Photo by Jake Lyell/CRS

USAID/Uganda OVC Portfolio Review

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Table of Contents

List of Tables

List of Figures

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The Coordinating Comprehensive Care for Children (4Children) project is a five-year, USAID-funded project designed to improve health and wellbeing outcomes for Orphans and Vulnerable Children (OVC) affected by HIV and AIDS and other adversities. 4Children is a consortium of organizations that brings together decades of experience, expertise and commitment to strengthening the capacity of key actors within a child's system of care and support in order to improve the lives of children. 4Children is led by Catholic Relief Services (CRS) with partners IntraHealth, Maestral International, Pact, Plan and Westat. African Child Policy Forum (ACPF), Parenting Africa Network (PAN) and the Regional Psychosocial Support Initiative (REPSSI) also serve as collaborating partners.

The views contained in this report do not necessarily reflect the opinion of USAID or 4Children and any of the 4Children partners.

List of Acronyms

A/CDOs	Assistant Community Development Officer
AIDS	Acquired Immune Deficiency Syndrome
AOET	Aids orphan Education Trust
ART	Antiretroviral treatment
SCORE	Sustainable Comprehensive Responses (SCORE) for Vulnerable Children and their families
BRC	Birth Registration Certificate
CAOs	Chief Administrative Officers
CBSD	Community Based Services Departments
CDD	Community Driven Development
CDOs	Community Development Officers
CEM	Cardno Emerging Markets
CFPU	Children and Family Protection Unit
CHAU	Community Health Alliance Uganda
COP	Chief of Party
CPA	Core Program Area
CPC	Child Protection Committees
CSI	Child Status Index
CSOs	Civil Society Organizations
DBTAs	District Based Technical Assistance Agent
DCDOs	District Community Development Officers
DIM	Data and Information Management
DMC	District Management Committee
DOP	District Operational Plan
DOVCC	District OVC Coordination Committees
FY	Financial Year
GSSWA	Global Social Service Workforce Alliance
GoU	Government of Uganda
HEI	HIV Exposed Infants
HES	Household economic strengthening
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
IAC	Inter Agency Committee
IGA	Income Generating Activity
IHAA	International HIV/AIDS Alliance
IP	Implementing Partner
LDP	Leadership Development Program
LG	Local Government
LLG	Lower Local Government
LQAS	Lot Quality Assurance Sampling
M & E	Monitoring and Evaluation
MEEPP	Monitoring and Evaluation of Emergency Plan Progress
MFPED	Ministry of Finance Planning and Economic Development
MGLSD	Ministry of Gender, Labor and Social Development
MIS	Management Information Systems
MoLG	Ministry of Local Government

MOU	Memorandum of Understanding
MSH	Management Sciences for Health
NOP	National OVC Policy
NSPPI	National Strategic Program Plan of Interventions
NUSAF	Northern Uganda Social Action Fund
OVC	Orphans and other Vulnerable Children
PEP	Post-exposure Prophylaxis
PEPFAR	President's Emergency Plan for AIDS Relief
PITC	Provider Initiated Testing and Counseling
PPP	Private Public Partnerships
PWO	Probation Welfare Officers
QI	Quality Improvement
QITs	Quality Improvement Teams
RHU	Reproductive Health Uganda
SAGE	Social Assistance Grants for Empowerment
SCC	Standing Committee of Council
SDS	Strengthening Decentralization for Sustainability
SI-TWCs	Strategic Information Technical Working Committees
SOPs	Standard Operating Procedures
SOVCCs	Sub-county OVC Coordination Committees
SoW	Scope of Work
SWOT	Strengths, weaknesses, opportunities and threats
SUNRISE-OVC	Strengthening Uganda's National Response for Implementation of Services for Orphans and Other Vulnerable Children
TASO	The AIDS Support Organization
TPC	Technical Planning Committee
TSO	Technical Service Organization
UCHL	Uganda child helpline
UFC	Uganda Finance Commission
UGX	Uganda Shilling
ULGA	Uganda Local Government Association
UNICEF	United Nations Children's Fund
URC	University Research Co.
USAID	United States Agency for International Development
USD	United States Dollar
UWESO	Uganda Women's Efforts to Save Orphans
VSLA	Village Savings and Loans Association

