Yekokeb Berhan Program for Highly Vulnerable Children In Ethiopia
Mid-Term Evaluation Report

June 2014

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ACRONYMS

ABH	Alliance for Better Health
AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Therapy
BD	Business Development
BoLSA	Bureau of Labor and Social Affairs
BoWCYA	Bureau of Women, Children & Youth Affairs
CBO	Community Based Organization
CC	Community Committee
CCC	Community Care Coalition
CG	Caregivers
CSG	Community Support Group
CSI	Child Support Index
CSO	Civil Society Organization
CSSG	Community Saving and Self-help Group
CV	Community Volunteers
DHS	Demographic and Health Survey
ECD	Early Childhood Development
ES	Economic Strengthening
FGD	Focus Group Discussion
FHI360	Family Health International 360
GPS	Global Positioning System
HAPCO	HIV/AIDS Prevention and Control Office
HEW	Health Extension Worker
HES	Household Economic Strengthening
HIV	Human Immunodeficiency Virus
HVC	Highly Vulnerable Children
INGO	International Non-Governmental Organization
IR	Intermediate Result
IP	Implementing Partner
KII	Key Informant Interview
ME	Microenterprise
ME/MERL	Monitoring and Evaluation/Monitoring, Evaluation, Reporting & Learning
MoU	Memorandum of Understanding
MoWCYA	Ministry of Women, Children & Youth Affairs
MUAC	Mid-Upper Arm Circumference
NGO	Non-Governmental Organization
OCA	Organization Capacity Assessment
OVC	Orphans and Vulnerable Children

PC3	Positive Change: Children, Communities, and Care Program
PEPFAR	President's Emergency Plan for AIDS Relief
PSNP	Productive Safety Net Program
PTA	Parent/Teacher Associations
RH	Reproductive Health
SCI	Saving, Credit and Investment
SNNPR	Southern Nations, Nationalities and People's Region
SPM	Selection, Planning and Management
SPSS	Statistical Package for the Social Sciences
SSDG	Standard Service Delivery Guidelines
TOCA	Technical and Organizational Capacity Assessment
TVET	Technical and Vocational Education Training
UNAIDS	Joint United Nations Program on HIV/AIDS
USAID	United States Agency for International Development
WFP	World Food Program

DEFINITIONS OF TERMINOLOGIES

Birth certificate	An official record of the name, date and place of birth of a child issued by authorized government offices in Ethiopia. For the purpose of this evaluation, birth certificates issued by churches, mosques and other religious institutions were not considered.
Fully vaccinated	Children were categorized as fully vaccinated if the caregiver reported that the child had received all of the age-appropriate vaccinations through the routine vaccination schedule in Ethiopia. For the purpose of this evaluation, this was confirmed by data collectors' observation of the child's vaccination card.
HVC	A highly vulnerable child (HVC) is a child who is less than 18 years of age and whose survival, care, protection and/or development might have been jeopardized due to a particular condition. The child is currently in a situation that precludes the fulfillment of his or her rights and is enrolled in to Yekokeb Berhan program for support. The definition adheres to the guideline of Pact/Yekokeb Berhan and the Ethiopia's Standard Service Delivery Guidelines for Orphans and Vulnerable Children Care and Support Programs.
HVC household	An HVC household is a household with at least one HVC and at least one of these children enrolled in to Yekokeb Berhan program for support.
Moderate acute malnutrition	Children under five years of age were categorized as having moderate acute malnutrition when their mid upper arm circumference measurement was between 11 to 12 cm.
Severe acute malnutrition	Children under five years of age were categorized as having severe acute malnutrition when their mid upper arm circumference measurement was less than 11cm.

EXECUTIVE SUMMARY

BACKGROUND

Since mid-2011, Pact has been implementing a USAID-funded program for Highly Vulnerable Children (HVC) called Yekokeb Berhan. This five-year program is designed to reduce vulnerability among HVC and their families by strengthening supportive systems and structures to deliver quality essential services and increase resiliency.

The program has four primary objectives: 1) build the capacity of stakeholders to effectively use improved data management systems and employ a national HVC supervision system; 2) employ effective and efficient family-centered, age-appropriate and inclusive HVC care management system; 3) enhance the capability of communities for coordinated and improved responsiveness towards HVC care; and 4) establish effective and efficient monitoring, evaluation, reporting and learning systems ensuring evidence- based programming and policy formulation.

In order to achieve these objectives, Pact has been working in partnership with Family Health International 360 (FHI360), Child Fund, 39 local civil society organizations (CSOs) and public sector organizations at the federal level: Ministry of Women, Children and Youth Affairs (MoWCYA), HIV prevention and Control Office (HAPCO) in nine regional states and two City Administrations of Addis Ababa and Dire Dawa where the program has been implemented. The program has been implemented in Tigray, Afar, Amhara, Oromia, Somali, Benishangul Gumuz, Southern Nations Nationalities and Peoples' Region (SNNPR), Gambella and Harari regions and Addis Ababa and Dire Dawa cities. Yekokeb Berhan Program is targeted to reach 500,000 HVC and their caregivers annually in urban and peri-urban areas with relatively high HIV prevalence. Yekokeb Berhan Program has five regional cluster offices in Addis Ababa, Bahir Dar, Jimma, Hawassa and Adama towns and is currently working with 39 Implementing Partners (IPs), with ten operating in more than one region.

In 2013, Alliance for Better Health (ABH) Services was commissioned by Pact to undertake the midterm evaluation of Yekokeb Berhan Program to document progress against various outcome level indicators as well as changes in the lives of beneficiaries.

METHODS

A combination of quantitative and qualitative methods was employed to collect data to determine the program's achievements and to identify benchmarks that were not addressed in the baseline survey. Quantitative data were collected through a cross sectional survey of HVC households. In the qualitative assessment, focus group discussions and key informant interviews were conducted with beneficiaries, community volunteers, implementing partners (IPs), community committees and government office staff. Secondary data including the baseline survey, routine reports, supervision reports and other relevant program documents were also reviewed to complement the primary data in order to address the four midterm evaluation objectives.

The evaluation was conducted in four major target regions where the majority of beneficiaries of Yekokeb Berhan Program are found: Amhara, Oromia, SNNPR, Tigray and the Addis Ababa City Administration. Using Epi Info (Center for Disease Control, Atlanta, USA) statistical software and multi-stage sampling, sample size was determined to be 2,142 households for the household survey. This was allocated to the five regions proportional to the number of beneficiary children. Zones, woredas, *kebeles* and households were selected randomly. One HVC enrolled in Yekokeb Berhan Program or their primary caregiver was interviewed from each of the selected households using survey questionnaires. When there were more than one children in the household, one was randomly selected. If the child was younger than 14 years of age, the caregiver was interviewed on behalf of the child. Children 14 years or older responded to the questions by themselves.

Focus group discussions (FGDs) were conducted with caregivers, community committees (CCs), community volunteers (CVs) and saving groups in selected program sites, and a total of twenty sessions of FGDs were completed. Key informant interviews (KIIs) were conducted with thirty-four individuals representing: implementing partners; MoWCYA officers at federal, regional and woreda levels; international non-governmental organization (INGO) partners (Pact, FHI 360 and Child Fund); and Yekokeb Berhan Program regional cluster managers.

Quantitative data were entered into SPSS (IBM Corp, New York, USA) computer software, cleaned and analyzed – frequencies were run, and cross tabulations, graphs and charts were produced. Chi-square tests were done on certain variables to test differences as appropriate. Qualitative data were transcribed and compiled under pre-defined thematic areas. Data from all sources were synchronized before producing the final report.

KEY RESULTS

Program Objective 1: build the capacity of stakeholders to effectively use improved data management systems and employ a national HVC supervision system

Building capacity of the different stakeholders involved in the implementation of the program was a primary expectation of Yekokeb Berhan Program. With this regard, it was found that the program conducted capacity assessment of implementing partners (IPs), government offices and the community using different approaches. Gaps and needs were identified for all levels. Different capacity building training materials were developed for each stakeholder and a series of trainings provided to IPs, government partners and community structures were hold using the corresponding training materials. In developing capacity of the different stakeholders, Pact, Child Fund and FHI 360 worked in close partnership but with distinct responsibilities.

Evidence from different sources at all levels revealed that implementing CSOs received different types of capacity building through training, supportive supervision, coaching and mentoring. Such capacity building endeavors were found to enable IPs and community structures to identify HVC

using standard formats, to mobilize support from stakeholders at different levels and to continuously monitor and record accomplishments.

Despite actions being taken to build the capacity of stakeholders, data from the field identified specific capacity gaps at different levels. The major capacity gaps identified at government level consist of: continuing staff turnover and consequent limitation of awareness about the project; poor partnership with CSOs; a lack of standard alternative care; and poor logistics to undertake monitoring and supportive supervision.

Program Objective 2: employ effective and efficient family-centered, age-appropriate and inclusive HVC care management system

Most of the indicators related to health and healthcare services clearly indicate a positive effect of Yekokeb Berhan package of interventions in improving the health status of the HVC as well as their families. Reported episodes of HVC illness in the previous two weeks decreased from 30% in baseline to 16.8% and the change was significant ($p<0.05$). Similarly, HVC who reported having diarrhea in the two weeks preceding the evaluation fell to 6.1% at the midterm evaluation from 10.8% at baseline ($p<0.05$). Health-seeking behavior of HVC has improved since the initiation of the program with 63.9% of those who had fever seeking treatment at the midterm compared to 48.4% at the baseline ($p<0.01$). Similarly, those who sought treatment for diarrhea also increased from 49.7% to 86.2% ($p<0.01$).

Coverage of age-appropriate vaccination for under-five HVC, as confirmed from immunization card, was 57.6% at the midterm compared to 33.9% at the baseline ($p<0.05$). HVC vaccination coverage found in midterm was also higher than the national urban coverage of 48.1%. In the midterm, 272 (60.3%) adolescent HVC aged 14-17 reported having access to reproductive health (RH) information. Based on self-report, 988 (46.6%) HVC were tested for HIV over the twelve months preceding the evaluation, and there was no difference between boys and girls. In the baseline survey, however, it was found that only 38.7% of the HVC were ever tested for HIV.

When school enrollment was assessed for HVC aged 3 years and above, 21,754 (85.7%) were reported to be attending school or pre-school during the evaluation compared to 71.1% of HVC at the baseline ($p<0.05$). The finding that 92% of HVC aged 14 years and above were in school was especially promising. Of those HVC who were in school during the evaluation, 264 (15.1%) benefited from formal tutorial activities organized by Yekokeb Berhan Program. Significantly more girls (16.9%) than boys (13.1%) received tutorial services from the program ($p<0.05$). Overall, 94.7% of in-school HVC reported regular attendance compared to 89.3% in the baseline ($p<0.05$). There was no difference between boys and girls in regular school attendance. When school performance of HVC was assessed, 1049 (85.8%) were promoted to the next grade in the previous academic year, and there was no difference between boys and girls.

In 771 (36.1%) households, at least one adult family member has received nutrition related training, counseling or advice in the past year through the support of the program. A child was prescribed

food by health/nutrition workers over the past one year in 166 (7.8%) households, and 129 (77.7%) of them received the prescribed food while the rest did not get it. Nutritional assessment of 695 children aged less than five years using mid-upper arm circumference (MUAC) testing found that 21 (3.0%) of them had moderate acute malnutrition while 8 (1.2%) had severe acute malnutrition. No significant differences were found between boys (4.3%) and girls (3.7%) in the rate of acute malnutrition in the midterm evaluation.

When the housing conditions of the HVC households were assessed, it was reported that in 910 (42.6%) houses, water leaked into the part of the house where the children slept when it rained, but this was significantly lower than found in the baseline (52.5%: $p<0.05$). Similarly, the proportion of houses where wind blew into the part of the house where children slept decreased from 50% at the baseline to 879 (41.1%) at the midterm ($p<0.05$).

Focusing on economic strengthening (ES) activities of Yekokeb Berhan Program, 819 (38.3%) households were engaged in ES activities including involvement in: trainings, provision of market information; technical support through ES animators/facilitators; and/or provision of matching funds. Of ES targeted households, 493 (60%) received training in community saving and self-help groups (CSSGs) through Yekokeb Berhan Program. CSSG training is an entry point for Yekokeb Berhan ES activities and all those enrolled to ES received this training. The discrepancy between number enrolled and trained is perhaps due to similar activities like organizing microenterprises (MEs) and saving groups being undertaken in other programs and study participants may not have differentiated between these and Yekokeb Berhan Program's ES supports.

One-quarter of those households engaged in ES were involved in small scale business or MEs. Of these, 49% reported that they were able to expand or diversify their business over the past one year. Out of ES households engaged in small scale business or MEs, 58% were able to save some money from their business. It was found that 106 (12.9%) of the ES households acquired additional productive assets over the past two years including working capital, cattle, sheep, goat and farm land.

Caregivers involved in saving groups reiterated that ES support has positively changed their lives as well as that of their children. However, there was some dissatisfaction from volunteers, saving groups and CCs in all study settings such as suggestions that the matching funds were often too small and was not available in time.

Legal protection is an integral component of the TB Program. Of all the caregivers involved in the evaluation, 147 (6.9%) reported that their household had experienced some form of violence in the past one year. Out of the households that experienced violence, 92 (62.6%) went to police to get legal services while 45 (30.6%) did nothing. The majority (53%) of households who were referred or linked to legal services for various reasons over the past year were by Yekokeb Berhan Program through IP staff, CCs or CVs. More than half (51.7%) of the households said that they feel more secure in terms of legal protection this time than before they were involved in Yekokeb Berhan

Program. Assisting HVC to get birth registration is one of the key components of legal protection services the program has been providing to the beneficiaries. However, only 185 (8.7%) of the HVC were found to have birth certificate from an authorized government office as confirmed by the surveyors, though it was significantly better than the baseline when only 5.5% of HVC had birth certificate ($p<0.05$).

Program Objective 3: enhance the capability of communities for coordinated and improved responsiveness towards HVC care

The program has been able to effectively identify and work with community structures and local resources. Capacity of the community to care for HVC was developed through various trainings and material supports including stationaries and office furniture. Strong links between community structures and different government offices, specifically with the Bureau of Women, Children and Youth Affairs (BoWCYA), were established. This linkage seems to help the program to ensure that its interventions are supported by government structures. Yekokeb Berhan Program has strengthened the BoWCYA offices at all levels to enable these offices to coordinate care for HVC and their families

Coordination of care has improved over time through established mechanisms and standards to engage government bodies, CSOs, communities and the private sector. In order to coordinate and harmonize care and support to HVC and their families, implementing NGOs were encouraged to sign memoranda of understanding (MoU) with different stakeholders, particularly with health facilities, microfinance actors and education institutions. This situation has improved service provision to HVC through referral linkages. In support of this argument, it was found that some CCs have mobilized support from local government and private institutions and community members including *iddirs* (culturally-based burial associations), religious organizations and individual community members to improve care and support for HVC and their families.

In as much as coordination of care is critical component of the program, there were gaps that were identified by the different categories of participants. At the community level, there were some challenges coordinating the different structures (CVs, CCs and community care coalitions (CCCs)) as designed in the program.

Program Objective 4: establish effective and efficient monitoring, evaluation, reporting and learning systems ensuring evidence- based programming and policy formulation

It was found that Yekokeb Berhan Program has established a well-defined method of collecting, managing and reporting about HVC situations and services. Standard tools were developed to collect, compile, analyze, report and use routinely collected data. Mechanisms were developed to collect data on HVC and their families at the household level. CVs make door-to-door visits to HVC and their families to record the state of service provision on a weekly basis using formats developed for this purpose. CVs submit a report to the CC every month who, in turn, verifies and

share it with a community facilitator. Data generated by CVs at the household level pass through successive verification and approval steps.

Another important activity that the program has undertaken in order to achieve objective 4 was strengthening regular meetings to review program activities at all levels. It was found that IPs conducted monthly and quarterly meetings with government partners including: health offices, the MoWCYA, education sector actors and HAPCO offices. Review meetings were also held at community level with CC/CCC members and volunteers to discuss achievements, identify gaps and work on improvement. A key informant described this as: *'we conduct regular meetings with CC/CCC and CVs in all kebeles and discuss progress and challenges. This has helped us a lot to solve problems that may affect our program at the implementation level.'* (KII, IP staff, Hawassa).

Secondary data review also revealed that the IPs carry out periodic review meeting with partners and discuss issues that affect implementation of the program like high turnover of CVs. From review of program reports it was found that Yekokeb Berhan Program also conducted regional quarterly review meetings in all the five clusters where Yekokeb Berhan and IP staffs and regional government representatives (BoWCYA, Bureau of Labor and Social Affairs (BoLSA) and HAPCO) were involved. The meetings were intended to review the program progress, facilitate experience sharing focusing on coordination of care and ES among the IPs, review strengthening and ways to address improvement areas and discuss program priorities for subsequent time.

RECOMMENDATIONS

- The proportion of HVC who had a Human Immunodeficiency Virus (HIV) test over the previous year has shown improvement over the baseline data. However, less than half of the HVC were tested and knew their HIV status. HIV testing and counseling is an entry point to the continuum of care and is an important component of HIV services. It is even more important for HVC as this group has elevated HIV risk because of their vulnerability. Considering this fact, more focus on increasing HIV counseling and testing coverage for HVC in the program support areas is needed.

- More tutorial services are called for to improve school performance of HVC. Despite such needs and the evident contribution to improved school performance, only a small proportion of HVC got tutorial support. This service may be more sustainable if bureaus of education are engaged to sustain and scale up tutorial support to HVC at national level. Negotiations with local universities and colleges to engage college students for community services would help to scale up the service.

- Parenting skills are essential for caregivers to enable them to provide quality care for their children. There were efforts by the program to provide caregivers with this skill through parenting trainings. However, only 52% of the caregivers reported attending better parenting skills trainings provided by the program. In order to achieve sustainable impact of the program

by improving care for HVC, coverage of better parenting training for caregivers should be increased.

- Birth registration and acquisition of a birth certificate is one of the important components of legal service to HVC, and Yekokeb Berhan Program has been supporting this service. However, only 8.7% of the HVC had a birth certificate issued from authorized government office. This proportion is very small and more efforts should be exerted to increase the coverage of birth certificate for HVC in the program areas.

- Members of CVs and CCs desire capacity building trainings and/or refresher trainings that would sustain their engagement. It is recommended to either develop mechanisms to motivate them and keep their active support or develop a strategy where members of such structures graduate within one year to reduce turnover and recruit other members, train and engage them to sustain necessary numbers. Similarly, continuous auditing of capacity gaps by CSOs and government partners and designing cost effective on going capacity building intervention are important considerations.

- Coordination of care in Yekokeb Berhan Program is an important component that helps to address more HVC in need and help stakeholders to work together for common goal. Yet, there is lack of clarity on how to ensure accountability of the parties involved. This calls for development of strategy to ensure accountability and determine who follows up such partnerships.

1. BACKGROUND

1.1 BACKGROUND OF PACT'S YEKOKEB BERHAN PROGRAM

Pact has been implementing Yekokeb Berhan Program for Highly Vulnerable Children (HVC) since April 2011. *Yekokeb Berhan*, meaning 'illuminating light from a star,' is representative of the resiliency and potential of each and every child.

The five-year program, funded by the United States Agency for International Development (USAID) and the President's Emergency Plan for AIDS Relief (PEPFAR), is designed to reduce vulnerability among HVC and their families by strengthening systems and structures to deliver quality essential services and to increase resiliency. In order to meet such a broad goal, Pact works in partnership with Family Health International 360 (FHI360) and Child Fund; 39 local civil society organizations (CSOs); and public sector institutions at the federal level including: the Ethiopian Ministry of Women, Children and Youth Affairs (MoWCYA) and HIV prevention and Control Office (HAPCO) in nine regional states (Tigray, Afar, Amhara, Oromia, Somali, Benishangul Gumuz, Southern Nations, Nationalities and People's Region (SNNPR), Gambella and Harari) and the two City Administrations of Addis Ababa and Dire Dawa. The program targets 500,000 HVC in urban and peri-urban areas with relatively high human immunodeficiency virus (HIV) prevalence. The long-term vision of Yekokeb Berhan Program is to have a child-focused social welfare framework developed in Ethiopia that allows all children, including HVC to thrive.

The primary objectives are to: 1) build the capacity of stakeholders to effectively use improved data management systems and employ a national HVC supervision system; 2) employ effective and efficient family-centered, age-appropriate and inclusive HVC care management system; 3) enhance the capability of communities for coordinated and improved responsiveness towards HVC care; and 4) establish effective and efficient monitoring, evaluation, reporting and learning systems ensuring evidence-based programming and policy formulation.

In order to facilitate smooth implementation of the program, Yekokeb Berhan initiative has five regional cluster offices, including Addis Ababa (located at the head office in Addis Ababa), Amhara (Bahir Dar), West Oromia (Jimma), SNNPR (Hawassa) and East Oromia (Adama). The program has established and organized the cluster offices to facilitate close monitoring of activities done by its implementing partners (IPs) and provide them with hands-on technical support.

Currently, the program has 39 IPs, with 10 operating in more than one region. FHI360 and Child Fund are international partners that are working with Pact and offer technical assistance on key technical programming issues, including design of guidelines and training materials and provision of follow-up technical support to other teams and IPs. At the grass-roots level, Yekokeb Berhan staff assist IPs and local governments in supervision, training and support for over 20,000 local community volunteers (CVs) who go home-to-home to share their skills and knowledge with

beneficiary families, promote referrals, provide follow-up and develop one-on-one relationships with targeted children for supplementary care, encouragement and emotional support.

Alliance for Better Health (ABH) Services was commissioned by Pact to undertake the midterm evaluation of Yekokeb Berhan Program to document progress for various outcome level indicators as well as changes in the lives of beneficiaries. This report presents findings from the midterm evaluation and provides conclusions and recommendations based on the findings.

1.2 LITERATURE REVIEW

1.2.1 Global HVC Situation

PEPFAR defines a vulnerable child as one who is living in circumstances with high risks and whose prospects for continued growth and development are seriously threatened.[1] Similarly, the Joint United Nations Program on HIV/AIDS (UNAIDS) defines vulnerable children as children whose survival, well-being or development is threatened by HIV/ Acquired Immunodeficiency Syndrome (AIDS).[2] However, other factors, apart from HIV/AIDS may influence vulnerability. These factors need to be considered to better define the context related to children and vulnerability. These factors include: poverty, access to shelter, education, health facilities or other basic services, stigma due to HIV/AIDS and political and socio-economic crisis. Skinner et al.[3] have identified a list of variables to measure vulnerability in children including: death or desertion of parents; severe chronic illness of parents: HIV/AIDS or others; illness of a child; physical or mental disability of a child; poverty; access to basic needs such as education, health, social services, etc.; inadequate clothing; emotional problems; abuse of the child; and drug abuse by caregivers or the child.

HVC constitute the most vulnerable members of any society since they lack basic needs such as food, health care, shelter and education and are stigmatized, exposing them to further abuse and exploitation. In as much as vulnerable children suffer consequences, community and family members are also stressed as they try to care for these children. As most vulnerable children and their families struggle to meet their basic needs in developing countries, they must also deal with the effects of isolation, marginalization, trauma and grief. In child-headed households, lacking adults to talk to them, teach them important life skills and offer a source of protection, many orphans and vulnerable children report feelings of loneliness and isolation.[4] There is also long-term economic stagnation or decline as children grow into unskilled workers, become vulnerable to HIV infection through increased morbidity and malnutrition and face greater risk of exploitation and abuse.

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[1]Orphans and Other Vulnerable Children Programming Guidance for United States Government In-Country Staff and Implementing Partners, The President's Emergency Plan for AIDS Relief Office of the U.S. Global AIDS Coordinator, July 2006.
[2]Children on the Brink 2004, *A Joint Report of New Orphan Estimates and a Framework for Action,* UNAIDS,UNICEF and USAID, July 2004.
[3]Skinner, D. et.al, *Social Aspects of HIV / AIDS and Health Research Program, Cape Town, 2004.*
[4]CARE. *A Model for Community-Based Care for Orphans and Vulnerable Children: Lessons learnt*, 2005.

Globally, an estimated 153 million children worldwide have lost either one parent (single orphan) or both parents (double orphan). Of these, 56.1 million (37%) live in sub-Saharan Africa and 16.6 million (11%) have lost their parent(s) due to AIDS.[5] Despite the rapidly growing burden of orphans and vulnerable children (OVC) in sub-Saharan Africa due to the spread of the HIV/AIDS epidemic, many countries in the region do not have effective programs to support OVC and caregivers.[6] This problem is partly attributable to a lack of data on the prevalence and the situation of OVC in most countries in the region.

1.2.2 HVC/OVC Situation in Ethiopia

In Ethiopia, there were an estimated 4.2 million orphans in 2013, accounting for approximately 12% of the total child population.[7] Of these, 792,840 (19%) were orphaned due to HIV/AIDS. The 2011 Ethiopian Demographic and Health Survey (DHS) estimates that 25.6% of all households are caring for a foster[8] and/or an orphan child under 18 years of age.[9] All OVC are at increased risk for neglect, abuse, malnutrition, poverty, illness and discrimination and as they get older, are at increased risk for HIV infection. Overall, girls suffer more than boys by not being able to attend school, having to care for others and being forced into early marriage.

Meeting HVC's immediate needs is vital not only to their current well-being but also to their future. Basic needs include food/nutrition, shelter and care, legal protection, health care, psychosocial support and education. Illness in the family or the loss of a parent or parents is extremely disruptive for children, and often seriously disadvantages their chances for obtaining basic living needs as well as for securing a place in school or future employment. Financial and material resources are often required to meet many of these needs and this makes economic strengthening of vulnerable children an essential component of targeting services to this group. PEPFAR has identified priority interventions that address the needs of children through OVC programs. These interventions consist of components including education, psychosocial care and support, household economic strengthening (HES), social protection, health and nutrition, child protection, legal protection and capacity building.[10] Similarly, the Ethiopia OVC Standard Service Delivery Guidelines (SSDG) recommends seven core service areas which are considered critical components of a set of services for programming targeting vulnerable children. These are: Shelter and Care, Economic Strengthening, Legal Protection, Health care, Psychosocial Support, Education, Food and Nutrition and Coordination of Care.[11]

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[5]UNICEF, UNAIDS, and WHO. *Children and AIDS: Fifth Stocktaking Report*.
[6]Mishra, Vinod, and SimonaBignami-Van Assche. 2008. *Orphans and Vulnerable Children in High HIV-Prevalence Countries in Sub-Saharan Africa.DHS Analytical Studies No. 15.*Calverton, Maryland, USA: Macro International Inc.
[7]*HIV Related Estimates and Projections for Ethiopia – 2012*, Ethiopian Health and Nutrition Research Institute Federal Ministry of Health, August, 2012.
[8]Foster children are those under age 18 living in households with neither their mother nor their father present.
[9]Ethiopia Demographic and Health Survey 2011, Central Statistics Agency, Addis Ababa, Ethiopia.
[10]Guidance for Orphans and Vulnerable Children Programming, PEPFAR, July 2012.
[11]Standard Service Delivery Guidelines for Orphans and Vulnerable Children's Care and Support Programs, Federal Democratic Republic of Ethiopia, February 2010.

Over the past decade, the Government of Ethiopia, with the support of international non-governmental organizations (INGOs) and through bilateral collaborations, has undertaken a range of activities that support HVC and OVC with the aim of mitigating the impacts of poverty and HIV/AIDS on this segment of the population. Of these, the most notable are the Productive Safety Net Program (PSNP), Multisectoral Plan of Action for HIV (2007-2010) and Positive Change: Children, Communities, and Care Program (PC3).

Ethiopia has successfully implemented the first Multisectoral Plan of Action for Universal Access to HIV Prevention, Treatment, Care and Support in Ethiopia during 2007–2010. One of the objectives of the plan was to improve the quality of life of OVC by providing support to OVC guardians and taking actions to increase the current school attendance ratio of orphans to non-orphans (age 10-14) from 60% to 80%.[12] Implementation of the plan has seen major achievements in HIV/AIDS services expansion, including provision of antiretroviral therapy (ART) and reduction in the rate of new HIV infections.[13]

The PC3 Program was designed to provide OVC and their families with comprehensive and coordinated services in health services, education, economic strengthening, psychosocial support, food and nutrition and legal protection. The program ran over five years (2004-2008) and targeted 500,000 OVC in seven regions with a total budget of about US $20 million.[14] The goal of PC3 was to improve the well-being of 500,000 OVC and families affected by HIV/AIDS. The program was able to build on existing community network created by burial societies (*Iddirs*) and created a holistic, child-friendly environment for community-based activities. PC3 did this through developing the capacity of local non-governmental organizations (NGOs) who, in turn, partnered with a variety of community-based organizations (CBOs). Pact has sought to apply the lessons learned from PC3 to Yekokeb Berhan Program. Hence, many of the lessons learned from previous initiatives were built into the design of Yekokeb Berhan Program.[15] Pact has established effective working relationships with key government partners and has developed and utilized manuals, guidelines and checklists for training and tracking Yekokeb Berhan implementation.[16]

[12]Multisectoral Plan of Action for Universal Access to HIV Prevention, Treatment, Care and Support in Ethiopia 2007 – 2010, HIV/AIDS Prevention and Control Office (HAPCO).

[13]Multi-sectoral HIV/AIDS Response Monitoring & Evaluation Report for 2004 EFY, July 2011 - June 2012, Federal HIV/AIDS Prevention and Control Office.

[14]Ethiopia Positive Change: Children, Care and Communities (PC3) End-of-Project Evaluation, July 2008.

[15] Evaluation of USAID/Pact Program for Highly Vulnerable Children: Yekokeb Berhan, Baseline Findings, September 2012.

[16] USAID/Pact: PEPFAR In country Reporting System: Pact Yekokeb Berhan for Highly Vulnerable Children, Annual Progress Report FY2012.

2. OBJECTIVES AND SCOPE OF THE EVALUATION

2.1 OBJECTIVES OF THE EVALUATION

The midterm evaluation has the following objectives:

1. To identify baseline values for outcome indicators that were not addressed in the program's baseline survey;
2. To objectively measure outcome level results and changes registered by the program against baseline measures;
3. To provide practical programmatic recommendations to improve the impact of the program;
4. To identify and document critical lessons learned and knowledge generated in the course of implementation of the program.

2.2 SCOPE OF THE MIDTERM EVALUATION

The scope of this midterm evaluation was to measure progresses made in program implementation since the beginning of the program in order to recommend actions or interventions for improvements. The midterm evaluation addressed all the four objectives of the program related to: 1) systems, structures and policy framework; 2) quality of services; 3) community capacity development; and 4) evidence-based programming. To this effect, the baseline survey report and available program related documents were reviewed, appropriate data collection tools developed and quantitative and qualitative data collection was undertaken.

Primary data obtained from the quantitative and qualitative methods and data from secondary sources were analyzed, compiled and presented based on objectives of the program. Conclusions and recommendations were made based on the findings.

