

Our Children, Our Hope

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Lessons Learned and Best Practices from the Hope for Children Affected by HIV
& AIDS Project in Kenya, Zambia and Haiti (2004-2010)



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The six year USAID/PEPFAR-funded OVC program was implemented in Kenya, Zambia and Haiti through the following AERDO HIV & AIDS Alliance Partners

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To all of you, and many others I have not mentioned by name, we express our gratitude for your significant contribution. Thanks.

List of Acronyms

AERDO	Association of Evangelical Relief & Development Organizations (now called Accord)
AHA	AERDO HIV/AIDS Alliance
AIDS	Acquired Immune Deficiency Syndrome
CRWRC	Christian Reformed World Relief Committee
FH	Food for the Hungry International
HIV	Human Immunodeficiency Virus
IGA	Income Generation Activity
MAI	Medical Ambassadors International (now called LifeWind International)
MAP	Medical Assistance Program International
M&E	Monitoring and Evaluation
NCM	Nazarene Compassionate Ministries
OBI	Operation Blessing International
OVC	Orphan and Vulnerable Child(ren)
PEPFAR	President's Emergency Plan For AIDS Relief
TSA	The Salvation Army
USAID	United States Agency for International Development
WC	World Concern
WCDO	World Concern Development Organization
WH	World Hope International
WHIZ	World Hope in Zambia
WR	World Relief Inc.

1.0 Introduction

Over a period of six years (October 2004-September 2010), World Concern, an international development and relief organization, has provided leadership to a consortium of nine international non-governmental organizations in Kenya, Zambia and Haiti. With funding from the PEPFAR program these member agencies, under the auspices of the Association of Evangelical Relief and Development Agencies (AERDO), HIV/AIDS Alliance (AHA) came together to mobilize comprehensive community and faith-based responses to HIV & AIDS.

Five of these AHA agencies in Haiti, six in Kenya and four in Zambia worked together to meet the needs of orphans and vulnerable children (OVC) as well as building the capacity of their caregivers and community volunteers to continue providing care and support to children in the long run. As the prime recipient of this grant World Concern provided a grant management, M&E and reporting role. Through the years as an organization we have learned a lot of lessons both as an implementer and grant manager. This publication seeks to highlight some of these key lessons learned, document what worked very well and was regarded as best practices in OVC programming as well as present some of the success stories we have documented over the years. These are sourced from the many agencies that were part of this consortium in the three countries. The project had five main objectives, listed in the box to the right.

Building upon the complementary strengths and coverage of these agencies, AHA mobilized community interventions for the care of more than 153,663 OVC affected by HIV/AIDS, thus alleviating

suffering and providing hope for a bright future. With the leadership of World Concern as the lead agency, all of the AHA agencies worked in partnership with 3,466 local churches, faith-based and community organizations in the three countries. Collaboration with local churches and organizations aimed at strengthening their capacity to provide care and support to OVC within their community — a more sustainable approach given that churches and most local organizations are prominently present in the communities.

Churches specifically, also have a spiritual mandate to provide care and support for vulnerable members of society and therefore this became a strong entry point for AHA agencies which are all Christian based. Because of the Alliance's extensive community network of churches, schools and local organizations, the program was built on a solid, sustain-

The 5 objectives of the AHA OVC Project

1. Strengthen 23,000 caregivers to support 150,500 OVC affected by HIV/AIDS in Kenya, Haiti and Zambia.
2. Mobilize and strengthen 2,375 churches and 200 community-based organizations to respond to growing needs of OVC affected by the AIDS epidemic.
3. Increase the capacity of 1,400 older children (ages 15-17) to meet their own needs.
4. In selected cases based on need, ensure access to vocational or formal education for 3,600 OVCs.
5. Raise awareness among 4,044,000 people, including families, churches, surrounding communities and society in general to create an environment that enables support for children affected by HIV/AIDS.

able foundation. The majority of implementers in each country were national staff and community-identified and agency-trained volunteers so that they can continue serving OVC and their caregivers long after the end of the project. USAID provided most of the funds with the agencies, matching about 37% of the total program budget.

Implementation began in earnest late in the year 2004. It is worth to note that none of the participating agencies had wide experience in OVC programming before and so this project was also a great learning and experience-building for most of them. Global knowledge and information on HIV & AIDS and OVC programming was also not as widespread as it is today. Because most agencies were already engaged with churches and other local organizations in HIV/AIDS or related care programs (on a rather small scale), the approach of this project was not about re-inventing the wheel, but rather in using these existing opportunities to scale up and expand support and care services to OVC as well as building the capacity of the existing churches as well as other churches and indigenous organizations in facilitating care and support.

In other words, the concept of local ownership and local solutions was at the core of this program since inception. The rationale of working with local institutions aimed at raising an enormous movement of community actors that could provide essential services to OVC within the vicinity of their homes. The activities of the project were as shown below. However, it's crucial to note that though the activities were largely the same, the methodology and approach differed with the agency and country. This was meant to encourage context-specific implementation.

Objective 1

- Conducting inventories of OVC to be recruited in the program (within 2 km radius)
- Supporting elderly caregivers to meet daily needs
- Strengthening of economic coping capacities of caregiver households
- Providing basic farming resources to caregivers affected by HIV/AIDS
- Advocate for the protection of property and assets of families affected by HIV/AIDS
- Linking children to essential health & social services where available
- Provide start up capital to families or groups to undertake sustainable IGAs
- Respond to psycho-social needs of OVC
- Training caregivers and the children on basic hygiene and disease prevention

Objective 2

- Recruiting partner churches and CBOs into the Program
- Supporting the establishment of caregivers' care-groups including elderly caregivers
- Enabling local churches and CBOs to develop and maintain their own support programs to OVC
- Providing consignments of food contributions (done at the initial months and later only to dire cases)
- Providing adult role models and mentors to affected children, especially child-headed households and reinforce responsible fatherhood
- Setting up of home visit schedules to ensure that trained volunteers and/or social workers regularly visit affected caregivers and child-headed households

Objective 3

- Training and mentoring older children in agriculture/animal husbandry and related small scale economic activities
- Training children in child-child care and psychosocial support, especially older to better care for young siblings

Objective 4

- Providing training to OVC in vocational skills
- Assisting OVC to remain in the formal education system

Objective 5

- Enabling community and religious leaders to clearly articulate Traditional and Faith-based values regarding care of OVC.
- Using broadcast media to highlight the treatment of the OVC and provide a context for reflection and discussion.
- Establishing HIV education programs for children

Soon after implementation picked up, agencies in each country came together to form a country secretariat, comprised of the project managers from the various agencies. This forum was critical in promoting cohesiveness and inter-agency learning. The forum as much as possible met every month on a rotation basis, and sometimes made joint field visits to learn as well as share ideas on how program effectiveness could be enhanced. The forum was usually convened and chaired by the project manager from the lead agency in that country i.e. Christian Reformed World Relief Committee (CRWRC) in Zambia, World Relief Project Manager in Kenya and World Concern Project Manager in Haiti. The overall project staff i.e. Project Coordinator from WC and the M&E Specialist (from WR, and later WC), were also active members of these secretariats. Their main role was in providing technical backstopping, monitoring and evaluation.

To ensure that the program remained on track and oriented to deliver on its promises, a robust monitoring and evaluation system was established. This system, made up of field based data collection tools, reports and a computer based interface ensured that essential data about the process and outputs of the project were generated. Data collection tools were mainly filled and kept by community based volunteers trained by the agencies. This initiative ensured that data was as accurate as possible. A protocol of data flow was clear among all players and as such the project was able to produce quality data for reporting and decision making. As such the project was able to adopt evidence-based decision making and program adjustment. Data collection, analysis and reporting used approved research methods and as such research played a critical role in the project. Both quantitative data (such as data on beneficiary targets reached) and qualitative data (such as the Child Status Index and periodic evaluations) were generated.

By the end of the first year, the Alliance had reached 29,214 OVC through 478 churches and 114 community-based organizations in the three countries. But at the end of the original five years (before more funds were availed for an extra year) the project comfortably achieved and surpassed its target of 150,500 OVC by 2,863 more OVC with at least one key essential service. Among the many reasons that led to this as will be discussed later in this document was the commitment and passion these agencies had in the project. Leadership at all levels of these agencies (Headquarters and field) provided all required support and this was a great ingredient of the success this consortium had. The table below summarizes the targets that were met over the life of the program in the five main objectives.