Glossary of Terms

Best interest determination: A formal process with specific procedural safeguards and documentation requirements that is conducted for certain children of concern to UNHCR, whereby a decision-maker is required to weigh and balance all the relevant factors of a particular case, giving appropriate weight to the rights and obligations recognized in the CRC and other human rights instruments, so that a comprehensive decision can be made that best protects the rights of children.[1]

Case management: Case management is a core component of a social service system designed to effectively prevent and respond to children and families' vulnerabilities. Case management can be understood as the process of assessing, referring and monitoring the delivery of services in a timely, context-sensitive and individualized manner.[2]

Cash transfer programs: This refers to programs that transfer cash to eligible people or households. Common variants include child allowances, social pensions, needs-based transfers, and conditional cash transfers.[3]

Child protection: All activities associated with preventing and responding to child abuse, violence, exploitation, neglect, and family separation.[4] Abuse, violence, exploitation, and neglect are often practiced by someone known to the child, including parents, other family members, caretakers, teachers, employers, law enforcement authorities, state and non-state actors, and other children. They can occur in homes, families, schools, care and justice systems, workplaces, and communities across all contexts, and also as a result of conflict and natural disasters.[5]

Child protection system: A comprehensive system of laws, policies, procedures and practices designed to ensure the protection of children and to facilitate an effective response to allegations of child abuse, neglect, exploitation and violence. [6]

Child safeguarding: All activities intended to protect children from harm and address incidents of abuse, exploitation, and neglect in a timely and appropriate manner, including incidents involving orphans and vulnerable children project staff, subcontractors, sub-grantees, and volunteers.[7]

Graduation: Graduation is typically understood as the process of moving a household, family or child from receiving services i.e., they are found to be in a place wherein they do not require services. Graduation is also utilized when discussing household economic strengthening and refers to a

[1] UNHCR (2008). Guidelines on the Determination of the Best Interests of the Children.
[2] Global Protection Cluster (2014). Interagency Guidelines for Case Management and Child Protection: The Role of Case management in the Protection of Children – A guide for Policy and Programme Managers and Caseworkers; Davis, R., for USAID (2014). Case Management Toolkit: A User's Guide for Strengthening Case Management Services in Child Welfare.
[3] Grosh, M., del Ninno, C., Tesliuc, E. & Ouerghe, A. *For Protection and Promotion: The Design and Implementation of Effective Safety Nets.* Washington, D.C.: The World Bank. 2008.
[4] This definition draws from the UNICEF definition in its Child Protection Strategy (2008), but adds family separation as a child protection issue.
[5] 4Children (2014). Program Guidance for 4Children.
[6] President's Emergency Plan for AIDS Relief (2012). *Op cit*.
[7] President's Emergency Fund for AIDS Relief (2012). *Op cit.*

household moving from one type of economic vulnerability to a less vulnerable level.[8]

Household economic strengthening: A portfolio of interventions to reduce the economic vulnerability of families and empower them to provide for the essential needs of the children they care for, rather than rely on external assistance. Defining features are a focus on families as direct beneficiaries, with success measured by a family's ability to invest in the education, nutrition, and health of the children they care for. HES tends to focus on shorter-term outcomes, especially around how families accumulate and spend their money.[9]

Referral: A referral is the process of noticing a concern about a child or family, deciding that action needs to be taken or a service needs to be delivered and reporting that information to someone who with the relevant responsibility. Referrals can happen within the same sector (child protection) or between sectors (e.g., health and social welfare).[10]

Referral mechanisms: Referral mechanisms are the processes or procedures that exist to ensure that referrals within and between and across sectors occur and are monitored. Effective referral systems are necessary to support effective case management by skilled service providers responding to complex individual child or family vulnerabilities.[11]

Social protection: Social protection is an umbrella term encompassing an array of government-led policy instruments for reducing vulnerability and risks faced by disadvantaged groups. Social protection promotes greater focus on longer-term outcomes as well as a greater need for systemic and government-led initiatives to sustain interventions. It emphasizes investments in human capital (e.g., education and health) to deal with long-term poverty and vulnerability issues, especially to interrupt the transmission of poverty from one generation to the next.[12]

Social service system: A social service system is understood as one that addresses both the social welfare and protection of vulnerable populations and includes elements that are preventative, responsive, and promotive. A well-functioning social service system should include strong linkages with sectors such as health, justice, and education. The system should work to alleviate poverty, facilitate access to basic services, and prevent and respond to issues of abuse, exploitation, neglect, and family separation. [13] In this document social service system and social welfare system are used interchangeably.

