Catholic Relief Services'
OVC PEPFAR Programs

A Midterm Multicountry Program Evaluation

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TABLE OF CONTENTS

ACRONYMS

AB	Abstinence, Be Faithful, prevention
AIDS	Acquired Immune-Deficiency Syndrome
ART	Anti-Retroviral Treatment
CRS	Catholic Relief Services
FGD	Focus Group Discussions
HIV	Human Immunodeficiency Virus
HH	Household
NGO	Nongovernmental Organization
OVC	Orphans and Vulnerable Children
PEPFAR	President's Emergency Fund for AIDS Relief
VCT	Voluntary Counseling and Testing

INTRODUCTION

The situation of orphans and vulnerable children (OVC) has become an important issue facing the world. Worldwide, it is estimated that 15.2 million children under age 18 have lost one or both parents to acquired immunodeficiency syndrome (AIDS).[3] The vast majority of HIV-affected households are in sub-Saharan Africa, where approximately 12 million children under 18 have lost one or both parents to HIV. This number is expected to grow to more than 14 million by 2015. In Botswana and Zambia, two highly HIV-affected countries in which CRS operates, an estimated 20% of children under 17 are orphans with most orphaned as a result of HIV.[4] The enormous scope of the crisis requires a rapid scaling up of sustainable interventions that will meet the long-term needs of affected communities, a broad resource base, and effective collaboration to ensure the best use of resources.

The effects of HIV and AIDS on children, families, communities, and countries are products of many interrelated factors and require responses that vary by family, community, and country. These factors include the local pattern of the spread of HIV, economic activities, service availability, resources, public knowledge and awareness, the social environment, culture, the legal environment, and political leadership. For responses and interventions to be effective with a strategic use of resources, they must be informed by a working understanding of the most significant of these factors and how they relate to each other in terms of causality and mitigation of the devastating impact.

Children affected by HIV and AIDS suffer from the stigma and discrimination associated with the disease, the loss of caring adults, and depletion of household financial resources. Interventions must go beyond care and support of OVC to a focus on Integral Human Development of children and their families.

THE PEPFAR OVC PROGRAM

Orphans and vulnerable children (OVC) programs are one of the cornerstones in the President's Emergency Fund for AIDS Relief (PEPFAR). Fifteen countries have been the focus for PEPFAR funding because they are among the countries with the highest rates of HIV infection worldwide.

3 2005 Report on the Global AIDS Epidemic, UNAIDS, Geneva, 509.
4 2008 Report on the Global AIDS Epidemic, UNAIDS, Geneva, 163-168.

Although the interventions vary across each country, PEPFAR's OVC programs build capacity within affected communities and within partner organizations. By so doing, the quality of life is improved for OVC. Core services developed within each program include a cluster of services, selected from the following priority areas within the PEPFAR OVC program: education, health, psychosocial support, food and nutrition, economic strengthening, shelter, and child protection.

Catholic Relief Services' PEPFAR-funded OVC programs are implemented in six countries. Five participated in the midterm evaluation: Haiti, Kenya, Rwanda, Tanzania and Zambia. The OVC programs are developed by the local partners and by the in-country staff within CRS. The goal of the Catholic Relief Services' PEPFAR OVC programs is to improve the quality of life for orphans and vulnerable children affected by HIV and AIDS. These programs also have the following two strategic objectives:

1. Increase the capacity of communities, families, and orphans themselves to respond effectively to the needs of OVC.

2. Increase institutional capacity of faith-based and community-based partners to deliver sustainable, high-quality OVC interventions.

Catholic Relief Services' partners use a broad range of strategies and activities to build the capacity of communities. In addition, CRS has actively worked with the partners to build internal capacity and competencies to deliver sustainable high-quality OVC interventions. Since 2004, the number of OVC reached has more than doubled, from 47,194 to nearly 101,456 (FY09 Workplan). Over the length of the program, more than 18,000 guardians and parents have received training in supporting OVC and more than 109,312 family members have been indirect beneficiaries of the program. Similarly, partner staff have received training, and they have benefitted from the development of special tools to monitor programs activities and outcomes.

RATIONALE FOR PROGRAM EVALUATION

Catholic Relief Services undertook this evaluation of its PEPFAR-funded Track One OVC programs in 2007, because the organization wanted to assess how the CRS PEPFAR OVC program was being implemented, the extent to which the OVC program has met the needs of the beneficiaries, and the ways to improve the capacities of communities to provide quality services. The evaluation was structured to measure the impact of this program for children who were enrolled since 2005, and as such, it permitted CRS to assess the progress of the PEPFAR OVC program at the midterm.

"It is those [NGOs] which are religious-based whose aids reach directly targeted OVC."

-Tanzanian community leader

CRS' OVC programs are unique because most have been developed using a parish model. Many of the partners involved with the design and the development of these programs work within the structure of their country's dioceses. CRS believes that the parish structure fortifies communities, and thus it is an ideal structure to integrate a support program for children affected by the AIDS epidemic.

Each CRS country program selected specific dioceses for their OVC program, and their selections were guided by their knowledge of those regions with the highest prevalence of AIDS. CRS programs in Haiti chose to focus on institutions in which orphans had been placed for residential care and support, and as such the program in Haiti had some rather unique qualities.

This report will focus on the quantitative data that was collected to evaluate the five programs. A series of focus group discussions and in-depth interviews with OVC and community leaders were also conducted; quotations from qualitative data are included to illustrate quantitative findings.

DATA COLLECTION METHODS

Two groups, stratified by age, were surveyed about the services offered by Catholic Relief Services' OVC programs and the perceived benefits of such services. The younger group was 7-12 years of age, and the older, adolescent group was 13-18 years of age. Two questionnaires were developed: one was given directly to the OVC 13-18 years old, and the

other questionnaire was given to caregivers of younger OVC, aged 7-12 years. The sample sizes were informed by two major factors: the assumed proportions of OVC living in the project areas and the survey cost. Two hundred twenty-five OVC in each age group were chosen for interviews in each country, using a systematic sampling technique. In the event that a family refused to complete the survey, an alternate OVC was selected. In most instances, the alternate OVC was selected using a random selection technique. As a result, 450 OVC were included in each country's database, and a total of 2,250 OVC were included in the entire evaluation.

Rwanda and Tanzania also selected a group of OVC to serve as a comparison group, and this group was interviewed using the same survey instrument. This control/comparison group was selected from the subpopulation of OVC living in the same region who were not accessing CRS' OVC services. This group was selected by an independent agency, and this agency used identical selection techniques to choose the OVC who participated as controls.

Research was conducted by fieldworkers who were trained to survey children and caregivers. They were given skills in identifying OVC and families, and they were also trained to track people who might have been difficult to locate for the survey. Questionnaires were translated in the local language of the country and the region in which the interviews were conducted.

Baseline data was not available for the children who completed this survey, as children were not evaluated prior to enrolling in this program. This may pose some limitations in determining the program's impact. Nevertheless, this midterm evaluation permitted CRS to make some assessments about the status of children currently served by the program.

Focus group discussions (FGD) were conducted separately for boys and girls in each age group. The FGD were aimed at determining the perceptions of OVC, the living conditions of the OVC and their level of awareness of the community services being offered to OVC.

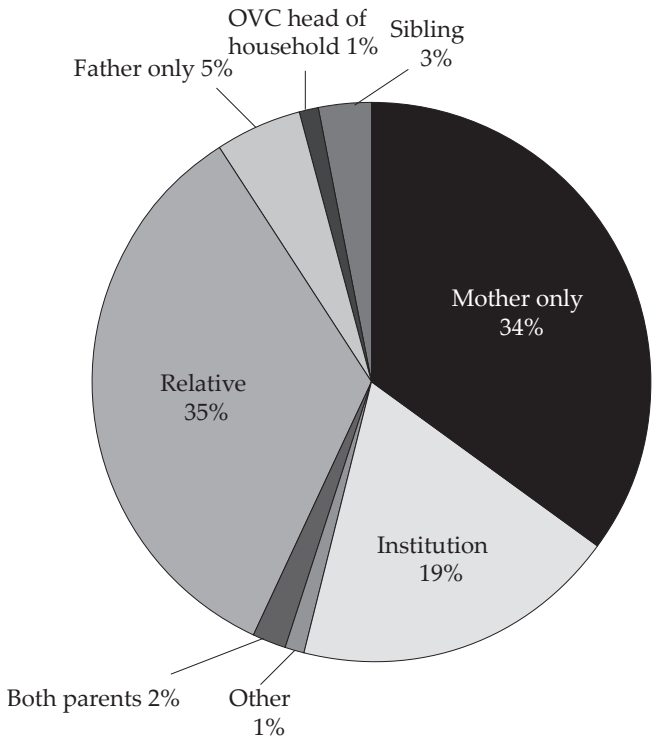
FGD were held separately for community leaders and for volunteers. Besides obtaining information on types of services currently offered to the OVC in their communities, the FGD among community leaders were

aimed at determining: (i) their perceptions of the problems and conditions of OVC, (ii) what the community is doing to improve the conditions of the OVC, and (iii) what they think should be done to improve the CRS OVC project to better meet the needs of the OVC.

