A Summary

Slowly but Surely: Evaluations of Three Programs Supporting Most Vulnerable Children in Tanzania Show Some Benefits

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Introduction

This policy brief provides a concise summary of key findings from three orphan and vulnerable children (OVC) program evaluations conducted in Tanzania. It examines the policy and programmatic implications of study results and offers recommendations for service providers and other decision-makers at the program and national levels. Details about individual studies can be found in each project's published evaluations reports and case studies.[1-7]

Programs Evaluated

The three OVC programs evaluated in Tanzania were: Mama Mkubwa & Kids Club implemented by The Salvation Army, Tanzania Command (hereafter referred to as TSA), which had been operating for two years in the Mbeya region; Tumaini Project implemented by CARE International, Family Health International, and a faith-based organization Allamano (hereafter referred to as Allamano), operating for five years in Iringa region; *Jali Watoto* implemented by Pact and a community-based organization, SAWAKA, operating for two years in Karagwe, Kagera region (hereafter referred to as *Jali Watoto*). These programs implemented different combinations of intervention strategies, including community mobilization and sensitization; health education and HIV prevention activities; home visits by trained volunteers; kids' clubs; income generating activities; and the provision of direct material support such as school materials, health services, and food support. Each of these programs offered other intervention components that were not evaluated.

Study Design and Methods — These studies applied a post-test study design with intervention and comparison groups to examine the effects of program interventions on child and caregiver outcomes. Data were obtained via sample surveys conducted in 2007 and 2008 among children aged 8-14 years and their caregivers for the TSA

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and Allamano programs, and among children aged 7-15 years and their caregivers in the case of *Jali Watoto* (see Table 1). About 20% to 25% of these samples couldn't be located for interviews due to the inaccuracies within the beneficiary lists across the three programs. These surveys were preceded by case studies of each program. For each program, children exposed to interventions were compared on several measures including psychosocial, family relationships, support networks, stigma, and discrimination to those who had not been exposed. Group differences and program effects were tested for significance at the $p < .05$ level, using appropriate statistical techniques. Also, cost-effectiveness analysis was conducted on two programs. Necessary ethical procedures including protocols for consent, referrals, and confidentiality were put in place before data collection started.

Limitations — The main limitation of these evaluations is the application of a post-test study design. Baseline data were not collected and, as a result, the full measure of the program's effect cannot be ascertained. In addition, some of the evaluated programs had been in operation for too short-period of time (i.e., one year) to show measurable effects on most outcomes.

Key Evaluation Findings

This section presents a synthesis of key findings from the three program evaluations. The discussion focuses on findings that have programmatic relevance including: a description of the OVC program beneficiaries, types of services provided to beneficiaries, effects of services provided directly to children, as well as indirectly through initiatives targeting households and the broader community, and unintended negative effects on OVC and their caregivers receiving services.

It is important for the reader to note that mixed effects on child and caregiver outcomes were observed among the three programs evaluated, even for similar interventions. This might be partly attributed to the varied period length of program exposure (i.e., TSA for two years, verses five years for Allamano).

Sample Description — Table 2 presents key vulnerability characteristics of the children who were included in the analysis. Children in samples across all programs were vulnerable on several fronts. For instance, the majority of beneficiaries were orphans (Allamano, 85.7%; *Jali Watoto,* 80.9%; TSA, 66%). This compares poorly to the national orphan prevalence of 11%. The TSA study compared the characteristics of children from the general population in the community with those on the TSA beneficiary list (Figure 1). Orphanhood prevalence in the general community-based sample was less than 12%, whereas 66% of TSA beneficiaries were orphans. This suggests that OVC programs are indeed targeting the most vulnerable children (MVC) and supports the established Tanzanian national guidance for identifying and supporting MVC

Table 1. Samples for the Intervention and Comparison Groups for Evaluated Programs, Tanzania

	Allamano	TSA	*Jali Watoto*
Intervention Group	People living with HIV and AIDS (PLWHA) and their children (8-14 years) receiving services for at least one year	List of beneficiary children (8-14 years) participating in kids' clubs in a community where the program was in operation	List of beneficiary children (7-15 years) participating in the *Jali Watoto* program
Comparison Group	Newly identified PLWHA and their children in a neighboring community but not yet receiving services	Children aged 8-14 in the village registers of general child population in neighboring village not exposed to TSA interventions	Newly identified most vulnerable children in an adjacent district but not yet receiving services

