



Yekokeb Berhan Program for Highly Vulnerable Children in Ethiopia Endline Evaluation Report

EVALUATION CONDUCTED BY



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Acronyms

ABH	ABH Services PLC
AIDS	Acquired Immune Deficiency Syndrome
APR	Annual progress report
ART	Anti-Retroviral Treatment
BoWCA	Bureau of Women and Children Affairs
CBO	Community Based Organization
CC/CCC	Community Care Coalition/Community Committee
CDC	Centers for Disease Control and Prevention
CSA	Central Statistical Agency
CSI	Child Support Index
CSSG	Community Savings and Self Help Group
CSO	Civil Society Organization
CSPRO	Census and Survey Processing System
CV	Community Volunteer
DHS	Demography and Health Survey
ES	Economic Strengthening
FDRE	Federal Democratic Republic of Ethiopia
FGD	Focus Group Discussion
FHI360	Family Health International 360
HAPCO	HIV and AIDS Prevention and Control Office
HIV	Human Immunodeficiency Syndrome
HVC	Highly Vulnerable Children
INGO	International Non-Governmental Organization
IGA	Income Generating Activity
KII	Key Informant Interview
M&E	Monitoring and Evaluation
MERL	Monitoring, Evaluation, Reporting and Learning
ME-SPM	Micro-Enterprise Selection, Planning and Management
MoWCA	Ministry of Women and Children Affairs
NGO	Non-Governmental Organization
OCA	Organizational Capacity Assessment
OVC	Orphan and Vulnerable Children
PC3	Positive Change: Children, Communities and Care Program
PEPFAR	President's Emergency Plan for AIDS Relief
PSNR	Productive Safety Net Program
RH	Reproductive Health
SNNP	Southern Nations, Nationalities and Peoples' Region
SSDG	Standard Service and Delivery Guidelines
UNAIDS	United Nations Programme on HIV/AIDS
USAID	United States Agency for International Development
YB	Yekokeb Berhan

Definitions of Terms and Concepts

Civil society organizations (CSOs) refer specifically to the Yekokeb Berhan (YB) Project's implementing partners that are providing HVC care and support programs in communities.

Household productive assets consist of any asset that can generate/facilitate access to income resulting from the ES support and income generation activity (IGA) engagement. The assets include but may not be limited to additional marketable skills, savings, productive equipment, farm animals, hives, petty trade shops, etc.

Highly vulnerable children (HVC) are those children under age 18 whose safety, well-being or development is at significant risk due to inadequate care, protection or access to essential services. HVC include those who are orphaned; receive inadequate adult support because of death, abandonment, economic distress or chronic illness; have HIV/AIDS or are suspected of having HIV; are directly affected by armed conflict; live outside of family care; or in some other way have suffered from a collapse of traditional social safety nets in their communities. This definition encompasses **orphans and vulnerable children (OVC)** which specifically refer to those children under the age of 18 whose mother, father, parents, or a primary caregiver has died [often from HIV/AIDS] who is need of care or protection.¹

HVC service standards refer to national standards for delivering services to HVC produced by the Government of Ethiopia [lead by the Ministry of Women and Children Affairs (MoWCA) and the federal HIV/AIDS Prevention and Control Office (HAPCO)] released in February, 2010.

Technical and organizational support refers to any capacity development arrangement such as technical assistance, coaching, mentoring, training, information and resources as well as peer exchange and learning events and opportunities that can be facilitated and provided for organizations and their staff.

*Seven core services from the Standard Service Delivery Guidelines (SSDGs) for OVC Care and Support Programs.*²

Economic strengthening (ES) services are services that seek to enable families to meet their own needs from an economic perspective regardless of changes in the family situation.

Educational services are services that seek to ensure that orphans and vulnerable children receive educational, vocational and occupational opportunities needed for them to be productive adults.

Food and nutrition services are services aim to ensure that vulnerable children have access to similar nutritional resources as other children in their communities.

¹ USAID. 2007. *Highly Vulnerable Children: Causes, Consequences and Actions*. Washington D.C.: USAID.

² Federal Democratic Republic of Ethiopia. 2010. *Standard Service Delivery Guidelines for Orphans and Vulnerable Children's Care and Support Programs*. Addis Ababa, Ethiopia: MoWCYA and HAPCO.

Health care services are services that include provision of primary care, immunization, treatment for ill children, ongoing treatment for HIV positive children and HIV prevention.

Legal protection services are services that aim to reduce stigma, discrimination and social neglect while ensuring access to basic rights and services protecting children from violence, abuse and exploitation.

Psychosocial services are services that aim to provide OVC with the human relationships necessary for normal development. They also seek to promote and support the acquisition of life skills that allow adolescents in particular to participate in activities such as school, recreation and work and eventually live independently.

Shelter and care services are services that strive to prevent children from going without shelter and work to ensure sufficient clothing and access to clean safe water or basic personal hygiene. An additional focus of these services is ensuring that vulnerable children have at least one adult who provides them with love and support.

Executive Summary

BACKGROUND: In 2011, USAID awarded the Yekokeb Berhan (YB) Program for Highly Vulnerable Children (HVC) to Pact for implementation. The YB Program was designed to improve the lives of HVC and their families, with the following four objectives:

- To strengthen the capacities of regional and local government and civil societies to provide, manage and monitor integrated and comprehensive care to HVC and their families;
- To increase access to health and social services for HVC and their families;
- To increase the capacity of community members and households caring for vulnerable children in an ongoing manner to meet their basic needs; and
- To establish effective and efficient monitoring, evaluation, reporting and learning (MERL) systems ensuring evidence-based programming and policy formulation.

To meet these four objectives, Pact has been working in partnership with multiple actors including the Government of Ethiopia through the Ministry of Women, Children and Youth Affairs (MoWCA), FHI 360, Child Fund, and with 32 local implementing partners to rollout the program in the country. Initially, the program targeted all regions of the country to support 500,000 HVC and their families, annually. With USAID/PEPFAR guidance on geographic prioritization, the program refocused efforts to concentrate programming interventions in five regions, namely Amhara, Oromia, Tigray, SNNP, and Addis Ababa City Administration.

METHODS: The evaluation employed quantitative and qualitative study methods to generate data and compare endline data with the baseline and the midline evaluations done in 2012 and 2014, respectively. ABH was contracted and conducted a quantitative, cross-sectional study among households with HVC to generate information on program beneficiaries. The qualitative assessment used focus group discussions (FGD) and key informant interviews (KII) to explore the lived experiences of HVC and other key informants. In addition, organizational capacity assessment (OGA) and resource mapping exercises were conducted to highlight existing resources and gaps in resources within government structures and within CSOs and community based organizations (CBOs).

The evaluation was conducted in the five selected regions. A total of 2,341 households participated in the quantitative household survey. Survey participants included a caregiver-HVC pair enrolled in the YB Program for each selected household. For HVC under the age of 14, the adult caregiver responded for both themselves and the HVC. To supplement the quantitative data, ABH collected qualitative data through 30 focus group discussions (FGDs) among HVC, caregivers, community committees (CCs)/community care coalitions (CCCs), community volunteers (CVs) and savings groups. Key informant interviews (KIIs) were conducted with 53 individuals representing implementing partners, MoWCA at federal, regional and woreda levels, HAPCO, Pact, FHI 360, Child Fund, and YB Program regional cluster managers.

Quantitative data were collected using Computer Assisted Personal Interviewing (CAPI) software, and the structured questions were aligned with the midline evaluation and analyzed with SPSS and STATA software. Qualitative data were transcribed and imported into NVivo 10 Software and analyzed using thematic framework analysis. Data from all sources were triangulated and synthesized for producing the final report.

KEY RESULTS

Evaluation Question 1: To what extent has involvement in the program strengthened the capacity of implementing partners and regional/local government, including CCs/CCCs, to identify, plan, coordinate and respond to the needs of HVC and their families?

Needs based capacity building activities were undertaken by YB and its core partners including FHI360, CF, MoWCA, implementing partners (IPs), regional and woreda women and children affair offices, CCs, and CVs. The capacity building activities were conducted in a cascaded manner through training, supportive supervision, coaching and mentoring. The capacity building has enabled 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 and gaps. The evaluation also found lack of skill because of short duration of the training compounded by high turnover and relocation of trained staff in government offices and less commitment of some volunteers because of minimum or no incentives, like recognition and award, as gaps to sustain institutional capacity.

The YB program had effectively identified and worked with community structures and local resources to increase the capacity of community members and households caring for HVC. Capacity strengthening interventions had been implemented using various methods including trainings, material supports such as provision of stationeries, school uniforms, office furniture, and supportive supervision and coaching. Linkage was created between community structures and different government offices, specifically with the Bureau of Women and Child Affairs (BoWCA). These linkages appear to have helped the program in ensuring the interventions were supported by government structures.

The CC/CCCs and YB have identified additional resources in the community that could improve the lives of HVC and their families. Implementing partners played significant roles in facilitating the coordination of care through the established mechanisms and standards assisted by government bodies, CSOs, communities and the private sectors engaged in the program. To have a strong basis for the community-private-Government partnership, memoranda of understandings were signed as a harmonization and coordination tool by implementing partners and the CC/CCCs. As a result, HVC and their families were fulfilling their needs through referrals to community resources (including hotels, barbershops, hair salons, private clinics, pharmacies) depending on their needs. Major gaps were related to legalization of CCs that affected efforts of local resource mobilization where CCs were unable to collect cash as they lacked legal receipt. Some of the CC/CCCs were still lacking in capacity and therefore, require continuous follow up and support.

Evaluation Questions 2 and 3: How have the availability, accessibility and quality of health and social services for HVC in Ethiopia changed since 2012, and how have YB activities plausibly contributed to these changes? To what extent are the services and support that are being provided improving health and educational outcomes of HVC and their families (comparing baseline, midterm and endline findings)?

Positive outcomes were found in the health status of HVC and their families indicating the healthcare, environmental and social interventions were effective. The proportion of HVC who reported having diarrhea in the two weeks preceding the evaluation has decreased significantly

from 6.1% at the midterm to 3.2% at endline ($p < 0.05$). Health-seeking behavior of HVC has also improved significantly. For example, 83.0% of HVC who had diarrhea sought health care in the endline compared to 63.9% at midterm ($p < 0.001$). According to the qualitative study findings, program participants are using the reimbursement mechanism which has remained throughout the program. This could have encouraged more people to seek health care for their children. On the other hand, the prevalence of HVC who were too sick to participate in daily activities in the last two weeks preceding the survey has not changed between the midterm and endline. Coverage of age-appropriate vaccination for under-fives was 91.2% at the endline. Despite fewer adolescents aged 14-17 reporting having access to reproductive health (RH) counseling at the endline (56% compared to 60.3% at midterm, the YB Program was reported as a source of information for RH issues for 19.0% of adolescents (compared to 13.0% at the midterm).

Based on self-report, more (61.6%) HVC received HIV testing at endline compared to 46.6% during the midline evaluation over the twelve months preceding the evaluation. Of those tested (1,435), 43 (3.0%) tested positive, which was lower than the midline evaluation where 56 (5.8%) tested positive. At the endline, all girls who were HIV positive were linked to treatment and 95.2% were on a regular follow up, whereas only 81.0% of HIV positive girls were linked to treatment at the midterm.

School enrollment of HVC aged 14 years and above has shown significant improvement. It had increased from 92.0% at midline to 98.5% at endline. Of those HVC who were in school during the endline evaluation, 22.5% reported having had tutorial services provided by the YB Program at endline compared to 15.1% at midline. More girls (67.0%) than boys (63.5%) had received tutorial services at endline. However the difference observed is not statistically significant. Overall, school performance of HVC indicated that 95% of HVC were successfully promoted to the next class compared to 85.8% at the midterm, and the change was statistically significant ($P < 0.01$), but there was no significant difference among boys and girls.

During the past year preceding the endline evaluation, the proportion of households that had at least one adult in the family receiving nutritional support had increased from 36.1% at midline to 40.1% at endline. The proportion of households experiencing a severe food shortage has significantly declined from 41.4% at midline to 30.5% at endline ($p < 0.001$). There was no statistically significant difference between midline and endline findings with respect to food prescription by health/nutrition workers over the past one year (6.3% at endline compared to 7.8% at midline). Similarly, those who received training on micro-enterprise selection, planning and management (ME-SPM) significantly increased from 32.6% at the midterm to 43.2% at the endline. The number of households who reported having a sustainable daily income has also increased from 57.6% at midterm to 83.2% at endline. However, qualitative findings suggest that the likelihood of HVC families graduating after ES was lower except in some areas (Tigray and some areas of Oromia).

Regarding legal protections, though it is not significant, violence incidents in the year preceding the survey at HVC household level indicated a slight decline from 6.9% at midline to 4.5% at the endline evaluation. Out of the households that experienced violence, however, the proportion of those who received legal services has declined from 62.6% at midline to 47.1% at endline. The contribution of the YB Program in referring or linking the victims to legal services has, however, increased significantly from 26.1% during midline to 38.3% at endline ($p < 0.05$). The qualitative

findings also indicated that implementing partners regularly link HVC who faced violence to legal bodies. Contrary to the quantitative findings, the community participants in the qualitative study and resource mapping activities indicated that they never missed cases where legal service was needed. Assisting HVC to get birth registration is one of the key components of legal protection services that the program has been providing to the beneficiaries. With this regard, the proportion of HVC who received a birth certificate has significantly increased at endline to 26.4% from 8.7% at midline ($p < 0.05$).

Evaluation Question 4: To what extent are economic strengthening activities effective in improving the capacity of households and HVC to meet their basic needs?

The YB Program has implemented an ES package that primarily focuses on helping caregivers to generate financial resources required to address the needs of HVC and other family members and ultimately leading to economic self-reliance. Caregivers were organized into community savings and self-help groups (CSSGs) and empowered by CVs and CCs to generate their own livelihood through credit schemes, mainly saving and loan provision services. The YB Program has advocated and promoted a saving culture to sustain HVC care and support initiatives through training components that emphasize starting and operating a small-scale business and initiating their own income-generating activities (IGAs).

With regard to R activities, the proportion of caregivers that participated in ES activities has increased from 38.3% of households during the midline to 48.8% at endline ($p < 0.001$). The number of households receiving training in starting and maintaining CSSGs increased from 60.0% at midline to 78.8% at endline. Similarly, those who received training on ME-SPM had significantly increased from 32.6% during the midline to 43.2% at the endline. The number of households who reported having a sustainable daily income has also increased from 57.4% at midline to 83.2% at endline. Participants in the ES program have benefited from income obtained from running own businesses established through the help of the CSSG and daily works facilitated by the program. According to the qualitative information obtained during the evaluation, participants in the ES program have mainly focused on meeting the basic needs of the household such as acquiring essential household items, covering health and educational expenditures of their children and satisfying basic needs of household members rather than on expanding business. It seems that the overall strategy adopted by participants of the ES at the moment is geared towards satisfying basic needs and requirements without compromising the smooth running of business at modest expansion levels as expressed below;

“ ... We see changes now, we can feed our children two or three times per day and try to pay back the money we borrowed. We have to pay back as we are responsible for the saving group and our children... too” (SNNPR Saving groups FGD,)

Such effects are practically observed on the health status and health seeking behavior of HVC as well as school attendance and school performances of the HVC. Statistically significant differences were observed in the improvement of health and education outcomes of HVC living in households participating in different packages of the ES as well as not participating.

It should, however, be noted that the ES program is operating smoothly with the majority of the beneficiaries maintaining the status quo for over the previous two years. The fact that the proportion of ES participants who had expanded business at the endline has slightly decreased

does not necessarily mean that the ES package is not operating very well. Expanding business through the ES package requires time as caregivers with HVC have urgent priorities of satisfying basic needs before expanding the business itself. The prevailing situations with regard to participants in the ES package of the YB Project is generally encouraging as the program is tilting towards success in the long run. Maintaining the balance and supporting the beneficiaries accordingly is an essential element in the future.

Evaluation Question 5: To what extent has the YB Project enhanced the capacity of implementing partners to establish effective and efficient monitoring, evaluation, reporting and learning systems to inform program management?

This evaluation has identified data management and use as one of the strongest interventions undertaken in the YB Project. The project included the training of implementing partners, government offices, CCs and CVs on data collection and management depending on their level of engagement. Standardized tools were used to collect data on HVC at household level by CVs using the Child Support Index (CSI) tool. Data were passed on to the CC and then from the CC to the implementing partner. At the implementing partner level, data were encoded and analyzed by the YB assigned data management staff using the monitoring, evaluation, reporting and learning (MERL) system. After analysis, reports were sent to all stakeholders including local government partners. Feedback from supportive supervisions of the implementing partners and the MoWCA, was used by the CVs and the CCs. Publication of the E-book was also an attempt to use the data for learning among stakeholders. However, use of data for policy formulation was not observed.

Conclusions

The YB Project has documented several successes in achieving its core objectives. The capacity building activities provided to the implementing partners, government stakeholders, CC/CCCs were effective in improving the lives of HVC and their families. Both the qualitative and quantitative data indicated that community structures were able to target HVC and their families to be enrolled in the YB Program and provide HVC care and support well. In collaboration with government stakeholders and CC/CCCs, implementing partners were able to coordinate, manage, document and report their activities. The ES interventions mitigated economic dependency for many HVC families despite their limited result on business expansions and diversification. The support related to health and education were very effective with significant positive changes documented in school drop-out and healthcare seeking practices. In terms of legal protection, despite the less encouraging quantitative findings, the qualitative findings showed increased HVC and community awareness in recognition and reporting of negative interactions with legal bodies by way of protecting HVC. On the other hand, HIV testing was low for reasons which were largely related to shortage of test kits as mentioned in the qualitative findings. The fact that HVC families who improved economically following the ES activities were still in the HVC support program is an issue that needs attention. Increasing the capacity of government stakeholders in data management is an area that needs attention and improvement.

Recommendations

We recommend the following based on the data: further strengthening of community structures to sustain and expand resource mobilization activities and maintain HVC program ownership; institutionalized trainings at government level to provide regular and need-based trainings for

CC/CCC and government office staff, especially in the areas of data management, reporting and evidence-based decision making; revisions to ES activities according to the current market needs; institutionalize an exit strategy and learning forum to encourage HVC families whose economic status has improved and to provide services to new beneficiaries; communicate the changes in HVC lives brought about by the YB Program to local and international donors in order to maintain their level of commitment and to avoid fatigue.

Yekokeb Berhan Project for Highly Vulnerable Children: Endline Evaluation

Introduction

Globally, an estimated 153 million children have lost either one or both parents during their childhood. Of these, 56.1 million (37%) live in sub-Saharan Africa where 6.6 million (11%) have lost their parent(s) due to HIV/AIDS.³ Despite the rapidly growing number of OVC in sub-Saharan Africa, many countries in the region do not have effective programs to support OVC and caregivers.⁴

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.⁵ 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/AIDS.⁶ However, apart from HIV/AIDS, other factors such as poverty, access to shelter, education, health and other basic services, stigma due to HIV/AIDS and political and socio-economic crisis may increase the vulnerability of children. HVC constitute the most vulnerable members of a society as the children are deprived of basic needs such as food, health care, shelter and education and suffer from the associated stigma, abuse and exploitation. In as much as vulnerable children suffer the consequences, community and family members are also stressed as they try to care for these children. In developing countries, most vulnerable children and their families struggle to meet their basic needs as well as dealing with the effects of isolation, marginalization, trauma and grief. In child-headed households, the absence of adults to talk to children, teach important life skills and offer a source of protection, is an important cause for the feelings of loneliness and isolation that many orphans and vulnerable children report.⁷ There is also long-term economic stagnation or decline as children grow into unskilled workers in addition to the increased risk of getting HIV

In Ethiopia, there were an estimated 4.2 million orphans in 2013, accounting for approximately 12% of the total child population.⁸ 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 child⁹ and/or an orphan child under 18 years of age.¹⁰ All OVC are at increased risk for neglect, abuse, malnutrition, poverty, illness and discrimination and as they get

³ UNICEF, UNAIDS, WHO, UNFPA and UNESCO. 2010. *Children and AIDS: Fifth Stocktaking Report*. Geneva: UNICEF, UNAIDS, WHO, UNFPA and UNESCO.

⁴ 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: Macro International Inc.

⁵ PEPFAR. 2006. *Orphans and Other Vulnerable Children Programming Guidance for United States Government In-Country Staff and Implementing Partners*. Washington D.C.: PEPFAR.

⁶ UNAIDS, UNICEF and USAID. *Children on the Brink 2004, A Joint Report of New Orphan Estimates and a Framework for Action*. Washington D.C.: UNAIDS, UNICEF and USAID.

⁷ CARE. 2005. *A Model for Community-Based Care for Orphans and Vulnerable Children: Lessons learnt, 2005*. Atlanta: CARE International.

⁸ Federal Democratic Republic of Ethiopia. 2012. *HIV Related Estimates and Projections for Ethiopia – 2012*, Addis Ababa, Ethiopia: Ethiopian Health and Nutrition Research Institute Federal Ministry of Health.

⁹ Foster children are those under age 18 living in households with neither their mother nor their father present.

¹⁰ Federal Democratic Republic of Ethiopia. 2011. *Ethiopia Demographic and Health Survey 2011*. Addis Ababa, Ethiopia: Central Statistics Agency.

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.

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 ES, social protection, health and nutrition, child protection, legal protection and capacity building.¹¹ Similarly, the Ethiopia OVC Standard Service Delivery Guidelines recommend 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.¹²

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), Multi-sectoral Plan of Action for HIV (2007-2010) and Positive Change: Children, Communities and Care Program (PC3).

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.¹³ 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 NGOs who, in turn, partnered with a variety of CBOs. Pact has sought to apply the lessons learned from PC3 to YB Program.¹⁴

The YB Project is, a five-year cooperative agreement with USAID/Ethiopia, designed to reduce vulnerability among HVC/OVC and their families in Ethiopia. The program has prioritized communities most affected by HIV to ensure that children and families are appropriately targeted and supported. As a prime recipient of the award, Pact works in partnership with multiple actors including the Government of Ethiopia through the MoWCA, FHI360, Child Fund, and 32 local implementing partners to implement the program in the country. The YB Program's aim is to achieve four goals: 1) regional and local government and civil society have strengthened capacity to collaboratively provide, manage, and monitor integrated and comprehensive care to HVC and their families; 2) HVC and their families have increased access to health and social services; 3) community members and households caring for vulnerable children have increased and on-going

¹¹ PEPFAR. 2012. *Guidance for Orphans and Vulnerable Children Programming*. Washington D.C.: PEPFAR.

¹² Federal Democratic Republic of Ethiopia. 2010. *Standard Service Delivery Guidelines for Orphans and Vulnerable Children's Care and Support Programs*. Addis Ababa, Ethiopia: MoWCYA and HAPCO.

¹³ USAID. 2008. *Ethiopia Positive Change: Children, Care and Communities (PC3) End-of-Project Evaluation, July 2008*. Washington D.C.: USAID.

¹⁴ USAID and Pact: 2012. *In country Reporting System: Pact Yekokeb Berhan for Highly Vulnerable Children, Annual Progress Report FY2012*. Washington D.C.: USAID and Pact.

capacity to meet their basic needs; and 4) shared learning and the evidence base to improve programming and inform policy and program investment are strengthened.

To achieve the stated goals the program focuses on strengthening systems and structures including strengthening regional and local capacities for sustainable responses, strengthening capacity of community structures such as CC/CCCs to support vulnerable households, strengthening vulnerable households to provide better care for HVC and prevent further vulnerability, and strengthening the social service workforce. The coordination of care approach has been designed to encourage coordination amongst and collaboration between key actors within the YB Project (i.e., local implementing partners) and government structures at different levels, helping to increase the capacity of existing structures and systems to respond to the needs of HVC. HVC and their caregivers are supported by a whole network of government and community structures and service providers, with community volunteers at the forefront. The program takes a systematic approach to identifying vulnerable children and families and their needs, developing specific action plans, reviewing progress and making further adjustments until the needs are fully addressed. Significant positive changes and impacts were observed at child, family and community levels.

Initially the program had targeted all the 11 regions of the country to support 500,000 HVC and their families, annually. With USAID/PEPFAR guidance on geographic prioritization in September 2013, the program has refocused efforts to concentrate programming interventions in five regions – namely Amhara, Oromia, Tigray, SNNP and Addis Ababa City Administration. In 2017, USAID has commissioned ABH Services, PLC, an affiliate of Jimma University and a local consulting firm in Ethiopia, to undertake an endline evaluation of the YB Program activities. The purpose of the evaluation is to analyze the effectiveness of the activities and systems strengthening approach to improve access to quality services and health outcomes for HVC and their families, within the following research goals and questions.

YB Project for HVC Endline Evaluation Research Questions

The following are the YB Project for HVC endline evaluation research questions:

1. To what extent has the YB Project strengthened the capacity of implementing partners and regional/local government, including CC/CCCs, to identify, plan, coordinate and respond to the needs of HVC and their families?
 - a. What evidence exists showing improved capacity and increased performance or effectiveness of these entities to implement program activities and achieve expected results? Are these capacities and resulting service delivery improvements likely to continue after closure of the YB Project?
 - b. Which of the capacity building activities and approaches, such as different types of training and technical assistance, can be plausibly linked to the most significant improvements in the effectiveness of service delivery?
 - c. Are there any remaining gaps in technical, programmatic, management, financial and partnership capacities that were not addressed through the YB Project and should be targeted by future activities?
2. How have the availability, accessibility and quality of health and social services (including psychosocial services) for HVC in Ethiopia changed since 2012 (YB Project baseline year), and how have YB interventions plausibly contributed to these changes?
 - a. Has the availability, accessibility, quality of services provided by the 34 local partner institutions improved? (quality should be assessed based on the definition by the 2008 Quality Improvement Standards for HVC in Ethiopia)¹⁵
 - b. What are the key remaining barriers, possibly including gender, to access high-quality health and social services for HVC?
3. To what extent are the services and support that are being provided improving health and educational outcomes of HVC and their families (comparing baseline, midterm and endline findings)?
 - a. Are there any significant differentials by gender in the outcomes, and if so, what are the causes for this and what needs to be done to improve this?
 - b. The midterm evaluation recommended emphasizing tutorial support, including partnering with local universities - was there any success in this regard since the midterm performance evaluation?
4. To what extent are economic strengthening activities effective in improving the capacity of households and HVC to meet their basic needs?
 - a. Are the economic strengthening activities plausibly contributing to enhancing the capacity of households caring for vulnerable children to generate income and increase resiliency to shocks?

¹⁵ Federal Government of Ethiopia and USAID. 2008. *Quality Assurance and Improvement Standards for OVC Programs in Ethiopia*. Addis Ababa, Ethiopia: Federal Government of Ethiopia.

- b. Are there any significant differentials by gender (female headed households compared to male headed households), and if so, what are the causes for this and what needs to be done to address these differentials?
5. To what extent has YB Project enhanced the capacity of implementing partners to establish effective and efficient monitoring, evaluation, reporting and learning systems to inform program management?
- a. How effective are the databases and systems to identify HVC in communities in need and to link them to appropriate services?
 - b. What is the level of information sharing between NGOs and implementing partners to ensure equity in service provision?
 - c. To what extent have gender appropriate metrics been incorporated into the implementing partners' monitoring and evaluation systems?
 - d. To what extent are data generated from routine data collection meet quality standards and used for decisions-making?

Methodology

Study Area

The study was conducted in five regions (Oromia, Amhara, SNNP, and Tigray and Addis Ababa City Administration) where the YB Project has been implemented.¹⁶ About 90% of the total Ethiopian Population live in these areas.¹⁷ According to the 2015 National Estimates and Projection of HIV Prevalence, among the Adult Population, the prevalence of HIV was 4.9% in Addis Ababa, 1.7% in Tigray, 1.4% in Amhara, 0.9% in Oromia, and 0.7% in SNNP.¹⁸ Overall, these areas account to close to 90% of adults and children living with HIV in Ethiopia and 88.3% of the total AIDS orphans in the country.

Study Period

Quantitative and qualitative data collection for the endline evaluation took place from March 31 – April 15, 2017.

Study Design

The endline evaluation used a cross-sectional descriptive study design, collecting quantitative and qualitative data to determine if the intended results of the YB Project for HVC were achieved by comparing the endline findings against baseline and midterm evaluation results.

¹⁶ Pact. *Yekokeb Berhan HVC Project Cooperative Agreement No. AID-663-A-11-00005. Performance Monitoring Plan 2011-2016*. Addis Ababa, Ethiopia: Pact.

¹⁷ Central Statistical Agency. 2012. *Population Projections for Ethiopia 2007-2037*. Addis Ababa, Ethiopia: CSA

¹⁸ Ethiopia Public Health Institute. 2015. *HIV Related Estimates and Projections for Ethiopia-2015*. Addis Ababa, Ethiopia: Ministry of Health.

Target Population

Both quantitative and qualitative data were collected from the beneficiary HVC and their caregivers, CC/CCCs, implementing partners, regional and local government offices and award recipients. The respondents for the quantitative HVC household survey were caregivers and HVC.

The target population for the qualitative evaluation were HVC age 14 - 17, HVC caregivers, CC/CCCs, saving groups, CVs, implementing partners, HAPCO, MoWCA, Pact, Child Fund and FHI360 (Table 1).

The target population for the organizational capacity assessment exercise were implementing partners, MoWCA and regional BoWCA and regional HAPCO offices and CC/CCCs involved in the YB Project for HVC. The resource mapping targeted kebeles/CCs to assess the availability of resources for HVCs at community level.

Sample Size and Sampling Procedures for the HVC Household Survey

A single population proportion formula was used to determine the number of HVC households for the quantitative survey with the following assumptions: a target population of 325,000, 95% confidence level, 3.0% margin of error (to maximize precision and align with the midterm evaluation design) and p of 50%. A proportion of 50% was taken in order to obtain a maximum sample size to give better power to make estimations and comparison disaggregated by gender and age. Since a multistage, sampling technique was used, a design effect of 2 was considered. Imputing the above assumptions into OpenEpi software, a sample size of 2,128 HVC households was obtained. Considering a 10% non-response rate and rounding for regional distribution, the final sample size reached was 2,346 HVC households.¹⁹

A multi-stage sampling technique was used in this study. Ten percent (29) of the program beneficiary woredas from all the five program areas (Amhara, Oromia, SNNP, Tigray and Addis Ababa) were targeted for the evaluation. The woreda sample sizes were then distributed to the regions based on the proportion of the beneficiaries. The number of zones per region was determined by dividing the number of woredas allocated per region by two, with the aim of picking two woredas per zone. Zones then were selected purposively, based on the size of the beneficiaries. Three kebeles/CCs per woreda randomly picked from each woreda. The HVC household sample size was distributed to each region based on the size of beneficiaries and then equally distributed to each woreda and kebele/CC. Based on these, 27 – 50 households were sampled from each kebele. In woredas where only one CC existed, additional woredas and kebeles/CCs were randomly selected from the same zone. Accordingly, the total sample size was distributed to 17 zones, 29 woredas and 58 kebeles/CCs.