Planned targets Vs Actuals		
Objectives	Planned 5 year Target	Actual Achieved
1. Strengthen 23,000 caregivers to support 150,500 OVC affected by HIV/AIDS in Kenya (60,000 OVC), Haiti (22,500 OVC) and Zambia (68,000 OVC).	150,500	153,663
2. Mobilize and strengthen 2,375 churches and 200 community-based organizations to respond to the growing needs of OVC affected by the AIDS epidemic.	2,375	1,988
	200	739
3. Increase the capacity of 1,400 older children (ages 15-17) to meet their own needs	1,400	6,759
4. In selected cases based on need, ensure access to vocational or formal education for 3,600 OVCs.	3,600	27,943
5. Raise awareness among 4,044,000 million people including families, churches, surrounding communities and society in general to create an environment that enables support for children affected by HIV/AIDS.	4,044,000	6,495,030

As earlier mentioned the Alliance provided support in seven essential service areas. The focus of this document will be on best practices in the delivery of each of these services to children. These essential service areas are:

1. Food & Nutrition
2. Shelter & Care
3. Protection
4. Health
5. Psychosocial support
6. Education
7. Economic empowerment

2.0 Some selected best practices or successful approaches

The AERDO HIV/AIDS Alliance has implemented this program for more than five years now and definitely a number of lessons on what works have been gained through experience. For this publication we'll define a best practice as an approach, strategy or practice that proved to be successful in the delivery of OVC support. These best practices are largely lessons learned during the process of implementation and as such they are not absolute truths, but there is some evidence that they formed part of the pre-condition for success.

2.1 Best practices in working as a consortium

Working as a team is not always easy. The AHA consortium was comprised of ten relief and development agencies. These agencies were quite diverse in background, experience, interests and capacity. This diversity can easily result in a rather chaotic co-existence or break-up if not well managed, and can affect the delivery of promises to the community. On the contrary, the consortium actually worked and lasted through the project period. So the question is, what are the approaches and practices that enabled the consortium to last and achieve its targets? The following points below may be seen as some of the best practices in the consortium model.

1. Shared goal but freedom to innovate. All the agencies had one project goal and set of common activities. This unified them towards one vision: to help OVC but at the same time allowed the freedom to innovate or tailor approaches to best fit their contexts — as long as it was in sync

with PEPFAR guidelines. This “space” was critical in giving each organization the self-confidence to implement activities in the way they knew best. Organizations did not feel “forced” to do things in a certain way.

2. Commitment and alignment to organizations' mission. This project enjoyed the support and active participation of leaders both at headquarters and in the field. This was despite the fact that each agency had other, perhaps even bigger, programs. The nature of this work demanded a lot of organizational commitment and passion to help the children. Of the total program budget these organizations matched 37% of the total budget as a demonstration of the commitment they had in bringing hope to the children of Africa and Haiti. It is apparent that these agencies did not join the consortium for the intention of funds but to fulfill deep-seated compassion for children and those affected by HIV & AIDS. This is a critical aspect. The mission of the project aligned so well with the organizations' mandates. This is quite critical otherwise you find that headquarter/leadership tend to push back or not provide full support. We therefore advise that before starting any consortium, potential members must undertake a self-evaluation of their honest intentions because this will affect their commitment and loyalty to the larger group. Commitment of the staff, who worked beyond the call of duty and were based at the community level was critical for success too.
3. Coordination and communication. Regular interactions are crucial in promoting cohesiveness and cooperation among members. It defeats a

consortium model if each organization operated in a silo. Forums need to be created to interact, learn, solve differences and chart a way forward. It is not true that everything was just rosy at all times. Differences were there, but with forums to “talk” and provide honest feedback with each other being available, the ground was set for a fairly healthy consortium. In each country consortium members held monthly meetings, and at the headquarters level, semi-annually. These meetings enabled members to share experiences, receive updates and more importantly learn and share best practices with each other. In Kenya for example the teams met more often and on a rotation basis and for the most part they would pay a field visit to learn what the host agency was doing and provide their ideas. The Zambia team met less often and Haiti perhaps the least. The key lesson learned on the consortium meetings is that actively scheduling meetings is a must. And it has to start early in the program, or an increase demand on time can feel like a burden to the partners.

When working in a consortium regular change in staffing does not augur very well with consistency and good flow of implementation. As a consortium we suffered a bit of that and this affected the flow of activities. It also takes time before the successor learns the ropes. It’s thus critical to initiate effective staff retention mechanisms. Recognizing this early was key so that there was constant capacity building of field staff and community volunteers. In addition, for this type of program, a key desire was to transfer responsibility to the community, meaning that by the end of the program most key functions were realized by field and in-country staff as well as community-based volunteers as they carry out their normal daily roles.

2.2 Community participation and ownership

The PEPFAR program was among the largest HIV & AIDS interventions in the three countries. There was therefore a danger of making communities feel that they were only but recipients of the program. However, the program approach of using local churches and organizations ensured that the community members were lead agents in the process. The alliance worked with 2,727 local churches and organizations (FBOs & CBOs) at the community level. The consortium built their capacities through training and exposure and engaged them at the fore-front of implementation. As such it was not the face of the “external NGOs” that was seen at the community, but that of the local church or organization that beneficiaries easily identified with. This aspect was actually confirmed during the final evaluation. In some of the service delivery sites, the AHA consortium member was not even well known like the local organization or church that was the lead facilitator. Churches like most faith institutions of most religions around the world have a spiritual mandate to help the poor and the hurting in society. This is an enduring mandate. Additionally,



in most African countries the church is a much respected institution and those who are hurting turn to it for help. Therefore, if you choose to work with churches you need to just strengthen their capacity to do what they always do. The local community will be very cooperative because of the moral authority the church has.

The alliance did not venture to destroy or replace the position and work of the church, but rather partnered to enter the community and to sustain the whole venture. The community leadership on the other front took leadership in identifying which OVC or caregiver household should be supported. Groups that were supported with IGAs were also given the opportunity to choose the type of IGA they were good at and were interested to venture in. This enhanced ownership and reinforced the principle of beneficiary participation-one of the strengths of this project.

“If WHIZ decided to discontinue in this community, we would not lose out. This is because we have been equipped with survival skills. I have been empowered to an extent where WHI will only cease to exist in my life the day I will die”.
(Jembo in Zambia describing this project’s empowerment)

2.3 OVC/beneficiary recruitment processes

The number of OVCs is quite high in most African countries where the HIV & AIDS prevalence is also high. As such few programs have enough resources to reach all OVC with adequate, quality support. As such one needs to develop criteria to select. The registration process itself can be a source of stigma and raised expectations and as this consortium learned, it is critical to be open and transparent.



Some of the partners used staff to register OVC to the program. The consortium used an inventory form to record all child details. This process alone especially when done by staff raised a lot of expectations. Later these agencies decided to change the approach by using community volunteers to bring the names and the actual inventory form filling done outside the home, e.g. at the church. You can also match the recruitment with another service e.g. you can register children in a health day where all children get to benefit, e.g. receive a health talk, or de-worming. Also only fill in any forms for children to be supported by the program, not for a larger number of potential beneficiaries only when you intend to support a few. There will always be expectations when you collect anybody’s data. Also it demands that you explain more issues about the nature of the funding and how it has been structured to avoid unrealistic expectations and instead build the appropriate expectations. In a nutshell full, clear and consistent information sharing will help manage expectations. In situations where this information was not clearly and consistently relayed to the beneficiaries, there were imminent negative reactions when they learned that the program was coming to an end. This can be traumatizing to the children because the immediate reaction

may be that they would no-longer be able to go to school, food may become scarce and generally their future is bleak.