Social service workforce: is an inclusive term referring to a variety of workers—paid and unpaid, governmental and nongovernmental—that contribute to the care, support, promotion of rights, and empowerment of vulnerable populations served by the social service system. These workers are present at all levels of society, from community members to civil society and nongovernmental organizations to

[8] CGAP Ford Foundation Graduation Model found at: http://www.seepnetwork.org/cgap-ford-foundation-s-graduation-program-pages-20353.php; SEEP network definition of graduation found at: http://www.seepnetwork.org/glossary-pages-20358.php#graduation
[9] President's Emergency Fund for AIDS Relief (2012). *Op cit.*
[10] Roelen, Long & Edstrom. Pathways to protection – referral mechanisms and case management for vulnerable children in Eastern and Southern Africa Lessons learned and ways forward. 2012.
[11] *Ibid.*
[12] President's Emergency Fund for AIDS Relief (2012). *Op cit.*
[13] President's Emergency Fund for AIDS Relief. *Op cit.* (2012).

government positions.[14]

Social welfare system: See 'Social service system.'

[14] Bunkers, K., Bess, A., Collins, A., McCaffery, J., and Mendenhall, M. (2014). The composition of the social service workforce in HIV/AIDS-affected contexts. Washington, DC: Capacity*Plus*/IntraHealth International.

I. Executive Summary

HIV and AIDS continue to be a major contributing factor to vulnerability in Uganda. High HIV prevalence alongside economic challenges, internal migration, family breakdown and other illnesses have resulted in significant numbers of orphans and vulnerable children. These children have faced significant shocks and adversities, but have typically lacked access to a spectrum of supports and services. In addition, many have been unable to access the traditional mechanisms of extended family care that were available prior to the epidemic. In response to the wide-range of vulnerabilities faced by orphans and vulnerable children in Uganda, USAID and its implementing partners are managing a portfolio of projects designed to improve government social welfare and health care systems, support HIV/AIDS care and treatment programs, promote health messages and support household economic strengthening. The goal of the current USAID Orphans and Vulnerable Children Strategy (the "Strategy") is: *Improved health, nutrition, and psycho-social well-being and reduced abuse, exploitation and neglect among children affected by HIV and AIDS.*

The USAID Mission in Uganda requested a review of the portfolio of OVC programming in Uganda. The original Scope of Work (SoW) requested an up to date analysis of information collected through a desk review and key informant interviews of the strengths, weaknesses, opportunities and threats (SWOT) of the Strategy. Upon further discussion with representatives of the Mission, the SoW was reassessed and a specific focus on several priority issues was included: (1) targeting case management and referral mechanisms; (2) graduation; (3) links with HIV/AIDS care and treatment partners; and (4) overall coordination amongst implementing partners. Although the overall review was completed within a SWOT, the main content of the portfolio review is structured around these core components of the Strategy.

The 4Children team adopted a primarily qualitative approach for the Portfolio Review. Primary qualitative data was collected from project stakeholders including USAID, OVC implementing partners, UNICEF, care and treatment project staff, national and district level government officials and Technical Service Organizations (TSOs) working closely with district and sub-county government under the SUNRISE-OVC Project. The Portfolio Review was conducted simultaneously with the SUNRISE OVC Final Evaluation, and the team combined the information needs of both projects.

Key Findings

As agreed upon with USAID/Uganda, the team prioritized review of specific topics related to OVC programming in Uganda including systems strengthening, child protection, targeting and enrollment, graduation and coordination with care and treatment partners. A rapid analysis of the existing USAID OVC Strategy for Uganda was also included as part of the portfolio review. These findings are informed by the desk review, key informant interviews and an understanding of the current context, both nationally and globally, regarding OVC programming priorities. In general, the team found the existing strategy to be comprehensive, reflect global and national priorities related to OVC and was evidence based with minimal need to change or adapt the existing strategy or approach.

