Positioning Programs for Cost Effective Outcomes

The Uganda Interagency OVC Portfolio Review and Cost Analysis

January 2016

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Cover Photo: Terence Beney. Community volunteers assisting one of USAID's implementing partners in the SCORE program.

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

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This document was submitted by Dexis Consulting Group to the United States Agency for International Development under USAID Contract No. AID-OAA-C-14-00067.

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ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal care
APR	Annual percentage rate
ART	Antiretroviral treatment
AVSI	Asociación de Voluntarios Para El Servicio Internacional/Association of Volunteers in International Service
BOCY	Better Outcomes for Children and Youth
CBO	Community based organization
CDC	Center for Disease Control
CDD	Community driven development
CDO	Community Development Office®
CEM	Cardinal Emerging Markets
COP	Country Operational Plan
CPA	Core program areas
CSO	Civil society organization
DHO	District Health Office(r)
DOD	Department of Defense
EA	Expenditure analysis
ECD	Early childhood development
EID	Exposed infant diagnosis
EPRC	Economic Policy Research Centre
GH PRO	Global Health Development Project
GOU	Government of Uganda
HES	Household economic strengthening
HIV	Human Immunodeficiency Virus
IP	Implementing partners
M	Mechanism
MGLSD	Ministry of Gender, Labor, and Social Development
M&E	Monitoring and evaluation
MEEP	Methods for Economic Evaluation Project
MER	Monitoring, evaluation, and reporting
MOU	Memorandum of understanding

NGO	Non-governmental organization
NICRA	Negotiated indirect cost rate agreement
NUSAF	Northern Uganda Social Action Fund
OVC	Orphans and vulnerable children
PATH	Program for Appropriate Technology in Health
PEPFAR	President's Emergency Fund for AIDS Relief
PFP	Private for profit
PIN	Production for Improved Nutrition
PM	Program management
PMTCT	Prevention of mother-to-child transmission
PNFP	Private not for profit
POS	Point of service
RCT	Randomized control trial
ROM	Reach Out Mbuya
SCORE	Sustainable, Comprehensive Responses for Vulnerable Children and their Families
SDS	Strengthening Decentralization for Sustainability
SIMS	State Innovation Models Initiative
SOCY	Sustained Outcomes for Children and Youth
SUNRISE	Strengthening Uganda's National Response for Implementation of Services for Orphans and Other Vulnerable Children
TWG	Technical working group
UNAIDS	United Nations Programme on HIV and AIDS
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNIFEM	United Nations Development Fund for Women
UPE	Universal primary education
UPMB	Uganda Protestant Medical Bureau
USAID	United States Agency for International Development
USG	United States Government
VHT	Village health teams
VSLA	Village savings and loan association

EXECUTIVE SUMMARY

PURPOSE, OBJECTIVES AND SCOPE

The PEPFAR Uganda Interagency Orphans and Vulnerable Children (OVC) Portfolio Review and Cost Analysis was conducted in November 2015. The purpose of the review is to provide evidence to support planning that will maximize the impact of the PEPFAR Uganda OVC portfolio. To this end, the report:

- Identifies and describes the implementation approaches within the PEPFAR Uganda OVC portfolio, indicating the strengths and weaknesses of each model with respect to their capacity to achieve intended outcomes;
- Provides a cost analysis of the various implementation models, considering both site level and above site level costs; and
- Offers recommendations, based on evidence of effective practice and lessons learned, to strengthen the efficiency and effectiveness of the PEPFAR OVC activities.

It should be noted that this review is not an evaluation of the identified approaches and the mechanisms that constitute them. An outcomes evaluation of the entire OVC portfolio is well beyond the scope of this exercise. This review considers the capacity of each approach to achieve outcomes, based on the existing evidence on what works in OVC programming, and considers the costs associated with each approach. An understanding of effective practices and how these contribute to the capacity to achieve outcomes, in combination with some indication of what it costs to implement effective practices, will serve the imminent strategic planning needs of PEPFAR Uganda.

APPROACHES TO IMPLEMENTING OVC PROGRAMS

The review revealed three sets of factors that distinguish approaches to implementing OVC programs, namely, 1) with whom and how the prime implementer partners (partnering); 2) the nature of the processes through which services are delivered (delivering services); and 3) the depth of the activities or interventions that are implemented (depth of interventions). Based on these sets of factors five approaches are identified and described, as summarized in

Table 1: Approaches to Implementing OVC Programs

Approach and IPs	Description	Descriptors	
Approach 1 *AVSI, CRS, World Education*	These are 100% HKID-funded approaches, implemented at scale (wide geographic reach and large numbers of beneficiaries), with an emphasis on specialized technical capacity in all OVC service areas throughout the multiple layers of sub-partners.	Award ($) to mechanism COP 2015	SCORE – 4,000,405 SOCY – 5,468,164 BOCY – 4,473,953
		No. of districts served	SCORE – 33 SOCY – N/A BOCY – N/A
		No. of OVC served	SCORE - 110,204 SOCY – N/A BOCY – N/A
Approach 2 *Mildmay and CEM*	These approaches get less than or up to 30% of their funding from HKID, and are characterized by a very broad base of CBOs and community level associations as implementing sub-partners.	Award ($) to mechanism COP 2015	MILD MAY – 602,508 CEM/PHS – 1,659,164
		No. of districts served	MILD MAY –16 CEM/PHS – 34
		No. of OVC served	MILD MAY – 14,672 CEM/PHS (PNFP) – 42,256 CEM/PHS (PFP) – 4,705
Approach 3 *Reach Out Mbuya, RTI, UNHCR, CAFU*	These approaches get less than or up to 30% of their funding from HKID, and are characterized by implementation through partners with a fairly limited scale of operation (geographically focused and a comparatively small number of beneficiaries) in specific locations, covering most service areas within a small technical team that emphasises case management.	Award ($) to mechanism COP 2015	ROM – 172,607 RTI – 284,633 UNHCR – 46,972 CAFU – 519,235
		No. of districts served	ROM – 2 RTI – 8 UNHCR – 2 CAFU – 2
		No. of OVC served	ROM – 8,350 RT1 – 3,136 UNHCR – 1,023 UNHCR – CAFU – 1,645
Approach 4 *Baylor, Walter Reed, UPMB and Kalangala*	These approaches get less than or up to 20% of their funding from HKID, with their OVC activities focused on and implemented through a health-facility based workforce, with links to community structures, such as local government and authorities and civil structures such as churches and associations.	Award ($) to mechanism COP 2015	Baylor PIDIC – 1,131,726 Baylor COMP – 751,955 UPMB – 92,238 Walter Reed – 542,158 Kalangala DHO – 1,706
		No. of districts served	Baylor PIDIC – 7 Baylor COMP – 16 UPMB – 6 Walter Reed – 3 Kalangala DHO – 1

Approach and IPs	Description	Descriptors	
		No. of OVC served	Baylor PIDIC – 18,036 Baylor COMP – 8,561 UPMB – 4,034 Walter Reed – 19,412 Kalangala DHO - 31
Approach 5 *State Department and Peace Corps*	These are highly localized interventions (located in and focused on very few communities in a geographically delimited area) using small grants disbursed directly to a CBO.	Award ($) to mechanism COP 2015	State – 248,000 Peace Corps – 90,000
		No. of districts served	State – 7 Peace Corp – 5
		No. of OVC served	State – N/A Peace Corps – N/A

FACTORS DETERMINING THE CAPACITY TO ACHIEVE OUTCOMES

How the factors that distinguish approaches are expressed in each approach is also associated with the capacity of each approach to achieve outcomes in the four outcome categories circumscribing PEPFAR's vision for children of Healthy, Safe, Stable and Schooled.

How Partnering Practices Influence Capacity to Achieve Outcomes

Technical Capacity

How the prime implementing partners within approaches select and strengthen sub-partners determines the extent to which technical capacity in the OVC service areas (HES, health and nutrition, education, psychosocial support, and child protection) is embedded in service delivery. Technical capacity is clearly associated with the quality of services and the capacity to achieve outcomes. The following key observations on technical capacity are discussed in this review:

- While all prime implementing partners demonstrate some care in selecting sub-partners, the thoroughness with which sub-partners are selected for their technical capacity is differentiated across approaches. A related distinction is the extent to which prime partners augment sub-partners' technical capacity through preparation (management systems support, training and joint planning) before the launch of services to OVC.
- Approach 1 is characterized by specialized technical capacity in OVC service areas, within all layers of sub-partners. It includes technical sub-partners that function entirely or primarily as technical support to other implementing sub-partners. Specialization is observed even at the social workforce level, where volunteers may be trained in specific service areas.
- The hallmark of the best examples in Approach 3 (in which partners are required to reach fewer beneficiaries) is technical specialization on small professional teams. The limited scale of implementation also enables technical staff to more effectively supervise the social workforce with whom they are partnering. Approach 5 demonstrates a similar balance between specialist technical capacity and limited scale.
- Technical capacity is a challenge for Approach 2 mechanisms, which are trying to implement services to scale. Variable or severely limited technical capacity among sub-partners imposes an unanticipated burden on the supervisory and support function of the prime partners,

which, because of their limited number of technical staff, are not consistently able to supplement the deficits of less capable sub-partners.

- In Approach 4, where sub-partners are usually health facilities, staff assigned to implement OVC activities typically do not have the required technical specialization in OVC service areas. They are usually adding OVC responsibilities to an already burdensome workload.
- Technical capacity strengthens or undermines implementation in three ways:

    1. *Comprehensive implementation:* Existing evidence shows that for outcomes to be achieved, a complete scope of activities must be implemented under each service area. Observations from the field indicate that even when activities were comprehensive (in that all service areas were offered), they were not always comprehensively implemented (not all activities necessary for achieving outcomes were being implemented in each service area).
    2. *Skillful implementation:* This refers to the wise application of technical expertise in context. For example, the choice of crop based agriculture as an income generating activity (IGA) must consider type of crop, environmental conditions influencing yields, cost of inputs, market conditions determining return on investment for households, and potential environmental impacts of farming practices.
    3. *Responsive implementation:* This refers to the expertise to manage unanticipated risk or exploit unanticipated opportunities that emerge during implementation. For example, withdrawal of support for school materials saw a drop in school attendance from 300 to 86 learners for one sub-partner, while another partner mitigated the risk by leveraging its relationship with a safe schools program and sustained school attendance.

Resourcing

The extent to which prime implementing partners within approaches are able to ensure that sub-partners have adequate resources (access to funding in particular) to execute their assigned roles and responsibilities is clearly associated with the capacity to achieve outcomes. The following key observations on resourcing are discussed in the review:

- The ability of prime partners to resource their sub-partners adequately is limited principally by the extent to which their funding matches the scale at which they are expected to implement. While the comparative capacity to manage a grant will differ across prime partners, resource challenges are related to trying to meet performance expectations with resources unequal to those expectations, and not a function of grant management capacity.
- Where sub-partners are adequately resourced, to approximately the full cost of implementing activities, households are consistently enrolled in services comprehensively addressing their care requirements (e.g., Approach 1). Where there are resource deficits, that is the performance requirements do not appear to be adequately matched by the funding (e.g., Approach 2), households cannot access services.
- Mechanisms (M) in Approach 2 have attempted to address resource deficits through the formation of networks of community-based organizations (CBO) and other service providers within communities. This networking is partly an attempt to distribute the resource burden. If one of the CBOs is short on resources, it can refer households requiring support to another CBO in its network. The assumption that there are resources

at local level external to the mechanism that can be leveraged is frequently proven false, and households fall victim to futile circles of referral.

- District government plays a crucial complementary role in the effective delivery of OVC services, by facilitating coordination and resolving severe child protection cases. Without funding these functions falter, to the extent that key informants consistently refer to child protection as 'a core program area in crisis'.

- The resource dependency of the capacity to achieve outcomes also exacerbates and is exacerbated by technical capacity deficits. When funding was cut to sub-partners in Approaches 2 and 4, activities were simply eliminated. In the absence of responsive implementation, a lack of resources to match the expected scale of implementation will curtail comprehensive care that works, and the capacity to achieve outcomes.

How Implementation Processes Influence Capacity to Achieve Outcomes

The review identifies three implementation processes that influence the capacity of approaches to achieve outcomes. These include how beneficiaries are identified, assessed and enrolled in services; how case management and referrals are managed for the continuum of care; and how coordination and linkages are implemented. The following key observations on each of these processes are discussed in the review.

Identification, Assessment and Enrollment in Services

- All approaches first identify potential beneficiary households and then perform an assessment before enrolling them. Implementing partners make efforts to prioritize by identifying 1) those directly affected by HIV such as children of positive parents, children who are positive, and children in households with a positive family member; and 2) children in very vulnerable situations who are most at risk of HIV infection or other health risks, such as out-of-school youth, victims of abuse, malnourished children, and children in extreme poverty.

- There is differentiation across approaches in the breadth of channels utilized to identify children and households, and this is associated with a difference in the proportion of households with children directly HIV affected versus households with at risk children enrolled in services.

- More community-centered approaches (Approach 1), with a wide variety of identification channels, tend to enroll a higher proportion of at risk children; more facility-based approaches (Approaches 3 and 4) tend to emphasize identification through index HIV positive cases, and claim a higher proportion of households enrolled with children directly HIV affected.

- Facility-based approaches serve multiple communities, often in large catchment areas, and as a result struggle with sustaining consistent participation in group activities because 1) travelling to facilities incurs costs for beneficiaries; and 2) participating in activities associated with HIV carries a risk of being stigmatized. Travel costs would similarly apply to the social workforce responsible for home visits and case management.

- The new Approach 1 mechanisms are designing processes that emphasize targeting more households with directly HIV affected children, however challenges with those targets may persist. Enrollment of large cohorts and subsequent delivery of services on mass is most practically accomplished within a time delimited enrollment window. The feasibility of identifying and enrolling large numbers of directly HIV affected children within a short space of time is limited at best.

Case Management and Referrals for the Continuum of Care

- With strong community programs and multiple networks, some approaches have a solid basis for referrals to partners who are able to provide a service, especially for education, child protection and health. (Approaches 1, 3, and 5). However, if personal and procedural relationships are not maintained with local health facilities, children and families requiring health services may not complete a referral (Approaches 1, 2).

- Referral completion in approaches that rely on partners that have poor resources and low technical capacity is generally found to be inadequate (Approaches 2 and 4 especially). Where in-depth and thorough service provider mapping, including site meetings for confirmations and Memorandums of Understanding (MoUs), has been undertaken, partners reported improved referral completion (Approaches 1, 4).

- Partners rely on parasocial workers to make referrals and follow up with families. Given the various steps in case management—assessment, case planning, case monitoring, referrals and service provision, graduation, and transition and case closure—it is unlikely that a volunteer will be in a position to fully execute a case management strategy. Without adequate compensation and incentives for these cadres, volunteers are difficult to retain, thus decreasing the efficacy of their training and weakening referral follow-ups.

Coordination and Linkages

- Approach 1 partners are heavily vested and integrated in community organizations, while Approaches 3 and 4 have close links or are co-located at clinics or health facilities. Both approaches use district and sub-country local government structures as a platform for coordination.

- The economic strengthening activities are often a platform for other services. For example, mobilizing individuals for HIV testing or providing information on child protection issues in the community.

A number of partners' annual reports, the recent United States Agency for International Development (USAID) OVC Portfolio Review, and Center for Disease Control (CDC) and USAID State Innovation Models Initiative (SIMS) data state there is too little coordination between community-based OVC and facility-based care and treatment programs.

- Health workers find it difficult to take on extra tasks (counseling) due to work pressures (Approach 4) and may not know of the existence or the capacity of community organizations within their catchment area (Approach 4).

How the Depth of Interventions Influence Capacity to Achieve Outcomes

The provision of a service to a family or a child is not equivalent across partners or across models. The approaches show variation in 1) the constituent components of the different services delivered; and in 2) the technical expertise available to facilitate some of the components.

Household economic strengthening activities, particularly under Approach 1, have a very robust intervention that generally involves a village savings and loan association (VSLA), business skills training, market linkages, apprenticeships, and provision of limited materials. In the strongest examples, VSLA groups also provide a platform for parenting skills and mobilizing for HIV testing. Other approaches offer a VSLA, but often without the additional components required to lift people out of vulnerability. This seems to be due to their lack of technical capacity in the sector.

Education support may include temporary consumption support in the form of basic educational materials or financial assistance with fees, including the recently introduced lunch fee. Most approaches have elements of this. All approaches speak to parents concerning the value of education, and Approach 1 works in schools to facilitate a child friendly and safe environment, which given the high levels of reported violence in schools, is extremely necessary. Approaches that have weak household economic strengthening (HES) and little educational technical capacity to operate within the school system, may be compelled to continue educational support to ensure continued enrollment of vulnerable children.

Health and nutrition interventions are run out of clinics and from community organizations, including VSLAs (all). Approaches organize 'Know Your Status' campaigns and make referrals for children and family members for HIV testing. Growth monitoring for children exiting prevention of mother-to-child transmission (PMTCT) and other vulnerable children is undertaken, but there was no evidence of additional early childhood development stimulation activities for young children. Sexual and reproductive health (SRH) for adolescents is not comprehensively addressed, and informants often referred to the stigma children feel in requesting family planning (FP) advice and products.

Child protection interventions have benefitted from the training of parasocial workers under Approach 1. This has allowed for significant task shifting from points of service (POS) and Community Development Offices (CDOs) to parasocial workers, freeing up time of the POS and CDOs for serious cases. There has been significant community outreach to raise awareness among children and parents resulting in increased reporting of child abuse and provision of birth certificates.

KEY RECOMMENDATIONS

Recommendations per Approach

Approach 1

- Improve targeting of directly HIV affected children and their households. Although we can't be certain what the appropriate targets are to accommodate enrollment at scale, and balance the numbers between those at risk and those directly affected for optimal control of

the epidemic, diminishing resources represent a reality that must be aligned with. Look to Approaches 2 and 4 for effective practices.

- Introduce a hierarchy of case management so that children in the most dire situations are monitored appropriately, and resources for child protection are available. Look to Approach 3 for effective practices.
- A clearer understanding of the actual resource needs of households is required in order to ensure that the vigilance on dependency is not undermining the achievement of outcomes, especially in service areas such as education.

Approach 2

- Build in more technical capacity at a prime partner and supervisory level to supplement the technical deficits in some sub-partners that undermine capacity to achieve outcomes. Look to Approach 1 for effective practices.
- Make the difficult decisions regarding scale and match it to available resources. Look to especially Approach 3, but also Approach 5.

Approach 3

- Only if necessary, extend reach by building effective referral networks that include mapping of capable services providers. Look to new Approach 1 mechanisms, which include in-person vetting of potential network partners.
- Also consider ways of augmenting resources beyond PEPFAR through local fundraising, looking to Approach 5 partners for effective practices.
- DO NOT OVER-REACH. Stick to appropriate scale and resource balance. Approach 3 is effective, and there is no need to fix that which isn't broken.

Approach 4

- Make the difficult decisions regarding scale and match it to available resources. Look to especially Approach 3, but also Approach 5.
- Build in more OVC specific technical capacity at sub-partner level. Look to Approach 3 for effective practices.

Approach 5:

- Improve on already effective network building. Make use of Peace Corps volunteers and look to augment early childhood development (ECD) specializations. Grow fundraising and grant management capacity to steadily extend reach. DO NOT OVER-REACH.

General Recommendations

1. Possibilities for increasing the use of community OVC platforms to identify HIV affected and vulnerable populations not currently accessing services, and to connect them with both facility-based HIV and community-based socio-economic services;[1] and increasing the use of facility-based OVC programs to identify HIV positive children and the children of HIV

[1] 2016 OVC Technical Considerations, PEPFAR

positive parents or siblings and connect them with community-based socio-economic services.

- As explained in the findings, some approaches are currently better placed to identify HIV infected and directly affected children and families — those who begin at a clinic providing HIV testing and move out into the larger community through index clients. Approaches that are more community based can improve the likelihood of identifying such children by establishing relationships with the nearest HIV testing and antiretroviral treatment (ART) site. This may entail situating staff at such facilities (e.g., linkage facilitators) or at a minimum having regular formalized contact possibly through memorandums of understanding (MOU), case conferencing, and regular meetings to strengthen coordination mechanisms.
- The community outreach activities undertaken by different approaches is a positive and useful way to bring HIV services and child protection services closer to the intended beneficiaries. Expanding this practice with a special focus on hard to reach groups, including out-of-school children, children on the street, married girls, and expecting young mothers can increase uptake.
- To be efficacious, referrals require the fullest depth of intervention possible and all partners should design comprehensive referral systems that include:
  - Mapping of services and validation,
  - Referral forms,
  - Memorandum of understanding between providers,
  - Regular case conferencing and coordination meetings,
  - Personal contact for follow-up,
  - Material or transport assistance to assist the client (assisted referral), and
  - Clear guidelines for documentation of referrals within a case management framework.

2. Possibilities to maximize OVC platforms' capacity to mitigate the social effects of AIDS and to contribute to the full continuum of prevention and care, including reduced HIV risks for adolescent girls; earlier identification and retention of children affected, exposed and infected by AIDS; and improved stability of families affected by the pandemic.[2]
   - The situation of adolescent girls — early marriage, early pregnancies, abuse in schools, low survival rates in primary and secondary — is very serious and requires concerted attention. The gender differences in illiteracy (higher for females than males), in HIV prevalence (higher for females than males), and in early marriages (higher in girls than boys) need to be highlighted an addressed as a matter of urgency. It will not be possible to control the HIV epidemic if the life experiences of poor adolescent girls are not substantially altered.

[2] 2016 OVC Technical Considerations, PEPFAR

- OVC programs are ideally placed (they identify vulnerable families; they target HIV affected households; they have a presence in communities; they work within trusted local organizations; they conduct home visits; they liaise with child protection institutions) to reach adolescent girls with combination prevention strategies and education strategies that can begin to address some of these inequalities. The need to address girls' sense of self-efficacy and confidence should not be underestimated as shyness and embarrassment are often given as reasons for not accessing or requesting condom use.[3] OVC programs reach families with protection messages to ensure girls are given an equal opportunity to remain in school instead of being married. OVC programs can work with and within health facilities to improve youth friendly services that are taken to the most vulnerable.
- Evidence and lessons emerging from the **D**etermined, **R**esilient, **E**mpowered, **A**IDS-free, **M**entored, and **S**afe (DREAMS) initiative will be very important in providing 1) opportunities to intensify interventions with adolescent girls; and 2) document the emerging best practices for keeping girls safe, schooled and AIDS free.
- The children of children (25% of Ugandan teenage girls get pregnant), both babies and their teenage mothers, require intensive support and assistance to ensure healthy early childhood development for the child and better health and educational outcomes for the young mother. The same applies to mothers exiting PMTCT and their HIV exposed babies. Approaches that have a facility entry point have an ideal opportunity to develop curriculum-led parenting and early intervention support for these mother-baby pairs. Alternatively, approaches that are not located at facilities could be designated to develop and provide such services at convenient locations. Approaches that include OVC activities into much larger care and treatment services risk deprioritizing OVC activities. The services offered at health facilities are currently generally limited to basic health care, but could be expanded to include additional complementary services such as ECD, youth friendly adolescent SRH, etc. This will be contingent on validating that expected services are in fact offered and on strengthening additional services by ensuring that sufficient and dedicated OVC technical capacity is in fact based at the facility or through coordination with other partners and approaches to offer such services.
- Following the 2012 Guidance and the 2015 Technical Considerations, partners focused their attention on HES as a way to stabilize families and to ideally facilitate the graduation of beneficiaries. To fully realize these goals, approaches need to invest in the full HES/VSLA package, including temporary injections of assets for members or temporary education and health subsidies. Approaches, apart from Approach 1, need to ensure they have the technical staff to maximize the economic strengthening activities. For example if HES has an agricultural component, then it should concentrate on technically sound agricultural intensification. Support for the non-farm rural economy (including vocational skills for youth) is an appropriate complementary intervention but again should be implemented by competent professionals.

[3] Department of Social Work and Social Administration, Makerere University and African Institute for Child Studies, Analysis of the Situation of the Ugandan Child. MELP, November 2015

3. Continue investments in social welfare systems strengthening to prevent and respond to neglect, violence, and exploitation of children and adolescents at risk.
    - Current case management practices have limitations. They may not be comprehensive, up to date, easy to manage, or useful in addressing needs. The key constraints—limited resources and skills within the available social workforce—need to be considered. The way to do that is to differentiate participating beneficiaries and reserve intensive case management for those with the most dire needs and problems that require ongoing supervision, with more intensive and frequent follow-up and tracking.
    - The assumption that volunteers, such as parasocial workers, can be expected to do intensive case management is questionable. The roles and responsibilities of different levels of the social welfare workforce should be carefully delineated, with paid staff responsible for oversight and case management quality and for clients with more complicated or serious needs.
    - In the same way, community organizations have enormous potential to contribute to the protection of children and to enhancing their opportunities. However, these community organizations require extensive capacity development, resourcing and supportive supervision to realize this potential. Simply referring children to community services or outsourcing activities to such partners, without establishing the quality of the service, is an ineffective practice.
4. Sufficient resources should be allocated to measure outcomes for program impact (MER 1.5) and teams should budget for adequate staffing of the OVC program.
    - The collection of actual outcome data will enable a clear assessment of program effectiveness which can then be compared to expenditure.
    - The different United States Government (USG) Agencies through the Uganda OVC Technical Working Group (TWG) and PSC can continue the positive interagency discussions to develop a shared understanding of key concepts, including which OVC are targeted by the portfolio; what constitutes vulnerability; what sub-populations should be prioritized and how; what constitutes case management; what is graduation; and which outcomes will be prioritized. Common tools, such as the vulnerability index and vulnerability assessments, and in the future other quality assessment and outcome evaluation tools could also be reviewed at an interagency level.
    - Agencies and their implementing partners require sufficient OVC technical staff who can provide oversight, guidance, and inspiration for effective and evidence led implementation.
5. Strengthening approaches and coordination.
    - The very positive interagency collaboration evidenced in this Portfolio Review, and particularly in the combined site visits that took place with the PEPFAR OVC TWG representatives, was welcomed by the Uganda PEPFAR Steering Committee. Ongoing interagency learning journeys and interagency visits to partner sites should be scheduled. Other interagency work could include review of SIMS data leading to improvement plans.

- The Uganda OVC TWG body should be mandated to review and discuss best practices, standardized tools for identification, assessment and graduation. They could also develop a common PEPFAR OVC strategy that includes the above elements.

A proper cost effectiveness study for OVC needs to be completed urgently. While a number of cost analyses and studies of PEPFAR programs have been done, and expenditure analysis (EA) is becoming routine, these are of limited value when trying to understand what it costs to secure particular outcomes for households and children in their care. A cost effectiveness study would equip the Uganda Mission, and PEPFAR Missions globally, with the understanding necessary to match resources to scale and inform reasonable performance requirements imposed on implementing partners. Without a credible evidence-based understanding of what outcomes cost and why, planning will remain handicapped by a significant blind spot that cannot be addressed by current remedial efforts. Scale will continue to be misjudged, expectations unmet, performance perceived as inadequate, and myths about dependency will persist.

I. INTRODUCTION

BACKGROUND TO THE REVIEW

PEPFAR's Uganda OVC portfolio, which consists of a large number of implementing mechanisms under five agencies—USAID, CDC, Department of Defense, State and Peace Corps—had not been reviewed in its totality before this assignment. Consequently, an understanding of complementary contributions across agencies to addressing Uganda's OVC related challenges, how the cumulative outcomes of these efforts contribute to the control of the epidemic, and how efforts might be optimized, were not clearly understood. In its Country Operational Plan (COP) 15, PEPFAR Uganda decided to conduct an interagency study to better understand the broader OVC portfolio, the relative effectiveness of interventions, and their associated costs.

Through GH Pro, a team of three international consultants and two local research assistants was identified with the necessary OVC, evaluation, and costing expertise. The review took place during October and November 2015, with the full team in country from November 2–27 and December 6–12, 2015.

PURPOSE AND OBJECTIVES

This review provides evidence to support planning that will maximize the impact of the PEPFAR Uganda OVC portfolio by describing the implementation models within the portfolio; the capacity of each model to achieve outcomes; how coordination contributes to achieving outcomes; and aspects of models that are cost effective.

This broadly stated purpose is specified in the following three objectives:

1. Describe each of the *implementation models* within the PEPFAR OVC portfolio, indicating the strengths and weaknesses of each model with respect to achieving intended outcomes by considering the model design, inputs, activities implemented, quality of implementation, contribution of program management (PM), and backstopping at implementing partner and agency level;
2. Determine the cost effectiveness of the various implementation models, considering both site level and above site level costs; and
3. Make recommendations, based on evidence of effective practice and lessons learned, to strengthen the efficiency and effectiveness of PEPFAR OVC activities.

For the purpose of the review, implementation models were understood to encompass the range of approaches to implementing OVC activities as adopted by partners. It was assumed that by describing the various approaches, a typology would emerge that would facilitate the consideration of the relative effectiveness of approaches in terms of cost and capacity to achieve outcomes. As the review progressed this assumption held true, and the term 'implementation model' (implying rigidity in program design and implementation) was replaced by the more apt 'implementation approach', which better reflected the range of implementation choices within the OVC portfolio.

The review does not assess the achievement of outcomes that, discounting feasibility impediments for the moment, is well beyond its scope. Instead the review attempts an analysis

of the capacity of each implementation approach to achieve outcomes, based on what is already known to work in OVC programs. This analytical tactic is the key concept framing the review.

The outcomes of interest are drawn from PEPFAR guidance, including guidance on indicators such as the PEPFAR Next Generation Indicators (2009) and the Essential Survey Indicators for OVC programs (2014). It should be noted however that the indicators mentioned do not represent a stipulation of standardized outcomes applicable to all PEPFAR OVC programming. Outcomes are broadly articulated in the guidance, allowing implementing partners to pursue results that fall within service areas and outcome categories that delineate "PEPFAR's Vision for Children"[4] (See section 0). This broad articulation of outcomes is functional in that it accommodates accounting for OVC related challenges as expressed in the specific country context in program design. It also allows for flexibility in implementation as annual guidance directs partners to adjust implementation in accordance with emerging PEPFAR priorities.

The review retains this broad approach to outcomes in its assessment of implementation approaches. Outcomes are not operationalized as indicators. Instead the outcome categories of Healthy, Safe, Stable and Schooled are adopted, and the capacity of each implementation approach to deliver within these outcome categories is deliberated.

The analytical questions posed in the Scope of Work addressed these objectives:

1. What are the different implementation models within the PEPFAR Uganda OVC portfolio in terms of the model design; inputs; activities and implementation processes; quality of implementation; and the contribution of PM at implementing partner and agency levels?
2. What are some of the strengths and weaknesses of each of the implementation models, with respect to achieving intended outcomes, according to PEPFAR's guidance and authorizing legislation?
3. How cost effective[5] are the various OVC implementation models?
4. What is the current status of coordination and collaboration across the OVC portfolio in Uganda, including strengths, opportunities and gaps?
5. Based on the evidence of best practices and lessons learned, what is required to improve the effectiveness and efficiency of the OVC PEPFAR activities?

[4] PowerPoint presentation PEPFAR's Vision for Children, Jason Wolfe, OCAG, November 13, 2014.
[5] Cost effectiveness is understood to refer to the optimal cost associated with achieving the intended outcomes.