Table 2. Selected Vulnerability Characteristics of Children Identified by Study Site

Characteristic of Identified Children	Allamano (N=1104) %	TSA* (N = 564) %	*Jali Watoto* (N=895) %
Orphan status			
Not an orphan	14.3	33.7	19.1
Single orphans	49.7	40.6	59.4
Double orphans	36.1	25.6	21.5
Orphans (all types)	85.7	66.3	80.9
Affected by illness			
Chronically ill primary caregiver	21.0	28.7	12.6
Child's caregiver			
Primary caregiver is not child's natural mother	53.3	47.4	46.3
Primary caregiver is age 50 or above	32.8	23.6	27.4
Household food security			
Moderate to severe food insecurity	89.1	87.1	86.3
Child's material well-being status			
Child lacked a blanket	58.2	55.1	49.2
Child lacked a pair of shoes	58.2	57.8	72.8
Child lacked a mattress	70.5	94.1	82.2

* TSA (N) includes only intervention group; comparison group was made of general child population.

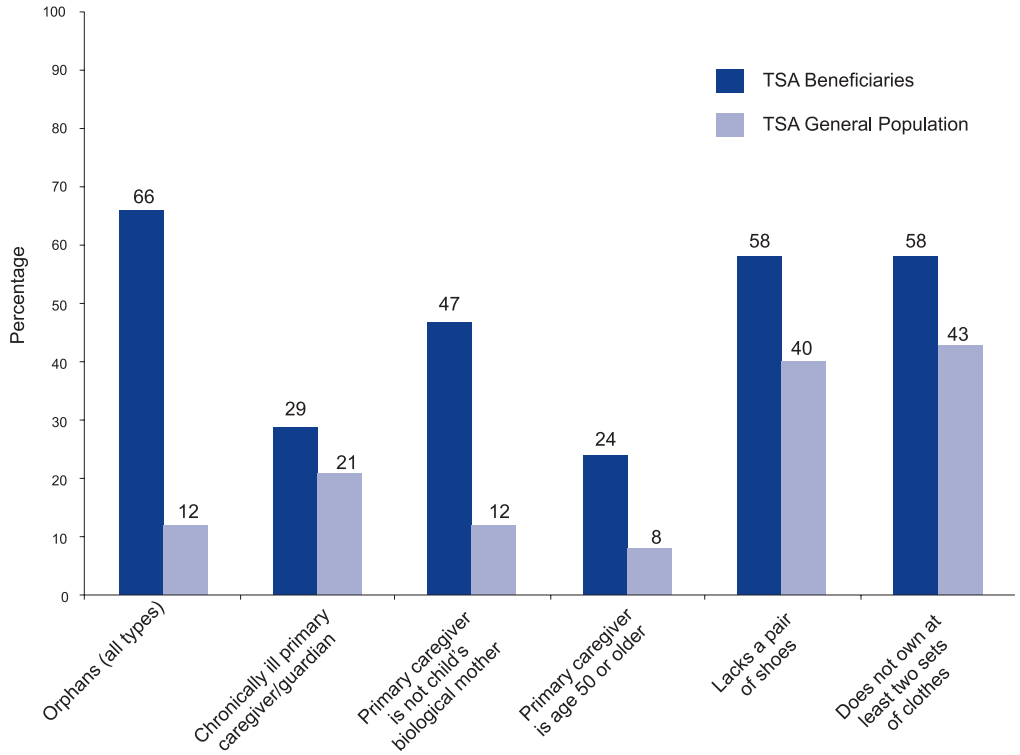

Figure1. Vulnerability characteristics of TSA beneficiaries versus the general population of children in an adjacent village in Mbeya, Tanzania.

through community committees. Importantly, the most vulnerable children's community committees (MVCC) consider other vulnerability criteria beyond orphan status, such as living situation (e.g., with a chronically ill or elderly primary caregiver, or in extremely poor or food-insecure household).