3. METHODS

3.1 STUDY DESIGN

In the midterm evaluation, a combination of quantitative and qualitative methods was employed to collect data required to determine program achievements and to identify benchmarks that were not addressed in the baseline survey. For the quantitative component, a cross-sectional survey that involved households with HVC was employed. In the qualitative assessment, focus group discussions (FGDs) and key informant interviews (KIIs) were conducted with beneficiaries, community volunteers (CVs), partners, community committees (CCs) and others. Comparison of key outcomes was made between the midterm evaluation and baseline findings wherever applicable. Full comparison was not possible due to differences in the methods and target groups of the two surveys (the baseline survey included non-HVC households). Besides the midterm survey, secondary data including the baseline survey, routine reports, supervision reports and other relevant sources were thoroughly reviewed to complement the primary data in order to address the four

midterm evaluation objectives. The different data sources of the midterm evaluation allowed triangulation of data yielding more valid results. Utilization of the different data sources allowed the evaluation team to make valid conclusions and recommendations in order to improve program performance leading to positive outcomes and impacts on children and families.

3.2 SAMPLE SIZE AND SAMPLING PROCEDURES

This midterm evaluation was conducted in four major target regions: Amhara, Oromia, SNNPR, Tigray and the Addis Ababa City Administration. Sample size for the survey was determined based on a 50% planned proportion estimate, 3% margin of error and 95% confidence level. This computation was carried out using the StatCalc function for sample size estimation of Epi Info version 7, (Center for Disease Control, Atlanta, USA) statistical software package. The sampling procedure was multi-staged and there was a need to adjust for a design effect. In this survey a design effect of two was considered, which is used in most practical situations. Based on these requirements, the sample size for questionnaire survey was estimated to be 2,130. A final sample size of 2,142 was determined based on distributions at the *woreda* level. This total sample size was allocated to each of the four survey regions and Addis Ababa City Administration proportional to number of beneficiary HVC in each region.

The primary sampling unit was region followed by zone, *woreda* and *kebele*. Accordingly, four regions, Amhara, Oromia, SNNPR, Tigray and Addis Ababa city Administration were purposely selected. From each region, two or three zones were selected based on the size of the HVC beneficiary population. Three zones (including the capital city of the region) were randomly selected from each of the Amhara, Oromia and SNNPR regions while two zones were selected from each of Addis Ababa and Tigray regions. Among the two zones considered from Tigray region, the city of Mekelle was included in order to be consistent regarding inclusion of the regional capitals. Hence, a total of 13 zones were included in the evaluation. Taking into account the total number of program *woredas* and the mathematical relevance of the given data points, it was assumed that a total of 21 *woredas* (about 10% of the total program *woredas*) would be representative. Amhara, the region with the largest number of beneficiary HVC, was used as a reference point and sample sizes other regions were allocated based on proportion of HVC in this region to achieve the largest number of survey households. *Woredas* were randomly selected from each region to meet random allocations. The distribution of survey *woredas* is presented in Figure 1.

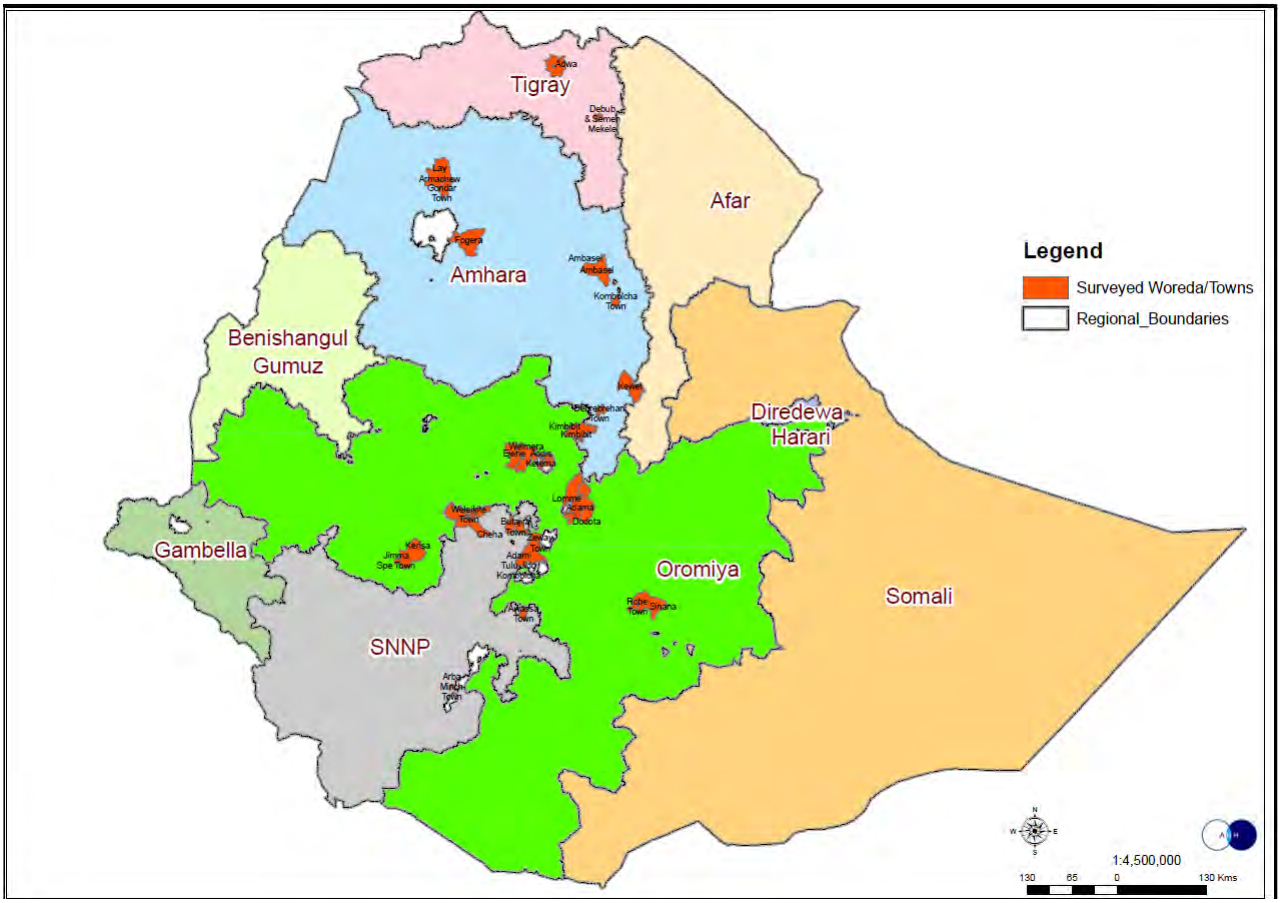


Figure 1: Distribution of survey woredas

To enhance geographic variability within *woredas*, it was agreed to take three *kebeles* per *woreda* so that 34 households would be surveyed in each *kebele*. Accordingly, three *kebeles* were randomly selected in each of the selected *woreda*. At a household level, a caregiver and an HVC (either under 14 or 14-17 years old) were interviewed for every selected household. When there was more than one HVC, one child was randomly selected using lottery method (every child enrolled in the program was listed separately on a piece of paper and the paper folded and one drawn randomly). When the selected child was less than 14 years, the caregiver was interviewed about the child using part two of the survey questionnaire. When the selected child's age was 14-17 years the child him/herself was interviewed using part three of the survey questionnaire. From the program's document, it appears that the proportion of young HVC (<14 years) to adolescent HVC (14-17 years) is 2:3. Based on this proportion, we expected to get 1,400 young HVC and 730 adolescent HVC upon random selection of the children. The caregiver was interviewed in every survey household.

Seventeen sites were selected for the qualitative study and allocated for each region based on population size. Accordingly, two each from Addis Ababa and Tigray; four sites each from Amhara

and SNNPR and five sites from Oromia were involved in the study. Community structures and organizations including IPs, women, children and youth affairs sectors (labor and social affairs in the case of Tigray) were purposefully selected and involved in the study. Additional stakeholders including coordinators at regional levels as well as federal-level partners participated in the study. Data on awareness about Yekokeb Berhan Project, implementation capacity, coordination of care, service provision, recruitment and enrollment of HVC and their families and data management and reporting were collected.

3.3 VARIABLES

The survey collected information on socio-demographic, health and health care, education, food and nutrition, psychosocial support, shelter and care, legal protection, economic strengthening and coordination of care variables.

3.4 DATA COLLECTION

Quantitative data was collected using questionnaires that were translated into three major languages—Amharic, Oromifa and Tigrigna—that were used in areas where the respective language is spoken. The questionnaire consisted of three parts (Annex IV). The first part consisted of a module for caregivers of HVC; the second part comprised of a module pertaining to HVC under 14 years of age with the respondents being caregivers; and the third part consisted of a module for older HVC aged 14-17 years with the children themselves responding. Mid-upper arm circumference (MUAC) measurements were taken for all under-five children in a household. Similarly, coordinates of each surveyed household were recorded using a global positioning system (GPS) apparatus by data collectors for further analysis.

Qualitative data was collected using FGDs and KIIs in order to explore shared perceptions and lived experiences. Perceptions and experiences primarily related to capacity building at community and implementing partner levels, coordination of care, data collection and reporting mechanisms and perceived changes in connection to Yekokeb Berhan Program. Qualitative data provided context for deeper probing deeper into types of services provided by the program and supplemented quantitative data findings.

Twenty FGDs were completed with five target groups, namely community committees, savings groups, caregivers and four among community volunteers with a total of 33, 36, 52 and 37 participants respectively. Key informant interviews were conducted with a total of 34 individuals representing Ministry of Women, Children & Youth Affairs (MoWCYA) at federal, regional and woreda levels; Pact at Addis Ababa and regional levels; FHI360 and ChildFund (Annex II).

Participants for the qualitative study were purposely identified and selected from program sites representing the different program stakeholders. Data were collected with an application of tools developed in reference to the objectives of the midterm evaluation, baseline tools and the Yekokeb Berhan Program documents.

3.5 DATA ANALYSIS

Quantitative Data: Quantitative data were entered into a data template created for this analysis using SPSS computer software (IBM Corp, New York, USA). The template was created using the final version of data collection tools by an experienced statistician. Data entry, cleaning and analysis was carried out by the data management team. Relevant cross tabulations, graphs and charts were produced as appropriate. Chi-square tests were done on certain variables to test differences between populations as appropriate. The statistical tests were applied to see differences among males and females, age categories and differences between the midterm survey and baseline findings.

Qualitative Data: Qualitative data were transcribed and checked for consistency by an assistant who was not involved in the data collection. Transcribed data were read and re-read to define themes and sub-themes and organized according to objectives of the study. Two individuals were engaged to summarize data under themes and sub themes. Differences were checked and verified. Key quotes were used verbatim with efforts to retain original meaning where necessary to substantiate arguments.

3.6 DATA QUALITY ASSURANCE

The tools for the data collection were developed from instruments used for the baseline survey in Ethiopia and questionnaires used elsewhere. Ethiopian SSDGs and other international guidelines such as the PEPFAR OVC guidelines and Measure Evaluation Core OVC program impact indicators were referenced. All data collectors and supervisors had previous experience of data collection in similar settings. The data collectors and supervisors had a minimum of first degree in health or social sciences. A three-day intensive training that included presentations, role plays and field testing of the instruments was conducted. Pre-testing for the quantitative and qualitative methods was conducted in Addis Ababa sites that were not included in the survey. One supervisor was assigned for four to six data collectors and filled questionnaires were checked and corrected on the spot. The supervisory team included supervisors, investigators and also teams from Pact/ Yekokeb Berhan program. Feedback sessions were conducted among supervisory teams at different levels, and immediate corrections were made when problems observed. For qualitative data, double entry was done and frequencies were run to check consistency and to ensure data quality. Data entry and analysis were conducted by experienced data clerks and by statisticians with experience in handling large surveys.

3.7 ETHICAL CONSIDERATIONS

An introduction letter was written by Pact or relevant IP offices to the respective regional MoWCYAs and approval was obtained from these entities. Qualitative participants were informed about the study, objectives and ethical procedures prior to being engaged. Data collection began once verbal consent was obtained from a participant after reading out a consent section for each data collection method. It was made clear to every participant that they had the right to refuse to

respond to any of the questions. Names of caregivers were not written on the questionnaire and HVC names were delinked during analysis as well as in the report. In data dissemination, only the type of data collection and geographical setting was reported for a participant's responses.

4. RESULTS

Data were collected in March 2014 from all evaluation sites. A total of 2,138 (99.8% of the planned 2,142) households with a HVC were involved in the quantitative survey. The survey was administered to 2,138 caregivers and 2,121 HVC. Twenty FGDs and 34 KIIs (involving a total of 192 people) were conducted with the target groups in the qualitative methods.

4.1 DEMOGRAPHIC CHARACTERSTICS OF CAREGIVERS

As detailed in Table 1 below, of the total respondent caregivers, 2022 (95%) were female and 116 (5%) were male. Nine (0.4%) of the caregivers were found to be less than 18 years old while 124 (5.8%) were elderly people aged 65 years and above. Approximately half of the caregivers (45.5%) were married while 29% and 20% were widowed and divorced, respectively. Approximately half (46.7%) of the caregivers had formal education – 36.3% achieving primary and 10% secondary and above level of education. When occupation of the caregivers was assessed, it was found that 35.6% were wage laborers while 22% were engaged in small-scale businesses. In the surveyed HVC households, mean number of family size and children under 18 years of age was 4.7 and 2.4, respectively.

Table 1: Socio-demographic characteristics of caregivers

	Male No. (%)	Female No. (%)	Total No. (%)
Age Group			
Total	116	2022	2138
<18	2 (1.7)	7 (0.3)	9 (0.4)
18-24	7 (6.0)	116 (5.7)	123 (5.8)
25-45	63 (54.3)	1424 (70.4)	1487 (69.6)
46-64	25 (21.6)	370 (18.3)	395 (18.5)
65+	19 (16.4)	105 (5.2)	124 (5.8)
Mean age	45.0	38.8	39.2
Marital status			
Total	116	2022	2138
Single	12 (10.3)	78 (3.9)	90 (4.2)
Married	79 (68.1)	894 (44.2)	973 (45.5)
Divorced	11 (9.5)	426 (21.1)	437 (20.4)
Widowed	14 (12.1)	608 (30.1)	622 (29.1)
Live with partner/cohabit	0	16 (0.8)	16 (0.8)
No Response	0	0	0

Highest level of school completed			
Total	116	2022	2138
No formal education	39 (33.6)	1100 (54.4)	1139 (53.3)
Primary (grade 1-8)	45 (38.8)	731 (36.2)	776 (36.3)
Secondary (grade 9-12)	15 (12.9)	133 (6.6)	148 (6.9)
Preparatory (11-12)	11 (9.5)	32 (1.6)	43 (2.0)
10+TVET	6 (5.2)	16 (0.8)	22 (1.0)
College/university	0	2 (0.1)	2 (0.1)
No Response	0	8 (0.4)	8 (0.4)
Occupation of the caregiver			
Total	116	2022	2138
Farming	15 (12.9)	64 (3.2)	79 (3.7)
Wage Laborer	47 (40.5)	714 (35.3)	761 (35.6)
Government employee	7 (6.0)	23 (1.1)	30 (1.4)
NGO	3 (2.6)	25 (1.2)	28 (1.3)
Business	7 (6.0)	463 (22.9)	470 (22.0)
Student	3 (2.6)	10 (0.5)	13 (0.6)
Housewife	3 (2.6)	477 (23.6)	480 (22.4)
Other	19 (16.4)	150 (7.4)	169 (7.9)
No occupation	11 (9.5)	92 (4.5)	103 (4.8)
No Response	1 (0.9)	4 (0.2)	5 (0.2)
Engagement in paid work in the last 3 months			
Total	116	2022	2138
Yes	49 (42.2)	828 (40.9)	877 (41.0)
No	67 (57.8)	1176 (58.2)	1243 (58.1)
No Response	0	18 (0.9)	18 (0.8)

4.2 DEMOGRAPHIC CHARACTERSTICS OF HVC

A total of 2,121 HVC were interviewed in the evaluation out of which 1024 (48.3%) were male and 1097 (51.7%) female. Of these, 1670 (78.7%) were young children aged less than 14 while 452 (21.5%) were adolescents aged 14-17 years and the mean age was 9.9 years. Of the total surveyed HVC, 1738 (81.9%) have ever attended formal school with 81.2% of males and 82.7% of females HVC reported ever attending school (Table 2).

When vulnerability factors were assessed, 599 (28.2%) of HVC had lost both parents, 683 (32.2%) had lost a father and 227 (10.7%) had lost a mother. Other vulnerability factors such as living in a household headed by a chronically ill person, an elderly individual or a child were also found in smaller proportions of households.

Table 2: Demographic characteristics of HVC

	Male	Female	Total
	No (%)	No (%)	
Age group (n=2121)			
0-4	118 (11.5)	120(10.9)	238 (11.2)
5-9	316 (30.9)	336(30.6)	652 (30.7)
10-13	394 (38.5)	386(35.2)	780 (36.8)
14-17	196 (19.1)	255(23.2)	451 (21.3)
TOTAL	1024 (48.3)	1097 (51.7)	2121
Mean age (year)	9.8	10.0	9.9
Ever attended school (n=2121)			
Yes	831 (81.2)	907 (82.7)	1738 (81.9%)
No	151 (14.7)	149 (13.6)	300 (14.1%)
Not applicable (child < 5yrs)	42 (4.1)	41 (3.7)	83 (4.0)
Highest level of education completed (n=1738)			
KG	29 (3.5)	2 (0.2)	31 (1.8)
Grade 1-8	723 (87)	762 (84)	1485 (85.4)
Grad e 9-10	70 (8.4)	97 (10.7)	167 (9.6)
Grad e 11-12	3 (0.4)	14 (1.5)	17 (1.0)
10+ TVET	6 (0.7)	2 (0.2)	8 (0.5)
University/College	0 (0)	1 (0.1)	1 (0.1)
No response	0 (0)	29 (3.2)	29 (1.7)
Child vulnerability factor (n=2121)[17]			
Both mother and father are dead			599 (28.2)
Mother is dead			227 (10.7)
Father is dead			683 (32.2)
Chronically ill			55 (2.6)
HIV positive			66 (3.1)
Has some kind of disability			27 (1.3)
Household is headed by a child (<18)			16 (0.8)
Household is headed by elderly			198 (9.3)
Household is headed by ill person			291 (13.7)
Household is headed by disabled			41 (1.9)
Others[18]			757 (35.7)
No response			20 (0.9)

[17] More than one factor applies to some HVC, hence the total is more than n.

[18] Children from households with severe economic problem, street children and children in conflict with the law, who according to the national OVC Standard Service Delivery Guidelines fulfill the criteria, may have been enrolled and categorized in this category.

The majority of the children (76.8%) lived with at least one parent while 13.2% lived with their grandparents. Proportion of double orphan HVC seems high compared to those reported living with at least one parent. This is perhaps in many parts of the country culturally non-biological parents are considered as parents and this may have increased number of those reported living with at least one parent. A small proportion of HVC lived with other relatives and 1.4% with people without blood relation (Figure 2). Seventy (3.4%) of the HVC reported having some form of disability. Out of HVC with disability, 46 (65.7%) said that their daily activity was limited by their disability. Physical disability was the most common form of disability accounting to 37.1% of the disabilities followed by deafness or partial deafness (24.3%) and blind or partially blind (11.4%).

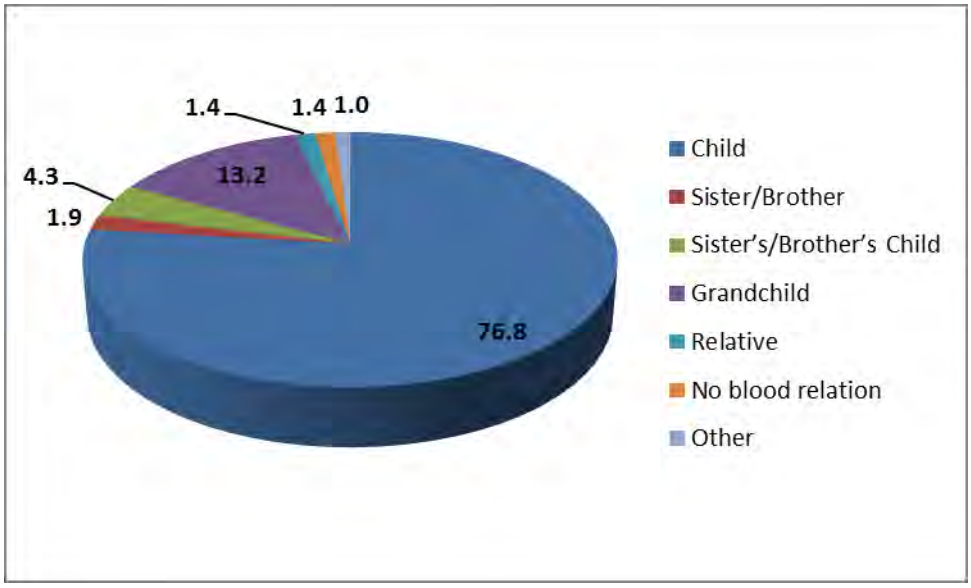


Figure 2: Relationship between HVC and Caregiver

4.3 IDENTIFICATION AND ENROLLEMENT OF HVC

When knowledge of the caregivers about the program was assessed, 95.6% said they knew about Yekokeb Berhan Program. Qualitative data from participants in CCs and CSSGs reveal the common assertion that '*the program was meant to support poor children*.' Although some CSSG participants mentioned the program's role in '*building the culture of saving*' to benefit vulnerable children, participants often could not identify many components of the program.

About two-thirds (64.4%) of the beneficiary HVC were initially identified by *kebele* administration staff for support by Yekokeb Berhan Program while 17% said they were identified by IP staff. CC and CV also identified 13.3% of the HVC for enrollment into the program. Basically, IP staffs were not involved in identification and selection of HVC and this perhaps emanated from lack of differentiation by the respondents between these entities. According to the respondents, final decision of enrollment of HVC was made mostly by CCs and *kebele* administration.

Qualitative data has revealed that recruitment of vulnerable children was guided by specific procedures and tools. Participants from different regions unanimously stated that:

'*[A]t the beginning of the* program *HVC selection was not free from bias because we did not have clear guide to recruit HVC. Now, Yekokeb Berhan Program provides us with a format [the Child Support Index (CSI)] and trains us on how to use the format to recruit. The volunteers do the assessment and community committee review, verify and approve.'(IP staff, Dugda, Oromia)*

4.4 FINDINGS BY PROJECT OBJECTIVES

4.4.1 Objective 1: Build the capacity of stakeholders to effectively use an improved data management system and employ a national HVC supervision system

Yekokeb Berhan Program has ventured to build the capacity of different stakeholders involved in the implementation of the project. This intervention is one of the most important components of the project in view of the fact that implementation of the project and sustaining the initiative depends on whether IPs at different levels have the relevant capacities.

An interview with Pact Yekokeb Berhan Program focal person suggests that at the program's inception, 49 CSOs were identified and brought on board as potential IPs to this initiative. Capacity of these institutions was assessed with an application of Technical and Organizational Capacity Assessment (TOCA) tool. Assessment focused on their technical, programmatic, management (human technical, financial) and partnership capacities.

From the assessment, capacity gaps of the IPs varied. However, the common capacity gaps were seen in: project leadership, management practices, human resources, capacity to support partners, infrastructure and logistic, communication and external relations, how to ensure sustainability of interventions, monitoring and documentation, volunteers' management and coordination of care, local resource mobilization and ability to overcome challenges.[19]

The project has further assessed the capacity of government institutions as a key partner to Yekokeb Berhan Program. Capacity assessment for this partner focusing on the women, children and youth affairs and labor and social affairs for the Tigray region reveals that government partners for this project have strong capacities in: 1) establishing partnership with other sectors and mainstreaming child care to these sectors; 2) establishing close working relations with the community at operational level and recognition of community as key stakeholders; 3) identifying service providers at *woreda* and city administration level; and 4) disseminating national OVC service guideline to operational levels.[20]

[19] PACT. TOCA preliminary report per implementing organization, ND.
[20] Consolidated Report of Organizational Capacity Assessment conducted for Government Partners for all Regions of Ethiopia (All Bureaus and selected Zone and *woreda* offices), September, 2012.

Despite these strengths, there were a number of capacity gaps identified including: 1) weak attention by leaders to child affairs especially in allocation of resources; 2) limitation of financial and material resources to implement child-focused programs and undertake monitoring activities; 3) failure to consider gender and disability in identification of vulnerable children; 4) limitation of operational guideline for child focused program; 5) weak clarity between sectors on responsibility between BoWCYA, the Bureau of Labor and Social Affairs (BoLSA) and HAPCO; 6) limitations in providing capacity development supports to lower level structures; 7) weak database management and supportive supervision; 8) poor infrastructure and logistics to facilitate works of HVC; 9) limited work relationship with NGOs that work; and 10) weak resource mobilization skills.[21]

At the community level, implementing CSOs employed the Community Capacity Barometer to identify capacity gaps of community level structures. Accordingly, leadership skills, active participation, resource mobilization, coordination of care, operational plan development, communication and facilitation as well as data management and reporting were major gaps identified.[22]

Capacity building of the different stakeholders was taken as an entry to roll out of project implementation at various levels. Capacity of implementing CSOs, government partners and community structures was built by providing a series of training, supportive supervision, coaching and mentoring. Capacity building interventions of the program were designed to offer technical assistance on key technical programming areas by the different partners. Information from the field recognized capacity building interventions.

Training appears to be the main capacity building intervention involved in Yekokeb Berhan Program. However, the project has introduced different capacity building interventions other than training. These include hands-on technical guidance on implementation of project components provided to IPs by Yekokeb Berhan regional cluster managers and standardized supportive supervision provided to IPs and community structures by technical staff of headquarters of Pact, FHI360 and Child Fund. Child Fund focuses more on capacity building related to economic strengthening, FHI360 on better parenting, life skill and food related training such as urban gardening and PermaGardening and Pact has put greater focus on coordination of care.

Some of the common training activities identified by implementing partners, CSOs and other community structures include: MERL (monitoring, evaluating, reporting and learning) module I and II, economic strengthening (e.g. market study and analysis, business development, saving and loan group establishment and strengthening, microenterprise selection, planning and management and business development services), early childhood development, life-skill trainings, CSI-I and CSI-II,

[21] Consolidated Report of Organizational Capacity Assessment conducted for Government Partners for all Regions of Ethiopia (All Bureaus and selected Zone & woreda offices), September, 2012.
[22] Consolidated community capacity Barometer report, ND.

parent-teacher association (PTA) trainings, better parenting, coordination of care, psychosocial support, emotional wellbeing, personal hygiene and sanitation and standard service delivery.

Regarding the types of trainings received, IPs involved in the study uniformly reported that different of trainings were received by the project. Evidence from different sources at community level reveals that implementing partners involved in the study uniformly reported to have received different types of training.

*'There are 18 training packages in the program. I personally took basic volunteer, economic support, coordination of care, journey of life/better parenting, gardening and all of these were cascaded to operational level. Such capacity building interventions enabled us not only internalize the problems of HVC but also made us committed to do as much as we can to reach out to more HVC by mobilizing support from the community.' (*Staff member, EKHC, Arbaminch)

'*Generally, Pact has given us more than 20 trainings on different aspects that could help us implement Yekokeb Berhan program and several operational guidelines which we applied to improve the capacity of our stakeholders at community level.'* (Staff member, EDA-Debreberahn)

The evaluation also revealed that trainings provided by the program have positively impacted services to HVC. This was highlighted by the study participants as follows:

'I strongly feel capacity building by Yekokeb Berhan program has brought tangible changes to our service provision and to reach the right target beneficiaries with the right services.' (Staff member Dugda IP, East Shoa)

'My organization has obtained opportunities for capacity building that helps us to employ standard approach in addressing the needs of HVC. This was not usually the case. Now, my organization knows what to do to address problems of HVC and how to address it.' (Member, Progynist, Wolkite)

Government partners reflected on the impact of capacity building efforts of Yekokeb Berhan Program:

'Yekokeb Berhan project has contributed to bridge capacity gaps by providing office furniture, provision of training to staff members of BoWCYA, different forms of training to community structures and beneficiaries.' (Staff members, BoWCYA, Amhara)

The CSI tool and coordination of care in particular were repeatedly mentioned to have far reaching implications for sustainable HVC care and support planning, implementation and policy decisions.

'*The CSI HVC data base is a whole new way of data generation and management. It consists of every aspect of service provisions and the data generated from the data base is unbiased.'* (Staff member, Progyist Butajira)

'*The system is advance where it prohibits redundancy where one HVC may not get support from two sources. The data are useful for any organization that would be interested in helping HVC.'* (Staff member, Mary Joy, Hawassa)

In Yekokeb Berhan Program, training of IPs is not considered as an end in itself. IPs were expected to roll out training received by Yekokeb Berhan Program to community-level structures such as caregivers, volunteers, CCs and CCSGs who were found at the frontline of Yekokeb Berhan Program intervention. According to a staff member from the MoWCYA:

'There has never been an organization engaged in building community system and capacity in response to children's problems. Yekobeb Berhan program however introduced a new initiative to build capacities and systems at community levels to sustain care and support to HVC and their families.' (Children affairs mainstreaming and partnership team leader, MoWCYA, Federal)

Community structures were provided with training that contributes to improved implementation of Yekokeb Berhan Program. Based on information gathered from the community structures themselves, different sets of training were provided.

Community committee were generally found to have been trained on *'child care, parenting skill, child-family relationship, how to select HVC using available format, collection and reporting of data on HVC on a regular basis and coordination of care'* (Member of CC, Adama). Members of CCs were generally regarded as having the capacity to link HVC with services. This was highlighted by one of the participants: *'We have the capacity to link HVC with health bureau, justice office and private schools at all levels and to mobilize local resources to help HVC'* (Member of CCC, Adwa).

Community level structures (CCs, CVs and CSSGs) were provided with different types of trainings. CVs were trained on: *'... CSI including how to fill CSI and reporting system, parenting skill, psychosocial and life skills, better parenting, coordination of care'* (CV, Mekele). On the other hand, it was stated that: *'Caregivers were trained on 'psychosocial support, emotional wellbeing, parenting and life skill, gardening and on hygiene and sanitation.'* (Staff member, Padet, Gondar). Besides, CSSGs were reported as trained on: '*market analysis, prima garden, rules and regulations for savings'* (Member of CSSG, Mekele).

Despite such capacity building actions for different stakeholders, the study identified prevailing capacity gaps at different levels. One of the major capacity gaps identified at government level was staff turnover which led to gaps in institutional memory and consequently, limited awareness about the project, poor partnership with CSOs, lack of standard alternative care and poor logistics to undertake monitoring and supportive supervision.