II. THE CONTEXT OF OVC PROGRAMS

THE STATUS OF CHILDREN IN UGANDA

The total population of Uganda is 34,844,095 with 17.1 million below the age of 18 and 6,282,000 of these under the age of 5.[6]

Ugandan policy defines vulnerable children as orphans and/or other children at risk of physical, emotional or mental harm, including children living with HIV, children abused or neglected, children in child-headed households, children in need of alternative family care, children living with disabilities, and children living in street situations. In Uganda, 8% of children are considered critically vulnerable and 43% are moderately vulnerable. Over 11% of children are orphans.[7]

A disturbing picture of risk, vulnerability, and neglect threatening the well-being of Ugandan children is presented when these facts are considered: HIV prevalence among children; children not yet accessing ART; the number of children not completing primary school; the percentage of under-5s who are stunted; the extent of girls experiencing early marriage; teenage pregnancies and violence in schools; low use of condoms or other FP methods among adolescents; and extensive poverty.[8] They outline a situation where educational outcomes, health outcomes, HIV prevention outcomes, nutritional outcomes, child protection outcomes and gender equality outcomes are unlikely to be realized without substantial effort and visionary collaboration. The recent National Forum on the State of the Ugandan Child, held in October 2015, highlighted the extent of the problem across all sectors. Some of the most salient points, with special reference to control of the HIV epidemic, are mentioned below.

The national HIV prevalence is estimated at 7.3%[9] and 1,301,084 Ugandans are estimated to be living with HIV. In 2015, an estimated 147,394 children aged between 0 and14 were living with HIV, just over 10% of the total HIV positive Ugandans. There were an estimated 5,200 new pediatric HIV infections in 2014, and almost 5% of babies born to HIV positive mothers tested positive for HIV in August 2015. The vulnerability of the very young and infected is exacerbated by poverty and assumed poor feeding practices, as evidenced by the fact that about 2 million under-5 children are stunted and 801,000 are underweight. It is estimated that in 2015, six in every 10 children aged 0-14 living with HIV and eligible were **not** receiving ART.

HIV prevalence among people aged 15–24 years was 3.7% in 2011, having increased from 2.9% in 2004/5. Rising prevalence in this age group is related to behavioral challenges. In 2011, only four out of 10 young males and females aged 15–24 had comprehensive knowledge about HIV prevention; one in every four girls aged 15–19 has begun childbearing; two in every five women aged 20–24 were married or in a union before 18 years; nearly 6 in 10 young women aged 15–24 (58%) had sex before age 18; and only five in 10 unmarried sexually active young women

[6] Ugandan Bureau of Statistics (UBOS) 2014 census
[7] Situational Analysis of Children in Uganda, Republic of Uganda, MGLSD and UNICEF, 2015
[8] The Uganda National Household Survey of 2013/14 reports 6.7 million rural poor, of which 3 million are children living below the poverty line.
[9] UAIS, 2011

aged 15–19 reported using a method of contraception[10].Adolescent girls account for 66% of new infections and AIDS is the major cause of death among adolescents.[11]. In 2020, there are expected to be 215,141 people living with HIV (PLHIV) aged 15–24.

Female literacy is lower than male literacy, at 59% and 79% respectively. School retention rates are very low with 70% of children starting in Primary 1 not completing Primary 7. Of girls, 31% drop out of school due to marriage and 20.5% drop out due to pregnancy. Early marriages are correlated to poverty. In the poorest quintile, 45% of women under age 25 experienced marriage before age 18, while in the highest wealth quintile saw 16.9%.[12] For boys, the major reason for dropping out is loss of interest in school. In this scenario, vulnerable children continue to face a range of difficulties, many of them with a gender dimension.

Teenage girls who have never attended school are three times more likely to start childbearing as are those with secondary education and 53% more likely to be married.[13] Addressing barriers to education, especially for girls, is a key for development, child health, and HIV risk reduction. Schools however have been found to be unsafe for children, and 77% of children report sexual abuse in schools.[14]

The introduction and expansion of ART has made a significant impact on keeping parents alive and thus helping ensure a better future for children. However the systemic drivers of the epidemic pose a persistent risk to children, increasing their vulnerability to infection, and undermining epidemic control. Not only is it important to ensure that parents and affected families continue to benefit from expanded testing and ART provision, but that infected children are served, and that children at risk benefit from prevention efforts. Absolute control of the epidemic would also appear to require that parents and affected families possess the means to provide for their children; and that the community and larger society should provide an enabling environment for the growth and development of safe, schooled, stable and healthy children.

SUMMARY OF THE PEPFAR UGANDA OVC PORTFOLIO

The current PEPFAR Uganda OVC Portfolio is managed by all five USG Agencies—CDC, USAID, Department of Defense (DOD), State and Peace Corps.

The Government of Uganda's National Strategic Programme Plan of Interventions for Orphans and Other Vulnerable Children 2011/12–2015/16 is organized around four major expected outcomes:

1. Improved economic security for orphans and other vulnerable children, their caregivers and families/households;

[10] Department of Social Work and Social Administration, Makerere University and African Institute for Child Studies, Analysis of the Situation of the Ugandan Child. MELP, November 2015
[11] Situational Analysis of Children in Uganda, Republic of Uganda, MGLSD and UNICEF, 2015
[12] MGLSD, UNICEF and EPRC. *Situation Analysis of Child Poverty and Deprivation in Uganda.* (2015). Kampala: Ministry of Gender, Labor and Social Development, Uganda; UNICEF, Uganda, Economic Policy Research Centre, Uganda.
[13] Situational Analysis of Children in Uganda, Republic of Uganda, MGLSD and UNICEF, 2015
[14] Windsor Consult, Assessing Child Protection, Safety and Security Issues for Children in Ugandan Primary and Secondary Schools. Republic of Uganda Ministry of Education and Sport and UNICEF, 2012.

2. Improved access to and utilization of essential services for orphans and other vulnerable children, their caregivers and families/households;
3. Improved child protection and access to justice for orphans and other vulnerable children, their caregivers and families/households; and
4. An effective policy, legal and other institutional mechanisms that delivers coordinated OVC response.

These are operationalized in seven priority intervention areas or core program areas (CPA): economic strengthening; promotion of food and nutrition security; provision of health; education; psychosocial support and basic care; and legal and child protection services. The seventh CPA addresses strengthening legal, policy and institutional mechanisms. PEPFAR OVC programs align their five service areas (HES, health and nutrition, psychosocial support, education and child protection) to these CPA and address the same outcomes.[15] Partners have also begun to concentrate increasingly on improving coordination between clinical and socio-economic care. For example: improved coordination of community-based clinical and socio-economic services for efficiency and effectiveness along the continuum of care (new Approach 1 partner) or strengthened linkages for increased access to HIV/AIDS services (Approach 2).

These approaches are undertaken with consideration to PEPFAR OVC Program Guidance and should result in improved comprehensive care.

The past year, 2015, has been one of continued transition for Uganda PEPFAR, with emphasis on geographical HIV prevalence, disease burden, and evidence of presence of key and priority populations. Attention has been given to district-level operations, quality, reporting, and linkages along the continuum of care. Efforts around linkages to facility-based HIV counseling and testing (HTC) have been intensified, as have innovative interventions to identify and link key and priority populations, pregnant women, and children into HIV programs.

Contributing to the control of the epidemic and addressing the various vulnerabilities of OVC in Uganda, the portfolio is diverse and extensive. Within the OVC portfolio, there are a number of mechanisms operating throughout the country (see Table 2 and in the Appendix). Partners operate in anywhere from one to 34 districts, with annual awards ranging from USD $2000 to USD $5.4 million, reaching between 31 to 46,000 OVC. Many of the larger mechanisms have a regional presence and a number of prime partners sub-partner with a large number of local non-governmental organizations (NGO) and CBOs, reaching deep into many communities with HIV and OVC services, and improving understanding of the needs of children in the HIV epidemic. Most districts have more than one OVC mechanism.

[15] National Strategic Programme Plan of Interventions for Orphans and Other Vulnerable Children 2011/12—2015/16. Government of Uganda, Ministry of Gender, Labor and Social Development, May 2011

Table 2: Summary of OVC PEPFAR Uganda Portfolio

Summary of OVC PEPFAR Uganda Portfolio 2015	
Number of Agencies	5
Number of Mechanisms/Prime Partners	17/19
Number of TA Prime Partners	5
Number of Sub-partners (NGOs and CBOs)	>250
Number of Districts	57 Priority 25/2– Maintenance/Transition
Number of Children served	404,207 (COP 15 target)
Total Budget	24,010,000

FOCUSING ASSISTANCE THROUGH PEPFAR GUIDANCE

PEPFAR OVC programming is grounded in the Hyde Lantos reauthorization bill, which defines OVC as "children who have lost a parent to HIV/AIDS, who are otherwise directly affected by the disease, or who live in areas of high HIV prevalence and may be vulnerable to the disease or its socio-economic effects."[16] Agencies and implementing partners are further guided by the PEPFAR Guidance for OVC Programming of 2012. This Guidance highlights the need to promote resilience and reduce adversity by building services and systems that reach people directly in their homes and communities. By addressing the socio-economic and socio-emotional effects of the epidemic, OVC programs reduce the likelihood of children and adolescents moving from being affected by the epidemic to being infected.

The following principles undergird all PEPFAR OVC work:

- Strengthening families as primary caregivers of children;
- Strengthening systems to support country/ community ownership;
- Ensuring prioritized, focused interventions that address children's most critical care needs; and
- Working within the continuum of response to achieve an AIDS-free generation.

These principles are focused year by year with Technical Considerations for Agencies to address.

[16] H.R. 5501; Tom Lantos and Henry J. Hyde United States Global Leadership Against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act of 2008

Table 3: Summary comparison OVC PEPFAR Guidance

2015 Technical Considerations	2016 Technical Considerations
Locate OVC services in close proximity to other PEPFAR-supported HIV services within prioritized geographic areas.	Alignment of OVC programming in the highest HIV prevalence areas.
Improve targeting to address the most vulnerable children and adolescents, building resilience in children and families, preventing HIV infection, and identifying HIV positive children.	Improved use of data to identify the most vulnerable children and families in scale-up districts, including expanding the use of evidenced-informed graduation models and monitoring the transition of children and families in sustained and central support districts to avoid harm to children.
Emphasize family-centered socio-economic care.	Continue investments in social welfare systems strengthening to prevent and respond to neglect, violence, and exploitation of children and adolescents at risk.
Focus on core interventions for the most vulnerable children and adolescent girls.	Maximize OVC platforms to mitigate the social effects of AIDS to contribute to the full continuum of prevention and care. This includes reduced HIV risks for adolescent girls (in DREAMS and non-DREAMS countries); earlier identification and retention of children affected, exposed and infected by AIDS; and improved stability of families affected by the pandemic.
Invest in referral networks to ensure HIV positive children are linked and retained in care and treatment.	Increase the use of community OVC platforms to ensure children and families access HIV service.

The Review took cognizance of the PEPFAR 2012 OVC Programming Guidance, the 2015 Technical Considerations and the recently released 2016 Draft Technical Considerations. Taken together these provide a framework for addressing the key child outcome categories of:

- Healthy (access to health and HIV services);
- Safe (protection from violence, abuse and neglect);
- Stable (economic strengthening and family preservation); and
- Schooled (enrollment in and progress through school).

III. METHODOLOGY

OVERVIEW

This section describes the methodological choices made in order to fulfil the purpose and objectives of the review, within the prevailing constraints of budget, timing and data limitations. The purpose and objectives of the assignment clearly direct the research towards a description of the approaches to implementation evident in the OVC Uganda portfolio, and additionally, a consideration of the capacity of the identified approaches to achieve outcomes (See Purpose and Objectives section). The latter dimension of the assessment is not based on an evaluation of actual outcomes of the mechanisms being implemented, an effort well beyond the scope of this assignment. Instead it is an informed judgment based on what we know works in OVC programs, and a consideration of the described approaches in the light of that knowledge (See Annex B: Evidence Matrix, of the PEPFAR 2012 Guidance for OVC Programming). The literature and documentation on effective practices are referenced throughout this review.

RESEARCH DESIGN

The review adopts a mixed methods design that integrates secondary monitoring and cost data, as well as data from project documents, with primary data generated to both supplement and validate the secondary evidence. This design represents the most feasible approach to responding to the review purpose and objectives within the prevailing constraints and in accordance with the PEPFAR evaluation standards of practice.[17].

The review focuses on implementation approaches as the unit of analysis, and the relative capacity of each to achieve outcomes as they are stated in particular program objectives and linked to the relevant PEPFAR guidance. The description of approaches includes program design, activities and processes; the quality of implementation; and the contribution of PM and backstopping to achieving outcomes. The relative capacity of implementation approaches to achieve outcomes is complemented by an analysis of the costs associated with each approach, allowing for a consideration of the relative cost appropriateness of approaches. While the review set out to provide an assessment of cost effectiveness there was ultimately insufficient data to meet all the objectives of this component (See section 0 for Limitations). Nevertheless, the cost analysis does offer an evidence base that is indicative of the costs associated with achieving outcomes across implementation approaches. In addition the contribution of coordination and collaboration across implementation approaches to the achievement of outcomes is incorporated where observations allow.

The choice of implementation approaches as the unit of analysis, and the clear description of each, improves the precision and utility of the review for the strengthening the OVC PEPFAR Uganda Portfolio.

[17] PEPFAR Evaluation Standards of Practice, 2014

DESCRIBING IMPLEMENTATION APPROACHES

In order to identify and then compile comprehensive descriptions of the range of approaches being implemented in the OVC PEPFAR Uganda portfolio, the following data collection and analysis process was employed:

1. *Review of project documents:* A range of documents was collected from agencies and their prime partners implementing OVC mechanisms or mechanisms incorporating OVC activities. Documents included the COP for the relevant period, annual percentage rate (APR) and SAPR data, quarterly and annual reports, work plans, evaluation reports and any supplementary documents such as logic models and PowerPoint presentations that described the design and implementation of implementing partners' programs and activities. These documents were analyzed and an initial typology of approaches produced.

2. *Implementing partner survey:* Based on the emerging understanding of approaches and the sets of factors distinguishing them, a survey was prepared and sent to implementing partners via email. Partners were required to respond to a short selection of open-ended items, and to submit supporting documentation or refer to supporting documentation already submitted, to substantiate their responses. The survey responses were used to further develop the emerging typology of implementation approaches.

   Site visits: Based on the emerging typology of approaches, a site visit schedule was prepared in collaboration with USG Agencies. Sites were selected in accordance with the criteria listed in Table 4. Ten implementation sites were visited in nine different districts, and approximately 120 key informants engaged with, including partner and sub-partner staff, social workforce cadres, government officials and caregivers of OVC (see Appendices for further details). Fieldwork data proved crucial, significantly enlightening the understanding of both the different approaches to implementation, as well as the contextual factors enabling or constraining their relative efficacy.

3. *Implementing partner workshops:* Two implementing partner workshops were hosted at which key elements of the descriptions of approaches were presented. Workshops were very well attended and the discussions frank and thorough. Feedback was documented in detail and incorporated to validate, correct or adjust the research findings.

4. *Fact checking:* In compiling the final descriptions, the research team continued with ad hoc fact checking, engaging implementing partners via telephone or email, to ensure that the evidence being incorporated into descriptions was verified.

Table 4: Criteria for Sampling of Sites for Inclusion in Fieldwork

Criteria	Rationale
Basic Criteria	
Every agency had to be represented in the set of mechanisms or projects visited.	All the agencies should benefit from the review by having findings derived from data directly applicable to mechanisms or projects they are funding. In addition it would be important to identify any characteristics of approaches that differed systematically by funding agency.
The implementation sites had to be located in Scale-up Districts.	Strengthening of the OVC portfolio should align with the general prioritization of PEPFAR investments in Uganda. Basing findings of the review on data from Scale-up Districts would enhance their direct relevance in this regard.
Each Emerging Model Represented	
The full range of potential partners and sub-partners (iNGOs, local NGOs, CBOs, district government, health facilities, schools) had to be represented in aggregate across the mechanisms visited, *AND* *The full range of different implementation sites (health facilities, CBOs, schools, VSLA groups etc.) had to be represented in aggregate across the mechanisms visited.*	The characteristics of the partners and the base from which they chose to implement OVC activities were reasonably assumed to be key predictors of the capacity of approaches to achieve outcomes, and were therefore prioritized for observation.
Rich Implementation Context	
At least some of the sites had to be in districts with multiple mechanisms being implemented simultaneously, *AND* *At least some of the sites had to be in districts where the OVC and Care and Treatment leads were not the same implementing partners.*	One of the review objectives required a consideration of the contribution of coordination across different prime implementing partners and mechanisms to the achievement of outcomes for OVC. As improving linkages between community based services and health facilities is a current emphasis in PEPFAR, coordination across OVC and Care and Treatment partners was seen as particularly important to observe.
At least one of the sites had to be in a district where the SDS[18] mechanism was being implemented, *AND* *At least one of the sites had to be in a district where the SDS mechanism was not being implemented.*	District government assumes a role in all mechanisms being implemented through PEPFAR funding. Analysis of secondary data suggested that how district government performs may have a significant influence on the capacity of the different approaches to achieve outcomes. The presence of the SDS mechanism offered a useful initial proxy for distinguishing between better and poorer performing districts, with the assumption that the presence of SDS probably signalled better performing districts.

[18] SDS was a USAID mechanism intended to improve the functionality of local government and community systems in support of comprehensive OVC services. SDS complemented the work of other OVC mechanisms, hence it's consideration in the sampling criteria.

ANALYZING THE COST OF SERVICE DELIVERY

The interagency review of the OVC Portfolio aimed to describe the various approaches to implementing OVC programs within the PEPFAR Uganda OVC Portfolio, and the capacity of those approaches to achieve outcomes. These descriptions are complemented with an assessment of the costs associated with each implementation approach. The overall objective of the cost analysis was to provide an indication of the cost effectiveness[19] of the various OVC implementation approaches. While the principle of cost effectiveness assessment — understanding the cost of achieving an outcome — would guide the exercise, a methodologically orthodox approach to assessing cost effectiveness was understood to be beyond the scope of the assignment. It would be sufficient to present indicative rather than conclusive evidence, to the extent possible. As such, the analysis aimed to:

- Determine the costs associated with each implementation model, distinguishing between site level and management level costs; and
- Provide unit costs per beneficiary category for each of the models.

The scope of the cost analysis, as agreed at inception, included three sets of analyses per approach:

1. The analysis would produce a unit cost for services delivered, where the unit cost represents a cost per beneficiary. For every implementation approach identified, we set out to estimate unit costs per service area (health access and health promotion, educational support, economic strengthening, psychosocial support, food and nutrition, child legal protection and shelter), where feasible and relevant, broken down by age groups.
2. The analysis would determine costs associated with implementation processes where possible. A generic range of implementation processes were defined for this purpose and included identification; assessment and enrollment; supervision of the social workforce; coordination and linking to health care; referrals and case management for the continuum of care (including graduation or case closure).
3. The cost analysis would distinguish between site level and management costs, and describe the above site level cost drivers in as much detail as is feasible, given data and time constraints.

Based on the evidence from the cost analysis, recommendations would be made on what needs to be considered to make implementation more efficient.

The decision to base the cost analysis primarily on the EA data of the implementing partners was expedient, and made in the light of the constraints under which the review had to be completed. It was also anticipated that expenditure data would offer a fair approximation of cost of implementation of the identified approaches. In addition to this, we envisaged obtaining relevant supplementary information and clarifications directly from implementing partners, through key informant interviews. Information sources and data collection methods are summarized in Table 5.

[19] Cost effectiveness is understood to refer to the optimal cost associated with achieving an outcome. In this assignment, we **do not** estimate the cost effectiveness of OVC interventions. Instead, we rely on unit expenditure (expenditure per OVC served) to provide an indication of attempt some conclusions about cost-effectiveness.

Table 5: Summary of Methods for Cost Data Collection and Sources

Data collected	Method of collection / analysis	Source of data
Total expenditure on OVC		
Expenditure on service areas for OVC (site level expenditure)	We conducted face-to-face key informant interviews with different IPs. During these interviews, we requested for data on PEPFAR EA. From this, we obtained information on expenditure broken down by the different service areas/core program areas (as categorized in the EA files).	PEPFAR EA reports obtained from IPs
Expenditure on PM	From EA file, we obtained the total amount spent on PM. We also obtained the proportion of that total PM expenditure that was allocated to OVC. Based on these, we calculated PM expenditure for OVC. From the IPs, we also obtained information on overheads for all sub-grantees of a given IP.	
Expenditure on OVC broken down by core program areas	We conducted face-to-face key informant interviews with different IPs. During these interviews, we requested for data on expenditure, broken down by the different service areas/core program areas.	Data provided by IPs
Expenditure on implementation processes	We requested for this information directly from IPs during the key informant interviews. The data were provided readily as unit costs (i.e., cost per process per OVC served).	Data provided by IPs
Number of OVC (broken down by core program areas)	We obtained this information directly from IPs through key informant interviews. Specifically, we asked them to provide (a total OVC served, and b) number of OVC served in the different core program areas.	Data provided by IPs
Cost per OVC served	We calculated this using the EA data and the APR data provided by the IPs.	Data provided by IPs

In general, the IPs were responsive and provided the information requested from them. An initial analysis of their data revealed numerous gaps and inconsistencies. Follow-up key informant interviews resulted in the data inconsistencies and gaps being resolved up to a point. The process of getting a full set of data that was accurate and usable was time consuming, but sufficiently successful for the objectives of the cost analyses to be met to some extent. However, as explicated in the Findings on OVC Cost ANALYSIS section and anticipated in the limitations described below, the findings on cost are indicative, and not sufficiently robust to confidently present conclusive statements on cost effectiveness in its strictest sense.

INTEGRATING APPROACH DESCRIPTIONS AND COST ANALYSIS

In both the general discussion of findings (*See*

Findings on Approaches to Implementing OVC Programs), and the specific descriptions of implementation approaches (See Description of the Capacity of Approaches to achieve Outcomes), an indication is given as to the implications for the capacity of each approach to achieve outcomes. This path of inquiry is dictated by the second review question guiding the research, and is the key perspective framing the analysis in the review.

The General Findings in section 5 and the Specific Approach Descriptions in section 7 are to be considered when reflecting on the Cost Analysis in section 6. While the limitations applying to the cost analysis proscribe any conclusive pronouncements on the cost effectiveness of implementation approaches, the three sections taken together offer some indicative evidence of the strengths and weaknesses of each approach, and the cost associated with their relative effectiveness. This evidence is also the basis upon which recommendations deriving from this review are proposed.

Overall the research questions operationalize the review objectives and represent the organizing principle for the analysis of the data. The data applicable to each research question, how it was collected and the use to which it was put, is summarized in Table .

LIMITATIONS

A number of the mechanisms in the portfolio were in transition at the time of the review. Some mechanisms were introducing new practices that would enhance effectiveness (e.g., Mildmay, SOCY and BOCY); others were withdrawing from certain sites, in anticipation of closing out (e.g., Sustainable, Comprehensive Responses for Vulnerable Children and their Families [SCORE]); newly awarded mechanisms, although included in the review, had not yet launched services for OVC and their families (e.g., SOCY and BOCY). While this dynamic context has to be acknowledged it could not be compensated for, and the cross-sectional character of the review should be noted when considering findings.

4. Assessing the capacity to achieve outcomes would have been substantially more robust had the review had access to performance and outcomes evaluations of all the OVC PEPFAR Uganda portfolio mechanisms. While the analysis of each implementation approach's capacity to achieve outcomes is evidence based, in that it references the knowledge base of what we know works in OVC programs, it lacks that detailed scrutiny of each individual mechanism in the implementation context that outcomes and impact evaluations provide.

5. The lack of outcome and impact data also imposed limits on the cost analysis. In order to make pronouncements on cost effectiveness the cost of implementation must be considered in the light of outcomes realized. Cost effectiveness, understood as the relative cost of achieving an outcome across implementation modalities, could therefore not be judged in a credible manner because neither outcomes nor impacts had been comprehensively documented across the OVC portfolio.

6. The EA data was used as the primary source of cost data. Although supplemented by additional data requested from and submitted by implementing partners, the quality of expenditure data is not yet optimal, and the cost analysis findings are subject to error inherent in the expenditure data quality deficits.

7. Implementing partners do not (and are not required to) routinely collect cost data as expended against service areas, and implementation processes. The attempt to collect cost data with respect to the implementation processes defined for the assignment exposed both the current limits to cost data management, as well as the erroneous assumptions in the

review methodology. What was learned in the attempt will be offered as recommendations for subsequent efforts.

8. While the section on Depth of Interventions gives an indication of the extent and quality of activities within service areas, this information has not been quantified and included in the cost analysis. Differences in cost per beneficiary across approaches is significantly influenced by the depth of services delivered; lower costs per beneficiary do not necessarily indicate cost efficiencies, but must be considered with respect to the capacity of approaches to achieve outcomes. Unfortunately an analytical procedure that would more directly present this relationship was not found, due to the mismatch in the types of data analyzed.

9. Insufficient data was collected on the supervision of sub-partners by prime partners for a thorough comparative analysis of approaches to be concluded on this particular implementation process. Some findings are included in the review where valid.

10. Where SIMS data was available, it was reviewed and triangulated against especially in terms of the findings on implementation processes. However, it is apparent that using SIMS data to compare performance across implementation approaches is problematic, because SIMS instruments are not fashioned for inter-rater reliability and comparative measurement.

Table 6: Summary of Research Questions, Methods, and Analysis

	Evaluation/Analytic Question	Research Methods	Data Use
1	What are some of the different implementation models within the PEPFAR Uganda OVC portfolio, in terms of the model design; inputs; activities and implementation processes; quality of implementation; and the contribution of PM at implementing partner and agency level?	Document and data review Survey Key informant interviews Group interviews	Data from the review of documents from the USG Agencies and their implementing partners - typically all documents containing project descriptions – together with data from a survey distributed to implementing partners, was used to draft the initial descriptions of the various implementation models. Key informant and group interviews with agency and implementing partner staff will provide data to refine and validate the implementation models.
2	What are some of the strengths and weaknesses of each of the implementation models, with respect to achieving intended outcomes, according to PEPFAR's guidance and authorizing legislation?	Document and data review Secondary analysis of existing data Key informant interviews Group interviews	The implementation model descriptions were considered in the light of: What works in achieving outcomes for OVC, based on existing evidence; The secondary analysis of existing APR data, supplemented by additional monitoring data from IPs; Key informant and group interviews with agency, IP, and sub-partner staff at national, regional, district and site/facility level; Focus group discussions with community level workers within PEPFAR OVC programs Key informant and group interviews with Ugandan government officials, working with PEPFAR OVC programs at national, district and site/facility level.
3	How cost effective[20] are the various OVC implementation models assessed?	Secondary analysis of existing data Key informant interviews	Relevant data was obtained from the PEPFAR EA, and supplemented with data obtained directly from IPs. The data was used to: Determine the costs associated with each implementation model, distinguishing between site level and above site level costs Provide unit costs per beneficiary category for each of the models.

[20] Cost effectiveness is understood to refer to the optimal cost associated with achieving an outcome.

	Evaluation/Analytic Question	Research Methods	Data Use
4	What is the current status of coordination and collaboration across the OVC portfolio in Uganda, including strengths, opportunities and gaps?	Document and data review Secondary analysis of existing data Key informant interviews	Analysis of project descriptions identified intended coordination and collaboration mechanisms. The implementation and efficacy of these mechanisms was assessed by relevant secondary data where available, such as records of completed referrals. Key informant interviews validated the findings and offered data on issues such as persistent challenges undermining coordination, collaboration and ultimately the effectiveness of the OVC PEPFAR portfolio, as well as opportunities to strengthen coordination and collaboration and address gaps.
5	Based on the evidence of best practices and lessons learned, what is required to improve the effectiveness and efficiency of the OVC PEPFAR activities?	Recommendations proposing improvements in portfolio effectiveness and efficiency are based on the sum of data, analysis, findings provided and lessons learned, in response to the preceding review questions.	

IV. FINDINGS ON APPROACHES TO IMPLEMENTING OVC PROGRAMS

Q1. What are the different implementation models within the PEPFAR Uganda OVC Portfolio in terms of the model design; inputs; activities and implementation processes; quality of implementation; and the contribution of PM at implementing partner and agency level?

APPROACHES TO IMPLEMENTING OVC PROGRAMS

The review identifies and describes five different approaches to implementing OVC programs, as listed in Table 7. These approaches are distinguished by three sets of factors, namely, partnering, delivering services, and scope of interventions. These sets of factors are explained more thoroughly in section 5.2, titled Distinguishing Between Different Approaches; while the approaches are described in more detail in section 6, titled Description of the Capacity of Approaches to achieve Outcomes.

Partnering, delivering services and scope of interventions together determine the capacity of the different approaches to achieve particular outcomes. How these factors position approaches for achieving outcomes is described in sections 5.3 to 5.5, with reference to existing evidence and observations from the field. The more effective practices in the portfolio related to these determining factors are also described, with a view to proposing recommendations at the conclusion of this review. It is worth noting that the availability of resources, discussed as a factor under partnering, is also strongly associated with an approach's capacity to achieve outcomes.

The descriptive analysis of approaches informs the analysis of the cost effectiveness in section 6. A more complete description of each approach, based on the partnering, delivering services and scope of interventions framework, and the associated capacity to achieve outcomes, is provided in section 7.

DISTINGUISHING BETWEEN DIFFERENT APPROACHES

The analysis of project documentation and fieldwork data revealed three sets of factors that distinguish approaches to implementing OVC programs, namely, with whom and how the prime implementer partners (partnering); the nature of the processes through which services are delivered (delivering services); and the depth of the activities or interventions that are implemented (depth of interventions). In addition to serving as the criteria by which approaches can be distinguished, the sets of factors display a relational order: partnering practices adopted have implications for how services are delivered and the scope of interventions that can expected; similarly service delivery practices have implications for the scope of interventions observed. Ultimately, how these factors are expressed in each approach is associated with the capacity of each approach to achieve particular outcomes.

Each of these discriminating sets of factors are described in detail in the sections that follow. Figure offers a summary of these sets of factors, the distinguishing factors that apply in each, and some explanatory notes on how they position approaches for outcomes.