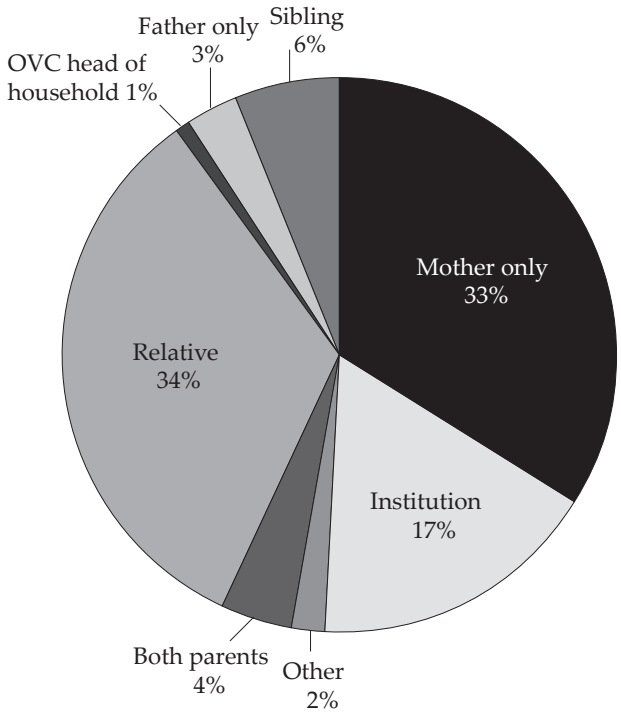
The FGD notes were transcribed by the local consultant. The transcribed notes (in English) were sent to the external consultants, who then did a content analysis of the notes.

OVC CHARACTERISTICS

This report reviews the characteristics of beneficiaries living in households headed by both parents (vulnerable children), fathers, mothers, other relatives, or children. The charts below (Figure A) indicate the distribution of household types, for the younger OVC and for the adolescent OVC.



Distribution of OVC types, ages 7-12



Distribution of OVC types, ages 13-17

Figure A: Distribution of OVC types

Only 2% of younger OVC and 4% of adolescent OVC live with both parents. More OVC lived with their mothers as the surviving parent than with their fathers. One-third of OVC in both age groups lived with their mothers. Only five percent of the younger OVC and 3% of the adolescent OVC lived in households headed by their fathers. Thirty-four percent of all OVC surveyed lived with other adult relatives.

Between 17% and 19% of OVC in each group lived in institutions. This proportion represents the Haitian OVC cohort. All of the OVC in Haiti who were interviewed for this evaluation lived in institutions. In many instances, the status of these OVC's parents is unknown. All the OVC in the other four countries were living in community settings at the time of the interview.

All children included in this evaluation were enrolled into their country's OVC program because they were deemed to be the most vulnerable of the vulnerable children living in the target areas. Of the 2,495 OVC interviewed, less than forty lived in a traditional household with both parents.

In the case of orphans, the causes of fathers' and mothers' deaths varied; however, HIV and AIDS-related complications constituted the most common reasons cited in all of the countries, except Haiti and Rwanda. The majority of Haitian OVC did not know reasons for the loss of their parents. (Some Haitian OVC may be rendered vulnerable because they were abandoned at orphanages.) In the case of Rwanda's adolescent OVC, 41% were dual orphans. The fathers were deceased in the households of an additional 31% of Rwanda's adolescent OVC interviewed. Nearly a third of these men died in the 1994 genocide.

RESULTS

Education

School attendance was high at the time of this survey. Ninety-nine percent indicated that they had some formal schooling. For the younger OVC, 99% were presently attending school. The percentage of adolescent OVC currently attending school was only slightly lower at 94%. Tanzania's adolescent OVC had the lowest school attendance rate (84%). While many children indicated that they were absent from school at least once, less than 5% of OVC surveyed missed six days or more during the

past year. Adolescent OVC were more likely than the younger OVC to miss school ($p<0.002$, OR=1.29).

Illness was the most common reason for being absent from school. Significantly more OVC from Haiti and Kenya, and the younger OVC from Tanzania reported illness as the reason for being absent from school ($p<0.01$). More adolescent OVC than younger OVC reported household chores, house work, and the lack of school fees as reasons for missing school. This observation was significant among adolescents from Rwanda and Tanzania who were enrolled in the OVC programs. Nearly ten percent of younger OVC living in Rwanda and Tanzania also stated that absences from school were due to housework and chores. See Figure B below:

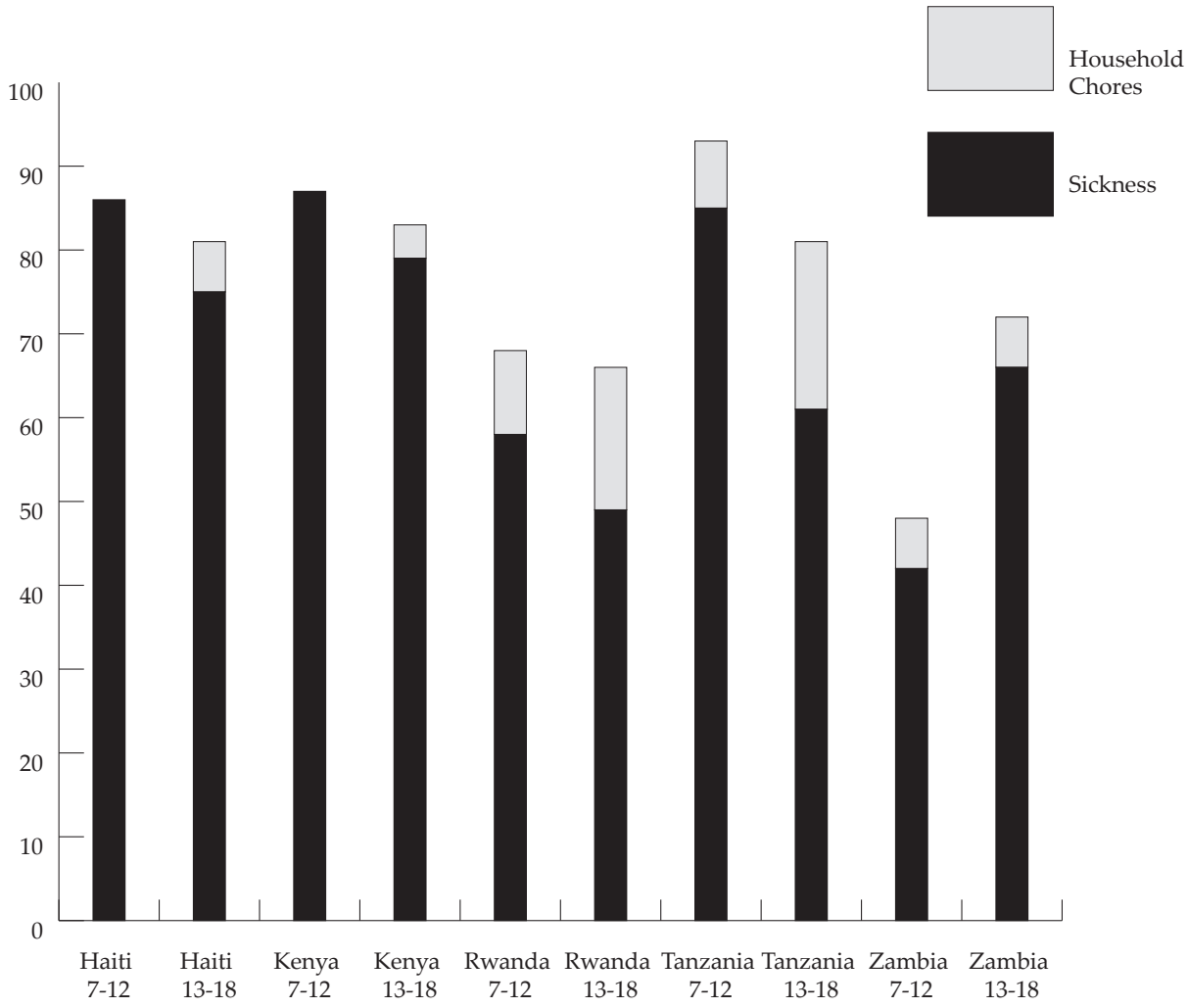


Figure B: Cause of absences from school

Most children indicated they had sufficient time to study. For all five countries, 75% of the younger OVC indicated they had enough time to

