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Learning How to Measure the Well-Being of OVC in a Maturing HIV/AIDS Crisis

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Abstract: The HIV/AIDS epidemic in Africa is frequently referred to as a crisis while the principal U.S. program to address it is labeled *emergency* relief. These terms trigger specific policy responses and corresponding evaluation activities. In this article, three stages in the response to HIV/AIDS are distinguished: awareness, emergency, and structural integration. In the awareness phase, emphasis is on defining and then estimating the affected population. In the emergency phase, evaluation activity is focused on demonstrating accountability for the assistance provided; and finally, in the structural integration phase, concern shifts to demonstrating the impact of assistance on improving the recipients' well-being. The shifting focus of evaluation is discussed in terms of how to measure the impact of aid on the well-being of orphaned and vulnerable children. A case study based on work in rural Tanzania is presented and then discussed in term of its broader implications for evaluating future aid.

Key words: HIV/AIDS, orphans, research policy, Africa.

Emergencies vs. Crises

In a 2007 visit to Tanzania and Kenya, the authors met with a variety of officials responsible for programs supporting the needs of children orphaned or made vulnerable by AIDS (hereafter referred to as OVC). We were there to present the findings of a study designed to develop and test protocols for measuring the well-being of OVC. We heard a broad range of responses, from supportive to skeptical. When we identified the setting where we had applied our research as a residential community center, some were quick to label it an orphanage and to then respond that orphanages don't work, as if to end the discussion, despite the fact that this center was developed through a community consensus process and only served the community's orphans.

In retrospect, we have come to understand that we were not just hearing responses to our specific work, but expressions of different perceptions regarding the nature of the OVC challenge in sub-Saharan Africa. Some people were concerned with measuring the extent of the need, others with demonstrating accountability for the aid received,

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and still others with measuring well-being. Michael Lipsky and Steven Rathgeb Smith make a useful observation concerning differences of opinion such as those we encountered. They write that "the most critical moments in the life cycle of an issue may well be the outcome of the contest over how it will be understood."[1, p. 7] When an issue is perceived as an emergency, extraordinary resources are made available to assist the affected. But if the emergency is not short-lived, then other perceptions may set in. According to Lipsky and Smith, "A critical question is whether emergency policies will deteriorate into routine policies with lower levels of service and reduced constituencies to evoke a commitment to deal with [the] chronic or structural problems from which emergencies arise."[1, p. 9]

Viewed from a historical and development perspective, the response to the OVC challenge has evolved through three stages: awareness, emergency, and structural integration. The awareness stage consists of recognizing the problem, specifically recognizing that a challenge requires a policy response. Although the rate of HIV infections and attendant deaths was growing at epidemic proportions throughout sub-Saharan Africa during the 1980s and 1990s, the problem was largely ignored by policymakers in part because they did not fully understand its magnitude but also because there were scant resources to address it. Needless to say, the problem of a growing population of OVC resulting from the disability and death of so many parents and caregivers was even further off the radar. In 2002, Carol Bellamy, the executive director of the United Nations Children's Fund (UNICEF), bluntly concluded, "The silence that surrounds children affected by HIV/AIDS and the inaction that results are morally reprehensible and unacceptable. If this situation is not addressed, and not addressed now with increased urgency, millions of children will continue to die, and tens of millions more will be further marginalized, stigmatized, malnourished, uneducated, and psychologically damaged."[2]

The 1997 publication of the report *Children on the Brink* by the Joint United Nations Programme on HIV/AIDS (UNAIDS) served to raise awareness of the OVC problem greatly.[3] That report was supported by and stimulated much research designed to enumerate and classify OVC. Even as awareness was growing, policymakers tacitly assumed that OVC were being cared for by other family members, so even if their numbers were great, there was a safety net to catch them.[4]

The awareness stage was followed by the emergency stage. With a spotlight now illuminating the once invisible OVC population, international efforts were organized to provide assistance. Awareness of the situation helped establish the basis for declaring it an emergency, and the promise of resources offered new motivation to help identify those in need. The nature of an emergency response is to provide short-term bridging resources. Because these resources are limited, there are policy concerns about who to target and for what length of time. In Lipsky and Smith's characterization, there is a "routinization" of response.