'*We have not received any capacity building from PACT although our regional bureaus are benefitting from the different training activities.'* (Staff member, MoWCYA, Federal)

'Limited awareness about HVC and procedures of service provision is not very clear to community level partners.' (Staff member, BoWCYA, Jimma)

'Lack of experience in community facilitation by CC and CVs; weak monitoring and supervision capacity at government partner's level was reported.' (Staff member, Rest, Mekele)

'Every quarter we receive supportive supervision by a team that comes from regional office of Yekokeb Berhan. They work closely with us and provide feedback to every challenge we encountered. This was quite empowering for us.' (Staff member, ANNPCAN, Gondar)

Supportive supervision was found to be an important approach to build the capacity of the implementing partners. This was underscored by a key informant as:

'*One implementing partner (NGO) obtains at least one supportive supervision once every quarter of the year. At the end of each supportive supervision meeting, partners are provided with both oral and written feedback. Actions based on previous feedback are tracked during the next supervision.'* (Regional manager, Yekokeb Berhan, Amhara)

'Over the last year we have provided supervision to implementing partner (NGO), caregivers and HVC at household level monitoring if training worked well and consequent accomplishments service standards.' (Staff member, FHI360)

4.4.2 Objective 2: Employ effective and efficient family centered, age -based and inclusive HVC care management system

HEALTH CARE

The primary health outcomes assessed in this study for HVC are given in Table 3 by age and sex. Assessment of HVC's perception of their own health status over the last 12 months showed that 1,585 (74.7%) stated their health status was either good or very good. In the baseline survey, only 61.6% of the HVC perceived their health status as either good or very good and the difference is statistically significant ($p<0.05$). On the other hand, 194 (9.1%) of the HVC reported their health status to be either poor or very poor and this was significantly better than the baseline where 14.7% assessed their own health as either poor or very poor ($p<0.05$). There was no statistically significant difference between boys and girls in perception of their own health status in the midterm evaluation.

Overall, 356 (16.8%) HVC were reported to have an episode of illness over the past two weeks as a result of which they could not participate in daily activities. In the baseline 30% of the HVC reported having illness in the two weeks preceding the survey. Disaggregation of data by sex showed no significant difference between boys (17.6%) and girls (16.1%) in the baseline. Fever in the two weeks preceding the midterm evaluation was reported by 399 (18.8%) of the HVC compared to findings from the baseline (15.7%). There were no differences by sex for having fever. For diarrhea in the preceding two weeks, at baseline, 10.8% of the HVC reported diarrhea in the two weeks before the survey. In the midterm evaluation, 130 (6.1%) HVC had diarrhea in the last

two weeks preceding the survey. There were slightly higher rates for boys, 60 (6.8%), compared to girls, 70 (5.5%). Health-seeking behavior of HVC was also assessed by asking whether they sought treatment for their fever and diarrheal episodes. Of those who reported having fever in the midterm, 63.9% sought treatment while 86.2% of those who had diarrhea did the same. In the baseline 48.4% and 49.7% who had fever and diarrhea, respectively reported seeking treatment for these illnesses. The changes in proportion of HVC who sought treatment for fever and diarrhea from the baseline to the midterm were both highly significant ($p<0.01$). Overall, health seeking behavior was found to be similar for boys and girls in the midterm as 65.1% of boys and 61.2% of girls sought treatment for their fever and 88.6% boys and 83.3% girls received treatment for diarrhea. There was no difference in prevalence of fever and diarrhea and also health seeking behavior across the age for both boys and girls.

Table 3: HVC health outcomes by age and sex

	0-4		5-9		10-13		14-17		Total		
	M	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**Total**
	No (%)	No (%)	No (%)	No (%)	No (%)	No (%)	No (%)	No (%)	No (%)	No (%)	No (%)
Total (n)	118	120	316	336	394	386	197	254	1025	1096	2121
Too sick to participate in daily activities in the last 2 weeks (n=2121)											
Yes	26 (22.0)	22 (18.3)	54 (17.1)	45 (13.4)	69 (17.5)	63 (16.3)	31 (15.7)	46 (18.1)	180 (17.6)	176 (16.1)	356 (16.8)
No	92 (78.0)	98 (81.7)	262 (82.9)	291 (86.6)	325 (82.5)	323 (83.7)	166 (84.3)	208 (81.9)	845 (82.4)	920 (83.9)	1765 (83.2)
Had fever in the last two weeks (n=2121)											
Yes	32 (27.1)	29 (24.2)	61 (19.3)	63 (18.8)	72 (18.3)	75 (19.4)	24 (12.2)	43 (16.9)	189 (18.4)	210 (20.5)	399 (18.8)
No	86 (72.9)	91 (75.8)	255 (80.7)	273 (81.3)	322 (81.7)	311 (80.6)	173 (87.8)	211 (83.1)	836 (72.6)	886 (80.5)	1722 (81.2)
Had diarrhea in the last two weeks (n=2121)											
Yes	18 (15.3)	14 (11.7)	25 (7.9)	19 (5.7)	19 (4.8)	19 (4.9)	8 (4.1)	8 (3.1)	70 (6.8)	60 (5.5)	130 (6.1)
No	100 (84.7)	106 (88.3)	291 (92.1)	317 (94.3)	375 (95.2)	367 (95.1)	189 (95.9)	246 (96.9)	955 (93.2)	1036 (94.5)	1991 (93.9)
Had fever and sought treatment (n=299)											
Yes	23 (71.9)	16 (55.2)	42 (68.9)	43 (68.3)	47 (65.3)	51 (68.0)	12 (50.0)	21 (48.8)	123 (65.1)	131 (62.4)	255 (63.9)
No	9 (28.1)	13 (44.8)	19 (31.1)	20 (31.7)	25 (34.7)	24 (32.0)	12 (50.0)	22 (51.2)	66 (34.9)	79 (37.6)	144 (36.1)
Had diarrhea and sought treatment (n=130)											
Yes	17 (94.4)	9 (64.3)	24 (96.0)	19 (100)	17 (89.5)	18 (94.7)	4 (50.0)	4 (50.0)	62 (88.6)	50 (83.3)	112 (86.2)
No	1 (5.6)	5 (35.7)	1 (4.0)	0	2 (10.5)	1 (5.3)	4 (50.0)	4 (50.0)	8 (11.4)	10 (16.7)	18 (13.8)
Child fully vaccinated for age (n=238)											
Yes	72 (61.0)	65 (54.2)							72 (61.0)	65 (54.2)	137 (57.6)
HVC tested for HIV (n=2121)											
Yes	54 (45.8)	45 (37.5)	149 (47.2)	149 (44.3)	188 (47.7)	171 (44.3)	90 (45.7)	142 (55.9)	481 (46.9)	507 (46.3)	988 (46.6)
No	64 (54.2)	75 (62.5)	167 (52.8)	187 (55.7)	206 (52.3)	215 (55.7)	107 (54.3)	112 (44.1)	544 (53.1)	589 (53.7)	1133 (53.4)
Adolescent HVC got health information/counseling about reproductive health (n=451)											
Yes							113 (57.4)	159 (62.4)	113 (57.4)	159 (62.4)	272 (58.3)
No							31 (15.7)	48 (18.9)	31 (15.7)	48 (18.9)	79 (17.5)
No response							53 (26.9)	47 (18.5)	53 (26.9)	47 (18.5)	100 (24.2)

In the midterm survey, 137 (57.6%) of the under-five HVC were fully vaccinated for their age as confirmed from their vaccination card. Baseline data however shows that only 33.9% of the HVC had age-appropriate vaccination confirmed by card and the change is statistically significant ($p<0.05$) between the baseline and midterm. HVC vaccination coverage found in this midterm is also higher than the national urban coverage of 48.1%.[23] It was also gathered that 61% of boys and 54.2% of girls less than five years of age received age appropriate vaccine and there was no significant difference for boys and girls in the midterm.

In the midterm, adolescent HVC aged 14-17 were asked whether they had access to information about reproductive health (RH) and 272 (60.3%) reported having access to RH information. There was no difference between girls (62.6%) and boys (57.4%) in accessing reproductive health information. The primary source of RH information for 76.8% of HVC who had access was schools. Yekokeb Berhan Program was the source of RH information for 12.5% of HVC having access to such information. Other sources of RH information that served small proportion of HVC included government health facilities, health extension workers and private health facilities (see Figure 3).

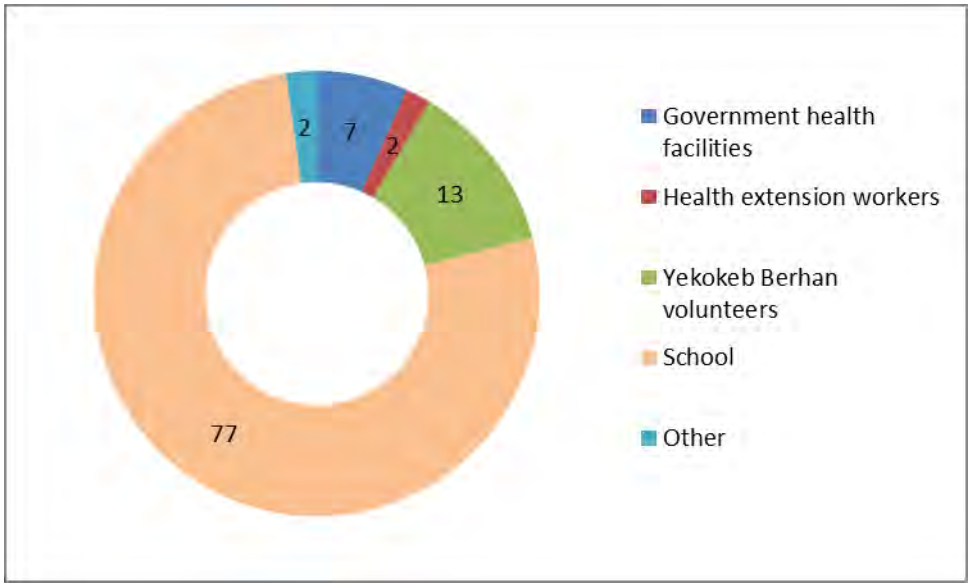


Figure 3: Sources of RH information for adolescent HVC (proportion)

When asked if they have received information on counseling about HIV (including transmission routes, methods of prevention, care and treatment) by health workers over the past 12 months, 389 (86.4%) of adolescent HVC responded favorably. Information related to HIV education and counseling services to HVC was not collected in the baseline. Overall, 988 (46.6%) HVC were tested for HIV over the last twelve months preceding the evaluation and there was no difference

[23] Ethiopia Demographic and Health Survey 2011, Central Statistical Agency, Addis Ababa, Ethiopia and ICF International, Calverton, Maryland, USA, March 2012.

between boys and girls having accessed testing (Figure 4). In the baseline survey, however, only 38.7% of HVC were ever tested for HIV.

Of 963 HVC (481 boys and 507 girls) who received HIV test results in the midterm, 56 (5.8%) were positive for HIV. When disaggregated by sex, 24 (5.1%) boys and 32 (6.5%) girls reported being HIV positive and the difference was not statistically significant. Baseline data shows that 14.2% of HVC who were tested and received their results were positive for HIV. Altogether, 48 or 85.7% of HIV positive HVC reported being on ART during the midterm and of these, 48 (85.7%) reported having regular follow up in a health facility (Figure 4). In the baseline only 61% of those HIV positive HVC were receiving ART treatment.

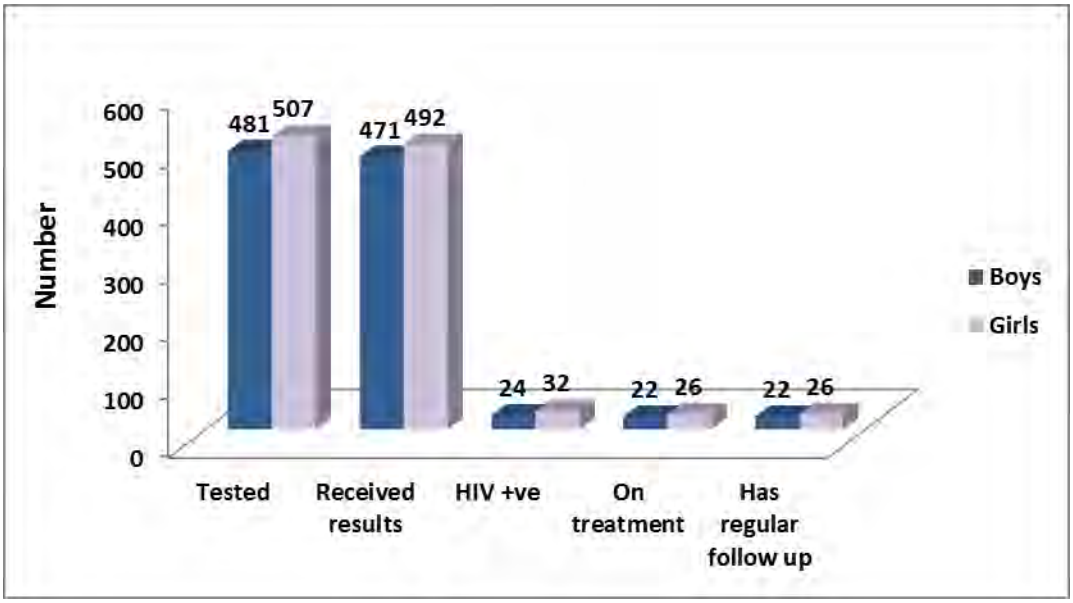


Figure 4: Number of HVC tested for HIV, received test result, on ART and with regular follow up

Regional disaggregation of HIV testing of HVC showed that Oromia has the highest testing rate with 56% of the interviewed HVC reporting testing in 12 months preceding the midterm (Figure 5.). Addis Ababa had the lowest HIV testing rate with only one-third of the HVC tested. Positivity rate among the tested HVC was found to be the highest for Addis Ababa (10%) followed by Amhara and Oromia each with a 7% rate. For all regions, these positivity rates were much higher than the national HIV counseling and testing data where they range from 3.4% for Addis Ababa to 0.6% for SNNPR.[24] This is perhaps because of naturally high prevalence rate among HVC compared to the general population.

[24] Federal HIV/AIDS Prevention and Control Office 2005 EFY Multisectoral HIV/AIDS Response, Annual Report, July 2012 to June 2013.

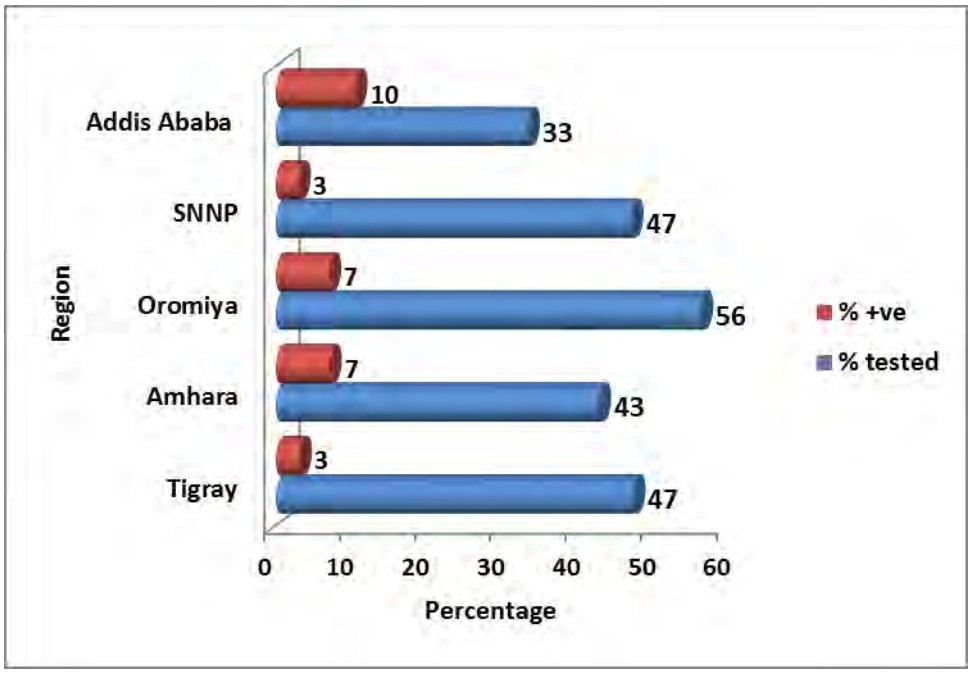


Figure 5: Proportion of HVC tested and positive for HIV by region

Health status and health-seeking behavior of caregivers were assessed as the poor health condition of caregivers potentially has an impact on their children. The majority of the caregivers (60%) stated that their health status was good or very good in the 12 month preceding the midterm compared to only 50% at the baseline and the difference was significant ($p<0.01$). Similarly, the proportion of caregivers who said their health status was either poor or very poor decreased from 28.1% at the baseline to 20% in the midterm ($p<0.01$) (Figure 6).

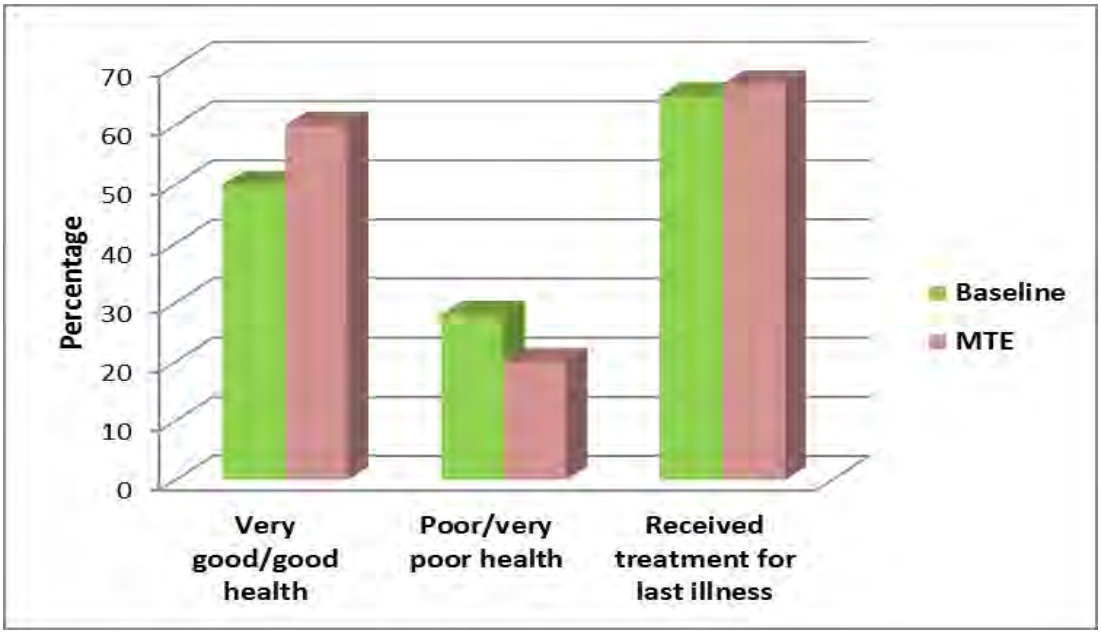


Figure 6: Caregivers' health status and care seeking behavior

Less than one-quarter (23.8%) of the caregivers reported being too ill to participate in routine daily activities in the two weeks preceding the midterm. Out of the caregivers who had some illness in the last two weeks, more than two-thirds (67.0%) received treatment from health providers for their illness in the midterm. This was slightly higher compared to 64.6% of caregivers who sought treatment for an illness preceding this episode. In the midterm, three-quarters of the caregivers sought heath care for their last illness went to government health facilities to seek health care while 17.6% sought treatment in private hospitals or clinics. For the midterm participants, reasons for not seeking treatment for the last illness vary. However, for the majority (68.6%) it was lack of money to cover treatment related expenses while 12% and 9.7% said illness was not serious enough to seek treatment and health facility was far, respectively.

In this midterm, it was found that 84.4% of the caregivers received HIV counseling or education by health workers and 76% were tested and of these, 98.6% received test results (Figure 7). Out of those caregivers who were tested and received test result, 231 (14%) were positive for HIV. At the baseline 12% of caregivers tested were positive for HIV. There was no statistically significant difference between HIV rates comparing the baseline to midterm surveys. Out of the HIV positive caregivers at the midterm, 89% were on ART and out of these 98 % reported to have regular follow-up with health care providers.

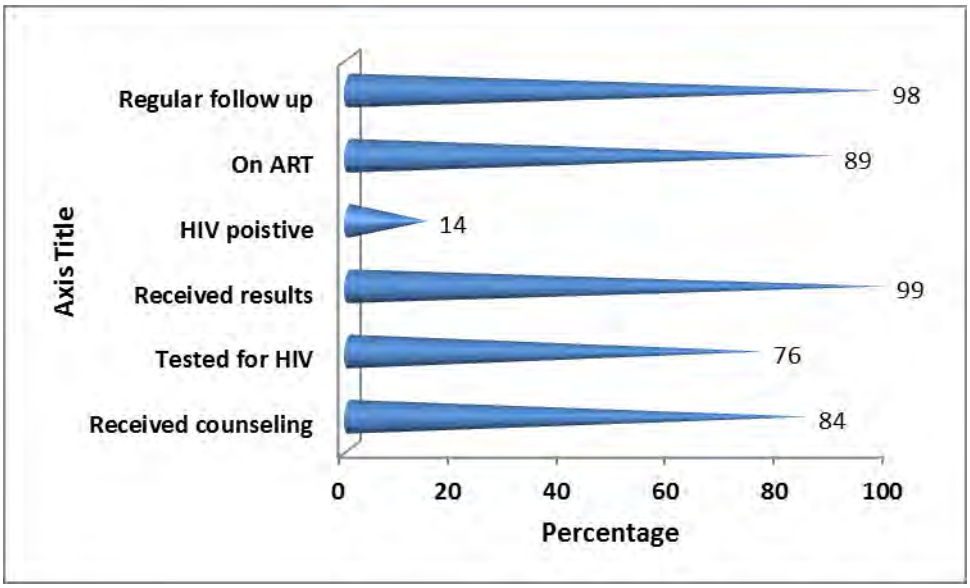


Figure 7: Proportion of caregivers received different HIV services

Data from the qualitative assessment suggested that procedurally, HVC with health problems were reported to CVs who coordinate transfer of such children to health facilities. Health service provision was generally the responsibility of local health facilities and specialized facilities through referral. In principle, HVC obtain health services free of charge through referral arrangements mainly from public health facilities. However, for emergency health problems, cost recovery for service delivery was organized either with direct payment by caregivers through reimbursement or on a credit arrangement with health facilities by Yekokeb Berhan IPs.

In some settings, for instance in Hawassa and Gondar, a credit system was instituted with an agreement between health facilities and the implementing partner so that the former provides health care services for HVC on credit basis when a child encounters emergency medical problems. In other settings, HVC obtain health services through a reimbursement process where caregivers are expected to pay for the service and the cost would be reimbursed by the IP (or CSO) on presentation of receipt. Despite such variation in cost recovery, emergency health services were generally found to be provided to HVC free of charge. Yet, it was clear that services that deemed expensive were supposed to be addressed through coordination of care depending on prior arrangement with potential stakeholder in the community.

'*The cost of health services covered is limited often only meant to cover cost of laboratory investigation or small expenses for medicine such as for syrups. You can't cover cost of big health expenses with this program.'* (Senior Project Coordinator, Mary Joy, Hawassa)

There were also situations where even emergency health service provision has stopped. In Arbaminch, the IP EKHC reported that health service provision to HVC has been stopped due to shortage of budgetary resources.

Within the health service components, raising awareness on healthy living with a focus on immunization, HIV/AIDS and hygiene and sanitation was carried out by CVs and health extension workers (HEWs). Many of the CVs, IPs and government partners involved in this evaluation believed that such awareness creation activities have not only contributed to the prevention of diseases but also developed a positive health seeking behavior among caregivers. One of the Community volunteers captures the common arguments related to awareness creation endeavors:

'*Previously some community members didn't know that there are people who are living in desperate living condition in their neighbor. They even ask why we visit some families every week. Such personal discussions in each area increased the communities' awareness about HVC, their problems and what to do about it at our level.'* (CVs Hawassa)

PSYCHOSOCIAL SUPPORT

Evidence on whether an adult member of a household received information or skills on better parenting (how to better care for children) shows that 1117 (52.2%) of the caregivers reported that there was someone in the household who had received better parenting training. Similarly, about two-thirds of the households (64.1%) reported that someone from the household has received counseling, some form of advice and/or emotional support from Yekokeb Berhan program as part of psychosocial support. Most HVC suggested emotional stability as only 5.8% of those less than 14 years of age had sudden changes in mood or behavior in the past month. Furthermore, 1,125 (52.6%) caregivers reported having someone to turn to in order to share concerns and get support in case of a problem with a slightly higher proportion of respondents in the baseline reporting having someone to turn to (55.3%). In the midterm survey, sources of such support were found to be family members for 647 (57.5%) of the respondents while for 245 (21.8%) of the respondents either friends or neighbors are sources of such support. Yekokeb Berhan IP staff, CC members and CVs were also mentioned by 207 (18.4%) of caregivers as source of support when problem is encountered. Out of the total 451 HVC aged 14 and above, 125 (27.7%) have received life skill training through Yekokeb Berhan Program in the past two years while 38 (8.4%) said someone in the household has received it. Most of the psychosocial indicators presented above were not collected in the baseline and hence comparison was not possible.

Data from qualitative methods shows that psychosocial support to HVC was found to be expanding during the last few years. Following parenting and life skills training provided to volunteers and caregivers, it was gathered that HVC benefitted from psychosocial support at household level. Furthermore, coaching on life-skills was provided by community caregivers and volunteers to HVC to promote their self-confidence and enable them to plan their future life. CVs described that they were involved in arbitration of conflicts between HVC and their caregivers to foster smooth relationships and avoid potential stress. In the same vein, it was gathered that children with special needs such as physical disability were provided with special supports such as provision of wheelchairs, although this is not found in all the study communities.

EDUCATION

Educational support to HVC involved in Yekokeb Berhan program was found to include distribution of school uniform and supplies, tutorial support and assistance with school fees. Volunteers routinely tracked HVC school attendance and performance. CCs and CCCs in different locations reported to have signed memoranda of understandings (MoU) with education bureaus, government and private education institutions, business men, teachers and the community at large in their respective areas to better serve the educational needs of HVC.

School enrollment was assessed for HVC aged three years and above. Out of a total of 2,046 HVC three years of age or above, 1,754 (85.7%) were reported to be attending school or pre-school during the midterm survey (see Table 4). Data from the baseline survey shows that only 71.1% of the HVC were enrolled in school during the survey and the difference between the baseline and midterm was statistically significant ($p<0.05$).

Table 4: HVC education outcomes

	3-4		5-9		10-13		14-17		Total		
	M	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**Total**
	No (%)	No (%)	No (%)	No (%)	No (%)	No (%)	No (%)	No (%)	No (%)	No (%)	No (%)
Total (n)	81	82	316	336	394	386	197	254	988	1058	2046
Children currently attending school or pre-school (n=2121)											
Yes	21 (25.9)	19 (23.2)	258 (81.6)	280 (83.3)	383 (97.2)	377 (97.7)	180 (91.4)	236 (92.9)	842 (85.2)	912 (86.2)	1754 (85.7)
No	60 (74.1)	63 (76.8)	58 (18.4)	56 (16.7)	11 (2.8)	9 (2.3)	17 (8.6)	18 (7.1)	146 (14.2)	146 (13.8)	292 (14.3)
Children who have someone who could help with school work when needed (n=1754)											
Yes, often	6 (28.6)	5 (26.3)	75 (29.1)	76 (27.1)	69 (18.0)	82 (21.8)	27 (15.0)	34 (14.4)	177 (21.0)	197 (21.6)	374 (21.3)
Yes, sometimes	6 (28.6)	2 (10.5)	58 (22.5)	64 (22.9)	78 (20.4)	70 (18.6)	39 (21.7)	59 (25.0)	181 (21.5)	195 (21.4)	376 (21.4)
Never	9 (42.9)	12 (63.2)	125 (48.4)	140 (50.0)	236 (61.6)	225 (59.7)	114 (63.3)	143 (60.6)	484 (57.5)	520 (57.0)	1004 (57.2)
Children ever participated in a tutorial activity organized by Yekokeb Berhan program or in the community (n=1754)											
Yes	0 (0.0)	1 (5.3)	21 (8.1)	20 (7.1)	45 (11.7)	74 (19.6)	44 (24.4)	59 (25.0)	110 (13.1)	154 (16.9)	264 (15.1)
No	21 (100.0)	18 (94.7)	237 (91.9)	260 (92.9)	338 (88.3)	303 (80.4)	136 (75.6)	177 (75.0)	732 (86.9)	758 (83.1)	1490 (84.9)
Children promoted to next grade/ level in the previous academic year (n=1222)											
Yes	2 (25.0)	3 (50.0)	120 (71.9)	154 (80.6)	263 (89.8)	262 (92.9)	104 (88.9)	141 (89.2)	489 (83.6)	560 (87.9)	1049 (85.8)
No, he/she repeated	1 (12.5)	0 (0.0)	7 (4.1)	10 (5.2)	22 (7.5)	13 (4.6)	10 (8.5)	15 (9.5)	40 (6.8)	38 (6.0)	78 (6.4)
No response	5 (62,5)	3 (50.0)	40 (24.0)	27 (14.1)	8 (2.5)	7 (2.5)	3 (2.6)	2 (1.3)	56 (9.8)	39 (6.1)	95 (7.8)

When school enrollment was analyzed by age category, 91% of children in the age group 5-13 and 92% of those aged 14 years or above were enrolled at the midterm (see Figure 8). At the baseline, school enrollment of 5-13 years and 14 years and above age groups was 77%. Similarly, 75% of aged 3-4 years were enrolled to pre-school education at the midterm while only 4% of children of this age group were in pre-school at the baseline. All changes of school enrollment across the age groupings between the midterm and the baseline were statistically significant ($p<0.05$).

