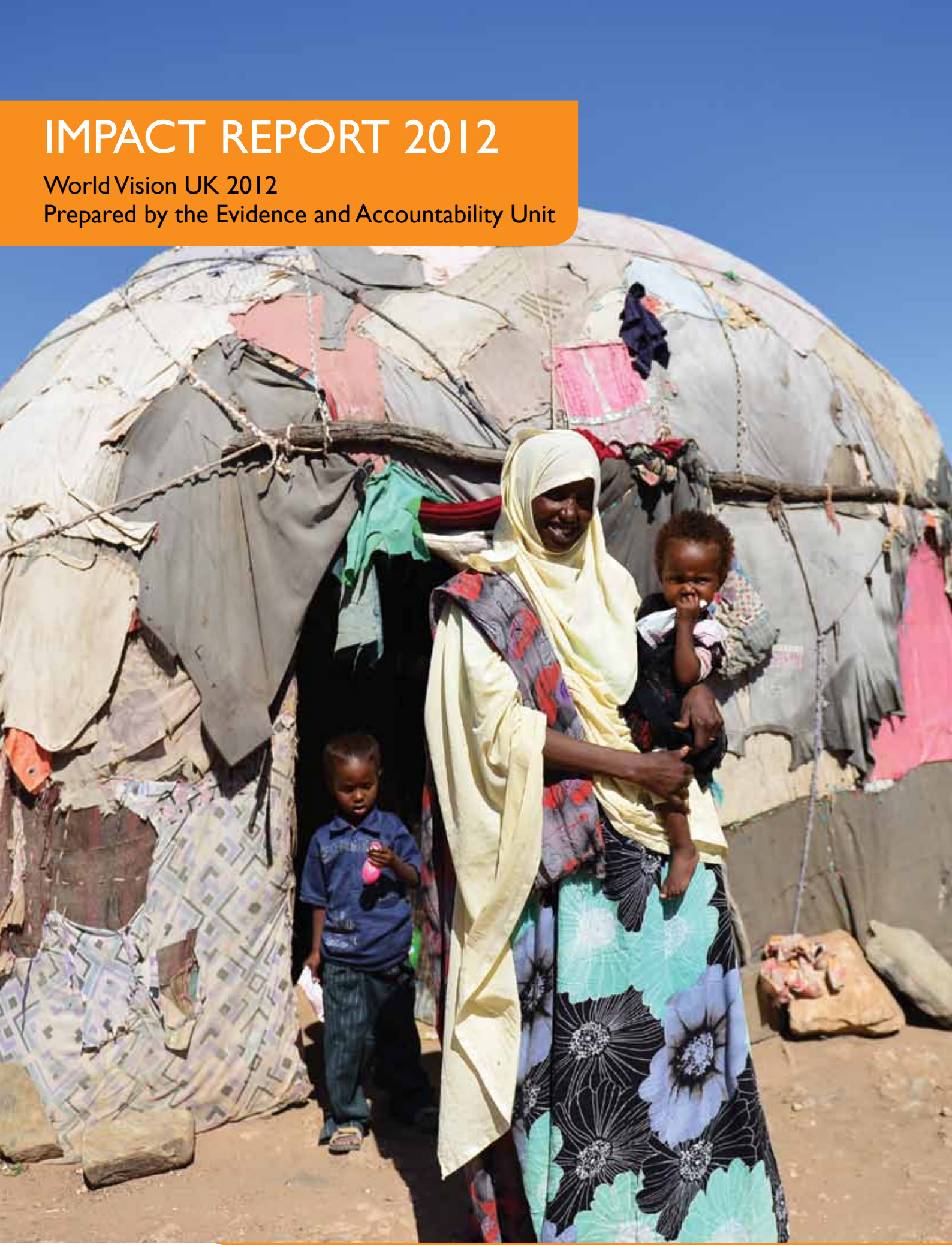
IMPACT REPORT 2012

World Vision UK 2012
Prepared by the Evidence and Accountability Unit



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Finally to our World Vision National Office Programme and Project colleagues, we are continuously grateful for your commitment to improving the lives of the poorest people.

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This page: Children at a child friendly space in the Philippines, built after Typhoon Bopha, throw paper planes containing their hopes and prayers to symbolise their aspirations for the New Year.

Cover: Nimeo, two, with his mother and older brother, is part of the Maternal Child Health Programme Outpatient Therapeutic Programme. Nimeo is assessed each week at the local health centre, receiving treatment ranging from therapeutic food to antibiotics.

Demonstration of nutritional feeding, Chowfaldandi ADP, Bangladesh. © World Vision

GLOSSARY

ADP Area Development Programme

BBC British Broadcasting Corporate

BOND British Organisations for NGOs in Development

CAFOD Catholic Agency For Overseas Development

CBO Community Based Organisation

CHW Community Health Worker

CI Confidence Interval

CMAM Community Management of Acute Malnutrition

CWB Child Well-Being

CWBI Child Well-Being Indicators

DAC Development Assistance Committee

DCN District Child Network

DCWB District Child Welfare Board, Nepal

DFID Department for International Development

DHSBS District Health Services Baseline Survey, Sierra Leone

FGD Focus Group Discussion

FY Financial Year

GAM Global Acute Malnutrition

HARD Horn of Africa Response to Drought

HC Health Centre

HERO Haiti Earthquake Response Office

HoA Horn of Africa

IPU Inter Parliamentary Union

IDP Internally Displaced People

M&E Monitoring and Evaluation

MCCP Mobilising Communities for Child Protection, Cambodia

MNCH Maternal, Newborn and Child Health

ODI Overseas Development Institute

OECD Organisation for Economic Cooperation and Development

OTP Out-patient Therapeutic Programme

PPA Programme Partnership Agreement

PTA Parent Teacher Association

PWD People with Disability

SAM Severe Acute Malnutrition

SC Stabilisation Centre

TBA Traditional Birth Attendants

TC Town Council, Uganda

ToC Theory of Change

TSF Triceps Skin fold Thickness

TSFP Targeted supplementary feeding programmes

TTC Timed and Targeted Counselling

VCPPC Village Child Protection and Planning Committee, Nepal

VHSG Village Health Support Group

VHT Village Health Team

WASH Water and Sanitation and Hygiene Promotion

WELD Western Equatoria Livelihood Diversification

WFP World Food Programme

WVUK World Vision UK

WVI World Vision International

EXECUTIVE SUMMARY

This is the third impact report which World Vision UK has published. Its objective is to honestly report and reflect on the impact of World Vision UK programme and advocacy work in our 2012 financial year (October 2011 – September 2012) as we seek to bring real hope to the lives of millions of children in the world's hardest and most fragile contexts.

Evidence of Real Change for Children

Global impact is assessed through three dimensions:

- Global overview to present our coverage and equity
- Meta analysis across WVUK's three priority themes (Child Health, Child Rights to Care and Protection and Humanitarian Response) structured around the thematic theory of change and operating models based on evaluations, reviews and annual reports
- Rigorous review and reflection of 15 evaluations conducted this year that provide a 13% sample of all programmes for in-depth impact assessment and 3 advocacy impact studies

Global Overview

In 2012 World Vision UK supported programmes benefitting 3.77 million children through 329 projects in 34 countries. This represents a decrease of 220,000 children from the previous year, predominantly due to a reduction in large scale emergencies in World Vision UK priority countries. 60% of children reached by World Vision UK benefitted from programming in our three main themes – child health, child protection and humanitarian action. Furthermore, 70% of child beneficiaries are within fragile contexts, a marked increase from 2011 representing our strategic intent to further focus on fragile contexts.

Meta-Analysis

World Vision has fifteen global child well-being outcomes with an associated compendium of indicators, based primarily on industry standards. Where applicable, programmes include one of these indicators in their programmes and this enables a global aggregation of change to be cited and contributes towards a reflection on operating models and theories of change.

A summary of overall impact from the 27 evaluations (15 in 2012 and 12 in 2011), in which data was available, showed that on average in World Vision UK long term development programme cycles (Between 52 and 61 months duration):

Health

- Underweight children decreased by 5.33%
- 17.86% increase in children who are fully immunised
- 12.43% increase in mothers who exclusively breastfed their babies for 6 months
- 20.05% increase of births at a hospital or with a skilled birth attendant
- Access to safe drinking water increased by 16.2%
- 26% improvement in livelihoods resulting from improved agriculture

Child Protection

- Average increase of 26.7% of 'Children living a life free from neglect, violence and abuse' representing 78,812 children across 13 programmes.
- School enrolment rate increased by 22.04% while the drop-out rate decreased by 13.53%

Humanitarian Action

World Vision UK contributes to large-scale World Vision responses to major disasters, and in 2012 supported 971,090 people with emergency assistance following the food crises in East Africa and the Sahel and the typhoon in the Philippines. There is also ongoing support for recovery and rehabilitation to previous major disasters including the Haiti earthquake and the floods in Pakistan as well as for chronic fragile contexts such as Somalia, North and South Sudan and Afghanistan.

Assessing impact in humanitarian response requires assessment of a myriad of factors as impact is often not long-term and sustained but the effectiveness of a response ensures maximum immediate impact. Impact in humanitarian response is therefore assessed against the following criteria:

- Relevance
- Timeliness
- Coverage
- Management Effectiveness
- Accountability
- Connectedness and Sustainability

In 2012, all emergency responses rated above average against the stated criteria with particularly good results for timeliness due to a current engagement in the countries enabling rapid scale-up and responding to early warning systems. World Vision also has strong evidence of accountability with transparency, feedback and complaints mechanisms being fully embedded within emergency responses. Robust evidence of relevance

linking the community assessment to the design and implementation of projects is good but there is limited evidence of the disaggregation of intervention by social groups. World Vision's work on benchmarking with other agencies will continue to strengthen the management effectiveness to ensure value for money principles continue to be applied and enhanced.

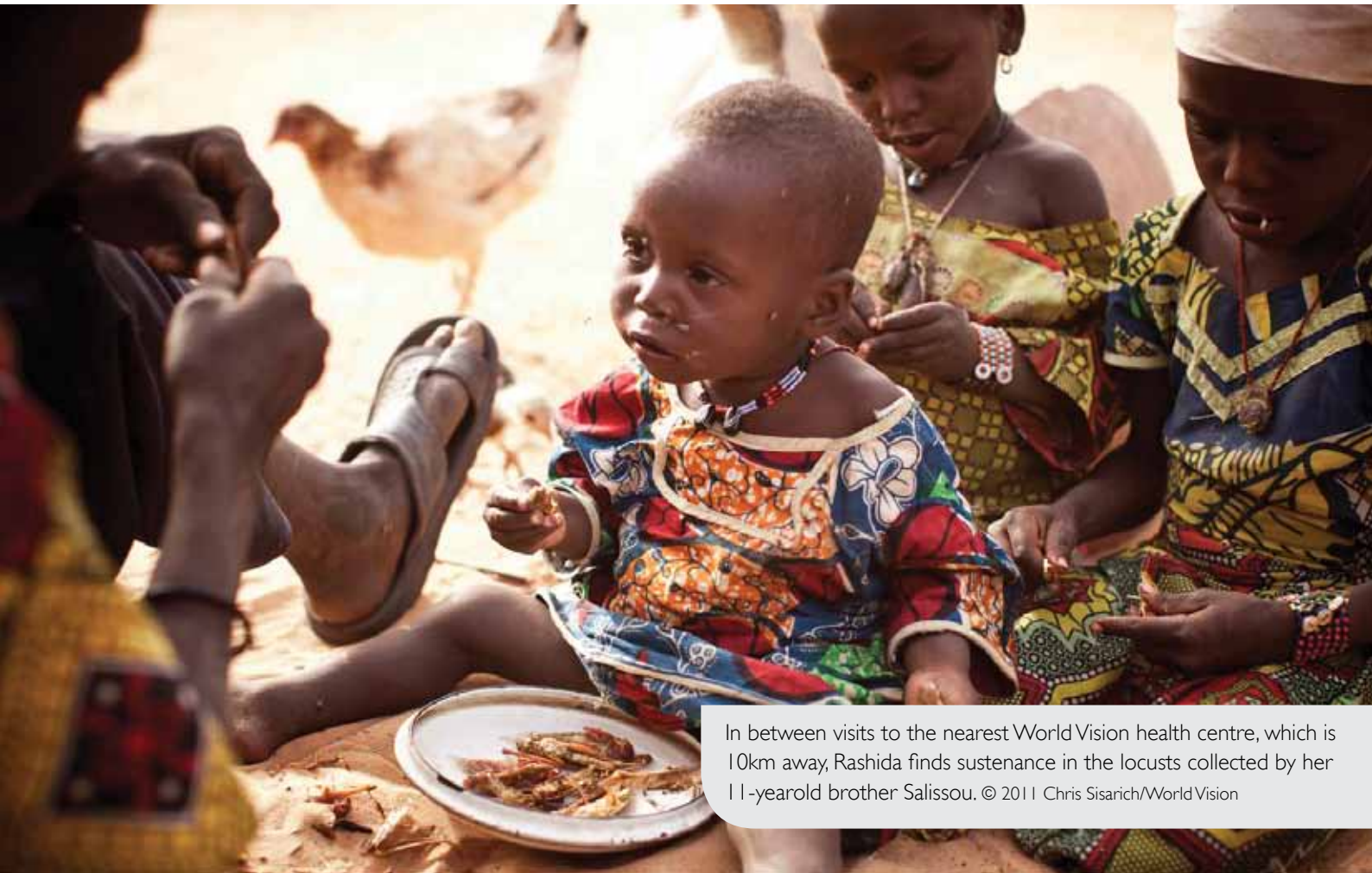
Rigorous Review and Reflection

Each year improvements are being made to assess impact with increased rigour but still further work is required. Internally, evidence is beginning to be structured around a theory of change and this has enabled evidence (primary and secondary) to be utilised to prove the underlying causal linkages and therefore ensures a degree of reliance on the approach. A sampling methodology is being applied to ensure that the theory of change is correct in reaching the desired impact with constant learning loops to refine and adapt the methodology. However, it is also recognised that change is non-linear and a number of factors (see bullets below) need to be considered within impact assessment. Further steps are being taken in 2013 in this regard to continue to improve impact assessment, (See Section 11 – Recommendations) particularly to explore causal links in more depth.