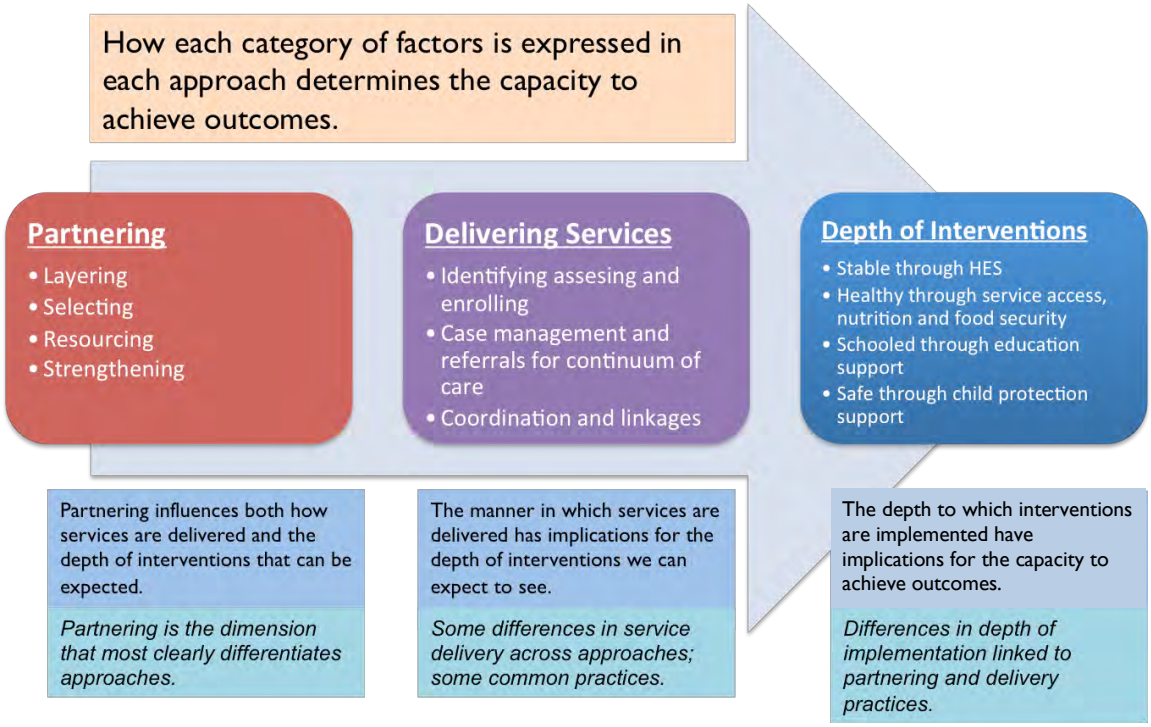
Table 7: Approaches to Implementing OVC Programs

Approach and IPs	Description	Descriptors	
Approach 1 *AVSI, CRS, World Education*	These are 100% HKID funded approaches, implemented at scale (wide geographic reach and large numbers of beneficiaries), with an emphasis on specialised technical capacity in all OVC service areas, throughout the multiple layers of sub-partners.	Award ($) to mechanism COP 2015	SCORE – 4,000,405 SOCY – 5,468,164 BOCY - 4,473,953
		No. of Districts Served	SCORE 33 SOCY - BOCY - 13
		No. of OVC served	SCORE - 110,204 SOCY – N/A BOCY – N/A
Approach 2 *Mildmay and CEM*	These approaches get less than or up to 30% of their funding from HKID, and are characterised by a very broad base of CBOs and community level associations as implementing sub-partners.	Award ($) to mechanism COP 2015	MILD MAY – 602,508 CEM/PHS - 1,659,164
		No. of Districts Served	MILD MAY – 16 CEM/PHS - 34
		No. of OVC served	MILD MAY – 14,672 CEM/PHS (PNFP) – 42,256 CEM/PHS (PFP) – 4,705
Approach 3 *Reach Out Mbuya, RTI, UNHCR, CAFU*	These approaches get less than or up to 30% of their funding from HKID, and are characterised by implementation through partners with a fairly limited scale of operation (geographically focussed and a comparatively small number of beneficiaries) in specific locations, covering most service areas within a small technical team that emphasises case management.	Award ($) to mechanism COP 2015	ROM – 172,607 RTI – 284,633 UNHCR – 46,972 CAFU - 519,235
		No. of Districts Served	ROM – 2 RTI – 8 UNHCR – 2 CAFU - 2
		No. of OVC served	ROM – 8,350 RT1 – 3,136 UNHCR – 1,023 CAFU – 1,645
Approach 4 *Baylor, Walter Reed, UPMB and Kalangala*	These approaches get less than or up to 20% of their funding from HKID, with their OVC activities focussed around and implemented through a health facility based workforce, with links to community structures, such as local government and authorities and civil structures such as churches and associations.	Award ($) to mechanism COP 2015	Baylor PIDIC – 1,131,726 Baylor COMP - 751,955 UPMB – 92,238 Walter Reed – 542,158 Kalangala DHO – 1,706
		No. of Districts Served	Baylor PIDIC – 7 Baylor COMP – 16 UPMB – 6 Walter Reed – 3 Kalangala DHO - 1

Approach and IPs	Description	Descriptors	
		No. of OVC served	Baylor PIDIC – 18,036 Baylor COMP – 8,561 UPMB – 4,034 Walter Reed – 19,412 Kalangala DHO - 31
Approach 5 *State Department and Peace Corps*	These are highly localised interventions (located in and focussed on very few communities in a geographically delimited area) using small grants disbursed directly to a CBO.	Award ($) to mechanism COP 2015	State – 248,000 Peace Corps - 90,000
		No. of Districts Served	State - 7 Peace Corp - 5
		No. of OVC served	State – N/A Peace Corps – N/A

Source: COP Budget 15, SAPR OVC outputs by IP and district

Figure 1: Factors Distinguishing Approaches to Implementing OVC Programs



PARTNERING

The manner in which partnering is executed has implications for the capacity to achieve outcomes. The selecting, layering and strengthening of sub-partners by the prime implementing partner is associated with the technical capacity recruited and embedded to deliver services. Deficits in technical capacity undermine the capacity to achieve outcomes. It is also apparent that without material resources (and adequate funds in particular) sub-partners cannot deliver services. This is true independent of technical capacity.

Elements of Partnering

All prime implementing partners enter into partnerships with a variety of sub-partners. Patterns of partnering however are distinctive across the different approaches identified, and can be distinguished by considering the number of partnership layers in an approach, and the manner in which the prime partner selects, resources and strengthens the capacity of its various sub-partners.

There are numerous sub-partners with which a prime partner might engage to implement OVC programs (See Table 8). These sub-partners are either implementing activities or providing technical support to other sub-partners, and in some instances fulfill a combination of both those functions. In addition, there are partners who fulfil a support function in that they facilitate access to beneficiaries, such as units delivering social services, health facilities and schools. It is necessary to partner with these (primarily government) institutions because they control access to people.

A particularly important category of sub-partner is the social workforce, which consists of a number of cadres in Uganda (e.g., parasocial workers, paralegal workers, community based trainers, village health teams, peer educators, linkage facilitators), and which deliver the services directly to households and children. Partners will most often mobilize existing cadres of the social workforce (e.g., village health team members), but may also be in a position to supplement the social workforce by recruiting, training and deploying additional staff (e.g., community based trainers). It is common to find the same person in a community assuming a number of these social workforce roles.

Table 8: Possible Sub-partners for Approaches

	Partner	Description and Function
Civil Society		
Technical	Peer-level sub-partners	These are sub-partners that are organizational peers of the prime, and have been chosen as partners primarily to provide technical support to implementing sub-partners.
	Ugandan NGOs	These are Ugandan NGOs that are organizationally sophisticated, have a track record of successful participation in programs, and may have national or regional presence. They are most often partnered with to provide technical support to implementing sub-partners.
Implementing	Local CBOs	These are formal not-for-profit organizations with a local presence, frequently have a track record of participation in programs, and manage a social workforce to implement activities.
	Community structures and associations	These may be formal or informal highly localised structures such as women's groups, PLHIV groups, or even VSLA groups that are often beneficiaries as well as members of the social workforce supporting the implementation of activities.
Social Workforce		
Implementing	Mobilized	Programs will most often mobilise the cadres already available to participate in the social workforce.
	Supplemented	Programs will sometimes recruit, train, equip and deploy a new social workforce cadre.
	Cadres included in this category of partners are parasocial workers, paralegal workers, community based trainers, village health teams, peer educators, linkage facilitators	

	Partner	Description and Function
Government		
Implementing	Health facilities	Health facilities are the key sub-partner in some mechanisms (most often in Approach 4), serving as the focal point of activities for vulnerable households and their children, with the technical staff responsible for OVC operating from the facility. In the remaining approaches health facilities are a key referral partner for access to health services and identifying eligible OVC for enrollment in OVC programming.
Support	Schools	Prime partners and their sub-partners will engage with schools to try and support school attendance and retention of the children enrolled in programs and identify eligible OVC for enrollment in OVC programming.
Support	District government	Prime partners will engage with the district government and the personnel who are responsible for services to vulnerable households and their children. These include the Probation Officer and the District Community Development Officer and her/his staff. Programs with a care and treatment focus will also be engaging with the District Health Office personnel. District government fulfils a crucial coordinating role in OVC programs, provides technical support to other implementing partners, and is responsible for resolving serious child protection cases.

Preparation supplements technical capacity through deploying or refining management systems, equipping sub-partners and staff, enhancing skills through training and supporting implementation fidelity through joint planning. The need for preparation varies across approaches, primarily due to the scale at which the mechanism is being implemented and the existing technical capacity and experience of sub-partners. The lack of adequate preparation and selection will therefore undermine the capacity of an approach to achieve outcomes.

Table 9: Resourcing Options for Approaches

Resourcing Options	Description
Internal Resourcing	
Sub-grants	The prime partner provides sub-partners with sub-grants to fund their assigned technical roles and implementation activities. Certain mechanisms also provide sub-grants to District government to support service delivery that complements PEPFAR activities.
Substantial material support	The prime partner provides sub-partners with significant material inputs, at times with funding from other budgetary sources, but which then complements OVC activities. An example would be the renovation of a health facility, which operates as a base for OVC activities.
Limited material support	The prime partner provides sub-partners with material inputs such as IT equipment, start-up kits for vocational training candidates etc.

Resourcing Options	Description
Emergency material support	The prime partner provides the sub-partners with the means to address the critical needs of most vulnerable beneficiaries at enrollment, such as providing for school materials or urgent nutritional needs.
Stipends and cost support	The prime partner offers stipends to cover the costs incurred by the social workforce cadres in delivering services and implementing activities.
External/Leveraged Resourcing	
Performance based grants	Some district governments were beneficiaries of performance-based grants through a technical assistance mechanism, SDS. This support provided resources for the district government partners to fulfil their coordination, technical support and implementation roles significantly improving the broader capacity to achieve outcomes.
Linking to externally funded mechanisms	Prime partners are at times in a position to link sub-partners to sources of external funding, such as government programs or programs funded by other donors.
Resource supplementing mechanisms	This term applies to approaches that link sub-partners in a referral network intended to distribute the resource burden. Sub-partners within the referral network, such as local CBOs, can then refer identified children to another CBO in the network if they do not have the resources (or technical capacity in a particular service area) to provide support.

While all prime partners take a degree of care in selecting sub-partners for implementation of OVC activities, the variations in the selection and preparation of sub-partners can be substantial. In certain approaches, a proportion of sub-partners are assessed and selected through a competitive process and prime partners are able to spend the first months after the award of an agreement preparing sub-partners to implement before OVC services are formally launched (Approach 1). This preparation includes developing and implementing management systems, training staff, and facilitating joint planning. In most approaches sub-partners are engaged through recommendations from government or community structures, with less time set aside for preparing them ahead of delivery (Approaches 2, 3 and 4). In facility enhanced approaches partners are initially selected for implementing care and treatment or prevention activities are assigned responsibility for OVC activities in addition, with little or no time set aside for intensive preparation (Approach 4 in particular).

The prime partner may offer a variety of resources to its sub-partners, ranging from a sub-grant (Approaches 1 and 2) to limited material support, such as stipends or cost support for the social workforce (All Approaches) to no material support at all (for certain partners in Approaches 2 and 4). However all partners invest in strengthening the capacity of sub-partners through training and equipping with tools to better execute processes such as identifying, enrolling and assessing households for support; referring households or children to other services; and monitoring and reporting on their activities.

Partnering for Technical Capacity

Approach Based Observations

Approaches differ in the extent to which they embed technical capacity specific to OVC service areas, and this has implications for how comprehensively, skillfully and responsively implementation is executed. As a result, the differentiated technical capacity across implementation approaches has implications for the capacity of each approach to achieve particular outcomes, with the lack of technical capacity undermining the capacity to achieve outcomes.

Approach 1 includes layers of technical sub-partners that function entirely or primarily as technical support to implementing sub-partners. Technical sub-partners employ staff with specialist expertise in OVC service areas, and assign these staff to oversee the relevant service areas (or results areas in the language of mechanisms in Approach 1), exclusively. Both technical and implementing sub-partners in Approach 1 are frequently engaged through a competitive process in which calls for proposals are issued and submissions are assessed, in part, for technical capacity and experience. Technical specialization is a consistent emphasis throughout the approach, and includes training and deployment of different social workforce cadres that each focus to some extent on specific outcome areas.

While Approach 3 does not include layers of exclusively technical sub-partners, technical specialization is evident in its best examples. Teams of technical specialists are in a position to intensively case manage households and their children, enabled by the limited scale of implementation typical of Approach 3 mechanisms. In addition the limited scale of implementation enables the technical specialists to more effectively supervise the social workforce with whom they are partnering. Approach 5 demonstrates a similar balance between specialist technical capacity and limited scale, which favors the capacity to achieve outcomes.

Mechanisms in Approaches 2 and 4 demonstrate variable technical capacity in OVC specific service areas. This is particularly challenging for Approach 2 mechanisms that are attempting to implement to scale with a very large contingent of implementing sub-partners, and a single prime responsible for supervision and technical support. While technical capacity is available within the implementing sub-partners to some extent, observations in the field and discussions with prime partners made it clear that in a number of instances capacity is not remotely equal to the need. Variable, or in some instances severely limited, technical capacity among sub-partners imposes an unanticipated burden on the supervisory and support function of the prime partner. Even with required specialization on staff at the prime partner, prime partners may not be consistently able to adequately supplement the deficits of less capable sub-partners, because there are not enough prime partner technical staff to do so.

Mechanisms in Approach 4 are confronted with similar challenges to Approach 2 mechanisms. The genesis of the challenge however is different in that the implementing sub-partners are usually health facilities that do not have the staff with the required technical specialization in OVC service areas. Moreover the staff that are assigned are typically adding OVC responsibilities to an existing, already over-burdened workload.

Impact of Technical Capacity

Technical capacity strengthens or undermines implementation in three ways:

Comprehensive implementation: Sufficient technical capacity in each of the service areas is associated with the implementation of *comprehensive* activities in the OVC outcome areas of Healthy, Safe, Stable and Schooled. Existing evidence describes the scope of related activities in HES, nutrition and health, education support and child protection that, implemented together, are most efficacious in producing outcomes. These combinations of activities in service areas are illustrated and discussed in 0 Scope of Interventions. This is also true to a lesser extent of implementation processes such as identification and enrollment, case management, coordination and linkages, and graduation. A technical capacity deficit may result in the incomplete implementation of activities (despite the comprehensive nature of PEPFAR and agency guidance) and the inefficient implementation of processes, with the consequent undermining of outcomes. Observations from the fieldwork indicate that even when activities were comprehensive (in that all service areas were offered), they were not always comprehensively implemented (not all the necessary activities for achieving outcomes were being implemented within each service area). Observations in this regard a discussed further in sections 5.4 and 5.5.

Skillful implementation: Sufficient technical capacity in each of the service areas is associated with the *skillful* implementation of activities in the OVC outcome areas of Healthy, Safe, Stable and Schooled.

- Skillful implementation requires sufficient expertise to address the conditions in the implementation context that dictate the most appropriate implementation choices for comprehensive activities. It is the wise application of technical capacity. For example, the choice of crop-based agriculture as an IGA in a comprehensive HES offering needs to carefully formulated, taking into consideration factors such as choice of crop; environmental conditions influencing yields; cost of inputs; market conditions that determine return on investment for households; and potential environmental impacts of farming practices.

- Skillful implementation also refers to the accumulation and application of specialized knowledge that augments the implementation of activities in the different service areas. For example, while there are standardized child protection procedures that are broadly applicable to most cases, child protection procedures for supporting children living outside of the home are not common knowledge. An implementing partner in Approach 5 has been working with street children in Kampala for some time and has cultivated the expertise to implement services for this sub-population that is evident among few other IPs in the OVC PEPFAR Uganda Portfolio.

Responsive implementation: Sufficient technical capacity is associated with the *responsive* implementation of activities in the OVC outcome areas of Healthy, Secure, Schooled and Safe. Responsive implementation requires the expertise to manage and mitigate substantial and unanticipated risk, or to exploit unanticipated opportunities, that emerge during implementation. When a sub-partner in Approach 2 was required to withdraw the provision of school materials, the school it supported saw a drop in attendance from 300 to 86 learners. A partner in Approach 1 that was also required to withdraw the provision of school materials was able to mitigate risk by leveraging its relationship with an organization external to the mechanism that focused on promoting safe schools, and succeeded in maintaining school enrollment and attendance figures in the schools it was supporting.

Resourcing Sub-partners

Approaches differ in the extent to which prime partners are able to ensure that sub-partners are adequately resourced to complete tasks and implement activities. This has implications for mechanisms being able to deliver comprehensive services to households and children in their care. Without comprehensive services the capacity to achieve outcomes is severely undermined.

The ability of prime partners to resource their sub-partners adequately is limited principally by the extent to which their funding matches the scale at which they are expected to implement. All prime partners have to demonstrate their capacity to manage grants before receiving awards. While the comparative capacity to manage a grant will differ across prime partners, difficulties in managing grants are related to trying to meet performance expectations with resources unequal to those expectations. Ultimately there is substantial dependency across approaches on the availability of resources, which influences their capacity to achieve outcomes. This is a dependency that all approaches are not equipped to successfully address.

Resource dependency of the capacity to deliver services, and therefore achieve outcomes, is clearly illustrated from multiple sources of evidence in the field. In both Approaches 1 and 2, sub-partners are provided with sub-grants, commensurate with the prime partner's capacity to do so (the funds available to them). Where sub-partners are adequately resourced to approximately the full cost of implementing activities, households are consistently enrolled in services comprehensively addressing their care requirements (Approach 1). Where there are resource deficits—that is the performance requirements do not appear to be adequately matched by the funding (Approach 2)—households, regardless of prioritized vulnerability, cannot access services.

Examples from Approach 2 accentuate the extent of resource dependency on the capacity to achieve outcomes. Mechanisms in this approach have attempted to address the resource deficits through innovations in program design. Technical support from the prime partner facilitates the forming of informal networks of CBOs within communities. This networking is partly an attempt to distribute the resource burden. If one of the CBOs is short on resources, it can refer households requiring support to another CBO in its network. The assumption is that there are resources at local level external to the mechanism that can be leveraged. Observations in the field indicate that unfortunately this assumption is frequently false, and households fall victim to futile circles of referral. The prime implementing partner is in the process of adjusting its implementation in this regard, attempting to extend additional resources to sub-partners. However, their assertion that resource related challenges will persist as a result of the scale at which they are attempting to operate, is plausible.

A further observation demonstrating the resource dependency of the capacity to achieve outcomes is related to external or leveraged resourcing, as described in Table 9. District government plays a crucial complementary role in the effective delivery of OVC services. Coordination mechanisms, such as technical committees in which PEPFAR implementing partners participate together with district officials and other service delivery organizations, are facilitated by the district. Without funding, these coordination mechanisms falter. USAID's Strengthening Decentralization for Sustainability (SDS) mechanism, which provided performance based grants to district government, is credited by district officials in Kamwenge in particular with ensuring functional coordination of services. They also expressed unease with the close out

of SDS, because there are no guaranteed alternative resources to the SDS performance based grants.

More dire consequences of the lack of resources for district government were observed in the field. Probation Officers and District Community Development Officers admit that severe child protection issues — including cases of abuse, defilement and extreme neglect — remain unresolved because district officials do not have the resources required for the persistent activity (visits and follow-up) that these cases require. In fact, because the district government's management of child protection is hampered by resource issues, the child protection service area (core program area or CPA in the government of Uganda terminology) is frequently considered to be a service area in crisis.

The resource dependency of the capacity to achieve outcomes also exacerbates and is exacerbated by technical capacity deficits, as examples from the field show. When funding was cut to sub-partners in Approaches 2 and 4, activities were simply eliminated. While a prioritization of activities guided the decisions on which activities to cut, it is apparent that, in the absence of the capacity for responsive implementation, comprehensive care that works will be curtailed, and the capacity to achieve outcomes undermined.

DELIVERING SERVICES

Q2. What are the strengths and weaknesses of each of the implementation models, with respect to achieving intended outcomes, according to PEPFAR's guidance and authorizing legislation?

Three service delivery processes are discussed below:

1. Identifying, assessing and enrolling children;
2. Referrals and case management for the continuum of care (including graduation or case closure); and
3. Coordination and linkages.

The process is first described in general, and then the specific strengths and weaknesses associated with different approaches are outlined. This does not imply that every partner categorized in a particular approach will display the same strengths and weaknesses.

The examples given come directly from partner responses to the Review Survey.

Identifying, Assessing and Enrolling

In accordance with the 2012 Guidance and recent technical considerations, partners are improving their targeting so that vulnerable children, especially children at risk of HIV infection, HIV positive children and the children of HIV positive parents/caregivers, are identified, assessed and enrolled.

Across all approaches there is typically a two-stage process before a child or family is enrolled. Families and children are initially identified through a number of possible channels, including clinics, community organizations, community members or government official; and then followed-up with a home visit by a partner staff member or, more often, a trained member of

the social workforce (such as community worker, parasocial worker, or village health teams [VHT]), for assessment and potential enrollment. The intention of a two-stage process is to ensure that the most vulnerable are reached with the limited resources at the disposal of the OVC portfolio, and in so doing enhancing the capacity to achieve outcomes.

Given limited funds and high levels of need, partners make efforts to prioritize by identifying those most directly affected by HIV. These can include children of positive parents; children who are positive; and children in households with a positive family member; and children in very vulnerable situations who are most at risk of HIV infection or other health risks, such as out-of-school youth, victims of abuse, malnourished children, and children in extreme poverty. There is some differentiation across approaches in the breadth of channels utilized to identify vulnerable children and households, and this is associated with a difference in the proportion of households with HIV positive children or members that are enrolled in services. More community centered approaches such as Approach 1, with a reported proportion of 15% of households with HIV positive members, report a wide variety of identification channels. These approaches tend to enroll a higher proportion of vulnerable children who are at risk of being infected or affected by HIV.

Partner Response (Approach 1)—Possible Identification Avenues Include:

- Home visits,
- Community dialogues, outreaches and legal clinics,
- Life skills and parenting skills training engagements,
- Referrals from community structures,
- Walk in by clients themselves,
- Coordination meetings, and
- Other engagements with the households.

Partner Response (Approach 1). Prospective beneficiaries are identified through a range of channels including referrals from other projects, lists of vulnerable people obtained from CDO offices, clinics, clinic- and community-based HIV positive groups, community civil society organizations (CSO), and other actors supporting PLHIV to ensure inclusive outreach and identification of HIV infected and affected households, community dialogues in target sub-counties. The households are subsequently assessed using the Ministry of Gender, Labor, and Social Development (MGLSD) vulnerability prioritization tool, and those who qualify are enrolled.

Approaches that are more facility based tend to report utilizing fewer channels to identify households, with an emphasis on identification through index HIV positive cases. For example, partners based in or closely associated with a clinic (Approaches 3 and 4) identify children when a child or their family member tests HIV positive. The family's details are then taken and if considered potentially vulnerable, a home visit is made and the family is assessed. Partners in Approaches 3 and 4 claim a far higher proportion of households with HIV positive members

enrolled. These approaches tend to enroll a higher proportion of children infected or directly affected by HIV. However they are confronted with a number of challenges that undermine the consistent participation of enrolled beneficiaries in OVC service activities.

These challenges emerge from the fact that facilities have multiple communities in their catchment area, which may be extensive. Participation in group activities located at facilities would therefore inevitably incur travel costs for beneficiaries, jeopardizing consistent involvement. And traveling to a clinic to participate in activities associated with HIV risks being stigmatized, an issue that persists in Uganda. Travel costs would similarly apply to the social workforce responsible for home visits and case management, although this is mitigated to some extent when facilities are located in densely populated areas. The anticipated advantages of basing OVC activities at a facility site that might accrue to care and treatment efforts, such as incentivizing retention in care and facilitating adherence monitoring, would be subject to these same challenges.

Partner Response (Approach 3). The program uses three approaches to identify OVC households for support:

1. Through community household assessments by community volunteers and local council leaders,
2. During home-based HCT conducted by staff assisted by volunteers the vulnerability of a household is assessed, and
3. Using HIV positive children or caregivers as an entry point into the household for an assessment during home visits for adherence support.

Partner Response (Approach 3). OVC are reached through testing at OVC homes or orphanages. Once HIV positive OVC are identified, they are referred or linked to care and treatment services in the health facilities.

The new mechanisms in Approach 1 are designing processes that emphasize identification through closer collaboration with facilities and care and treatment partners to improve targeting households with HIV infected and affected children. Challenges with enrolling high proportions of HIV infected and affected children are likely to continue. In particular, this is the case for mechanisms enrolling large numbers, simply because enrollment of large cohorts and the subsequent delivery of services on mass is most practically accomplished within a time delimited enrollment window. HES services, for example, involve the sequencing of training and activities of groups of beneficiaries, where consistent participation in and the integrity of the group over time are key factors in the capacity to achieve outcomes for beneficiaries. The feasibility of identifying and enrolling large numbers of HIV infected and affected children within a short space of time, in order to ensure consequential participation in group activities over time, is limited at best.

This cohort-based service delivery modality will also test closer collaboration between community-based approaches and health facilities, which will not be enrolling HIV positive patients in convenient cohorts or with regard for the enrollment windows of large mechanisms.

After being identified, families are assessed before enrollment and then annually, at a minimum, (for most partners) to track progress towards possible graduation. The assessment of vulnerable children typically follows the GoU procedures, under MGLSD, using the vulnerability index or the vulnerability assessment tools most frequently. Some partners use an adaptation of these to assess vulnerability and changes in vulnerability due to interventions or changes in circumstances. Partners using adaptations of the tools report doing so because of perceived inadequacies in the instrument. Some partners are considering the use of the Child Status Index tool to track household progress, an instrument designed for population level assessments and not suited to the task of tracking household level progress. Users of the VI tool also explained that they regard strict adherence to vulnerability scoring an inadequate criterion for the decision to enroll households, and that discretion is necessary to complement the assessment of vulnerability.

Partner Response (Approach 4). Beneficiaries are identified using the VI tool. Each child in the household and the household itself is assessed for vulnerability; the same tool is currently being used to assess the readiness of children and households to graduate OVC. The Child Status Index tool has not been used previously but will be used to assess progress of the child after they receive a service. The service outlet point is the sub-county although the identification process begins in the ART clinics in supported sites within the catchment area of the sub-county.

The evidence on the implementation of assessment procedures suggests that simply administering tools and basing judgments on their results alone are inadequate. While technical assistance is being provided to examine and improve the VI tool, it is apparent that that some level of tacit expertise will continue to be required to complement the utility of assessment tools. Appropriate supervision of the assessment process is therefore necessary, and this will place demands on the technical capacity of prime partners and their sub-partners, in proportion to the scale of implementation.

Partner Response (Approach1). Using the OVC Vulnerability Identification and Prioritization Tool (endorsed by MGLSD), the regional implementing partners embarked on the first phase of beneficiary enrollment for Year 1. The two sub-counties were selected based on a number of key criteria including the high prevalence of HIV/AIDS and child abuse within the districts. The enrollment was conducted by community OVC resource persons including para social workers, village health team members, child protection committee members and other key community volunteers. For quality assurance, the project IP staff, community development officers and probation officers made spot checks in all the villages to ensure that the teams were collecting the right information and identifying the right households.

Table 10: Strengths and Weaknesses in Identifying, Assessing, and Enrolling

Strengths	Weaknesses
Partners use multiple community structures and coordinated partner efforts (such as updated registers) to identify the highly vulnerable and the HIV affected (Approaches 1 and 3 to some extent).	Households with HIV positive children and family members may not necessarily be prioritized, because status not known (Approaches 1 and 5).
Clinic-centric models are able to identify HIV affected children and families in an ongoing manner through the HIV testing on site. The families of HIV positive clients are assessed, and, if vulnerable, enrolled in the program. All HIV positive children are usually automatically enrolled in the program. (Approaches 3 and 4).	Very vulnerable children and families may not be accessing health facilities due to stigma or poverty and may therefore be missed (Approach 3 and 4).

Referrals and Case Management for the Continuum of Care

In line with PEPFAR OVC Guidance and technical considerations, partners are improving their referral practices and building their referral networks to ensure HIV positive children are linked and retained in care and treatment, and that vulnerable children access needed social services.

- A review of the documentation, discussion with key informants and information provided on site visits confirmed that all approaches rely on referrals as a means of providing services and all partners refer to and rely on the health facilities to address critical health needs and for HIV testing.
- All approaches use some type of referral form and try to track completion, either through hard copy documentation, such as a triplicate form or three-piece form or one-to-one feedback.
- All partners recognize the importance of clients' knowing their HIV status and that of their children. They institute activities to encourage HIV testing through home visits to families of known positive clients, through community outreach activities, and through encouraging HIV testing in platforms such as VSLA groups.

Partner Response (Approach 3): Referral forms are issued from the health facility for community services or from community services to the health facility, or from community services to other community services, etc. OVC then take forms to the service points where they are acknowledged and a feedback section at the bottom of the form is removed and sent back to the referral point to confirm whether a service has been provided or not. This process is spearheaded by a focal person at the various referral points. At the start of the process, consensus meetings are held with organizations providing this support and the referral process explained to the providers.

Partner Response (Approach 4): During quarterly meetings with OVC caregivers, caregivers with un-tested children are referred using OVC referral forms for testing at the health facility.

Partner Response (Approach 4): OVC are supported to access HIV services through different strategies that include VHT and expert clients' linkage and referrals from the

community to the health facility for HTC, care and treatment. OVC are referred for HTC from all households that have an index client accessing care and treatment. The VHT issue referral forms that are acknowledged by the health workers.

- There are efforts undertaken, such as meetings with clinic staff, aimed at improving the referral completion from community to health facility to ensure HIV positive children are linked and retained in care and treatment. The Review Team found evidence that referral networks among clinics, community organizations and social services within the community or within government were being developed or improved, but were not all fully functional at all sites. For example, partner staff reported that they did not always receive feedback on a client whom they had referred for a service.
- Case management is interpreted and executed in a variety of ways by partners. Effective referrals require case management that provides an effective, professional, child-focused response, situated within the continuum of care for children and families. Effective case management works with government health and social services and utilizes their legislative mandates and processes to assist children. Descriptions of case management approaches ranged from weekly meetings to discuss individual children (Approaches 3 and 5) through monthly meetings with caregivers, to quarterly government convened coordination meetings.
- The Review Team saw a number of case files of local sub-partners which were deemed to be sub-standard with insufficient information, no evidence of recent interventions, and little evidence of referral completion.
- Partners rely on parasocial workers to make referrals and follow-up with families. Given the various steps in case management — assessment, case planning, case monitoring, referrals and service provision, graduation, and transition and case closure — it is unlikely that a volunteer will be in a position to fully execute a case management strategy. Approach 1 partners have recognized this and are using case managers or social workers employed by CSO partners to train and oversee the parasocial workers.

Partner Response (Approach 1): The implementation of the activities below are for improved well-being of OVC and their caregivers.

- Conducting beneficiary household assessments to identify household livelihood gaps, vulnerability risks and drivers.
- Using household assessment results to support beneficiary households to develop need based action improvement plans.
- Using individual vulnerability assessment data to plan and develop individual case plans.
- Increasing beneficiary access to comprehensive services through linkages and referrals networks.
- Conducting sub-county quarterly referral reflection meetings for coordination, information and experience sharing.

Partner Response (Approach 1): CSOs will recruit and assign experienced social workers or case managers to support, monitor and track the activities of parasocial workers. The CSO social workers or case managers will provide all the necessary on-the-job training, case management tools and referral forms to coordinate case identification, planning and closure, as well as ensure effectiveness and functionality of referral processes in all intervention sub-counties. The case managers will also monitor the implementation of household plans, effectiveness of referrals, and documentation of reporting purposes, and coordinate sub-county referral reflection meetings. Parasocial workers will report to social workers at the end of every month on referrals made and completed, number of beneficiaries who tested and received results, and progress on implementation of household plans. CSO social workers will monitor the progress of beneficiary households and individual household members using routine monitoring reports in the parasocial workers' case registers or record books.

Partner Response (Approach 1):

Step 1: Case identification/reporting,

Step 2: Case assessment (involves collecting key information pertaining to the case),

Step 3: Service point identifications,

Step 4: Conduct a pre-referral dialogue with the family members and relevant sub-county leaders (CDO, police and health workers),

Step 5: Follow-up, and

Step 6: Concluding the referral.

Partner Response (Approach1): Following an assessment, it is possible to identify and target households for dedicated education about HIV services and referral. At aggregate level, each implementing CSO can organize HCT outreaches to communities with particularly low rates of testing. Also, the connections with health facilities through the service mapping make it possible for health facilities to reach out to the CSOs and PSWs to follow-up on clients who miss appointments or verify adherence to treatment. Thus, there is not a single standard process, but a flexible approach centered on the principles of case management and of work based on the specific situation of each family and community.

