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EVALUATION

EVALUATING THE COST AND QUALITY OF SERVICE DELIVERY FOR ORPHANS AND VULNERABLE CHILDREN BY INTERNATIONAL NON-GOVERNMENTAL ORGANIZATIONS AND LOCAL CIVIL SOCIETY ORGANIZATIONS IN RWANDA

April 2015

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April 2015

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ACRONYMS

9/12YBE	Nine- and twelve-year basic education
AEE	African Evangelistic Enterprise
AIDS	Acquired immune deficiency syndrome
CHW	Community health worker
CSO	Civil society organization
ECD	Early childhood development
EPR	Eglise Presbytérienne du Rwanda
FFS	Farmer Field Schools
FXB	François Xavier Bagnoud Foundation
GC	Global Communities
HCT	HIV counseling and testing
HES	Household economic strengthening
HICD	Human and Institutional Capacity Development
HIV	Human Immunodeficiency virus
IGA	Income generating activity
INGO	International non-governmental organization
IP	Implementing partner
ISLG	Internal Savings and Lending Groups
M&E	Monitoring and evaluation
NCC	National Commission for Children
NGO	Non-governmental organization
OVC	Orphans and vulnerable children
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PLHIV	People living with HIV
PMTCT	Prevention of mother-to-child transmission of HIV
PSS	Psychosocial support
SACCO	Saving and credit cooperative
TVET	Technical and vocational educational training
USAID	United States Agency for International Development
WASH	Water, sanitation, and hygiene
WHO	World Health Organization

GLOSSARY OF TERMS

While this evaluation report has employed U.S. Agency for International Development (USAID) and U.S. President’s Emergency Plan for AIDS Relief terminology (PEPFAR), a number of additional terms were introduced to support the evaluation. These terms acknowledge distinctions within the structure of programs, which offered a useful logic for analyzing quality and cost. These terms are presented in Table 1 below.

Table 1: Terms Employed in the Evaluation

Term	Definition
Service Categories	These are the categories of services provided by USAID implementing partners (IP) in Rwanda, i.e., education, household economic strengthening (HES), psychosocial support (PSS), health (medical care – not facility based), and nutrition and food security. These map approximately to the eight PEPFAR priority areas for orphan and vulnerable children programming.
Type of Intervention	Each service category includes a set of interventions. Education interventions include provision of school materials, payment of school fees (primary and/or secondary), and support to attend technical and vocational education training (TVET); HES interventions feature Internal Savings and Lending Groups (ISLG) prominently, although there is also limited support for forming cooperatives; nutrition and food security interventions include Farmer Field Schools and deviant hearth groups. Although IPs report PSS activities, the service category does not consistently feature distinct interventions.
Level of Support	Interventions may be delivered to differing extents. An education intervention may provide school materials only or both school materials and payment of school fees; ISLGs may be supported with basic startup materials or with both materials and financial capital. In addition, interventions may be supported by civil society organization staff and volunteers to differing extents, in terms such frequency of home visits over a particular time period.
Program Models	There are differences between IPs at a program design level, e.g., concentration of package of services per household or proportion of expenditure and effort invested in capacity development.

EXECUTIVE SUMMARY

EVALUATION PURPOSE, OBJECTIVES, AND QUESTIONS

In line with U.S. Agency for International Development (USAID) Forward priorities, the evaluation of cost and quality of orphan and vulnerable children (OVC) programs in Rwanda aimed to provide evidence to inform international and local partner implementation of USAID-funded OVC programs, with a view to identifying a high-quality, cost-effective OVC response in Rwanda. To that end, the evaluation objectives were to: 1) assess the quality of OVC services provided by USAID's implementing partners (IP); 2) analyze the costs incurred by international non-government organizations (INGO) and local civil society organizations (CSO) during delivery of OVC services; and 3) identify gaps in organizational capacity that need to be filled to ensure that delivery of quality OVC services continues to improve.

The evaluation purpose and objectives were operationalized in the following evaluation questions:

- To what extent do services to children meet the acceptable quality standards as defined by international standards, and Rwanda's relevant policies and guidelines?
- What is the geographic service coverage and number and type of beneficiaries served by the various components of the package to OVC and vulnerable households?
- Are the management systems including: planning, finance, monitoring and evaluation, contracting and grants making, and procurement systems, adequate and functioning to meet the service implementation demands of quality service delivery to OVC and vulnerable households?
- What are the best practices, lessons learned, and recommendations for OVC services, costs and efficiencies, as implemented by INGOs and CSOs in Rwanda?
- What are the costs associated with delivering services to children in Rwanda? Including:
 - What is the unit cost per child reached over a one-year period by priority area, intervention, and geography?
 - What is the total annual cost for program implementation?
 - What are the cost drivers by priority area, intervention, and geography?
 - What are the advantages and disadvantages in terms of costs of using one service delivery model over another?

PROJECT BACKGROUND

This project evaluated the entire USAID/Rwanda OVC portfolio encompassing five projects costing a total of US\$ 66,953,473 that began implementation from 2009 to 2012.

USAID/OVC programs in Rwanda seek to contribute to an AIDS-free generation by responding to the socio-economic and emotional consequences of HIV for children, their families, and the communities that support them. Two INGOs – FHI 360 and Global Communities (previously known as CHF International) – have been implementing HIV/AIDS activities in Rwanda since 2005. Global Communities concluded the implementation of the USAID/Higa Ubeho program in March 2015 and is commencing a new agreement for “Improved Services for Vulnerable Populations” (ISVP). The current agreement with FHI 360 is slated to close out by 2016. USAID/Rwanda has awarded projects to three local CSOs to implement OVC programs:

African Evangelical Enterprise-Rwanda (AEE), CARITAS Rwanda, and FXB Rwanda. The three CSOs have been operating these awards since September 2012.

USAID/OVC programs implement interventions in five service categories. More than half of current partner expenditures go to educational support, in the form of school materials and fees at primary, secondary, and vocational tertiary levels. Approximately one-quarter of partner expenditure is for household economic strengthening, based on the logic that strengthening households with the ability to generate and sustain income will allow beneficiaries to incrementally assume education and health insurance costs over the life of the program. The remaining expenditure is distributed as follows: 12% to nutrition and food security; 9% for psychosocial and spiritual care; and a small percentage for medical care. All USAID/OVC programs sensitize and closely monitor beneficiaries and make referrals to health and social services.

EVALUATION DESIGN, METHODS, AND LIMITATIONS

The evaluation was designed as an integrated mixed methods evaluation in that it addressed three distinct components (cost, organizational capacity, and quality) while combining evidence to arrive at overarching findings. The evaluation relied substantially on the review and analysis of secondary data, while generating primary data for corroboration and verification.

Quality Assessment Methodology

The evaluation's quality assessment adopted a criteria-based approach developed by the University Research Co., LLC and endorsed by international child development partners (PEPFAR, UNICEF, and USAID). This approach formulates criteria in ten Dimensions of Quality (see Appendix for definitions) informed by standards from Kenya, Namibia, and Uganda and integrates Government of Rwanda policies, especially the Integrated Child Rights Policy and the Early Childhood Development Plan. Using the tool to guide a desk review, data was collected from IP project documents and reports, supplemented with primary data from discussions with IPs, and verified in the field through focus group discussions and site visits with beneficiary representatives and project staff.

Costing Methodology

To improve understanding of the IP costs associated with providing OVC services, the evaluation team collected and analyzed financial and program data from USAID/Rwanda OVC partners and integrated analysis of this data with information gathered in field visits and interviews. The financial and program data provided extensive detail about costs associated with delivery of OVC services. In most cases, service costs not funded by USAID, including costs associated with community volunteer caregivers, were included in the IP cost share required by the cooperative agreements. The detailed financial reports were compared to data reported for the PEPFAR Expenditure Analysis (EA)¹ and were, in all cases, consistent with EA data.

Capacity Assessment Methodology

A desk review of organizational capacity assessments (OCA) of local CSOs—prepared by HICD, which is implementing the organizational development program for local IPs—provided the initial data set for this component. Capacity assessment scores and progress made toward

¹ Expenditure analysis data show what PEPFAR funds were used for in each country/region according to major and detailed cost categories.
<http://www.pepfar.gov/funding/c63793.htm>

implementing capacity development plans were extracted from HICD reports for each organization. The secondary analysis was complemented by primary data gathered from interviews conducted at IP headquarters, guided by an adapted version of the OCA (developed for USAID’s New Partner Initiative project and now a standard methodological framework for organizational capacity assessments). Interviews were conducted with international partners (FHI and Global Communities) to review their capacity development tools and how these contributed to OVC programming for sub-recipients.

Limitations

- The timing of the evaluation resulted in site visit options being curtailed because of the close-out of Higa Ubeho.
- PEPFAR service categories—education, food security and nutrition, household economic strengthening, medical care (not facility-based), and psycho-social support—each embrace a wide range of interventions, resulting in cost averages across very dissimilar services. The value of unit cost calculations is therefore questionable.
- Data routinely collected by IPs lacks the detail required to determine a meaningful cost-per-beneficiary finding.
- The ultimate arbiter of the quality of OVC programs is the achievement of outcomes for children. Outcome- and impact-level evaluation results were not available for most partners and therefore a conclusive statement on the comparative quality-for-cost of OVC programming across local CSOs and INGOs was not possible.

FINDINGS AND CONCLUSIONS

What is the geographic service coverage and number and type of beneficiaries served by the various components of the package to OVC and vulnerable households?

In FY2014, USAID/Rwanda IPs provided OVC-related services to approximately 143,091 beneficiaries in 27 out of 30 districts. The geographic coverage is almost ubiquitous, although there is substantial variation in numbers reached per sector. While HIV prevalence is increasingly a factor in geographic coverage, it should be noted that with the exception of the Kigali City region, HIV prevalence is fairly uniform across provinces.²

To what extent do services to children meet the acceptable quality standards as defined by international standards, and Rwanda’s relevant policies and guidelines?

All IPs exhibit some aspects of a quality intervention and some areas requiring quality improvement. INGOs implement through local organizations while simultaneously building the capacity of the local organizations to implement as planned. Local sub-partners of INGOs did not consistently implement at either higher or lower quality than other local CSOs at site level.

Table 2: Priorities for Quality Improvement

Term	Action for Quality Improvement
Safety	<ul style="list-style-type: none"> • All partners (with the exception of AEE) lack child protection policies. Such policies need to be developed.

² Rwanda DHS 2010

Effectiveness	<ul style="list-style-type: none"> • All IPs need to comprehensively track children’s progress through school. • Standardized tools for assessing progress and outcomes in other areas such as early childhood development (ECD) and household economic strengthening need to be adjusted to correspond to MER 1.5 indicators. • Partners providing ECD services with non-PEPFAR funds need to explore ways to integrate these into current programs.
Technical performance	<ul style="list-style-type: none"> • All partners need to assess and update gender training materials in line with PEPFAR and Government of Rwanda guidelines and to ensure all staff and volunteers receive the appropriate exposure to the guidelines. • Partners (Caritas, Global Communities) providing ECD interventions need to establish minimum levels of frequency, duration, and service quality.
Efficiency	<ul style="list-style-type: none"> • Education support interventions need to be critically reviewed and alternatives, such as block grants, need to be explored. • AEE and Caritas need to develop a household assessment tool to determine areas of critical need.
Continuity	<ul style="list-style-type: none"> • AEE and Caritas require written agreements with local clinics and other service providers to establish how referrals are tracked.
Appropriateness	<ul style="list-style-type: none"> • Provision of sexual and reproductive health information should be supported with job aids. • AEE needs to assess and address personal HIV risks faced by Catch-Up students. • Caritas should explore how best to integrate early childhood stimulation into nutrition demonstrations.

Are the management systems including: planning, finance, monitoring and evaluation, contracting and grants making, and procurement systems, adequate and functioning to meet the service implementation demands of quality service delivery to OVC and vulnerable households?

While basic management capacities, which are included in current capacity development programs, support implementation of programs at site level, these do not sufficiently equip CSOs to assume the role that INGOs currently play. The key capacities differentiating INGOs and CSOs must be developed among local organizations in order to facilitate transition. These include the capacity to implement programs to scale, the capacity to generate and disseminate knowledge, and the capacity to adapt programs to respond rapidly and effectively to changes in the implementation environment.

What are the costs associated with delivering services to children in Rwanda?

What is the unit cost per child reached over a one-year period by priority area, intervention and geography?

This evaluation provides a number of cost-per-child calculations by service category (see Table). The evaluation also found, however, that the data required to produce cost-per-child

calculations at the level of detail required for accurate and useful cost analysis is not currently available. There are two primary reasons for this:

- OVC programming serves children directly or indirectly through services to households and the caregivers of children. In order to attribute the cost of serving households and caregivers to a child an additional level of data would be required, i.e., the number of children in the household or under the care of the caregiver. This data is not routinely recorded by IPs. The adoption of a case management approach in mechanism design would address this data gap.
- There is no generic OVC entity that benefits from OVC programming. Instead there are a number of age categories of children that receive a different blend of interventions within service categories and the costs associated with those interventions vary significantly. The level of detailed data required would distinguish individual children on the basis of age categories and specify the particular blend of interventions each child received.

As a result of this lack of data, any cost-per-beneficiary calculated—even with a service category—is insufficient for reliable decision-making.

What are the cost drivers by priority area, intervention and geography?

Evidence from the evaluation demonstrates that the key cost drivers of delivering services to children are:

- *Partner program models.* Global Communities, the larger of the two INGOs, invests almost one third of their expenditure in building sub-partner capacity to deliver interventions to standard. FXB shows a higher cost for beneficiary numbers reached compared to the other local CSOs because its program model dictates the delivery of a comprehensive blend of interventions for each child in their program.
- *The blend of interventions and level of support.* The type of interventions children receive within a service category accounts for the most important variances in the cost of support for a child. The type of intervention a child receives is associated with the immediate needs of the age group in which they fall. A very young child will be eligible for support to attend an early childhood development program, while an older child would be eligible for support to attend secondary school. In the case of the older child, the amount of costs incurred would depend on if the support is for boarding school fees (more expensive) or for day school fees (less expensive).

What are the advantages and disadvantages in terms of costs of using one service delivery model over another?

This evaluation could not reach a conclusion about service delivery models based on costs, for two reasons:

- A credible method for assessing cost depends on the availability of data that is not currently documented systematically.
- The most crucial basis for determining the better model – evidence of efficacy – is not currently available because not all mechanisms in the OVC portfolio have been evaluated for outcomes and impact. An assessment of quality would not provide a clear

and credible distinction in quality across partner categories to substitute for a proper measure of outcomes and impact.

What are the best practices, lessons learned, and recommendations for OVC services, costs and efficiencies, as implemented by INGOs and CSOs in Rwanda?

- The integration of OVC services by Rwandan IPs is notable and commendable. ISLGs serve multiple purposes, such as improving saving for children’s health and education expenses, building self-esteem and self-efficacy among members, and providing a platform for community information, action, and incentives for community volunteers. The Global Communities model that has been taken up by local non-governmental organizations (NGOs)—combining Farmer Field School techniques with ISLG, positive deviant hearth practices, and inputs for educational support—is felt to be a strong package of support enabling improved health and wellbeing of all family members.
- According to participants in focus group discussions, the use of local volunteers to regularly visit homes and talk with children and parents is a replicable and highly appreciated approach. These volunteers serve as a link between the family, community health workers, and other government community workers. The volunteer is aware of the family reality and can intervene or make referrals for those on ARVs, those who have not been tested, those requiring nutritional support, those not in school, and those children who are malnourished. A wide range of issues are thus addressed with this approach, including child care, sexual and reproductive health, improvements in the home, and reinforcement of the importance of education.

RECOMMENDATIONS

Quality Improvement

The newly awarded ISVP should consider facilitating development of quality standards for OVC services in Rwanda, including key interventions such as education support, household economic strengthening, and early childhood development. After quality criteria are designed for different service interventions, individual IPs can then undertake guided self -assessments to inform quality improvement plans. The Government of Rwanda should be engaged as a partner in this process to determine their level of interest in taking the development of quality standards further.

Education Support

USAID/Rwanda should convene a meeting with all its IPs to determine the most appropriate intervention methodology for its education support. The meeting could consider the following questions:

- Is paying for school materials and school fees for individual children the most efficient mechanism for supporting OVC educational outcomes? Would other approaches be acceptable, such as block grants to schools that provide fee exemptions for vulnerable children? What other mechanisms are appropriate for Rwanda?
- What are the current models for ECD programs implemented by partners (with and without PEPFAR funding) and who accesses these? What promising high-quality, cost effective models for providing essential ECD interventions to vulnerable families are already being used in Rwanda?

Case Management

All of the IPs work in close collaboration with cell, sector, and district officers to identify the most vulnerable and needy families and children that meet criteria and are provided services. Given the high percentage of people living in poverty in Rwanda and the many needs faced by severely poor children and those affected by HIV, it is important to develop and strengthen the case management system of IPs so that urgent needs can be met, referrals can be made and followed through, and resources can be allocated efficiently. IPs do keep some records of children and families visited and of the services received. Two areas particularly can be strengthened: A) a standard operating procedure for referrals, perhaps through a memorandum of understanding with clinics; and B) case plans, perhaps through monitoring and modification as actions are completed and goals achieved.

Gender Mainstreaming

A clear process of mainstreaming gender in organizational capacity should be developed. This will help identify-organization level gaps. It is equally important that OVC needs assessments identify gender factors that increase the vulnerability of adolescents and children and how these can be addressed during implementation. The varying experiences and needs of boys and girls should be better articulated and addressed in each key area of support. These are specified for sexual and reproductive health; HIV prevention and health; PSS and addressing gender-based violence provided by community volunteers; education, including TVET; nutrition and early childhood development; ISLG; and income generating activities.

Monitoring and Evaluation

The quality of OVC programs must ultimately be judged in terms of their effectiveness in achieving outcomes for children. While the monitoring of these programs is useful, neither PEPFAR Level 1 nor the 9 Essential Indicators provide USAID/Rwanda with outcome-level assessments of interventions. USAID evaluation standard operating procedures, as described in the USAID evaluation policy, should be adopted and consistently implement for all OVC mechanisms. This will result in credible data being available to inform accurate and useful quality and cost analyses.

Assessing and Tracking Cost per Child Served

Accurately assessing cost per child served is crucial for informed planning that completes transition of the OVC response in Rwanda. It also has more immediate utility in that it can deliver critical program management data to support implementation, especially if a case management approach to OVC programming is to be adopted.

An appropriate methodology would recognize that there is no generic OVC entity, but that children served fall into multiple categories differentiated by their intervention needs (which tend to be age group related) and distributed across service categories. The cost-per-child methodology would also account for the qualifying of results by level of support received.

Capacity Building for Transition

Capacity building programs for local CSOs should be revised to include the building of key capacities that differentiate INGOs from local CSOs and that will equip the latter with the abilities needed to assume the implementation of large-scale mechanisms in the future. In addition to the enhancement of basic management skills (which existing programs tend to focus on), a future capacity building curriculum should also include development of:

- the capacity to manage substantial grants and implement large-scale mechanisms, which is the key differentiating capacity between INGOs and local CSOs;
- the capacity to generate and disseminate credible knowledge to influence policy and programming outside of the partner’s current activities; and
- the capacity to mobilize resources for adjusted program implementation in response to changing circumstances in the implementing environment.

Balance of INGOs and CBOs in Delivery of PEPFAR-Funded OVC Programs

The ISVP has already been awarded to Global Communities, which will implement through a two-tier system of local sub-partners. Evidence from this evaluation suggests that this particular model is currently the best option to address the transitioning priority. Three reasons emerge from the evaluation evidence to support this recommendation:

- INGOs have played an important role in building the capacity of local CSOs to deliver at site level and to improve management systems to the level required to successfully support technical delivery of programs.
- Evaluation evidence suggests that key capacities for transition that distinguish INGOs from local CSOs have not yet been sufficiently incorporated into capacity development programs for local CSOs, suggesting a lack of readiness for total transition. INGOs also play a substantial role in managing implementation of mechanisms through multiple local CSOs. If USAID/Rwanda were to adopt a model of implementation through multiple local CSOs, the administrative and management responsibilities and cost would shift—possibly to the Mission.
- The cost advantages that may be realized when transition is complete are not clear as of yet, because a valid costing methodology must still be implemented. Appropriate data must be routinely collected, analyzed, and used to inform planning for transition.

I. INTRODUCTION

EVALUATION PURPOSE AND OBJECTIVES

In early 2015, the United States Agency for International Development (USAID) commissioned an evaluation of the quality and cost of services delivered to orphans and vulnerable children (OVC) in Rwanda. Initial data collection took place from 10-25 February 2015, followed by data analysis and report writing from 14-30 April. The purpose of the evaluation was to provide evidence to inform a balancing of local and international partner implementation of OVC programs in Rwanda and, ultimately, support decision-making by USAID/Rwanda and the Government of Rwanda about the transition of OVC service delivery to local civil society organizations (CSOs). A motivating factor behind the evaluation was uncertainty about how transition would influence the sustainability of the national response, the cost of services to children, and the quality of services delivered.

Localizing the national response is critical to the USAID Forward agenda, which prioritizes results-oriented and innovative development solutions, as well as sustainability. The decision by USAID/Rwanda and the Government of Rwanda to transition OVC service delivery to local CSOs stems from the assumption that increased local ownership of HIV/AIDS programs will, in the long term, result in a more sustainable national response to challenges confronting OVC. Diminishing funding by the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) globally and the consequent imperative to find the most cost-effective interventions for children in a local setting exacerbate the necessity for such a transition. The objectives of USAID Forward, however, and the imperative to address the costs of OVC service delivery are both matched by a need to ensure that the quality of OVC services are not only maintained but continue to improve. Transitioning the responsibility of services for children and families, delivered or supported through USAID/Rwanda implementing partners (IPs), necessarily implies transitioning the capacity to deliver those services.

Therefore the three objectives of the evaluation were: 1) to assess the quality of OVC services provided by USAID IPs in Rwanda; 2) to better understand the costs incurred by international non-governmental organizations (INGOs) and local CSOs to deliver OVC services; and 3) to identify the organizational capacity gaps that need to be addressed to ensure that delivery of quality OVC services continues to improve.

The evaluation aimed to provide an overview of the current quality of services being delivered through IPs and identify quality improvement priorities, especially for local CSOs. It would also inform the organizational development priorities for strengthening local CSOs to improve the quality of services to children, with a view to ultimately transition the OVC response. An analysis of costs associated with delivering services to children would also contribute to an informed and realistic understanding of the investment required to realize the improvement of prospects for OVC in Rwanda.

EVALUATION QUESTIONS

The evaluation purpose and objectives was operationalized in five evaluation questions addressing quality and cost of services for children and the organizational capacity of IPs to deliver those services. The cost question included four sub-questions. The evaluation questions are presented in Table 3.

Table 3: Evaluation Questions by Objective

Evaluation Question	Purpose/Objective
1. To what extent do services to children meet the acceptable quality standards as defined by international standards, and Rwanda’s relevant policies and guidelines?	Quality
2. What is the geographic service coverage and number and type of beneficiaries served by the various components of the package to OVC and vulnerable households?	Overarching
3. Are the management systems (including planning, finance, monitoring and evaluation, contracting and grants making, and procurement systems) adequate and functioning to meet the service implementation demands of quality service delivery to OVC and vulnerable households?	Capacity
4. What are the best practices, lessons learned, and recommendations for OVC services, costs and efficiencies, as implemented by INGOs and CSOs in Rwanda?	Quality and cost
5. What are the costs associated with delivering services to children in Rwanda?	Cost
A. What is the unit cost per child reached over a one-year period by priority area, intervention, and geography?	
B. What is the total annual cost for program implementation?	
C. What are the cost drivers by priority area, intervention, and geography?	
D. What are the advantages and disadvantages in terms of costs of using one service delivery model over another?	

ORGANIZATION OF THE DOCUMENT

The Project Background section of this report provides an overview of the context informing the evaluation. A brief discussion of the evaluation methodology and its limitations is then presented, followed by the presentation of key findings. Findings are arranged in terms of the evaluation objectives, namely to:

- assess the quality of OVC services provided by USAID’s implementing partner organizations;
- analyze the costs incurred by INGOs and local CSOs to deliver OVC services; and
- identify the organizational capacity gaps that need to be addressed to ensure that the delivery of quality OVC services continues to improve.

Evaluation questions are responded to in a concluding discussion that draws from the findings. The conclusions are followed by a brief, substantiated set of recommendations.

II. PROJECT BACKGROUND

This section provides an overview of the implementation context and the USAID/Rwanda OVC portfolio. The project background informs the analysis of evidence and subsequent conclusions of the evaluation, particularly in light of USAID Forward priorities and the overarching purpose of the evaluation.

USAID FORWARD

USAID Forward, an initiative launched in 2010 by then-Administrator Rajiv Shah, focuses on three main areas: 1) use of a results-oriented targeted approach to development; 2) promotion of sustainability through increased direct investment in partner governments and local organizations; and 3) identification and scale-up of innovative, breakthrough solutions to development challenges. As part of the effort to advance this initiative, USAID/Rwanda is prioritizing the shift of OVC service delivery from INGOs to local CSOs. This decision has implications not only for the sustainability of the national response, but also for the cost of services to children and, potentially, the quality of delivering those services.

The objectives of USAID Forward and the imperative to address the costs of OVC service delivery are both matched by the need to ensure that the quality of OVC services are not simply maintained but continue to improve. The rationale of linking quality, cost, and capacity can be articulated in the following terms.

The capacity of IPs to deliver quality services is the key consideration for partnering with an organization. Services to OVC must be of such a level of quality that, provided implementation is not significantly undermined by unexpected exigencies, we would expect outcomes for children to be achieved. If there is no expectation that the organization is capable of achieving outcomes, then they are not an appropriate choice of partner. It is assumed that the capacity of an organization to effectively manage processes that support implementation is predictive of the likelihood of achieving outcomes for children. Any deficits in the organization's ability to govern, plan, manage finances, and monitor implementation represent a risk to effective program implementation and would presumably undermine the achievement of outcomes.

All things being equal the comparative cost of delivering quality services to children becomes a prime consideration in the balance of local and international partner implementation. It is critical, however, to acknowledge that a simplistic cost analysis that does not distinguish the cost of services from the cost of quality services is misleading and would not provide useful evidence for decision-making. This evaluation acknowledges the importance of quality in the consideration of cost of services by combining the assessments of cost and quality in a single study. As this type of combined review becomes more frequent, a consistent methodology for assessing the cost of effective interventions for OVC should emerge. Recommendations toward such a methodology are included in this report.

OVC IN RWANDA

Rwanda has a young population, with children accounting for 48 percent of the total resident population (NISR, Rwanda Fourth Population and Housing Census, 2012). Since 2005, Rwanda has made considerable progress in reducing child mortality (children under 5 years of age) from

152 per 1,000 live births in 2005 to 76 per 1000 live births in 2010 (RDHS, 2010). Malnutrition is one of the major causes of infant, child, and maternal morbidity and mortality and data indicates that 44 percent of young children under five years of age are stunted, the highest level being 55 percent for children aged 18-23 months (RDHS, 2010).

The country experiences a mixed HIV epidemic, generalized in the adult population at approximately 3 percent prevalence and concentrated in key populations (e.g., female sex workers). Prevalence in 2010 was higher among women (3.7 percent) than men (2.2 percent) and higher in urban than in rural areas, at 7.3 percent and 2.2 percent respectively. Mother-to-child transmission is down to 2.9 percent for HIV-exposed infants at 18 months of age. About 213,924 adults and 21,426 children are estimated to be living with HIV (EPP Spectrum estimations, 2014). Eleven percent of children are single- or double orphans (2012 Census) and there are an estimated 100,000 AIDS orphans (EPP Spectrum estimations, 2014).

