementing partners and staff.

### 6. Communication

USAID country offices were often been excluded from the communication loop between Plan, Save the Children and WCRP offices in the USA, on one hand, and the implementing partner country offices in Kenya, Uganda and Zambia, on the other hand.

## 4.0 RECOMMENDATIONS

1. During formalization of partnerships, there is need for all implementing partners to agree on an Organizational Capacity Assessment (OCA) framework to be employed in capacity assessment. Early efforts should be made to address identified capacity gaps.

2. Plan should improve its monitoring and evaluation system to enable the capturing of data that can be disaggregated into sponsorship and grant-funded children, with ability to track changes in the lives of the beneficiaries as a result of interventions.

3. To strengthen legal redress mechanisms in the three countries, an intervention akin to BB should prioritize collaboration with national authorities and other development institutions to develop tools and policies that cultivate strong political will and strengthen legal systems to address violation of child rights.

4. Through interviews it clear that BB has increased women's participation, however they are not empowered enough to make crucial decisions at the house hold level. In subsequent projects, USAID should work with development institutions, such as the BB implementing partners, to challenge and change power relationship that are the root cause of gender inequality which impact negatively on children, particularly OVC.

5. Unsustainable interventions such as direct material support, which often take form of relief, should be minimized since they cannot be effectively, regularly and consistently delivered; besides they tend to create dependency. Such interventions, should, right from commencement, be combined with strong household income and advocacy efforts. In subsequent phases of the project the latter should be emphasized as direct material support tapers off in order to minimize dependency of OVC and their families on the project(s).

6. Advocacy work across multiple countries with a host of partners need to be guided by an agreed, over-arching advocacy strategy to maximize its impact. Were the BB project to be extended in the present or modified form, the development of such a strategy would be essential.

7. USAID support for BB should be continued long enough to entrench sustainability, which in our estimate will take three years. This would also be used to advance the advocacy agenda in support of OVC in the three countries of Kenya, Uganda and Zambia. In pursuing this, implementing partners should pay keen attention to the need to continue with a regional program vis-à-vis adhering to the 'Three Ones' principle.

## 5.0 CONCLUSIONS

Overall, the BB project was successful in reducing vulnerability and improving the well-being of OVC. BB has also made significant steps to ensure the sustainability of its interventions. Furthermore, BB complied with USAID, national and local government requirements, the UN Convention on the Rights of the Child (CRC) (1989), UNGASS and MDGs and did much in contributing to the fulfillment the objectives of PEPFAR.

BB was able to register success despite a number of challenges, notably the collapse of HACI at the initial stages which led to loss of time and goodwill. Key to the success of BB were the synergy among BB implementers; effective local structures and integration with other programs.

BB achieved the following intermediate results:

1. BB tackled the structural causes of poverty which, among other things, were a barrier to OVC access to education. BB worked to improve access to quality education, psychosocial support, and community-based care for children and families affected by HIV and AIDS.

2. Through a variety of interventions BB has increased capacity of vulnerable children, families and communities to mobilize and manage internal and external resources needed for quality care and support for children and families affected by HIV and AIDS.

3. BB implementing partners have worked to create a supportive environment in which children, families and communities engage with government, community-based organizations (CBOs), faith-based organizations (FBOs) and civil society to advocate for the provision of essential services, and to reduce stigma and discrimination related to HIV and AIDS.

Following a mid-term review, BB focused its efforts on economic empowerment and advocacy in order to address sustainability. Much has been achieved although a lot more still needs to be addressed. It would be prudent for the implementing partners to seek and secure further PEPFAR funding to further strengthen advocacy and entrench sustainability in Kenya, Uganda and Zambia.


MUTUTU BASIC SCHOOL
PO BOX 81227, KABWE.
Plan
USAID

# 6.0 APPENDICES

## 6.1 APPENDIX I: TERMS OF REFERENCE

### 1 General Objective

The overall purpose was to evaluate the effectiveness of strategies applied and the performance of Plan's Breaking Barriers interventions in respect to orphans and vulnerable children care, support and protection and the extent to which these contributed to sustainable provision of quality OVC programming in Kenya, Uganda and Zambia.