¹⁹The final sample size is determined to be 2,346 due to rounding while distributing the sample size by woredas.

Selection of HVC Household, Caregivers and HVC

From each kebele/CC, HVC households were selected by systematic random sampling techniques using a recent kebele/CC beneficiaries list as a sampling frame obtained from Pact. One HVC and one HVC caregiver in the household were interviewed per household. In situation when two or more HVC existed, a single digit random table was used to select one HVC randomly for interview from the list of HVC in the household by the interviewer. All HVC caregivers and HVC aged 14 – 17 were interviewed directly, and for HVC less than 14 years of age, the respondent was the caregiver as was the case during the midline evaluation. For details of HVC household sampling, see Table 1.

Sample size and sampling procedure for the qualitative study

Participants for FGDs and KIIs were selected purposively. A total of 30 FGDs, five in each region targeting male HVC, female HVC, CCs, CVs and savings groups. KIIs were conducted with Pact, MoWCA, HAPCO, corresponding regional officials and implementing partners. For details see Annex 1.

Organization capacity assessment

Eighteen implementing partners working in the 29 sampled woredas were targeted for the organization capacity assessment. See Annex 2 for the list of implementing partners and included in the assessment.

Resource Mapping

For the resource mapping, one randomly selected CC per woreda was targeted. Accordingly, a total of 29 woredas were selected for assessing the presence of various resources for HVC.

Variables

The study included information on caregiver and HVC socio-demographic characteristics and their health and social situations and changes obtained from participating in the YB Project. In addition, information on performance and capacities of CC/CCCs, implementing partners, regional and local governments were collected using qualitative and quantitative study approaches.

Data Collection Techniques and Tools

For the HVC household survey, two sets of structured questionnaires, one each for HVC caregiver and HVC, were used to capture information pertaining to the caregivers and HVC through face to face interview at the household level. The questions were aligned with the midline evaluation questions for purpose comparing findings and were pretested, and translated into Amharic, Afan Oromo and Tigrigna. CSPro V6.3 software for Android was used to capture data using a tablet. Data collected by the interviewers were transferred to the supervisor tablet using Bluetooth after confirming completeness and consistency. All data transferred to the supervisor were then sent to ABH server on daily basis for review and storage.

Table 1: Summary of number of beneficiaries, woredas and kebeles sampled by region

Region	Zone/Sub-City	Woreda	CC	Number of HVC Beneficiaries	Sample size	Total
Addis Ababa	Addis Ketema	Addis Ketema Woreda 9	23003	2307	50	450
	Gulele	Gulele Woreda 3	18003	825	50	
		Gulele Woreda 4	34001	746	50	
	Kolfe Karaniyo	Kolfe Woreda 12	07012	1071	50	
		Kolfe Woreda 13	07013	943	50	
		Kolfe Woreda 7	22004	328	50	
	Nifas Silk	NLafto Woreda 1	29001	811	50	
		NLafto Woreda 2	29002	1069	50	
		NLafto Woreda 4	29004	815	50	
Amhara	Bahir Dar	Bahir Dar (2 Woredas)	03600	634	40	240
			03605	508	40	
			03609	160	40	
			43002	934	40	
			43007	890	40	
			43012	301	40	
	North Gonder	Gonder Town	02001	577	40	240
			02010	644	40	
			02015	417	40	
		Dabate	24005	302	40	
			24006	321	40	
			24007	294	40	
		Kewot	12002	645	40	240
			12003	901	40	
			12006	384	40	
		Debre Birhan	12010	519	40	
			12011	1334	40	
			12013	625	40	
	South Wello	Dessie	03017	508	40	240
			03019	628	40	
			03023	437	40	
		Kalu	03133	371	40	
			03137	160	40	
			03151	179	40	
Oromia	East Shewa	Adama	10013	449	42	252
			10015	356	42	
			10020	450	42	
			10024	450	42	
		Mojo/Lomme	10011	1241	42	
			10012	1321	42	
	Arsi	Robe	28007	1436	43	129
			28008	2186	43	
			28009	2580	43	
	South West Shewa	Woliso	20006	1045	42	126
		Sebeta	20018	1000	42	
			20020	500	42	
SNNP	Sidama	Aleta Wondo	25005	2012	36	72
		Yirgalem	25006	2000	36	
	Gedeo	Dilla	25001	4333	36	72
		Yirgacheffie	25011	1620	36	
	Hawassa	Hawassa Town	25015	805	36	72
			25016	657	36	
	Wolayita	Sodo Town	11008	1032	35	105
			11009	1325	35	
			11010	2314	35	
Tigray	Central Tigray	Adigrat Town	31101	572	27	54
			31104	964	27	
	Makale	Semen	31113	105	27	54
			31228	231	27	

An Excel-based Standard OCA tool was used to assess the organizational capacity of implementing partners. This same tool was used at baseline. A paper-based resource mapping matrix was prepared to document HVC resources available at community level. Interviewers were instructed to ask and observe existing resources.

Interview guides with extended probing questions were used to conduct FGD and KII. Voice recorders and field notes were used to capture information during KIIs and FGDs.

A total of 44 field individuals in 5 teams (5 supervisors, 10 interviewers and 29 enumerators), were deployed in 29 woredas across the five regions for the data collection.

Data Quality Control

The following steps were taken to ensure data quality: thorough review and pretest of questionnaires translated to three local languages and aligned with midline evaluation tool; use of software to collect data with inbuilt program for data consistency, completeness, restrictions of values to be entered and non-usability of the data by third party as a result of the need to have dictionary to interpret the codes; including a supervisor within the team to manage field data collection activities, regularly spot check interviews, conduct 1 in 10 mandatory interviews and facilitate communications; field supervision by the study team and continuous review and check for data consistency and completeness by the data manager on completed and uploaded interviews on the server and provision of timely corrections while the team on the site.

Data Compilation, Processing and Analysis

All electronically collected data were transferred to a server located at ABH office for storage and quality checks. Following completion of the data collection, the data were exported to SPSS v20 for processing and analysis. Program performance in line with the OVC standards and HVC and caregiver vulnerabilities were analyzed using descriptive statistics using tables and figures. The endline findings were compared with the baseline and midline findings using two-proportion sample t-tests in STATA. Qualitative data were transcribed, translated and transferred to NVivo software using framework analysis. Descriptive statistics were used to analyze the organizational capacity assessment and resource mapping findings.

Both the quantitative and qualitative data analysis were done by the study team members who are experts in using both qualitative and quantitative procedures and software.

Ethical Considerations

An introduction and support letter was written by the MoWCA to the respective regional offices and approval was obtained from these entities. USAID's Child Protection Policy were strictly adhered to protect the rights, privacy and benefits of respondents and the child for home they are caregiving. All data collection instruments were accompanied with informed consent forms in local languages. All respondents were informed about the purpose, potential benefits and harms of the study by reading out the informed consent statements prepared for this evaluation. Though there was no such incident, the field team was instructed to link seriously ill HVC or caregivers encountered during household data collection to the local health care system for care and treatment.

Strength and Limitation of the Study

This endline study was based on a sampling framework generated from the recent and up-to-date list of beneficiary HVC obtained from Pact. The list of beneficiary HVC for the sampled CC was used to identify sampled households generated at ABH head offices, which avoided sampling bias altogether and has helped to achieve a 97.6% response rate. Moreover, the use of CAPI interviewing techniques has allowed to control the quality of data (due to inbuilt checks and restrictions) and complete data collection, transfer, compilation and analysis within short period of time.

The baseline lack some of the indicators that this final evaluation assessed and therefore a pre/post analysis was not possible for all indicators. There are also some differences in the methodology in the baseline assessment and available data were extracted as appropriate. Although the beneficiaries of the program have shown changes in important indicators, it is difficult to attribute these changes to the program alone. The organizational capacity assessment tool rating was unable to give information to compare implementing partners between the baseline and endline, due to the subjective nature of the instrument, and the intention of the assessment at baseline where the implementing partners focus was to show that they have the capacity to implement the program and obtain grants.

The inclusion of several indicators that were measured at the baseline, midline and endline evaluations has enabled comparison at different time points in the life time of the project and could show changes brought about by the interventions. On the other hand the lack of control groups, different baseline methodology and the shift in program focus from direct support to ES in the last two years of the program could have altered the earlier achievements of the program, especially in the area of health and social services for HVC and their families.

Evaluation Findings

Data collection took place from March 31 to April 15, 2017 with a response rate of 97.6% (2,290). A total of 4,576 structured interviews (2,290 caregivers, 2,286 HVC), 30 FGDs, 50 KIIs, 15 OCAs and 29 resource mappings in 29 CCs were conducted in this endline evaluation.

Socio-demographic characteristics of caregivers

Of the 2,290 caregivers interviewed, 2,094 (91.4%) were female, 1,708 (74.6%) were between the age of 25 – 45 years, 965 (42.1%) were currently married, 134 (49.5%) had no formal education and 855 (37.3%) were wage laborers. See demographic details in Table 2.

Table 2: Socio-demographic characteristics of caregivers: YB Project for HVC endline survey April 2017

Variables	Male, No. (%)	Female, No. (%)	Total, No. (%)
Total	196	2,094	2,290
Age Group			
<18	3 (1.5)	11 (0.5)	14 (0.6)
18-24	5 (2.6)	57 (2.7)	62 (2.7)
25-45	107 (54.6)	1601 (76.5)	1708 (74.6)
46-64	56 (28.6)	317 (15.1)	373 (16.3)
65+	25 (12.8)	108 (5.2)	133 (5.8)
Mean age	45.8	39.2	39.8
Marital status			
Never married	17 (8.7)	94 (4.5)	111 (4.8)
Currently Married	126 (64.3)	839 (40.1)	965 (42.1)
Divorced	12 (6.1)	483 (23.1)	495 (21.6)
Widowed	37 (18.9)	652 (31.1)	689 (30.1)
Live with partner/cohabitate	4 (2.0)	25 (1.2)	29 (1.3)
No Response	0 (0.0)	1 (0.0)	1 (0.0)
Highest level of school completed			
No formal education	62 (31.6)	1072 (51.2)	1134 (49.5)
First cycle primary (grade 1-4)	38 (19.4)	301 (14.4)	339 (14.8)
Second cycle primary (grade 5-8)	57 (29.1)	458 (21.9)	515 (22.5)
Secondary (grade 9-12)	20 (10.2)	182 (8.7)	202 (8.8)
Preparatory (11-12)	10 (5.1)	44 (2.1)	54 (2.4)
10+	6 (3.1)	18 (0.9)	24 (1.0)
College/university	3 (1.5)	17 (0.8)	20 (0.9)
No Response	0 (0.0)	2 (0.1)	2 (0.1)
Occupation of the caregiver			
Farming	28 (14.3)	100 (4.8)	128 (5.6)
Wage Labourer	75 (38.3)	780 (37.2)	855 (37.3)
Government employee	18 (9.2)	86 (4.1)	104 (4.5)
NGO	11 (5.6)	30 (1.4)	41 (1.8)
Business	25 (12.8)	551 (26.3)	576 (25.2)
Student	2 (1.0)	7 (0.3)	9 (0.4)
Housewife	1 (0.5)	348 (16.6)	349 (15.2)
Other	21 (10.7)	34 (1.6)	55 (2.4)
No occupation	15 (7.7)	157 (7.5)	172 (7.5)
No Response	0 (0.0)	1 (0.0)	1 (0.0)
Engagement in paid work in the last 3 months			
Yes	92 (46.9)	941 (44.9)	1033 (45.1)
No	104 (53.1)	1153 (55.1)	1257 (54.9)
No Response	0 (0.0)	1 (0.0)	1 (0.0)

Socio-Demographic Characteristics of HVC

Of the 2,286 HVC interviewed, 51.1% were female. By age, 3.5% were between the age of 0 - 4 and 26.9% were between 14 - 17 years of age. The mean age was 11.1 years and the large majority (90.8%) were enrolled in school with little difference between the sexes. Of those enrolled in school, 83.3% were in primary school. Assessing child vulnerability factors, over one-quarter (28.6%) of HVC have lost their father, 5.6% have lost their mothers and 5.3% have lost both their mother and father. Many (13.2%) households were headed by ill person (Table 3).

Table 3: Socio-demographic characteristics of HVC: YB Project for HVC at endline: 2017

Variables	Male	Female	Total
	No (%)	No (%)	No (%)
Total			
Age group			
0-4	43 (3.8)	37 (3.2)	80 (3.5)
5-9	355 (31.8)	358 (30.7)	713 (31.2)
10-13	428 (38.3)	450 (38.5)	878 (38.4)
14-17	292 (26.1)	323 (27.7)	615 (26.9)
TOTAL	1118 (48.9)	1168 (51.1)	2286
Mean age (years)	11.0	11.2	11.1
Ever attended school			
Yes	980 (91.0)	1024 (90.5)	2004 (90.8)
No	97 (9.0)	107 (9.5)	204 (9.2)
Highest level of education completed			
KG	76 (7.8)	55 (5.4)	131 (6.5)
Grade 1-4	482 (49.2)	493 (48.1)	975 (48.7)
Grade 5-8	323 (33.0)	371 (36.2)	694 (34.6)
Grade 9-10	86 (8.8)	91 (8.9)	177 (8.8)
Grade 11-12	9 (0.9)	8 (0.8)	17 (0.8)
10+	1 (0.1)	4 (0.4)	5 (0.2)
No response	3 (0.3)	2 (0.2)	5 (0.2)
Child vulnerability factor²⁰			
Both mother and father are dead			124 (5.4)
Mother is dead			129 (5.6)
Father is dead			654 (28.6)
Chronically ill			41 (1.8)
HIV positive			84 (3.7)
Has some kind of disability			46 (2.0)
Household is headed by a child (<18)			8 (0.3)
Household is headed by elderly			175 (7.6)
Household is headed by ill person			302 (13.2)
Household is headed by disabled			80 (3.5)
Others ²¹			997 (43.5)
No response			35 (1.5)

²⁰ More than one factor applies to some HVC, hence the total is more than n.

²¹ Children from households with severe economic problems, 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 major child vulnerability factor noted, however, was the “Others” category, which was the economic factor accounting for 939 (41.1%) HVC compared to 753 (35.5%) at midterm with a statistically significant difference ($p < 0.01$).²² Compared to the midterm, at endline the proportion of children who lost both mothers and fathers has declined from 28.2% to 5.3%. This could be due to the dilution effect, as more children have entered into the program for economic reasons which could have led to change in the characteristics of the sampled population at the endline evaluation compared to the midterm evaluation (Table 3 and Figure 1).

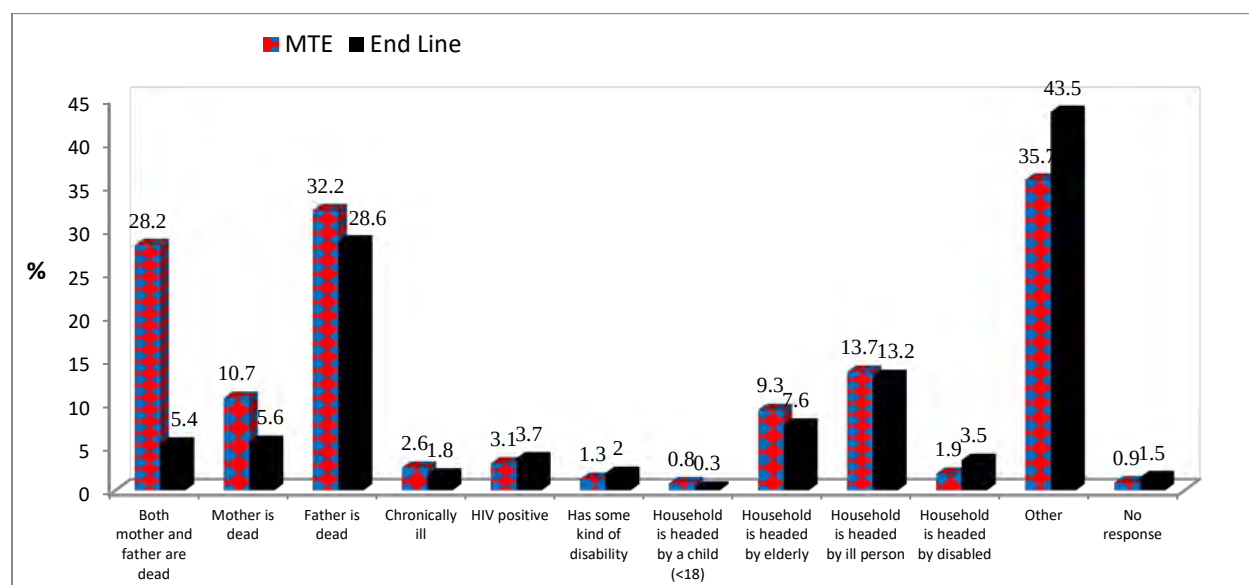


Figure 1: Child vulnerability factors at midterm and endline surveys: 2014 and 2017

Assessing the relationship of the HVC to the household head, 1,888 (82.6%) HVC were living with their parents compared to 76.8% HVC at midterm (Figure 2). Compared to the midterm, at endline the proportion of children who lost both mothers and fathers has declined from 28.2% to 5.3%. This change again could be due to the inclusion of vulnerable children for economic reasons, as well as the family re-integration work done by implementers. The qualitative study reported that:

“Children from very low income family who are not able to feed and send their children to school are also included.” (SNNP, KII, CC)

²² Of children included in the program due to ‘Other Factors’ than those clearly stipulated in the child vulnerability index, 873 (92.9%) of them at the endline compared to 617 (81.5%) at midterm are due to economic reasons.

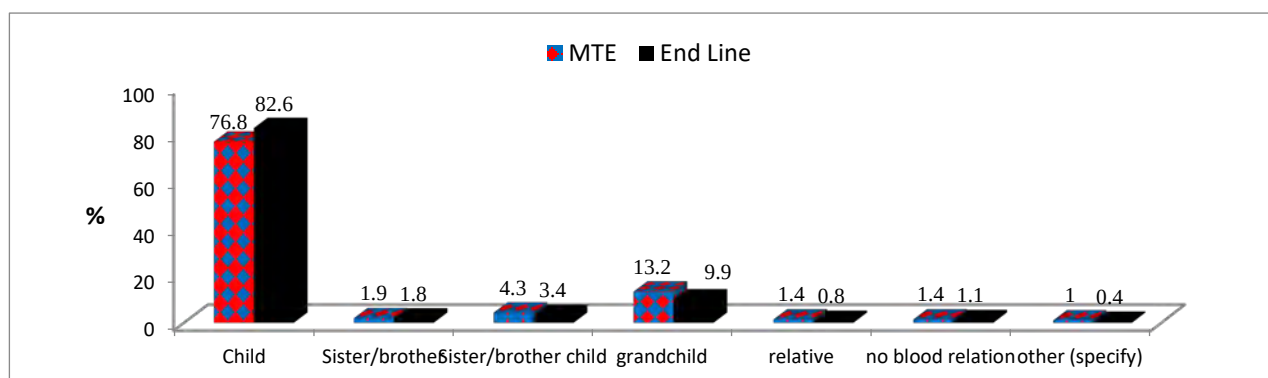


Figure 2: Relationship between the HVC and caregivers at midterm and endline surveys: 2014 and 2017

Of the 1,671 young HVC, 58 (3.5%) had disability and of the 617 adolescent HVC 17 (2.8%) had a disability (see Table 4).

Table 4: Disability status of HVC YB Project endline survey: April 2017

Disability Status	Young HVC (< 14)	Adolescent HVC (14-17)
Disabled	58 (3.5)	17 (2.8)
Not disabled	1613 (96.5)	600 (97.2)
Type of disability²³		
Difficulties of movement	13 (0.6)	4 (0.6)
Blind or partially blind	14 (0.6)	4 (0.6)
Deaf or partially deaf	11 (0.5)	2 (0.3)
Mental retardation	19 (0.8)	0 (0.0)
Difficulty to speak	14 (0.6)	8 (1.3)
Other	1 (0.0)	2 (0.3)

Below are the evaluation findings, organized by the evaluation questions as well as the comparisons between the baseline, midterm and endline evaluation findings whenever such exercise is indicated.

Evaluation Question 1

To what extent has involvement in the program strengthened the capacity of implementing partners and regional/local government, including CCs/CCCs, to identify, plan, coordinate and respond to the needs of HVC and their families?

Implementing Partners

The qualitative findings indicated that the YB Project was engaged in building the capacity of implementing partners through different approaches after identified capacity gaps. The capacity building focused on need identification in the thematic areas of organization capability, training

²³ Percentages do not add up to 100 due to multiple responses.

on the area of HVC targeting, coordination of care, data management and on the seven OVC service standards, in general. The prime partners, Pact Ethiopia, FHI 360 and Child Fund have delivered targeted training, technical support, mentoring and supervision to implementing partners.

“To build the capacity of implementing partners, formal and standardized training of the trainers was given for economic strengthening officers and monitoring, evaluation, reporting and learning officers, and then the training was cascaded to lower level.” (Amhara, KII, Implementing Partner)

Implementing partners have cascaded the training to lower structures such as CC/CCCs, volunteers and caregivers in order to improve the life of HVC households. At the beginning of the project Pact Ethiopia conducted an OCA for each implementing partner. The evaluation team used the same instrument as that of the baseline to assess the implementing partner’s capacity.²⁴ The result of the Re-OCA based on the different components is shown in Annex 3.²⁵

Governance and Leadership

All implementing partners are legally registered with renewed licenses and clear and documented administrative and governance structure. Most of the implementing partners have strategic plan document that clearly indicates a focus on HVC. Staff of implementing partners have been engaged in the revision and/or development of strategic plans that included in the vision and mission of their respective organization.

Based on the OCA tool, the overall average rating regarding governance is about 5.67. Compared with the baseline score of 4.55 it shows an increase of 1.12 score points. The only organization that scored a lower rate was ANNPCAN (-0.25) while ADA scored the highest change from the baseline by 2.33.

Human Resource and Staff Development

The study showed that, implementing partners have adequate staff to implement YB project and are guided by a human resource management manual. Implementing partners tend to recruit trained and competent staff but all lack a staff development plan. The YB Project was the prime capacity building project for the staff of implementing partners, especially in the area of standard service components including monitoring and evaluation. The overall human resource and staff development ratings of implementing partners have increased from 4.19 at baseline to 5.27 at the endline evaluation. Two organizations (ANNPCAN and BLEA) have shown declining trends while another (ADA) registered the highest increase of 2.86 due to internal dynamics and poor governance.

Program Development

In this evaluation, program development was done through assessing sub categories of service areas based on the SSDGs, including the conceptualization, design, implementation and

²⁴ See the annexed OCA tool.

²⁵ See the annexed OCA rating summary sheet and detail figures based on OCA components.

monitoring and evaluation. The change in the program development was 1.25 from a baseline of 4.17 to 5.42.

Networking and Collaboration

The YB project aimed at strengthening local structures, and as a result, each implementing partner was obliged to work with local government particularly with women and children affairs offices. In addition to government offices, there were also collaborations with other non-YB projects. In the YB Project area all local HVC/OVC service providers were identified, mapped and documented with the necessary details for ease of referrals. Networking with private sector was also an important change observed due to the system strengthening approach. The overall increment regarding networking and collaboration component is 1.06, a change from 4.29 at baseline to 5.35 at endline. This component has scored the least compared to other components in the OCA tool. Probably, this component involved non-YB partners' engagement.

Sustainability

The change in implementing partners' sustainability rating scores showed an increase by 1.23 from 4.79 at baseline. Implementing partners have managed to continue providing services such as shelter and care in collaboration with CC/CCCs, while YB Project has terminated shelter and care funding in the middle of the program. The Pact YB Project October 1, 2016 - March 31, 2017 Report shows more than 435 thousand beneficiaries have got services related to shelter. However, two implementing partners, BLEA and Maedot, have registered declining trend from the baseline figure -0.33 and -0.14, respectively.

Overall, the result from the organizational capacity assessment has shown that the implementing partners' capacities in different categories have changed positively. The average rating from the sampled implementing partners is 5.31 out of the maximum 6. Compared to the baseline 4.22 rating, it has 1.09 point increase.

“The volunteers and the CC have received a variety of capacity building trainings. If one implementing partner or partner phases out, they (CC and CV) will sustain the work as they are in the community and have already acquired sufficient skills... in some areas the CCs are already legal entities designated as CC/CCC” (SNNP, KII, Implementing Partner))

Regional and local government and CBOs

Government stakeholders' capacity has been assessed using rapid assessment by conducting KIIs with the respective bureau at the regional level (mostly MoWCA). KII and FGD results revealed all government structures and CC/CCCs have developed different skills that enabled them to undertake the necessary activity to cater the needs of HVC and their caregivers at community level. The following statements indicate the achievements:

- All CCs have done the Child Support Index (CSI) annually to select the right beneficiaries and those who shall graduate.
- CC/CCCs have developed skills to map available resources in the community and prepared service directory. The resource mapping exercise during the endline evaluation has also helped to identify available resources to facilitate referral. In most areas the CC/CCCs have identified community resources (Hotel, Barberry, Beauty Salon, Private Health Facilities,

Pharmacy, Transport Providers, Diaspora, etc.,) and signed a memorandum of understanding (MoU) among CC/CCC and supporting individual or organization to cover the gaps identified depending on needs of HVCs (Annex 4).

- Supervise the volunteers to ensure if they have provided the necessary services to the HVC and their families using service maps and service directory.
- Able to coordinate other CSOs and CBOs beyond the YB Project to plan and implement service deliveries to HVC for resource optimization.

The approach and strategies to build partner capacities vary according to the entities. The discussions with the implementing partners, government structures and CC/CCC indicated that:

- Most of the trainings were found relevant to understand the standard OVC service delivery guideline. The communities were well versed in expressing the needs of HVC in the community.
- Development of manuals and guidelines were also an important intervention. With this regard, the development of child protection policy at all levels is also a success mentioned by all implementing partners. This has been adapted to organizational policy beyond the YB Project.
- Intensive monitoring, joint supportive supervisions and mentoring have also created opportunity to share experience and community best practices among different implementing partners.
- Provisions of furniture and office equipment to Woreda level women and child office have been identified as important intervention.
- Staff secondment to implementing partners was also identified as one of the programmatic capacity building intervention provided by YB Project.

Although the Re-OCA and the KIIs revealed positive capacity building results, there were also areas that needed attention which were not addressed by previous interventions.

- Implementing partners tend to use the capacity building interventions only for YB project implementation. For example the strong MERL system built for the YB Project could have been adopted to other organizational M&E system.
- Demand for continuous refresher training to cope up with staff turnover and knowledge gaps due to short period of training provided.

Identification and enrollment of HVC in YB Program

Results of the endline evaluation showed that CVs were responsible for identifying 1,780 (77.8%) of sampled HVC included in the program, followed by CCs, 281 (12.3%) and kebele administration, 181 (7.9%). Final selection for enrollment into the program was made by kebele administration, 820 (35.9%), CVs, 676 (29.6%), CCs 512 (22.4%) and implementing partner staff,

200 (8.7%). Seventy six (3.3%) respondents didn't know who made the final selection. Results of the endline evaluation shows that there were high involvement of the community in the identification of HVC while the roles of implementing partners were limited to providing the financial, material and technical support in the implementation of the program.

Government

The community indicated that the government should have been responsible for the organization of recreational activities, special court for HVC and providing affordable housing for HVC. Provision of educational services by the government was the most appreciated intervention in the resource mapping exercise.

CSOs

The community was also well aware of the role of CSOs and other NGOs. In addition, the community was aware of the support available at the CSO level to cover school fees, school feeding and training of paralegal professionals.

CBOs

Almost all indicated that communities take part in creating linkage with stakeholders to protect and report abuse. The CBO participation in monitoring health situation of HVC and follow up of adherence was high. They also participate in financial, material and labor contribution for shelter and care. However, CBOs are less involved in school based nutrition support, giving shelter, safe study area after school and saving matching fund for ES activities.

Evaluation Questions 2 and 3

How have the availability, accessibility and quality of health and social services for HVC in Ethiopia changed since 2012, and how have YB activities plausibly contributed to these changes? To what extent are the services and support that are being provided improving health and educational outcomes of HVC and their families (comparing baseline, midterm and endline findings)?

The YB Project has worked to provided accessible and quality health and social services (including psychosocial services) for HVC in Ethiopia since 2012 (YB Activity baseline year). The findings below show how the YB interventions plausibly contributed to these changes and to what extent the services and support that were provided have improved the health and educational outcomes of HVC and their families comparing baseline, midterm and endline findings as appropriate

From the program point of view, the implementing partners have adopted the SSDGs for HVC in Ethiopia that defines specific service components to be implemented to improve the health and social conditions of HVC and their families. Access to different health and social services is ensured through local resource mapping, referral linkages and coordination of care to fulfill the needs of HVC (Annex 4).

The participants of this study interpreted quality in terms of availability of services and its effect on HVC:

“The service is quality as the community is participating and implementing partners are working on changing the mindset of the community. As a result, the beneficiaries are reflecting the changes

on the ground; - their children are learning, the caregivers are practicing gardening, they are washing their hand at critical times, mothers know the value of breastfeeding more than before. The HVC family are benefiting from saving and credit services.” (Oromia, FGD, CC)

Concerns about the continuity is also voiced “...however, the provisions have no continuity, such as three exercise books, one pen and one pencil is not enough for one year.” (Oromia, FGD, CC)

Overall, there were also concerns on the quality of health services provided:

“We are worried about the resurgence of stigma and discrimination as health providers disclosing the status of HVC which deter health care seeking by the beneficiaries and health workers do not convince the HVC to start treatment on time. Even the health facilities have agreement with YB Project to provide quality health service without payment but the way they treat the HVC is not attractive. They refuse the HVC when they are referred from the community.” (Oromia, FGD, CC)

HVC Health Status

The primary health outcomes assessed among HVC in this endline evaluation are shown in Table 5. The self-reported HVC health situation at midterm and endline evaluation results revealed that there is statistically significant improvement in their health situation. HVC who reported their health situation as very good or good had increased from 60.0% to 86.1% while those who reported very poor or poor had reduced from 20.3% at midterm to 4.5% during the endline. The differences at each category of the self-reporting are statistically significant (Figure 3).