Social Service Systems and Child Protection Capacity

Strengthening the social service system requires understanding and addressing (1) the unique and mandated role of government to oversee, coordinate and manage the system to ensure that interventions are sustainable; (2) the active and planned engagement of civil society to support government, especially in the provision of social services; and (3) the need to develop or strengthen a range of interventions aimed at coordinating and strengthening the different components that make up

the system. Given that the systems strengthening approach is relatively new within the OVC sector, it was not surprising that there was significant variance in OVC implementing partners' understanding of the approach and the role of government, as well as what is meant by terms such as 'child protection.' These differences in understanding were particularly acute among non-OVC focused implementing partners that have OVC among their target populations, but not as their primary mandate.

The USAID Mission in Uganda is in a unique position to support the transition to a more standardized approach and understanding by all OVC implementing partners of both the systems strengthening approach and the importance of child protection. If USAID continues to integrate OVC funds into larger non-OVC projects, then it may be worthwhile for project management of these projects to participate in a one-day management level orientation to social services strengthening and child protection based on the Makerere University Child Protection Training outlined in this report. This workshop would help implementing partners to adopt standardized terminology and a shared understanding of key concepts, building the foundation for improved coordination across the OVC response, and strengthening linkages with the government social welfare system.

Targeting and Enrollment

Targeting and enrollment are the processes used to identify and enroll households and children that will be served by a specific project or intervention. The USAID Mission has identified the most HIV affected areas of Uganda as geographic targets for their OVC programming, but each implementing partner uses different approaches and tools to identify beneficiaries. For example, one approach was a community mapping by district social welfare officers under the SUNRISE-OVC project, where data and targeting information was shared with other USAID projects such as the Sustainable Comprehensive Responses for Vulnerable Children and their families project (SCORE) and with smaller civil society organization initiatives in the districts. In contrast, district and sub-county government officials typically used the Child Status Index (CSI) and Child Protection Registration Forms while other OVC projects used the Vulnerability Index. Several projects developed their own tools and approaches. USAID-funded partners might be required to utilize government-endorsed targeting and enrollment tools in order to improve the consistency of approach across projects and to foster recognition of the government's role within the system. Those tools might also benefit from some review and modification.

Graduation

Graduation is typically understood as the process of moving a household, family or child from receiving services (i.e., they are found to be in a place wherein they do not require services). Graduation is also utilized when discussing household economic strengthening and refers to a household moving from one type of economic vulnerability to a less vulnerable level.[15] From key informant interviews with implementing partners, it appears that not all of them have an explicit graduation strategy. Those that do use a range of criteria to graduate beneficiaries including the age of the child, the level of schooling, and (in projects with a strong household economic strengthening component) analysis of household economic vulnerability using a combination of the Vulnerability Index (VI) and CSI or a project-specific assessment tool. USAID, in partnership with the Ministry of Gender, Labour and Social Development

[15] CGAP Ford Foundation Graduation Model found at: http://www.seepnetwork.org/cgap-ford-foundation-s-graduation-program-pages-20353.php; SEEP network definition of graduation found at: www.seepnetwork.org/glossary-pages-20358.php#graduation

(MGLSD), may want to consider convening a technical working group on graduation. The working group would be tasked with providing definitions of graduation in different contexts, how to measure graduation and what level of resiliency and/or changes in vulnerability can be anticipated over specific time periods ranging from, say, one to five years.

Case Management

The Portfolio Review found that there is no unified approach to case management and that implementing partners use a range of case management and referral mechanisms. There are two main findings related to case management systems: 1) Lack of a unified approach to case management and 2) lack of a common monitoring and evaluation (M & E) system to support case management.

SUNRISE-OVC appears to have placed significant emphasis on developing case management, supporting district and sub-county government officials to use the CSI to complete home visit forms and to track consultations in a case management book. In spite of these achievements, there are inconsistencies within that project in the use of the tools and shortcomings in the existing approach. For example, there is no unique identifier for beneficiaries to assign cases by child or household, rather than by incident. There is also limited reach to deliver services at the community level and a lack of a clear follow-up process to ensure the case is resolved.