Partner Response (Approach 3): Based on the scores per OVC (from a vulnerability assessment), the critically vulnerable are targeted and enrolled in the program using an OVC enrollment form that tracks details and a photo of OVC and their guardians. Data and services offered are documented in an OVC service register, OVC register, family support register, and nutrition register among others. A child index assessment is carried out to ascertain child's status, and to monitor progress and status of children on the program.

Many partners use a vulnerability assessment tool to determine the readiness a household to graduate or transition. Some partners have elaborate mechanisms for working toward graduation and for monitoring families post-graduation (Approach 1). Often a family or child is transitioned from support once successfully completing an apprenticeship and starting to earn an income.

Partner Response (Approach 1): This exercise will be followed by a household assessment exercise that aims at establishing the actual household gaps and vulnerability risks to inform the development of household improvement and case management plans. The assessments will be undertaken using the Household Assessment Tool (HAT) beginning in January 2016 by parasocial workers working under CSOs.

Partner Response (Approach 2): Continuous assessment of household economic empowerment activities with a view to identifying remaining gaps, phase out some and extend support to new ones, using the OVC household VI tool adapted from MGLSD.

Partner Response (Approach 1): 70% of OVC under formal education were graduated from scholastic material support using a proxy indicator of level of household income at the time; and only 30% were still deemed critically vulnerable and were provided scholastic materials. This was a positive indicator as the program didn't receive complaints from the households that were phased out. Further graduation will be done using the VI tool later in the program to determine real levels of improvements across different indicators.

The review team identified the strengths and weaknesses in Table 10.

Table 11: Strengths and Weaknesses in Referrals and Case Management for the Continuum of Care

Strengths	Weaknesses
Partners have devised tools such as family plans to case manage and to facilitate graduation (Approaches 1 and 3).	Lack of strong and functional bi-directional linkages between community programs and health facilities. Referrals from clinics to community services is still weak and is somewhat dependent on knowledge of services through a service mapping and/or personal relationships (Approach 4).
With strong community programs, some partners have a solid network for referrals to partners able to provide a service, especially for education, child protection and for health. (Approaches 1, 3, and 5).	If personal and procedurals relationships are not maintained with local health facilities, children and families requiring health services may not complete a referral. (Approaches 1 and 2).
Partners ensure children get follow-up health care — even same day enrollment in care — especially HIV testing if their parents are positive, follow up for EID, encouraging caregivers to know their status and that of their children (Approaches 3 and 4).	Referrals for education, child protection or other social service support are made, but not necessarily completed if the expertise and required resources are not available either at district or community levels (Approaches 2, 4 and 5).
Case management and referrals are improved by facilitating participation for multiple partners in government coordination mechanisms (Approaches 1 and 4).	Referral completion in approaches that rely on partners that have poor resources and low technical capacity is inadequate (Approaches 2 and 4 especially).
Routine – even weekly - case management and referrals are facilitated within a site by a multi-disciplinary team (Approach 3).	Referral completion for serious child protection cases is particularly poor because government is not adequately resourced to fulfil its legal mandate (All).

Strengths	Weaknesses
Where in-depth and thorough service provider mapping, including site meetings for confirmations and MoUs, has been undertaken, partners reported improved referral completion (Approach 1, 4)	The reliance on a partially volunteer social workforce as a key link in the referral chain (e.g., parasocial workers and VHT) is understandable and appropriate. However, without adequate compensation and incentives for these cadres, volunteers are difficult to retain, thus decreasing the efficacy of their training and weakening referral follow-ups. (All).
Innovations for assisted referrals help ensure completion. These include facilitating transport, arranging outreaches (All) and providing referral linkage facilitators with responsibility for ensuring completion of referrals (Approach 1).	

"The assumption that there will always be other partners to provide missing wrap-around services is not correct! Some hard to reach communities hardly have other service providers to contribute to a comprehensive service package thus leaving many gaps in service delivery." — Partner survey response

Coordination and Linkages

What is the current status of coordination and collaboration across the OVC portfolio in Uganda including strengths, opportunities, and gaps?

In accordance with the PEPFAR OVC Guidance and recent technical considerations for COP 2015, partners have been geographically aligned to ensure close proximity to other PEPFAR supported HIV services within prioritized geographic areas. In the districts, partners work with the local district government, particularly the health office, probation officer, and the community development office.

- High-level coordination and linkages among implementing partners; between partners and local government structures; and between clinics and communities are critical for ensuring efficiency and sustainability of OVC services. The Review Team found evidence in evaluations, annual reports, and during site visits and key informant interviews that such coordination is happening and is valuable for ensuring access to the continuum of care. Coordination has also resulted in increased sharing of human, in-kind and financial resources. Some partners have MoUs to formalize the relationship.
- At the same time, a number of partners' annual reports, the recent USAID OVC Portfolio Review, and CDC and USAID SIMS data state there is too little coordination between community based OVC and facility based care and treatment programs. This was detailed in a recent evaluation of the Strengthening Uganda's National Response for Implementation of Services for Orphans and Other Vulnerable Children (SUNRISE) program that identified a need for more training of parasocial workers in HIV issues to facilitate linkages to care and treatment services and more appropriate care for HIV positive children.[21]

[21] SUNRISE-OVC Project Evaluation, 4Children, September 2015

- Approach 1 partners are heavily vested and integrated in community organizations, while Approach 3 and 4 have close links or are even co-located at clinics or health facilities. Both approaches use district and sub-country local government structures as a platform for coordination. National level government is engaged primarily through the MGLSD. Technical support has been given for improving the OVC MIS, facilitating district level use, and quality data inputs into the national system. One partner (SDS) has provided support to district level government in the form of performance grants for the CDO.

- Partners work in a holistic family centered manner, which entails linking families to a variety of opportunities. The economic strengthening activities are often a platform for other services, such as mobilizing individuals for HIV testing or providing information on child protection issues in the community. All partners work with district government and/or sub-county and village government, especially the CDO, attending coordination meetings, referring clients and responding to referrals that may come via local government personnel.

Partner Response (Approach 2): This approach utilizes group business interventions as entry points to other services including water, hygiene and sanitation education, awareness creation on child protection, gender-based violence and HIV prevention. It supports grantees to consolidate transformational gains already registered, and support linkages with the district Community Driven Development (CDD) program, the Northern Uganda Social Action Fund (NUSAF) program, micro-financial institutions, and other stakeholders for additional funds and other forms of support to OVC care givers groups.

- The establishment and/or strengthening of DOVCCs and SOVCCs has reportedly increased administrative functions. These committees and other management committees at District levels coordinate different development sectors within local government and civil society, outside of government, including implementing partners. The Review Team was told by one CAO of the District that he appreciated the reports that he was now getting on OVC activities in his District but would also like to know budget allocations to improve planning.

Partner Response (Approach 3): Approach 3 liaises with the health centers in the sub-county to provide HIV testing and counselling for the OVC with unknown status. Identified children with hearing impairment were linked into care in collaboration with the sub-county chief and service provider CSO at the district. Child protection meetings were held in conjunction with the Officers in charge of families and welfare departments at the sub-counties in order to sensitize OVC guardians how to identify, report and follow up on child abuse cases using village child protection committee members, LCS and police and the partner liaised with the sub-county community development officer to process birth certificates hence supporting children to register and get birth certificates.

Partner Response (Approach 2): A study of children in care showed that health facilities (24%) and family (23%) referred a substantial number of children into care. The majority (29%) were referred by other actors. It was established that most of these other actors were the various community structures. Table 11 outlines the strengths and weaknesses in coordination and linkages across the four approaches.

Table 12: Strengths and Weaknesses in Coordination and Linkages

Strengths	Weaknesses
Partners utilize existing coordination mechanisms of local government, such as quarterly management meetings, DOVCC and SOVCC (All).	Coordination through systems strengthening requires resources and specific, specialized technical expertise that are not always included in project design (Approaches 2, 4 and 5).
Partners use their close working relationships with clinic staff to address LTFU and EID for example (Approaches 3 and 4).	Health workers find it difficult to take on extra tasks (counseling) due to work pressures (Approach 4).
Partners are able to leverage other technical and material support (Approach 1, 3 and 5 particularly).	Health facility staff may not know of the existence or the capacity of community organizations within their catchment area. (Approach 4).
Partners work with clinic and community organizations on outreach activities (All).	The strength of community-wide coordination is highly dependent on resources (such as transport) available to participants, including local government (Approach 2, 4 and 5).
Home-based care staff or community workers may provide some support to community OVC programs. In one program, the HBC volunteers are the front line team who visit OVC households, calling upon more specialized social work staff as needed. This is a cost efficient methodology. (Approaches 3 and 4 particularly)	While staff capacity and outreach have improved, resource issues, particularly around transport, remain a challenge that limits the ability to deliver services. (Approach 2 particularly).
Partners may have large numbers of technical partners with whom they can coordinate (Approach 1).	

DEPTH OF INTERVENTIONS

The approaches show variation in 1) the constituent components of the different services delivered; and 2) the technical expertise available to facilitate some of the components.

The provision of a service to a family or a child is not equivalent across partners or across models. This is illustrated most clearly in interventions that address:

- HES,
- education,
- health and nutrition, and
- child protection.

These four respond to the four PEPFAR outcomes for vulnerable children: Stable, Schooled, Healthy and Safe. These are discussed below in relationship to the strengths and weaknesses of the Portfolio in general and the approaches in particular.

Household Economic Strengthening

Aim:[22] To reduce the economic vulnerability of families and empower them to provide for the essential needs of the children in their care.

Indicator of progress:[23] Households are able to access money to pay for unexpected household expenses.

Evidence: Evidence is emerging that savings groups can help families survive shocks and deal with some consumption needs.[24] The evidence shows that the addition of material assets such as matched funding, agricultural or animal husbandry assets or toolkits enables individuals in VSLAs to progress out of severe vulnerability, to acquire household assets, to send their children to school, and to have improved nutrition. A comprehensive VSLA package that includes provision of assets, skills training or some limited financial inputs, can move families out of vulnerability.[25]

There is also evidence that socio-economic vulnerability increases risky sexual behavior in certain circumstances. A recent longitudinal national study of 6,000 South African adolescents (Cluver et al, 2014) found that the greater the economic and social disadvantages reported by adolescent girls, the greater the increase in transactional sex. The percentage of adolescent girls having transactional sex who 1) had a healthy family; 2) had an AIDS-sick parent; 3) was abused and hungry; and 4) was abused, hungry and had an AIDS-sick parent was 1%, 7%, 13% and 57% respectively.[26]

VSLAs alone have anecdotally been shown to provide a vehicle for addressing stigma, building group solidarity, and encouraging good parenting practices.[27] Given the scale of child poverty in Uganda, the Portfolio's emphasis on family economic strengthening is well placed, and in line with recent technical considerations and Guidance.

The various approaches, and even partners within a similar approach, differ in the level of expertise that their staff brings to HES activities. Approaches 2 and 4 may not have the personnel at IP level or at facility level to give sufficient training, guidance and technical support to VSLA groups and to the individuals to maximize its potential. Expertise in leveraging the basic HES activity, VSLA, with additional assets, links to markets, and other family strengthening services differed among approaches. In some cases this may even result in agricultural practices that are less than optimal (i.e., the environmental impact of some practices seemed not to have been considered).

Needed expertise in the agricultural sector includes, but is not limited to, information on market demand for agricultural and other goods, the established best regional land use, and

[22] All statements on Aims taken from PEPFAR Guidance for OVC Programming 2012
[23] All indicators are taken from PEPFAR Monitoring, Evaluation, and Reporting Indicator Reference Guide, 2.1 March 2015.
[24] 3ie Multi-country RCT on Household Economic Strengthening
[25] Promoting Economic Security and Well-Being in Vulnerable Households in Ethiopia, Yekokeb Berhan program, USAID/Pact
[26] Cluver L et al. *Combination Social Protection Halves HIV-Risk Behaviour Incidence amongst Female and Male South African Adolescents*. 20th International AIDS Conference, Melbourne, abstract MOAC0104, July 2014.
[27] Yates D, Beney T, Whitworth R, Malama N, Investing for Results: Quality and Cost of Delivering Services for Orphans and Vulnerable Children in Rwanda, Global Health Program Cycle Improvement Project (GH Pro) April 2015

latest intensive farming techniques. For vocational training, needed expertise might include local market demand for services, the ideal duration of apprenticeships or vocational training, and the contents of a start-up kit.

A detailed analysis of what a household must expend to cover the costs of meeting the critical needs of its children has not been undertaken, nor is an analysis of what inputs a family may require in order to reach the required level of self-sufficiency. Thus, the level of support required by families to ensure that they can reasonably address a child's nutrition, education and health needs is not consistently available. In this regard, the Review Team had unresolved concerns as to whether the level of economic strengthening provided (particularly in Approaches 2 and 4) was sufficient to achieve outcomes for children. An example is the cost of education, which despite universal primary education (UPE) remains prohibitive for some families. Even with VLSA savings distribution and improved incomes as reported by a strong Approach 1 partner, it is evident that education expenses are out of the reach of the very vulnerable. VLSAs are not a panacea or a mechanism for automatic graduation. It needs to be applied selectively with families that are not destitute and requires careful, sensitive additional material or financial injections to members. Families that are destitute may require other economic interventions, even time limited cash transfers, in order to meet financial needs until VSLAs mature. Economic approaches tailored to the economic needs and resources of a household and encouraging progressively more self-sufficiency are essential to a successful graduation model. A partner in Approach 1 reports that 2,211 families are graduating from the project and the vulnerability of 7,604 families are now below enrollment level, signifying less vulnerability.

A simple calculation based on reports from partners, information gathered from the field and the Uganda National Household Survey (2012/13), suggests the dire situation of many vulnerable families served by the partners. With a monthly income of perhaps UGX 150,000 per month[28] and a VSLA benefit of perhaps UGX 17,000 per month (from annualized savings), families need to pay UGX 40,000 a month for medical care, [29] and at least UGX 35,000 a month for school lunch fee and materials (if they only have two children in school). These figures belie the assumption that a VSLA program will automatically move a family out of critical vulnerability and allow for graduation. The depth of HES intervention varies by approach. Approach 1 partners have the most comprehensive package of services as outlined in the diagram below.

The above scenario is based on information from a partner providing an in-depth VSLA intervention. The limitations will be much more pronounced with other lighter interventions. In some instances, the team heard that VSLA groups had not survived if members were too poor to make monthly contributions; if members lived too far from the group; or if members, for whatever reason, were not able to trust each other. In one instance the chairperson had run off with the funds. Such stories speak to inadequate preparation and oversight from a partner with insufficient technical expertise.

Designing an activity based on an understanding of the cost of critical needs, and matching activity results to those needs over time, is essential for sustainable outcomes. Currently HES

[28] The UNHS gives UGS 325,000/month as the average rural income. SCORE reports monthly income of UGS 140,000 for its target families. This seems reasonable as they will be targeting the very vulnerable.
[29] Uganda National Household Survey, 2012/2013

across the portfolio is not based on such planning, which is possible given the availability of data observed in this review.

The predominant components found in a VSLA intervention within the portfolio are in the figure below:

Figure 2: Comprehensive HES Interventions

Key:
Darker shades = all approaches
Lighter shades = some approaches

In discussions with VSLA groups and project staff, the following issues emerged.

Table 13: Strengths and Weaknesses in HES

Strengths	Weaknesses
Maintaining a family strengthening focus, partners have VSLA at the heart of all interventions (All).	VSLA group formation around a health facility is hard to maintain if members must travel long distances to meet and are not well acquainted with each other (Approaches 2 and 4).
Some additional training (in business skills) or support (such as agricultural implements) is provided to VSLA members (All).	VSLA alone without sufficient value added injections will not meet families' education, nutrition and health expenses (Approaches 2 and 4).
Partners have a long track record in VSLA and bring best practice experience of VSLA (Approach 1).	Limited technical expertise in agriculture or business (Approaches 2 and 4).
Partners use VSLAs as a platform for other interventions (e.g., nutrition and parenting skills training) (Approach 1 primarily).	Insufficient resourcing of VSLA groups to allow for growth/graduation in some instances. (Approach 2 and 4).
Vocational training, including apprenticeships, is effective in increasing family income but has limited reach.	Partners do not undertake a thorough family assessment of economic opportunities, resources and needs (Approaches 2, 3 and 4).

Education Support

Aim: To improve educational access and learning for children by first and foremost addressing barriers to education experienced by children affected by AIDS.

Indicator of progress: Children attend regularly and progress through school annually.

Evidence: There is evidence that more highly educated girls and young women are more likely to negotiate safer sex and thus reduce HIV rates. Higher education levels correlate with increased AIDS awareness and knowledge, higher rates of contraceptive use, and greater communication regarding HIV prevention among partners.[30] Providing cash transfers to keep girls in school reduced risky behavior among the adolescent girls.[31]

Despite Uganda's introduction of UPE, the cost of education remains high for poor families and prohibitive for many families. As resources diminish, partners have considered alternatives to directly funding school costs. These costs include school materials, school lunch fees (USD $12 – $34 annually per child), and vocational fees (US $128 per apprentice). A focus on economic strengthening of families, especially VSLA, is expected to mitigate the withdrawal of other support by providing families with the means to pay for their children's educational expenses. This premise has not been fully tested and given the apparent costs of education, and the low enrollment rates, it may not be sufficient.

[30] UNAIDS/UNFPA/UNIFEM. (2004). Women and HIV/AIDS: Confronting the Crisis. Accessible at: http://www.unfpa.org/hiv/women/report/index.htm

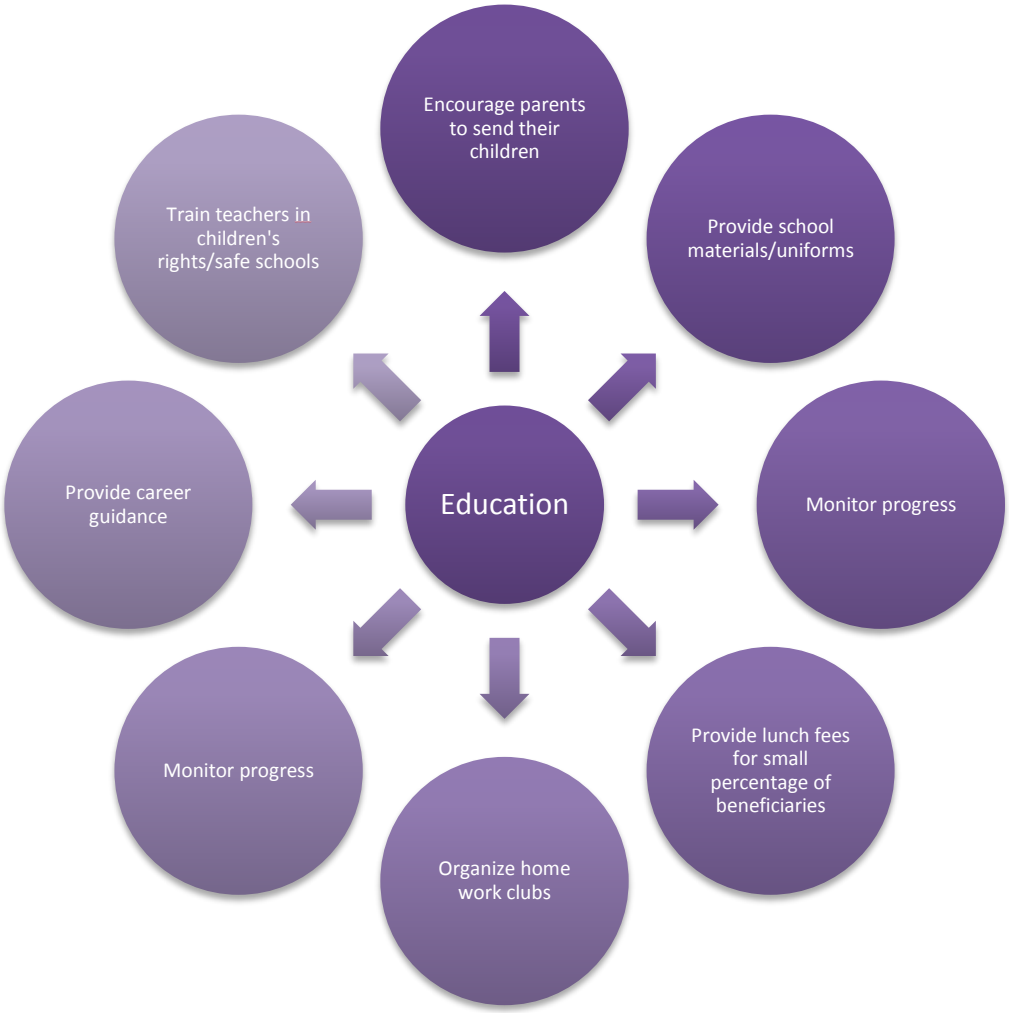
[31] Baird S et al. (2009). The Short-term Impacts of a Schooling Conditional Cash Transfer Program on the Sexual Behavior of Young Women. The World Bank Development Research Group: Poverty and Inequality Team October 2009. Impact Evaluation Series No. 40

During fieldwork, there was stark evidence that the cost of simple school materials was prohibitive for poor families. A school principal reported that when school materials were withdrawn, enrollment went from 382 children to 82 children. A visit to the school seemed to confirm this.

Partners across all approaches undertake a variety of activities to support education enrollment and progress. Some partners have been able to mitigate the withdrawal of school materials by leveraging resources from complementary programs external to the mechanisms on behalf of schools. Sadly, it appears that generally poor children who cannot afford the lunch fee are admitted and attend school, but watch other children eat. They may or may not bring food from home depending on their circumstances.

The following spread of activities that contribute to education support were found in annual reports, during site visits, and confirmed by partners in a workshop.

Figure 3: Comprehensive Educational Support Interventions



Key:
Darker shades = all approaches
Lighter shades = some approaches

A review of reports and discussions in the field indicate the following issues for education support.

Table 14: Strengths and Weaknesses in Education Support

Strengths	Weaknesses
Provision of school materials has helped maintain enrollment (All).	School lunch costs are prohibitive for the poor and thus discriminatory and not sufficiently addressed (All).
Supporting schools as safe schools may help support enrollment by sensitizing personnel and creating a more child-friendly environment (Approach 1).	VSLA may not compensate for loss of material educational support (especially Approaches 2, 3, and 4).
Partners may link to other NGOs with education programs (Approach 1).	SRH strategies do not appear to feature in the support given to schools (Approaches 2, 3, and 4)
Partners can leverage additional educational support from private sector, charities and philanthropies for individual children (Approach 1, 3, and 5).	Imperative to address child protection in schools, given the reported level of violence within these institutions (all except Approach 1).
Out of school children are assisted with informal apprenticeships (Approaches 1, 2, 3, and 4).	Clear steps, beyond talking to parents, are needed to reduce child marriage and teen pregnancy and to keep girls in school (Approaches 2, 3, and 4).

Health and Nutrition

Aim: To improve children's and families' access to health and nutritional services.

Indicators of progress: Percent of children whose primary caregiver know the child's HIV status and percent of children < 5 who are undernourished.

Evidence: Clear links have been established between nutrition and adherence.[32] For control of the epidemic, it is critical to identify and reach HIV positive people and to limit loss to follow-up. Literature attests to the positive impact on child and family well-being of home visiting programs where a trained staff or volunteers visit households regularly and spend adequate time with children and families.[33]

The evidence from impact evaluations suggests that comprehensive programs are an effective approach to addressing young people's SRH needs. Programs should combine strategies with sufficient dose of the following:

- Behavior change communication that addresses risk behaviors;
- Youth-friendly services for HIV and other sexually transmitted infections, counseling and testing, and use of modern contraceptives, including condoms; and

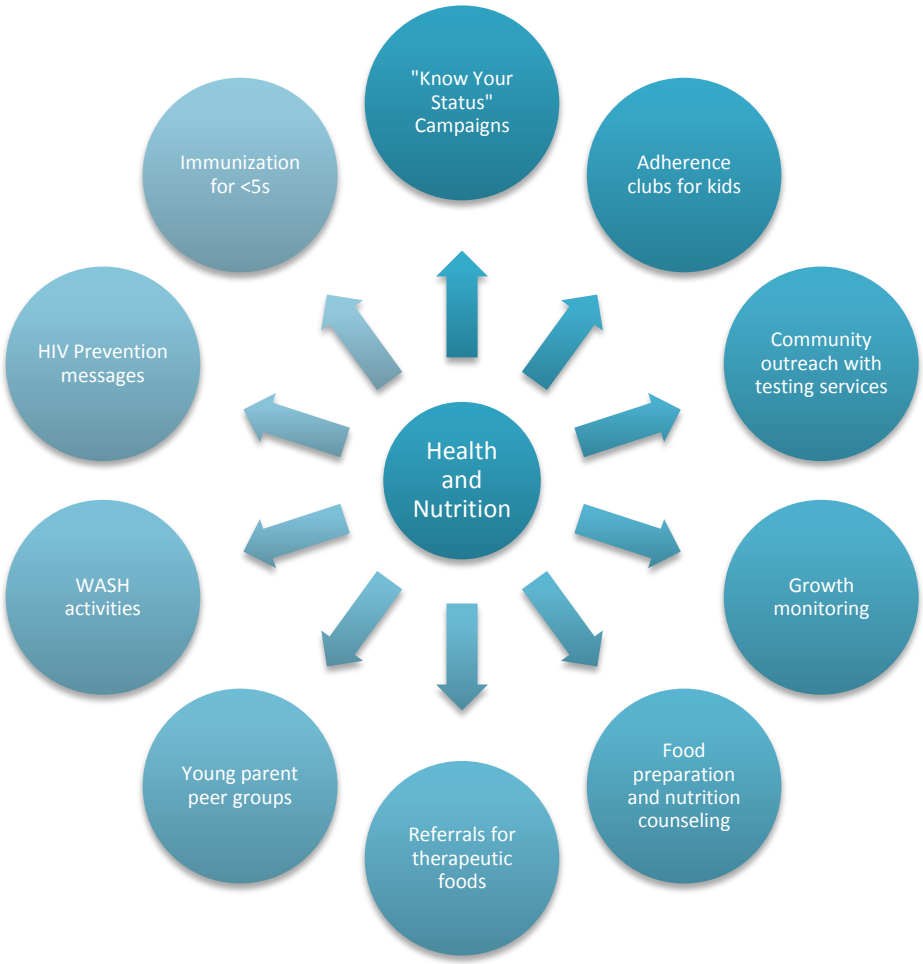
[32] Sherr L, Zoll M. (2011). PEPFAR OVC Evaluation: How Good at Doing Good? Prepared for PEFPAR through USAID by Global Health Technical Assistance Project.
[33] Richter L, Sherr L, Adato M, et al. (2009). Strengthening Families to Support Children Affected by HIV and AIDS. AIDS Care: Psychological and Socio-medical Aspects of AIDS/HIV. 21 (S1), 3-12

- Outreach services such as peer education and other activities in the community.[34]

Sexual and reproductive health information and communication for vulnerable children and youth and adolescents is thin within the OVC portfolio. Some of the descriptions of life skills activities appear not to incorporate current best practice approaches to adolescent SRH messaging. For example, a life skills session held at a clinic will not meet adolescents' need for trusted information and product sources that minimize stigma and embarrassment. Social franchising, peer, and social media approaches are currently absent. This was recognized by key informants and partners.

Partners were undertaking a multitude of health related activities as illustrated below:

Figure 4: Comprehensive Health and Nutrition Interventions



Key
Darker shades = all approaches
Lighter shades = some approaches

[34] Boonstra H, Advancing Sexuality Education in Developing Countries: Evidence and Implications Summer 2011 | Volume 14, Number 3 | Guttmacher Policy Review

Table 15: Strengths and Weaknesses in Health and Nutrition

Strengths	Weaknesses
Strong system for identifying HIV affected households and follow-up (Approaches 3 and 4).	Little current emphasis on integrating ECD messages in follow-up for mother-baby pairs exiting PMTCT; early stimulation in growth monitoring and nutrition activities (All).
Use of VHT and parasocial workers to undertake regular home visits and the frequent merging of the two functions in one person (All).	Low incentivizing of VHT and parasocial workers may result in high turnover.
Strong focus on nutrition and food security through VSLA (Approach 1, 3, and 4).	Comprehensive SRH information that includes HIV prevention for adolescent girls was not seen within the OVC portfolio.
"Know Your Status" campaigns and referrals for children and family members for HIV testing (All).	Little deliberate attempt to address stigma (Approach 4 particularly).
Community outreach campaigns taking services directly to communities (All).	Partners do not articulate clearly how adolescent OVC will be provided with or helped to access SRH services.

Child Protection

Aim: To develop appropriate strategies for preventing and responding to child abuse, exploitation, violence, and family separation.

Indicator of progress: Caregivers of active beneficiaries agree that harsh physical punishment is not an appropriate means of discipline or control in the home or school.

Evidence: Experience of abuse has the highest correlation with risky sexual behavior.[35]

The Child Protection System is Uganda is under-resourced and under-developed, seriously affecting program implementation. Levels of violence and abuse against children are high, especially at the very place, the school, which should serve as a safe haven.

Partners report activities at three levels of intervention: community sensitization; changing norms; and strengthening those with a legal mandate to act.

The training and promotion of parasocial workers has been a boon, enabling them to deal with less serious child abuse cases swiftly at the local level, while freeing up the professional cadres to deal with the more serious cases. Their advocacy role in the community has increased understanding of children's rights, especially the education for girls. More serious cases however often go unresolved.

The prevention of abuse especially in schools is addressed by Approach 1 partners through implementing the safe school model and in communities through community dialogues. Community volunteers help to ensure the early identification of abuse cases and link survivors

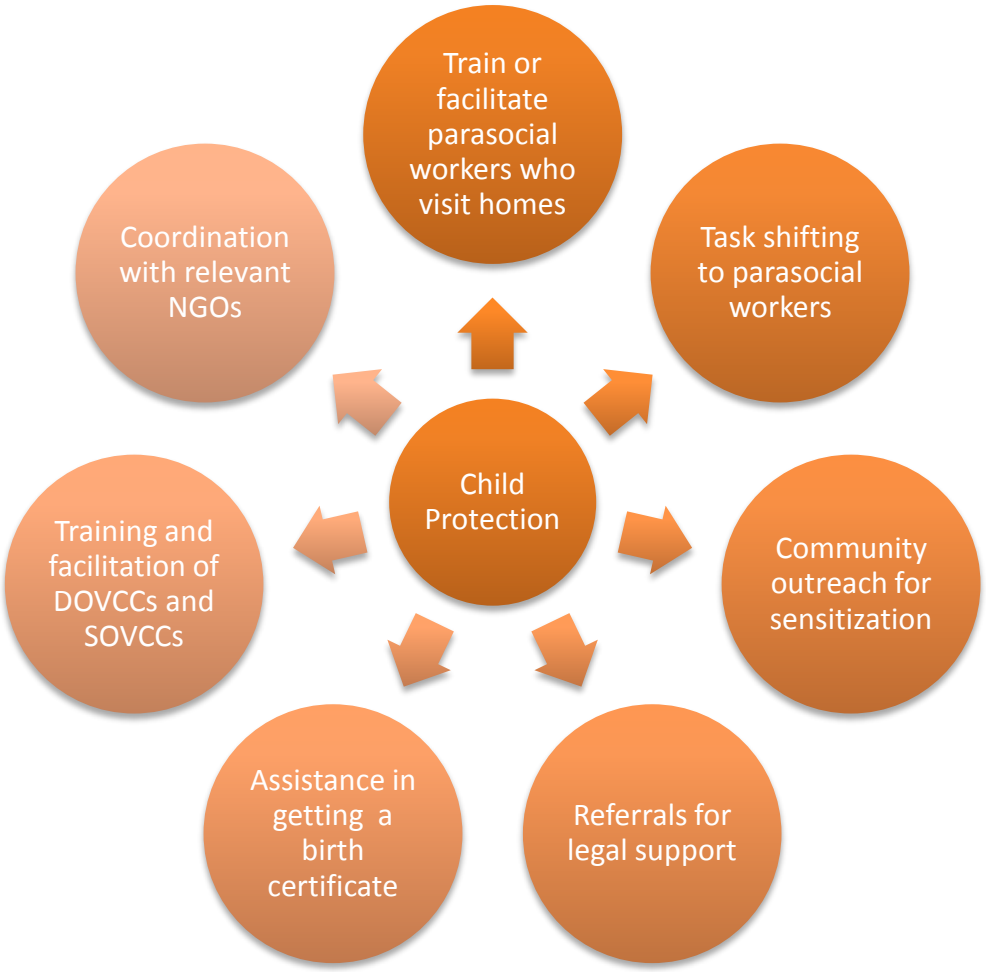
[35] AIDS 28 (suppl 3):S261-S268. http://journals.lww.com/aidsonline/toc/2014/07001

to the formal structures for professional services. In some cases these are followed up with police for legal redress until cases are closed.