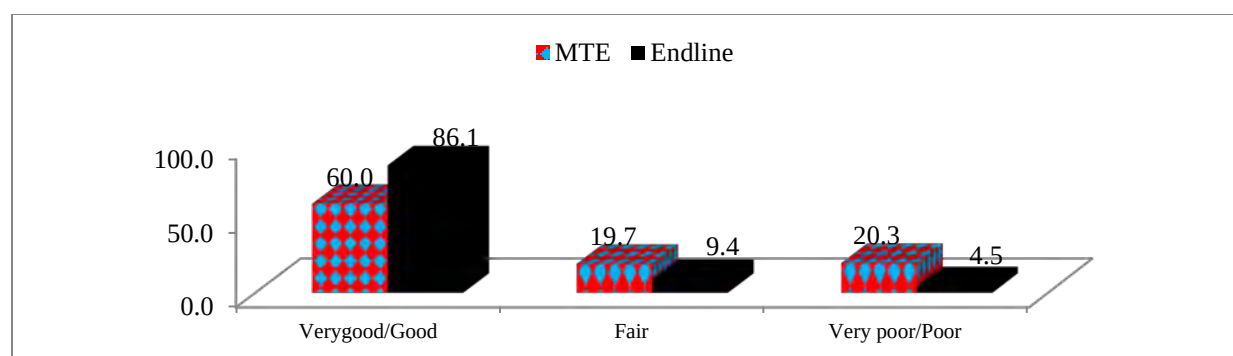


Figure 3: Self-reported HVC health at midterm and endline: 2014 and 2017

Of the 2,284 participants, 398 (17.4%) of HVC (184 (16.5%) male and 214 (18.3%) female) reported that they were too sick to participate in daily activities in the last two weeks prior to endline survey. At the midterm evaluation, 356 (16.8%) of HVC [(176 (16.1%) female, (180 (17.6%) male)] reported to be too sick to participate in daily activities. No statistically significant difference was observed between the endline and midterm findings (Figure 4). No similar data was generated at baseline for comparison.

Table 5: HVC health indicators by age and sex at endline: 2017

Total (n)	0-4		5-9		10-13		14-17		Total		
	M	F	M	F	M	F	M	F	M	F	T
	No (%)	No (%)	No (%)	No (%)	No (%)	No (%)	No (%)	No (%)	No (%)	No (%)	No (%)
	43	37	355	358	428	450	292	323	1118	1168	2286
Was child too sick to participate in daily activities in the last 2 weeks? (n = 2284)											
Yes	10 (23.3)	3 (8.1)	66 (18.6)	67 (18.7)	78 (18.2)	92 (20.4)	30 (10.3)	52 (16.1)	184 (16.5)	214 (18.3)	398 (17.4)
No	33 (76.7)	34 (91.9)	289 (81.4)	291 (81.3)	350 (81.8)	358 (79.6)	261 (89.7)	270 (83.9)	933 (83.5)	953 (81.7)	1886 (82.6)
Had child fever in the last 2 weeks preceding the survey? (n = 2284)											
Yes	8 (18.6)	1 (2.7)	49 (13.8)	54 (15.1)	54 (12.6)	57 (12.7)	19 (6.5)	36 (11.2)	130 (11.6)	148 (12.7)	278 (12.2)
No	35 (81.4)	36 (97.3)	306 (86.2)	304 (84.9)	374 (87.4)	393 (87.3)	272 (93.5)	286 (88.8)	987 (88.4)	1019 (87.3)	2006 (87.8)
Had child diarrhoea in the last 2 weeks preceding the survey? (n = 2284)											
Yes	4 (9.3)	0 (0.0)	12 (3.4)	19 (5.3)	12 (2.8)	19 (4.2)	2 (0.7)	6 (1.9)	30 (2.7)	44 (3.8)	74 (3.2)
No	39 (90.7)	37 (100.0)	343 (96.6)	339 (94.7)	416 (97.2)	431 (95.8)	289 (99.3)	316 (98.1)	1087 (97.3)	1123 (96.2)	2210 (96.8)
Had the Child Fever and Sought treatment? (n = 278)											
Yes	6 (75.0)	1 (100.0)	39 (79.6)	46 (85.2)	35 (64.8)	45 (78.9)	11(57.9)	26 (72.2)	91 (70.0)	118 (79.7)	209 (75.2)
No	2 (25.0)	0 (0.0)	10 (20.4)	8 (14.8)	19 (35.2)	12 (21.1)	8 (42.1)	10 (27.8)	39 (30.0)	30 (20.3)	69 (24.8)
Had the Diarrhoea and Sought treatment? (n = 74)											
Yes	4 (100.0)	0 (0.0)	12 (100.0)	18 (94.7)	8 (66.7)	18 (94.7)	0 (0.0)	5 (83.3)	24 (80.0)	41 (93.2)	65 (87.8)
No	0 (0.0)	0 (0.0)	0 (0.0)	1 (5.3)	4 (33.3)	1 (5.3)	2 (100.0)	1 (16.7)	6 (20.0)	3 (6.8)	9 (12.2)
Had child fully vaccinated for age? (n = 80)											
Yes	40 (93.0)	33 (89.2)								33 (89.2)	73 (91.2)
Had HVC tested for HIV? (n = 2285)											
Yes	21 (48.8)	21(56.8)	214 (60.3)	222 (62.0)	276 (64.5)	301 (67.0)	165 (56.5)	215 (66.6)	676 (60.5)	759 (65.0)	1435(62.8)
No	22 (51.2)	16 (43.2)	141 (39.7)	136 (38.0)	152 (35.5)	148 (33.0)	127 (43.5)	108 (33.4)	442 (39.5)	408 (35.0)	850 (37.2)
Adolescent HVC got Health Information/Counselling about reproductive health? (n = 615)											
Yes							139 (47.6)	210 (65.0)	139 (47.6)	210 (65.0)	349 (56.7)
No							153 (52.4)	113 (35.0)	153 (52.4)	113 (35.0)	266 (43.3)

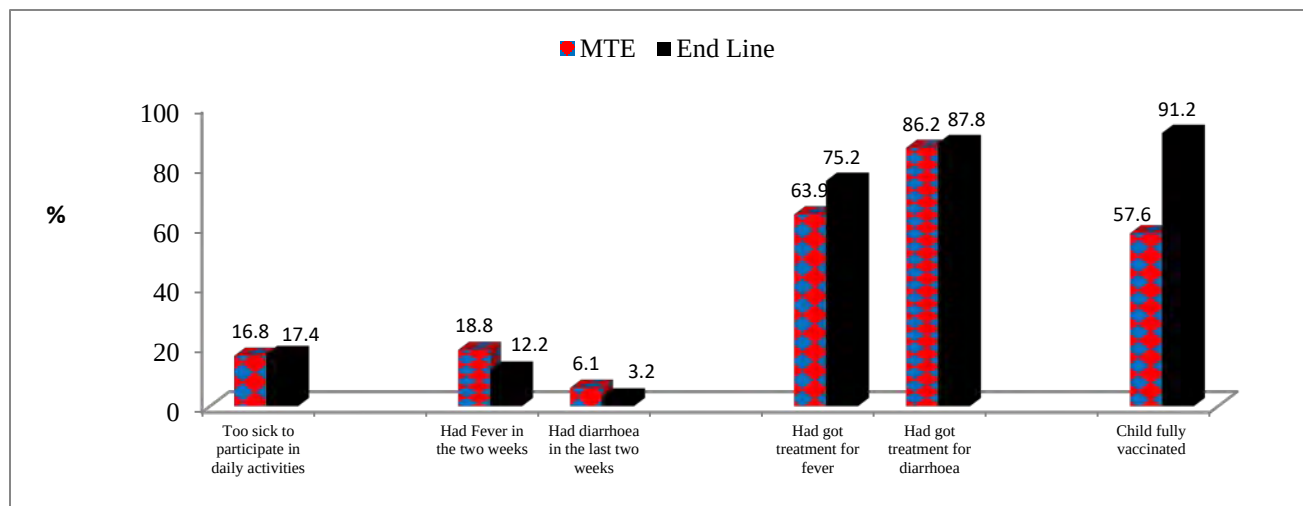


Figure 4: HVC health indicators at midterm and endline: 2014 and 2017

At endline, 278 (12.2%) HVC [210 (20.5%) female, 189 (18.4%) male] reported an episode of fever in the last two weeks preceding the survey compared to 399 (18.8%) at midterm and 230 (15.7%) at baseline (Figure 4). The observed differences at endline and midterm as well as baseline were statistically significant ($p < 0.001$). Seventy four (3.2%) HVC, [44 (3.8%) female, 30 (2.7%) male] reported diarrhea in the two weeks at endline compared to 130 (6.1%) at midterm and 158 (10.8%) at baseline. The observed differences were statistically significant ($p < 0.001$) with an overall reduction of diarrhea episodes at endline when compared to both the midterm and baseline. Findings from the qualitative study also indicate that HVC were receiving education on primary health care that could contribute to the decline in diarrhea episodes.

“The volunteers teach us about personal hygiene, keeping our environment clean and use of toilet and washing our hands with soaps after visiting toilets.” (Tigray, KII, Male HVC)

With respect to health-seeking behavior, 209 (75.2%) HVC with fever and 65 (87.8%) HVC with diarrhea sought treatment at endline compared to 255 (63.9%) HVC with fever and 112 (86.2%) with diarrhea at midterm and 77 (48.4%) HVC with fever and 114 (49.7%) HVC with diarrhea at baseline (Table 5). The increase in treatment seeking behavior for fever at endline is statistically significant ($p < 0.001$) compared to midterm while no such difference in treatment seeking for diarrheal illnesses. Unlike this, the difference in health seeking behavior between endline and baseline were statistically significant ($p < 0.001$) both for fever and diarrhea illness. The difference in health seeking behavior noted between endline and baseline were also statistically significant ($p < 0.001$). The provision of health information, home visits and free treatment given by the government and cost reimbursement by implementing partners expressed in the qualitative study might have contributed to the increase in health seeking behavior (Table 6).

“Free treatment letter is written from the kebele and is approved by social affairs office. So the support given by (name of the implementing partner) is good for the health of HVC and their families.” (Oromia, KII, Woreda WCYA office)

Others also indicated the refund by the implementing partner has helped them to get regular medical services for their chronically sick children despite the HIV status.

“My child has a cardiac problem, his medical expenses are refunded to me by (name of the implementing partner... I do not know what would happen to my child if (name of the implementing partner) phases out).” (Addis Ababa, KII, Caregiver)

Table 6: Health cost coverage for HVC at midterm and endline: 2017

Who covers the health cost?	Midterm		Endline	
Free	10	1.4	5	0.7
The household itself	491	67.4	598	87.1
Relatives	62	8.5	28	4.1
Neighbours/acquaintances	42	5.8	16	2.3
CBOs (Idir, etc)	3	0.4	1	0.2
Yekokeb Berhan program	32	4.4	21	3.1
Volunteer people/(their own donations)	11	1.5	10	1.7
Other	58	8.0	8	1.2
No response	19	2.6	0	0.0
Total	728	100.0	687	100.00

Comparing the treatment-seeking behaviour by gender, although more female than male with fever, 118 (79.7%) vs. 91 (70.0%) as well as diarrhoea, 41 (93.2%) vs. 24 (80.0%) have received treatment the difference is not statistically significant at 95% confidence interval. No statistically significant difference by gender was also noted at midterm.

At endline, among the 80 HVC 0 – 4 years of age, 73 (91.2%) were fully vaccinated for age compared to 137 (57.6%) at midterm and 124 (33.9%) at baseline. The observed differences between the endline and midterm as well as endline and baseline are statistically significant ($p < 0.001$) (Table 5 and Figure 5).

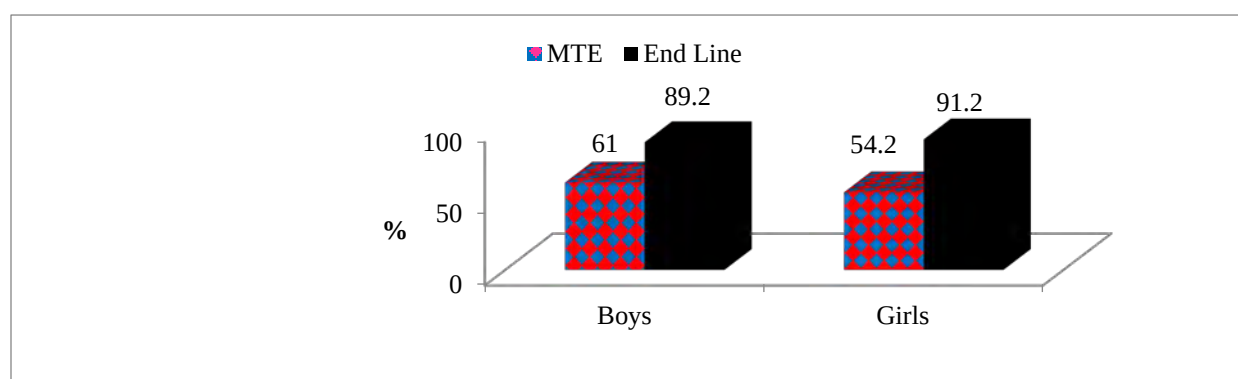


Figure 5: Proportion of fully vaccinated at midterm and endline: 2014 and 2017

Of the 615 adolescents 14 – 17 years of age included in the endline survey, 349 (56.7%) reported that they have received health information/counselling about reproductive health (RH). More

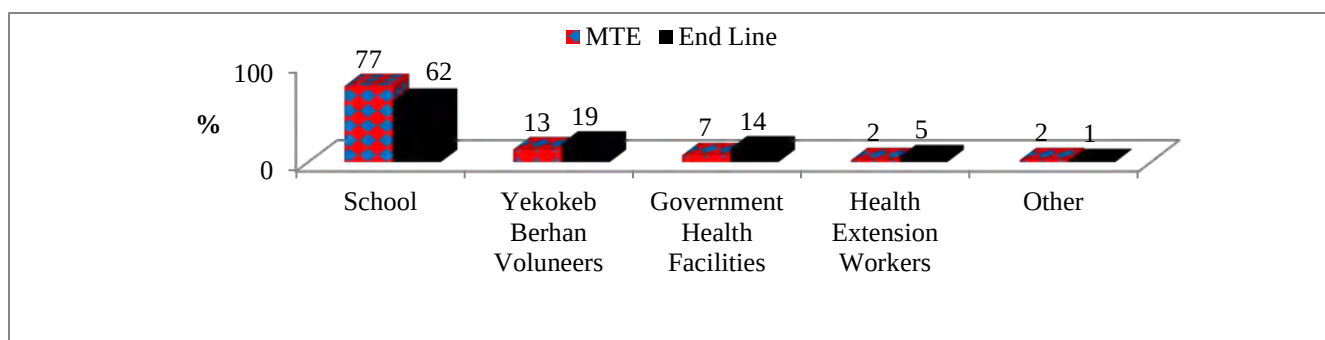


Figure 6: Source of RH information for HVC adolescents at midterm and endline: 2014 and 2017

At midterm, 272 (60.3%) reported having access to RH information with no statistically significant difference between girls (62.6%) and boys (57.4%) in accessing reproductive health information (Table 5).

A slightly lower proportion of adolescents reported having received RH information at endline compared to the midterm, 56.7% vs. 60.3% but the difference noted is not statistically significant. It is surprising that the proportion of boys receiving RH information at endline has significantly declined compared to the midterm while no statistically significant difference is observed among girls' access to RH information at endline and midterm. The qualitative findings also indicated that:

“Female HVC get additional psychosocial support from community volunteers since they are more vulnerable to pregnancy and abortion.” (Amhara, KII, Caregiver)

This implies that the program shall give due attention to both sexes as RH related information is very critical to protect oneself against STIs including HIV.

With respect to main sources of RH information, schools remained as the primary source of information both at endline and midterm but with a decline from 77% at midterm to 62% at endline. However the roles of YB volunteers, government health facilities, and health extension workers as source of RH information has increased at endline; from 13% to 19% for YB volunteers, from 7% to 14% for government health facilities, and from 2% to 5% for health extension workers (Figure 6). The drop in school as a source of information is statistically significant ($P < 0.01$) and possible explanation for such a decline could be the increased role of health facilities and CBOs in reaching out adolescents with vital information as that of schools.

At endline 463 (75%) adolescent HVC [204 (69.4%) male, 259 (80.2%) female] have received information or counseling about HIV by health workers or anybody else in the last 12 months compared to 389 (86.4%) at midterm (Table 5). Information related to HIV education and counseling services to HVC was not collected in the baseline. Three hundred eighty (61.6%) adolescent HVC have received HIV testing at endline in the last 12 months. Of these 165 (56.1%) were male and 215 (66.6%) were female.

Over the last twelve months preceding the survey, a total of 1435 (62.6%) HVC of all ages, [676 (60.5%) male, 759 (65.0%) female] were tested for HIV at endline, compared to 988 (46.6%) HVC [46.9% male, 46.3% female] at midterm where the increase in testing at endline is statistically

significant ($P < 0.001$) both for the overall proportion and gender. Of those tested 99.1% of boys at endline and 97.9% at midterm have received test results. Similarly 99.2% and 97.0% female have received test result at endline and midterm respectively. No statistically significant difference at endline and baseline with regard to receiving HIV test result. The above finding was corroborated in the qualitative findings where the number HVC tested for HIV has increased.

“Initially, most of the beneficiaries were not willing to get their blood tested, and they don’t disclose their result after the test; this is PEPFAR fund, as you know; hence, their HIV status should be known. However, in the past one year, most of them were tested for HIV and brought their test result, some HIV positive genuinely ask for advice, even they were willing to help others, to advice the public with their experience; this means the house to house service has brought a lot of changes.” (Addis Ababa, KII, Implementing partner)

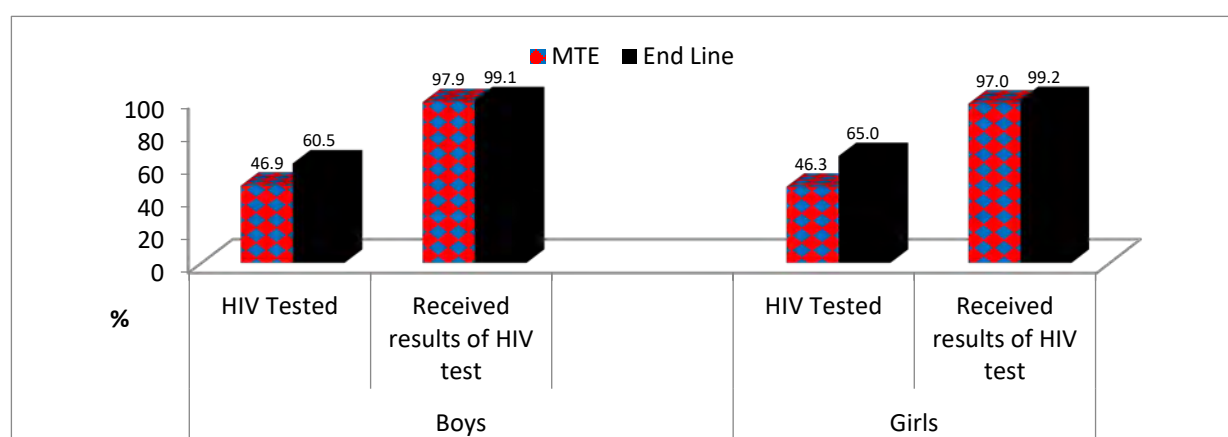


Figure 7: Proportion of HVC tested for HIV and received HIV test results at midterm and endline: 2014 and 2017

Of the total of 1435 HVC tested 43 (3.0%) were HIV positive. Of these, 22 (3.3%) were male and 21 (2.8%) were female. Of the 22 HIV positive boys identified, 19 were on treatment and 17 were receiving regular follow up. All the 21 female were on treatment and 20 were on regular follow up (Table 5 and Figure 7).

At midterm, 56 (5.8%) HVC were positive for HIV. When disaggregated by sex, 24 (5.1%) boys and 32 (6.5%) girls reported being HIV positive but the difference was not statistically significant. Compared to the midterm the proportion of girls linked to treatment has shown improvement 26 (81.0%) vs. 21 (100%). Baseline data shows that 14.2% of HVC who were tested and received their results were positive for HIV. Altogether, 37 (86.0%) HIV positive HVC at endline, 48 (85.7%) HIV positive HVC at midterm were on ART. In the baseline only 61% HIV positive HVC were receiving ART which was much lower in comparison to the midterm and endline findings (Figure 8).

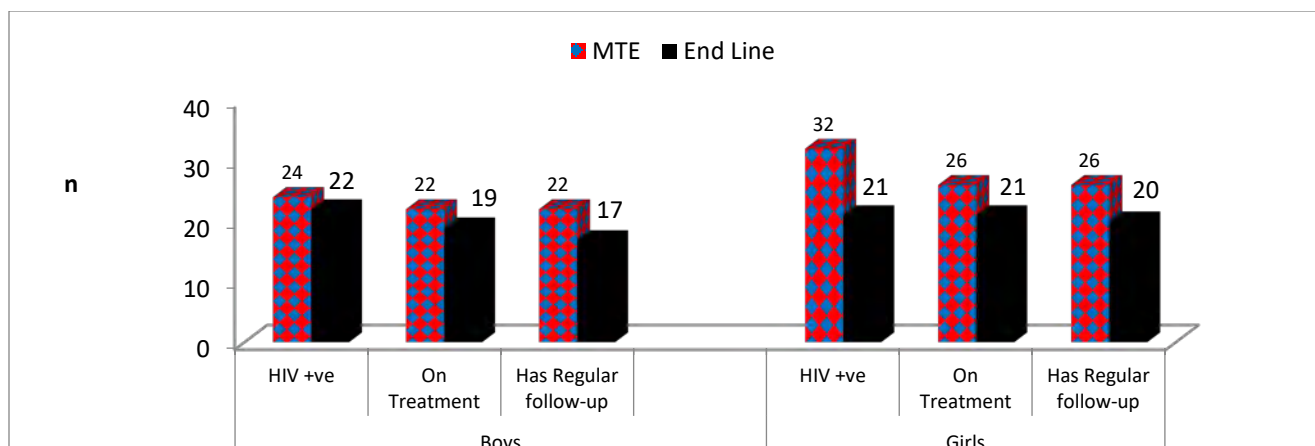


Figure 8: Number of HIV positive HVC, on treatment and regular follow-up at midterm and endline: 2014 and 2017

Looking HIV testing by region, it has increased at endline in all regions except in Oromia. Amhara has tested 75% of the HVC, followed by SNNP, 61.0%, Tigray, 54.1%, Addis Ababa 51.7% all higher than the midterm testing rate. However the increment in HIV testing is statistically significant ($P < 0.001$) in Amhara, SNNP and Addis Ababa. Although Oromia has tested 51.7% HVC, it is the only region that tested less compared to the midterm performance. HIV positivity had declined in all regions, nevertheless, decline is statistically significant ($P < 0.01$) only in Amhara and Addis Ababa (Figure 9).

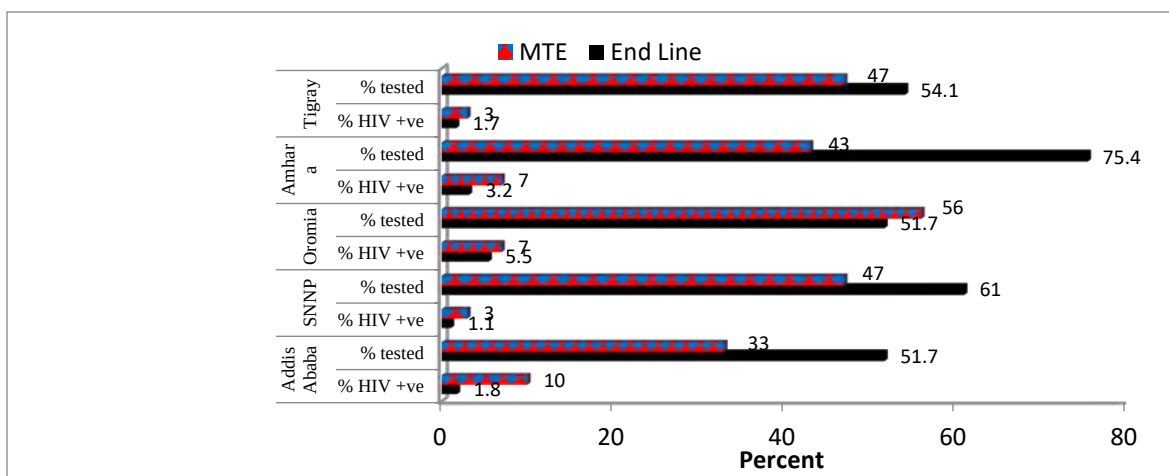


Figure 9: Proportion of HVC tested and Positive for HIV by region at midterm and endline: 2014 and 2017

Shortage of test kits could be one of the reasons for the decline in HIV testing observed in Oromia as expressed in the qualitative study:

“For example, while the plan was to conduct HIV testing for 8000 individuals in a catch up campaign, testing was possible only for 500 individuals. They (the campaign team) told us they will come back to conduct the testing later but they never showed up” (Bale Robe, KII, ODA)

Caregivers' health status

In the overall self-rating of health status 75% of caregivers reported their health status in the 12 months preceding the survey, as very good/good compared to 60% and 50% at midterm and baseline and the observed change is statistically significant ($p < 0.001$). Only 15% of caregivers rated their health as poor or very poor at endline compared to 20% and 28% at midterm and baseline. Likewise, the proportion of caregivers who reported their health status as poor/very poor has also consistently declined, and the change is statistically significant ($p < 0.001$) (Figure 10).

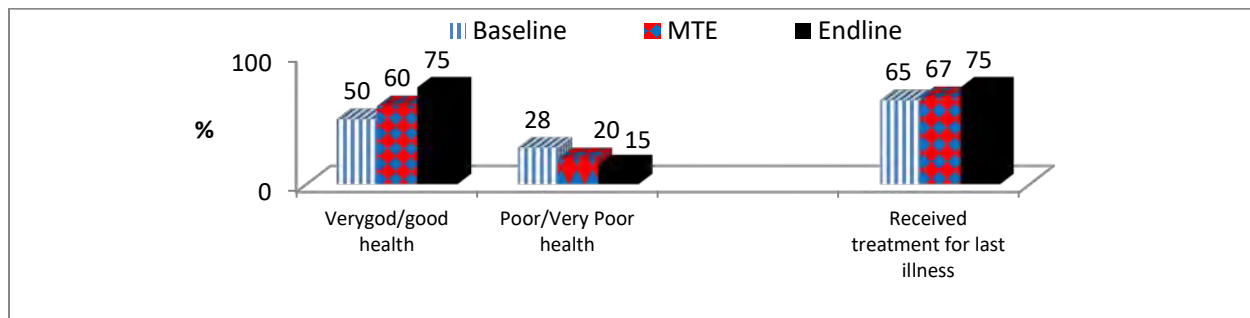


Figure 10: Caregivers perception of their health status at baseline, midterm and endline: 2012, 2014, 2017

At endline 533 (23.3%) of caregivers reported that they were too ill to participate in daily activities in the last two weeks preceding the survey compared to 23.8% at midterm. At endline 397 (74.5%) caregivers who were too sick in the two weeks period have sought treatment for their illness compared to 67.0% at midterm and 65.0% at baseline (Figure 10), and the change is only statistically significant ($p < 0.01$) between the midterm and endline surveys. At endline 304 (76.6%) of caregivers sought treatment at government health facility and 84 (21.2%) went to private hospital/clinic for treatment. The figures for the midterm were 75.0% and 17.6%, respectively. For caregivers who didn't seek treatment, the commonest reasons was 'no money' 92 (67.6%) followed by 'illness not too serious' 28 (20.6%). In the midterm evaluation, 'lack of money to cover treatment related expenses' was 68.6% while 'illness was not too serious enough to seek treatment', 12% and 'health facility was far', 9.7%. None mentioned distance of health facility as a deterring factor for not seeking treatment at the endline.

At endline 79% caregivers received counselling compared to 84% at midterm. Of these, 74% were tested for HIV, 99% received test result and 13% were positive and 95% were on ART and 89% of them were having regular followup. Compared to the midterm, the proportion of caregivers who received counseling for HIV testing and those who are on regular ART follow up have shown statistically significant decline. The proportion of caregivers on ART has, however, shown a statistically significant increment. No statistically significant change was observed in HIV testing, results received and HIV positivity among caregivers at midterm and endline (Figure 11). However, the qualitative study indicated that caregivers got advise about ART adherence at household level.

