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HAPSAT HAITI: THE SUSTAINABILITY OF OVC PROGRAMS

March 2011

This publication was produced for review by the United States Agency for International Development. It was prepared by Elaine Baruwa, Darwin Young, Asha Sharma, and Rachelle Cassagnol for Health Systems 20/20 Project.

HEALTH SYSTEMS 20/20

Mission

The Health Systems 20/20 **cooperative agreement,** funded by the U.S. Agency for International Development (USAID) for the period 2006-2011, helps USAID-supported countries address health system barriers to the use of life-saving priority health services. Health Systems 20/20 works to strengthen health systems through integrated approaches to improving financing, governance, and operations, and building sustainable capacity of local institutions.

March 2011

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Cooperative Agreement No.: GHS-A-00-06-00010-00

Submitted to: Robert Emrey, CTO
Health Systems Division
Office of Health, Infectious Disease and Nutrition
Bureau for Global Health
United States Agency for International Development

Recommended Citation: Baruwa, Elaine, Darwin Young, Asha Sharma, and Rachelle Cassagnol. March 2011. *HAPSAT Haiti: The Sustainability of OVC Services.* Bethesda, MD: Health Systems 20/20 project, Abt Associates Inc.

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ACRONYMS

CBCS	Community-Based Care and Support
CBO	Community-based Organization
EMMUS-IV	*Enquête Mortalité, Morbidité et Utilisation des Services* (Mortality, Morbidity and Service Utilisation Study)
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HAPSAT	HIV/AIDS Program Sustainability Analysis Tool
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
HHR	Household Rations
IGA	Income-generating Activities
M&E	Monitoring and Evaluation
OVC	Orphans and Vulnerable Children
PEPFAR	President's Emergency Program for AIDS Relief
PLWHIV	People Living with HIV
RUTF	Ready-to-Use Therapeutic Food
SCMS	Supply Chain Management Systems
USAID	United States Agency for International Development
USG	United States Government
WFP	World Food Program

ACKNOWLEDGEMENTS

We would like to thank USAID for the funding with which this work was conducted. We are also grateful to the Haiti Mission staff for all of their assistance: Olbeg Desinor, Stephane Morisseau, Judith Timyun, Chandra Baier, and Jorge Velasco. In addition, we convey our thanks to the partners who provided considerable time and access to the team: Larousse Ceus, Jean Monetoile Marseille, Andrinette Cadet, and Leonardo Shamamba.

Finally, we would like to state our deepest respect and admiration for everyone mentioned here. We are humbled at the dedication we were privileged to observe by the people working with us in Haiti and we remain inspired by what is possible in the face of seemingly insurmountable odds. Thank you.

EXECUTIVE SUMMARY

In December 2009, the USAID Haiti, Port-au-Prince, asked Health Systems 20/20, a USAID-funded health systems strengthening project, to conduct an HIV/AIDS Program Sustainability Analysis. Data collection for this effort began December 2009 and was due to conclude in January 2010. Following the devastating earthquake of January 12, 2010, work on this analysis was suspended. In July 2010, this work was re-started after the Partners Conference of the President's Emergency Plan for AIDS Relief (PEPFAR). At this time it was determined that the most useful outcome of a sustainability analysis of the HIV program in the current context would be an analysis that focused on the care being delivered to orphans and vulnerable children (OVC). Health Systems 20/20 therefore focused efforts on the collection and analysis of data on OVC care.

The following report provides an in-depth sustainability analysis on the costs and types of care provided to OVC by PEPFAR-funded implementing partners. It describes and analyzes the range of interventions being delivered by four partners. The costs from this analysis were fed into an analytical model developed by Health Systems 20/20 as part of its HAPSAT/Sustainability analysis process to cost and compare 'packages' of care. After describing a Haitian context-specific package of care, this model was used to determine the cost of delivering this package to all eligible OVC. Given the substantial cost of such a program (given the number of OVC who could be classified as being eligible or 'in need'), a second, smaller package with lower target levels of coverage was also costed and the gaps between needs and targets highlighted. The report concludes with recommendations for strengthening this aspect of Haiti's HIV response.

The results and model used in this report can assist in the planning and expansion of current programs in a sustainable manner in several ways. By describing a clear and consistent package of care, funding partners will be able to 'agree' on a more specific set of targets that truly reflect the objectives of both the funder and implementer – that is, to improve the well-being of OVC rather than merely the delivery of services. A costed package supports this objective by preparing for more specific monitoring and evaluation indicators that convey impact rather than process alone. A costed package provides valuable information to funding partners wishing to leverage their efforts by working together. For example, where one partner has funding to work in education and another has funding to work in nutritional support, the costed package and modeling exercise laid out in this report allows each partner to allocate funding to the program with specific expectations of outcomes. This specificity may encourage partnerships by removing the possibility of partner funding 'disappearing' into a program and making it easier for partners to report their own individual efforts in impact terms rather than monetary terms. Finally, as partners increase efforts towards the strengthening of Haiti's public sector, any effort at costing programs is potentially useful information for the many ministries that ought to be involved in providing OVC care including ministries of health and public health, education, and social welfare.

1. INTRODUCTION

1.1 BACKGROUND

Haiti has the highest prevalence rate of HIV in the western hemisphere (2.2 percent). It is also the poorest country in the hemisphere. These two factors made the situation for orphans and vulnerable children (OVC) particularly dire prior to the massive earthquake on January 12, 2010. The earthquake exacerbated the situation for children residing in and around the quake's epicenter just outside Port-au-Prince, the country's densely populated capital. Approximately 35 percent of Haiti's 9.6 million people are less than 15 years of age – an implied 3.5 million children. The Mortality, Morbidity and Service Utilisation Survey (*Enquête Mortalité, Morbidité et Utilisation des Services*, or EMMUS-IV) conducted in 2005/6 estimated that 11 percent of children less than 18 years of age have a lost a mother, father, or both and that a further 15 percent of children are considered vulnerable. This combination of HIV prevalence, poverty, and socio-demographic characteristics imply a severe and massive problem that has the potential to have a significantly negative impact on Haiti's future economic and social development. Already it is estimated that 29 percent of children under five are moderately to severely underweight, that primary school enrollment over 2003–08 was only 50 percent, and that the immunization rate for DTP3 in children less than one year of age was just 53 percent in 2008. It is expected that having an HIV-positive head of household or losing a head of household to HIV will potentially render OVC even more vulnerable than the poverty that already erodes their quality of life.

The report "The Situation of Orphans in Haiti: A Summary Assessment," written by Family Health International in 2000, though dated, provides an important understanding of the situation and its causes. That report estimated that 25 percent of children under 15 years of age could be classified as being 'vulnerable' – very similar to the more recent EMMUS-IV findings. Today, with 35 percent of the population under 15, if 25 percent are assumed to be orphans or vulnerable, it means that there were approximately 880,000 OVC living in Haiti 2010 prior to the earthquake.

Since Family Health International's OVC review, two major funding partners have begun funding large-scale OVC care and support programs in Haiti. Since 2003, the Global Fund To Fight AIDS, Tuberculosis and Malaria (GFATM) has provided funding for the care of OVC in both Round 1 and Round 5 of its HIV grants. Also since 2005, the United States Government's (USG) President's Emergency Plan for AIDS Relief (PEPFAR) has been funding care and support for OVC in Haiti that is delivered through implementing partners that in turn provide services through community-based organizations (CBOs) that interact directly with children and their families. Prior to 2009, these partners operated as contractors to USAID. Since then, many partners and programs have been consolidated under the Community Health for AIDS Mitigation Project (CHAMP).