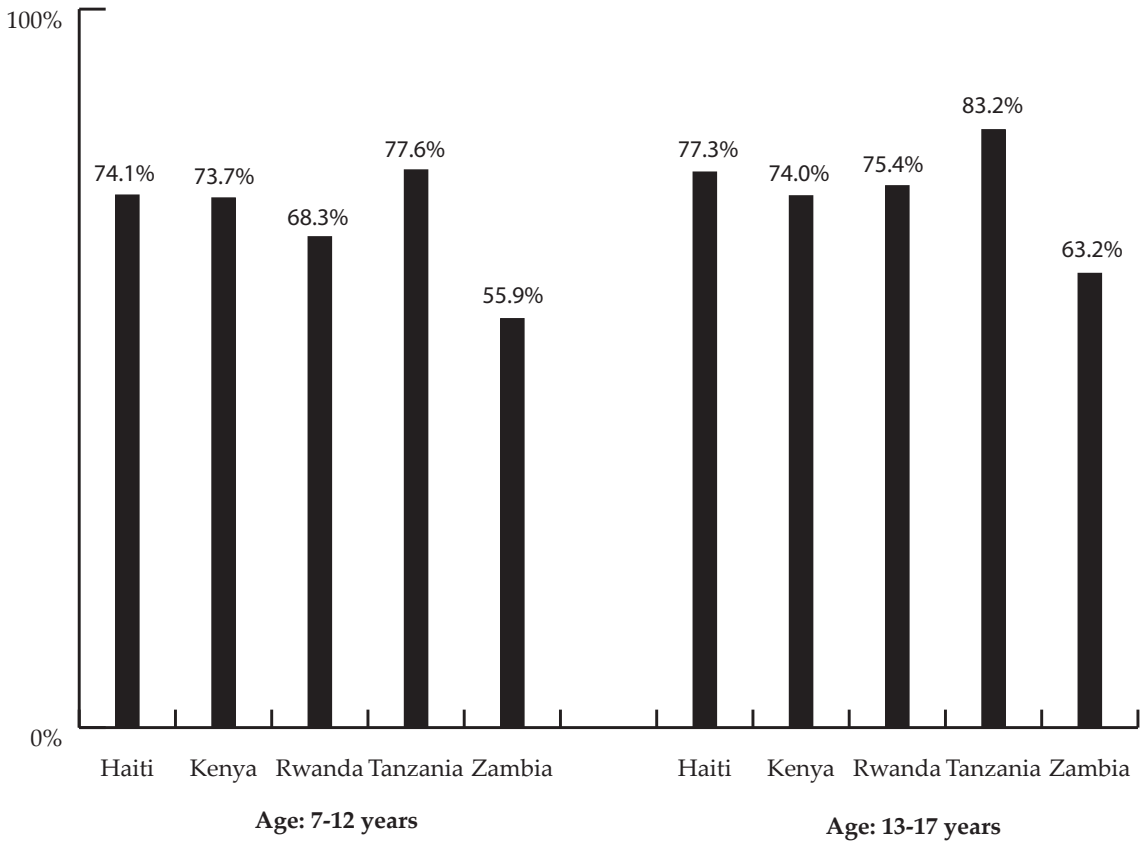


Figure C: Academic performance
(% of CRS-assisted OVC who passed last term exam)

study, whereas 59% of the adolescents gave a positive response. Less than 10% of all OVC surveyed stated they had no time at all to study. Approximately three of four OVC assisted by CRS passed their last end-of-term exams (Figure C). Older (13–17) Tanzanian children, with a success rate of 83.2%, had the best exam results. Both younger and older Tanzanian OVC assisted by CRS had significantly higher pass rates than counterparts in their respective control groups (63% and 70%). These results are in part attributed to the strong program link to a designated OVC assistant teacher in each of the schools. In spite of this program feature a significantly and substantially low 33.3% of young Tanzanian OVC living in households led by themselves or a sibling passed their exams. Young (7–12) Rwandan OVC males (76%) did significantly better than their female (61%) counterparts; this was one of the few instances where any outcome was associated with gender.

Health

Most of the OVC interviewed experienced at least one illness in the past year. Most OVC also indicated they received treatment at a hospital or

a clinic, or that they received medications over-the-counter to treat the illness (Figure D). Only younger OVC in Rwanda and adolescent OVC in Haiti reported receiving no treatment to a significant degree, when compared to age groups in the other countries.

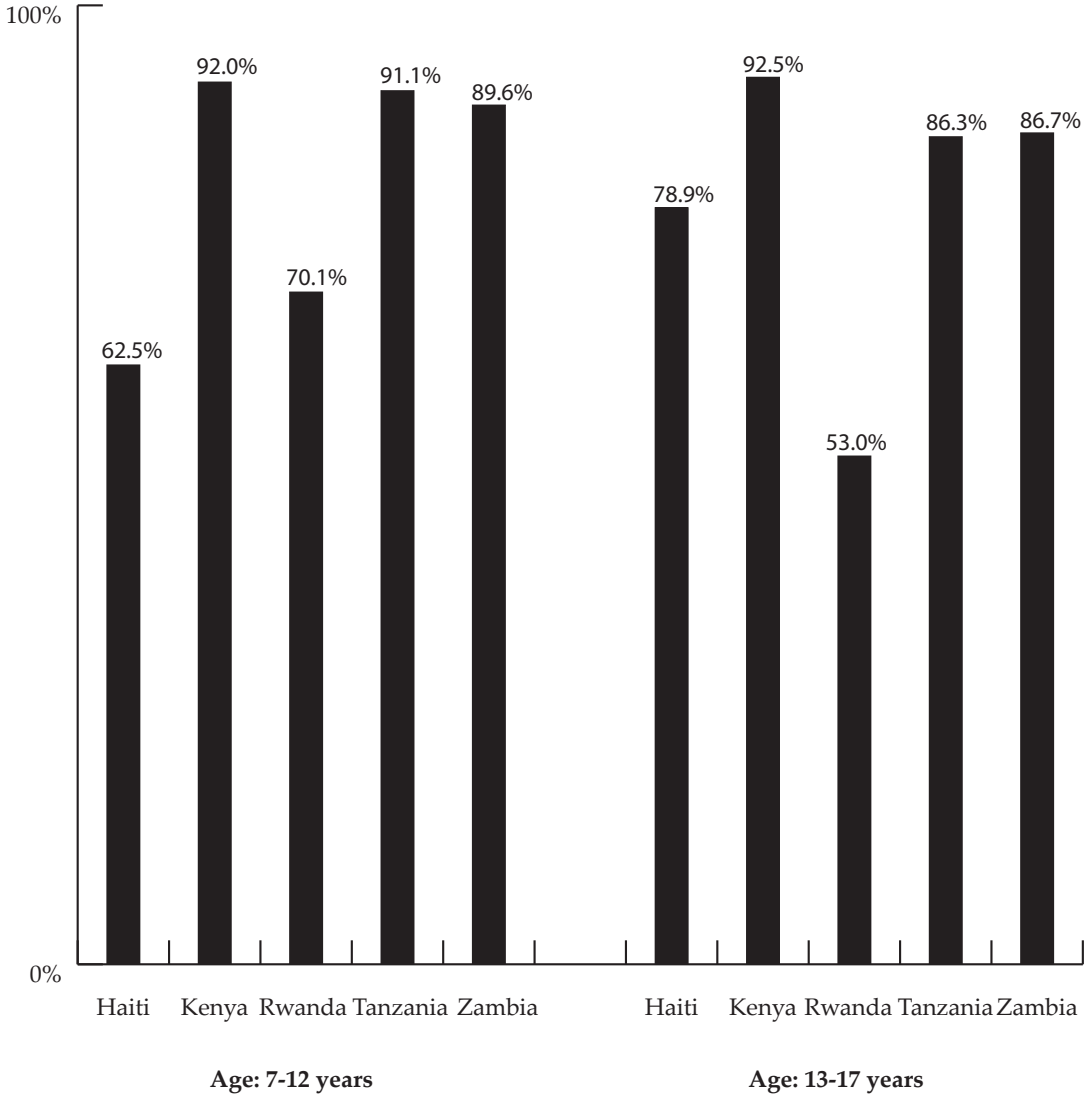


Figure D: Ability to obtain treatment
(% of CRS-assisted OVC who reported receipt of necessary medicine when ill)

