

What have we learnt?

A review of evaluation evidence on community interventions providing care and support to children who have been orphaned and rendered vulnerable

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Executive Summary: What have we learnt from evaluations of community OVC programmes?

- **Approaching twenty years after the first studies drew attention to the issues faced by children affected by HIV, evaluation data from OVC programmes remains limited and clustered, especially when considered in relation to the magnitude of donor spending.**
- **Methodologies of existing evaluations reflect diverse aims and research questions. All existing studies fall short of the traditional requirements of randomised controlled trials, due to practical and ethical obstacles. However, important lessons for intervention development can still be learnt from the existing evidence base.**
- **Evidence illustrates a range of practical approaches that can be employed in the community under appropriate circumstances to effect tangible change in the lives of children and families affected by HIV.**
- **Findings support the importance of household visits, volunteerism, community mobilisation and community and child participation as guiding principles for intervention.**
- **There remains a need for an ongoing research agenda to inform responsible spending. The use of quasi-experimental and process evaluation methodologies, as well as costing studies and participatory qualitative research, will be key to maintaining appropriate levels of rigour while building the evidence base.**

1 Introduction

The AIDS epidemic has introduced an unprecedented challenge to families and communities throughout sub-Saharan Africa, threatening the survival and development of children who have been orphaned and rendered vulnerable by their individual, household or community circumstances. The resulting changes in children's wellbeing are cumulative, multifaceted and interlinked; including increased risks of school drop-out and poor performance (Ainsworth et al. 2005; Case and Ardington 2006), impaired food security (Nyambedha et al. 2001), diminished psychosocial wellbeing (Lester et al. 2006; Nöstlinger et al. 2006), reduced access to healthcare and other services (Andrews et al. 2006; Miller et al. 2006), and other problems associated with poverty (Andrews et al. 2006; Miller et al. 2006) and lacking adult care (Heymann et al. 2007). Recent studies in sub-Saharan Africa (Gregson

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et al. 2005; Thurman et al. 2006a; Juma et al. 2007) document elevated risks of HIV infection and STIs among children, particularly among females, who have been orphaned or otherwise rendered vulnerable.

Nearly twenty years after the first studies called attention to the issues being faced by children affected by HIV and AIDS, what has been learnt about how to support these children and their families? This paper reviews evaluations of community interventions aimed at mitigating the impacts of HIV among children in high-prevalence African settings, in order to determine the state of the existing evidence base, explore overall lessons learnt from the evaluations in light of their methodologies, and assess implications for an ongoing evaluation research agenda to inform quality programme implementation.

Who are the children who have been orphaned and rendered vulnerable?

Early efforts to assess the extent of the “orphan problem” due to HIV sounded warning bells for the rising number of orphans and associated social breakdown (Hunter 1990; Preble 1990). However, it soon became apparent that the impacts of HIV and AIDS on children begin long before being orphaned by the death of a parent, as evidence of the risks described above emerged. Evidence from varied settings of high HIV prevalence indicates that the impact of AIDS on children begins long before the death of a parent, as households navigate changing circumstances and finances during parental illness and children take responsibility for caregiving (Catholic Relief Services/Zimbabwe and USAID/Zimbabwe 2003; Bauman et al. 2006; Esu-Williams et al. 2006; Robson et al. 2006). As parental health declines, children – even while not yet actually orphaned – face increasing household adversity and rising levels of responsibility.

To reduce inequities and avoid stigma, impact mitigation interventions should therefore aim to reach all children affected by HIV, not just those who have been orphaned (Foster 2006). The operational term “orphans and vulnerable children” (OVC) has been coined to recognise the varied causes of children’s vulnerability; including not only children who are demographically orphans following parental death, but also children who have been rendered vulnerable due to other household or individual factors, such as parental illness. Definitions of what constitutes child and family vulnerability are highly sensitive to context, and must be contextualised locally in order to achieve practical relevance for policy makers and service providers (Skinner et al. 2004).

What kinds of interventions have been proposed to respond to these children and their families?

With the absolute number of orphans and their associated degrees of vulnerability rising alarmingly, there is an urgent need for intervention (Desmond and Gow 2002; Subbarao et al. 2004), beginning at the fundamental point of preventing children from becoming orphans in the first place, e.g. through addressing maternal mortality, or HIV prevention and treatment. While families remain the first line of support for support children affected by HIV, there is a moral and economic imperative for external organisations, including governments and NGOs, to direct immediate attention to strengthening family and community coping capacity among the most vulnerable without stigmatising them (Beer et al. 1988; Foster et al. 1997b).

In the face of the overwhelming needs of children affected by HIV, governments and international agencies are working together in an unprecedented manner to raise awareness and offer guidance to impact mitigation initiatives. International agencies have jointly published data and recommendations to support efforts to meet the needs of children affected by HIV (UNICEF et al. 2004). UNICEF (UNICEF 2004) have proposed response strategies to mitigate the impact of HIV among children that have been widely endorsed by a variety of international stakeholders, and have partnered with other international agencies to release guidelines for monitoring and evaluating national responses to children affected by HIV (UNICEF 2005).

Initial responses saw agencies rushing to establish orphanages that would meet children's immediate needs for care and protection. Such models later came under criticism for adverse psychological and social effects undermining traditional models of care, discouraging agencies from providing support within communities and alienating children from their family and culture (Foster et al. 1995; Matshalaga and Powell 2002; Tolfree 2003). Institutional responses became viewed as resource-intensive and unsustainable, with limited capacity to respond to the scale of the orphan crisis. Their continuing presence in some areas demands a response, and the international policy community takes the position that such institutions should only be used as a model of last resort (Dunn et al. 2003; UNICEF 2004).

A move towards community OVC programmes has since emphasised the importance of community self-reliance. Where possible, community OVC programmes are seen as preferable to institutional care, since they build on traditional norms of extended family support and avoid the separation of children from their families and communities (Phiri et al. 2001; Strebel 2004; Williamson 2004; Beard 2005).

What is a community OVC programme?

Community OVC programmes aim to complement existing coping mechanisms by supporting the care of children within their own communities, in a family or family-like setting, and encouraging community leaders to oversee child-care and well-being (Phiri et al. 2001; Williamson 2004). They aim to build the capacity of caregivers and communities by enhancing traditional care and support systems based on family, kinship, or community ties.

Strategies supporting orphaned and vulnerable children are varied; they may include broad-based community-mobilisation initiatives (Donahue and Williamson 1998; SCOPE-OVC/Zambia and Family Health International/Zambia 2003), or specific components such as planning for children's future fostering and preventing land-grabbing through will-writing (Horizons et al. 2004); providing psychosocial support (Gilborn et al. 2006); addressing poverty through income-generating activities (Donahue 1998; Khonyongwa and ActionAid Malawi 1998); or fostering positive prevention behaviours to mitigate future impacts of HIV (Gachuhi 1999). Complementary initiatives may also address household food insecurity through supplementary feeding, nutrition or agriculture programmes; support school attendance by providing uniforms or fees; or strengthen preventive and primary healthcare for childhood diseases through school-based or facility-based interventions (Desmond and Gow 2002; Subbarao et al. 2004). All such programmes share a common goal of improving children's quality of life, ultimately working towards achieving the Millennium Development Goals of improving children's health and education.

There remains considerable ambiguity among researchers and implementers regarding the precise definition of community OVC programmes. Debate focuses on the required degree of community participation and initiative, and appropriate roles for external agencies (Ansell and Young 2004; Williamson 2007). The spectrum of interventions described as community OVC programmes may include any initiative physically located at sites within the community (i.e. any programme that does not rely on institutional care); or may be restricted to programmes where organisation is at the community level but initiated and/or funded externally (e.g. services coordinated through local Community AIDS Committees (National Task Force on Orphans in Malawi 1996; RAPIDS 2006)); or more specifically, care models exclusively initiated and facilitated by community-based organisations (e.g. (Foster et al. 1996)).

For the purposes of this paper, a community OVC intervention is understood to mean an intervention supporting the care of children within their own communities, requiring the importance of community engagement, commitment and initiative in programme implementation (Thurman et al. 2008). This review therefore includes community OVC programmes in which community members play varying roles, including as participants, volunteers, planners-implementers-analysts, client-beneficiaries, and managers of community-based organisations (CBOs). External organisations playing other key functions in the development and implementation of interventions covered in this review include international and local non-governmental organisations (NGOs) and international and national Government agencies, whose varied roles include direct service provider, promoter-planner-trainer, funder, or catalyst and capacity builder. For further descriptions of types of community interventions and the roles played by different stakeholders, see (Foster 2002c; Foster 2005).

2 Methods

Sources reviewed were evaluation and research studies including published peer-reviewed research studies and evidence from the unpublished programmatic “grey literature” from international implementers and evaluators located through database and internet searches. Websites and databases searched were: AED/SARA, AIDSPortal, Better Care Network, GH Tech, Google, Google Scholar, HIV/AIDS Impact on Education Clearinghouse, ISI Web of Knowledge, ISI Web of Science, OVCsupport.net, PubMed, Synergy Resource Centre, UNICEF Evaluation and Research database and USAID Development Experience Clearinghouse. Additionally, contacts were made with key individuals and organisations known to be working among community OVC programmes to seek out further evidence.