On recruitment it is advisable that you jointly develop a criterion for identifying who is needy. The definition of a “needy OVC” varies from community to community and so it’s critical to have a discussion with your local partners to clarify that. Do not impose your own criteria. Additionally, let the local leaders, churches and volunteers decide exactly who becomes a beneficiary using the set criteria. The PEPFAR program defines who an OVC is and who is not and it is largely inclusive. As such we are of the opinion that HIV status (and/or mandatory HIV test) is not necessary for inclusion in the program. Testing at all times needs to be voluntary based. There are also other indicators that you can look at to know the extent to which the child is affected. For example, an illness of a parent for three of the past twelve months, local prevalence rates, etc. should be sufficient to avoid stigmatizing the potential beneficiaries. As the agency although you may not directly be recruiting beneficiaries, you need to monitor the process and verify that the criteria was followed, because corruption can take place, e.g. the leaders may present names of their relatives. There were a few instances in some of our sites where initially some groups felt aggrieved because deserving cases were not selected for assistance. However, most agencies were able to work on this and by the end of the project, almost none of the respondents of the final evaluation indicated that the project was riddled with favoritism or discrimination.

Due to financial constraints and high community demands, the project in most cases used to directly support only one OVC per household-and as such many households were involved. The other mem-

bers of the household would benefit indirectly. Most communities would prefer to enroll as many households as possible, irrespective of the service package. Helping one child per household tends to cause resentment and jealousy within a household and also it tended to reduce impact. As such, the consortium learned that it’s better to adopt just a few households and register all the OVC in each household because some of the siblings may feel discriminated against. This demands a very clear targeting process and negotiation with a community so that you reach the most needy households. One of the weaknesses of this project was the desire to reach as many OVC as possible. We adopted too many households but were not able to support all the children in the household. Working with all children also ensures that the program benefit all children up to 18 years.

2.4 Duration and style of implementation

In our case we worked with yearly cohorts. This means that the project used to work with a different group of OVC in each year of implementation with the previous cohort becoming indirect beneficiaries and/or receiving direct services from community based efforts, i.e. from the individual caregivers, local churches, CBOs and FBOs that we had built capacity to continue with the work. However, we recommend that working with the same group of children over a prolonged time period may be a better approach. Consider education support for example; it is better to support just a few OVC through their full or almost full education than one time support in the cohort year, only for the child to drop in the next year. This is so relevant for secondary/high school education. In our view programs must run on a minimal two year project cycle. This

is to afford enough time for:

1. relationships to be developed and/or strengthened,
2. children to be enrolled and properly served and
3. building the capacity of local partners to ensure program sustainability

However, as support is provided, there is need to get the family to contribute in a way so that dependence is not created. Programs should not replace functions that can be performed by the child's extended family and/or community. Instead activities should be focused towards developing, strengthening and encouraging relationships or networks that can afford long-term support beyond the timeframe and parameters of the program. To avoid this, programs will need to conduct enough preliminary studies or baseline assessments so that before starting service provision there is sufficient information about what families are already doing and basically how the household and community unit functions. This allows you to place yourself in a space where you complement the household best.

Also programs should be careful not to create a discrepancy between the supported OVC and other children in the locality. Over-investment in one child will establish an unrealistic higher living standard for the supported OVC. Keeping their quality of life relatively proportional to that of other children in the community is critical to avoid resentment and a perception of favoritism.

The other aspect is what forms the core of the program. Because HIV & AIDS affects individuals, funds must be directed towards the vulnerabilities created by HIV & AIDS, rather than community-level needs that result from chronic poverty. Issues of chronic poverty can be addressed through linkages and wrap-arounds—helping families to access services available through other funding streams.

When you focus on macro-level community issues you lose the personal attention that is needed to ensure that those hurting actually get relief, and are enabled to participate on an equal platform with the rest in community development activities. This is not to mean that issues of chronic poverty should be ignored by HIV and AIDS programs but we advise that programs seek alternative funding or establish linkages with other sources of support to address these issues. Another key aspect in regard to project implementation is the delivery of essential services to OVCs. Most programs will not be resourced enough to provide all the services in equal measure. Though all services are essential, with the above fact, it behooves that the agency and the community consult in a bid to prioritize what constitutes the most essential services in their context.

A combination of community ideas and expert recommendations may lead to what we may call a minimum package for OVC services. In our case we had difficulty in defining what this minimum package would be. All three countries could agree on the sub-categories (health, nutrition, psychosocial etc.), but could not agree on whether a minimum package required that all of these areas be touched upon for each OVC, or whether a minimum package meant that an OVC received support in at least one of the sub-categories. Most countries are in the process of developing national standards/guidelines to define what a minimum package of services constitutes. It is imperative that programs consult these guidelines. There is also the "good enough" concept applicable even in emergency relief situations.

2.5 Working with volunteers

In total all partners worked with over 3,000 volunteers who were the lynch-pin of this program. First



these volunteers were identified by the church or community groups. The benefit of using the church is to ensure that people with a real calling and well known to the community are selected. Since program resources will always never be adequate, you must capitalize on locally available resources — both human and material. Volunteers form part of this locally available human resource. Incorporating volunteers into the program ensures a commitment to the OVC target group. As intermediaries, volunteers do not have competing interests, thus are able to direct program benefits to OVC. But it is paramount in an OVC program to use community volunteers of high integrity because these people act as parental figures and role models. Given that they are members of that community, relatives, neighbors and friends, it ensures a sustained care relationship.

This was best demonstrated in the Alliance's Zambia program where these volunteers provided sec-

ondary care-giving to OVCs and provided a friend-parent relationship to OVC. They are home visitors, guardian angels and friends of the children. They visited and helped do household chores, played with the OVC and provided guidance and counseling among many other functions. Most interviewed volunteers indicated that they were willing to continue doing the same even after the end of the project. Indeed, some of the volunteers worked with in the first and second year cohorts, were found doing the same work in year six of the project. This underlines the role community volunteers play in spurring of a community based care & support program. When working with volunteers it's a best practice to allocate each volunteer a number of households and/or OVC to be responsible for. This should not be far from his/her home otherwise visitation becomes a problem. For this project, OVCs were recruited within a 2km radius to ensure that they were within the same area making monitoring them easier.

The Volunteer: OVC/HH ratio should be kept as low as possible to ensure that home visitation (not group meeting) actually takes place and to avoid burn out. In some of our sites the ratio was very high, forcing volunteers to meet OVC as a group in a central place which is not the best way to build a relationship-based care-giving. The project should together with the volunteers decide a realistic frequency of visits. We learned that as more frequent visitation was demanded, it led higher to higher burn out and lower quality of services. It could also affect retention. Once or twice a week visits may be too demanding given that the volunteers also have their own lives to manage. It's also advisable that a "home visit" is made rather than "meet" the OVC elsewhere e.g. in school or church.

When the child is met in his/her home a lot of observations, both physical and psychological are

made that can help the volunteer provide the best and most relevant support. The work of the volunteer should not replace the primary caregiver's role, but should be seen as a helper. As such, as the volunteer provides some form of care-giving, his/her strategy should be to build the capacity of the parent/guardian to provide the same support in his/her absence. In retention there was a debate on what age group of volunteers is retained longer. When you work with young volunteers (e.g. recent high school graduates), you benefit from their great energy, creativity and higher literacy. However, this group tends to be highly mobile as the years go by. They get jobs elsewhere, go to college, migrate to urban areas, etc. and so you end up losing them. Since they have many needs they may also be attracted by higher incentive offers elsewhere. On the other hand, older volunteers may have travel problems (especially if looking after sparsely located households), and may be semi-illiterate, thus making reporting difficult. The advantage is that they are resident in the community and so they are a resource that is sure not to migrate.

Their motivation may be less monetary since they can meet some of their basic needs and can also share with the OVC, e.g. most of these would be owning their own farms where they produce food stuffs and so they are not hard pressed like the youngsters with the desire to meet their needs. So in principle, when looking at retention one needs to critically consider these points in determining who exactly fits to be a volunteer. Retention how-

"As a volunteer I wondered how I can be of importance to OVC and always expected to be given allowances but I have realized that there is a lot I can do to support the OVC without pay."