“The volunteers conduct close follow-ups especially for the needy. For example for those who had discontinued medication, they advise them to adhere and have a balanced diet.” (Tigray, KII, Male HVC)

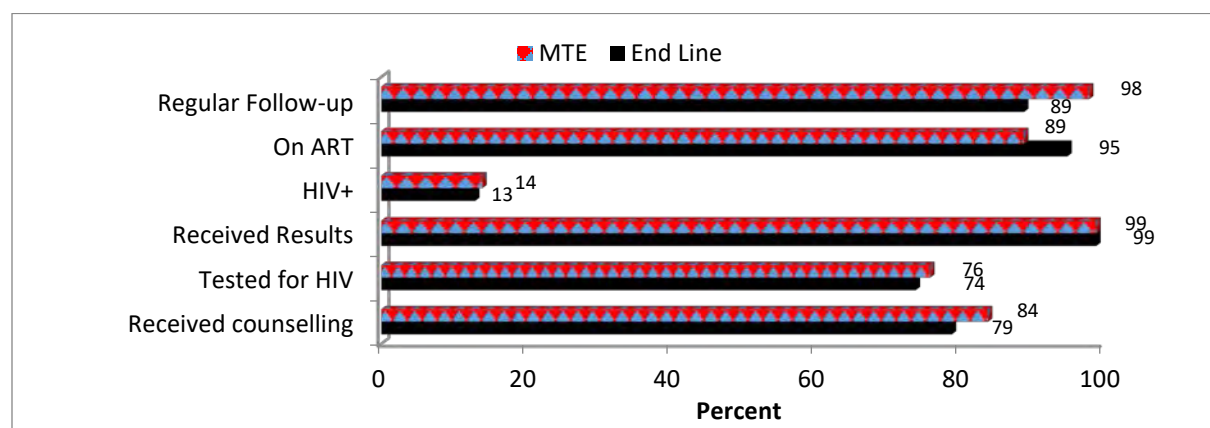


Figure 11: Proportion of caregivers received different HIV services at midterm and endline Surveys: 2014 and 2017

Psychosocial support

Training on Better Parenting was one of the interventions by YB Project to improve the knowledge and skills of caregivers in caring for HVC. In this survey, 1,242 (54.2%) households have someone who received information or skill on Better Parenting compared to 1,117 (52.2%) at midterm. The increased proportion at endline is not statistically significant. No information on psychosocial support was collected in the baseline to make comparison. Though to a lesser degree, compared to the midterm, 1,125 (52.6%), family members were still the main sources of social support at endline, 295 (40.0%). The role of implementing partner staff has increased from 50 (4.4%) at midterm to 127 (17.2%) at endline and that of CVs has gone up to 188 (25.5%) at endline compared to 144 (12.8%) at midterm indicating increased engagement of the program. Overall, 1,282, (56.0%) caregivers said someone from the household has received counseling, advice or emotional support with at endline, a decline from the midterm of 64.1%. At endline, 177 (28.7%) HVC aged 14 and above years have received life skills training with almost the same proportion as observed at midterm, 125 (27.7%) which is an area that requires further intervention in terms of the need to shape the future adult. The proportion of children <14 years old noticed for having sudden changed in mood have gone up from 98 (5.8%) at midterm to 130 (7.8%) at endline, with no statistically significant difference. See Annex 5 for details. Though there are encouraging inputs, reservations were expressed by HVC on the strength of psychosocial support:

“The program helped us just to wake-up, it is not enabling us to stand alone... Some children who started going to school had dropped out and went back to the streets and continued their previous life [stealing and substance abuse]. There psychosocial support is not adequate.” (Oromia, FGD, Female HVC)

“My volunteer never provided me psychosocial support, she is so busy with other things.” (Bahir Dar, FGD, Female HVC)

Education

Educational support is one of the programmatic support areas of the HVC supported by the YB Project. The educational support scheme includes distribution of school uniform and supplies, tutorial support and assistance with school fees. School enrollment was assessed for HVC aged five years and above. The greatest majority; that is, 2,202 (90.8%) of the 2,206 HVC aged five years and above were reported to be attending school during the endline survey. See Annex 6. The trend in school enrollment among HVC had shown significant improvement only between the baseline and midterm as it had increased from 77% during the baseline survey to 90.8% during the midterm and the difference was statistically significant ($p < 0.01$). Though not statistically significant, enrollment rate has declined between the midterm and endline survey periods (Figure 12). Some of the reasons mentioned for never been to school during the endline include there is no money for fees, materials, transport to send the child to the school (22.8%), child has to work to help family (16.9%), child is too sick to attend school (15.4%), school is too far away (13.8%) and child is too young to attend school (17.9%). Similar reasons were also mentioned during the midterm for being out of school: no money for fees, materials, transport (20.4%), and child is too sick to attend school (13.8%), stigma at school (7.8%), and child is too young to attend school (47.3%). It seems that the category for ‘child is too young to attend school’ during the midterm seems to encompass absence from school to provide assistance for the family and the child’s inability to travel long distance to attend school.

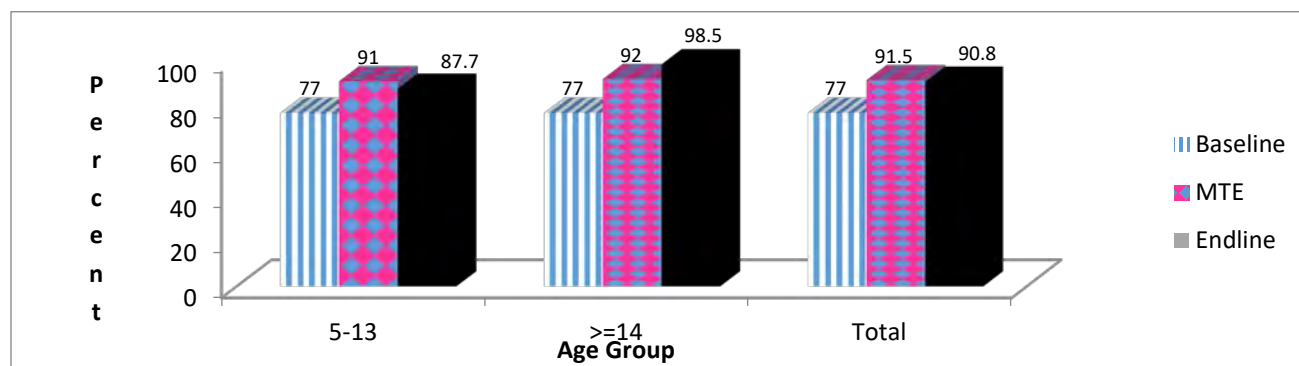


Figure 12: Comparison of school enrollment of HVC at baseline, midterm and endline: 2012, 2014 and 2017.

Age disaggregated data reveal that school enrollment has increased progressively among older (14-17 years) HVC from the baseline to midterm and endline surveys, and the differences are statistically significant. For HVC of primary school age (5-13 years) school enrollment has significantly increased only between baseline and endline ($p < 0.01$) while it has significantly declined ($p < 0.05$) between midterm and endline evaluation periods. Taking all age groups together, enrollment among HVC has significantly increased only between baseline and endline while no change is observed between the midterm and endline. This might be the shift in program focus, from direct HVC support such as providing school materials regularly to ES activities. The same pattern was also observed in school enrollment of HVC by gender.

Tutorial support for in-school HVC has increased significantly as nearly two-third of them have reported to have received assistance from someone during the endline compared to only 42.8% during the midterm. Though, the program was designed to support both boys and girls slightly more girls (67.1%) than boys (63.5%) have reported to get the assistance. The tutorial support specifically provided by YB program has also increased from 15.1% during the midterm to 22.5% during the endline survey and the difference is statistically significant ($p < 0.01$) (see Figure 13 and Annex 6).

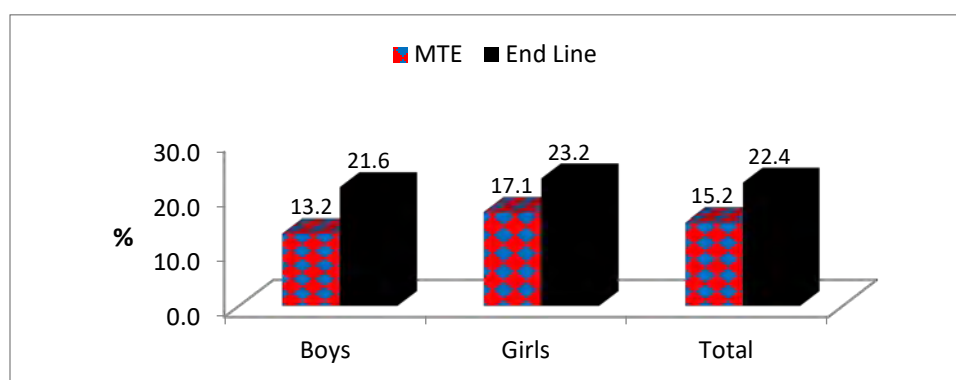


Figure 13: Proportion of HVC ever participated in a tutorial services organized by YB at endline: 2017

Data on HVC's school performance also show that 95% of the HVC had successfully promoted to the next grade/level in the previous academic year compared to 85.8% during the midterm, and the difference is statistically significant ($p < 0.01$). Though there was no statistically significant difference, repetition rate was lower among girls than boys and the pattern was the same during the midterm. With regard to coverage of school expenses including books, uniform, stationeries, transport, school fees, etc., only 995 (51.7%) of the HVC reported that their school expenses were covered by the YB Program during the endline compared to 69.9% during the midterm. The decline in the coverage of school expenses during the mid-term and endline evaluation periods was statistically significant ($p < 0.001$) probably due to the change in program focus described above. Though statistically insignificant, slightly more boys 499 (53.4%) than girls 496 (50.1%) have reported that their school expenses were covered by YB during the endline evaluation.

Assessment of regular school attendance of HVC enrolled in the YB educational support program revealed that, though not statistically significant, the proportion of HVC who did not miss school at all for any reason during the four weeks preceding the survey had declined from 70.7% during the midterm to 68.6% the endline evaluation. The proportion of HVC who missed less than a quarter of the school days was 28% during the endline evaluation compared to 24% during the midterm. Regular school attendance among those currently attending school has, however, shown significant improvement during the endline (96.1%), compared to midterm (94.7%) and baseline (89.3%). The improvement in regular school attendance was statistically significant at all evaluation periods ($p < 0.05$).

Food and Nutrition

Assessment of the provision of food and nutrition services during the midterm and endline evaluation periods was presented in Annex 7. The proportion of households that had at least one

adult family member who received nutrition related training, counseling or advice in the past 12 months preceding the survey had increased from 36.1% during the midterm to 40.1% during the endline, and the difference was statistically significant ($p < 0.01$). The proportion of HVC households experiencing shortage of food in the past twelve months had significantly declined from 58% during the midterm to 41% during the endline ($p < 0.01$). When the food shortage was assessed by days, 30% of the households did not have enough food to eat for 1-2 days during the midterm compared to 41.3% during the endline. Although about 35% of the household experiencing food shortage for 3-6 days during the two periods there was statistically significant difference ($P < .001$) among those experiencing food shortage for seven days or more in the one month period prior to the evaluation, 24.3% during the midterm vs. 16.8% at the endline. HVC households with extreme food shortages (i.e. having no enough food throughout the month) had also significantly declined from 8.8% to 6.4% ($p < 0.05$). Significantly lower proportion (30.5%) of HVC households reported having no food store during the endline compared to 41.4% during the midterm evaluation and the difference is statistically significant ($P < 0.001$). The proportion of HVC households that had food reserve enough for one or more weeks has increased from 20% during the baseline to 37.1% during the midterm and reached 46.2% during the endline, and the differences are statistically significant ($p < 0.05$) for all evaluation periods.

Even though availability of supplementary and therapeutic foods for children who needed them was used as one of the indicators to assess the dimensions for food and nutrition services to the HVC, no statistically significant difference was observed with regard to the proportion of HVC for whom food was prescribed by health/nutrition workers over the past one year during the midterm (7.8%) and endline (6.3%). Over 70% of the households for which food was prescribed had also received the services (Table 6 Annex). Similarly, no statistically significant difference in malnutrition rate was observed among children aged less than five years of age for whom nutritional assessment was done using MUAC. Prevalence of malnutrition was less than 5% both during the midterm and endline evaluation periods. No child with severe acute malnutrition found at this survey. Though it was interrupted in recent days, food and nutrition was one of the major interventions for HVC as indicated in the qualitative part of the study:

“We used to get five to six kilos of flour and oil. However, we are not getting it anymore now. Compared to our friend, ours situation in terms of nutrition is very bad.” (Amhara, KII, male HVC)

Legal Protection

Indicators of legal protection status of the HVC during the midterm and endline evaluation are presented in Annex 8. The proportion of HVC who had birth certificate from an authorized government office as confirmed by the surveyors had increased from 5.5% during the baseline to 8.7% at the midterm and reached 26.4% during the endline which is statistically significant ($p < 0.05$). No gender difference was noted. The increment in the proportion of HVC who had obtained birth certificate is mainly the initiative of the project intervention than the contribution of the newly established Vital Events Registration Agency that provides the services for the needy.

Although the prevalence was low, there is statistically significant decline in proportion of HVC households in which a member had experienced some form of violence in the past one year during the midterm 147 (6.9%) compared to 104 (4.5%) at the endline evaluation. Of those experiencing the incidence, the proportion of victim households that encountered physical violence significantly declined ($p < 0.05$) from 60 (40.8%) during the midterm to 29 (27.9%) at the endline. Further

analysis of the data revealed that although the difference was not statistically significant between the midterm and endline evaluations most of the violence were perpetrated by neighbors (47.6% vs. 51.0%), unknown people (17.7% vs. 10.6%) and spouses, (12.2% and 19.2%), respectively during the midterm and endline periods. With regard to actions taken after the violence occurred, the proportion of victims who went to police or sought legal services declined from 92 (62.6%) during the midterm to 49 (47.1%) at the endline while those who told a relative or neighbor increased from 14 (9.5%) during midterm to 19 (18.3%) at the endline. The proportion who did nothing or took no measure was about a third at both of the evaluation periods. The possible reason for this decline is the shift in program focus that cut incentives for the provisionally instated HVC focused law enforcement arrangements (such as setting up a separate desk for addressing legal issues pertaining to HVC).

The proportion of households referred or linked to any legal services in the 12 months preceding the survey had not also shown statistically significant difference. Only 176 (8.2%) and 120 (5.2%) of the households were referred or linked to legal services. The contribution of YB implementing partner in referring or linking the victims to legal services had, however, significantly increased ($p < .05$) from 26 (26.1%) during the midterm to 46 (38.3%) at the endline. The qualitative study also indicated that CBOs and implementing partners were protecting the rights of HVC and their families on regular basis:

“Whenever somebody faced any violation of rights there is a legal protection. People from the different government bodies including women and children affairs and the legal system are organized to protect the right of HVC.” (SNNP, KII, CC)

The majority (54%) of the referral was done by the CC, CV and kebele administration during the midterm compared to 60.1% during the endline. The proportion of the households that said that they feel more secure in terms of legal protection this time than before they were involved in the YB Project had significantly reduced ($p < 0.001$) from 1105 (51.7%) during the midterm to 878 (38.3%) at the endline.

Evaluation Question 4

To what extent are economic strengthening activities effective in improving the capacity of households and HVC to meet their basic needs?

Effects of economic strengthening activities

The ES activities provided by YB Project mainly focuses on helping caregivers, in a long run, to generate financial resources and become economically self-reliant and thereby address the needs of their families and HVC. Qualitative data shows that caregivers were organized in to CSSGs and empowered by CVs and CCs to generate their own livelihood through credit schemes mainly saving and loans provision services. 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 YB 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. The 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.” (Hawassa, FGD, CSSG)

Results of ES indicators from the quantitative study are given in Annex 9. The proportion of HVC households engaged in ES had significantly increased from 819 (38.3%) during the midterm to 1,117 (48.8%) at the endline ($p<0.001$). The YB Program ES package includes training, market information, technical support through ES animators/facilitators or provision of matching funds. Of those households engaged in ES, the proportion that have received training in CSSGs through the YB Program that provides a wide range of benefits helpful to strengthen their household's financial condition had also significantly increased from 493 (60.0%) during the midterm to 880 (78.8%) at endline ($p<0.001$). The training is designed to enhance their saving habits, formation of social bonds, setting vision with clear objectives and goals, as well as accessing loan funds for MEs. Similarly, the proportion of HVC households participating in ES program that received training on Microenterprise selection, planning and management (ME-SPM) had significantly increased from 267 (32.6%) during the midterm to 488 (43.2%) at the endline ($p<0.001$). ME-SPM training provided skills to understand the local market opportunities for their products/services and the skills to run the microenterprise operation smoothly. Equally important was a statistically significant improvement ($p<0.05$) in the proportion of the targeted households that reported having a regular income on daily, weekly, monthly, quarterly or a biannual basis during the midterm (593 (72.4%)) when compared to the endline (983 (83.2%)) evaluation period. About two-thirds (67.4%) households earning regular income have obtained their income for their own business established by CSSG (38.5%) and earning from daily works facilitated by the program (28.8%). The qualitative study showed that:

“Savings groups are strong with members as high as 150 women and a lending capacity of 10,000 ETB at a time.” (Amhara, FGD, Caregivers)

Despite making considerable efforts to initiate HVC households to engage in ES activities and receive training on how to run microenterprise, the proportion of beneficiaries who were involved in a small-scale business or microenterprise had not shown much improvement. Only about a quarter of the HVC households engaged in ES activities had managed to establish business both at midterm, 204 (24.9%) and endline, 302 (27.0%). In the same manner, the proportion of ES households that could manage to expand or diversify small scale business in the 12 months preceding the survey had not shown statistically significant change although it had increased from 100 (39%) during the midterm to 174 (57.6%) at the endline. The proportion of ES households that acquired additional productive assets such as working capital, cattle, sheep, goats, farm land and the like over the past two years had rather declined from 106 (12.9%) during the midterm to 98 (8.8%) at the endline. Nonetheless, it is worth noting a significant increase ($p<0.01$) in the proportion of ES households that reported having same productive assets as a year ago 142(17.3%) during the midterm vs. 859 (76.9%) at the endline) and a statistically significant decline ($p<0.01$) in the proportion who reported having productive less than a year ago during the midterm (570 (69.6%) vs. 159 (14.2%) at the endline). Findings of the evaluation also revealed slightly over a quarter of the HVC households (27.4% at both of the evaluation periods) had reported that they feel financially more secure at the moment compared to the situation a year ago. The proportion of HVC households that reported no change in terms of financial security was nearly the same: 965 (45.1%) during the midterm compared to 928 (40.5%) at the endline.

Table 7: Economic strengthening effects on HVC health outcomes at endline: 2017

Household engaged in ES program (n=2,286)	HVC has Good/Very Good Health; n (%)	Child has Fever; n (%)	Child has Diarrhoea; n (%)	HVC HIV Testing; n (%)	Caregiver Treatment for Last Illness; n (%)	Caregiver HIV Testing; n (%)
Yes	978 (87.6)*	150 (13.4)	52 (4.7)***	781 (70.0)***	190 (76.6)	924 (82.7)***
No	989 (84.6)*	128 (11.0)	22 (1.9)***	652 (55.8)***	207 (72.9)	777 (66.4)***
ES household had training in CSSGs (n=1,116)						
Yes	778 (88.4)	119 (13.5)	36 (4.1)	622 (70.8)	143 (76.5)	735 (83.5)
No	200 (84.4)	31 (13.1)	16 (6.8)	159 (67.1)	47 (77.0)	189 (79.7)
ES households access to financial technical services (n=1,117)						
Yes	225 (90.7)	43 (17.3)*	15 (6.0)	187 (75.4)	59 (88.1)*	217 (87.5)
No	753 (86.7)	107 (12.3)*	37 (4.3)	594 (68.4)	131 (72.4)*	707 (81.4)
ES households other training on how to set up a business and run it (ME-SPM) (n=1,117)						
Yes	436 (89.3)	71 (14.6)	28 (5.7)	350 (71.7)	83 (83.8)	418 (85.7)*
No	542 (86.2)	79 (12.6)	24 (3.8)	431 (68.6)	107 (71.8)	506 (80.4)*
ES households that had regular income in the past 12 months (daily, weekly, monthly, quarterly, biannually) (n=1,117)						
Yes	820 (88.3)	127 (13.7)	46 (5.0)	664 (71.6)*	158 (77.8)	771 (83.0)
No regular income	158 (84.0)	23 (12.2)	6 (3.2)	117 (62.2)*	32 (71.1)	153 (81.4)
ES households involved in a small scale business or micro-enterprise (n=1,117)						
Yes	265 (87.7)	42 (13.9)	15 (5.0)	211 (69.9)	48 (73.8)	252 (83.4)
No	713 (87.5)	108 (13.3)	37 (4.5)	570 (70.0)	142 (77.6)	672 (82.5)
ES households expanded or diversified small scale business over the past one year (n=302)						
Yes	152 (87.4)	28 (16.1)	10 (5.7)	127 (73.0)	32 (78.0)	145 (83.3)
No	113 (88.3)	14 (10.9)	5 (3.9)	84 (65.6)	16 (66.7)	107 (83.6)
Compared to last year, how do ES households feel about their financial security (n=1,116)						
More secure	376 (93.3)***	65 (16.2)*	24 (6.0)	293 (72.9)	64 (81.0)	347 (86.1)*
No change/ Less secure	602 (84.3)***	85 (11.9)*	28 (3.9)	488 (68.3)	126 (74.6)	577 (80.8)*
<i>Chi-square test is significant at:</i> * $p < 0.05$; ** $p < 0.01$; *** $p < .001$						

Further analysis of data to observe the effect of ES on the health and educational outcomes of HVC revealed that the ES program was contributing to the improvement of the health conditions and educational attainment of the HVC. As shown in Tables 7 and 8 there is a statistically significant difference ($p < 0.05$) in the self-reported health status of HVC, episodes of diarrhea, testing for HIV both among HVC and caregivers between HVC households participating in the ES program and non-participants. A statistically significant difference was also observed in HVC's fever episodes, caregivers' treatment for last illness and the motivation to uptake voluntary counselling and treatment (VCT) by different packages of the ES program (Table 7).

It is also very interesting to observe statistically significant differences ($p < 0.05$) in HVC's school attendance and performance in school by the different components of the ES package (Table 8). Wellbeing of HVC if implemented properly and run effectively over long duration. The program tends to bring about positive changes in the wellbeing of household members (specifically educational and health outcomes) though much improvement is not observed in expanding the business but maintaining the acquired resources two years ago when the ES program was initiated. It should also be noted that ES is showing progress in business expansion over longer time as immediate needs such as acquiring basic household items such as sofa, TV, residential houses, etc. are competing with business expansion in the short run.

The qualitative findings also indicated that though not universal, HVC families in parts of Tigray and Oromia who had an improvement in their economic status had graduated from the support program.

“Our community had owned the program where they are able to differentiate HVC families whose economic status had improved and replaced them with newly identified HVC family.” (Tigray, KII, CC)

“We have achieved a lot in ES, most families are improving in their economic status. Those who are better off are replaced by new ones.” (Oromia, KII, CC)

Table 8: Economic strengthening effects on HVC educational outcomes at endline: 2017

	HVC Ever School Attendance; n (%)	HVC's Better School Performance; n (%)
Household engaged in the ES program (n=2,286)		
Yes	981 (90.6)	672 (71.0)
No	1021 (90.9)	696 (71.5)
ES household had training in CSSGs (n=1,116)		
Yes	791 (92.5)***	566 (74.0)***
No	190 (83.3)***	106 (58.6)***
ES households with access to financial technical services (n=1,117)		
Yes	223 (92.9)	165 (76.4)*
No	758 (89.9)	507 (69.5)*
ES households other training on how to set up a business and run it (ME-SPM) (n=1,117)		
Yes	442 (93.4)**	328 (76.5)***
No	539 (88.4)**	344 (66.5)***
ES households that had regular income in the past 12 months (daily, weekly, monthly, quarterly, biannually) (n=1,117)		
Yes	811 (90.2)	545 (69.6)*
No regular income	170 (92.4)	127 (77.9)*
ES households involved in a small scale business or micro-enterprise (n=1,117)		
Yes	289 (97.6)***	201 (71.5)
No	692 (87.9)***	471 (70.8)
ES households expanded or diversified small scale business over the past one year (n=302)		
Yes	163 (95.9)	126 (78.3)*
No	118 (94.0)	75 (62.5)*
Compared to last year, how do ES households feel about their financial security (n=1,116)		
More secure	348 (88.5)	257 (75.4)*
No change/less secure	633 (91.7)	415 (68.6)*
<i>Chi-square test is significant at:</i> * $p < 0.05$; ** $p < 0.01$; *** $p < .001$		

Evaluation Question 5

To what extent has Yekokeb Berhan enhanced the capacity of implementing partners to establish effective and efficient monitoring, evaluation, reporting and learning systems to inform program management?

Monitoring, Evaluation, Reporting and Learning (MERL)

This evaluation identified that data management and use is one of the strongest interventions of the YB Project. The project uses standardized tools to collect data on HVC at the household level. CVs collect data using the CSI tool, which has a total of 20 questions (seven were administered among the caregivers and 13 for HVC). The collected data is submitted and checked by the CC for its quality, and then submitted to implementing partners. The implementing partners then check the quality of the data both on desk and at a field level (by doing a random check at least on 10% of the data as reported by the informants at all level). The team has observed that MERL system has inbuilt checks for data completeness and consistency. The data are then encoded and analyzed by the YB data management person using the MERL system, and reports are sent to all stakeholders including local governments and other partners. The data management system is depicted in Annex 10.

Informants in this from both implementing partners and government partners reported that the YB Project provided capacity building trainings on data management and use for WCYA Bureaus at each level. However, government offices widely collect and use paper based data except in Addis Ababa and Amhara. Though, the government offices do not use an electronic data management system, they acknowledged that they are able to generate and use information about HVC by using the community structure laid by the YB Project.

“We have a strong structure stretched to the grassroots level which reaches each caregiver. This structure enabled us to get any information about each HVC such as health status, migration, if the HVC gets additional supports from multiple implementing partners and so on.” (Kalu Woreda, KII, BoWCA)

Some woreda-level WCA informants indicated that they have limited knowledge of data processing and analysis despite the fact that the data generated at household level is reliable and usable for decision making.

“The data generated by community volunteers is reliable, but we do not know how to organize and analyze data using computers. We do not have trained personnel and the necessary materials too.” (Dessie Woreda, KII, BoWCA)

Data management and use at regional bureaus is not different from that of the woreda bureaus. However, the regional BoWCA contribute a lot to data quality assurance using different methods such as training of CCs and CVs. They also indicated that they use the data for planning monitoring and evaluation but for directing policy, local data are less important compared to national ones.

“Data quality must be ensured when collected at a HH level, hence we give due emphasis on the training of community volunteers and CCs. Once the data is collected and processed by the implementing partners it can be used to prioritized care and support for HVC and their families.” (Bahir Dar, KII, BoWCA)

On the other hand, implementing partners benefited directly from the capacity building by YB and were able to use the MERL system data for decision making:

"We have MERL system which enables us to record, analyze and use the data...we have fixed time for reporting at each level where we report to the region and Pact national office quarterly.... This data management system had helped us to check the HIV status of HVC and link them to ART or testing services depending on their status." (Amhara, KII, ADA)

Unlike implementing partners, government offices indicated that, they compile data collected by community volunteers and reports sent from implementing partners and use it for planning and programming purposes but they do not have a fixed reporting period and share it as requested.

"We have paper-based data and reports/not soft copy, we share with our sub-city when they want it, there is no fixed time for reporting, it is based on request or when problems arise... for example when the sub-city wants to know the number of HVC, we just open our folder and provide the numbers including supporting pictures." (Kolfe Woreda, KII, BoWCA)

This evaluation indicated strong collaboration among partners in the monitoring and evaluation of the YB HVC Project implementation. In addition to the use of data, review meetings were conducted among CBOs, implementing partners and government structures to assess the progress, challenges and success of the project towards achieving improvement in the lives of HVC as noted in the YB Project periodic reports.

"There are review meetings periodically. We are working together and helping each other. We discuss issues in relation to HVC and their caregivers, before the implementation process, during implementation and whenever challenges occurred." (Hawassa, KII, BoWCA)

In addition to the YB Project MERL system, the Child Wellbeing Database was developed at the MoWCA level and piloted. However, as the system depend on data-entry and management at the woreda level, it needs a follow up with trained staff and provision of computers and accessories.

Conclusions

Objective 1: Build the capacity of implementing partners and regional/local government, including community care coalitions/community committees (CC/CCC), to identify, plan, coordinate, and respond to the needs of highly vulnerable children and their families

The role of implementing partners in cascading the capacity building trainings and technical support was observed to enhance the understanding and implementation of the YB initiatives. This has been demonstrated by the clear understanding of the objectives and implementation strategies of the YB Project by the government, CSOs and CBOs that are engaged in the implementation of the project. However, the OCA tool which has been used to measure the capacity of implementing partners has not shown the relative position of each implementing partner as some of the issues are prone to subjectivity and over estimation whilst undertaking self-assessment and ranking ones organizational capabilities. Hence, it is hardly possible to make comparison on the institutional capacities among the implementing partners.

Even though the YB Project has made unreserved efforts to build the capacity of local government and communities, the benefits obtained from the capacity building varies from place to place. The

attainments of the capacity intervention initiatives are often eroded by the frequent staff turnover at the lower government structures particularly at woredas and kebele levels. Due to frequent change of kebele administration officials as a result of reshuffling of local council members, the capacity at community level is also affected since local authorities constitute a given portion of the CC and CCC members.

Participation of the community particularly CVs and CC/CCC members, who are selected from the community, local administration and other stakeholders has helped YB to identify the target beneficiaries and subsequently deliver appropriate services. The community engagement in implementing the project at local level has created a sense of ownership, trust and belongingness which in turn would ensure sustainability of the YB initiatives. The fact that political and administrative officials are part of the CC/CCCs has also facilitated networking, coordination, and referral in the YB Project. The CC/CCCs had also played significant roles in identifying local donors and generating resources at community level that could possibly ensure the sustainability of the project beyond the funding period.

Objectives 2 and 3: Increase access and provide quality health and social services for HVC and their families and changes since 2012

The YB Project was successful in reaching the intended annual enrollment target of 325,000 HVC, an indication that it has been functioning as intended at the community level with effective targeting of HVC and their families. However, the high percentage of HVC enrolled with “other” vulnerability factors indicates the inclusion of “economic factors” as one of the program admission criteria. This may be related to discomfort to disclose the HIV status of the HVC by caregivers at the time of the interview as they may not have disclosed the HIV status to the HVC or they might not be comfortable to pass on the information at all. Adolescent HVC might not also be willing to disclose their HIV status rather just said they are in the program because of their poverty status.

The fact that the majority of HVC are living with one or both parents are encouraging, as they are likely to get a continuous parental supervision and support from the family and to benefit from the ES intervention.

Overall, the YB Project has achieved its intended objectives in improving the lives of HVC and their families through strengthening local structures and systems by its capacity building program. This capacity building intervention at all levels has enabled the rollout of a harmonized, coordinated and integrated HVC support program which also led to the ownership by the community as evidenced by local resource mobilization and coordination effort. As a result, the foundation laid by YB is amenable for replication at community level for implementation of programs targeting vulnerable groups in the community and elsewhere.

The endline evaluation found that the health status of HVC and their families had been improved progressively showing the effectiveness of health and health related intervention of the program. Enrollment into ART and regular follow up were higher among girls compared to boys. This could

be due to the fact that female HVC are getting attention because of additional vulnerability factors or that boys are likely to run away from families and ending up on the street due to lack of strong psychosocial support. Future programming should address these issues to narrow the gap.