In each thematic section of this report, the evaluations are reviewed in more depth, ensuring quantitative data is triangulated with qualitative information. This builds an evidence base to assess how effective our work and models are in impacting the lives of poor and marginalised children and where evidence is available (often limited) considers:

- Exploration of a control or counterfactual reference point, ideally within a matched cohort
- Exploration of the contribution/attribution of the organisation to the change
- Detailed exploration of the causal links from inputs to outputs through to outcomes and impact
- Assessment of the robustness of the evidence to ascertain degree of reliance

This year all evaluations are assessed for robustness of evidence using BOND's checklist for assessing evidence of effectiveness and the rating is shown on page X. The robustness of evidence was peer reviewed by CAFOD's M&E team on a sample basis to provide cross-organisational learning and validate accuracy in our self-assessment. The review showed that of the 15 evaluations, 12 exceeded the minimum standard of evidence criteria for which reliance could be placed upon them, while 3 of these were of a good standard. 2 evaluations were considered weak evidence and therefore limited reliance could be placed upon them as a piece of evidence. This process has enhanced transparency around the quality of evidence underpinning the impact and identified common areas where WVUK should strengthen its baselines and evaluations to enhance the robustness of the evidence. (See Section 7)



In between visits to the nearest World Vision health centre, which is 10km away, Rashida finds sustenance in the locusts collected by her 11-yearold brother Salissou. © 2011 Chris Sisarich/World Vision

ONE: INTRODUCTION

The objective of this report is to honestly present and reflect on the impact of World Vision UK programming.

1.1 STRUCTURE OF THE REPORT

After this introduction and a summary of the methodology, section 3 provides an overview of the scale of impact across World Vision UK (WVUK) funded projects and programmes. Sections 4 to 6 consider impact within WVUK's three themes.

- Child Health
- Child Protection
- Humanitarian Action

Within the themes a meta-analysis review has been undertaken followed by an in-depth analysis of the evidence presented including evaluations, annual reports and policy reviews. Key lessons learned have been drawn out.

Three further sections have been added: section 7 on how we have assessed the quality of the evidence, section 8 on World Vision's global child well-being reporting and section 9 on how we have improved effectiveness through the use of digital data.

The report has then been drawn together with conclusions (section 9) and conclusions & recommendations from the third party validators (Oxford Policy management) in Annex I & II[1].

1.2 BACKGROUND TO WORLD VISION UK AND OUR APPROACH TO IMPACT REPORTING

To help navigate the report, this section provides a quick guide to how World Vision's work is structured and how that shapes our approach to impact reporting.

World Vision is the world's largest overseas aid charity working to bring real hope to the lives of millions of children in the world's hardest places. Our Christian foundation and focus on children, combined with global reach and grassroots presence, give us a distinct identity among development agencies in the UK. It is a partnership operating in over 90 countries around the world. World Vision UK is a support office within the partnership which provides funding and expertise to national offices which implement our programming – we currently support 28 of these national offices around the world.

1.2.1 World Vision's programming

World Vision works to impact the lives of children in three ways:

1. **Long-term development** – the basic model is the Area Development Programme in which we work for 12-15 years with a geographically defined community to identify and address their development needs. The Area Development Programme is made up of constituent projects, which vary according to context but which might often address issues of health, education, water and sanitation, food security, income generation, community advocacy and child protection.
2. **Humanitarian relief** – this includes both the immediate response to disasters, providing food, water and shelter, and creating 'safe zones' for vulnerable children, but also work with communities to help them recover.
3. **Advocacy** – increasingly World Vision is working in partnership with communities to influence decision making at the local, national and international levels. World Vision UK both supports advocacy programming in partnership with national offices, but also conducts advocacy with the UK Government and multilateral institutions.

1.2.2 World Vision UK's three focus themes

While the wider World Vision partnership addresses a whole range of sectors, World Vision has recently decided to focus on, and specialise in, three main themes:

1. **Child health** – addressing health issues, including nutrition so that 'Mothers and Children are well nourished, protected from infectious diseases and access essential services'.
2. **Child protection** – supporting the rights of children in order to 'protect and rebuild the lives of children affected by violence, exploitation, abuse and neglect in the world's hardest places'

[1] OPM was responsible for validating the conclusions we drew from a sub-set of individual evaluation reports, and for providing suggestions on our approach to the process of reporting on impact

A mother and her children outside the family's hut in the Butinle Refugee Camp, Somalia. © Jon Warren/World Vision

3. **Humanitarian action** – both disaster response and also working with communities to build up their resilience to contribute to 'saving & rebuilding the lives of children affected by violence and natural disasters'.

1.2.3 World Vision UK's approach to impact reporting

World Vision adopts a child-focused approach to development, and this is reflected in a recent initiative to systematically report on its impact on children. In 2010, the partnership endorsed a set of child well-being aspirations, outcomes, indicators and targets.

World Vision's approach to impact reporting reflects both the nature of World Vision's work and our experience of publishing impact reports in 2010 and 2011.

1.2.4 A note on use of the term 'impact'

World Vision UK's working definition of impact is "significant or sustainable change in people's lives brought about by a given action or a series of actions"[2]. Increasingly we use the term in distinction to the other steps in the results chain (input-process-output-outcome-impact). However given World Vision's size and diversity, the language used in our evaluation reports does not always neatly match this version of the results chain. In particular World Vision programming uses the term 'goal' to describe either an outcome or impact level. Also some of the 'child well-being outcomes' could actually be seen as being at impact level. In the case of humanitarian relief, with its very short-time scales, we primarily focus on effectiveness in achieving outputs and outcomes. However wherever possible this impact report seeks out evidence of impact in the sense of significant and sustainable change and it is our commitment to increase our capacity to understand the impact in this wider definition.

To assess impact within humanitarian response, we have adapted the DAC principles of measuring development assistance (relevance, effectiveness, efficiency, impact, sustainability) and used the criteria of relevance, timeliness, coverage, management effectiveness, connectedness and sustainability to demonstrate examples of impact across the humanitarian programmes

[2]Roche (1999) Impact Assessment for Development Agencies, Oxford: Oxfam.

TWO: METHODOLOGY

The following methodology has been applied to analyse and report on impact.

2.1 OVERVIEW: BENEFICIARY NUMBERS

The best available data for capturing the coverage of our programming is numbers of direct beneficiaries of World Vision UK supported programming. This section analyses them by sector, geography, and theme and across time - comparing them with previous year (2011) figures. The beneficiary totals include programmes or projects which have directly supported beneficiaries (through service delivery, community empowerment, training and awareness raising) and which either had been funded by World Vision UK in 2012 or which had received funding in previous years that covered ongoing activities in 2012. The calculations are based on the following:

- Direct beneficiary is defined as a person who has participated in the project in some way that benefitted them.
- If a number of households was reported rather than number of people and no assumption is reported on how many people per household, we made a consistent assumption that there are 5 people per household.
- The source of beneficiary numbers was the project's annual report, or if not available, the design document for the project, using an appropriate ratio.
- Double counting was avoided in cases when two or more projects cover the same/some of the same people by counting the one project with the largest number.
- Factoring in part funded projects was done by counting the respective proportion of beneficiaries. For example, if World Vision UK provided 10% of the funding we only included 10% of the total project beneficiaries.

Our programme management system does not yet classify the sectors of projects in line with the definition of World Vision's three priority themes, but rather through a wider understanding of sectors. This means that in the breakdown of beneficiary numbers per sector, for example in health, programmes focused not only on maternal and child health, but also water and sanitation and HIV/AIDS are included.

2.2 WVUK THEMES - CHILD HEALTH, CHILD PROTECTION AND HUMANITARIAN ACTION.

Evidence is primarily drawn from evaluations and reviews of World Vision UK supported programming conducted in this financial year (2012). In addition, each section commences with a global synthesis of change based on evaluation reports for the past two years to frame the overall change we are contributing towards over a period of approximately five The sample of evaluations are not pre-selected but are evaluations that were due to take place in this year as they had completed their programme cycle and therefore were either closing or entering a process of re-design.

WV has also utilised annual reports from all projects in order to extract information on progress towards child well-being. World Vision UK has identified 12 child well-being indicators (related to the 15 child well-being outcomes and 4 targets) that reflect the change we are seeking to make in targeted children's lives. Since this is a new initiative, many of the older ADPs are not set up to measure these indicators. As such, for the three themes that the 12 indicators cover, 30 out of 78 ADPs have included at least one CWBI for Child Health, 16 ADPs for Child Protection and 2 ADPs for Humanitarian Action. Given the difficulties of drawing accurate conclusions from small samples, only the Child Health and child protection indicators have been reviewed in this report.

Community Validation of the evaluation findings is an integral part of WVUK evaluations. Three programme evaluations provided strong evidence of validating evaluation results with community members while six others referred to the process. This continues to be a priority for WVUK in recognition that the assessment of impact and 'value' should be primarily assessed by those we claim to have impacted. WVUK has prioritised accountability to communities across its work through enhanced transparency, feedback, participation and complaints mechanisms, there is strong evidence this leads to enhanced impact from WVUK's Accountability for Development pilots and embedding accountability principles across all streams of work.

Girls enjoy class at their school in Pakistan, which benefited from a World Vision rehabilitation project following the 2010 floods. © 2012 Sandra Barrows/World Vision

Humanitarian relief: This was based on the most recent evaluations and final reports from responses that World Vision UK had supported in 2012. These included:

- Horn of Africa Response to Drought (HARD)
- Haiti Earthquake Response Office (HERO)
- Typhoons Nesat & Washi Emergency Responses, Philippines
- Emergency Assistance to Most Vulnerable Persons in Killarney and Trenance (IOM Project), Zimbabwe
- Integrated Health & WASH Project for Ezo and Tambura Counties, Western Equatoria, South Sudan
- Emergency nutrition in Digaluna Tijo, Tena, Lode Hitosa, Tiyo and Arsi Negale, Ethiopia
- Pakistan Flood Response.

Advocacy: The World Vision partnership is starting to develop systematic approaches to measuring the impact of our advocacy, but in the meantime this impact report draws from policy influence in Sierra Leone and Uganda, 2 external reports on WVUKs Child Protection Influencing work and one external report on Influencing humanitarian policy in Somalia. The process for selection was bias towards areas of success identified by colleagues and therefore should not be considered representative of all policy work. In 2013, a randomised process of selection will be introduced.

Technology: WVUK is investing now in digital data collection to ensure the baseline data exists and is robust for broader and deeper impact assessment. This section of the report showcases some of the work WVUK has been supporting in 2012 and how it has improved effectiveness.

THREE: GLOBAL OVERVIEW

During the World Vision UK 2012 Financial Year and through a combination of grants and sponsorship, World Vision UK supported 329 projects across 34 countries.

OVERVIEW OF IMPACT: BENEFICIARY NUMBERS

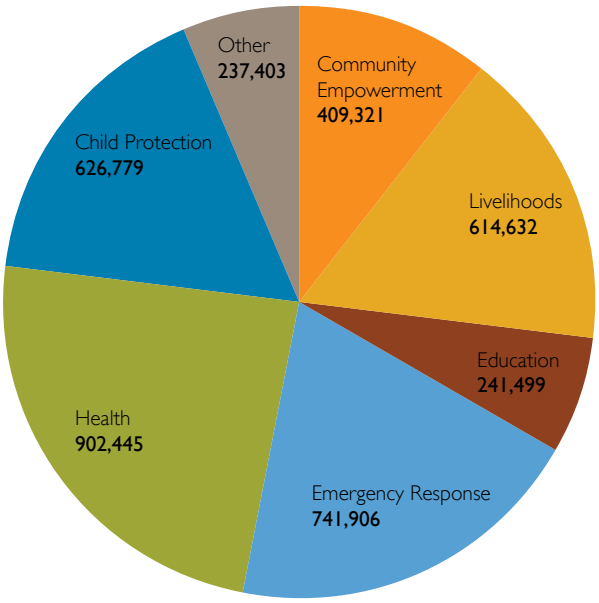
All beneficiaries 6,079,450 (6 million)

Children 3,773,985 (3.8 million)

In FY12, WVUK contributed towards the improved well-being of 6.1 million people of which 3.8 million are children. The small reduction from last year is mainly due to fewer emergencies in WVUK priority countries during the year. Of these, an increasing number and percentage of children are within the three priority themes (health, child protection and humanitarian) as well as an increased proportion within fragile states, thus reflecting the priorities of our strategy up to 2015.

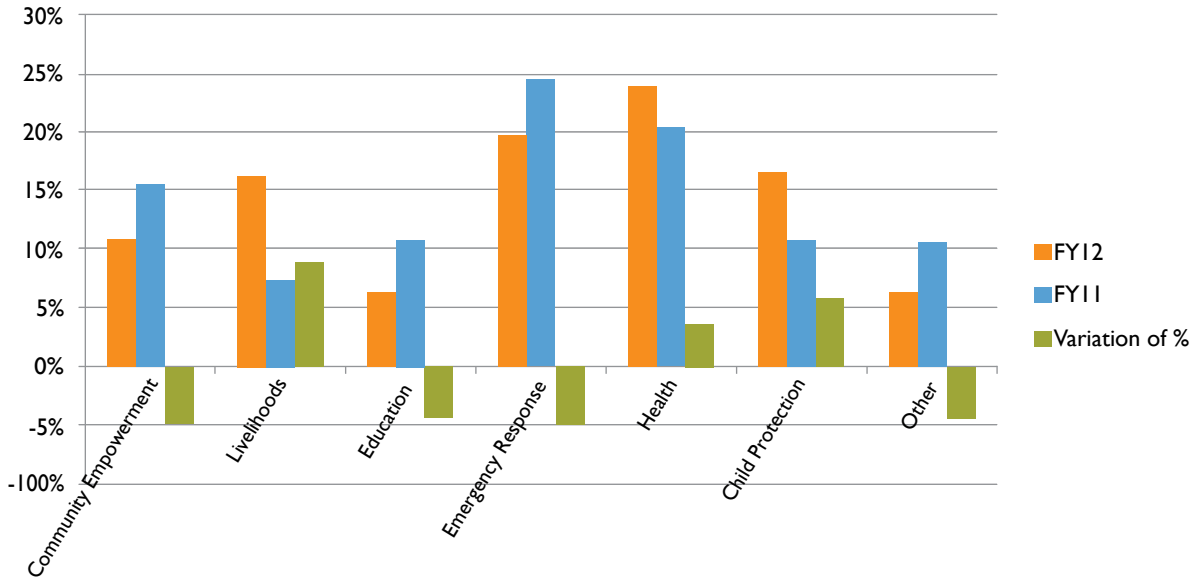
As each year goes by there is increasing accuracy of these numbers of beneficiaries as the National Offices begin to analyse their reach and impact more intentionally. In FY12, 329 projects were supported across 34 countries.