- A Volunteer in Kenya

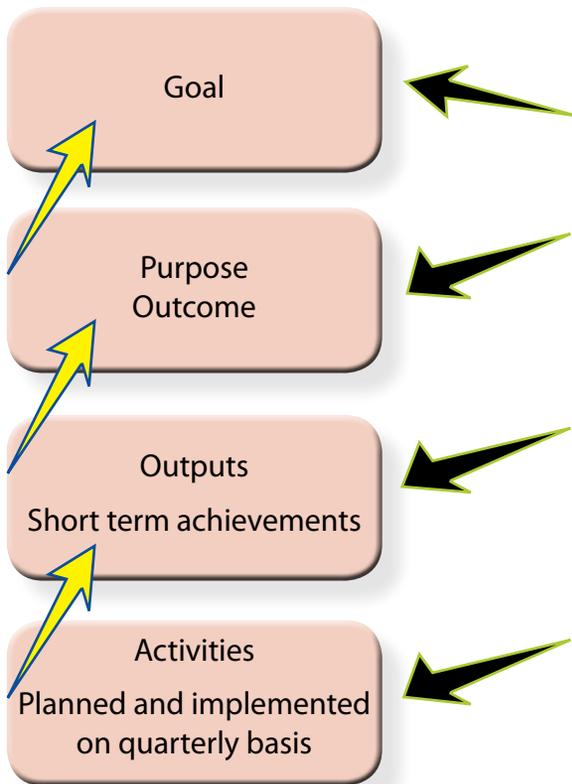


ever goes with other factors such as reward/motivation and capacity building.

Any program working with volunteers needs to establish a strong recognition system to motivate volunteers in their work. We won't recommend whether this has to be monetary or material or non-material. The principle however is that there is a need to develop a locally acceptable strategy that can keep volunteers for a long time. Whatever strategy this would be, it would need to be recognized and valued by the volunteers and the community. At the bottom line, a true volunteer is not driven by the benefits he/she accrues from his work but the satisfaction he/she gets by serving others without any conditions. As such, when you are starting a program, so many volunteers will show up with diverse interests and expectations. However, the ingenuine ones weed themselves out with time so that there remains only those with a heart to serve. The loss of volunteers should not be reason for discouragement because it might be just a sifting process to the benefit of the program.

2.6 Monitoring & Evaluation

A strong Monitoring and Evaluation framework was pivotal for the success of this program. The AHA alliance adopted a robust M&E system that met the



Evaluations

To measure performance at the purpose and goal levels evaluations at periodic intervals E.g. Baseline, mid-term evaluation, CSI survey, field visits. Activity performance (below) informed these levels.

Project Tracking System (PTS) tools (process & output monitoring)

These two levels are monitored on a quarterly basis and reported on a six month period. PTS tools (inventory, QPR, ESTF, financial report were used for data collection. Activity performance is a pre-cursor to performance at the higher levels i.e. purpose and goal. If activity performance is unsatisfactory, there may be need to reconsider evaluation plans at purpose and goal levels.

heavy data demands of PEPFAR. The Project Tracking System (PTS) was the medium used to collect, analyze, and store data on the project processes. The diagram below describes the various components of the M&E framework.

The AHA OVC Project M&E Framework

PTS tools that were used included: Quarterly Planning and Reporting Tool

Each partner used this tool to plan quarterly activities under each of the five strategic objectives. The tool was primarily used for output/process monitoring as it tracked achievement of targets and timeliness in implementation. The value of this tool was to instill a

culture of planning and discipline in implementation. Data from these reports would be aggregated to track how far the project was in attaining its targets.

OVC Inventory form

This is a basic inventory form that was used to collect baseline data for each OVC recruited into the program. It was filled during recruitment into the program. Information gathered through this process included 1) personal characteristics of each OVC (e.g. health status of parents and education level), 2) personal characteristics of household members ages 18 and under, 3) the socio-economic status of OVC caregivers, and 4) the physical condition of the OVC residence. Data from these forms

was used to assess OVC needs so that appropriate services are provided by the program. This information was a baseline against which to measure improvements in the OVC household overtime and also to correctly identify the recruited OVC. All this information was stored in an electronic database. As a best practice it is important to have all details concerning the children you are supporting. This helps you to focus your intervention to meet the OVC's actual needs. Having it computerized enables the program to run quick analyses and generate reports that are resourceful for planning, reporting or evaluation.

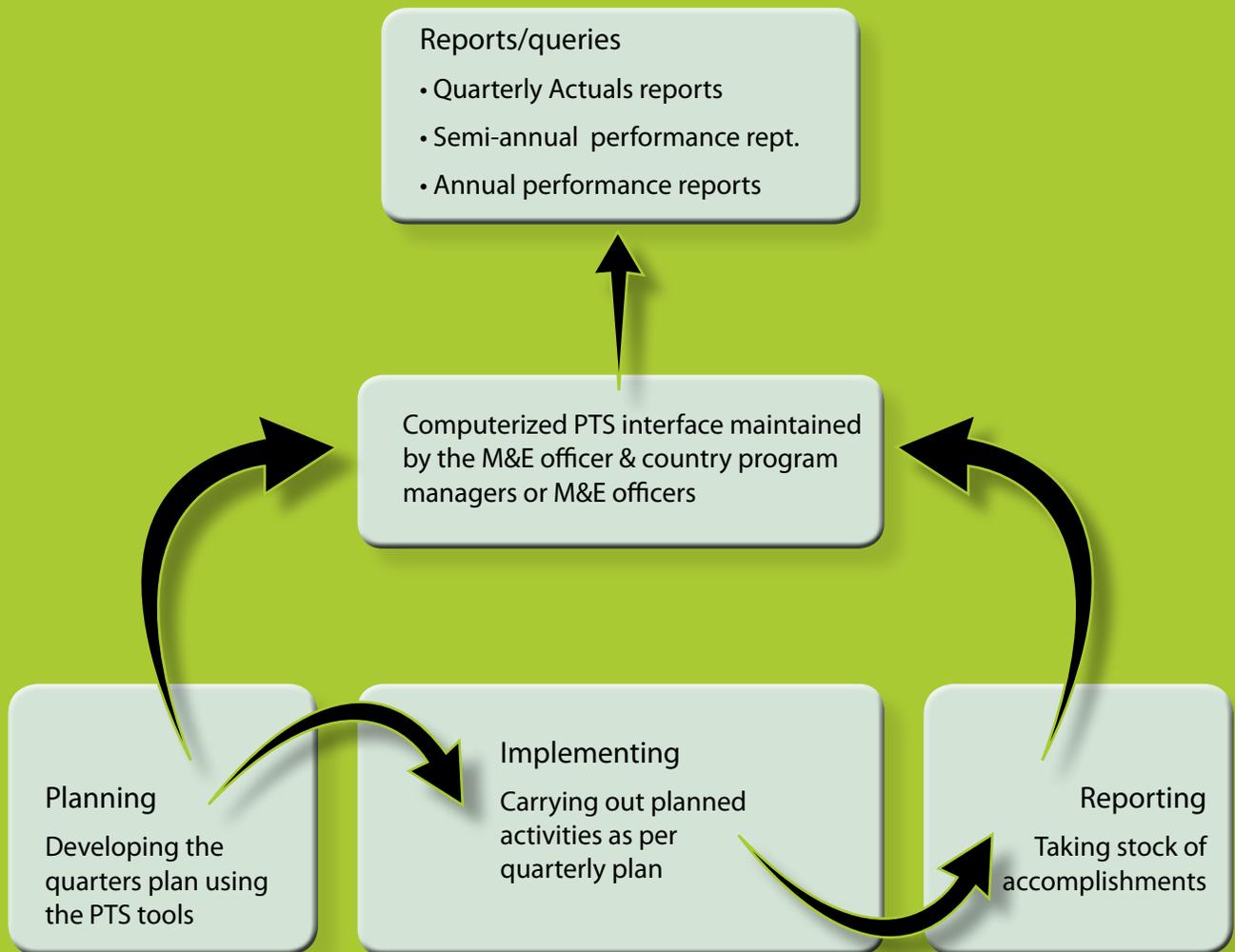
Essential Services Tracking & Summary Form

The essential service tracking form was designed to help track and document the type of services delivered by the program to the OVC. This form provided data on the number of OVC provided with each of the seven essential services. Each child recruited in the program had an essential service tracking form depicting the history of services ever delivered to him/her during the time he/she was being supported directly. In most cases the form was kept and updated by the volunteer after any type of service was provided. The volunteer would then provide a summary to the AHA agency every six months. Although having the volunteer keep & update the forms in real time is good, we had several cases of uncompleted forms largely attributable to training and poor follow up (monitoring). It's advisable that if community based forms were to be used, then a good training and follow up trainings are conducted alongside regular monitoring to en-

sure that the forms are actually filled. Another area of improvement with this tool was that it was too general and you would not be able to tell the specific type of service delivered, e.g. if a child received school fees subsidy, it only required that the date the fees are provided is indicated and a mark made under "education" to indicate that a form of education support has been given. With this you cannot differentiate with when a smaller service like a pencil is provided. So our lesson was that in a future project such a tracking tool should have the ability to indicate the specific form of support provided. This will bring the quality of service delivered to the center stage at every analysis period.