In order to capture a wide range of studies and methods, inclusion criteria were deliberately broad: included in this review was any evaluation, review or assessment of a community programme conducted by researchers, programme implementers or donors, designed to support orphans and vulnerable children in a high HIV prevalence setting with at least one round of post-intervention data collection focussing on health and welfare outcomes having been conducted. Search terms included combinations of the terms “OVC care and support”, “community intervention” or “programme”, and “evaluation”, “review” or “assessment”. Studies focussing exclusively on HIV prevalence, risk

behaviour, treatment or financial livelihoods outcomes were excluded. Since the purpose of the review was to determine the state of the literature, no inclusion or exclusion criteria were set for study quality.

3 Results

Overall, a total of 21 evaluations of community OVC interventions were identified in twelve countries (Botswana, Kenya, Lesotho, Malawi, Namibia, Rwanda, South Africa, Swaziland, Uganda, Tanzania, Zambia, Zimbabwe) conducted since 1996 (Table 1). Studies suggest a notable degree of clustering in countries where donor funds and interests are concentrated (e.g. five studies include Zambia sites, four studies include Tanzania sites). At least one of the evaluations included in the review had not yet made post-intervention data publically available.

The literature search also revealed examples of quantitative baseline surveys conducted in association with interventions in Mozambique, Namibia, Tanzania, Uganda, Rwanda and Zimbabwe but for which no plans for follow-up post-intervention outcome data collection appeared to be readily available (Chatterji et al. 2005; Dougherty et al. 2005; Bronson et al. 2006; Howard et al. 2006; Population Council 2006a). Such baseline data is useful to inform a needs assessment and the development of ongoing interventions, and could still add to this evidence base if post-intervention data are collected. However, they were not included in the review since they did not meet the inclusion criterion of having conducted at least one round of post-intervention data collection.

In the following sections, findings from the evaluations are reviewed in terms of evaluation aims, identification of implementers and evaluators, intervention strategies, outcome indicators, evaluation methodologies employed and evaluation findings. Reviewed studies are summarised in Table 1.

<< INSERT TABLE 1 >>

3.1 Evaluation aims and questions

The reviewed evaluations spanned a broad range of aims and research questions, reflecting the priorities of funding and implementing agencies. Studies encompassed diverse goals, ranging from quantifying programme impacts on key populations, through identifying best practices transferable to other programmes, to deriving immediate operational lessons for the intervention and/or its subsequent scale-up. As a result, evaluation methodologies are correspondingly varied, reflecting the diversity of research questions that evaluators aimed to address.

Across the 21 studies reviewed, all shared the common broad goal of informing programmatic management and resource allocation decisions. Where they differed however was in the scope of their findings and their intended audience: the more evaluation-focussed assessments aimed to feed operational lessons straight back into the programme being assessed, while the more research-focussed activities aimed to derive broader and more generalisable lessons for other programmes or

to make an explicit contribution to the academic research literature. Several were project-specific evaluations with potentially limited scope to apply findings outside of their particular programmatic circumstances; while others were driven by the need to demonstrate that donor objectives had been satisfied. Some explored specific thematic priorities, e.g. intervention sustainability, child participation, income generation; while others were more general evaluations of implementation processes rather than impacts.

This diversity of methodologies severely limits the comparability of findings, and highlights the difficulty and indeed inappropriateness of making any overall assessment of individual evaluation quality. Each study aimed to answer a different set of research questions (e.g. seeking evidence of impact or descriptive lessons for programme operations), with differing implications for evaluation design and the extent to which results may be generalised.

3.2 Intervention implementers and evaluators

The reviewed studies reflect diversity among intervention implementers included under this definition of community OVC programmes. While several of the interventions partnered with national governments on various aspects of service provision, only one of the studies (Tanzania MVC [10]²) evaluated a programme that had been implemented by national government. A few of the evaluated interventions reviewed were implemented by local NGOs (e.g. Tanzania VSI [11], Zimbabwe FOCUS [19]), and the majority involved international NGOs as implementers (e.g. Malawi COPE [4], Rwanda Village Model [6], Zambia Chikankata [17]). Few were directly implemented by community-based organizations (e.g. Botswana and South Africa [2]), reflecting the reality that even though such small-scale locally-driven initiatives play a vital role in mitigating the immediate impacts of HIV and AIDS at community level, these community-based projects are extremely unlikely to be able to devote significant resources to evaluation or otherwise find ways to access evaluation expertise.

Within the body of evaluation literature reviewed, studies included data collected directly by internal programme staff and studies conducted by external evaluators and researchers independent of the intervention. Internal reviews are subject to a complicated conflict of interests with mixed incentives for staff to truthfully reveal programmatic insights, especially if their continued employment or programme funding is dependent upon demonstrating satisfactory results. In contrast, external evaluators have to work harder to gain the trust of programme staff and come up to speed with understanding of programme operations. The decision as to whether or not to commission an external programmatic evaluation depends on a number of practical factors (most notably budget), but also the balance that is sought between insiders' intimate knowledge of the programme and the objectivity of outsiders.

3.3 Intervention strategies

² Numbers in square brackets indicate the study numbers referred to in Table 1.

Interventions assessed by the 21 reviewed evaluations aimed to address various combinations of children's rights to health, education and psychosocial wellbeing. Details of intervention strategies are reported in a column of Table 1. However, the frequency of overlap between multiple intervention strategies and the lack of consistency in details reported by evaluators prevents any systematic quantification of intervention strategies, permitting only the identification of the following four emergent themes:

Household visits

A common approach to OVC care and support programming is to provide regular visits to vulnerable households (e.g. Rwanda mentoring [7], Zimbabwe FOCUS [19]). Visitors (often community volunteers) are trained to respond to household needs, including supporting children whose care responsibilities prevent them from attending school, mentoring youths heading households in the absence of an adult, and assisting parents who are chronically ill with household tasks.

Reliance upon volunteers

Several of the reviewed studies relied upon the labour of volunteers from within the community, motivated by dedication to their peers, often by virtue of religious belief, a sense of community responsibility, or hope for reciprocity (e.g. Zambia RAPIDS [18]). Wages for such individuals were rarely seen, but programmes frequently provided training, work tools and incentives in order to equip and motivate volunteer service providers.

Community mobilisation

Another popular strategy also playing a prominent role in the interventions reviewed was the mobilisation of community leaders and other stakeholders to advocate on behalf of orphans and vulnerable children (e.g. Zambia SCOPE-OVC [15], Malawi COPE [4], Zimbabwe STRIVE [21], Tanzania MVC [10]).

Community and youth participation

Across the intervention studies reviewed, the importance of community participation and youth participation in decision-making was emphasised as crucial to programme success in different contexts, exemplified by the high priority accorded to children's participation in the child-led intervention in Tanzania VSI [11].

3.4 Outcome indicators

In order to evaluate the success of an intervention to mitigate the impact of HIV on children and families, it may be helpful to define appropriate quantitative outcome indicators. Since community interventions rarely have robust record-keeping schemes for monitoring and evaluation, the evidence upon which they can be evaluated is typically scanty. Existing standardised indicators proposed for national frameworks (e.g. (Ministry of Finance and National Planning [Zambia] and International Monetary Fund 2002; UNICEF 2005)) do not address the more detailed programmatic needs of project evaluation.

Across the diverse range of intervention strategies in this review, it is immediately apparent that each requires different indicators relevant to programme goals for the evaluation of results. Despite sharing ultimate goals to improve child wellbeing, the 21 interventions employ a variety of outcome indicators to capture programme effects, including traditional indicators in the health and education domains (e.g. school attendance, food security, children's immunisation) and composite indices representing children's psychosocial wellbeing (used in Rwanda mentoring [7], Zimbabwe psychosocial support [20], Tanzania VSI [11], Uganda and Zambia Core HIV and AIDS Models [14]). Other studies employed specific indicators reflecting other programmatic goals, including will-writing, knowledge of HIV, and sexual behaviour.

A popular method for measuring the disruptions to children's lives is to use indicators of children's educational participation to represent short- and longer-term opportunities for children's development. Focussing on educational outcomes has the disadvantage of neglecting direct measurement of other aspects of children's well-being, but may be closely correlated with them (e.g. since children who are unhealthy are less likely to be attending school). School participation measures (school enrolment or attendance) are easily accessible through household surveys and triangulation with school data, and have been demonstrated to capture tangible differences between children who have been orphaned and other children (Ainsworth and Filmer 2002; Schierhout and Mungani 2002).

An option growing in popularity is to measure children's psychosocial functioning and well-being through individually administered instruments, asking children to consider for example, how often they feel sad or whether they feel that they have someone they can confide in when they have problems (Horizons et al. 2004; Gilborn et al. 2006). However, although international organisations are making efforts to seek consensus on such measures of psychosocial wellbeing, they remain very much under development (UNICEF 2005).