New partners are planning various child protection activities such as child protection training for children and adolescents; support for reporting mechanisms and multidisciplinary investigation and response teams; and alternative community-based family care, with psychosocial support for survivors.

The following diagram shows the different interventions undertaken by partners.

Figure 5: Comprehensive Child Protection Interventions



Key:
Darker shades = all approaches
Lighter shades = some approaches

Table 16: Strengths; and Weaknesses in Child Protection

Strengths	Weaknesses
Training of parasocial workers has allowed for significant task shifting from POS and CDOs to parasocial workers, freeing up the POS and CDOs time for serious cases (Approach 1 and TA).	The reliance on a partially volunteer social workforce, the parasocial workers and the VHT is cost effective. However, without adequate compensation and incentives, these cadres may be difficult to retain, thus decreasing the efficacy of their training (All Approaches, except Approach 3 in some instances).
Close links with CDOs including probation officers facilitates referrals for child protection (All Approaches).	Few resources available to allow CDO to respond to serious cases (especially Approaches 2, 4, and 5)
Facilitated community outreach to raise awareness has increased reporting of child abuse and provision of birth certificates (All Approaches).	Limited technical expertise in child counseling (All Approaches, except Approach 1).
Partners use safe schools and linkages with technical partners (e.g., Raising Voice to address the high levels of violence in schools) (Approach 1).	The prevalence of early marriages persists. It is difficult to determine partners' contribution to addressing this.

SUMMARY OF FACTORS DETERMINING CAPACITY TO ACHIEVE OUTCOMES

The analysis of partnering, delivering services, and depth of interventions observed in the various approaches constituting the PEPFAR Uganda OVC Portfolio suggest that the following factors are most predictive of the capacity to achieve outcomes:

Embedding sufficient technical capacity for each outcome area within the implementation approach. With OVC focused technical expertise in all outcome areas, activities are more likely to be comprehensive, evidence based, and generate high-quality results; implementation to scale is more effective, more responsive to changes in context or implementation requirements; and effective case management is possible.

In the absence of adequate technical expertise, activities are less likely to be comprehensive, evidence based, and generate high-quality results; implementation is unresponsive, not only to changes in context and implementation requirements, but to the routine needs of vulnerable households and OVC in their care that appropriate expertise would be sensitive to. Adding to the implementation burden of sub-partners with technical expertise in other areas such as care and treatment, without supplementing their technical capacity in OVC outcome areas is not effective; even less so is expecting sub-partners with very limited or no technical capacity to deliver OVC services.

Ensuring the availability of adequate resources for all sub-partners and activities. Even with adequate technical capacity embedded, a lack of resources incapacitates sub-partners and makes implementation to the level required for achieving outcomes impossible. The expectation that approaches can leverage resources external to their funding appears unreasonable. The implementation context is resource poor in general. If resources are not equal to the scale of implementation and performance expected, no approach can deliver results.

Closer coordination between community based and health facility based services. Community based approaches need mechanisms for cooperation with health facilities to be positioned to realize health outcomes and optimize OVC programming's contribution to controlling the epidemic. Facility-centered approaches require community reach to enroll the most vulnerable and deliver OVC services where they are needed and ensure that children enrolled at facilities receive adequate community-based socio-economic services. When the vulnerable are required to shoulder a cost to access services or they risk stigmatization, retention in the program is undermined. Effective practices observed in the field include:

- Placing sufficient and technically adept staff at facilities to implement facility-based OVC programs.
- Arranging outreaches with facility staff to catchment communities for advocacy and to deliver HCT and other services.
- Ensuring facility staff participation in coordination and case management mechanisms.
- Identifying staff at facilities or embedding staff at facilities with specific responsibility for coordinating referrals and vice versa within community services.
- Collaboration between facility- and home-based care workers to find the inactive poor who do not and cannot access services, and the stigmatized who will not access services.
- Linkages between community interventions and clinic services, and among service providers, are possible and require multi-pronged action. A good practice included a thorough mapping of service providers, including a validation through face-to-face contact of what services were actually available when and where; the use of a multi-part referral form; assistance for beneficiaries to reach the service point when required; and follow-up telephone calls or meetings to establish the outcome of the referral.
- Regular coordination meetings between facility and community service providers to support case conferencing, trouble shoot and improve referral mechanisms, and identify and address any bottlenecks, etc.

Implementing comprehensive, evidence-based activities for each outcome area. Evidence for improving the efficacy of activities is available in each outcome area. Incomplete implementation is simply not cost-effective. Where the activities are not comprehensive the capacity to achieve outcomes is undermined and in some instances not possible.

Ensuring that there are no activity gaps. While the portfolio demonstrates the expected range of OVC interventions, there are gaps in the integration of activities that are crucial to PEPFAR outcomes and core in the PEPFAR Guidance. Without adequate integration these outcomes will not be realized. Activity gaps that identified by the Review Team include:

- Child protection requires continuing to task shift, retraining of the social workforce where necessary, resourcing the mandated government function as required, and strengthening community places of safety.

- Currently SRH is not comprehensive, nor is it consistently integrated into interventions such as existing parenting, life skills, youth clubs, school clubs and community outreach activities.
- Currently, early childhood development (ECD) lacks a more deliberate emphasis in parenting skills training in follow-up for mother-baby pairs exiting PMTCT and as early stimulation in growth monitoring and nutrition activities.

Each approach identified in this review can strengthen its capacity to achieve particular outcomes by examining effective practices.

V. FINDINGS ON OVC COST ANALYSIS

Q3. How cost effective are the various OVC implementation models? What is the cost of the various OVC implementation models?

This section summarizes the findings of the cost analysis for the OVC implementation approaches. Section 3.1 summarizes findings on *total expenditure* by the different implementation approaches. Section 3.2 presents details on *expenditure per OVC served* for the different implementation approaches, while section 3.3 briefly discusses the *amount of resources reaching OVC and the resources spent on PM to support implementation of OVC activities* for the different service areas. Section 3.4, briefly presents *expenditure on different processes* of interest in the implementation of OVC activities.

The quality and accuracy of the cost analyses results presented here are dependent on the quality and accuracy of data in the expenditure analysis reports of IPs, as well as the information partners provided on the number of OVC. In the process of data collection, review and analysis, it is noted that some of the data provided by IPs was not of very high quality. In some instances, care was taken to follow up IPs to obtain more reasonable data and for them to provide clarification on data that seemed inconsistent.

Cost of OVC Services

All information presented here is extracted from the expenditure analysis reports provided by implementing partners (IP) for FY 2014/15. In this section, the analysis has been summarized according to the different implementing approaches described earlier. Note that expenditure information is unavailable for BOCY and SOCY (some of the two biggest recipients of HKID funds) because they were recently awarded and in their inception phase at the time of this review.

Figure 6 shows the total amount of resources spent on service areas for OVC, based on site-level expenditure for nine mechanisms implemented by seven IPs. The total amount of OVC resources represented in Figure 6 is $8,169,471; it shows that *economic strengthening* and *nutrition and food security* (each taking about 26% of total OVC resources) consume the highest amount of resources. Nutrition and food security has the second highest level of spending and is provided by eight out of nine mechanisms. *Child protection* and *psychosocial support* each take about $1.4 million in this portfolio (i.e., about 18.5% of total resource envelope). Psychosocial support is provided by all nine mechanisms, while child nutrition is provided by eight out of nine IPs. Case management has the lowest total cost with $46,084 (only provided by three IPs).

Figure 6: Expenditure on Service Areas for a Selected Number of IPs

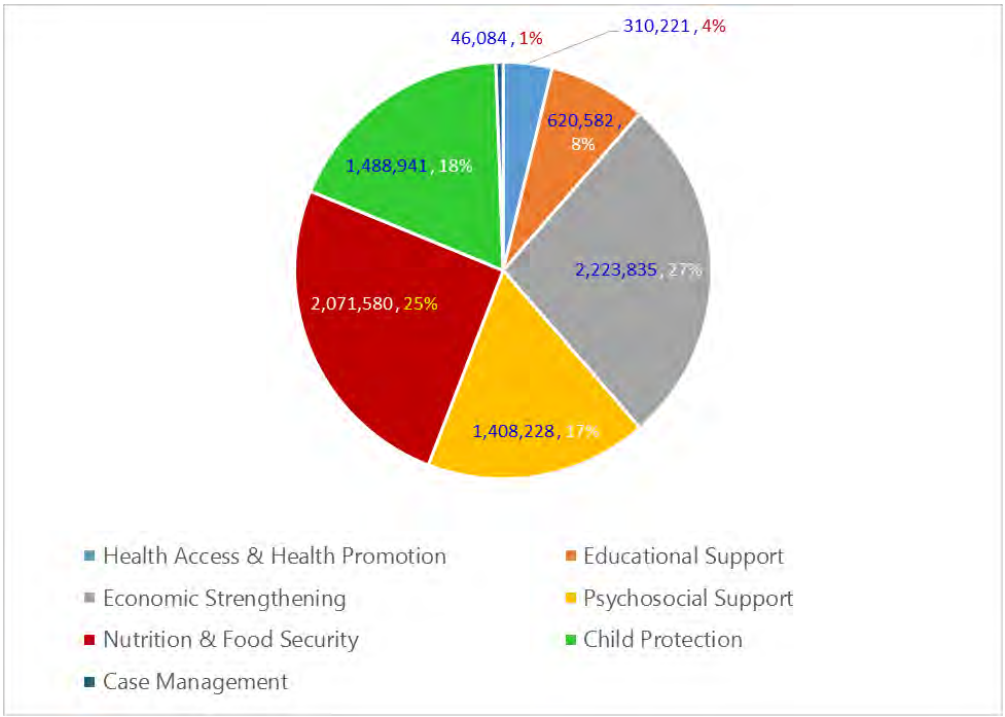


Figure 7 provides an overview on the resourcing for different implementation approaches. The information shows the *total site level expenditure on OVC* for the different approaches in the FY 2014/15. This "site level" expenditure includes overhead (PM) expenditure by sub-grantee CSOs, but it excludes PM expenditures by the Prime IPs.

It should be noted that Approach 1 has a significantly higher amount of resources compared to all other implementing approaches. Approach 2 and Approach 3 IPs each spent about a half-million dollars on OVC support, and the Approach 4 IPs spent the least amount of resources. It is important to note that IPs under the Approach 1 are entirely OVC-focused with 100% of their funding is entirely for OVC activities. On the other hand, the remaining implementing approaches have PEPFAR funding for other activities, in addition to support for OVC, with the OVC funding varying between 6% – 30% of their total PEPFAR funding.

Figure 7: Summary of OVC Expenditure by Different Implementing Approaches

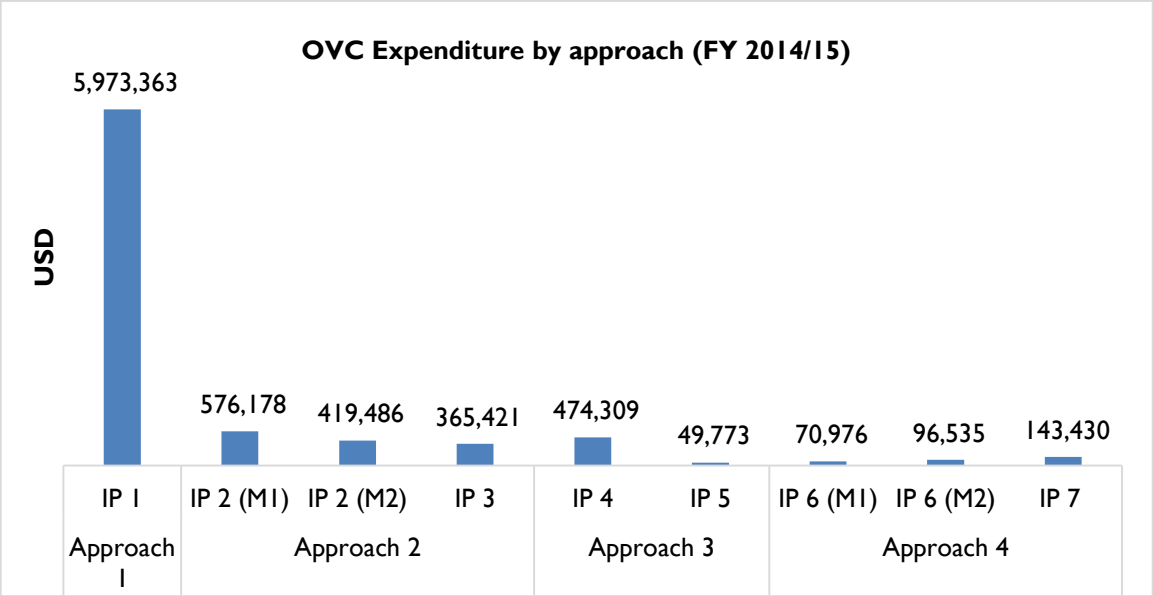


Figure 8: provides further insight when considering both the resourcing levels for each implementing approach, as well as the number OVC served by each IP. The distribution of OVC served among the IPs ranges from 1,458 to 110,204. It is important to note, though, that support to OVC varies significantly and as such, for example, "an OVC reported to receive education support" by one IP is not necessarily the same as "an OVC reported to receive education support" by another IP, because the scope of education support they receive is different (see Table 15, which describes the variation of the scope of services provided by each IP under each service area or core program area). Another important matter to note is that having a big number of "OVC reached" may not be fully reflective of efficiencies, because some implementation approaches may not be comprehensive, in terms of the scope of the services they offer, and yet they may reach many OVC with a very small scope of services. Nonetheless, this review makes an attempt at crudely comparing levels of spending with levels of "outputs" for the different implementing approaches. To some extent, the differences observed in the *number of OVC served per IP* boils down to scope of funding available (i.e., resources awarded and targets agreed at project inception). The analysis presents a combination of relatively low spending and relatively high number of OVC served (e.g., by IP 2 (M1), IP 3, IP 6 and IP 7). This pattern of low expenditure and high number of OVC seems to be mainly reflected in Approaches 2 and 4. Relatively speaking, a combination of higher expenditure and lower OVC reached is reflected by IP 2 (M2) under Approach 2 and by IP 4 under Approach 3. Note that IP (M2) represents a mechanism that started implementation only recently (with heavy PM costs) and therefore had few OVC reached in that period. Further, the IP representing Approach 1 serves the highest total number of OVC and spends the highest amount of resources. The examination of cost per OVC served is explored in Figure 8.

Figure 8: Comparing OVC Expenditure and Total OVC Served by Different Approaches

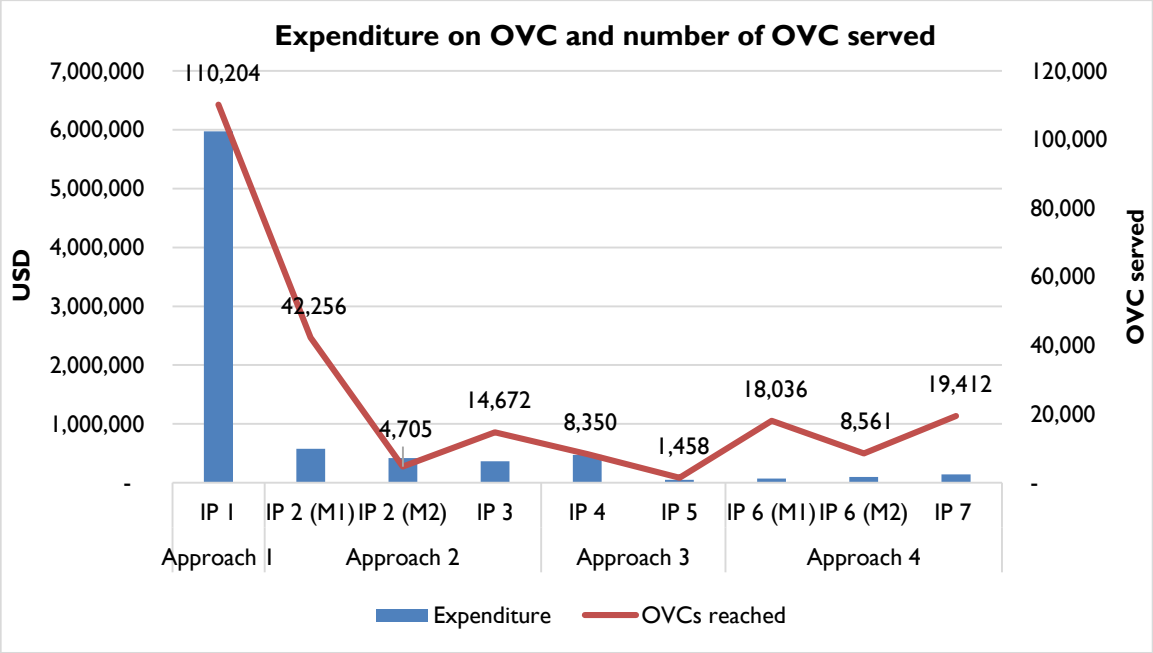


Table 17: Breakdown of Number of OVC Served per Service Area for the Different IPs

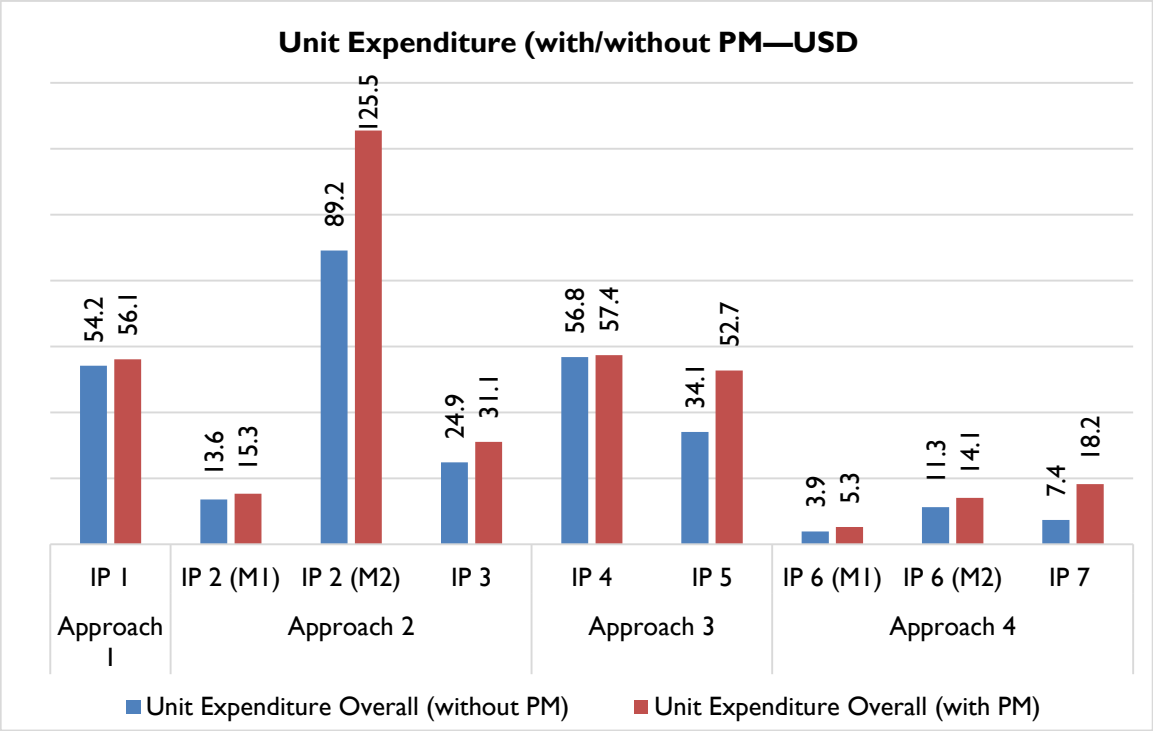
	Total OCVs Served	Health Access and Health Promotion	Educational Support	Economic Strengthening	Psychosocial Support	Food and Nutrition	Legal, Child Protection and Shelter
IP 1	110,204	0	0	84,287	73,754	74,406	129,168
IP 2 (M1)	42,256	37,207	37,713	1,469	37,674	8,241	-
IP 2 (M2)	4,705	3,722	2,379	4,619	4,705	3,309	2,793
IP 3	14,672	4,645	4,291	1,605	14,672	1,650	3,302
IP 4	8,350	1,007	2,280	835	2,085	2,015	128
IP 5	1,458	1,458			238		
IP 6 (M1)	18,036	9,807	1,500	800	9,807	400	233
IP 6 (M2)	8,561	5,777	7,372	504	4,194	800	106
IP 7	19,412	19,412	583		19,412		

The information presented in Figure shows the *cost per OVC served* for the IPs in the different implementing approaches. A set of two unit costs is presented for each IP, one where program management costs (of the Prime IP) are excluded, and one where the PM costs of IPs are included. Note that expenditure on PM presented in Figure 9 and Table excludes the negotiated indirect cost rate agreement (NICRA), which implies that the unit costs in Figure 9 are an under-estimated of the actual unit cost of these services. The results speak to the relative efficiencies of delivering of OVC services, keeping in mind the limitation of the differences in the scope of services received by an "OVC reached" (as discussed earlier). First, Figure 9 shows that there is wide variation in *cost per OVC served*, ranging from $3.9 to $89.2 (for unit costs that exclude PM costs). When considering the unit costs that include PM costs, the cost per OVC served ranges from $5.3 to $100 (or $125.5 when we include private sector resources). Note that IP 2 (M2), which has the highest unit expenditure of $89.2, includes resources provided by private sector partners. When the private sector contributions are excluded, the cost per OVC served is reduced to $63.8 (see Table), but remains the highest cost per OVC served. As noted earlier, IP 2 (M2) is in inception phase and, as such, it has relatively fewer OVC served compared to its level of expenditure with the highest unit costs. Further, we note that Approach 4 has the lowest cost per OVC served, while Approach 2 seems to be relatively close to Approach 4 in terms of relative efficiency. Approaches 1 and 3 seem to be within the same range of unit costs. We also noted that IP 1 (under Approach 1) takes advantage of existing PEPFAR funds to ensure that services (that they cannot provide) are provided by other partners to benefit their beneficiaries. A more detailed exposition of unit costs is presented in Figure 9.

Table 18: Summary Expenditure Information for IP 2

	Total Site level Expenditure	OVC served	Unit cost	Total OVC Expenditure site level + OVC PM	OVC served	Unit cost (site level + PM)
IP 2 (M1)	576,178	42,256	13.6	648,516	42,256	15.3
IP 2 (M2)	419,486	4,705	89.2	590,688	4,705	125.5
IP2 (M2)(LESS private sector contribution)	300,000	4,705	63.8	471,202	4,705	100.1

Figure 9: Cost per OVC Served by Different Approaches



The information in Figure provides a breakdown of unit costs by service area for each of the IPs. The unit costs presented are based on "site level" expenditure which excludes PM costs of prime IPs, but include overheads/PM costs for sub-grantees.

Figure 10 shows a wide variation of in unit costs for the OVC services offered. A quick comment on each of the core program area is warranted.

- **Educational support:** There is significant wide variation in the unit cost for this service, ranging from $4.1 to $145.6 (with an average of $33.2). IP4 has the highest unit cost because they provide a comprehensive education package that includes school fees, scholastic material and a hot meal for lunch. The package also includes support given for vocational training. When removing the outlier unit cost of $145.6, the average unit cost for this service area becomes $14.5.
- **Economic strengthening**: The unit costs for this service area ranges from $8.9 to $91.1 (with an average of $41.7). As indicated, the scope of support provided for this service areas varies significantly with different IPs, and this possibly partially explains the variation in the cost her household reached. Other possible factors responsible for the variation in costs are implementation approach, management costs, and the number of OVC reached with services. These factors also explain the variation in unit costs for all other service areas described below.
- **Psychosocial support**: The unit cost for this service area ranges from $1.1 to $104.6 (with an average of $18). Interestingly, when excluding the outlier unit cost of $104, the average unit cost for this service area becomes $7.2.

- **Nutrition and food security**: The unit cost for this service area ranges from $14 to $35.3 (with an average of $25). This CPA has the least variation in unit cost.
- **Child protection**: The unit cost for this service area ranges from $5.5 to $30.5 (with an average of $16.7).
- **Health access and health promotion**: The unit cost for this service area ranges from $0.4 to $17.1 (with an average of $7.2). It has the lowest unit cost among all other service areas. It is important to note that this cost mainly refers to activities of linking OVC to care, monitoring them to ensure their adherence to treatment, and promoting health care. They do not include the actual costs of treatment or care for OVC.

Figure 10 demonstrates that IPs provide varying scopes of OVC packages. IP 4 and IP 2 (M2) seem to offer all the services in the six service areas, while other IPs like IP 5 and IP 7 offer only a few.

It is important to note that unit costs for the service areas are not additive. In other words, overall unit costs of an OVC is not sum of the unit costs of the different service areas, as presented in Figure 10. Therefore, we **cannot** say that IP 7 is the most efficient and that IP 4 is the least efficient. The purpose of Figure 10 is to show the variation in unit costs for the different service areas across the different implementation approaches.

Figure 10: Cost per OVC Served Broken Down by Service Area (FY 2014/15)

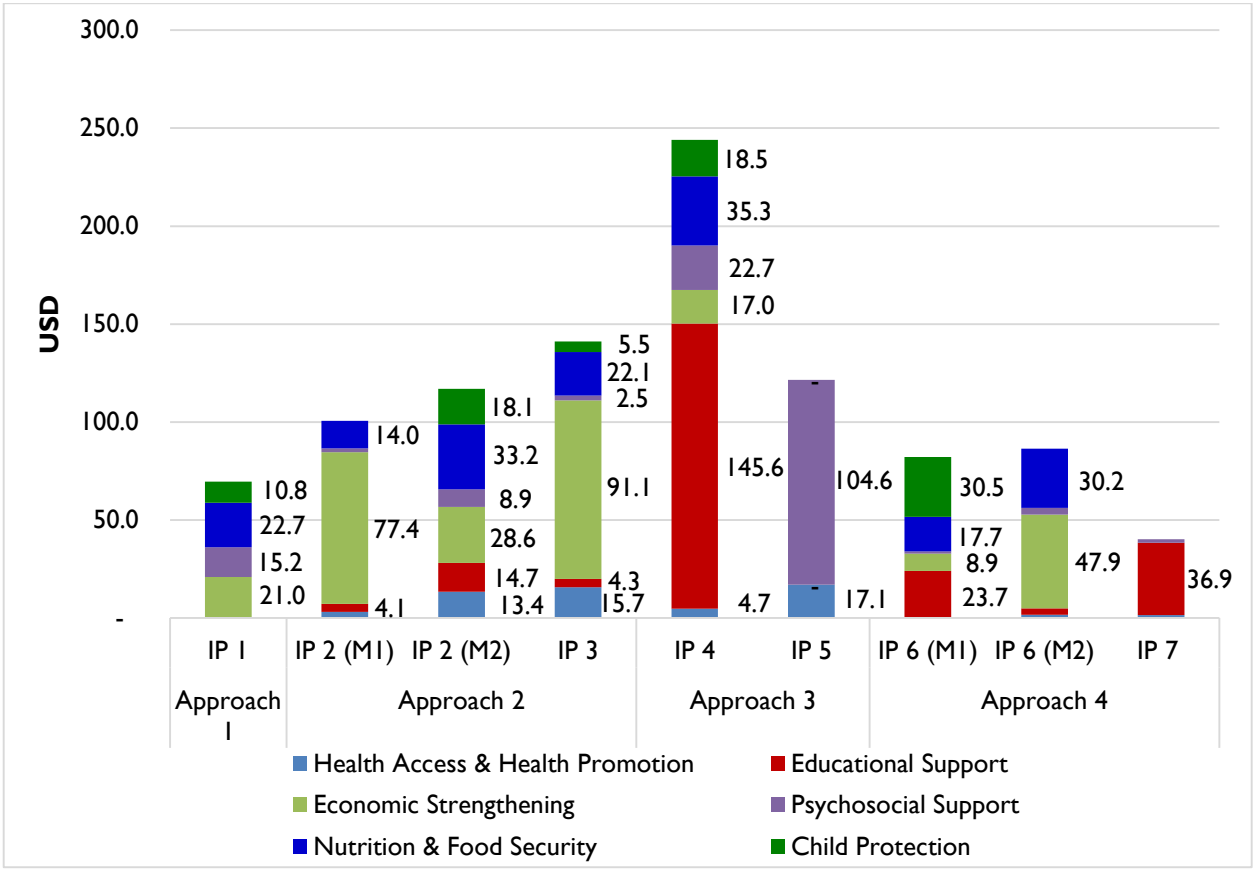
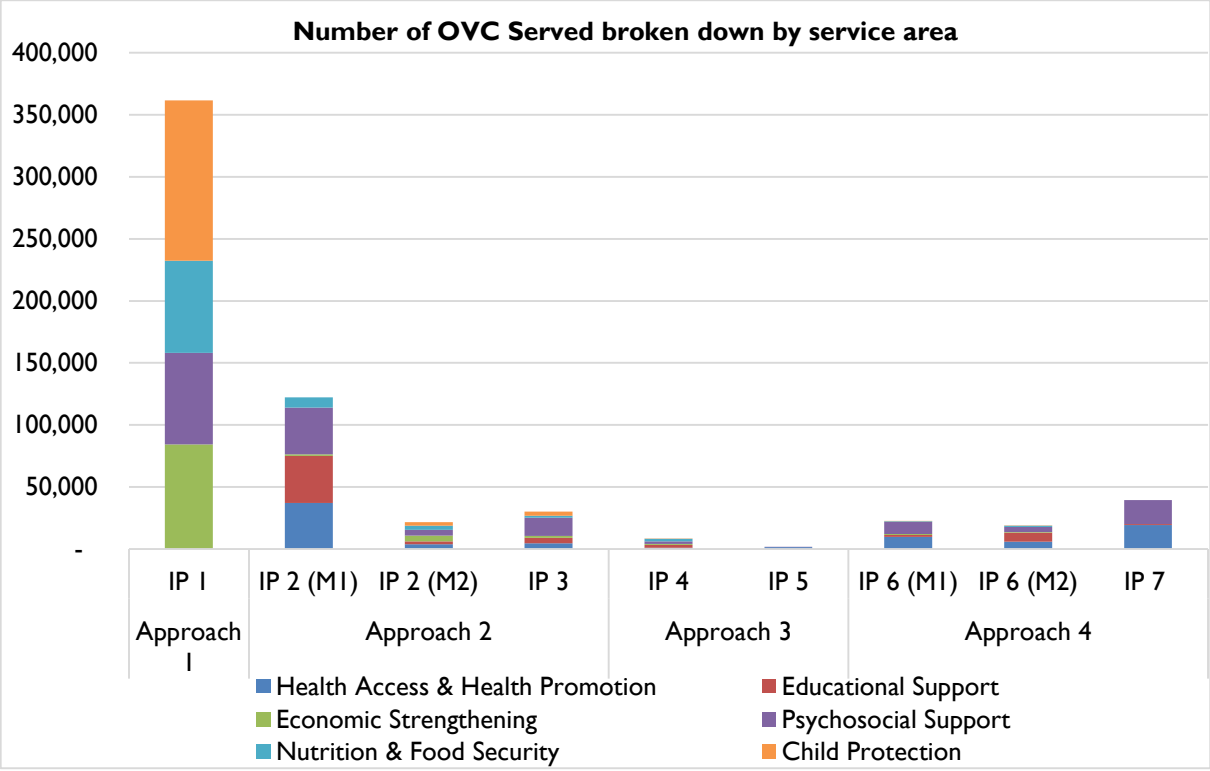


Figure 11 summarizes the number of OVC served broken down by service area. Note that the number seen in the different service areas should be not added to obtain the total OVC seen by an IP. Some of the OVC served in one service area as the same OVC served in another.