With the OVC population in sub-Saharan Africa projected to reach 18 million by 2010, the perception and treatment of the challenge as an emergency no longer seems appropriate or adequate. (See Table 1.) Instead, countries have been entering the stage of structural integration where they must try to find ways of addressing OVC that meet not only their short-term demands but their long-term developmental needs. What is called for, as Lipsky and Smith observe, is a commitment to deal with chronic or

structural problems from which the emergencies arise."[1, p. 9] Applied to the context of sub-Saharan Africa, it can be observed that some countries—for example, those that have established a system of village-level committees to identify their OVC, determine their needs, and distribute resources—are already at that stage of programmatic structural integration, but most are not. Throughout the sub-continent, gaps are being filled by a large number of non-governmental organizations (NGOs), many faith-based, that work locally but lack the power to inform and promote structural policy changes. Even as the amount of money available from international NGOs has increased—such as through the 2008 reauthorization of the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) program—most countries have a poorly articulated system for getting that money from the national to the local level. While the concern for enumeration remains, it is refocused on trying to define the target population for what will now be more long-term interventions.

The Changing Role of Evaluation

For each of these stages in the evolution of policy responses there is a corresponding form of evaluation. At the awareness stage, evaluation focuses on enumeration. Debate revolves around how to define OVC (cf. UNAIDS/UNICEF's *Report on the technical consultation on indicators development for children orphaned and made vulnerable*[6]) and how to estimate the population from various sampling methods. At the emergency

Table 1.

ESTIMATED NUMBER OF AIDS ORPHANS IN SUB-SAHARAN AFRICA (2005)[5]

Countries with the highest number of AIDS orphans	Number of orphans due to AIDS alive in 2005	AIDS orphans as a percentage of all orphans, 2005
South Africa	1,200,000	49%
Tanzania	1,100,000	44%
Zimbabwe	1,100,000	77%
Kenya	1,100,000	46%
Uganda	1,000,000	45%
Nigeria	930,000	11%
Zambia	710,000	57%
Democratic Republic of Congo	680,000	16%
Malawi	550,000	57%
Sub-Saharan Africa	12,000,000	25%

Source: UNICEF

stage, the focus of evaluation shifts to demonstrating accountability for the resources made available. Similarly, because there are large numbers of children to be served, there is concern for demonstrating the cost-effectiveness of alternative distribution programs (cf. work by Stover et al.[7] and Prywes et al.[8]). At the structural stage, focus shifts again from an evaluation of short- to long-term effects (cf. work by DeMarco[9]). At this stage it becomes important to know not simply how many OVC are being fed, clothed, or sheltered, but whether their psychosocial needs are being met and whether they are likely to grow up to be productive members of society. Here debate focuses on the relevant dimensions of well-being in the context of countries already suffering from high rates of poverty. A related challenge for evaluation is to be able to identify the effectiveness of different programs. With numerous efforts to meet the needs of OVC developing in each country—many spawn at the local level and with the assistance of faith-based organizations—which are deserving of public support, and which are most likely to be sustainable?

With these three stages in mind (see Box 1), it is easier to hear various perceptions and perspectives from professionals reacting to a measurement of the well-being of OVC. "Bean counters" are searching for measures of accountability, other professionals are looking for measures of well-being that can serve policies formulated for the long haul, and still others are continuing to ask, "Isn't it true that families are taking care of their own OVC?"

As an increasing number of developing countries, especially in sub-Saharan Africa, reach a stage-three policy focus (i.e., where they recognize that addressing the needs of OVC is not a matter of addressing a short-term emergency, but rather of developing a structurally integrated response), they are struggling to develop appropriate measures of OVC well-being. In 2004 and 2005, the United States Agency for International Development (USAID) published two resource guides for conducting participatory situation analyses of OVC.[9,10] The purpose of those guides was "to promote realistic, effective, and feasible interventions. . . ."[9, p. 1] The approach was based on situation analysis rather than needs assessment. Whereas the typical needs assessment focuses on demands or deficits, a situation analysis also tries to identify capacities or assets for addressing a problem. In addition, it can be a tool for helping to develop consensus among key stakeholders.