### 2 Specific Objectives

The specific objectives of the end-term evaluation included the following;

i) To assess the efficiency of implementation of Breaking Barriers project activities in achieving set objectives

ii) To assess the relevance of the Breaking Barriers project and the strategies(direct service delivery, capacity building, economic empowerment and advocacy) and policies used in its implementation vis-à-vis external and internal frameworks

iii) To assess the effects and impact of the programs to boys, girls, women, men, institutions and people's quality of life especially OVC and PLWHA.

iv) To assess the effectiveness of Breaking Barriers interventions and the quantitative and qualitative outcomes of support to OVC in the context of child-centered programming.

v) To assess the sustainability of changes and outcomes achieved through the program's support to orphans and vulnerable children in the three countries.

vi) To identify key processes and factors that influenced performance of the program with regard to relevance, effectiveness, outcomes, sustainability of the program's OVC interventions.

vii) To assess the effectiveness and efficiency of Breaking Barriers project partnerships in delivery of support, care and protection to OVC.

viii) Assess the contribution of the project to greater accountability of duty bearers such as Governments.

ix) To identify, interpret and document lessons learnt and good practices from implementation of Breaking Barriers project interventions

x) Assess how monitoring and evaluation information generated by the project was shared and used for learning and project improvement.

xi) To make recommendations to improve strategic responses and performance of Plan's interventions in OVC.

## 3. Scope of Work

The assignment was an end–term evaluation in Kenya, Uganda and Zambia of the Breaking Barriers project.

In Kenya, the consultancy covered (1) Inter-religious Council of Kenya (2) Pandpieri Kisumu and (3) Rang'ala - Siaya in Nyanza and (4) St John Community Centre /Inter-religious Council of Kenya.

In Uganda the exercise covered mainly (a) Central and (b) Eastern provinces.

In Zambia the evaluation covered the two sites of (i) Mazabuka, in Southern Zambia and (ii) Chibombo in Central Zambia.

The total sample size for quantitative aspect of the evaluation was 1,200 respondents distributed in proportion to number of targeted beneficiaries and funding portfolio. Upward Bound interviewed all the respondents under each partner.

## 6.2 APPENDIX II: TOOLS

KEY INFORMANT INTERVIEW GUIDE

### Context

1. Brief introductory remarks.

### 1. Relevance

1. Which specific studies were done and to what extent did they inform project design and development?

2. How aligned were Breaking Barriers strategies to government policies and its interventions?

3. What were the assumptions underlying the project intervention and how aligned were they to global and national policies such as CRC, UNGASS and OVC policies.

4. How aligned were the project assumptions, strategies and policies to international trends and best practice?

5. How did Breaking Barriers strategies ([i]. Direct service delivery [ii]. Capacity building [iii]. Economic empowerment and [iv]. Advocacy) and policies respond to the structural causes of child poverty and the need for fulfillment of child's rights?

6. How were beneficiaries of Breaking Barriers interventions identified?

7. How did Breaking Barriers interventions contribute to solving problems identified by the communities in the project sites?

### 2. Efficiency

1. Were the project activities carried out on time?

2. Were the outputs achieved at the budgeted cost?

3. Were the monetary budget and other resources adequate and disbursements timely?

4. How do Breaking Barriers costs compare to similar projects?

5. Was the project management structure adequate to deliver the planned output?

6. What noticeable difference did Breaking Barriers partnership bring to the implementation of its interventions especially the delivery of support, care and protection to OVC?

7. Were there other ways that could have led to achievement of the same or better results?

### 3. Effectiveness

1. What were the project outcomes –qualitatively and quantitatively- and how child centered were they?

2. To what extent has the Breaking Barriers project addressed identified problems?

3. Have the project results contributed to the achievement of the project strategic objectives?

4. To what extent has working through Plan contributed to the achievement or non-attainment of the project goals?

5. To what extent has working through project partners contributed to the achievement or non-attainment of the project goals?

6. Looking at the systems and policies that have been established (by Plan, partners and communities) for implementing the project, which factors:

a) Facilitated the success of project interventions?

b) Hindered the project?

7. Looking at the environment in which project has been operating,

a) Which factors have facilitated the success of project interventions?

b) What factors have hindered the project?

### 4. Outcomes, Impact and Sustainability

1. What are the long term effects of the projects? (a) expected (b) unexpected (c) positive and (d) negative.

2. What are the effects and impact of the programs to:
(a) boys (b) girls (c) women (d) men (e) communities (f) institutions and to (g) people's quality of life, especially for orphans and vulnerable children (OVC), people living with HIV and AIDS (PLWHA) and children with disabilities?

3. How have the roles of different actors in the (a) implementation and (b) monitoring and evaluation of the project affected sustainability of its changes and outcomes?

## 5. Accountability

1. What mechanisms were put in place to ensure project accountability to:
    - children
    - community
    - partners
    - donors
    - Government?

2. How has the project contributed to greater accountability of primary duty bearers such as the Government.

## 6. Learning, Innovation and Scaling-up

1. How is information from project reports and from evaluation and other studies shared to all actors?

2. What feedback mechanisms are in place and working?

3. In which ways have the project monitoring and evaluation information used for learning and program improvement?

4. What lessons can be drawn from the project experience in its design, planning, implementation, monitoring and evaluation?