This review draws attention to the lack of standardisation in outcome measures. Given inevitable variations in programme approaches focussing on different domains of child well-being, it is hard to conceive of universal outcome indicators directly relevant to all. In order to detect effects across targeted domains, indicators for multifaceted, multi-sectoral intervention approaches are tied directly to the intervention whose effects they seek to measure and are as broad and varied. The many gaps in the column in Table 1 illustrating key child-level quantitative outcomes further reiterate the gaps in the evidence base and the difficulty of collecting such data.

3.5 Evaluation methodologies

Depending on the evaluation questions, important design elements for the conduct of evaluation research may include comparing outcomes between baseline and follow-up data and/or between intervention and comparison groups; following-up individual programme participants longitudinally over time; assessing the costs of service delivery; and seeking insights into the factors governing service quality and delivery processes. Table 2 illustrates that each of the 21 evaluations reviewed included different combinations of these features.

<< INSERT TABLE 2 >>

Evaluations should ideally be planned to include data collection before the programme commences, in order to establish a baseline against which to measure subsequent change. Eight of the reviewed studies collected baseline data, of which five (Rwanda mentoring [7], Uganda succession planning [12], Zambia RAPIDS [18], Uganda/Rwanda/Kenya AVSI [13], Uganda and Zambia Core HIV and AIDS Models [14]) also collected post-intervention outcomes data suitable for comparison. The remaining three studies collecting quantitative baseline data (Zambia SCOPE-OVC [15], Zimbabwe FOCUS [19], Zimbabwe STRIVE [21]) used quantitative baseline surveys to inform initial programme development, but subsequently changed to participatory review methodologies to explore programme implementation. At least one study (Zambia Chikankata [17]) had aimed to conduct a baseline but was unable to do so due to logistical and resource constraints. Two of the studies (Zambia RAPIDS [18], Zambia Bwafwano [16]) employed multiple (two) rounds of data collection following the introduction of the intervention, in order to track the trajectories of change during the programme implementation period.

Without baseline data, four of the studies reviewed (Kenya & Tanzania MEASURE [3], Tanzania VSI [11], Zambia Bwafwano [16], Zimbabwe psychosocial support [20]) retrospectively analysed post-intervention data among programme participants and non-participants to explore relationships between programme exposure and selected outcomes.

Where data collection includes multiple survey rounds, following-up with individual respondents longitudinally over time is a potentially powerful methodology to track changes. However, obstacles include the risks of high losses to follow-up, especially among communities affected by HIV where household dissolution and reformation is common. This is exemplified by the Rwanda mentoring evaluation, where high loss to follow-up required researchers to analyse data as two rounds of cross-sectional data rather than the longitudinal design originally intended, yet still yielded convincing results. Only one of the reviewed studies (Uganda / Rwanda / Kenya AVSI [13]) still aims to analyse results longitudinally.

Seven studies employed a comparison group, using differences between intervention recipients and non-recipients (individuals or communities) to measure intervention effects through establishing a counterfactual. However, since establishing a comparison group requires deliberately withholding an intervention from some of the research participants, determining who should receive the intervention is ethically problematic. Thus, none of the reviewed studies employed randomisation to allocate the intervention and create a true control group, as required by the “gold standard” RCT methodology. Three of the studies (Uganda succession planning [12], Rwanda mentoring [7], Uganda and Zambia Core HIV and AIDS Models [14]) responded to this dilemma by creating a comparison group through programme roll-out dynamics, comparing intervention recipients to those slated to receive the intervention later (variations on the “stepped-wedge” design (Brown and Lilford 2006)), while two others (Tanzania VSI [11], Zambia Bwafwano [16]) created comparison groups through matching techniques. Responding to the ethical principle of beneficence, evaluators acknowledged a commitment to extending the interventions to comparison sites immediately following disclosure of any positive evaluation findings. Without a separate comparison group, one

study (Zambia RAPIDS [18]) surveys intervention communities only, comparing cross-sectional outcomes from baseline through two post-intervention survey rounds using time-series (or reflexive control) design.

Almost all the quantitative studies reviewed are designed to collect data among programme recipients only, recruiting research participants through their participation in intervention services. Only one study (Zambia RAPIDS [18]) employs a population-based methodology, which brings the additional advantage of providing population estimates of programme eligibility and coverage, but requires additional resources for sampling and data collection. Since all the other evaluations reviewed focus on the perspectives of clients, this is the only one with the ability to explore the way in which the programme is perceived by the wider community and its effects beyond its direct beneficiaries.

Seven of the studies indicated that some costing information would be collected, broadly defined as providing any data on costs of service provision, although the extent of available data ranged from summarising the total cost of construction inputs (Malawi Orphan Care [5]), through estimating per-household intervention costs (Rwanda Village Model [6]), to more sophisticated methodologies for estimating cost-effectiveness and monthly costs of a minimum standard of care (South Africa costing [8]).

All but two of the 21 studies included qualitative methodologies, alone or in combination with quantitative data collection. Among the mixed-method research studies, variations in timing reflect different evaluation priorities. In some (e.g. Zambia RAPIDS [18], Uganda succession planning [12]), focus group discussions and in-depth interviews were employed after quantitative data collection to triangulate and further explore survey findings. In contrast, researchers in the AVSI three-country study [13] stated that qualitative approaches were used prior to quantitative data collection to develop indicators.

The qualitative methods most commonly used were focus group discussions among adults connected with the programme; including parents/guardians, programme staff and local stakeholders. Two of the studies (Botswana etc collaboration and sustainability study [1]; care models in Botswana and South Africa [2]) collected data exclusively from programme staff and leadership, through surveys and in-depth interviews. For data collected directly among children, participatory qualitative methodologies are indicated as the most suitable approaches to explore children's views, as reflected by the twelve studies using these methods. Children have a right to participation and expressing their own views concerning services provided to them, however this must be balanced with their right to protection from any associated trauma or exploitation that could result from such exposure. Thus, children's involvement in research requires designing age-appropriate informed consent processes and data collection methodologies (Schenk et al. 2006). While some of the reviewed studies did not fully document such procedures, others paid close and prominent attention to the ethical principles underlying children's participation (e.g. Tanzania VSI [11]).

Several of the studies (e.g. Kenya and Tanzania [3], Botswana and South Africa [2], Botswana etc collaboration and sustainability study [1]) employed a case study approach to exploring interventions. Having purposively selected the intervention/s to demonstrate key features for

exploration, operational lessons are then derived from the selected programming models under consideration. These case studies provide detailed examinations illustrating specific goals and principles, but the extent to which findings may be generalised is limited.

Evaluations using participatory review techniques (e.g. Zimbabwe FOCUS [19], Zambia SCOPE-OVC [15]) relied on methods including document review and key informant interviews, often employing participatory learning and action tools (e.g. ranking, diagrams) to explore programme functioning. These methods do not measure outcomes in the traditional sense of an evaluation, but aim to derive lessons for refining the intervention while building ownership, and are especially valuable for developing scale-up plans. They gather relatively short-term data about the processes of intervention delivery during the programme cycle, using immediate feedback to implementers and stakeholders to improve operations and make funding decisions. Such programmatic reviews may be conducted internally by programme staff or by an external evaluator, depending on the balance that is sought between insiders' intimate knowledge of the programme and the objectivity of outsiders. Internal reviews are subject to a complicated conflict of interests with mixed incentives for staff to truthfully reveal programmatic insights, especially if their continued employment or programme funding is dependent on results. External evaluators have to work harder to gain the trust of programme staff and come up to speed with understanding of programme operations.

3.6 Evaluation findings

Quantitative programme effects and outcomes

Out of the 21 evaluations reviewed, five currently provide quantitative data estimating programme effects, demonstrating quantifiable improvements in key outcomes (Rwanda mentoring [7], Tanzania VSI [11], Uganda Succession Planning [12], Zimbabwe Psychosocial Support [20], Uganda and Zambia WV Core models [14])³. While in each study, methodological limitations acknowledged by the authors (and referred to above) restrict the precision and wider applicability of findings; taken together however, they illustrate a range of practical programmatic approaches that can be employed in the community under appropriate circumstances to effect tangible change in the lives of children and families affected by HIV.

Operational programme delivery processes

Other evaluations reviewed addressed operational questions of how to deliver an OVC intervention. These evaluations included observations revealing both negative (e.g., lack of formal management structures) and positive findings (tendency to employ local resources and leadership; focus on responding to immediate and locally-identified needs; reliance on principles of reciprocity and self-reliance) (Foster 2002b; Foster 2002a; International HIV/AIDS Alliance and Family AIDS Caring Trust 2002). Lessons learnt include the importance of multi-sectoral collaborations between local government, community structures, and NGOs and faith-based organisations to avoid exhausting

³ New and ongoing studies in Zambia, Kenya and Tanzania (Population Council 2006b; Chatterji et al. 2007; Measure Evaluation 2007) promise to add new quantitative outcomes data on programmatic effects in the near future.

family and community goodwill, which may be insufficient to fully meet children's overwhelming needs in high HIV prevalence areas (Christian Aid et al. 2006; Olson et al. 2006; Tearfund 2006); and of supporting linkages between local service providers to develop a referrals network and connect with HIV prevention strategies (Esu-Williams et al. 2000; Horizons 2007a). Promoting children's psychosocial wellbeing is a crucial priority requiring attention from trained caregivers (Gilborn et al. 2006; Horizons 2007a).