FY12 CHILD BENEFICIARIES BY SECTOR

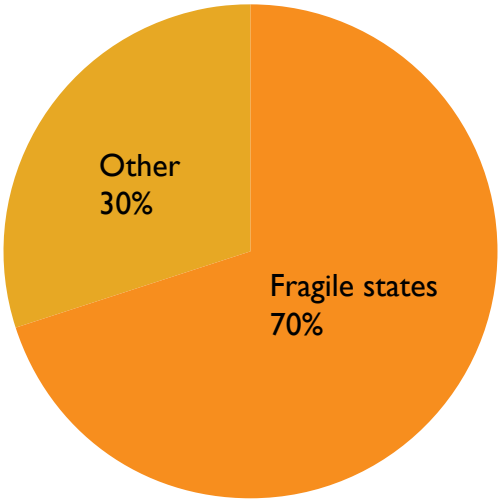


Sector	Children	All Beneficiaries
Community Empowerment	409,321	789,003
Livelihoods	614,632	1,062,867
Education	241,499	415,183
Emergency Response	741,906	971,090
Health	902,445	1,637,706
Child Protection	626,779	640,650
Other	237,403	562,951
Grand Total	**3,773,985**	**6,079,450**

PERCENTAGE OF TOTAL CHILDREN BY SECTOR FY11, FY12 AND VARIATION



FRAGILE STATES



Fragile States 2,659,622 children

Other 1,114,363 children

In World Vision UK's 2011-15 strategy an increased emphasis was placed on programming in fragile contexts. In 2012, 70% of child beneficiaries are living in Fragile States (Fragility is based on the World Bank's Country Policy and Institutional assessment (CPIA) Indicators). Whereas countries can have varying degrees of fragility, including varying within its borders, seven countries were defined as most fragile: North Sudan, South Sudan, Afghanistan, DRC, Haiti, Pakistan and Somalia. In 2012, child beneficiaries in these most fragile contexts made up 37% of the total.

FOUR: HEALTH

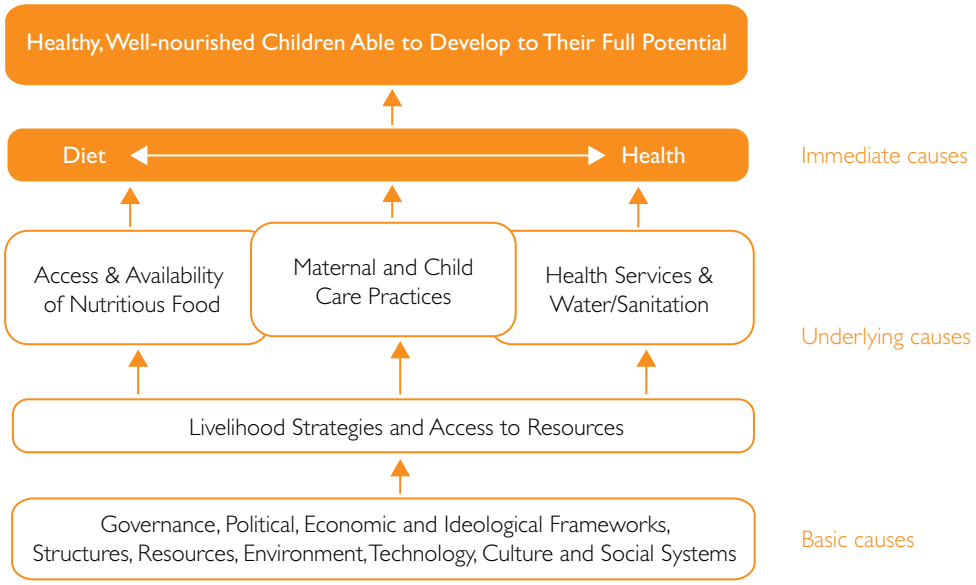
4.1 SUMMARY IMPACT FROM EVALUATIONS

The following 4 indicators have been utilised to support the measurement of progress of World Vision projects and programmes towards the goal of 'healthy children developed to reach their full potential'.

Based on all evaluation reports in the past 2 years where health projects have been evaluated and the above indicators have been applicable and included, the combined global change over 5 years[3] can be reported as:

	Child Well-being Indicator	Impact	Sample Size
Maternal, Newborn and Child Nutrition and Food Security	Prevalence of undernourished children under 5 years of age	Children who are underweight decreased by an average of 5.33%	3 programme evaluations benefitting 71,003 people
	Proportion of children exclusively breast-fed for the first six months of life	12.43% more mothers breastfeed their babies effectively	4 programme evaluations benefitting 184,590 people
Maternal and Child Health	Proportion of births attended by skilled health personnel	Births at hospital / with a skilled birth attendant increased by an average of 20.05%	2 programmes benefitting 52,236 people
	Proportion of 1 year old children immunised against measles.	Children fully immunized has increased by an average of 17.86%	9 programme evaluations benefitting 381,473 people

WVUK Child Health and Nutrition Theory of Change[6]



[3]The Programme cycles are between 52 and 61 months in duration

[5]This theory of change was adapted from a number of similar conceptual frameworks specific to nutrition but applicable to health. It is considered a working theory of change and is subject to new ideas or questions as the team moves forward with activities to improve child well-being.

4.2 APPROACH TO CHILD HEALTH

WVUK's Health strategy 2011 - 2015 seeks 'Real Change for Children,' this actively includes the poorest children[4] living in the poorest and hardest places enjoy good health.

As a contribution towards this goal, the WVUK Child Health strategy seeks to improve Maternal, Newborn and Child Health (MNCH) in fragile contexts and sustainably improve Maternal, Newborn and Child nutrition and food security across at least 300 communities by supporting activities in more than 12 countries. We seek for mothers and children to be well nourished, protected from infection and disease, and have access to essential health services.

WV aims to focus primarily on health and nutrition education and behaviour change at the household level, empowering caregivers and children to keep themselves healthy, prevent ill health and access essential services. At a community level, WV builds the capacity of community structures to promote improved health outcomes by addressing and monitoring local causes of illness, malnutrition and death and to advocate for quality health services and monitor home-based care services. At a national, regional and international level WV emphasises partnerships with national government and other stakeholders to ensure delivery of quality health and nutrition services at the community level, proactively promoting community and health systems strengthening.

4.3 IMPACT BY CHILD WELL-BEING INDICATORS (FROM EVALUATIONS)

WVUK measures progress against key child health indicators and has grouped evidence under the selected CWBI to present the findings. Programme and project evaluations use a mix of qualitative and quantitative methods, including insights from the various stakeholders to understand and analyse the impact made upon maternal and child health/nutrition. Evidence from projects illustrate a positive, neutral or negative change in the health and nutrition of children and their mothers and an analysis of the causal links to enact this change.

To help in framing this, the four Child well-being Indicators tracked will be utilised as sub headings.

	Child Well-being Indicator
Maternal, Newborn and Child Nutrition and Food Security	Prevalence of undernourished[6] children under 5 years of age
	Proportion of children exclusively breast-fed for the first six months of life
Maternal and Child Health	Proportion of births attended by skilled health personnel
	Proportion of 1 year old children immunised against measles.

4.3.1 Prevalence of Undernourished children under 5 years of Age.

In Ethiopia (Digaluna, Tijo, Tena, Lode Hitosa, Tiyo and Arsi Negale Wordeas), World Vision has been supporting government programmes designed to address acute malnutrition in response to a severe drought in 2011 by training staff at 133 outpatient nutrition sites, mainly at primary healthcare centres. In total about 17,000 acutely malnourished children and 6,500 thin pregnant and breastfeeding mother were admitted to the program from when it started the autumn of 2011 until it was handed over to the ministry of health the following spring. Most were treated successfully as the programmatic indicators for death, default and cure rate were well within international standards.

The treatment of children with acute malnutrition is critical as they have a much higher risk of death compared to a well nourished child, especially if the child suffers from severe acute malnutrition (SAM). The final evaluation of the programme stated 'The project has started to curb the consequences of SAM through the implementation of Community Management of Acute Malnutrition (CMAM) projects in the districts. The project planned to achieved <10% GAM and <1% SAM throughout the year. According to the end line nutrition survey conducted in August 2012, the prevalence of GAM in the Arsi Negele Woreda was 1.9 % (95%CI: 0.9 – 4.2) and SAM was 0.4 % (95% CI: 0.1 – 2.8). The current nutritional status of the Woreda is therefore classified as 'typical' for chronically malnourished population in the absence of aggravating factors (according to Ethiopian emergency assessment guidelines). This indicates that the current food security situation of the population is showing improvement.

'There are some possible likely explanations for improvement of nutritional status. Wold Vision Ethiopia's targeted supplementary feeding programme and a productive performance in the past six months can be considered as one contributing factors'. However the

[4] Appropriately seeking to include disabled children and children with HIV

[6] Quantified by child wasting, underweight or stunting

A mother and her young child pictured at one of the health centres in Komabangou ADP, Niger.
© World Vision

evaluator points out a key limitation to drawing complete conclusions as 'A nutrition survey assesses the outcome or impact of a nutrition programme indirectly through the evaluation of changes in population level mortality and malnutrition rates'.(Programme evaluation report 2012).

In **Warrab State, South Sudan**, levels of acute malnutrition have been assessed over the course of ongoing emergency nutrition support provided in 5 districts, see table below. This population has been affected by significant shocks such as food price rises, conflict, and flooding, resulting in levels of acute malnutrition being high for many years. Although the results reflect a slight improvement in the prevalence of global acute malnutrition (one with a considerable improvement) when comparing assessments conducted during the hungriest part of the year, the prevalence of acute malnutrition still remains higher than international cut-offs for a critical situation in two of the districts. Though some of the improvements can be attributed to the ongoing nutrition program and other work going on to improve food security for vulnerable households through WV/WFP food assistance programmes, a critical review of the programmes in 2012 highlighted that more needed to be done to further improve nutrition for children. This evaluation also highlighted a weakness in its analysis and the need to explore a control sample, external factors and causal links in more depth to ascertain what this limited change means within this context.

In **Cambodia, Kampong Tralach ADP**, improving food security was the one of the main goals of the programme, especially for the poorest in the community. Key problems faced were regular flooding and drought, poor irrigation, low rice and crop production, limited animal raising and home gardening, low incomes and lack of initial ideas and low capacity to start micro-business opportunities.

- **Yields and food shortage** – An improvement was seen in terms of rice yield between 2008 and 2012 where the percentage of those surveyed who reported an increased yield over the previous 3 years was from 18.6% to 70.8%. A similar figure was shown for non rice crops, where 60.8% reported increasing yield. However from the qualitative data, it was noted that increased yield did not necessarily mean increased profit from the sale of produce. The reason for this is that people were spending more of their assets on agriculture, using machines instead of following traditional methods (ox ploughing) and using larger amounts of chemical fertilizers. Renting labour work for seeding, harvesting also create higher expenses. Traditionally people exchanged food for labour more rather than working on a cash basis. In order to assess food shortages, community members were asked if they had enough food to eat over the previous year. Overall 51.7% of households reported that they have enough food to eat year round compared to a baseline (2008) figure of 36.9%. Of those facing shortage the number of months facing shortage was reduced, and very few households were in the worst categories of over 6 months shortage.

State	County	June 2011 Acute Malnutrition	June 2012 Acute Malnutrition	Source
Warrab	Gogrial East	19.9%	18.5%	WVI SMART Survey
	Tonj South	18.9%	18.1%	WVI SMART Survey
	Tonj North	19.0%	12.6%	WVI SMART Survey

Figure 1 GAM and SAM rates from Sudan: Emergency response to Malnutrition among Returnees, IDPs and Vulnerable Host Communities in South Sudan, Warrab regional programme.

Mrs Theavy feeding her chickens, Kompong Tralach ADP, Cambodia. © World Vision

- **Poor and poorest households** - The figures for rice shortage were examined to see how the changes had affected different groups, particularly the poorest. As might be expected nearly all those facing the longest food shortage were in the poorest groups. However it is encouraging to see a number of the poorest households reporting that they had sufficient food for the whole year had increased.

In **Ghoroghat ADP, Bangladesh** results show very little change in rates of global stunting and underweight. However, there was a considerable decline in the number of children suffering from acute undernutrition and a slight decline in the prevalence of severe stunting. Static levels of chronic undernutrition has led to WV Bangladesh developing a large scale nutrition initiative they intend to roll out and evaluate in order to address undernutrition more effectively across multiple ADPs.

Komabangou ADP, Niger: there is a significant improvement in the coverage of potable drinking water, which increased from 39% in 2007, to 49% in 2010; an increase of 10%. There was also a marked increase in the rate health coverage that from 30% in 2007 to 48.25% in 2011. However, because of recurrent grain shortages and recurrent drought in the Sahel region, the acute malnutrition rate has increased (despite the synergy of several partners) from 3.5% in 2007 to 12.25% in 2011.

Indicator	Baseline 2007	Evaluation April 2012
Proportion of boys aged 6-59 months severely stunted reduced from ---% to ---%.	19.9%	19.0%
Proportion of girls aged 6-59 months severely stunted reduced from ---% to ---%.	19.9%	18.5%
Prevalence of global stunting in children under five years of age	47.4%	50.4%
Prevalence of global wasting in children under five years of age	26.3%	16.8%
Prevalence of global underweight in children under five years of age	55.9%	54.5%

Figure 2 Evaluation results from Ghoroghat ADP, Bangladesh Evaluation Report

Project Indicator	Baseline (2008)	Endline (2012)
Maternal Health		
Antenatal Care	43.3%	76.0%
Presence of Skilled birth attendants	66.9%	92.4%
Infant Feeding		
Exclusive breast feeding	78.4%	78.1%

Figure 3 Kampong Tralach ADP Evaluation - Health data

4.3.2 Proportion of children exclusively breast-fed for the first six months of life

Kampong Tralach ADP, Cambodia showed a marked increase in the antenatal and postnatal care available, with much higher support from the health centre and attendance at the health centre (or by a midwife at home) for delivery. However, rates of exclusive breastfeeding for the first 6 months remained relatively static. Some of the key figures are shown in the table below:

Some of the nutritional indicators showed excellent improvements, particularly the early breastfeeding and taking of iron/ folic acid tablets. These were associated with better antenatal care and birth attendance; other nutritional indicators such as mother's diet, exclusive breastfeeding and complementary feeding showed little change. These results were backed up by the focus groups conducted with mothers of young children, who confirmed a much better availability of care and services from the health centre.

"Now we only have to pay 10000R for delivering baby and it is done safely by the health centre staff. All villagers go to get antenatal service, delivery service, and post delivery at the health centre. If the woman is still weak after delivery we can also stay at the health centre for 1 week."

"I'm already old and get pregnant again, I feel that I'm not strong enough, but giving birth still easier than before because it is at the health centre and there are many mid-wives and others nearby to help me. My older kids, they didn't get vaccine, no good nutrition, didn't eat enough food, and no vitamin A. But my younger kids get better health care and enough food."

(Focus group, mothers with children under 2yrs)

Mother's knowledge of nutrition was good and most had attended some training in this area. However, in line with other monitoring report findings, only a minority of families actually practised some of the things they knew. The reasons for not following these guidelines were stated as lack of time, not having enough money to buy the required foods or them not being easily available, and children not liking the nutritious food when it was presented to them.

The proportion of children showing stunting remained similar to the 2008 baseline measurement (31.4%) at 31.3%, and underweight children were also similar at 23.7% (compared to a baseline of 24.6%). The proportion of children showing wasting had dropped from 10.5% to 7.7% currently. This last change was positive showing some improvement in levels of acute undernutrition. Improvements in maternal and newborn health highlighted above should improve children's health and nutritional status in the future.