Although thorough and well-grounded in a participatory or empowerment evaluation approach,[11] the USAID guides do not offer any scientifically validated instruments for evaluating psychosocial well-being. Rather, they recommend employing a combination of interviews and focus groups. Such methods are appropriate for qualitative, locally norm-based characterizations, but not reliable for tracking change over time or for comparing programs with a valid metric. Moreover, in 2005 there was just the beginning of the application of standardized scales for the evaluation of psychosocial well-being, e.g., CARE in Cambodia and the Regional Psychosocial Support Initiative (REPSSI) in South Africa. These measurement efforts were still in the early stages of establishing the cross-cultural validity of their instruments.[9,12]

Box 1.

STAGES OF PROBLEM PERCEPTION AND RESPONSE

Stages of perception and response	Policy focus	Evaluation focus
Stage 1. From invisibility to awareness techniques	The focus is on determining the extent of the problem and whether it is necessary to develop a policy response. Orphaned and vulnerable children (OVC) and appropriate	Enumerating the numbers of individuals affected involves developing operational definitions of sampling.
Stage 2. From awareness to emergency response	The situation is declared an emergency, requiring the mobilization of resources. This shift in perception at the national level is stimulated in part by the availability of international aid.	With a commitment to distribute aid, the focus of evaluation turns to measuring the cost-effectiveness of distribution systems and their accountability or transparency.
Stage 3. From short-term emergency response to long-term structural response	The long-term impacts of the problem become evident, and policy shifts from stabilizing the physical conditions of OVC to defining how their well-being can be assured. Because of the increased commitment of resources at this stage, there is new emphasis on targeting which OVC should be eligible.	Evaluation here becomes a tool for measuring OVC well-being and for distinguishing which interventions effectively contribute to it. There is also a concern for identifying the socioeconomic sustainability of different programs.

Lundy-Idweli Project Evaluation Protocols

In August 2005 the Rockefeller Foundation made a grant to the Denver-based Lundy Foundation to develop and field-test evaluation protocols measuring the psychosocial well-being of OVC. The grant application was championed by Dr. Pathmanathan ("Pat") Naidoo, who was director of the foundation's health equity program based in Kenya. As a trained pediatrician, Dr. Naidoo was intimately aware of the conditions that OVC faced, and he was frustrated by the slow pace of progress in recognizing and

addressing their needs. In particular, Dr. Naidoo felt that it was essential to advance practices of evaluation so that it would be possible both to characterize the impact of HIV/AIDS on the psychosocial well-being of OVC and to evaluate whether interventions designed and employed to assist OVC were actually having an impact. In short, he hoped to provide a basis for the kind of programmatic structural integration that Lipsky and Smith designate a mature response to crisis.

Study protocols. Although the grant to Lundy focused on psychosocial well-being, the research was designed to view well-being more broadly through three lenses: the psychosocial, the physical (health), and the socioeconomic. This last lens was intended to reflect the sustainability of specific interventions as well as the economic supports available for children. The proposed protocols could be used to characterize the condition of OVC themselves and to evaluate the effectiveness of programs developed to address their needs. This was regarded as an important dimension of stage-three evaluation where the role of the evaluator extends beyond enumeration and characterization of the OVC population to consider the effectiveness of different kinds and levels of support being provided by programs in the field.

There had been considerable testing of the psychosocial well-being of HIV/AIDS orphans in the United States and Europe. Therefore, the approach taken in the Lundy project was to identify the instruments demonstrated to be most useful in those countries that had potential applicability for field use in sub-Saharan Africa. Dr. Claude Mellins, a pediatric psychologist from Columbia Presbyterian Hospital in New York, was the lead investigator identifying applicable instruments. Her counterpart in Tanzania was Dr. Sylvia Kaaya, head of the Dept. of Psychiatry and Mental Health at Muhimbili University in Dar es Salaam, Tanzania. The plan was for selected instruments to be modified for cultural differences in Tanzania, field-tested, and then applied at one site—the village of Idweli in southwestern Tanzania.