Child Status Index (CSI) Form

All the above described tools were developed by the AHA. The CSI was however developed by MEASURE Evaluation to monitor and evaluate the well being of children. Described as the first attempt to measure the quality and impact of the project's services, the AHA consortium adopted this tool and carried out two data collection sessions, within about a year's interlude. The AHA consortium was among the first agencies in PEPFAR to successfully use the CSI and provide lessons and capacity building to a number of other agencies. The value that such a tool adds to your program is the ability to evaluate the change (impact) on an individual child at different stages of the project. You can also aggregate the data to make general conclusions about the impact of your program, the current needs of the OVC and the identification of other players/providers in the child's life.



Components of the Project Tracking System

From the detailed analysis above it is apparent that the AHA M&E system was quite detailed and was able to generate all essential data for the program. The other best practice was that a lot of data collection and management was done at the community level. This practice promoted community participation in M & E. The essential services tracking, the CSI data collection and filling out of the inventory forms were all tasks performed in the field by the community volunteers. This means that the data that was eventually reported had the blessings and participation of community representatives, making it a participatory process. It is critical for any program to have the community approve of the data submitted to the donors. This enhances accountability and data ownership. The fact that they kept most of these records also gave them confidence that the AHA consortium was not reporting exaggerated data, since AHA would only report on the data provided by the field. However a key lesson learned is that community based partners need to be informed in advance that this data would be needed for archiving at the end of the project to avoid suspicion when it is asked for. This applies especially in USAID-funded projects.

3.0 Best practices in provision of essential services to OVC

3.1 Food & Nutrition support

Direct provision of food packages is not recommended except in very dire situations or in a situation where food shortage is an emergency. In a disaster, one would certainly need to save lives. The best approach is to address the issue of food security as a livelihood concern. It all sums up in economically empowering the household to be able to fend for the OVC. The approach that seemed to work best was through initiating an IGA for the household. Agriculture based IGAs were successful in all three countries. This mainly involved keeping small animals: goats, rabbits and poultry were particularly successful. The household can slaughter one of the animals and prepare a balanced diet, but much more commonly they would sell and buy food items that were absent in their daily diet. Most households usually have a problem of protein deficiency in their diet, and the presence of poultry in the home would be a constant provider of eggs. Chicken also has a ready market usually in the



neighborhood and so when a need for cash arose, the family would easily sell one or a few. Providing small animals worked best because they are cheaper — they require less capital and so you can reach many households, and provide a sustainable lifeline, holding all other factors constant.

Also related to this, we found that provision of seeds and farm implements such as fertilizers and tools was a more sustainable approach. Provision of high quality seed may guarantee good yield in subsequent sowings. Due to poverty many households lack basic tools to make work easier. Bearing in mind that some of the caregivers may be unhealthy it is recommended that you make their work as easy as possible by providing them with tools.

The other key aspect is in regard to networking and collaboration with local government agencies. We found that working closely with the local ministry of agriculture staff was key because it opened doors for more opportunities for capacity building and market research information among others. Creating a link between the households and the local agriculture ministry provides an opportunity for your work to continue even after the end of the project since the government will always be there. It also saves money to collaborate because government officials do not usually require pay but facilitation and a small token of appreciation. The government (especially in Kenya) sometimes provides similar support to poor families (e.g. farm inputs) and as such a strong collaboration will avail extra benefits to the OVC family. In summary, providing more sustainable food support (such as small ani-

mals, seeds and farm inputs rather than direct food supplies) and close networking and collaboration with the agriculture ministries promotes community ownership enables you to reach more OVC and provide hope for improved food and dietary intake over a longer time, while networking helps to introduce extra benefits to the household apart from linking the household to a more sustainable source of help in their locality.

3.2 Health

In health care what seemed to work best is linking the OVC household to a health facility in the locality, rather than providing medical services as an agency. The agency through the church or volunteers can negotiate with the health facility to provide free or subsidized health services to the OVCs. This worked in the three countries.

Apart from linking, the agency can facilitate the ministry of health personnel to undertake outreach activities. These may include mobile clinics, immunization campaigns, health education rallies, de-worming exercises and home-based care for those with AIDS among others. Most of the time the ministry of health is willing to do this but lack of finances limits their ability to do it. When you collaborate you end up opening a new wide avenue for additional services to the household. Since this government department will always be there, the expiration of your project does not result in poorer access to health services. Already a relationship with the ministry and a health seeking behavior will have been established.

The implementing agency also needs to invest in health education. Trainings on hygiene and disease prevention are critical beyond seeking medical assistance. There isn't enough investment in preven-



tion programs in the three countries and as such it is critical for agencies to complement the government in this. Additionally because the main audience of this program was children, it was a good age to instill good health seeking behaviors at a tender age. Such practices like personal hygiene and environmental hygiene are best inculcated at a young age. Given that most OVCs may not have parents/guardians who are able to mentor them, the program through its volunteers can provide this mentorship to ensure that we bring up a generation that knows how to take care of themselves and their environment. If enough investment is made in disease prevention including HIV/AIDS prevention, it will reduce the burden on health facilities and possibly improve the quality of services delivered there.

3.3 Education & vocational training

In Kenya, Zambia and Haiti, education is highly valued. Any one who does not acquire education is viewed by society as doomed to fail in life. As such education is one big area of a caregiver's concern. If

an HIV+ caregiver is about to die, one of the biggest questions that they grapple with, is “who will educate my children when I die?” Among the OVCs assisted to acquire some education, a few interviewed during the final evaluation reported that they had hope in life. This is because education is viewed as the key to a bright future. When implementing an OVC support project, educational support is a very critical consideration. Additionally education is one



of the basic rights of a child under the UN Convention on the Rights of the Child (UNCRC).

Educational support should target both in-school and out of school children. Those out of school can be assisted to acquire some non-formal education in terms of vocational training so that they can acquire skills that they can use to empower themselves. As earlier discussed, the best kind of support is fees subsidy. It's not advisable to take over the whole burden, otherwise you replace the role of the caregiver and/or community. The agency should be seen as a helper and a partner rather than a provider. The parent/guardian still has a role to educate his/her child and as such this capacity should be built. However, there was a general agreement in the three countries that the best practice in educational support is to assist the child to remain in school as long as possible (if not graduate).

Investing in a child's education only for the child to drop out of school in later years, tends to wash away your earlier investment. As such another best approach is to select a realistic number of OVC that the program can sustainably educate, rather than recruiting a very large number of OVCs where each gets a very small and insignificant support. Small is always good and so programs should adopt a small enough number that you can make a felt difference.

Networking is critical in providing educational support opportunities for OVCs because a program may not be able to support all. In Kenya for example most volunteers were able to secure educational bursary for OVC through networking. Some of these volunteers became members of the bursary disbursement committees to ensure that OVC were considered. Networking with other agencies or trusts that undertake education programs also opens up more opportunities for OVC and leverages on the program work.

Another approach used in Kenya seemed to yield good results. Bright students in secondary school were targeted for support. It was found that when investing in bright children, schools are reluctant to let the child drop out even after funds have run out. Schools find pride in having well performing students because in the national exams these students help the school to shine and improve its profile nationally. As such these students are treasured and so a modest support to the child to keep him in that school and prove his worth may be all what is required to keep that child in the school.

Another approach is to invest in those students about to graduate, rather than those with several years of secondary school left, because they believe it is the best use of their money to ensure that those close to completion actually graduate. This stresses



the point made earlier that graduation is usually the preferred option rather than just acquiring education whatever the duration spent in school.