1.2 OBJECTIVES

USAID/PEPFAR would like to have a detailed understanding of what services are being provided to OVC in Haiti and at what cost. Health Systems 20/20 conducted a rapid cost assessment to understand the variety of services being provided. The information on services and their unit costs informed the design of an illustrative package of care that was costed using the OVC Care and Support Planning Tool, a component of Health System's 20/20's HIV/AIDS Program Sustainability Analysis Tool (HAPSAT). The

resulting program cost estimates can be used to assist funding partners, like PEPFAR, with the budgeting, planning, implementing, and monitoring and evaluation (M&E) of sustainable OVC programs.

1.3 METHODOLOGY

To understand the current context and magnitude of the situation, a review of available reports and documentation on OVC in Haiti was conducted. Several of these publications are noted in this document. Following this review, four PEPFAR-funded implementing partners, recommended by USAID, were approached for costing and service delivery data.

1.3.1 DATA COLLECTION

Costing data were obtained from key informant interviews conducted with the program manager for each partner/program and their financial staff. Annual reports for each partner were also obtained and reviewed. This exercise provided data on:

- The types of services that are delivered by each partner;
- The unit costs of providing each service comprising:
    - the direct costs of materials (e.g., the cost of the contents of a hygiene kit)
    - the direct costs of labor required to delivery the service (e.g., the level of effort in terms of time and the salary of the staff required to produce one psychosocial meeting or home visit)
    - the indirect costs of administrative support (e.g., the overhead and salary costs incurred by the implementing partner who received the funding that is provided to CBOs to deliver services; and
- The quantity of services delivered to OVC.

Cost data were collected for 2009 or the fiscal year that covered most of 2009 so all data/analysis are pre-earthquake unless specifically stated otherwise.

Service delivery data were collected from the Community-Based Care Services Registers (*Registre Soins Palliatifs Communautaires*) that were designed to track the care delivered to individuals receiving non-health facility-based services, including OVC. Each partner was asked to choose two of its supported sites, and a trained data collector visited the sites to abstract service delivery information for up to 100 registered OVC. Table 1 shows the breakdown of OVC age categories that were used in the random selection of OVC.

TABLE 1. NUMBER OF SUBJECTS USED FOR SERVICE DELIVERY DATA COLLECTION BY AGE

Age Group	Number of Subjects
<2 years	20
2-5 years	40
6-14 years	20
15-18 years	20

The data collector would open the register for patients registering at the beginning of 2008 and take the first child in each age category on that page, abstracting some socio-demographic data on that child and any data on which services were received in the 12 months after registration. This process was followed for each subsequent page of the register. No identifying data were abstracted for any children or their caregivers.

1.3.2 DATA ANALYSIS – OVC CARE PACKAGE COSTING MODEL

An Excel-based module of the HAPSAT was used to cost a package of care that could be delivered to a target group of OVC. The model was designed to be dynamic so that a user is able to add or take away services from a package with ease and to allow a different packages to be specified for 'high' need or 'low' need children within each age group (where the age groups were under five years, 5–14 years, and 15–18 years).

After reviewing all the intervention data from the data collection, unit costs were estimated for each intervention, which were then added to the model's intervention menu so that it each intervention could be selected as a 'line item' for inclusion in a package of care. Where more than one partner delivered the same service, an average cost per unit was estimated and included as a separate line item that could be included in a package of care.

Figure 1 shows the summary page of the costing tool.

***Resource Envelope**:* The tool estimates the difference between the funding resources available and the cost of delivering a defined package of care to a defined number of children.

***Population Classification**:* The tool requires the user to enter the size of the target populations by age and by need. For example, the user must entire the size of the under five population that is classified as being 'orphaned and vulnerable.' Following this, the user can further divide that population into high, medium and low need categories. For the analysis in Haiti, only the low and high categories are used. Population and socio-demographic classifications of OVC were taken from EMMUS-IV.

***Menu of Interventions Groups**:* The tool can accommodate the following groups of interventions: nutritional, educational, psychosocial, health, economic, shelter, and protection,

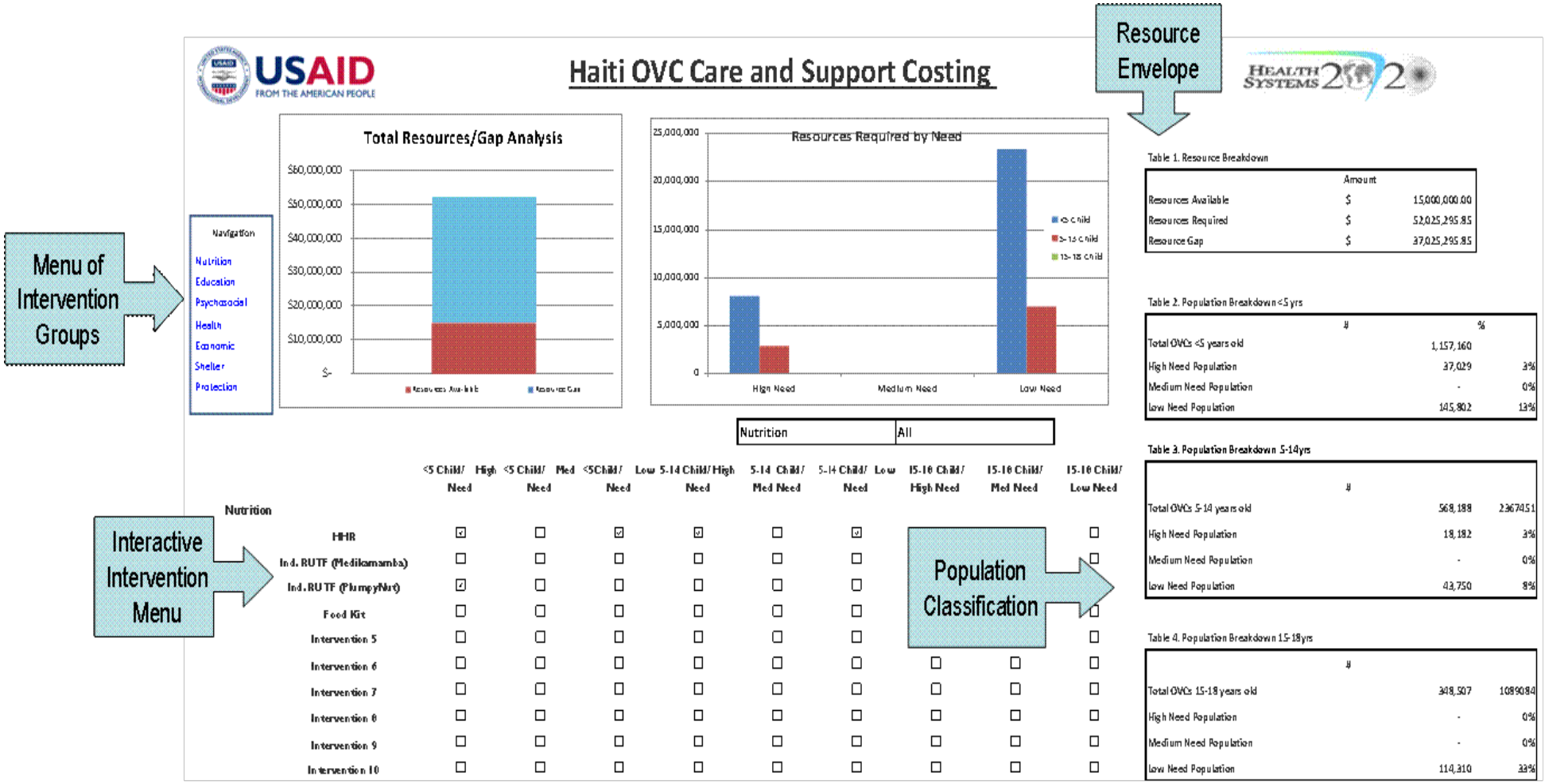
Interactive Intervention Menu: The tool can accommodate up to 10 interventions in each group. From these interventions, the user can choose which ones will be provided to each population category as defined by the Population Classification. An example of a nutritional package is described in Figure 1.