Kampong Tralach ADP evaluation was an end of programme evaluation and therefore a key focus was on the sustainability of the programme outcomes.

The Village Health Support Group (VHSG) work that was supported by the programme was found to be only partially sustained one year after project closure. Some examples were seen of VHSG continuing to give health advice in minor ways and for them their previous training and knowledge was being well used.

It seemed messages about clean water had both been heard and followed by a majority of the population, of which about $^{2}/_{3}$ of people drank filtered or boiled water. In contrast, while knowledge around how to support good child nutrition had improved, practices in this area had changed little.

The improvements to health services, particularly ante-natal and natal care were well integrated into the health system and showed every sign of being sustained. However, it was unclear if micronutrient supplementation programmes World Vision Cambodia had supported would continue. There was some indication this activity would be undertaken by a local agency supporting health services.

Young girl being weighed at a local health centre in Kampong Tralach ADP, Cambodia. © World Vision

4.3.3 Proportion of 1 year old children immunised against measles.

Ghoroghat ADP, Bangladesh: According to information from both vaccination cards and reports from mothers, 87.3% of children of the Ghoraghat ADP area aged 12-23 months are fully vaccinated. The percentage of fully immunized children has slightly increased since the 2008 baseline (from 86.8% to 87.3%) and remains in an acceptable interval. It is higher than the national percentage of 76%.

Kampong Tralach ADP, Cambodia: The project aimed to improve the health and nutrition of vulnerable children and families, working with health centers with the active involvement of village level volunteers (VHSG). The wider 'Jumpstart' project had been operating in the area since 2009.

VHSG members were well known (by 93%) and used (by 90%) at village level, mainly helping to deliver immunization and health education as well as emergency support. Health education was often facilitated by Health Centre or World Vision staff, with close cooperation. Significant improvements in the health centre were noted in most aspects of their service.

Following the ADP closure, the VHSG work was only partially sustained with limited funding available that meant about 50% of the volunteers stopping being supported. Changes to antenatal and natal care seemed well established and encouraged by government; the presence of other organisations working in this sector will help encourage further sustainability, though it was found that more links and arrangements with these other partners would have been helpful.

Exploring the counterfactual – control sample

The report recognises that to fully understand the balance of contribution and attribution of WV to impact is limited without a non-contaminated control group with an identifiable cohort. However, there are significant ethical, cost and complexity issues that need to be examined before an extensive counterfactual can be

	Type of the Household	
Measles vaccination	Beneficiary	Non beneficiary
Took vaccine for measles	97.1	93.3
Not received	2.9	6.7

Figure 4 Ghoroghat ADP Evaluation – Vaccination data
*Non beneficiary is defined as a household who in not involved in a development group

Arafat, five months, being given an oral polio virus vaccination at a local Expanded Programme of Immunisation centre, Bangladesh. © 2010 Prokash Chambugong/World Vision

established. This area of impact assessment is being further developed by WVUK but two examples of comparing to secondary data are outlined below

Taking one example from **Ghoroghat ADP, Bangladesh**; the table below shows that in the communities where WV is working there is a slightly higher number of people who have been immunised.

Kpanda Kemo-Sogbini (Tegloma ADP), Sierra Leone: Information on vaccination coverage was only collected from vaccination cards shown to the interviewer. According to data obtained from the survey, vaccination cards were available for four out of every five children less than a year and 16.6% of the children less than a year were fully immunised compared to 2009 estimates of 32.4% for Bonthe in 2009 (DHSBS).

At the Validation Workshop, the community stakeholders informed the team that parents refuse to go for vaccination because of the fever that follows the vaccination and therefore further sensitisation is required.

4.3.4 Proportion of births attended by skilled health personnel

Ghoroghat ADP, Bangladesh: Respondents of the survey reported the death of 5.8 percent of the children who had been born in the 5 years preceding the survey. Since under 5 mortality is counted per thousand live births, the rate of under 5 mortality in Ghoroghat area is 58 (58/1000). The Vital Registration System (SVRS) 2009 by the Bangladesh Bureau of Statistics, as cited in the 'Millennium Development Goals Bangladesh Progress Report 2011', page 47, reports a 50/1000 under 5 mortality rate, which would make Ghoroghat ADP rate higher than the national average. The baseline and evaluation data are not fully comparable as the baseline measured infant mortality (172/1000) rather than the under 5 mortality measured by the evaluation. However, as under 5 mortality includes infant mortality, we can say that the findings of the evaluation survey show that the rate of infant and under 5 mortality have reduced considerably in the project area since baseline times. In spite of this, U5 mortality remains in a critical interval and needs to be addressed.

Indicator	Baseline	Evaluation	National Average
95 % of mothers delivering with help of skilled birth attendants/ Medically Trained Provider (MTP)	10% by skilled birth attendants (90% delivered by TBAs)	27.3%	26.5%[7]

Figure 5: Progress of deliveries attended by skilled birth attendants

An example from Ghoroghat ADP, Bangladesh highlights the impact of the health project by comparing the number of mothers delivering with the help of skilled birth attendants in the ADP area with that of the National average; this is a significant improvement towards maternal health.

Stepanavan ADP, Armenia: Overall the majority of household members (57.5%) evaluate the quality of community health care service during last 5 years as improved. The same opinions were received from 86.2% of nurses. It must be considered though, that projects aimed at health care systems usually have their results visible only some period of time later.

Patna ADP, India: The community people in 8 slums took part in FGD and shared information on health practices 5years ago compared to present practice through the use of the '10 seed technique'; an average of these 8 FGD was taken and the result shown below.

Analysis on the community perspectives

The indicators on percentage of mothers who underwent institutional delivery indicate that the utilisation of the services increased from 47.5% to 87%. However the remaining mothers do not use the available resources.

Other significant changes:

1. HHs go to hospital when they are sick increased from 60 to 77%
2. 76.25% mothers take their children for immunization voluntarily

Practice/performance Indicator	Then %	Now %
Access to toilets	16	36
No of households (HH) go to hospital when they are sick	60	77
No. of pregnant women go to hospital for delivery	47	87
No. of mothers use ORS when their child suffers from diarrhoea	38	70
No. of mothers give colostrums (first milk – Kasha Khira) within first hour of child birth.	52	90

[7] Bangladesh Maternal Mortality Survey 2010, as cited in the 'Millenium Development Goals Bangladesh Progress Report 2011', page 55.

Three-year-old Finda, and her mother Hannah, who can now access quality health centre services through their local clinic in Sierra Leone, renovated with the aid of World Vision. © 2010 Jonathan Bundu/World Vision

3. The radio programme on health and nutrition broadcasted from 2009 to 2011 was given a significant budget, however as the audience of the radio programme is minimal; it probably did not contribute to much change.

Kpanda Kemo-Sogbini (Tegloma ADP), Sierra Leone

Increasing the number of babies delivered in health facilities and the proportions of babies delivered under the supervision of trained health provider are important factors in reducing the health risks to both the mother and baby. Proper medical attention and hygiene during delivery can reduce risks of complications and infections that can cause sickness or death to either the mother or the baby.

The survey shows that most recent births are delivered in hospital or Public Health Unit (PHU). According to the data illustrated in Figure 7, 67.6% of all recent births in the ADP were in hospital or PHUs far exceeding the average estimated for Bonthe in 2009 of 29.1% (the District Health Services Baseline Survey (DHSBS)). The chiefdom differentials were minimal. Slightly less than one-third of the delivering was carried out in homes. This may largely be due to the increased awareness to give birth in hospitals and PHUs as a result of the Free Health Care Initiative.

The Survey shows that 71.2% of most recent births are delivered with the assistance of health professional (doctor, nurse/midwife or MCH Aide) and 28.8 by others (including TBAs). This compares favourably with what obtained few years ago. According to the 2009 District Health Services Baseline Survey (DHSBS), about 53.0% of births were delivered by skill attendant.

Overall, the improvement in behaviour towards delivering in a health facility and by skill attendant cannot be unconnected to the increased and more coordinated support to maternal and child health by government development partners (donors and NGOs) as a result of the introduction of the Free Health Care initiative.

A lactating mother made the following remarks when asked about improvements and gaps in health care during the FGD in Ngueh, Ndopiesection, Sogbini chiefdom.

"There is some improvement in health care services. The nurse we have is better than the one we had before. She is polite and committed to duty. Although, not adequate but we are provided basic drugs that can keep our children alive. Yet, the supply of drugs is irregular. We are usually told that transporting the drugs to Ngueh is the problem. Besides, due to the sensitisation, more people visit clinics. With limited staff, waiting time has increased. We require food during the waiting time."

A lactating woman in Ngueh, Ndopie Section, Sogbini Chiefdom

4.4 ANNUAL MONITORING DATA

The Table below (figure 8) shows a summary of health data collected from all annual reports from World Vision UK funded projects. This is presented following the same 4 CWB indicators as mentioned throughout this section of the report and provides further evidence and analysis of change.

* estimated based on information in narrative

- Positive Change
- Baseline/Endline Figure present only
- Negative Change
- Indicator either not relevant or not reported on

Country	Name	Prevelence of underweight children under 5 years of age		Proportion of 1 year old children immunised against measles		Proportion of births attended by skilled health personnel		Proportion of children exclusively breast-fed for the first six months	
		Baseline	FY12	Baseline	FY12	Baseline	FY12	Baseline	FY12
Ethiopia	Adijbar	13.0%	12.2%	74.0%	91.0%	not available	21.7		
Ethiopia	Banja		0 reported	72.0%	94.0%				
Kenya	Winam			89.0%	94.0%				
Uganda	Rukiga			90.0%	92.0%				
Uganda	Kimu			86.0%	89.0%				
Uganda	Ntwetwe			53.1%	78.0%				
Malawi	Namachete	2.0%	0% (severe)	83.0%	88.0%	34.0%	87.4%	600(% not available)	85%
Malawi	Kayezi	10.4%	6.0%	30.0%	92.0%	65.0%	90.0%	92.90%	88%
Zambia	Keembe	2.9%	13.7%	45.0%	80.0%	not available	100%		
Zimbabwe	Makorokoro			69.9%	71.6%	not available	70%		
Niger	Komabongou	3.5%	12.3%						
Senegal	Basa			82.0%	84.0%				
Senegal	Mbella	5.0%	3.0%			30.0%	29.9%		
Senegal	Loul					57.0%	68.0%		
Albania	Lezha				100.0%				
Armenia	Sisian							no baseline	10% increase
Myanmar	Amarapura	84% (well nourished)	72.5%			81.8%	91.7%		
Cambodia	Samaki Meanchey	24.7%	not mentioned	84.4%	not mentioned	63.3%	95.0%	47.8%	97.0%
Cambodia	Koh Krolor	24.7%	not mentioned	15.7%	51.0%	63.7%	99.0%	47.8%	99.2%
Cambodia	Sok Nikum					65%	36%	65.0%	80.0%
India	Bhojpur	52.3%	eval	33.1%	58.5%	22%	77%	52.0%	56.0%

Figure 6: Child Well-being Health Outcome Indicators - Progress from Annual reports 2012

What does the table show?

Prevalence of Underweight Children

There is an overall positive trend in the information we see in that malnutrition rates are decreasing. However the data quality is not always consistent.

- Three ADPs have seen an increase in Malnutrition rates: Komabangou, Niger, Amarapura, Myanmar, and Keembe ADP, Zambia.

The figure reported for Komabangou ADP, Niger is a finding from their evaluation in FY11. Project staff estimate the rate in FY12 is higher still; - there is no ADP specific data, but from a SMART survey in Jan '12 (i.e. before the peak of the food crisis) GAM for Tillaberi region was at 17.1%.

Two main reasons for this significant increase are; a) the food and nutrition crises across Niger in 2010 and 2012, has led to elevated malnutrition rates (Tillaberi being one of the most affected regions) and b) the baseline measurement is likely to be inaccurate. GAM in Tillaberi in a good year hovers between 10-15%. A GAM of 3.5% seems highly unlikely.

In Amarapura ADP, Myanmar: The reasons that project staff gave for the increased result was that the sampling methodology was different between the baseline and endline; this will have affected the result. Also many of the children are being cared for by elder siblings who also have poor nutrition; this needs to be addressed in order to make an impact upon the reduction of children who are underweight.

Proportion of 1 year old children who are immunised against measles

- 16 Annual Progress Reports have measured the proportion of 1 year old children immunised against measles in FY12; All 16 of these projects showed an increase in the number of 1 year old children who were immunised

Presence of Skilled Birth Attendants

- Annual Reports: 10 ADPs have measured the presence of skilled birth attendants in FY12, each of which has shown a positive increase.

Proportion of children who are exclusively breast fed

- 9 Annual progress reports have measured the numbers of children who were breast fed in the first 6 months of life; 7 projects have shown an increase and 2 have shown a decrease.

Kayezi ADP, Malawi: the 'baseline' figure (92.9%) is taken from the 2010 ADP evaluation, whilst the FY12 figure (of 88%) is from one health centre, hence the 'drop' although comparing these figures might misrepresent the situation. This different approach to measurement means that a direct comparison in this case is not possible.

Tacopaya ADP, Bolivia there was a recorded decrease in the proportion of children who were exclusively breast fed for the 1st 6 months of life. The 95% recorded in FY12 represents 60 mothers, 57 of who applied exclusive breast feeding. Of the 3 mothers who did not apply exclusive breast feeding, the reasons were given as follows:

Two children, (1 girl and 1 boy), were given herbal remedies for sickness, and 1 girl was exclusively breast fed until she was 5 months old. These do not represent significant failures to the project.

The baseline figure of 100% was obtained based on sampling knowledge, rather than practice, of breast feeding and therefore this decrease should not be fully relied upon but can be used to understand the general practice and long term impact of teh interventions.

Limitations of the Annual report data

From annual progress reports it is often difficult to determine which aspects of malnutrition (underweight, stunting, or wasting) are being described. The methodology used to measure these indicators is also not always described nor is the time of year in which the data has been collected. Measurement taken at different points in the seasonal calendar will obviously have a significant impact on the numbers. This is especially vital for data on child wasting or acute malnutrition, as the prevalence will change throughout the year depending on rains and seasonal hunger gap.

Another limitation with the annual progress report data is that it is very unlikely to see much of a change in malnutrition rates within a year. Results from 2 of the Bolivian ADPs show a significant change (Bolivar and Khantati ADPs), however this is due to both recording a change which was measured over a 5 year period. Changes in health indicators will take time to occur and evaluate. A period of at least 3 or ideally 5 years is usually needed to see a significant change in an indicator specific to chronic undernutrition. Indicators specific to wasting or acute malnutrition can change more rapidly. However, these are difficult to assess with confidence.

Another limitation is that national office reports rarely consider statistical confidence in their data analysis, limiting our ability to note whether we can have confidence in a downward or upward change in prevalence.