In general, all three programs incorporated some level of community-based intervention activities. However, this was the main focus for the *Jali Watoto* program, which implements community-based HIV prevention, care and support initiatives designed to educate and sensitize youth and other community members to increase community support for OVC and people living with HIV and AIDS, and reduce stigma. The effects of the *Jali Watoto* program were mixed, ranging from positive, negative, to neutral. Positive effects of the *Jali Watoto* included increased community in-kind support to OVC households and enhanced HIV prevention knowledge among children. Also, there were other marginal positive effects including better emotional health among caregivers, and improved self-esteem among children.

Effects of Home Visiting to OVC Households — Home visiting was the most common intervention approach, instituted by all three programs. Home visiting volunteers were expected to provide psychosocial support, health education, home-based care, and other practical support including referrals for other services as needed. Evaluation results from the Allamano and TSA programs show limited impact of home visiting on psychosocial and health outcomes among caregivers but more of such effects among children.

Table 3 presents home visiting exposure data among caregivers by program. Among those who reported ever receiving a home visit, approximately 58% from Allamano, 27% from TSA, and 20% from *Jali Watoto* had received a visit within the past year. Among these caregivers who reported a home visitor, only 16.1% of those from *Jali Watoto*, 31% of those from TSA, and 67% from Allamano reported receiving a visit at least once a month.

It is evident that the effects of home visiting on child and caregiver outcomes varied by program (Table 4). Specifically, home visiting under the Allamano program was associated with higher levels of adult support and lower isolation, while it was associated with higher levels of child self-esteem among TSA beneficiaries. Also, under Allamano, receipt of home visiting was associated with better reported health status among children but not for caregivers. Also, home visits were not positively associated with the emotional state of caregivers. Comparisons between the two home visiting programs are difficult to establish as each program is unique and the expectations and skills of program volunteers also varied. For example,

Table 3. Prevalence and Frequency of Home Visiting by Program

	Allamano %	TSA %	*Jali Watoto* * %
Prevalence of home visiting	(n=414)	(n=486)	(n=335)
Caregivers in intervention group reporting a home visitor	57.5	27.2	19.6
Frequency of visits	(n=319)	(n = 132)	(n=63)*
Once a week or more	24.5	9.1	3.2
Once every 2 weeks	17.2	5.3	3.2
Once a month	24.8	16.7	9.7
Once every 2 months	6.0	4.5	4.8
A few times a year or less	27.5	64.4	79.0

* Due to the small sample number who were exposed, effects of home visits were not assessed for the Jali Watoto program.

Table 4. Effects of Home Visiting on Child and Caregiver Outcomes, by Program

Home Visiting Intervention	Programs and their effects on outcomes in multivariate analyses: Allamano %	TSA %
Child outcomes		
Psychosocial		
Personal self-esteem	Neutral (NS)	Positive
Difficult behaviors	NA	NA
Pro-social behaviors	NS	NS
Emotional symptoms	NS	NS
Social isolation	Positive	NS
Adult support	Positive	NS
Health		
Reported health status	Positive	NS
Caregiver outcomes		
Psychosocial		
Family functioning	NS	NS
Negative feelings	NS	NS
Positive feelings	NS	NS
Marginalization	Negative	NS
Health		
Reported health status	NS	NS

TSA volunteers were typically assigned up to 10 households and at the time of survey had not received any compensation for their work; whereas an Allamano volunteer may have had as many as 15 households but while receiving incentives, such as transport reimbursements. It is interesting that Allamano beneficiaries reported more frequent visits, despite the fact that these volunteers had a higher caseload.