Educating girls continues to be an important strategy for economic growth and improved population health. The percentage of women who have begun child bearing between the ages of 15-19 (i.e., as teenagers) is 24 percent: 9 percent of women with no education, 6.1 percent of women with primary education, and 3.6 percent of women with secondary education. The primary net enrolment rate is 96.5 percent, while the upper secondary net enrolment rate is only 25.4 percent. There is still a low (52.5 percent) completion rate of basic education and it is likely that poverty is a significant cause of this poor result (2012 Education Statistics Yearbook, Ministry of Education, Rwanda, February 2012).

Services directed toward OVC and people living with HIV (PLHIV) act as the primary entry point for targeting vulnerable households in an integrated manner. Recognizing the need for coordination and consistency in Government interventions for children, the Government of Rwanda through the Ministry of Gender and Family Promotion (MIGEPROF) developed the Integrated Child Rights Policy (ICRP), a comprehensive national document, detailing Rwanda's vision and commitment to all children. The National Commission on Children (NCC) is committed to improving services to vulnerable children and ensuring that their rights are met through the provision of basic needs and services for all children in the country.

The current re-integration of children from orphanages into families has been successful and has highlighted the importance of trained psychologists and social workers for this intensive intervention. These cadres will eventually be deployed to districts in Rwanda and will be supported by community child protection workers.

At community level there is a high degree of coordination between the different government extension workers, including community health workers (CHW). Likewise there is good vertical coordination from district to sector to cell level. Data on vulnerable families is made available down to cell level. All partners are expected to work with the government cadres and systems. USAID OVC IPs all reported working with district and sector staff to identify vulnerable families to be served, using the poverty categories (Ubedehe 1 and 2) with a focus on families and children affected by HIV.

OVERVIEW OF OVC PORTFOLIO

Implementing Partners and Program Models

OVC programs in Rwanda contribute to the achievement of an AIDS-free generation by responding to the socio-economic and emotional consequences of the disease on children, their

families, and communities that support them. In so doing, this helps to break the vicious cycle of vulnerability, increases access to health care, and reduces loss to follow-up.

Five prime partners implement the OVC program for USAID/Rwanda. Three of the partners are CSOs: African Evangelical Enterprise-Rwanda (AEE), CARITAS Rwanda, and FXB Rwanda. The other two partners are INGOs (FHI 360 and Global Communities). The international organizations, Global Communities (previously known as CHF International) and FHI 360, have been implementing HIV/AIDS activities in Rwanda since 2005.

USAID/Rwanda concluded a previous cooperative agreement with Global Communities in March 2015 and is commencing a new agreement with them for the Improved Services for Vulnerable Population (ISVP) activity. The current agreement with FHI 360 is planned to close out by 2016.

The three CSOs have been operating their awards since September 2012 and are being granted extensions beyond the original end of September 2015. Two of the CSOs (AEE and Caritas) were previously sub-grantees of Global Communities before graduating to direct USAID funding. FXB Rwanda became a registered national non-governmental organization (NGO) in 2012, having previously been part of FXB International.

Table 4: Summary of Implementing Partner Programs

International Organizations		
Implementing Organization	FHI 360	Global Communities (CHF)
Project	ROADS TO A HEALTHY FUTURE (ROADS III)	Support Services for Vulnerable Populations in Rwanda (HIGA UBEHO)
Project Dates	October 2013-September 2016	November 16, 2009 – February 28, 2015
Project Funding	US\$ 7,500,000	US\$ 50,557,766
Districts/Sectors	7 Districts / 48 Sectors	19 Districts / 146 sectors
Beneficiaries reached in 2014	<ul style="list-style-type: none"> • 2580 active beneficiaries served by PEPFAR OVC programs for children and families affected by HIV/AIDS • 1780 active beneficiaries received support from PEPFAR OVC programs to access HIV services • 186 providers/caretakers trained 	<ul style="list-style-type: none"> • 76,130 active beneficiaries served by PEPFAR OVC programs for children and families affected by HIV/AIDS • 39,370 OVC served by OVC program • 1,609 providers/caretakers trained in caring for OVC • 75,125 households provided with a minimum of one care service

Distinctive aspect of program model	ROADS III targets key and vulnerable populations. In Rwanda that includes commercial sex workers and their clients, long distance truckers, fisher folk, and OVC often related to the key populations served. The program has a strong prevention orientation and has costs linked to reaching beneficiaries that are difficult to access. ROADS III worked through local partner organizations.	Higa Ubeho was the largest OVC activity, led by an INGO that provided capacity development for ten local NGOs to implement at site level. Up to 50% of the implementing budget was assigned to capacity building activities, including training and supervision, with implications for both cost and quality. Higa Ubeho promoted and tested an integrated and mixed service model with an emphasis on household economic strengthening through internal savings and loans groups (ISLGs).	
Local Rwandan Civil Society Organizations			
Implementing Organization	CARITAS - Rwanda	African Evangelical Enterprise (AEE) - Rwanda	FXB - Rwanda
Project	Strengthening Support to Vulnerable Populations in Rwanda (GIMBUKA)	Strengthening Support to Vulnerable Populations in Rwanda (UBAKA EJO)	Strengthening Civil Society To Support Vulnerable Populations in Rwanda (TURENGERE ABANA)
Project dates	September 12, 2012 – September 11, 2015	September 12, 2012 – September 11, 2015	September 12, 2012 - September 12, 2015
Project Funding	US\$ 4,655,281	US\$ 2,150,000	US\$ 2,090,426
Districts/Sectors	14 Districts / 112 Sectors	12 Districts / 45 Sectors	7 Districts / 14 sectors

<p># of beneficiaries reached in 2014</p>	<ul style="list-style-type: none"> • 15,163 OVC served by OVC program • 82,775 adults and children provided with a minimum of one care service • 20,494 people reached by an individual, small group, or community-level intervention or service that explicitly aims to increase access to income and productive resources of women and girls impacted by HIV/AIDS 	<ul style="list-style-type: none"> • 14,500 OVC served by OVC programs • 14,744 eligible adults and children provided with psychosocial support (PSS) • 16,519 reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required • 1678 eligible adults and children provided with nutrition services • 4491 people provided with economic strengthening services • 2870 children provided with health care referral services 	<ul style="list-style-type: none"> • 9960 OVC served • 62,449 adults and children provided with a minimum of one care service • 1160 providers/ caretakers trained in caring for OVC • 459 community volunteers who completed pre-service training • 1160 households reached with a minimum of one care service
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Distinctive aspect of program model	Caritas is a faith-based local organization, part of the Roman Catholic Church. There are Caritas volunteers at parish level, some of who are supported by the Gimbuka program. As a previous sub-partner of Higa Ubeho, Caritas follows a similar intervention model with a greater focus on nutrition for lactating and pregnant women living with HIV/AIDS.	AEE is a faith-based umbrella organization for protestant churches. As a previous sub-partner of Higa Ubeho they follow a similar intervention model based on strengthening household resilience through health, social and economic service provision, and nutritional and educational support. AEE is the only partner supporting an education catch-up program for out-of-school youth.	FXB recently became an independent local organization (2012). It uses the FXB International model of village support and receives some technical support from FXB International. Their interventions are focused on fewer districts and fewer families with more intensive support, including early childhood development programs not funded by USAID/Rwanda. This model has implications for costs and presumably the outcomes per individual beneficiary.
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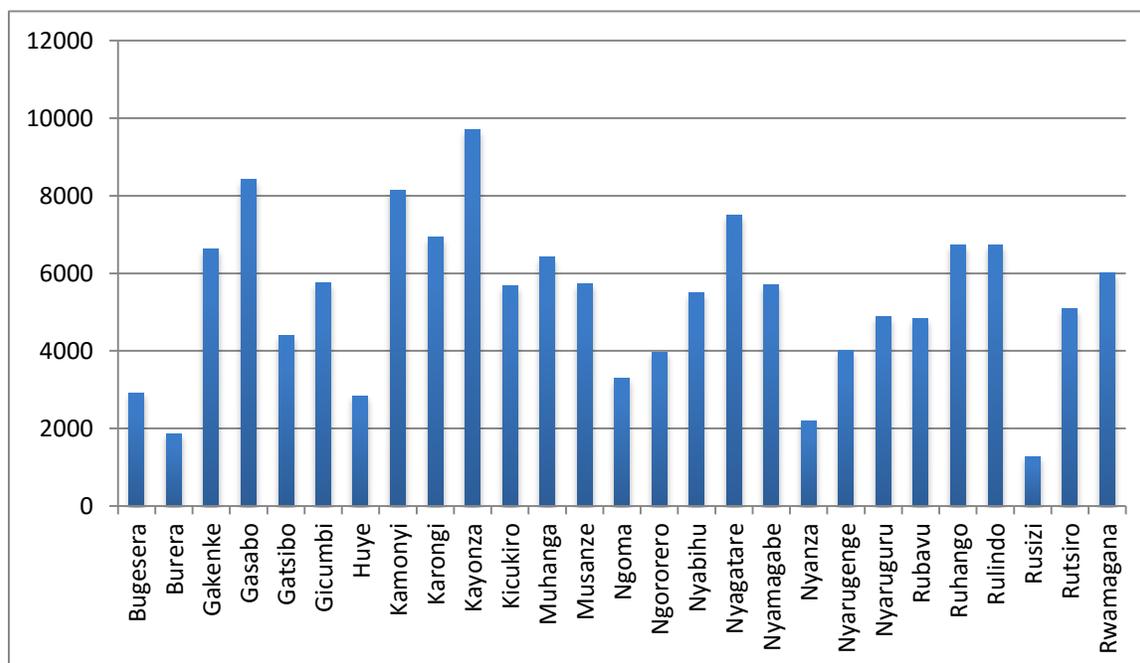
Geographic Coverage and Reach

In FY2014, USAID/Rwanda IPs implemented OVC interventions in 27 out of 30 districts, across all four provinces and the Kigali City region. Geographic coverage is almost ubiquitous, without much differentiation based on geographic HIV prevalence rates. While there is increasing consideration of the geographic distribution of HIV/AIDS in programming choices it should be remembered that apart from the high concentration of prevalence in the Kigali City region (7.3 percent), HIV prevalence occurs fairly uniformly across Rwanda’s provinces (ranging from 2.1 percent to 2.7 percent)³. As indicated in Figure 1, the number of beneficiaries reached may vary substantially from one district to the next; however, there are no systematic programming decisions that explain the variation consistently. Instead the variation reflects decisions taken by each IP based on the priorities at the time and the limitations of each IP – such as their operational reach.

Table 4 shows the reach of each IP in terms of beneficiary numbers. Global Communities, the recipient of the largest proportion of USAID/Rwanda OVC funding, reaches the most beneficiaries. FHI 360, recipient of the second largest proportion of funding, reaches the fewest OVC beneficiaries. Roads 2 is primarily a prevention program, however, with OVC representing a small proportion of the intended beneficiary population. Caritas, recipient of the third largest proportion of funding, reaches a substantially larger number of beneficiaries than the other IPs, with the exception of Global Communities. As a faith-based CSO, Caritas makes effective use of the congregational system to achieve its numbers.

³ Rwanda DHS 2010

Figure I: OVC Program Beneficiaries by District



Source: 2014 PEPFAR Expenditure Analysis

Expenditure by Service Categories

More than half of current partner expenditures go to educational support, in the form of school materials and fees at primary, secondary, and vocational tertiary levels. While education is officially free in Rwanda for 9- and 12-year basic education for day scholars (9/12YBE), schools pass costs on to parents in a variety of payment obligations that are not formally presented as school fees. Education currently represents a significant cost burden to families and is set to increase with the recent policy directive from the Government of Rwanda making school feeding compulsory (another cost that schools will pass on to parents). Evidence is strong that prolonging education leads to delay of sexual debut, especially for girls, and contributes to HIV prevention.⁴ Educational support is an inflexible service category in that costs are fixed, fairly high in sum, and not consistently supplemented with any significant value adding features, such as interventions to support academic performance. Community volunteers conduct school monitoring visits and home visits.

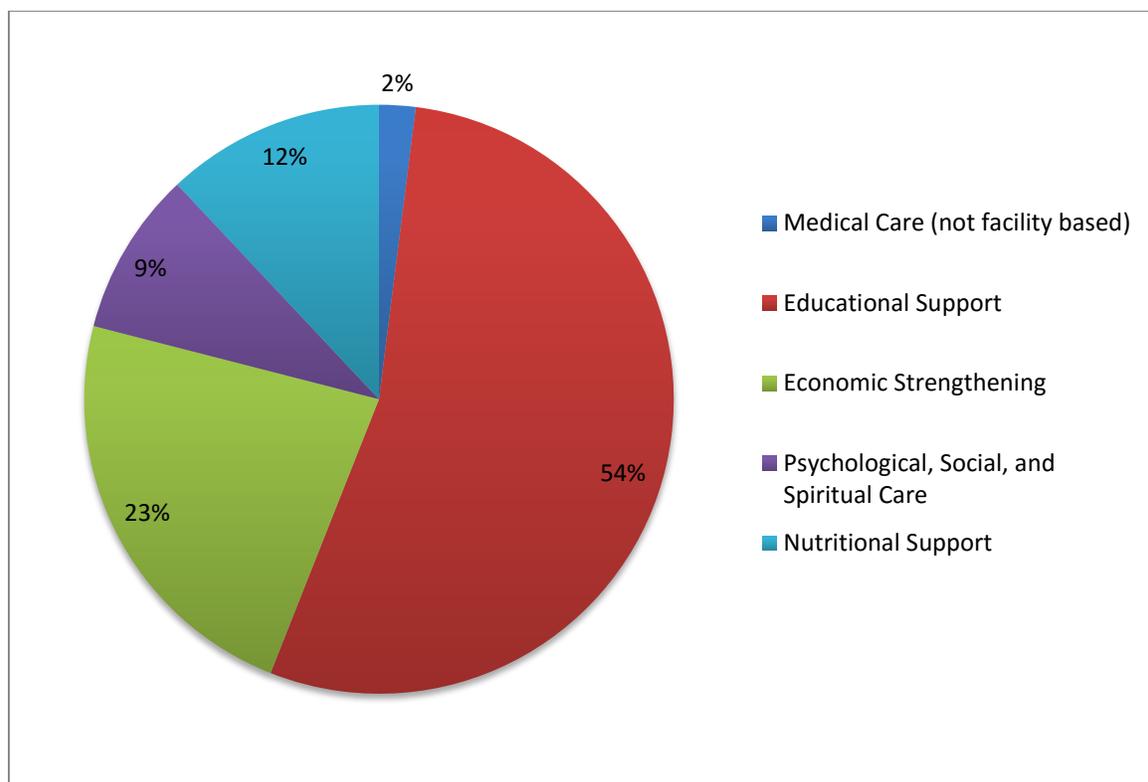
⁴ Blackett-Dibinga K, Anah K, Matinhure N. (2006). Innovations in Education: The role of the education sector in combating HIV/AIDS. Africare: Office of Health and HIV/AIDS; Bryant M, et al. (2011) Evaluating the Effectiveness of Educational Block Grants to Orphans and Vulnerable Children. USAID Project SEARCH Research Report: Boston University OVC-CARE Project. Cho H, Hallfors DD, Mbai II, Itindi J, Milimo BW, Halpern CT, Iritani BJ. (2011). Keeping Adolescent Orphans in School to Prevent Human Immunodeficiency Virus Infection : Evidence From a Randomized Controlled Trial in Kenya. J Adolesc Health. 48(5), 523-526. Epub 2011 Feb 18.

Approximately one-quarter of partner expenditure is assigned to household economic strengthening. The model inherited from Higa Ubeho follows the logic that strengthening households with the ability to generate and sustain income will allow beneficiaries to incrementally assume education and health insurance costs over the life of the program; however, partners report challenges in realizing this outcome. Figure 3 shows that all partners implement interventions in the Education and Household Economic Strengthening (HES) service categories.

The remaining expenditure is distributed as follows: 12 percent is allocated for nutrition and food security; 9 percent for psychosocial and spiritual care, which reduces vulnerability to infection and may contribute to adherence to ART treatment; and a small percentage is allocated for medical care (not facility-based), which in the context of OVC programming in Rwanda refers to the payment of medical insurance (“mutuelle santé”). Only three of the five IPs record expenditure in these three service categories, however, namely the two INGOs and FXB. The FXB program model dictates that a comprehensive blend of interventions be delivered to each beneficiary.

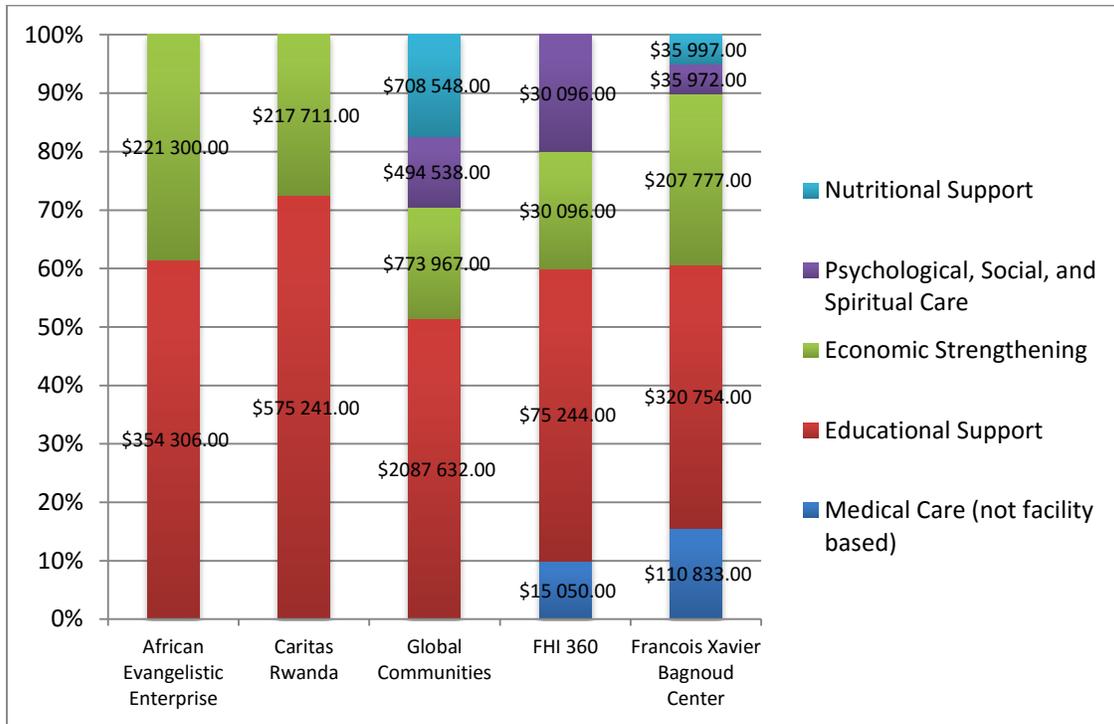
All the OVC programs sensitize and closely monitor beneficiaries and make referrals to health and social services. In addition, they ensure that increased income from household economic strengthening is partly used to purchase health insurance.

Figure 2: Average Partner Expenditure across Service Categories



Source: 2014 PEPFAR Expenditure Analysis

Figure 3: Proportional Expenditure across Service Categories by IP



Source: 2014 PEPFAR Expenditure Analysis

III. EVALUATION METHODS AND LIMITATIONS

This section presents a summary of the evaluation's methods and limitations.⁵

EVALUATION DESIGN

The evaluation design represents an appropriate response to the evaluation purpose and objectives within the constraints inherent in the implementation context, budget, and timeline. It is conceived as an integrated mixed methods evaluation in that it consists of three distinct components (quality, cost, and organizational capacity) while integrating evidence for overarching findings in the final analysis. It also takes into consideration program results as reflected in monitoring data, annual reports, and program evaluations. The evaluation relied substantially on the review and analysis of secondary data while generating some primary data for supplementation, corroboration, and verification purposes.

Quality Assessment Methodology

The University Research Co., LLC (URC) approach to developing standards has been adopted by various international child development partners (e.g., PEPFAR, UNICEF, and USAID) and provided the basis for devising the quality assessment tool for this study. This approach begins with the ten Dimensions of Quality (see Appendix for definitions). These have been used by Ethiopia, Kenya, Malawi, Namibia, Uganda, and Zimbabwe to inform the development of national quality standards and to guide implementation of services for OVC and vulnerable households.

The assessment tool drew upon quality standards from Kenya, Namibia, and Uganda and integrated these with Government of Rwanda policies, especially the Integrated Child Rights Policy and the Early Childhood Development Plan.⁶ The SIMS (Site Improvement Monitoring System) tools recently developed and implemented by PEPFAR were also reviewed and particular criteria incorporated into the tool.

The tool provided an instrument for systematically assessing quality as described by the ten dimensions of quality in the provision of OVC services, e.g., health, education, protection, PSS, nutrition, and family livelihoods.

The tool was completed by the consultants through a desk review of IP annual reports, followed by in-depth discussions with IP programme managers at their head offices. This was then verified through observation and focus group discussions at sites with beneficiaries, volunteers, and local staff. Two sites were visited for each IP. For international IPs, two sub-recipients were visited at their implementation site. The data generated was used to determine the practices that contribute positively to quality services and where gaps exist in the quality of services provided.

⁵ Schedule of site visits, assessment tools and names of key informants can be found in the Annex

⁶ Ministry of Education. (2011). Early Childhood Development Policy. Ministry of Education: Government of Rwanda. & Ministry of Gender and Family Protection. (2011, August). National Integrated Child Rights Policy. Ministry of Gender and Family Protection: Government of Rwanda.

Costing Methodology

To improve understanding of IP costs associated with providing OVC services, the team collected and analyzed financial and program data from USAID/Rwanda OVC partners and integrated analysis of this data with information gathered from field visits and interviews. The financial and program data provided substantial detail on costs associated with OVC services. Service costs not funded by USAID, including community volunteer caregivers, were in most cases included in the IP cost share required in the cooperative agreements. The more detailed financial reports were compared to data reported for the PEPFAR Expenditure Analysis (EA)⁷ and were, in all cases, consistent with EA data.

Capacity Assessment Methodology

Capacity assessment reports, quarterly reports, and annual reports to USAID from the Human and Institutional Capacity Development (HICD) project—specifically tasked with the organizational development of local CSO implementing partners—were reviewed for the three local IPs. Capacity assessment scores and progress made toward implementing their capacity development plan were extracted from the HICD reports for each organization. Interviews with HICD staff were used to further triangulate and verify the information to gain a fuller understanding of how the organizations responded to the capacity building process and what challenges had been encountered.

A semi-structured questionnaire, based on the Organizational Capacity Assessment (OCA) tool, specifically developed for the New Partnership Initiative, was used to guide discussions at both headquarter and field level in order to understand what systems exist and function within each organization and to assess their capacity development levels and gaps. Interviews were conducted with FHI and Global Communities to review their capacity development tools and how these contributed to OVC programming for sub-recipient IPs. A review of the Global Communities Organization Sustainability Index assessment result and graduation plan was conducted. A review of FHI Partner Organizations Capacity Assessment report provided an overview of core capacity strengths and gaps across sub-recipient IPs.

Two IPs of each INGO were visited and discussions with field level staff/volunteers were carried out to assess the knowledge/understanding of what capacity support had been provided in order to contribute to the successful implementation of their OVC programs.

The approach to each component of the study is further summarized in Table 5.

LIMITATIONS

- The timing of the evaluation resulted in site visit options being curtailed because of the close-out of Higa Ubeho. Members of the evaluation team had visited Higa Ubeho sites previously and were able to incorporate pre-existing field visit data in the evaluation.
- The evaluation scope of work (SOW) discussed interventions classified by the eight Priority Areas of the PEPFAR 2012 OVC Guidance. USAID/Rwanda OVC IPs are not required to, and generally do not, record or report achievements or expenditures by Priority Area. In recent years, IPs report estimated total expenditures for “service categories” that align roughly with PEPFAR Priority Areas.

⁷ Expenditure analysis data show what PEPFAR funds were used for in each country/region according to major and detailed cost categories.
<http://www.pepfar.gov/funding/c63793.htm>

- The SOW discussed cost analysis disaggregated “by intervention/priority area and geography.” This report analyzes costs disaggregated separately by “intervention/priority area” and by geography. While IPs record a range of activities, achievements and costs disaggregated by district, they do not, are not required to, and could not reasonably be expected to maintain records of disaggregated interventions at the district level.
- The breadth of the PEPFAR “service categories,” each embracing a wide range of dissimilar interventions, results in cost averages across very dissimilar services. Great care is required in the use of “unit costs” aggregated even further across all service categories.
- The ultimate measure of the quality of OVC programs is the achievement of outcomes for children. Routine monitoring and reporting against PEPFAR level I indicators, as well as the proposed 9 essential indicators, delivers almost entirely output level results. Outcome- and impact-level evaluation results were not available for most partners and therefore a conclusive statement on the comparative quality for cost of OVC programming across local CSOs and INGOs was not possible.

Table 5: Evaluation Design Matrix

Component	Approach	Data Collection and Analysis	Evaluation Objective and Questions
Quality	<p>The quality component of the study assessed:</p> <ul style="list-style-type: none"> • Quality by service category through a qualitative critical review; • The integration and implementation of quality in organizational and programming processes against international standards; and • The quality of select interventions against best practices. 	<ul style="list-style-type: none"> • Primary data was generated through focus groups and team interviews with partner staff, guided by a semi-structured protocol based on international quality standards for OVC programming. • Primary corroborating data was generated through a select number of site visits, sampled based on high HIV prevalence and OVC burden. Data was collected from focus group discussions with project staff and beneficiaries. • Additional primary corroborating data was utilized from site visits conducted by team members in 2014. • Secondary data was obtained from partner documentation, such as project descriptions and reports to USAID, with specific reference to implementation and program performance. <hr/> <ul style="list-style-type: none"> • Data was analyzed by triangulating the multiple sources of qualitative evidence (1) in response to the items in the standards protocol and (2) based on the grounded themes emerging. 	<p>To assess the quality of OVC services provided by USAID IPs in Rwanda:</p> <ul style="list-style-type: none"> • To what extent do services to children meet the acceptable quality standards as defined by international standards, and Rwanda’s relevant policies and guidelines? • What are the best practices, lessons learned, and recommendations for OVC services, costs and efficiencies, as implemented by INGOs and CSOs in Rwanda?

Component	Approach	Data Collection and Analysis	Evaluation Objective and Questions
Cost	The cost component executed secondary analyses of existing data from the recent EA, supplemented by additional data from partner reporting and financial data provided by partners. The data was subjected to an iterative analysis process, with regular reviews to check the validity of results against implementation realities.	<ul style="list-style-type: none"> • Secondary data was obtained from the EA and directly from partners (including financial data). • Additional secondary data was obtained from partner documentation. <hr/> <p>Data was analyzed by:</p> <ul style="list-style-type: none"> • reviewing the existing cost data from the EA; • identifying relevant cost categories; • matching and then supplementing the EA cost data with data from financial data obtain from partners and partner reports; • running initial cost-per-beneficiary calculations on cost data, disaggregating by key programming categories (including districts and service areas), and reviewing the validity of results in evaluation team and partner discussions; and • adjusting the analysis for validity, accommodating program realities, and supplementing data gaps where possible. 	<p>To better understand the costs incurred by INGOs and local CSOs to deliver OVC services.</p> <ul style="list-style-type: none"> • What are the costs associated with delivering services to children in Rwanda? <ul style="list-style-type: none"> ○ What is the unit cost per child reached over a one-year period by priority area, intervention, and geography? ○ What is the total annual cost for program implementation? ○ What are the cost drivers by priority area, intervention, and geography? ○ What are the advantages and disadvantages in terms of costs of using one service delivery model over another? • What are the best practices, lessons learned, and recommendations for OVC services, costs, and efficiencies, as implemented by CSOs and INGOs in Rwanda?