The package of nutritional care is described for each age group by need. The group of under five children who are classified as being 'high' need (in the ***Population Classification***, Table 2 on the right of the figure) are being provided with a package of care that includes the two interventions, household rations (HHR) and ready-to-use therapeutic food (RUTF) that have been check-marked in the ***Interactive Intervention Menu*** on the left. Children under five who are classified as being 'low" need are receiving only the check-marked HHR intervention. Similar selections are made from among all the other intervention groups listed in the ***Menu of Intervention Groups***.

The first graph in the figure shows the gap between the funding resources available, as entered in the ***Resource Envelope***, Table 1 at the top right-hand corner. The second graph shows the cost of providing the chosen nutritional packages of care to OVC by need and by age. These graphs can be

updated to show the same information for education, health, etc. and for all interventions by selecting the desired combination from the drop-down menu boxes directly underneath the graph.

FIGURE 1. OVC CARE AND SUPPORT COSTING TOOL



2. RESULTS

The first half of this chapter presents the results of the analysis carried out including brief descriptions of the implementing partners visited, descriptions of the interventions being delivered (grouped by intervention type), and unit costs. All of these data are combined and presented in the second half of the chapter, where the cost of providing an illustrative package of care is determined.

2.1 IMPLEMENTING PARTNERS SURVEYED

Health Systems 20/20 approached four implementing partners to obtain cost and service delivery information, and two organizations that provide logistics support to OVC program through their procurement of essential commodities. These partners, recommended by USAID Haiti, are shown in Table 2.

TABLE 2. IMPLEMENTING PARTNERS THAT PROVIDED COSTING AND SERVICE DELIVERY DATA TO THE STUDY

World Concern
World Hope
Catholic Relief Services (CRS)
Plan International (Plan)
Supply Chain Management Systems (SCMS)*
World Food Program*

*Only provides logistical support provided to other partners)

A brief description of each implementing partner is given below.

World Concern:

World Concern leads a consortium of nongovernmental organizations that includes the Salvation Army and Food for the Hungry. World Concern works in the Ouest department of Haiti, which includes the city of Port-au-Prince. Prior to 2009, World Concern had 'indirect' contact with OVC in that all services delivered were delivered through the children's caregivers/families. Its support was mostly training and income-generating activities (IGAs).

However, since the earthquake, World Concern has begun providing direct care to OVC, most notably through psychosocial support and school tuition. OVC are recruited by World Concern liaison agents from 10 hospitals in the department. After recruitment, the OVC receive services from four points of service delivery, located in Delmas 31 (approximately 2,000 registered OVC), Delmas 68, Delmas 2, and Carrefour. Altogether World Concern supported approximately 25,243 children in some form during 2009.

World Hope International:

In Haiti, World Hope International partners with five Haitian organizations to provide prevention, counseling and testing, adult care/support, and OVC care in four departments through the Haitian Partners for Health program. In 2009, the program reached 15,890 OVC with a broad range of care

services; nutritional support, education psychosocial, protection, home visits, and IGA interventions. In addition, 3,969 caregivers received training on caring for OVC.

Catholic Relief Services:

Catholic Relief Services (CRS) operates in five of Haiti's departments, supporting services delivered by health facilities and CBOs that receive sub-grants. Nutritional support is delivered at 18 sites; on average, 296 children were provided RUTF and 3,400 families were provided HHR per month during 2009. In addition to nutritional support, home-based care is delivered by community health workers who visit families at home and deliver hygiene and home-based care kits. Finally, CRS delivers psychosocial support through CBOs that typically have at least one physical structure in the community where group meetings can be held with each group meeting monthly.

Plan International:

Plan International delivers a limited amount of OVC care in the Nord-Est department, a particularly isolated and poverty-stricken area of Haiti, through the Stop HIV project in the North East (SHINE). A cohort of 1,000 OVC were identified and supported during 2009. The children received nutritional support, psychosocial support, education/tuition support (through FONKOZE), and home visits. Where necessary, children were also referred to health services.

Supply Chain Management Systems:

Supply Chain Management Systems (SCMS) procures RUTF on behalf of PEPFAR for seriously malnourished children. Due to its weight and the fact that each child needs many packets for one course of treatment, RUTF is resource intensive in terms of logistics administration as well as purchase costs. Several alternatives are under development, notably a local production facility that was being built to locally produce a groundnut-based RUTF product, but these will not be eligible for purchase using PEPFAR funds until their production facilities meet the pharmaceutical "Good manufacturing practice" standard.

World Food Program:

The World Food Program (WFP) works with different nongovernmental organizations across the Haiti as well as the Ministry of Health's public health clinics and hospitals. The WFP relies on donations, to purchase and package both an individual ration package (25,000 individuals a year) and a HHR package (125,000 household members a year). A household refers to a family of five. The WFP sets targets each year but will reach those targets only if the yearly donations are sufficient.

Title 2/Food for Peace Program:

Recognizing the complex biological and economic links between HIV and Nutrition, the USG's Food for Peace program works with PEPFAR to address the nutritional needs of groups most affected by HIV including OVC, lactating women and those initiating antiretroviral treatment who are already severely malnourished. This program provides a household monthly dry ration (4,000 a year) but also feeds a small number of OVC three daily meals (2,500 a year).

2.2 UNIT COSTS OF SERVICES DELIVERED

The unit costs of delivering care to OVC are summarized in the Annex A, but in this section each 'group' of interventions is discussed in turn. These costs have not been adjusted to account for the implementing partner's indirect costs (or overheads), which are treated separately in this section. However, where data were available costs have been adjusted to include the direct cost of labor at the CBO level (e.g., community health worker time) and the cost of any commodities required to deliver the services (e.g., the cost of an annual supply of household food rations.)

Direct costs: These are costs that are incurred when commodities are handed over to a client, or when staff/personnel interact directly with a client. These costs are determined on a unit cost basis. For example, the unit cost of a group psychosocial visit includes direct costs such as amount of transportation money given to clients, the cost of any food/drink provided to clients, the cost of facilitation by a social worker (divided through by the number of clients that attend a group meeting on average).

***Indirect costs*:** These are costs incurred in managing a program, such as the labor time and rent of partner offices in Port-au-Prince. Partners typically provide training to CBOs and health facility staff so that they can carry out their role of directly providing services.

2.3 NUTRITIONAL SUPPORT

Poverty has a major impact on the nutritional status on all children in Haiti but is particularly severe among children living in households that have been affected by HIV. Nutritional support tends to be resource intensive, as the required commodities have to be procured, packaged, stored, and transported. In addition, the intervention tends to be required by those who need to receive it for lengthy if not indefinite periods.

A variety of nutritional support interventions are being used in Haiti, including HHR, individual rations, daily meal provision, and RUTF in the case of severely malnourished children. Costs are shown in Table 3. Rations are typically made up of corn-soy flour blend that is micronutrient-fortified, vitamin A-enriched vegetable oil, iodized salt, and legumes such as lentils. Two forms of RUTF are used mainly, PlumpyNut (made by Nutriset in France and procured by SCMS and UNICEF) and Medika Mamba, a locally made version of the same high-energy groundnut (peanut) and sugar paste further fortified with micronutrients.

TABLE 3. ANNUAL COST OF PROVIDING OVC CARE AND SUPPORT FOR NUTRITION

	WFP	Plan Int'l	World Concern	World Hope	CRS
Household rations	$452.59* (8 months)	-	$156	$300 ($25/package)	$240** ($20/package)
Individual rations	$60.02 * (8 months)	-	-	-	-
Individual RUTF (Medika Mamba)	-	$110	-	-	-
Individual RUTF (PlumpyNut)	-	-	-	-	$57.90
3 meals a day (Title 2)	-	-	-	-	$219 (0.20/day)**

* Inclusive of all logistics costs

** Provided by Title 2/USG

Since 2009, prior to and after the earthquake, there have been interruptions in the availability of nutritional support in the country. At least one partner has reported that it has been unable to provide any nutritional support after fiscal 2009 as its partners were unable to supply it with the necessary commodities. At the time of data collection a task force was addressing the issue of inconsistent funding and supply. In addition, due to changes in the administration of GFATM money, several health facility based programs previously supported by GFATM funding via the WFP have reported that their patients are no longer receiving nutritional support.