The overall HIV positivity rate in HVC is very high compared to the prevalence of HIV in children in the general population (on average 3% in HVC and less than 1% nationally) indicating that the YB Project has assisted the right group for intensified intervention and prevention of the pandemic in the future. The reported adherence to follow up by HIV positive caregivers is very good and this could be due to the close and strong support that caregivers obtain from the program, such as home visit by CVs. Interventions in the area of psychosocial support are considered by the caregivers as beneficial and have suggested the program to be more robust.

Educational interventions have been a key input for HVC in the YB program. The progressively increasing school enrollment rate, provision of tutorial services to a large number of HVC, higher rate of regular attendance, higher school performance and lower rate of class repetition by HVC and coverage of school expenses as a result of effective linkage to school services are evidence of the success of YB in this endeavor. However, irregularity of support related to stationeries, books and school uniforms has introduced dissatisfaction among beneficiaries despite the intention by some implementing partners to reduce sense of dependency of caregivers by introducing cost sharing/partial coverage of school expenses in provision of school materials. However, the study has revealed that the intention of cost sharing or partial coverage of school expenses was not clearly communicated to the beneficiaries.

Though food and nutrition services are not directly implemented by the YB Program, it is one of the most mentioned positive interventions by the project. There was no child with severe acute malnutrition in this endline survey implying that the ES activities and referrals mechanisms are fruitful in their endeavors.

A quarter of HVC have obtained birth certificate and this is much higher than the earlier findings showing a progressive improvement from the baseline which was 1 in 20. All forms of violence have shown a modest decline. Although physical violence has shown a significant decline, verbal abuse has gone up probably due to factors related to stigma associated with the program enrollment. Linkage to legal services has not shown significant improvement from the earlier findings and the proportion of households who report that they feel more secure in terms of legal protection has declined. This may be related to less follow up by the CVs and CC/CCC.

Objective 4: Economic strengthening activities and health and educational outcomes

ES interventions were widely accepted and appreciated throughout. More HVC households have reported engagement in ES activities, even though the proportion of household engaged in small scale business and microenterprises has not shown improvement. Contrary to expectation among those who are engaged in small scale businesses, the proportion of those who were able to expand or diversify their business is low. This could be related to the provision of small amount of seed money to attract the attention of beneficiaries and the effect of inflation in running business

smoothly. Even though ES program got more focus in the past two years, the analysis of its effect on health and education variables shows that the ES interventions are positively linked with certain health and education outcomes despite the shorter duration.

Objective 5: Establish effective and efficient monitoring, evaluation, reporting and learning systems

Establishment of the MERL system was found as one of the strongest activities in the YB Project. Particularly in building the capacity of implementing partners, by secondment of MERL staff, to collect collate and analyze data related to HVC for local decision making and experience sharing by publishing e-books. It is also found that the community was using the CSI tool for decision making. However, the government partners were not able to catch up with the training and reporting system as intended due to staff turnover, lack of equipment and commitment.

Recommendations

Capacity building

Although the YB Project capacity building intervention was worthwhile in bringing change in the lives of HVC, there were certain pitfalls which should be considered for further improvement. As recommended below:

- Institutionalize and own training activities at the local government level to address eroded capacity gaps due to staff turnover and relocation.
- Strengthen the community structure, upgrade CC to CCC, to ensure sustainability of the already started positive achievements and shall be replicated in non-YB project areas.
- Strengthen community engagement for local resource mobilization and ensure sustainability.
- Communicate the change in HVC lives to local donors in order to keep their commitment and avoid fatigue.
- The collaboration between the government, implementing partners, community structures and the private sector is a best practice that should be instituted and strengthened further.
- Strengthen resource mapping and referrals for health and social services as they are having a positive impact on the health of HVC and the caregivers.

Access to health and other social services

The main focus area of YB Project was to increase access and provide quality health and social services for HVC and their families. In this regard the YB Project has registered positive results. However, items that need more focus and further work include:

- Understanding that the program is intended to halt the transmission of HIV by supporting HIV-affected families, the fact that it enrolled poor families is commendable as it is a means of reducing further vulnerability and decreasing HIV spread. Therefore, program inclusion criteria should be further expanded to include other child vulnerability criteria.

- Intervention towards timely disclosure of HIV status to adolescent shall be introduced to control HIV transmission by uninformed adolescents and ensure that HIV positive HVC are linked to ART treatment at all times.
- Health workers should be trained on companionate and respectful care in order to increase care seeking among HVC.
- With regard to educational support, supplies to school children shall consider their actual needs in terms of type and quantity.
- Legal and psychosocial services were the weakest links in the program and therefore need more emphasis.
- Program implementers should pay due attention to the needs of HVC and have closer communication about program packages and expectations.

Economic Strengthening

ES is one of the strongest interventions in the YB project which has changed the lives of HVC positively. Areas of improvement are as follow:

- Encourage graduation of HVC families when they are in a better situation to lead their life independently possibly after linking with microfinance institutions.
- ES interventions shall be revised according to the current market need, demand and supply for example amount of seed money, training type, organizing modality (to work on private or in groups).

Monitoring, Evaluation, Reporting and Learning

Though the MERL intervention has introduced an encouraging start, a lot needs to be done to sustain the data management system in the government structure.

- Recently incorporated YB interventions at the Federal level—child wellbeing data management system should be supported to be used nationally to enhance evidence-based policy making.
- Local data management system capacity should be part and parcel of the HVC support program at government facility level.
- Regular follow-up and training to local government implementers should be provided to offset staff turnover.
- Periodic dissemination of findings at a higher level should be encouraged to influence evidence-based policy making.

Lessons Learned

The capacity building and systems approach has enabled the rollout of a harmonized, coordinated, and standardized and evidence-based interventions across the country. Capacity building interventions at the community level has created strong awareness of issues facing HVC and has made them to be part of the solution. Another key lesson learnt is the strong engagement of the community at each step of the implementation of the program mobilizing them to identify as well as generate local resources and link those in need of these services through a referral system. In

addition the program has facilitated the creation of sense of protection of the vulnerable segment of the community expressed in terms of help-seeking from legal bodies as it occurs is encouraging.

Annexes

Annex 1: Summary of qualitative study targets by level and technique

Tool	Target	Level	Remark	Number of informants
KII 1	Pact	Federal		1
	Child Fund	Federal		ND
	FHI 360	Federal		1
	Pact, Child Fund and FHI 360 coordinating office	Regional (5)	Found in Hawassa and Bahir Dar	6
KII 2	HAPCO	Federal		1
	MoWCA	Federal		1
	BoWCA	Regional (5)	1 per region	5
	BoWCA	Woreda (29)	1 per woreda	29
KII 3	Implementing partners (see list below)	Regional (or lower as appropriate)	18 implementing partners in the survey area	15
FGD 1	HVC caregivers	Community (5)	1 per region	40
FGD 2	CCs	Community (5)	1 per region	40
	CVs	Community (5)	1 per region	40
	Saving groups	Community (5)	1 per region	40
FGD 3	HVC Male	Beneficiary (5)	1 per region	80
	HVC Female	Beneficiary (5)	1 per region	
Total				312

* Addis Ababa is not currently divided into kebeles.

** For woredas having less than 3 CCs, an additional woreda from the same zone was selected randomly to achieve the targeted number CCs in that particular woredas.

Annex 2: List of implementing partners

S. NO	Full name of implementing partner	Short name	Sampled for data collection	Area of operation	Remark
1	Amara Development Association	ADA	X	Amhara Region	
2	Association for National Planned Program for Vulnerable Children and In Need	ANPPCAN	X	Amhara Region	
3	Arada	Arada			
4	Bezalehiwot Ethiopia Association	BLEA	X	Addis Ababa	
5	Child Development and Transformation	CHADET			
6	Developing Families Together	DFT			
7	Dugda Child & Family Development Association	Dugda	X	Oromiya Region	
8	Emanuel Development Association	EDA	X	Amhara Region	
9	Ethiopia Kale Hiwot Churc	EKHC	X	SNNPR	
10	Ethiopia Orthodox Church	EOC			
11	Fayya Integrated Development Organization	FIDO	X	Oromiya Region	No information for OCA
12	Handicap Ethiopia	Handicap			No baseline data for OCA
13	Hiwot Integrated Development Association	HIDA	X	Addis Ababa	
14	HUNDEE	HUNDEE			No baseline data for OCA
15	Integrated Service for Health and Development Organization	ISHDO/ISAPS O	X	Addis Ababa	
16	Jimma Idir Union	JIU			OCA No information
17	Love of Children/Kore	LoC	X	Addis Ababa	
18	Maedot	Maedot	X	Addis Ababa	
19	Mary Joy Development Association	MJDA	X	SNNPR	
20	Mahiberhiwot Social Development Association	MSD	X	Amhara Region	
21	Migbare Senay Child and Family Support Organization	MSCFSO			
22	Nekemte Community Based Charitable Association	NCBCA			
23	Orom Development Association	ODA	X	Oromiya Region	
24	Professional Alliance for Development in Ethiopia	PADET			
25	Progynist	PROGYNIST	X	Addis Ababa	
26	Propride	Propride			No baseline data for OCA
27	RATSON	RATSON			
28	Relief Society of Tigray	REST	X	Tigray Region	

S. NO	Full name of implementing partner	Short name	Sampled for data collection	Area of operation	Remark
29	Sheger Child & Family Development Association	Sheger	X	Addis Ababa	
30	Save Your Holy Land Association	SYHLA			
31	Tesfa Social Development Association	TSDA			
32	Wabe Children Aid and Training	WCAT			

Annex 3: Organizational capacity assessment results of implementing partners

Category and Component		ADA	ANPCAN	BLECA	Dugda	EDA	EKHC	HIDO	ISHDO	LoC	Maedot	MSD	MJDA	Progynist	REST	Shegere	
Over All Capacity	Current	5.80	5.09	4.02	4.9	5.74	5.43	5.26	5.33	5.61	5.29	5.44	5.60	5.03	5.40	5.85	5.32
	Baseline	3.34	5.04	4.45	4.4	4.65	3.96			4.03	4.92	3.62	4.03	4.50		3.60	3.37
	Change	2.46	0.05	-0.43	0.50	1.09	1.47	5.26	5.33	1.58	0.37	1.82	1.57	0.53	5.40	2.25	1.95
Governance and Leadership																	-
	Current	5.90	5.5	5.36	5.7	5.64	5.36	5.43	5.29	5.86	5.57	5.71	5.86	5.71	6.00	5.86	5.65
	Baseline	3.57	5.75	3.85	5.4	5.28	3.85			5.00	5.00	3.71	5.00	5.14		4.00	3.70
	Change	2.33	-0.25	1.51	0.30	0.36	1.51	5.43	5.29	0.86	0.57	2.00	0.86	0.57	6.00	1.86	1.95
HR and Staff Development																	-
	Current	5.86	4.57	4.07	4.90	5.43	5.79	4.64	5.36	5.50	5.29	5.36	5.50	5.40	6.00	5.79	5.30
	Baseline	3.00	4.75	4.36	4.50	4.29	4.43			4.43	5.14	3.43	4.43	4.86		3.90	3.43
	Change	2.86	(0.18)	(0.29)	0.40	1.14	1.36	4.64	5.36	1.07	0.15	1.93	1.07	0.54	6.00	1.89	1.86
Program Development																	-
	Current	5.77	5.19	4.23	5.00	5.87	5.31	5.32	5.40	5.84	5.54	5.51	5.82	5.05	5.20	5.91	5.40
	Baseline	2.87	4.73	4.44	4.60	4.50	3.56			4.09	5.00	3.67	4.09	4.73		3.70	3.33
	Change	2.90	0.46	(0.21)	0.40	1.37	1.75	5.32	5.40	1.75	0.54	1.84	1.73	0.32	5.20	2.21	2.07
Networking and Collaboration																	-
	Current	6.00	5.39	4.06	4.60	5.89	5.33	5.44	5.22	5.50	5.78	5.28	5.50	4.89	5.00	5.94	5.32
	Baseline	3.56	5.65	4.67	3.80	4.89	5.06			3.33	4.89	3.67	3.33	4.00		3.00	3.32
	Change	2.44	(0.26)	(0.61)	0.80	1.00	0.27	5.44	5.22	2.17	0.89	1.61	2.17	0.89	5.00	2.94	2.00
Sustainability																	-
	Current	6.00	4.82	3.59	4.50	5.87	5.34	5.46	5.40	5.33	4.32	5.34	5.33	4.05	5.00	5.76	5.07
	Baseline	3.80	4.30	3.92	3.70	4.32	2.89			3.33	4.46	3.61	3.33	3.77		2.90	2.96
	Change	2.20	0.52	(0.33)	0.80	1.55	2.45	5.46	5.40	2.00	(0.14)	1.73	2.00	0.28	5.00	2.86	2.12

Organizational Capacity Assessment Result for implementing partners who have Baseline Data

Category and Component		ADA	ANPCAN	BLEA	Dugda	EDA	EKHC	LoC	Maedot	MSD	MJDA	Progynist	Shegere	Average
Over All Capacity	Current	5.80	5.09	4.02	4.9	5.74	5.43	5.61	5.29	5.44	5.55	5.03	5.85	5.31
	Baseline	3.34	5.04	4.45	4.4	4.65	3.96	4.03	4.92	3.62	4.14	4.50	3.60	4.22
	Change	2.46	0.05	-0.43	0.50	1.09	1.47	1.58	0.37	1.82	1.41	0.53	2.25	1.09
Governance and Leadership														-
	Current	5.90	5.5	5.36	5.7	5.64	5.36	5.86	5.57	5.71	5.82	5.71	5.86	5.67
	Baseline	3.57	5.75	3.85	5.4	5.28	3.85	5.00	5.00	3.71	4.00	5.14	4.00	4.55
	Change	2.33	-0.25	1.51	0.30	0.36	1.51	0.86	0.57	2.00	1.82	0.57	1.86	1.12
HR and Staff Development														-
	Current	5.86	4.57	4.07	4.90	5.43	5.79	5.50	5.29	5.36	5.32	5.40	5.79	5.27
	Baseline	3.00	4.75	4.36	4.50	4.29	4.43	4.43	5.14	3.43	3.14	4.86	3.90	4.19
	Change	2.86	(0.18)	(0.29)	0.40	1.14	1.36	1.07	0.15	1.93	2.18	0.54	1.89	1.09
Program Development														-
	Current	5.77	5.19	4.23	5.00	5.87	5.31	5.84	5.54	5.51	5.76	5.05	5.91	5.42
	Baseline	2.87	4.73	4.44	4.60	4.50	3.56	4.09	5.00	3.67	4.11	4.73	3.70	4.17
	Change	2.90	0.46	(0.21)	0.40	1.37	1.75	1.75	0.54	1.84	1.65	0.32	2.21	1.25
Networking and Collaboration														-
	Current	6.00	5.39	4.06	4.60	5.89	5.33	5.50	5.78	5.28	5.50	4.89	5.94	5.35
	Baseline	3.56	5.65	4.67	3.80	4.89	5.06	3.33	4.89	3.67	5.00	4.00	3.00	4.29
	Change	2.44	(0.26)	(0.61)	0.80	1.00	0.27	2.17	0.89	1.61	0.50	0.89	2.94	1.05
Sustainability														-
	Current	6.00	4.82	3.59	4.50	5.87	5.34	5.33	4.32	5.34	5.33	4.05	5.76	5.02
	Baseline	3.80	4.30	3.92	3.70	4.32	2.89	3.33	4.46	3.61	4.45	3.77	2.90	3.79
	Change	2.20	0.52	(0.33)	0.80	1.55	2.45	2.00	(0.14)	1.73	0.88	0.28	2.86	1.23

Annex 4: Resource mapping summary matrix

Services Area	Local GO	NGO/CSO	Community/Idir. CC
Shelter and Care	- Provision of affordable housing (66%) - Facilitation of home inheritance (79%) - Shelter Maintenance	- Support shelter construction (62%) - Support rehabilitation of existing home of HVC (93%) - Provision of home utensils (66%)	- Maintain HVC/Caregivers house (76%) - Contribute Material and cash for clothing (86%) - Give shelter to HVC (21%)
Economic Strengthening	- Avail revolving fund and working places (72%) - Business Development Training (76%) - Create employment and linkage (79%)	- Organizing HVC and caregivers/SAC, Self -help groups (93%) - Business Development Skill Training (100%) - Provide technical support to organized saving and credit groups (100%)	- Save matching fund (41%) - Participate in micro enterprise (66%)
Legal Support/Reduce Vulnerability	- Child friendly policing (97%) - Special court for HVC (48%) - Exemption from inheritance fees (90%)	- Awareness Creation Material Development (100%) - Legal Counseling (69%) - Training of Paralegal professional (52%)	- Reporting of cases (Abuse, neglect, exploitation, etc) (97%) - Assign caregivers (76%) - Linkage with stakeholders (with CSO and GO structures) (100%)
Health	- Health Facilities (100%) - Free medical services (100%) - Health Extension Workers and other health professionals (100%)	- Training of Health Extension workers and older HVC (90%) - Provide technical and Health education to the community (93%) - Health Education to the community (93%)	- Linkage with stakeholders for deworming (76%) - Monitor health situation of HVC (93%) - Adherence follow-up (93%)
Psycho Social Support	- Organize recreational tours for OVC (17%) - Guidance ((73%)	- Religious Institutions engaged in emotional support (90%) - Training par-councilors (79%) - Organize home visit (100%)	- Participate in experience sharing tours (41%) - Identify emotional needs of HVC (90%) - Create linkage for guidance and counseling (97%)
Education	- Enhance education facilities/Free education (93%) - Avail education materials (76%) - Referral equation support for graduating HVC (62%)	- Support school supplies (97%) - Tutorial class supports (86%) - Pay school fee in private school (38%)	- Provide school supplies (66%) - Avail safe study areas (41%) - After school and homework assistance (38%)

Services Area	Local GO	NGO/CSO	Community/Idir. CC
Food and Nutrition	Organize resources from different stakeholders (83%)	- Provide school feeding support (55%) - Provide food support (76%) - Training of home gardening and food portioning/ supplementary feeding (100%)	- Cash/Material Contribution Grain, / (66%) - Participate in gardening (72) - Food support for school feeding (21%)

Annex 5: Psychosocial indicators at midterm and endline: 2014 and 2017

	Midterm; n (%)	Endline; n (%)
Adult member of the household who ever received information or skills on Better Parenting (how to better care for children)?	1117 (52.2)	1242 (54.2)
Someone from the household who get help solving a problem	1125 (52.6)	738 (32.2)
Sources of social support	(n=1125)	(n=738)
Family members	647 (57.5)	295 (40.0)
Friends	80 (7.1)	38 (5.1)
Neighbours	165 (14.7)	58 (7.9)
Staff of implementing partner	50 (4.4)	127 (17.2)
CV	144 (12.8)	188 (25.5)
CC	13 (1.2)	10 (1.4)
Other (specify)	16 (1.4)	22 (3.0)
No response	10 (0.9)	0 (0.0)
Someone in the household who received counselling, advice-giving or emotional support	64.1	1282 (56.0)
Among children < 14, who have been noticed for having sudden changes in mood or behaviour	98 (5.8)	130 (7.8)
Among HVC aged 14+, who receive life skills training in the two years preceding the survey		(n=617)
Yes, I received	125 (27.7)	177 (28.7)
Yes, somebody received	38 (8.4)	14 (2.3)
No	288 (63.9)	426 (69.0)

Annex 6: HVC educational indicators at endline: 2017

Total (n)	5-9		10-13		14-17		Total		
	M	F	M	F	M	F	M	F	Total
	355	358	428	450	292	323	1075	1131	2206
Children currently attending school or pre-school (n= 2206)									
Yes	305 (85.9)	318 (88.8)	386 (90.2)	387 (86.0)	287 (98.3)	319 (98.8)	978 (91.0)	1024 (90.5)	2002 (90.8)
No	50 (14.1)	40 (11.2)	42 (9.8)	63 (14.0)	5 (1.7)	4 (1.2)	97 (9.0)	107 (9.5)	204 (9.2)
Children who have someone who could help with school work when needed (n= 1924)									
Yes, often	117 (39.3)	142 (44.9)	155 (40.9)	166 (44.4)	92 (35.9)	111 (36.9)	364 (39.0)	419 (42.3)	783 (40.7)
Sometimes	69 (23.2)	77 (24.4)	79 (20.8)	78 (20.9)	81 (31.6)	91 (30.2)	229 (24.5)	246 (24.8)	475 (24.7)
Never	112 (37.6)	97 (30.7)	145 (38.3)	130 (34.8)	83(30.5)	99 (31.9)	340 (36.5)	326 (32.9)	666 (34.6)
Children ever participated in a tutorial activities organized by the Yekokeb Berhan Program or in the community (n= 1924)									
Yes	37 (12.4)	45 (14.2)	92 (24.3)	84 (22.5)	73 (28.5)	101 (33.6)	202 (21.7)	230 (23.2)	432 (22.5)
No	261 (87.6)	271 (85.8)	287 (75.7)	290 (77.5)	183 (71.5)	200 (66.4)	731 (78.3)	761 (76.8)	1492 (77.5)
Children promoted to next grade/level in the previous academic year (n=1924)									
Yes	273 (91.6)	295 (93.4)	359 (94.7)	361 (96.5)	244 (95.3)	288 (95.7)	876 (93.9)	944 (95.3)	1820 (94.6)
No, he/she repeated	21 (7.0)	19 (6.0)	20 (5.3)	12 (3.2)	12 (4.7)	13 (4.3)	53 (5.7)	44 (4.4)	97 (5.0)
No response	4 (1.3)	2 (0.6)	0 (0.0)	1 (0.3)	0 (0.0)	0 (0.0)	4 (0.4)	3 (0.3)	7 (0.4)

Annex 7: Food and nutrition indicators at midterm and endline: 2014 and 2017

A family member received nutrition related training, counselling or advice in the last one year	Midterm	Endline
	(n=2138)	(n=2290)
Yes	771 (36.1)	918 (40.1)
No	1344 (62.9)	1372 (59.9)
Don't know	5 (0.2)	0 (0.0)
No response	18 (0.8)	0 (0.0)
Household experienced shortage of food in the past 12 months	(n=2138)	(n=2290)
Yes	1239 (58)	941 (41.1)
No	897 (42)	1349 (58.9)
No response	2 (0.1)	0 (0.0)
Number of days a household did not have enough food to eat in the past month?	(n=1238)	(n=941)
No enough food all days	109 (8.8)	60 (6.4)
1-2 days	375 (30.3)	389 (41.3)
3-4 days	261 (21.1)	253 (26.9)
5-6 days	177 (14.3)	80 (8.5)
7 days or more	313 (24.3)	158 (16.8)
No response	0 (0.0)	1 (0.1)
How long food would reserves/stores of the household last?	(n=2138)	(n=2290)
No food store at all	886 (41.4)	699 (30.5)
Less than 1 week	446 (20.9)	534 (23.3)
1-4 weeks	611 (28.6)	757 (33.1)
1-2 months	125 (5.8)	262 (11.4)
3-6 months	31 (1.4)	32 (1.4)
More than 6 months	30 (1.4)	6 (0.3)
No response	9 (0.4)	0 (0.0)
A child was prescribed food by health workers/ nutrition workers over the past one year	(n=2138)	(n=2290)
Yes	166 (7.8)	145 (6.3)
No	1965 (91.9)	2144 (93.6)
No response	7 (0.3)	1 (0.0)
Child received the prescribed food	(n=166)	(n=145)
Yes	129 (77.7)	105 (72.4)
No	33 (19.9)	40 (27.6)
No response	4 (2.4)	0 (0.0)
Nutritional status of children 0-4 years (MUAC)	(n=695)	(n=139)
No malnutrition	666 (95.8)	133 (95.7)
Moderate malnutrition	21 (3.0)	6 (4.3)
Severe malnutrition	8 (1.2)	0 (0.0)

Annex 8: Legal protection indicators at midterm and endline: 2014 and 2017

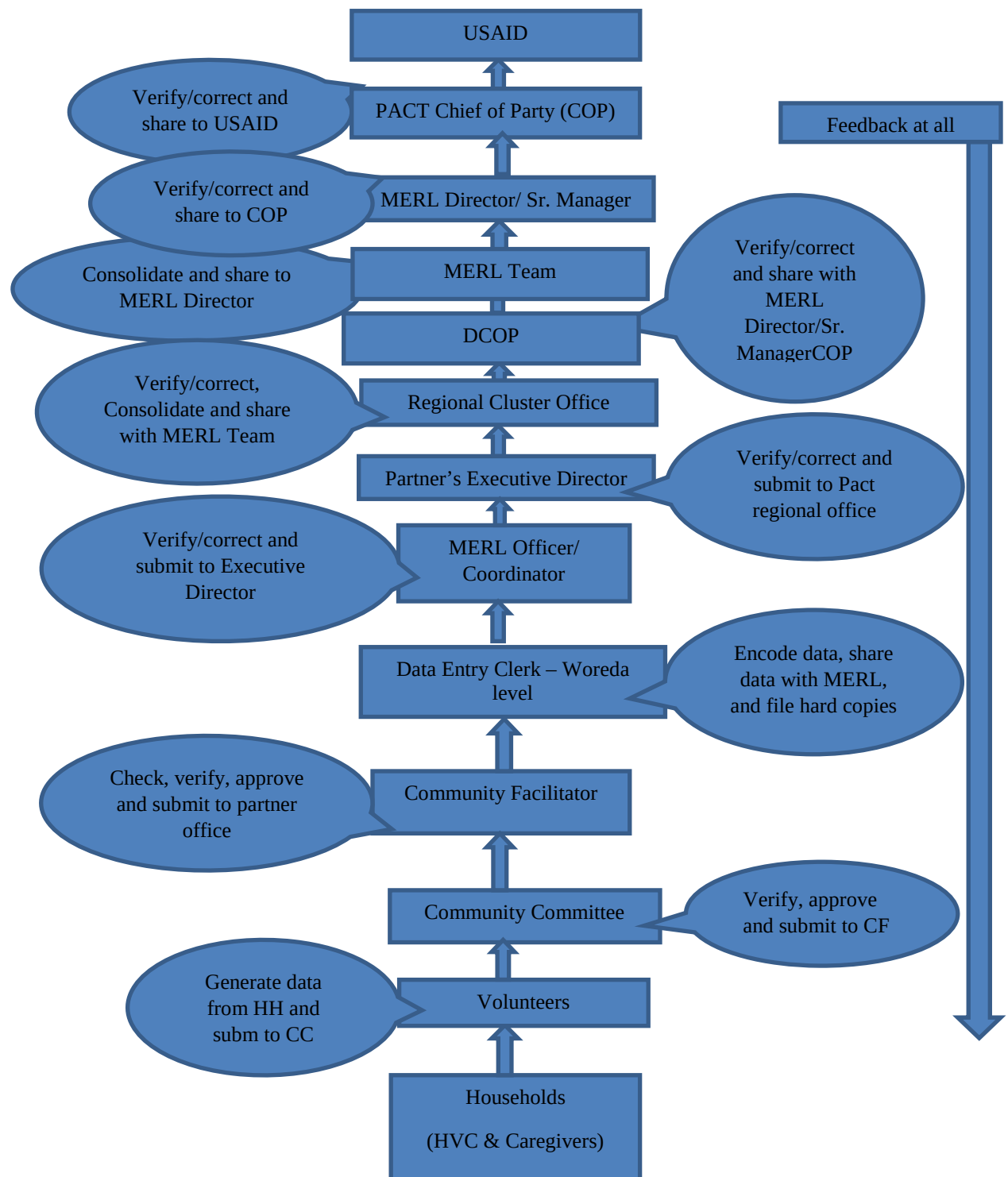
Indicators	Midterm	Endline
	N (%)	N (%)
HVC has birth certificate issued from authorized government office (seen and confirmed)	185 (8.7)	604 (26.4)
Over the past 12 months, any member of your household experienced any violence	147 (6.9)	104 (4.5)
Type of violence experienced	(n=147)	(n=104)
Physical violence	60 (40.8)	29 (27.9)
Verbal abuses	68 (46.3)	60 (57.7)
Sexual violence	6 (4.1)	10 (9.6)
Other	13 (8.8)	3 (2.9)
No response		2 (1.9)
Action taken after the violence occurred	(n=147)	(n= 104)
Went to police/sought legal services	92 (62.6)	49 (47.1)
Went to health center/clinic	21 (14.3)	14 (13.5)
Went to Kebele/ women & children affairs	25 (17.0)	18 (17.3)
Told a relative or neighbor	14 (9.5)	19 (18.3)
Did nothing	45 (30.6)	36 (34.6)
Other	1 (0.7)	2 (1.9)
No response	7 (4.8)	0 (0.0)
Who mostly perpetrated the violence?	(n=147)	(n=104)
Spouse	18 (12.2)	20 (19.2)
Neighbor	70 (47.6)	53 (51.0)
Older child	11 (7.5)	11 (10.6)
Unknown people	26 (17.7)	11 (10.6)
Other	13 (8.8)	9 (8.7)
No response	9 (6.1)	0 (0.0)
Households referred or linked to any legal services over the past 1 year	176 (8.2)	120 (5.2)
Who referred or linked you to legal services he/she needed?	(n=176)	(n=120)
Yekokeb Berhan implementing partner	46 (26.1)	46 (38.3)
CCs	26 (14.8)	14 (11.7)
CVs	22 (12.5)	20 (16.7)
Kebele administration	47 (26.7)	38 (31.7)
Other	24 (13.6)	2 (1.7)
No response	11 (6.3)	0 (0.0)
Household that feel more secure in terms of legal protection this time than before you were involved in Yekokeb Berhan program	1105 (51.7)	878 (38.3)