However, evidence from the annual report, when used in parallel and triangulated with a wider evidence base can help to support analysis on the effectiveness of programmes. The monitoring data can also be further explored with communities to ascertain if any learning or changes to the design and implementation should be made to improve effectiveness.

4.5 EVIDENCE OF POLICY INFLUENCE / POLICY CHANGE

- 17 WV offices used evidence based lobbying[8] to influence the 126th Inter Parliamentary Union (IPU) Assembly to adopt a resolution urging national parliaments to increase their efforts to reduce child and maternal deaths. A key success factor in this resolution becoming a reality was the secondment of a staff member into the challenging political work environment of the IPU. This innovation was the first NGO secondment to the IPU in its 120 year history.
- In Zambia, 7 communities in Lufwanyama and Katembula successfully influenced the local leadership to prioritise the construction of a new health centre within the 2012 district-wide action plan. This was achieved after community-led monitoring activities identified the need to have a health facility situated within the stipulated five kilometres walking distance.
- In India and Armenia, 17 communities have worked with government departments, and local authorities to establish roadmaps of reforms with corresponding action plans to prioritise and address service delivery failures. This has been achieved by WV's ongoing CVA training and mentoring with community groups and local authorities and resulted in increased citizen influence in decisions that affect their lives
- In Sierra Leone, WV has influenced the content of a National Training Curriculum for Community Health Workers. As a result of WV's interaction and training with the Ministry of Health as part of PPA and Irish Aid-funded Assessment and Improvement Matrix (AIM) Health project, the Ministry has recommended the adoption of WV's CHW Timed and Targeted Counselling (TTC) approach and curriculum throughout the country. Importantly, WV Sierra Leone have implemented CHW functionality and service assessments and are working closely with government through the national coordinating committee to develop the Sierra Leone MOH CHW National Strategic Plan.
- In Uganda, WV As part of the national VHT coordinating committee contributed to the development of growth monitoring and promotion/ positive deviance health guidelines for the MOH national nutrition programmes. Based on locally identified evidence the project is also supporting the development of the National Behavioural Change Communication /Advocacy Strategy for Malaria as well as a National VHT Motivation Strategy.
- During the reporting period a WVUK PPA funded research study produced by ODI, 'Aid and Accountability for Health', was referenced within the 2011 Organisation for Economic Cooperation and Development (OECD) report on "Progress and Challenges in Aid Effectiveness: What Can We learn from the Health Sector" and used as a resource in the run up to the 2011 4th High Level Forum on Aid Effectiveness.

[8] Documentary evidence - WV Inter-Parliamentary Union Assembly Action Circular.

FIVE: CHILD PROTECTION

5.1 SUMMARY IMPACT

WVUK uses four indicators to track progress in 'protecting and rebuilding the lives of children affected by violence, exploitation, abuse and neglect in the world's hardest places'. These are:

1. Proportion of children who live a life free from neglect, violence and abuse
2. Reduction in harmful traditional or customary practices which violate the protection of rights of children
3. Communities are able to respond adequately to violations of child protection rights in coordination / partnership with local justice mechanisms
4. Proportion of children with a birth certificate

Limited data exists except for the first indicator in 2012 although further information is expected in 2013 as the child protection work develops and matures. The first indicator can be reported upon and education is also reported upon here but not analysed in depth, as improved education is linked to enhanced child protection.

- There has been an average increase of 26.7% of 'Children live a life free from neglect, violence and abuse'; this represents 78,812 children across 13 programmes.
- School enrolment rate increased by 22.04% while the drop out rate decreased by 13.53%

5.2 CHILD PROTECTION THEORY OF CHANGE

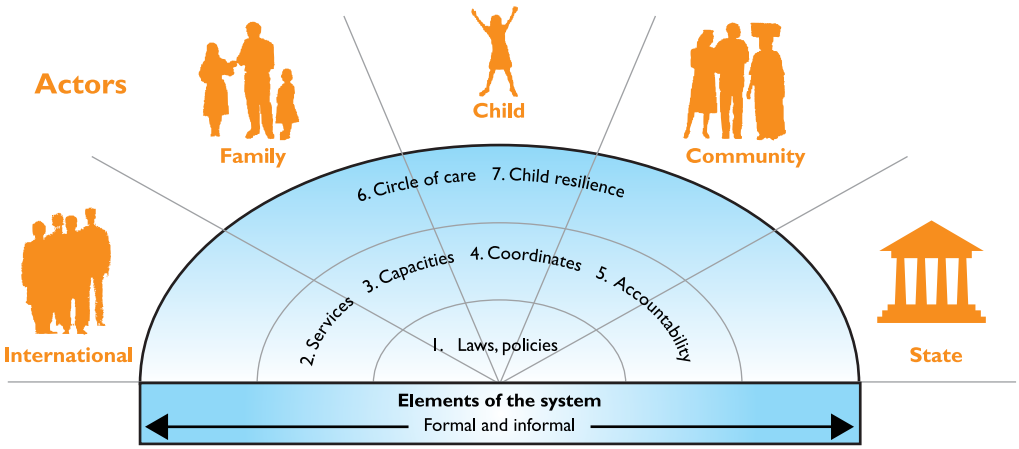
WVUK's objective is to protect and rebuild the lives of children affected by violence, exploitation, abuse and neglect in the world's hardest places.

World Vision understands that this is most effectively and sustainably achieved through strengthening the protective 'system' around the child which consists of seven elements and five actors, as illustrated in the diagram below. World Vision conducts programming and advocacy to strengthen these elements, and, crucially, the linkages between them.

World Vision's community presence makes it particularly well placed to support a 'bottom up' approach that empowers children to protect themselves and equips their families and communities to provide that immediate cover of protection. Our 'Child Protection and Advocacy' programme model emphasizes these interventions and then draws from local intelligence to call for a strengthening of the national and international elements of the system.

5.3 IMPACT FROM EVALUATIONS AND PROJECT REPORTS

From evaluations of programmes and reporting of projects that included interventions relevant to the four child protection focused 'child well-being indicators', the following impact can be identified.



Children particpating in educational activities at a local children's club in Vaishali ADP, India. © World Vision

5.3.1 Children who live a life free from neglect, violence and abuse

Across a portfolio of specific projects tracking this indicator, there has been an average increase of 26.7% of 'Children live a life free from neglect, violence and abuse', representing 78,812 children. Examples from two of these 13 projects include:

India: as part of the life skills training activities supported by a WVUK project, 125 children attended the first ever Child Rights State Assembly in West Bengal to discuss health, education, budget, inclusion and child protection issues. Prasenjit Saha, a medical consultant at Calcutta Medical College and a member of the expert panel remarked, "These children are so empowered. They are aware of their rights and duties. We were not as aware when we were young" and a child participant reported, "This event taught me a lot about child rights. I want to open a club back home that will focus on child labour issues. I also want to pass on whatever information I acquired here to other children who are still unclear of our rights".[9]

Democratic Republic of Congo: children's clubs have provided training for children on their rights and qualitative evidence suggests that they are already equipping children to better protect themselves, most notably the gender specific 'Girls Power' clubs. One participant affirmed, "I am 17 years old; I was raped two years ago when I was 15 years old and got pregnant. Because of that, my parents dismissed me from home. After I gave birth... (I)... decided to join the brothels, thanks to Girls Power I have left the brothels. I am really grateful for everything I got so far from children clubs."

ADPs have not yet been directly monitoring this indicator, but have reported progress on indicators, particularly the empowerment of children, that appear to contribute towards this outcome.

Skhodra ADP, Albania: In one education project 65% of children and 81% of parents perceived an improvement in the safety and protectiveness of the school environment. This appears attributable to the increased activity of student governments.

In Sisian ADP, Armenia: The evaluation noted the 'most visibly significant changes' were related to children's empowerment: increased confidence, independence, self reliance and increasingly demanding their rights.

[9] http://www.telegraphindia.com/1120413/jsp/calcutta/story_15369694.jsp

Kampong Tralach ADP, Cambodia: The evaluation noted that the children's clubs had a 'remarkable impact' and community members and children themselves attributed to the clubs a number of important changes in behaviour: more respect for others, more effort towards schoolwork and the ability to act less violently and solve conflicts.

"The children at the child club showed a change to be polite and friendly to others and very respectful to older people. They became more confident and worked hard at their studies much more than before."
(Village leader interviews)

"We know how to help kids, not fight each other; we have learned not to use violence as it causes many bad problems."
(Children)

"Through learning about our rights we became more brave to speak up."
(Children)

Tegloma ADP, Sierra Leone: The indicator tracked in this ADP was 'the proportion of parents and caregivers who feel their community is a safe place'. While a baseline was not available, the Household Survey demonstrated that 88.8% of parents or care givers feel that the communities are very safe or safe and 90.6% of children reported that they are safe in their communities. Focus group participants suggested this was a significant improvement on earlier levels, though largely as a result of the ending of the war.

5.3.2 Reduction in harmful traditional or customary practices which violate the protection of rights of children

While this indicator is not yet systematically tracked in our programmes, the following ADP evaluations give insight into progress on related indicators.

Samaki Meanchay ADP, Cambodia: domestic violence has decreased while awareness of the issue increased. Participants in the evaluation attributed this increased awareness to community activities, such as showing relevant movies, distribution of leaflets, training workshops and elders making the case that affected families 'wasted' their hard-earned income when they use it to pay for doctor's fees and police fees. Reporting domestic violence cases to local authorities has been practiced recently and was believed to have helped in preventing it.

Children of Komabangou ADP in Niger enjoy a storytelling session. Using WVUK's Storyteller's Map and Cards children improve their life skills and literacy, whilst creating and sharing great, insightful stories to their friends, community and sponsors.
© Steve Richards/World Vision

Komabangou ADP, Niger: The evaluation noted that there had been an enrolment of children, especially girls, and that early marriages (including forced marriages) have begun to be reported, but noted that the programme wasn't sufficiently focused on child protection issues.

5.3.3 Communities are able to respond adequately to violations of child protection rights in coordination / partnership with local justice mechanisms

World Vision is increasingly focusing on building the capacity of communities to respond to and, where appropriate, refer child protection incidences to the relevant authorities.

Cambodia: The establishment of community-level action groups, known as Child Protection Committees, has led to at least two reported incidents of prevention of child abuse cases: a case of sexual assault of a 13 year old girl by her step-father, and a 16 year old girl, who was reported missing by the Committee , found and reunited with her family after follow-up from Committee members.

South Sudan: 120 people across 22 communities are now volunteering in local Child Protection Committees to raise awareness among the community about child protection and to liaise with the traditional authorities who handle children's courts.

Sierra Leone: local justice systems in 30 communities, including chiefs and local judiciary, have received training to help them adjudicate allegations of child abuse and collaborate better with other child protection structures

within the community. As the administration court chairman from Tihun explains, *"the training has helped them to distinguish between child abuse cases that can be handled at the local level and those that need to be referred to ensure appropriate actions".*

Tegloma ADP, Sierra Leone: while not comparable with a baseline, the evaluation highlighted important differences in what households and children did in response to cases of child abuse. Households are more likely to report to the village chief (35.6%) and children more likely to report to report to the Child Welfare Committee (46.1%).

5.3.4 Proportion of children with a birth certificate

A birth certificate is an important protection against the violation of a child's rights and in one two ADPs in India there were significant increases in the percentage of children with birth certificates: from 42% in 2007 to 88% in 2012 in Pathanamthitta and from 12% to 60% respectively in Patna.

5.4 IMPACT FROM ANNUAL MONITORING DATA

The table below (figure 6) shows a summary of child protection data collected from all annual reports from WVUK ADPs. This is presented using the same four child well-being indicators as above.

Findings:

5.4.1 Children live a life free from neglect, violence and abuse.

Annual reports: 13 ADPs have measured this indicator; 12 of which have seen a reported improvement in the numbers of children who feel safe in their respective environments. The same indicator was not used in all ADPs, with the following variants tracked:

- Lezha ADP, Albania – children who view the school as a violence free environment
- Stephanavan ADP, Armenia – surveyed children believe they are protected and can stand up for their rights if necessary
- Bhojpur ADP, India – children stated they feel protected that both boys and girls can go out in the community without fear
- Bolivar ADP, Bolivia - measured the number of children reporting a life free of any form of discrimination in their home, school or community.

5.4.2 Reduction in harmful traditional or customary practices which violate the protection of rights of children

Only 2 ADPs (Ntwetwe ADP, Uganda and Hurungwe ADP, Zimbabwe), measured this indicator; both reported a reduction in harmful practices carried out against children.

5.4.3 Communities are able to respond adequately to violations of child protection rights in coordination / partnership with local justice mechanisms

Three ADPs measured this indicator (Rukiga ADP, Uganda, Hurungwe ADP, Zimbabwe and Samaki Meanchey ADP, Cambodia). Two (Rukiga and Samaki Meanchey) showed an improvement, and one (Hurungwe) a reduction in the ability to adequately respond to violations of child protection rights.

5.4.4 Proportion of children with a birth certificate

Two ADPs have documented progress towards registering the birth of children; increasing in one and decreasing in the other. Where it decreased (Rattanak Mondel ADP) the baseline was only carried out in August 2011 and the children who were measured at baseline and after one year were selected using different sampling techniques. As such the result is not an accurate reflection of the project effectiveness.

5.5 IMPACT OF CHILD PROTECTION POLICY WORK

Objectives

WVUK advocated for the UK government and other relevant international bodies to make an even greater contribution to child protection issues including through:

1. protecting, restoring and securing justice for children affected by armed conflict
2. protecting children from exploitation by UK nationals travelling abroad
3. protecting children from early marriage in humanitarian and fragile contexts

Protecting, restoring and securing justice for children affected by armed conflict

Children are massively impacted by conflict. For example about half of the estimated 26 million people currently displaced by armed conflict and violence are children. But conflict affects children in many different ways and long

	Country	Name	Children live a life free from neglect, violence and abuse		Reduction in harmful traditional or customary practices which violate the protection rights of children		Communities are able to respond adequately to violations of child protection rights in coordination/ partnership with local justice mechanisms		Proportion of children with a birth certificate	
			Baseline	FY12	Baseline	FY12	Baseline	FY12	Baseline	FY12
1	Kenya	Winam					109 reported cases FY11	234 reported cases		
2	Uganda	Rukiga	60.0%	90.0%			48.0%	56.9%		
3	Uganda	Ntwetwe	69.0%	74.1%		85.5% perceive a reduction in child abuse				
4	Malawi	Kayezi	10 communities	14 communitiues						
5	Zimbabwe	Hurungwe				70% reduction in child abuse cases (evidenced by DoSW)	5 institutions able to respond to cases of child abuse	3 institutions able to respond to cases of child abuse		
6	Zimbabwe	Sanzukwe	3 No. of functional child protection committees	6 No. of functional child protection committees						
7	Senegal	Basa	2164 No. of children involved in child rights awareness raising	2216 No. of children involved in child rights awareness raising						
8	Senegal	Mbella	99.0%	25.0%						
9	Albania	Lezha	149 children who view school as a violent free environment	244 children who view school as a violent free environment						
10	Armenia	Stephanavan	89.4%	97.7%						
11	Cambodia	RatanakMondel							86%	68%
12	Cambodia	Samaki Meanchey	0.0%	87.0%			0%	10%		
13	India	Bhojpur	0%	64%					17%	53%
14	Bolivia	Bolivar	46.0%	56.0%						
15	Bolivia	Sacaca	55.9%	60.5%						
16	Bolivia	Tacopaya	85.0%	90.3%						

after conflict ends through sexual exploitation and abuse and the wider weakening of formal and informal protection systems.