Component	Approach	Data Collection and Analysis	Evaluation Objective and Questions
Capacity	<p>The organizational capacity assessment component adopted the standard OCA methodology as its framework. It relied on the extensive secondary data already available as a result of previous OCAs conducted by other USAID partners (such as HICD) supporting organizational development of local IPs. The component also introduced a rubric for the critical qualitative assessment of additional readiness criteria relevant to capacities for transition.</p>	<ul style="list-style-type: none"> • Primary data was generated through interviews with partners, guided by a semi-structured interview protocol based on the OCA tool. • Secondary data, primarily OCA assessment results, was obtained from HICD (which implements the current local IP organizational capacity development program) and partners. <hr/> <ul style="list-style-type: none"> • Secondary and primary data was reviewed, supplemented as necessary, and analyzed against adapted OCA criteria. • The analysis was jointly reviewed by the evaluation team to assess critically and ensure validity. • Additional readiness categories were generated, based on team discussions and interview data, and data supplemented as necessary. 	<p>To identify the organizational capacity gaps that need to be addressed to ensure that the delivery of quality OVC services continues to improve.</p> <ul style="list-style-type: none"> • Are the management systems (i.e., planning, finance, monitoring and evaluation, contracting and grants making, and procurement systems) adequate and functioning to meet the service implementation demands of quality service delivery to OVC and vulnerable households?
Integration	<p>The approach to integration was to conceive of the program portfolio as a whole; order findings in a progressive presentation of evidence that softened the distinctions between quality, cost, and capacity components; and remain flexible on the execution</p>	<p>Secondary data was obtained from partner and USAID/Rwanda evaluation reports, in particular the evaluations of Global Communities interventions, FXB's evaluation of its mechanism, and the USAID review of the OVC portfolio.</p>	<p>All the evaluation questions, and the implementation context.</p> <ul style="list-style-type: none"> • What is the geographic service coverage and number and type of beneficiaries served by the various components of the package to OVC and vulnerable households?

Component	Approach	Data Collection and Analysis	Evaluation Objective and Questions
	<p>of the evaluation in order to be responsive to the evaluation purpose, objectives, and questions, as well as what the evaluation process was revealing in the field. The integration also attempted an assessment of quality and cost in the light of impact.</p>		

IV. FINDINGS

“Quality is something that makes a difference in someone’s life; a service that brings a change.”
(Director of National Commission on Children, Rwanda)

FINDING 1: IMPLEMENTING PARTNERS AND PROGRAM MODELS

IPs provide a similar range of services to vulnerable families and OVC through an integrated approach that includes education, household economic strengthening, and psychosocial, nutrition, and health support as common service categories.

All IPs are guided by the principles of the Global Health Initiative for Rwanda, the PEPFAR OVC Guidance of 2012, the Government of Rwanda’s National Strategic Plan for HIV (2013-2018), and the National Integrated Child Rights Policy (2011), as well as other guidance and policies from the National Commission for Children (NCC). It is therefore not surprising that the range of services that is provided to OVC and their families by these partners – AEE, Caritas Rwanda, FHI 360, FXB Rwanda, and Global Communities – are similar.

Rwandan government policies and programs place a strong emphasis on self-reliance and this is mirrored in USAID-supported activities. All partners, for example, encourage and support families through some economic strengthening services, primarily ISLGs. Groups are composed of parents and caregivers of OVC, other volunteers, and other community members (often including health workers). In certain districts and cells, these members are also the beneficiaries of nutrition support through Farmer Field Schools or positive deviant hearth (PDH) interventions. They and their families are sensitized to send their children to school, to be tested for HIV, and to adhere to treatment regimens (if HIV positive). Group members receive training and, in turn, may train others on child protection and prevention of gender-based violence.

Children who receive material support to attend school also receive school or home visits from community volunteers who discuss health, hygiene, sanitation, and good nutrition. Technical and vocational education and training (TVET) and secondary school students benefit from life skills training.

The evident integration of services is a strength of the USAID/Rwanda portfolio, as is locating service provision within a household and community, rather than focusing on an individual child in isolation of her/his family. This is consistent with PEPFAR Guidance for Orphan and Vulnerable Children Programming (2012), which states as a principle that program planners and implementers should ensure prioritized and focused interventions that address each child’s most critical care needs through family strengthening. Child-focused, family-centered interventions at the household level take precedence over handing out materials only to children identified as “OVC.” Consequently, while vulnerable children are the prime beneficiaries, the whole family is engaged to some degree, and the numbers of adults reached is actually larger than the number of children reached.

Household-focused interventions are in line with guidance, but programs may need to devise a stronger case management approach for particularly vulnerable children such as those who are malnourished, those who have dropped out or are not in school, those who are living with HIV, or those living with parents or guardians who are living with HIV. A case management approach

ensures that the child receives the required services in a timely manner. Sustainability through capacity building and transfer of program responsibility to promote country ownership are imperative and must be balanced with careful planning and monitoring to ensure children’s immediate needs are met.

In addition to implementation commonalities evident across partners, there are differences that distinguish their respective program models. These differences have implications for both quality and cost, as described in subsequent sections of this report. Features distinguishing partner program models are presented in Table 4: Summary of Implementing Partner Programs.

FINDING 2: QUALITY ASSESSMENT BASED ON DIMENSIONS OF QUALITY

Overall, services provided by IPs meet an acceptable standard of quality, but quality improvements are required in all service areas. Variations in partners’ observance and operationalization of the dimensions of quality have implications for results.

Quality care implies that an appropriate mix of services and support are provided to ensure children affected by HIV grow and develop as valued members of their families and community. Providing such care is complicated by the magnitude of children needing care and the many service areas required. Children need food and nutrition support, shelter and care, protection, health care, PSS, education and vocational training, and economic opportunity. Families and communities need support to be the primary providers of care to children (Establishing Service Standards for Improving Quality of OVC Services: A Facilitator’s Guide).⁸

The litmus test of quality is that a desired outcome for children is achieved. Although IPs do not currently or consistently document such outcomes, observations concerning partners’ degree of compliance with the different dimensions of quality reveal that there is scope for simple and meaningful quality improvement initiatives in every service area and for every IP. The dimensions of quality indicate the extent to which principles of quality are integrated into program implementation processes and that organizational processes support site-level implementation. The assumption is that these could contribute to improved outcomes. Observations on the dimensions of quality are presented in Table 7.

In the table below, findings from the desk review, interviews, and field visits are organized by the Dimensions of Quality and the portfolio assessed using the following color coding system:

Basic requirements are met to ensure minimum quality standards	
Basic requirements are either not consistently met or are only partially met and this area requires improvement	
Insufficient attention is given to this dimension of quality and it requires urgent attention	

⁸ DiPrete Brown, L. 2008. Published by Pact and University Research Co, LLC for the United States Agency for International Development. www.ovcsupport.net

Table 6: Observations on Dimensions of Quality

Dimension of Quality and Descriptors	Findings	Assessment
Safety		
Activities do not stigmatize child or family	<ul style="list-style-type: none"> • Staff, community volunteers, and caregivers all reported decreased levels of stigma or discrimination against PLHIV from service providers, from community members, or from family members. Volunteers and staff did, however, report continuing stigma for young people accessing family planning and for men who have sex with men accessing health services. • Belonging to a group, especially an ISLG, was credited during focus group discussions with lowering stigma and discrimination and with building self-esteem among members due to their ability to look after themselves and even to contribute to community events. 	
There is a child protection policy	Only one partner (AEE) reported having a child protection policy signed by staff.	
Access		
Community structures are used in establishing the target beneficiaries	All IPs use district and sector structures and lists to identify the most vulnerable families and children. IPs discuss the criteria used to identify these families and children (e.g., affected by HIV) with local government officials who then provide a master list from which beneficiaries are selected.	
Explicit steps are taken to identify and reach the isolated, marginalized, and most vulnerable, and affected by HIV *(SIMS)	All IPs through their staff in the districts reported special efforts taken to find the most marginalized, isolated, or HIV-affected. FHI 360 uses networks of commercial sex workers and PLHIV. AEE also reported going through associations of PLHIV. FXB reports that some families may be “forgotten” and thus shares information on the project in public forums. Caritas targets villages with high malnutrition (based on stunting).	

Dimension of Quality and Descriptors	Findings	Assessment
<p>Assessment of barriers such as hidden costs, venue, time, are recognized and addressed/removed with cognizance taken of gender differences (SIMS)</p>	<ul style="list-style-type: none"> • Participation by girls in secondary education is encouraged through provision of sanitary items. The different reasons for school dropouts should be investigated more by each partner. The USAID/Rwanda report mentions discipline problems in a number of instances, but the gender is not given. • Members of ISLGs reported during focus group discussions that participation of the very poor in ISLGs is problematic. For some extremely poor individuals, in particular divorced women or widows, the monthly saving requirement could be too high. Such households could benefit from the provision of farming implements, other household items (such as blankets), or health insurance. 	
Participation		
<p>Families are the key entry point – and respected as the primary caregivers</p>	<p>Families are key entry point for all IPs and more adult beneficiaries are recorded than child beneficiaries (approximately 81,000 and 62,500 respectively). Not all members of the family are targeted for support, with the exception of families in the FXB village model. It was frequently reported that only one child in a family would receive school materials or support for educational expenses.</p>	
<p>Local resource people are involved in the activities (social workers; nurses; CHWs)</p>	<p>All IPs work closely with community-level organizations and staff (such as CHWs), clinic nurses, and district and sector social and education officers and contribute to Joint Action Development Forums. FXB has space in sector offices and a signed agreement. AEE reports unpaid contributions by water engineers, nurses, police officers, agricultural extension officers, and social affairs officers at sector level. Caritas trains CHWs and staff from health centers on child malnutrition and provides them with kits for growth monitoring. Global Communities targeted local leaders with information on the project as part of its hand-over.</p>	

Dimension of Quality and Descriptors	Findings	Assessment
Equal participation is encouraged for boys and girls; men and women	Women are the primary beneficiaries of the program, with 71 percent of adult beneficiaries being female and 52 percent of child beneficiaries being female. The majority of volunteers were women but men were also represented.	
Appropriateness		
Activities and messages are age appropriate with all targeted ages catered for	Children’s and adults’ different development needs and requirements for PSS are not well differentiated. So, for example, there is no mention of early stimulation of children as part of good nutrition practice, of special needs of young mothers, or of sexual and reproductive health issues facing adolescents. All partners make an effort to reach children of all ages in the household with some level of support.	
Both men and women act as mentors/volunteers/trainers	Partners have a preponderance of women in ISLGs and have a gender balance in education support. Vocational training subject choices follow gender stereotypes. Global Communities has analyzed this among their beneficiaries. Younger children’s needs are not fully catered for.	
Compassion		
During the year, the same adult engages with the children or visits the household The ratio of adults to children is reasonable	Consistency of care provided through household visits by a community volunteer was evident with all partners and highly valued by beneficiaries. The frequency of the visits varied, but it appears that a weekly visit was normal, with some volunteers making more frequent informal visits as required. Volunteers were responsible for approximately 10-15 households or 9-25 children. The ISLG beneficiaries reported that participation has built confidence and solidarity, lessened stigma, and awakened hope and potential in the members.	
Continuity and Linkages		

Dimension of Quality and Descriptors	Findings	Assessment
Children and family members are referred for social and health services and uptake of HTC and PMTCT, EID, and ART services are actively encouraged and assisted	All partners make referrals to health and social service providers and try to track these referrals verbally or in writing. Referrals are made for legal issues, especially land and inheritance issues, cases of gender-based violence, HIV counseling and testing and treatment, and malnutrition among children. Referrals from community to facility are not consistently systematized.	
A system is in place with standard tools to track referrals to services, including HIV testing (SIMS)	Partners (FXB and Global Communities) have helped develop service directories to assist in focused, effective referrals. Partners may have written forms, but they may not be consistently used by the clinics. Memorandums of understanding or written agreements with individual clinics seem to work for one partner.	
The partner receives referrals from health facilities (bi-directional)	While partners report that they do receive referrals, these are not systematically documented.	
Technical Performance		
Volunteers or staff are trained in the subject matter through a recognized curriculum	<ul style="list-style-type: none"> • All partners report training their community volunteers, but the frequency and intensity of the training and supervision vary. • INGOs report significant investment in developing training materials and in delivering training to volunteers and beneficiaries. INGOs have robust training components for local sub-partners and community volunteers. They can provide strategic inputs and technical advice to government agencies concerning key populations (FHI) and TVET (Global Communities). Caritas used an INGO (Catholic Relief Services) to train its own staff and health workers on management of malnutrition. Global Communities identified and trained mentors to work with cooperatives on accessing markets and improving products. 	

Dimension of Quality and Descriptors	Findings	Assessment
The providers or volunteers receive supportive supervision (at least four/year)	All partners report supervising their community volunteers, but the frequency and intensity of the training and supervision differ. Supervision of volunteers ranged from once a month to once a quarter.	
Program creates awareness among communities on child rights and protection, gender norms laws and services available through campaigns and IEC materials	The level of gender awareness and gender analysis among community staff and volunteers may be insufficient to be transformative. Volunteers were able to articulate the different needs of boys and girls in the households they visit but not how to address these needs. The training provided in gender norms either did not happen, was of insufficient duration (10 hours), or was in need of updating to meet the required standard.	
Efficiency		
Initial assessment and regular follow-up of every child /family is done by appropriately skilled service providers (SIMS)	Not all IPs do a household-level assessment to determine level and appropriateness of planned interventions. FXB does and, in addition, develops a family progress plan.	
The appropriate duration, frequency, and quantity of the service has been determined and is followed	All partners integrate their services, so a child receiving school materials will also receive some level of psychosocial counseling, health insurance support, and nutrition support. FXB has a recognizably comprehensive and integrated package which addresses all service areas for the entire family. Global Communities' partners likewise offer integrated service through Farmer Field Schools, ISLGs, and provision of school costs and health insurance.	
Activities are co-located or integrated with HIV clinical services (potential)	There was little evidence of services being co-located; only one partner based services within a clinic.	

Dimension of Quality and Descriptors	Findings	Assessment
Sustainability		
<p>Basic livelihood options are provided to poor and vulnerable families</p> <p>There is an explicit exit strategy or sustainability plan to ensure that beneficiaries graduate from PEPFAR support and/or that ongoing external support will continue to be provided independent of PEPFAR</p>	<ul style="list-style-type: none"> • All partners prioritize building self-reliance through household economic strengthening activities. These activities are targeted primarily at women. Partners track total savings and loans from the ISLGs. Participants report the benefits of belonging to these groups, including being able to purchase health insurance and cover some educational costs. • Destitute families and those struggling to make ends meet require additional material inputs as well as counseling to progress to the next level. FXB has been noted for using such an approach. • The gradual decreasing of project support for education from 100 percent to 25 percent is supposed to graduate families, but it presents a risk to children whose families are not able to cover these cost. 	
Effectiveness		
<p>There are records of each child and parent/guardian (SIMS)</p>	<p>FXB does an assessment of each family every year to track progress on agreed benchmarks. Caritas volunteers keep a record of visits and families.</p>	
<p>Children have or are helped to get health insurance</p>	<p>All IPs ensure beneficiaries have health insurance. Two local partners only facilitate families to purchase health insurance through savings. Other partners also purchase the insurance.</p>	
<p>Children under 3 years of age are receiving integrated childhood services and those <5 have their growth monitored</p>	<p>Caritas tracks improvement in child nutrition, i.e., the number rehabilitated through community nutrition interventions (in cases of moderate malnutrition) and through referrals to health centers (for severe malnutrition). Other partners' PDH approaches focus on families with children under 5.</p>	
<p>Programs target vulnerable households to improve access to clean water and sanitation</p>	<p>All partners provide some support for household-level water and sanitation, such as through tippy-taps, rehabilitation of water points, provision of latrines, or training in kitchen cleanliness.</p>	

Dimension of Quality and Descriptors	Findings	Assessment
Staff and volunteers identify children whose births are not registered and mobilize their families/caregivers to register them	Partners refer children for these services, but few report the number of children with and without birth registration. FXB refers couples for registration of marriage.	
Enrolment and retention in ECD, pre-primary, primary and lower secondary schools is monitored (SIMS)	There is limited evidence from partners of beneficiaries' progress through school. Only Global Communities is reporting on progress via a sample. IPs report that monitoring of beneficiary progress is made through school visits and that the distribution of school materials is based on previous progress. There is an indicator for children ending a school year but the figures are missing. The level of savings and income through income-generating activities (IGAs) and ISLGs remains insufficient to cover full costs of education for children.	

FINDING 3: QUALITY ASSESSMENT BY INTERVENTION AND LEVEL OF SUPPORT

The interventions in each service category vary across IPs in regard to the type and level of support provided to beneficiaries.

Implementing partners design interventions to mitigate the burden of caring for vulnerable children and to help families transition out of poverty to self-sufficiency. The optimal level of support and mix of interventions to accomplish this has not yet been established. Program gaps that may jeopardize achievement of the desired outcomes for vulnerable children (Safe, Stable, Schooled, Healthy – are highlighted by service in the discussion below.

Linkages Across the Continuum of Response

Well-coordinated, comprehensive activities that reduce the vulnerability of OVC and family members to HIV and systematically link them to clinical services for care and treatment contribute to controlling the HIV epidemic.

All partners make referrals to health and social service providers and try to track these referrals either verbally or in writing. Referrals are made for legal issues (especially land and inheritance); cases of gender-based violence; HIV counseling, testing, and treatment; early infant HIV diagnosis; and malnutrition among children.

Partners (FXB Rwanda and Global Communities) have assisted in the development of service directories to support focused, effective referrals. Global Communities partners report working closely with CHWs to monitor growth of children and with clinic staff to ensure clients adhere to HIV treatment. Caritas refers severely malnourished children to health facilities and receives reports from health facilities. It also reports some bi-directional referrals from the clinics to its program staff, especially in regard to ARV adherence and nutrition.

FXB Rwanda works closely with fifteen health centers and has trained 459 CHWs in nutrition and provided them with growth monitoring kits. They have a referral form with a section to be completed by the referral organization, but report that it is not consistently used and sometimes there are delays in getting information from clinics. FHI 360 uses referral cards and has written referral agreements with local health centers. They meet once a quarter with the local clinic and are introducing a case management approach.

Potential Quality Gaps

Referrals from community to facility and from facility to community are not consistently systematized. AEE and FXB Rwanda count referrals when there is a documented response, but report difficulty in getting the information from the health facilities. Many referrals are only verbal. Having a form is also not a guarantee that the provider will complete and return it.

Education Support

There is international evidence that keeping children in school contributes to prevention of HIV infections. All partners prioritize education support and, as discussed below, education support accounts for the largest share of district-level expenditure of all partners. Education support ranges from provision of a basic package of school materials to one child in the family through to covering the full cost of a one-year TVET course. Parents are expected to incrementally take

up the cost of day scholars' 9/12YBE as their economic situation improves through participation in ISLGs. This includes school materials as well as school feeding, which one partner said was approximately US\$ 5 per month.

Education support covers different age ranges through early childhood playgroups, nursery school materials, 9/12YBE materials and fees if applicable, boarding school, and technical education fees and materials. Global Communities has expanded its playgroups for the under-fives. AEE is unique in supporting children in catch up programs that allow out-of-school children and adolescents to study a basic education curriculum. This program appears to reach very vulnerable children, including adolescents who are not living with their families and have moved to urban areas. The lack of adult supervision and family life outside of the education program is a concern, for both boys and girls, but may especially put girls at risk of exploitation. All IPs support both boys and girls in education support, including TVET. Global Communities was commended by one of its sub-partners for offering comprehensive support to TVET students that included fees, transport, hygiene items, internships, and follow-up advice.

“Secondary is expensive, but only finishing primary school does not help an OVC in the same way as TVET does. After TVET an OVC can earn something,” (Sector Social Affairs Officer, male, Musambira Sector).

Potential Quality Gaps

With the rising cost of education, even for 9/12YBE (school feeding fees are now required), it is doubtful whether savings or income from ISLGs will be sufficient to cover an entire family's expenses for education. This will be exacerbated by the systematic reduction in support from IPs over time. This might be partially addressed by mobilizing strong support for the government policy that children are not to be “chased away” from school for lack of payment; however, local pressure for families to contribute will continue.

There is a risk of children dropping out of school if basic costs are not covered, in which case the full benefit of that investment will not be realized. The USAID/Rwanda team found, for example, that 80 percent of parents could not pay the balance of fees. In addition, all partners surveyed by USAID/Rwanda experienced a percentage of children for whom fees were paid but were no longer attending school.⁹

The provision of educational materials for one child in the family, though highly valued (costing approximately US\$ 10 dollars or less) for a poor family, is not an efficient mechanism for ensuring educational attendance, progress, and completion. There is a substantial difference in magnitude between covering the cost of secondary boarding school or TVET and providing primary school education materials. Fees alone for a year of secondary boarding school are about US\$ 200 per student per year. TVET fees are about US\$ 150 per year. A primary school uniform and school materials is about US\$ 14 per child per year.

“Children who are unable proceed to upper level education should be granted access to TVET Programs. TVET will help them be independent and have ability to join ISLGs,” (caretaker Kimisangara).

Support for TVET courses are highly valued by families and community leaders and are highlighted in the Government of Rwanda's strategy for workforce development. There is

⁹ OVC Review Report. USAID: Rwanda. (2014, October 6)

evidence of gender stereotyping in the courses chosen by boys and girls, however, with the majority of girls electing to study sewing, hairdressing, and hospitality, while boys elect to study carpentry, building, and mechanics. While it is good practice to let students choose their favored course of study, more needs to be done by all partners to mitigate the strong gender biases in such choices.

Psychosocial Support

All implementing partners use volunteer community workers to provide PSS. These may be community caregivers (AEE and Caritas), trained para social workers (FXB) or community psychosocial workers, or Abahizi Family Day Facilitators (Global Communities). PSS may be provided through home visits (all partners), school visits (Caritas), holiday camps (AEE), or Abahizi Clubs and life skills training (Global Communities). FXB has special sessions for couples on family communication and dynamics for dealing with conflict.

Volunteers who visit the home try to model good communication with the children. Community members mentioned conflict in the home quite often. When probed, it seems this refers primarily to conflict around money management. Couples work, done by FXB, appears as a good practice in building communication in the home between parents. Abahizi Club-based groups under Global Communities also seem an appropriate mechanism for working with adolescents who are at a stage when they are influenced by peers and peer relationships.

“I was chased away from school, but I had training at the Abahizi Club and finished school. Now I organize my life for a purpose. Students see changes in me and I am a role model for others. I tell them show commitment,” (ADEPRI beneficiary).

Potential Quality Gaps

The aim of the different PSS interventions is neither well-articulated across partners nor differentiated by age. The basic aim seems to be to ensure that children remain in school. Global Communities has worked on ensuring that children in secondary school and TVET have the necessary life skills. An understanding of how psychosocial needs of young children will manifest do not feature anywhere.

Volunteers emphasized the importance of talking to boys and girls separately about their needs. But in focus group discussions it appears that female volunteers are more comfortable talking to girls, while the male volunteers talk to boys. Thus it is unlikely in one household for boys and girls to receive gender-differentiated services, as one volunteer will be responsible for one household.

Health

Health services include the payment of health insurance, delivery of HIV prevention messages in small group sessions, and referrals to health facilities. AEE (with the exception of catch-up students) and Caritas do not pay for health insurance, but encourage families to pay their own health insurance through household economic strengthening activities. Other partners purchase health insurance for children and family members. FXB provides health insurance as well as a package of hygiene and sanitation materials for the family. FHI 360, through ROADS III Rwanda, concentrates on HIV prevention and mitigation among key populations in strategic transport corridor sites in the country, including border communities. Their focus on key populations includes female sex workers and their clients, men who have sex with men, and adolescent girls. They work closely with testing and counseling services of the Ministry of Health.

All partners make referrals to health facilities and encourage antenatal visits for PMTCT, HCT, and treatment adherence. Caritas reported that they regularly refer people to health centers and that the advice that clients receive improves behavior.

“If this project was not there I most likely would have been infected by HIV,” (care giver from Gikondo sector).

Potential Quality Gaps

The quality of sexual and reproductive health information provided by community volunteers at household level may not be sufficient to address the different needs of adolescents. Focus groups reported discrimination and cultural disapproval toward unmarried girls accessing family planning commodities. The team did not hear how partners addressed this challenge. Volunteers requested more training on sexual and reproductive health to enable them to help young people. The local staff employed by FXB Rwanda who do family visits and conduct family counseling sessions appeared to have additional information in this regard.

“We advise the boys not to waste their time writing love letters,” (Female volunteer, Rukoma Sector).

The burden of purchasing health insurance on families has not been determined, but at approximately US\$ 4 per person it is likely to be substantial. In most instances there is insufficient data to determine if all people in a family have health insurance.

Nutrition Support

Farmer Field Schools, kitchen gardens, PDH approaches, growth monitoring, cooking demonstrations, and water, sanitation, and hygiene (WASH) interventions are common nutritional support activities. Training of IP staff, health facility staff, CHW, and caregivers in nutrition or management of malnutrition is common among partners. FXB also provides food support. Caritas has a special focus on nutrition for pregnant and lactating women, which includes nutrition information sessions, intensive cooking demonstrations, with feeding and growth monitoring for children. It has an additional component that provides small stock to pregnant and lactating women.

PDH methodologies, such as those employed by Global Communities partners, were credited with improving child feeding practices and family hygiene. From visits, it appears that women were more actively engaged in food preparation, hygiene, and feeding than men.

Parent evenings, initiated by local government and supported by IPs, focus on nutrition for under-fives and how to bring up children.

“I am no longer buying vegetables. I can have a balanced diet without spending,” (elderly female member of a PDH and Farmer Field School intervention through ADEPRI).

Potential Quality Gap

Nutrition for children in the under-five age group is not comprehensively addressed by all partners. No partner describes an intervention that encompasses food support, nutritional information, and the necessary parenting skills shown by studies to be an effective strategy to

address stunting.¹⁰ During visits, the team judged that there were missed opportunities to improve parenting practices associated with infants and young children, such as when mothers (with large number of young children) meet in a home for a cooking demonstration. This is an opportunity for structured group play and discussion about the importance of play and nutrition for child development.

Some groups felt that under-fives are not “OVC” because an OVC is someone who is of school going age. This reflects the importance of education support.

Household Economic Strengthening

All partners support ISLGs. These groups may be composed of PLHIV, widows, or vulnerable youth. FXB also supports income generating activities and provides some start up resources. Two partners (FHI 360 and Global Communities) support the graduation of groups into cooperatives. The FXB program has a particularly family-focused implementation strategy. Improvements to the home include improved pit latrines, outdoor kitchens, and hand washing facilities. Income generating activities include the training of heads of households and the provision of assets with which to commence. Widows and female-headed households are prioritized.

The social benefits of ISLGs (e.g., lowering of stigma and discrimination, building group solidarity, and enhancing personal efficacy) were frequently mentioned in focus groups.

“Since I joined the group I have gone for a test and now receive treatment. My husband left me and I care for all my seven children alone. The group has helped me to put a roof on my house,” (female member of the Abarindiriye ISLG under Caritas).

“My life has changed through support from this project. ASOFERWA is a parent, I used my savings loan to start small restaurant. I am now able to pay school fees,” (member of the Gikondo savings group).

Potential Quality Gaps

Unless ISLGs can graduate to cooperatives, it is unclear that the members will be in a position to cover the full costs of their children’s education and health needs. The establishment of ISLGs cannot be a substitute for other material support to families.

“The loans that we get are too low to start a sustainable project. Particularly for a person like me living with HIV, sometimes we fall sick and are unable to contribute to savings, and therefore have no access to loans,” (female member of the ISLG under Jumba Diocese/FHI360).