Annex 9: Economic strengthening indicators at midterm and endline: 2014 and 2017

	Midterm	Endline
Household engaged in economic strengthening (ES) program	(n=2138)	(n=2290)
Yes	819 (38.3)	1117 (48.8)
No	1315 (61.5)	1171 (51.1)
No response	4 (0.2)	2 (0.1)
ES household had training in Community Saving and Self-help Groups (CSSG)	(n=819)	(n=1117)
Yes	493 (60.2)	880 (78.8)
No	316 (38.6)	237 (21.2)
No response	10 (1.2)	0 (0.0)
ES households other training on how to set up a business and run it (ME-SPM)	(n=819)	(n=1117)
Yes	267 (32.6)	488 (43.7)
No	533 (65.1)	629 (56.3)
No response	19 (2.3)	0 (0.0)
ES households that had regular income in the past 12 months (daily, weekly, monthly, quarterly, biannually)	(n=819)	(n=1117)
Yes	593 (72.4)	929 (83.2)
No regular income	221 (27.0)	182 (16.3)
No response	5 (0.6)	6 (0.5)
ES households involved in a small scale business or micro-enterprise (n=819)	(n=819)	(n=1117)
Yes	204 (24.9)	302 (27.0)
No	608 (74.2)	815 (73.0)
No response	7 (0.9)	0 (0.0)
ES households expanded or diversified small scale business over the past one year	(n=204)	(n=302)
Yes	100 (49.0)	174 (57.6)
No	91 (44.6)	128 (42.4)
No response	13 (6.4)	0 (0.0)
Productive assets of the household engaged in ES compared to a year ago (n=819)	(n=819)	(n=1117)
Acquired additional productive assets than a year ago	106 (12.9)	98 (8.8)
Same as a year ago	142 (17.3)	859 (76.9)
Less than a year ago	570 (69.6)	159 (14.2)
No response	1 (0.1)	1 (0.1)
Compared to last year, how do households feel about their financial security (n=2138)	(n=2138)	(n=2290)
More secure	586 (27.4)	627 (27.4)
Less secure	587 (27.5)	730 (31.9)
No change from last year	965 (45.1)	928 (40.5)
No response	0 (0.0)	5 (0.2)

Annex 10: Data generation and reporting procedure for the Yekokeb Berhan project

Source: Data generated from different participants in assessment, April 2017



Annex 11: HVC Household Survey Questionnaire

YEKOKEB BERHAN PROGRAM FOR HIGHLY VULNERABLE CHILDREN

END-LINE EVALUATION – MARCH 2017, ETHIOPIA

QUANTITATIVE QUESTIONNAIRE

PART 1: SURVEY QUESTIONS FOR CAREGIVERS OF HVC

SECTION 0: IDENTIFICATION DATA

Q01 QUESTIONNAIRE IDENTIFICATION NUMBER |_____|_____|_____|

Q02 Region_____

Q03 Zone/Sub-City_____

Q04 Woreda_____ **Q05** Town_____ **Q06** CC_____

Q07 House Number_____

Q08a Latitude_____ **Q08b** Longitude_____ **Q08c** Altitude_____

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	Never Married Currently Married Divorced Widowed Live with partner/cohabit No Response (Do not Want to Answer)	1 2 3 4 5 98	
Q104	Have you ever attended formal school?	Yes No No Response	1 2 98	→Q106
Q105	What is the highest level of education you have completed? (CIRCLE ONE)	First Cycle Primary (grade 1-4) Second Cycle Primary (grade 5-8) Secondary (grade 9-10) Preparatory (11-12) 10+TVET College/university No Response (Do not Want to Answer)	1 2 3 4 5 6 98	
Q106	What is your <u>MAIN</u> occupation?	Farming Daily Laborer Government employee NGO employee Trading/business Student Housewife Other (Specify) _____ No work No Response (Do not Want to Answer)	1 2 3 4 5 6 7 8 9 98	
Q107	Have you been engaged in paid work (where you earned any amount of money) in the last 3 months?	Yes No No Response (Do not Want to Answer)	1 2 98	
Q108	Including yourself, how many people live in this household as usual resident?	Total Male Female No Response (Do not Want to Answer)	_____ _____ _____ 98	
Q109	How many persons under the age of 18 live in this household as usual resident?	Total Number of boys Number of girls No Response (Do not Want to Answer)	_____ _____ _____ 98	

	Names of all the children younger than 18 years of age who usually live in your household <i>[Usual resident is someone who has an intention of living in the household forever/longer period of time or who have lived in the household for at least six months even though he/she has an intention to leave]</i>	Age	Sex 1 = Male 2 = Female	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) 98 = No response.	For all children age 6-59 months, take MUAC in MM (if age <6 months and >59 months skip to Q109.10)	If age is less than 5 years, write the age of a child in months	Classify the nutritional status of each child 1= no malnutrition 2 = moderate malnutrition 3 = severe malnutrition	Eligibility for Interview Is the child under 18 years supported by the YB Project? 1. Yes 2. No
	Q109.1	Q109. 2	Q109.3	Q109.4	Q109.5	Q109.6	Q109.10	
1								
2								
3								

Q110	Do you know about the Yekokeb Berhan project that is supported by USAID/Ethiopia and implemented by _____(implementing partner) in your area?	Yes No No response (Do not Want to Answer)	1 2 98	
Q111	How many children under 18 in this household are enrolled in the Yekokeb Berhan project that is implemented by _____ (implementing partner) in your area?	None _____ Boys _____ Girls _____ Total _____ No Response (Do not Want to Answer)	1 2 3 4 99	→Q116
Q112	When did the Child/ren start participating in the HVC care and support program of Yekokeb Berhan? <i>[If there are more than one child getting support, collect the information for the first enrolled child]</i>	Since five years ago Since four years ago Since three years ago Since two years ago Since one years ago Other (specify) _____ No Response (Do not Want to Answer)	1 2 3 4 5 6 98	

Q113	Who first identified the Child/ren to possibly become involved in the Yekokeb Berhan care and support program? <i>[If there are more than one child getting support, collect the information for the first enrolled child]</i>	A Community Committee Community Volunteers Kebele Administration ____(implementing partner) staff Other (specify) _____ Don't know who they were No Response (Do not Want to Answer)	1 2 3 4 5 88 98	
Q114	Who finally selected the Child/ren to be involved in the Yekokeb Berhan care and support program? <i>[If there are more than one child getting support, collect the information for the first enrolled child]</i>	A Community Committee Community Volunteers Kebele Administration ____(implementing partner) staff Other (specify) _____ Don't know who they were No Response (Do not Want to Answer)	1 2 3 4 5 88 98	
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? <i>[If there are more than one child getting support, collect the information for the first enrolled child]</i>	Yes No Don't know No Response (Do not Want to Answer)	1 2 88 98	
Q116	Do you (the caregiver) have any disability (i.e. difficulties in seeing, hearing, speaking, movement etc.)?	Yes No No Response (Do not Want to Answer)	1 2 98	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 Difficulties of speaking Difficulties of movement Mental retardation Other (specify) _____ No Response (Do not Want to Answer)	1 2 3 4 5 6 98	
Q119	Are you receiving any kind of assistive device or other support for you disability?	Yes No I don't know No Response (Do not Want to Answer)	1 2 88 98	Q201 Q201 Q201

Q120	What kind of assistive device or support/services are you receiving from the Yokokeb Berhan program? (Multiple responses are possible)	None Prosthesis(artificial leg or arm) Eye glasses Hearing aid Crutches Wheelchair Medical care Home-based care Financial support Others (specify) _____ No Response (Do not Want to Answer)	0 1 2 3 4 5 6 7 8 9 98	
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 (Do not Want to Answer)	1 2 3 4 5 98	
Q202	In the last 2 weeks, have you been too ill to participate in daily activities?	Yes No No Response (Do not Want to Answer)	1 2 98	Q206 Q206
Q203	Did you get treatment from a health provider for this illness?	Yes No No Response (Do not Want to Answer)	1 2 98	Q205 Q205
Q204	Where did you seek health care for your illnesses? <i>(if there is more than one response, please write only one response they consider most common)</i>	Government health facility Private hospital/clinic Pharmacy Traditional healer Other (specify) _____ No Response (Do not Want to Answer)	1 2 3 4 5 98	} Q206
Q205	For your last illness if you did not seek care, what was your 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 (Do not Want to Answer)	1 2 3 4 5 6 7 98	
Q206	In your opinion, do you think that any of your household members has not got adequate health care during illness in the past year?	Yes No No Response (Do not Want to Answer)	1 2 98	

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 (Do not Want to Answer)	1 2 98	
Q208	Were you tested for HIV in the past 12 months?	Yes No No Response (Do not Want to Answer)	1 2 98	Q210 Q401
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 (Do not Want to Answer)	1 2 3 4 5 6 98	Q217 Q212 } 217 }
Q210	Did you receive your HIV test results?	Yes No NA (not tested) No Response (Do not Want to Answer)	1 2 3 98	Q212 Q217 Q217
Q211	If you did not receive HIV test results, why not?	Did not want to know result Result took too long Still waiting for the result Other (specify) _____ No Response (Do not Want to Answer)	1 2 3 4 98	
Q212	What were your HIV test results?	Negative Positive No response (Do not Want to Answer)	1 2 98	Q401 Q401
Q213	If HIV positive, are you currently taking ART?	Yes No Told not eligible for ART No Response (Do not Want to Answer)	1 2 3 98	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 I miss the schedule I often miss the schedule No Response (Do not Want to Answer)	1 2 3 98	} 217 }
Q215	If told not eligible for ART, do you have follow up at a health facility for HIV care?	Yes No No Response (Do not Want to Answer)	1 2 98	Q217 Q217
Q216	If 'No' to Q215, what is the main 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 (Do not want to answer)	1 2 3 4 5 6 98	

Q217	(If caregiver is female, HIV positive and age 15-49, ask this question) Now I would like to ask you a very personal question: Are you currently pregnant?	Yes No Not applicable (male, HIV –ve, or >49 yr) No response (Do not want to answer)	1 2 3 98	Q401 Q401 Q401
Q218	If YES, are you currently attending antenatal care?	Yes No No response (Do not want to answer)	1 2 98	
Q219	Has anyone talked to you about ways to prevent transmitting HIV to your unborn child?	Yes No No response (Do not want to answer)	1 2 98	Q401 Q401
Q220	If YES, who talked to you about how to prevent transmission of HIV to your unborn child? [Multiple answer possible]	Health workers Community Volunteers Health Extension workers A friend A family member Other (specify)_____	1 2 3 4 5 6	
Q221	Have you received PMTCT services to prevent infection of your newborn?	Yes No No response (Do not want to answer)	1 2 98	Q401 Q401
Q222	If 'No', why? [State the Main Reason]	Fear of stigma Husband did not agree Did not want to take Other (specify)_____ No response (Do not want to answer)	1 2 3 4 98	
	Section 4: Food and Nutrition			
Q401	Over the past year, has your household experienced any shortage of food?	Yes No No response (Do not want to answer)	1 2 98	Q403a Q403a
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 (Do not want to answer)	1 2 3 4 5 98	
Q403 a	How many times was meal served in this household yesterday?	No meal One meal Two meals Three meals Four and more meals No response (Do not want to answer)	1 2 3 4 5 98	Q404 Q404 Q404 Q404

Q403 b	If NO Meal or only ONE Meal, why?	Not food at home Insufficient food Served elsewhere Strictly Fasting No one to prepare meal at home	1 2 3 4 5	
Q404	For how long do you think the 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 (Do not want to answer)	1 2 3 4 5 6 98	
Q405	How do you assess the adequacy of food supply in your household over the past 12 months?	Not enough Barely enough Just enough Excess No response (Do not want to answer)	1 2 3 4 98	
Q406	In your household, is there a child for whom food was prescribed by the health worker/nutrition worker in the last 12 months?	Yes No No response (Do not want to answer)	1 2 98	Q408 Q408
Q407	Did the child receive the prescribed food?	Yes No No response (Do not want to answer)	1 2 98	
Q408	Did any member of your household receive nutrition related training, counseling or advice in the last 12 months?	Yes No No response (Do not want to answer)	1 2 98	

	Section 5: Psychosocial Support			
Q501	Has any adult member of this household ever received information or skills on Better Parenting (how to better care for children)?	Yes No No response (Do not want to answer)	1 2 98	
Q502	Is there someone that you can go to get help solving a problem?	Yes No No response (Do not want to answer)	1 2 98	Q504 Q504
Q503	If Yes, whom do you USUALLY consult or ask for help?	Family members Friends Neighbors Staff of implementing partner Community Volunteers Community Committee Other (specify) _____ No response (Do not want to answer)	1 2 3 4 5 6 7 98	
Q504	In the last 12 months, did you or someone in your household receive any counseling, advice-giving or emotional support from someone who comes from __implementing partner 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 (Do not want to answer)	1 2 3 4 98	
	Section 6: Shelter and Care			
Q601	How many rooms (excluding kitchen and toilet rooms) does the dwelling unit of your household have? Observe and confirm	Number of rooms No response (Do not want to answer)	 98	
Q602	When it rains, does water leak into the part of the house where the children sleep?	Yes No No response (Do not want to answer)	1 2 98	
Q603	When it is windy outside, does the wind blow into the part of the house where the children sleep?	Yes No No response (Do not want to answer)	1 2 98	
Q604 a	Do you feel that your house is fairly safe from burglary?	Yes No No response (Do not want to answer)	1 2 98	Q605 Q605

Q604 b	If NO, has any intervention been made to make it safer? [Indicate the FIRST Action taken]	Reported to police Reported to <i>kebele</i> administration Reported to community/local guards Nothing No response (Do not want to answer)	1 2 3 4 8	
Q605	What is the main water source drinking water for the household?	Pipe Protected well Unprotected well Protected Spring Unprotected Spring Other (specify) _____ No response (Do not want to answer)	1 2 3 4 5 6 98	
Q606	What is the main type of toilet facility used by household members?	Flush Pit latrine No toilet Other (specify) _____ No response (Do not want to answer)	1 2 3 4 98	
Section 7: Legal Protection				
Q701	Over the past 12 months, has any member of your household experienced any violence?	Yes No No response (Do not want to answer)	1 2 98	Q705 Q705
Q702	If yes to Q701, what type of violence has occurred mostly?	Physical violence Verbal abuse Sexual/gender violence Other (specify) _____ No response (Do not want to answer)	1 2 3 4 98	
Q703	What have you done after the violence occurred? [Multiple response possible]	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 (Do not want to answer)	1 2 3 4 5 6 98	
Q704	Who mainly committed the violence?	My spouse Older child male Older child female Neighbor Unknown people Other (specify) _____ No response (Do not want to answer)	1 2 3 4 5 6 98	
Q705	Have you ever been referred or linked to any legal services over the last 12 months?	Yes No Had no need No response (Do not want to answer)	1 2 3 98	Q707 Q707 Q707

Q706	Who referred or linked you to legal services he/she needed over the last 12 months?	Yekokeb Berhan implementing partner staff Community committee Community Volunteers Kebele administration Other (specify) _____ No response (Do not want to answer)	1 2 3 4 5 98	
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 (Do not want to answer)	1 2 3 98	
	Section 8: Economic Strengthening			
Q801	Is your household engaged in economic strengthening program of the Yekokeb Berhan (training, market information, technical support through ES animators/facilitators, matching fund provision, etc.)	Yes No No response (Do not want to answer)	1 2 98	Q806 Q806
Q802	Have you received training in Community Saving and Self-help Groups (CSSG)?	Yes No No response (Do not want to answer)	1 2 98	Q804 Q804
Q803	In what way this training has helped you to advance on self-help endeavor <i>[Multiple answers possible]</i>	Developed saving habits Increased own saving funds which was not possible in the past Became visionary with set objectives and goals Increased social bonds Able to access loan fund for MSE Other (specify) _____ No response (Do not want to answer)	1 2 3 4 5 6 98	
Q804	Did you receive any additional training on how to set up a business and run it—for example, Selection, Planning and Management (SPM) training?	Yes No No response (Do not want to answer)	1 2 98	Q806 Q806

Q805	How has this training helped you to engage in establishing a new or expanding the existing Micro Enterprise?	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 (Do not want to answer)	1 2 3 4 5 98	
Q806	Have you ever got assistance to access financial or technical services from community or government microfinance institutions?	Yes No No response (Do not want to answer)	1 2 98	
Q807	How often do you usually work?	Not working Throughout the year Seasonally/part of the year Once in a while No response (Do not want to answer)	0 1 2 3 98	
Q808	What is the main source of income for the household?	Employed (salary) Self-employed (Own business) Spouse's income Pension Earning from daily work Working children Charity (from NGOs) Charity (from community) Support from relatives Other (specify) _____ No response (Do not want to answer)	1 2 3 4 5 6 7 8 9 10 98	
Q809	On average, how much does the household earn every month (from all sources)? If not exact, take the best estimate	 No response (Do not want to answer)	 _____ Birr 9998	
Q810	How often do you usually earn your income in the past 12 months?	Daily Weekly Monthly Quarterly Biannually Not regular No response (Do not want to answer)	1 2 3 4 5 6 98	
Q811	Are you or any member of your household currently involved in any form of small scale business or micro-enterprise?	Yes No No response (Do not want to answer)	1 2 98	Q816 Q816

Q812	When was the small scale or micro-enterprise business started?	Less than 6 month 6-12 month ago 12-18 month ago 18-24 month ago More than 24 month No response (Do not want to answer)	1 2 3 4 5 98	
Q813	Have you been able to expand or diversify your small scale business over the last 12 months?	Yes No No response (Do not want to answer)	1 2 98	
Q814	On average, how much money do you make from this business per month?	No response (Do not want to answer)	_____ Birr 9998	
Q815	Have you been able to save some money from the small scale business or micro-enterprise that you are engaged in?	Yes No No response (Do not want to answer)	1 2 98	
Q816	Thinking about the last time you bought food for household consumption, how did you pay? Do not read responses. Record one primary response only. <i>Prompt if necessary: maize meal, sugar, cooking oil</i>	Current income (cash) Withdrew money from saving Loan from family or friend Loan from money lender Sold livestock Sold poultry I have not bought any food recently Other (specify)_____ No response (Do not want to answer)	1 2 3 4 5 6 7 8 98	
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 implementing partner 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):_____ Not able to pay I don't recall school related expenses Other (specify)_____ No response (Do not want to answer)	1 2 3 4 5 6 7 8 8 9 10 11 12 13 14 98	

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): _____ Not able to pay I don't recall unexpected household expenses Other (specify) _____ No response (Do not want to answer)	1 2 3 4 5 6 7 8 8 9 10 11 12 13 14 98	
Q819	Compared to last year, how do you express the financial security of your household?	More secure Less secure No change from last year No response (Do not want to answer)	1 2 3 98	
Q820	Compared to other households in your community, how well do you feel you can meet the needs of the children in your care? [Read out responses]	Much better than the other households A bit better than the other households About the same as the other households A bit worse than the other households Much worse than the other households No response (Do not want to answer)	1 2 3 4 5 98	
Q821	Thinking of what the household had two years ago, how do you describe the current productive assets of your household? (Productive assets are possessions that help the household generate income)	We have less productive assets than a year ago We have the same productive assets as a year ago We have acquired additional productive assets than a year ago No response (Do not want to answer)	1 2 3 98	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 for residence Additional rooms/House for living or renting Poultry Working capital Other (specify) _____ No response (Do not want to answer)	1 2 3 4 5 6 7 8 98	

Q823	In the last 12 months, has your household experienced any loss of Income or assets?	Yes No No response (Do not want to answer)	1 2 98	
Q824	In the last 12 months, has your household experienced any children dropping out of school due to financial problem?	No School age children Yes No No response (Do not want to answer)	0 1 2 98	
Q825	In the last 12 months, were any of your children forced to work outside home during school days/time to earn income due to household financial problem?	No School age children Yes No No response (Do not want to answer)	0 1 2 98	
	Section 9. Coordination of care			
Q901	In the last 12 months, have you or your household member been referred to another organization, office or individual to obtain any services that you needed?	Yes No Don't Know No response (Do not want to answer)	1 2 88 98	C101 C101 C101
Q902	If YES, 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 (Do not want to answer)	1 2 3 4 5 6 7 8 98	
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 (Do not want to answer)	1 2 3 98	
Q905	When was the last time you or your household member was referred for a service or support? [Write response in days]	_____ days ago No response (Do not want to answer)	_____ 98	

Q906	Who provided the referral?	Community Committee Kebele administration Yekokeb Berhan implementing partner staff Community volunteers Another NGO Government office Other(specify)_____ No response (Do not want to answer)	1 2 3 4 5 6 7 98	
Q907	Was there any follow up to know if you or your household member received the services (feedback)?	Yes No No response (Do not want to answer)	1 2 98	

PART 2: Survey Questions for Young HVC (<14 Years)

Interviewer: Please select a child aged less than 18 years in the household from the list in Q109.1 above using a single digit random table.

If the randomly selected HVC is less than 14 years complete this part of the questionnaire.

If the randomly selected HVC is 14-17 years, GO to Part 3.

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	How old is --- (name)?	(If less one year old, enter 0)	_____ years	
C102	What is (name's) sex?	Male Female	1 2	
C103	Which is true about (name)? (Multiple responses are possible)	Both mother and father are dead Mother is dead Father is dead Child is chronically ill Child is HIV positive Has some kind of disability Household is headed by a child (<18) Household is headed by elderly (>=60) Household is headed by ill person Household is headed by disabled Other (specify) ----- No response (Do not want to answer)	1 2 3 4 5 6 7 8 9 10 11 98	
C104	Does (name) have a disability (i.e. difficulties in seeing, hearing, speaking, movement, mental retardation, etc.)?	Yes No No response (Do not want to answer)	1 2 98	C201 C201

C105	If yes, how would you describe (name's) disability? (Multiple responses are possible)	Blind or partially blind Deaf or partially deaf Difficulties of speaking Difficulties of movement Mental retardation Other (specify) _____ No response (Do not want to answer)	1 2 3 4 5 6 98	
C106	Does the disability make it difficult for (name) to participate in daily activities?	Yes No No response (Do not want to answer)	1 2 8	
C107	Is (name) receiving any kind of assistive device or support for his/her disability from the Yekoken Berhan Project?	Yes No I don't know No response (Do not want to answer)	1 2 88 98	C201 C201 C201
C108	What kind of assistive device or support/services (name) is receiving from the Yekoken Berhan Project? <i>[Multiple responses are possible]</i>	Prosthesis (artificial leg or arm) Eye glasses Hearing aid Crutches Wheelchair Medical care Home-based care Financial support Others (specify) _____ No response (Do not want to answer)	1 2 3 4 5 6 7 8 9 98	
Section 2: Health and Health Care				
C201	In your opinion, how would you rate (name's) general health situation in the last 12 months?	Excellent Good Fair Poor Very poor No response (Do not want to answer)	1 2 3 4 5 98	
C202	Where does (name) usually seek health care for the illnesses? <i>(if there is more than one response, write only one response they consider most common)</i>	Government health facility Private hospital/clinic Pharmacy Traditional healer Other (specify) ----- No response (Do not want to answer)	1 2 3 4 5 98	
C203	In the last 2 weeks, has (name) been too sick to participate in daily activities?	Yes No No response (Do not want to answer)	1 2 98	C206a C206a
C204 a	Has (name) had fever in the two weeks preceding the survey?	Yes No No response (Do not want to answer)	1 2 98	C205a C205a

C204 b	Did (name) receive treatment - from a health provider for this illness?	Yes No No response (Do not want to answer)	1 2 98	C204d C204d
C204 c	Who covered (name's) 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 donations) Other _____ No response (Do not want to answer)	0 1 2 3 4 5 6 7 98	C205
C204 d	If (name) did not receive treatment, what was the reason? (Multiple responses are possibility, take only the main reason)	No time to escort him/her No money No transport Hospital, health center far away Illness not serious Patient did not want treatment Clinic is too crowded Illness was too serious Other (specify) _____ No response (Do not want to answer)	1 2 3 4 5 6 7 8 9 98	
C205	Has (name) had diarrhoea in the last two weeks?	Yes No No response (Do not want to answer)	1 2 98	C206a C206a
C205 b	Did (name) receive treatment - from a health provider for this illness?	Yes No No response (Do not want to answer)	1 2 98	C205d C205d
C205 c	Who covered (name's) 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 donations) Other _____ No response (Do not want to answer)	0 1 2 3 4 5 6 7 98	C206a

C205 d	If (name) did not receive treatment, what was the reason? (Multiple responses are possibility, take only the main reason)	No time to escort him/her No money No transport Hospital, health center far away Illness not serious Patient did not want treatment Clinic is too crowded Illness was too serious Other (specify) _____ No response (Do not want to answer)	1 2 3 4 5 6 7 8 9 98	C207
C206 a	Did (name) receive treatment - from a health provider for any other illness in the recent past?	Yes No No response (Do not want to answer)	1 2 98	C207
C206 b	For (name's) last illness if he or she did not seek care, why not? (Multiple responses are possibility but take only the main reason)	No time to escort him/her No money No transport Hospital, health center far away Illness not serious Patient did not want treatment Clinic is too crowded Illness was too serious Other (specify) _____ No response (Do not want to answer)	1 2 3 4 5 6 7 8 9 98	C209
C207	About how much did the household spend on (name's) healthcare during the last illness (including at clinics, pharmacy, traditional healer, transport costs etc.)?	No payment from the Household No response (Do not want to answer)	 birr 9998	C209
C208	Who covered (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 (Do not want to answer)	1 2 3 4 5 6 7 98	
C209	If (name) is under 5, 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 (Do not want to answer)	1 2 3 98	C212 C212 C212

C210	Does (name's) have vaccination card? <i>(Ask the caregiver to show vaccination card)</i>	Yes (card shown) No Said had card, but was not shown No response (Do not want to answer)	1 2 3 98	C212 C212 C212
C211	Is (name) fully vaccinated for his/her age? <i>(Don't ask, see the vaccination card and choose appropriate answer as described during the training)</i>	Yes, full vaccinated Only partially vaccinated No response (Do not want to answer)	1 2 98	
C212	If (name) gets sick and needs to see a doctor, is there anyone who could often help the child to see a doctor or other health care provider?	Yes No No response (Do not want to answer)	1 2 98	
C213	Has (name) been tested for HIV in the last 12 months?	Yes No No response (Do not want to answer)	1 2 98	C217 C217
C214	Did (name) or you receive his/her HIV test results?	Yes No No response (Do not want to answer)	1 2 98	C216
C215	If (name) or you did not receive the HIV test result, why not?	Did not want to know the result Result took too long Still waiting for the result Other (specify) _____ Do not know No response (Do not want to answer)	1 2 3 4 88 98	C218
C216	What was (name's) test result?	Negative Positive Don't know No response (Do not want to answer)	1 2 88 98	C300a
C217	Does (name) know his/her HIV status?	Yes No Too young to understand Don't know No response (Do not want to answer)	1 2 3 88 98	C219 C219 C219 C219
C218	If (name) does not know his/her HIV status, why not?	Never tested Tested but has not yet received the result Too young to understand Decided child should not know No health problems/no concerns Other (specify) _____ No response (Do not want to answer)	1 2 3 4 5 6 98	C300a

C219	If (name) is HIV positive, is he currently taking ART (on treatment for AIDS)?	Yes No Told not eligible for ART Not Applicable (HIV negative) Do not know No response (Do not want to answer)	1 2 3 8 99 98	C300a C221 C300a C300a C300a
C220	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 (Do not want to answer)	1 2 3 88 98	
C221	If told not eligible for ART, does (name) have follow up at a health facility for HIV care?	Yes No No response (Do not want to answer)	1 2 98	C300a C300a
C222	If no to C221, what is the reason?	Did not want because of fear of stigma Did not know that I have to Did not want because the child is healthy Too busy to go Lack of money for transport Other (specify) _____ No response (Do not want to answer)	1 2 3 4 5 6 98	
Section 3: Education (Only for children ≥ 3 years of age) (If child is less than 3 skip to Section 4)				
C300a	Has (name) ever attended formal school?	Yes No Not applicable (child < 5 years) No response (Do not want to answer)	1 2 3 98	C313 C401 C401
C300b	If ever attended school, what is the highest level of grade (name) has completed?	Kindergarten Grade 1 Grade 2 Grade 3 Grade 4 Grade 5 Grade 6 Grade 7 Grade 8 Grade 9 Grade 10 Grade 11 Grade 12 TVET College/university No response (Do not want to answer)	0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 98	
C301	Does (name) currently attend school or pre-school?	Yes No No response (Do not want to answer)	1 2 98	C312 C312

C302	If yes, what grade is (name) attending right now?	Kindergarten Grade 1 Grade 2 Grade 3 Grade 4 Grade 5 Grade 6 Grade 7 Grade 8 Grade 9 Grade 10 Grade 11 Grade 12 TVET College/university No response (Do not want to answer)	0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 98	
C303	If (name) needs help with school work, is there someone who could help him/her?	Yes, often Sometimes Never No response (Do not want to answer)	1 2 3 98	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 (Do not want to answer)	1 2 3 4 5 6 98	
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 a	How many days was (name) absent from school in the past four weeks? (Please estimate if not sure)	No response (Do not want to answer)	None days 98	C308 C308

C307 a	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 Child is not interested in school Parent/Caregiver is not interested in school Poor treatment by teachers at school Poor treatment by peers at school Stigma at school Other (specify) _____ No response (Do not want to answer)	1 2 3 4 5 6 7 8 9 10 11 98	
C307 b	(For girls 12 years and above only) In the last two months, did (name) miss school for at least one whole day because of menstruation?	Yes No Not applicable (Male) No response (Do not want to answer)	1 2 3 98	
C308	During the previous academic year, has (name) been promoted to next grade/ level?	Yes No, he/she repeated Just started/enrolled this year No response (Do not want to answer)	1 2 3 98	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 (Do not want to answer)	1 2 3 4 98	
C310	How would you rate (name's) last year school performance compared to the previous year?	Better No change Worse Not applicable (Just enrolled this/last year) No response (Do not want to answer)	1 2 3 4 98	
C311	Who usually covers (name's) school expenses (books, uniform, stationeries, 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 implementing partner Volunteer people (their own donations) Other _____ Not applicable (child is not in school) No response (Do not want to answer)	1 2 3 4 5 6 7 8 9 98	} C401

C312	What was the main reason to stop 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 (Do not want to answer)	1 2 3 4 5 6 7 8 9 10 11 12 13 14 98	} C401
C313	If (name) never enrolled in the 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 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 (Do not want to answer)	1 2 3 4 5 6 7 8 98	
C314	If (name) is out of school, would (name) like to return/enroll to school?	Yes No Undecided/Not Sure Do not know No response (Do not want to answer)	1 2 3 88 98	
Section 4: Food and Nutrition				
C401	What is true about (name's) food consumption in the last four weeks? It has been...	Less than enough Just enough More than enough No response (Do not want to respond)	1 2 3 98	
C402	In the last four weeks, did [name] have to <u>eat a smaller meal</u> than you felt he needed because there was no enough food?	Yes No No response (Do not want to answer)	1 2 99	C404 C404
C403	If yes – How many days did this happen? Read out responses.	Rarely (1-2 days in the last 4 weeks) Sometimes (3-10 days in past 4 weeks) Often (> 10 days in past 4 weeks) No response (Do not want to answer)	1 2 3 98	