Another area of growing consensus revealed by this review is the value of community participation, which is crucial to targeting resources appropriately and also constitutes a fundamental step towards ownership and sustainability (Catholic Relief Services and United States Agency for International Development (USAID) 2003; Donahue and Mwewa 2006; Schenk et al. 2008b). Community members have a vital role to play in determining eligibility for support, rather than external actors imposing rigid criteria developed elsewhere. An important lesson is the need to develop holistic interventions that are locally relevant, reflective of children's rights and their gendered vulnerabilities, sensitive to stigma associated with HIV, and responsive to children's evolving concerns as they grow up and progress through parental illness, death, and its aftermath. Tailoring programmes to local context includes giving children the opportunity to participate meaningfully in programme development and implementation (Foster et al. 1996; Catholic Relief Services and United States Agency for International Development (USAID) 2003; SCOPE-OVC/Zambia and Family Health International/Zambia 2003; Clacherty and Donald 2005).

However, programme implementers and evaluators emphasise the need to be realistic about what such programmes can actually achieve due to factors at the micro and macro levels: children devastated by traumatic loss may require more specialised individual attention (Horizons 2007a) or families whose stress is a direct result of the broader economic climate may not see long-term improvements without broader policy responses addressing economic and socio-cultural factors contributing to their distress (Gilborn et al. 2006). An important conclusion from implementers of programmes in this review (Foster et al. 1996; Drew et al. 1998; Foster 2002b; SCOPE-OVC/Zambia and Family Health International/Zambia 2003) and reiterated by authors from other settings (Levine et al. 1996; McKerrow 1996; Mutangadura et al. 1999; Desmond and Gow 2002; Bhargava and Bigombe 2003; Giese et al. 2003; UNICEF 2003; Richter et al. 2004; Beard 2005; Williamson 2005) is that without community motivation, long-term external funding, and technical support, community programmes are unsustainable; in any case, implementers should be transparent about their exit strategy and/or plans for scale-up.

4 Discussion: Broadening the research paradigm

Due to ethical and practical challenges⁴, none of the reviewed studies employed randomisation, the most rigorous yet resource-intensive method by which to allocate intervention and comparison groups. While randomised methods remain the gold standard for evaluation design, increasingly it is recognised that these may not always be appropriate, practical or ethically feasible to conduct. The continuing search for empirically proven best practices underscores the need to broaden the research paradigm and employ innovative alternative approaches to evaluation that maintain acceptable rigour. Even major proponents of randomised controlled trials (RCTs) agree that different forms of evidence are helpful in building up a complete picture of the operations of an intervention and exploring the operations lying behind programmatic outcomes (Ross and Wight 2003). Instead of relying on the single data source of a RCT, researchers frequently propose collecting and triangulating between multiple information sources, using both quantitative and qualitative data, to improve understanding of programme operations in different settings and among different groups (Oakley 2000; Ulin et al. 2004).

There is a growing interest in developing new approaches to evaluating large-scale complex interventions, such as community OVC programmes (Stephenson and Imrie 1998; Campbell et al. 2000; Green and Thorogood 2004). Some researchers have acknowledged the importance of retaining the principles of RCTs from pharmaceutical research and deriving lessons for health services research (Medical Research Council 2000), but the continuing search for empirically proven best practices in public health interventions has given rise to new approaches to evaluation methodologies. It is possible that, given sufficient budget and implementer co-operation, obstacles to randomisation are not insurmountable; however the reviewed studies indicate that valuable findings can still be achieved by building the evidence base through other sound methodologies – including quasi-experimental and process evaluation approaches – and highlight the utility of qualitative and participatory methods.

There remain opportunities to maintain acceptable levels of rigour in evaluations of community OVC programmes, through process evaluations and quasi-experimental research designs. The studies reviewed illustrate ways in which to make the most of available data and resources: for example without baseline data, retrospective post-intervention analysis may be used; without a comparison group, time-series data may provide useful information. Facing a lack of sound empirical data to guide intervention development, as well as numerous complexities to the design and conduct of such research, policymakers should not rely on seeking evidence from RCTs alone, and must acknowledge that alternative forms of evidence are also valuable for generating lessons to inform

⁴ Ethical difficulties include creating a control group not receiving the intervention in a resource-poor setting – it is preferable to use a comparison group receiving the best available local services rather than a control group not receiving any services. Should the intervention prove beneficial, the comparison site must eventually have access to it (Connell et al. 1985; Stimson and Power 1992; Horizons et al. 2004; Schenk and Williamson 2005; Schenk et al. 2006). Practical difficulties include randomising recipients within pre-set programme realities (Kippax and Van de Ven 1998; Nutbeam 1998) and preventing contamination between groups when interventions are social in nature (Kippax and Van de Ven 1998; Torgerson 2001). Such contamination was acknowledged to be a considerable problem in the above-mentioned succession planning evaluation in Uganda, where discussion of the ideas proposed by the intervention spread rapidly into neighbouring communities intended as comparison groups not exposed to such discussions (Horizons et al. 2004).

spending decisions and field implementation. The value of quasi-experimental research designs and mixed methods lies in the ability of these approaches to unpick evidence of processes and plausibility of effects and intervention challenges. Given the complexity of OVC interventions, it is imperative that programme implementers, evaluators and researchers take advantage of existing opportunities to evaluate pioneering community programmes, and that such research aims to inform both empirical programme development and the methodological research agenda.

4.1 Quasi-experimental approaches

Quasi-experimental designs provide opportunities for estimating programme effects where strict randomisation is not possible, creating a comparison (not control) group through practical means. Examples of different quasi-experimental designs employed in the reviewed studies include Rwanda mentoring [7], Tanzania VSI [11] and Zambia RAPIDS [18]. Although such studies provide important information about the intervention, without the full complement of randomisation and control conditions, their ability to establish counterfactual evidence is more limited. Any changes documented in outcomes cannot be definitively attributed to the intervention, and careful triangulation with other data sources is required to rule out other explanations of temporal change. Proponents of quasi-experimental designs argue that using such comparisons generates information that is more directly relevant and accessible for managers and funders, and more generalisable to structurally similar situations, than randomised models (Habicht et al. 1999; Shadish et al. 2001; Victora et al. 2004). The increasing importance of quasi-experimental study designs (Black 1996; Kirkwood et al. 1997) is reflected by the development of reporting guidelines (Des Jarlais et al. 2004). The use of these methodologies may yet be improved by prospective or retrospective matching (e.g. propensity scores), or further expanded using the regression-discontinuity design (West et al. 2008).

While the collection of pre- and post-intervention data among intervention and comparison groups is methodologically preferable, the range of studies reviewed illustrate that evaluation options remain even if ethical, logistical, or budgetary barriers prevent baseline data collection or establishing comparison groups. Although the strength of findings may be more limited, carefully managed retrospective post-intervention data collection can still provide insight into intervention operations and outcomes. When the use of comparison groups is impossible, alternative ways to explore programme effects include observing the programme in multiple settings, at different levels of intensity or isolating different programme components (factorial designs). Triangulating with high quality data collected through multiple sources (e.g. caregivers, children, household members, programme staff, key stakeholders) and approaches (quantitative, qualitative) helps to ensure robust and useful findings (Schenk and Williamson 2005).

4.2 Process evaluations

Process evaluations (also known as operational evaluations) seek to explore the processes by which a programme is implemented and operates. Although almost all of the reviewed studies include elements investigating processes in order to derive lessons for intervention functioning, studies directly exploring processes included Malawi COPE [4] and Zimbabwe STRIVE [21]. The results of process evaluations are valuable either independently (learning how to improve programme operations during the project cycle or to successfully replicate interventions elsewhere) or in partnership with evaluations tracking programme outcomes (exploring how intervention effects have been achieved and interpreting results). Process evaluations have a particular role to play when evaluators seek to increase understanding about internal relationships and decision-making, and the experiences of service recipients in order to improve the quality and efficiency of programme operations (Nutbeam 1998; Calnan and Ferlie 2003; Oakley et al. 2004). Where process data include observations gathered through routine monitoring systems, care must be taken to maintain high data quality, and verify insights through additional qualitative and quantitative exercises (e.g. observations from client-provider interactions, focus group discussions). Process evaluation allows researchers to take advantage of realistically variable programme quality to investigate the conditions affecting success of implementation, rather than make broad generalisations based on aggregated population-level impact indicators. The types of research question most suited to process evaluations are those that explore the circumstances favouring successful intervention implementation, focussing on the accessibility, acceptability and feasibility of the services.

4.3 Costing studies

Building on sound outcomes and process evaluations, cost and efficiency are crucial questions for ongoing funding of community OVC services. This review has found that while some of the existing studies include cost data, contributing to a growing body of research on costing HIV care and support interventions in general (e.g. (Quinlan and Desmond 2002; Homan and Searle 2005)), evidence focussing specifically on children is variable and limited (Desmond and Gow 2001; Dougherty et al. 2005). Since initial findings indicate that some of the lowest-cost interventions fail to meet minimum standards of care (Desmond and Gow 2001), quantitative outcomes data are still required to connect cost information to programme effectiveness.