As noted, the basic design of the overall evaluation was to view well-being through three lenses: psychosocial, physical, and socioeconomic. It was assumed that all three dimensions support one another and that they collectively offer a measure of well-being.

Psychosocial measures. A key dimension of psychosocial well-being is the presence and degree of depression. The Children's Depression Inventory (CDI) is one of the most widely used instruments for assessing depression in children. The original, 27-item English version of the CDI is a self-report measure of childhood and adolescent symptoms of depression, originally normalized on a large sample of U.S. schoolchildren.[13] The 14-member U.S./Tanzanian project team adapted the CDI by translating it first into Swahili and then back into English to ensure fidelity, and then testing it with a small sample of children to adjust response scales and language to fit the cultural context.

Another tool that was adopted for use in Tanzania was the Social Supports Questionnaire (SSQ). This instrument was developed by Dr. Mellins and her colleagues at Columbia University in their work with U.S. children who had been orphaned or made vulnerable by HIV/AIDS. The six-item survey measures the number of individuals whom children identify as having provided them with different types of psychosocial supports (e.g., helping with homework, providing personal affirmation). This instrument was also double-translated and field-tested.

A third instrument, this time for use with parents or caregivers rather than OVC themselves, was the Strengths and Difficulties Questionnaire (SDQ–Parent Version). It is a short survey that asks parents or caregivers to rate a child's capacity for addressing some common problems.[14] The SDQ has been used worldwide, including in Africa, with good reliability across cultural contexts.

To ensure the validity of these instruments (i.e., to test that they were measuring what they were assumed to be measuring in the Tanzanian context), other measures were included in the study to provide both objective and subjective information on a child's psychosocial well-being. These included records of school attendance and performance, and one-on-one interviews with children and caretakers.

Physical health measures. There is a demonstrated relationship between psychosocial well-being and physical health. Children who are healthy in one dimension are usually healthy in the other. To get a measure of physical health that could be used to support measures of psychosocial well-being, a standardized instrument was adopted: the body mass index (BMI), an internationally employed measure that correlates height, weight, and age.[15] The BMI has been norm-adjusted for different countries and populations, including Tanzania. In addition to the BMI, the physical health of children can be assessed by the number of doctor or clinic visits, and by the number of days of school missed for illness.

Sociocultural sustainability measures. This lens involves two levels of sustainability: household and community or project. At the household level, the Lundy project adapted elements of the economic status survey developed as part of the USAID *Framework and Resource Guide*.[9] As adapted, this survey provides a basis for comparing the level of economic support available for orphaned and non-orphaned children in a community versus what is made available to OVC who may be supported by a specific program or intervention.

The second level of sustainability focused on the ongoing viability of specific programs. Here, the concern was whether a program was perceived as being part of the community or whether it was regarded as something that was provided by outsiders (e.g., an international NGO) and that was their responsibility. Another part of program sustainability depended on whether a community or village might be able financially to sustain an OVC support program if external assistance was reduced or terminated. The methods employed here were focus groups and one-on-one interviews with key informants, including the village chief, the regional economic development officer, and the directors of the contributing NGOs.

Using the three-lens model of evaluation enabled us to triangulate data and develop a more complete and robust picture of OVC well-being in a specific community. For purposes of the pilot study, it was possible to use findings from the physical health and socioeconomic lenses to support the validity of selected measures employed in the psychosocial lens.

The pilot site and sampling design. The site for this case study was the village of Idweli in southwestern Tanzania. Villagers in Idweli primarily work on subsistence farming with some cash crops. The national highway connecting Malawi with the port at Dar es Salaam runs by the village. A constant stream of truckers combined with local sex workers help fuel a level of HIV infection twice the national average. At the

time of data collection for the study (January to May 2006), Idweli had a population of approximately 2,500. Forty percent of its children were orphans, with half estimated to be orphans as the result of the death of one or both parents to HIV/AIDS.