Protecting, restoring and securing justice for children affected by armed conflict requires different actors to work and in March 2012 World Vision UK sponsored and co-organised a Wilton Park conference that convened the main international actors working on the issue, including the UN Special Representative of the Secretary General on Armed Conflict, seven UN agencies, nine governments, 14 NGOs and four academic institutions. The agreed outcome document reflected World Vision's call for a 'continuum of protection' to address children's needs before, during and post-conflict, and this approach is gaining momentum both at government and UN level and World Vision has established itself as an important authority that is able to give voice to the children affected by armed conflict.

"I'd like to thank World Vision and Wilton Park for organising this very important seminar. It's been about 5 years since we had an assessment like this of what is taking place... It's been a wonderful seminar and the discussion gives us a sense of the richness of this topic."

Radhika Coomaraswamy, former UN Special Representative for Children and Armed Conflict (up to 13 July 2012)

Protecting children from exploitation by UK nationals travelling abroad

World Vision UK's "Small World, big responsibility: the UKs role in the global trade in children' highlighted the scale of the exploitation of children from the world's poorest countries, and pointed to how the UK can take action. The report was covered by Radio 4's Sunday programme, informed the BBC's Fast: track documentary on child sex tourism and led to dialogue with the Ministry of Defence on the UK's commitment to ending the use of child soldiers around the world.

World Vision joined with other NGOs to lobby for an amendment of the Sexual Offences Act to eliminate the '3 day loop-hole' which allowed registered sex offenders to travel outside of the country without notification. Following consultation by the Home Office, which included a submission by World Vision, the law has been amended and the loophole closed.

Protecting children from early marriage in humanitarian and fragile contexts

World Vision has added its voice to the calls to end child marriage, and in particular has highlighted the particular threat in humanitarian and fragile contexts. World Vision was one of five NGOs providing oral evidence for a report by the All Party Parliamentary Group on Population, Development and Reproductive Health and its evidence was the basis for the section 'Child Marriage in Contexts of Emergency, Conflict and Crisis'. This is pushing the UK government to increases its efforts to combat child marriage in its programming and World Vision is now considered an authority in providing the perspective of communities, particularly those in fragile contexts.

"Education is a big part of the solution to child marriage but it is not the fundamental solution because it does not actually address perceptions that communities have about the value of girls; it does not address perceptions and beliefs communities have about the role of child marriage in protecting children but also in furthering livelihoods, so what we would support is a much broader child protection system strengthening approach to addressing child marriage which looks at who are the actors around a child that serve to keep them safe and how can we work with those actors to build their capacity, their knowledge and their behaviours in order to address child protection issues of which child marriage is one."

(Philippa Lei, World Vision, oral evidence) Quote from 'A Childhood Lost' A Report on Child Marriage in the UK and the Developing World from the UK All-Party Parliamentary Group on Population, Development and Reproductive Health

* estimated based on information in narrative

- Positive Change
- Baseline/Endline Figure present only
- Negative Change
- Indicator either not relevant or not reported on

SIX: HUMANITARIAN ACTION

A review of reports from 9 emergencies formed the basis of articulating impact in World Vision UK's humanitarian work in 2012. These were Haiti, Pakistan, Ethiopia, Horn of Africa, Sahel, Zimbabwe, Philippines, Sudan and Myanmar. Recognising the difference in context between emergency and development programmes, it is widely recognised that a different methodology is required to measure the success of rapid onset emergency programmes as compared to using counterfactuals in development programming.

CRITERIA USED TO MEASURE

In this report we have adapted the DAC principles of measuring development assistance (relevance, effectiveness, efficiency, impact, sustainability) and used the criteria of relevance, timeliness, coverage, management effectiveness, connectedness and sustainability to draw examples of impact across the humanitarian programmes.

The results show that all major responses were effective across the six criteria and outstanding in the areas of 'Timeliness' and 'Accountability'. Relevance is also perceived to be high based on strong community assessments but evidence of why a particular intervention was chosen over another was not always evidenced as well as it could be. World Vision's UK enhanced focus on resilience as a cross-cutting theme is apparent and growing with strong examples within the HARD, Pakistan and Philippine responses as well as throughout development programmes. A continued strategic focus on Resilience will result in this being a more prominent cross-cutting theme in future impact reports.

6.1 COVERAGE

971,090 people directly benefitted from WVUK's emergency response work in the past year of which 741,906 were children. A range of interventions are made in an emergency to respond, ensure recovery and promote resilience. Examples of achievements include:

OUR IMPACT ON CHILDREN

370,841
people benefited from improved livelihood activities

2,388
improved hygiene facilities provided

728,299
people benefited from food supplies/food aid

9,891
shelters constructed

33,131
hygiene promotion activities were conducted

"I enjoy playing and learning at the centre so much that I don't want to go home from here," says Humera, 10, Pakistan. Humera is one of many children who now have access to non-formal education for the first time thanks to the local World Vision drop-in centre, where they learn life skills, health and hygiene awareness, and how to integrate into formal education for a better future. © 2012 Muhammad Ali/World Vision

Relevance

100% of evaluations showed strong analysis for the interventions proposed and implemented based on the nature of the emergency and resulting impact on the affected population as highlighted through community based assessments.

The community based assessments enable WV to work with the community to determine the most pressing needs and also to consider the range of stakeholders to ascertain where WV can add the most value with its support. This included:

- Improved livelihoods were promoted to facilitate long term recovery from emergencies including seed and livestock distribution in Ethiopia and Pakistan and sewing materials for women and girls in Pakistan. Seed distribution also facilitated the diversification of food sources and reduced vulnerability on a few crops (Pakistan, Myanmar).
- Child friendly spaces were provided in Somalia. Pakistan and Haiti where children were at particular risk so enabled a safe environment and they learnt life skills, child rights and other skills. Children were involved in increasing awareness of child right issues in Zimbabwe, Pakistan and Myanmar and in Pakistan children participated in identifying 150 children protection/abuse incidents in their villages. Children in Pakistan, Ethiopia, Zimbabwe, Haiti and Philippines all received children's educational supplies to assist children to return to school as soon as possible after the emergency.
- Water, Sanitation and Hygiene (WASH) was evident in Sudan, Pakistan, Zimbabwe and Haiti including specific facilities for children and IDPs. In addition to construction and rehabilitation of water infrastructure, community hygiene messages were promoted resulting in 98.4% of caregivers in Sudan reporting washing hands at critical times, 400 children in Pakistan being involved in children's hygiene forums and open defecation in targeted villages in Pakistan reducing from 82% to 52.61% and the % of surveyed families with an unclean environment around the house (animal waste, garbage, stagnant water, flies) posing a public health risk had decreased from 75% to 48.7%. Where appropriate, shelter and local infrastructure were constructed or rehabilitated (Zimbabwe, Haiti, and Pakistan). Peacebuilding was integrated into responses in Zimbabwe, Kenya and Somalia given the contribution of conflict to exacerbating crises, and health and nutrition promotion was a focus in Haiti and Sudan
- In Ethiopia, all evaluation participants unanimously reported that change in the lives of children remarkably improved since the beginning of the project. Rapid recovery of children and low child morbidity and mortality rates were considered as the

outcome of the project. The opportunity also helped children to receive immunization and other health care services from the health facilities.

- One year into the Horn of Africa response, WVUK has reached over 17,600 people. WVUK has responded to the needs of many people in the areas of food aid (over 11,000 beneficiaries), health and nutrition (over 4,000 beneficiaries), WASH (over 4,000 beneficiaries) and livelihoods programming (over 3,000). Programming was targeted to meet the needs of those most vulnerable first, while also assisting the broader population of families and children affected by this crisis. Programming highlights include immediate food aid distribution and health and nutrition programming across all countries, long term environmental livelihood programming in Ethiopia, Child Protection advocacy initiatives in Kenya, durable and long term solutions to water scarcity in Somalia, and distribution of improved seed varieties in Tanzania. The response has been inter-sectoral and where factors such as environment or insecurity have been contributors to the crisis, World Vision has responded accordingly. For example, in Ethiopia, solar lamps and fuel efficient stoves were distributed to mitigate environmental strain from refugee populations

6.2 TIMELINESS

In terms of timeliness, given that World Vision works through long term development programmes, when an emergency situation hits an area, it is able to respond quickly and appropriately, and a rapid scale up is possible through a national and, in the case of large scale emergencies, global response through private and grant funding. For example, in Haiti the WV response started on day one, and in the Philippines staff were deployed to the typhoon response through existing trained personnel in the humanitarian team which enabled WV to immediately deploy rapid assessment teams to areas where WV had existing programming. A response structure was established, based on the WVI emergency management system to provide effective management to the response making use of existing staff, deploying specialists, and ensuring quick recruitment to fill positions.

Through an increased emphasis on early warning systems, and emergency preparedness, response teams were able to react quickly and appropriately (e.g. Ethiopia, Pakistan) and increased emphasis on these systems will help to respond even better to emergencies in future.

World Vision delivers drinking water to a community affected by drought near the Dadaab Refugee Camp, Kenya.

6.3 ACCOUNTABILITY

In terms of accountability, World Vision UK and World Vision International have been promoting the integration of the Programme Accountability Framework and key humanitarian accountability standards into humanitarian responses through training of field staff in four aspects of accountability (information provision, consulting with communities, promoting participation and collecting and acting on feedback and complaints). Examples of all four aspects were found through the programme evaluations and include active complaints and response mechanisms (Haiti, Pakistan, HoA, Myanmar), including suggestion boxes, complaints logbooks, and complaints/feedback hotline among others. Community committees received and monitored complaints, with support of WV staff. Community notice boards, leaflets, brochures and other methods were used to provide beneficiaries with information provision about World Vision and programme activities (including child specific tools in Haiti).

70% of respondents in Haiti agreed or strongly agreed that WV shared key information with households and the community. More than half agreed that WV encourages the community to give feedback on its activities and programmes, that WV provides opportunities for the community to discuss and participate in programmes and that WV informs the community when and why it will be ending a programme. In Myanmar, accountability mechanisms were documented to have resulted in changes in programming activities and in Haiti programme participants were divided on whether or not this had been the case. In several countries, World Vision received feedback that communication had not been sufficiently clear about its exit (e.g. Ethiopia) which is an area for improvement.

6.4 MANAGEMENT EFFECTIVENESS

In terms of management effectiveness, World Vision was able to maximise impact through partnership with local NGOs and local government, and in some cases through supporting the creation of local CBOs and other local level groups who were equipped to continue to carry out activities in the long term. In order to increase effectiveness, programmatic innovations were initiated (e.g. in Horn of Africa) and creative solutions to problems were sought e.g. in circumventing logistical and procurement issues to ensure those who most needed services received them (e.g. Haiti). Response structures in offices affected by emergencies followed the tried and tested WVI Emergency Management system. On the UK side, WVUK also ensured the closer monitoring of spending rates to avoid over or under spending and is engaged with a UK consortia to benchmark input costs.

Families build huts for shelter in Garowe, Somalia.
© World Vision

In Zimbabwe, the project learnt an essential lesson of shelter design, i.e. the importance of consulting the local council before designing the shelters. It was only a 9 month long project and it was delayed for 6 months to finalise negotiations with the local council. The end product was good and in line with local standards, but it took a long time to achieve.

The Horn of Africa Response has served as a platform for innovation in World Vision. Some of the innovations include applying GIS (Geographic Information System) technology to response activities, assessing the impact of child-friendly spaces on child wellbeing, and initiating Secure the Future, a new programmatic approach to bring about resilience to drought in the Horn of Africa.

6.5 CONNECTEDNESS AND SUSTAINABILITY

The key to ensuring connectedness and sustainability is involvement of local communities in planning and carrying out programmes, participation of local government and ensuring that interventions are focused not only on short term "fixes" but ensuring long term solutions to vulnerability to disasters, particularly in high risk areas. In Pakistan, 48 early recovery schemes were initiated having been identified by the communities themselves and once completed were handed over to village development committees to monitor. Disaster Risk Reduction (DRR) and resilience were key themes in most of the humanitarian projects, particularly those in the transition or recovery phase (e.g. Horn of Africa, Pakistan, Philippines). The impact of the DRR initiatives will not be fully evident until there are future disasters. In Pakistan, villagers learnt techniques for putting in deep foundations and planting trees and 100 men were trained as master trainers in DRR concepts. Community activists will monitor developments in their villages and be focal

points for the implementation of transmitted DRR knowledge. Fostering local ownership was promoted in Pakistan and Zimbabwe among other countries. In Pakistan, children were included as activists in child to child hygiene promotion, and in the Philippines teachers were trained about Child Friendly Spaces so that they were equipped to continue psycho-social activities with children.

In addition to DRR, early warning and investment in early action will result in greater sustainability of approaches. World Vision humanitarian work has also invested in advocacy (e.g. in Kenya, Haiti and Philippines with national government, in Zimbabwe with Bulawayo county council) in order to push for long term changes in policy. In South Sudan focus was on increasing the capacity of local ministries. Collaboration occurred not only with local government and local groups but with UN agencies and other NGOs (e.g. Haiti, Horn of Africa).

6.6 EXAMPLE OF POLICY IMPACT FROM SOMALIA

On 23 February 2012, the Somalia London Conference took place in London. WV with a number of other agencies worked through private advocacy to push for humanitarian issues to be discussed at the conference. The WVI Humanitarian Policy Advisor commissioned an internal review[10] of the situation to identify the components that worked well and the components that need to be improved to ensure more effective partnership work by World Vision internally and externally in the future.

Amongst the findings were that Humanitarian issues in Somalia were brought back on the agenda of decision makers and while there was generally good internal coordination in World Vision regarding Somalia (particularly through the fragile states working group), this could be improved. A need was identified to develop a WV partnership policy agenda for Somalia and to Strengthen advocacy in National Offices as well as Policy capacity for fragile states.