Figure 11: Number of OVC Served Broken Down by Service Area (FY 2014/15)



NOTE: The number of OVC for each IP should NOT be additive.

The challenge with the unit expenditures in Figure 11, the scope of services provided by each IP under a given service area is different. For example, for education, while one IP may give scholastic materials, school fees and lunch, another IP may only work with the school to create a conducive learning environment. Both models contribute to increased enrollment and retention but the unit expenditures will vary since "scopes of services" are not comparable.

SITE LEVEL AND MANAGEMENT EXPENDITURE FOR OVC

Assessment for expenditure above site level helps to provide some insights about the amount of resources that actually reach the intended beneficiaries (i.e., the OVC). There are several levels of expenditure that relate to PM for OVC services, namely 1) the NICRA, which usually is negotiated for "above national" expenses as overheads for parent organizations of the prime IPs; 2) PM expenses of the prime partners; and 3) PM expenses for sub-grantees (where this is applicable). We set out to collect information on all the three levels of overheads, but we were only successful in getting PM costs for prime IPs and for sub-grantee organizations (in a few cases). The findings for this analysis are briefly presented below.

Table 19: Site Level and Above Site Level Cost by Implementation Approach

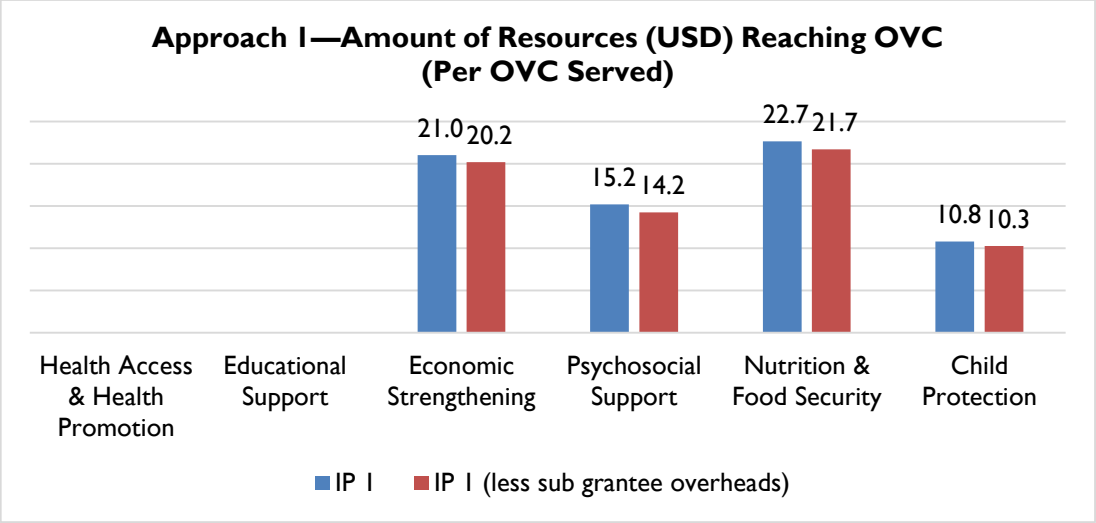
		Site level OVC Expenditure	*As a % of Total Exp*	Expenditure Program Management	*as a % of total Exp*	Sub-grantee Overheads	*As a % of Total Exp*
Approach 1	IP 1	5,973,363	97%	214,478	3.5%	281,260	5%
Approach 2	IP 2 (M1)	576,178	89%	72,338	11.2%	144,045	22%
	IP 2 (M2)	419,486	71%	171,202	29.0%	62,923	11%
	IP 3	365,421	80%	91,356	20.0%		
Approach 3	IP 4	474,309	99%	4,712	1.0%		
	IP 5	49,773	65%	27,133	35.3%		
Approach 4	IP 6 (M1)	70,976	75%	24,001	25.3%		
	IP 6 (M2)	96,535	80%	24,558	20.3%		
	IP 7	143,430	40%	210,743	59.5%		

Source: PEPFAR EA reports of the IPs

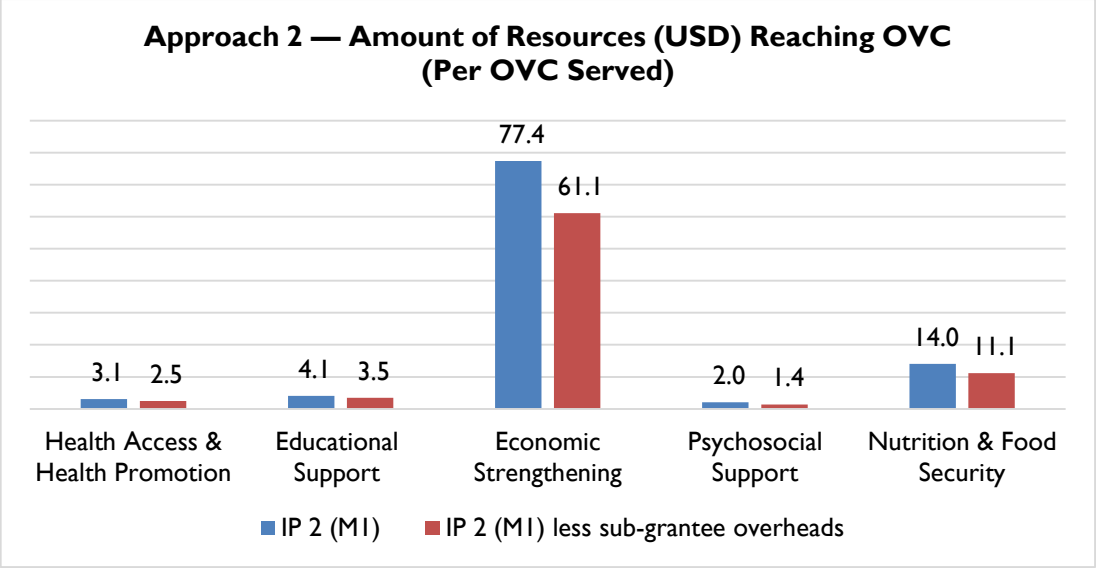
Results in Table show that the proportion of resources spent on PM for prime IPs varies widely between 1% and 60%. The information on expenditure on program management was obtained from expenditure analysis data provided by IPs, and the accuracy of these finds heavily depends on the quality of data in their EA reports.

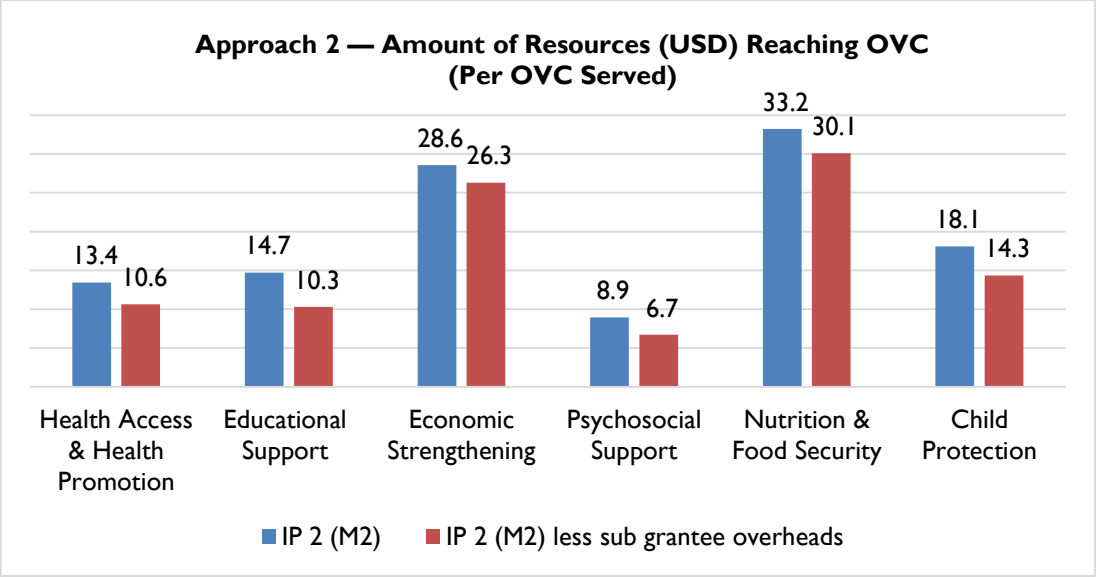
Only three out of the nine IPs reported expenditure on overheads by their sub-grantees. Most of the remaining IPs said they did not sub-grant. Based on the information of the three IPs who provided this information, overheads of sub-grantees take up between 5% and 22% of total OVC expenditure. A simple analysis of the impact of sub-grantee overheads on the cost of OVC served is presented in Figure 12. The results provide a good example of the extent to which high overheads for sub-grantees will result in relatively lower spending on beneficiaries. In the case of Approach 1, which has only 5% of total expenditure being spent on overheads for sub-grantees, we note there is little difference in expenditure per OVC served, that is, for example $21 compared to $20.2 for HES (when we exclude expenditure on overheads for sub-grantees). The resources reaching an OVC served for other services areas (for IP 1) do not change significantly when we exclude the amount of resources spent on management costs for sub-grantees (see Figure 9). In the case of Approach 2 for IP 2 (M1), where the overhead of sub-grantees takes up to 22%, there are significant differences in the resources reaching an OVC served (when we exclude resources spent on overheads for sub-grantees from total expenditure). IP 2 (M2) provides a middle ground, where overheads for sub-grantees make up about 11% of total expenditure on OVC by that IP. These three examples show that the more money spent on management costs of sub-grantees, the less money is spent on the actual beneficiaries. This somewhat confirms that implementing approaches that have multiple layers of partners in the chain of implementation are likely to spend relatively higher resources on management costs and therefore relatively less on OVC.

Figure 12: Amount of Resources (USD) Reaching OVC



Note: Under Approach 1, the IP supports OVC to access health services through referrals and linkages and promotes health using a VSLA+ model and in community dialogues. Under education, the IP does not directly offer education services and works with schools using a good school model that supports retention of students.





EXPENDITURE ON PROCESSES FOR SERVICE DELIVERY

We set out to estimate the amount of resources spent on processes of interest. In particular, we wanted to know how much money is spent on identification and enrollment, linkages to care, and graduation of OVC. Most IPs could not provide robust expenditure estimates for these processes. However, this section provides a brief summary from those IPs who provided this information.

Very few conclusions can be drawn from Table . We note that the process of identification and enrollment is one where most IPs could provide estimates on expenditure. We also note that it is the required resources range from $0.4 to $9.8 per OVC or per household enrolled (with an average of $4.8). Supervision of OVC activities, particularly for IPs that have sub-grantees seems to cost between $1 and $3.2. We found that most IPs found it difficult to estimate the cost of graduation (as a process) because few had been actively engaged in this process. However, for the few that report, it appears that have a cost as low as $0.3 per OVC graduated, and as high as $32 per OVC or household graduated.

Table 20: Expenditure per OVC Served for Key Processes

		Enrollment Per OVC/Household	Supervision	Graduation
Approach 1	IP 1			
Approach 2	IP 2 (M1)		1.02	0.3
	IP 2 (M2)	2.06	1.02	
	IP 3	4.83	3.22	32.20
Approach 3	IP 4	1.3	1.5	
	IP 5			
Approach 4	IP 6 (M1)	9.75		13.5
	IP 6 (M2)	9.75		13.5
	IP 7	0.41		

PM costs do not appear to be related to an approach, but to individual mechanisms. It may also be that some partners are better able to distribute costs across expenditure items.

The varying costs for service areas is reflective of the variation in what constitutes a service. It is interesting to note that Approach 1 is not recording any spending in education, however economic strengthening accounts for the largest expenditure under every approach, reflecting its primacy in the portfolio. With one major exception under Approach 3, expenditure on psycho-social support is the lowest or second lowest expenditure item per OVC. This may be because psycho-social support is often associated with home visits by a volunteer social service workforce such as parasocial workers.

VI. DESCRIPTION OF THE CAPACITY OF APPROACHES TO ACHIEVE OUTCOMES

What are the strengths and weaknesses of each of the implementation models, with respect to achieving intended outcomes?

The following section offers a more detailed description of each approach identified in this review, with particular reference to the capacity of each approach to achieve results. The results considered are those prioritized in the PEPFAR Guidance; how Approaches are positioned for broader outcomes is discussed elsewhere. In reading this section it is important to remember the limitations to the review as set out in section 0. In particular, it should be remembered that while the description of approaches is based on secondary and observational data and validated by implementing partners, the capacity to achieve outcomes is not based on evaluated performance. It is instead informed by what we know works in OVC programming. Judgments based on evidence removed from the specific context and specific performance, even with taking great care in application, is always less preferable than specifically measured and directly applicable outcome data.

APPROACH 1

Approach 1 includes all the 100% OVC-focused mechanisms (based on a proportion of their funding received from HKID money), implemented at scale and serving a very high number of OVC in a large number of districts. The key differentiating characteristic of Approach 1 is an emphasis on specialized technical capacity in all OVC outcome areas throughout the multiple layers of sub-partners. There is little variation across the different mechanisms, in terms of the factors determining the capacity to achieve outcomes.

Technical

Approach 1 is characterized by partnering with multiple sub-partners at all layers of partnering. The emphasis on ensuring technical capacity is observed consistently in partnering practices, which includes:

1. Engaging sub-partners in the technical partnering layers. The function of technical sub-partners is exclusively or predominantly technical supervision and support of implementing sub-partners.
2. Selecting implementing sub-partners through competitive calls for proposals that prioritize technical capacity.
3. Vetting potential sub-partners with district government to ensure that organizations have credibility and a historical record of delivering services locally.
4. Formalizing contracting mechanisms and MOUs

5. Ensuring a long lead time before the launch of services, during which appointed sub-partners are technically prepared through training and improving organizational systems.
6. Ensuring technical specialization of sub-partner staff to focus exclusively on specific outcome areas.
7. Ensuring technical specialization of social workforce cadres to focus primarily on specific outcome areas.

The care taken with selection has the additional advantage of ensuring continuity in delivery of services across succeeding mechanisms, because the process favors experienced sub-partners or CBOs that have a history of delivering services, often through preceding PEPFAR mechanisms.

The result of the emphasis on partnering for technical capacity is evidenced in:

1. Technical strength embedded in planning and resource materials; monitoring and evaluation outputs are available;
2. Comprehensive implementation with complete interventions in each outcome area, as discussed below in the Depth of Activities section;
3. Skillful implementation – eyes to see; and
4. Responsive implementation — adapting, innovating or mitigating implementation in context.

Partnering practices that emphasize technical capacity position the approach to achieve outcomes.

Resources

Approach 1 is characterized by levels of resourcing for all layers of partnering that facilitate implementation.

The prime partner distributes sub-grants to both technical and implementing sub-partners that are sufficient to support sub-partner activities. The social service workforce is resourced primarily with support for costs of executing activities and, in limited cases, stipends and salaries. The social service workforce also receives limited material support in some instances, such as bicycles, to support executing activities.

Approach 1 does not provide for the resourcing of government partners. However, resources have been deliberately leveraged to assist government partners to execute activities critical to supporting program outcomes, such as education and child protection, through other mechanisms or by engaging organizations external to the mechanism partnership.

Partnering practices that ensure resourcing for activities position the approach to achieve outcomes.

Coordination and Bi-directional Linkages to the Continuum of Care

Targeting and enrollment in communities is based on:

- OVC register, which partners update during implementation,
- Inputs from community structures,

- Vulnerability assessment to assist in prioritizing the most vulnerable, and
- Vulnerability assessment will support graduation.

Community-based targeting and enrollment does not specifically target infected or directly affected OVC. As a result, the proportion of infected and affected OVC is estimated at 15%, with limited disclosure. Measures to improve this proportion are succeeding in some mechanisms.

The coordination with facility will vary across implementation site, but efforts are made to ensure referral completion and thorough case management.

This positions Approach 1 to achieve outcomes to some extent, but is not optimal for health outcomes.

Depth of Activities

There is very limited direct educational support for destitute families, but there is effective leveraging of partnerships to establish for safe schools which in turn help maintain enrollment.

Household economic strengthening is strong in this approach with technical specialized staff and comprehensive activities that build on VSLAs to incorporate parenting skills and skills training, support, and inputs.

Health and nutrition is also characterized by technically specialized staff that includes the social service workforce. Nutrition support includes kitchen gardens; cooking demonstrations; farmer field schools with training that improves yields and harvest management; and building agriculture into IGA for surplus production. There is variable strength of relationship with health facilities.

Child protection services use specialized technical staff including the social service workforce. The district government have been assisted to improve outreach.

APPROACH 2

The mechanisms included in Approach 2 are 30% HKID focused (based on the proportion of funding received from HKID money), serving a fairly high number of OVC in a large number of districts. The key differentiating characteristic of Approach 2 is that a very broad base of CBOs and community-level associations are engaged as implementing sub-partners. There are, however, notable differences across mechanisms in terms of the factors determining the capacity to achieve outcomes.

Technical

The IP fully assumes technical supervision and the support role; it does not partner to supplement this function. There are significant challenges with this when considering support and supervision staff ratio to implementation sites.

This is not consistent across mechanisms within Approach 2, with less investment on careful selection. The major risk is inherent in the variance in technical capacity across sub-partners. An example is the ratio of supervision and support teams to sites (Mildmay), and expression from sub-partners in needing more technical skills at site level (CEM-sub).

These partners strengthen the capacity of the social service workforce through training, but there is not enough specialization, which is especially important in that at least one mechanism relies on specialization in referral circles. There is some evidence of technical strength embedded in planning and resource materials, as well as monitoring and evaluation.

Approach 2 is characterized by partnering with a broad range of sub-partners at the implementation layers of partnering. There is an emphasis on linking OVC programming to care and treatment programs. Practices include:

1. No sub-partners are engaged with an exclusively or predominantly technical supervision and support function for implementing sub-partners;
2. Careful selection of implementing sub-partners through reviewing technical capacity and vetting of potential sub-partners with district government ensures that organizations have credibility and a historical record of delivering services locally;
3. Formal contracting mechanisms and MOUs;
4. Some technical specialization of sub-partner staff to focus exclusively on specific OVC outcome areas; and.
5. Very limited technical specialization of social service workforce cadres to focus primarily on specific outcome areas.

The care taken with selection of the sub-partners has the additional advantage of ensuring continuity in delivery of services across succeeding mechanisms because the process favors experienced sub-partners or CBOs that have a history of delivering services, often through preceding PEPFAR mechanisms.

The result of the emphasis on partnering for technical capacity is evidenced in:

1. Technical strength embedded in planning and resource materials; and monitoring and evaluation outputs are available;
2. Comprehensive implementation; variability in complete interventions in each outcome area, as discussed below in the Depth of Activities section; and
3. Skillful implementation.

Partnering practices, while recognizing the importance of technical capacity, still demonstrate weaknesses. Generally, Approach 2 is positioned to achieve outcomes.

Resources

Resourcing of sub-partners is done through sub-grants, but it is across a substantially varying range of funding. Reduced resources has had an effect in M1, low funding is particularly problematic in M2. Only 50% of sub-partners in M2 receive grants. There is dependence on leveraging but it is misplaced as the level of many sub-partners does not allow for it.

Resourcing levels significantly influence ability to achieve outcomes. This is clearly illustrated in Approach 2 by a mechanism attempting implementation to an inappropriate scale with similar design, but different funding levels.

Coordination and Bi-directional Linkages to the Continuum of Care

Targeting and enrollment in community projects through linked care and treatment programs is based on:

- An OVC register, which partners update during implementation,
- Inputs from community structures,
- Infected and affected OVC identified at linked facilities,
- Vulnerability assessment to assist in prioritizing the most vulnerable, and
- Vulnerability assessment will support graduation.

The combined targeting and enrollment does favor infected or directly affected OVC who are already accessing care and treatment services. As a result, the proportion of infected and affected OVC is higher than 15% with limited disclosure.

Coordination for case management is there, but varies. The community partners are often under-resourced, so full case management costs may be undermined. Lack of technical capacity is evident from variation in quality of case management records.

Coordination with facility is more deliberate with linkages to facility care and treatment programs implemented at a site that may include a health facility.

Depth of Activities

Approach 2 demonstrates a wide variance in the depth of activities implemented, which is dependent on both the variable technical capacity of sub-partners, and the accompanying challenge confronting the technical support and supervisory function of the prime partner. This is exacerbated by resource deficits in some mechanisms.

APPROACH 3

The key differentiating characteristic of Approach 3 is implementation through a prime partner with a fairly limited scale of operation in specific locations, covering most outcome areas within a small technical team that emphasizes case management. Partners receive up to 30% of their funding from HKID. There is some variation across different mechanisms in terms of the factors determining the capacity to achieve outcomes.

Technical

Prime partners in Approach 3 have a site-specific focus with both health and socio-economic services and technical staff available. A strong Approach 3 partner will have technical staff on the team, at the primary delivery site or hub. Comprehensive implementation is possible as there are technical staff to cover different service areas such as legal support, child protection, psycho-social support, economic strengthening and educational support.

For example, DoD's implementing partner RTI, works in army barracks with the health clinic and other service providers in the barracks or near-by. Reach Out Mbuya operates from its premises, which include a health facility, counseling services, and even a vocational training arm.

United Nations High Commissioner for Refugees (UNHCR) uses state resources to assist in refugee settlements in Uganda. A sub-partner Windle Trust provides education support and collaborates with the other service providers in and around a refugee settlement.

Skillful implementation is possible, but with few or no sub-partners Approach 3 teams may face difficulties if they lack capacity in a critical technical area. For example, partners in Approach 3 requested more information on how to implement economic strengthening in particular settings, such as income generating ideas for the urban poor. Likewise, the documentation of outcomes may be weak, with little in-house or externally available capacity for evaluation and studies.

Approach 3 partners are responsive to the community they serve and to the requirements of their sector.

Resources

In Approach 3, HKID funds are a small proportion of funding. However, since there are no sub-partners, the funding can be channeled more directly to services for children. In the best examples of Approach 3, the well-coordinated and collaborative operation means that despite limited resources, OVC benefit from the range of services offered by the organization including those provided by home-based care providers, clinics, or prevention officers who receive funding through other budget codes.

As Approach 3 partners generally work in limited geographic areas, there is a high level of knowledge of the circumstances and needs of individual clients or beneficiaries. Approach 3 partners concentrate resources in a family. For example, a partner provides a family with educational materials, lunch fees, and possibly vocational support for as many as three children in the household.

This approach may result in a high unit cost per child.

Depth of Activities

With sufficient technical staff and a project design that is appropriate to their funding level, the outcome areas can be adequately supported to achieve results. Approach 3 partners demonstrate a strong understanding of child protection with sufficient technical knowledge and human resource on the team. For example, one partner has an in-house legal advisor who connects with paralegals and has addressed 50 child protection cases in the year.

Where the technical expertise is not in-house, there may be few options for improving practices.

Partners requested more information for particular economic environments (e.g., the urban poor). Without sufficient grounding in economics, the process of graduation may be somewhat arbitrary and not truly reflect families' ability to cope with demands.

Coordination and Bi-directional Linkages to Continuum of Care

With a health facility on site, children can be referred directly or even provided with services for health issues, including HIV testing and screening for sexual transmitted infections. In the same way, other needs, such as for legal services or educational services, are provided either directly by the partner or addressed through regular meetings where case management issues are considered.

A strong Approach 3 is characterized by supervised case management. This is possible because the team either work for the same organization or work together as a unit within a specialized locality (army barracks or refugee settlements) and with a clear mandate.

With a very specific population and mandate, UNHCR convenes an interagency team weekly to plan, and monthly to discuss individual cases, including follow-up action required and tracked. Another Approach 3 partner reported weekly case management meetings where an individual child's needs are discussed and action planned with the technical team of legal advisors, social workers and community-based health workers.

Clients/Population Served

A large proportion of Approach 3 beneficiaries are HIV infected and affected children and their families. Clients who test positive at a clinic are screened for vulnerability and are then visited by a social worker for a further assessment.

As with other approaches, in Approach 3 the majority of its beneficiaries are identified through an index client —an HIV positive household member. If clients of the participating health facility are HIV positive, the household is assessed for vulnerability. If the household is vulnerable, the children are enrolled. If an HIV positive child is found, all the children in his or her household are enrolled.

Through home-based care providers, children of HIV infected caregivers and parents will be referred for HIV testing and followed-up at the next visit.

Given its limited scale combined with sufficient staff (social workers and community workers for each village) this approach is able to respond to referrals of other vulnerable children from community or government.

This approach works through well-established organizations that have presence and credibility in a community.

APPROACH 4

The key differentiating characteristic of Approach 4 is the co-location of OVC activities that are focused around and implemented through a health facility based workforce, with links to community structures. Partners will get less than or up to 20% from HKID funds. There is some variation across the different mechanisms in terms of the factors determining the capacity to achieve outcomes.

Technical

Partners in Approach 4 work closely with district offices, particularly the Health Office but also the Community Development Office. They operate primarily from health facilities and thus have access to the technical capacity in the clinics, such as midwives, nurses or similar cadres offering ANC clinics, sexually transmitted disease counseling, adherence counseling, and HIV testing.

Comprehensive implementation is difficult under this approach as there are no funded sub-partners to undertake activities; existing clinical staff are heavily involved in health interventions; and other district level staff may not have the necessary skills or time for child protection and prevention activities.

Skillful implementation is possible, especially around the health related activities. There is scope to maximize the clinic platform to provide early childhood development messages to antenatal care (ANC) mothers and mothers in PMTCT; prevention messages to adolescents seeking sexual and reproductive health services; and nutrition messages and support for families with children on ART. It is more difficult for Approach 4 partners to ensure technical capacity in other outcome areas such as HES, education, and child protection because there is no dedicated staff for these outcome areas. Referrals to community service providers are an option discussed under coordination below.

Responsive implementation that allows for adapting, innovating or mitigating challenges will be highly dependent on individuals. Staff at clinics are already multi-tasking, and the additional responsibilities of acting as OVC focal person may be overwhelming. Partners who do not have full time paid staff will not have sufficient technical skills to address all the different outcomes for children.

Resources

Resources available at all levels are limited. Funds are made directly to service providers. For example, district health staff and small amounts of funds are provided to support facilitation of district community development offices for coordination and limited child protection activities.

VHT and community health workers, community home-based care providers or parasocial workers comprise the social workforce. Due to resource constraints and institutional location, this approach will not generally have its own social service workforce employed directly by projects.

Since the percentage of OVC resources that make up an Approach 4 partners' PEPFAR budget, is small (under 15% to 20%), there is a risk that OVC activities may not receive adequate attention and thus non-health outcomes may not be achieved.

Depth of Activity

Approach 4 partners, based in health facilities, have the potential to offer comprehensive health services to OVC and their families' population. Unfortunately very few health facilities offer adolescent friendly health services or any early childhood development information for others.

Household economic strengthening activities and educational support are offered through groups established at the facility. The technical expertise to offer comprehensive services in these areas is limited. Since a health facility draws its clientele from a wide area, in some instances it may be difficult to organize VSLA groups given their reliance on trust and familiarity between members. VSLA groups that are made up solely of HIV positive clients are also not generally recommended.

Coordination with and Linkages to the Continuum of Care

Coordination with community services is weak according to key informants and to the SIMS data provided. To address this, Approach 4 partners are liaising more with the Community Development Office and referring children to that office for services. In addition, they attend the coordination meetings held at sub-country and district level.

There are very few instances of community organizations receiving a referral from a health facility. But Approach 4 partners have done some service provider mapping in order to better understand what services, outside of the health sector, are available for children.

Targeting and Client Population

With staff based in clinics, Approach 4 partners identify and reach HIV infected children and children with HIV infected parents or family members. In some cases this is close to 100% of the beneficiaries. The clinics are also generally able to respond to referrals received from community organizations for health services. Children vulnerable to HIV infection are not specifically targeted. Key informants recognized that the stigma of HIV infection remains and can inhibit participation in activities if the community associate such activities with ART clients only.

APPROACH 5

Approach 5 reflects the work of two agencies: State and Peace Corps, which both have small grant mechanisms. Peace Corps uses HKID funds to provide volunteers with easily accessible grant of up to USD $10,000 for work with community OVC projects. The State offers small grants of up to USD $20,000 to community projects working with OVC. Currently the State has 10 community partners utilizing the OVC small grant, while Peace Corps has not received any requests for grants this fiscal year.

These two grant mechanisms have a special niche within the Uganda OVC Portfolio. Peace Corps volunteers have also been instrumental in identifying and supporting small CBOs. In at least one instance, this support lead eventually to a local organization applying for and receiving a small grant from the State. Peace Corps volunteers have been placed with local partners who are engaged in OVC work under the USG portfolio. Both the Peace Corps small grant and the State community grant help facilitate the identification of strong CBOs that can be graduated to participate in more complex mechanisms.

The potential to benefit from both the Peace Corps and the State connections with small local organizations has not yet been fully exploited by the other agencies.

The small grants further offer an entry into special populations, such as street children or children in remand institutions. Small CBOs have the advantage of intimate knowledge of their constituencies. Although they are dependent on the character and dynamism of the leader, they are able to respond quickly to changing circumstances in the community and to take advantage of emerging funding and programming opportunities. Usually small organizations have a holistic approach, addressing a variety of community needs. Such circumstances often lead to innovation, but they may lack sufficient and diverse technical staff to implement necessary programming.

By their very nature (small amounts of money to less formal localized organizations), small grants require more intense PM than other approaches that rely on highly professional, specialized partners. So although it is difficult to scale up this approach, it plays an important and specific function in the overall Portfolio.

CROSS-CUTTING SYSTEMS STRENGTHENING AND SPECIALIZED TECHNICAL SUPPORT

A number of technical assistance mechanisms in the USAID portfolio have supported OVC-related social welfare systems strengthening and provided specialized technical support. This systems strengthening support is complementary to SUNRISE, which ended last year, and the systems strengthening support provided by BOCY and SOCY, which are considered a follow-on to the SUNRISE and SCORE projects. Unlike SUNRISE and BOCY and SOCY, only a portion of the budgets assigned to the projects listed below is HKID funded. Since these mechanisms are not involved in service delivery for OVC, they were not described as a separate approach. All agencies expressed appreciation for this cross-cutting support and that they have benefitted from the partners' work with government systems at national or district levels and the specialized technical assistance that they provide. Such interventions support results, and the review suggests that some mechanisms are essential to do so (e.g., SDS).

Project	IP	Focus
Production for Improved Nutrition (PIN) Project	PIN-RECO	Strengthen the capacity of local and regional companies to become sustainable manufacturers and distributors of therapeutic and supplementary food.
Advocacy for Better Health	PATH	Partners with initiatives to advocate for health and social services especially for women, young people, people with disabilities and most at risk populations.
Strengthening Decentralization for Sustainability (SDS)	CEM	Support decentralization for health and social welfare through grant making to strengthen local government structures.
Applying Science to Strengthen and Improve Systems (ASSIST) Project	URC-CHS	Promoting quality within the continuum of response for HIV programming.
Strengthening National OVC Management Information System (MEEP)	URC-CHS	Support M&E of PEPFAR and the GoU national M&E system for the overall HIV/AIDS response.