4.4 Qualitative research

Although donor interest is often primarily focussed on seeking quantitative evidence of programme impact, the reviewed studies illustrate the accessibility and utility of employing qualitative evidence in evaluation design in building the evidence base, whether alone or in combination with quantitative methods, especially to highlight some of the nuances of programme operations or to shed light upon some of the more complex research questions. Qualitative data collection methods are especially helpful tools for increasing local community participation in developing the

intervention, by documenting participant experiences. Age-appropriate qualitative research methods carefully tailored for children have multiple benefits including increasing children's participation and providing invaluable research insights to enhance the intervention.

6 Conclusion

It has been estimated that by 2010, US\$1-4billion will be needed annually to meet the needs of orphans and vulnerable children in sub-Saharan Africa, representing at least a four-fold increase from resources available in 2003 (Stover et al. 2007). Although the total number of so-called "orphan support" interventions is not known, spending by the largest organizations in the 17 most affected countries during 2003 (latest available data) has been estimated in the order of US\$200–300 million (Stover et al. 2007). Although sizeable increases in funding from donor countries and private foundations are flowing through governments, non-governmental agencies, and faith-based organisations; still only a fraction of the needed resources are available to respond to the complex needs of the millions of orphaned and vulnerable children (UNICEF et al. 2004). The widely endorsed UNICEF framework (UNICEF 2004) suggests strategic approaches to mitigating the impacts of HIV among children who have been orphaned and rendered vulnerable, recognising the paramount importance of strengthening the capacity of families and communities to respond to children in their midst. Despite the recent funding influx and calls for yet further funds for programme implementation, there exists little evidence to inform policymakers and donors about whether and how their investments are improving the lives of vulnerable children and meeting key benchmarks such as the Millennium Development Goals.

This review may be interpreted as indicating the potential for community interventions to improve the wellbeing of children and families affected by HIV, although there remains a role for continuing research to inform improvements in implementation. Existing evidence highlights some specific lessons emerging from a nascent field, including the importance of programmes developing strong links with households and communities through personal visits and community participation. However, this review has shown that existing evidence on the evaluation of community programmes addressing the circumstances of children and families affected by HIV is undermined by variable methodologies and inconsistent data quality. Evaluation of community OVC interventions in the research and programmatic literature on families affected by HIV and AIDS remains at best scanty, even in settings where the epidemic is generalised. Considering the widespread experience in implementing OVC programmes represented by spending to date, the evidence base guiding resource allocation is disappointingly limited. The evidence base in low prevalence settings is weaker still (Quality Assurance Project and UNICEF 2007).

Indeed, it was this dearth of evidence that provided the motivation for the formation of JLICA in the first place, tasked with "mobilizing the scientific evidence base and producing actionable recommendations for policy and practice" (Joint Learning Initiative on Children and AIDS 2007). Building a sound empirical evidence base to address questions of programme management and policy decision-making remains a key gap. Without a comprehensive body of sound evaluation data, policy makers and donors risk making decisions about the implementation and financing of programmes that have not been proven effective. It is inappropriate to simply assume that because

such care and support programmes are operating among extremely deprived communities, any well-intentioned intervention will be beneficial to its impoverished recipients. Even well-designed community OVC programmes may have inadvertent detrimental effects; for example, if a programme targets only orphaned children and ignores other vulnerable children in a community, the intervention may create the perverse effect of so-called “lucky orphan syndrome”, dividing the community and resulting in jealousy against the “privileged” orphans eligible for programme assistance. Such observations emphasise the importance of thoroughly evaluating pilot programmes before taking interventions to scale, in order to make sure that programmes above all “do no harm”, and are managed efficiently to achieve optimum benefit.

Some have argued that the paucity of robust evidence evaluating HIV impact mitigation interventions in general can be attributed to the pandemic’s rapid onset necessitating urgent action (Patel et al. 2002). Alternatively, the persisting evaluation gap in research on how to improve the wellbeing of orphans and vulnerable children may be seen as symptomatic of a larger malaise affecting social development programmes generally, as a result of the “public good” nature⁵ of evaluation research (Savedoff et al. 2006).

With calls for an ever-increasing increasing level of resources to be devoted to scaling-up responses to the perilous situation of orphans and vulnerable children, it behoves donors and managers to build the evidence base informing intervention development, to ensure that funds will be spent wisely, reflecting lessons learnt from prior experience. Donors, programme implementers and policy makers require sound data to make decisions about how to most effectively improve the quality of life of families affected by AIDS without inadvertently causing harm, and to derive lessons for how best to manage and deliver interventions. Developing and scaling-up effective interventions to mitigate the impacts of HIV and AIDS among children without further jeopardising their rights requires evaluation, including seeking input of community members and stakeholders.

As this review illustrates, there remain many obstacles to evaluating community OVC programmes; including ethical challenges, operational and funding realities, and lack of consensus on measurement and analytical approaches. In addition, incentives for conducting evaluations may conflict with implementers’ priorities: evaluation may be seen as competing with programme activities for intensive use of resources including staff time, thus undermining existing activities to produce results that may even threaten continued funding. External evaluators, caught between the urgent need to build local evaluation capacity and the reality that programmes cannot afford to wait for it, may be seen as a further distraction and drain on resources that fails to build internal capacity. Managers and evaluators may conflict over demands to generate data useful for meeting local needs or for meeting reporting requirements of donors seeking regional comparisons – dialogue addressing this conflict is urgently required in order to retain the specifics even when seeking the generalisable.

However, these challenges should not be used to justify developing a policy agenda uninformed by empirical evidence (Davey Smith et al. 2001). As this review has shown, there remain opportunities

⁵ The costs of a public good are borne by individual organisations, but the benefit of results is shared diffusely among many stakeholders.

to maintain acceptable levels of rigor in evaluations of community OVC interventions, through approaches including process evaluations and quasi-experimental research designs. The studies reviewed illustrate ways to making the most of available data and resources: e.g. without baseline data, retrospective post-intervention analysis may be used; without a comparison group, time-series data may provide useful information. Evaluation designs need to be responsive to changing field conditions, including the welcome consequences of gradually expanding access to antiretroviral treatment, which is changing the context of care and support programmes. Researchers and evaluators must be careful to safeguard data quality and keep study design compatible with questions under investigation.

While programme implementers require funding and technical expertise to conduct methodologically sound evaluations, they should also make more strategic use of already existing data gathered through routine monitoring. Since monitoring data is often of variable quality, strengthening systems and building local capacity are key priorities that will have multiple pay-offs. Researchers should explore whether other rich sources of data on children (including DHS and MICS) may already provide relevant data or may be open to oversampling in specific programme locations, to take advantage of existing data collection frameworks. Evaluators should respond to the short supply of evaluation funding and technical expertise and create training opportunities. But all of these recommendations need funding.

Given the significant expense, effort and expertise required, it is hardly surprising that donors do not require implementers to incorporate robust research into every funded intervention in order to evaluate it. But as long as donor reporting requirements consist largely of providing inventories simply counting the number of services delivered or recipients served, without exploring processes or resultant outcomes, OVC programmes will miss the opportunity to deliver quality services (see also (Blackett-Dibinga and Sussman 2008) report for JLICA LG2). Indeed, one of the studies in the literature review observed that focussing on collecting numbers of children (e.g. attending school, enrolled in programme) may have diverted implementers away from qualitative data that would have been valuable for developing more holistic programming (Depp et al. 2006). Highlighting small-scale best practices may indeed be a starting point; but unless every pilot programme includes a sound and well-funded evaluation component, subsequent scale-up and policy development will be ill-informed (Moroni et al. 2007). Donors funding programme implementation also need to prioritise the development of a strategic evaluation agenda identifying geographic and thematic research priorities (e.g. whether to focus on extant impact in high-prevalence settings or prepare to avert future impacts in low-prevalence settings; which intervention evaluations ought to prioritise questions of cost-effectiveness and which emphasise the importance of qualitative insights into programme delivery?).

In order to derive lessons for the scale-up of effective and efficient support interventions for children affected by AIDS, immediate imperatives are for existing programmes to strengthen monitoring and evaluation systems and build local technical capacity for evaluating processes and outcomes of the intervention, including cost-effectiveness and service quality. Donors urgently need to prioritise building an evidence base that will inform the development of OVC programmes whose scale-up they are funding, while maintaining required levels of quality and rigour in the empirical evidence. Collective action to gather political and financial commitment to evaluating community

OVC programmes may be required. While investment in methodologically sound evaluation research is undoubtedly more technically demanding and resource-intensive than service delivery, the long-term pay-offs of developing a solid evidence base will ensure that future spending is better directed at producing better outcomes among more children. Future investments towards achieving the Millennium Development Goals, especially to improve the quality of life of children who have been orphaned and rendered vulnerable by AIDS, must be driven by empirical data to address the key questions of what works in providing care and support and how to do it.