In vocational training, it should be targeted to older OVC who did not make it to the higher levels of formal education. The type of vocational course to be taken should be as much as possible one that is marketable in their locality. For example if you provide support for a masonry course and yet that society is not known for building stone houses, it may be a waste. So it's important to match the vocational course with the available demand for that skill. After the OVC completes the course, programs may consider helping them to start up.

The cost of initial materials such as tools can be a major hindrance to the achievement of the purpose why you wanted the OVC to acquire the skill. So programs can consider providing start-up materials (not cash) or through the program networks help the graduate get employment where he/she can develop their career and make money to start

their own venture and eventually create opportunities for others.

If the latter is the option taken, then further trainings may be required such as business management, financial management, marketing and customer care among others. Agencies that provided start-up capital to formerly supported OVC or groups ensured that this nature of trainings was also provided to ensure they have the requisite knowledge on how to run a business venture.

3.4 Economic empowerment

For the AHA consortium economic empowerment was seen as both an essential service and a sustainability strategy. The ability of a caregiver to provide for the children is critical in the long run when the program can longer provide financial support. As such this program had a very robust economic strengthening component. Economic empowerment support was targeted to individual households/caregivers, groups of households/caregivers or to OVC themselves. The group approach was the most common and arguably the most effective approach because it promotes synergy and accountability. Apart from income generation, the group members provide psycho-social support to each other. It is also easier to monitor a group than individuals. In Kenya the entry point was through care groups, where caregivers were grouped and supported to start a common income generating activity. In Zambia caregivers were also grouped and supported together. World Hope in Zambia specifically called these groups Trusts. In Haiti the approach was largely a savings and loan, where micro-credit was extended to members to undertake their own business ventures.

In both Kenya and Zambia, agriculture based IGAs



were found to be more successful probably because a majority of the population are involved in farming and the fact that most project sites were in rural areas. The various forms of IGAs undertaken included small animal keeping (goats, rabbits, poultry, pigs) and crop farming (vegetables, cereals, fruits). These would either be shared among the members for home consumption or sold off and the proceeds banked for future use in supporting their children.

Some of the groups were quite successful and were able to generate large sums of money that would enable them to self-finance OVC support and care activities (see success stories section). The main limitation with agriculture based IGAs is weather changes and/or pests and diseases. In the case of rain-fed agriculture, drought would cripple the IGA completely (the alternative is to provide irrigation water). Animals can also be struck by an infectious disease that kills all or most of them.

In initiating income generating activities, the most fundamental principle is that of community ownership. Let the groups or individuals choose the best IGA for themselves. Never impose your ideas. If you let them do what they love doing, they'll put their best efforts to ensure that it succeeds. There is a place for technical advice but the beneficiaries need to make their decision based on their aspirations so that the advice you provide only propels them on their charted course.

The other important consideration is to provide the training necessary for success. Since an IGA is typically a business (though in some especially the farming based, members would share the produce), business skill-related trainings are essential. Training enables the beneficiary to plan, start, and run their own business more competently. Entrepreneurial training is a successful approach to stabilizing incomes among caregivers and older OVC.

As a program you will therefore need to budget adequate funds to also enable training and/or mentorship because most of the caregivers may not have any business experience.



A monitoring mechanism is also necessary. First groups sometimes focus on income generation too much at the expense of other functions, e.g. psychosocial support. It's crucial that groups are directed towards holistic service. Monitoring also will help the group to learn and improve processes towards effectiveness. Also important, monitoring how the generated funds are spent is perhaps the most critical. Because the main purpose of supporting the IGA is to benefit the children, it's essential that follow up is done to ensure that these funds actually benefit the OVC. It is very easy for the adults to share the income and still deprive essential services to OVC.

The program should therefore help the group to budget and hold it accountable for the way they expend the income. For example the Trusts approach used by World Hope is very effective in monitoring as well as mentoring the group gradually to self-sustenance. Initially the trust's bank account is managed by World Hope over a number of years as they build capacity. When they are satisfied that the group has matured (using a pre-determined criteria), they gradually begin to transfer control to the trust. Even after full control, the agency still undertakes monitoring of the trust's activities to ensure that they deliver on their promises. Each trust has an allocated staff to provide technical advice and facilitate this monitoring.

The micro-credit approach did not work very well because when beneficiaries learned that they would need to repay with some interest, many of them became disinterested. However, we found that trainings should come first before providing the loan. Then after the training, provide the loan immediately without much delay. This is to capitalize on the momentum created by the training. Continuous technical assistance and/or further training is necessary thereafter.

3.5 Psychosocial support

This service is quite subtle and sometimes goes without recognition. In our case psycho-social support largely took the form of spiritual support and counseling. This is attributed to the fact that most of our partners were churches or faith based organizations. Churches were providing this type of support even before the program started. Building upon that proved quite successful. During the final evaluation, the majority of the over 300 OVC interviewed in Kenya and Zambia said that they felt loved and cared for. The church/community volunteers were key in achieving this among the children, the majority of whom have lost their parents or whose parents are chronically ill.

The OVC and caregivers often had a lot of opportunities to meet and provide psychosocial support in church, at home or in school. Though the IGA groups formed were primarily for economic empowerment they provided another opportunity for caregivers to support each other psychologically. Mentorship is another successful approach. Role



models have a strong moral and social (and in our case spiritual) authority over the children. As such they are great influencers and can positively influence good behavior formation. An OVC who is a total orphan and living with a guardian or an old grandparent may develop behavior attributed to lack of parental authority or modeling. Providing a mentor helps the child to learn how to live with other people in society, as well as encourages the child to live a focused life in spite of the circumstances of orphan hood.

These are people that OVC can look up to for advice on social, spiritual and academic issues. This mentorship program works best with older OVCs (usually in the teenage years) as they discover themselves. Since some of them at that age become household heads as they take care of their younger siblings, it becomes paramount that someone provides prop-

er guidance and counseling. As such, role models should be people of impeccable character, who are available within the child's geographical location and willing to share their life experience with the OVC in a bid to influence them positively. Some churches usually have mentorship arrangements (for the youth) and so it adds value to partner with them if implementing psychosocial support activities in your program.

"The program has really helped children realize that someone is thinking about them."
- Program Volunteer, Haiti



SECTION II

STORIES OF HOPE

Collection of success stories and quotes from Project Sites in Haiti, Kenya and Zambia

Intervention and hope again for Japheth, Kenya



Japheth, age 15, was raised by his single mother (now deceased). He was then left under the care of his grandmother who also died three years later. He moved in with his aunt and uncle, but was eventually kicked out of the home once the uncle learned that Japheth was HIV+. As culture would allow, Japheth had inherited a small piece of land from his mother, but this was grabbed and sold by the uncle. World Concern's sub-partner, Food for the Hungry (FH), was contacted about the case and decided to respond through the PEPFAR-funded OVC program in the upper Eastern province Meru area. FH through its network of churches and FBOs, was able to contact one of the local church leaders and successfully secured a foster family for Japheth. Through advocacy efforts FH also worked with the local administration official (the Chief) and the Children's Department to redeem the land that had been grabbed by the uncle, and managed to link Japheth with the nearby Maua Methodist Hospital which agreed to help in paying for his school fees. Thanks to this program's advocacy and networking Japheth is now living in a supportive home environment and was able to complete his primary school education by scoring 330 points (out of 500) in the national examinations(KCPE). This earned him admission into Nijia High School. If the project had not intervened, Japheth would have probably been destitute and out of school, but now he has a hope to continue with his life and make it better by pursuing education.

Hope for a better livelihood for Arnold, Zambia

Arnold Mtonga is a vulnerable child coming from Emusa village in chief Magodi of Lundazi District, Zambia. Arnold is the sixth and the only child of his family who had reached secondary school level. After completion of his secondary education, he had nothing to do apart from just doing simple piece works. Arnold was selected by the World Concern/AHA program to do a carpentry course at Zganganikachinga Youth Resource Center. He graduated and is now a full time carpenter. After he graduated, the program introduced him to the Education Department who offered him a contract to make chalkboards and office repairs. He was also able to secure a contract from the Health Department to make beds for a clinic. Through these contracts he has been able to buy tools and open his own workshop. From the income from his workshop, he has been able to better support his family, including his younger siblings. All this thanks to a small effort to provide some vocation skills and linking by the program, Arnold is able to stand on his own.