Key highlights of impact were that:

- All WV key messages made it to the conference
- All except for one recommendation made it to the final report

This piece of work was conducted in consortia and therefore success can only be considered of the consortia and assessing WV's contribution within that. WV was well positioned to influence the strategy, since a WV advocacy advisor who is based in New York was seen as the most active member of the New York Coalition; the WV advocacy advisor based in Washington DC was the co-chair of the InterAction Working Group, and had established relationships with the US government and direct connection to the Somalia Coalition in Nairobi. In the UK WV along with SAVE and OXFAM dealt with the British foreign ministry and Government. In Nairobi, WV is part of the Somalia coalition and part of the steering committee. In addition WV's internal coordination mechanism allowed for better contribution to the coalition work that was taking place.

It was noted that despite this success, while there was overall good internal coordination, this could have been improved. Secondly, there is a need to develop a partnership policy agenda for Somalia (to inform strategy and to use as a communications tool to engage others) and thirdly a need to strengthen NO advocacy and Policy capacity for fragile states through improving the channels through which WV shares concrete and contextual information from the field in order to inform policy and through adequate advocacy and policy capacity in the field.

[10]The methodology used was as follows: A qualitative approach involving a number of different stakeholders was used to understand people's opinions about WV's work with regards to the Somalia London Conference.
• An online questionnaire was sent to 30 staff across WVI (Support Offices (SO), National Offices (NO), and Global Centre (GC) staff) of which 10 responded (2 from NO, 6 from SOs and 2 from GC). The questionnaire was sent on March 8th 2012.
• Parallel to this online questionnaire: a) 5 interviews were held with staff who were directly involved with the London conference b) 4 interviews were held with peer agencies that played a leading role in the Conference preparations; c) Evidence was also gathered through a desk review

A teacher stirs the porridge that will be given to students as part of the school feeding programme. As many of the children wake early and walk the 30km to school each day the programme provides them with the breakfast and lunch they would otherwise miss out on.

SEVEN: ASSESSING THE QUALITY OF EVIDENCE

Last year's impact report highlighted the range in quality of evidence that had been included. It was also noted that each piece of evidence used in the report could not share its underlying methodology as this would be overly cumbersome. Therefore, WVUK decided to assess and disclose its rating on the robustness of the evidence used to generate this report using BOND's evidence of effectiveness principles[11], this was completed by World Vision UK's Evidence & Accountability Unit. World Vision UK has actively contributed towards developing and piloting these principles through a process led by BOND in collaboration with a group of NGOs and donors. The principles are currently in a wider phase of piloting.

While this is a self-assessment, World Vision UK asked a peer agency, CAFOD, to review a random sample of WVUK's evaluations and compare the self-assessed rating given. From the sample compared (25%), it was found that the ratings given were 100% consistent within the overall categories and 91% the same within the sub-categories. WVUK therefore concluded that its self-assessment of robustness of evidence was an accurate reflection on the quality of evidence reflected.

The Principles for assessing the quality of evidence are based around five areas:

1. Voice and Inclusion: the perspectives of people living in poverty, including the most marginalised, are included in the evidence, and a clear picture is provided of who is affected and how
2. Appropriateness: the evidence is generated through methods that are justifiable given the nature of the purpose of the assessment
3. Triangulation: the evidence has been generated using a mix of methods, data sources, and perspectives
4. Contribution: the evidence explores how change happens and the contribution of the intervention and factors outside the intervention in explaining change
5. Transparency: the evidence discloses the details of the data sources and methods used, the results achieved, and any limitations in the data or conclusions.

Evaluation Reports

Overall, WVUK was pleased that 87% of its evaluation reports meet the minimum standard for being a credible and robust piece of evidence. Applying this tool enabled WVUK to draw a number of lessons for how to improve its quality of evidence at the terms of reference stage, implementation and reporting stages which will be implemented next year.

Key lessons included:

- In 2012, an increased investment of technical time and resource was given to strengthening terms of reference for evaluations, this continues to be a priority as well as reviewing methodologies proposed prior to commencing the evaluation to ensure a suitable balance of qualitative and quantitative methods are being deployed
- The evaluation reports documentation of the level of participation of communities throughout the evaluation process was fairly generalised and non-specific, particularly in presenting and analysing conflicting views of stakeholders. However, community validation of results as an emerging process has significantly enhanced extensive beneficiary engagement throughout the process
- Appropriateness and transparency consistently scored well but further efforts should be made to reach full transparency (gold standard) and to review the quality of each evaluation against the cost of the evaluation and the programme costs for a level of consistency and cost-benefit analysis

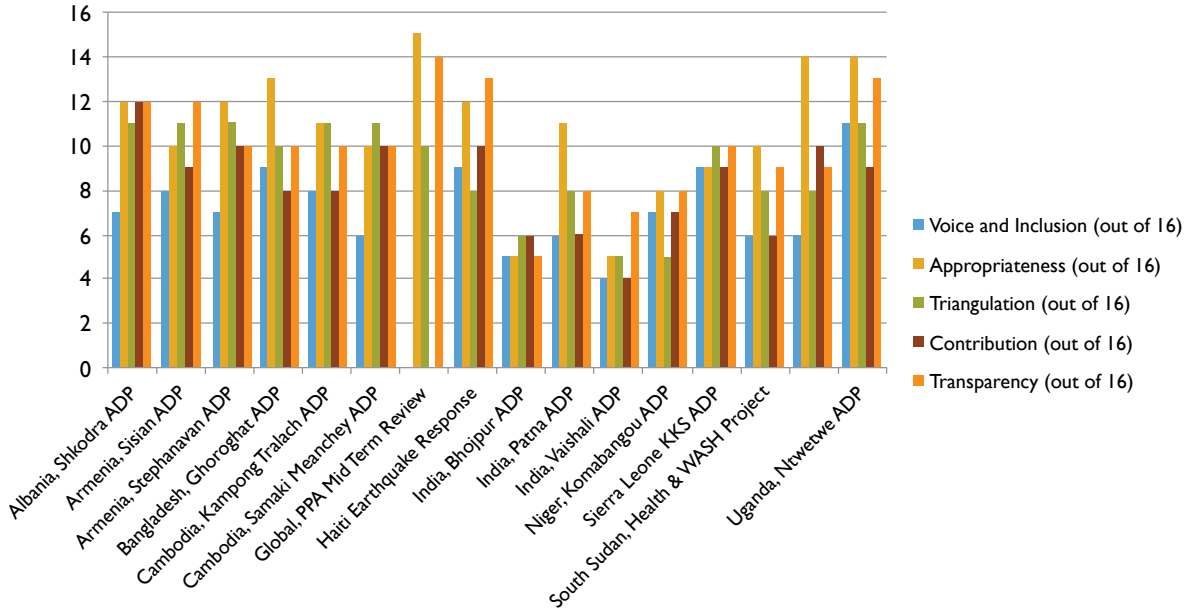
The maximum score available using the principles checklist is 80 and a colour rating is given for each principle[12]. World Vision UK created the following overall scoring scale to give an overall rating.

Score	Rating
0-34	Weak
35-54	Minimum
55-74	Good
75-80	Gold

[11] See www.bond.org.uk

[12] See www.bond.org.uk for more information on the evidence principles

Project Name	Voice and Inclusion (out of 16)	Appropriateness (out of 16)	Triangulation (out of 16)	Contribution (out of 16)	Transparency (out of 16)	TOTAL (out of 80)	Evidence Assessment
Albania, Shkodra ADP	7	12	11	12	12	54	Minimum
Armenia, Sisian ADP	8	10	11	9	12	50	Minimum
Armenia, Stephanavan ADP	7	12	11	10	10	50	Minimum
Bangaldesh, Ghoroghat ADP	9	13	10	8	10	50	Minimum
Cambodia, Kampong Tralach ADP	8	11	11	8	10	48	Minimum
Cambodia, Samaki Meanchey ADP	6	10	11	10	10	47	Minimum
Global, PPA Mid Term Review	0	15	10	0	14	39	Minimum
Haiti Earthqake Response	9	12	8	10	13	52	Minimum
India, Bhojpur ADP	5	5	6	6	5	27	Weak
India, Patna ADP	6	11	8	6	8	39	Minimum
India, Vaishali ADP	4	5	5	4	7	25	Weak
Niger, Komabangou ADP	7	8	5	7	8	35	Minimum
Sierra Leone, KKS ADP	9	9	10	9	10	47	Minimum
South Sudan, Health & WASH Project	6	10	8	6	9	39	Minimum
South Sudan, Western Equitoria Livelihood Diversification	6	14	8	10	9	47	Minimum
Uganda, Ntwetwe ADP	11	14	11	9	13	58	Good
TOTAL	**108**	**171**	**144**	**124**	**160**		



Final Reports reviewed for Impact Report

Horn of Africa	180 day report, learning report, final report
Zimbabwe	PRP Final Completion report
Senegal	Improving Nutrition Through Dairy And Cereal Enrichment
Zimbabwe	IOM Final Report
Philippines	Final Report for Typhoons Nesat Emergency Response
Ethiopia	ECHO Emergency Nutrition
Pakistan	Flood Response – Final DEC Report

Annual Reports reviewed for Impact Report

78 Annual Development Programme reports were reviewed for assessing impact and level of effectiveness. The reports were also used to aggregate global coverage and draw lessons learned.

EIGHT: WV GLOBAL CHILD WELL-BEING REPORTING

CASE STUDY - SENEGAL NO CHILD WELL-BEING REPORT

WV Senegal, along with a number of other World Vision National Offices, is piloting an Annual Report based on Child Well-being (CWB) data.

This Annual Report brings together data from existing sources (such as regular monitoring reports, baselines and evaluations, sponsorship data and other relevant research) and compiles the data into a single summary report. It is designed to streamline reporting and make better use of data already collected, so that reporting can be achieved at a higher and more strategic level. National Office CWB summary reports will be used to provide leadership with a clear picture of achievements and challenges towards achieving CWB, in line with national and partnership-wide strategy, in order to support evidence-based decision making at all levels.

In 2012 Senegal published its Annual Child Well-being report for 2011. Senegal's process for compiling this report was comprehensive and rigorous in its validation by WV Ministry Quality experts and key government stakeholders. From its analysis, WV Senegal was able to gain a better understanding of the status of CWB across 23 ADPs. This picture showed that the ADPs perform relatively well in some health indicators: for instance 86% of Senegal ADPs have an assisted birth rate, higher than national average of 65%; and 83% of children in Senegal ADPs who were identified as moderately malnourished were fully recuperated. It also shows that WV Senegal could be well positioned to have an impact in the area of education, as only 85% children have access to schooling, much less than the national average of 94%. Also, whereas the national pass rate of students is 87% it is only 65% in ADPs; and only 43% of children progress into middle school in Senegal ADPs compared to the 90% at the national level.

This kind of information helps WV Senegal to better understand where the most vulnerable children live. It highlights areas requiring intervention, suggests areas where programming could be improved, and enables WV Senegal to be more strategic in allocation of resources. Using consistent indicators will help Senegal to track achievements over consecutive years and will enable WV Senegal to track these against national data. Finally, CWB reporting enables a National Office to look across all its ADPs and easily identify areas of success in programming as well as areas for improvement. In this way, it provides opportunities for learning across communities.

However there are some challenges to this approach of reporting. Primarily, such a high level of standardisation could make programs less flexible to contextual needs. In addition, while it creates opportunity for a consortium based approach with other partners in government and the development community, thus enabling sharing of information; there have been challenges to collecting, analysing and organising large quantities of information for the report. WV Senegal has noted that the rigour of these processes will need to be reinforced to improve overall quality of reporting.

Next year, WVUK hope to be able to utilise more of these child well-being reports in its assessment of impact.

Children collect vegetables from their family's garden, Basa ADP, Senegal. © World Vision

NINE: IMPROVING EFFECTIVENESS - DIGITAL DATA

WVUK is investing now in digital data collection to ensure the baseline data exists and is robust for broader and deeper impact assessment.

MOBILE PHONES FOR ASSESSMENTS

Problem:

Paper slow and inaccuracies easy, Personal Digital Assistants (PDAs) are expensive and an external agency required, knowledge of using mobiles zero but 'it can't be hard' attitude prevailed

Solution:

- Process map of assessments
- Pilot of phones & Smap software
- Training (embedded in Learning Labs)

Outcome:

- Smartphones now used globally for faster
- Humanitarian Rapid Assessments e.g. Goma, Democratic Republic of the Congo and the, Horn of Africa Drought
- Child well-being baselines – Latin America, Africa, Asia, Middle East/Eastern Europe

REAL TIME EVALUATION

Problem

Two weeks to survey staff and evaluate the Horn of Africa Response to Drought (HARD) across Ethiopia, Kenya, Tanzania, Somalia. Online surveys get low responses from staff who are busy on emergency response.

Solution:

- Survey texted to staff using the phone in their pocket
- Free FrontlineSMS software enables mass communication
- Video of beneficiaries on staff smartphones

Outcome:

- 60% (35 out of 60) staff across Ethiopia, Tanzania and Kenya responded to the text survey
- Text and video added extra layer of breadth and depth of evidence at fast speed

World Vision Uganda staff member talking to a member of the local community, using the new smartphone system for recording and assessment. © Jamo Huddle/ World Vision

World Vision Uganda staff receiving training in the Citizen Voice in Action database. © Becky Thorn/ World Vision

SOCIAL ACCOUNTABILITY

Problem:

Global co-ordinators of Citizen Voice & Action, a local advocacy approach, needed a software solution to make uploading flip charts of data easy for local staff and viewing aggregated data easy for national advocacy staff

Solution:

WVUK brought in Graymatter to design and build an affordable online solution, engaging with WV Zambia, WV Uganda and WVI in design

Outcome:

Phase 1 built, Uganda and India staff trained and excited about potential for improved local to national dialogues on standards in education and health

MOBILE HEALTH (MHEALTH) IN SIERRA LEONE

Problem:

WV 7-11 health approach includes Timed and Targeted Counselling (TTC) of expectant and new mothers by Community Health Workers (CHWs). In Sierra Leone, CHWs in rural areas find communication with District Health centres challenging

Solution:

WVUK with WV Ireland provided funding and technical support to the design and deployment of a mobile app and infrastructure for CHWs and District Health centres to record mother & child info as well as TTC messages

Outcome:

This project dovetailed with other mHealth projects to create one mHealth platform: MoTech with support from Gates Foundation, Grameen and Dimagi deployed in Sierra Leone Feb 2013 and globally 2013 onwards

TEN: CONCLUSIONS

In 2012, 3.77 million children are benefitting from World Vision UK supported projects, a slight reduction from 3.99 million in 2011, largely due to a reduction in emergency responses. Of these, an increasing number and percentage of children are within the three priority themes (health, child protection and humanitarian) as well as an increased proportion within fragile states, thus reflecting the priorities of our strategy up to 2015.

OVERALL

Based on feedback to last year's report, this year the report is structured around the three priority themes. Child well-being indicators are tracked within evaluations and annual reports for health and child protection, these have been used to frame the evidence of change while the in-depth analysis from each evaluation examines the causal links and external factors to provide a more accurate reflection of World Vision UK's contribution to the change.