Child Protection, Legal Support, and Gender Awareness

According to head office staff and verified at district level with staff and caregivers, IPs provide some training on gender norms, child protection, and legal rights to community caregivers and volunteers. They also refer children and parents to regularize marriages, obtain birth registration, and address inheritance issues and gender-based violence. FHI 360 reports a

¹⁰ *Labor Market returns to an early childhood stimulation intervention in Jamaica*, Paul Gertler, James Heckman, Rodrigo Plato, Arianna Zanolini, Christel Vermeersch, Susan Walker, Susan M Change, Sally Gratham-McGregor Science. 2014 May 30;344(6187):998-1001. doi: 10.1126/science.1251178.

number of individuals referred for rape services. Global Communities trained play group volunteers, community psychosocial workers, and family day facilitators.

Potential Quality Gap

The role of volunteers in regard to child protection may be circumscribed by their lack of training. The team had little evidence of the child protection interventions or gender training to review. This in itself may illustrate an important programming gap.

FINDING 4: IPS CONSISTENCY TO INTERNATIONAL SERVICE STANDARDS

All IPs demonstrate some, though not all, of the necessary components (analogous to or consistent with the dimensions of quality) of a quality intervention according to international standards.

Service standards are not in place in Rwanda, but there is evidence of most if not all quality criteria being met in at least four different interventions by IPs. Observations are presented on the quality characteristics of specific interventions or services, drawn from different partners, to illustrate what a quality intervention would entail.

The TVET intervention has the characteristics of a quality program.

- There are written and transparent criteria for selection.
- It is aligned to and supports government priorities.
- The providers are screened for quality.
- Participant aptitudes and interests are considered.
- The different costs are covered, including fees, materials, internships, and transport.
- Startup kits help ensure that graduates can earn a living.
- Progress and results are tracked.
- Graduates are able to be self-reliant and assist others.
- Gender biases in choices related to field of study are actively addressed through career counselling.

The ISLG intervention has characteristics of a quality program.

- Participants identified are often the most vulnerable (PLHIV, widows, and young people).
- Participants self-select.
- Technical standards are adhered to (loan cycles, contributions, and so on).
- Basic materials (e.g., registers and money boxes) are provided.
- Groups are mentored by a trained provider.
- There is on-going monitoring of savings and loans.
- Savings are used to build the economic base of family and pay for child related expenses.
- There is a trajectory for graduation (cooperatives) and on-going support is provided to groups.

The home visiting interventions have characteristics of a quality program.

- Beneficiaries identified with local government use agreed upon criteria (sector list).

- Assessments are made of needs of all children and adults in the household.
- Children and adults are referred to appropriate services (for moderate or severe malnutrition, HCT, ARV, birth registration) and followed up.
- A consistent caregiver provides regular visits to a limited number of households.
- Volunteers meet regularly (at least once per quarter) for supportive supervision.
- Volunteers receive training and refresher training following a set curriculum.

The nutrition interventions have most of the characteristics of a quality program.

- The most vulnerable OVC are identified and the neediest ones identified by community members.
- Training and input on food production (e.g., Farmer Field Schools) is required.
- Training is provided on nutrition (balanced diet, exclusive breast feeding, and food preparation, preservation, and handling).
- Exclusive breast feeding and safe complementary feeding practices is encouraged.
- The progress of nutritional status of OVC is monitored.
- Context-based nutritional assessment is conducted.
- CHWs and volunteers are trained in the basics of malnutrition diagnosis and referral.
- Other stakeholders are identified and engaged to strengthen linkages and referral systems.
- Case management is used to follow up on all under-nourished children.
- There is Advocacy and networking with government offices and potential stakeholders.
- Integrating parenting support for early stimulation of infants and young children accompanying feeding practices (missing).

The USAID/Rwanda OVC Portfolio also illustrates some best practices in integrated service delivery.

Examples of Best Practices

- The integration of services for OVC by the Rwandan IPs is notable and commendable. The Global Communities model, taken up by local NGOs, combining Farmer Field School techniques with ISLG and PDH practices and inputs for educational support, is felt to be a strong package of support enabling improved health and wellbeing of all family members. The integrated model highlights the fact that vulnerable children and families have multiple needs and that, in a poor country like Rwanda, providing only one service to a child will likely not result in meaningful outcomes.

For example, ISLGs are used for multiple purposes including improving savings for children's health and education expenses, building self-esteem and self-efficacy among members, and providing a platform for community information, action, and incentives for community volunteers. The importance of group solidarity is particularly evident for PLHIV and they report how being a member of a group is in itself helpful. The groups serve both the very vulnerable (such as widows and PLHIV) and community volunteers, including CHWs. The groups also serve as a natural platform for mobilization of HIV counseling, testing, and treatment services, and groups report on testing and

mobilization of others to be tested. Savings are used to buy health insurance and other essential items, including school materials for children in the family.

“ADEPR offered a complete package that raised the income of families and promoted the mind set of self-reliance. The savings groups built group solidarity,” (District officer, Kageyo Sector).

“HIV is addressed in a holistic manner. This woman was helped to buy a mattress, rebuild part of her house, build a latrine, and get a pig,” (Caritas volunteer, Byumba Sector).

“We see the change in the community members who belong. The group members develop vision and a goal,” (female Executive Secretary of the Bushenghi Cell in Mutwire Sector).

- Using local volunteers who can regularly visit homes to talk to children and parents is replicable and highly appreciated by families. This person serves as a link between the family, the CHW, and other government community workers. The volunteer is aware of the family reality and can intervene or make referrals for those on ARVs, those who have not been tested, those needing nutritional support, those not in school, and children who are malnourished. A wide range of issues can thus be dealt with including child care, sexual and reproductive health, improvements in the home, and the importance of education. The most appropriate role for a volunteer, the level of skills of the volunteer, and the amount of time which he/she can reasonably be expected to give to program activities are important considerations when relying upon this program model.

In addition, volunteers require training, refresher training, supportive supervision, and on-going encouragement. If volunteers are used to collect monitoring data there will be substantial data quality support needed. An appropriate balance needs to be maintained between the number of staff and volunteers required for these inputs, while respecting time constraints volunteers face.

“The children we follow up have become our children. We follow up and make sure we monitor their wellbeing,” (volunteer from Musambira sector).

“Since I started visiting children, I am loved by their parents,” (care giver, Rubona Sector).

FINDING 5: COST VARIATIONS WITHIN AND BETWEEN IPS

(a) Variations in cost are consistently observed between implementing partners.

(b) Variations in cost are consistently observed within the same IP programs across geographic locations.

Recurrent expenditures per child at district level are highly variable, as shown in Figure 4. FHI 360 stands out for the extreme differences in recurrent district cost-per-child among the five districts in which it operates, as well as the relatively low number of beneficiaries. The difference between the highest and lowest FHI 360 recurrent district cost-per-child was US\$ 76.53, ranging from US\$ 25.28 (in Gicumbi with 573 beneficiaries) to US\$ 101.81 (in Gasabo with 223

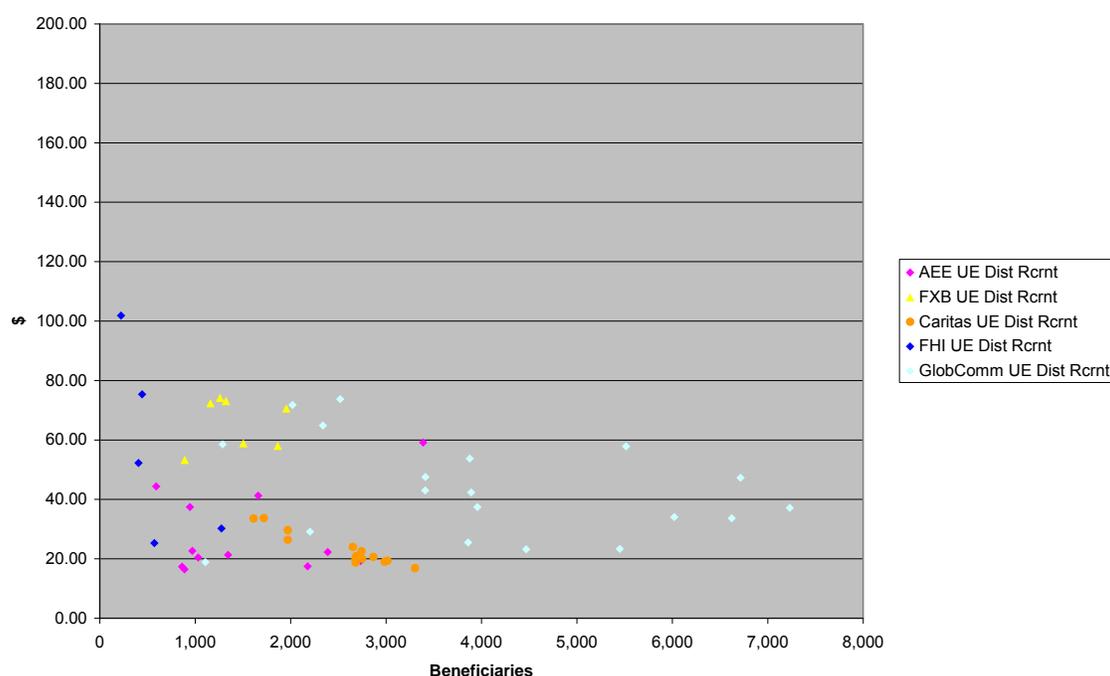
beneficiaries, the lowest district beneficiary count). The FHI 360 district with the most beneficiaries was Rusizi (1275 beneficiaries).

The ROADS III program being implemented by FHI 360 is focused on HIV prevention, although it has an OVC component. It reaches children linked to key populations, such as the children of commercial sex workers, and, according to interview data, it is this specialized nature of the program that would to some extent account for the high costs per child and the low numbers reached.

Note: The figures below use different colored shapes to represent partners. The districts can be read across the Y axis (as in Figure 6) and are:

Number	District	Number	District	Number	District
1	Bugesera	10	Rubavu	19	Musanze
2	Gatsibo	11	Rusizi	20	Rulindo
3	Kayonza	12	Rutsiro	21	Huye
4	Ngoma	13	Gasabo	22	Kamonyi
5	Nyagatare	14	Kicukiro	23	Muhanga
6	Rwamagana	15	Nyarugenge	24	Nyamagabe
7	Karongi	16	Burera	25	Nyanza
8	Ngorero	17	Gakenke	26	Nyaruguru
9	Nyabihu	18	Gicumbi	27	Ruhango

Figure 4: District Recurrent Cost-Per-Child by IP



Source: 2014 PEPFAR EA and Partner Expenditure Data¹¹

Two INGOs are conspicuous for a wide range of cost-per-child by district (FHI 360) and a wide range of beneficiaries per district (Global Communities). Global Communities also has a wider range of cost-per-child by district than any of the Rwanda CSOs, although not as wide a range as FHI 360.

Global Communities is remarkable for the wide range of beneficiaries per district, from 1107 in Ngoma to 7231 in Gasabo (the highest among IPs, by a substantial margin). Global Communities had its lowest recurrent district cost-per-child, as well as its least number of beneficiaries in Ngoma (US\$ 18.84 with 1071 beneficiaries). Its highest district recurrent cost-per-child was in Gicumbi (US\$ 73 with 2521 beneficiaries). Other IPs show less variation in recurrent cost-per-child among districts and in the number of beneficiaries per district. AEE's recurrent expenditures per child ranged from US\$ 16.43 (Huye, 889 beneficiaries) to US\$ 59.12 (Rwamagana, 3390 beneficiaries). For Caritas, district recurrent cost-per-child ranged from US\$ 16.87 (Nyamagabe, 3304 beneficiaries) to US\$ 33.66 (Rwamagana, 1721 beneficiaries).

FXB recurrent cost-per-child are more tightly clustered with respect to both cost and beneficiary numbers. FXB ranged from US\$ 53.28 (Rwamagana, 891 beneficiaries) to US\$ 74.20 (Musanze, 1260 beneficiaries). FXB's cost-per-child is consistently higher than those of the other local CSOs. The partner implements a program model that delivers a comprehensive blend of interventions to each child recruited into its programs, supported by regular household visits. The difference in cost-per-child between FXB on the one hand, and AEE and Caritas on the other, is largely attributable to this more intensive program model.

Although Global Communities has the most substantial variation in numbers reached across districts, some variation in numbers reached across districts is apparent with all IPs. From discussions with interviewees a number of factors influencing the variability of beneficiaries across districts emerge. These are primarily programming decisions though and indirectly resource-related. The presence of the partner at the location determines what can be offered and to how many beneficiaries. If the various factors determining prioritization of programming geographically indicated a specific location, however, resources could be assigned to support a more intensive presence and more extensive reach. Cost is therefore not a direct influence on numbers per district.

The final observation to note from this initial cost analysis is that there appears to be no consistent relationship between each IP's cost-per-child and the numbers it reaches. It would be expected that an increase in numbers reached would have either little effect on the cost-per-child, provided that the same blend of interventions was provided to each beneficiary. Figure 4 shows this to be the case to some extent for Caritas and FXB, where costs show little variation by numbers reached. FXB's model dictates that a consistent blend of services is offered to each child and this is incidentally the case for Caritas. If the blend of services offered differs for different beneficiaries, however, then the cost-per-beneficiary should vary substantially. This is the case for all the remaining IPs and indicates a challenge to the usefulness of cost-per-beneficiary as an analytical tool.

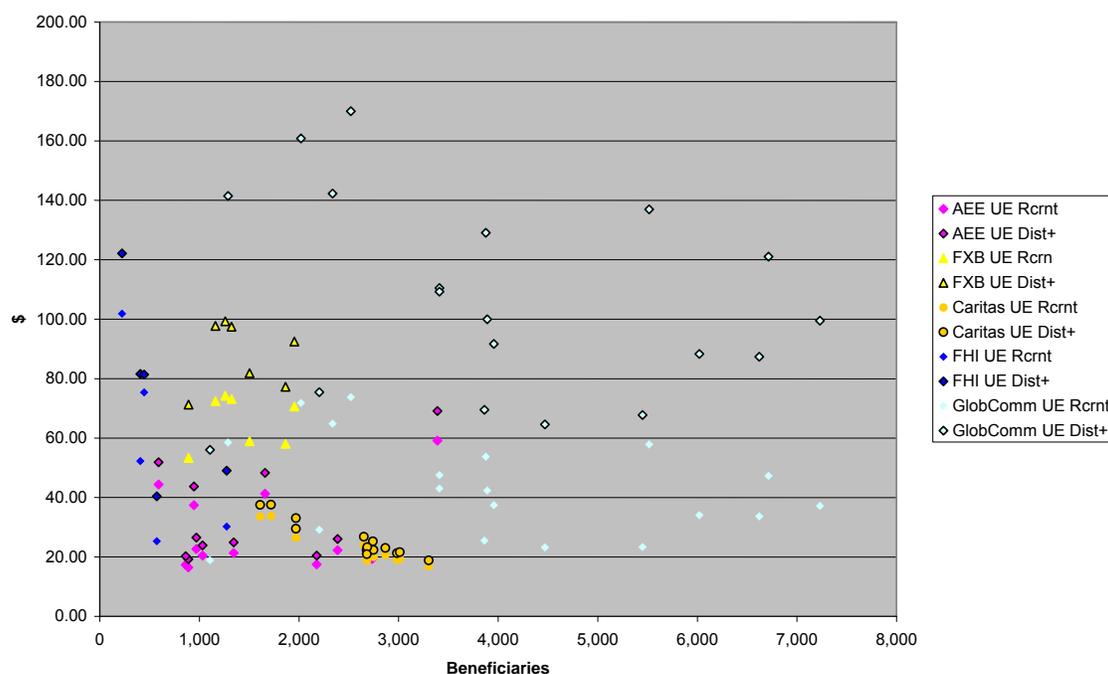
¹¹ The data for this and the following graphs can be found in tables in Annex 4.

FINDING 6: COST VARIATIONS IN ABOVE DISTRICT COSTS BETWEEN INGOs AND LOCAL CSOS

There is a substantial difference between INGOs and local CSOs in district level expenditure.

The data in Figure 5 show total district expenditures including recurrent, non-recurrent, and above-district-level expenditures (outlines shapes). The above-district-level expenditures are allocated to districts in proportion to district level expenditures, in order to calculate cost-per-child at district level. With the total and allocated expenditures, the cost-per-child is predictably higher, but the pattern is much the same, with the exception of Global Communities.

Figure 5: District Cost-per-Child by IP, Recurrent and with Allocated Central



Global Communities reports almost half of its expenditures at levels above the district and a quarter of its district-level expenses as training, which is a non-recurrent expense. With training expenses included, and above-district expenditures allocated to the districts, the cost per child across districts becomes extremely dispersed, from US\$ 56.01 (in Ngoma, with 1107 beneficiaries) to US\$ 169.92 (in Gicumbi, with 2521 beneficiaries).

Global Communities' expenditures for training are much greater than the other OVC IPs. The Global Communities program model is based on implementation through sub-partnerships. It works through ten Rwanda Partner Organizations and reported US\$ 930,537 in training expenditures, almost a third (29.6%) of which was spending for recurrent district-level expenditures.

Rwandan CSOs report minimal training expenditures. AEE and Caritas report no training expenditures for FY2014 and FXB reports a total of US\$ 2838 for training. While it can be concluded that the training implemented by these IPs is not comparable to training implemented through Global Communities, this does not necessarily reflect the amount of training executed,

but rather how IPs are reporting. The inconsistency of reporting expenditures between partners is repeated in a number of areas, including the reporting of interventions in the PSS category and the reporting of cost share. FHI 360 reports US\$ 16,297 for training.

Table 7: Comparing IP Above-District Expenditure Totals

	AEE	Caritas	FXB	FHI 360	Glob Communities
Total Expenditure US\$	672,602	884,110	878,766	209,637	7,820,744
Training	0	0	2,838	16,297	930,537
<i>as % of total</i>	0%	0%	.003%	7.8%	11.9%
Program Mgt	96,996	91,158	167,433	50,202	3,693,824
<i>as % of total</i>	14.4%	10.3%	19.1%	23.9%	47.2%
Dist Personnel	66,115	159,922	182,918	66,265	2,261,690
<i>as % of total</i>	9.8%	18.1%	20.8%	31.6%	28.9%

Source: 2014 PEPFAR EA and Partner Expenditure Data

Program management represents the most substantial cost distinction between INGOs and local CSOs. While an analysis of project management expenditure for Global Communities is possible, a comparable analysis across partners is not because reporting is not consistent. Local CSOs, for example, report all program management expenditures at the national level (14.4 percent for AEE, 10.3 percent for Caritas, 14.4 percent for FXB). AEE has three districts where they report no personnel expenditures, but have some other spending. Caritas reported the same amount (US\$ 11,423) for personnel spending in every district.

While Global Communities assumes a substantial cost burden for training, capacity development is also a significant contributor to the cost of delivering services for the local CSOs (although that cost is externalized). The HICD project implemented by DAI provided support for AEE, Caritas, and FXB. The support included a performance analysis and Performance Solutions Packages (PSP) to address performance gaps. HICD is not required to, and does not, track spending per partner organization. HICD estimates that spending for each of the three partner organizations totaled US\$ 500,000, including the performance analysis and implementation of the PSP. These costs are already integrated in Figure 5.

FINDING 7: COST AND GEOGRAPHIC LOCATION

There is no observable relationship between geographic location of programs and cost.

While geographic differences in program costs are typically expected, evidence from the analysis indicates that this is not substantially the case in Rwanda. This conclusion is the result of:

- comparing costs-per-child between partners operating in the same district; and
- comparing the difference in cost-per-child across districts for each IP.

If the geographic context influenced costs, then the rate at which costs change across districts for each partner should be comparable. This is not the case, as Figure 6 demonstrates. The scatter plot shows recurrent district-level-costs by IP for each partner and district. Twenty-four

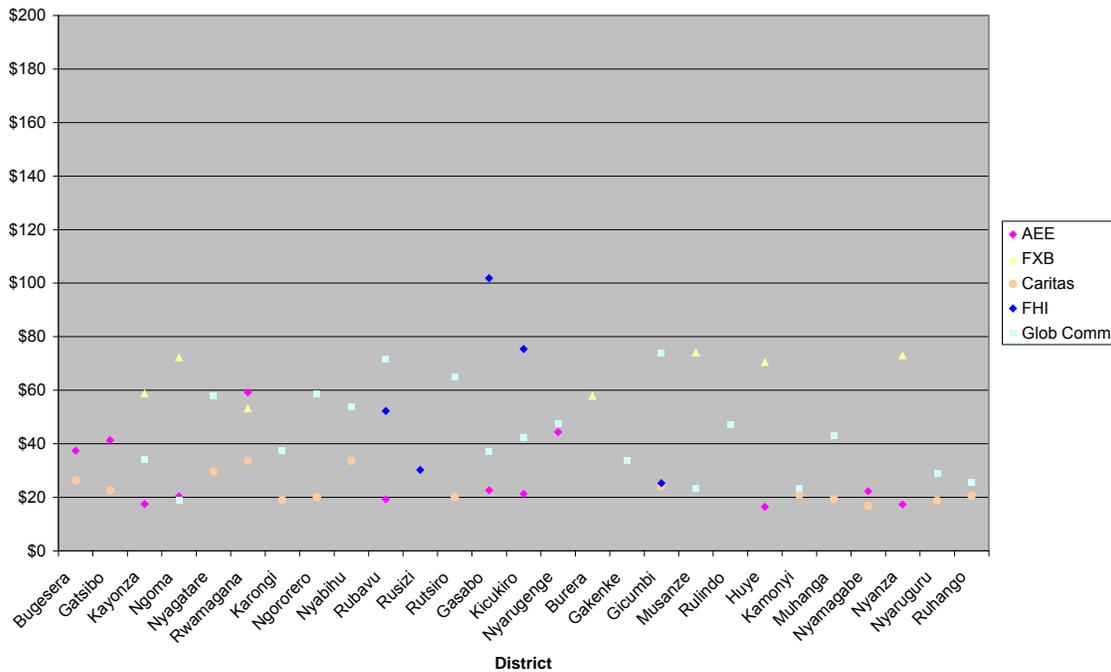
of the 27 districts served by USAID/Rwanda OVC IPs have more than one of the five IPs operating. There are 16 districts with two OVC IPs and eight districts with three IPs.

For each IP, there is substantial variation in recurrent expenditures per beneficiary by district. There is also substantial variation in expenditure per beneficiary for IPs operating in the same district, however, with no discernible pattern. For example, Ngoma (#4, in East Province) is among the higher-cost districts for FXB, but among the lower-cost districts for AEE and Global Communities, which also operate in Ngoma. Rwamagana (#6, also in East) has FXB's lowest expenditure per beneficiary (US\$ 53.28) and the highest expenditure per beneficiary for both AEE (US\$ 59.12) and Caritas (US\$ 33.66). Gicumbi (#18) has FHI's lowest expenditure-per-beneficiary (US\$ 25.28, relatively close to Caritas' US\$ 24.00) and the highest for Global Communities (US\$ 73.73).

The lack of geographic-based cost patterns continues in other districts served by IPs. The highest FHI expenditure per beneficiary (US\$ 101.81) is in Gasabo (#13, in Kigali), where AEE had one of its lower expenditure-per-beneficiary rates, US\$ 22.66. In Kicikuro (#14, also in Kigali) the FHI recurrent unit expenditure (UE) was substantially lower (US\$ 75.37) and AEE's was slightly lower (US\$ 21.26), while Global Communities had a slightly higher recurrent UE in Kicikuro (US\$ 42.33, compared to US\$ 37.16 in Gasabo).

There are a few exceptions where IPs have similar recurrent expenses per beneficiary in the same district. For example, the FXB expenditure in Rwamagana is quite close to AEE's, but both are substantially more than Caritas' expenditure per beneficiary in Rwamagana. Whatever the reasons for the convergence of cost-per-child within a district, the evidence suggests that it is incidental to geography rather than systematically associated with it.

Figure 6: IP Cost-per-Child Recurrent by District



Source: 2014 PEPFAR EA and Partner Expenditure Data

FINDING 8: COST DRIVERS

Within each service category the observable cost drivers are the IP program models, the blend of intervention types, and the level of support provided by each intervention.

The findings presented thus far indicate that there is substantial variation in costs associated with delivering services to OVC and that the differences are associated with the differences in program models of the IPs.

For FY2014, PEPFAR financial reporting includes estimates of spending for five service categories: medical care (not facility-based); educational support; economic strengthening; psychological, social, and spiritual care; and nutrition and food security. These service categories map approximately to the eight PEPFAR priority areas and, as the IPs do not report achievement or expenditure based on the latter, the service categories will be adopted to begin investigating the cost-per-child of services delivered.

Data availability significantly limits analysis of expenditures per beneficiary for the service categories, despite partners' diligent compilation and submission of data for the PEPFAR EA exercise. An initial analysis of cost-per-child in each service category produces the results shown in Table . Even when supplementing it with EA data extracted from the OVC IP financial and program reports, limitations persist and caution is required in interpreting the aggregate figures. For example, the beneficiary numbers are not reports of achievement for PEPFAR, because the IPs do not report achievement by priority area or service category.

Table 8: District Expenditures and Cost-per-Child by Service Area

		Education	PSS	Health	Nutrition	Econ S
AEE	Beneficiaries	13,900	14,744	14,803	79,600	4491
	Unit expenditure (US\$)	25.49				49.28
	Total expenditure (US\$)	354,306				221,300
Caritas	Beneficiaries	14,455	13,528		61,387	25,894
	Unit expenditure (US\$)	39.80				8.41
	Total expenditure (US\$)	575,241				217,711
FXB	Beneficiaries	4,530	8536	70,829	983	1160
	Unit expenditure (US\$)	70.81	4.21	1.56	36.60	179.12
	Total expenditure (US\$)	320,754	35,972	110,833	35,977	207,777
FHI 360	Beneficiaries	1,840	2523	4958	1999	1573
	Unit expenditure (US\$)	40.89	11.93	3.04		19.13
	Total expenditure (US\$)	75,244	30,096	15,050		30,096
Glob Comm	Beneficiaries	24,057	1626	16,673	15,678	36,891
	Unit expenditure (US\$)	86.78	304.14	42.50	45.19	\$20.98
	Total expenditure (US\$)	2,087,632	494,538	8,548	708,548	773,967

There are additional limitations inherent in the calculation of cost-per-child per service category. Integrated service categories are broad, embracing a wide range of interventions. Interventions within service categories are packaged in multiple configurations and interventions for a particular child or household may include interventions from other service categories. These configurations are not always apparent in the data and often obscure the cost of particular services to particular children/families and the amount of actual support one child/family may receive.

An example of how the structure of programming and patterns of reporting makes cost analysis problematic is in the education service category. Educational Support might include distribution of school materials for primary students (relatively inexpensive), payment of fees for secondary boarding schools (high expenditure per student), or funding a beneficiary to obtain a TVET qualification (the most expensive intervention in education support). Cost per child (or any similar statistical concept such as UE employed in the EA) averages cost out over the total number of education beneficiaries, ignoring the distinct interventions within the service category. This methodology obscures the most important observation: that not only is education the largest component of district level spending, but that a large component of education spending is secondary school or TVET fees for a small portion of the total number of beneficiaries.

Cost-per-beneficiary is also therefore not a useful tool for comparing IPs education support-related expenditure. The difference among OVC IPs in expenditure per education beneficiary reflects the different services that are provided to OVC. The differences depend on programming choices: which interventions to include, or—because the type of intervention correlates with a child’s age—which age groups to serve. In addition the chosen intervention may be implemented at various levels of support.

Support for primary education, for example, may entail the provision of schools materials to a household or each child in a household. The level of support may also diminish over time. OVC IPs reported varying strategies with respect to student families paying a portion of the school fees. The strategy differences (progressively decreasing subsidy over years versus a level subsidy amount with case-specific exceptions) have reduced significance in light of the USAID/Rwanda OVC Beneficiary Review, which found that in all schools visited, “more than 80% of the supported students were unable to pay their contribution to the school fees.” Global Communities reports implementing this strategy on a case-by-case basis as it became clear that families were not coping, indicating that even within an intervention the level of support is not uniform. The usefulness of a cost analysis that omits these differences through the blunt tool of aggregating costs is questionable.