Services provided to clients during home visits also varied considerably between the two programs (Table 5). About 40% of caregivers in each program reported that they had received counseling from the volunteer, but many of them reported that counseling was more commonly provided to children in their home than to themselves. This may explain both the lack of psychosocial impact overall (of the home visiting program), as well as why psychosocial effects were more evident among children than caregivers. In

Table 5. Services Provided by Volunteer Home Visitors

Services Received During Home Visits	Allamano (N=319) %	TSA (N=132) %
Counselling adults	40.2	40.2
Counselling children	56.4	48.8
Food	71.8	55.3
Clothing	48.0	55.3
School Materials	85.6	59.1
School Fees	23.8	-
Legal support	8.2	-
Nursing Care	46.1	-
Medications	59.6	-
Information on hygiene	50.8	-
Referrals	18.8	7.5

addition, Allamano volunteers appeared to have had better resources and referral linkages to aid their support to MVC, compared to those in TSA. For example, unlike the TSA volunteers, the Allamano home visiting volunteers provided nursing care, medications, and information on hygiene, which may explain why only this program was associated with better child health outcomes. Also, the services beneficiaries received during home visits may be viewed as a proxy for the skill and training level of volunteers. Indeed, each initiative applied different training curricula. Volunteers from TSA reported insufficient knowledge about child health and nutrition and frustration with their inability to attend to such needs.[5]

Kids' Clubs for Children — Kids' clubs was another intervention implemented by all three programs. The kids' clubs are expected to provide children with recreational opportunities and serve as a forum to deliver psychosocial support and key information to enable them to make better and healthy decisions about their lives.

Table 6 displays program beneficiaries' exposure to kids' clubs. A higher proportion of children in the Allamano intervention group had attended a

Table 6. Kids' Club Exposure and Intensity across Programs

	Allamano %	TSA %	*Jali Watoto* * %
Attended a kids' club meeting	(n=552)	(n=564)	(n=434)
Children in intervention site who reported having attended at least one kids' club meeting in community or school	44.2	27.4	11.1
Extent of exposure*	(n=301)	(n = 147)	(n=48)*
Frequency of child's attendance once or more per month	56.7	67.3	45.7
Frequency of child's attendance every other month or less	43.3	32.7	54.3
First time the child started attending			
Two or more years ago (2005 or before)	13.0	7.5	4.2
One year ago (2006)	49.5	55.8	8.5
Less than a year ago (2007 or 2008)	37.6	36.7	87.3

* N is too small for any further analysis.

kids' club (about 44%) compared to those in the TSA and *Jali Watoto* programs (27% and 11%, respectively). Frequency of attendance was high among TSA and Allamano beneficiaries. Among those who had ever attended a kids' club meeting, a majority of TSA and Allamano children had attended once a month or more frequently (67% and 57%, respectively). Also, the duration of kids' club attendance among beneficiaries of both programs was fairly similar (two-thirds had started attending one year ago).

These evaluations examined the effects of kids' club attendance on children's self-esteem, social skills, emotional well-being, and support networks (Table 7). Overall, participation in the Allamano kids' club was associated with significantly fewer emotional problems, better pro-social behavior, and increased adult support among children. For TSA, no significant differences were found between program beneficiaries reporting kids' clubs attendance and those not reporting attendance on any of the psychosocial outcomes examined. Further, frequency of exposure had no effect. We also examined the effect of other, linked factors on psychosocial outcomes, including curriculum applied and volunteer training (Table 8). For both programs, a majority of the children who attended a kids' club reported participating

Table 7. Effects of Kids' Club Participation by Program on Children's Psychosocial Outcomes

Outcomes	Allamano	TSA
Global self-esteem	neutral (NS)	NS
Emotional symptoms	positive	NS
Pro-social behavior	positive	NS
Adult support	positive	NS
Social isolation	NS	NS

Table 8. Kids' Club Training and Activities, by Program

Child-Reported Activities and Information Learned during Meetings	Allamano N=301 %	TSA N=147 %
Life skills	39.5	19.0
Games, songs, dances	87.0	94.6
Learn health/nutrition	61.1	27.2
Learned HIV prevention	40.2	21.0
Learns body hygiene	76.4	46.3
Learn about chores at home	79.1	-
Learn good behavior	82.7	-
Stigma and discrimination	-	12.9
Psychosocial/community counseling	-	35.4
Discuss OVC needs	-	42.9

in activities such as games, songs, and dance (95% for TSA and 87% for Allamano). However, the training curricula were somewhat different. Where Allamano volunteers taught about health hygiene, chores at home, and good behavior, TSA volunteers provided psychosocial/community counseling, discussed stigma and discrimination, and provided OVC care.