In May 2005, a community center was opened to provide residential care for 58 of the neediest OVC in the community. The center also provided preschool and after-school programs for other village children. The center came to be through a participatory process that included women and children, as well as the community's traditional male decision makers. A collaboration of one local Tanzanian NGO and two U.S.-based non-profit organizations supported the decision-making process. With financial and technical support from these three organizations, villagers constructed the children's center complex. Although some critics would eventually call the center an orphanage, the fact that it was the product of a community-based decision-making process and that it served only the orphans of Idweli make it quite different from the typical orphanage in sub-Saharan Africa.

The evaluation study in Idweli[16] therefore allowed for field testing the protocol as well as evaluating a specific intervention—the Children's Center. For sampling purposes, all of the children at the center above the age of seven were administered the psychosocial instruments. Matched samples of orphans living in the village with extended family and non-orphaned children living with their nuclear families provided control or comparison groups. In all, 209 children were interviewed and administered standardized tests (i.e., the CDI and SSQ). The parents or caregivers for these children were also interviewed: They completed a household budget survey and the SDQ. In addition, 70 key stakeholders in the village participated in individual interviews and/or focus groups. (See Box 2 for a summary of the evaluation design.)

Findings from the pilot study. It is important to note that most of the standardized instruments employed in the Idweli study are not norm-referenced for Tanzania so that something like the CDI scores could not be compared with national norms. (The one area where such norms do exist is for the BMI.) However, scores could be compared across the three village samples: center orphans, village orphans, and village non-orphans. The kinds of results that can be employed using the protocols from Idweli are illustrated by the actual findings listed below. (The standardized instruments employed are shown after the area of measurement along with the level of significance.)

Depression (CDI). Center orphans were significantly less depressed (on average, they reported half as many symptoms) than orphans living in the village with extended family members ($p<.05$). They also were significantly less depressed than children living with both parents ($p<.05$).

Emotional and behavioral functioning (SDQ). There were no significant differences among the groups of children with respect to their emotional and behavioral functioning ($p>.05$) even though previous research in Africa and elsewhere suggests that OVC would be expected to demonstrate more emotional and behavioral problems.

School performance. School attendance of center orphans was better than that of village orphans. Center orphans expressed greater optimism and hopefulness about being able to shape a positive future for themselves, specifically through knowledge and study.

Physical health (BMI). The three groups of children did not differ significantly in

Box 2.

EVALUATION DESIGN FOR IDWELI AND ITS CHILDREN'S CENTER[20]

Research question	Standardized instrument and data collection methods	Sample population
Does living at the center positively impact the psychosocial well-being of resident orphans?	Children's Depression Inventory (CDI) —interviews	Children ages 7 and older in all sample groups —Center double orphans (51) —Village double orphans (40) —Village non-orphans (99)
	Social Supports Questionnaire (SSQ) —interviews	Children ages 7 and older in all sample groups (same as above)
	Strengths and Difficulties Questionnaire (SDQ) —interviews	Parents and caregivers for all sampled children
	School Performance Survey —review of attendance and test scores	School headmaster for all sampled children who attended primary school
	Children's Sense of Well-Being —interviews	Children in all sample groups (no age criteria, n=209)
	Caring for Children —focus groups	Male and female parents and caregivers
	Support and Sustainability Survey —interviews leaders, doctor, school headmaster)	Key informants (e.g., village chief, 10 cell leaders, district and regional commissioners, religious

(Continued on p. 179)

Box 2. (*continued*)

Research question	Standardized instrument and data collection methods	Sample population
Does living at the center positively impact the orphans' physical health?	Body Mass Index (BMI) —interviews —review of medical records	Center nurse and dispensary physician for all sampled children
	Support and Sustainability Survey —interviews	Key informants (same as above)
	Caring for Children —focus groups	Male and female parents and caregivers
Is the support provided by the center socially and economically sustainable?	Support and Sustainability Survey —interviews	Key informants (same as above)
	Housing and Budget Survey —interviews	Households of all children in village sample groups
	Children's Center Development Process —focus groups	Children and adults participating in Future Search process

Source: Lundy Foundation

weight and other measures of physical health, even though center orphans were chosen from among the neediest children in the village.