The importance of detailed data on the blend of interventions and the level of support provided for understanding cost is demonstrated in the example of education support in Table 9. As is apparent from this cursory review of education support, data on the cost-per-child number is not a useful tool for understanding or comparing the cost for providing services to children. What would begin to prove more useful is to consider cost-per-child within intervention categories.

There are similar challenges in the use of aggregate data for the other service categories. Again, it is important to keep in mind that IPs are not required to, and generally do not, maintain records of results or expenditures by service category. The expenditure is an estimate provided

by the IP for the Expenditure Report (which asks only for an estimate). Data for results by service category must be gleaned from IP data and reports, which do not contain explicit statements of results by service category. For example, Global Communities shows a high cost of US\$ 304.14 per beneficiary for PSS. The number of beneficiaries reflects the number of students who participated in a life skills program. Global Communities also provided in-service training for 639 Community Psychosocial Workers (CPWs) and technical support and supervision for 1385 CPWs. The CPWs, are not OVC beneficiaries and Global Communities does not maintain records of the number of OVCs seen by each of the CPWs. The numerator (expenditures), includes amounts clearly associated with the provision of PSS, but the denominator (beneficiaries) does not include either the CPWs or the families that benefited from the CPW support. The result is a "unit expenditure" calculation that clearly overstates the expenditure per ultimate beneficiary.

AEE and Caritas, on the other hand, estimated zero expenditures for PSS but had records that showed a substantial number of PSS beneficiaries. This does not mean that AEE and Caritas are hyper-efficient providers of PSS but that their PSS expenditure estimates were flawed.

The variation in UE for each of the service categories and for each of the IPs, reflects both inaccuracies of the IP estimates of total expenditures by service category and the absence of reliable data for the number of beneficiaries by service category. These data deficiencies would be difficult to remedy, since a given effort could easily have components of more than one service category. For example, PSS services for families will often be intended to keep children in school but may also have components of nutrition counseling. Indeed, other than direct support for school attendance, it is likely that OVC care will include components of more than one service category, usually with no clear separation.

Ultimately, the calculation of cost-per-service category is more useful as a spur to investigate the details of the substantive programming than as an indicator of IP efficiency in providing services.

Table 9: Cost-Per-Child Implications of Intervention Blends per IP in Education Support

Partner	Interventions	Beneficiaries	Costs	
AEE	Primary and secondary basic (materials)	12,800	Total	US\$ 354,306
	Secondary school fees (boarding)	500	Per child	US\$ 25.49
	TVET (fees)	600		
Caritas	Primary and secondary basic (materials)	7728	Total	US\$ 575,241
	Secondary school fees (day)	6649	Per child	US\$ 39,80
	Secondary school fees (boarding)	1382		
	TVET (starter kits)	68		
	TVET (fees)	78		
FXB	ECD	270	Total	US\$ 320,754

	Primary and secondary basic (materials)	4100	Per child	US\$ 70,81
	TVET	120		
Global Communities	ECD	6839	Total	US\$ 2,087,632
	Primary and secondary basic (materials)	14,044	Per child	US\$ 86,78
	Secondary school fees (boarding)	204		
	TVET	3174		

FINDING 9: COST PER BENEFICIARY AS AN ANALYTICAL TOOL

The utility of cost per beneficiary as an analytical tool is severely undermined by how services are delivered, to whom they are delivered, and how they are reported.

This particular finding is arguably the most pertinent to the cost analysis exercise. Because of the three factors discussed in this finding, there are severe limits on the utility of a cost analysis as a factor in selecting an organization to manage a mechanism and determining when local CSOs are ready for transition. This conclusion is given added weight when considering that the primary cost data generated in this exercise approximates the data employed in the EA, implying that there is nothing in addition to be obtained from partners unless the routine collection of cost-related data is adjusted. More pointedly, a breakdown of the cost per beneficiary, with the current data available, has very little information value; without very careful use, it is more likely to mislead than to illuminate.

Sub-finding 9.a: Interventions within and across service categories might be delivered to a child, members of the child’s household, or to beneficiaries outside of the household such as CHWs.

Understanding the costs of providing services to children is also problematic because services are frequently provided to children indirectly and the number of children benefitting are often not or cannot be documented in these cases. Examples of such interventions include:

- All the IPs described components in which caregivers visited OVCs and their families to provide counseling and advice and in which program staff facilitated volunteer caregivers to access more specialized support and services for OVCs and their families. Even though the visits and referrals represent substantial effort, not all programs report on the number of beneficiaries of these efforts, obscuring the actual UE.
- The 4491 beneficiaries of economic strengthening services from AEE received training in improved agricultural techniques and support for participation in ISLGs. The participants also received training in how to maintain a balanced diet with produce from the improved gardening techniques, a service that overlaps with the nutrition category.
- In FY2014, AEE supported rehabilitation of 66 springs in five districts. An improved water source of clean water has impact for both health and nutrition. The wells serve an estimated 27,783 households with an estimated 79,600 individuals. This number far exceeds the 18,991 beneficiaries reported by AEE for FY2014 and overlaps with beneficiaries of other services in those districts.

Sub-finding 9.b: Partners report no cost in certain categories but the narrative reports describe activities that clearly cannot be achieved at zero cost.

- There are a number of examples of the inconsistent application of reporting practices, where the omission of expenditure associated with substantial interventions make the analysis of the cost of OVC service delivery incomplete. IPs are not required to, and do not, record spending per service category; the EA figures are explicitly estimates. A specific instance is AEE reporting no FY2014 expenditures for PSS, medical care (not facility-based), or nutrition and food security, but reporting a substantial number of beneficiaries that can reasonably be classified in those service areas. AEE reported that it mobilized 11,933 individuals to obtain health insurance, of whom it paid the fee for 382 OVC in a “catch-up” program. The project also worked with school officials and community members to provide health care referrals for 2870 children. AEE conducted HIV/AIDS awareness sessions that reached 16,519 parents/guardians and children. These results cannot have been achieved at zero cost. The IPs are capable of tracking expenditure by service category, but have no reason to do so under current agreements and oversight.

FINDING 10: THE CONTRIBUTION OF COST SHARE

Including non-PEPFAR costs to determine cost of services to children is likely to significantly increase the management and reporting burden without adding value for oversight or planning.

Sub-finding 10.a: The cost share portion of OVC services in Rwanda is a relatively small component of total costs. The utility of cost share for determining cost of services to children is currently negligible.

Cost share, including imputed cost for volunteer services, is not a major component of overall cost for OVC services. Also predictably, the IPs with the largest cost share percentage show a greater increase in costs when the cost share is included.

Sub-finding 10.b: Accounting for cost share is inconsistent across partners.

Partners commit to a cost share target in their award agreement with USAID/Rwanda. These cost share commitments vary substantially across partners. Partners follow the cost share guidance in accounting for cost share and are unlikely to renege on the agreed targets. In the review of cost share a number of observations were made that have implications for incorporating cost share into a cost analysis.

Because the cost share need not be and is not allocated equally with spending per year, the cost share per beneficiary can be expected to vary from year to year. For each of the Rwandan IPs, the cost share is less than 10% of FY2014 PEPFAR OVC funds. Because the cost share commitment is stipulated in the award agreement, however, the cost share component of the total cost of programming is predictable and not likely to vary.

The evaluation team has no reason to doubt that all IPs comply with all accounting requirements for cost share. For FY2014, there is considerable variation across IPs in the items included in cost share. Examples of activities that could contribute to cost share that were not accounted for were noted, while other included items might support extended discussions. For example,

parents are expected to pay a portion of school fees, with the parents' portion being included as part of the cost share in some instances (AEE).

Perhaps the most important observation, however, is that cost share represents a relatively small component of total cost. This would include the imputed cost of the labor of the large contingent of volunteer staff that implement interventions. **Error! Reference source not found.** shows the result if the cost share is allocated equally among all beneficiaries, rather than allocated among districts as in Figure 7. The FY2014 cost share per beneficiary ranged from US\$ 1.25 for AEE to US\$ 16.10 for FHI 360.

Figure 7: District Cost-per-Child by IP, Recurrent, with Allocated Central and Cost Share

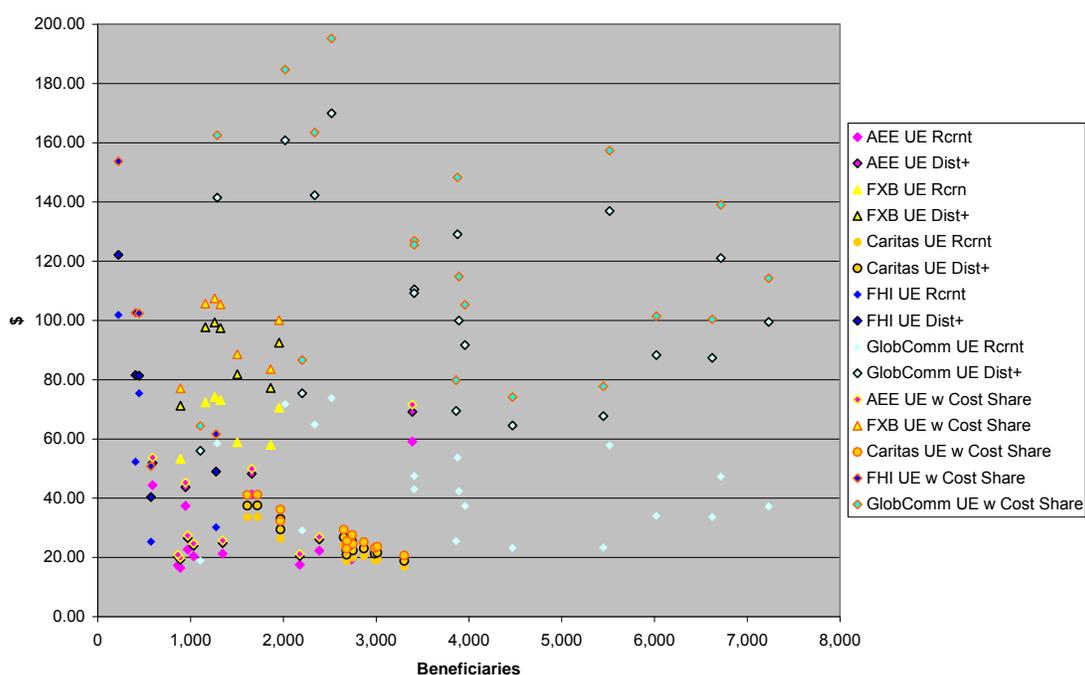


Table 6: Cost-per-Child with Cost Share by Partner

	FY2014 Cost Share	FY2014 PEPFAR	Beneficiaries	Cost Share / Beneficiary	UE
AEE	\$23,750	\$672,602	18,991	\$1.25	\$35.42
Caritas	\$84,379	\$884,110	35,639	\$2.36	\$24.81
FXB	\$72,236	\$878,766	9,960	\$7.25	\$88.23
FHI 360	\$47,069	\$182,189	2,923	\$16.10	\$62.33
Global Communities	\$1,162,744	\$7,820,744	75,921	\$15.35	\$103.01

FINDING 1 I: GENDER MAINSTREAMING

Gender has not been mainstreamed in organizational development processes and tools and subsequently is not well mainstreamed into program implementation.

The basis for gender mainstreaming is that the internal system cannot produce that which is different from itself. This means that the systems, procedures, and structures must be engendered in order to reflect or support gendered practices and programs. It is impossible to run a program that responds to the different needs of men and women and recognizes the disparities in their experience of HIV/AIDS if the internal systems and structures fail to recognize the disparities of how men and women experience and relate to the organization itself (Murison, 2004).

The FHI 360, Global Communities, and HICD capacity assessment tools did not include gender and gender has not been in mainstreamed in their capacity development processes.

Organizational procedures address some gender issues, such as discrimination and harassment in the workplace. Implementing partners were, however, not able to describe how or what gender gaps exist within organization processes. In addition, gender was not addressed either as a strength or as a gap within organizational capacity development plans and progress reports.

The PEPFAR OVC Guidance (2012) indicates that “gender has an impact across all aspects of a child’s life (from education to safety to economic opportunities etc.) and gender can affect girls and boys differently depending on their age and stage of development”. In reports, all IPs segregated their report by sex. Discussions at field level indicated that volunteers knew where to refer cases of gender abuse, for example to local leadership and the police. Technical gaps related to gender include:

- Field level staff and volunteers were unable to describe how gender considerations are taken into account in OVC programming. The only difference noted in programming between boys and girls was that “girls in secondary school are provided with sanitary materials.” All IPs report on how many boys and girls were reached by the education intervention, but additional gender analysis is not evident. The USAID/Rwanda report on education support did not disaggregate the reasons for dropouts by gender. Thus a reason for dropping out was “discipline problems” but it was not clear if this was for a boy or a girl.
- A review of FY2013 IP reports indicated that gender was omitted, with the exception being the FHI 360 Roads to Health III project. It was not clear whether programs analyze and report on how activities impact boys, girls, men, and women or on gender roles and relations. FHI 360 reported training 152 community volunteers in management of sexual and other forms of gender-based violence (SGBV) and reaching 2291 people with gender-related activities. The supported health facilities reported 43 new SGBV cases who received appropriate care. What was not clearly addressed, particularly for a project that is dealing with an at-risk population, was the power dynamics that exist between sex workers and their clients, the risks to their children, especially female children, and how all children are linked to OVC services.
- At community level, volunteers were able describe how they address issues of reproductive health with girls but not with boys.

FINDING 12: EFFECTIVENESS OF CAPACITY DEVELOPMENT

Capacity development support has contributed to improving the management systems and practices of local IPs, necessary to support implementation of quality services; however some capacity gaps persist.

Capacity Gains

Implementation of OVC programs by international organizations is largely through sub-partner organizations. The capacity building support that INGOs are providing is contributing to sub-partners' successful implementation of project activities. The assessment team visited two FHI 360/ROAD III partners (ASOFERWA and Jumba Diocese) and two Global Communities/Higa Ubejo partners (ADEPR and EPR). All sub-partners indicated that substantial capacity development had been provided and had contributed to successful project implementation.

FHI 360 adapted the OCA tool that was being used under the New Partner Initiative project. Capacity assessments were implemented in June 2013 for 13 sub-partners, including one faith-based organization, three local non-governmental organizations, and nine cooperatives as part of the ROADS II project. FHI 360 reported that substantial time was invested in building capacities of smaller local organizations and cooperatives.

While implementing the USAID/Higa Ubeho project, Global Communities provided capacity building to ten local civil society organizations, known as Rwanda Partner Organizations (RPOs) to deliver a holistic package of services in 19 USG-supported districts (per PEPFAR's FY2013 Country Operational Plan for Rwanda). The ten RPOs worked directly with the local authorities, community volunteers, and other local partners to deliver services to vulnerable families. Global Communities developed a Sustainability Index Tool (SID) for assessing capacity and developing graduation plans for the RPOs. This tool evaluates six organization domains: organizational capacity, financial viability, policy engagement, service provision, infrastructure, and public image.

Global Communities reported that not all organizations are responsive to the capacity development process or set aside time to implement capacity assessments. AEE and Caritas were graduated because they were responsive to the capacity development process. This is a notable achievement. AEE and Caritas indicated that Global Communities contributed to building their OVC technical capacity and enabled them to implement the package of services introduced under Higa Ubeho. It was noted, however, that the Global Communities SID was introduced near the end of the project, limiting its effectiveness. One partner reported that the Global Communities capacity development approach was previously "one size fits all," possibly retarding the development of some core competencies and institutional capacity.

"Capacity Development support should precede funding of local organization," (FHI 360 Capacity Development Manager).

The HICD project was designed solely to strengthen institutional and human capacity of targeted CSOs. The HICD approach to organizational performance is to assess organizational performance, define gaps, and recommend solutions. HICD does not provide technical support for HIV or OVC implementation. A Performance Solution Package (PSP) is tailored to each institutional context taking into account mission, goals, strategies, and culture. Each organization is able to define their capacity performance gaps using a root cause analysis. A memorandum of understanding among three parties (HICD, the IP, and USAID/Rwanda) was signed to ensure

parties' commitment to the capacity development process. Staff changes in HICD affected the capacity building support provided and delayed the implementation of Organizational Development plans of local IPs, according to all parties.

HICD development support contributed to improving capacities of the three local implementing partners. The HICD root cause analysis for performance gaps helped the organization to prioritize high impact activities to deal with more than one gap. Based on the gaps identified, a PSP is identified with a number of recommendations.

The local IPs have made progress in implementing their PSP and reported that the HICD capacity development model has been effective in gauging organizational capacity and identifying areas for improvement. This is illustrated by progress in implementing their PSP recommendations.

Table 7: Number of PSP Recommendations per Local CSO

PSP Recommendations			
IP	Total Recommendations	Implemented in Year II	% Implemented
AEE	97	48	49.4%
Caritas	63	31	51%
FXB	71	40	56.3%

Source: Human and Institutional Capacity Development Project In Rwanda October 2013 – September 2014 Annual Report

Local IPs assessed the HICD interventions in terms of sustainability and impact. All the scores were very good or excellent. Key achievements as perceived by the IPs are mentioned below.

Table 8: Capacity Development Achievements by Local CSO

Area	FXB	Caritas	AEE
Monitoring and Evaluation	New monitoring and evaluation system for storing more accurate data and generating data that is shared with Districts and NCC for decision-making.	A web-based database has been developed to ensure good practice of data collection and a management information system is aligned to the monitoring and evaluation plan for Caritas.	A harmonized monitoring and evaluation system has been developed to drive decision-making. Performance indicators were defined in alignment to the organization strategic objectives and data collection forms are used. The web-based system is under construction.
Strategic Planning	All levels of the organization were involved in developing a strategic plan, the first ever.		A strategic plan was developed and is owned by staff.

Advocacy	The data on outcomes for beneficiaries will be useful for advocacy.	The criteria that Caritas uses for selection of OVCs was shared and subsequently used by district government. As a result, the revisions have been made and adopted by districts across the country.	Developed a three-year national advocacy engagement plan and strategy. The communication plan has improved AEE visibility both internally and externally.
Business Development	Business development staff respond to calls for proposals and build relationships with donors.	Roles and responsibilities of the resource mobilization team are identified. Implementing a business development plan and pre-positioning for upcoming tenders.	Staff are enriched with business intelligence in resource mobilization.
Financial Management			Staff are familiarized with Audit A133 on general compliance and control. There is an updated financial procedure manual and job descriptions/disaggregated of duties in the finance department.

Source: *Human and Institutional Capacity Development Project In Rwanda October 2013 – September 2014 Annual Report*

Persistent Capacity Gaps

The capacity assessments by IPs, field visits, and review of annual process reports revealed that despite the ongoing capacity development efforts, gaps still exist.

Human resource management and technical skills

A persistent capacity gap is in human resource management. Effective implementation requires the ability to employ and manage more staff, more volunteers, and more sub-partners. The capacity assessment for IPs indicated human resource management as the weakest area.

Recruitment of qualified staff was reported as a challenge across both local organizations and international organizations. Global Communities described the time-consuming challenges in recruiting appropriately trained staff. Although 2000 applications were received for a monitoring and evaluation position, very few were appropriately qualified or experienced. The organization did consider gender in recruitment, but it was more important given these limitations to “find a star first.”

FHI 360 indicated that, particularly for CBOs and cooperatives, recruitment of staff is dependent on individuals willing to volunteer. People with the technical skills needed to implement quality OVC programs, including knowledge on ECD, sexual and reproductive health, and HIV prevention, treatment, and care are in demand and difficult to recruit and retain.

INGOs report investing substantial resources in training to ensure that staff have the technical capacity to deliver HIV/OVC services. Small organizations (i.e., sub-recipients) provide no formal internal training, coaching, and/or mentoring of staff. The sub-partners visited reported having no staff performance appraisal and development system and limited resources to meet required staffing needs.

AEE relies on staff recruited on project basis. There is one human resource manager for a possible 200 staff complement. Their annual report indicates that field staff are faced with heavy work load with follow-up visits to ISLGs and OVCs. There are nine staff fully paid by the USAID Ubaka Ejo Program: three at their headquarters and six at the field level paid by the project.

Caritas relies heavily on a large volunteer base from the Diocese; the challenge is that Diocesan staff are not directly accountable to the organization. Though Caritas has been very successful using this model of implementation, coordination across all the Diocese remains weak, as acknowledged during field visits.

FXB Rwanda has both an HR manager and a communication officer. These positions are part of the structure; however, limited funding has inhibited the filling of these positions.

Monitoring and Evaluation and Reporting (MER)

INGOs, particularly Global Communities, have commissioned evaluations and studies (on Gender, on Play-groups, on ISLGs) that provide useful findings and generate knowledge. In its PMP, Global Communities has tracked certain outcomes, such as progress through school.

The MER of the local IPs is improving but is not yet functioning optimally.

Caritas is in the process of developing its monitoring and evaluation systems with support from HICD. AEE is working on developing standardized tools for its monitoring and evaluation. FXB is developing its monitoring and evaluation framework with support from HICD to complete this process.

Financial and Program Management

The INGOs engaged in capacity development reported that financial reporting among smaller local organization was a challenge. Global Communities stated that partner financial burn rate was very low, affecting activity implementation. Burn rate review was done on a quarterly basis.

The INGOs use sub-granting to expand their reach and coverage. The local IPs have no sub-granting mechanisms. AEE provides materials to partners through purchase orders, but has no sub-granting mechanisms for long-term activity implementation.

INGOs manage large budgets that enable them to reach large numbers of beneficiaries. Local IPs are not tried and tested in this regard. Their funds have been small in comparison with the INGOs.

If USAID were to multiply the mechanisms for OVC service delivery using only local IPs, there would be a greater program management burden on USAID/Rwanda, requiring additional staff and resources. It may be possible to incrementally increase budgets and targets of local IPs and

provide demand-driven financial, management, and monitoring and evaluation capacity as required.

FINDING 13: KEY CAPACITIES FOR TRANSITIONING

While capacity development interventions have focused on improving organizational systems and processes that support the quality of implementation at site level, they have not addressed the key capacities differentiating INGOs and local CSOs, namely the capacities to implement to scale, generate and disseminate knowledge, respond to implementation challenges, and innovate.

If the ultimate objective is to transition significant mechanisms to local partners for implementation, then capacity development programs need to include the key capacities that differentiate INGOs from local CSOs. These capacities and how they are unequally evident across the two categories of partners are summarized in below.

Table 9: Capacities Differentiating INGOs from Local CSOs

Capacity	INGO	Local CSO
Basic Management		
These capacities are indicated by the systems and procedures typically included in capacity development programs for local CSOs, including strategic planning, governance, monitoring and evaluation, and financial management.	INGOs in longstanding relationships with USAID are required to demonstrate basic management capacity and do so consistently. This is the case with the INGOs with which USAID/Rwanda has partnered. In addition, the INGOs have experience with building the management capacity of local sub-partners.	The local CSOs partnering with USAID/Rwanda have benefitted from capacity development in these areas, both under the INGOs before graduating to direct funding and subsequently under the HICD program. While the data indicates that the local CSOs perform well on assessments they continue to be required to participate in these programs, prompting questions concerning how their capacity is perceived by USAID. The local NGOs have little or no experience with building the capacity of sub-partners.
Site Level Implementation		
The technical capacity to implement services and interventions to an acceptable level of quality	The data available and the quality assessment conducted during this evaluation confirms that INGOs have the technical capacity to implement at site level to an acceptable level of quality through local	The data available and the quality assessment conducted during this evaluation confirms that local CSOs have the technical capacity to implement at site level to an acceptable level of quality.

	partners whose capacity is being both developed and tested.	
Implementing to Scale		
The capacity to manage substantial grants and implement large-scale mechanisms; the key differentiating capacity for implementing transition	INGOs manage grants of substantially more value than local CSOs, operate in more districts and sectors, and reach more beneficiaries. They also manage a substantially higher number of volunteers through a large number of sub-partners. The capacity to implement to scale has been proven under previous agreements.	Compared to INGOs, local CSOs manage less money, operate in fewer districts and sectors, and reach fewer beneficiaries. They also manage fewer staff and have few or no sub-partners. They do have a pool of volunteers to call upon through their existing structures. Their current resources would require significant augmentation to manage a larger mechanism and they have no proven track record as yet for doing so.
Generate and Disseminate Knowledge		
The capacity to generate and disseminate credible knowledge to influence policy and programming outside of the partner's current activities	INGOs have produced evaluations of previous programs and have participated in policy-level dialogue in Rwanda, employing evidence from their implementation experience to produce knowledge for advocacy purposes.	With one notable exception (FXB), local CSOs have not managed to produce evaluations of their programs. They have participated in policy dialogue to a lesser extent than the INGOs.
Adapt and Innovate		
The capacity to mobilize resources to adjust program implementation in response to changing circumstances in the implementing environment	The INGOs are very responsive to both Government of Rwanda and PEPFAR priorities. An example is Global Communities' engagement on workforce development in response to a Government of Rwanda call.	Local CSOs report having a number of different funders and projects. They have not integrated or leveraged the different project activities to adjust implementation.

Assessment Team's Framework

FINDING 14: JUDGING BY RESULTS

There is insufficient outcome- and impact-level data on the interventions administered across the OVC portfolio, making it currently unfeasible to determine which combination of service categories, blend of interventions, and level of support offer the optimal impact and at what cost.

The ultimate arbiter of quality of a program is the achievement of outcomes for children. While the systematic monitoring of programs is useful, neither PEPFAR Level I indicators nor the proposed MER 9 essential indicators represent results above output level. In addition, they were not developed with the intent to assess program level outcomes, but rather to track PEPFAR investments at portfolio or country level and higher. Data from their implementation should not be expected to provide adequate measures for an analysis that will offer an indication of the cost of effective services for children.

Of the current mechanisms, only Higa Ubeho has completed a systematic evaluation of the HES service category. FXB has embarked on a systematic evaluation of its program, but while the results will no doubt be useful, they will not necessarily provide output that is comparable to evaluations produced by other partners. USAID's standard operating procedures for evaluation, as described in the USAID evaluation policy¹², provide guidance as to the conditions under which the measurement of program outcomes and impacts are required. As a result, the new OVC mechanism being implemented in Rwanda includes an integrated impact assessment, which will provide the information on results needed to improve the validity of future cost analyses. Identifying the effectiveness of programs in achieving results is the overriding criteria for considering and justifying cost, as well as assessing the usefulness of quality standards and quality improvement efforts. The current review has made it apparent that it is critical to recognize that in the absence of credible results data the utility of any cost analysis is limited.

Table 10: Program Results Routinely Assessed through Nine Essential Indicators

Indicator	Result Level	Comment
NCI. Percent of children whose primary caregiver knows the child's HIV status	Output	Knowledge of a child's HIV status equips caregivers to more effectively attend to the child's health needs. At an outcome level we might measure how this knowledge has improved a child's access to life-saving care, treatment and support interventions.
CWI. Percent of children <5 years of age who are undernourished	Output	This indicator, if measuring the result of nutrition oriented programming, is an output indicator. At an outcome level we might measure children's development against normative standards, such as Ages and Stages.