Data about health and illness was analyzed based upon the type of household in which the OVC lived. The highest proportion, nearly one-third, of OVC who report they do not receive treatment when they are sick live in households headed by OVC. This may be an indicator of poor access to health services for this group of orphans. Children who receive care indicate their guardians pay for health care, thus those who do not live with an adult may not receive medical care if there is no adult

available to pay for these services.

OVC who indicated they did not receive treatment or medicine when they needed it, were asked why they did not get treatment. The majority of respondents reported their families lacked the money to buy the medicine. Only adolescents from Kenya and Zambia frequently reported the medicines were not available. See Figure E below.

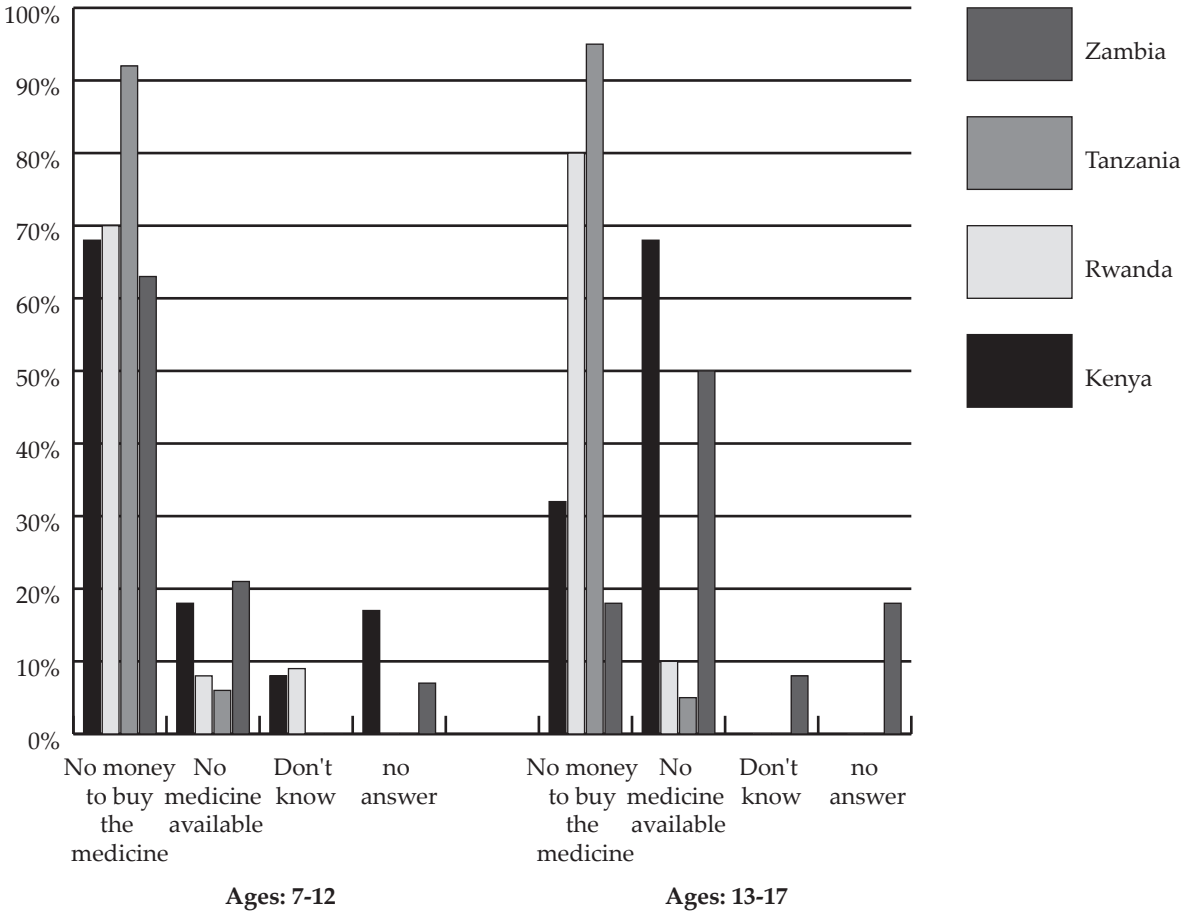


Figure E: Why didn't you get the medicine you needed?

Payment for health care is largely provided by the guardian or the caregivers, but the parish also plays a significant role in the coordination of reimbursement for health care services. Over one-third of the OVC in Kenya and Tanzania indicated their parish, or in Haiti their safety net institutions, provided payment for medical care. Health care payments through parishes and safety net programs are largely supported through mechanisms developed by Catholic Relief Services' OVC programs.

Nutrition

Although nutrition is a core component of PEPFAR OVC services, the availability of nutritional inputs and supplements for OVC is country-specific and is not a standardized intervention across the country programs. Whenever possible, the OVC program attempts to link to other available food aid programs within countries (e.g., Kenya and Haiti). In other countries, no food aid is available (e.g., Zambia), however, in all countries education on healthy nutrition choices is part of training given to OVC.

Small percentages of OVC in both age groups reported that they did not eat at all the day before the interview: 2.8% of beneficiary OVC ages 13-18 and 2.61% of guardians reported that their children, ages 7-12, did not eat the day before. These results are somewhat skewed by the large percentage of older OVC (ages 13 to 18) who reported not eating in the previous 24 hours within the Rwandan sample. It is important to note that the younger OVC surveys were completed on their behalf by caregivers, so there may be some under-reporting of not having anything to eat.

Rwanda had the highest percentage of both older (6.03%) and younger (4.55%) OVC who reported not eating the day before the interview. Kenya had the lowest percentage of both older (1.39%) and younger (1.35%) OVC who reported not eating the day before the interview (Figure G).

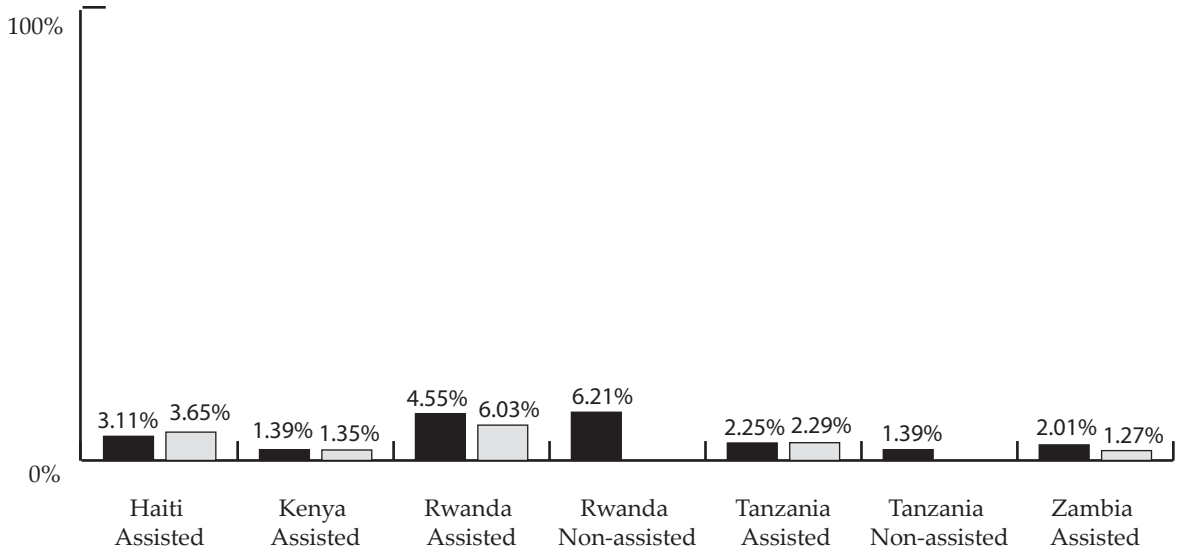


Figure G: Percentage of OVC reporting they did not eat the day before the interview

When asked what they had eaten the day before the survey, OVC in both age groups predominantly reported eating carbohydrates. Haitian OVC were more likely to report having eaten fruit the day before the survey, which is in line with the local food availability in-country as many fruits are easily accessible and cheap. There were no significant differences between the control and treatment groups in regards to which foods were reported as being eaten the day before the interview.