5. Examining Plan's work, what can be listed as the:
    a. best practices
    b. bad practices?

6. To what extent can project's work be (i) Replicated (ii) Scaled up and (iii) Institutionalized at the following levels:
    a. community
    b. district
    c. National
    d. International

## 7. Recommendations

1. What more could the project have done to enhance fulfillment of Children's rights?

2. What should have been done differently by the Breaking Barriers project to fulfill the rights of children?

3. What should Plan do to improve its performance and strategic responses in its interventions for OVC?

CHILDREN DISCUSSIONS GUIDE

## Climate setting

1. A variety of appropriate activities.

## Inquiry

1. What do you think are your priority needs in your community?

2. Has the Breaking Barriers Project addressed some of these needs?

3. What could the Breaking Barriers Project do to address your needs better?

4. How has the work of the Breaking Barriers Project benefited children in your community?

5. Do you know of any orphaned and vulnerable children who have been excluded from Breaking Barriers Project?

6. From your interaction with the Breaking Barriers Project what are the most important things you have learnt?

7. What are some of the best things Breaking Barriers Project has done in your area?

8. What are some of the things the Breaking Barriers Project has done that you do not like?

9. What are some of the things/teachings, lessons that you will remember and use them over a long time form your association with the Breaking Barriers Project?

10. Did the Breaking Barriers Project staff come to ask you what they should do for you and the community?

11. Does the Breaking Barriers Project staff come to tell you what they have done and why they did not do some of the things they promised to do?

12. Give us five things you would like Breaking Barriers to do in the future.

MOST SIGNIFICANT CHANGE STORY GUIDE

## Context

1. Brief introductory remarks.

## Change

1. In your opinion what has been the most important achievement(s) of the Breaking Barriers Project?

2. What change has it made in your life?

3. What change has it made in the lives of others and in fulfillment of children's rights?

4. As the Breaking Barriers Project comes to an end, what would you continue to do even after it?

BENEFICIARY (OVC) QUESTIONNAIRE

Note to Interviewer- Indicate if the respondent is a …….boy ……..girl.

1. What is your nationality?.....Kenyan ……Ugandan …….Zambian …….. Other (specify……)

2. What is your age? .....3-7years …….8-12 years ……13-18

3. Where do you stay?.....Home ..... Institution.....Others (specify.....)

4. Which one of your parents is still alive?.....Both …….Father ……..Mother

5. Who do you stay with? …….Parents
…….Relatives (specify……..……)
…….Guardian (specify……..)
……....Others (Specify……)

6. If you do not stay with your parents are you an orphan?.....Yes ……..No

7. Do you know about the Breaking Barriers Project? ……. Yes ……..No

8. Have received any benefits from the Breaking Barriers Project? …..Yes ……No

9. Do you go to school? …….Yes ……. No

10. If you go to school, what class are you currently attending?.....

11. If you do not go to school, which class were you last attending?.....

12. Do you lack any of the following?

…….Pencils…….. Pen ……. Book ……..Ruler ……Uniform
…….Food at school
……. Others (specify……)

13. Have you received any of the following from the Breaking Barriers Project?

…….Pencils ……. Pen ……Book ……Ruler …….Uniform …….Food at school
…….Others ( specify……)

14. Have you received any vocational training? .....Yes ……..No

15. If you have received vocational training, specify the type……

16. Was the vocational training provided with the help of the Breaking Barriers Project? …..Yes ……No ……..Not sure …….Don't know

17. Do you have a member of your family who is living with HIV and AIDS?
.....Yes ……..No

18. Does the member of your family who is living with HIV and AIDS receive Home Based Care?
.....Yes ……..No

19. Do you take care of the member of family who is living with HIV and AIDS?
.....Yes ……..No

20. Have you received any guidance and counseling related to HIV and AIDS under the Breaking Barriers Project?
.....Yes ……..No

21. Do you participate in activities that generate income or other earnings that could be used to support you and your family? …….Yes …….No

22. Does your family participate in activities that generate income or other earnings that could be used to support you and your family? …….Yes …….No

23. Has any member of your family been trained on better management of money and resources by the Breaking Barriers Project ? …….Yes …….No

24. Have you ever told anyone about the need for any of the following related to HIV and AIDS?
Better services …….Yes ……No
Reduction of stigma …….Yes …….No
Reduction of discrimination …….Yes …….No

25. Has any member of your family told anyone about the need for any of the following related to HIV and AIDS?
Better services …….Yes ……No
Reduction of stigma …….Yes …….No
Reduction of discrimination …….Yes …….No

26. Who helped you to join this Breaking Barriers Project?
……..Parent
……..Community Health Workers
…….. Home Based Care Giver
……..Others (Specify ……)
Thank you very much