2.4 EDUCATIONAL SUPPORT

The EMMUS-IV found that OVC aged 10–14 are less likely to be in school than other children in this age group whose parents are alive, indicating that OVC are experiencing educational disadvantages. The public school system in Haiti is weak, and comprises less than 20 percent of schools. School fees at private schools, typically faith-based institutions, start at $200 per year and higher; this is a substantial amount of money given extent of poverty in Haiti. The level of support provided to OVC varies quite significantly among partners, as shown in Table 4; in many cases, only some of the tuition is provided and families have to pay the difference. Oldest children are more likely to receive vocational training, such as plumbing or carpentry.

TABLE 4. ANNUAL COST OF PROVIDING OVC CARE AND SUPPORT FOR EDUCATION

	Plan Int'l	World Concern	World Hope	CRS
Tuition (Primary)	$60	$200/child	$25-60/year/child	$70-90
Tuition (Secondary)	$60	$200/child	-	$70-90
Uniform	-	-	$40	-
Bags	-	-	$10	-
Adult literacy	-	$15	-	-
Vocational training	-	-	$255	-

2.5 PSYCHOSOCIAL SUPPORT

In HIV programs around the world, there is a general lack of consensus as to what constitutes psychosocial support. In general it would appear that some level of regular contact with a counselor, social worker, or other persons living in a similar situation constitutes a form of support in the sense that the person affected or infected with HIV derives benefit from receiving solace, support or just being among 'like' or empathetic people. In this context, psychosocial support may be given to the OVC themselves but may also be needed by those caring for these children, whether they are 'burdened' by having to provide care or are they themselves the HIV positive. The support provided ranges from individual one-on-one counseling to group activities/meetings. Group meetings or peer-to-peer support are generally run by people living with HIV (PLWHIV) themselves; a social worker or counselor may be on hand to facilitate if necessary and to provide transportation money, food, and drinks. Typically these groups meet monthly and may be held at a health facility or at a CBO facility.

TABLE 5. ANNUAL COST OF PROVIDING OVC PSYCHSOCIAL SUPPORT

	Plan Int'l	World Concern	World Hope	CRS
Peer group support	-	$60	$10	$79.44
Individual counseling	-	-	$45/year	-

2.6 HEALTH SUPPORT

For OVCs, particularly those under five who have lost a mother, the lack of access to health care is a significant risk factor that leads to an increased risk of mortality. As previously noted in the introduction basic 'well-child' health services like immunization, are not adequately accessed by Haitian children regardless of whether they fall into the OVC classification. Table 6 shows that there is a wide disparity in the health support being provided to OVC. It is important to note that CRS, which appears to have the broadest capacity to provide health support, in fact functions out of health facilities as well as through CBOs. All the partners are able refer OVC to health facilities and indeed many of them 'receive' their clients from health facilities to begin with, but it is unclear whether this referral process is effective.

TABLE 6. ANNUAL COST OF PROVIDING OVC HEALTH CARE SUPPORT

	Plan Int'l	World Concern	World Hope	CRS
Immunization	-	-	-	-
Vision	-	-	$5.60	-
Water purification kits (Dlo Lavi)	$7.56*	-	-	$7.56
Hygiene kits	-	$11.50	-	$7.76
Mosquito nets	-	-	-	$14*
De-worming	<$0.50*	-	<$0.50*	-
HBC kits	-	-	-	$9.08

* De-worming drugs are extremely cheap; this cost reflects the cost of mass administration.

2.7 ECONOMIC/IGA SUPPORT

Recognizing that poverty accounts for much of the hardship experienced by OVC, the importance of supporting households containing OVC so that they are able to generate adequate income to support themselves is the rationale behind the IGA that partners carry out. Table 7 illustrates the range of IGA that partners have trained and supported OVC households to pursue. The per household costs of these activities range from less than $10 up to $256, when households are given grants with which to set up a petty trading business, such as providing an individual with a quantity of rice, beans, etc. with which to start trading.

TABLE 7. ANNUAL COST OF PROVIDING IGA HEALTH CARE SUPPORT

	Plan Int'l	World Concern	World Hope	CRS
Phone (Papadap)*	-	$100	-	-
Petty trading	-	$256	-	-
Community gardens	-	-	$8	-
Animal husbandry	-	-	$8	-

*Selling phone credit to mobile phone users or using a mobile phone to sell 'phone calls to people who want to make calls but don't have phones.

2.8 OTHER SERVICES

'Other' services that may be delivered to OVC vary widely in terms of type and reach across programs. For example, one partner provided funeral assistance or shelter (rent) for fewer than 10 clients/families in 2009. Another partner covered the use of 'accompagnateurs,' also infrequently. The accompagnateur is a community member who takes responsibility for ensuring that the client, whether an OVC or a PLWHIV, gets the help they need, comes to the relevant institution to receive care and support if necessary, receives their food rations, etc. The accompagnateur may or may not be salaried, but if not salaried their transportation is reimbursed and they may receive incentives such as phone cards and t-shirts. They usually liaise on behalf of more than one client but it was not possible to verify this and therefore their costs are assumed to be unit costs for a single client but this is likely to be an overestimate. This analysis it is assumed they ensure that the child/children gets to a support site or health facility once a month where the child receives whatever care they are in need of.

TABLE 8. ANNUAL COST OF PROVIDING OVC WITH 'OTHER' SUPPORT

	Plan Int'l	World Concern	World Hope	CRS
Shelter	-	-	-	-
Rent	-	$256	-	-
Protection	-	-	-	-
Funerals	-	$256	-	-
Home visits	-	-	-	$27
Accompagnateur incentives*	-	-	$17	-
Accompagnateur transport*	-	-	$35	-

* May be lower if the one accompagnateur cares for 2 or 3 children/families

2.9 OVERHEADS AND INDIRECT COSTS

There are several possible methods for including indirect costs in the service delivery costs for providing care. When an implementing partner provides only OVC care, all the indirect costs can be totaled and then divided by the number of services delivered. For example, if total indirect costs are $1,000, this figure could be divided by 50 if five OVC received 10 interventions each during the course of a year. However as will be discussed in the next section, in Haiti (and most countries) this level of detail for service delivery is not available.

Another way to determine an overhead unit cost is to divide total costs by the number of children who receive care, with the caveat that this figure will not account for the 'efficiency' of service delivery if children receive more than one type of service (e.g., monthly rations and a vision exam) in one visit. However, this is the type of service delivery data that was available and this was the approach taken in this analysis. An estimate of overhead costs per child was determined for each partner. After reviewing the range of interventions delivered by each partners, it was assumed to be reasonable to estimate that each child received approximately three interventions and so the overhead cost per child was then divided by three and this final figure was added to each estimation of direct unit cost for each intervention when the package of care was costed in the next step of the analysis. (Note: to reiterate, none of the previously discussed unit costs included overhead, except for the cost of food rations provided by WFP and USG's Title 2.)

TABLE 9. OVERHEAD COST APPLIED TO EACH INTERVENTION BY PARTNER

Partner	Overhead
World Concern	$22.00
World Hope	$10.79
Plan International	$24.00
CRS	$29.30
Average	$21.47

For example,

- Partner overhead costs (annual) = $100,000
- Total number of OVC reached = 5,000
- Per child overhead = $20

If it is assumed that each child receives three services then

- Per intervention overhead = $6.67

Therefore, if a nutritional intervention such as a HHR costs $25, the final cost of that intervention, including indirect costs, would be $31.67.