¹² USAID Evaluation Policy, Evaluation: Learning from Experience, January 2011

CW4. Percent of children too sick to participate in daily activities	NA	This indicator is not measuring a program result, although it might show improvements in health for the population of children over time. This in turn might imply that PEPFAR programs are effective in terms of facilitating access to care.
CW9. Percent of children who have a birth certificate	Output	Possession of a birth certificate allows children to access a myriad of services in terms of child and social protection. At an outcome level we might measure how a child's access to services has improved their circumstances.
CW11. Percent of children regularly attending school	Output	Keeping children in school has been shown to reduce vulnerabilities and improve prospects. This is particularly true if retention in school leads to progress through school. At an outcome level we would measure reduced risks and improved prospects.
CW12. Percent of children who progressed in school during the last year	Outcome	At an outcome level we might measure progress through school, although this too is arguably an output indicator.
CW13. Percent of children <5 years of age who recently engaged in stimulating activities with any household member over 15 years of age	Output	Stimulating activities support child development. At an outcome level we might measure how this knowledge has improved a child's access to life-saving care, treatment, and support interventions.
CW14. Percent of caregivers who agree that harsh physical punishment is an appropriate means of discipline or control in the home	Output	Appropriate discipline leads to an emotionally stable child. At an outcome level we would want to measure the contribution of appropriate discipline to a child's emotional wellbeing.
HW2. Percent of households able to access money to pay for unexpected household expenses	Outcome	Provided this indicator is applied to households participating in HES activities, it may be construed as an outcome level indicator. This indicator does not directly measure outcomes for children, however.

V. CONCLUSIONS AND RECOMMENDATIONS

CONCLUSIONS

The concluding discussion is presented as a set of direct responses to the evaluation questions. The order of the questions has been adjusted to accommodate the logical flow of the discussion.

What is the geographic service coverage and number and type of beneficiaries served by the various components of the package to OVC and vulnerable households?

In FY2014, USAID/Rwanda IPs provided OVC related services to 143,091 beneficiaries in 27 out of 30 Districts. The geographic coverage is almost ubiquitous, though there is substantial variation in numbers reached per sector. Neither the choice of districts nor the numbers reached geographically is satisfactorily explained by consistently applied programming criteria. While focusing on high HIV prevalence areas is increasingly considered, it should be noted that—with the exception of the Kigali City region—prevalence is fairly uniformly distributed across provinces.¹³

To what extent do services to children meet the acceptable quality standards as defined by international standards and Rwanda’s relevant policies and guidelines?

INGOs implement through local organizations while simultaneously building the capacity of the local organizations to implement as planned. The implementing local sub-partners of INGOs were not consistently of higher or lower quality than the local CSOs in implementation at site level. All IPs show some aspects of a quality intervention and show some areas requiring quality improvements.

Priorities for quality improvement are summarized in Table 115.

Table 11: Priorities for Quality Improvement

Term	Action for Quality Improvement
Safety	All partners (with the exception of AEE) lack child protection policies. These need to be developed
Effectiveness	<ul style="list-style-type: none"> All IPs need to track children’s progress through school at the end of an academic year and to document reasons for any dropouts, paying attention to gender differences. Standardized tools for assessing progress and outcomes in other areas such as ECD and household economic strengthening need to be adjusted to correspond to MER 1.5 indicators. Partners providing ECD services with non-PEPFAR funds need to explore ways of integrating these into current programs where possible.

¹³ Rwanda DHS 2010

Technical performance	<ul style="list-style-type: none"> • All partners need to assess their gender training materials and to update them in line with PEPFAR and Government of Rwanda guidelines and to ensure all staff and volunteers receive the appropriate exposure. • Partners (Caritas, Global Communities) providing ECD interventions need to establish a minimum level of frequency, duration, and quality of service.
Efficiency	<ul style="list-style-type: none"> • The provision of education support is the largest OVC expenditure. Providing school materials to thousands of individual children is not efficient and other mechanisms should be explored such as block grants to schools accompanied by memorandums of understanding. • AEE and Caritas need to develop a household assessment tool to determine areas of critical need.
Continuity	AEE and Caritas require written agreements with local clinics and other service providers to establish how referrals are tracked.
Appropriateness	<ul style="list-style-type: none"> • The provision of sexual and reproductive health information requires job aids. • AEE needs to assess and address personal HIV risks faced by Catch-Up students. • Caritas should explore how best to integrate early childhood stimulation into nutrition demonstrations.

Are the management systems (including planning, finance, monitoring and evaluation, contracting and grants making, and procurement systems) adequate and functioning to meet the service implementation demands of quality service delivery to OVC and vulnerable households?

Global Communities successfully built the capacity of two local NGOs to transition to direct USAID funding. During the implementation of ISVP these local NGOs partners (both of which are Tier 1 partners) will gain more skills and experience in sub-granting and project management. In addition, some other local NGOs may become ready for direct USAID funding. While developing capacity that supports the implementation of programs at site level may continue to be required, additional capacity development objectives that focus on key capacities and enable transition need to be integrated.

While basic management capacities included in current capacity development programs support implementation of programs at site level, these do not equip CSOs sufficiently for assuming the role INGOs fulfill. The key capacities differentiating CSOs and INGOs are the crucial prerequisites that must be fulfilled by local organizations in order to facilitate transition. These include the capacity to implement programs to scale, the capacity to generate and disseminate knowledge, and the capacity to adapt programs to respond rapidly and effectively to changes in the implementation environment.

What are the costs associated with delivering services to children in Rwanda?

Given that all partners provide a range of similar services to beneficiaries, it might be expected that the UE at district level would be closer than it is. However, it is the details of the service provision that are key cost drivers and seem to account for the differences. The program

model, especially of the INGOs that operate through local partners requiring capacity development, accounts for increasing differences when adding above-district costs. The added value of INGOs is the capacity building that they provide through training and supervision to local sub-recipients that might otherwise not be in a position to implement at the current quality or scale. It may be that the differences between the sub-partners implementing under INGOs account for some of the district-level differences in unit cost.

What is the unit cost per child reached over a one-year period by priority area, intervention and geography?

This evaluation has provided a number of cost-per-child calculations by service category, mapped to priority area (see Table). However, the evaluation also finds that the data required for producing cost-per-child calculations at the level of detail required for accurate and useful cost analysis is not currently available. The evaluation cautions against using the cost-per-child calculations for any consequential planning or decision-making.

There are two primary reasons for this:

- OVC programming serves children directly or indirectly through services to households and the caregivers of children. In order to attribute the cost of serving households and caregivers to a child an additional level of data would be required, i.e., the number of children in the household or under the care of the caregiver. This data is not routinely recorded by IPs. The adoption of a case management approach in mechanism design would address this data gap
- There is no generic OVC entity that benefits from OVC programming. Instead there are a number of age categories of children that receive a different blend of interventions within service categories and the costs associated with those interventions vary significantly. The level of detailed data required would distinguish individual children on the basis of age categories and specify the particular blend of interventions each child received.

As a result of this lack of data, any cost-per-beneficiary calculated—even with a service category—is insufficient for reliable decision-making. For example, costs for supporting a child of four-to-six years of age to attend an early childhood development program is not equivalent to the costs for supporting a vulnerable youth between 16 and 19 years of age to complete TVET. However, using the data that the feasibility study confirmed is available would average these costs and present a result that obscures the crucial details that determine costs and that need to be accounted for if any cost per beneficiary number is to prove useful.

What are the cost drivers by priority area, intervention and geography?

Evidence from the evaluation demonstrates that the key cost drivers of delivering services to children are:

- *Partner program models.* Global Communities, the larger of the two INGOs, invests almost one third of their expenditure in building sub-partner capacity to deliver interventions to standard. FXB shows a higher cost for beneficiary numbers reached compared to the other local CSOs because its program model dictates the delivery of a comprehensive blend of interventions for each child in their program.

- *The blend of interventions and level of support.* Intervention delivery decisions have definitive cost implications. The type of interventions children receive within a service category accounts for the most important variances in the cost of support for a child. The type of intervention a child receives is associated with the immediate needs of the age group in which they fall. A very young child will be eligible for support to attend an early childhood development program, while an older child would be eligible for support to attend secondary school. The costs associated with the two interventions are radically different. In the case of the older child, the amount of costs incurred would depend on if the support is for boarding school fees (more expensive) or for day school fees (less expensive).

What are the advantages and disadvantages in terms of costs of using one service delivery model over another?

At this stage, this evaluation could not reach a conclusion about service delivery models based on costs, for two reasons:

- A credible method for assessing cost depends on the availability of data that is not currently documented systematically. The data in question are stipulated in the discussion on the calculation of cost-per-child.
- The most crucial basis for determining the better model – evidence of efficacy – is not currently available because not all mechanisms in the OVC portfolio have been evaluated for outcomes and impact. The assessment of quality is a proxy for program effectiveness. In this particular evaluation, the assessment of quality did not provide a clear and credible distinction in quality across partner categories to substitute for a proper measure of outcomes and impact.

What are the best practices, lessons learned, and recommendations for OVC services, costs and efficiencies, as implemented by INGOs and CSOs in Rwanda?

The evaluation identified two current best practices and several quality service standards (Finding 4) that would enhance the efficacy of the portfolio and strengthen OVC services in terms of curbing the epidemic. Additional recommendations follow.

RECOMMENDATIONS

Quality Improvements

The process of developing quality standards for OVC services can contribute to more uniform services. This may be something that the newly awarded ISVP should consider facilitating development of quality standards for OVC services in Rwanda, including key interventions such as education support, household economic strengthening, and early childhood development. After quality criteria are designed for different service interventions, individual IPs can then undertake guided self-assessments to inform quality improvement plans. There are a number of guides for such a process, one of which has been footnoted in the report. As discussed in Finding 4, the IPs are implementing aspects of quality service standards but not necessarily in a systematic manner that can be harnessed for quality improvements. The Government of Rwanda should be engaged as a partner in this process to determine their level of interest in taking the development of quality standards further.

The consultants found that a number of the SIMS criteria mirrored quality criteria and could be a starting point for such an exercise.

Education Support

USAID/Rwanda should convene a meeting with all its IPs to determine the most appropriate intervention methodology for its education support. The meeting could consider the following questions:

- Is paying for school materials and school fees for individual children the most efficient mechanism for supporting OVC educational outcomes? Would other approaches be acceptable, such as block grants to schools that provide fee exemptions for vulnerable children? What other mechanisms are appropriate for Rwanda?
- What are the current models for ECD programs implemented by partners (with and without PEPFAR funding) and who accesses these? What promising high-quality, cost effective models for providing essential ECD interventions to vulnerable families are already being used in Rwanda?

Case Management

All of the IPs work in close collaboration with cell, sector, and district officers to identify the most vulnerable and needy families and children that meet criteria and are provided services. Given the high percentage of people living in poverty in Rwanda and the many needs faced by severely poor children and those affected by HIV, it is important to develop and strengthen the case management system of IPs so that urgent needs can be met, referrals can be made and followed through, and resources can be allocated efficiently. IPs do keep some records of children and families visited and of the services received. Two areas particularly can be strengthened: A) a standard operating procedure for referrals, perhaps through a memorandum of understanding with clinics; and B) case plans, perhaps through monitoring and modification as actions are completed and goals achieved.

Gender Mainstreaming

A clear process of mainstreaming gender in organizational capacity should be developed. This will help identify-organization level gaps. It is equally important that OVC needs assessments identify gender factors that increase the vulnerability of adolescents and children and how these can be addressed during implementation. Some of the issues are outlined below. IPs should be given these to review and prioritize for action.

Table 12: Considerations for Addressing Gender Issues in Organizations and Programs

Intervention	Key Opportunities to Reduce Gender Gaps and Promote Gender Equity
PSS and gender-based violence provided by community volunteers	<ul style="list-style-type: none"> • Give special attention in training of volunteers to the vulnerability of women and girls to trans-generational and transactional sex and intimate partner violence. • Promote alternative ways for men to resolve conflicts within the household through promotion of positive norms for masculinity. • Consider women’s ability to negotiate decisions in sero-discordant couples and emphasis on couples testing and counseling. • Consider clients’ preferences for either female or male providers.

	<ul style="list-style-type: none"> • Incorporate community outreach and mobilization efforts focused on boys and men. These could include, for example, community meetings, training, sensitization activities, theater, sport, and other cultural activities. • Seek male religious and other community leaders and well-known role models to act as agents of change and to speak publicly in support of gender equality, human rights, the well-being of girls and women. • Include assessment of potential gender bias and gender stereotyping in all social and behavior change communication materials. • Support programs to empower girls and women to improve self-esteem and build negotiation skills. • Increase awareness of possible inequalities in inheritance practices affecting orphans and women and mechanisms to address these, e.g., loss of farming assets by widows.
Sexual and Reproductive Health, HIV Prevention and Health	<ul style="list-style-type: none"> • Use affirming messages underscoring the positive roles boys and men can play to improve their own health and support the health and rights of girls and women. • All reproductive health programming for adolescent and pre-adolescent boys and girls to address sexual coercion and abuse and promote elements of healthy relationships. • Review strategies to consider how men and women/boys and girls are involved in the decisions on choice and use of sexual and reproductive health services and products.
ISLGs and Income Generation	<ul style="list-style-type: none"> • Develop and use gender relevant training products and core gender modules in ISLG groups to build gender awareness. • Ensure efforts to secure the role of women and vulnerable groups in decision-making in cooperatives and ISLGs. • Ensure business and marketing skills training is women and family friendly (e.g., training for women by women) and done at convenient times and in safe and convenient venues. • Promote gender equality in leadership and governance of groups and encourage greater participation of women in leadership roles. • Differentiate interests of and barriers for young and old men and women in IGAs and micro-business opportunities. • Ensure decisions on distribution of benefits within the household as well as within the group are informed by different gender priorities. • Consider ways to mitigate potential violence against women related to household income and expenditure. • Consider how to target female headed households and households with single mothers and widows and to increase their access to key resources, including credit. • Use female trainers whenever possible to serve as role models for stakeholders and use men as gender trainers.
Education, including TVET	<ul style="list-style-type: none"> • Ensure local understanding of the different barriers of boys and girls to school enrollment, retention, and success.

	<ul style="list-style-type: none"> • Address gender-specific risk factors for school drop outs (e.g., pregnancy in girls, need for income for boys' discipline). • Consider training in public participation and speaking for girls to confront some of the traditional attitudes and stereotypes that limit women's participation. • Make adequate provision for sanitation and safety needs for girls. • Address gender conventions and stereotyping in the different educational subject choices and opportunities, especially at secondary and vocational level. • Build capacity of youth especially young women to gain employment or generate an income after studies are completed.
Nutrition and ECD	<ul style="list-style-type: none"> • Address women's time and knowledge constraints and other barriers that affect their capacity to care for their children. • Ensure adequate consideration is taken of the needs of children for space and safety. • Develop specific strategies to engage men in supporting their wives and children's nutrition and health needs. • Strive for gender balance when hiring extension agents to help implement the activities. • Gather more information on how gender inequality in Rwanda affects women's and children's nutrition and health status.

Monitoring and Evaluation

The quality of OVC programs must ultimately be judged in terms of their effectiveness in achieving outcomes for children. While the monitoring of these programs is useful, neither PEPFAR Level 1 nor the 9 Essential Indicators provide USAID/Rwanda with outcome-level assessments of interventions. USAID evaluation standard operating procedures, as described in the USAID evaluation policy, should be adopted and consistently implemented for all OVC mechanisms. This will result in credible data being available to inform accurate and useful quality and cost analyses.

Assessing and Tracking Cost per Child Served

Accurately assessing cost per child served is crucial for informed planning that completes transition of the OVC response in Rwanda. It also has more immediate utility in that it can deliver critical program management data to support implementation, especially if a case management approach to OVC programming is to be adopted.

An appropriate methodology would recognize that there is no generic OVC entity, but that children served fall into multiple categories differentiated by their intervention needs (which tend to be age group related) and distributed across service categories. The cost-per-child methodology would also account for the qualifying of results by level of support received.

USAID/Rwanda should work with OVC IPs to establish consistent reporting procedures for OVC services and related expenditures. Strategic analysis of the USAID/Rwanda OVC portfolio is hampered by the difficulty of accessing data on the range of OVC services provided by OVC IPs. The OVC IPs appear to provide quality services, but it is exceedingly difficult to access data about the blend of services provided by each IP and more so about geographic differences in the blend of services provided by each IP.

Sound strategic decisions require reference to both objectives and the means to achieve the objectives. The IPs provide OVC services across multiple functional domains, with widely varying costs per beneficiary. There is virtually no documentation to explain the mix of interventions provided by USAID/Rwanda OVC IPs and little systematic data to describe the mix of interventions by or across IPs. Consistent reporting procedures for specific interventions, and related expenditures, would support a more robust discussion of efforts appropriate to achieve defined objectives.

USAID/Rwanda, in concert with OVC IPs, should identify OVC interventions and align financial and performance reporting with the interventions. The interventions should be identified with sufficient specificity to allow meaningful comparison of each intervention across IPs and geographic area. The combination of interventions provided should reflect a documented strategic assessment of the contribution of each intervention to program goals. The aggregate OVC UE would likely still vary substantially across locations and IPs, but the variation would reflect strategic choices and the cost components would be accessible and associated with performance data.

Capacity Building for Transition

Capacity building programs for local CSOs should be revised to include the building of key capacities that differentiate INGOs from local CSOs and that will equip the latter with the abilities needed to assume the implementation of large-scale mechanisms in the future. In addition to the enhancement of basic management skills (which existing programs tend to focus on), a future capacity building curriculum should also include development of:

- the technical capacity to implement services and interventions to an acceptable level of quality at site level;
- the capacity to manage substantial grants and implement large-scale mechanisms, which is the key differentiating capacity between INGOs and local CSOs;
- the capacity to generate and disseminate credible knowledge to influence policy and programming outside of the partner's current activities; and
- the capacity to mobilize resources for adjusted program implementation in response to changing circumstances in the implementing environment.

Balance of CBOs and INGOs in delivery of PEPFAR-Funded OVC Programs

The ISVP has already been awarded to Global Communities, which will implement through a two-tier system of local sub-partners. Evidence from this evaluation suggests that this particular model is currently the best option to address the transitioning priority. Three reasons emerge from the evaluation evidence to support this recommendation:

- INGOs have played an important role in building the capacity of local CSOs to deliver at site level and to improve management systems to the level required to successfully support technical delivery of programs.
- Evaluation evidence suggests that key capacities for transition that distinguish INGOs from local CSOs have not been sufficiently incorporated into capacity development programs for local CSOs, suggesting a lack of readiness for total transition. INGOs also play a substantial role in managing implementation of mechanisms through multiple local CSOs. If USAID/Rwanda were to adopt a model of implementation through multiple

local CSOs, the administrative and management responsibilities and costs would shift—possibly to the Mission.

- The cost advantages that may be realized when transition is complete are not clear as of yet, because a valid costing methodology must still be implemented. Appropriate data must be routinely collected, analyzed, and used to inform planning for transition.

VI. DISSEMINATION PLAN

This report will be available in an electronic version on the GH Pro website. The USAID Mission in Rwanda will also distribute the report to the five OVC IPs. Extracts of the report will be shared with the Government of Rwanda as appropriate.

VII. REFERENCES

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ANNEX I. SCOPE OF WORK GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT PROJECT

GH Pro
Contract No. AID-OAA-C-14-00067

RWANDA OVC (031)
Analytic Activity Statement of Work
12/22/14

Title

Evaluating the quality and costs of orphans and vulnerable children (OVC) service delivery by international non-governmental organizations (INGO) and local civil society organizations (CSO) in Rwanda

Requester

USAID/Rwanda

Performance Period

The desired start date for the evaluation is February, 2015, with a draft report to be delivered to USAID/Rwanda by May, 2015, and the final report being submitted by June 2015.

Funding Source

USAID/Rwanda Mission, Health and HIV/AIDS Office

Rationale

The purpose of the evaluation is two-fold: 1) Better understand the costs incurred by INGO/CSO to deliver OVC services, and 2) Assess the quality of OVC services provided by the different organizations. The decision by USAID/Rwanda and the Government of Rwanda to transition OVC service delivery to local CSOs stems from the assumption that increased local ownership of HIV/AIDS programs will in the long term, result in a more sustainable national response to OVC. What is unknown, however, is the capacity of local CSOs in terms of technical strategies and approaches to deliver quality programs. The quality component of the evaluation will help to inform USAID/Rwanda and Government of Rwanda to identify key technical and program management related strengths, weaknesses, opportunities, and threats to the implementation of OVC programs. Given INGOs long-term experience in implementing OVC programs in Rwanda, the evaluation will attempt to compare the quality and comprehensiveness of their services with that of local CSOs. The findings will be used by USAID/Rwanda and Government of Rwanda to identify and address any gaps in capacity and quality of services provided by CSOs and to improve OVC program planning.

To support the program planning process it is critical to understand the costs associated with OVC service delivery by the different organizations. Results from the costing piece of the evaluation will inform decisions related to the transition as well as the future direction of USAID Forward in Rwanda, in terms of greater utilization of local organizations for implementation of development assistance.

Background

USAID Forward, an initiative launched in 2010 by President Obama and Secretary of State Clinton, focuses on three main areas: 1) Use of a results-oriented targeted approach to development, 2) Promotion of sustainability through increased direct investment to partner governments and local organizations, and 3) Identification and scale-up of innovative, breakthrough solutions to development challenges. As part of the effort to advance this initiative, USAID/Rwanda has made the decision to move OVC service delivery implementation from INGOs to local CSOs.

Presently, USAID/Rwanda has or is in the process of concluding cooperative agreements with two INGOs and has awarded funds to three CSOs to implement OVC programs. The international organizations (Table 1), Global Communities (previously known as CHF International) and FHI 360, have been implementing HIV/AIDS activities in Rwanda since 2005 and are slated to close out by 2015 and 2016 respectively. The local CSOs (Table 2), African Evangelical Enterprise-Rwanda (AEE), CARITAS Rwanda, and FXB Rwanda, have been in operation since September 2012 and are expected to close in September 2015.

Implementing Organization	FHI 360	Global Communities (CHF)
Project	ROADS TO A HEALTHY FUTURE (ROADS III)	Support Services for Vulnerable Populations in Rwanda
Agreement number	AID-696-A-13-00005	AID-696-A-09-00003
Project Dates	October 2013-September 2016	November 16, 2009 – February 28, 15, 2015
Project Funding	US\$ 7,500,000.00	US\$ 62,998,061.00
Key activities	<ul style="list-style-type: none"> ▪ Provide education support to OVC/MVC ▪ Assist OVC/MVC to access health services (payment of health insurance - <i>mutuelle de santé</i>) ▪ Support OVC/MVC to access legal and protection services ▪ Mobilize community in supporting OVC/MVC for shelter and care ▪ Improve nutrition status among OVC/MVC (nutritional education, kitchen gardens, small livestock, etc.) ▪ Support OVC/MVC households to improve financial safety nets and economic resilience 	<ul style="list-style-type: none"> • Increase insurance coverage • Increase community knowledge about SGBV and Child Rights • Training of caregivers in growth monitoring and basic nutritional education • Improve use of beneficiary identification tools • Increase savings of PLHIV. • Training of PLHIV in savings and business skills. • Support school enrollment of OVC

TABLE 2: Civil Society Organizations			
Implementing Organization	CARITAS - Rwanda	African Evangelical Enterprise (AEE) Rwanda- Ubaka ejo	FXB - Rwanda
Project	Strengthening Support to Vulnerable Populations in Rwanda (GIMBUKA Program)	Strengthening Support to Vulnerable Populations in Rwanda (UBAKA EJO Program)	Strengthening Civil Society To Support Vulnerable Populations in Rwanda
Agreement No.	AID-696-A-12-00003	AID-696-A-12-00005	AID-696-A-12-00004
Project dates	September 12, 2012 – September 11, 2015	September 12, 2012 – September 11, 2015	September 12, 2012 - September 12, 2015
Project Funding	US\$ 4,655, 281.00	US\$ 2,150,000.00	US\$ 2,090,426.00
Key activities	<ul style="list-style-type: none"> • Conduct cooking demonstrations during PDH sessions using locally grown foods • Conduct counseling and nutrition education sessions, and one to one counseling of the mother with a malnourished child • Conduct monthly growth monitoring and promotion sessions for the children under 2 yrs • Monitoring of hygiene and sanitation practices at household level • Monitoring of nutrition status for lactating and pregnant women living with HIV and AIDS • Establishment of savings and credit groups from members and HIV+ people • Promotion of kitchen gardens • Distribution of chickens and rabbits to vulnerable lactating and pregnant women 	<ul style="list-style-type: none"> • Support OVC and their families and other vulnerable households and to improve their health, social and economic wellbeing. • Identifying and reaching vulnerable populations, providing needed services, and strengthening referral systems including linkages between community and health facilities, and other supportive institutions. of Rwanda spread • Strengthening household resilience through health, social and economic service provision, nutritional and educational support. • Conduct community sensitization on social protection including family law and succession plan, child right and protection, gender-based violence prevention and support as well as referrals 	<ul style="list-style-type: none"> • Support livelihood grants and training; • Increase food security • Provide health behavior training • Provide education and early childhood development services • Provide child protection and legal • Provide psychosocial counseling • Water, sanitation, and hygiene improvements • Provision of trainings in prevention and voluntary counseling and testing (VCT), child protection, and • Financial trainings; • Develop comprehensive referral directories • Form and support some saving and lending associations, cooperatives, youth clubs, OVC

Service Implementation Overview

The PEPFAR approach (<http://www.pepfar.gov/documents/organization/195702.pdf>) to children is based on a socio-ecological model that considers the child, family, community, and country contexts and recognizes the unique yet interdependent contributions of actors at all levels of society to the well-being of children affected by HIV/AIDS. The principles which govern all OVC programming are: 1) Strengthening families as primary caregivers of children, 2) Strengthening systems to support country ownership, including community ownership, 3) Ensuring prioritized and focused interventions that address children's most critical care needs, and 4) Working within the continuum of response to achieve an AIDS-free generation.

OVC programs in Rwanda have the overall objective of improving the well-being of OVC in country. Different organizations vary in their approaches (i.e. package of services) and intervention areas. Of the primary OVC intervention areas, the PEPFAR OVC Guidance (2012) describes eight priority areas including: 1) Education, 2) Psychosocial Care and Support, 3) Household Economic Strengthening, 4) Social Protection, 5) Health and Nutrition, 6) Child Protection, 7) Legal Protection, and 8) Capacity Building.

Approaches can also be categorized into direct support to OVC through provision of goods and services, or indirect support through support of guardians, families, and communities. Addressing these multiple effects due to vulnerability resulting from HIV/AIDS also includes **enhancing integration with and coordination among prevention, care, and treatment activities**. While the majority of care for children in the epidemic happens in the home and in communities, programs should not miss opportunities for integration, especially with PMTCT, antiretroviral therapy (ART), and other health services that are critically important for children to survive, thrive, and avoid infection. The strong presence of OVC programs in the home and community provide a foundation to actualize a true continuum of response across the PEPFAR portfolio. Numerous opportunities exist to ensure that care provided in clinical settings is complemented by socioeconomic, psychological, and spiritual support. Linkages to other sectors and across the continuum of response to reach the goal of an AIDS-free generation should be promoted.

Evaluation Design

A mixed methods design will be used for the evaluation. The design will allow for a comparison of the service delivery technical strategies and approaches used by INGOs and local CSOs in comparison to international standards. Quantitative data, mainly service statistics, estimated number of the targeted beneficiaries, performance targets, and financial data will be collected and used to determine the service coverage and costs of delivering OVC services.

Qualitative data will be used to put context and explain the perspectives of the beneficiaries, local government, community leaders and other stakeholders' on the quality of services. The findings will provide a detailed analysis of the quality of services provided to OVC and vulnerable households in Rwanda compared to the acceptable national, regional and international standards. The international and/or global standards were developed by the University Research Co., LLC (URC) and adopted by the international child development partners such as UNICEF, USAID and PEPFAR. These standards^{14,15}

¹⁴ Ministry of Gender, Labor and Social Development (June 2007). A Guide for Interpreting and Applying National Quality Standards for the Protection, Care and Support of Orphans and Other Vulnerable Children in Uganda (page 7).

¹⁵ Ministry of Gender, Children and Social Development (2012). Minimum Service Standards for Quality Improvement of Orphans and Vulnerable Children Programs, Kenya (page 8).

have been used successfully in Uganda and Kenya OVC programs to guide implementation of services to OVC and vulnerable households.