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Table 1: Community interventions to support children and families affected by HIV and AIDS in Africa that have been evaluated

Intervention location and name	Implementer and evaluator	OVC Intervention strategies	Key child-level quantitative outcomes indicators	Key findings, recommendations
[1] Botswana, Lesotho, Namibia, South Africa, Swaziland – Collaboration and sustainability study (Rosenberg et al. 2008)	Interventions implemented by local chapters of international organisations, CBO/ Government/ private sector partnership, academic institution. Interventions and evaluations funded by Bristol-Myers Squibb's Secure the Future initiative. Evaluated by Center for Interdisciplinary Research on AIDS, Yale University.	Faith-based community care approaches (Lesotho and South Africa). Faith-based psychosocial support programmes through day care with community outreach (Botswana) and camps and youth clubs (Namibia). Building community capacity to serve OVC (South Africa, Swaziland, Lesotho). Dissemination of information about accessing social grants (South Africa).	n/a	For eight out of the nine projects, evaluations provided evidence of the importance of the government partnership for sustainability. Government collaboration was important in projects designed to help families access government grants, initiate community-based solutions, and advocate for OVC rights through legislation. Government partnerships were also critical to the sustainability of two projects involved in placing children in foster care, but these showed signs of tension with government partners. In addition to the more common factors associated with sustainability, such as organisational characteristics, donors and NGOs should concentrate on developing strong partnerships with local and national government agencies for the sustainability of their projects.
[2] Botswana and South Africa – Two models of community-based care (Kidman et al. 2007)	Centralised approach implemented by Bana ba Keletso (CBO). Decentralised approach implemented by Ikamva Labantu (CBO). Evaluated by McGill University.	Centralised approach to orphan care: supervised daycare for pre-school aged children; meals, skills-building and psychosocial counselling for older children; family outreach through home visits. Decentralised approach to care of orphans and vulnerable children: indirect support to a network of daycare centres; direct household support through material support, nutritional assistance, social worker visits, assistance in accessing grants, school fee waivers and school uniforms.	n/a	Centralised approach allows for comprehensive outreach, ensures direct benefit from resources, facilitates good quality control; but is labour intensive to scale up. Decentralised approach allows orphans to remain more integrated within their community; reduces costs and facilitates scale-up through use of existing structures; but less control over service quality and benefits.
[3] Kenya and Tanzania – Four programmes (Measure Evaluation 2007)	Implemented by Pact, Salvation Army, CARE, Allamano, FHI, Pathfinder International, Integrated AIDS Program, Catholic Relief Services. Evaluated by	Four different programmes all employing community mobilisation and some combination of child-, family-, or community-centred approaches to improve child well-being.	Education, health, food, and nutrition, child protection, psychosocial well-being, HIV and AIDS knowledge, sexual behaviour (adolescents only), community support,	Challenges experienced across the 4 case studies include: <ul style="list-style-type: none"> • addressing the many and diverse needs of OVC households; • fostering household independence and discouraging dependency on the intervention; • inflexible target numbers of beneficiaries that do not respond to changing local circumstances or permit enrolling new clients; • addressing community expectations of direct material

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	MEASURE Evaluation.		adult perception of child wellbeing	<p>assistance;</p> <ul style="list-style-type: none"> • realising the goals of vocational training (IGA success is highly variable); • urban challenges to service provision and community ownership; • management of sub-grantees and volunteers (difficulty of attracting and retaining volunteers without remuneration, variable volunteer motivation and skill, volunteers unprepared for child and adolescent needs, volunteers require support in developing detailed work plans. training, guidance, equipment, economic strengthening); • social, medical, and transport services are lacking in rural areas, especially where caseload is geographically dispersed; • insufficient time currently allotted for community engagement process. <p>Innovations and successes across the 4 case studies emphasise the importance of:</p> <ul style="list-style-type: none"> • community participation and engagement (engaging OVC, guardians and PLHA as active programme participants; partnering with community stakeholders; training community members as trainers; empowering local leaders; helping communities create action plans; involving youth as active programme participants to foster leadership skills) • adapting interventions to community-identified needs (beneficiary selection based on local definitions of vulnerability); • direct material support and service provision by the community to enhance participation and sustainability; • local capacity building (building the capacity of educational institutions; offering training in a community setting; encouraging CBOs to be self-sufficient; building staff capacity; capitalising on strengths/talents of established organisations; participatory planning with sub-grantees) • creating transparent project implementation (disseminating information at committee meetings; community sensitisation and mobilisation in urban settings; providing comprehensive caregiver services; assuring better volunteer supervision)
[4] Malawi – Community-based Options for Protection and Empowerment	Implemented by Save the Children/US. Evaluated internally and with support from Horizons.	Community mobilisation intervention including formation and strengthening of community care alliances.	n/a	Fragmented, compartmentalised programmes were less effective than integrated approaches to assisting families affected by HIV and AIDS including care for PLHA & OVC, income generation, micro-credit. Links between HIV and AIDS, orphans and chronic illness were better understood in villages with a mobilisation committee.

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(COPE) (Donahue and Williamson 1996; Donahue and Williamson 1998; Esu-Williams et al. 2000; Williamson and Donahue 2001; Hunter 2002; Donahue and Mwewa 2006)				Unlike villages reached by the intervention, villages without a mobilisation committee had not taken any tangible, collective action regarding the care and support of PLHA and orphans. The orphan subcommittee was the most visible and recognised of the subcommittees, but accomplishments were uneven. Youth subcommittees played a pivotal role in HIV and AIDS activities and were poised to do more. Home-based care subcommittees remained active in villages with mobilisation committees but morale was low because of the increasing number of ill people. The need for income-generating activities was great but inputs and expertise were limited. HIV prevention activities for high-risk groups were the weakest component of the programme. Programme phase-out occurred too soon to build adequate capacity and trust. Community ownership and participation in decision-making and action were essential for initiating and sustaining community action.
[5] Malawi – Orphan Care Activities (Ledward et al. 2001)	Implemented by Save the Children (UK). Evaluated internally.	Facilitated Orphan Care Committee; provided safe shelter for pre-school and trained caregivers; rehabilitated borehole; provided short-term inputs including fertiliser, seeds, teaching materials.	n/a	Community ownership (especially commitment from local leadership) and village level advocacy (including multi-sectoral support) have been key to intervention implementation. Physical inputs (e.g. borehole, preschool) have delivered health and education benefits and provided a focus for community led and community managed activities. Short term inputs of fertiliser, seed and for the pre-school can address immediate needs but can also raise expectations of longer term support which need to be discussed at an early stage. Community level activities should be complemented at the household level, especially by providing material support for families lacking labour and food. Support for food security and school fees is especially needed, as part of a multi-sectoral approach acknowledging household resource constraints. Provision of safe water was a helpful entry point for integrating other orphan care activities; more effort is required to link additional programmatic components including HIV prevention, addressing HIV-related stigma, providing psychosocial support to children. Further monitoring and evaluation needs must be addressed to determine project future.
[6] Rwanda - FXB Village Model (Desmond 2007; Wilson and Berkman 2007)	Implemented by Association Francois-Xavier Bagnoud. Evaluated by Human Sciences Research Council and Columbia University.	Grants for income-generating activities (group and individual projects), assistance with school fees, nutritional support, help in accessing healthcare/health insurance psychosocial counselling, child protection and HIV prevention activities. Household visits from staff including coordinator, nurse-counsellor, social worker.	Household economic data including incomes, consumption, expenditure, expenditure on education, children's educational progress	Survey among a sample of former beneficiaries estimates that a majority are not living below the poverty line – i.e. poverty rates are lower than the national average. (The presumption is that since they were originally selected into the programme on the basis of vulnerability, many were previously living in poverty.) Effects of increasing access to antiretroviral treatment may be presumed to also play a role in improving outcomes. Urban-rural differences – e.g. in accessing markets – must be taken into account in assessing impacts. Monitoring data on children's educational progress suggest improving outcomes among beneficiaries, but more data is needed. In order to scale-up programme activities within intervention villages and beyond, further attention is needed to strategic issues including