More than one-third of all OVC beneficiaries (32.06%) reported that most of the OVC's food came from food aid provided by a NGO, government or Church. Haiti and Kenya carried the highest frequencies of OVC reporting that most of their food came from food aid. Only 3.45% of non-beneficiary controls in Rwanda and Tanzania reported that most of the OVC's food came from food aid. In Rwanda, both beneficiary OVC and control OVC reported similar low levels of reliance on food aid. However, in Tanzania, OVC beneficiaries were much more likely to report relying on food aid in both age groups than their matched control groups. Overall, there was a statistically significant link between food aid and whether the OVC reported always having enough to eat ($p<.001$). OVC who received food aid were more likely to report always having enough to eat (53.9%) compared to OVC who did not receive food aid (34.6%). Figure H graphically demonstrates the percentage of respondents who receive most food through food aid.

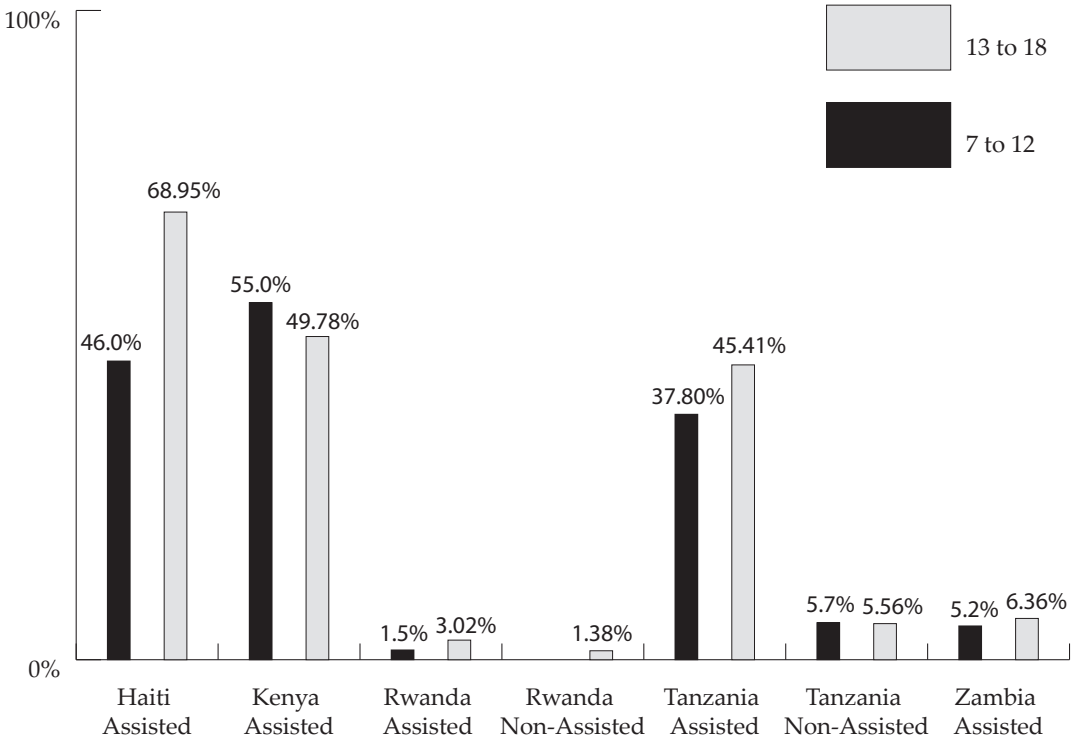


Figure H: Percentage of respondents reporting that most of child's food comes from food aid

OVC were asked to select how often they had enough to eat. Most OVC reported that they "sometimes" have enough to eat, except in Haiti. In Haiti, where CRS program targeted to reach 100% of enrolled OVC, 96.0 percent of younger (7-12) and 92.7 percent of older (13-17) OVC reported always having enough to eat (Table 4.1). At the other end of the spectrum was Zambia where only 4.8 percent of younger and 6.5 percent of older OVC reported always having enough to eat. The other three countries ranged from a low of 22.2 percent for young CRS assisted OVC in Tanzania to 46.2 percent for older CRS assisted OVC in Rwanda.

Despite targeting food support to all of their OVC, Kenyan OVC were practically identical to their counterparts from Tanzania, where only 13.0 percent of OVC were targeted for food support, and slightly behind OVC in Rwanda, where only 37.5 percent of OVC were targeted. Zambian OVC were not targeted for food and nutritional support; they were also the least likely to report "always having enough to eat" (Figure I).

OVC with neither parent deceased reported the lowest levels of "never having enough to eat." In eight of the thirteen observed strata, zero percent of these OVC reported never having enough to eat. It was the OVC that were unable or unwilling to divulge the status of their parent's mortality that most often reported "never having enough to eat".

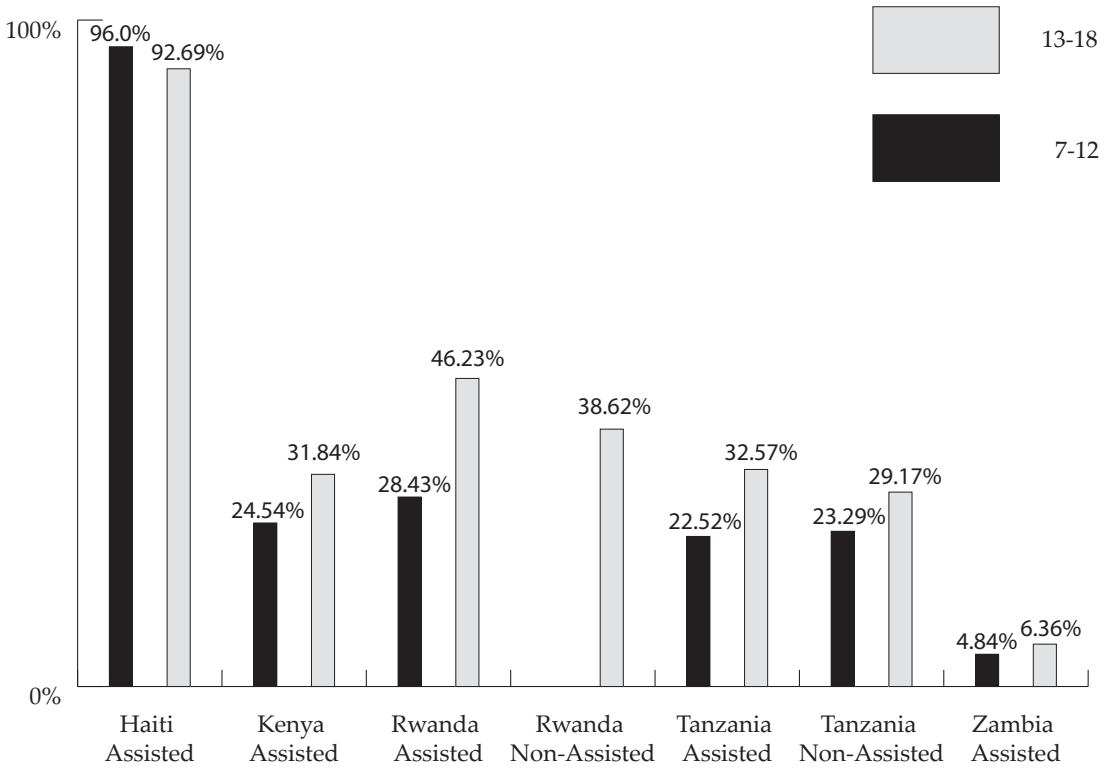


Figure I: Percentage of OVC reporting they always have enough to eat

Nutrition and Agricultural Training

OVC were asked whether their families or they had ever received any type of agricultural training. See Figure J. Positive responses were highest in Haiti, Kenya and Rwanda, with the highest respondent category being the 13-18 year old Haitian sample (37.96 respondents had received training). Tanzanian respondents reported the lowest levels of agricultural training. Beneficiary OVC were more likely than non-beneficiary OVC to report having received agricultural training. Rwandan OVC who received agricultural training were significantly more likely to report greater frequencies of having enough food to eat than those who did not receive the training ($p<.001$).