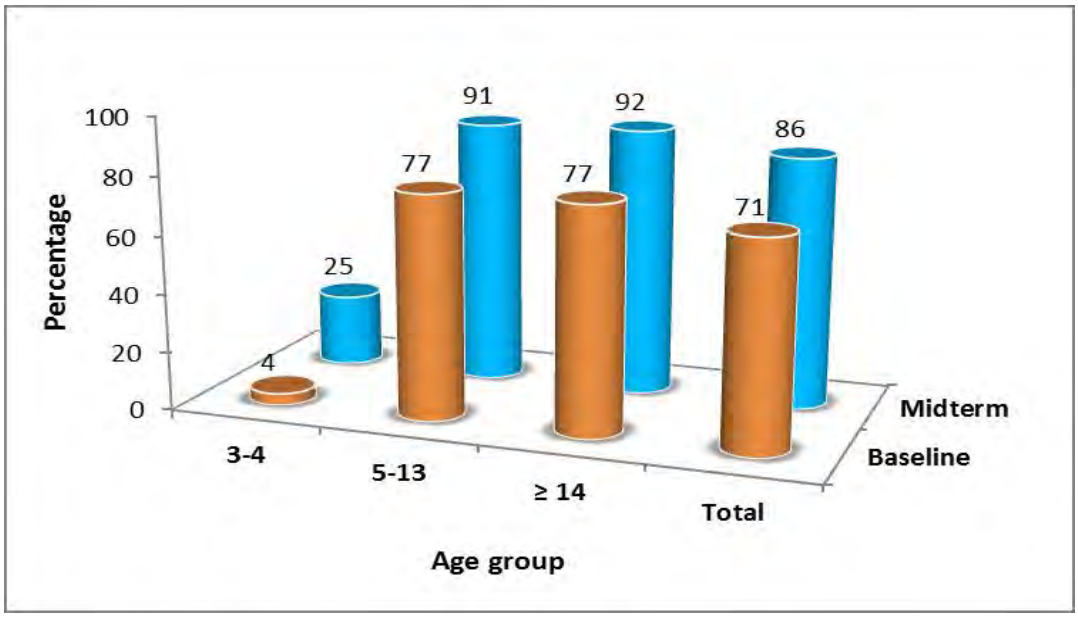
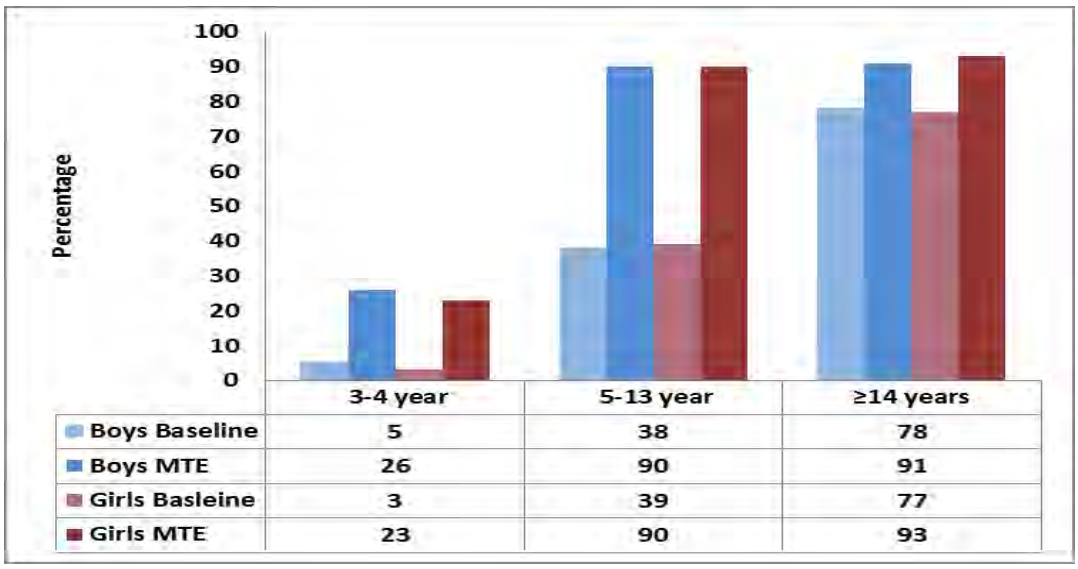


Figure 8: Comparison of school enrollment of HVC at baseline and MTE

When school enrollment was disaggregated by sex, 842 (85.2%) boys were enrolled at the midterm versus 70.3% at the baseline and the change was significant ($p<0.05$). Similarly, 912 (86.2%) girls were in school during the midterm compared to 72% at the baseline and the difference was significant ($p<0.05$).



	3-4 year	5-13 year	≥14 years
Boys Baseline	5	38	78
Boys MTE	26	90	91
Girls Basleine	3	39	77
Girls MTE	23	90	93

Figure 9: Comparison of school enrollment of HVC at baseline and MTE by sex

Out of in-school HVC, 1,222 (69.7%) reported that their school expenses including books, uniform, stationaries, transport, school fees, etc., were covered by Yekokeb Berhan Program. Further analysis by sex shows that 582 (69.4%) boys and 640 (69.9%) girls reported having their school expenses covered by the program. Of HVC who are currently in school, 264 (15.1%) benefited from tutorial activities organized by Yekokeb Berhan Program. Significantly more girls (16.9%) than boys (13.1%) received tutorial services from the program ($p<0.05$). On the other hand, only 750 (42.8%) in-school HVC reported to have someone to help with their school work. When major reasons for not enrolling to school for the 290 out of school HVC during the midterm were analyzed, two-thirds of respondents suggested that it was because of illness of the child, the child had to work to support family (9%) and lack of money to cover school expenses (7.2%). In the baseline survey, 42.1% of those who were not enrolled in school stated it was because they were needed in the household to help family members in household while child illness was a reason given for 41.1% of these respondents.

Regular school attendance of HVC enrolled in Yekokeb Berhan education support activities was also assessed based on the number of school days missed in the month preceding the survey. The majority of these children (70.7%) did not miss school while 24% missed ≤ 25% of school days. Overall, regular school attendance rate for Yekokeb Berhan -supported HVC was 94.7% with males' and girls' regular attendance rate being 94.8% and 94.5%, respectively. At baseline, 89.3% of those in school reported regular attendance with sex breakdown of 90% boys and 88.5% girls. Overall school attendance of HVC was significantly better at the midterm than the baseline

($p<0.05$). There was no statistically significant difference between boys and girls in regular school attendance during the midterm.

Of HVC provided education support, 1049 (85.8%) were promoted to the next grade in the previous academic year while 6.4% were held back while information was not available for the rest of them. More girls (87.9%) were able to progress to the next grade compared to boys (83.6%) in the midterm and this was statistically significant ($p<0.05$). However, promotion to next grade was not different between young and adolescent HVC. In the baseline, this was assessed differently – HVC were asked if they have ever repeated a grade and 24% of them reported repeating a grade in the past.

As revealed from the qualitative results, follow up on the performance of HVC was conducted by volunteers both at home and at school level. Most caregivers and volunteers who participated in the study confirmed that students were provided with guidance and tutorial support to ensure their school attendance and successful accomplishment. Caregivers argued that parenting training helped them develop a new habit of making follow up in the academic performance of HVC in most of the situations.

Most IPs involved in the study indicated that tutorial support to HVC was useful to help the needy HVC to catch up with their academic performance. Besides, there were coaching and help with homework, or when the child did not understand something, that were provided by volunteers and these supports were also found to be useful for HVC. However, there were reservations about the sustainability of such support since volunteers are stretched visiting 25 HVC per week. Most of the IPs and participants in FGDs agreed that the delivery of school uniforms and education materials has helped HVC to stay in school and increased educational performance. Information from some caregivers and volunteers, however, revealed that educational support, specifically school uniforms and stationary materials, were not available to them in time. Some CC participants (e.g. Hawassa, Fogera, NSL, Mekele and Adama) shared this idea and echoed their concern over the delayed provision of educational materials which may affect HVC's school attendance.

FOOD AND NUTRITION

Table 5 presents details related to provision of food and nutrition services. Over one-third (36.1%) of households had at least one adult family member who has received nutrition related training, counseling or advice in the past one year. Over half (58%) of the households involved in the midterm reported that they have experienced a shortage of food in the past twelve months. When the food shortage was assessed by days, 30% of the households did not have enough food to eat for 1-2 days, 35% for 3-6 days and 24.3% for seven days or more in the one month period prior to the evaluation. For extreme cases, 109 (8.8%) households reported that they did not have enough food throughout the month. Significantly higher numbers of respondents (66%) reported having food shortage in the month preceding the survey.

Respondents were asked they had some food reserve or store to cope up with an unexpected situation of loss of income or resources for food purchase. Slightly more than half (58%) said they had food reserve of various levels during the evaluation. However, only 37.1% of the households had food reserve that was enough for one or more weeks. At the baseline, availability of food reserve was reported for only 20% of the households and the difference compared to the midterm was significant ($p<0.05$).

Availability of supplementary and therapeutic foods for children who need them was assessed as one of the dimensions for food and nutrition services to the HVC. A child was prescribed food by health/nutrition workers over the past one year in 166 (7.8%) households and 129 (77.7%) of them received the prescribed food while the rest did not get it (see Table 5).

Nutritional assessment using MUAC of 695 children aged less than five years of age in the households involved in the study revealed that 21 (3.0%) of these children had moderate acute malnutrition while 8 (1.2%) had severe acute malnutrition. No significant differences were found between boys (4.3%) and girls (3.7%) in the rate of acute malnutrition in the midterm.

Table 5: Food and nutrition indicators

	No (%)
A family member received nutrition related training, counseling or advice in the last one year (n=2138)	
Yes	771 (36.1)
No	1344 (62.9)
Don't know	5 (0.2)
No Response	18 (0.8)
Household experienced shortage of food in the past 12 months	
Yes	1239 (58)
No	897 (42)
No response	2 (0.1)
Number of days a household did not have enough food to eat in the past month?(n=1238)	
No enough food all days	109 (8.8)
1-2 days	375 (30.3)
3-4 days	261 (21.1)
5-6 days	177 (14.3)
7 days or more	313 (24.3)
How long food would reserves/stores of the household last? (n=2138)	
No food store at all	886 (41.4)
Less than 1 week	446 (20.9)
1-4 weeks	611 (28.6)
1-2 months	125 (5.8)
3-6 months	31 (1.4)
More than 6 months	30 (1.4)
No response	9 (0.4)
A child was prescribed food by health workers/ nutrition workers over the past one year (n=2138)	
Yes	166 (7.8)
No	1965 (91.9)
No Response	7 (0.3)
Child received the prescribed food (n=166)	
Yes	129 (77.7)
No	33 (19.9)
No Response	4 (2.4)
Nutritional status of children 0-4 years (MUAC) (n=695)	
No malnutrition	666 (95.8)
Moderate malnutrition	21 (3.0)
Severe malnutrition	8 (1.2)

Qualitative data suggest that food and nutrition support was provided mainly through the collaboration between the Yekokeb Berhan Program and the World Food Program (WFP). Caregivers and HVC who needed food support were referred to WFP and provided with flour, oil and lentils on a monthly basis. In some areas, the program also mobilized local private institutions

(like bars and restaurants), universities and community members to assist in meeting the food needs of HVC. Informants suggested that IPs create more linkages with hotels and universities to fill the gap in availability of food for the needy HVC since food provision by WFP was not sufficient. Insufficiency of food support was described by a study participant as:

'*The support is insufficient especially the food distribution is not adequate – it is just like sprinkling holy water.'* (Staff member, ANNPCA, Gondar)

Through the Yekokeb Berhan Program, an initiative called ParmaGarden was reported to have been introduced in Mekele, Arbaminch, Debreberhan, Hawassa, to help caregivers to produce food for the family and surplus for market. Although findings varied by site, information from one site shows:

'PermaGardening on small space helped to cultivate vegetables (cabbage; carrot etc) which helped families to feed their children and now several families become independent in food.' (Staff member, EDA, Debrebirahn)

SHELTER AND CARE

Of the surveyed HVC households, in 1,262 (59%) households, the family lived in a one-room house while 651 (30.4%) living in a two-room and 9% in a three or more rooms household. Twenty two (1.0%) households lived in a temporary shelter.

When housing condition of the HVC households was assessed, it was reported that in 910 (42.6%) houses, water leaked into the part of the house where the children slept when it rained. This was significantly lower than the 52.5% of HVC who had the same problem at the baseline ($p<0.05$). Similarly, the proportion of houses where wind blew into the part of the house where children slept when it is windy outside went down to 41.1% at the midterm from 50% at the baseline ($p<0.05$). The proportion of HVC who lived in an adequate shelter during midterm evaluation was found to be about one-third. Comparison with the baselines was not however possible as data was not complete for this indicator.

One component of care and support service to HVC families by Yekokeb Berhan Program was the renovation of existing depleted houses of destitute households to protect them from exposure to various problems. This was undertaken by mobilizing local resources from the community by the community. Evidence from KIIs revealed that there were several families in most of the survey sites that have benefitted from construction or renovation of houses.

ECONOMIC STRENGTHENING

The economic strengthening packages involved in Yekokeb Berhan Program mainly focus on helping caregivers to generate financial resources and become economically self-reliant in the long run which allows for sustainable support to an HVC and their entire family. One approach designed by Yekokeb Berhan in this regard is to encourage caregivers to be involved in saving groups. To

this effect, caregivers were provided with economic strengthening training (e.g. basic saving and loan training, microenterprise selection planning and management and business development services) and matching funds to expand small scale business.

Qualitative data shows that caregivers and CSSGs were identified and empowered by CVs and CCs to be able to be able to take care of HVC and generate their own livelihood. While caregivers were head of the household that hosted HVC, CSSGs were established with an objective to enable group of caregivers to improve their livelihood through saving and credit schemes. With this initiative, a number of family members were able to generate income that could be used to feed and send their children to schools. Furthermore, the Yekokeb Berhan Program has advocated and promoted a saving culture to sustain HVC care and support initiatives. To this effect, CSSGs and caregivers were trained on starting and operating a small scale business and were assisted to initiate their own savings. These community level groups were provided with trainings.

'The major capacity we have received through economic strengthening training is how to start small business and thrive. They Yekokeb Berhan project provided us with relevant knowledge that has long standing implication on our economic activities throughout our life. We started from nothing and now we are all leading a successful life.' (Member of CSSG, Hawassa)

Table 6 below summarizes findings from economic strengthening variables. It was found that 819 (38.3%) households were engaged in economic strengthening activities with the support of the Yekokeb Berhan Program including training, market information, technical support through ES animators/facilitators or provision of matching funds. Of those households engaged in ES, 493 (60%) have received training in CSSGs through the Yekokeb Berhan Program. Participants of CSSG trainings described a wide range of benefits of the training in strengthening their household's financial condition. The majority of (76.3%) said it enabled them develop saving habits. Other benefits mentioned were increased savings which was not possible in the past (23%), increased formation of social bonds (22%), increased vision with set objectives and goals (12%) and access to loan funds for MEs. Microenterprise selection, planning and management (ME-SPM) training was received by 267 (32.6%) of those households engaged in ES activities. According to the respondents, the ME-SPM training enabled more than 50% of the participants to understand the local market opportunities for their products/services while in about one-third they understood about the need for ME operation skills. One-quarter of the households engaged in ES said they have received assistance from the program to access financial or technical services from community or government microfinance institutions.

Twenty five percent of those households engaged in ES activities were involved in small-scale businesses or MEs and out of these, 49% stated that they were able to expand or diversify their business over the past one year. When asked if they were able to save some money that they generated from the small-scale business or micro-enterprise that they were engaged in, 119 (58%) responded affirmatively while 72 (35%) said no.

In support of this, participants of CSSG pointed out that they have developed saving habits which in turn have implication on improving the lives of their children.

'The training we received is very important. This is the basis for our saving knowledge. Currently, saving of 17 women has reached 11,000 with only 10 birr saving a week' (Member of saving group, Hawassa). A group in Adama explained the 'Our income improved that we are able to feed our children and some of us start to buy school materials for children. We are really happy for getting involved in the saving group.' (Member of saving group, Adama)

Table 6: Economic strengthening outcomes

Household engaged in economic strengthening (ES) program (n=2138)	**No (%)**
Yes	819 (38.3)
No	1315 (61.5)
No Response	4 (0.2)
ES household had training in Community Saving and Self-help Groups (CSSG) (n=819)	
Yes	493 (60.2)
No	316 (38.6)
No Response	10 (1.2)
ES households other training on how to set up a business and run it (ME-SPM) (n=819)	
Yes	267 (32.6)
No	533 (65.1)
No response	19 (2.3)
ES households that had regular income in the past 12 months (daily, weekly, monthly, quarterly, biannually) (n=819)	
Yes	593 (72.4)
No regular income	221 (27.0)
No response	5 (0.6)
ES households involved in a small scale business or micro-enterprise (n=819)	
Yes	204 (24.9)
No	608 (74.2)
No response	7 (0.9)
ES households expanded or diversified small scale business over the past one year (n=204)	
Yes	100 (49.0)
No	91 (44.6)
No Response	13 (6.4)
Productive assets of the household engaged in ES compared to a year ago (n=819)	
Acquired additional productive assets than a year ago	106 (12.9)
Same as a year ago	142 (17.3)
Less than a year ago	570 (69.6)
No response	1 (0.1)
Compared to last year, how do households feel about their financial security (n=2138)	
More secure	586 (27.4)
Less secure	587 (27.5)
No change from last year	965 (45.1)

Out of the targeted households, 593 (72.4%) reported having a regular income on daily, weekly, monthly, quarterly or a biannual basis. Out of the total surveyed HVC households, 27% stated that they were financially more secure, 45% said they were at the same level and 28% less secure than a year before. Information on regular income of households was not collected at the baseline.

Figure 10: Proportion of households by major economic strengthening indicators

It was found that 106 (12.9%) of the ES households acquired additional productive assets over the past two years while 142 (17.3%) had the same productive assets and 570 (69.6%) had less than what they had a year ago. Acquired productive assets included working capital, cattle, sheep, goats and farm land.

Caregivers involved in saving groups reiterated that ES support has changed the life of participants as well as that of their children. Several accounts from participants revealed that economic strengthening through saving has recovered people in the community from poverty.

'*Initially I was nothing. I did not have anything and was waiting for peaceful death. Through this program however I was given the opportunity to get loan through revolving fund and am now in good shape supporting my children with basic needs.' (Participant from the FGD of CG, Gondar)*

'One of the useful lessons from saving is that I was able to stop waiting for my husband whom I used to sit around and wait for to give me money for household use. Now, I am capable of making money and meeting household needs and am planning to reach better level.' (CSSG participant, Hawassa)

'Saving helped to generate income on which women have full authority to decide on. I am not worried about expenses for my children's education or what to feed them since I have money no matter how small it is.' (CSSG member, Nifas, Silk Lafto)

In addition to saving and credit schemes, ES initiatives have also enabled caregivers to do gardening. Extensive training has been provided to caregivers and saving groups on perma gardening that helped families to produce food for them, and some have started marketing such product. While all participants were highly fond of the gardening initiative there appears to be a sense of remorse for failing to recognize this as pointed out by one of the participants: '*we were fully asleep, we just woke up* (Caregiver, Butajira).

Despite such widely recognized successes in connection to saving, which some refer to as a '*change in their culture where saving and gardening is recognized as an easy doable strategy*,' there were some complaints. Volunteers, saving groups and CCs in all study settings complained about matching funds that were often too small and not available in time.

LEGAL PROTECTION

Provision of legal protection is an integral component of Yekokeb Berhan Program. Implementation of the program follows specific procedures whereby the justice system and police are represented in different forums (*woreda* coordination forum and *kebele* CC) and a child abuse protocol is adopted. It was gathered that Yekokeb Berhan Program has put in place a reporting system with appropriate legal office bodies on abuse of HVC. The legal protection and support include: protection of the rights of HVC, protection of HVC from different kinds of abuses and delivery of birth certificates. To this effect, caregivers, community volunteers, CC members and saving groups were trained on protection and safeguarding the right of HVC and protecting them from abuses. In addition, HVC were provided with information on their rights, especially the right to services, and on how to exercise it.

Table 7 below summarizes findings related to legal protection variables. Of all the caregivers involved in the study, 147 (6.9%) reported that their household has experienced some form of violence in the past one year. Of these, 68 (46.3%) encountered verbal abuse while 60 (40.8%) encountered physical abuse. Sexual violence was also reported by 4.1% of the households. According to the respondents, most of the violence was perpetrated by neighbors or unknown people while household violence by a spouse accounted only for 12% of the cases. Out of the households that experienced violence, 92 (62.6%) went to police to get legal services while 45 (30.6%) did nothing. On the other hand, 8.2% of the households were referred to legal services for various reasons over the past year, and the majority (53%) of this referral was done by Yekokeb Berhan Program through IP staff, CCs or CVs. More than half (51.7%) of the households said that they feel more secure in terms of legal protection this time than before they were involved in Yekokeb Berhan Program.

Only 185 (8.7%) of the HVC had a birth certificate from an authorized government office as confirmed by the surveyors. This was low but significantly higher compared to the baseline where only 5.5% of the HVC had birth certificate during the survey ($p<0.05$). In the midterm there was no difference between boys (8.4%) and girls (9.0%) in terms of possession of birth certificate.

Table 7: Summary of legal protection variables

	Total	%
HVC has birth certificate issued from authorized government office (seen and confirmed) (n=2121)	185	8.7
Over the past 12 months, any member of your household experienced any violence (n=2138)	147	6.9
Type of violence experienced (n=147)		
Physical violence	60	40.8
Verbal abuses	68	46.3
Sexual violence	6	4.1
Other	13	8.8
Action taken after the violence occurred (n=147)		
Went to police/sought legal services	92	62.6
Went to health center/clinic	21	14.3
Went to Kebele/ women & children affairs	25	17.0
Told a relative or neighbor	14	9.5
Did nothing	45	30.6
Other	1	0.7
No response	7	4.8
Who mostly perpetrated the violence? (n=147)		
Spouse	18	12.2
Neighbor	70	47.6
Older child	11	7.5
Unknown people	26	17.7
Other	13	8.8
No response	9	6.1
Households referred or linked to any legal services over the past 1 year)n=2138)	176	8.2
Who referred or linked you to legal services he/she needed? (n=176)		
Total		
Yekokeb Berhan IP	46	26.1
Community committee	26	14.8
Community Volunteers	22	12.5
Kebele administration	47	26.7
Other	24	13.6
No response	11	6.3
Household that feel more secure in terms of legal protection this time than before you were involved in Yekokeb Berhan program (n=2138)	1105	51.7

4.4.3 Objective 3: Enhance the capability of communities for coordinated and improved responsiveness towards HVC care

Community structures and coordination of care

At the community level, there were three important structures that were found functional in connection to Yekokeb Berhan Project. These are: CCs/CCCs,[25] CVs and CSSGs. Each of these structures was either established in connection to this project or was already functioning and was therefore strengthened. Nonetheless, it was clear that these structures were empowered to play their specific roles which were found to cover those exhibited in the table below.

1. **Community structures**
    a) **Community committee/community care coalitions**

Community committee was found to be a structure with a responsibility to coordinate support for HVC at community level. This structure is found to be chaired by the chairman of the *kebele* administration with *kebele* chief executive officer as a secretary. The members are from representatives of MoWCYA, HAPCO, health, education, NGOs, faith based organizations, and community based organization and community representatives. Participants' representing CC explained their specific roles as follows:

'The role of CC in relation to Yekokeb Berhan program is to identify poor households with vulnerable children based on specific criterion and determine level of poverty, prioritize children that should get support, initiate working relationship with government sectors to support HVC and link them with different NGOs to get relevant support.' (Member of CCC, Mekele)

According to this group, care and support for HVC requires coordinated multi-sectoral response to avoid duplication of support. Members of the CC in all study areas believe they will be responsible to sustain the project after it phases out.

'We are here to assure sustainability of care and support to HVC initiated by Yekokeb Berhan project through mobilization of resources from the community. We are engaged in building community awareness to ensure community's ownership of HVC. Furthermore, they pointed out that CC collects worn out cloth, money and other materials to support HVC and their family for immediate solution but our main target being to sustain the initiative after the project is phased out.' (CC member, Gondar)

Similar opinions were reflected on the role of CC which coordinates HVC's care and support at community level by mobilizing community resources and sustaining initiative activities.

[25] In Tigray and since recently in Amhara region such groups are referred to as community care coalition (CCC)

The CC monitors and supervises distribution and utilization of support provided to HVC and their families, supervise community volunteers and strengthen community-based child care and support initiatives.' (Member of CC, Adama)

The CC is composed of different stakeholders involved in care and support for orphans and vulnerable children or are believed to have a stake in this.

'*We meet with different structures: iddir, teachers, youth and women associations, government and nongovernmental institutions as members of CCC. This is a forum we discuss and work and evaluate our work with Yekokeb Berhan program every 3 months.'* (Member of CCC, Mekele)

At the community level, scheduled monthly meeting is held among CC and CVs to discuss on accomplishments and challenges encountered.

'*The different groups [CC and CVs] meet every month to discuss about their progress, problems encountered, and solutions attempted.'* (Member of CSSG, Nifas Silk Lafto)

Resources mobilized from within the community have helped CCs to provide educational materials, free training opportunities for HVC over 18 years of age and construction and renovation of houses. This is mentioned to be the case by CC participants from all settings. It was found that: '*often resources mobilized from community level fill urgent gaps in addressing the needs of HVC'* (Member of CCC, Mekele).

b) Community volunteers

CVs are members of the community who are identified by CCs. They are provided with relevant trainings as pointed out above and are responsible for 25 HVC and their families. According to information from Pact team, currently there are over 20,000 CVs supervised by community facilitators. Every CV meets with group of HVC and their families as well as community volunteers each week. CVs are the front line in implementation of Yekokeb Berhan Program, identifying challenges and reporting about Yekokeb Berhan Program operation.

The below statement from one of the volunteers captures their role:

'We work closely with HVC and their families. We raise their awareness about Yekokeb Berhan program and how they could sustain their life in its absence by initiating their own through involvement in saving groups and using loan. We follow and help HVC to attend their school, guide them on use of their time to study and equip them with moral and discipline. We also help caregivers to keep their environment clean, on housekeeping and environmental sanitation. We visit every care giver as well as HVC every week to keep records and help them solve problems in addition.' (CVs, Nifas Silk Lafto)

Furthermore, CVs are provided with various trainings that they, in turn, share with beneficiary families.

'We train caregivers on parenting, sanitation, fill CSI to track problems HVC encountered in relation to their education, food and health. We bring this to the attention of CC to solve their problems. Our role is to bring change on the outlook of the community towards vulnerable children. We checked out the child's development and problems.' (CV, Mekele)

CVs are responsible for generating data and reporting to the CC on progress and challenges in response to HVC at the community level.

'We were trained on child care/parenting skill, child-family relationship, how to select HVC using the available format, collection and reporting of data on HVC on a regular basis.' (Member of CCC, Mekele)

Yet, government partner at regional level do not feel capacity building at community structure's level is yet sufficient.

2. Coordination of care

Coordination of care is one of the core components of Yekokeb Berhan Program. The objective of this component of the project is to establish strong partnerships between different stakeholders to improve level of care and support to HVC. At federal level, Pact, FHI360 and Child Fund have created partnerships to guide the project following government's strategy.[26] Such partnerships have translated to community level where community members, government sectors such as education and health, CSOs operating in the community, private (for profit) institutions and individual members of the community work together to improve the life of HVC and their families. Coordination of care works in such a way that once HVC are identified, they are provided services within the reach of Yekokeb Berhan Program and referred to other stakeholders for more support that could not be accommodated within Yekokeb Berhan Program. Data generated from Pact as well as community structures revealed that for food support HVC are referred to WFP, while for chronic health problems the health sector would take responsibility. At the community level, community facilitators[27] are responsible:

'To bring CC and volunteers together and guide them to track source of support at community level and link HVC with such support.' (Yekokeb Berhan regional manager, SNNPR)

Evidence from the field shows that:

'*Service mapping is carried out to determine available sources of support and develop directory of services so as track types of resources at community level.'* (Members of CC, Robe and Hawassa)

[26] Although level of partnership between HAPCO and MoWCYA was not clear, resistance from HAPCO to participate in this study appears to shade light on the fact that HAPCO is not quite happy for not being a direct partner to Yekokeb Berhan for this program.

[27] Paid field level worker responsible to supervise 600-700 CVs, responsible to provide technical support and guidance to community structures, liaise community structures with Implementing CSOs.

'Such service mapping and directory is a reference for community structures to mobilize support for HVC and their families based on needs identifed through CSI.' (Amahara regional coordinator)

At the *woreda* level, a coordination forum is established where membership include representatives of the WCYAs office, women associations, schools, community leaders, police, education and health sectors and CSOs chaired by the WCYAs office.

'*The objective of such forums is to share experiences and solicit solutions for problems' (Gondar, PADET)*. Furthermore, it was argued that '*such forums will also be considered to identify potential support stakeholders could provide.'* (ODA staff, Robe)

IPs and regional cluster managers underscored that the project encourages maximum utilization of locally-available resources (human, material and financial) by mobilizing such resources from different stakeholders through the CCs at the community level. To this effect, Yekokeb Berhan Program built capacity of implementing partners and CCs were trained to enhance their capacity to mobilize resources and coordinate with stakeholders operating within their setting to improve care and support to HVC and their families.

Interview with Pact staff members reveals that as part of the effort to coordinate and harmonize care and support to HVC and their families, implementing NGOs were encouraged to sign MoUs with different stakeholders (government and non-governmental) to improve service provision to HVC at community level on referral basis. Often such MoUs were reported to be with health facilities, microfinance institutions and education institutions.

CCs at operational levels reported to have mobilized support from local government and private institutions and community members including *iddirs*, religious organizations and individual community members so as to improve care and support for HVC and their families. In fact, the composition of CC itself is considered as a step towards coordination of care.

In addition to the above components of the coordination of care and support, many participants of this study suggest that coordination of care and support initiatives laid the basis for sustainability of the program. Most of them also suggest the need to intensify coordination of care by building the capacity of CCs. Besides, it is important to note the value of such a strategy by ensuring ownership and close follow up of government partners.

Table 8: Summary of roles of community structures in connection to the Yekokeb Berhan Program

Partner	Roles
CCs	• Recruitment of HVC and their families to be enrolled into the Yekoekb Berhan program • Determine which vulnerable children should receive what support • Establish relationship with likeminded institutions (civil society organizations (CSOs), private organizations and government structures) to mobilize support for children and their families • Ensure there is no double use of available resources – avoid duplications • Support and supervise volunteers • Visit beneficiaries at home with volunteers
Caregivers	• Take full responsibility for a smooth growth of children • Care for our children • Send children to school • Provide psychosocial support to children • When the child gets sick take them to health center for medical support • Provide food and ensure personal hygiene of children
CSSGs	• Save every week (the amount of money that they save would be decided by the members of the group) • Develop their internal rules and regulations • Report their progress through the chair • Proper management of their business • Active and sustained engagement in production of livelihood
CVs	• Responsible for 25 HVC whom they visit at HHs to • Identification and registration of potential beneficiaries • Carry out vulnerability assessment using CSI • Share assessment result with CC for approval • Advice family members on how to care for their children. • Follow and guide children on their education • Advice caregivers on self-reliance and how to start income generating activities • Train caregivers on parenting and truck on they apply the skill for improved child care • Advice HVC and their families on personal hygiene • Record accomplishments and report to Community Committee • Facilitate linkage between caregivers with sick child with health facilities for medical support • Raise community awareness on HVC and sustainable HVC care and support • Maintain strong and close working relations with caregivers and HVC • Preparing and submitting the monthly activity report

Source: Data generated from different participants of the midterm evaluation, March 2014

4.4.4 Objective 4: Establish effective and efficient monitoring, evaluation, reporting and learning system ensuring evidence based programming and policy formulation

Evidence-based programming

Yekokeb Berhan Program has a well-defined method of collecting, managing and reporting about HVC. Standard tools were developed to collect, manage, report, analyze and use data for planning purposes. Mechanisms were developed to collect data on HVC and their families at the household level. Volunteers make door-to-door visits to HVC and their families to record state of service provision on a weekly basis using formats developed for this purpose. They submit the report to CC every month who, in turn, verifies and share it with community facilitator. Data generated by volunteers at household level passes through successive verification and approval steps as shown in figure below.