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				determining whether the programme is focussed on HIV or poverty and re-examining programme entry criteria.
[7] Rwanda – Mentoring youth-headed households (Brown et al. 2005; Boris et al. 2006; Thurman et al. 2006b; Horizons 2007a; Horizons 2007b)	Implemented by World Vision. Evaluated by Rwanda School of Public Health, Tulane University, Horizons.	Trained adult volunteers from the community provide mentorship through home visitation to youth-headed households.	Psychosocial indices including feelings of depression, grief, marginalisation	Baseline found high levels of psychosocial distress among youth. Intervention was associated with improvements in psychosocial outcomes among participants.
[8] South Africa costing (Desmond and Gow 2001; Desmond et al. 2002)	Implemented by Nazareth House, Durban Children's Society, Sophie Jardim House, Sinosizo, the Pin Project, and Nceba Village. Evaluated by UNICEF.	Six intervention models: informal or non-statutory foster care; community-based support structures; home-based care and support; unregistered residential care; statutory adoption and foster care; and statutory residential care.	Costs of replicating care model, costs of providing a minimum standard of care	The most cost-effective way of caring for children is through community-based organisations, but further discussion is required to highlight other issues including differences in quality of care between different models. The six models have different benefits and different success in providing for the minimum standard of care. The most cost-effective models of care do not always meet children's basic needs due to difficulties accessing necessary childcare resources.
[9] Tanzania: Care Tumaini Programme Assessment (Attawell et al. 2005; Measure Evaluation 2007)	Implemented by CARE Tanzania, Center for Counselling, Health and Nutrition Care, Family Health International, Healthscope Tanzania, Heifer International, and Muhimbili University College of Health Sciences; operating through 23 grantees. Evaluated by USAID.	Home-based care for people living with HIV and support for orphans and vulnerable children, aiming to improve access to health, educational and socio-economic support.	n/a	Challenges include relationships between partners, establishing effective linkages and referrals, institutional weaknesses, high staff turnover. Sub-grantees require high levels of organisational and technical inputs and support for follow on activities, training and volunteer support. Recommendations include the need to improve management and coordination, consolidate training and supervision, strengthen technical support and quality of services, strengthen referral linkages and systems, and assess impact.
[10] Tanzania: Most Vulnerable Children (Mhamba 2004; Measure Evaluation 2007)	Implemented by Department of Social Welfare in collaboration with UNICEF. Evaluated by UNICEF.	Community dialogue aimed at advocacy and mobilisation; community facilitation in the identification of criteria of vulnerability; identification of the most vulnerable children in the community; mobilisation of community resource contribution (human, material and financial) to provide them with support; provision of	n/a	The intervention is not yet adequately owned by the community, indicated by lack of community commitment and inadequacy of organisational support by leaders at all levels that has reduced programme effectiveness in providing adequate care, support and protection. Programme implementation process is constrained at all levels by poor coordination, lack of integration with other development efforts, under-resourcing, poor data management and lack of follow-up and, lastly, lack of integration of the non-state actors in the implementation of the programme (i.e. NGOs, FBOs, and NGOs). Nevertheless, some success has been achieved in the provision of educational support, including school materials and fees

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		matched fund contributions to cover costs of school, healthcare and contingencies, construction materials for shelters, bedding, clothes, etc.		for a small proportion of children. Scaling up is required to increase coverage and range of services provided. Further community dialogue is required to re-sensitise community members and leaders.
[11] Tanzania: Vijana Simama Imara (VSI) (Clacherty and Donald 2005)	Implemented by Humuliza / Terres des Hommes. Evaluated by Clacherty and Associates.	Child-led organisation providing material support activities, counselling, HIV information and counselling, self defence training, agricultural training, recreational activities.	Social networks (number of peer friends and supportive adults), emotional stress scale, HIV knowledge, current earnings, budgeting awareness	Across a range of indicators and two age groups, children participating in the interventions showed better outcomes than children not participating in the interventions, in terms of psychosocial wellbeing and socio-economic indicators. An organisational model based on children's participation should be considered more widely as an intervention strategy.
[12] Uganda – Succession planning (Horizons et al. 2004)	Implemented by Plan/Uganda, Grasslands, NACWOLA. Evaluated by Horizons, Makerere University.	Help families and communities prepare for children's future well-being parental death.	Parental HIV status disclosure, appointment of standby guardian, having a written will	Intervention was associated with increase in parents appointing successor guardian, will-writing, HIV status disclosure. Need to enhance opportunities for community involvement in programme, especially men.
[13] Uganda/ Rwanda/ Kenya – AVSI (AVSI 2007; Castelli et al. 2007)	Implemented by AVSI through 82 local partners. Evaluated by Fondazione per la Sussidiarietà.	Holistic package of services including schooling assistance, healthcare, nutritional support, psychosocial support, household income generating activities, school rehabilitation and support, community sensitisation and outreach.	Composite indices constructed to represent disease, nutrition, caregiving, school performance, family economic wellbeing, social risk	Self-reported health and care quality are overall good. Families face economic and environmental risks. Educational delays are common but school attendance is mostly regular. Cross-sectional baseline data (used to construct indices) indicate that school performance index is positively correlated with family income and quality of children's relationships with adults and peers and negatively correlated with number of children in the classroom and cost of school fees. Follow-up data not yet available.
[14] Uganda and Zambia – Core HIV and AIDS Models (World Vision 2007)	Implemented by World Vision. Evaluated internally by World Vision's Operations Research Project.	Main OVC programming model: Community Care Coalition aiming to improve quality of life of OVC through mobilising and equipping community organisations to care for OVC and people who are chronically ill Additional complementary initiatives assessed include working with faith leaders to address attitudes and enable churches and FBOs to respond to HIV and AIDS in their community; and promoting HIV prevention	Child and c status schoc enroll immunisation for children aged <5 years old (possession of immunisation card, received BCG/polio/DPT/measles immunisations); children's food security (access to adequate food during last 30 days); malaria	At both sites, the intervention was associated with an increase in the proportion of children with access to adequate food and an increase in the proportion of children sleeping under a bednet. In Zambia, the intervention was associated with an increase in the proportion of OVC currently enrolled in school. There were no significant changes between baseline and follow-up in overall children's schooling outcomes, immunisation status or psychosocial challenges. Overall food insecurity increased between baseline and follow-up in both locations, and was significantly higher among OVCs (especially among females in Uganda). Despite variations between the two study sites, results indicating increased OVC access to services (including psychosocial support, bed nets, food, healthcare, schooling) and increased community response and leadership in addressing children's prevention and in meeting OVC needs provide some limited but encouraging evidence for an intervention effect after 14 months of implementation. However, OVC needs continue to far

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		among children aged <18 years old by promoting communication, negotiation and decision-making through values-based lifeskills training, peer education and clubs, sports and art programmes.	prevention and access to medical care (sleeping under a bednet, children's chronic illness during past 12 months, child's access to medical care when sick); psychosocial wellbeing of children aged 5-17 years old (psychosocial score index based on 12 questions to caregivers)	outweigh existing community resources. There remains an urgent need to increase advocacy for more funding for OVC programming. Food is a critical basic need for OVC. Community empowerment interventions to address OVC needs can be effective in reducing food insecurity, and need to take into account the long-term nature of food security for increasing numbers of OVC by acknowledging the importance of locally sustainable strategies (including resources and skills), careful community monitoring of effects, and considering targeting approaches sensitive to local conditions including highly affected communities. Implementers need to strengthen community capacity to support OVC, particularly regarding sexual abuse and general child protection issues. There remains a need for operations research on the relative effectiveness of intervention strategies that focus on changing social and gender norms as strategies for reducing vulnerability to HIV; and on different mechanisms of providing food for OVC (e.g. through school-feeding programmes, provision to households, voucher schemes or cash transfers).
[15] Zambia – Strengthening Community Partnerships for the Empowerment of Orphans and Vulnerable Children (SCOPE-OVC) (SCOPE-OVC/Zambia et al. 2002; Craft 2003; SCOPE-OVC/Zambia and Family Health International/Zambia 2003; Donahue and Mwewa 2006)	Implemented by FHI, Care and Family Health Trust. Evaluated internally.	Community mobilisation intervention, including formation of community committees and networks, advocacy, capacity building, grant making.	n/a	Community-based mobilisation approaches are important and relevant. They should target households rather than individuals for broader, more holistic care and support. Further work is needed on effectiveness, sustainability, scale-up. Sub-grants providing support to community schools are improving learning environments for students, but further strengthening is required, including staffing and construction. Community ownership and participation in decision-making and action are essential for initiating and sustaining community action.
[16] Zambia – Bwafwano program (Chatterji et al. 2005; Dougherty et al. 2005; Chatterji et al. 2007)	Implemented by Bwafwano and Project Concern International (PCI) Zambia. Evaluated by Community REACH (baseline) and MEASURE Evaluation (endline).	Programme components include education, home-based care, food assistance, clinic-based healthcare, psychosocial counselling.	School attendance and performance (including correct grade for age, age at starting and finishing school), nutrition, psychosocial wellbeing, sexual behaviour	Data analysis in progress. Preliminary results indicate that the intervention was not effective in getting children into school at an earlier age, but was successful at keeping children in school longer despite secular trends in the opposite direction.
[17] Zambia – Chikankata (Mulenga 2002)	Implemented by Salvation Army. Evaluated by UNICEF.	Orphan support programme to increase community capacity (including income generating activities) and training for	n/a	Programme constraints include: community inability to select and run IGAs generating sufficient profits to cover OVC basic needs, due to lack of skills (e.g. entrepreneurship) and capital; inadequate transport; no baseline due to lack of funds and expertise; limited