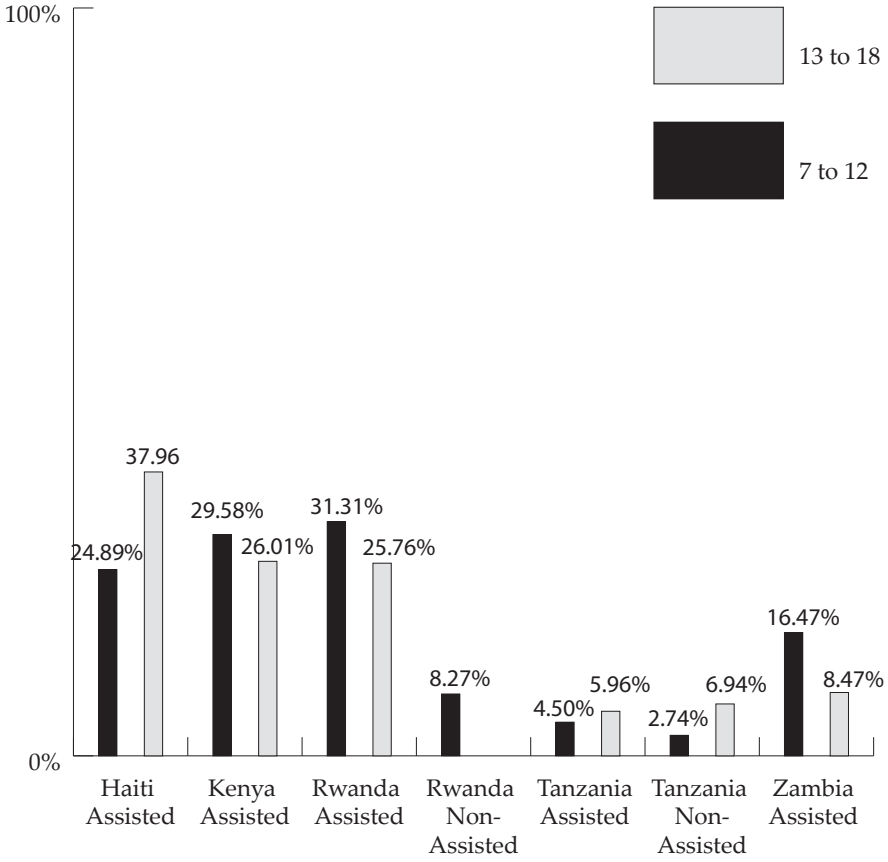


Figure J: Percentage of OVC reporting having received agricultural training

The beneficiaries from each country who confirmed that they had participated in agricultural training were then asked what types of training they had received. The types of agricultural training varied, but four main categories emerged including crop diversification/natural resource management, irrigation techniques, use of difficult land (i.e., flooded areas), and increased productivity with small amounts of land.

Respondents were also asked whether they had received any support for farming such as seeds, tools, free land or free labor for anyone in the household. See Figure K. Rwandan beneficiary OVC aged 13 to 18 were most likely to report having received this support. In Rwanda, beneficiary OVC aged 13 to 18 were significantly more likely to have received farming support than non-assisted OVC ($p<.001$). These same Rwandan OVC who received farming support were significantly more likely to report greater frequencies of having enough food to eat than those who did not receive support ($p<.001$).