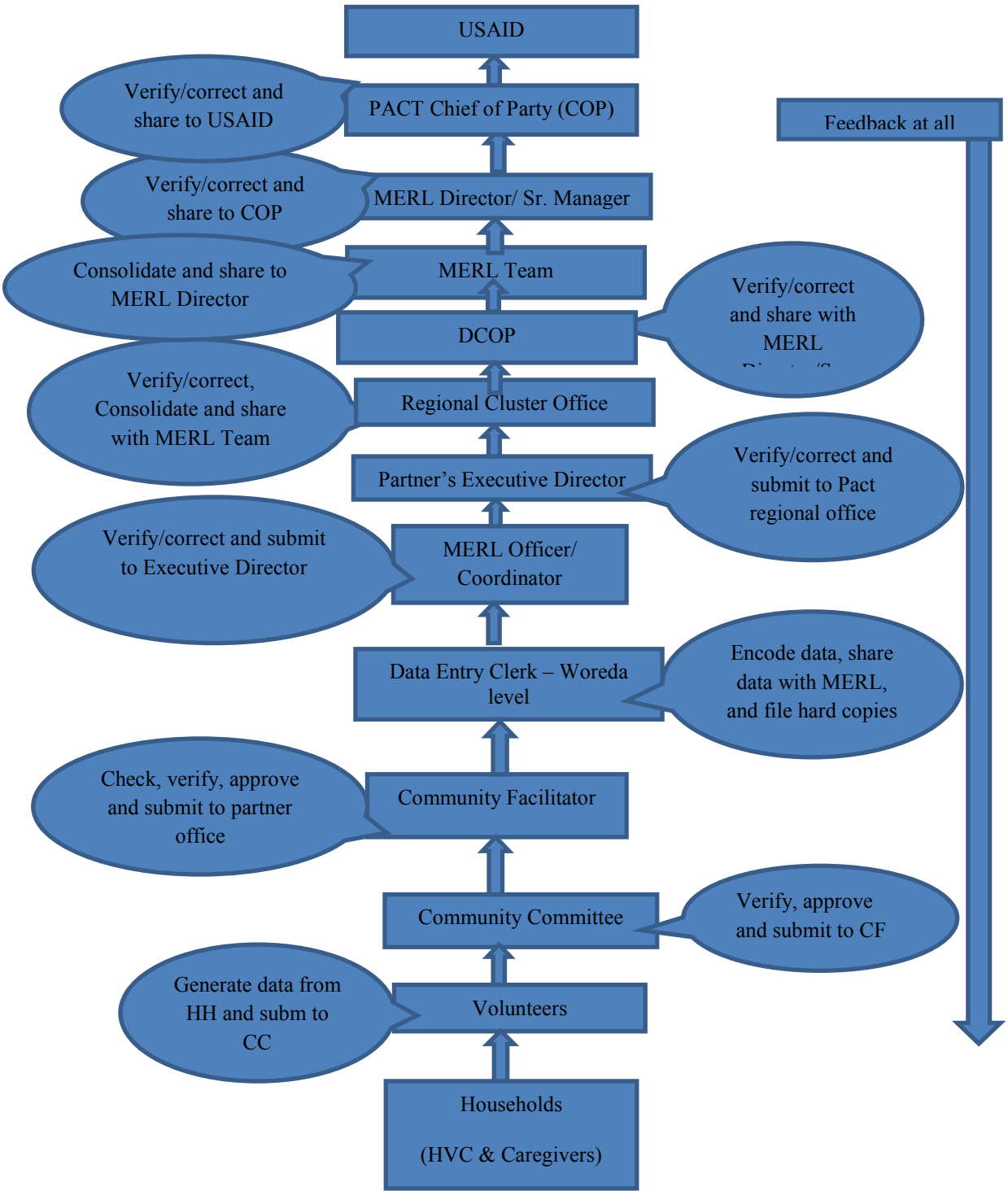


Figure 11: Data generation and reporting procedure for Yekokeb Berhan project, April 2014

Source: Data generated from different participants in assessment, March 2014

Participants from government offices at regional and *woreda* levels were found to have limited or no information on changes regarding routine data generation, management and reporting although they are aware of national level endeavors to establish a child related database. Even if data is shared with BoWCYA regional offices, there appears to be lack of appreciation as revealed by a representative of one of the regional office staff: '*Yekokeb Berhan Program sends quarterly plan and reports to our office, but we do not pay attention to the plan or report.'*

At the *woreda* level, however, IPs recognized that data is routinely generated and compiled at the implementing NGO level, providing an opportunity to track the state of HVC in the *woreda*. As pointed out in one of the data source:

'In previous years we did not have data on the number of HVC supported in our woreda and who provides such support. As a result, some children get support from three or four NGOs while others barely get one.' (Hawasa, BoWCYA)

Yet, it was gathered that still there are gaps as reflected by most government partners at operational levels. Despite some evidence of improved capacity (through training) on data management and reporting to the government partners, the importance of data appears to be undervalued where data is not shared with the *woredas*. This, however, was not seen at all sites since some *woredas* are proactive and benefitted from Yekokeb Berhan Program.

'Yekokeb Berhan Program has helped us to enrich our previous data collection form and now we have detail data due to HH level data collected by volunteers.' (BoWCYA Butajira)

Similar insights were reflected where:

'*Previously, we were documenting HVC information but after the beginning, Yekokeb Berhan program we were able to manage and use data properly but still there is gap on timely documentation.'* (BoLSA Adaw)

Furthermore, routine data collection and management by Yekokeb Berhan program has facilitated easy recruitment of HVC for support.

'In earlier days when service providers request us for needy children, we used to send them to kebele who will readily identify children for the intended purpose without strong evidence. Now, thanks to Yekokeb Berhan program, now data on how many children deserve support and where they are found are all available.' (BoWCYA, Hawassa)

In addition to the use of such data for identification beneficiaries, respondents suggested that it is used for planning of child related activities.

'*When we plan child focused activities in a particular kebele or when we are asked about children current in support, we resort to data generated through Yekokeb Berhan program.' (*BoWCAYA, Kombelcha*)*

Another important activity that the program undertaken in order to achieve its objective 4 was strengthening regular meetings to review programs at all levels. It was found that IPs conducted monthly and quarterly meetings with government partners including health offices, MoWCYA, education sector and HAPCO offices. Review meetings were also held at community level with CC/CCC members and volunteers to discuss achievements, identify gaps and work on improvement. A key informant described this as:

'[W]e conduct regular meetings with CC/CCC and CVs in all kebeles and discuss progress and challenges. This has helped us a lot solve problems that may affect our program at the implementation level.' (IP staff, Hawassa)

Secondary data review also revealed that the IPs carry out periodic review meeting with partners and discuss issues that affect implementation of the program like high turnover of community volunteers.[28,29] From review of program reports it was found that Yekokeb Berhan also conducted regional quarterly review meetings in all the five clusters where Yekokeb Berhan and IP staffs, and regional government representatives (BoWCYA, BoLSA and HAPCO) were involved. The meetings were intended to review the program progress, facilitate experience sharing focusing on Coordination of care and economic strengthening among the implementing partners, discuss on strengthens and ways to address improvement areas and discuss program priorities for subsequent time.[30,31]

4.4.5 Perceived changes at community level in consequence to Yekokeb Berhan project

In all settings study participants explained changes brought about due to Yekokeb Berhan Program and resulting community structures. Some of such changes were highlighted as follows:

'In former times, community members insult orphan children with offensive terms words saying komat (poor), abou zidefe (who kills his/her father). This is history and no one would say this. Children consider these structures and refer to them as 'kokeb berhan' where as some caregivers refer to us as 'embur berhan' (colored light).' (CV, Mekele)

Findings show that the Yekokeb Berhan Program was mobilizing support and ensuring that HVC attend schools.

'A lot of children have been exempted from school fees and have all materials necessary for them to attend their education. In one wereda alone we can find 500 or 600 children exempted from school fee due to the intervention of the CC.' (Yekokeb Berhan regional manager, Eastern cluster)

[28] Pact, Minutes on Partners' Quarterly Performance Review Meeting, Nekemte, June 04, 2012.
[29] Pact, Minutes on Partners' Quarterly Performance Review Meeting, Jimma, November 22-23, 2012.
[30] Pact Yekokeb Berhan Program for Highly Vulnerable Children, Annual Progress Report, Oct 2012 to Sept 2013.
[31] Pact Yekokeb Berhan Program for Highly Vulnerable Children, Semi-annual Progress Report, Oct 2013 to Mar 2014.

More specifically a CG in Hawassa explained that:

'I have three children. I wouldn't have sent them all to school if it was not for this project to support two of my children. I am not worried for exercise book, pen and pencil.' (Members of CGs, Hawassa)

Now more families are economically empowered to the point that they can sustain their own livelihoods.

'Many individuals who were jobless are engaged in self-income generating activities and changed their life.' (Padet, Fogera)

–'*The life of most HVC has improved in terms of school attendance, development of self-confidence, better (renovated) house. Besides, now community is taking more responsibility to support HVC.'* (Staff member of EKHC, Arbaminch)

Similarly, it was argued that community's capacity was built to provide support to HVC with local resources.

'Because of coordination of care the community was able to support HVC. They were able to realize capacity within the community and they were able to mobilize that to care for and support HVC.' (Staff member of ODA, Robe)

At the IP level it was gathered that capacity of CSOs as implementing partners was improved. Specific mention was made of the experience in harnessing local resources to support HVC.

'*I think this is the first project that works on using the local resource. We were able to have the experience of mobilizing local resource. This project has formalized local resource mobilization.'* (Staff member of Mary Joy, Hawassa)

Besides, the data base system introduced was widely recognized as important contribution from Yekokeb Berhan project. It was argued that:

'*Previously service delivery was informed by information that was not based on accurate database. The current database contains its own care plan and now that can verify and used for decision making on who get the service and what type of service.'* (Staff member of Padet, Fogera)

5. DISCUSSION

In this section, findings presented in the previous sections are discussed in comparison with the baseline findings, wherever information is available from the baseline. The challenge here, however, is that many of the variables were not documented in the baseline. Efforts have been made to get as much information as possible by reanalyzing the baseline data. However, most of the relevant variables to the program were missing. Health, education and shelter variables were better collected in the baseline and hence comparisons with the midterm findings have been better in these areas. Variables related to psychosocial and legal protection, apart from birth certificate, were not collected in the baseline. Some economic strengthening and food and nutrition variables were collected differently than the programs activities and direct comparison of these variables with the midterm findings was not possible. For variables that were not documented in the baseline and for those documented in a different manner, comparison is made with national data and other sources, including secondary data as appropriate.

a. Program Objective 1

Yekokeb Berhan Project introduced a system to identify and enroll HVC to benefit from standardized care and support. In order to enable stakeholders at different levels, different systems and structures were put in place or strengthened. Dissemination of the National OVC Standard Service Delivery Guidelines (SSDG) was perhaps the foremost step of the program in strengthening the capacity of key government partners. This finding was consistent with the project reports which state that large number of copies of SSDG were distributed to IP staffs, CC/CCC members, volunteers, and government officers were oriented to enhance their understanding of the guidelines.[32,33] Similarly, the various trainings provided to IPs and government, as described by the study participants, were found to be congruent with what the program reported in its annual and semi-annual reports.

The innovative method of assessing capacity of the community known as Community Capacity Barometer enabled the program to identify capacity strengths and gaps at the community level. Based on the findings, the program designed various capacity building activities for CCs/CCCs including training, supply of stationery and office furniture and supportive supervision by IPs. Community capacity building endeavors of the program were acknowledged by government partners as stated by a staff of MoWCYA: '*There has never been an organization engaged in building community system and capacity in response to children's problems…'* and this may be what the makes Yekokeb Berhan Program unique.

Capacity building of IPs, government partners and community structures as well as improving guidance and skills for coordination of care were important initiatives for system building. Such system improvement for delivery of services to HVC may help to sustain the program's initiatives

[32] Pact Yekokeb Berhan Program for Highly Vulnerable Children, Annual Progress Report, Oct 2012 to Sept 2013.
[33] Pact Yekokeb Berhan Program for Highly Vulnerable Children, Semi-annual Progress Report, Oct 2013 to Mar 2014.

beyond it life. Nevertheless, challenges that undermine the capacity building efforts of the program exist. This is mainly related to high staff turnover in the government offices which usually leads to gaps in institutional memory and consequently limited awareness about the project which in turn leads to poor partnership with CSOs.

b. Program Objective 2

HEALTH AND HEALTH CARE

Health services are an essential component of a comprehensive HVC program. Yekokeb Berhan Program has created access to health care for both preventive and curative services for HVC and their families by working closely with the government health care system and the private sector to expand children's access to health services. The impact of this support seems visible as HVC's assessment of own health status over the twelve month period prior to the midterm evaluation indicated improvements from the baseline. The proportion of HVC who perceived their own health to be either very good or good has significantly increased from the baseline. Similarly, those who felt that their health was either poor or very poor have significantly decreased over the course of the project implementation. This was also supported by the finding that children who reportedly fell sick in the two weeks preceding the survey decreased by more than 40% from the baseline. This finding was in line with the finding of comparative analysis of CSI-I and CSI-II where in the indicator 'child free from signs of disease' number of children with score 1s has decreased and those with score 2s, 3s and 4s have increased.[34]

Assessment of rate of diarrhea among HVC as one of the key indicators for their health status was also in favor of improvement of HVC's health situation. Episodes of diarrhea among HVC in the two weeks preceding the survey has significantly decreased at the midterm compared to the baseline. However, rates of fever among HVC during the two weeks preceding the survey increased from the baseline, and this is perhaps attributed to slight geographic variations between the baseline and midterm evaluation areas and the difference in the seasons of the surveys (baseline survey was conducted during the rainy season while the midterm evaluation was in dry season), both of which have role in occurrence of malaria and other febrile illnesses.

Positive changes in health seeking behavior of HVC, as assessed by whether treatment was sought for recent fever and diarrhea, were one of the most noticeable changes in the health outcomes. The changes in proportions of HVC who sought treatment for fever and diarrhea gave evidence for positive change of health-seeking behavior of HVC.

The immunization status of children against vaccine-preventable disease was another important indicator of health for HVC. Coverage of age-appropriate vaccination for under-five children as confirmed by vaccination has shown significant improvement from the baseline and was even higher than the national coverage for urban settings. This finding was compatible with the

[34] Yekokeb Berhan CSI Report from FY13 Annual Report.

comparative analysis of CSI-I and CSI-II of the program also shows that children with scores of 1s and 2s have reduced significantly while those with 3s and 4s have increased showing positive trend in coverage of immunization.[35] Similarly, comparison of the child health access indicator in the two CSIs shows significant reduction of score 1s and at the same time increase in 2s, 3s and 4s.

Yekokeb Berhan Program prioritizes access to health care for both preventive and curative services to HVC and their families and, to this effect, works closely with the government health care system, especially with the health extension program, and the private sector to expand children's access to health services.[36] Volunteers coordinate with HEWs to identify and refer children needing health care, promote child and maternal health through health education (HIV/AIDS, hygiene and sanitation and breast feeding), and facilitate and follow up on immunization of children. These interventions of the program may have contributed to improvements in health and health-seeking behavior of HVC between the baseline and midterm.

HIV and AIDS related services were also among the health services that were provided to HVC and their caregivers through the support of Yekokeb Berhan Program. The program supports IPs to strengthen health referrals for HVC including for HIV prevention (e.g. prevention of mother-to-child transmission of HIV) and to HIV testing, care and treatment.[37] Though this information was not collected at the baseline, the finding in the midterm that large proportion of caregivers and adolescent HVC reported having access to HIV information and counseling service over the past 12 months was generally high. However, this finding was not congruent with the program progress report which states that significantly lower proportion of beneficiaries (26%) were supported to access HIV services.[38] This is perhaps because HVC and their caregivers may have obtained HIV information and counseling services through other sources including public health facilities, schools, youth clubs and from mass media where these services are often available.

With 12% of teenage women in Ethiopia starting childbearing,[39] high rates of sexually transmitted infections including HIV and a high maternal death rate, improving access of youths to reproductive health continues to be urgent need in Ethiopia.[40] This is even more important when it comes to HVC who are usually underserved and vulnerable. The finding in this midterm evaluation that less than two-thirds of adolescent HVC had access to RH information was still much lower compared to a study conducted in Jimma town in 2009[41] where 95% of the adolescents had easy access to information, education and communication about RH, though the settings are different and Yekokeb

[35] Yekokeb Berhan CSI Report from FY13 Annual Report.
[36] Pact Yekokeb Berhan Program for Highly Vulnerable Children, Semi-annual Progress Report, Oct 2013 to Mar 2014.
[37] Pact Yekokeb Berhan Program for Highly Vulnerable Children, Semi-annual Progress Report, Oct 2013 to Mar 2014.
[38] Pact Yekokeb Berhan Program for Highly Vulnerable Children, Semi-annual Progress Report, Oct 2013 to Mar 2014.
[39] Ethiopia Demographic and Health Survey 2011, Central Statistical Agency, Addis Ababa, Ethiopia and ICF International, Calverton, Maryland, USA, March 2012.
[40] UNFPA Ethiopia: http://countryoffice.unfpa.org/ethiopia/2008/12/30/266/reproductive_health_and_hivaids/ (accessed on 11/5/2014).
[41] T. Ayalew, G. Yeshigeta. *Adolescent Reproductive Health Services in Jimma City: Accessibility and Utilization*. Ethiop J Health Sci. July 2009; 19 (2): 91-102.

Berhans Program's target group are selectively defined. Schools appeared to be the most important source of RH information for adolescent HVC as they account for three-quarters of the sources. This indicates the need to support schools to strengthen their capacity to continue providing the right information. On the other hand, the role of Yekokeb Berhan CVs, who also have opportunities to interact with HVC, could be expanded as sources of RH information for adolescent HVC.

With regard to HIV testing of HVC, having ever been tested was assessed at the baseline and direct comparison with the midterm finding where testing was assessed for the 12 month period prior to the evaluation may have limited value. Nonetheless, HIV testing rate found in this midterm was higher than the baseline and routine data of the program. Similarly, the finding that three-quarters of the caregivers reported having HIV test in one year prior to the evaluation was much higher than the national adult HIV testing coverage of 20%.[42] This may reflect the program's impact on accessing HIV/AIDS services by HVC and their families as it has been providing HIV and AIDS-related education and referrals for counseling and testing over the past two years.[43,44] The fact that many HVC and their caregivers are affected by HIV and as a result belong to high-risk group may drive them to seek HIV testing more readily than the general population hence showing higher testing rate than the national coverage. The finding that proportion of HIV-positive HVC that was on ART significantly increased from baseline was perhaps attributed to the program's support to HVC to access HIV and AIDS information, education and services hence improving their health-seeking behavior. However, as described above, there may be public and CSO actors providing HIV information and education hence augmenting Yekokeb Berhan Program's efforts in this regard. HIV positivity rate both among HVC and caretakers were much higher than the national prevalence of 1.2%[45] for obvious reason that many of these households may have been affected by HIV as a result of which vertical and horizontal transmissions could be possible.

PSYCHOSOCIAL SUPPORT

Psychosocial support services aim to provide HVC with psychosocial support that helps them build confidence to interact with friends and the family and can plan their future responsibly. Such support is believed to break potential stigma and discrimination against HVC. In addition, the service seeks to promote and support the acquirement of life skills that allow adolescents in particular to participate in school and recreation activities without any restraints.[46] The importance of parenting skills for caregivers to care for vulnerable children who are often subjected to psychological and social problems cannot be overemphasized. Better training and refreshers could improve not only breaking stigma and discrimination but also the smooth and responsible

[42] Ethiopia Demographic and Health Survey 2011, Central Statistical Agency, Addis Ababa, Ethiopia and ICF International, Calverton, Maryland, USA, March 2012.
[43] Pact Yekokeb Berhan Program for Highly Vulnerable Children, Annual Progress Report, Oct 2012 to Sept 2013.
[44] Pact Yekokeb Berhan Program for Highly Vulnerable Children, Semi-annual Progress Report, Oct 2013 to Mar 2014.
[45] HIV Related Estimates and Projections for Ethiopia, Ethiopian Health and Nutrition Research Institute, Federal Ministry of Health, Addis Ababa, August 2012.
[46] Standard Service Delivery Guidelines for Orphans and Vulnerable Children's Care and Support Programs, February 2010, Addis Ababa.

development of HVC. As one of the package of services provided to HVC, this support is also believed to reinforce the impact of other services among which are education and health. HVC who are not stigmatized and discriminated in school and at community level are believed to be self-confident and can contribute to their own development.[47,48]

The large majority of HVC appeared to be emotionally stable as proportion of those who had sudden change of mood found to be very small and this seems encouraging. Though there was no data on psychosocial needs of HVC at the baseline, the fact that improvements were observed for children who scored the lowest ('in greatest need') in psychosocial assessments when comparing two years of CSI scores on some psycho-social indicators[49] indicate that there was improvement in psychosocial wellbeing of HVC. This may be attributed to the program's counseling and guidance services provided to a large number of HVC through home visits by volunteers and in collaboration with religious institutions and professional counselors.[50,51] Better parenting training that was provided by the program to more than half of the households may have also helped caregivers provide better care for the HVC hence helping the latter to be emotionally stable.

EDUCATION

Different studies have shown that orphans and vulnerable children are less likely to be enrolled in schools than non-orphans.[52,53] Consequently, Yekokeb Berhan Program has been working closely with local education bureaus and *kebele* authorities to support HVC households to enroll and keep their children in school. The program has supported and mobilized local resources to provide scholastic materials and school uniforms to HVC and has facilitated tutorial services and exemptions from school fees. Such support coordinated by CCs has involved the community as well as school authorities to improve education service to HVC. From this particular study as well as previous reports, such support is documented to have improved student's school performance and reduced school dropout rates.[54]

Overall school enrollment of HVC in the project area has significantly increased in the midterm from the baseline. The change was across all age groups and for both boys and girls alike. The biggest change was however observed for youngest children aged 3-4 years where enrollment increased from just 4% at baseline to 75% in the midterm. Not only enrollment but also regular

[47] Grace Zhou. Understanding psychosocial wellbeing of Orphans and vulnerable children: The intersection of research and policy, May 2012.
[48] FHI360. Guidelines and programming options for protecting vulnerable children in community based care and support programs, 2012.
[49] Yekokeb Berhan CSI Report from FY13 Annual Report.
[50] Pact Yekokeb Berhan Program for Highly Vulnerable Children, Semi-annual Progress Report, Oct 2013 to Mar 2014.
[51] Pact Yekokeb Berhan Program for Highly Vulnerable Children, Annual Progress Report, Oct 2012 to Sept 2013.
[52] Mishra, Vinod, and Simona Bignami-Van Assche. 2008. Orphans and Vulnerable Children in High HIV-Prevalence Countries in Sub-Saharan Africa. DHS Analytical Studies No. 15. Calverton, Maryland, USA: Macro International Inc.
[53] David K. Evans and Edward Miguel, *Orphans and Schooling in Africa: A Longitudinal Analysis*. Demography Feb 2007, 44(1) 35-57.
[54] Pact Yekokeb Berhan Program for Highly Vulnerable Children, Semi-annual Progress Report, Oct 2013 to Mar 2014.

school attendance is vital for children to perform well in school. Regular school attendance (class attendance of a minimum of 75% of school days as defined by the program)[55] in the midterm was significantly better than that was documented in the baseline survey ($p<0.01$) and this is encouraging. Successful completion of the academic year and transfer to next grade/level at the end of the year was measured to assess how an HVC is performing with his/her education. Based on data from this evaluation, and program report,[56] school performance of HVC was found to have improved at the program sites. The overall grade promotion rate of 85.8% found in this evaluation showed that Yekokeb Berhan -supported HVC were performing well in school. Though direct comparison is not possible, this finding showed improvement over the baseline where a quarter of HVC reported they have repeated grade and by implications three-quarters were promoted.

Although this may be partly attributed to the aggressive implementation of the government's Education Policy, the fact that the improvements are marked indicates that contributions of Yekokeb Berhan program with its partners including communities and households are significant. In particular, the approach by Yekokeb Berhan Program of strengthening early childhood development (ECD) program both in the family context and at established ECD centers may have contributed to the big change observed in school enrollment among HVC aged 3-4 years. It was found out that the program currently supports 42 ECD centers through provision of outdoor playing materials, renovation/expansion of center facilities and training of facilitators.[57] The finding that school expenses were covered by the program for more than two-thirds of the in-school HVC also supports the argument that changes in school enrollment rate could be attributed to the impact of the program.

Tutoring services for HVC was one of the supports found to be provided by the program in collaboration with government schools and volunteers. In principle, this support bridges the gap of HVC who need help with their school work but do not have anyone to help with this regard. However, the finding that only small proportion (15%) of those in school received tutorial service while more than half of them did not have anyone to help them with their school work seems a gap. This indicates that there has been unmet need of HVC for tutorial support. Moreover, sustainability of the tutorial service seems of concern for the community as the service has been provided by volunteers who had many other tasks and were not in a binding commitment for this service. One of the key lessons from the end-of-project evaluation of PC3 was overburdening community volunteers particularly in partners with limited resources.[58] Furthermore, high turnover of community volunteers has been discussed in Yekokeb Berhan partners' quarterly review meetings.

[55] Yekokeb Berhan /Pact Program for Highly Vulnerable Children Performance Monitoring and Evaluation Plan, 04/20/2011 - 04/19/2016, Updated in February 2013.
[56] Yekokeb Berhan CSI Report from FY13 Annual Report.
[57] Pact Yekokeb Berhan Program for Highly Vulnerable Children, Semi-annual Progress Report, Oct 2013 to Mar 2014.
[58] Ethiopia Positive Change: Children, Care and Communities (PC3) End-of-Project Evaluation, July 2008.

These indicate possible implications on performance of volunteers in regards to extending help in school work or provision of tutoring services to HVC.[59,60]

FOOD AND NUTRITION

According to the national SSDGs, food and nutrition support is one of the core service areas which are considered critical components of a set of services for a program targeting vulnerable children. These services aim to ensure that vulnerable children have access to similar nutritional resources as other children in their communities.[61] Support from Yekokeb Berhan program targets households faced with serious food shortage and children who are malnourished and focuses on strengthening families through education on nutrition and creating linkages with organizations that provide food and nutritional supports such as the WFP.

The finding in the midterm that slightly more than one-third of the households reported having an adult received nutrition-related trainings, counseling or advice was similar to what the program gathered through its periodic report.[62] However, this does not seem enough, though there is no baseline data on this, as strengthening families through education on nutrition is one of the critical components of food and nutrition support of the program.

The impact of food and nutrition supports at household level, however, was remarkable as proportion of households who reported food shortage significantly reduced from the baseline. The finding that 58% of the household did not have enough food for various numbers of days in the month preceding the evaluation indicated that the gap with this regard is big though this was lower than the baseline of 66%. Similarly, the finding that only slightly more than one-third of the households had some kind of food reserve/store to cope up with unexpected situation was unchanged from the baseline figure. These indicate that a lot needs to be done in achieving food security for targeted HVC and their households through strengthening the collaboration with partners.

Yekokeb Berhan Program actively identifies HVC in need and refers those with moderate and severe acute malnutrition to food and nutrition providers, particularly to the WFP, and also to government health facilities for nutritional supports. However, the finding that services were not available to about a quarter of children who were prescribed food by health/nutrition workers over the past one year indicate that there were unmet needs with this regard. Furthermore, the amount of food rations provided was generally argued to be far less than demands. This clearly shows the shortage of food support and irregular initiatives by community committees to mobilize food support from private institutions such as restaurants. This may not meet demands, on the one hand, and sustain food support to HVC on the other.

[59] Pact, Minutes on Partners' Quarterly Performance Review Meeting, Nekemte, June 04, 2012.
[60] Pact, Minutes on Partners' Quarterly Performance Review Meeting, Jimma, November 22-23, 2012.
[61] Standard Service Delivery Guidelines for Orphans and Vulnerable Children's Care and Support Programs, February 2010, Addis Ababa.
[62] Pact Yekokeb Berhan Program for Highly Vulnerable Children, Annual Progress Report, Oct 2012 to Sept 2013.

Malnutrition data was not collected at baseline and it was not possible to examine the changes since the commencement of the program. However, the Ethiopian DHS 2011 shows that 10% of Ethiopian children are wasted, and 3% are severely wasted based on weight-for-height measurement. Though the MUAC and weight-for-height measurements are not directly comparable, both moderate and severe malnutrition rates found in this midterm evaluation are lower than the DHS wasting (10%) and severe wasting (3%) rates, respectively.[63] Similarly, in the comparison of two CSI results of Yekokeb Berhan Program, a sharp incease in the number of children with 3 and 4 scores was observed in the indicator on child malnutrition, indicating that a significant proportion of children had been cured of malnutrition.[64] This is perhaps attributed to the program's food and nutrition support to large number of HVC through the linkages established with WFP, NGOs, and private organizations as well as local communities to address the food and nutritional needs of HVC and their families. The program's efforts to mobilize private institution and community memebers to meet food and nutrition needs of HVC as described by the respondents of in the qualitative data may have also helped to reduce rate of malnutrition among the targeted HVC. Howerver, as was explained by some IPs, the support was found be inadequate compard to the large number of needy HVC and this was identified as agap.

SHELTER AND CARE

The number of rooms used for sleeping in relation to the number of household members is an indicator of the extent of crowding, which in turn increases the risk of contracting communicable diseases. The finding that about 60% of the HVC households lived in one-room house, hence all family members in those households sleep in the same room is significantly better than the national situation where 70 percent of Ethiopian households use one room for sleeping ($p<0.01$).[65] Similarly, the proportion of HVC households with two and three or more rooms was much higher than what was found in Ethiopia DHS 2011. Shelter is considered reasonably comfortable for living when it is warm, safe and dry.[66] The proportion of houses with water leaking and wind blowing into the part of the house where the children sleep has significantly improved from the baseline. Improvement in the housing conditions of HVC and their households was supported by the results from Yekokeb Berhan CSI report. Comparing CSI I and CSI II scores, it was noted that the magnitude of score of 1s was shrinking while the scores 2 and 3 & 4 were significantly increasing in the CSII compared to CSI I.[67] In the first year of the program implementation only, 2,084 HVC were linked with *kebele* administration offices and obtained housing/shelter[68] this could contribute to improvement.

[63] Ethiopia Demographic and Health Survey 2011, Central Statistical Agency, Addis Ababa, Ethiopia and ICF International, Calverton, Maryland, USA, March 2012.
[64] Pact, Child Support Index Report from FY2013 Annual Report.
[65] Ethiopia Demographic and Health Survey 2011, Central Statistical Agency, Addis Ababa, Ethiopia and ICF International, Calverton, Maryland, USA, March 2012.
[66] Yekokeb Berhan /Pact Program for Highly Vulnerable Children Performance Monitoring and Evaluation Plan, 04/20/2011 - 04/19/2016, Updated in February 2013.
[67] Pact, Child Support Index Report from FY2013 Annual Report.
[68] Pact Yekokeb Berhan Program for Highly Vulnerable Children, Annual Progress Report, Oct 2012 to Sept 2013.

Though there are noticeable changes in the housing condition of HVC in Yekokeb Berhan Program areas, the finding that only one-third of the households live in an adequate shelter may indicate that more efforts are required to improve the situation.

ECONOMIC STRENGTHENING

Economic strengthening support was one of the critical components of HVC care. The ability of caregivers' to meet basic needs of HVC largely depends on the income and other asset bases of the household and these are usually meager because of their vulnerability itself. ES services hence seek to enable families to meet their own needs from an economic perspective regardless of changes in the family situation.[69] Significant investments have been made by Yekokeb Berhan Program with this regard to ensure that households targeted for economic strengthening have access to the resources, skills and knowledge they require to improve their own livelihood.