There are encouraging highlights representing the change from the baseline, over a programme cycle (between 52 and 61 months)within the programme areas and across the sample of evaluations including:

- **Children who are underweight decreased by an average of 5.33%**
- **12.43% more mothers breastfeed their babies effectively**
- **Births at hospital / with a skilled birth attendant increased by an average of 20.05%**
- **Children fully immunized has increased by an average of 17.86%**
- **There has been an average increase of 26.7% of 'Children live a life free from neglect, violence and abuse'; this represents 78,812 children across 13 programmes.**
- **School enrolment rate increased by 22.04% while the drop out rate decreased by 13.53%**

It is important to note that these indicators represent change within the community over the life of the project but when viewed in isolation they do not illustrate the contribution or attribution of World Vision UK's interventions to the change. The deep dive approach within each evaluation, applying both qualitative and quantitative methods to understand the causal links of programme interventions within wider spheres of influence enables a more comprehensive understanding of the impact that World Vision UK's programmes have enacted on the lives of the people it serves.

The sample size from which these statements of change are drawn is also disclosed to help the reader to frame the level of global representation. This sample size will grow each year as it is an emerging evidence base of the overall change that World Vision UK sees globally within its programme areas.

It is encouraging to see this year that there is a growing body of evidence of the impact of programmes and the evaluations and increased strength in the rigour of the evidence. Furthermore, there is increasing exploration of counterfactual reference points including secondary data or control groups particularly in Bangladesh, Sierra Leone and India as well as deeper analysis of the role and engagement of other stakeholders within the community when analysing the impact. However, it is also noted that World Vision UK is still on a long journey in assessing and articulating impact. Further work needs to be done to truly assess the causal linkages, the counterfactual and the contribution/attribution levels of World Vision UK to enhance analysis of impact.

Disaggregation of data by gender is improving but further steps need to be taken as well as disaggregation by other social parameters to enable effective cohort tracking and matched control cohorts where possible. This will enable impact on different segments of the community to be understood in more depth.

This year, humanitarian action was analysed against six criteria, thus recognising the differing nature of impact assessment in emergency responses. This enabled a constructive analysis of the effectiveness of the responses with an implicit assumption that an effective response will lead to the greatest impact.

Increased efforts were made in 2012 to assess the impact of policy work. However, it should be noted that examples of policy impact were not based on a sampling approach but were presented as examples that could be assessed. Assessing impact and effectiveness of policy and campaign work has improved in the past year with enhanced efforts to baseline campaign work (including the 'IF' campaign) and to assess World Vision UK's contribution within networks and coalitions. Empowering citizens to be agents of change is a key component of

Kumari and Naina are members of a local chidren's club called 'The Star'. The group has facilitated many changes within their community from the closing of a liquor store to lobbying local government to rebuild the village primary school. © 2012 Ajitson Samuel Justus/World Vision

World Vision UK's approach and the change that communities perceive is measured on World Vision UK's Influence and Engagement tool, a scalar tool based on community perception and triangulated with evidence from focus groups, observations and secondary data.

Quality of Evidence: The BOND checklist for assessing evidence of effectiveness has enabled evaluation reports to be assessed against agreed criteria. This information has highlighted the strengths and weaknesses of WV's approach to evaluation and lessons have been identified to strengthen evaluations. In particular it has been noted that the results are not sufficiently disaggregated by social differences and involvement of beneficiaries should be increased in the assessment process. Analysis of causality, unintended changes and the contribution of outside factors should be analysed in greater detail to give a clear overview of the changes that have been reported.

The highest scores were observed in the areas of 'appropriateness', 'triangulation' and 'transparency'. This shows that the evaluation methodology used is relevant and proportional and those leading the evaluation are skilled for the task and the data has been analysed to a good standard (on average). Most often more than one data source has been used, and different stakeholder opinions have been presented and shared with the relevant stakeholders. In terms of transparency, sample size and methods of data collection have been explained and justified in the majority of evaluation reports.

Monitoring & Evaluation: It is encouraging to see the increase in community validation of evaluation findings. This year there are three strong examples of the community validating specific results; there were examples from Bhojpur in India where the community had been asked to validate immunisation rates; Tegloma ADP in Sierra Leone had validated many of the key findings by holding FGD in 8 villages to confirm the accuracy of the results and in Ghoroghat ADP, Bangladesh where communities were given the opportunity to feed their opinions back into the final evaluation documents. In Bangladesh, a counterfactual (non-beneficiary) group were included in the assessment of each of the areas of impact. It is encouraging to see the progress of these approaches.

World Vision UK are aware that the increased focus over the past three years on strengthening programme designs and baselines will result in the ability to continually improve the ability to more rigorously assess impact in the next few years.

A World Vision community trained vaccinator helps immunise a child against measles at a transit camp in Northern Sudan. © 2010 Geoffrey Denye Kalebbo/World Vision

HEALTH

In terms of mother and child nutrition there have been gains particularly in reducing the level of stunting, improving exclusive breastfeeding and reducing undernutrition.

In regard to Child Health, there have been very positive gains in the number of children who have been immunised. The focus of National Governments, UNICEF, as well as other actors has contributed to making a significant change in this area. There are also positive improvements in ante natal, delivery and post natal care as well as provision of general health services within communities. Evidence is emerging that World Vision's social accountability approach to empower citizens as agents of change is strengthening the service provision of health facilities through communities monitoring and advocating for their rights to be upheld.

As has been identified through the quality of evidence tool, the analysis around causality and contribution of WV towards the observed change is a weakness in the evaluation and final reports. There are examples of where some level of contribution has been fully analysed, however this is in the minority of cases. Consideration needs to be given to the level of information required by the community, WV and other actors into how rigorously we pursue the need for the counterfactual as well as balancing this with the need to fully understand the reasons for the positive or negative change.

CHILD PROTECTION

World Vision's focus on measuring child protection outcomes is relatively new and the extent and quality of the evidence about progress in our ADPs is therefore limited. As such it is difficult to draw conclusions about the second, third and fourth indicators of child protection (reduction in harmful traditional or customary practices, communities' response to violations, and birth registration) beyond the need to more intentionally address them as part of our programming, and systematically measure progress.

There is more systematic evidence on the first indicator (children who live a life free from neglect, violence and abuse) and indications of strong progress in most ADPs along with a portfolio of projects supported by the Programme Partnership Arrangement with DFID. A consistent theme emerges of the centrality of children's own empowerment and ability to demand their rights, and this impact report details significant achievements. As yet the data does not allow for a detailed exploration of whether progress in this indicator is related to this increase in children's empowerment, but as more systematic data emerges the challenge will be to evidence the link between World Vision's 'bottom up' approach to system strengthening and child protection outcomes. WVUK is working closely with the wider partnership on a four year learning and evidence building initiative to directly address this question.

HUMANITARIAN RELIEF

Applying the six criteria to assess the effectiveness of a humanitarian response has enabled a more systematic approach to understanding impact and to identify lessons learned from a broader evidence base. The results show that all major responses were effective across the six criteria and outstanding in the areas of 'Speed' and 'Accountability'. Relevance is also perceived to be high based on strong community assessments but rational of why a particular intervention was chosen over another was not always evidenced as well as it could be. World Vision UK's enhanced focus on resilience as a cross-cutting theme is apparent and growing with strong examples within the HARD, Pakistan and Philippine responses as well as throughout development programmes. A continued strategic focus on Resilience will result in this being a more prominent cross-cutting theme in future impact reports.

Roda, pictured here with two of her children, Shaban, six, and Abdi, 10, has received support from World Vision Somalia in rehabilitating two acres of her land with drought tolerant crops. She hopes that the crops, which mature faster, will provide her with a good yield from her land, and allow her to send all her children to school.

ELEVEN: RECOMMENDATIONS

The following recommendations are suggested, while recognising that many of these will take multiple years to complete and are largely already part of the World Vision UK strategy.

QUALITY OF EVIDENCE

- Continue to strengthen Terms of Reference for evaluations to ensure the evaluation will produce a rigorous piece of evidence that can be relied upon
- Ensure that evaluations explain in detail the causal links between the change that has occurred and the factors that have contributed towards this
- Produce a Value for Money study of the cost versus quality of the range of evaluations to ascertain the key factors that enable a high quality evaluation and undertake a cost-benefit analysis prior to each evaluation to ascertain if a minimum level of evidence is sufficient or whether additional investment will deliver a more robust piece of evidence and is required
- Emerging evidence that Community Validation is challenging evaluation results and providing enhanced depth is encouraging and should continue to be systematically built in to evaluations

IMPACT ASSESSMENT (DEPTH)

- Continue to assess at baseline and during evaluation, how and if contribution/attribution will be assessed. Question whether examining causality will be sufficient or should a counterfactual be established such as a control group or reference to secondary data
- Where possible establish cohorts for tracking and a matched control cohort for comparison
- Conduct ex-post evaluations (evaluation of impact, conducted after project completion) to assess the sustainability of the impact
- Continue to ensure that all programmes have an accurate baseline, including a comparison with national level statistics and suitable indicators at the correct level (output, outcome and impact), using suitable proxy indicators where this has not been the case. Ensuring the availability of adequate baseline data will also prevent using recall exercises at evaluation which are not very accurate.
- Ensure all programmes have a clear theory of change and that causal linkages have been researched and evidenced to enable stronger programming and assessment of effectiveness

EVALUATIONS & MONITORING DATA

- Continue to use the evaluation reports to provide the most in-depth evidence of impact but use annual monitoring data to track progress in child well-being data as a form of real-time assessment of impact to enable constant learning and review
- Baseline and evaluation design should be gender disaggregated as a minimum and further disaggregated by age, location and vulnerability where possible
- Continue to promote greater participation of children and communities in both the programme design and evaluation stages

STRUCTURE

- Structuring around the themes enabled an easier navigation of the report. However, there is strong evidence from the education sector, the social accountability approach and emerging evidence of resilience programming that is not highlighted. In 2013 this should be reviewed with stronger attention and focus within the themes to ensure this evidence is not buried
- Use a standardised tool for impact assessment within emergencies building on the lessons learned in 2012
- Include a Value for Money section to highlight the intentional application of these principles throughout our work

POLICY & CAMPAIGNS WORK

- Review and evaluate all policy and campaigns work in 2013 to enable lessons to be learned from both positive, negative and unrealised outcomes
- Ensure policy and campaigns work is baselined where applicable
- Develop a simple tool to support the evidencing of policy, advocacy and campaigning initiatives and work together with the wider World Vision partnership and other NGOs to improve documentation of impact.

ANNEX 1: CONCLUSIONS FROM EXTERNAL VALIDATION CONSULTANTS OXFORD POLICY MANAGEMENT ON THE 2012 REPORT

World Vision UK's Impact Report FY12 is the third externally available impact report and therefore continues World Vision's journey of reporting impact. As in previous years, this year's report aims to increase accountability and learning in terms of the impact of projects. World Vision has made specific attempts to address recommendations from last year's external validation: it has made changes to the structure of the report which makes it easier to navigate and has improved the use of clear terminology regarding methodology in relation to the distinction among outputs, outcomes and impact.

As in the last two years, overall the Impact Report is frank and open regarding the availability and assessment of evidence of impact. The report provides clear information of the coverage of World Vision UK's projects, or 'breadth of impact' (e.g. in terms of numbers of projects, countries and beneficiaries, etc). This year, it also uses a greater number of evaluations and final reports to assess the 'depth of impact for each of WV-UK's priority themes. In the four project case studies selected for review in this validation report, the evidence of impact was discussed where available and the conclusions drawn based on this data seem generally valid and do not appear exagerated or tenuous on the evidence available.

As each year, making changes to the methodology presents new challenges. For example while the revised structure improves the presentation of evidence, it has led to the exclusion of evidence in some areas that do not easily fit with WV-UK's priority themes. Far from being unimportant, these may in fact be new emerging areas or only be indirectly linked to WV-UK's priortity themes at a higher (impact) level.

The most important addition to this year's report is the endeavour to assess the robustness of evidence. This highlights a vital but challenging aspect of World Vision's commitment to report results of its work. Vital as quality of evidence is at the core of assessing impact, challenging as it will require mainstreaming of high-quality standards for the entire monitoring and evaluation cycle across its diverse programmes world-wide.

ANNEX II: RECOMMENDATIONS FROM EXTERNAL VALIDATION CONSULTANTS OXFORD POLICY MANAGEMENT ON THE 2012 REPORT

As last year, this year's Impact Report has made active attempts to incorporate the recommendations and this positive response to last year's recommendations is welcome—despite the long-term nature in addressing some of the challenges. The remainder of this section highlights four key recommendations:

The Impact Report by nature relies heavily on the quality of the individual reports and evaluations of ADP or humanitarian interventions. This year's Impact Report's initiative to assess the quality of evidence is therefore a valuable invention. The draft validation report included specific recommendations to strengthen the section "assessing the quality of evidence" (which could in the future be part of a revised methodology section) by providing more information on how evidence was assessed. The revised Impact Report responded to this recommendation and included further information on the process and importantly added the definition of the terms on which evidence was classified as "weak", "minimum" and "good" as an Annex to the Impact Report. This does enhance transparency for the benefit of the Impact Report's audience and could at the same time act as guidelines to assess the quality of evidence for the coming years.

Both previous validation reports recommended that projects should be well designed with logframes accurately and realistically reflecting the logic and causal chains; that indicators should be appropriate and measurable (including both proxy and qualitative indicators, where appropriate); and that regular monitoring occurs throughout the project implementation. Last year, World Vision's response to this correctly noted that this is a long-term investment and we would not expect any immediate changes following this recommendation. However, as these form an important basis for being able to conduct any evaluation of impact we would like to repeat this point again, whilst recognising the longer term nature of changes in this area.

Building on the recommendation above WV should consider strengthening its quality control throughout individual evaluations in order to achieve comparable quality in evaluations from different country programmes. The Impact Report's recommendations on "Quality of Evidence" rightly highlight the need to strengthen Terms of References as a basis of reliable evaluations. WV should make a careful assessment if in-house capacity is available to undertake the evaluations or if external support needs to be contracted (and how capacity can be built). Additional support and monitoring may be needed throughout the implementation of the evaluations and the production of their outputs.

Finally, we would recommend WV-UK to reconsider the use of the conceptual frameworks in this year's report, and perhaps plan to use them next year as a way to structure the evidence presented around the core themes of child health and protection. We also recommend that WV-UK considers developing theories of change to clarify the causal chains from inputs to outcomes and impact, and to frame the context as well as assumptions, in its evaluations, so that the concepts and terminology of inputs, outputs and impacts become ever sharper. This should also help in the systematic presentation of information on impact from individual evaluations in the Impact Report.

This page: Six-year-old, Joviah, Uganda, holding a mango seedling.

Back cover: 12-year-old sponsored girl Sumaia, playing with her friends, India.

For children. For change. For good.

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