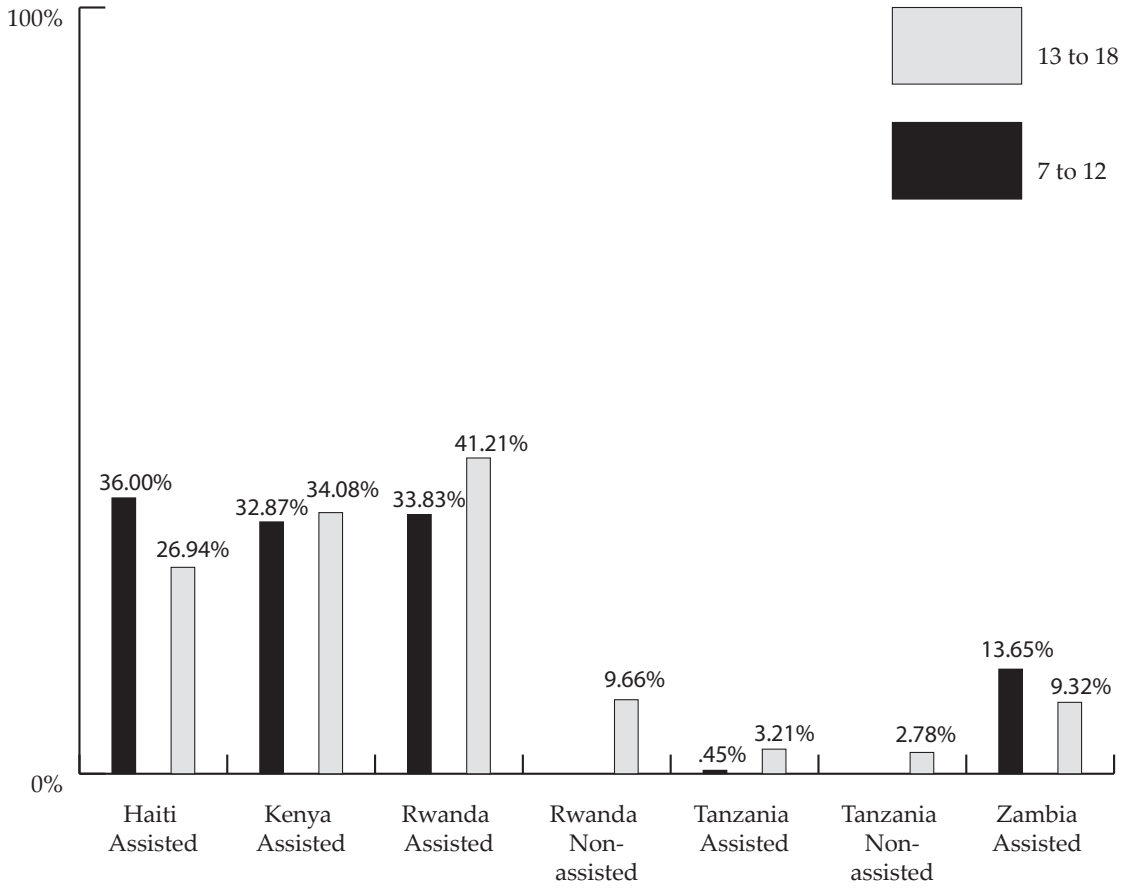


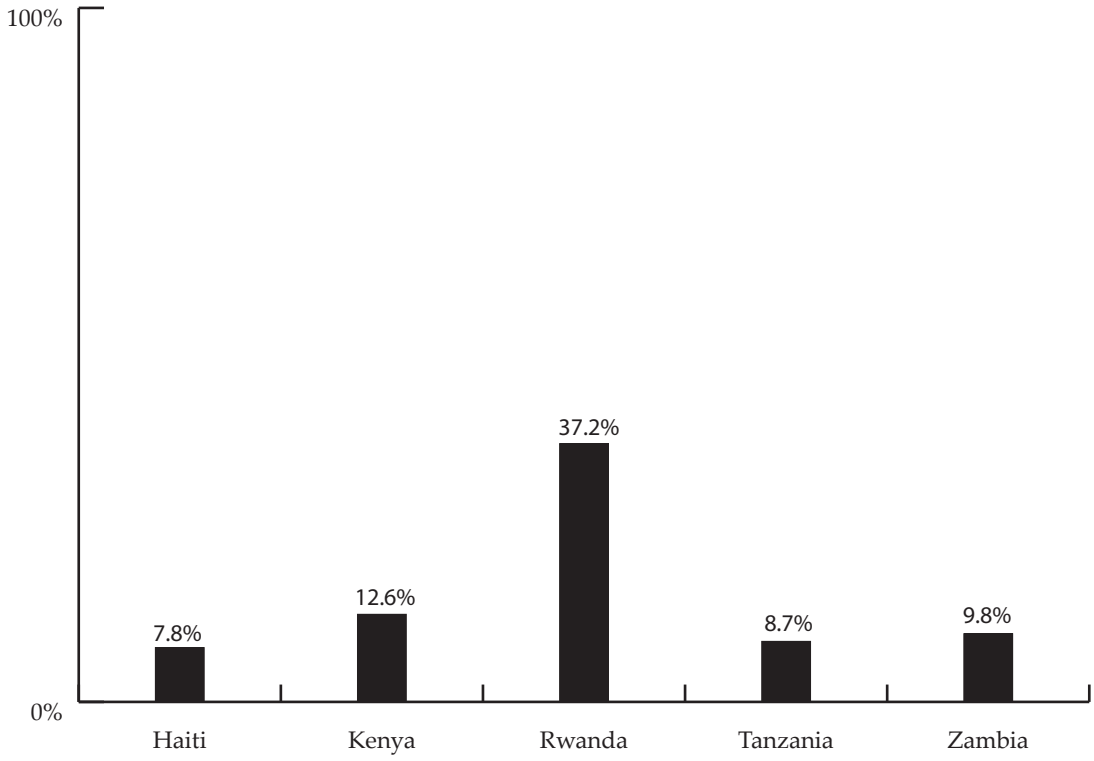
Figure K: Percentage of OVC reporting having received farming support

OVC were asked whether there was a garden for OVC in their communities. Haitian OVC were most likely to report the presence of a garden across both age groups. Kenya, Rwanda and Zambia all reported similar rates of gardens for OVC, while Tanzanian respondents reported the lowest rates. Overall, adolescent respondents who indicated the presence of a garden were more likely to report having enough to eat at greater frequencies ($p<.001$).

Risky Behaviors and HIV Prevention

Adolescent OVC who were interviewed for this evaluation were asked a series of questions about alcohol and drug abuse, sexual experiences, and about motivations to minimize their exposure to the HIV virus.

Alcohol



Age: 13-17 years

Figure L: Alcohol consumption (% of CRS-assisted OVC who report they have ever drunk)

OVC in the five countries were asked whether they had ever consumed alcohol. Figure L shows that the highest incidence of ever having drunk alcohol occurred in Rwanda, where 37.2% OVC reported ever drinking alcohol. The lowest incidence was in Haiti, where 7.8% reported drinking alcohol. Kenyan OVC with both parents still living had significantly higher incidence of ever having alcohol (30.8%): Rwandan OVC assisted by CRS also trended in this direction (40.9%). Dual orphans from the Rwandan control group had significantly lower rates of alcohol intake (19.2%) and the assisted OVC from Rwanda (32.9%) and Kenya (5.6%) also trended in this direction, suggesting that incidence of alcohol consumption in the two countries with the highest levels of OVC drinking may not be a function of vulnerability but related instead to the

availability of resources (households with 2 parents) for the purchase of alcohol.

Drugs

Reported drug use was extremely low across all five countries

Engaging in Premarital Sex

Sexual experiences were reported by 17.4% of the adolescent OVC. There were large differences between countries regarding the proportion of adolescents who had begun having sexual encounters. Only 7% of Rwanda's OVC had ever had sex, but 23.7% of adolescents in Haiti and Zambia had prior sexual experiences. In this minority population of sexually active youth, the mean age at first intercourse varied by country ranging from 10.3 years (Rwanda) to 12.8 years (Zambia). In general, the OVC reported having sex with a boyfriend or girlfriend (57.8%) or with another friend (22.9%).

Twenty-five percent of OVC who stated they had ever had sex, also stated that they had sex within the past six months. Adolescents cited numerous reasons for having sex, however love, affection, and desire was mentioned in 63.63% of the responses. In Rwanda 16.5% of OVC mentioned peer pressure as a reason for having sex and 6.6% indicated that they were forced to have sex. This will require a broader intervention. Of those who reported that they were forced to have sex, most (78%) felt like they had someone to talk to about it. Reports of forced sexual behavior and sex for money or other gifts during the previous six months were rare.

Analyses were completed to determine the association of household type to certain risk-taking behaviors for HIV. Overall, adolescents living with both parents tended to have the lowest proportion of respondents that reported having sex in the past 6 months.

Older (15–17) OVC being assisted by CRS were more resilient in resisting the pressures to engage in sexual intercourse than OVC from the control groups. In Tanzania, 94.1% of younger (13–14) CRS-assisted OVC and 95.4% of the control group reported never having sex. The number fell to 80.2% for older assisted orphans, but this was significantly higher than the 58.6% reported for the control group. A similar pattern was reported in Rwanda, where younger OVC from the control group reported the

lowest levels of sexual activity of any age group from any country. However, although the CRS-assisted OVC maintained their low levels of sexual activity as they aged, the control group increased their sexual activity. The differences between the assisted group and the control for older (15–17) Rwandans were not significant but as noted above, sex is a function of age. Once (direct) standardization techniques accounted for the age distributions of the assisted and control groups the difference between the two groups was significant ($p = 0.0387$).

Since the majority of adolescents are abstaining from sex, the survey inquired about motivations to avoid sexual contact. Fifty-nine percent stated they wanted to prevent themselves from getting HIV and sexually transmitted infections. Forty-one percent stated they felt they were too young to have sexual encounters.

Most adolescents have received information about HIV, and the majority of the adolescents who responded indicated they obtained information through mass media, such as radio (24.4%) or television (53.4%). Personal contact through community systems also provided information about HIV and AIDS. 25.3% obtained information through community workers and committees, and 35% obtained information through community health events and community mobilization. Friends and guardians provided information for 26% and 22.8%, respectively.

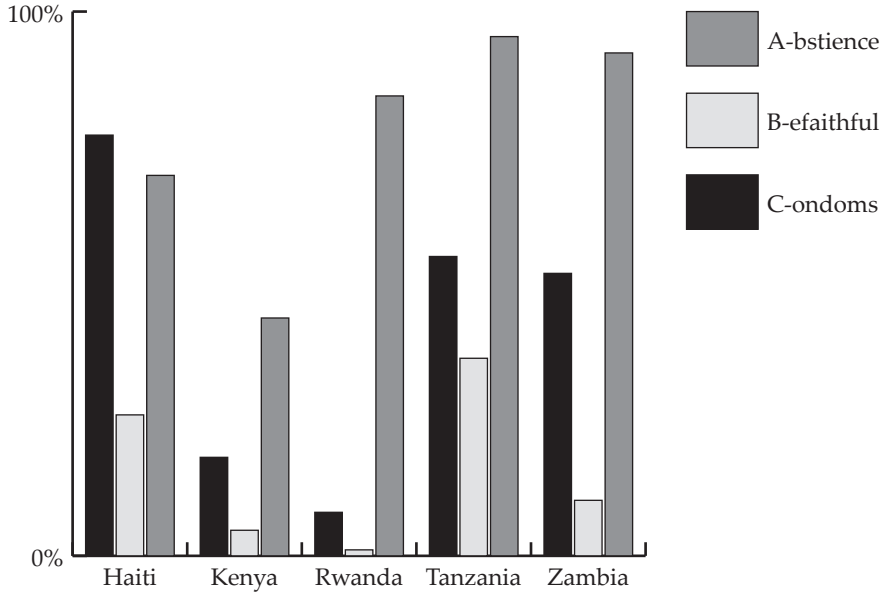


Figure M: Knowledge of ABC prevention (% of CRS-assisted OVC identifying method as a means of preventing HIV)

Prevention

Knowledge about the modes of transmission of HIV varied somewhat among the countries surveyed (Figure M). Ninety-three percent of adolescent OVC correctly identified at least two modes of HIV transmission. In Tanzania, 61.9% of adolescents were able to identify three valid methods for preventing HIV. Limiting the number of sexual partners was the least identified method of HIV prevention by OVC in every country.

Most adolescents surveyed received life skills training, which include information about abstinence from sex, HIV prevention, and decision-making skills. An average of 40% received separate HIV education, and 20% were enrolled in support groups.