Clearly there are limitations to this methodology and the data used in this analysis. The overhead costs of a few CBOs and health facilities that the patients actually visit are not included in some unit cost estimates. However CBOs, in particular, tend to be very small organizations and their main cost is labor, which is mostly direct and therefore accounted for when intervention cost is estimated. Secondly, it is certain that overheads by partner are overestimated for OVC care because in reality, many

implementing partners also conducted prevention or other HIV-related activities and so some of this overhead should be allocated to those activities. Attempts were made to review annual financial reports to funding agents where only the OVC care costs could be obtained but this was not possible for any partner as the data were not broken down by program.

Notwithstanding these limitations, there appeared to be a fairly low level of variation in overhead costs; the average overhead cost was approximately $7. This figure was added to every intervention costed later in this analysis.

2.10 SERVICE DELIVERY

Service delivery information was collected from Community-Based Care and Support (CBCS) registers where OVC and PLWHIV are registered when they start receiving care from a support site. Whenever an OVC receives care, the intervention is supposed to be noted in the register. The register contains some personal information about the child such as parental status, address, and date of birth. Services delivered may be direct care to the child or 'indirect' care that is delivered to the child's caregiver, such as HHR, IGA support, training in the care of OVC, and water purification kits.

Ideally, the registers ought to reflect the level of service delivery that was described by implementing partners. However, this is not the case, for several possible reasons.

- Sampling
- Loss to follow-up
- Need
- Variable/poor record keeping

Sampling: A randomly selected sample of 100 OVC at each site was selected, after which all the care data for that OVC was abstracted. Data were collected for four age categories see Table 1), to ensure that a reasonable number of patients in all age groups were included. This was important also because the support received by a child under five may be very different from the support needed by a child between the ages of five and 14. However, this selection does mean that the data are not necessarily representative of all the OVC registered at a site, because there may have been oversampling/ undersampling of some age groups.

Loss to follow-up: Because measuring loss to follow-up was not an objective of this analysis, the random selection of patients may have included many patients who were in fact lost to follow-up. This could account for at least some of the 'low' level of service delivery shown in Table 10 (see Section 2.10).

Need: Receiving support depends upon the HIV status of the OVC household members or the child receiving care. There is no standard mean-testing conducted to determine who 'needs' or 'doesn't need' support; therefore, it is difficult to assess whether children needed more support that the data show they received. While it is possible that the children at the sites visited genuinely had low need, it should be considered unlikely because the sites visited in Port-au-Prince include two in Carrefour, the largest, poorest area in Port-au-Prince.

Variable/poor record keeping: Prior to the data collection that was done at sites, interviews were conducted with staff of the implementing partners and they described the services that they delivered. In

addition, the annual reports of each implementing partner were reviewed. Although partners frequently report that several thousand of children receive different types of care, the data abstracted at the site level do not reflect this possibly because many more children are registered than are receiving consistent care throughout the year.

Due to the 'broad' nature of PEPFAR indicators, it is difficult to identify the number of services received by each child once they receive more than two and impossible to identify which services were received by each child. In fact some partners tend to report in slightly more detail than their M&E reports suggest (e.g., that 'X hundred OVC received educational support.'). But typically there is no information given on whether those children were provided with tuition payments or a book bag, services that have a different impact on each child and that vary significantly in terms of cost. Furthermore, it is not possible to determine whether each child received more than one type of service.

2.11 OVC SERVICE DELIVERY FINDINGS

From Table 10, we can see that among the children registered at the four sites visited, gender was balanced. In addition, across the sites at least 62 percent of the children registered had at least one parent who was alive at the time of registration.

As previously noted, the service delivery data allowed for the collection data for up to 60 children under five, 20 in the 5–14 age category, and a final 20 in the 15–18 age category. As the data collectors used the sampling method previously described, they did not have any difficulty selecting the required number in the two older age groups but on two occasions they were not able to fill up to 50 percent of the under five quota in the year 2009, suggesting (but not confirming) that older children are more likely to be registered than younger children.

The findings for interaction with children confirm the information from the World Concern interviews that services to OVC prior to 2010 were delivered primarily though caregivers rather than directly to children. The other partner's (World Hope's) two sites show substantial variation since one site carried out on average six home visits per child while the other site carried out less than one per child on average.

Both implementing partners were keen to continue providing food but reported that the supply of rations had proved difficult to source and inconsistent, resulting in limited capacity to provide rations. Furthermore, although partners reported distributing significant numbers of households with food rations, these interactions do not show up in the data collected from site registries at all over the course of the entire year for which data were collected at each site and this is the main reason why the registry data are considered to be too incomplete to warrant detailed analysis.

Numerous types of training have been designed by partners and carried out by the sites visited. These appear to be reported and recorded consistently in the registers, suggesting that the care delivered may be rather training 'heavy.' This is of particular interest since it is unclear what impact these trainings are actually having on the welfare of the children being indirectly supported.

Of particular concern is the observation that the registries recorded no psychosocial support as being provided to children. Since both partners whose sites are covered confirmed that they hold regular gatherings for children, this observation also strongly suggests that the registries are not capturing all of the care being delivered.

TABLE 10. SERVICES RECEIVED BY OVC AS DETERMINED FROM THE CBCS REGISTERS

Name of OVC institution	World Concern			World Concern			World Hope			World Hope		
Location (District/Province)	Ouest			Ouest			Ouest			Ouest		
Total Number of Sample Children N=			85			61			68			93
Ages	<5	5 to 14	15 to 17	<5	5 to 14	15 to 17	<5	5 to 14	15 to 17	<5	5 to 14	15 to 17
Total number of OVC supported	52	20	13	21	19	21	28	21	19	54	19	20
Total number of females supported	24	11	7	10	10	12	10	15	7	31	10	8
Total number of males supported	28	9	6	11	9	9	8	6	12	23	9	12
Parent's status												
Total number of children with at least one parent alive			61			41			53			58
Care Interactions												
Total number of interactions (home visits)			-			-			456			15
Total clinic referrals			-			-			-			-
Total number of psychosocial support			-			-			-			-
Total number of spiritual support			-			-			1			-
Total number of financial support			-			-			2			3
Total number of schools supplies			-			-			-			4
Total number of nutritional support			-			-			39			1
Total number of tuition assistance			-			-			40			-
Total number of dental consultations			-			-			-			
Total number of eye consultations			-			-			-			
Support to Caregivers												
Total number of caregiver trained (HIV services)			61			45			47			51
Total number of caregiver trained more than once (see line 41)			14			12			-			-
Total number of caregivers who received material support			-			2			33			70
Total number of caregivers who			-			-			6			

Name of OVC institution	World Concern	World Concern	World Hope	World Hope
Location (District/Province)	Ouest	Ouest	Ouest	Ouest
Total Number of Sample Children N=	85	61	68	93
received financial support				
Total number of caregivers who received spiritual support	-	-	-	-
Total number of caregivers who received nutritional support	-	-	20	
Total number of caregivers who received psychological support	-	-	35	1
Total number of caregivers who received eye consultation	-	-	2	
Total number of caregivers who received dental consultation	-	-	2	
Total number of caregivers who received training in economic reinforcement	-	-	-	40
Total number of caregivers who received other type of training	74	37	-	48

3. COSTING A PACKAGE OF CARE

In this chapter, a financial sustainability analysis is conducted using the intervention costing data presented in Chapter 2. Identifying a number of OVC is the first step of the analysis. Following this, the cost estimates are used to determine the cost of reaching all of the children identified (using the EMMUS-IV classification and numbers). Scenario/planning targets are also costed and the gap between target and needs identified in terms of costs. Finally, Health Systems 20/20 has developed a planning tool that can assist those who plan or implement OVC programs to determine target populations and the composition of packages of care for each target population and the cost of delivering that package of care.