Maline Olero: OVC advocate turned powerful community leader

Maline's involvement in the OVC project started at the onset of the project in late 2004 in Kisumu, Kenya working with one of World Concern's partners NCM at Kisumu border site on the outskirts of Kisumu city in Western Kenya. She was elected the chairperson of the OVC committee.

Over the years, she was an active volunteer, inspiring and mobilizing church and community members to respond to the needs of OVC. The project continued to build her capacity through training and exposure. In order to ensure sustainability, Maline and other committee members worked with caregivers to start a fruit-farming project, a nursery school, carpentry workshop, sewing workshop and a water project (initiatives that were strengthened by PEPFAR and World Concern sub-partner, NCM).

Maline believes that the opportunity to help children in her community actually helped to make her a happier person. Before the program she would spend the day doing household chores and then passing idle time talking, but now she does not feel idle. Instead she feels empowered to impact her community.

Maline's commitment, hard work and heart for orphans and vulnerable children was recognized by her wider community in the local ward. They found her best suitable to lead their ward at a higher level and as such they approached her to vie for a leadership position. During the 2007 Kenya general elections, the community elected Maline as their councillor. This has given her a higher pedestal to advocate for the rights of OVC as well as help OVC access support from the various government funds such as the bursary fund. She is also able to manage state-funded resources to initiate other major development projects such as road infrastructure and water projects to improve the ward, so that children have a better place to grow up in. This project not only transformed Maline into an OVC advocate but also provided her with an opportunity to develop her leadership skills.





Supported farming group scoops it all, Zambia

An Agriculture Zone field day was held in the Southern Province of Zambia--20 groups representing a variety of agencies and communities came together to compete for title of best conservation farming group. This included a community group supported by World Concern sub-partner, World Hope. This community group had been mobilized and capacity built by the program in order to respond to the needs of OVC. In 2008 they planted 5kg of maize, from which they harvested 650 kg. This was 30% more than all the other competitors, earning the community group first place in the competition and a prize of Zambia Kwacha 100,000 (approximately USD20). Perhaps USD20 seems like a small prize; but to the community group, it meant a lot. The prize was a significant source of encouragement, helping the group see their own potential for self-sustainability. In addition to maize, the group also harvested beans. Both the maize and beans are used to supplement OVC diets, while also providing caregivers with economic opportunities. All agriculture activities are strengthened with conservation farming trainings—helping families maintain steady food security throughout the year. This project had a strong focus on building community-based capacity to provide care and support for OVC.

Regina's Story, Kenya

Regina (pictured), found out she had HIV around the year 2005, after she had her 8th child. Her husband also lives with HIV. Together the couple used to travel more than 80 kms to the local mission hospital every 3 months for care and treatment. When World Concern found Regina, she was frail, thin and very ill. The program initiated psychosocial support to this family and from then regular visits and support from World Concern trained volunteers was done. The project also supported them with seeds and irrigation equipment to help them grow a variety of foods near their home so as to improve their dietary intake. They also sold the surplus and that enabled them to keep five of their children in school. The couple is open about their status and their hope for the future that this project brought in their lives. Although this couple was walking a very difficult and lonely path, the World Concern/PEPFAR program brought a new hope and phase in their lives



by instituting a community driven psychosocial and livelihood support. They are a wonderful example of how a supportive caring community can make a lot of difference.

Dulcia Dorena's personal story, Haiti

"I am Dulcia Dorena, living in the locality of Langlois. I am an educator and involved in a community group called Fanm Pa Chita. I was informed by some friends about the OVC program and I personally contacted the office. I was so interested in what I heard. The staff welcomed me and came to my locality to explain the vision of the OVC program to my group. We got very interested to be part of the initiative. We identified volunteers from the group who were then trained by the OVC program. Afterward, the group received several other trainings on important issues like income generating activities, hygiene, human rights, agri-business, HIV& AIDS and how to care for the vulnerable children in the community. After getting trained, our group is now better structured and manages a mutual solidarity fund and some parents get micro-credit from the program. Motivated by the vision of the OVC program, the group Fanm pa Chita has held an HIV & AIDS sensitization campaign in our locality and with support from different leaders and other institutions we have established a community school for OVC. The group capacity was really enhanced and we feel so happy to be more equipped to help our neighbors and the children." Another testimony of capacity and concern transferred to this group in Haiti. The World Concern sub-partner in this area was The Salvation Army (TSA).



Sonia & Soline's Dream now big, Haiti.

Sonia and Soline (pictured) were twin sisters living at an orphanage in Diquini that was supported by the OVC project. In December 2006 the OVC project supported them with tuition fees for the two girls to undertake a sewing training. Their mother was really elated at that support. At the dawn of the next fiscal year in October 2007, the OVC project staff visited the sewing school in order to evaluate the progress about all the students. Indeed, Sonia and Soline had become competent dressmakers. They could sew their own skirts and corsages. They were quite elated at their new found skill and in their own words, the "OVC project support was the greatest blessing that God could send us." Sonia and Soline also posted remarkable results in class tests. And now, their dream is BIG — to start the best sewing School in Haiti in the future. A case of hope restored!

Vocational skills for survival, Kisumu, Kenya

The inception of this project was an answered prayer for Kisumu Border Church of the Nazarene in the outskirts of Kisumu. They had had plans of starting a vocational training school to reach out to older OVC within the community but they lacked funds. They could only do a daily feeding program of providing porridge to the little children attending their nursery school. The church had a cry for the older orphans and wanted to help them become self sustaining. When the PEPFAR-funded World Concern/ NCM OVC program was started in the area, it sought to strengthen this community-based initiative and build their capacity to fulfill their dream. This was a common approach of this project- strengthening already existing community initiatives. One of the ways the project assisted was by starting the carpentry program in mid-2006 in which 6 OVC enrolled immediately for daily training. Many of these trainees indicated that carpentry was their ambition and they had been waiting for a facility like this since they dropped out of formal school. The graduates of this training were able to acquire skills to make chairs, tables and coffins among other wooden furniture. Below are some of the boys making chairs, and some nearly finished chairs.



Daniel's Hope extended up to University, Kenya

Daniel and his five siblings are orphans with their mother as their only source of support. The house they lived in before receiving support from the AHA OVC program was tiny. According to World Relief Kenya staff who first visited him during one of the annual OVC recruitment exercises, they were living in abject poverty.

Despite these very harsh conditions of living, and with the project's encouragement, Daniel completed his KCPE (Kenya Certificate of Primary Education) attaining an astounding 413 points out of the maximum 500 marks. As a result, he earned himself a rare place in one of the best national schools in the country by the name Mangu High School. Unfortunately his mother could not afford the high school fees in this school. They therefore decided to take him to a nearby school that was more affordable.

World Relief, the World Concern partner in that Vyulya area, partnered with a local church in the area in an effort to raise school fees for Daniel. The local church approached the local secondary school for Daniel's admission and the head teacher gladly welcomed Daniel to start his high school education. The local church and the headmaster managed to secure a bursary for Daniel for the next four years of his secondary education.

Through the project's mobilization, their house was also expanded and renovated, hence creating better living conditions. In 2009, Daniel called the World Relief OVC program manager to offer his heartfelt gratitude for the support that was availed to him through the partnership with the local church. He informed World Relief that he had completed his high school, passed well and that he had been admitted to study at the Kenya Polytechnic University College (a subsidiary campus of the University of Nairobi). He further stated that an individual had committed to paying half of his university fees. The OVC program gave a small contribution towards servicing the remaining fee balance.

Daniel beat the odds by excelling in his education despite the fact that he didn't make it to one of the best schools in the country, yet he still managed to make it to the university. The project did not provide much, but rather built the capacity of a lasting partner (the church) and mobilized it to support and care for those in need in their area.

This is a good example of how "small" initiatives can go a long way in producing big results. It is imperative that "external" projects deliberately work to strengthen existing community structures who can sustainably ensure that those in need in the community are served.