Social integration (SSQ). Center orphans reported as many social supports as the other groups of village children, and expressed no sense of being stigmatized or isolated. Many center children visited with family members on weekends, and village children attended pre- and after-school programs at the center.

Socioeconomic sustainability. Although the cost of maintaining a child at the center was somewhat greater than that of maintaining a child in a home environment, expenses were consistent with other community-based alternatives and were significantly lower than the costs of placement in traditional orphanages. Over time, the center was becoming increasingly integrated into the social life of the village. It operated under a local governing board that included women and youth. However, ongoing external financial support is essential to its long-term sustainability.

In addition to findings related to the utility of the instruments and research protocols employed, the Idweli pilot also suggests some important considerations for conducting this type of evaluation in the field. The USAID *Framework and Resource Guide* offers the following caution: "How this process is managed affects not only the quality and extent of the data collected but also how the data are eventually analyzed and used."[9, p. 15] To the extent that evaluation in stage three employs standardized instruments, it is essential that they be administered correctly, which requires professionally trained fieldworkers and management. This is not easy. In the Idweli study, there were 10 days of training using university students as fieldworkers under the supervision of a full-time manager.

Since the evaluators typically are people outside of the community, it is essential that the community understands the evaluation instruments and objectives, and that they are ready and willing to take part in the evaluation. The most obvious basis for such willingness is that the community sees a benefit to an assessment of its OVC's well-being—not one that simply provides a snapshot in time but that can be used to determine whether progress is being made as a result of their efforts to meet the needs of their OVC.

The Lundy-Idweli pilot demonstrates that an evaluation of well-being can be designed and conducted in the field, providing scientifically reliable and culturally valid results. Although the pilot study was relatively expensive because of the time required to develop and test instruments, the standardized instruments employed (CDI, SSQ, SDI, and BMI) are all short. The CDI, SSQ, and BMI could be administered by trained testers in a school setting, thereby capturing a cross-section of all children from a community (i.e., OVC and non-OVC). The SDI would have to be administered to parents and caregivers. It would be useful to repeat such tests at least every few grades to provide a basis for trend analysis and tracking of different cohorts. By testing in a stratified sample of communities, a countrywide profile of OVC well-being could be developed.

Implication for Stage-Three Evaluations

Being able to measure well-being efficiently is a critical objective of stage-three evaluations. However, the effectiveness of such evaluations depends on the political and

social context within which they are conducted.[17] Applying Lipsky and Smith's analysis of emergencies, stage-three evaluations are justified if policymakers are ready to make "a commitment to deal with [the] chronic or structural problems from which the emergencies arise."[5, p. 20] With the OVC problem still growing, a structural response is essential, but crafting one is difficult. Many of the parties currently engaged in funding as well as in receiving aid may resist any attempted change to the current system. These parties can argue with some justification that all available resources must continue to be used to address OVC demands as emergencies, and that funds employed in evaluation reduce the amount of support for those in need.

Even for those parties who have already moved to stage three, the whole process of aid becoming routine is fraught with tension. Those on the receiving end of assistance will want routinization to be set at the highest reasonable level of support, while those paying for that aid will want to set it at the minimal effective level. Similarly, in defining the target population for assistance, recipients will want an expansive definition, while donors will want a narrow definition (e.g., the target could be defined narrowly to include only double orphans or broadly to include those who are not yet orphaned but who are being affected by HIV through the serious illness of their caregiver).

A recent development that brings such debates into sharper focus is the availability of new support. In July 2008, the U.S. Congress reauthorized the President's Emergency Plan for AIDS Relief (PEPFAR). That legislation has a five-year budget of $48 billion, approximately 10% of which is designated for programs supporting OVC. Included within PEPFAR is language calling for more rigorous monitoring and evaluation. Section 101(c) states that evaluation under this act will focus on "impacts," or (presumably) measures of well-being. Also in that section, the legislation states, "Assessments and impact evaluations conducted under the study shall utilize sound statistical methods and techniques for the behavioral sciences, including random assignment methodologies as feasible."[18] In effect, evaluation will not focus exclusively on accountability (though there is language regarding the need for that), but also on demonstrating how U.S. assistance is affecting the lives of OVC. There is further language that speaks to disseminating findings and best practices to optimize delivery of services.