VII. CONCLUSION

This review identified five different approaches to implementing services to OVC across the USG Agencies. The approaches are distinguished by key design features coalescing around partnering, implementation processes, and depth of activities implemented.

This review further identified five factors that affect capacity to achieve outcomes. These include technical ability, level of resourcing of partners, methods for establishing coordination between the health facility and the community, the comprehensiveness of the interventions, and addressing gaps in delivery.

Although the approaches differ in their relative capacity to achieve outcomes based on their particular, unique combination of these factors, all approaches can be strengthened.

Each approach contributes effective practices to the portfolio. Strengthening individual approaches could be partly based on learning effective practices from other approaches.

Regardless of their relative strengths, approaches require better alignment so the potential capacity can be harnessed to achieve outcomes and adequately respond to the scale of the challenges confronting children in Uganda.

INTERRELATION OF SUCCESS FACTORS

The technical capacity and resourcing levels of partners are critical and have implications for the depth of interventions, which in turn contribute to the realization of outcomes. The depth of interventions is dependent on both the technical skills available through partners and the level of resourcing for partners and interventions. There are differences between approaches, and also within approaches, as to the depth of different interventions. An approach that provides school expenses and materials for primary school children, creates apprenticeships and start-up kits for adolescents, and undertakes institutional work with schools will be more likely to achieve the outcome of educational progress, especially for girls, compared to one that only provides basic school materials for one child in a family. There will be cost implications as well.

Improving capacity of the Portfolio to achieve outcomes as a whole within the context of diminishing resources will require difficult choices, and the comparison of an approach's capacity to achieve outcomes and a capacity to strengthen the quality of programming can inform those decisions.

IMPLICATIONS FOR COST EFFECTIVENESS

A consideration of cost effectiveness is important. However, the cost effectiveness analysis here is limited, due in part to data quality and the lack of outcomes data, but more importantly the immaturity of EA analysis, which can only therefore provide indicative rather than conclusive information.

At this stage it is difficult to compare what different partners spend on a particular service for a child or family, as the type and depth of each service varies. Providing annual educational materials for a primary school child costs less than providing six months of apprenticeship

training for an adolescent. The cost of different economic interventions also varies greatly and is highly dependent on quality.

Since there was no consistent outcome data across approaches or partners, a full cost effectiveness study was not possible. Once the MER 1.5 is undertaken, such a comparison will be possible. What is clear from the review is that interventions with insufficient depth will not achieve the level of outcomes as others. For example, a simple referral is unlikely to achieve the required outcome—a child has an HIV test, or gets a birth certificate, or enrolls in school. However, a referral that is backed by a service provider mapping, by MoUs with service providers, by personal contact with focal people, by a well understood system of documentation, and finally by a phone call or home visit is much more likely to achieve the intended outcome, but of course is more costly.

COORDINATION AND PROGRAM MANAGEMENT

Interagency level

The OVC TWG in Uganda is the interagency coordination mechanism for OVC work under PEPFAR Uganda. It has representation from all agencies and is co-chaired by a USAID representative and a CDC representative. It meets regularly and provided guidance and direction to this review. However, the TWG lacked a common understanding of the different elements of OVC programming. Representatives on the TWG had varying degrees of experience in and exposure to OVC programs. The Interagency Portfolio Review offered a unique opportunity to the TWG and to the PSC to learn from exposure to one another's work. Members expressed appreciation for this and requested continued interagency collaboration.

Inter-partner level

USAID and CDC have regular agency-specific partner coordination and briefing meetings. Partners from within an agency are deployed to specific regions and specific districts.

District level

In most of the priority districts, more than one agency is represented through an OVC implementing partner. During field work, the review team heard examples of collaboration between implementing partners across agencies.

Government coordination mechanisms that bring implementing partners together have been strengthened through previous mechanisms. The convening authority of district government provides a useful coordination platform through management committee meetings as well as through DOVCCs. Participation in these by USG OVC partners is good and forms a basis for multi-sectoral coordination.

VIII. RECOMMENDATIONS FOR STRENGTHENING OF THE PORTFOLIO AS A WHOLE, WITH SPECIAL FOCUS ON THE 2016 TECHNICAL CONSIDERATIONS

Based on the evidence of best practices and lessons learned, what is required to improve the effectiveness and efficiency of the OVC PEPFAR activities?

GENERAL RECOMMENDATIONS

1. Possibilities for increasing the use of community OVC platforms to identify HIV affected and vulnerable populations not currently accessing services and connect them with both facility-based HIV and community-based socio-economic services.[36] In addition, increasing the use of facility-based OVC programs to identify HIV positive children and the children of HIV positive parents or siblings and connect them with community-based socio-economic services.

   - As detailed in this review, some approaches are better placed to identify HIV infected and directly affected children and families, such as those who begin at a clinic providing HIV testing and move out into the larger community through index clients. Approaches that are more community based can improve the likelihood of identifying such children by establishing relationships with the nearest HIV testing and ART site. This may entail situating staff at such facilities (e.g., linkage facilitators) or at a minimum having regular formalized contact, possibly through MoUs, case conferencing, and regular meetings to strengthen coordination mechanisms.

   - The community outreach activities undertaken by different approaches is a positive and useful way to bring HIV services and child protection services closer to the intended beneficiaries. Expanding this practice with a special focus on hard-to-reach groups, including out-of-school children, children on the street, married girls, and pregnant young mothers can increase uptake.

   - To be efficacious, referrals require the fullest depth of intervention possible and all partners should design comprehensive referral systems that include:

     - Mapping of services and validation,
     - Referral forms,
     - MOUs between providers,
     - Regular case conferencing and coordination meetings,

[36] 2016 OVC Technical Considerations PEPFAR

- Personal contact for follow-up,
- Material or transport assistance to assist the client (assisted referral), and
- Clear guidelines for documentation of referrals within a case management framework.

2. Possibilities to maximize OVC platforms' capacity to mitigate the social effects of AIDS and to contribute to the full continuum of prevention and care including reduced HIV risks for adolescent girls; earlier identification and retention of children affected, exposed and infected by AIDS; and improved stability of families affected by the pandemic.[37]

   – The situation of adolescent girls—early marriage, early pregnancies, abuse in schools, low retention rates in primary and secondary—is very serious and requires concerted attention. The gender differences in illiteracy (higher for females than males); in HIV prevalence (higher for females than males); and in early marriages (higher in girls than boys) need to be highlighted an addressed as a matter of urgency. It will not be possible to control the HIV epidemic if the life experiences of poor adolescent girls is not substantially altered.

   – OVC programs are ideally placed (they identify vulnerable families, target HIV affected household, have a presence in communities, work within trusted local organizations, conduct home visits, and liaise with child protection institutions) to reach adolescent girls with a combination of prevention strategies and education strategies that can begin to address some of these inequalities. The need to address girls' sense of self-efficacy and confidence should not be underestimated as shyness and embarrassment are often given as reasons for not accessing or requesting condom use.[38] OVC programs reach families with protection messages to ensure girls are given an equal opportunity to remain in school instead of being married early. OVC programs can work with and within health facilities to improve youth-friendly services that are taken to the most vulnerable.

   – Evidence and lessons emerging from the DREAMS initiative will be very important in providing 1) opportunities to intensify interventions with adolescent girls; and 2) document the emerging best practices for keeping girls safe, schooled and AIDS free.

   – The children of children (25% of teenage girls in Uganda pregnant), babies and their teenage mothers, require intensive support and assistance to ensure healthy early childhood development for the child and better health and educational outcomes for the young mother. The same applies to mothers exiting PMTCT and their HIV exposed babies. Approaches that have a facility entry point have an ideal opportunity to develop curriculum-led parenting and early intervention support for these mother-baby pairs. Alternatively approaches that are not located at facilities could be designated to develop and provide such services at convenient locations. Approaches that include OVC activities into much larger care and treatment services risk de-prioritizing OVC

[37] 2016 OVC Technical Considerations PEPFAR
[38] Department of Social Work and Social Administration, Makerere Universityand African Institute for Child Studies, Analysis of the Situation of the Ugandan Child. MELP, November 2015

activities. The services offered at health facilities are currently generally limited to basic health care, but could be expanded to include additional complementary services such as ECD, youth friendly adolescent SRH, etc. This will be contingent on validating that expected services are in fact offered and strengthening additional services by ensuring that sufficient and dedicated OVC technical capacity is based at the facility, or coordinating with other partners and approaches to offer such services.

- Following the 2012 Guidance and the 2015 Technical Considerations, partners focused their attention on HES as a way to stabilize families and to ideally facilitate the graduation of beneficiaries. To fully realize these goals, approaches need to invest in the full HES/VSLA package, including temporary injections of assets for members or temporary education and health subsidies. All Approaches, apart from Approach 1, need to ensure they have the technical staff to maximize economic strengthening activities. For example, if HES has an agricultural component, then it should concentrate on technically sound agricultural intensification. Support for the non-farm rural economy (including vocational skills for youth) is an appropriate complementary intervention, but again should be implemented by competent professionals.

3. Continue investments in social welfare systems strengthening to prevent and respond to neglect, violence, and exploitation of children and adolescents at risk.

   - Current case management practices have limitations. They may not be comprehensive, up to date, easy to manage, or useful in addressing needs. The key constraints — limited resources and skills within the available social workforce — need to be considered. The way to do that is to differentiate participating beneficiaries and reserve intensive case management for those with the most dire needs and problems that require ongoing supervision, more intensive and frequent follow-up and tracking.

   - The assumption that volunteers, such as parasocial workers, can be expected to do intensive case management is questionable. The roles and responsibilities of different levels of the social welfare workforce should be carefully delineated, with paid staff responsible for oversight and case management quality and for clients with more complicated or serious needs.

   - In the same way, community organizations have enormous potential to contribute to the protection of children and to enhancing their opportunities. However, these community organizations require extensive capacity development, resourcing, and supportive supervision to realize this potential. Simply referring children to community services, or outsourcing activities to such partners, without establishing the quality of the service is an ineffective practice.

4. Sufficient resources should be allocated to measure outcomes for program impact (MER 1.5) and teams should budget for adequate staffing of the OVC program.

   - The collection of actual outcome data will enable a clear assessment of program effectiveness which can then be compared to expenditure.

   - The different USG Agencies through the Uganda OVC TWG and PSC can continue the positive interagency discussions to develop a shared understanding of key concepts, including which OVC are targeted by the portfolio, what constitutes vulnerability, what

sub-populations should be prioritized and how, what constitutes case management, what is graduation, and which outcomes will be prioritized. Common tools, such as the vulnerability index and vulnerability assessment, and in the future, other quality assessment and outcome evaluation tools could also be reviewed at an interagency level.

- Agencies and their implementing partners require sufficient OVC technical staff who can provide oversight, guidance and inspiration for effective and evidence-led implementation.

5. Strengthening approaches and coordination.

   - The very positive interagency collaboration evidenced in this review, and particularly in the combined site visits that took place with the PEPFAR OVC TWG representatives, was welcomed by the Uganda PEPFAR Steering Committee. On-going interagency learning journeys and interagency visits to partner sites should be scheduled. Other interagency work could include review of SIMS data leading to improvement plans.

   - The Uganda OVC TWG body should be mandated to review and discuss best practices, standardized tools for identification, assessment and graduation. They could also develop a common PEPFAR OVC strategy that includes the above elements.

RECOMMENDATIONS BY APPROACH

Approach 1:

- Improve targeting of directly HIV affected children and their households. Although we can't be certain what the appropriate targets are to accommodate enrollment at scale, and balance the numbers between those at risk and those directly affected for optimal control of the epidemic, diminishing resources represent a reality that must be aligned with. Look to Approaches 2 and 4 for effective practices.

- Introduce a hierarchy of case management so that children in the most dire situations are monitored appropriately, and resources for child protection are available. Look to Approach 3 for effective practices.

- A clearer understanding of the actual resource needs of households is required in order to ensure that the vigilance on dependency is not undermining the achievement of outcomes, especially in service areas such as education.

Approach 2:

- Build in more technical capacity at a prime partner and supervisory level to supplement the technical deficits in some sub-partners that undermine capacity to achieve outcomes. Look to Approach 1 for effective practices.

- Make the difficult decisions regarding scale and match it to available resources. Look to especially Approach 3, but also 5.

Approach 3:

- Only if necessary, extend reach by building effective referral networks that include mapping of capable services providers. Look to new Approach 1 mechanisms, which include in-person vetting of potential network partners.
- Also consider ways of augmenting resources beyond PEPFAR through local fundraising, looking to Approach 5 partners for effective practices.
- DO NOT OVER-REACH and stick to appropriate scale: resource balance. Approach 3 is effective, and there is no need to fix that which isn't broken.

Approach 4:

- Make the difficult decisions regarding scale and match it to available resources. Look to especially Approach 3, but also 5.
- Build in more OVC specific technical capacity at sub-partner level. Look to Approach 3 for effective practices.

Approach 5:

- Improve on already effective network building. Make use of PCVs and look to augment ECD specializations. Grow fundraising and grant management capacity to steadily extend reach. DO NOT OVER-REACH.

ANNEX 1. REFERENCE LIST

Agency and Partner Documentation	
Organization	Title of Document
4Children	Final SUNRISE Evaluation, Coordinating Comprehensive Care for Children (4Children), September 2015
4Chidlren	USAID/Uganda OVC Portfolio Review, April 2015
Baylor	Comprehensive annual report 2014
Baylor	Comprehensive annual progress report (October 2013-2014)
Baylor	Annual Project Progress Report (Project Narrative) 2014
Baylor	Annual Progress Report 2013
Baylor	Implementation approaches survey
World ED (BOCY)	A Case Study Highlighting The Results Of Integrated Child Protection And Care And Treatment Programming In Namatumba, Uganda
World ED (BOCY)	Activity Monitoring, Evaluation and Learning Plan (Amelp)
World ED (BOCY)	Implementation approaches survey
World ED (BOCY)	OVC Vulnerability Assessment and Prioritization Tool
CAFU	New Hope Application CAFU 5U2GGU000624-03 - Work Plan (Results frame work)
CAFU	Implementation approaches survey
CEM	Implementation approaches survey
CDC	Provision Of Comprehensive Public Health Services For The Fishing Communities In The Republic Of Uganda Under The President's Emergency Plan For Aids Relief (PEPFAR). Interim Progress Report For Year 01 And Continuation Application For Year 02
Mildmay	Midterm Evaluation Report For Mildmay Uganda Health Systems Strengthening Project In 16 Districts Of Central Uganda
Mildmay	Implementation approaches survey
Mildmay	MILDMAY UGANDA ANNUAL PROGRESS REPORT October 2012-2013
Mildmay	MILDMAY UGANDA ANNUAL PROGRESS REPORT October 2013-2014
Mildmay	Mildmay Uganda Performance Measurement Plan
Mildmay	MILDMAY UGANDA OVC VULNERABILITY ASSESSMENT REPORT (11th February 2015 to 30th June 2015)
PIN	3 year OVC expenditure (2012 to date)
PIN	OVC Budget 2013-2014
PIN	Annual report 2014 final
PIN	Annual report 2013-2014
PIN	Implementation approaches survey
Reach Out	Implementation approaches survey

Agency and Partner Documentation	
Organization	Title of Document
Reach Out	Reachoutmbuya Parish Hiv/Aids Initiative Annual Progress Report (September 2011- August 2012)
Reach Out	Reachoutmbuya Parish Hiv/Aids Initiative Annual Progress Report (September 2012- August 2013)
Reach Out	Reach Out Mbuya HIV/AIDS Initiative Continuation Fund Application Year 04
Reach Out	Reach Out Mbuya HIV/AIDS Initiative Continuation Fund Application Year 03
Reach Out	PROGRESSIVE REPORT, JANUARY–JUNE 2014
RTI	OVC annual report 2015
RTI	Copy of OVC expenses Oct 14- Sept 15
MEEP	Implementation approaches survey
MEEP	Copy of OVC Improvement Plan
SOCY	Activity Monitoring, Evaluation and Learning Plan
SOCY	SDS SOCIAL SECTOR BRIDGING Joint Concept Paper – Sustainable Outcomes (CRS) and Better Outcomes (WEI)
SOCY	Sustainable Outcomes Case Management Strategy
SOCY	Uganda OVC Identification and Prioritization Tool
UPMB	Uganda Protestant Medical Bureau QUARTERLY PROGRESS REPORT
PEPFAR	OVC annual hybrid report
PEPFAR	OVC funds tracking
PEPFAR	Year 1 annual report
PEPFAR	Year 1 Work plan
PEPFAR	Year 2 Work plan
PEPFAR	Decision making memo Small Grants 2015
PEPFAR	Country Operational Plan (COP) 2015 Strategic Direction Summary
PEPFAR	OVC Targets, Unit Costs and Packages
PEPFAR	EXPENDITURE ANALYSIS OF PEPFAR PROGRAMS IN UGANDA
PEPFAR	SAPR 2015—OVC Revised by IP and district
PEPFAR	Final COP 15 revised budget
PEPFAR	OVC COP 2015 targets
PEPFAR	Overall PEPFAR Master lists
PEPFAR	PEPFAR Summary sheets 2014
PEPFAR	PEPFAR Explanatory notes to summary sheets 2014
PEPFAR	PEPFAR Summary sheets 2013
PEPFAR	PEPFAR Explanatory notes to summary sheets 2013
PEPFAR	USAID Partner APR 2013 Performance
PEPFAR	USAID Partner narrative and SO outputs
PEPFAR	USAID Partner IP challenges
PEPFAR	2015 and 2016 Technical Considerations

Agency and Partner Documentation	
Organization	Title of Document
Additional Reference Material	
Author	Title
PEPFAR	Guidance on OVC Programming 2012
Measure	Collecting PEPFAR Essential Survey Indicators: A Supplement to the Orphans and Vulnerable Children Survey Tools, revised 2015
MGLSD; UNICEF Economic Policy Research Centre	Situation Analysis of Child Poverty and Deprivation in Uganda 2015
Uganda Bureau of Statistics	Uganda National Household Survey 2009/2010
Ministry of Health	Uganda AIDS Indicator Survey 2012
UNAIDS	Uganda UNGASS Country Progress Report 2012
Ministry of Gender Labor and Social Development	Strengthening Human Resources and Financing for Child Care and Protection Services (2011)
Bunkers, K., Bess, A., Collins, A.,McCaffery, J., and Mendenhall, M	The composition of the social service workforce in HIV/AIDS-affected contexts (2014)
African Child Policy Forum et al	Strengthening Child Protection Systems in Sub-Saharan. A Call to Action. Joint Agency Statement. (2013)
Ministry of Gender, Labor and Social Development	Assessing and Improving Quality of Interventions for Orphans and Other Vulnerable Children (2009)
Ministry of Gender, Labor and Social Development	Assessment of Uganda's National OVC MIS (Feb 10, 2015)
Ministry of Gender, Labor and Social Development	Framework for Alternative Care (Nov 1, 2012)
Ministry of Gender, Labor and Social Development	Guide for Service Quality Standards for Orphans and Other Vulnerable Children
Ministry of Gender, Labor and Social Development	Staff Performance Appraisal in the Public Service: Guidelines for managers and staff (2007)
UNICEF and MGLSDF	Situational Analysis of Children in Uganda, 2015
Winsor Consult	Assessing Child Protection / Safety And Security Issues For Children In Ugandan Primary and Secondary Schools, UNICEF and MoES, 2012.
Desmond C., Gow, J.	The Cost-Effectiveness of Six Models of Care for Orphan and Vulnerable Children in South Africa Health Economics and HIV/AIDS Research Division, University of Natal, Durban, South Africa February 2001

Agency and Partner Documentation	
Organization	Title of Document
Ministry of Gender, Labor and Social Development	Strategic Program Plan of Interventions for Orphans and Other Vulnerable Children 2011/12—2015/16 (May 2011)
Inter Religious Council Uganda	Tackling HIV/AIDS with a faith Foundation
Inter Religious Council Uganda	Business Management and Customer Care Training Report For Out of School Orphans and Vulnerable Children (September 2013)
Inter Religious Council Uganda	Evaluation Of IRCU-Supported Economic Empowerment Interventions For Orphans And Other Vulnerable Children (OVC) Caregivers And Households (August 2012)
Inter Religious Council Uganda	Evaluation of the Outcomes of Vocational and Apprenticeship Training of out of School Vulnerable Children supported by the Inter – Religious Council of Uganda (July 2012)
Santa-Ana-Tellez Y, DeMaria LM, Galárraga O.	Costs of interventions for AIDS orphans and vulnerable children (2011)
Menahem Prywes, Diane Coury, Gebremeskel Fesseha, Gilberte Hounsounou, and Anne Kielland	Costs of Projects for Orphans and other Vulnerable Children: Case studies in Eritrea and Benin (2004)
Dougherty, Leanne, Steven Forsythe, William Winfrey, Kathy Buek, and Minki Chatterji	A Costing Analysis of Community-Based Programs for Children Affected by HIV/AIDS: Results from Zambia and Rwanda (2005)
Paul Hutchinson, Tonya R. Thurman	Analyzing the Cost-Effectiveness of Interventions to Benefit Orphans and Vulnerable Children: Evidence from Kenya and Tanzania (2009)
Constance Formson, M.A. and Steven Forsythe,	A costing Analysis of Selected Orphans and Vulnerable Children (OVC) Programs in Botswana (2010)
Tekale, Daniel S. and Forsythe, S	Costing OVC in Ethiopia: Making sense of the Numbers (2010)
Deininger, Garcia, and Subbarao,	AIDS-Induced Orphanhood as a Systemic Shock: Magnitude, Impact, and Program Interventions in Africa (2003)

ANNEX 2. DATA COLLECTION GUIDES FOR SITE VISITS

District:		**Site:**
Agency and IP:		**Date:**
Team Members:		**Name of Key Contact:**
Quality	**Identification and Enrollment**	
Access	*Describe how you identify and enroll beneficiaries (children/households) in the project.* Using tools? Which ones? Cooperating with community structures? How? Steps to reach most marginalized/vulnerable? HIV positive children identified?	*Description, challenges and suggested improvements*
	Delivery of Services	
Compassion *Participation* *Appropriate-ness* *Safety* *Access*	*Describe how the services are delivered.* Who delivers the service(s)? Does the same person consistently support the child/household? Are families the key entry point for services? Is girls' transition from primary school to secondary school promoted/assisted? How are services packaged for different beneficiary groups? Are SRH issues for adolescent boys and girls sufficiently addressed? How are beneficiaries assigned to different service packages? Do activities take place in accessible venues that do not to stigmatize the child or family? Where are the OVC services provided? Are they in geographic proximity to other PEPFAR supported HIV services? Which ones?	*Description, challenges and suggested improvements*

	Following a Child	
Relevance *Effectiveness*	*Describe how each child is managed as a unique case.* Is there an initial assessment and regular follow-up of every child? Are there records of each child and parent/guardian (SIMS)? Are children's enrollment and progress through school monitored? Are there ways to deliver or link children to services based on their specific needs? What outcomes have you observed? What outcomes do you track?	*Description, challenges and suggested improvements*
	Linking and Referring to Services	
Continuity and Continuum of care	*Describe how children and household members are linked to other services.* Do 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 illness, abuse or other needs? Are children and family members are referred for social and health services? Is uptake of HTC and PMTCT, EID, and ART services are actively encouraged and assisted? Are referrals assisted when necessary? Does the project have such staff in place? Do partners receives referrals from health facilities (bi-directional) Is a system is in place with standard tools to track referrals to services (including HIV testing) (SIMS)	*Description, challenges and suggested improvements*
	Graduating Beneficiaries	
Sustainability	*Describe provisions made to support beneficiary graduation out of support.* Are procedures are in place for closing files and transitioning children and their families from program support (SIMS) Is there an explicit exit strategy to ensure that beneficiaries graduate from PEPFAR support and/or that ongoing external support? Have you measured the HES outcomes?	*Description, challenges and suggested improvements*

	Program Management, Coordination and Costs	
Technical	Describe How many staff work for the OVC program? FT/PT? How many community workers? Pd or Unpd? How much? How much supervision How do you coordinate between health facilities and community and social services? Who do work with in the community?	*Description, challenges and suggested improvements*

CD	General Questions	Household Economic Strengthening	Education	Psychosocial Support	Health and Nutrition	Child Protection
R	What is delivered? Describe what constitutes each service. What's in it? Exposure? (Duration, frequency, amount etc.)					Prompts: Does the program create awareness among communities on child rights and protection, gender norms laws and services available?
A	How does each service differ by beneficiary characteristics like age or gender?	Prompts: Are basic livelihood options provided to poor and vulnerable families?				
C	Are these delivered as a package or are there multiple packages?					
R	Priorities or special considerations being addressed?	Prompts:			Prompts: Programs improve access to clean water and sanitation? How are children linked to HIV services?	

ANNEX 3. SCHEDULE OF SITE VISITS

DATE	DISTRICT	AGENCY	IP	PEOPLE INTERVIEWED	NUMBER	AGENCIES WITHIN DISTRICT	OVCs SERVED IN 2015
NOV 5	MUKONO (KOOME ISLAND)	DOD	MUWR	Health facility staff (3), OVC coordinator-Walter Reed (1), VSLA group members (5)	9	DOD, USAID	4,840
NOV 6	KAMPALA	CDC	ROM	Reach out Mbuya staff (2), Community health worker (4), Social health workers (3), legal workers (2)	11	CDC, USAID	21,826
NOV 6	GOMBA	CDC	MILDMAY	Community Development Officer (2), Social Worker (2), VSLA group (2)	6	CDC, USAID	287
NOV 9	MBARARA	USAID	CEM/PNFP	CB0 (3), social worker (1), community development officer (1), VSLA group (1), OVC (1)	7	CDC, DOD, USAID	4,330
NOV 9	MBARARA	CDC	UPMB	Ruhaaro hospital director (1), OVC focal person (1), project co-ordinator (1)	3	CDC, DOD, USAID	4,330
NOV 9	ISINGIRO	State	UNHCR/WINDLE TRUST	Windle Trust staff (1), UNHCR staff (3), Medical Teams International bio-statistician (1), School teachers (3),	8	USAID, UNHCR	3,412
NOV 10	MITOOMA	USAID & Peace Corps	AVSI SCORE/ TPO/I-DO	TPO staff (3), I-DO staff(2), Peace Corps Volunteer (1), CBTs (2), Peer educators (1), VHTs (4), Community Legal Volunteer (2), Farmer Field Facilitator (2), VSLA group (7)	24	USAID	1,695
NOV 11	KAMWENGE	USAID	CRS/SOCY/ ACODEV	CRS staff (1), ACODEV staff (2), Community Development Officers (3), Parasocial workers/VHTs (5), Child Protection Specialist (1)	12	CDC, USAID	5,317
NOV 12	KASESE	CDC	BAYLOR/SNAP	Baylor staff(2), District Community Development Officer (1), para social worker (2), care givers (7)	12	CDC, USAID	11,201

NOV 13	KABAROLE	STATE	TOCI	TOCI staff (1), VSLA-women briquette production group (20)	21	CDC, USAID	7,667
DEC 7	WAKISO	USAID	SCORE	SCORE staff (2), CBO-FXB Uganda (5), VSLA group (7)	14	CDC, USAID, DOD	15,506
DEC 7	KAMPALA	CDC	UPMB	UPMB staff (2), social worker (1)	3	CDC, USAID	21,826
DEC 8	WAKISO	CDC	Mild May	Mild May staff (4), OVC beneficiaries (2), CBO Staff (2)	8	CDC, USAID, DOD	15,506
DEC 8	KAMPALA	USAID	PHSP	PHSP staff (6), meeting point CBO-OVC beneficiaries (4), VSLA group members (12)	22	CDC, USAID	21,826
DEC 8	KAMPALA	State	M-Lisada	M-Lisada staff (4)	4	CDC, USAID	21,826
Total	10 Districts	5 Agencies	11 IPs 17 Partners		164 people		

ANNEX 4. LIST OF PEOPLE CONSULTED

NAME	ORGANIZATION
Mwaima Gerald	ACT
Mwesezi Henry	ACT
Peter Galibowa	AVSI
Jordan Canocakacon	AVSI
Rita Larok	AVSI
Peter Galibwa	AVSI
Magdalene Ndagino	AVSI
Rita Larolc	AVSI
Leticia Namale	BAYLOR
Adeodata Kekitinwa	BAYLOR
Sandra Opio	BAYLOR
Enyaga Boroa	BOCY
Massimo Cowicui-Zucca	BOCY
Jackson Bitarabelo	CAF
Deborah Kyamagwa	CAFU
George Aluzimbi	CDC
Joseph Kapanda	CDC
Michelle Adler	CDC
Julius Kalamya	CDC
Teri Wingate	CDC
Steve Wiersma	CDC
Donna Kabatesi	CDC
Mark Tumweni	CDC
Ayo Florence	CRS
Gordon Tieriffe	CRS
Lucy Steinitz	CRS
Dalton Helana	CRS

NAME	ORGANIZATION
Condor Tuesigfe	CRS
Richard Elden	CRS
Helen Dalton	CRS
Fred Magala	DoD
Hardson Tibihenda	DoD
Christopher Mutaswaza	DOD
Katie Dustman	DOS
Kisolo Mwesigwa Kenneth	Kalangala Public Health Service Project (KCPHSP)
Nkumbi Willy	Kalangala District Local Government
Mwanji Daniel	KCPHSP-
David Bateganya	M-LISADA
Barbara Amuron	MGGP
Josephine Sanyu	MIAP
Grace Kabunga	MILD MAY
Yvonne Karamagi	MILDMAY
Stanley Mulambe	MRC
Agnes Sali	MRC
Anthony Khende	Muhono Municipality
Jennifer Namusobya	MUSOM/MJAP
Jane Kyosiimize	MUWRP
Immaculate Msangi	MUWRP
Chris Mutatwaza	MUWRP
Anne Nakirija	MUWRP
Moses Dombo	PATH
Dennis Okema	Peace Corps
Dennis Nuwagaba	PHS
Joy Batusa	PHSP
Jarvice Sekajja	PIN
Nathan Turyayesiima	PIN

NAME	ORGANIZATION
Brian Rwabwogo	PIN
James Lubowa	REACH OUT Mbuya
Betty Nsangi Kintu	REACH OUT Mbuya
Sylvia Nambozo Etyang	Reach Out Mbuya
Suley Parella	Reach Out Mbuya
Agnes Nakanwagi	Reach Out Mbuya
Agnes Nakanwagi	Reach Out Mbuya
Edith Namuddu	RTI/UPDF Project
Rita Larok	SCORE
Patrick Wahgambe	SCORE
Madina Nakibirige	SDS
Sophie Boehim	Set Her Free
Mikiko Fischel	Small Grants/ State
Oluluwa Fred	Small Grants/ State
Amuron Barbara	MEEP
Annie	State/UNHCR
Samuel Magolo	UG Police
Mwima Gerald	Uganda Episcopal Conference
Emmanuel Nsubuga	Uganda Episcopal Conference
Julius Kasozi	UNHCR
Judith Tindyebwa	UPMB
Luke Lakidi	UPMB
Elten Karamapi	URC
Mikiko Fischel	US Embassy Uganda
Lellie Reed	USAID
Cephas Goldman	USAID
Mariella Ruiz Rodriques	USAID
Joyce Wanican	USAID
Elizabeth Chester	USAID

NAME	ORGANIZATION
Jacqueline Calnan	USAID
Jimmy Oruut	USAID
Joseph Mawangi	USAID
Catherine Muwanga	USAID
Esther Nassali	ASSIST-URC
Juliana Nabwire Ssali	ASSIST-URC
Mark Meassick	USAID Uganda
Ivan Busulwa	PHSP
Dennis Nuwagaba	UPHS
Annet Namurane	UPHS
Anne Nakirijja	WALTER REED
Massimo Lowicki- Zuka	WORLD ED
Fulukas Boroa Enyaga	World Education

List of People Interviewed In Districts

DISTRICT	IP	PEOPLE INTERVIEWED
MUKONO (KOOME ISLAND)	MAKERERE UNI VERSITY WALTER REED PROJECT	Chris Mutatwala- OVC Coordinator Walter Reed Josephine Nassali- EMTCT Coordinator Walter Reed Fred Bagomose- In charge Koome HC III
KAMPALA	REACH OUT MBUYA	Dr. Betty Nsangi- Executive Director Agnes Nakanwagi- Community Support Programs Coordinator Sunday Pamela- MandE Coordinator
GOMBA	MILDMAY	Joweria Namugerwa- Senior probation and social welfare officer
		Morgan Aden Kawalya- District Community Development Offier Saad Luyinda- Social Worker Mildmay MILDMAY STAFF 2
MBARARA	CEM/PNFP	Bonny Nkabakyenga- HIV AIDS Focal person Diana Kmigisha- Finance Assistant OVC Project Gilbert Byamukama- Social Workeer Francis Katangi- Probabtion and Welfare Officer Twaha Bangyirana- C/M Kotooma United Farmers' Association Winnie Komuhangyi- CDO
MBARARA	UPMB	Dr. Mugisha- Ruhaaro hospital director Barbara- OVC Focal Person Allan- Project Coordinator
ISINGIRO	WINDLE TRUST	Henry Kizza- UNHCR Station commandant Anna Alimo- ACSA Eunice Akello- Program Mnager Windel Trust Alice Alaso- Health and Nutrition Focal Person UNHCR Emmanuel Omony- Medical Teams International Bio-stastitician
MITOOMA	AVSI SCORE/TPO/I-DO	Carol Kemigisha- Project Coordinator Gloria Atwiine- Program Officer David Mugize- Project Officer
		Dan Namanya Takwetsire- Director I DO
		Moses Tindyeebwa- I DO SW

DISTRICT	IP	PEOPLE INTERVIEWED
KAMWENGE	CRS/ACODEV	Florence Ayo- CRS Michael Ayeko- Program Coordiantor Kamwenge SOCY Lawrence Tumwesigye- CDO Child Protection Specialist Benon Gumisiriza- Parasocial worker
KASESE	BAYLOR/SNAP	Sandra Opio- Manager Psychosocial Services BAYLOR Richard Baruku- Baylor OVC Officer Evelyn Masika- CDO Edson. B. Syaipuma- Assistant CDO
KABAROLE	TOCI	Michael- TOCI Director

ANNEX 5. SCOPE OF WORK

UGANDA INTERAGENCY OVC PORTFOLIO REVIEW AND ECONOMIC ANALYSIS (IOPREA)

7 October 2015

PEPFAR EVALUATIONS (PEPFAR Evaluation Standards of Practice 2014)

Note: If PEPFAR funded, check the box for type of evaluation

■ **Process Evaluation** (Check timing of data collection)

☐ Midterm ☐ Endline ■ Other (specify): Uganda Interagency OVC portfolio review and economic analysis

Process Evaluation focuses on program or intervention implementation, including, but not limited to access to services, whether services reach the intended population, how services are delivered, client satisfaction and perceptions about needs and services, management practices. In addition, a process evaluation might provide an understanding of cultural, socio-political, legal, and economic context that affect implementation of the program or intervention. For example: Are activities delivered as intended, and are the right participants being reached? (PEPFAR Evaluation Standards of Practice 2014)

☐ **Outcome Evaluation**

Outcome Evaluation determines if and by how much, intervention activities or services achieved their intended outcomes. It focuses on outputs and outcomes (including unintended effects) to judge program effectiveness, but may also assess program process to understand how outcomes are produced. It is possible to use statistical techniques in some instances when control or comparison groups are not available (e.g., for the evaluation of a national program). Example of question asked: To what extent are desired changes occurring due to the program, and who is benefiting? (PEPFAR Evaluation Standards of Practice 2014)

☐ **Impact Evaluation** (Check timing(s) of data collection)

☐ Baseline ☐ Midterm ☐ Endline ☐ Other (specify):

Impact evaluations measure the change in an outcome that is attributable to a defined intervention by comparing actual impact to what would have happened in the absence of the intervention (the counterfactual scenario). IEs are based on models of cause and effect and require a rigorously defined counterfactual to control for factors other than the intervention that might account for the observed change. There are a range of accepted approaches to applying a counterfactual analysis, though IEs in which comparisons are made between beneficiaries that are randomly assigned to either an intervention or a control group provide the strongest evidence of a relationship between the intervention under study and the outcome measured to demonstrate impact.