Intervention location and name	Implementer and evaluator	OVC Intervention strategies	Key child-level quantitative outcomes indicators	Key findings, recommendations
		individuals working on OVC programmes.		community participation in training. Recommendations include: reconsider present policy of non-support to IGAs; include some older OVC at community planning level; empower women caring for orphans with basic seed capital; identify and engage an expert to carry out a baseline study in which all project staff participate; develop an action plan for all communities to re-sensitise guardians and other OVC care givers in order to raise the levels of cooperation; work out a consistent committee structure for all villages in the programme; strengthen service delivery packages in light of all available models of care across the country; identify trainable individuals in each community for OVC training.
[18] Zambia – Reaching AIDS-affected People with Integrated Development and Support (RAPIDS) (Population Council 2006b; RAPIDS 2006; Population Council 2008; Schenk et al. 2008a; Schenk et al. 2008b)	Implemented by World Vision, Catholic Relief Services, Africare, Salvation Army, Expanded Church Response, Care. Evaluated by Population Council.	Integrated multi-sectoral support for families and communities affected by HIV and AIDS through home-based care and support to PLHA and OVC and youth livelihoods interventions. Components include educational support, home visits by caregivers, food support, psychosocial support, income generating activities.	School attendance, enrolment and absenteeism, food security, programme contact	Baseline data revealed importance of clearly defining causes and consequences of children's vulnerability. Follow-up data suggest that the educational disadvantage suffered by children who have been orphaned and rendered vulnerable is getting smaller, especially among females. Findings emphasise the importance of transparency and accountability in client selection and service delivery, and opening channels of communication for client feedback.
[19] Zimbabwe – Families, Orphans and Children under Stress (FOCUS) (Foster et al. 1995; Foster et al. 1996; Foster et al. 1997a; Foster et al. 1997b; Drew et al. 1998; Lee 1999; Foster 2002b; Lee et al. 2002)	Implemented by Family AIDS Caring Trust (FACT). Evaluated internally.	Trained community volunteers identifying and supporting vulnerable households through visits and provision of targeted educational and material support.	n/a	Low cost intervention is a targeted, effective, sustainable and replicable way to provide community-based care to children affected by HIV and AIDS. Need to address sexual abuse; communication about sex and relationships; loneliness, stigma and discrimination experienced by orphaned children; and the need for greater children's participation. External organisations have an important role to play as catalysts to communities: coordinating responses, directing essential support to the most needy and helping to develop income-generating activities. Communities are capable of targeting OVC in greatest need.
[20] Zimbabwe – Psychosocial support interventions (Gilborn et al. 2006)	Implemented by CRS/STRIVE, REPSSI, and Masiye Camp. Evaluated by Horizons.	Community-based psychosocial support programmes and residential camp programme for vulnerable children and youth.	Psychosocial indices of well-being	Widespread indications of psychosocial distress among youth. Participation in a psychosocial support intervention was associated with greater self-confidence among males. Psychosocial support interventions need to explore, recognise and respond to the needs of vulnerable youth.
[21] Zimbabwe – Support for Replicable Innovative Village/ Community Level Efforts for	Implemented by Catholic Relief Services. Evaluated internally at mid-term with support	Community mobilisation intervention to support local NGOs in conducting psychosocial support, food security, education assistance	n/a	Programme partner capacity was good, with high levels of skill and commitment, but is not being fully utilised due to lack of funds and a relatively narrow understanding of opportunities. Communities are aware of the needs of vulnerable children but lack sufficient information and materials on childcare and protection, HIV prevention

Intervention location and name	Implementer and evaluator	OVC Intervention strategies	Key child-level quantitative outcomes indicators	Key findings, recommendations
Children Affected by HIV/AIDS (STRIVE) (Catholic Relief Services and United States Agency for International Development (USAID) 2003; Depp et al. 2006; Dube et al. 2006)	from FHI; final assessment by GH Tech for USAID.	and child protection interventions.		and treatment. Volunteers could be encouraged through additional recognition and limited material assistance. Empirical data collected through operations research is needed to identify and document traditional community practices (e.g. around child care, reproductive health) on which to build quality interventions. Educational Assistance is highly valued but resource intensive and unsustainable. Communities need meaningful income generating activities that can survive despite weak markets. More could have been done to learn from and support needs identified by communities and partners.

Note: Numbers in square brackets indicate the study numbers referred to in the text

Table 2: Evaluations of community interventions to support children and families affected by HIV and AIDS

Evaluation study location and name	Quantitative						Qualitative			
	Baseline data collection	Post-intervention data collection	Longitudinal follow-up	Comparison group	Population-based	Costing	Internal stakeholders (programme staff and volunteers)	External stakeholders (e.g. community leaders, teachers)	Programme recipients – adults	Programme recipients – children
[1] Botswana, Lesotho, Namibia, South Africa, Swaziland (Rosenberg et al. 2008)	x	x	x	x	x	x	✓	x	x	x
[2] Botswana and South Africa – Two models of community-based care (Kidman et al. 2007)	x	x	x	x	x	x	✓	x	x	x
[3] Kenya and Tanzania – Four programmes (Measure Evaluation 2007)	x	✓	x	✓	x	✓	✓	✓	✓	✓
[4] Malawi – Community-based Options for Protection and Empowerment (COPE) (Donahue and Williamson 1996; Donahue and Williamson 1998; Esu-Williams et al. 2000; Williamson and Donahue 2001; Hunter 2002; Donahue and Mwewa 2006)	x	x	x	x	x	✓	✓	✓	✓	✓
[5] Malawi – Orphan Care Activities (Ledward et al. 2001)	x	x	x	x	x	✓	✓	✓	✓	✓
[6] Rwanda - FXB Village Model (Desmond 2007; Wilson and Berkman 2007)	x	✓	x	x	x	✓	x	x	x	x
[7] Rwanda – Mentoring youth-headed households (Brown et al. 2005; Boris et al. 2006; Thurman et al. 2006b; Horizons 2007a; Horizons 2007b)	✓	✓	x	✓	x	x	✓	✓	✓	✓
[8] South Africa – costing (Desmond and Gow 2001; Desmond et al. 2002)	x	x	x	x	x	✓	x	x	x	x
[9] Tanzania: Care Tumaini Programme Assessment (Attawell et al. 2005; Measure Evaluation 2007)	x	x	x	x	x	x	✓	✓	✓	x
[10] Tanzania: Most Vulnerable Children (Mhamba 2004)	x	x	x	x	x	x	✓	✓	✓	✓
[11] Tanzania: Vijana Simama Imara (VSI) (Clacherty and Donald 2005)	x	✓	x	✓	x	x	x	✓	x	✓
[12] Uganda – Succession planning (Horizons et al. 2004)	✓	✓	x	✓	x	x	✓	✓	✓	✓
[13] Uganda/Rwanda/Kenya – AVSI (AVSI 2007; Castelli et al. 2007)	✓	✓	✓	x	x	x	✓	✓	x	x
[14] Uganda and Zambia – World Vision Core HIV and AIDS Models (World Vision 2007)	✓	✓	x	✓	x	x	✓	✓	✓	✓

Evaluation study location and name	Quantitative						Qualitative			
	Baseline data collection	Post-intervention data collection	Longitudinal follow-up	Comparison group	Population-based	Costing	Internal stakeholders (programme staff and volunteers)	External stakeholders (e.g. community leaders, teachers)	Programme recipients – adults	Programme recipients – children
[15] Zambia – Strengthening Community Partnerships for the Empowerment of Orphans and Vulnerable Children (SCOPE-OVC) (SCOPE-OVC/Zambia et al. 2002; Craft 2003; SCOPE-OVC/Zambia and Family Health International/Zambia 2003; Donahue and Mwewa 2006)	✓	✗	✗	✗	✗	✗	✓	✓	✓	✓
[16] Zambia – Bwafwano program (Chatterji et al. 2005; Dougherty et al. 2005; Chatterji et al. 2007)	✗	✓✓	✗	✓	✗	✓	✗	✗	✗	✗
[17] Zambia – Chikankata (Mulenga 2002)	✗	✗	✗	✗	✗	✗	✓	✓	✗	✗
[18] Zambia – Reaching AIDS-affected People with Integrated Development and Support (RAPIDS) (Population Council 2006b; RAPIDS 2006; Population Council 2008; Schenk et al. 2008a; Schenk et al. 2008b)	✓	✓✓	✗	✗	✓	✗	✓	✓	✓	✓
[19] Zimbabwe – Families, Orphans and Children under Stress (FOCUS) (Foster et al. 1995; Foster et al. 1996; Foster et al. 1997a; Foster et al. 1997b; Drew et al. 1998; Lee 1999; Foster 2002b; Lee et al. 2002)	✓	✗	✗	✗	✗	✓	✓	✓	✓	✓
[20] Zimbabwe – Psychosocial support interventions (Gilborn et al. 2006)	✗	✓	✗	✓	✗	✗	✓	✓	n/a	✓
[21] Zimbabwe – Support for Replicable Innovative Village/Community Level Efforts for Children Affected by HIV/AIDS (STRIVE) (Catholic Relief Services and United States Agency for International Development (USAID) 2003; Depp et al. 2006; Dube et al. 2006)	✓	✗	✗	✗	✓	✗	✓	✓	✓	✓

Note: Each row may refer to multiple methods used in separate activities within a single study.

Key:

✗ Methodology not employed in study

✓ Methodology employed in study

✓✓ Multiple rounds of methodology employed in study