C404	In the last four weeks, did [name] have to <u>skip a meal</u> because there was no enough food?	Yes No No response (Do not want to answer)	1 2 98	C409 C409
C405	If yes – How many days did this happen? Read out responses.	Rarely (1-2 days in past 4 weeks) Sometimes (3-10 days in past 4 weeks) Often (> 10 days in past 4 weeks) No response (Do not want to answer)	1 2 3 98	
C406	In the last four weeks did [name] go to <u>sleep at night</u> <u>hungry</u> because there was no enough food to eat?	Yes No No response (Do not want to answer)	1 2 99	C408 C408
C407	If yes – How many days did this happen? Read out responses.	Rarely (1-2 days in past 4 weeks) Sometimes (3-10 days in past 4 weeks) Often (> 10 days in past 4 weeks) No response (Do not want to answer)	1 2 3 98	
C408	In the last 4 weeks, how often did (name) go the whole day or night without eating?	Rarely (1-2 days in past 4 weeks) Sometimes (3-10 days in past 4 weeks) Often (> 10 days in past 4 weeks) No response (Do not want to answer)	1 2 3 98	
C409	In the last week, on average how many meals has (name) consumed in a day?	One Two Three Four More than four No response (Do not want to answer)	1 2 3 4 5 98	
C410	In the last week, how many days did (name) have protein meals (meat, fish, egg, milk, pulses)? Number of meat or fish meals (If fasting season, please note this)	Fasting	88	
C411	In the last week, how many days did (name) have vegetable meals (cabbage, lettuce, beetroot, carrot, etc)? Number of vegetable meals			

C412	In the last week, how many days did (name) have fruit (banana, orange, mango, avocado etc)		_____	
	Number of times fruit taken			
C413	See Q 109.6 If (name) <i>was classified as moderate or severe malnutrition</i> , was he/she prescribed or referred to some place to get supplemental or therapeutic food?	Yes No No response (Do not want to answer)	1 2 98	C501 C501
C414	Has he/she got the supplemental or therapeutic food?	Yes No No response (Do not want to answer)	1 2 98	C501 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 (Do not want to answer)	1 2 3 4 98	
	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 (Do not want to answer)	1 2 3 4 98	
C502	In the last four weeks, have you noticed any sudden changes in (name's) mood or behavior?	Yes No No response (Do not want to answer)	1 2 98	C601 C601
C503	If YES, how often did this happen to (name) in the last four weeks?	Once Twice Three times or more No response (Do not want to answer)	1 2 3 98	
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 don't know the cause No response (Do not want to answer)	1 2 98	

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 (Do not want to answer)	1 2 98	C601 C601
C506	If YES, where did you go for help?	Health center/clinic Community committee (CC) Yekokeb Berhan implementing partner staff Yekokeb Berhan volunteers Other (specify) _____ Did nothing No response (Do not want to answer)	1 2 3 4 5 6 98	
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 (Do not want to answer)	1 2 3 98	
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 Not applicable (age <3 or >5) No response (Do not want to answer)	1 2 3 98	
Section 7: Legal Protection				
C701	Does (name) have birth certificate issued from authorized government office?	Yes No No response (Do not want to answer)	1 2 98	C703 C703
C702	Could you please show me [name's] birth certificate?	Seen / confirmed Not seen / not confirmed No response (Do not want to answer)	1 2 98	
C703	Has (name) ever experienced discrimination by peers or any other persons in the community? (Discrimination includes stigma, inequality, exclusions, prejudice, unfair treatment or show of intolerable behavior)	Yes No No response (Do not want to answer)	1 2 98	C706 C706
C704	If YES to C703, how often the discrimination did happen?	Often Sometimes rarely No response (Do not want to answer)	1 2 3 98	

C705	What do you think was the MAIN reason for discrimination?	Because of AIDS Because of being poor Because he/she is orphan Because of his/her disability Other (Specify)_____ No response (Do not want to answer)	1 2 3 4 5 98	
C706	Has (name) encountered any legal problem in the last 12 months?	Yes No No response (Do not want to answer)	1 2 98	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 (Do not want to answer)	1 2 3 4 5 6 7 8 98	
C708	What measures did the family/caregiver take? [Multiple response]	Asked support from implementing partner staff Asked support from community committee (CC) Asked support from police Asked support from Yekokeb Berhan Volunteers Did nothing No response (Do not want to answer)	1 2 3 4 5 98	
C709	Has (name) been referred or linked to any legal services over the last 12 months?	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 YB Volunteers Kebele administration Other_____ No response (Do not want to answer)	1 2 3 4 5 98	
C711	Does (name) sometimes work for your household?	Yes No No response (Do not want to answer)	1 2 98	C714 C714

C712	What kinds of work does (name) sometimes do? Multiple responses are possible mentioned	Retail 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 (Do not want to answer)	1 2 3 4 5 6 7 8 9 10 98	
C713	How often does (name) work? Would you say....? Read response categories	Every day / most days Several times a week Once a week Once in a while No response (Do not want to answer)	1 2 3 4 98	
C714	Has (name) ever been neglected (being left alone or unsupervised for long period of time (for her/his age)	Yes No No response (Do not want to answer)	1 2 98	
C715	Over the last 12 months, did (name) experience physical, emotional or sexual abuse?	Yes No Do not know No response (Do not want to answer)	1 2 88 98	END END END
C716	What type of violence did (name) experience (physical, emotional or sexual abuse, etc)? [Multiple responses possible]	Physical abuse Psychological (emotional) abuse Sexual abuse Being left alone or unsupervised for long period of time (for her/his age) No response (Do not want to answer)	1 2 3 4 98	
C717	If YES, what did the family/caregiver do? [Multiple responses possible]	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 (Do not want to answer)	1 2 3 4 5 6 7 98	

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

If the randomly selected HVC is 14-17 years complete this part of the questionnaire.

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	Never married Currently married Divorced Widowed Live with partner/cohabit No response (Do not want to answer)	1 2 3 4 5 98	
A104	Which is true about you? [Multiple responses are possible]	Both mother and father are dead Mother is dead Father is dead Chronically ill HIV positive Has some kind of disability Household is headed by a child (<18) Household is headed by elderly (>=60) Household is headed by ill person Household I headed by disabled Other (specify) _____ No response (Do not want to answer)	1 2 3 4 5 6 7 8 9 10 11 98	
A105	Who is <u>mainly</u> taking care of you currently? Do not read 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 (Do not want to answer)	1 2 3 4 5 6 7 8 9 98	
A106	Do you have a disability?	Yes No No response	1 2 99	A111 A111
A107	If yes, does that make it difficult for you to participate in daily activities?	Yes No	1 2	

A108	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 (Do not want to answer)	1 2 3 4 5 98	
A109	Are you receiving any kind of assistive devices or supports for your disability?	Yes No I don't know No response	1 2 88 99	A111 A111 A111
A110	What kind of assistive devices or supports/services are you receiving? [Multiple responses possible]	Prosthesis(artificial leg or arm) Eye glasses Hearing aid Crutches Wheelchair Medical care Home-based care Financial support Others (specify) _____ No response (Do not want to answer)	1 2 3 4 5 6 7 8 9 98	
A111	Do you know about the Yekokeb Berhan project that is supported by USAID/Ethiopia and implemented by _____(implementing partner) in your area?	Yes No No response (Do not want to answer)	1 2 98	
Section 2: Health and Health Care				
A201	In your opinion, how do you rate your health situation in the last 12 months?	Excellent Good Fair Poor Very poor No response (Do not want to answer)	1 2 3 4 5 98	
A202	Where do you usually seek health care for your illnesses? <i>(if there is more than one response, write only one response they consider most common)</i>	Government health facility Private hospital/clinic Pharmacy Traditional healer Other (specify) _____ No response (Do not want to answer)	1 2 3 4 5 98	
A203	In the last 2 weeks, have you been too sick to participate in daily activities?	Yes No No response (Do not want to answer)	1 2 98	A206 A206
A204a	Have you had fever in the two weeks preceding the survey?	Yes No No response (Do not want to answer)	1 2 98	A205a A205a

A204b	Did you receive treatment from a health provider for this illness?	Yes No No response (Do not want to answer)	1 2 98	A204d A204d
A204c	Who has covered <u>most of</u> the costs of the above 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 (Do not want to answer)	1 2 3 4 5 6 7 8 98	} A205a
A204d	If you did not seek treatment for this illness, 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 (Do not want to answer)	1 2 3 4 5 6 7 9 98	
A205a	Have you had diarrhoea in the two weeks preceding the survey?	Yes No No response (Do not want to answer)	1 2 98	A206 A206
A205b	Did you receive treatment from a health provider for this illness?	Yes No No response (Do not want to answer)	1 2 98	A205d A205d
A205c	Who has covered <u>most of</u> the costs of the above 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 (Do not want to answer)	1 2 3 4 5 6 7 8 98	} A206
A205d	If you did not seek treatment for this illness, 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 (Do not want to answer)	1 2 3 4 5 6 7 9 98	

A206	How do you rate your health care in the past 12 months compared to the year before?	Better Similar Worse No response	1 2 3 99	
A207	If you get sick and need to see a doctor, is there anyone who could help you to see a doctor or a health worker?	Yes No No response (Do not want to answer)	1 2 98	
A208	What is true about the healthcare services that you are currently getting? It is...	Less than enough Just enough More than enough No response (Do not want to answer)	1 2 3 98	
A209	Did you receive information or counseling about HIV by health workers or anybody else (i.e. ways of transmission, methods of prevention, care and treatment) in the last 12 months?	Yes No Don't know No response (Do not want to answer)	1 2 88 98	
A210	Now I would like to ask you some sensitive questions about your health: Have you ever been tested for HIV?	Yes No No response (Do not want to answer)	1 2 98	A216 A216
A211	If YES, did you receive your HIV test result?	Yes No Don't know No response (Do not want to answer)	1 2 88 98	A213
A212	If you did not receive HIV test result, why not?	Did not want result Result took too long Still waiting for result Other (specify) _____ No response (Do not want to answer)	1 2 3 4 98	} A216
A213	If you received, what was your test result?	Negative Positive Don't know No response (Do not want to answer)	1 2 88 98	A216 A216 A216
A214	If you are HIV positive, are you currently taking ART?	Yes No Do not know No response (Do not want to answer)	1 2 8 98	A216 A216 A216
A215	If taking ART, do you always got to health facility for follow up as scheduled by the health workers?	Yes, always Yes, but sometimes miss schedule I Often miss schedule Don't know No response (Do not want to answer)	1 2 3 88 98	

A216	Have you ever got health information or counseling about reproductive health?	Yes No No response (Do not want to answer)	1 2 98	A300a A300a
A217	From where did you get the information or counseling about reproductive health?	Government health facilities Health extension workers Yekokeb Berhan volunteers School Other (specify)_____ No response (Do not want to answer)	1 2 3 4 5 98	
	Section 3: Education			
A300a	Have you ever attended formal school?	Yes No No response (Do not want to answer)	1 2 98	A300c A401
A300b	If you have never been 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 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 (Do not want to answer)	1 2 3 4 5 6 7 7 98	A316
A300c	If ever attended school, what is the highest level of grade (name) has completed?	Kindergarten Grade 1 Grade 2 Grade 3 Grade 4 Grade 5 Grade 6 Grade 7 Grade 8 Grade 9 Grade 10 Grade 11 Grade 12 TVET College/university No response (Do not want to answer)	0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 98	
A301	Are you currently attending school?	Yes No No response (Do not want to answer)	1 2 98	A314 A314

A302	If yes, what grade are you attending right now?	Grade 1 Grade 2 Grade 3 Grade 4 Grade 5 Grade 6 Grade 7 Grade 8 Grade 9 Grade 10 Grade 11 Grade 12 TVET College/university No response (Do not want to answer)	1 2 3 4 5 6 7 8 9 10 11 12 13 14 98	
A303	If you need help with school work, is there someone who can help you?	Yes, often Sometimes Never Do not know No response (Do not want to answer)	1 2 3 88 98	A305 A305 A305
A304	Who often helps you in this regard?	A family member/relative Peer group Classmates Yekokeb Berhan volunteers Teachers (after school classes) Other (specify) _____ No response (Do not want to answer)	1 2 3 4 5 6 98	
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 (Do not want to answer)	1 2 98	
A306	In last 12 months, did you get encouragement about your school works from Yekokeb Berhan or its implementing partner volunteers	Yes No No response (Do not want to answer)	1 2 98	
A307	(For girls 14 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 Not applicable (Male) No response (Do not want to answer)	1 2 3 98	

A308	How many days did you miss school during the last four weeks? (Please estimate if not sure)	None Not applicable (not in school) Do not know No response (Do not want to answer)	0 Days 96 88 98	A310 A310 A310 A310
A309	What was the 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 (Do not want to answer)	1 2 3 4 5 6 7 8 9 10 11 98	
A310	During the previous academic year, have you been promoted to the next grade/level?	Yes No, he repeated Just started No response (Do not want to answer)	1 2 3 98	A312 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 (Do not want to answer)	1 2 3 4 98	
A312	How would you rate your last year's school performance compared to the previous year?	Better No change Worse Not applicable (not in school) No response (Do not want to answer)	1 2 3 4 98	
A313	Who usually covers your school expenses (books, uniform, stationeries, 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 (Do not want to answer)	1 2 3 4 5 6 7 8 98	} A316

A314	If you have stopped/dropped attending school, what was the main reason for stopping to attend 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 (Do not want to answer)	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 98	
A315	Would you like to return/enroll to school?	Yes No Unsure/Do not know No response (Do not want to answer)	1 2 3 98	
A316	Have you received (receiving) any type of vocational training?	Yes No No response (Do not want to answer)	1 2 98	A401 A401
A317	If yes, who provided/provides the vocational training?	Yekokeb Berhan program Kebele/woreda office Community based organization An NGO Government (TVET college) Other (specify) _____ No response (Do not want to answer)	1 2 3 4 5 6 98	
Section 4: Food and Nutrition				
A401	What is true about your food consumption over the last four weeks? It has been...	Less than enough Just enough More than enough No response (Do not want to answer)	1 2 3 98	
A402	In the last four weeks, did you have to <u>eat a smaller meal</u> than you felt was needed because there was no enough food?	Yes No No response (Do not want to answer)	1 2 98	A410 A410
A403	If yes – How many days did this happen? Read out responses.	Rarely (1-2 days in past 4 weeks) Sometimes (3-10 days in past 4 weeks) Often (> 10 days s in past 4 weeks) No response (Do not want to answer)	1 2 3 98	
A404	In the last four weeks, did you have to <u>skip a meal</u> because there was no enough food?	Yes No No response (Do not want to answer)	1 2 98	

A405	If yes – How many days did this happen? Read out responses.	Rarely (1-2 days in past 4 weeks) Sometimes (3-10 days in past 4 weeks) Often (> 10 days in past 4 weeks) No response (Do not want to answer)	1 2 3 98	
A406	In the last four weeks did you go to <u>sleep at night hungry</u> because there was no enough food to eat?	Yes No No response (Do not want to answer)	1 2 98	
A407	If yes – How many days did this happen? Read out responses.	Rarely (1-2 days in past 4 weeks) Sometimes (3-10 days in past 4 weeks) Often (> 10 days in past 4 weeks) No response (Do not want to answer)	1 2 3 98	
A408	In the last 4 weeks, how often did you go the whole day or night without eating (apart from fasting)? (If fasting season, please note that)	Rarely (1-2 days in past 4 weeks) Sometimes (3-10 days in past 4 weeks) Often (> 10 days in past 4 weeks) No response (Do not want to answer)	1 2 3 98	
A409	In the last week, on average how many meals have you consumed in a day?	One Two Three Four More than four No response (Do not want to answer)	1 2 3 4 5 98	
A410	In the last 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		(Times)	
A411	In the past week, how many days did you have vegetable meals (cabbage, lettuce, beetroot, carrot, etc.)? Number of vegetable meals		(Times)	
A412	In the past week, how many days did you have fruit (banana, orange, mango, avocado etc.) Number of fruit meals	_____	(Times)	
	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 (Do not want to answer)	1 2 98	

A502	Do you have someone in your life that can take you to the health worker or a counselor if you need it?	Yes No No response (Do not want to answer)	1 2 98	
A503	Do you have someone in your life that shows you love and affection?	Yes No No response (Do not want to answer)	1 2 98	
A504	Did you receive any life skills training in the last two years?	Yes, I received Yes, somebody received No No response (Do not want to answer)	1 2 3 98	
Section 7: Legal Protection				
A701	Do you have birth certificate issued from authorized government?	Yes No No response (Do not want to answer)	1 2 98	A703 A703
A702	Could you please show me your birth certificate?	Seen / confirmed Not seen / not confirmed No response (Do not want to answer)	1 2 98	
A703	Have you ever experienced discrimination by peers or any other persons in the community? (Discrimination includes stigma, inequality, exclusions, prejudice, unfair treatment or show of intolerable behavior)	Yes No No response (Do not want to answer)	1 2 98	A706 A706
A704	If yes, how often did the discrimination happen?	Often Sometimes rarely No response (Do not want to answer)	1 2 3 98	
A705	In your opinion, what is the main reason for discrimination?	Because of AIDS Because of being poor Because I am of orphan Because of my disability Other (Specify) _____ No response (Do not want to answer)	1 2 3 4 5 98	
A706	Have you encountered any legal problem last the last 12 months?	Yes No No response (Do not want to answer)	1 2 98	A709 A709

A707	If yes, what type of legal problem have you encountered? (Multiple responses 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 (Do not want to answer)	1 2 3 4 5 6 7 8 98	
A708	What measures did you or your caregiver take for this legal problem? (Multiple responses are possible)	Asked support from a Yekokeb Berhan implementing partner Asked support from community committee (CC) Asked support from police Asked support from Yekokeb Berhan volunteers Other (specify) _____ Did nothing No response (Do not want to answer)	1 2 3 4 5 6 98	
A709	<u>In the last 6 months</u> , have you worked for a wage, salary, commission or any payment 'in kind'?	Yes No No response (Do not want to answer)	1 2 98	A712 A712
A710	About how much time have you spent 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 (Do not want to answer)	1 2 3 4 5 98	
A711	Have these works (i.e. working on school days) interfered with your schooling)?	Yes, always Yes, sometimes No No response (Do not want to answer)	1 2 3 98	
A712	Do you do <u>household chores</u> ?	Yes No No response (Do not want to answer)	1 2 98	A716 A716
A713	What types of 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 (Do not want to answer)	1 2 3 4 5 6 7 8 9 98	

A714	On average 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 (Do not want to answer)	1 2 3 4 5 98	
A715	Do these household chores (i.e. doing household chores during school days/time) interfere with your schooling?	Yes, they interfere No they don't interfere No response (Do not want to answer)	1 2 98	
A716	Over the last 12 months, did you experience any type of abuse (physical, emotional or sexual, etc)? [Multiple Response possible]	Yes No Do not know No response (Do not want to answer)	1 2 88 98	A719 A719 A719
A717	What type of violence did you experience? [Multiple Response possible]	Physical abuse Psychological (emotional) abuse Sexual abuse Other (specify) _____ No response (Do not want to answer)	1 2 3 4 98	
A718	What have you done for the violence?	Solved the problem in house/ family Reported to kebele Reported to police Reported to Community committee Reported to implementing partner volunteers Did nothing Other (specify): _____ No response (Do not want to answer)	1 2 3 4 5 6 7 98	
A719	Have you been referred or linked to any legal services in the last 2 years?	Yes No Not applicable (service not required) No response (Do not want to answer)	1 2 3 98	A721 A721 A721
A720	If YES, who referred or linked you to the legal services you needed?	implementing partner staff Community committee Yekozeb Berhan Volunteers Kebele administration Other (specify) _____ No response (Do not want to answer)	1 2 3 4 5 98	
A721	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 (Do not want to answer)	1 2 3 98	

Annex 12: KII and FGD guides

**YEKOKEB BERHAN PROGRAM FOR HIGHLY VULNERABLE
CHILDREN AND THEIR FAMILIES: MTR 2014**

Key Informant Interview (01)

**Stakeholders to YB project at Macro level (HAPCO, MoWCA, 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 (YB) HVC Project 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 YB to understand whether the project implementation has brought changes and what needs to change in the future.

Confidentiality: 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

Benefits and harm: There are no direct benefits for participating in this study. Nothing bad will happen to you or your family if you refuse to be in the study or you decide to quit. We will conduct the interview where you feel comfortable. You will not be given any financial benefit for the information you provide us. However, you will be served with refreshments.

If you have any questions you can ask the study leader, Dr Mengistu Tafesse, who can be reached at telephone number +251 911217919 or Dr Mitike Molla at +251 911131805

Would you be willing to participate?

Agree _____ Disagree _____

Region _____ Zone _____ Woreda _____

Urban setting _____

Date/Time (start and finish time) _____

Name and signature of facilitator _____

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 under this section are stakeholders at federal level including government partners (HAPCO and MoWCAs 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

Participants:

. Theme	S.No	Questions /probing												
General understanding of the project	1	Can you tell me what changes were noted at policy and programming level as a result of YB's project? Please provide examples.												
Capacity	2	What system was developed to build the capacity of implementing partner? Probe: - o How were capacity gaps of implementing partners identified? - o What systems and tools are in place to address the different gaps? Please specify capacity building interventions and corresponding approaches: <table border="1"> <thead> <tr> <th>Types of capacity gaps</th><th>Capacity building approaches</th><th>What tools/systems is/are in place</th></tr> </thead> <tbody> <tr> <td>-</td><td>-</td><td>-</td></tr> <tr> <td>-</td><td>-</td><td>-</td></tr> <tr> <td>-</td><td>-</td><td>-</td></tr> </tbody> </table> - o Which implementing partners benefitted from such capacity building interventions? - o What is the role of your organization in this? - o What change has been noticed in consequence at level of HVC and their families? - o Probe – how such change is tracked? ▪ Please provide examples? - o What mechanisms are in place to sustain the capacity of implementing partners If you are asked to redesign the capacity building program, 8. Which areas would you intend to focus on? - o Probe for strength and limitation of the program	Types of capacity gaps	Capacity building approaches	What tools/systems is/are in place	-	-	-	-	-	-	-	-	-
Types of capacity gaps	Capacity building approaches	What tools/systems is/are in place												
-	-	-												
-	-	-												
-	-	-												
Data management and use	3	- o What system is put in place to routinely generate data on accomplishments of care and service for HVCs and their families - o How is data generated from operational level and reported to the next level												

		- o check on what format and channel of reporting is used (get a copy if possible) - o what data management system is in place at implementing partners level - o Who developed this system? - o What was your organization's role? - o How regularly was the system used by implementing partners and community level structures? - o If not regular, probe on why not – check friendliness of formats and reporting channels. - o How was the data used for programming and policy? - o Please provide examples and levels - o How is data quality assured? - o check if random check is done at field and office level) - o What changes were introduced in data generation and - o management since the inception of the project? - o What consequences were noticed as a result of instituting - o data generation and management at operational level?
Support to implementing partners and community structures at operational level	4	- o What change has been introduced in support for implementing partners at community level (CSOs, CBOs, volunteers) to improve intervention? Probe – - o If there was/were tools to identify support needs of implementing partners? Eg technical and organizational capacity of partners - o If support provision is planned and regular? - o If such support was recorded and feedbacks are provided to implementing partners? - o Whether service standards were developed/adapted? And shared with implementers to guide service provision to - o HVCs and b) their families? - o If service standards were shared and enforced to guide interventions at operational level and how? - o What was the role of your organization in this? - o What support was provided to the different implementing partners during the last one year (probe in terms of supportive supervision? - o Did your organization face any challenges in this process - o What are the lessons learned?
Coordination among implementing partners	5	- o Assuming there are different implementing partners at operational level to provide care and services to HVC and their families; - o What measure was taken to improve coordination among - o the different implementers? - o More specifically check if there were procedures put in place and if that was implemented? - o What consequent change in the life of HVCs and their families was noted? - o How was that change known?

		- o Under circumstances where services are not available for - o HVCs in the community (eg for health care) what happens? - o Probe if there is procedures for referral and feedback is designed (check for which services) - o What was the role of your organization in this? - o How do you explain the role of YB in improving coordination of the different implementing partners? - o Please provide examples. - o Were there any challenges faced in coordinating the different implementers? - o What were the lessons learned?
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? <i>What were the challenges faced in identifying the right targets?</i> <i>What are the lessons learned?</i>

YEKOKEB BERHAN PROGRAM FOR HIGHLY VULNERABLE CHILDREN AND THEIR FAMILIES: MTR 2014

Key Informant Interview (02)

Implementing partners at community level (CSOs, CBOs and microfinance institutions (if are operational at this level))

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 (YB) 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 YB to understand whether the project implementation has brought changes and what needs to change in the future.

Confidentially: 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.

Benefits and harm: There are no direct benefits for participating in this study. Nothing bad will happen to you or your family if you refuse to be in the study or you decide to quit. We will conduct the interview where you feel comfortable. You will not be given any financial benefit for the information you provide us. However, you will be served with refreshments.

If you have any questions you can ask the study leader, Dr Mengistu Tafesse, who can be reached at telephone number +251 911217919 or Dr Mitike Molla at +251 911131805

Would you be willing to participate?

Agree _____ Disagree _____

Region _____ Zone _____ Woreda _____

Urban setting _____

Date/Time (start and finish time) _____

Name and signature of facilitator _____

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.

Change in role of implementing partners	1 What is the role of your organization in the effort to improve the life of HVC and their families? Probe for : - o What are the specific roles of your organization in meeting the needs of HVCs and their families? - o What change has been made to the organization's role in implementing the goal of the project? - o Why has such change introduced? - o 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)															
Capacity building support received	2 What capacity change was noted at your level to contribute to an improved wellbeing of HVCs over the last one year? o Probe what support and with what implication? <table border="1" data-bbox="816 1224 1528 1535"> <tr> <th>Type of capacity built (probe for all support received)</th><th>Who provided such support</th><th>Implication of such support for improved wellbeing of HVCs</th></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> o How do you explain if such capacity building has enabled the HH to play its role; please provide examples o What needs to improve in terms of capacity, • Please provide evidences of why this is desired?	Type of capacity built (probe for all support received)	Who provided such support	Implication of such support for improved wellbeing of HVCs	Training on			Financial for								
Type of capacity built (probe for all support received)	Who provided such support	Implication of such support for improved wellbeing of HVCs														
Training on																
Financial for																
Role/function of community structures (CBOs and volunteers)	Which community structures are operating in this community/wereda in connection to care and services for HVC and their families? o Probe – on all CBOs (iddir, saving groups, women groups, youth groups... and volunteers?															

		Community structure	Roles in care and services to a) HVC b) their families	Changes over the last one year
		- o 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? - o What is still considered as gaps in service provision at community structure level? Probe in terms of capacity (provide specific example)		
Coordination among partners	4	What measure(s) was/were taken to improve coordination among the different implementers in the community (wereda)? Probe – - o What system was put in place to improve coordination between CSOs, CBOS and volunteers? • Has this changed after the inception of the project? • Why? - o 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. - o 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) - o What was the role of your organization in this? - o How do you explain the role of YB in improving coordination of the different implementing partners? Please provide examples. - o Were there any challenges affecting coordination among implementing partners? - o What are the lessons learned?		
Data management and use	5	How has implementing partners been continuously generating data on accomplishments of care and service for HVCs and their families - o What tool(s) is there to generate data on accomplishment and how is it reported to the next level (system in place?) - o Who developed this system? - o When was this developed? - o What was your organization's role? - o How regularly is your organization generating data on interventions using the tool developed for this purpose? Where do you send the report?		

	- o How has such data used for programming at your level? Please provide examples. - o What change has been observed in consequence over the last one year? - o What were the challenges related to data management and use? - o What are the lessons learned?																														
Changes in care and services and means of verification Check for the quality dimensions by probing for the following: 1. Shelter: Whether OVCs, live in safe house, have sufficient clothing, access to basic personal hygiene and clean water 2. Legal protection: Whether they have access to basic rights, reduce stigma , discrimination and social neglect, protection from violence, abuse and exploitation 3. Health care: If they have access to primary care, immunization, treatment for ill children, ART for HIV positive 4. Food and nutrition: ask if they have access to similar nutritional resources as other children in the community. 5.Education: whether OVCs have access to educational including tutorial, vocational and occupational opportunities so that they could be productive 6.Ecnomic position: whether families were enabled to meet their own financial needs 7. Psychosocial support: provision of human relationship skills to normal development including participation in school activities	6 How do you explain changes in meeting the needs of highly vulnerable children and families in [the community? Wereda] Probe – - o What specific changes were there for the HVC? <table><tr><th>Services</th><th>Changes Probe (quality, coverage, appropriateness)</th><th>How did you know of the changes?</th></tr><tr><td>Shelter and care</td><td></td><td></td></tr><tr><td>Legal support</td><td></td><td></td></tr><tr><td>Health condition</td><td></td><td></td></tr><tr><td>Health care</td><td></td><td></td></tr><tr><td>Food and 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> - o What is the reason for such changes – probe if such change is associated to change at the level of implementing partners? - o Please provide evidences of change at the level of implementing partners in terms of e.g. Technical and organizational capacity (specify what this is). - o Probe for tutorial services. - o What is the role of your organizations in such changes? Please provide examples - o What is still considered as gaps in service provision? Probe in terms of whether all targets are reached? - o Quality and appropriateness of service needs further change; provide detailed information to each point. - o Was there a gender disparity in the changes? Why? - o What needs to be improved to mitigate gender disparity in the outcomes	Services	Changes Probe (quality, coverage, appropriateness)	How did you know of the changes?	Shelter and care			Legal support			Health condition			Health care			Food and Nutrition			Education			Economic position			Emotional wellbeing			Other areas		
Services	Changes Probe (quality, coverage, appropriateness)	How did you know of the changes?																													
Shelter and care																															
Legal support																															
Health condition																															
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Food and Nutrition																															
Education																															
Economic position																															
Emotional wellbeing																															
Other areas																															

YEKOKEB BERHAN PROGRAM FOR HIGHLY VULNERABLE CHILDREN AND THEIR FAMILIES: MTR 2014

FGDs (01)

Implementing partners at community level (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 (YB) 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 YB to understand whether the project implementation has brought changes and what needs to change in the future.

Confidentiality: 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.