Also, the pre-evaluation case studies revealed that Allamano volunteers had regular on-site supervision and support from the OVC program level focal person during meetings, and club activities followed a more standardized curriculum across sites. This was unlike the TSA approach. The TSA case study highlighted a poorly structured curriculum across kids' club sites, and limited training and support for volunteers. TSA volunteers were encouraged to form their own agendas and, as such, the activities depended upon the skills, ideas, and equipment already possessed by the volunteers, which were variable and often limited. Therefore, the positive effects found among Allamano kids' club attendees may be attributed to the structured and comprehensive curriculum.

Direct Material Support — Two of the programs (Allamano and *Jali Watoto*) provided direct material support, including school materials and food to the household. The Allamano program also provided free health services for beneficiaries. The vast majority of Allamano beneficiaries (89%), and approximately 80% of Jali Watoto beneficiaries had received school materials. The effects of possessing basic school materials on child educational and psychosocial outcomes were examined.

Results showed no effect of possessing basic school material on children's educational outcomes (enrollment and regular attendance) for either program; however, there was a positive effect on psychosocial outcomes (see Figures 2-6). Possessing a higher number basic school materials (a uniform, pen, exercise book, chair to sit at school, and a textbook) was associated with better self-esteem among children, fewer behavioral problems, more perceived adult support, and lower perceptions among children of community stigma towards OVC and HIV-affected families. This suggests that possession of school materials may mitigate anxiety among MVC and help them believe that they are significant and worthy.

Due to the post-test study design of these evaluations, it was difficult to evaluate the effects of health services provided by Allamano. However, there was significant correlation between hearing about the Allamano health center and acknowledging receipt of health services. Other explanations from respondents pointed to the need for programs to address health care barriers that went beyond treatment costs such as attitudes of health care providers, and transportation expenses.

Program Cost-Effectiveness — A cost-benefit analysis was conducted for Allamano and TSA. However, it was difficult to compare the costs of marginal changes in outcomes between the two programs because they lack a common unit of analysis (outcome). Nonetheless, results show that the costs per one unit improvement in social isolation in Allamano and self-esteem in the TSA program were $679.40 and $398.63, respectively. Also, to achieve a one unit reduction in negative feelings among guardians, Allamano would need to spend $610 per beneficiary on home-based care. Similarly, $78 spent on home visiting by TSA would achieve a one unit reduction in guardian perceptions of community stigma. These results are still useful in highlighting that some outcomes can be achieved more cheaply than others.

Unintended Consequences — In spite of the positive effects across all programs, some activities appear to have had unintended negative effects. These findings offer important information for program planners in that they may allow for the development of preemptive mechanisms to avoid such unintended negative consequences. In particular, several results

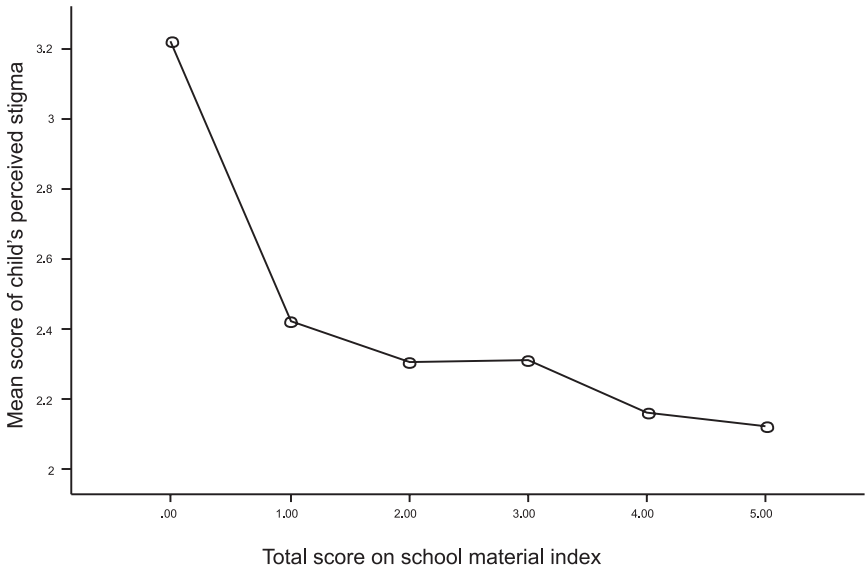

Figure 2. Relationship between having school materials and child' s perceived community stigma.