Since the reauthorization of PEPFAR and with implementation falling to a new administration in Washington, there is growing concern that the opportunity to use evaluation effectively is fully realized. Based on lessons from the Lundy-Idweli pilot and from experiences of other researchers[19,20] in the field, three principles can be identified to help guide the design and implementation of evaluation in stage three: transparency, mutual accountability, and sustainability.

Transparency. A central theme conveyed in President Barack Obama's message on his initiative to restart the U.S. economy[21] was the importance of being able to see clearly where monies are being spent and what results are being achieved. By connecting spending with results, the president signaled a shift from merely accounting for what was spent to evaluating the impacts of investments. He also announced that a web site had been set up so anyone could track the flow of funds and results. Arguably, the same high level of transparency should apply to foreign aid, and specifically to aid flowing through PEPFAR and other sources. Such transparency can only be achieved if there is an objective measurement of results. The argument presented here is that those

impacts should be evidence-based measures of the improvement of OVC well-being. This does not preclude qualitative measures and measures derived on a participatory basis, as long as they can provide reliable and valid data.

Mutual accountability. A complement to the principle of transparency is mutual accountability. The system of evaluation must provide a capacity for holding all parties accountable, and not just making those on the receiving end accountable to donors. This principle is embedded in a pay-for-performance approach to evaluating the merit of an employee's performance. If an employee agrees with an employer to try to achieve a certain measurable level of performance and achieves it, then the employer should be obligated to pay. If mutual accountability were applied to the distribution of aid, then donors and recipients would come to a shared understanding of what they were trying to achieve, and aid would flow based on performance. A critical point in implementing such a system rests in the design phase, when the affected parties must come to a common understanding of what they are trying to achieve. (Presumably this is what the bilateral provisions of PEPFAR are intended to address.)

Sustainability. Along with building mutual accountability into evaluation, it is essential to be building sustainability. Evaluation should help provide a basis for rewarding programs that are working, but it should also be capable of providing timely feedback to allow programs that are not performing optimally to improve. This would allow them eventually to show a level of effectiveness that would justify continuation. Evaluation capable of doing that could also help to identify emerging programs that deserve support. In Africa today there are hundreds if not thousands of small community-based programs like the Idweli Children's Center that seem to be effective in meeting local needs.[22] Because such programs fly below the radar, they go unnoticed and are therefore not considered for support from governments and large NGOs. Evaluation should provide a basis for certifying the effectiveness of such programs and thereby measuring their funding worthiness against already recognized programs. In short, evaluation should provide a basis for innovation as well as for continuous improvement.

Using the Window of Opportunity

In his analysis of the formation of public policies, John Kingdon[23] points to the importance of having a window of opportunity that allows proponents of new policies to get them on the agenda. As suggested earlier, the reauthorization of PEPFAR combined with a new administration in Washington has opened such a window by providing the opportunity to reshape the approach to OVC support, specifically by requiring impact evaluation. Properly taken, this opportunity could make evaluation a far more integral part of the entire effort to provide aid to OVC. Rather than using evaluation after the fact to demonstrate the suitable expenditure of funds, it could be an ongoing part of how funding decisions are made. It would serve to provide feedback to programs on the ground regarding how they are doing, thereby offering a basis for ongoing program improvement and recognition of innovations.

For evaluation to play such a role, a collaborative approach to its design and implementation is essential. Control over evaluation cannot reside exclusively on the donor's side, nor can high-level national representatives be the sole voices on the recipient side.

All the key parties, including community representatives, need a voice in selecting instruments, developing evaluation protocols, and interpreting the significance of the results. It is time to stop counting beans and to focus on measuring well-being.

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