Benefits and harm: There are no direct benefits for participating in this study. Nothing bad will happen to you or your family if you refuse to be in the study or you decide to quit. We will conduct the interview where you feel comfortable. You will not be given any financial benefit for the information you provide us. However, you will be served with refreshments.

If you have any questions you can ask the study leader, Dr Mengistu Tafesse, who can be reached at telephone number +251 911217919 or Dr Mitike Molla at +251 911131805

Would you be willing to participate?

Agree_____ Disagree _____

Region_____ Zone _____ Woreda _____

Urban setting _____

Date/Time (start and finish time) _____

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 caregivers to be identified from within the community

-

Current situation	1	What is the current reality in the provision of care and services for HVC? <i>(you may probe in terms of changes in the number of HVCs with problems, what has changed or not)</i>																				
Care and services for HVCs	2	What care and services are available for HVCs at: - o HH level – - o Please list all care and services provided to HVC at HH level including psychosocial support <table border="1" style="width: 100%;"> <tr> <td>Services</td><td>List all services provided</td></tr> <tr> <td>Legal support</td><td></td></tr> <tr> <td>Shelter and care</td><td></td></tr> <tr> <td>Health condition</td><td></td></tr> <tr> <td>Health care</td><td></td></tr> <tr> <td>Food and 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 <i>(Probe where the standards has come from, who developed it and where the partner got it from? If the standard was useful and why?)</i> - 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	Services	List all services provided	Legal support		Shelter and care		Health condition		Health care		Food and Nutrition		Education		Economic position		Emotional wellbeing		Other areas	
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		<i>(probe where the standards has come from, who developed it and where the partner got it from? If the standard was useful and why?</i> ○ 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 and disability															
Capacity building support received at HH level	3	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 border="1"> <thead> <tr> <th>Type of capacity built (probe for all support received)</th> <th>Who provided such support</th> <th>Implication of such support for improved wellbeing of HVCs</th> </tr> </thead> <tbody> <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> </tbody> </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?	Type of capacity built (probe for all support received)	Who provided such support	Implication of such support for improved wellbeing of HVCs	Training on.			Financial for								
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Shelter and care																	
Legal support																	

6. Psychosocial support: provision of human relationship skills to normal development including participation in school activities		<table border="1" data-bbox="834 191 1498 604"> <tr><td>Health condition</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 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 - o What changes were noticed in connection to improved wellbeing of HVC and capacity of HH? Probe on specific changes and implications - o 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 - o Has there been such referral during the last one year and what happened? Probe reason for referral and satisfaction with referral services and why? - o How do you explain the role of YB in such changes different levels? Please provide examples.	Health condition			Health care			Nutrition			Education			Economic support			Emotional wellbeing			Other areas		
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Other areas																							
Data management and use	5	How do you report service provision to HVCs at your level to the next level (probe – - o Where would accomplishments at HH level reported to? What reporting tool is applied? - o How such data was used at HH level; please provide examples. - o What change has been observed in consequence over the last one year?																					

YEKOKEB BERHAN PROGRAM FOR HIGHLY VULNERABLE CHILDREN AND THEIR FAMILIES: MTR 2014

FGDs (02)

Community committee, saving groups, community volunteers

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 (YB) 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 YB to understand whether the project implementation has brought changes and what needs to change in the future.

Confidentiality: 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.

Benefits and harm: There are no direct benefits for participating in this study. Nothing bad will happen to you or your family if you refuse to be in the study or you decide to quit. We will conduct the interview where you feel comfortable. You will not be given any financial benefit for the information you provide us. However, you will be served with refreshments.

If you have any questions you can ask the study leader, Dr Mengistu Tafesse, who can be reached at telephone number +251 911217919 or Dr Mitike Molla at +251 911131805

Would you be willing to participate?

Agree _____ Disagree _____

Region _____ Zone _____ Woreda _____

Urban setting _____

Date/Time (start and finish time) _____

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

General information	1	Can you please tell us: - o Who in community are highly vulnerable (children and their families) - o 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 – - o What do people in the community know about service packages to HVC? (Probe on what specific services?) - o Who are the providers of such information - o What is the channel of information provision (probe if community discussion, coffee ceremony, media...) - o Who organize such information provision in the community? - o What change is there in community's awareness about HVC and their families
Community's role	3	What was the community's role in the identification of HVCs and their families? - o Were those on supports the right groups? - o What should change in future in choosing targets for care and services? - o What other roles do community members play to ensure the wellbeing of HVC and their family? Please specify community members' role including volunteers?
Community capacity	4	What community capacity improvement was there over the last one year? - o Who provided such capacity improvement? - o On what specific area? What was the added value of capacity improvement?

Care and service providers	5	What support is/are available for HVC and their families <u>at community level?</u> o <i>Probe on what support, for whom, by whom and implications of such support</i> <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> o Please list all care and services provided to HVC at community level o Explain appropriateness of such care and service o Explain quality of such care and service o How do you explain if support to HVCs addresses all targets in terms of: Gender, age, disability o What needs to improve, please provide evidences of why this is desired?	Type of support (probe on available support at community level for HVCs and their families)	For whom (HVC/HH)	Who provide support	Implication of such support	Credit?				Training?											
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6. Psychosocial support: provision of human relationship skills to normal development including participation in school activities		- 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? - o 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?
Consequent changes in care and services	7	How do you explain changes at the level of HVC - o What specific changes were there? Please provide evidences: - o Health - o Nutrition - o Educational achievement - o Emotional wellbeing - o What is still considered as gaps in service provision? - o Probe in terms of whether all targets are reached? - o Quality and appropriateness of service needs further change; provide detailed information to each point.
		Changes at HH level - o What changes were noted at HH level over the last one year? - o Probe on specific changes and examples? - o Improved productive assets (<i>probe implication on paying for health and educational services, buying/producing food...</i>) - o Improved capacity to provide psychosocial support Changes at community level - o What changes were noticed in connection to improved wellbeing of HVC and capacity of HH? Probe on specific changes and implications - o Under circumstances where services are not available for HVCs at HH and within the community (eg for health care) what would you do? <i>Probe :if there is opportunities for referrals Has there been such an incident over the last one year and what happened?</i> - o How do you explain the role of YB in such changes at different levels? Please provide examples. - o Are there activities undertaken for the sustainability of the HVC care and support? Can you explain the activities/plan? - o If there is no activity so far, what are your thoughts/ what do you suggest? - o Were there any challenges in brining change to HVCs life at each level? - o How did you overcome those? - o What are the lessons learned?

YEKOKEB BERHAN PROGRAM FOR HIGHLY VULNERABLE CHILDREN AND THEIR FAMILIES: MTR 2014

FGDs (03)

Female HVC aged 14-17 years

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 (YB) 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 YB 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.

Benefits and harm: There are no direct benefits for participating in this study. Nothing bad will happen to you or your family if you refuse to be in the study or you decide to quit. We will conduct the interview where you feel comfortable. You will not be given any financial benefit for the information you provide us. However, you will be served with refreshments.

If you have any questions you can ask the study leader, Dr Mengistu Tafesse, who can be reached at telephone number +251 911217919 or Dr Mitike Molla at +251 911131805

Would you be willing to participate?

Agree _____ Disagree _____

Region _____ Zone _____ Woreda _____

Urban setting _____

Date/Time (start and finish time) _____

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 female HVCs aged between 14 and 17 and who are registered by implementing partners and identified from within the community

Socio-demography (use the separate sheet attached to record)	1	Age Education Current enrollment Living arrangement: asks if live with: (both parents/single/double orphan...) Number of siblings Disability: (if yes ask type)
Appropriateness of enrollment into the support program	2	How were you enrolled in the support program Probe: who identified you as a child that deserves the support/HVC? Were anybody/organization/community structure helped you to get the support/ to be selected? What were the criteria for the selection Do you think the selection process was fair? Do you think that there are other children who deserved the support but are not in the program? Did you face any challenge to be selected
Care and services for HVCs. (NB: the support each child gets may vary according to her need)	3	Can we talk about the services you get from (name of implementing partner) o What care and services do you receive? Probe for: shelter, nutritional, educational/tutorial/school material/ uniform, economical support, health care / probe for health education including sexual and RH, menstrual hygiene and FP, emotional support, legal Is the support you get helpful? How? Do you think the support you get is satisfactory? What needs to be changed?
Importance of the support	4	Looking back to the days that you were not receiving the supports; how would you compare the importance of the support you are getting now in terms of school attendance,

		health care, nutrition, psychological/emotional support, shelter, legal support etc...																														
Consequent changes Check for the quality dimensions by probing for the following: 1. Shelter: Whether OVCs, live in safe house, have sufficient clothing, access to basic personal hygiene and clean water 2. Legal protection: Whether they have access to basic rights, reduce stigma, discrimination and social neglect, protection from violence, abuse and exploitation 3. Health care: If they have access to primary care, immunization, treatment for ill children, ART for HIV positive 4. Food and nutrition: ask if they have access to similar nutritional resources as other children in the community. 4. Education: whether OVCs have access to educational including tutorial, vocational and occupational opportunities so that they could be productive 5. Economic position: whether families were enabled to meet their own financial needs 6. Psychosocial support: provision of human relationship skills to normal development including participation in school activities	5	How do you explain the changes in your life with respect to: your : - o Health - o Nutrition - o Educational achievement - o Shelter - o Emotional wellbeing - o Financial capacity Do you think you have received equal support and services with that of boys? Can you explain the changes in terms of differences by type of HH (female HH vs male HH) Comparing yourself with other children in your village, where do you put yourself? - o Probe if they fell inferior, or else. o What do you think needs to change in the service provision? Changes at HH level o What changes were noted at HH level over the last one year? Probe on specific changes and examples? <table border="1"> <thead> <tr> <th>Services</th> <th>Changes - Probe (quality, coverage,, appropriateness)</th> <th>How did you know of the changes?</th> </tr> </thead> <tbody> <tr> <td>Shelter and care</td> <td></td> <td></td> </tr> <tr> <td>Legal support</td> <td></td> <td></td> </tr> <tr> <td>Health condition</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 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> </tbody> </table> Changes at community level o Were you referred for services to other places where services were not available in your community? - o Probe if there is opportunities for referrals o Has there been such referral during the last one year and what happened? - o Probe reason for referral and satisfaction with referral services and why?	Services	Changes - Probe (quality, coverage,, appropriateness)	How did you know of the changes?	Shelter and care			Legal support			Health condition			Health care			Nutrition			Education			Economic support			Emotional wellbeing			Other areas		
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	6	Have you heard about Yekokeb Berhan Program? o If yes, what do you know about the program?
Stigma, discrimination and violence	7	Do you feel different from other children of your age? Why? o Probe for violence (sexual, verbal or physical), who was the perpetrator? Have you ever received differential treatment at school/community? Why? o Probe for discrimination because of their HVC status; taking ART
Suggested modality of the support?	8	Thinking about the modality of the service/support provision by the (name of the implementing partner), what do you think needs to change? Why?

YEKOKEB BERHAN PROGRAM FOR HIGHLY VULNERABLE CHILDREN AND THEIR FAMILIES: MTR 2014

FGDs (04)

Male HVC aged 14-17 years

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 (YB) 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 YB to understand whether the project implementation has brought changes and what needs to change in the future.

Confidentiality: 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.

Benefits and harm: There are no direct benefits for participating in this study. Nothing bad will happen to you or your family if you refuse to be in the study or you decide to quit. We will conduct

the interview where you feel comfortable. You will not be given any financial benefit for the information you provide us. However, you will be served with refreshments.

If you have any questions you can ask the study leader, Dr Mengistu Tafesse, who can be reached at telephone number +251 911217919 or Dr Mitike Molla at +251 911131805

Would you be willing to participate?

Agree_____ Disagree _____

Region_____ Zone _____ Woreda _____

Urban setting _____

Date/Time (start and finish time) _____

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 male HVCs aged between 14 and 17 years and who are registered by implementing partners and identified from within the community

Socio-demography (use the separate sheet attached to record)	1	Age Education Current enrollment Living arrangement ask if live with: (both parents/single/ double orphan...) Number of siblings Disability
Appropriateness of enrollment into the support program	2	How were you enrolled in the support program Probe: who identified you as a child that deserves the support/ HVC? Were anybody/organization/community structure helped you to get the support? What were the criteria for the selection Do you think the selection process was fair? Do you think that there are other children who deserved the support but are not in the program? Did you face any challenge to be selected

Care and services for HVCs. (NB: the support each child gets may vary according to her need)	3	Can we talk about the services you get from (name of implementing partner) What care and services do you receive? Probe for: (shelter, nutritional, educational/tutorial/school material/ uniform, economical support, health care (sexual health ad counseling), emotional support, legal Is the support you are getting helpful? How? Do you think the support you get is satisfactory? What needs to be changed?																								
Importance of the support	4	Looking back to the days that you were not receiving the supports; how would you compare the importance of the support you are getting now in terms of school attendance Health care; nutrition, psychological support, shelter, legal support etc...																								
Consequent changes Check for the quality dimensions by probing for the following: 1. Shelter: Whether OVCs, live in safe house, have sufficient clothing, access to basic personal hygiene and clean water 2. Legal protection: Whether they have access to basic rights, reduce stigma , discrimination and social neglect, protection from violence, abuse and exploitation 3. Health care: If they have access to primary care, immunization, treatment for ill children, ART for HIV positive 4. Food and nutrition: ask if they have access to similar nutritional resources as other children in the community. 4.Education: whether OVCs have access to educational including tutorial, vocational and occupational opportunities so that they could be productive 5.Ecnomic position: whether families were enabled to meet their own financial needs 6. Psychosocial support: provision of human relationship skills to normal development including participation in school activities	5	o How do you explain the changes in your life with respect to: your : - o Health - o Nutrition - o Educational achievement - o Shelter - o Emotional wellbeing - o Financial capacity Do you think you have received equal support and services with girls? Can you explain the changes in terms of differences by type of HH(female HH vs male HH) o How do you compare yourself with other children comparing yourself with other children in your village, where do you put yourself? Probe if they fell inferior, or else. What do you think needs to change in the service provision? Changes at HH level o What changes were noted at HH level over the last one year? Probe on specific changes and examples? <table border="1"> <thead> <tr> <th>Services</th><th>Changes - Probe (quality, coverage,, appropriateness)</th><th>How did you know of the changes?</th></tr> </thead> <tbody> <tr> <td>Shelter and care</td><td></td><td></td></tr> <tr> <td>Legal support</td><td></td><td></td></tr> <tr> <td>Health condition</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 support</td><td></td><td></td></tr> </tbody> </table>	Services	Changes - Probe (quality, coverage,, appropriateness)	How did you know of the changes?	Shelter and care			Legal support			Health condition			Health care			Nutrition			Education			Economic support		
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		Changes at community level - o Were you referred for services to other places where services were not available in your community? Probe if there is opportunities for referrals - o Has there been such referral during the last one year and what happened? Probe reason for referral and satisfaction with referral services and why? - o			
Awareness about YB	6	Have you heard about Yekokeb Berhan Program? What do you know about the program?			
Stigma, discrimination and violence	7	Do you feel different from other children of your age? Why? Probe for violence (sexual, verbal or physical), who was the perpetrator? Have you ever received differential treatment at school/community? Why? Probe for discrimination because of their HVC status; taking ART			
Suggested modality of the support?	8	Thinking about the modality of the service/support provision by the (name of the implementing partner), what do you think needs to change? Why?			

Annex 13: Resource mapping matrix

YEKOKEB BERHAN PROGRAM FOR HIGHLY VULNERABLE CHILDREN

Endline Evaluation. Resource Mapping Matrix

	Core Service Areas	Yes	No	Remark
1	What resources are available to ensure the shelter and care needs of HVC?			
1.1	Local Government Structures			
	Provision of affordable housing			
	Facilitation of home inheritance			
1.2	NGO/CSO			
	Support shelter construction			
	Support rehabilitation of existing home of HVC			
	Provision of home utensils			
1.3	CBO/Idir. CC, etc/			
	Maintenance of HVC/Caregivers house			
	Contribute Material and cash for clothing			
	Give shelter to HVC			

2	What resources are available to build the Economic capacity of HVC/Families?			
2.1.	Local Government Structures			
	Avail revolving fund and working places			
	Business Development Training			
	Create employment and linkage			

2.2	NGO/CSO			
	Organizing HVC and caregivers/SAC, Self -help groups			
	Business Development Skill Training			
	Provide technical support to organized saving and credit groups			
2.3	CBO/Idir. CC, etc/			
	Save matching fund			
	participate in micro enterprise			
3	What resources are available to protect HVC from vulnerability?			
3.1	Local Government Structures			
	Child friendly policing			
	Special court for HVC			
	Exemption from inheritance fees			
3.2	NGO/CSO			
	Awareness creation materials development			
	Legal Counselling			
	Training of par legal professionals			
3.3	CBO/Idir. CC, etc/			
	Reporting mechanisms (Abuse, neglect, exploitation, etc)			
	Assign caregivers for HVC			
	Linkage with stakeholders (with CSO and Government Structure)			

4	What resources are available to address the health needs of HVC?			
4.1	Local Government Structures			
	Health Facilities			
	Free medical services			
	Health Extension Workers and other health professionals			
4.2	NGO/CSO			
	Training of Health Extension workers and older HVC			
	Provide technical and material support to CBOS/CC			
	Health education to the community			
4.3	CBO/Idir. CC, etc/			
	Linkage with stakeholders for deworming			
	Monitor health situation of HVC			
	Adherence and follow-up			
5	What resources are available to give psychosocial support to HVC in the locality?			
5.1	Local Government Structures			
	Organize recreational tour for HVC and families			
	Facilitate linkage with institution for counseling and guidance			
5.2	NGO/CSO			
	Religious Institutions engaged in emotional support			
	Training par-councilors			
	Organize home visit			

5.3	CBO/Idir. CC, etc/			
	Participate in experience sharing /Recreational Tours			
	Identify emotional needs of HVC			
	Create linkage for guidance and counseling			
6	What resources are available to provide quality education service to HVC?			
6.1	Local Government Structures			
	Enhance education facilities/Free education			
	Avail education materials			
	Referral for educational support (scholarship, higher level education, etc)			
6.2	NGO/CSO			
	Support school supplies			
	Tutorial class supports			
	Pay school fee in private school			
6.3	CBO/Idir. CC, etc/			
	Provide school supplies			
	Avail safe study area			
	After school and homework assistance			

7	What resources are available to meet the food and nutrition needs of HVC's?			
7.1	Local Government Structures			
	Organize resources from different stakeholders			
7.2	NGO/CSO			
	Support school feeding			
	Provide food support			
	Training of home gardening and food portioning/ supplementary feeding			
7.3	CBO/Idir. CC, etc/			
	Cash/Material Contribution (Grain,			
	Participate in gardening			
	Food support for school feeding			

Annex 14: OCA tool used for the re-OCA

			USAID FROM THE AMERICAN PEOPLE				
Yekokeb Berhan/Pact Project for Highly Vulnerable Children							
Technical Organizational Capacity Assessment Tool - HVC Programming							
Appendix :							
		Rating Scale					
	Item No.	Description				Rate	
	I	Needs Urgent attention and improvement				1	
	II	Needs attention and improvement				2	
	III	Needs improvement on fairly wide scale, but not major or urgent				3	
	IV	Needs improvement in limited aspects, but not major or urgent				4	
	V	Room for some improvement				5	
	VI	No need for immediate improvement				6	
	Note:	IS stands for Initial Score which is a rating for the TOCA facilitators.					
		PS stands for Partner's Score which is for the implementing partner.					
		FS stands for Final Score which will be the average of the IS and PS ratings.					

						
						
					THE SCIENCE OF IMPROVING LIVES	
No.	Description	Score (1-6)			Reasons to support scoring	Evidence used
A	Governance and Leadership	IS	PS	FS		
1	The organization is registered and valid according to local regulations.					
2	The organization has a documented organizational structure with clearly defined roles and responsibilities					
3	The organization's vision and mission statement clearly indicates a focus on OVC					
4	The staff understand and share the organization's vision, values and guiding principles regarding their OVC work					
5	The organization has a system to collect, analyze, synthesize, disseminate and document data and information					
6	The organization has the required manuals to ensure transparency in financial and human management					
7	The organization has implemented work place policy like child protection and participation policy and others					
	Average score - governance and leadership	0	0	0.00		
B	HR and Staff Development					
1	Organization has an adequate number of technical staff to design participatory programming and support service delivery.					
2	A technical focal person is assigned to and responsible for the OVC project					
3	The technical staff has also demonstrated technical capacity in communicating and providing technical support and mentoring to partners					
4	There is staff learning opportunities to develop skills and knowledge in the whole OVC related technical areas					
5	The organization uses both intrinsic and extrinsic methods of motivating staff					
6	National OVC service quality standards are disseminated within the organization and understood by all staff					
7	There are learning/skills development opportunities in child growth and development-planning and all program intervention fields in OVC					

	Average score - HR & staff development	0	0	0.00		
No.	Description	Score (1-6)			Reasons to support scoring	Evidence used
C	Program Development	IS	PS	FS		
1	Program Conceptualization and Design					
1.1	Community needs assessment and extracting of lessons learned from past experiences is done prior to planning.					
1.2	Enough time is spent with the community on consultation to allow them identify and internalize the program					
1.3	Baseline information is obtained through participatory techniques					
1.4	Local skill, knowledge practice and resources are identified, recorded and built upon					
1.5	Program design is made in line with the organization's long term vision and plan					
1.6	The program design is in line with Request for Application (RfA) requirement					
	Average score-Program conceptualization & Design					
2	Program Implementation					
2.1	Program Planning					
2.1.1	The organization prepares and utilizes annual operational plan for all activities					
2.1.2	The organization involves other relevant agencies/partners like government offices, CBOs and beneficiaries in planning processes					
2.1.3	The organization conducts disability inclusive and gender sensitive OVC programming analysis and implementation					
2.1.4	Program staffs have knowledge and skills in gender and disability analysis, OVC programming and planning					
	Average score-Planning					
2.2	OVC Service Quality Standards					
2.2.1	Economic Strengthening					
2.2.1.1	Program staff have knowledge and skills in livelihood and economic strengthening methodologies					
2.2.1.2	OVC livelihood security is reflected in the overall strategy and plan of the organization					
2.2.1.3	There are specific economic strengthening activities (models/approaches) targeting OVC and their households					
2.2.1.4	The implementing partner's activities promote households caring for vulnerable children have sufficient income to care for children					

2.2.1.5	All economic strengthening interventions are linked to government GTP					
	Average score-Economic strengthening	0	0	0		
No.	Description	Score (1-6)			Reasons to support scoring	Evidence used
C	Program Development (continued)	IS	PS	FS		
2.2	OVC Service Quality Standards (continued)					
2.2.2	Psychosocial Support					
2.2.2.1	The implementing partner's activities promote HVC copes with loss and other trauma and has improved self-esteem and self-sufficiency					
2.2.2.2	Program staffs have knowledge and skills in psychosocial support.					
2.2.2.3	There are specific and appropriate psychosocial support frameworks, tools & activities (e.g. memory books, wills, recreation and psychosocial counseling)					
2.2.2.4	Effective and functional referral system for psychosocial support is in place					
	Average score -Psychosocial support	0	0	0		
2.2.3	Child Protection					
2.2.3.1	The implementing partner's activities promote HVC receives legal information and access to legal services as needed, including birth registration and property inheritance plans. HVC are protected from all forms of abuses, violence and neglect.					
2.2.3.2	There are child protection policies and guidelines exists in the organization(e.g. reporting child abuse & neglect; child protection policy; birth & death registration)					
2.2.3.3	OVC activities are guided by policy frameworks at national and international level (e.g. UNCRC, Children Act)					
2.2.3.4	Child protection is reflected in the overall strategy and plan of the organization.					
2.2.3.5	Program staffs have knowledge and skills in child protection.					
2.2.3.6	Effective and functional referral system for child protection is in place					
	Average score-child protection	0.00	0.00	0.00		
2.2.4	Health					
2.2.4.1	Key staff have knowledge and skills in primary health care for OVC					
2.2.4.2	Program staff have learning/skills development opportunities in primary health care for OVC					
2.2.4.3	Primary health care for OVC is reflected in the strategy and plan of the organization					

2.2.4.4	Effective and functional referral system for health is in place					
2.2.4.5	Appropriate manuals and guidelines are in place for OVC health related support					
2.2.4.6	Effective and appropriate health services are in place					
2.2.5.7	The implementing partner's activities promote child has access to health services, including HIV and AIDS prevention, care and treatment					
	Average score-Health	0.00	0.00	0.00		
No.	Description	Score (1-6)			Reasons to support scoring	Evidence used
C	Program Development (continued)	IS	PS	FS		
2.2	OVC Service Quality Standards (continued)					
2.2.5	Food and Nutrition					
2.2.5.1	Key staff have knowledge and skills in food security and nutrition					
2.2.5.2	Program staff have learning/skills development opportunities in food security and nutrition					
2.2.5.3	Food security and nutrition for OVC is reflected in the overall strategy and plan of the organization					
2.2.5.4	Nutrition manuals and guidelines are in place					
2.2.5.5	The implementing partner's activities promote balanced food is available for HVC and in accordance with their age and need					
2.2.5.6	Effective and appropriate nutrition services are in place					
2.2.5.7	Effective and functional referral system for food and nutrition is in place					
2.2.5.8	Appropriate nutritional status tracking system is in place					
	Average score -Food & nutrition					
2.2.6	Education					
2.2.6.1	Program staff have knowledge and skills in educational support for OVC					
2.2.6.2	Program staff have learning/skills development opportunities in educational support for OVC					
2.2.6.3	Educational support is reflected in the overall strategy and plan of the organization					
2.2.6.4	The implementing partner's activities promote HVCs are enrolled, regularly attends school and completes a minimum of TVET and preparatory education					
2.2.6.5	Specific and appropriate educational services are in place to ensure OVC attend and remain in school					

2.2.6.6	Linkage and coordination systems are in place to coordinate activities with other development actors					
	Average score-Education	0.00	0.00	0.00		
No.	Description	Score (1-6)			Reasons to support scoring	Evidence used
C	Program Development (continued)	IS	PS	FS		
2.2	OVC Service Quality Standards (continued)					
2.2.7	Shelter and Care					
2.2.7.1	Key staff have knowledge and skills in care and support for OVC					
2.2.7.2	Program staff have learning/skills development opportunities in care and support for OVC					
2.2.7.3	Care and support is reflected in the overall strategy and plan of the organization					
2.2.7.4	The implementing partner's activities promote all HVC have adequate shelter and care, clothing and personal hygiene (plus an) adult caregiver in accordance with community norms					
2.2.7.5	Specific and appropriate shelter and care services are in place to ensure OVC have appropriate shelter and care					
2.2.7.6	Specific and appropriate alternative child care mechanisms with close adult supervision is in place					
2.2.7.7	Effective and functional referral system for alternative child care services is in place					
	Average score-Shelter & care	0.00	0.00	0.00		
	Average score - OVC Service Quality Standard	0.00	0.00	0.00		
	Average score - Program Implementation	0.00	0.00	0.00		
3	Monitoring and Evaluation					
3.1	There is an M&E system (Performance Monitoring Plan (PMP) , log frame) in place.					
3.2	The organization has assigned focal person for M&E					
3.3	Data collection tools/instruments are in place					
3.4	Program staff have knowledge and skills in M&E					
3.5	Lessons and best practices in supporting OVCs in all programs are documented and shared with all stakeholders					
3.6	Collected data is summarized, analyzed and produced in reports at specific times					
3.7	There is a system for data storage and management					
3.8	Monitoring data is utilized by project staff and managers to review and update work-plans					
3.9	Baseline data/information is generated at the beginning of each project					

3.1	Project reports are completed and submitted to relevant stakeholders on time					
3.11	The NGO conducts evaluation for every project					
3.12	National OVC service quality standards are documented and periodically updated					
	Average score-Monitoring & evaluation	0	0	0.00		
	Average score - Program Development	0.00	0.00	0.00		
No.	Description	Score (1-6)			Reasons to support scoring	Evidence used
D	Networking and Collaboration	IS	PS	FS		
1	Major stakeholders are identified and regularly updated					
2	Feedback from coordination meetings are used to improve programs.					
3	There is a networking and collaboration strategy in place					
4	The organization has working relationships with other CSOs, government, media and private sector					
5	Linkage and coordination with government bodies exists for all service areas					
6	The organization is a member of a national/local network of HIV/AIDS and OVC organizations					
7	The organization engages regularly with other organizations in an already identified forum for sharing lessons and experiences					
8	Program staff have knowledge and skills in networking and collaboration					
9	All local OVC service providers are identified, mapped and documented with the necessary details for easy access for referrals.					
	Average score - networking and collaboration	0.00	0.00	0.00		
E	Sustainability					
1	Community Participation					
1.1	The NGO consults and seeks feedback from communities on its strategies and projects.					
1.2	The community (target group) participates in project activities and decision making of the organization					
1.3	Women are equally represented and taking part in the decision making process					
1.4	The community members are aware of the OVC issues and are interested to participate in the program					
1.5	The organization has managed to secure volunteers from the community to participate in the OVC care and support program					

1.6	The organization has documented contributions from the community members in the form of labor, finance, and material resources					
1.7	A community mobilization strategy and plan is in place.					
1.8	Program staff have knowledge and skills in community mobilization					
1.9	The organization works with the government offices to ensure future sustainability of the program					
1.1	The organization works to enhance awareness on child protection policy among local development partners					
1.11	Programs are planned with appropriate exit strategy and the organization has the experience in implementing them					
	Average score-community participation	0.00	0.00	0.00		
No.	Description	Score (1-6)			Reasons to support scoring	Evidence used
E	Sustainability (continued)	IS	PS	FS		
2	Local Resource Mobilization					
2.1	Effective community resource mobilization strategy and plan is in place.					
2.2	The NGO has diverse funding sources including the private sector.					
2.3	Board members participate in mobilization of resources for the NGO					
2.4	Various resource mobilization mechanisms/techniques are utilized to mobilize resources					
2.5	Program staff have knowledge and skills in resource mobilization					
2.6	Various fundraising mechanisms are used to diversify financial resource base (such as engaging in Income Generating activities)					
2.7	Local non-financial resources such as human resource and materials are mobilized					
2.8	Membership fees are regularly collected					
	Average score-Local resource mobilization	0	0	0		
	Average score - sustainability	0	0	0		
	Average score - all categories (A+B+C+D+E)	0.00	0.00	0.00		
Assessment team from Yekokeb Berhan (Name & Position) from Partners (Name & Position)					Assessment team	