Evaluation Questions

The overall purpose of the evaluation is to find out the extent to which local CSOs are able to provide comprehensive and quality OVC services to the target beneficiaries in comparison to the INGOs as well as the costs of delivering OVC services.

The dimensions of OVC quality standards that this evaluation is based on are: 1) Safety, 2) Access, 3) Effectiveness, 4) Technical Performance, 5) Efficiency, 6) Continuity, 7) Compassionate Relations, 8) Appropriateness, 9) Participation, and 10) Sustainability.^{16,17} Included in the quality standard guidelines are the standardized definitions for every standard dimensions which are applicable across all countries implementing PEPFAR funded OVC programs. Essential to OVC services are referrals to needed health, education and social services, as well as referrals from these services to other services and back to the community-based services. The evaluation team is expected to derive and/or develop detailed and more specific evaluation questions from the definitions.

1. To what extent do the individual, household and community level services meet the acceptable quality standards as defined by international standards (using Kenyan and Ugandan standards) and Rwanda's policies and guidelines?
2. What is the geographic service coverage and number and type of beneficiaries served by the various components of the package to OVC and vulnerable households?
3. Are the management systems including: planning, finance, M&E, contracting and grants making, and procurement systems, adequate and functioning to meet the service implementation demands of quality service delivery to OVC and vulnerable households? What are current management systems lacking, and how can those deficiencies be addressed?
4. What are the best practices, lessons learned, and recommendations for OVC services, costs and efficiencies, as implemented by INGOs and CSOs in Rwanda? This question must consider coverage, quality, cost and efficiencies, as well as gender integration and gender norms transformation.

Gender is a cross-cutting issue that should be incorporated to all the above evaluation questions. Issues related to gender equality, gender and cultural norms transformation should be considered within each of the evaluation questions

The costing piece of the evaluation will primarily focus on understanding the costs associated with delivering OVC services by INGOs and CSOs. Most of the OVC program activities are conducted by community volunteers, and assessing cost and quality together will help to identify potential improvements. Key questions pertaining to cost that need to be answered include:

¹⁶ Ministry of Gender, Labor and Social Development (June 2007). A Guide for Interpreting and Applying National Quality Standards for the Protection, Care and Support of Orphans and Other Vulnerable Children in Uganda (page 7).

¹⁷ Ministry of Gender, Children and Social Development (2012). Minimum Service Standards for Quality Improvement of Orphans and Vulnerable Children Programs, Kenya (page 8).

1. What is the unit cost per child reached over a one-year period by intervention/priority area and geography? The definition of children “reached” should mirror the method which partners use to report achievements to PEPFAR.
2. What is the total annual cost for program implementation?
3. What are the cost drivers by intervention/priority area and geography?
4. What are the advantages and disadvantages in terms of costs of using one service delivery model over another?

METHODOLOGY

Data Collection

The overall methodology for collecting data for both the quality and costing piece of the evaluation include quantitative and qualitative approaches that will allow for triangulation of information from multiple data sources. The proposed methods include: 1) Desk review of relevant documents, 2) Key informant interviews, 3) Field observations, 4) Focus group discussions, 5) Review of programmatic and cost data, and 6) Organizational Capacity Assessment. The evaluation team should develop data collection instruments and tools that will collect a series of quantitative and qualitative data that will enable them to analyze and interpret their findings.

Desk Review

The evaluation team will conduct a desk review of project documents and other relevant sources to better understand the OVC program context in Rwanda, particularly in terms of how overall service delivery strategies and annual work plans are aligned with national, regional, and international policies and guidelines. Suggested documents include, but not limited to: technical proposal, work plan, performance monitoring plan, quarterly reports (technical and financial), annual report, national OVC programming policies and guidelines, contracts, and close out reports.. Programmatic data, such as service delivery statistics, will be collected from project documents (i.e. annual work plans, quarterly reports, performance indicator data, etc.).Some IPs’ internal assessment findings may also be consulted as background, with appropriate steps taken in the analysis of these reports to avoid bias.

Key Informant Interviews

The evaluation team will conduct key informant interviews to collect data for both the quality and costing piece of the evaluation. A semi-structured interview methodology is recommended. Suggested individuals to interview include, but not limited to: INGO/CSO staff (program and finance), government officials working with child services programs, community leaders, and USAID/Rwanda staff managing and overseeing OVC project implementation. The aim of the interviews is to gather specialized knowledge about the quality and comprehensiveness of OVC services delivered, current geographical service coverage, and future plans for sustaining services to OVC and vulnerable households. The evaluation team is expected to use this method to explore and triangulate findings with other data streams to gain an in-depth understanding of the quality of care provided by the different organizations as well as the intensity of resources delivered to OVCs (i.e. package of services). Qualitative findings from the interviews will provide the contextual knowledge necessary to interpret study results.

Field Observation

The evaluation team will conduct field observations at the household and community levels to gain an insight on how and what services are delivered. Where possible and appropriate, the evaluation team should select the OVC and households to visit from the national OVC database, and should be

coordinated with the CSO who provides the service. Routine individual and family services can be observed with the consent of those involved. The consent must include a statement instructing the provider and the beneficiaries that at any time they can ask the observer to leave. If a minor is in the room s/he must provide consent if able, along with assent from the parent or guardian. A parent or guardian must be in the room with the minor OVC during the observation. Furthermore, at any time that sensitive and/or private issues are involved the observer must leave and the observation ends. Community-based OVC activities can be openly observed. Sites for field observation should be selected to reflect the wide range of OVC services delivered (i.e. school fees, nutrition, etc.) and geographic coverage. The goal of the field observations is to assess the range of services, referrals, and the quality services provided by the different organizations as compared to the OVC quality standards guidelines as well as to understand the comprehensiveness of OVC services delivered (i.e. resource intensity). The evaluation team will also utilize field observations to assess the opportunities that existing OVC services have had to integrate and overlap with non-OVC specific health services, specifically PMTCT and ART services that are also critical for child health and survival. The goal of this activity is to determine the role and effectiveness of clinical services outside the home and community (where the majority of OVC services take place) and how strongly they are linked or overlap with other OVC programs. Semi-structured form will be used to collect data on observations. Structured categorical and numeric questions will be used to collect data on services; while open-ended questions will capture notes of the observers related to the quality and nuances of the services. Likert scales may also be incorporated into the questionnaire to allow all observers to rate the services on a set scale, to strengthen the reliability of the data across observers.

Focus Group Discussion

The evaluation team will conduct focus group discussions (FGD) to collect qualitative data for the quality piece of the evaluation. Two types of focus groups will be forms: 1) OVC parents, guardians, and caregivers; and 2) INGO/CSO staff, representing the various package of services and geographic areas of operation. The overall purpose of the FGDs is to gain knowledge about the experiences and perceptions of quality provided by the IPs and according to the various technical intervention areas for OVC – the evaluation team will use these sessions to gain insight into different opinions, experiences, feelings, and perceptions among the different groups about the type and quality of services.

Costing Data Review

The evaluation team will develop and utilize data collection/abstraction tools to collect financial and programmatic data from both the mission and INGO/CSO. Cost data will first be abstracted from financial records (i.e. program budgets, expenditure reports), but may require additional inputs as needed. Programmatic data will be pulled from the Desk Review. Methods for categorizing and allocating programmatic and cost data will be based on the PEPFAR OVC priority areas.

Organizational Capacity Assessment

The evaluation team will adapt and utilize an organizational capacity assessment tool (OCAT) to evaluate the capacity of the CSOs to implement USAID funded OVC programs. The OCAT assesses the capacity of the organization across a variety of domains, including governance, program management, administration, financial management, human resources, service delivery, and sustainability. Included in this their Monitoring and evaluation (M&E) systems will be reviewed to determine if the right data is being collected, analyzed and used to guide program implementation. Contracting and grants management systems will be reviewed to assess whether grants to sub-partners are processed in a timely manner. Timely procurement of goods and services for OVC care and support is essential to the provision of quality services. The evaluation team will therefore review how well the procurement processes are responsive to the timely provision of services based on the identified needs of OVCs. Similar methods will be used to assess planning and finance. An assessment of these program

management systems will allow for a determination of CSO capacity to plan, manage, and sustain their interventions.

Sampling Strategy

Where possible a sampling strategy that includes adequate representation of all key stakeholders including direct beneficiaries and their families should be adopted. In order to ensure that the current OVC portfolio is comprehensively reviewed, the sampling design should in part, be informed by the coverage of the eight PEPFAR priority areas. A review of FY 2012 and FY 2013 (and FY 2014 if information is available) OVC programmatic service statistics that includes the number of OVC served by type of interventions could provide some insight on how to draw samples from the different regions. Purposive sampling will be employed for key informant interviews, focus group discussion, and observations. Sampling for each evaluation method will be reviewed and finalized during the Team Planning Meeting, in consultation with USAID/Rwanda.

Data Analysis Plan

The evaluation team will use a combination of quantitative and qualitative data analysis methods, applying data triangulation techniques to validate emerging evidence from different data collection methods. Descriptive statistical analysis will be used to show the different relationships between the various data elements, especially in terms of program targets, results and coverage, and will use this technique to summarize emerging trends. Statistical data will be disaggregated by gender, type of service, geography, and age. The age classification should be presented based on the school going age categories such as early childhood education (ECD), primary, secondary, and college as determined by the Government of Rwanda. Data should be presented in tables and graphics. Excel and/or SPSS could be used in the basic statistical analysis.

Content analysis, a qualitative data analysis technique, will be used to analyze data collected from the desk review, key informant interviews, focus group discussions and field observations to determine key emerging thematic areas related to quality service implementation and program management system effectiveness. Computer-aided qualitative data analysis programs could be used depending on the software and skills available.

The costing approach should be conducted from the perspective of the INGO/CSO and include the economic costs of delivering OVC services. Costing results should show the annual total cost, cost by resource type (i.e. investment or recurrent), cost by PEPFAR priority area, and cost per child reached over a one-year period of service delivery for each of the INGO/CSO.

Limitations

One potential limitation for the quality piece of the evaluation include the assumption that baseline data and historical performance and assessment data will be readily available. Lack of this will limit the ability of the evaluation to provide rigorous evidence on the quality and comprehensiveness of services to OVC. Subjectivity of the field observations and key informant interviews also present potential limitations. The evaluation team is expected to outline strategies for addressing study limitations in their work plan discussions with the mission and USAID/W.

TIMELINE AND DELIVERABLES

Prior to travelling to Kigali, Rwanda, the evaluation team is expected to review the statement of work and project documents. In addition, a draft work plan and data collection tools should be developed.

The team lead will facilitate the distribution of tasks among team members and will facilitate all correspondence and conference calls between the team, mission, and USAID/W to adequately prepare for the assignment. The Team Lead will also ensure that all team members finalize their travel arrangements prior to departure.

Planning Meeting

The Team Leader, assisted by the mission and USAID/W, will facilitate and conduct a two-day team planning meeting in Kigali prior to the commencement of data collection. The purpose of the meeting will be to:

1. Review and clarify questions related to the study and statement of work;
2. Clarify roles and responsibilities;
3. Establish communication protocols;
4. Clarify ethics/IRB procedures in Rwanda and submit and/or present relevant paperwork to the appropriate government structures (this will be initiated by the mission prior to the team's arrival in country and will be followed up during the planning meeting); and
5. Finalize the work plan including evaluation questions, study design, data sources, list of key informant interviews, and data collection tools.

Timeline

The evaluation study will need to begin no later than early-February 2015 because of the expected close out of Global Communities in February 2015. The estimated timeline for this activity is between February 2015 to June 2015. The timing of the evaluation activities will be determined by the table in the Level of Effort Section and actual dates will be determined once the team is assembled and begins work.

Deliverables

The evaluation team will be responsible for preparing the following deliverables, all requiring final approval by the mission and USAID/W.

- *Draft work plan and data collection tools:* Prior to arrival in country, the evaluation team will need to prepare and submit draft data collection tools and work plan to the mission and USAID/W. Documents will be finalized during the team planning meeting after mission and USAID/W review.
- *Outbrief with USAID/Rwanda:* The evaluation team is expected to conduct data analysis along with data collection in order to generate preliminary results prior to departure. Preliminary findings will be presented during the outbrief with USAID/Rwanda.
- *Draft evaluation report:* The evaluation team will prepare and submit a draft report to the mission and USAID/W at the end of one week after leaving Kigali. Contents of the report will include the following sections: 1) Table of contents, 2) Executive summary, 3) Background, 4) Evaluation questions, 5) Methodology, 6) Findings, 7) Conclusion, and 8) Recommendations. Data collection tools, work plan, and data sources (i.e. list of key of informant interviews) will be

included as an annex. USAID/Rwanda and USAID/W will provide consolidated comments to the evaluation team within 10 days of submission.

- *Final evaluation report:* Within one week of receiving comments and feedback, the evaluation team will revise and submit a final report to the mission and USAID/W. This will be a public report and GH Pro will edit/format and 508the document for external release and posting on USAID/DEC. It will take approximately one month for report production process.

TEAM COMPOSITION, SKILLS, AND LEVEL OF EFFORT

The evaluation team will consist of eight consultants that have demonstrated knowledge and experience in the areas described below. The suggested team composition will include one team leader, one OVC specialist, one costing specialist, evaluation specialist, organizational capacity development specialist, and three data collectors with collective skills that encompass the following competencies: evaluation design and implementation, quantitative and qualitative data collection and analysis, economic analysis research methods, and knowledge of USAID health programs particularly in the area of HIV/AIDS and OVC care and support would be a plus.

Team Leader

The Team Leader will oversee all aspects of the evaluation study and will be the main point of contact responsible for primary communications with USAID staff and providing oversight in the design, data collection, and data analysis process. The Team Leader will also be responsible for compiling and submitting a draft evaluation report, integrating USAID feedback into the final report, and providing an oral presentation of the preliminary results to USAID/Rwanda prior to departure. (**Note:** This person will may be selected from among the other key staff, and will meet the requirements of both this and the other position.) The qualifications of the Team Leader include:

1. Advanced degree (Masters or Doctoral) in public health, social work, education, or health economics;
2. At least 10 years' experience working in public health programs in Africa, including HIV and OVC programs.
3. Previous experience in serving successfully as a lead evaluator for a USAID evaluation, experience evaluating HIV programs and particularly OVC care and support interventions highly desirable;
4. Previous experience in conducting costing studies and/or comparative analysis evaluation;
5. Demonstrated expertise and experience in designing research instruments and methodologies;
6. Excellent oral and written communication skills in English, including the ability to conduct and analyze in-depth interviews;
7. Demonstrated knowledge of USAID's policies and programs; and
8. Experience in working in a developing country context preferred.

OVC Specialist

The OVC Specialist, along with the Costing Specialist, will be expected to participate with the Team Leader in helping to design the study, review and finalize the data collection instruments, collect, analyze, and interpret findings, as well as draft various components of the final evaluation report under the direction of the Team Leader. Qualifications for the OVC Specialist include:

1. Bachelor's degree or equivalent in public health, social work, education, psychology, and/or any other development discipline with strong experience in HIV/AIDS programming, preferably community based HIV/AIDS programs that promote child development and wellbeing;

2. Experience in OVC service delivery including: Household Economic Strengthening, Early Child Development, Nutrition, Social and Child Protection, Education, and Vulnerability;
3. Demonstrated expertise in designing program evaluation data collection instruments and methodologies, experience evaluating HIV/PEPFAR programs highly desirable;
4. Previous experience in the collection and analysis of quantitative and/or qualitative program evaluation data;
5. Excellent oral and written communication skills in English;
6. Demonstrated knowledge of USAID's policies and priorities; and
7. Experience in working in a developing country context preferred.

Evaluation Specialist

The Evaluation Specialist will be expected to participate with the Team Leader in helping to design and structure the evaluation, review methodologies, collect, analyze, and interpret findings, as draft various components of the final evaluation report under the direction of the Team Leader. Qualifications for the OVC Specialist include:

1. Bachelor's degree or equivalent in public health, social work, education, or health economics;
2. At least 8 years' experience working in M&E in Africa, including M&E on HIV and/or OVC projects;
3. Previous experience in working as an evaluator on a USAID evaluation, experience evaluating HIV programs and particularly OVC care and support interventions highly desirable;
4. Knowledge and understanding of evaluation tools and methodologies and substantial practical application;
5. Excellent oral and written communication skills in English, including demonstrated successful experience in report writing and editing;
6. Demonstrated knowledge of USAID's policies and priorities; and
7. Experience in working in a developing country context preferred.

Organizational Capacity Development Specialist

The Organizational Capacity Development Specialist will be expected to participate with the Team Leader in helping to design the study, review and finalize the data collection instruments, collect, analyze, and interpret findings, as well as draft various components of the final evaluation report under the direction of the Team Leader with a focus on analyzing the organizational capacity assessment portion of the evaluation. Qualifications for the Costing Specialist include:

1. Bachelor's degree or equivalent in public health, social work, education, or health economics;
2. At least 5 years working in organizational capacity development within Africa;
3. Previous experience in working as an evaluator on a USAID evaluation, experience evaluating HIV programs and particularly OVC care and support interventions highly desirable;
4. Knowledge of technical capacity assessments with local organizations is essential;
5. Excellent oral and written communication skills in English, including demonstrated successful experience in report writing and editing;
6. Demonstrated knowledge of USAID's policies and priorities; and
7. Experience in working in a developing country context preferred.

Gender Specialist

A Gender Specialist will be recruited in none of the other Evaluation Team member have skills to provide input and oversight to assure gender issues are properly addressed within this evaluation. The Gender Specialist will be expected to participate with the Team Leader in helping to design the study, review and finalize the data collection instruments, collect, analyze, and interpret findings, as well as draft

various components of the final evaluation report under the direction of the Team Leader with a focus on analyzing issues related to gender equality, gender norms transformation, female empowerment, and gender-based violence within this evaluation. Qualifications for the Costing Specialist include:

1. Bachelor’s Degree or equivalent in social sciences or related discipline;
2. At least 5 years’ experience working on gender issues within African programs;
3. Previous experience in working as an evaluator on a USAID evaluation, experience evaluating HIV programs and particularly OVC care and support interventions highly desirable;
4. Knowledge of programming for gender transformation;
5. Excellent oral and written communication skills in English, including demonstrated successful experience in report writing and editing;
6. Demonstrated knowledge of USAID’s gender policies and priorities; and
7. Experience in working in a developing country context preferred.

Costing Specialist

The Costing Specialist, along with the OVC Specialist, will be expected to participate with the Team Leader in helping to design the study, review and finalize the data collection instruments, collect, analyze, and interpret findings, as well as draft various components of the final evaluation report under the direction of the Team Leader. Qualifications for the Costing Specialist include:

1. Bachelor’s Degree or equivalent in health economics or a related field;
2. Experience in costing related to program development and implementation;
3. Demonstrated expertise in designing research instruments and methodologies, experience evaluating HIV/PEPFAR programs and particularly OVC care and support interventions highly desirable;
4. Previous experience in conducting economic analysis research and/or costing studies;
5. Excellent oral and written communication skills in English, including the ability to conduct and analyze in-depth interviews and produce well written evaluation reports;
6. Demonstrated knowledge of USAID’s policies and programs; and
7. Experience in working in a developing country context preferred.

Data Collectors (X3)

The Data Collectors will be expected to support the data collection process, particularly in terms of reviewing and abstracting programmatic and cost data, field observations, and focus group discussions. Qualifications for the Data Collectors include:

1. At least a Bachelor’s degree or equivalent in finance economics, social sciences, or public health;
2. Experience conducting and/or participating in data collection efforts;
3. Proven ability to conduct interviews;
4. Knowledge of Microsoft Excel and other data collection tools desired;
5. Excellent oral and written communication skills in English, including the ability to conduct and analyze in-depth interviews;
6. Willingness for some travel outside of Kigali if necessary; and
7. Demonstrated knowledge of HIV/AIDS and OVC programs a plus.

Level of Effort

The estimated level of effort (LOE) in days for the evaluation team is below.

Activity	Team Leader	Eval Specialist	Org'l Cap Dev Specialist	OVC Specialist	Costing Specialist	Gender Specialist	Data Collectors

Desk review, draft work plan and data collection tools	5	5	5	5	5	5	
International Travel to Rwanda	2	2	2	2	2	2	
Team planning meeting	3	3	3	3	3	3	3
Finalization of work plan, data collection tools	2	2	2	2	2	2	
Data collection	10	10	10	10	10	10	10
Data analysis	10	10	10	10	10	10	
Outbrief and presentation of key findings	1	1	1	1	1	1	
International travel from Rwanda	2	2	2	2	2	2	
Development and submission of draft report, due one week after outbrief and departure from country	5	3	3	3	3	3	
Incorporate USAID feedback and finalize report (GH Pro estimates that approx. 1 month is required for report edit/format/508 for public release)	4	2	2	2	2	2	
TOTAL*	44	40	40	40	40	40	13

*A 6 day work week is authorized while the evaluation team is in-country.

Roles and Responsibilities

GH Pro will coordinate and manage the evaluation team and will undertake the following specific responsibilities throughout the assignment:

- Recruit and hire the evaluation team.
- Make logistical arrangements for the consultants, including travel and transportation, country travel clearance, lodging, and communications.
- Format the final report and submit to the DEC.

USAID/Rwanda will provide overall technical leadership and direction for the evaluation team throughout the assignment and will provide assistance with the following tasks:

Before Field Work

- SOW. Respond to queries about the SOW and/or the assignment at large.
- Consultant Conflict of Interest (COI). To avoid conflicts of interest or the appearance of a COI, review previous employers listed on the CV's for proposed consultants and provide additional information regarding potential COI with the project contractors evaluated/assessed and information regarding their affiliates.
- Documents. Identify and prioritize background materials for the consultants and provide them to GH Pro, preferably in electronic form, at least one week prior to the inception of the assignment.
- Local Consultants. Assist with identification of potential local consultants, including contact information.
- Site Visit Preparations. Provide a list of site visit locations, key contacts, and suggested length of visit for use in planning in-country travel and accurate estimation of country travel line items costs.
- Lodgings and Travel. Provide guidance on recommended secure hotels and methods of in-country travel (i.e., car rental companies and other means of transportation).

During Field Work

- Mission Point of Contact. Throughout the in-country work, ensure constant availability of the Point of Contact person and provide technical leadership and direction for the team's work.
- Meeting Space. Provide guidance on the team's selection of a meeting space for interviews and/or focus group discussions (i.e. USAID space if available, or other known office/hotel meeting space).
- Meeting Arrangements. Assist the team in arranging and coordinating meetings with stakeholders.
- Facilitate Contact with Implementing Partners. Introduce the evaluation team to implementing partners and other stakeholders, and where applicable and appropriate prepare and send out an introduction letter for team's arrival and/or anticipated meetings.

After Field Work

- Timely Reviews. Provide timely review of draft/final reports and approval of deliverables.

USAID/Washington will provide timely technical review of the draft workplan and data collection tools, as well as draft and final reports, as outlined above.

USAID CONTACTS

Primary USAID/Rwanda POC

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USAID/Washington POC

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Evaluation Design Matrix

Complete the following matrix to displays the methods by question they are designed to answer. Often more than one method can be employed in an analytic activity to obtain evidence to address more than one question. A method should be listed by question when it will include specific inquiries and/or result in evidence needed to address this specific question.

Evaluation Questions	Illustrative indicators or other assessment criteria	Data Source/ Collection Methods	Sampling / Selection Criteria	Data Analysis Method
<p>I. To what extent do the individual, household and community level services meet the acceptable <u>quality standards</u> as defined by international standards (using Kenyan and Ugandan standards) and Rwanda's policies and guidelines?</p> <p><i>(Note: Data will be triangulated across all data sources)</i></p>	<p>Individual, household and community based OVC services are aligned international standards and Rwanda policies and guidelines</p>	<p>Desk Review</p>	<p>Documents on international standards and Rwanda policies and guidelines services</p> <p>OVC project reports with information describing OVC services in intervention sites</p>	<p>Determination of services and standards based upon national and international guidelines/policies.</p> <p>Compare description of existing services to international and national standards, guidelines & policies, stratified by individual, household and community based services</p>
		<p>Key Informant Interviews</p>	<p>Individuals with knowledge of services (providers, managers, IPs, and beneficiaries)</p>	<p>Compare description of existing services to international and national standards, guidelines & policies, stratified by individual, household and community based services.</p>
		<p>Field Observations</p>	<p>IP and CSO OVC services at intervention sites</p>	<p>Compare observations of existing services to international and national standards, guidelines & policies, stratified by individual, household and community based services.</p>

		Focus Group Discussions	1) OVC parents, guardians, and caregivers in intervention sites; and 2) INGO/CSO staff.	Compare description of existing services to international and national standards, guidelines & policies, stratified by individual, household and community based services.
<p>2. What is the geographic service coverage, and number and type of beneficiaries served by the various components of the package to OVC and vulnerable households?</p> <p><i>(Note: Data will be triangulated across all data sources)</i></p>	<p>Number of OVCs served by service and service package (disaggregated by sex, age and location)</p>	Desk Review	INGO and CSO IPs routine performance indicator reports	Total counts of OVC services provided disaggregated by type of service and/or service package and service site (geographical location, such as community or district). If report data give sex and age, data should also be disaggregated by sex and age.
		Field Observations	CSO and other services records	Total counts of OVC services provided disaggregated by type of service and/or service package and service site (geographical location, such as community or district). If service records give sex and age, data should also be disaggregated by sex and age.
<p>3. Are the management systems including: planning, finance, M&E, contracting and grants making, and procurement systems, adequate and functioning to meet the service implementation</p>	<p>Organizational capacity rating, stratified by assessment category (i.e., management, finance, grants management,</p>	<p>Organizational Capacity Assessment (OCA)</p>	<p>CSOs implementing OVC programs</p>	<p>Using an OCAT, adapted for OVC services in Rwanda, scores, ratings, and qualitative findings.</p>

demands of quality service delivery to OVC and vulnerable households?	service delivery, etc.)			
4. What are the best practices, lessons learned, and recommendations for OVC services, costs and efficiencies, as implemented by INGOs and CSOs in Rwanda? This question must consider coverage, quality, cost and efficiencies.	Best practices and key successes of current OVC service programs in Rwanda, focusing on coverage, quality, cost, & efficiencies.	Desk Review	IP and CSO reports	Successes and underlying or contributing factors/characteristics
		Key Informant Interviews	Individuals with knowledge of services (providers, managers, IPs, and beneficiaries)	Qualitative data on successes and underlying or contributing factors/characteristics
		Focus Group Discussions	1) OVC parents, guardians, and caregivers in intervention sites; and 2) INGO/CSO staff.	Qualitative data on successes and underlying or contributing factors/characteristics
		Field Observations	IP and CSO OVC services at intervention sites	Observations of repeated elements/events that consistently lead to positive outcomes
		OCA	CSOs implementing OVC programs	Using an OCAT, adapted for OVC services in Rwanda, highest scores, ratings, and qualitative findings.
		Costing Data (see below)	(see below)	(see below) Good cost-to-quality outcomes. Good investments
	Lessons learned and related shortcomings from current OVC service programs in Rwanda, focusing on coverage,	Desk Review	IP and CSO reports	Shortcomings and obstacles with underlying or contributing factors/characteristics
		Key Informant Interviews	Individuals with knowledge of services	Qualitative data on shortcomings and obstacles with underlying or

	quality, cost, & efficiencies.		(providers, managers, IPs, and beneficiaries)	contributing factors/characteristics
		Focus Group Discussions	1) OVC parents, guardians, and caregivers in intervention sites; and 2) INGO/CSO staff.	Qualitative data on shortcomings and obstacles with underlying or contributing factors/characteristics
		Field Observations	IP and CSO OVC services at intervention sites	Observations of repeated elements/events that consistently lead to weak outcomes
		OCA	CSOs implementing OVC programs	Using an OCAT, adapted for OVC services in Rwanda, lowest scores, ratings, and qualitative findings.
		Costing Data	(see below)	(see below) Poor cost-to-quality outcomes. Poor investments
Costing				
5. What is the unit cost per child reached over a one-year period by intervention/priority area and geography?	Average annual OVC unit cost per child by service and service package (disaggregated by location and type of organization)	INGO and CSO financial records on expenditures	INGOs and CSOs currently supported by PEPFAR/USAID for the current OVC project(s)	Annual average expenditures/costs calculated by service and/or service package disaggregated by service site (geographical location, such as community or district). Average expenditures/costs will be calculated for INGOs and CSOs showing indirect costs as well.
6. What is the total annual cost for program implementation?	Average annual cost to implement OVC program in Rwanda (disaggregate	INGO and CSO financial records on expenditures	INGOs and CSOs currently supported by PEPFAR/USAID for the	Annual average expenditures/costs of OVC program implementation disaggregated by type of service site (rural vs.

	d by location and type of organization)		current OVC project(s)	urban/semi-urban) and type of IP (INGO vs. CSO), showing indirect costs as well.
7. What are the cost drivers by intervention/priority area and geography?	Factors that change the cost of the OVC intervention	INGO and CSO financial records on expenditures	INGOs and CSOs currently supported by PEPFAR/USAID for the current OVC project(s)	Expenditures/costs broken down by factors that affect the cost of program implementation and service delivery, such as distance, population density, staffing costs, presence of other donor projects, etc.
		Key Informant Interviews	Individuals with operational knowledge of services (managers & IPs)	Qualitative analysis of factors that influence cost of implementing OVC program.
8. What are the advantages and disadvantages in terms of costs of using one service delivery model over another?	Benefits and/or advantages in terms of cost by service delivery mode.	INGO and CSO financial records on expenditures	INGOs and CSOs currently supported by PEPFAR/USAID for the current OVC project(s)	a) Predefined modes and packages of service delivery. b) Cost of each mode and package of service delivery disaggregated by type of organization (INGO vs CSO). c) Benefits & advantages of each mode and package of services delivery based on cost.
	Drawbacks and/or disadvantages in terms of cost by service delivery mode.	INGO and CSO financial records on expenditures	INGOs and CSOs currently supported by PEPFAR/USAID for the current OVC project(s)	a) Predefined modes and packages of service delivery. b) Cost of each mode and package of service delivery disaggregated by type of organization (INGO vs CSO). c) Drawbacks & disadvantages of

				each mode and package of services delivery based on cost.
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ANNEX II. EVALUATION TEAM

Team Lead and OVC and Gender Expert: DeeDee Yates

Elizabeth (DeeDee) Yates has over twenty-five years of experience in Southern and Eastern Africa within the education and development sectors with particular emphasis on policy development, program design, and evaluation related to gender, early childhood development, orphans and vulnerable children and community capacity. She has been the team leader for many Orphan and Vulnerable Children multi-country, multi-year and multi-million dollar program assessments and reviews. In addition she has led teams to develop OVC project descriptions for USAID in Rwanda and Tanzania. She worked in Namibia, Zimbabwe, Malawi, Tanzania and Ethiopia on initiating quality improvement programs which began with the development of quality standards. Her particular areas of interest and expertise include: programme development, evaluation and reporting; quality improvement initiatives; capacity development of local responses for children and families affected by HIV and AIDS. Primary clients are bi-lateral agencies, the UN, international NGOs and Government of Namibia.