■ Economic Evaluation (PEPFAR)

Economic Evaluations identifies, measures, values and compares the costs and outcomes of alternative interventions. Economic evaluation is a systematic and transparent framework for assessing efficiency focusing on the economic costs and outcomes of alternative programs or interventions. This framework is based on a comparative analysis of both the costs (resources consumed) and outcomes (health, clinical, economic) of programs or interventions. Main types of economic evaluation are cost-minimization analysis (CMA), cost-effectiveness analysis (CEA), cost-benefit analysis (CBA) and cost-utility analysis (CUA). Example of question asked: What is the cost-effectiveness of this intervention in improving patient outcomes as compared to other treatment models?

A. **Purpose**: Why is this evaluation or analysis being conducted (purpose of analytic activity)? Provide the specific reason for this activity, linking it to future decisions to be made by USG leadership, partner governments, and/or other key stakeholders.

   This review will provide an evidence base for maximizing the impact of the PEPFAR Uganda OVC portfolio by comprehensively describing: the implementation models within the portfolio; the capacity of each model to achieve outcomes; how coordination contributes to achieving outcomes; and aspects of models that are cost effective. This broadly stated purpose is specified in the following 3 objectives:

   1. Describe each of the *implementation models*[39] within the PEPFAR OVC portfolio - indicating the strengths and weaknesses of each model with respect to achieving intended outcomes - by considering the model design, inputs, activities implemented, the quality of implementation, and the contribution of PM and backstopping at implementing partner and agency level;
   2. Determine the cost effectiveness of the various implementation models, considering both site level and above site level costs;
   3. Make recommendations, based on evidence of best practice and lessons learned, to strengthen the efficiency and effectiveness of the PEPFAR OVC activities.

B. **Audience**: Who is the intended audience for this analysis? Who will use the results? If listing multiple audiences, indicate which are most important.

The Uganda OVC Interagency Technical Working Group, relevant agencies' offices, HQ interagency OVC Technical Working Group.

C. **Applications and use**: How will the findings be used? What future decisions will be made based on these findings?

Improve efficiency and effectiveness of program implementation across the OVC portfolio in Uganda to achieve greater impact.

D. **Evaluation/Analytic Questions and Matrix**:

   a) Questions should be: a) aligned with the evaluation/analytic purpose and the expected use of findings; b) clearly defined to produce needed evidence and results; and c) answerable given the time and budget constraints. Include any disaggregation (e.g., sex, geographic locale, age, etc.); they must be incorporated into the evaluation/analytic questions.

[39] For the purposes of this review an implementation model is understood to encompass the range of approaches to implementing OVC related activities, as adopted by implementing partners.

b) List the recommended methods that will be used to collect data to be used to answer each question.

c) State the application or use of the data elements towards answering the evaluation questions; for example, i) ratings of quality of services, ii) magnitude of a problem, iii) number of events/occurrences, iv) gender differentiation, v) etc.

	Evaluation/Analytic Question	Research Methods	Application or Data Use
1	What are the different implementation models within the PEPFAR Uganda OVC portfolio, in terms of the model design; inputs; activities and implementation processes; quality of implementation; and the contribution of PM at implementing partner and agency level?	Document and data review Survey Key informant interviews Group interviews	Data from the review of documents from the USG Agencies and their implementing partners, typically all documents containing project description, together with data from a survey distributed to implementing partners, will be used to draft the initial descriptions of the various implementation models. Key informant and group interviews with agency and implementing partner staff will provide data to refine and validate the implementation models.
2	What are the strengths and weaknesses of each of the implementation models, with respect to achieving intended outcomes, according to PEPFAR's guidance and authorizing legislation?	Document and data review Secondary analysis of existing data Key informant interviews Group interviews	The implementation model descriptions will be considered in the light of: What works in achieving outcomes for OVC, based on existing evidence; The secondary analysis of existing APR data, supplemented by additional monitoring data from IPs; Key informant and group interviews with agency, IP, and sub-partner staff at national, regional, district and site/facility level; Focus group discussions with community level workers within PEPFAR OVC programs Key informant and group interviews with Ugandan government officials, working with PEPFAR OVC programs at national, district and site/facility level.

	Evaluation/Analytic Question	Research Methods	Application or Data Use
3	How cost effective[40] are the various OVC implementation models?	Secondary analysis of existing data Key informant interviews	Relevant data will be obtained from the PEPFAR EA, and supplemented with data obtained directly from IPs. The data will be used to: Determine the costs associated with each implementation model, distinguishing between site level and above site level costs Provide unit costs per beneficiary category for each of the models.
4	What is the current status of coordination and collaboration across the OVC portfolio in Uganda, including strengths, opportunities and gaps?	Document and data review Secondary analysis of existing data Key informant interviews	Analysis of project descriptions will identify intended coordination and collaboration mechanisms. The implementation and efficacy of these mechanisms will be assessed by relevant secondary data where available, such as records of completed referrals. Key informant interviews will validate the findings and offer data on issues such as persistent challenges undermining coordination, collaboration and ultimately the effectiveness of the OVC PEPFAR portfolio, as well as opportunities to strengthen coordination and collaboration and address gaps.
5	Based on the evidence of best practices and lessons learned, what is required to improve the effectiveness and efficiency of the OVC PEPFAR activities?	Recommendations proposing improvements in portfolio effectiveness and efficiency will be based on the sum of data, analysis, findings provided and lessons learned, in response to the preceding review questions.	

E. **Methods**: Check and describe the recommended methods for this analytic activity. Selection of methods should be aligned with the evaluation/analytic questions and fit within the time and resources allotted for this analytic activity. Also, include the sample or sampling frame in the description of each method selected.

[40] Cost effectiveness is understood to refer to the optimal cost associated with achieving the intended outcomes.

General Comments related to Methods:

The review adopts a mixed method design that integrates secondary monitoring and cost data with primary data generated to both supplement and validate the secondary evidence. The design represents the most feasible approach to responding to the review purpose and objectives within the prevailing constraints - including budget, time and data limits – and in accordance with the PEPFAR evaluations standards of practice (2014).

The review focuses on implementation models as the unit of analysis, and the relative effectiveness of each in achieving intended outcomes, as stated in program objectives and linked to the relevant PEPFAR guidance. The description of models includes model design, activities and processes; the quality of implementation; and the contribution of PM and backstopping to achieving outcomes. The choice of implementation models as the unit of analysis, and the clear description of each, will strengthen the precision and utility of the review.

The relative effectiveness of implementation models is complemented by an economic analysis that presents an assessment of the costs associated with each. In addition the contribution of coordination and collaboration across implementation models to the achievement of outcomes is reviewed. The balance of effectiveness, efficiency (as demonstrated in the cost analysis) and coordination, will provide useful information for decision-making and strengthening the Uganda PEPFAR OVC portfolio as a whole.

■ **Document and Data Review** *(list of documents and data recommended for review)*

This desk review will be used to provide background information on the project/program, and will also provide data for analysis for this evaluation. Documents and data to be reviewed include:

- Uganda COP
- OVC project proposals
- OVC project annual reports
- OVC APR data and reports
- OVC project PMPs and indicator data reports
- Uganda AIS (2011)
- Uganda DHS (2011)
- MGLSD National Strategic Programme Plan Of Interventions For Orphans And Other Vulnerable Children 2011/12—2015/16
- MGLDS OVC MIS documents (http://ovcmis.mglsd.go.ug/)
- PEPFAR OVC Technical Guidance
- Hyde Lantos PEPFAR Authorization Earmark Language

OVC collaborating USG Agency documents:

- Project Evaluation reports
- USG OVC Strategy
- USAID, CDC, DOD, Peace Corps and State Dept. OVC Strategies
- Child Summit presentation
- EA report
- Guidance for OVC Programming July 2012 by PEPFAR
- FY 2015 Technical Considerations provided by PEPFAR TWGs for 2015 COPS and ROPS
- OVC Monitoring, Evaluation and Reporting Strategy

IP documents:

- Evaluations – internal and external
- Project reviews or assessments
- Additional costing and expenditure data

☐ **Secondary analysis of existing data** *(This is a re-analysis of existing data, beyond a review of data reports. List the data source and recommended analyses)*

Data Source (existing dataset)	Description of data	Recommended analysis
APR data	Monitoring data submitted by IPs to agencies, as per reporting requirements, tracking services delivered to recipients at output level.	Descriptive statistical analysis
IP monitoring data	Monitoring data in addition to APR data collected by IPs to track delivery of services.	Descriptive statistical analysis
PEPFAR expenditure analysis	Data collected from IPs and analyzed for the PEPFAR EA.	Analysis of data to determine unit cost per multiple unit costs categories; across service areas, and per implementation processes; and including both site level and above site level costs.
IP cost data	Cost and expenditure data collected by IPs for routine management purposes in addition to that submitted for the PEPFAR EA.	Analysis of data to determine unit cost per multiple unit costs categories; across service areas, and per implementation processes; and including both site level and above site level costs.

■ **Key Informant Interviews** *(list categories of key informants, and purpose of inquiry)*

Interviews will be conducted to obtain information about each agencies' OVC implementation model, strengths and weaknesses of existing project implementation and management,

understanding of Ugandan context for alignment and sustainability etc. Key informants include:

Direct program overseers and implementers:

- Interagency TWG: (USAID, CDC, DOD, PC, and State, PRM)

Purpose: to qualify and quantify programmatic and fiscal strengths and weaknesses of current programming

- IP representatives at headquarters and regional level
- PEPFAR supported Ugandan NGOs who provide OVC support and services under the OVC portfolio as primes or as sub-partners

Purpose: To investigate strengths, weaknesses, successes and challenges of current programs and offer suggested changes or modifications

Government officials responsible for or linking with OVC services at national, district and sub-county level.

- DOVCCs and SOVCCs
- Probation Officers and Community Development Officers
- OVC National Implementation Unit and senior technical staff at MGLSD eg Commissioner for children
- Regional or district health services

Purpose: To assess effectiveness of service linkages (and cost effectiveness) to child welfare services, define sustainability for the GOU, and identify gaps and evaluate sustainability and ownership following PEPFAR support to programs

Note: Key informants can be grouped together into a Group Interview, for efficiency.

■ **Focus Group Discussions** *(list categories of groups, and purpose of inquiry)*

Ugandan NGOs and staff who provide OVC support and services

- NGOs/CBOs management staff
- Field Level Staff

Adult beneficiaries (para-social workers, VHT members, VSLA trainers/monitors… etc.)

Purpose: To investigate strengths, weaknesses, successes and challenges of current programs and offer suggested changes or modifications

■ **Cost Analysis** *(list costing factors of interest, and type of costing assessment, if known)*

The costs analysis will focus on three sets of analyses per implementation model:

1. The analysis will produce a unit cost for services delivered, where the unit cost represents a cost per beneficiary. In order for unit costs to be meaningful the methodology will define multiple beneficiaries, most likely based on age groups, and calculate unit costs in multiple service areas as defined by the various implementation models.

2. The analysis will determine costs associated with implementation processes where possible. A generic range of implementation processes will be defined subsequent to completing the implementation model descriptions, and include categories such as identification, enrollment, case management etc. The full range of processes may not apply to all program models, an eventuality that will be provided for in the analysis as required.

3. The analysis will distinguish between site level and above site level costs, and will describe the above site level cost drivers in as much detail as is feasible, given data and time constraints.

Purpose: To estimate the cost effectiveness of the various OVC program/project implementation models across the USG Agencies in Uganda

■ **Survey** (describe content of the survey and target responders, and purpose of inquiry)

Phase 2: A survey will be designed to collect data on implementation models from IPs. The survey will request a mix of qualitative and quantitative data that can be used to prepare thorough descriptions of implementation models in terms of the model design; activities and implementation processes; quality of implementation; PM and backstopping; and coordination. The survey will be prepared in electronic format and mailed to IPs for completion. Corroborating documentation might be requested for certain items. The completed survey and supporting documents will be submitted by IPs to the review team in electronic format.

Purpose: To quantify real, or gauge perceived, value of services across the various implementation models

Human Subject Protection

The Analytic Team must develop protocols to insure privacy and confidentiality prior to any data collection. Primary data collection must include a consent process that contains the purpose of the analytic work evaluation, the risk and benefits to the respondents and community, the right to refuse to answer any question, and the right to refuse participation in the evaluation at any time without consequences. Only adults can consent as part of this analytic activity evaluation. Minors cannot be respondents to any interview or survey, and cannot participate in a focus group discussion without going through an IRB. The only time minors can be observed as part of this analytic activity evaluation is as part of a large community-wide public event, when they are part of family and community attendance. During the process of this analytic activity evaluation, if data are abstracted from existing documents that include unique identifiers, data can only be abstracted without this identifying information.

Analytic Plan

All analyses will be geared towards answering the review questions. Each review question will be answered by analyzing and corroborating data from multiple data sets, and each answer will benefit from an integration of both quantitative and qualitative data.

Effectiveness of Implementation Models

Review question 1 will be answered by integrating primarily qualitative data from documents containing project descriptions and data from a survey completed by IPs. The implementation models drafted from these two data sets will be verified by a further qualitative data set collected through key informant and group interviews. The 4 qualitative data sets will be subjected to content analysis to produce the required evidence and outputs.

Review question 2 will be answered by conducting a descriptive statistical analysis of program performance data from routine monitoring systems, either submitted by IPs to PEPFAR agencies in fulfillment of reporting requirements, or collected for routine management purposes. This descriptive statistical analysis will be corroborated by integrating an analysis of qualitative data obtained through key informant and group interviews, subjected to both content and thematic analyses. Where available an additional set of evidence – the findings of previous performance and outcome evaluations – will be integrated to further substantiate findings on implementation model effectiveness. It is anticipated that the latter data set will be mixed, and subjected to analytical methods as appropriate.

Review question 4 will be answered by a descriptive statistical analysis of monitoring data relevant to the issue of coordination and collaboration, where such data is available. The quantitative analysis will be supplemented by the content and thematic analysis of qualitative data obtained through key informant and group interviews.

Efficiency of Implementation Models

Review question 3 interrogates efficiency in terms of the costs associated with the various implementation models. The analytical approach is described in the preceding methods section, under cost analysis.

The Review Report will describe analytical methods employed in more detail.

Activities

Background reading—Several documents are available for review for this analytic activity. These include the Uganda COP, USG Agency plans the include OVC strategies and activities, as well as OVC project proposal, annual work plans, MandE plans, and routine reports of project performance indicator data, as well as survey data reports (i.e., DHS and MICS). This desk review will provide background information for the Evaluation Team, and will also be used as data input and evidence for the evaluation.

Team Planning Meeting (TPM) –

The TPM will:

- Review and clarify any questions on the Phase 2 evaluation SOW
- Clarify team members' roles and responsibilities for Phase 2
- Review and finalize Phase 2 evaluation questions with the evaluation matrix
- Review and finalize the Phase 2 timeline
- Develop Phase 2 data collection methods, instruments, tools and guidelines
- Review and clarify any logistical and administrative procedures for the assignment
- Develop a Phase 2 data collection plan
- Present a Phase 2 workplan for USG's approval
- Develop a preliminary draft outline of the Evaluation report

- Assign drafting/writing responsibilities for the final report

Briefing and Debriefing Meetings—Throughout the evaluation the Team Lead will provide briefings to USG. The In-Brief and Debrief are likely to include the all Evaluation Team experts, but will be determined in consultation with the Mission. These briefings are:

- Evaluation **launch**, a call/meeting among the USG, GH Pro and the Team Lead to initiate the evaluation activity and review expectations. USG will review the purpose, expectations, and agenda of the assignment. GH Pro will introduce the Team Lead, and review the initial schedule and review other management issues.
- I**n-brief with USG**, at the end of the Phase 2 TPM when the Evaluation Team will present the full workplan and data collection methods to USG. Also, the format and content of the Evaluation report will be discussed at this briefing.
- **In-brief with PSC, USG Agency representatives, including interagency OVC Technical working group**
- **In-brief with USG OVC implementing partners (IPs)** to review the evaluation timeline, and for the IPs to give an overview of their projects to the Evaluation Team and validate the implementation descriptions.
- The Team Lead (TL) will brief the USG Agency representative **weekly** to discuss progress on the evaluation. As preliminary findings arise, the TL will share these during the routine briefing, and in an email.
- A **debrief** will be held to present preliminary evaluation findings to USG and the Interagency OVC Technical working Group. During this meeting a summary of the data will be presented, along with high level findings and draft recommendations. For the debrief, the Evaluation Team will prepare a **PowerPoint Presentation** of the key findings, issues, and recommendations. The Evaluation Team shall incorporate comments received from USG during the debrief in the evaluation report. (***Note****: preliminary findings are not final and as more data sources are developed and analyzed these finding may change.*)
- **Presentation of draft report** with USG Agency Representatives and OGAC Interagency OVC technical working group at the Mission
- **Wider stakeholders' debrief** may be held with the OVC IP staff and other stakeholders identified by USG/ OVC TWG. This will occur following the final debrief with the Mission, and once the report has been approved, and if deemed appropriate. It will not include any information that may be deemed sensitive by USG.

Fieldwork, Site Visits and Data Collection—The evaluation team will conduct site visits for data collection.

- Selection of sites is to be determined based on a purposeful sample that providesrepresentation of the implementation models and includes all the USG Agencies, but not necessarily all the implementing partners. The final choice of sites will be agreed in consultation with the OVC TWG and before the arrival in-country of the consultancy team. The evaluation team will outline and schedule key meetings and site visits prior to departing to the field for data collection.
- Site visits with the OGAC OVC TWG will be conducted before the presentation of

the draft report. These will serve as familiarization visits and as background to the draft report.

Data Analysis and Key Findings—The Evaluation Team will work together in-country to compile, summarize and analyze the data according to the methods described. This will provide the basis for the key findings and draft recommendations to be presented in the debrief.

Evaluation/Analytic Report—The Evaluation Team, under the leadership of the Team Lead, will develop a report with findings and recommendations (see Analytic Report below). Report writing and submission will include the following steps:

1. Team Lead will submit draft evaluation report to GH Pro for review and formatting
2. GH Pro will submit the draft report to USG
3. The Evaluation Team will present the draft report to the OGAG OVC TWG
4. USG OVC technical working group will review the draft report in a timely manner, and send their comments and edits back to GH Pro
5. GH Pro will share USG's comments and edits with the Team Lead, who will then do final edits, as needed, and resubmit to GH Pro
6. GH Pro will review and reformat the final Evaluation/Analytic Report, as needed, and resubmit to USAID for approval.
7. Once Evaluation Report is approved, GH Pro will re-format it for 508 compliance and post it to the DEC.

The Evaluation Report **excludes** any **procurement-sensitive** and other sensitive but unclassified (**SBU**) information. This information will be submitted in a memo to USG separate from the Evaluation Report.

Deliverables and Products (Timelines and Deadlines to Be Adjusted)

Deliverable / Product	Timelines and Deadlines (estimated)
■ Launch briefing	September 14, 2015
■ In-brief with USG	September 22-23, 2015
■ Phase 1 Workplan with timeline	September 25 2015
■ Phase 1 Analytic protocol with data collection tools	September 25, 2015
■ In-brief with USG/Uganda and USG OVC TWG	September 25, 2015
■ Routine briefings (Phase 1 and 2)	weekly
■ Phase 1 debrief with USG/Uganda	October 7, 2015
■ Phase 1 debrief with USG OVC TWG and Mission with Power Point presentation	October 7, 2015
■ Phase 2 SOW	October 8, 2015
■ Phase 2 In-brief with USG OVC TWG	November 2, 2015
■ Phase 2 Workplan with timeline	November 6, 2015

Deliverable / Product	Timelines and Deadlines (estimated)
■ Phase 2 Analytic protocol with data collection tools	November 6, 2015
■ Routine briefings	Weekly
■ Debrief with Uganda OVC TWG with Power Point presentation	November 25, 2015
■ Site visits ad briefing meeting with OGAC OVC TWG on draft report.	Week of December 7-11
■ Draft report	December 10, 2015
■ Final report	TBD probably January 28
■ Raw data	TBD probably January 28
☐ Dissemination activity	
■ Report Posted to the DEC	February 15, 2016
☐ Other (specify):	

Estimated USG Review Time

Average number of business days USG will need to review Evaluation Report requiring USG review and/or approval?

10 Business days

Team (LOE)

Activity / Deliverable		Evaluation Team				
		Team Lead /OVC Specialist	Evaluation Specialist	Costing Specialist	Logistics / Admin Coordinator	Local Evaluator
Number of persons		1	1	1	1	2
1	Document review	3	3	3		4
2	Develop survey tool, review responses, develop intervention description	4	4			
3	Data collection: costing and outcome data from IPs			7		4
4	Travel to Uganda	1	1			
5	Phase 2 Team Planning Meeting	2	2	2	2	2
6	Phase 2 briefing with Mission	1	1	1	1	1
7	Phase 2 Data Collection DQA Assurance Workshop *(protocol orientation for all involved in data collection)*	2	2	2	2 venue/copies etc	2

Activity / Deliverable		Evaluation Team				
		Team Lead /OVC Specialist	Evaluation Specialist	Costing Specialist	Logistics / Admin Coordinator	Local Evaluator
Number of persons		1	1	1	1	2
8	Prep / Logistics for Site Visits	1	1	1	10	1
9	Data collection / Site Visits (including travel to sites)	12	12	12	12	12
10	Data synthesis and analysis	5	5	6		4
11	Debrief with Mission with prep	1	1	1	1	1
12	Depart Country and Return	2	2			
13	OGAC OVC TWG representatives briefing meeting with prep	3	3	3	1	1
14	Depart country	1	1			
15	Draft report(s)	6	6	6		2
16	GH Pro Report QC Review and Formatting					
17	Submission of draft report(s) to Mission					
18	USG Report Review					
19	Revise report(s) per USG comments	3	2	2		
20	GH Pro Finalize and submit report to USAID					
21	508 Compliance Review					
22	Upload Eval Report(s) to the DEC					
	Sub-Total LOE	47	47	46	29	34
	Total LOE	47	47	46	29	68

If overseas, is a 6-day workweek permitted■ Yes☐ No

Travel anticipated: List international and local travel anticipated by what team membere

	DeeDee Yates (OVC)	Terence Beney (MandE)	Charlotte Muheki (Costing)	Stephen Jasiel (logistics)	Stephen Lagony (Research assistant)	Belinda Nabukalu (Research assistant)
Windhoek-Kampala-Windhoek	3 trips					
Jo'burg-Kampala-Joburg		3 trips				
Kampala to central regions and return	1 trip of 5 days	1 trip of 5 days	1 trip of 5 days	1 trip of 5 days	1 trip of 5 days	-
Kampala to Southern and eastern regions and return	1 trip of 7 days	1 trip of 7 days	1 trip of 7 days	1 trip of 7 days	1 trip of 7 days	1 trip of 7 days

Logistics

Note: Most Evaluation/Analytic Teams arrange their own work space, often in their hotels. However, if Facility Access is preferred GH Pro can request it. GH Pro does not provide Security Clearances. Our consultants can obtain **Facility Access** only.

Check all that the consultant will need to perform this assignment, including USAID Facility Access, GH Pro workspace and travel (other than to and from post).

☐ USAID Facility Access

Specify who will require Facility Access:

■ Electronic County Clearance (ECC) (International travelers only)

☐ GH Pro workspace

Specify who will require workspace at GH Pro:

☐ Travel -other than posting (specify):

☐ Other (specify):

GH PRO Roles and Responsibilities

GH Pro will coordinate and manage the evaluation/analytic team and provide quality assurance oversight, including:

- Review SOW and recommend revisions as needed
- Provide technical assistance on methodology, as needed

- Develop budget for analytic activity
- Recruit and hire the evaluation/analytic team, with USAID POC approval
- Arrange international travel and lodging for international consultants
- Request for country clearance and/or facility access (if needed)
- Review methods, workplan, analytic instruments, reports and other deliverables as part of the quality assurance oversight
- Report production - If the report is public, then coordination of draft and finalization steps, editing/formatting, 508ing required in addition to and submission to the DEC and posting on GH Pro website. If the report is internal, then copy editing/formatting for internal distribution.

USG Roles and Responsibilities

Below is the standard list of USG's roles and responsibilities. Add other roles and responsibilities as appropriate.

USG Roles and Responsibilities

USG will provide overall technical leadership and direction for the analytic team throughout the assignment and will provide assistance with the following tasks:

Before Field Work

- SOW.
    - Develop SOW.
    - Peer Review 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., Mission 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 analytic 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.

ANNEX 6. SUMMARY OF OVC PORTFOLIO

Table 21A: Overview of OVC PEPFAR Uganda Portfolio: Implementing Mechanisms

AGENCY	PRIME PARTNER	MECHANISM	COP 15 AWARD (USD)	OVC's SERVED	DISTRICTS OF OPERATION
CDC	Children's AIDS Fund	New Hope Project –	519,235	7,351	2
CDC	Registered Trustees for the Uganda Episcopal Conference	Comprehensive CARE, Treatment and Prevention Services	157,506	2,230	17
CDC	Kalangala District Health Office	Provision of Comprehensive Public Health	1,706	31	1
CDC	Baylor College of Medicine Children's Foundation	Scaling up Comprehensive HIV/AIDS Services in Eastern and West Nile	751,955	8,561	16
CDC	Baylor College of Medicine Children's Foundation	Strengthening National Pediatric HIV/AIDS and Scaling up	1,046,324	18,036	7
CDC	Reach Out Mbuya	Provision of comprehensive, community-based HIV/AIDS services a	138,086	8,350	2
CDC	Uganda Protestant Medical Board	Provision of Comprehensive HIV/AIDS Care, Treatment and Prevention	92,238	4,034	6
USAID	Associazione Volontari Per Il Servizio Internazionale,	Scaling Up Community Based OVC Response (SCORE)	4,000,405	110,204	34
USAID	Program for Appropriate Technology in Health	Health Advocacy Program	400,000		3
USAID	FHI 360	Communication for Healthy Communities	100,000		

AGENCY	PRIME PARTNER	MECHANISM	COP 15 AWARD (USD)	OVC's SERVED	DISTRICTS OF OPERATION
USAID	RECO Industries	Production for Improved Nutrition (PIN) Project	68,808	1,727	12
USAID	Cardno Emerging Markets	Uganda Private Health Support Program	1,659,164	46,961	34
USAID	Catholic Relief Services	Sustainable Outcomes for Children and Youth	5,468,164		17
USAID	World Education	Better Outcomes for Children and Youth Eastern and Northern Regions	4,473,953		13
DOD	Research Triangle International	RTI (International)	284,633		
DOD	U.S. Department of Defense (Defense)	DOD Mechanism	31,985	3,053	11
DOD	Henry Jackson Foundation	Makerere University Walter Reed Project (MUWRP)	542,158	19,412	Buvuma, Kayunga, Mukono
STATE	U.S. Department of State	State Department	128,573	866	7
STATE	United Nations High Commissioner for Refugees	Supporting the Continuity of HIV/AIDS prevention and care programs for refugees in Uganda	46,972	526	2
PC	U.S. Peace Corps	US Peace Corps	90,000	662	5
5	19	18	17,294,815	183,411	

For more information, please visit
http://www.ghpro.dexisonline.com

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