Enrollment of households in ES support was based on an initial needs assessment for all households eligible for microenterprise interventions to select households that have the capacity to commit to launching a ME and this objective selection method has enhanced credibility of the program. Proportion of households enrolled in economic strengthening was higher than what was gathered through the program's routine system. This was perhaps there may be similar activities like organizing MEs and saving groups, as elsewhere in the country, which the study participants may not differentiate from Yekokeb Berhan Program's ES support. The finding that only 60% of the ES targeted households received CSSG training was also not in line with the program's routine activity where all households enrolled to ES first receive this training. This again can be attributed to higher number of households reported engaging in ES than the program's actual support with this regard. Another possible factor for the low coverage of ES training is perhaps participants may not clearly differentiate between CSSG and other additional economic strengthening training like ME-SPM,[70] BD and financial management which the program has also provided. Otherwise, it was gathered from the program review of secondary data that all ES households were given training on CSSG and majority of them also received additional training including ME-SPM, BD and financial management.[71]

It clearly came out from this evaluation that large proportion of the ES targeted households benefited from different training and other ES supports they received including the matching fund opportunities. Some of these benefits were developing saving habits, setting up or diversifying business, understanding local market opportunities, accessing loan fund for ME and being visionary in term of setting objectives and goals for their business. These benefits were further supported by the finding that a quarter of ES targeted households were able to establish small scale businesses including retailing of consumer goods, sale of local drinks and beverages, poultry farming, rearing

[69] Standard Service Delivery Guidelines for Orphans and Vulnerable Children's Care and Support Programs, February 2010, Addis Ababa.
[70] Microenterprise Selection, Planning and Management
[71] Pact Yekokeb Berhan Program for Highly Vulnerable Children, Semi-annual Progress Report, Oct 2013 to Mar 2014.

and fattening of cattle, and vegetable gardening. The finding that half of the households engaged in ES could expand their business and, more importantly, majority of them were able to save money form their business hence changing their lives could be attributed to the program's impact.

The finding that close to three-quarters of the ES households reported having regular income looks good though this was not documented at baseline and as a result it was not possible to see changes over time. Similarly, acquisition of additional productive assets by about 13% of ES households over the past two years may also indicate significance of the program's ES support in improving the livelihood of some HVC and their households.

However, the finding that large proportion of the households believed that they were financially less secure than or at the same level as before the program may indicate that a lot needs to be done in strengthening economic situation of HVC. Although a considerable proportion of households were covered with ES interventions, the fact that number of struggler households is growing exemplifies the option to be dragged into the destitute group is open until the program intensified its targets for economic strengthening in the coming years. It was also evident from the findings that the need for matching funds and business opportunities by caregivers was high and these needs were not met well. The fact that matching fund was limited to 1500 Birr would limit business to petty activities which may eventually adversely affect successes. This may also affect the efforts of the program to move struggler families to the next higher level.

LEGAL PROTECTION

It has been observed that almost all sectoral policies, including the Health, Education, Women, HIV/AIDS, Youth, etc. either don't address issues of OVC or touches upon it only in general terms.[72]

Although Ethiopia had developed and/or adapted legal provisions to ensure protection of children in general and vulnerable children in particular,[73] protection of vulnerable children remains challenging and often neglected in Ethiopia. The fact that such concerns are not often brought to the attention of law enforcement authorities complicate the problem and hamper responses. Nonetheless, the initiative by Yekokeb Berhan Project has drawn important lessons. Engagement of all stakeholders at community level has eased timely recognition of vulnerable children's enabled timely responses to problems. Policy and law enforcement bodies at *kebele* level were found to be members of the community committee which facilitates protection of the right of HVC and from different kinds of abuses. Besides at household level, caregivers and saving groups were trained on to ensure protection of HVC at household level. Furthermore, support to HVC to get birth certificate was another important initiative within legal protection.

[72] Zewdineh B.Haile. 2008. Review of the legal and policy frameworks Protecting the rights of vulnerable Children in the Federal Democratic Republic of Ethiopia.
[73] Oak and ODI. 2012. Linkages Study Linking social and legal protection to child protection mechanisms: The Ethiopian example.

Though there are no comparisons from the baseline, incidents of violence, including sexual, were reported by the caregivers. Most importantly, it was worrisome to find that many HVC households do not seek legal assistance for violence that occurs to them. Less than two-thirds of those victims went to the police to seek legal services and one-third did nothing, and perhaps this implies that more empowerment of HVC households is required.

The national standard guidelines stipulate that vulnerable children receive legal information and access to legal services including birth registration[74]. As part of its legal and protection services to targeted HVC, Yekokeb Berhan Program has supported beneficiaries to get birth registration. However, proportion of HVC who had birth certificate issued from authorized government office found in the midterm was very small though there was improvement from the baseline. This is perhaps because the evaluation considered only official birth certificates issued by designated government offices and did not take into account church baptismal certificates, mosque papers and local *Kebele* documents that can serve as a birth certificate for most purposes in the country. These alternate registrations are also promoted by Yekokeb Berhan Program, especially where the official birth certificate is relatively costly. Small fees required to get official birth certificate from government offices may also prohibit HVC from acquiring it. However, more could have been achieved with this regard by raising awareness of HVC and their families about the importance of birth certificate and by strengthening linkage with government offices where birth certificate is issued.

c. Program Objective 3

COORDINATION OF CARE

Coordination of care was found to be core component of Yekokeb Berhan Program. It is considered as a strategy to provide holistic support to HVC with mobilization of support and referral networks with likeminded institutions. This component of the project among others intends to sustain care and support to HVC. As it is documented in this assessment, government sectors such as schools and health, CSOs operating at community level, private sectors engaged in for-profit business and individual members of the community were found to be key stakeholders engaged in provision of support to HVC.

The coordination of care has enabled the program to benefit from resources available at different levels. While coordination at *woreda* level helped to avoid duplication of efforts and to leverage on local opportunities, coordination at *kebele* level helped to mobilize resources from community members, private organizations and CSOs operating in the *kebele* to better serve HVC and sustain interventions. The coordination of care and collaborative efforts with key stakeholders was

[74] Standard Service Delivery Guidelines for Orphans and Vulnerable Children's care and support program, Federal Democratic Republic of Ethiopia, February 2010, Addis Ababa.

demonstrated by the increasing number of HVC and adults receiving various services through referrals.[75]

Despite the contribution of coordination of care to the quality of support and sustainability, there were evident challenges. Firstly, there is no clear strategy which is endorsed and reinforced by government to ensure coordination of care works. It was learnt that to date there are limited formalization of such coordination of care that sustainability of support may not be ensured. Similarly, some of the stakeholders may be interested to provide support only once and there is no way such stakeholders could take responsibility for what would happen to HVC in consequence.

STRENGTHENING COMMUNITY SYSTEMS

Among others, capacity building interventions were integral component of Yekokeb Berhan Program. In view of this, the project is said to have taken series of steps to build the capacity of stakeholders at different levels. Capacity-building interventions were informed by evidence where capacity gaps were assessed for implementing partners, government stakeholder and community structures using tools that were either developed or adapted for this purpose.

The capacity-building initiative in the form of diverse trainings, supportive supervision, coaching and mentoring and meetings was found incredible. Implementing partners (CSOs), government stakeholder, community structures as well as HVC have benefited from such support. It is evident that with such capacities currently data management from community level to project management at federal level has become smoother, skills to provide services at household level has improved and materials are believed to have been developed for future such training actives. Besides, it is evident from the finding that through saving schemes, caregivers are able to generate income that enables them to send HVC to school and feed them. These are all positive developments in connection to capacity building endeavors.

Nonetheless, in view of the dynamism within each of such targets and increasing demands, the capacity building demand remains to be insatiable and challenging. Particular capacity concerns were flagged at CSOs and government level where continued staff turnover remains to take away those with required capacity for Yekokeb Berhan Project. At community level however, limited awareness about the packages of services, data management and coordination of care remains to be important challenges.

d. Program Objective 4

Data management and learning is recognized as an important contribution of Yekokeb Berhan Project to record HVC and make data available for decision making. Previously, there was no data on how many HVC are in a community and there was no tool to record them. Yet, information could be obtained with the introduction of CSI by Yekokeb Berhan Project including how many

[75] Pact Yekokeb Berahan Program for Highly Vulnerable Children , Annual Progress Report, FY2013.

HVC are found in the community and who are enrolled in what support and where. This is believed to improve planning interventions as well as policy decisions as well as avoid duplication of efforts. Government partners however were concerned over accessing such data. Although Yekokeb Berhan Project has established interim data base for the project which defines how data is generated from operation level, compiled and shared with Pact for synthesis, analysis and use for programming purpose, centralized data management appears to deny partners at different levels the opportunity to make use of the data for planning purposes.

6. LIMITATIONS OF THE EVALUATION

The evaluation was based on representative samples from Yekokeb Berhan's implementation *woredas* and *kebeles*. Like any sample survey, generalizations of the findings to the entire project area may be made with caution.

However, the major limitation of this study was the difference in design, targets and some parts of the tools between the baseline and the midterm survey which seriously affected direct comparison of outcomes as the goal of the evaluation is to critically examine whether the progress of Yekokeb Berhan Program is on track to meet the four expected objectives/results. For instance the baseline survey has included non-HVC households; classified households by poverty level; included all HVC in a household and used expenditure as main proxy for classifying households as poor and non-poor HVC. On the other hand, the midterm included only program-targeted households HVC involved in Yekokeb Berhan Program irrespective of their poverty status; randomly selected one HVC from a household. The baseline data was reanalyzed by the investigation team and minor changes to some denominators from the initial report was encountered. Though no major implication is anticipated because of these minor changes, comparisons were made only when the variables matched. Since respondents were asked mainly events that happened some time ago, recall bias may also be possible in responding to the evaluation questions.

7. CONCLUSIONS AND RECOMMENDATIONS

a. CONCLUSIONS

Program Objective 1

Finding from this assessment witnessed the level of efforts made to build capacity of actors in Yekokeb Berhan Project at different levels. It appears that the level and uniformity of effort to build capacity of stakeholders at different level is not straight forward. This is further jeopardized by the unlimited needs for capacity at different levels and variation of capacity limitations. Yekokeb Berhan's project capacity building strategy follows roll out model where capacity building intervention at implementing partner (CSOs) roll to community structures at community level. It is evident that further rollout of capacity building to community level structures by implementing partner (CSOs) may not necessarily be uniform and keep envisioned standards. In view of this, capacity building will remain challenging in the future and may not have easy solution.

Nonetheless, lessons drawn from Yekokeb Berhan initiative may help to reinvigorate capacity building endeavors not only in response to HVC and their families but also generic capacity building interventions in other development interventions.

Program Objective 2

The program has registered commendable results with regards to major indicators related to HVC services. Improvement in health-seeking behavior; reduction of childhood illnesses; increased immunization coverage; increased uptake of HIV services; improved school enrollment, attendance and performance; improved nutritional status of under-five children; improved shelter condition and improved economic situation of households imply that access to health and social services has been increased to HVC and their families over the past two years in Yekokeb Berhan Program areas.

On the other hand, although there were some progress in improving access to adolescent reproductive health services, provision of tutorial services for needy school children and enhancing birth registration for HVC, significant gaps were observed at the level of implementation in relation to the aforementioned services. Nutrition training for caretakers, inadequate food supply to HVC who are engaged in food and nutrition support, mismatch between the need and actual support of economic strengthening, and availability of therapeutic and supplemental food items at the referral points were also inadequate.

Program Objective 3

As was emphasized in this document, community structure and coordination of care is a major contribution of Yekokeb Berhan Project in response to HVC and their families. Findings from this assessment revealed that the problem of HVC and their families is getting owned by community members and development actors at community level. Community committee and volunteers are spearheading HVC focused interventions. They are taking responsibility to coordinate responses, mobilize resources and document accomplishments and challenges at their level. This is a big success in response to HIV in general and HVC in particular. One major concern here is on sustaining the effort at this level and ensuring accountability for coordination of care. Community structures appear to feel fatigue from their continued engagement with limited or no compensation. This may affect continuity of such structures and efforts. Secondly coordination at community level is at times a onetime contribution or does not have reinforcement mechanism even if agreement is reached to contribute to such contribution. This may pose challenges to sustainability of care and support to HVC and their families.

Program Objective 4

Evidence generated from this study reveals that now more than ever HVC and their problems are documented and data base is now available at different levels. Associated capacities are developed at different levels as well. Availability of such data is believed to improve HVC programming as well as contribute to policy dialogue as concerns HVC and their family. It however appears that

compilation of such data takes place at higher level that availability of data for programming and lower level policy dialogue remains far from expectation. In connection to this, capacity limitation to process and use data at *kebele*, zonal and regional government sector may affect timely use of data for decision making.

b. RECOMMENDATIONS

- The proportion of HVC who had HIV test over the previous year has shown improvement over the baseline data. However, only less than half of the HVC were still tested and knew their HIV status. HIV testing and counseling is an entry point to the continuum of care and is an important component of HIV services. It is even more important for HVC as this group has elevated HIV risk because of their vulnerability. Considering this fact, more focus on increasing HIV counseling and testing coverage for HVC in the program support areas is required.

- More tutorial services are called for to improve school performance of HVC. Currently despite such needs and evident contribution to improved school performance only small proportion of the needy HVC got tutorial support. This service may be more sustainable if bureaus of education are engaged to sustain and scale up tutorial support to HVC at national level. Negotiations with local universities and colleges to engage college students for community services would help to scale up the service.

- Programs providing parenting skills are essential for caregivers to enable them to provide quality care for their children. There were efforts by the program to provide caregivers with this skill through providing training. However only 52% of the caregivers reported having better parenting skills training provided by the program. In order to achieve sustainable impact of the program by improving care for HVC, coverage of better parenting training for caregivers should be increased.

- Expanding economic strengthening seems essential as the need for this service was found to be high while a relatively small proportion of households were engaged in the service. Also, in order to enhance and sustain benefits of economic strengthening of targeted households it is recommended that CSSGs are strongly linked with government-led microenterprise programs where they would get continuous support and guidance on business making

- Birth registration and acquisition of birth certificate is one of the most important components of legal service to HVC and Yekokeb Berhan Program has been supporting this service. However, only 8.7% of the HVC had birth certificate issued from authorized government office. This proportion is very small by any standard and more efforts should be exerted to increase the coverage of birth certificate for HVC in the program areas.

- It is well understood that there were differences in methods and targets between the baseline survey and the midterm which made comparisons limited and in most instances complex.

Some of the data required for evaluation were either not covered or differently addressed in the baseline survey, for instance malnutrition and economic strengthening variables. Hence findings on nutritional assessment, data management and utilization and coordination could be bench marked for the end line survey comparison. It is also recommended the instruments used in the midterm be maintained at least as a minimum for better subsequent comparisons between the evaluation surveys.

- Community committee (CC/CCC) and community volunteers are core stakeholders to Yekokeb Berhan Program at community level. They are frontline facilitators of HVC intervention. Both structures were providing their services voluntarily and play indispensable role in identifying and enrolling HVC. Furthermore, CC/CCC ensures proper provision of services and map providers to facilitate partnership among other stakeholders. Yet, members of community volunteers and community committee expressed concern over the limited capacity development support they obtain from the project. This may affect sustainability of their engagement. Thus, it is recommended to either develop continuous motivation mechanisms to keep them active in their activities or develop a strategy where members of such structures graduate after voluntary service for a given period of time before fatigue sets in and to recruit other members, train them and engage them.

- Capacity building is another core component of Yekokeb Berhan Program. As it was noted in the findings, such an endeavor followed systematic approaches where gaps of the different stakeholders to the project (implementing partners (CSOs), government partner and community structure were assessed with an application of defined tools. Based on findings, capacity building plans were drawn and implemented by Pact and rolled out to community structures and the community at large by implementing partners (CSOs). However, capacity limitation is still the case than an exception at all levels. In as much as capacity building can never be considered as done and complete given the dynamics within the targets, the Yekokeb Berhan Program should establish an internal mechanism at implementing partners and community structure's level to reinforce capacities. Perhaps the coaching mentoring/initiative should be strengthened so that there is a workforce within the government structure as well as other structures at implementers and community levels. Furthermore, standardizing the training guides/manuals and translating them in to major languages and establishing core trainers and guides within the government structure may help sustain capacity building endeavors.

- Coordination of care is an important component of Yekokeb Berhan Program. As such, at community and implementing partners' level, efforts were underway to engage other partners for an improved service provision to HVC and sustain such support. Nonetheless, available data show that success in engaging partners depends on the strength of CC. Even initiated coordination of care is often short lived and is not legally binding. Thus, it is

recommended that, coordination of care should be guided by clearly defined modalities and reinforcement mechanisms where government could also overlook such initiatives.

- Yekokeb Berhan Project was acknowledged for its initiatives in introducing the CSI and formats to collect information about HVC, analyze it and reporting it. Community was found to have the knowledge and skills to generate such information and use it for decision making at its level. Implementing partners were also found to have used the tools for data generation and use. This was reported to be a pioneering contribution by Yekokeb Berhan Project and child data is made available at project sites for decision making purpose. With this data right targets could be identified and enrolled in to the project, duplication in service provision could be avoided, planning is evidence informed and policy could benefit from evidences. Yet, as it stands now, there were concerns over availability of data for planning purpose at community level where it is originally generated. Thus, it is recommended that feedbacks on data generated should be given to community structures. It would in fact be desirable to build capacity of the community to collect and collate data at their levels and use if for planning and interventions.

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ANNEX I: Sources of qualitative data

Type of data collection	Number of Sessions	Total number of participants
KII – Pact, FHI360 and ChildFund	3	5
KII – Pact cluster coordinators	4	4
KII-Ministry of Womens, Children and Youth Affairs (MoWCYA) at federal, regional and wereda levels		26
FGDs-CC	5	33
FGD-CSSG	5	36
FGD-CGs	6	52
FGD-CVs	4	37

ANNEX II: Table showing details of evaluation sites

Region	Zone/Subcity	*Woreda*	Beneficiary HVC
Addis Ababa	Arada	Arada	6,243
	Nifas Silke Lafto	Nifas Silke Lafto	11,838
Amhara	South Wollo	Ambassel	4,357
	South Wollo	Kombolcha	2,000
	North Gonder	Gonder Town	7,449
	North Shoa	Debrebirhan	7,416
	North Shoa	Shewarobit	5,000
	South Gondar	Fogera	2,635
Oromia	East Shoa	Adama	5,834
	Jimma	Jimma	2,204
	East Shoa	Zeway	4,882
	Bale	Robe	6,202
SNNP	Gamogofa	Arbaminch	2,413
	Hawassa	Hawassa Town	4,754
	Gurage	Butajira	2,278
		Wolkite	1,862
Tigray	Central	Adwa	3,649
	Mekelle	Mekelle	9,119

ANNEX III: Comparison of indicators at baseline and midterm

No.	Indicator	Baseline(n=2606)	MTE (n=2121)	Remarks
1	**HVC perception of own health status over the past 12 months**			
	Very good	17.5	32.3	
	Good	44.1	42.4	
	Fair/satisfactory	23.8	15.7	
	Poor/very poor	14.7	9.1	
	No response	0.0	0.5	
2	**Children too sick to participate in daily activities in the weeks preceding the syrvey**	30.0	16.8	
3	**Child had fever in the last two weeks**	15.7	18.8	
4	**Child had diarrhea in the last two weeks**	10.8	6.1	
5	**Child had fever and sought treatment**	48.4	63.9	
6	**Child had diarrhea and sought treatment**	49.7	86.2	
7	**Children fully vaccinated for age (confirmed from vaccination card)**	33.9	57.6	
8	**Children tested for HIV in the past 2 weeks**	37.8	46.6	Ever-test was assessed at baseline
9	**HIV Positive (out of tested and received results)**	14.2	5.8	
10	**Proportion of children on ART (out of positive)**	61.0	85.7	
11	**Caretakers tested for HIV**			
12	**Family/HVC had someone to turn to in order to share concerns and get support in case of a problem**	55.3	52.6	
13	**School enrollment aged 3 years and above (overall)**	71.1	85.7	
	3-4 year	4.0	75.0	
	5-13 year	77.0	90.6	
	14 year and above	77.4	92.4	
	Boys	70.3	85.2	
	Girls	72.0	86.2	
14	**Regular school attendance (overall)**	89.3	94.7	
	Boys	90.0	94.8	
	Girls	88.5	94.5	

15	**Household experienced shortage of food in the past 12 months**	66.0	58.0	
16	**Household reported having food reserve/store during the evaluation**	20.0	58.4	
17	**HVC who have birth certificate issued from authorized government office**	5.5	8.7	
18	**When it rains, water leak into the part of the house where the children sleep**	52.5	42.6	
19	**When it is windy outside, does the wind blow into the part of the house where the children sleep?**	50.0	41.1	

ANNEX IV: Data collection tools

YEKOKEB BERHAN PROGRAM FOR HIGHLY VULNERABLE CHILDREN

MIDTERM EVALUATION – FEBRUARY 2014, ETHIOPIA

QUANTITATIVE QUESTIONNAIRE

PART 1: SURVEY QUESTIONS FOR CAREGIVERS OF HVC

SECTION 0: IDENTIFICATION DATA

Q01 QUESTIONNAIRE IDENTIFICATION NUMBER |_____|_____|_____|

Q02 Region_____ Partner _____

Q03 Zone _____

Q04 *Woreda*_____**Q05** Town_____**Q06** Subcity_____

Q07 House Number _____

Q08 GIS Code_____

Q09 Household size (total no. of people living in the house) _____

Q10 Implementing partner _____

Q11 Name of interviewer _____

Q12 Date of interview: _____

Q13 Time interview started_____

Q14 Time interview ended _____

INTRODUCTION

"My name is……I am collecting information that will help to understand how the YEKOKEB BERHAN program has been going, since the start of its implementation about two years ago. I will want to find out your experiences as a [vulnerable child/guardian]. in this program. Other people in your neighborhood are participating in similar interviews. The results, taken together will be used to improve services in the future. Your participation in this survey is voluntary and there is no remuneration or any other form of benefit for this participation.

CONFIDENTIALITY AND CONSENT

"I may ask you some very personal questions that some people may find difficult to answer. I am not going to talk to anyone about what you tell me. Your name will not be written on this form, and will never be used in connection with any of the information you tell me. You do not have to answer any questions that you do not feel comfortable with, and you may end this interview at any time you want to. However, your honest answers to these questions will help us better understand the situation of vulnerable children and their families – social, economic and psychological – and whether they are receiving support to alleviate these problems. We would greatly appreciate your help in responding to this interview. The interview will take about ***60 minutes***. Would you be willing to participate?"

1. ☐ **Yes:** Thank him/her and continue with the interview

☐

2. **No:** Note his reason briefly, thank him/her and proceed to the next household

_____

Incomplete Interviews Log

	Visit 1	Visit 2	Visit 3
Date			
Interviewer			
Comment			

Comment codes: Appointment made for later today 1; Appointment made for another day 2; Refused to continue and no appointment made 3; Other (Specify)

CHECKED BY FIELD SUPERVISOR: Signature _____ Date _____

No.	Questions And Filters	Coding Categories		Skip To
	SECTION 1: BACKGROUND INFORMATION ON CAREGIVER AND HOUSEHOLD			
Q101	Age of the respondent, as best she/he knows	[_____]		
Q102	Sex of the respondent	Male Female	1 2	
Q103	Marital status of the respondent	Single Married Divorced Widowed Live with partner/cohabit No Response	1 2 3 4 5 99	
Q104	Have you ever attended formal school?	Yes No No Response	1 2 99	→ **Q106**
Q105	What is the highest level of school you completed? (***CIRCLE ONE***)	Primary (grade 1-8) Secondary (grade 9-10) Preparatory (11-12) 10+TVET College/university No Response	1 2 3 4 5 99	
Q106	What is your occupation	Farming Wage Laborer Government employee NGO Trading/business Student Other (Specify)_____ No occupation No Response	1 2 3 4 5 6 7 8 99	
Q107	Have you been engaged in paid work (where you earned any amount of money) in the last 3 months?	Yes No No Response	1 2 99	
Q108	Including yourself, how many people live in this household?	Total_____ Male_____ Female_____ No Response	1 2 3 99	
Q109	How many persons under the age of 18 live in this house?	Total Number of boys Number of girls No response	____ ____ ____ 99	

	Names of all the children younger than 18 years of age who usually live in your household	Age	Sex 1 = Female 2 = Male	Relationship to the household head **1= Child,** **2=Sister/brother** **3= Sister's/brother's child** **4=grandchild** **5=relative** **6= no blood relation** **7 = other (specify)** **99 = No response.**	For all children age 6-59 months, take MUAC in MM	Classify the nutritional status of each child **1= no malnutrition** **2 = moderate malnutrition** **3 = severe malnutrition**
	Q109.1	Q109.2	Q109.3	Q109.4	Q109.5	Q109.6
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						

Q110	Do you know about the Yekokeb Berhan project that is supported by USAID/Ethiopia and implemented by _____(IP) in your area?	Yes No No response	1 2 99	

Q111	How many **children under 18 in this household** are enrolled in the Yekokeb Berhan project that is implemented by ____(IP) in your area?	None _____ Boys _____ Girls_____ Total_____ No response	1 2 3 4 99	→ **Q116**
Q112	When did **the Child/ren** start participating in the HVC care and support program of Yekokeb Berhan?	Since two years ago Since one year ago Other (specify)_____ No Response	1 2 3 99	
Q113	Who first identified **the Child/ren** to possibly become involved in the Yekokeb Berhan care and support program?	A Community Committee Community volunteers *Kebele* Administration ____(IP) staff Other (specify) _____ Don't know who they were No Response	1 2 3 4 5 88 99	
Q114	Who finally selected **the Child/ren** to be involved in the Yekokeb Berhan care and support program?	A Community Committee Community volunteers *Kebele* Administration ____(IP) staff Other (specify) _____ Don't know who they were No Response	1 2 3 4 5 88 99	
Q115	When **the Child/ren** were selected for HVC care and support were you asked about the major problems and needs of the child/ren?	Yes No Don't know No response	1 2 88 99	
Q116	Do you (the caregiver) have any disability?	Yes No No response	1 2 99	 Q201 Q201
Q117	If yes, does that make it difficult for you to participate in daily activities?	Yes No	1 2	
Q118	How would you describe your disability? **(Multiple responses are possible)**	Blind or partially blind Deaf or partially deaf I have difficulties learning Physical disability Other (specify)_____ No response	1 2 3 4 5 99	
Q119	Are you receiving any kind of assistive device or other support for you disability?	Yes No I don't know No response	1 2 88 99	

Q120	What kind of assistive device or support/services are you receiving?	Prosthesis(artificial leg or arm) Eye glasses Hearing aid Crutches Wheelchair Medical care Home-based care Financial support Others (specify)_____ No response	1 2 3 4 5 6 7 8 9 99	
	Section 2: Health and Health Care			
Q201	In general, how do you rate your own health over the past 12 months?	Excellent Good Fair Poor Very poor No response	1 2 3 4 5 99	
Q202	In the last 2 weeks, have you been too ill to participate in daily activities?	Yes No No response	1 2 99	 Q206 Q206
Q203	Did you get treatment from a health provider for this illness?	Yes No No response	1 2 99	 Q206 Q206
Q204	Where did you seek health care for your illnesses? *(if there is more than one response, write only one response they consider most common)*	Government health facility Private hospital/clinic Pharmacy Traditional healer Other (specify) ---------- No response	1 2 3 4 5 99	
Q205	For your last illness if you did not seek care, what was the reason? **(Multiple responses are possibility, take only the main reason)**	No money Hospital/health center too far Illness not serious Did not want treatment Clinic is too crowded Too ill to go Other (specify)_____ No response	1 2 3 4 5 6 7 99	
Q206	Over the past year, has your household experienced not getting adequate healthcare?	Yes No No response	1 2 99	

Q207	Did you receive any education or counseling about HIV by a health worker or someone else (ways of transmission, methods of prevention, care and treatment) in the past 12 months?	Yes No No response	1 2 99	
Q208	Have you been tested for HIV in the past 12 months?	Yes No No response	1 2 99	**Q210** **Q217**
Q209	If not tested, why not?	I didn't want it I already know my status I didn't think it is important for me Didn't know where to go Fear of positive result Others (specify) _____ No response	1 2 3 4 5 6 99	
Q210	Did you receive your HIV test results?	Yes No NA (not tested) No response	1 2 3 99	**Q212** **Q217** **Q217**
Q211	If you did not receive HIV test results, why not?	Did not want results Results took too long Still waiting for results Other (specify) _____ No response	1 2 3 4 99	
Q212	What were your HIV test results?	Negative Positive No response	1 2 99	**Q217** **Q217**
Q213	If HIV positive, are you currently taking ART?	Yes No Not eligible for ART No response	1 2 3 99	 **Q217** **Q215** **Q217**
Q214	If taking ART, do you always go to health facility for follow up as scheduled by the health workers?	Yes, always Yes, but sometimes misses schedule Often misses schedule No response	1 2 3 99	
Q215	If not eligible for ART, do you have follow up at a health facility for HIV care?	Yes No No response	1 2 99	
Q216	If no to Q215, what is the reason?	Did not want because of fear of stigma Did not know that I have to Did not want because I feel healthy Too busy to go for follow up Lack of money for transport Other (specify)_____ No response	1 2 3 4 5 6 7 99	

Q217	**(If caregiver is female, HIV positive and age 18-49, ask this question)** Now I would like to ask you a very personal question: Are you currently pregnant?	Yes No Not applicable (HIV –ve or >49 yr) No response	1 2 3 99	 **Q401** **Q401** **Q401**
Q218	If so, are you currently attending antenatal care?	Yes No No response	1 2 99	
Q219	Has anyone talked to you about ways to prevent infecting your unborn child with HIV?	Yes No No response	1 2 99	 **Q401** **Q401**
Q220	If so, who talked to you about how to prevent infecting your unborn child?	Health workers Community volunteers Health extension workers A friend A family member Other (specify)_____	1 2 3 4 5 6	
Q221	Did you take PMTCT in order to prevent infection of your newborn?	Yes No No response	1 2 99	**Q401** **Q401**
Q222	If not, why?	Fear of stigma Husband did not agree Did not want to take Other (specify)_____ No response	1 2 3 4 99	
	Section 4: Food and Nutrition			
Q401	Over the past year, has your household experienced any shortage of food?	Yes No No response	1 2 99	 **Q403** **Q403**
Q402	In the past month, how many days did your household not have enough food to eat?	None (we had enough food all days) 1-2 days 3-4 days 5-6 days 7 days or more No response	1 2 3 4 5 99	
Q403	How many meals did this household take yesterday?	No meals One meal Two meals Three meals Four meals No response	1 2 3 4 5 99	