Costing Expert: Dr. Regan Whitworth

Regan Whitworth has broad international experience supported by a PhD in economics and a law degree (Juris Doctor). Dr. Whitworth has worked in Africa, the former Soviet Union and Central Asia. He has had roles in virtually all technical areas, and in all phases, from strategy development through close-out and evaluation, including design of performance management plans and external evaluation of projects. He has worked closely with senior host government official, including co-chairing a donor coordination group. His experience with data analysis and collection runs from primary data collection through analysis of third-party reports and data sets, including both statistical analysis and narrative assessment. He has managed survey teams in a variety of contexts, led the design of survey instruments, analyzed focus group and in-depth narrative interviews and participated in interdisciplinary teams analyzing complex events. Experience with monitoring and evaluation is documented as early as co-authorship of a 1974 paper on social goals and indicators and in recent external evaluations.

Monitoring and Evaluation Expert: Mr. Terence Beney

Terence Beney has been an evaluator for over 13 years. He has participated in and led evaluations in a variety of sectors including health, education, democracy and governance, economic development, human rights and early childhood development. Terence has worked across the African continent for governments, international donors and NGOs. His technical strengths are in evaluation design and data analysis. Terence is the immediate past Chair of the South African Monitoring and Evaluation Association.

Organizational Capacity Development and Gender Expert: Ms. Namute Nalwamba-Malama

Namute Nalwamba-Malama has HIV related project management experience spanning over 15 years, working with international Non-governmental Organizations implementing USAID funded

projects in Zambia. Her core competences and interests include organizational development, gender and systems strengthening, and HIV and malaria prevention. She provided leadership in implementation of a five year USAID funded capacity building project that reached 103 organizations implementing HIV&AIDS related activities in Zambia. Notable experience gained from this capacity development included adaptations of organizational assessment and M&E tools, facilitation of development of organizational systems, integration of gender in OD and development of a graduation process. In addition, she has contributed to various project evaluations and studies – an OVC livelihood assessment, Anti – Malarial drug efficacy research and a Child Survivor Baseline survey.

Data Collectors

Christine Dushimiyimana has contributed to various studies implemented in Rwanda. She participated in data collection for the Ministry of Education organized jointly by the Centre of Geographic Information System and Remote Sensing of the National University of Rwanda (CGIS-NUR) and Rwanda Development Gateway Group (RDGG). In addition, she participated in a survey lead by Search for Common Ground Rwanda in Southern Province focused on gathering information on land use, land reform and land sharing in Rwanda, youth issues, elections and community information sources.

Gloriose Ingabire has contributed to five research studies with various government departments and International Non-Governmental Organizations in Rwanda. Among the notable studies are the Enumerator and Data entry of information on living conditions of people members of ISLGs (Internal Saving and Lending Groups) at CHF/Higa Ubeho and Ejoheza project/Global Communities, Data entry clerk on UBUDEHE database in Kamonyi district and her participation in the 4th population and housing census for Rwanda.

ANNEX III. SITE VISIT SCHEDULE

Date of Visit	District	Province	Sector	Implementing Partner/s	Local Partner	MVC (%)	HIV Pre-Valence
Monday Feb 16				9h00 AEE 13h00 Global Communities			
Tuesday Feb 17				9h00 FHI 360 13h30 Meet NCC 15h30 HICD			
Wednesday Feb 18				9h00 FXB 13h00 Caritas			
Thursday Feb 19	Nyarungenge	Kigali City	Kimisagara	8h30 AEE		1.6	8.2 Highest
Thursday Feb 19	Kicukiro		Gikondo	2h00 FHI360	Asoferwa	1.4	6.9 (2 nd)
Friday Feb 20	Gicumbi	North	Byumba	Caritas		4.2	2.7 (15 th)
			Kageyo	Global Communities	ADEPR		
			Cyumba (Rwankokojo Cell)	8h30 FHI360	Catholic Church		
Monday Feb 23	Rwamanga	East	Rubona	8h30 FXB		1.8	4.2 (4 th)
			Mwurire (Bushenyi cell)	1h30 AEE			
Tuesday Feb 24	Kamonyi	South	Musambira	8h30 Caritas		3.7	2.9 (9 th)
			Nyarubaka or Gacurabwenge	12h00 Global Communities	EPR kamonyi		
Wednesday Feb 25	Kayanza	East	Ruramira	FXB		3.5	3.4 (7 th)

ANNEX IV. PERSONS INTERVIEWED

HEAD OFFICE STAFF				
Organisation	Surname	Name	Location	Function/Position
AEE	KALENZI	John	Kicukiro, Kigali	COP/USAID Ubaka Ejo
	NDAYISENGA	Charles	Kicukiro, Kigali	Program Director/USAID Ubaka Ejo
	MAGEZI	Emmanuel	Kicukiro, Kigali	General Accountant
	NZAMWITA	Charlotte	Kicukiro, Kigali	M&E Coordinator
CARITAS-RWANDA	USANASE			
	KANYAMIBWA	Callixte	Nyarugenge, Kigali	OVC & Nutrition Coordinator
	KAYITARE	Pauline	Nyarugenge, Kigali	DAF
	KAYITESI	Christine	Nyarugenge, Kigali	OVC & Nutrition Coordinator
	NTAKIRUTIMANA	Jean	Nyarugenge, Kigali	Program Team Leader
RUBAGUMYA	Father Emmanuel	Nyarugenge, Kigali	Deputy Secretary-General	
RUTAYISIRE	Vedaste	Nyarugenge, Kigali	M&E Coordinator	
FHI360/ROADS III	AYINKAMIYE	Anne-Marie	Nyarugenge, Kigali	Technical Officer for OVC Program
	INGABIRE	Eugenie	Nyarugenge, Kigali	Capacity Building Officer
	KAMALI	Didier Rukabu	Nyarugenge, Kigali	COP
	MUGABO	Jean Baptiste	Nyarugenge, Kigali	Technical Officer for Economic Strengthening Program
	NDAYISHIMIYE	Egide	Nyarugenge, Kigali	M&E
	SUMANYI	Jean-Claude	Nyarugenge, Kigali	FP/RH-MNIH
FXB	HABYARIMANA	Emmanuel	Kigali	COP/Programs Director
	SEBAZIGA	Frank		Finance Manager

GH Pro	DUSHIMIYIMANA INGABIRE	Christine Gloriose		Data Collector Data Collector
Global Communities	ELL FUNES ISIBO KAYIHURA MUTABAZI	Michelle Milton Tona Juste Moise	Gasabo, Kigali Gasabo, Kigali Gasabo, Kigali Gasabo, Kigali Gasabo, Kigali	Program Coordinator COP/CD Senior M&E Team Leader Program Coordinator Capacity Building Team Leader
HICD/R/DAI	GONZALES NZAMUKWEREKA	Leslie Albert		DCOP P.M. CSO's
USAID	MCCHAREN	Nancy	Gasabo, Kigali	OVC Consultant
	MISKELLY	Reiko	Gasabo, Kigali	Health Program Management Adviser
	MUNGANYINKA	Triphine	Gasabo, Kigali	Gender Specialist
	NIYONSABA	Esron	Gasabo, Kigali	OVC Specialist
	NTIRANDEKURA	Rose		Health Program Assistant
LOCAL STAFF				
Organisation	Surname	Name	Location	Function/Position
ADEPR	KALISA	Esperance		Ex-Field Staff
	KUBWIMANA	Laurien	Gasabo, Kigali	Head of Development Services
AEE	MUREMANGINGO	Rene	Rwamagana District	DAF
	SINDAYIHEBA	Phaniel	Kigali	Kigali Coordinator
ASOFERWA	KANYEMERA	Flavie		Program Assistant
	NDAGIJIMANA	Bernard		Program Manager
	NSHIMIYIMANA	Appolinaire		Coordinator
	RURANGWA	Livin		M&E
BYUMBA DIOCESE	HATANGIMBABAZI	Oscar		M&E Officer
	MUKABIRASA	Gertulde		Program Assistant (OVC & PVV)

	NIYIBIZI NTIHABOSE	Ephrem Donatien		ES Program Program Officer
CARITAS-RWANDA	MWUMVANEZA	Father Anaclet	Musambira Sector	General Secretary
EAR	NSHIMIYIMANA HAJABAGABO	Thaddee Rev. JMV		EAR Byumba Staff/KAGEYO VTC Pastor
FXB	HATANGIMANA KAMUSINE MWUMVANEZA	Jean-Nepo Azela Alain		Field Facilitator Unit Manager Unit Manager
USAID Ebaka Ejo	BAKUNDUKIZE	Sylvain	Gasabo, Kigali	Project Officer
Unspecified	BASIGAYABO	Marcelline	Cyumba Sector	Executive Secretary
	BAYINGANA	JMV	Cyumba Sector	Executive Secretary
	BAZIRUWIHA	Marcel	Kamonyi District	Field Officer
	KABAGAMBA	Wilson	Rwamagana District	Regional Coordinator
	MASENGESHO	Vestine	Kamonyi District	Field Officer
	MUKUNZI	Athanase	Ruramira Sector	Executive Secretary
	MUTABAZI	Jean Baptiste	Rubona Sector	Executive Secretary
	MUTERAMBABAZI	Christine	Kamonyi District	Sedo Cell
	MWANAWIMPUHWE	Leoncie	Musambira Sector	Field Staff
	NKUNDIYAREMYE	J. de Dieu	Rwamagana District	Ex-Field Staff/HU
PASTEUR	Anaclet	Musambira Sector	Curé Musambira	
UWACU	Jean Claude	Rubona Sector	Field Coordinator	
UWERA	Claudine	Rwamagana District	Executive Secretary	
GOVERNMENT OFFICIALS				
	Surname	Name	Field/Location	Function/Position
	NDUWAYEZU	Anastase	Gicumbi District	JAF-PS

	NYARWAYA	Andrew	Gicumbi District	Immigration Head
	RUKUNDO	Eric	Gicumbi District	District Building Resilience Officer
	SIBOMANA	Albert	Gicumbi District	District Education Officer
	UWIMANA	Deogratias	Gicumbi District	Sector Education Officer
	GAFURUMBA	Felix	Kamonyi District	Director of Health
	MAZURU	Innocent	Musambira Sector	Social Affairs in Charge

ANNEX V. DATA COLLECTION INSTRUMENTS

1) Capacity Assessment Form for OVC Services in Rwanda Organization Capacity Assessment: February 2015

Service Area	Capacity Area	Head Office	Site Level
	Governance	<ul style="list-style-type: none"> • What governance structure and processes are in place? • How do Board Members play a role in long-term development of organization? • What gaps still exist? 	<ul style="list-style-type: none"> • What governance structures exist within sub-grantees?
	Administration	<ul style="list-style-type: none"> • Do the documented procedures adequately support the operational needs of the organization and donor/s? • What procurement measures are in place to ensure that these meet organization and different donor requirements? 	<ul style="list-style-type: none"> • Do you have adequate administrative equipment, materials, tools and other support? What is still required?
	Financial Management	<ul style="list-style-type: none"> • What financial systems exist to meet both donor/s and organization requirements? • What are strengths and challenges? 	<ul style="list-style-type: none"> • How do the resources get to you here? What support do you get to manage these resources? (\$)
	Program Management	<ul style="list-style-type: none"> • Is the program planning and resource development process adequate? • How does OVC fit in within the organization strategic plan? 	<ul style="list-style-type: none"> • Who do you work with in the community? Are there challenges (CHW, local government, other CSOs)?
	Communication	<ul style="list-style-type: none"> • Please explain your communication flow with sub-partners or local organisations. 	<ul style="list-style-type: none"> • How does HQ keep you informed of changes, priorities (internet, cell phones)?

	Human Resource Management	<ul style="list-style-type: none"> • What systems are in place to ensure staff retention exists? • Is there adequate and skilled staff for OVC programming 	<ul style="list-style-type: none"> • What training do staff receive? Volunteers receive? How many volunteers do you have? How many staff? (M/F). Who supervises the volunteers? • How many children/households does a volunteer visit
	Gender	<ul style="list-style-type: none"> • How is gender mainstreamed in all organization structures, systems and procedures? 	<ul style="list-style-type: none"> • Have staff been trained in gender norms/gender awareness? How?
	Sustainability	<ul style="list-style-type: none"> • How many funding sources • How has the organization ensured continuity of support to OVC beyond Donor Support • What structures are in place for organization survivor without the current Director/Board Chair person 	<ul style="list-style-type: none"> • What structures are in place at district / community level to ensure continuity in meeting OVC needs? • What are the gaps?
	Monitoring and Evaluation	<ul style="list-style-type: none"> • What M&E system is in place and how data analysis is integrated into decision-making. 	<ul style="list-style-type: none"> • What feedback mechanism is place and how input from beneficiaries is obtained.

2) Cover Sheet for Focus Group Discussions, Key Informant interviews and Observations
Quality & Costing Assessment for OVC Services in Rwanda: February 2015

What activities does the Implementing Partner do at this site?

Service Area	Describe
Early childhood: (describe)	
Education facilitation e.g. support to enrol and attend school	
Health and HIV referrals (HCT, EID ART, PMTCT)	
Nutrition e.g. growth monitoring; demonstrations, Farmer Field Schools, WASH	
Adolescent HIV prevention, sexual and reproductive health	

	Community sensitization (or referrals) on child protection; legal rights; gender-based violence	
	Household economic strengthening e.g. financial safety net; savings; money management; VSL	

Identification and Details of the Site

Details about the Site			
2.1	Name of Implementing Partner		
2.2	Name of Local Organisation (if different)		
2.3	Date	Day	Month Year
2.4	Time of visit	From:	To:
2.5	Region:	District:	
2.6	Sector		
2.7	City/Town/Village		
2.8	Contact's Name		
2.9	Phone Number		
2.10	Email Address (if applicable)		
2.11	Where does the activity take place? (Tick Only One)	<input type="checkbox"/> Community building <input type="checkbox"/> Religious building <input type="checkbox"/> Other _____	<input type="checkbox"/> Home <input type="checkbox"/> Outside <input type="checkbox"/> Government building
2.12	How often is this activity offered to the same participants? (Tick All That Apply)	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Twice a month <input type="checkbox"/> Once a month	<input type="checkbox"/> Once a quarter <input type="checkbox"/> Twice a year <input type="checkbox"/> Once a year
2.13	What is the duration of the activity?		
2.14	How many participants were there?	Male Adults	Female Adults

	Young adults (18-25)	Young adults (18-25)
	Adolescents (12-18)	Adolescents (12-18)
	Children (5-12)	Children (5-12)
	Young children (<5)	Young children (<5)

Key Informant Interviews with Staff

Quality

Access

How do you identify and enrol families in your program?

Effectiveness

What services are you providing at this site to the children?
 Which of these do you think of a high standard/quality? Why?
 What improvements would you suggest to improve quality of the services?

Appropriateness

What are the different needs of boys and girls in your community? Are these different needs being addressed?

Continuity and Linkages

Explain how you make referrals and what challenges you face.
 Do health facilities refer children or families to you? How does that work?

Capacity

What capacity strengthening activities have you been provided with? By whom?

 What are you doing well? What not so well? Why? What makes it difficult? What makes it easy?
 What can you do to improve?

 How is your monitoring done? What issues are you having with M&E? (Challenges). How do you use your M&E information?

 How do you manage procurement? What do you procure at this site? What do you need to request HQ to procure for you?

Parent/Caregiver/Volunteer Focus Group Discussion

Targeting

How did you become part of this activity/program?
 Are there others in your community who you think should be participating who are not? Why?

Effectiveness/Priority Service Area

What services/activities are you or your children involved in supported by XXXXXX?

How have you and your children benefitted from the program? *Probe:* Frequency of service (e.g. how often does the home visitor come? How often do you go to the ECD play group?

Appropriateness: Do you have any problems participating in the activity?

What has been especially helpful to you and your family?

What would you say still needs to be done/added/improved?

Continuity and Linkages

What other services are available in your community (health, social services)? Who are the providers?

Are you able to access these other services?

Volunteering

How much time do you spend volunteering on this project? What do you do with your time?

How do you report it?

3) Dimensions of Quality

Dimensions of Quality	Definition
Safety	The degree to which risks related to care are minimized: do no harm
Access	The lack of geographic, economic, social, cultural, organizational, or linguistic barriers to services
Effectiveness	The degree to which desired results or outcomes are achieved
Technical performance	The degree to which tasks are carried out in accord with program standards and current professional practice
Efficiency	The extent to which resources needed to achieve the desired results are minimized and the reach and impact of programs are maximized
Continuity	The delivery of ongoing and consistent care as needed, including timely referrals and effective communication among providers
Compassionate relations	The establishment of trust, respect, confidentiality, and responsiveness achieved through ethical practice, effective communication, and appropriate socio-emotional interactions
Appropriateness	The adaptation of services and overall care to needs or circumstances based on gender, age, disability, community context, culture, or socio-economic factors.
Participation	The participation of caregivers, communities, and children in the design and delivery of services and in decision-making regarding their care.
Sustainability	The degree to which the service is designed so that it can be maintained at the community level, in terms of direction and management as well as procuring resources, in the foreseeable future

4) Quality Assessment Form for OVC Services in Rwanda

Based on International Standards for OVC Services and the Government of Rwanda Integrated Children’s Rights Policy and Integrated Early Childhood Development Policy

Introduction and Methodology

USAID/Rwanda is undertaking an assessment of the quality of OVC services offered by different partners throughout Rwanda. This Assessment form is based on the different services that OVC receive – Health, Education, Protection, Nutrition, Psycho-social support and household economic strengthening. It uses ten Dimensions of Quality to assess the services.

This form is an instrument for systematically assessing quality in the provision of OVC services. The data generated will be used to consider what contributes to quality and where there may be gaps. The completion of the form will be done through in-depth discussions with implementing partner programme managers at head office and then verified through observation and focus group discussions at site level. The evidence for the partner responses and more detailed descriptions will be collected.

The form will be administered by DeeDee Yates (OVC and Gender Specialist) and Terence Beney (M&E Specialist). Based on the findings key areas will be followed up and verified at site level through focus group discussions with beneficiaries and volunteers and local level staff.

Identify the Type of Activity

	National Level Office	Describe
	Early childhood: (describe)	
	Education facilitation e.g. support to enrol and attend school	
	PSS	
	HIV prevention	
	Health and HIV referrals (HCT, EID ART, PMTCT)	
	Nutrition e.g. growth monitoring; demonstrations, Farmer Field Schools, WASH	
	Community sensitization (or referrals) on child protection; legal rights; gender-based violence	
	Household economic strengthening e.g. financial safety net; savings; money management; VSL	

Identification and Details

Details about the Site			
1	Name of Organization		
2	Date	Day	Month Year

3	Region:	District:	
4	Sector		
5	City/Town/Village		
6	Contact's Name		
7	Phone Number		
8	Email Address (if applicable)		
9	Where does the activity take place? (Tick Only One)	<input type="checkbox"/> Community building <input type="checkbox"/> Religious building <input type="checkbox"/> Other _____	<input type="checkbox"/> Home <input type="checkbox"/> Outside <input type="checkbox"/> Government building
10	How often is this activity offered to the same participants? (Tick All That Apply)	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Twice a month <input type="checkbox"/> Once a month	<input type="checkbox"/> Once a quarter <input type="checkbox"/> Twice a year <input type="checkbox"/> Once a year
11	What is the duration of the activity?		
12	How many participants were there?	Male Adults Young adults (18-25) Adolescents (12-18) Children (5-12) Young children (<5)	Female Adults Young adults (18-25) Adolescents (12-18) Children (5-12) Young children (<5)

Assessment of Minimum Quality Standards

Quality Standard No. 1: Safety		
Indicators:	Level of Attainment	
	Yes/No	Comment
Activities are designed so as not to stigmatize the child or family.		
The organization has a child protection policy.		
Comments:		

Quality Standard No. 2:	Access
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Indicators:	<i>Level of Attainment</i>	
	Yes/No	Comment
The targeting of beneficiaries is well understood by all members of the community.		
Community structures are used in establishing the target beneficiaries.		
Explicit steps are taken to identify and reach the isolated, marginalized, and most vulnerable, and affected by HIV (SIMS).		
Any barriers to participation such as hidden costs, venue, time, are recognized and addressed/removed with cognizance taken of gender differences.		
Comments:		

Quality Standard No. 3:	Technical standards and professional practice (links to ICRP of Government of Rwanda)	
Indicators:	<i>Level of Attainment</i>	
	Yes/No	Comments
Volunteers or staff are trained in the subject matter through a recognized curriculum.		
The providers or volunteers receive supportive supervision (at least four/year).		
For children under five their growth is monitored.		
Staff are able to recognize signs of child abuse, neglect and illness, and are aware of the procedure for reporting to senior management or to local authorities.		
Program creates awareness among communities on child rights and protection, gender norms laws and		

services available through campaigns and IEC materials.		
Comments:		

Quality Standard No. 4: Compassionate Relationships		
Indicators:	<i>Level of Attainment</i>	
	Yes/No	Comments
During the year, the same adult engages with the children/or visits the household.		
Confidentiality is maintained (SIMS).		
The ratio of adults to children is reasonable (1-25 for those >5).		
Comments:		

Quality Standard No. 5: Appropriateness		
Indicators:	<i>Level of Attainment</i>	
	Yes/No	Comments
Activities and messages are age appropriate with all targeted ages catered for.		
Both men and women act as mentors/volunteers/trainers.		
IEC materials are in local languages.		
Comments:		

Quality Standard No. 6: Participation		
Indicators:	<i>Level of Attainment</i>	
	Yes/No	Comments
Families are the key entry point for services.		

Families are respected and supported as the primary carer of their children and involved wherever appropriate in the activities.		
Local resource people are involved in the activities (social workers; nurses; CHWs)		
Equal participation is encouraged for boys and girls; men and women.		
Comments:		

Quality Standard No. 7:	Continuity and Linkages	
	<i>Level of Attainment</i>	
Indicators:	Yes/No	Comments
Staff and volunteers have knowledge of location and responsibilities of various local social, health and protection services providing support to children/ families with disabilities, chronic or long term illness, abuse or other needs.		
Children and family members are referred for social and health services and uptake of HTC and PMTCT, EID, and ART services are actively encouraged and assisted.		
The referrals are assisted when necessary.		
The partner receives referrals from health facilities (bi-directional).		
A system is in place with standard tools to track referrals to services (including HIV testing) (SIMS).		
Comments:		

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Quality Standard No. 8:	Effectiveness (including action items from ICRP of Government of Rwanda)	
	<i>Level of Attainment</i>	
Indicators:	Yes/No	Comments
There are records of each child and parent/guardian (SIMS).		
Initial assessment and regular follow-up of every child is done by appropriately skilled service providers (SIMS).		
Children have or are helped to get Health Insurance.		
Children under 3 years of age are receiving integrated <input type="checkbox"/> childhood services.		
Programs improve access to clean water and sanitation. <input type="checkbox"/>		
Staff/volunteers identify children whose births are not registered and mobilize their families/ caregivers to register them.		
Assessment of barriers to education and interventions to address them are made (SIMS).		
Enrolment and retention in ECD, pre-primary, primary and lower secondary schools is monitored (SIMS).		
Comments:		

Quality Standard No. 9:	Efficiency	
	<i>Level of Attainment</i>	
Indicators:	Yes/No	Comments
Community and government structures are consulted when		

determining which services to prioritize and provide.		
The appropriate duration, frequency and quantity of the service has been determined and is followed.		
The program is able to reach xx% of the target group (coverage).		
Activities are co-located or integrated with HIV clinical services (potential).		
Comments:		

Quality Standard No 10: Sustainability		
Indicators:	<i>Level of Attainment</i>	
	Yes/No	Comments
Links are made with the VUP program when possible.		
Extension workers (agricultural, health, protection) are trained in aspects of the program and encouraged to participate.		
Basic livelihood options are provided to poor and vulnerable families.		
Procedures are in place for closing files and transitioning children and their families from program support (SIMS).		
There is an explicit exit strategy or sustainability plan to ensure that beneficiaries graduate from PEPFAR support and/or that ongoing external support will continue to be provided independent of PEPFAR (SIMS).		
Comments:		

Priority Area	OVC Reached (Beneficiary)		Invest / Recurrent	Expenditure		In-Kind			
	M	F		Labor	Non-labor	Labor		Non-labor	
						Value	Hours	Value	Phys. Units
1) Education									
2) Psychosocial Care and Support									
3) HH Economic Strengthening									
4) Social Protection									
5) Health and Nutrition									
6) Child Protection									
7) Legal Protection									

8) Capacity Building									

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