Guardians are most frequently reported as the source to which OVC turn when they are experiencing problems. 55-92% of OVC ages 13-17 and 89-96% of OVC ages 7-12 report that guardians are the first ones that they ask for help with problems.

Child Rights and Protection

Less than half of the OVC surveyed had birth certificates in Tanzania, Zambia, and Kenya, whereas 70% of Rwanda and 95% of Haitian OVC had birth certificates. Thirty-five percent of older OVC reported that they believed that inheritance theft was a common event. Twenty-one percent of OVC reported that they had personal experience with inheritance theft. OVC living in a sibling-led household and those who lived with other relatives had the highest likelihood of reporting that some of their inheritance had been taken away, compared to those OVC in other living situations. In the five countries, the range of OVC reporting that they had a will in place varied from 8%-30%; OVC in possession of a will, reporting that their wills were honored ranged from 78% to 93% in the five countries.

Religiosity

Religiosity or active participation in a religious community is believed to prevent engagement in risky behavior. This

understanding of religiosity suggests that the attitudes and behaviors that come from being socialized in a religious community protect OVC from undesirable outcomes. In our survey greater than 90% of OVC and guardian respondents stated that "faith in God helps me."

Education was the dimension most affected by religiosity. OVC who attended religious services regularly were more likely to be enrolled in school, less likely to be absent from school, and much more likely to pass their end of term exams. There were no instances of significant negative associations between religiosity and desirable educational outcomes. Although the differences were not always significant, OVC with regular religious attendance more frequently reported desirable outcomes than their counterparts.

Risky behaviors such as early sexual involvement, and drug and alcohol consumption, were less commonly reported by OVC that regularly attended religious services. In the case of Haiti and Rwanda, there was a statistically significant difference in risky behaviors reported between the OVC who attended church regularly and those who did not attend church.

"People with lust for [orphans'] properties, sometimes take such properties, leaving empty-handed those legally deserv[ing of the] inheritance"

-Community Leader, Tanzania

DISCUSSION

Whereas the literature indicates that orphaned children and those with sick parents have lower rates of school attendance[3] , 94-99% (older and younger age groups, respectively) of OVC in the CRS PEPFAR-supported program attend school. Studies have also supported the fact that girls are the first group to have their education neglected[4], yet this evaluation found no gender differences in school attendance among OVC in the CRS program. Likewise, studies have shown that orphaned children and those with sick parents have a reduced access to health care[5], yet the majority of OVC in the CRS program were able to obtain treatment for illnesses in the past year. Research on the nutrition status of orphans is limited, but children who have lost one or both parents often live with older caregivers who may not have a regular source of income and a large percentage of orphans live in households that are classified as "food insecure with child hunger.[6]" CRS programs vary in the priority given to food aid with some giving direct food aid and others linking OVC to other food aid. Programs

3 Enhanced Protection for Children Affected by AIDS, UNICEF, March 2007. (page 14)
4 UNDP, 2007
5 Enhanced Protection for Children Affected by AIDS, UNICEF, March 2007. (page 14)
6 IBID (page 13)

not involved in direct food aid are doing other nutritional support activities such as agricultural and/or nutritional training, seed banks, OVC gardens, etc. A small percentage of OVC reported not eating the day before, but most OVC reported that they "sometimes" had enough to eat.

"We need organizations such as churches to help the orphans and widows. When we do this, we help them grow spiritually and physically. Otherwise if it is done by individuals we cannot manage."

-Giriama Parish community leader, Kenya

This report confirms that Catholic Relief Services' OVC programs, supported by PEPFAR Track One, have provided a number of important services to OVC in the five countries included in this evaluation. The CRS-supported OVC project beneficiaries received a variety of services from the CRS partners. The services include education support (in form of payment of school fees and supply of school materials – uniforms, books, pens etc.), medical support (in form of purchase of medicine, payment of treatment costs), food and nutrition support, and psychosocial support. The services were informed by the needs of the children. In addition to the physical needs, this report confirms the high importance of "faith in God" in the lives of OVC and guardian respondents. CRS will continue to offer spiritual content in life skills curricula and monitor psychosocial and spiritual wellness via CRS Well Being tool. Overall, the OVC guardians reported that the project activities have responded to the needs of the OVC and 53-95% of guardians reported satisfaction with CRS OVC program.

IMPLICATIONS

In all the five countries, the OVC reported (or were reported) to generally find it difficult to meet basic needs of life. The problems of the OVC include inadequate shelter, poor access to educational opportunities, ill health, insufficient food, and sexual abuse. Unfortunately, with the continuing impoverishment of the populations, extended family members have found it increasingly difficult to meet the needs of the OVC. Thus, for several needs, the OVC and their households have come to depend heavily on the CRS partner organizations. With the needs of the OVC so many and diverse, all segments of the population need to be involved – the local communities, the government and the private sector in the provision of services.

In spite of the acknowledgment that the services offered respond to the needs of the OVC, there is a general feeling that the services have been inadequate in reach. The services are perceived to have limited coverage thus leaving out a high percentage of the OVC. While the

project might be achieving numerical targets, the targets do not mean much to communities with great needs. The CRS-supported projects should establish partnerships with other projects and other components of the PEPFAR projects. For instance, increasing the scope of integrating the delivery of the OVC services with ongoing home-based care programs at the community level will increase the access of OVC to VCT, antiretroviral treatment and nutritional services. The project should also seek the assistance of the private sector in the provision of health care and other services to the OVC.

While acknowledging the roles the projects have played to increase awareness on the rights of the children, the CRS partners should explore means by which more children could benefit from child protection services. Inheritance theft continues to be a problem. It is worth noting, however, that where wills are in place they are generally honored. Greater emphasis must be made in building public awareness around these issues in addition to training parents, OVC and guardians about the need to have a will in place. Also, there is a need to train more paralegals that can assist parents, OVC, and their guardians with will writing. The study results support the literature which highlights the need for the project to do more to promote child rights. Efforts should be made to collaborate more with rights organizations in each country to advocate for the enforcement of existing rights protection laws and the enactment of new laws where necessary.

Life skills education was a positive influence in preventing adolescents from risky sexual behavior. Also, CRS-assisted OVC maintained their low levels of sexual activity as they aged, while the control group increased their sexual activity.

The age of sexual debut for the minority of OVC reporting sexual activity, however, is earlier than the age group most life skills programs are targeting. Limiting the number of sexual partners was the least identified method of HIV prevention by OVC in every country. There needs to be a greater emphasis on reaching younger OVC with appropriate life skills interventions.

There is also a need for more life skills programs that educate older adolescent about the risk of multiple and concurrent partners with the goal of preparing these youth for healthy sexual relationships in the context of marriage.

"The close relatives take up the burden of these children. Most of the time the burden is too much on the relative and he ends up neglecting the child."

-Chonyi, Kenya community leader

"There were a few serious problems which are no longer there, the orphans now have hope for a bright future after they receive education and having some other of their needs met."

-Kenya community leader

Except in Haiti, where OVC are cared for in institutions, a high percentage of the children and their guardians reported that the OVC do not always have enough to eat. To ensure a steadier supply of food, the CRS partners should encourage activities which increase local production of food through agricultural training, seeds, and tools. Since most OVC are enrolled in school, feeding programs could be integrated with the schools to ensure a midday meal for students or OVC can be trained to meet their own food needs through agricultural training or OVC gardens.

The guardians are usually the first to be consulted by the OVC whenever they have the need to discuss personal/emotional issues. Therefore it is important that the guardians receive training in counseling and in helping children with emotional needs.

CONCLUSION

This report confirms that Catholic Relief Services' OVC programs supported by PEPFAR Track One have provided a number of important services to OVC in the five countries included in this evaluation. The CRS supported OVC project beneficiaries received a variety of services from the CRS partners. The services include education support (in form of payment of school fees and supply of school materials – uniforms, books, pens, etc.), medical support (in form of purchase of medicine, payment of treatment costs), food and nutrition education, and psychosocial and spiritual support. The OVC and their guardians reported that the project activities have responded to the needs of the OVC. While there are some limitations to these data, it indicates that Catholic Relief Services provides a broad range of support and care for children and youth that has improved the quality of life of the OVC who have been adversely affected by the AIDS epidemic. With continued involvement in such programs, there is every indication that these children will have opportunities that might otherwise be unavailable to them.

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