Fednel's support to other children-Haiti

Fednel lives in Montagne Noire, just outside of Port-au-Prince, the capital of Haiti. He is a great example of how investing in one child can impact the lives of others. Fednel is one of the older OVC who received support to attend vocational training. He was trained in tailoring/sewing and is now able to make an income—impacting a variety of other sectors such as health, food security and the like. What makes Fednel's story unique is that he has also been able to use his new skill to help other children. How? Fednel makes uniforms for other children—relieving some of the burden on caregivers while removing a major barrier to education for other children in his community affected by the pandemic.



Agnes's keeps hope alive, Kenya

Agnes Odero is an old grandmother caregiver living in the outskirts of Kisumu town in a small village called Holo. She narrates her story on how she had taken care of 15 orphans whose parents had passed away due to HIV and AIDS related diseases. She said life had not been easy for her before the World Concern/NCM OVC program came to their area. "I had to struggle so hard to make sure that these orphans become responsible citizens of Kenya and more so we used to eat only one meal a day – that is at night." Today she is proud that most of them have completed high school because of support by the project. The project also ensured that she was part of an income generating activity (fish for resale, maize and beans for resale, and sale of second hand clothes) — started by the care group and empowered by NCM. The purpose of this was to ensure that Agnes can have her own source of income to continue providing hope to these children under her care. They will remember her in the future. "We are also able to take three meals a day regularly without struggling like it was before," said Agnes recently. Agnes is an icon of a selfless spirit ready to keep hope alive by providing a future for the children. It is people like Agnes that this project sought to encourage and support.

Emma's Journey of valleys and mountains-Copperbelt, Zambia

Emma Bwalya was born on September 21, 1993, in Kapoto in the Copperbelt Province. She is 16 years old and the fourth born in the family of seven. Emma's father died when she was quite young. Her mother sold vegetables at the Ipusukilo market. Her meager income could not support the whole family adequately, let alone educate the children. Some years later her mother got married, but her step-father did not love the step-children. Because of this, Emma's mother neglected her and her other siblings. Rebecca, the elder sister, had no option but to find a one-room house for rent in Kapoto to care for her siblings. Emma and her sister never experienced the love, care and protection of parents like other children do. Life for Rebecca was not easy. She had to support them on her own, and was forced into early marriage in 2003. Emma and her elder sister found comfort in this, even though the brother-in-law was not formally employed.

One day the pastor of a church Emma used to attend learned of Emma's troubles. He took action and enrolled her into Ipusukilo Community School and supported her for two years. He later stopped because he could no longer afford to support her. It was around that time that Emma's case was highlighted to the AHA/CRWRC Zambia OVC project. She was recruited into the program in December, 2007. In 2008 the project took over by paying her school fees and provided for her school requirements — uniforms and supplies. Emma sat for her grade seven examinations in 2008 and she was successfully selected to Ipusukilo Basic School where she is in grade eight. Emma is now happy to be in school. She dreams of becoming an accountant some day.

Small investments; major impact: The case of Cheronno, Kenya

Tuiyoluk is a small village in Koitoro, Uasin Gishu District, in Kenya where Cheronno, a 72-year-old caregiver, lives with his six grandchildren. Cheronno lost his son in 2006 after a long illness. The son had been treated for opportunistic infections associated with HIV and AIDS, and had been started on ART. Unfortunately, complications due to problems with adherence resulted in his eventual passing. During that same year the mother of the children also fell ill and passed away.

The OVC support program in the community identified the family, enrolled them in the program and began to provide regular home visits. After a few visits, the volunteers began to discuss the needs of the family. One obvious need was shelter. The family was living in a one-room grass thatched hut. And there was only a single bed for all of the children. Community volunteers trained by CRWRC, World Concern's partner in the area, decided to put to use some of the knowledge and tools they had received through training on OVC care and support. As a result, they were able to mobilize resources from within the community including labor, nails, posts and timber. Volunteers then approached CRWRC for a donation of iron sheets because they are more expensive. Combined, the volunteers had what they needed to provide the family with a new home.

The success they achieved by supporting Cheronno encouraged them to continue to mobilize resources, including food donations for Cheronno and other needy households. Beyond meeting physical needs, the activities of the volunteers have also served to reconnect OVC households with their communities—helping them feel loved, cared for and accepted by their own people. This was a great programmatic success for World Concern, because it shows how small investments, brought about by effective partnerships can lead to major impacts at the community, household and individual level.

Quotes of transformation and Hope: Zambia

"This project has touched the lives of both children and adults in our community. Not a single life is still the same. There's a sense of love and unity that has never existed before in our community. We have been touched both spiritually and physically." (Kalonda)

"Before the Trust I could not provide for my family. It was discouraging. I felt like a failure as a parent and it squeezed my heart. Now I can provide and my heart is lighter! I live like a normal woman now." (Muntuwabulongo)

"Today I know that there lies a bright future ahead of me because the project has helped me continue with my education. I started receiving this support 2 years ago and my prayer is that this support will continue until I complete my secondary education in 3 year's time." (Nakowa)

"We have been lifted both in spirit and in flesh as a community. It is so encouraging". (Chingobe)

"My time to die has come but I'm not worried because my children will have an opportunity to acquire skills to sustain them through this initiative. I'm so glad on their behalf." (Kachomba)

"We thank the project for supporting us (our community). We have acquired skills through this program and the many orphans in this area have been relieved of their burdens. Today one can see a smile on their faces." (Gwembe)

Quotes of transformation and hope: Kenya

"Before I used to do casual jobs for people in the village, I would earn very little money each day, and sometimes none at all. With the small shop that you assisted me to start, I now earn at least one hundred to two hundred shillings a day." A child household head

"Now that you have visited me and my children in our problems, I feel like some sweet oil has been poured down my chest." An elderly caregiver (grandfather)

"We actually did not have any hope for a meal but I now thank God for He has really heard our prayer." A caregiver

"We have been trained by many organizations but your trainings are very unique! They are clear and to the point, showing us clearly how we too can offer help to the OVC even though we have our own needs." A volunteer

"Sincerely, our churches have never had programs for assisting OVC but we have realized that we were going wrong. As God commands us in James 1:27, we should actually be the first ones to advocate for OVC support by the church!" A church leader

"I really thank God for the OVC program because I never used to have something to do in the afternoons but now I take that time to visit OVC in their homes to find out how they are doing...the lives of OVC have improved a great deal because of the program." Peterlis, a volunteer in Siaya

"Since the OVC program came in this area, we are being visited at least once a week by volunteers. Some of them bring us food and even counsel us. This is something that never used to happen before the OVC program came to this area." Millicent, an OVC in Homabay

"This program has rekindled our African spirit of collective care for our children." A Community leader in Uringu

"We are now the same!" 11 year old boy in Meru Central who jumped and shouted the above statement after getting a new school uniform

"Our village had been sidelined for a long time. The government and many NGOs believe that there is no poverty in central division since it is located in town but the OVC program thorough Food for the Hungry is the only one that has responded to our cry." Habiba Mohammed, Tupendane CBO – Isiolo town

"I felt odd in school to study without a school uniform. I thought my tattered home clothes were a mark to prove to my fellow schoolmates that I was a total orphan. Thanks to the OVC project I have a school uniform and now I resemble other children in school." – Aldo Ngimoe – OVC from a community in Isiolo

"My grandchild has never been immunized and I had not seen any importance of it, but I will start it immediately, in fact tomorrow." A training participant after a training on child illnesses and diseases

"You have covered my shame!" A caregiver whose house was rehabilitated

"I won't disappoint you. I will set a good example to other orphaned girls who have gotten pregnant and given up and are confused on how to pick up again in life without being over dependent on people who take advantage of you because your parents are not there." An orphan who had dropped out of school and got pregnant. The project subsidized her vocational training fees.

World Concern is a Christian humanitarian organization that provides disaster relief and sustainable development solutions for more than 6 million people in 22 of the poorest countries in Africa, Asia and the Americas. At World Concern, our goal is to provide life, opportunity and hope to all we serve, regardless of race, religion or gender. We work in a variety of places, but we excel at providing relief and development services in under-served areas. In all cases, we seek out the poorest and most vulnerable.



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