## 6.3 APPENDIX III – BB PROJECT END TERM EVALUATION - ITINERARY AND CALENDAR OF EVENTS

| Month | Day | Dates | Activity | Location | Flag |
|---|---|---|---|---|---|
| Feb | Wed | 17 | Entry and scoping meeting | Nairobi | |
| | Thurs-Tue | 18-23 | Background document review<br>Preparing draft tools<br>Drafting Inception Report | Nairobi | |
| | Wed | 24 | Handing in Inception Report and draft tools | Nairobi | |
| | Thurs | 25 | Review meeting with BB Project Team | Nairobi | |
| | Fri | 26 | Testing of tools | Nairobi | |
| | Sat | 27 | Review of tools | Nairobi | |
| March | Mon | 1 | Handing in final Evaluation Tools | Nairobi | |
| | Tue | 2 | Preparation for Fieldwork<br>Training of Research Assistants | Nairobi | |
| | Wed | 3 | Field work-<br>St. John's Community Centre | Nairobi | |
| | Thurs | 4 | Field work-<br>St. John's Community Centre | Nairobi | |
| | Fri | 5 | Field work-<br>St. John's Community Centre | Nairobi | |
| | Mon | 8 | Flight to Kisumu<br>Travel to Rang'ala<br>Field work- Rang'ala Kenya | Nairobi<br>Siaya<br>Siaya | |
| | Tue | 9 | Field work- Rang'ala Kenya | Siaya | |
| | Wed | 10 | Travel to Pandpieri<br>Field work- Pandpieri | Kisumu | |
| | Thurs | 11 | Field work- Pandpieri | Kisumu | |
| | Fri | 12 | Flight back to Nairobi | Nairobi | |
| | Mon | 15 | Field work-<br>Inter-religious Council of Kenya(IRCK) | Nairobi | |
| | Tue | 16 | Field work-<br>Inter-religious Council of Kenya(IRCK) | Nairobi | |
| | Wed | 17 | Field work – Plan Kenya office – BB Project | Nairobi | |
| | Thurs | 18 | Field work – Funding partner Kenya office | Nairobi | |
| | Fri | 19 | Field work – Plan Kenya office<br>Preparation for travel to Uganda | Nairobi | |
| | Mon | 22 | Flight to Uganda<br>Brief meeting with the management of the 3 organizations- Plan, SCiU, IRCU | Kampala | |
| | Tue | 23 | Field work – Central Uganda- Luwero district | Luwero | |

| Month | Day | Dates | Activity | Location | Flag |
|---|---|---|---|---|---|
| | Wed | 24 | Field work – Central Uganda- Luwero district<br>Travel to Nakasongola | Luwero | |
| | Thurs | 25 | Field work Nakasongola<br>Travel to Eastern Uganda – Tororo | Nakasongola | |
| | Fri | 26 | Field work - Eastern Uganda – Tororo | Tororo | |
| | Mon | 29 | Field work –Eastern Uganda – Tororo | Tororo | |
| | Tue | 30 | Travel to Kampala<br>De-brief meeting with BB team in Uganda<br>Flight back to Nairobi | Kampala<br><br>Nairobi | |
| | Wed | 31 | Data collation, synthesis and analysis<br>Draft report preparation | Nairobi | |
| April | Thurs | 1 | Field work-<br>Inter-religious Council of Kenya(IRCK) | Nairobi | |
| | Mon | 5 | Flight to Zambia | Lusaka | |
| | Tue | 6 | Entry meeting with Plan Zambia<br>Travel to Mazabuka and Chibombo | Mazabuka & Chibombo | |
| | Wed | 7 | Field work – Mazabuka and Chibombo | Mazabuka & Chibombo | |
| | Thurs | 8 | Field work – Mazabuka and Chibombo<br>Travel back to Lusaka | Mazabuka & Chibombo | |
| | Fri | 9 | Interviews in Lusaka- Plan and other partners<br>Debrief meeting | Lusaka | |
| | Sat | 10 | Flight back to Nairobi | Lusaka<br>Nairobi | |
| | Mon -Tue | 12 – 13 | Completion data collation, synthesis and analysis | Nairobi | |
| | Wed-Thurs | 14 – 15 | Completion of draft report | Nairobi | |
| | Fri | 16 | Draft report submitted | Nairobi | |
| | Mon - Wed | 19 – 21 | Draft report disseminated by BB Project team | Nairobi | |
| | Thurs | 22 | Validation workshop | Nairobi | |
| | Fri | 23 | Incorporating feedback and preparation of final report | Nairobi | |
| | Mon | 26 | Incorporating feedback and preparation of final report | Nairobi | |
| | Tue | 27 | Completion and binding of final report | Nairobi | |
| | Wed | 28 | Final report submission | Nairobi | |

Key: Deadline Meeting with Breaking Barriers Project team