Q404	How long would food reserves/stores of the household last?	No food store at all Less than 1 week 1-4 weeks 1-2 months 3-6 months More than 6 months No response	1 2 3 4 5 6 99	
Q405	How do you assess adequacy of food supply in your house over the past year?	Not enough Barely enough Just enough Excess No response	1 2 3 4 99	
Q406	In your family, is there a child who was prescribed food by health workers/ nutrition workers over the past one year?	Yes No No response	1 2 99	 Q408 Q408
Q407	Did the child receive the prescribed food?	Yes No No response	1 2 99	
Q408	Did any family member receive nutrition related training, counseling or advice in the last one year?	Yes No No response	1 2 99	
	Section 5: Psychosocial Support			
Q501	Has any adult member of this household received information or skills to help with Better Parenting (how to better care for children)?	Yes No No response	1 2 99	
Q502	Is there someone that you can go to, to help solve a problem?	Yes No No response	1 2 99	 Q504 Q504
Q503	If yes, whom do you consult or ask for help?	Family members Friends Neighbors Staffs of IP Community volunteers Community committee Other (specify)_____ No response	1 2 3 4 5 6 7 99	

Q504	In the last 12 months, did you or someone in the household receive any counseling, advice-giving or emotional support from someone who comes from __IP or from the Yekokeb Berhan Program	Yes, I received Yes, somebody else received No, no body in the household received No service was not required No response	1 2 3 4 99	
	Section 6: Shelter and Care			
Q601	What type of dwelling does the family live in? ***Observe and confirm***	single house several structures flat room in larger dwelling improvised housing Shared room Temporary shelter other (specify)_____ No response	1 2 3 4 5 6 7 8 99	
Q602	When it rains, does water leak into the part of the house where the children sleep?	Yes No No response	1 2 99	
Q603	When it is windy outside, does the wind blow into the part of the house where the children sleep?	Yes No No response	1 2 99	
Q604	Is your house fairly safe from thieves?	Yes No No response	1 2 99	
Q605	What is the main water source of the household?	Pipe Protected well Unprotected well Spring Other (specify)_____ No response	1 2 3 4 5 99	
Q606	What is the main type of toilet facility used by household members?	Flush Pit latrine No toilet Other (specify)_____ No response	1 2 3 4 99	
	Section 7: Legal Protection			
Q701	Over the past 12 months, has any member of your household experienced any violence?	Yes No No response	1 2 99	 Q705 Q705

Q702	If yes to Q701, what type of violence?	Physical violence Verbal abuses Sexual violence Other (specify)_____ No response	1 2 3 4 99	
Q703	What did you do after the violence occurred?	went to police/ legal services went to health center/clinic went to *Kebele*/ women & children affairs told a relative or neighbor did nothing other (specify)_____ No response	1 2 3 4 5 6 99	
Q704	Who mostly perpetrated the violence?	My spouse Neighbor Older child Unknown people Other (specify)_____ No response	1 2 3 4 5 99	
Q705	Have you ever been referred or linked to any legal services over the past 1 year?	Yes No No response	1 2 99	 **Q707** **Q707**
Q706	Who referred or linked you to legal services he/she needed?	Yekokeb Berhan IP staff Community committee Community Volunteers *Kebele* administration Other (specify)_____ No response	1 2 3 4 5 99	
Q707	Do you feel more secure in terms of legal protection this time than before you were involved in Yekokeb Berhan program?	Yes No Not sure No response	1 2 3 99	
	Section 8: Economic Strengthening			
Q801	Is your household engaged in economic strengthening program of Yekokeb Berhan program (training, market information, technical support through ES animators/facilitators, matching fund provision, etc)	Yes No No response	1 2 99	 Q806 Q806
Q802	Did you have training in Community Saving and Self-help Groups (CSSG)?	Yes No No response	1 2 99	 Q804 Q804

Q803	In what way this training has helped you to advance on self-help endeavor(multiple answers possible)	Developed saving habits Increased own saving funds which was not possible in the past Became visionary with set objectives and goals Increased social bonds Abled to access loan fund for ME Other (specify)_____ No response	1 2 3 4 5 6 99	
Q804	Did you receive any additional training on how to set up a business and run it—for example, SPM training?	Yes No No response	1 2 99	Q806 Q806
Q805	How has this training helped you to engage in a new/expand existing ME?	Understood the local market opportunities for my product/service Understood the need for ME operation skills understood source and allocation of initial capital able to analyze profit loss calculations others (specify)_____ No response	1 2 3 4 5 6 99	
Q806	Do you have assistance to access financial or technical services from community or government microfinance institutions	Yes No No response	1 2 99	
Q807	Do you usually work throughout the year, or do you work seasonally, or only once in a while?	Throughout the year Seasonally/part of the year Once in a while No Response	1 2 3 99	
Q808	What is the main source of income for the household	Employed (salary) Self-employ (Own business) Spouse's income Pension Daily work Working children Charity (from NGOs) Charity (from community) Donations from relatives Other (specify) _____ No response	1 2 3 4 5 6 7 8 9 10 99	
Q809	On average, how much does the household earn every month (from all sources)? **If not exact, take the best estimate**	Below 200 200-300 Br 300-500 Br 500-1000 Br 1000-2000 Br More than 2000 Br No response	1 2 3 4 5 6 99	

Q810	How regular was your income in the past 12 months?	Daily Weekly Monthly Quarterly Biannually Not regular No response	1 2 3 4 5 6 99	
Q811	Are you or any member of your family currently involved in a small scale business or micro-enterprise?	Yes No No response	1 2 99	 Q816 Q816
Q812	When was the small scale or micro-enterprise business started?	Less than 6 month 6-12 month 12-18 month 18-24 month More than 24 month No response	1 2 3 4 5 99	
Q813	If engaged in a business, have you been able to expand or diversify your small scale business over the past one year?	Yes No Not applicable (not engaged in business) No response	1 2 3 99	
Q814	On average, how much money do you make from this business per month?	Below 200 200-300 Br 300-500 Br 500-1000 Br 1000-2000 Br More than 2000 Br No response	1 2 3 4 5 6 99	
Q815	Have you been able to save some money that you generated from the small scale business or micro-enterprise that you engage in?	Yes No No response	1 2 99	
Q816	Thinking about the last time you bought any food for eating or cooking, how did you pay? **Do not read responses. Record one primary response only.** ***Prompt if necessary:*** *maize meal, sugar, cooking oil*	Current income (cash) Savings Loan from family or friend Loan from money lender Sold livestock Sold poultry I have not bought any food recently Other (specify)_____ No response	1 2 3 4 5 6 7 8 99	

Q817	Thinking about the last time you had to pay for any school- related expenses, how did you pay? **Do not read responses. Record up to two primary responses only.** **Prompt if necessary:** PTA fees, uniforms, books, other materials	Current income (cash) Yekokeb Berhan or the IP Loan from family or friend Loan from savings group Savings group social fund grant Loan from microfinance Loan from money lender Sold food surplus Sold food meant for consumption Sold livestock Sold poultry Sold other asset (specify):_____ Could not pay I don't recall school related expenses Other (specify)_____ No Response	1 2 3 4 5 6 7 8 8 9 10 11 12 13 14 99	
Q818	Thinking about <u>the last time</u> you had to pay for an <u>unexpected</u> household expense, such as a house repair, or urgent medical treatment, how did you pay? **Do not read responses. Record up to two primary responses only.**	Current income (cash) Savings Loan from family or friend Loan from savings group Savings group social fund grant Loan from microfinance Loan from money lender Sold food surplus Sold food meant for consumption Sold livestock Sold poultry Sold other asset (specify): _____ Could not pay I don't recall school related expenses Other (specify)_____ No Response	1 2 3 4 5 6 7 8 8 9 10 11 12 13 14 99	
Q819	Compared to last year, do you feel that your household is more or less financially secure?	More secure Less secure No change from last year No response	1 2 3 99	
Q820	Compared to other households in your community, how well do you feel you can meet the needs of the children in your care? Would you say …? **Read out responses.**	Much better than other households A bit better than other households About the same as other households A bit worse than other households Much worse than other households No response	1 2 3 4 5 99	

Q821	Thinking of what the household had two years ago, how do you describe the current productive assets of your household? **(Productive assets are assets that help the household generate income)**	We have less than a year ago We have same as a year ago We have acquired additional productive assets than a year ago No response	1 2 3 99	Q823 Q823 Q823
Q822	If the household acquired <u>additional productive assets</u> over the past two years, what is/are this/these? **(Multiple responses are possible)**	Farm land Cattle Sheep/goats Plot of land House Poultry Working capital Other (specify)_____ No response	1 2 3 4 5 6 7 8 99	
Q823	Over the past year, has your household experienced any loss of Income or assets?	Yes No No response	1 2 99	
Q824	Over the past year, has your household experienced any children leaving school due to financial problem?	Yes No No response	1 2 99	
Q825	Over the past one year, has your household experienced any children having to do work outside the home during school days/time due to financial problem?	Yes No No response	1 2 99	
	Section 9. Coordination of care			
Q901	In the past one year, have you or your family member been referred to another organization, office or individual to obtain any services that you needed?	Yes No Don't Know No Response	1 2 88 99	 C101 C101 C101

Q902	If so, for what services have you or your family member been referred to? **(Multiple responses are possible)**	Food and nutrition Shelter Education Healthcare Psychosocial support Economic strengthening Legal services Other:_____ No response	1 2 3 5 6 7 8 99	
Q903	If referred for any of these services, were the services obtained?	Yes, fully Yes, partially No, not at all No response	1 2 3 99	 Q905 Q905
Q904	If obtained, were you satisfied with the quality of the services you received?	Yes, I was fully satisfied Not well-satisfied but it was okay Not satisfied at all No response	1 2 3 99	
Q905	When was the last time you or your family member was referred for a service or support?	_____ days ago _____weeks ago _____months ago No response	1 2 3 99	
Q906	Who provided the referral?	Community Committee *Kebele* administration Yekokeb Berhan IP staff Community volunteers Another NGO Government office Other(specify)_____ No response	1 2 3 4 5 6 7 99	
Q907	Was there any follow up to know if you or your family member received the services (feedback)	Yes No No response	1 2 99	

PART 2: SURVEY QUESTIONS FOR YOUNG HVC (< 14 YEARS)

Interviewer: Please select a child age less than 14 years in the house hold from the list in Q109.1 above using a simple random sampling method.

Now, I want to ask you questions about child (name) who is enrolled in Yekokeb Berhan Program.

No.	Questions And Filters	Coding Categories	Code	Skip To
	SECTION 1: BACKGROUND INFORMATION OF THE CHILD			
C101	Which is true about (name)? **(Multiple responses are possible)**	Mother is dead Father is dead Both mother and father are dead Chronically ill HIV positive Has some kind of disability Household is headed by a child (<18) Household is headed by elderly Household is headed by ill person Household is headed by disabled No response	1 2 3 4 5 6 7 8 9 10 99	
C102	Has (name) ever attended formal school?	Yes No Not applicable (child < 5 years) No Response	1 2 3 99	 **C104** **C104** **C104**
C103	What is the highest level of school (name) completed? (***CIRCLE ONE***)	Primary (grade 1-8) Secondary (grade 9-12) 10+TVET College/university No Response	1 2 3 4 99	
C104	Does (name) have a disability?	Yes No No response	1 2 99	 **C201** **C201**
C105	If yes, does that make it difficult for (name) to participate in daily activities?	Yes No	1 2	
C106	How would you describe (name's) disability? (**Multiple responses are possible)**	Blind or partially blind Deaf or partially deaf I have difficulties learning Physical disability Other (specify)_____ No response	1 2 3 4 5 99	
C107	Is (name) receiving any kind of assistive devise or support for his/her disability?	Yes No I don't know No response	1 2 88 99	 **C201** **C201** **C201**

C108	What kind of assistive device or support/services (name) is receiving?	Prosthesis(artificial leg or arm) Eye glasses Hearing aid Crutches Wheelchair Medical care Home-based care Financial support Others (specify)_____ No response	1 2 3 4 5 6 7 8 9 99	
	Section 2: Health and Health Care			
C201	In general, how would you rate (name's) health over the past 12 months?	Excellent Good Fair Poor Very poor No Response	1 2 3 4 5 99	
C202	In the last 2 weeks, has (name) been too sick to participate in daily activities?	Yes No No Response	1 2 99	 **C211** **C211**
C203	Has (name) had fever in the two weeks preceding the survey?	Yes No No response	1 2 99	 C205 C205
C204	Did (name) receive treatment - from a health provider for this illness?	Yes No No response	1 2 99	
C205	Has (name) had diarrhea in the last two weeks?	Yes No No response	1 2 99	
C206	Did (name) receive treatment from a health provider for this illness?	Yes No No response	1 2 99	 **C208** **C208**
C207	Where did you seek health care for the illnesses of (name)? *(if there is more than one response, write only one response they consider most common)*	Government health facility Private hospital/clinic Pharmacy Traditional healer Other (specify) ---------- No response	1 2 3 4 5 99	

C208	For (name's) last illness if he or she did not seek care, why not? **(Multiple responses are possibility, take only the main reason)**	No time to escort him/her No money No transport Hospital, health center too far away Illness not serious Patient did not want treatment Clinic is too crowded Illness was too serious Other (specify)_____ No response	1 2 3 4 5 6 7 8 9 99	
C209	About how much did the household spend on (name's) healthcare during the last illness (including at clinics, pharmacy, traditional healer, transport costs etc.)?	<100 Birr 101 – 200 Birr 201-300 Birr 301 -400 Birr 401-500 Birr 501+ No response	1 2 3 4 5 6 99	
C210	Who covers (name's) above costs of treatment?	The household itself Relatives Neighbors/acquaintances CBOs (Idir, etc) Yekokeb Berhan program Volunteer people (their own donations) Other_____ No response	1 2 3 4 5 6 7 99	
C211	If <u>(name) is under 5</u>, has he/she received age appropriate vaccinations? **(Refer to the provided note for the definition of age-appropriate vaccination)**	Yes No Not applicable (> 5 years) No response	1 2 3 99	**C213** **C213** **C213**
C212	Does (name's) have vaccination card? ***(Ask the caregiver to show vaccination card)***	Yes (card shown) No Said had card, but was not shown No response	1 2 3 99	**C214** **C214** **C214**
C213	Is (name) fully vaccinated for his/her age? ***(Don't ask, see the vaccination card and choose appropriate answer as described during the training)***	Yes, full vaccinated Only partially vaccinated	1 2	
C214	If (name) was sick and needed to see a doctor, is there someone who could help get child to doctor or another health care provider?	Yes No No response	1 2 99	
C215	Has (name) been tested for HIV in the past 12 months?	Yes No No response	1 2 99	 **C219** **C219**

C216	Did (name) or you receive his/her HIV test results?	Yes No No response	1 2 99	**C218**
C217	If (name) or you did not receive HIV test results, why not?	Did not want results Results took too long Still waiting for results Other (specify) _____ Do not know No response	1 2 3 4 88 99	
C218	What were (name's) test results?	Negative Positive Don't know No response	1 2 88 99	
C219	Does (name) know his/her HIV status?	Yes No Too young to understand Don't know No response	1 2 3 88 99	C221
C220	If (name) does not know his/her HIV status, why not?	Never tested Too young to understand Decided child should not know No health problems/no concerns Other (specify) _____ No response	1 2 3 4 5 99	
C221	If (name) is HIV positive, is he currently taking ART (on treatment for AIDS)?	Yes No Not eligible for ART Not Applicable (HIV negative) Do not know No response	1 2 3 8 99	C223
C222	If taking ART, does (name) always go to health facility for follow up as scheduled by the health workers	Yes, always Yes, but sometimes misses schedule Often misses schedule Don't know No response	1 2 3 88 99	
C223	If not eligible for ART, does (name) have follow up at a health facility for HIV care?	Yes No No response	1 2 99	
C224	If no to C224, what is the reason?	Did not want because of fear of stigma Did not know that I have to Did not want because I am healthy Too busy to go Lack of money for transport Other (specify)_____ No response	1 2 3 4 5 6 99	
	Section 3: Education (Only for children ≥ 3 years of age)			

C301	Does (name) currently attend school or pre-school?	Yes No No response	1 2 99	 **C312** **C312**
C302	If yes, what grade is (name) in right now?	_____ Do not know No response	1 88 99	
C303	If (name) needed help with school work, is there someone who could help him/her?	Yes, often Sometimes Never No response	1 2 3 99	 **C305** **C305**
C304	Who often helps (name) with this regard?	A family member/relative Peer group Classmates Yekokeb Berhan volunteers Teacher or tutors via the school Other (specify) _____ No response	1 2 3 4 5 6 99	
C305	Has (name) ever participated in a tutorial activity organized by Yekokeb Berhan program or in the community?	Yes No Do not know	1 2 88	
C306	How many days was (name) absent from school during the past month? *(Please estimate if not sure)*	None 1-3 days 4-6 days 7-9 days 10 days or more No response	1 2 3 4 5 99	**C308** **C308**
C307	What was the main reason for (name's) being absent from school?	No money for fees, materials, transport Child is too sick to attend school School is too far away Child has to work to help family Child had to care for sick family members Not interested in school Poor treatment by teachers at school Poor treatment by peers at school Stigma at school Other (specify)_____ No response	1 2 3 4 5 6 7 8 **9** 10 99	
C308	During the previous academic year, has (name) been promoted to next grade/ level?	Yes No, he repeated No response	1 2 99	**C310** **C310**
C309	If no, what was the reason?	Failed end of year exam/poor grades Disciplinary dismissal Dropped/stopped attending Other (specify) _____ No response	1 2 3 4 99	

C310	How would you rate (name's) school performance in the past 12 months compared to the previous year?	Better No change Worse No response	1 2 3 99	
C311	Who usually covers (name's) school expenses (books, uniform, stationaries, transport, school fee, etc) since the past 12 months? (In the case of multiple responses, take the most common one)	Household (from income) Household (sold assets) Relatives Neighbors/acquaintances CBOs (Idir, etc) Yekokeb Berhan program IP Volunteer people (their own donations) Other_____ Not applicable (child is not in school) No response	1 2 3 4 5 6 7 8 9 99	
C312	If (name) is not currently enrolled in school, what was the reason? **Do not read responses. Circle up to two primary responses.**	No money for fees, materials, transport Child is too sick to attend school School is too far away / no school Child has to work to help family Child needs to care for sick household members Child does not like school Child is too young to attend school Other(specify)_____ No response	1 2 3 4 5 6 7 8 99	
C313	If (name) has stopped/dropped attending school, what was the main reason that (name) stopped attending school?	Could not pay fees, materials, transport Cared for sick family member Poor school performance Caring for siblings Graduated from school Pregnant or parenting Got married Illness Child not interested Got a job Expelled Work at home Disability Other (specify)_____ No response	1 2 3 4 5 6 7 8 9 10 11 12 13 14 99	
C314	If (name) is out of school, would (name) like to return to school?	Yes No Do not know No response	1 2 88 99	
	Section 4: Food and Nutrition			

C401	What is true about (name's) food consumption over the past month? **It has been…**	Less than enough Just enough More than enough No response	1 2 3 99	
C402	In the past four weeks, did [name] have to <u>eat a smaller meal</u> than you felt was needed because there was not enough food?	Yes No No response	1 2 99	**C404** **C404**
C403	**If yes –** How many times did this happen? **Read out responses.**	Rarely (1-2 times in past 4 weeks) Sometimes (3-10 times in past 4 weeks) Often (> 10 times in past 4 weeks) No response	1 2 3 99	
C404	In the past four weeks, did [name] have to <u>skip a meal</u> because there was not enough food?	Yes No No response	1 2 99	**C409** **C409**
C405	**If yes –** How many times did this happen? **Read out responses.**	Rarely (1-2 times in past 4 weeks) Sometimes (3-10 times in past 4 weeks) Often (> 10 times in past 4 weeks) No response	1 2 3 99	
C406	In the past four weeks did [name] go to <u>sleep at night hungry</u> because there was not enough food to eat?	Yes No No response	1 2 99	
C407	**If yes –** How many times did this happen? **Read out responses.**	Rarely (1-2 times in past 4 weeks) Sometimes (3-10 times in past 4 weeks) Often (> 10 times in past 4 weeks) No response	1 2 3 99	
C408	How often did (name) go a whole day or night without eating in the last 4 weeks?	Rarely (1-2 times in past 4 weeks) Sometimes (3-10 times in past 4 weeks) Often (> 10 times in past 4 weeks) No response	1 2 3 99	
C409	In the past week, how many meals (name) consumed a day on average?	One Two Three Four More than four No response	1 2 3 4 5 99	

C410	In the past week, how many times did (name) have protein meals (meat, fish, egg, milk, pulses)? **Number of meat or fish meals** **(If fasting season, please note this)**	_____		
C411	In the past week, how many times did (name) have vegetable meals (cabbage, lettuce, beetroot, carrot, etc)? **Number of vegetable meals**	_____		
C412	In the past week, how many times did (name) have fruit (banana, orange, mango, avocado etc) **Number of times fruit taken**	_____		
C413	If (name) was classified as moderate or severe malnutrition, was he/she prescribed or referred to some place to get supplemental or therapeutic food?	Yes No No response	1 2 99	**C501**
C414	Did he/she get it?	Yes No No response	1 2 99	**C501**
C415	If no, why not	Didn't have time to go Shortage of prescribed food Didn't know where to get it Other (specify)_____ No response	1 2 3 4 99	
	Section 5: Psychosocial Support			
C501	How do you describe (name's) general emotional status? **(Ask for his/her usual observation about the child)**	Usually happy, joyful, interactive Quiet, not interactive but happy Not interactive, angry and sad Rebellious/disobedient No response	1 2 3 4 99	

C502	In the past month, have you noticed any sudden changes in (name's) mood or behavior?	Yes No No response	1 2 99	 C601 C601
C503	If so, how often did this happen to (name) in the past month?	Once Twice Three times or more No response	1 2 3 99	
C504	Do you know what was the cause of this sudden change in mood or behavior of (name)?	Yes, I know the cause No, I didn't know the cause No response	1 2 99	
C505	Did you try to get any help for (name) when you discovered the change in mood?	Yes, I tried No, I didn't try No response	1 2 99	
C506	If so, where did you go help from?	Health center/clinic Community committee (CC) Yekokeb Berhan IP staff Yekokeb Berhan volunteers Other (specify)_____ Did nothing No response	1 2 3 4 5 6 99	
	Section 6: Shelter and Care			
C601	Does (name) have a blanket or night clothes for sleeping at night?	Yes Yes, but not enough No No response	1 2 3 99	
C602	If age of (name) is 3-5 years old, did (name) receive home, community, or center-based early childhood support/services from Yekokeb Berhan in the past 12 months?	Yes No No response	1 2 99	
	Section 7: Legal Protection			
C701	Does (name) have birth certificate issued from authorized government office?	Yes No No response	1 2 99	 **C703** **C703**
C702	Could you please show me [name's] birth certificate?	Seen / confirmed Not seen / not confirmed No response	1 2 99	

C703	Does (name) experience discrimination by peers or any other persons in the community? (discrimination includes Stigma, bias, attitudes, treatment or behavior)	Yes No No response	1 2 99	 **C706** **C706**
C704	If yes to C703, how often the discrimination happen?	Often Sometimes rarely No response	1 2 3 99	
C705	What is the primary reason for discrimination?	Because of AIDS Because of being poor Because he/he is orphan Because of his/her disability Other (Specify)_____ No response	1 2 3 4 5 99	
C706	Has (name) encountered any legal problem over the past 1 year?	Yes No No response	1 2 99	 **C709** **C709**
C707	If yes to Q706, what type of legal problem was encountered? **(Multiple response are possible)**	Related to child abuse and neglect Related to children in conflict with the law Related to inheritance Related to land ownership Related to divorce Related to sexual violence Related to domestic violence Other (specify)_____ No response	1 2 3 4 5 6 7 8 99	
C708	What measures did the family take?	Asked support from IP staff Asked support from community committee (CC) Asked support from police Asked support from Yekokeb Berhan volunteers Did nothing No response	1 2 3 4 5 99	
C709	Has (name) been referred or linked to any legal services over the past 1 year?	Yes No No response	1 2 99	 **C711** **C711**
C710	Who referred or linked (name) to legal services he/she needed?	CSO staff HVC committee Volunteers *Kebele* administration Other_____ No response	1 2 3 4 5 99	

C711	Over the last one year, did (name) experience physical, emotional or sexual abuse?	Yes No Do not know No response	1 2 88 99	 **A101** **A101** **A101**
C712	What type of violence did (name) experience (physical, emotional or sexual abuse, etc)?	Physical abuse Psychological (emotional) abuse Sexual abuse Being left alone or unsupervised for long period of time (for her/his age) No response	1 2 3 4 99	
C713	If so, what did the family do?	Solved in house Reported to *kebele* Reported to police Reported to community committee Went to health center or clinic Did nothing Other (specify): _____ No response	1 2 3 4 5 6 88	
C714	Does (name) sometimes do care for a family member of your household?	Yes No No response	1 2 88	
C715	What kinds of other work does (name) sometimes do? **Multiple responses are possible mentioned**	Hawk goods Sell food at market Household / farm chores for others Work in a restaurant or bar Help out in shop Construction Sewing Mechanic Clerk, Delivery, Administrative Other (specify) _____ No response	1 2 3 4 5 6 7 8 9 10 99	
C716	How often does (name) do other work? Would you say….? **Read response categories**	 Every day / most days Several times a week Once a week Once in a while No response	1 2 3 4 88	
C717	Has (name) ever been neglected (being left alone or unsupervised for long period of time (for her/his age)	Yes No No response	1 2 99	

PART 3: SURVEY QUESTIONS FOR ADOLECSENT HVC (14-17 YEARS)

No.	Questions And Filters	Coding Categories		Skip To
	SECTION 1: BACKGROUND INFORMATION OF THE RESPONDENT			
A101	Age of the respondent	[_____]		
A102	Sex of the respondent	Male Female	1 2	
A103	Marital status of the respondent	Single Married Divorced Widowed Live with partner/cohabit No Response	1 2 3 4 5 99	
A104	Which is true about you?	Mother is dead Father is dead Both mother and father are dead Chronically ill HIV positive Has some kind of disability Household is headed by a child (<18) Household is headed by elderly Household is headed by ill person Household I headed by disabled No response	1 2 3 4 5 6 7 8 9 10 99	
A105	Who is taking care of you currently? **Do not read responses. Circle up to two primary responses.**	Mother and/or father Sister and/or brother Aunt and/or uncle Grandmother and/or Grandfather Other relative Neighbor Friend No one/self Other (specify)_____ No response	1 2 3 4 5 6 7 8 9 99	
A106	Have you ever attended formal school?	Yes No No Response	1 2 99	 **A108** **A108**
A107	What is the highest level of school you completed? (***CIRCLE ONE***)	Primary (grade 1-8) Secondary (grade 9-10) Preparatory (11-12) 10+TVET College/university No Response	1 2 3 4 5 99	
A108	Do you have a disability?	Yes No No response	1 2 99	 **A113** **A113**

A109	If yes, does that make it difficult for you to participate in daily activities?	Yes No	1 2	
A110	How would you describe your disability? (Multiple responses are possible)	Blind or partially blind Deaf or partially deaf I have difficulties learning Physical disability Other (specify)_____ No response	1 2 3 4 5 99	
A111	Are you receiving any kind of assistive devices or supports for his/her disability?	Yes No I don't know No response	1 2 88 99	 **A113** **A113** **A113**
A112	What kind of assistive devices or supports/services are you receiving?	Prosthesis(artificial leg or arm) Eye glasses Hearing aid Crutches Wheelchair Medical care Home-based care Financial support Others (specify)_____ No response	1 2 3 4 5 6 7 8 9 99	
A113	Do you know about the Yekokeb Berhan project that is supported by USAID/Ethiopia and implemented by _____(IP) in your area?	Yes No No response	1 2 99	
	Section 2: Health and Health Care			
A201	In general, how would you rate your health over the past 12 months?	Excellent Good Fair Poor Very poor No Response	1 2 3 4 5 99	
A202	In the last 2 weeks, have you been too sick to participate in daily activities?	Yes No No Response	1 2 99	 **A210** **A210**
A203	Have you had fever in the two weeks preceding the survey?	Yes No No response	1 2 99	 A205 A205
A204	Did you receive treatment - from a health provider for this illness?	Yes No No response	1 2 99	
A205	Have you had diarrhea in the last two weeks?	Yes No No response	1 2 99	 A207 A207

A206	Did you get treatment from a health provider for this illness?	Yes No No response	1 2 99	 **A208** **A208**
A207	Where did you seek health care for your illnesses? *(if there is more than one response, write only one response they consider most common)*	Government health facility Private hospital/clinic Pharmacy Traditional healer Other (specify) ---------- No response	1 2 3 4 5 99	
A208	For your last illness if you did not seek care, what was the reason? **(Multiple responses are possibility, take only the main reason)**	No money No transport Hospital, health center too far away Illness not serious Did not want treatment Clinic is too crowded Illness was too serious Other (specify)_____ No response	1 2 3 4 5 6 7 9 99	
A209	Who covers your above costs of treatment?	It was free (in public health facilities) The household itself Relatives Neighbors/acquaintances CBOs (Idir, etc) Yekokeb Berhan program Volunteer people (their own donation) Other_____ No response	1 2 3 4 5 6 7 8 99	
A210	How do you rate your health care since the past 12 months compared to a year before?	Better Similar Worse No response	1 2 3 99	
A211	If you were sick and needed to see a doctor, is there someone who could help you get to a doctor or a health worker?	Yes No No response	1 2 99	
A212	What is true about your healthcare services you currently get whenever needed? It is…	Less than enough Just enough More than enough No response	1 2 3 99	
A213	Did you receive information or counseling about HIV by health workers or anybody else (ways of transmission, methods of prevention, care and treatment) in the past 12 months?	Yes No Don't know No response	1 2 88 99	

A214	**Now I would like to ask you some sensitive questions about your health:** Have you ever been tested for HIV?	Yes No No response	1 2 99	
A215	If so, did you receive your HIV test results?	Yes No Don't know No response	1 2 88 99	A217
A216	If you did not receive HIV test results, why not?	Did not want results Results took too long Still waiting for results Other (specify) _____ No response	1 2 3 4 99	
A217	If you received, what were your test results?	Negative Positive Don't know No response	1 2 88 99	**A220** **A220** **A220**
A218	If you are HIV positive, are you currently taking ART?	Yes No Not Applicable (HIV negative) Do not know No response	1 2 3 8 99	
A219	If taking ART, do you always got to health facility for follow up as scheduled by the health workers?	Yes, always Yes, but sometimes misses schedule Often misses schedule Don't know No response	1 2 3 88 99	
A220	Did you ever get health information or counseling about reproductive health?	Yes No No response	1 2 99	
A221	Where from do you get information or counseling about reproductive health?	Government health facilities Health extension workers Yekokeb Berhan volunteers School Other (specify)_____ No response	1 2 3 4 5 99	
	Section 3: Education			
A301	Do you currently attend school?	Yes No No response	1 2 99	 **A314** **A314**
A302	If yes, what grade are you in right now?	_____ Do not know No response	 88 99	
A303	If you needed help with school work, is there someone who could help you?	Yes, often Sometimes Never Do not know No response	1 2 3 88 99	 **A305** **A305** **A305**