3.1 COSTING OVC CARE AND SUPPORT FOR 2011

Data and classifications from the EMMUS-IV were used to classify a proportion of the population under 18 years of age as being OVC. These classifications were then used to subdivide each age group into those that could be considered 'high' need (specifically double orphans, who have lost both parents) and those who might be considered non-high need or 'low' need. 'Low' is used in a relative sense: in reality these children may also be very vulnerable. In this way the analysis takes into account the fact that not every child requires the same 'package' of care and that the package of care will differ between children of different ages and children with different levels of need within each age category.

TABLE 11. DETERMINING THE TARGET NUMBERS OF OVC IN NEED AND TO BE REACHED

Program Classification	Mid-year Population 2010	EMMUS-IV (%)	Number in Need	Example 2011 Targets 50% Coverage
Children <5 years	1,157,160			
OVC High Need	% double orphans	3%	37,029	1.6%
OVC Low Need	(% of OVC - Double Orphans)*	13%	145,802	6.3%
Children 5-14 years	2,367,451			
OVC High Need	% double orphans	3%	75,758	1.6%
OVC Low Need	(% of OVC - Double Orphans)	8%	182,294	3.9%
Children 15-18 years	1,089,084			
OVC High Need^	% double orphans			
OVC Low Need	(% of OVC - Double Orphans)	33%	357,220	16.4%

* This is the percentage of OVCs in this age category MINUS the percentage of double orphans who have already been classified as 'high' need. The percentages are taken from the EMMUS-IV, 2005/6.

^It is assumed that children in this age group are somewhat independent and therefore not likely to be "high" need; therefore, this figures presents all the children classified by EMMUS-IV as OVC.

3.2 RATIONALE FOR HAVING AN OVC PACKAGE

In practical terms, the benefit of defining a package of care for each age group is that a funding agent such as PEPFAR would like to know *a priori* what it is paying for and how many children are being reached. PEPFAR 1 indicators have been designed to clearly report how many children are reached but they are not indicative of what care or how much care children can be assumed to have received with a given level of funding.

A package of care for each age group and each need classification is described in Table 12 (and costed in Table 13 after this discussion). In Table 12, an 'X' in an intervention row cell implies that this intervention has been included for the OVC group (columns).

All the 'groups' of interventions offered by partners in Haiti are important and if delivered properly and consistently, will have a significant impact on the welfare of OVC. However, in the package described, emphasis has been placed on those interventions that are likely to have measurable 'outcomes' namely, nutrition, education and health even though OVC programs have tended to focus on 'process' indicators (those that describe the 'amount' of care delivered) rather than 'impact' indicators' (those that measure the impact of receiving the care.) For this reason, certain interventions, namely IGA interventions and some others interventions that are known to have been provided in Haiti, have been excluded because there is little or no evidence that they have the 'impact' that they are intended to have and the physiological pathway to impact is unclear relative to nutrition etc. By contrast, nutrition is measurable (e.g., weight gain) even though this critical M&E step is not currently being conducted in such a way as to enable the quantification and measurement of this intervention's impact.

TABLE 12. INTERVENTIONS INCLUDED IN A PACKAGE OF CARE TO ALL OVC IN NEED AND A PACKAGE FOR 2011 TARGETS (AS COSTED IN TABLE 13)

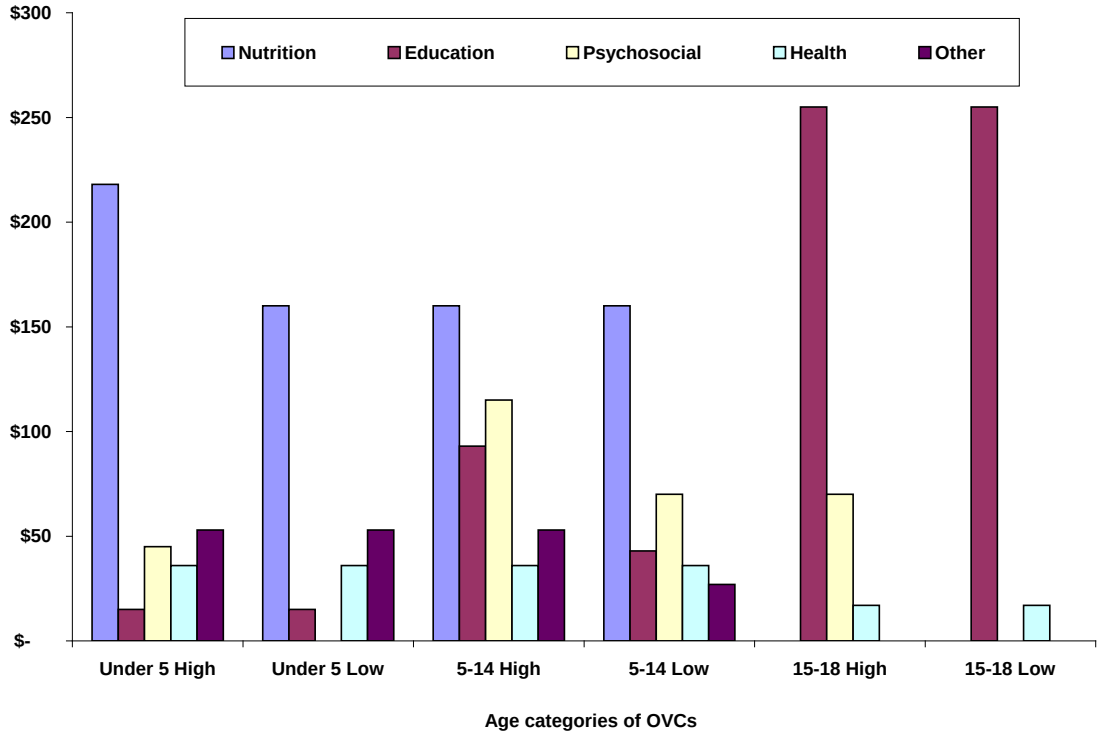
	Package of Care to Those in Need						**Package of Care Funded by 2011 Targets**					
	<5		**4-14 years**		**15-18 years**		**<5**		**4-14 years**		**15-18 years**	
	High	**Low**	**High**	**Low**	**High**	**Low**	**High**	**Low**	**High**	**Low**	**High**	**Low**
Cost of OVC Package	**$367**	**$264**	**$456**	**$335**	**$342**	**$272**	**$367**	**$264**	**$456**	**$183**	**-**	**-**
Nutrition												
HHR	X	X	X	X			X	X	X	X		
Individual. RUTF (PlumpyNut)	X						X					
Cost per child	$218	$160	$160	160	-	-	$218	$160	$160	$160	-	-
Education												
Tuition			X	X					X			
Uniform			X						X	X		
Bags			X						X	X		
Adult literacy	X	X					X	X				
Vocational training					X	X						
Cost per child	$15	$15	$93	$43	$255	$255	$15	$15	$93	$50		

	Package of Care to Those in Need						Package of Care Funded by 2011 Targets					
	<5		4-14 years		15-18 years		<5		4-14 years		15-18 years	
	High	Low	High	Low	High	Low	High	Low	High	Low	High	Low
Psychosocial Support												
Peer group counseling			X	X	X				X	X		
Individual counseling	X		X				X		X			
Cost per child	$45	-	$115	$70	$70	-	$45	-	$115	$70	-	-
Health												
Water kits (Dlo Lavi)	X	X	X	X	X	X	X	X	X	X		
Mosquito nets	X	X	X	X			X	X	X	X		
De-worming	X	X	X	X			X	X	X	X		
Hygiene kits	X	X	X	X	X	X	X	X	X	X		
Cost per child	$36	$36	$36	$36	$17	$17	$36	$36	$36	$36	-	-
Economic												
Other												
Home visits				X						X		
Accompagnateur incentives	X	X	X				X	X	X			
Accompagnateur transport	X	X	X				X	X	X			
Cost per child	$53	$53	$53	$27	-	-	$53	$53	$53	27	-	-

X implies that that service is provided.