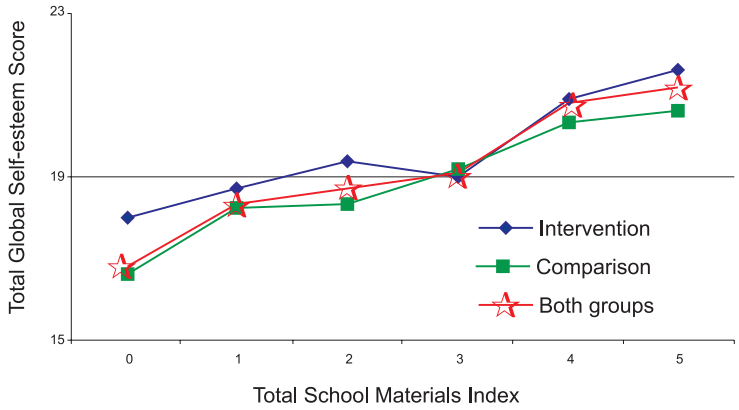

Figure 3. Relationship between having school materials and child's self-esteem, *Jali Watoto*.

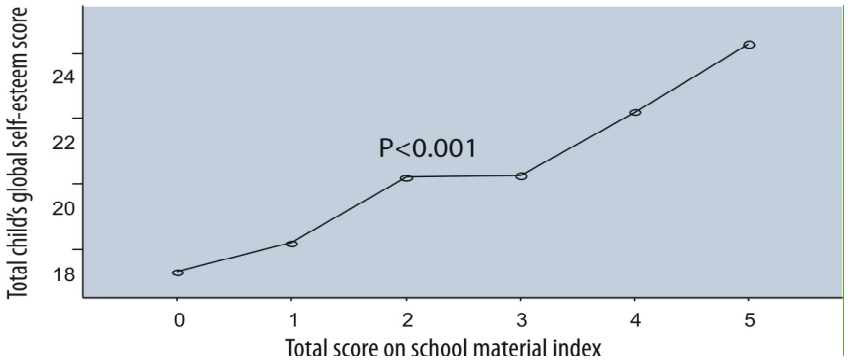

Figure 4. Relationship between having school materials and child's self-esteem, Allamano.

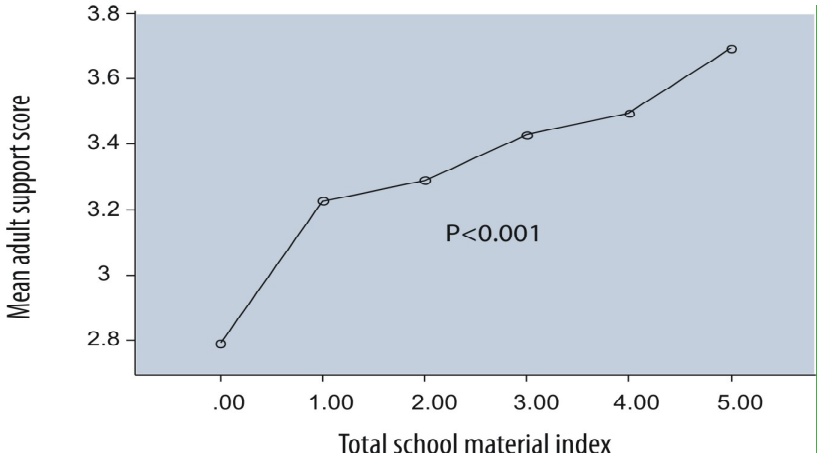

Figure 5. Relationship between having school materials and adult support, Allamano.