A304	Who often helps you with this regard?	A family member/relative Peer group Classmates Yekokeb Berhan volunteers Teachers (after school classes) Other (specify) _____ No response	1 2 3 4 5 6 99	
A305	Have you ever participated in a tutorial activity organized by Yekokeb Berhan program or a school or another organization in your community?	Yes No No response	1 2 99	
A306	In past 12 months, did you get encouragement about your school works from Yekokeb Berhan or its IP volunteers	Yes No No response	1 2 99	
A307	**(For girls 12 years and above only)** In the last two months, did you miss school for at least one whole day because you were menstruating?	Yes No No response	1 2 99	
A308	How many days did you miss school during the past month? *(Please estimate if not sure)*	None 1-3 days 4-6 days 7-9 days 10 days or more Not applicable (not in school) Do not know No response	1 2 3 4 5 6 88 99	**A310** **A310** **A310** **A310**
A309	What was your main reason for missing school?	No money for fees, materials, transport Child is too sick to attend school Due to menstruation (for girls only) School is too far away Had to work to help family Had to care for a sick family member Not interested in school Poor treatment by teachers at school Poor treatment by peers at school Stigma at school Other (specify)_____ No response	1 2 3 4 5 6 7 8 **9** 10 11 99	

A310	During the previous academic year, have you been promoted to next grade/ level?	Yes No, he repeated No response	1 2 99	**A312** **A312**
A311	If no, what was the reason?	Failed end of year exam/poor grades Disciplinary dismissal Dropped/stopped attending Other (specify) _____ No response	1 2 3 4 99	
A312	How would you rate your school performance in the past 12 months compared to the previous year?	Better No change Worse Not applicable (not in school) No response	1 2 3 4 99	
A313	Who usually covers your school expenses (books, uniform, stationaries, transport, school fee, etc) since the past 12 months? (In the case of multiple responses, take the most common one)	Household (from income) Household (sold assets) Relatives Neighbors/acquaintances CBOs (Idir, etc) Yekokeb Berhan program Volunteer people (personal donation) Other (specify)_____ No response	1 2 3 4 5 6 7 8 99	
A314	If you are not currently enrolled in school, what is the reason? **Do not read responses. Circle up to two primary responses.**	No money for fees, materials, transport Child is too sick to attend school School is too far away / no school Child has to work to help family Child needs to care for sick household members Child does not like school Child is too young to attend school Other(specify)_____ No response	1 2 3 4 5 6 7 8 99	
A315	If you have stopped/dropped attending school, what was the main reason that (name) stopped attending school?	Could not pay fees Cared for sick family member Poor school performance Caring for siblings Graduated from school Completed grade 10 and did not pass exam Pregnant or parenting Got married Illness Stigmatized by peers Got a job Expelled Work at home Disability Other (specify)_____ No response	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 99	

A316	If you are out of school, would you like to return to school?	Yes No Do not know No response	1 2 88 99	
A317	If you are out of school, did you receive (receiving) any type of vocational training?	Yes No No response	1 2 99	 **A401** **A401**
A318	If yes, who provides the vocational training?	Yekokeb Berhan program *Kebele*/*woreda* office Community based organization An NGO Government (TVET college) Other (specify)_____ No response	1 2 3 4 5 6 99	
	Section 4: Food and Nutrition			
A401	What is true about your food consumption over the past month? **It has been…**	Less than enough Just enough More than enough No response	1 2 3 99	
A402	In the past four weeks, did you have to <u>eat a smaller meal</u> than you felt was needed because there was not enough food?	Yes No No response	1 2 99	 **A410** **A410**
A403	**If yes –** How many times did this happen? **Read out responses.**	Rarely (1-2 times in past 4 weeks) Sometimes (3-10 times in past 4 weeks) Often (> 10 times in past 4 weeks) No response	1 2 3 99	
A404	In the past four weeks, did you have to <u>skip a meal</u> because there was not enough food?	Yes No No response	1 2 99	
A405	**If yes –** How many times did this happen? **Read out responses.**	Rarely (1-2 times in past 4 weeks) Sometimes (3-10 times in past 4 weeks) Often (> 10 times in past 4 weeks) No response	1 2 3 99	
A406	In the past four weeks did you go to <u>sleep at night hungry</u> because there was not enough food to eat?	Yes No No response	1 2 99	
A407	**If yes –** How many times did this happen? **Read out responses.**	Rarely (1-2 times in past 4 weeks) Sometimes (3-10 times in past 4 weeks) Often (> 10 times in past 4 weeks) No response	1 2 3 99	

A408	How often did you go a whole day or night without eating in the last 4 weeks? **(If fasting season, please note that)**	Yes No No response	1 2 99	
A409	In the past week, how many meals did you consume a day on average?	One Two Three Four More than four No response	1 2 3 4 5 99	
A410	In the past week, how many times did you have protein meals (meat, fish, egg, milk, pulses)? **(If fasting season, please note that)** **Number of meat or fish meals**	_____		
A411	In the past week, how many times did you have vegetable meals (cabbage, lettuce, beetroot, carrot, etc)? **Number of vegetable meals**	_____		
A412	In the past week, how many times did you have fruit (banana, orange, mango, avocado etc) **Number of fruit meals**	_____		
	Section 5: Psychosocial Support			
A501	Do you have someone in your life that you can confide in or talk to about yourself or your problems?	Yes No No Response	1 2 99	
A502	Do you have someone in your life that can take you to the health worker or a counselor if you needed it?	Yes No No Response	1 2 99	
A503	Do you have someone in your life that shows you love and affection?	Yes No No Response	1 2 99	
A504	Did you receive any life skill training over the two years?	Yes, I received Yes, somebody received No No response	1 2 3 88	

	Section 7: Legal Protection			
A701	Do you have birth certificate issued from authorized government?	Yes No No response	1 2 99	 **A703** **A703**
A702	Could you please show me your birth certificate?	Seen / confirmed Not seen / not confirmed No response	1 2 99	
A703	Do you experience discrimination by peers or any other persons in the community? **(discrimination includes stigma, bias, attitudes, treatment or behavior)**	Yes No No response	1 2 99	 **A706** **A706**
A704	If yes, how often the discrimination happens?	Often Sometimes rarely No response	1 2 3 99	
A705	What is the primary reason for discrimination?	Because of AIDS Because of being poor Because I am of orphan Because of my disability Other (Specify)_____ No response	1 2 3 4 5 99	
A706	Have you encountered any legal problem over the past 1 year?	Yes No No response	1 2 99	 **A709** **A709**
A707	If yes, what type of legal problem was encountered? **(Multiple response are possible)**	Related to child abuse and neglect Related to children in conflict with the law Related to inheritance Related to land ownership Related to divorce Related to sexual violence Related to domestic violence Other (specify)_____ No response	1 2 3 4 5 6 7 8 99	
A708	What measures did you or the family take for this legal problem?	Asked support from a Yekokeb Berhan IP Asked support from community committee (CC) Asked support from police Asked support from Yekokeb Berhan volunteers Other (specify)_____ Did nothing No response	1 2 3 4 5 6 99	

A709	Over the last one year, did you experience any type of abuse (physical, emotional or sexual, etc)?	Yes No Do not know No response	1 2 88 99	 **A712** **A712**
A710	What type of violence did you experience?	Physical abuse Psychological (emotional) abuse Sexual abuse Other (specify)_____ No response	1 2 3 4 99	
A711	What did you do for the violence?	Solved the problem in house/ family Reported to *kebele* Reported to police Reported to Community committee Reported to IP volunteers Did nothing Other (specify): _____ No response	1 2 3 4 5 6 7 99	
A712	Have you been referred or linked to any legal services over the past 2 years?	Yes No Not applicable (service not required) No response	1 2 3 99	 A714 A714
A713	If yes, who referred or linked you to legal services you needed?	IP staff Community committee Yekokeb Berhan Volunteers *Kebele* administration Other (specify)_____ No response	1 2 3 4 5 99	
A714	Do you feel more secure in terms of legal protection this time than before you were involved in HVC program?	Yes No Not sure No response	1 2 3 99	
A715	<u>In the past 6 months</u>, have you worked for a wage, salary, commission or any payment 'in kind'?	Yes No No response	1 2 99	
A716	About how much time do you spend per day doing this work?	Less than 1 hour 1-2 hours 3-4 hours More than 4 hours It depends / it is different everyday No response	1 2 3 4 5 99	
A717	Did these works interfere with your schooling (working during school days/time)?	Yes, always Yes, sometimes No No response	1 2 3 99	
A718	Do you do <u>household chores?</u>	Yes No No response	1 2 99	 **End** **End**

A719	What household chores do you usually do? **Multiple responses are possible; circle all mentioned.**	Prepare food Fetch water Clean toilets Take care of younger children Plant/tend to/harvest crops Feed, care for animals Wash clothes, blankets Care for sick family member Other (specify)_____ No response	1 2 3 4 5 6 7 8 9 99	
A720	About how much time do you spend per day doing these household chores?	Less than 1 hour 1-2 hours 3-4 hours More than 4 hours It depends / it is different everyday No response	1 2 3 4 5 88	
A721	Do these household chores interfere with your schooling (doing household chores during school days/time)?	Yes, they interfere No they don't interfere No response	1 2 99	

YEKOKEB BERHAN PROGRAM FOR HIGHLY VULNERABLE CHILDREN AND THEIR FAMILIES: MIDE TERM EVALUTAION, FEBRUARY 2014

Key Informant Interview Questions (1)

Stakeholders to Yekokeb Berhan program at Federal/Regional level (HAPCO, MoWCY, PACT, Child Fund and FHI)

Confidentiality and consent

[Moderator: Please read the following paragraph to the participants and continue the discussion only if they consented to participate in discussion]

Good morning/ good afternoon! My name is _____I and my colleagues (depending on if you are two) are collecting information on behalf of Yekokeb Berhan related to implementation of highly vulnerable children (HVCs) and their families in high HIV prevalent urban area.

We are asking you for your time to participate in this study. We are looking for information on changes to the life of highly vulnerable children and their families. The information you provide us will help Yekokeb Berhan to understand whether the project implementation has brought changes and what needs to change in the future.

We would greatly appreciate your participation. Please note that the information collected in this study will remain confidential. Your identity as a participant will never be used in connection with any of the information you tell us will not be revealed to people other than the facilitators. Any references to information that would reveal your identity will be removed or disguised in the preparation of the research reports and publications. Would you be willing to participate?

Agree_____ Disagree _____

Region_____ Zone _____*Woreda* _____

Town_____ Subcity_____Tape code_____

Name of the organization _____

Position of the informant in the organization_____

Year of service in the present position_____

Sex of respondent: Male [ ] Female [ ]

Age: [ ]

Date of the interview_____

Time started_____ Time finished _____

Name and signature of interviewer _____

Instruction to facilitator:
Note that under this section, we are interested to get information related to changes in system to improve provision of care and services to HVC and their families at community level. Specifically, we wanted to know if changes were introduced in systems, procedures and tools that contributed to impacts on improved wellbeing of HVC and their families.

Participants:
Participants under this section are stakeholders at federal level including government partners (HAPCO and MoWCYAs and International CSOs such as PACT, FHI and Child Fund. Specific targets here are OVC focal persons at Federal, Regional and Wereda level representing these institutions.

<table>
<tr><td>Theme</td><td>S.No</td><td>Questions /probing</td></tr>
<tr><td>General understanding of the project</td><td>1</td><td>Can you tell me what changes were noted at policy and programming level as a result of Yekokeb Berhan's project? Please provide examples.</td></tr>
<tr><td>Capacity</td><td>2</td><td>What system was developed to build the capacity of implementing partner? Probe –

- How were capacity gaps of implementing partners identified?
- What systems and tools are in place to address the different gaps (please specify capacity building interventions and corresponding approaches?)
<table><tr><td>Types of capacity gaps</td><td>Capacity building approaches</td><td>What tools/systems is/are in place</td></tr><tr><td>-</td><td>-</td><td>-</td></tr><tr><td>-</td><td>-</td><td>-</td></tr><tr><td>-</td><td>-</td><td>-</td></tr></table>- Which implementing partners benefitted from such capacity building interventions?
- What is the role of your organization in this?
- What change has been noticed in consequence at level of HVC and their families? Probe – how such change is tracked? Please provide examples?</td></tr>
<tr><td>Data management and use</td><td>3</td><td>What system is put in place to routinely generate data on accomplishments of care and service for HVCs and their families

- How is data generated from operational level and reported to the next level (check on what format and channel of reporting used, what data management system is in place at implementing partners level)
- Who developed this system? What was your organization's</td></tr>
</table>

		role? - How regularly was the system used by implementing partners and community level structure? If not regular probe on why not – check friendliness of formats and reporting channels. - How has such data used for programming and policy? Please provide examples and levels - What changes were introduced in data generation and management since the inception of the project? - What consequences were noticed as a result of instituting data generation and management at operational level?
Support to implementing partners and community structures at operational level	4	What change has been introduced in support for implementing partners at community level (CSOs, CBOs, volunteers) to improve intervention? Probe – - If there was/were tools to identify support needs of implementing partners? eg technical and organizational capacity of partners - If support provision is planned and regular? - If such support was recorded and feedbacks are provided to implementing partners? - Whether service standards were developed/adapted?? And shared with implementers to guide service provision to a) HVCs and b) their families? - If service standards were shared and enforced to guide interventions at operational level and how? - What was the role of your organization in this? - What support was provided to the different implementing partners during the last one year (probe in terms of supportive supervision…)
Coordination among implementing partners	5	Assuming there are different implementing partners at operational level to provide care and services to HVC and their families; - What measure was taken to improve coordination among the different implementers? - More specifically check if there were procedures put in place and if that was implemented? - What consequent change in the life of HVCs and their families was noted? - How was that change known? - Under circumstances where services are not available for HVCs in the community (eg for health care) what happens? Probe if there is procedures for referral and feedback is drawn (check for which services) - What was the role of your organization in this? - How do you explain the role of Yekokeb Berhan in improving coordination of the different implementing partners? Please provide examples.
Targeting	6	What changes were introduced to ensure HVC and their families are reached with care and services? Probe –

		- If gender - Age - Disability etc were given due attention in selecting the right beneficiaries - What was the role of your organization in this?

YEKOKEB BERHAN PROGRAM FOR HIGHLY VULNERABLE CHILDREN AND THEIR FAMILIES: MIDE TERM EVALUTAION, FEBRUARY 2014

Key Informant Interview Questions (2)

Implementing partners at community level (CSOs, CBOs) and microfinance associations

Confidentiality and consent

[Moderator: Please read the following paragraph to the participants and continue the only if they consented to participate in discussion]

Good morning/ good afternoon! My name is _____I and my colleagues (depending on if you are two) are collecting information on behalf of Yekokeb Berhan related to implementation of highly vulnerable children (HVCs) and their families in high HIV prevalent urban area.

We are asking you for your time to participate in this study. We are looking for information on changes to the life of highly vulnerable children and their families. The information you provide us will help Yekokeb Berhan to understand whether the project implementation has brought changes and what needs to change in the future.

We would greatly appreciate your participation. Please note that the information collected in this study will remain confidential. Your identity as a participant will never be used in connection with any of the information you tell us will not be revealed to people other than the facilitators. Any references to information that would reveal your identity will be removed or disguised in the preparation of the research reports and publications. Would you be willing to participate?

Agree_____ Disagree _____

Region_____ Zone _____*Woreda* _____

Town_____ Subcity_____Tape code_____

Name of the organization _____

Position of the informant in the organization_____

Year of service in the present position_____

Sex of respondent: Male [ ] Female [ ]

Age: [ ]

Date of the interview_____

Time started_____ Time finished _____

Name and signature of interviewer _____

Instruction to facilitator:
Note that under this section, we are interested to get information related to changes in the provision of care and services to HVC and their families at community level. Specifically, we wanted to know if there were changes at implementing partners' level in terms of provision of 'package of services' to HVCs and their families. We would ultimately intend to know how this has improved wellbeing of HVC and their families.

Participants:
Participants under this section are implementing partners at community or wereda level level including CSO, CBOs and microfinance institutions.

<table>
<tr>
<td>Change in role of implementing partners</td>
<td>1</td>
<td>What is the role of your organization in the effort to improve the life of HVC and their families? Probe –

- What are the specific roles of your organization in meeting the needs of HVCs and their families?
- What change has been made to the organization's role in implementing the goal of the project?
- Why has such change introduced?
- What consequences were noted in connection to such change in terms of meeting the needs of HVCs and their families (note this could be positive or negative change)</td>
</tr>
<tr>
<td>Capacity building support received at HH level</td>
<td>2</td>
<td>What capacity change was noted at your level to contribute to an improved wellbeing of HVCs over the last one year? Probe what support and with what implication?

<table>
<tr><td>Type of capacity built

(probe for all support received)</td><td>Who provided such support</td><td>Implication of such support for improved wellbeing of HVCs</td></tr>
<tr><td>Training on ..</td><td></td><td></td></tr>
<tr><td>Financial for</td><td></td><td></td></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td></tr>
</table>
- How do you explain if such capacity building has enabled the HH to play its role; please provide examples</td>
</tr>
</table>

<table>
<tr><td></td><td></td><td>- What needs to improve in terms of capacity, please provide evidences of why this is desired?</td></tr>
<tr><td>Role/function of community structures (CBOs and volunteers)</td><td>3</td><td>Which community structures are operating in this community/wereda in connection to care and services for HVC and their families? Probe – on all CBOs (iddir, saving groups, women groups, youth groups… and volunteers?

<table><tr><td>Community structure</td><td>Roles in care and services to a) HVC b) their families</td><td>Changes over the last one year</td></tr><tr><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td></tr></table>
What service standards guide service provision to a) HVCs and b) their families (probe if there are standard service package as a guide, who developed it and where the partner got it from?

What is still considered as gaps in service provision at community structure level? Probe in terms of capacity (provide specific example)</td></tr>
<tr><td>Coordination among partners</td><td>4</td><td>What measure(s) was/were taken to improve coordination among the different implementers in the community (wereda)? Probe –

- What system was put in place to improve coordination between CSOs, CBOS and volunteers? Has this changed after the inception of the project? Why was it changes?
- Please provide evidences of consequent implication on the wellbeing of HVCs and their families over the last one year? Probe changes in terms of quality of specific services, coverage of services.
- Under circumstances where services are not available for HVCs in the community (eg for health care) what happens? Probe if there is procedures for referral and feedback is drawn (check for which services)
- What was the role of your organization in this?</td></tr>
</table>

<table>
<tr><td></td><td></td><td>- How do you explain the role of Yekokeb Berhan in improving coordination of the different implementing partners? Please provide examples.</td></tr>
<tr><td>Data management and use</td><td>5</td><td>How has implementing partners been continuously generating data on accomplishments of care and service for HVCs and their families

- What tool(s) is there to generate data on accomplishment and how is it reported to the next level (system in place?)
- Who developed this system? When was this developed? What was your organization's role?
- How regularly is your organization generating data on interventions using the tool developed for this purpose? Where do you send the report?
- How has such data used for programming at your level; please provide examples.
- What change has been observed in consequence over the last one year?</td></tr>
<tr><td>Changes in care and services</td><td>6</td><td>How do you explain changes in meeting the needs of highly vulnerable children and families in [the community? Wereda] Probe – for HVC

- What specific changes were there?
<table>
<tr><th>Services</th><th>Changes Probe (quality, coverage, appropriateness)</th><th>How did you know of the changes?</th></tr>
<tr><td>Health</td><td></td><td></td></tr>
<tr><td>Health care</td><td></td><td></td></tr>
<tr><td>Nutrition</td><td></td><td></td></tr>
<tr><td>Education</td><td></td><td></td></tr>
<tr><td>Economic position</td><td></td><td></td></tr>
<tr><td>Emotional wellbeing</td><td></td><td></td></tr>
<tr><td>Other areas</td><td></td><td></td></tr>
</table>
- What is the reason for such changes – probe if such</td></tr>
</table>

		change is associated to change at the level of implementing partners? Please provide evidences of change at the level of implementing partners in terms of eg. technical and organizational capacity (specify what this is) - What is the role of your organizations in such changes? Please provide examples - What is still considered as gaps in service provision? Probe in terms of whether all targets are reached? Quality and appropriateness of service needs further change; provide detailed information to each point.

YEKOKEB BERHAN PROGRAM FOR HIGHLY VULNERABLE CHILDREN AND THEIR FAMILIES: MID TERM EVALUATION, FEBRUARY 2014

FGD Guide (1)

Caregivers

Confidentiality and consent

[Moderator: Please read the following paragraph to the participants and continue the only if they consented to participate in discussion]

Good morning/ good afternoon! My name is _____I and my colleagues (depending on if you are two) are collecting information on behalf of Yekokeb Berhan related to implementation of highly vulnerable children (HVCs) and their families in high HIV prevalent urban area.

We are asking you for your time to participate in this study. We are looking for information on changes to the life of highly vulnerable children and their families. The information you provide us will help Yekokeb Berhan to understand whether the project implementation has brought changes and what needs to change in the future.

We would greatly appreciate your active participation. Please note that information you provide are equally important and there is no right or wrong answer. Note also your response remains anonymous and reference is made to your collective point instead of who said that. If reference is made to personal identity, personal identifiers will be removed or disguised in the preparation of the research reports and publications. Would you be willing to participate?

Region_____ Zone _____*Woreda* _____

Town_____ Subcity_____Tape code_____

Date of the FGD_____

Time started_____ Time finished _____

Name and signature of facilitator _____

Instruction to facilitator:
Note that under this section, we are interested to get specific information on changes in the wellbeing of HVCs as well as the HHs. More particularly, we are interested to find out if intervention has changed the way HVCs live and how empowered HHs are in meeting the needs of HVCs.

Participants:
Participants under this section are care givers to be identified from within the community

Participant's code	Age	Sex	Education (highest grade completed)	For how long have you been involved in the Yekokeb Berhan program?
P1				
P2				
P3				
P4				
P5				
P6				
P7				
P8				
P9				
P10				
P11				
P12				

<table>
<tr><td>Current situation</td><td>1</td><td>What is the current reality in the provision of care and services for HVC? (you may probe in terms of changes in the number of HVCs with problems, what has changed or not)</td></tr>
<tr><td>Care and services for HVCs</td><td>2</td><td>What care and services are available for HVCs at:
- HH level –
o Please list all care and services provided to HVC at HH level including psychosocial support
<table>
<tr><td>Services</td><td>List all services provided</td></tr>
<tr><td>Health</td><td></td></tr>
<tr><td>Health care</td><td></td></tr>
</table>
</td></tr>
</table>

<table>
<tr>
<td></td>
<td></td>
<td>
<table>
<tr><td>Nutrition</td><td></td></tr>
<tr><td>Education</td><td></td></tr>
<tr><td>Economic position</td><td></td></tr>
<tr><td>Emotional wellbeing</td><td></td></tr>
<tr><td>Other areas</td><td></td></tr>
</table>

o What service standards guide service provision to a) HVCs at family level (probe where the standards has come from, who developed it and where the partner got it from? If the standard was useful and why?
o Explain appropriateness of such care and service
o Explain quality of such care and service
o What is still considered as gaps in service provision at this level?

- Community level-

o Please list all care and services provided to HVC at community level
o Explain appropriateness of such care and service
o What service standards guide service provision to a) HVCs at community level (probe where the standards has come from, who developed it and where the partner got it from? If the standard was useful and why?
o Explain quality of such care and service
o What is still considered as gaps in service provision at this level

- How do you explain if support to HVCs addresses all targets in terms of:

o Gender
o Age
o Disability

</td>
</tr>
<tr>
<td>Capacity building support received at HH level</td>
<td>3</td>
<td>What capacity change was noted at HH level to improve the wellbeing of HVCs over the last one year? Probe what support and with what implication?
<table>
<tr><td>Type of capacity built</td><td>Who provided such support</td><td>Implication of such support for improved</td></tr>
</table>
</td>
</tr>
</table>

<table>
<tr><td></td><td></td><td>
<table>
<tr><td>(probe for all support received)</td><td></td><td>wellbeing of HVCs</td></tr>
<tr><td>Training on ..</td><td></td><td></td></tr>
<tr><td>Financial for</td><td></td><td></td></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td></tr>
</table>
- How do you explain if such capacity building has enabled the HH to play its role; please provide examples
- What needs to improve in terms of capacity, please provide evidences of why this is desired?
</td></tr>
<tr><td>Consequent changes</td><td>4</td><td>How do you explain changes at the level of HVC

- What specific changes were there? Please provide evidences:
o Health
o Nutrition
o Educational achievement
o Emotional wellbeing

- What is still considered as gaps in service provision? Probe in terms of whether all targets are reached? Quality and appropriateness of service needs further change; provide detailed information to each point.</td></tr>
<tr><td></td><td></td><td>Changes at HH level

- What changes were noted at HH level over the last one year? Probe on specific changes and examples?
<table>
<tr><td>Services</td><td>Changes - Probe (quality, coverage, appropriateness)</td><td>How did you know of the changes?</td></tr>
<tr><td>Health</td><td></td><td></td></tr>
<tr><td>Health care</td><td></td><td></td></tr>
<tr><td>Nutrition</td><td></td><td></td></tr>
<tr><td>Education</td><td></td><td></td></tr>
<tr><td>Economic</td><td></td><td></td></tr>
</table>
</td></tr>
</table>

<table>
<tr><td></td><td></td><td>
<table>
<tr><td>support</td><td></td><td></td></tr>
<tr><td>Emotional wellbeing</td><td></td><td></td></tr>
<tr><td>Other areas</td><td></td><td></td></tr>
</table>

Changes at community level

- What changes were noticed in connection to improved wellbeing of HVC and capacity of HH? Probe on specific changes and implications
- Under circumstances where services are not available for HVCs at HH and within the community (eg for health care) what would you do? Probe if there is opportunities for referrals
- Has there been such referral during the last one year and what happened? Probe reason for referral and satisfaction with referral services and why?
- How do you explain the role of Yekokeb Berhan in such changes different levels? Please provide examples.</td></tr>
<tr><td>Data management and use</td><td>5</td><td>How do you report service provision to HVCs at your level to the next level (probe –

- Where would accomplishments at HH level reported to? What reporting tool is applied?
- How such data was used at HH level; please provide examples.
- What change has been observed in consequence over the last one year?</td></tr>
</table>

YEKOKEB BERHAN PROGRAM FOR HIGHLY VULNERABLE CHILDREN AND THEIR FAMILIES: MID TERM EVALUATION FEBRUARY 2014

FGDs (2)

Community committee, community volunteers and saving groups

Confidentiality and consent

[Moderator: Please read the following paragraph to the participants and continue the only if they consented to participate in discussion]

Good morning/ good afternoon! My name is _____I and my colleagues (depending on if you are two) are collecting information on behalf of Yekokeb Berhan related to implementation of highly vulnerable children (HVCs) and their families in high HIV prevalent urban area.

We are asking you for your time to participate in this study. We are looking for information on changes to the life of highly vulnerable children and their families. The information you provide us will help Yekokeb Berhan to understand whether the project implementation has brought changes and what needs to change in the future.

We would greatly appreciate your active participation. Please note that information you provide are equally important and there is no right or wrong answer. Note also your response remains anonymous and reference is made to your collective point instead of who said that. If reference is made to personal identity, personal identifiers will be removed or disguised in the preparation of the research reports and publications. Would you be willing to participate?

Agree_____ Disagree _____

Region_____ Zone _____*Woreda* _____

Town _____ Subcity_____

Date of FGD _____

Time started_____

Time finished _____

Name and signature of facilitator _____

Instruction to facilitator:
Note that under this section, we are interested to get specific information on changes in the wellbeing of HVCs as well as the HHs and the contribution of community committees, saving groups and volunteers. More particularly, we are interested to find out if there are changes in this group that sustains improved the wellbeing of HVCs and their families.

Participants:
Participants under this section are members of community committee, saving groups and volunteers that would be identified from within the community

Participant's code	Age	Sex	Education (highest grade completed)	For how long have you been involved in the Yekokeb Berhan program?
P1				
P2				
P3				
P4				
P5				
P6				
P7				
P8				
P9				
P10				
P11				
P12				

General information	1	Can you please tell us: - Who in community are highly vulnerable (children and their families) - Why are these vulnerable?
Sources of information	2	Where do people in this community get information on care and services for HVCs and their families? Probe – - What do people in the community know about service packages to HVC? (probe on what specific services?) - Who are the providers of such information - What is the channel of information provision (probe if community discussion, coffee ceremony, media,… - Who organize such information provision in the community? - What change is there in community's awareness about HVC and their families

<table>
<tr><td>Community's role</td><td>3</td><td>What was the community's role in the identification of HVCs and their families? Were those on supports the right groups? What should change in future in choosing targets for care and services?

What other roles do community members play to ensure the wellbeing of HVC and their family? Please specify community members role including volunteers?</td></tr>
<tr><td>Community capacity</td><td>4</td><td>What community capacity improvement was there over the last one year? Who provided such capacity improvement? On what specific area? What was the added value of capacity improvement?</td></tr>
<tr><td>Care and service providers</td><td>5</td><td>What support is/are available for HVC and their families at community level? Probe on what support, for whom, by whom and implications of such support

<table>
<tr><td>Type of support (probe on available support at community level for HVCs and their families)</td><td>For whom (HVC/HH)</td><td>Who provide support</td><td>Implication of such support</td></tr>
<tr><td>Credit??</td><td></td><td></td><td></td></tr>
<tr><td>Training?</td><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td><td></td></tr>
</table>
- How do you explain if such support is satisfactory in enabling the HH to play its role; please provide examples
- What needs to improve, please provide evidences of why this is desired?</td></tr>
<tr><td>Care and services for HVCs</td><td>6</td><td>What care and services are available for HVCs at:

- HH level –
What care and services are available for HVCs at:

- HH level –
o Please list all care and services provided to HVC at HH level including psychosocial support</td></tr>
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<td></td>
<td>
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<tr><td>Nutrition</td><td></td></tr>
<tr><td>Education</td><td></td></tr>
<tr><td>Economic position</td><td></td></tr>
<tr><td>Emotional wellbeing</td><td></td></tr>
<tr><td>Other areas</td><td></td></tr>
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What service standards guide service provision to a) HVCs at family level (probe where the standards has come from, who developed it and where the partner got it from? If the standard was useful and why?
Explain appropriateness of such care and service
Explain quality of such care and service
What is still considered as gaps in service provision at this level?

Community level-

Please list all care and services provided to HVC at community level
Explain appropriateness of such care and service
Explain quality of such care and service
What is still considered as gaps in service provision at this level

How do you explain if support to HVCs addresses all targets in terms of:

Gender
Age
Disability

</td>
</tr>
<tr>
<td>Consequent changes in care and services</td>
<td>7</td>
<td>How do you explain changes at the level of HVC

What specific changes were there? Please provide evidences:

Health
Nutrition

</td>
</tr>
</table>

		o Educational achievement o Emotional wellbeing - What is still considered as gaps in service provision? Probe in terms of whether all targets are reached? Quality and appropriateness of service needs further change; provide detailed information to each point.
		Changes at HH level - What changes were noted at HH level over the last one year? Probe on specific changes and examples? o Improved productive assets (probe implication on paying for health and educational services, buying/producing food… o Improved capacity to provide psychosocial support Changes at community level - What changes were noticed in connection to improved wellbeing of HVC and capacity of HH? Probe on specific changes and implications - Under circumstances where services are not available for HVCs at HH and within the community (eg for health care) what would you do? Probe if there is opportunities for referrals (has there been such an incident over the last one year and what happened? - How do you explain the role of Yekokeb Berhan in such changes at different levels? Please provide examples.