By exploring the individual costs of a package of care directed at each age group, as shown in Figure 2, the potential 'cost drivers' of a package of care can be explored. In Figure 2, it immediately can be seen that nutrition is an important driver of costs in a package of OVC care regardless of age group. The educational support provided to the oldest children, who are considered 'too' old for school but could benefit from vocational training, is also a significant driver of costs.

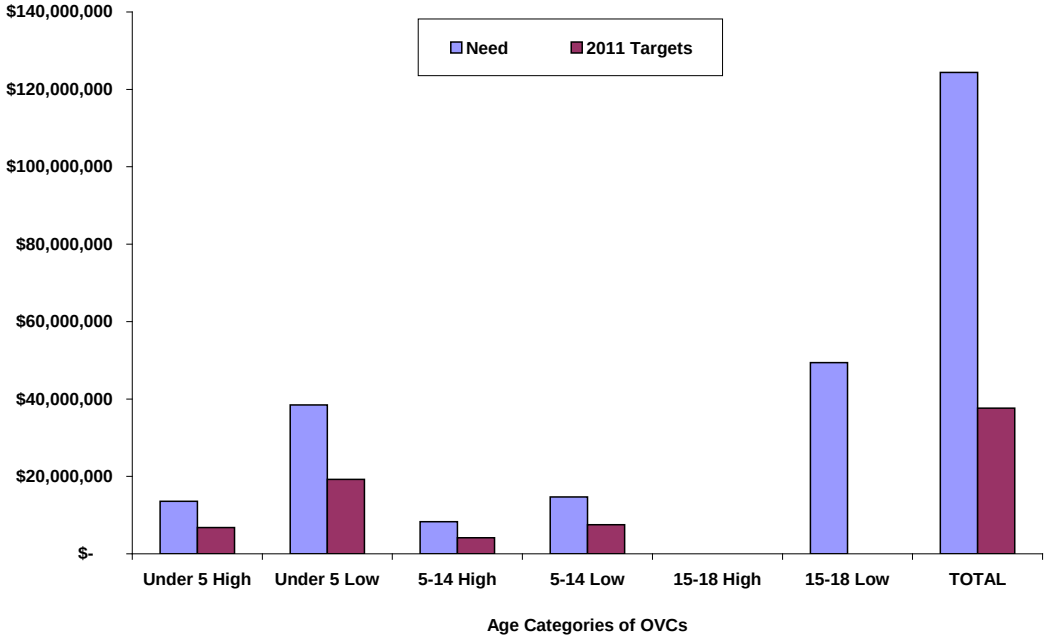
FIGURE 2. COST OF CARE PACKAGE PROVIDED TO OVCS BY AGE GROUP AND NEED



The graph in Figure 2 is helpful when considering only unit costs, but in reality, these costs are aggregated over a certain number of children. In this sustainability analysis, the 'numbers' of children have been described as the numbers in need and the numbers that can be reached in a given a set of targets. The tool used in this analysis can also be used to determine a third group of numbers, namely the number that can be reached given a certain level of funding and a certain package of care. However this was not done in this analysis as there is no 'target' level of funding currently and the package of care used here is a suggestion, not an agreed-upon consensus. The costs aggregated across number in need and targets are shown alongside aggregated costs in Figure 3 with a detailed breakdown in Table 13.

Essentially, Figure 3 is accounting for the fact that the actual number of children classified in each age group (and therefore need category) differs with fewer young children being classified in need relative the large number in the 5–14 and 15–18 year-old age groups (as previously shown in Table 11.)

FIGURE 3. COST OF PROVIDING A DEFINED PACKAGE OF OVC CARE AND SUPPORT TO THOSE IN NEED (EMMUS-IV) AND TO A TARGET NUMBER OF CHILDREN IN 2011



The values shown in Figure 3 are specific to the package of care outlined in Table 10. The package of care costs for 2011 targets is a slightly modified version, where care for younger children is prioritized in the sense that they receive more care. Another approach to target setting and costing may be to prioritize the coverage of high-need young children by increasing coverage above 50 percent for this group and then focusing on older or low-need children afterwards. However, it may not be realistic to attempt targets where coverage is extremely high because children are dispersed throughout Haiti and it may be necessary to adjust the unit costs of each intervention to account for the fact that some proportion of children live in difficult-to-access areas possibly with few or no CBOs to deliver care.

The model that accompanies this report is designed to allow the package of care to be easily adjusted to include/exclude interventions and to allow the number of children reached to be adjusted up or down.

In Table 13, the number that is estimated to be in need is shown beside the cost of reaching that number. The final two columns assume that rather than reaching everyone described as being in need, a 50 percent coverage target is the objective of the program with a view to possibly increasing the number of high-need OVCs while holding the low-risk children's service constant (but any other prioritization or focus deemed important could also be included).

TABLE 13. SUSTAINABILITY ANALYSIS OF HAITI'S OVC PROGRAM 2010

Support Type	Level of Need	Number of OVC in Need	Cost of Meeting Need	Number of OVC at 50% Coverage	Cost of 50% Coverage
Nutrition	< 5 High	37,029	8,068,645	18,515	4,034,322
	< 5 Low	145,802	23,328,345	72,901	11,664,172
	5-14 High	18,182	2,909,123	9,091	1,454,561
	5-14 Low	43,750	7,000,079	21,875	3,500,039
	15-18 High*	-	-	-	-
	15-18 Low	114,310	18,289,641	57,115	-
Total			59,595,833	179,497	20,653,094
Education	< 5 High	37,029	555,436	18,515	277,718
	< 5 Low	145,802	2,187,032	72,901	1,093,516
	5-14 High	18,182	1,681,837	9,091	840,919
	5-14 Low	43,750	1,859,836	21,875	1,093,762
	15-18 High	-	-	-	-
	15-18 Low	114,310	29,149,115	57,115	-
Total			35,433,256	179,497	3,305,915
Psychosocial	< 5 High	37,029	1,666,310	18,515	833,155
	< 5 Low	145,802	-	72,901	-
	5-14 High	18,182	2,085,842	9,091	1,042,921
	5-14 Low	43,750	3,050,284	21,875	1,525,142
	15-18 High	-	-	-	-
	15-18 Low	114,310	-	57,115	-
Total			6,802,436	179,497	3,401,218
Health	< 5 High	37,029	1,340,084	18,515	670,042
	< 5 Low	145,802	5,276,580	72,901	2,638,290
	5-14 High	18,182	658,007	9,091	329,004
	5-14 Low	43,750	1,583,330	21,875	791,665
	15-18 High	-	-	-	-
	15-18 Low	114,310	1,964,993	57,115	-
Total			10,822,994	179,497	4,429,001
Shelter	< 5 High	37,029	-	18,515	-
	< 5 Low	145,802	-	72,901	-

Support Type	Level of Need	Number of OVC in Need	Cost of Meeting Need	Number of OVC at 50% Coverage	Cost of 50% Coverage
	5-14 High	18,182	-	9,091	-
	5-14 Low	43,750	-	21,875	-
	15-18 High	-	-	-	-
	15-18 Low	114,310	-	57,115	-
Total			0	179,497	0
Protection	< 5 High	37,029	1,944,883	18,515	972,442
	< 5 Low	145,802	7,657,978	72,901	3,828,989
	5-14 High	18,182	954,976	9,091	477,488
	5-14 Low	43,750	1,181,263.35	21,875	590,632
	15-18 High	-	-	-	-
	15-18 Low	114,310	-	57,115	-
Total			**11,739,100**		**5,869,551**
Grand Total			**$124,393,619**		**$37,658,779**

*All children in the 15-18 age group are considered "low" need and therefore accounted for in the low need costing row.