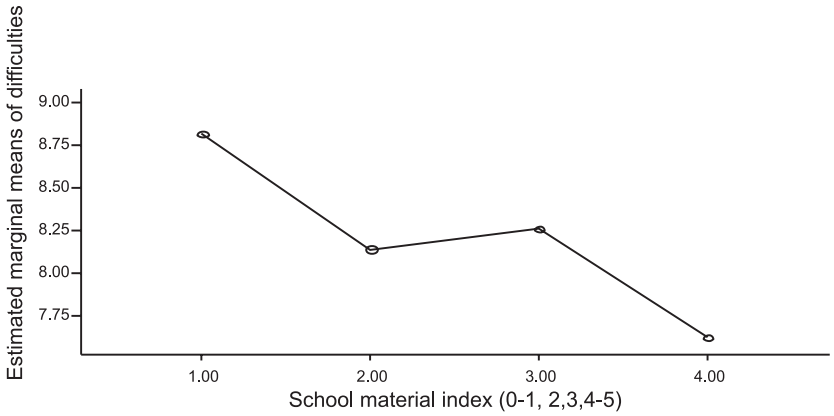

Figure 6. Relationship between having school materials and child's total difficulty behavior, *Jali Watoto*.

across all programs suggest that service delivery to OVC and their households may indirectly induce jealousy, resentment, and other negative attitudes towards HIV-affected families and OVC from the surrounding community, and increase expectations of external support from nongovernmental organizations (NGOs) and government. For example, a considerable fraction of each sample of program beneficiaries perceived that there was community jealousy of services provided to OVC and their families. In poor communities, many children and families may be in need of services, but the differential aid to OVC may cause resentment among their neighbors and peers. These results highlight the importance of engaging the community in decisions regarding who will receive services, and of sensitizing the community on the needs of OVC and those of HIV-affected families.

In addition, these studies provide insight on the expectations of community members concerning who is responsible for the support of OVC. Approximately 34% of *Jali Watoto* beneficiaries felt it was the responsibility of NGOs or government to care for orphans, compared to only 22% of comparison group samples. Perhaps being a beneficiary contributes to increased reliance upon

and expectations of support from NGOs; however, this suggestion is merely speculation in light of the study's limitations and the fact that these samples were drawn from different communities. Nonetheless, program planners should work to prevent dependence among beneficiaries by setting realistic expectations, building their capacity, and expanding their alternative support networks.

Also, some program interventions were negatively associated with family relationships. In the TSA program evaluation, caregivers whose children had attended a kids' club meeting had less positive feelings towards their children than those whose children had never attended. In the *Jali Watoto* program, caregivers in the intervention group reported poorer family-functioning than those in the comparison group. Also, some program interventions were negatively associated with family relationships. In the TSA program evaluation, caregivers whose children had attended a kids' club meeting had lower positive feelings towards their children than those whose children had never attended. In the *Jali Watoto* program, caregivers in the intervention group reported poorer family-functioning than those in the comparison group.

These findings may be indicative of household tensions among family members that need to be addressed. For example, kids' clubs take a child away from helping with chores at home without caregivers' consent.

Policy and Programmatic Implications

In light of the evaluation findings, several recommendations for the advancement and improvement of OVC programs are offered below.

Continue to engage MVCCs in identifying and supporting OVC

It is well demonstrated through these studies that communities are best positioned to identify MVC and their families. The national OVC identification guidelines in Tanzania have harmonized MVC selection across programs. Partners should continue to reach out and engage community members in supporting OVC to ensure that their needs are met. This is a key factor in promoting community ownership and deterring the negative reactions concerning services provided to MVC.

Strengthen the monitoring systems to register and track OVC

The inaccuracies within the beneficiary lists across the three programs highlight the need for a strengthened system for registering and tracking OVC and their families. The fact that so many children could not be located because they had moved or because lists contained inaccurate information about their age, names, and households has important policy and programmatic implications. This raises questions regarding the quality and validity of the reported total numbers of OVC served by programs and the services provided to those children. Also, the "lost" children may be in even more danger and in need of urgent assistance. It is recommended that the existing National Data Management System (DMS) be strengthened and adapted by all programs to help track the total number of OVC served, and monitor progress and service delivery. Individual programs should also ensure high data quality. DMS will be ineffective if reported information is flawed.