4. DISCUSSION

The objective of this study was to provide an in-depth sustainability analysis on the costs and service delivery levels of care provided to OVC by PEPFAR-funded implementing partners and sub-recipients. In addition, a Haitian context-specific package of care has been described on the basis of the findings and a model was built to determine the cost of delivering this package to all OVC in Haiti and/or to a given target level of OVC.

4.1 VARIATION IN SERVICES

While implementing partners deliver services that can be broadly categorized into groups such as nutrition, and education, the actual service may differ significantly in terms of cost and impact even when the service looks very similar across partners. For example, tuition support is a specific type of educational intervention that would seemingly have little variation but if one partner gives each child $20 and another $200 then clearly this is not the same intervention. Although this analysis did not attempt to make an assessment of impact, it is reasonable to assume that where there are significant differences in the service being delivered, there is likely to be a significant difference in impact.

4.2 DETERMINING IMPACT

Implementing partners and funders would have a better understanding of what impact their programs could have and how those programs could be leveraged to provide more care services to more children if there was increased clarity and shared information around what each partner is doing. It is hoped that this report will contribute to increasing the shared knowledge of OVC services. Ideally one would expand programs and share knowledge of programs that are 'successful.' However, there are limitations in the reporting found during the course of this analysis that prevent the study from classifying programs or interventions as 'successful' or otherwise; the current data limit an evaluation to saying only 'this program delivered services to 15,000 children,' which identifies neither efficiency or impact.

4.3 COSTING OF A PACKAGE OF CARE

Following the determination of intervention costs, a package of care was designed from combinations of interventions directed as specific populations of OVCs. The main populations were the high need under five year olds, the low-need under fives, the high-need 5–14 year olds. The costs shown in Table 14 were found and are shown beside the numbers of children in need using the EMMUS-IV classifications.

TABLE 14. COSTING A PACKAGE OF CARE TARGETED AT NEED/AGE GROUPS OF OVC

	Cost of Package	Number Estimated in Need
<5 High Need	$367	37,029
<5 Low Need	$264	145,802
5-14 yrs High Need	$465	18,182
5-14 yrs Low Need	$335	43,750
15-18 yrs High Need	$342	114,310
15-18 yrs Low Need	$272	

5. RECOMMENDATIONS AND CONCLUSIONS

The following specific recommendations are made:

1. Defining a package of care by consensus between funders and implementing partners would help both institutions and prospectively the relevant Haitian government institutions to understand what care is being delivered to OVC and to avoid duplication across partners and donors, particularly if there are plans to scale up the delivery of OVC care and support.

2. Nutrition should be a priority given the co-existence of poverty and HIV in Haiti. However, several partners expressed some frustration with the consistency of the availability of food. Consistent supply of food could be a useful mechanism to ensure that children maintain contact with the implementing partner and can receive other services. In line with this report's general focus on consistency and measurability, it is recommended that more work be done around understanding the impact of individual and household rations. While it is logical to assume that feeding a household will benefit the individual child, there is a lack of connection between process and impact (children are not weighed or measured during this process) and there is little evidence to suggest that this is the most effective way to ensure that a child does not suffer from any nutritional deficit. For example, there may be a combination of foods that might naturally ensure that children receive what they need. Furthermore, clear and consistently applied criteria may be necessary to determine which households receive this support given the high cost of providing it.

3. While all partners provide tuition support, some also provide direct educational services. However, the seemingly similar support actually varies widely; for example, tuition support varying from $50 to more than $250. If the tuition support is lower than the school fess, it is necessary to know whether the support is in fact resulting in a child attending school.

4. Health support for OVC appears to be limited as well as varied. The findings in this report suggest that a valuable opportunity is being missed to reach OVC with potentially high-impact health interventions such as de-worming, mosquito nets, and safe water kits.

5. At least some interventions are 'assumed' to have a positive impact on OVC households but there is no evidence for this. For example, only one implementing partners was able to state that X number of people had received vocational training and Y percent were employed as a result of this training. Most interventions are reported as process indicators with no information as to the impact of those interventions. This is particularly true of all the IGAs currently being implemented by partners. While this report does not suggest these activities should not be carried out, it does conclude that these activities appear to be relatively expensive and inconsistently delivered without enough clarity on their impact, and they merit further evaluation.

6. The CBCS register is potentially an important source of information regarding the care being delivered at the community level. However, it was not found to be as helpful in practice when determining the actual care received by each child. The register is designed to capture a fairly detailed level of information but that information is 'aggregated' to monthly reports that are then

passed on to M&E staff. The aggregation process prevents a regular evaluation of what the average child is receiving and whether each child is likely to be receiving all the services available consistently. It would be helpful to be able to aggregate the raw data more conveniently for M&E. A possible action would be that, during the Data Quality Audit process once the data have been collected and checked for accuracy and completeness, the data could then be handed to an identified consultant who would provide a summary view of what each child/PLWIH is receiving in terms of care for a random sample of children.

7. Expanding the use of partnerships to provide health, educational, and nutritional support would benefit the entire program. Because the care for OVC tends to involve the delivery of several 'sectors' it would be useful to develop more partnerships between these sectors so that the connection between these sectors and the CBOs is 'tighter' than it currently is and the relationships particularly with respect to health care providers would move beyond the use of referrals. This would also be useful moving forward as funding partners increase emphasis on strengthening Haiti's public service sector such as ministries of health, public health, education, and social services.

Conclusions

As the USG pledges and disburses increased funding towards those infected and affected by HIV in Haiti, there is an unprecedented opportunity to improve the lives of Haitian OVC along several dimensions. HIV and poverty have had a detrimental impact on OVC, affecting their development in both biological and educational terms. By identifying, supporting, and monitoring those most in need of assistance and prioritizing nutritional, health, and educational support, PEPFAR has the opportunity to make a significant impact on the current status of these children. However these activities can have a greater impact if appropriately combined and delivered consistently. Although strengthening this integrated approach will require further funding, it ought to be considered as an investment in Haiti's socio-economic future.

ANNEX A. COST OF PROVIDING OVC CARE AND SUPPORT

TABLE A1. ANNUAL COST OF PROVIDING OVC CARE AND SUPPORT INTERVENTIONS PER OVC

	Plan Int'l	World Concern	World Hope	CRS
Nutrition				
HHR (World Concern)	-	$156	-	-
Ind. RUTF (Medikamamba)	-	-	-	$110
Ind. RUTF (PlumpyNut)	-	-	-	$57.90
Food kit	-	-	$300	$240
Education				
Adult literacy	-	$15	-	-
Tuition (Primary)	-	$200/child (Parents pay difference)	$25-60/year	-
Tuition (Secondary)	-	$200/child (Parents pay difference)	-	-
Uniform	-	-	$40	-
Bags	-	-	$10	-
Vocational training			$255	-
Psychosocial Support				
Group counseling	-	$60	$10	$79.44
One-on-one counseling	-	-	$45/year	-
Health				
Immunization	-	-	-	$15.60
Vision	-	-	$5.60	
Water kits (Dlo Lavi)	-	-	-	$0.63
Hygiene kits	-	$11.50	-	
Mosquito nets	-	-		$14
Deworming	-	-	$5	-
Home-based care visits	-	-	-	$27
Home-based care kits	-	-	-	$9.08
Economic				
Phone	-	$100	-	-
Petty trading	-	$256	-	-
Community gardens	-	-	$8	-
Animal husbandry	-	-	$8	-
Shelter				
Rent	-	$256	-	-

	Plan Int'l	World Concern	World Hope	CRS
Protection				
Funerals	-	$256	-	-
Accompagnateur incentives	-	-	$168	-
Accompagnateur transport	-	-	$307.20	-