Improve the quality and intensity of program services among beneficiaries

Low intervention exposures rates were observed in each of these studies. Considering that study samples were drawn from beneficiary lists, this indicates poor-quality services. The different combinations of interventions applied, coverage, and other quality aspects of the services provided to OVC may be responsible for the mixed results. It is recommended that programs balance between quality and quantity. Debates on scaling-up programs should not focus only on improving coverage but more on ensuring that each intervention component is of good quality (i.e., meets minimum standards).

Develop and promote comprehensive training and support for volunteers

The evaluations suggest that programs offering comprehensive volunteer training, ongoing support and supervision of volunteers, and following standardized curricula were more effective than those that did not. Some training curricula were missing core topics and some volunteers lacked information and skills to effectively bring about change in child well-being. Therefore, a review process is urgently needed to ensure that volunteers' training curricula are standardized, comprehensive, and coordinated across programs. This would help to ensure that volunteers are trained in a systematic manner and that they acquire a range of relevant skills that may ultimately enhance their effectiveness.

Provide incentives for volunteers

As demonstrated by the differential between Allamano and TSA volunteers, the success of volunteers visiting MVC households can be greatly enhanced through small incentives. Considering that even volunteers are not well off, we recommend providing them with some incentives that may be beneficial to their well-being, such as transportation and a supportive working environment. These steps will motivate them to do more for others in the community.

Involve caregivers and children in designing interventions to address OVC needs

While the ultimate focus of many OVC programs is on children, these evaluations highlight the importance of engaging and supporting caregivers. Even activities designed for children, such as kids' clubs, could be more effective if caregivers were engaged at the planning stage. Program planners should ensure caregivers' understanding of the importance of children's involvement in these activities, as well as gather their input on the initiatives' design and structure (i.e., schedule of activities). Engaging both caregivers and children may help to improve family functioning, child participation, may identify key issues for the curriculum, and may deter any resentment caregivers may feel about how program activities absorb their children's time.

Enhance linkages among OVC care and support providers

It is evident that no one program can address the myriad of needs of OVC and their caregivers. Therefore, efforts to build relationships and partnerships across humanitarian groups, other service organizations, and the community would help to ensure holistic support to beneficiaries.

Conduct regular assessments of program coverage and client participation

Beneficiary reports of services received did not match the expectations of service providers, who considered all the children appearing in their beneficiary list as "recipients of an intervention." However, for services that require active participation of clients (e.g., attending meetings), there may be client-specific or even intervention-specific barriers affecting their attendance that programs could address. The reasons for low participation in interventions are unknown and may range from low relevance to incongruence with clients' needs, to limited access. We therefore recommend for regular follow-up with individual beneficiaries to determine how many clients are truly receiving services, and to uncover potential barriers to service participation is highly recommended.

Prioritize evaluations as an integral part of overall program implementation

Organizations that participated in this evaluation were very interested in the activity, as they wanted to learn and have documentation of both their program's achievements and areas needing improvement. We recommend that every program conduct a self-assessment regularly to improve their programs. This could easily be done at a low cost by using simple, existing tools, such as the Child Status Index (CSI), to assess and monitor beneficiary well-being periodically.

Incorporate direct support to strategies aimed at improving child psychosocial well-being

Possession of the necessary school materials, such as a book, pencil or pen, and uniform was related to better self-esteem and perceived adult support among school-age children. Thus, as part of the overall care and support strategy for OVC, programs should include a basic school materials provision component for school-age children.

Address perceived negative attitudes from the community towards program beneficiaries

Although all programs were designed to increase community support to vulnerable families and reduce stigma, beneficiaries commonly reported perceptions of jealousy, resentment, and stigma from the community. Innovative ways to address these perceived negative attitudes are urgently needed.

Conduct a follow-up survey among the same sample of consenting participants

The willingness of many respondents to participate in a follow-up survey presents a ripe opportunity for determining the impact of these OVC programs. Consenting participants provided contact and tracking information for potential future follow-up. Conducting surveys among these samples in two to three years would enhance understanding of program impacts. Data reported herein may serve as a baseline, and follow-up data would allow for assessments of changes over time, and definitive attributions of outcomes to programs.

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