This review found across the portfolio that there is an absence of unique identifiers, standard case files and/or procedures to store case files, as well as limited movement to transition to electronic case files, which would allow for improved trend analysis and linkages across the system. The National OVC MIS system facilitates tracking children reached, but is not designed as a case management tool, although it has the potential to serve as an important component of a strengthened case management system.

Referral mechanisms

Case management and referral mechanisms are closely linked. A strong case management system must include clear and coordinated referral procedures to ensure that any given case plan (and the services to be delivered) is followed in a coordinated, timely and child sensitive manner. This review found that each project had some kind of referral system in place that linked health facilities, CSOs and/or government service providers, but that there was significant variation in the specific strategy and effectiveness of these systems. Referral mechanisms reviewed ranged from formal to informal. Some provided the client with a standard referral form, while others relied on word of mouth or direct accompaniment of the client to the next point of service (which can be particularly important for victims of child protection violations such as defilement or abuse). According to key informant interviews, actors from several projects stated that completion of the referral by the client depended on several factors including perceived value of the service by the client, geographic location and distance/transport options to reach the service, availability of the service and whether the client met the selection criteria. Given the gaps and limitations identified in the current system, there's a need to review and leverage lessons learned from the portfolio and work might be launched to develop standard operating procedures for case management and the associated referral mechanisms.

HIV/AIDS and OVC

A growing evidence base demonstrates the linkages between HIV and child protection related adversities. For example, there appears to be an association between HIV infection and early sexual debut and/or sexual violence. There is also the increased likelihood of children in households affected by HIV of contracting the disease. Children affected by HIV in turn face protective challenges such as

stigma or lack of family or suitable alternative care.[16] The Portfolio Review paid particularly attention to the linkages between HIV and OVC vulnerability, specifically, the identification of pediatric cases, disclosure and treatment adherence, sexual violence and HIV and coordination between community-based OVC services and facility-based care and treatment partners.

- *Case identification.* Care and treatment partners interviewed believed they are exhausting efforts to identify HIV+ children that have not been tested or are not receiving appropriate care and treatment. They are conducting near universal testing in pediatric wards, increasing provider initiated testing and follow up (PITC), following up on HIV Exposed Infants (HEI) at reproductive health clinics (whose mothers gave birth at home) and increasing HIV testing during antenatal visits. Most are finding low prevalence of HIV among children and question UNAIDS estimates. In contrast, OVC partners know of HIV+ children in their communities who never reach care and treatment centers, likely due to fear of being stigmatized within their communities. Overall, new cases of children has made a noted decrease in the past several years most likely due to an increase in PMTCT services and roll out of ART.[17]
- *Disclosure and adherence*. In key informant interviews OVC partners expressed concern at the manner in which HIV status of children and their parents is disclosed to children and indicated that clinical staff are often not trained on age-appropriate disclosure communication .[18] Even when children's status is known, children often fail to access or adhere to treatment due to lack of knowledge on drug use and dosage, drug-sharing within families and/or lack of oversight and attention from parents.
- *Sexual violence and HIV.* Most OVC partners understood the linkages between sexual violence and HIV transmission and recognized that child sexual abuse requires both a legal and medical response. That said, not all partners were aware of the 72-hour window for PEP.[19]
- *Coordination.* Coordination between community-based OVC and facility-based care and treatment partners is very limited, although care and treatment partners were receptive to increasing collaboration with the social service sector. Para social workers and other social welfare actors would benefit from some training on HIV to support pediatric enrollment and adherence.

Both OVC and care and treatment programs need to identify areas of intersection, whereby both can leverage their comparative expertise to ensure that more children and families are reached with care and treatment services and the social welfare support they need.

Coordination

Under SUNRISE-OVC and other projects within the OVC portfolio, USAID programming has resulted in improved coordination and working relationships between government and civil society organizations, as well as across USAID projects. This development is evidenced by a growing number of formal and informal relationships between institutions and projects. Opportunities for further alignment remain – ensuring projects work within and understand government planning cycles for the fiscal year starting July 1st would help to support OVC priorities within government plans. Likewise more direct leadership

[16] Long, S. & Bunkers, K. (2013). *Building Protection and Resilience Synergies between child protection systems children affected by HIV and AIDS.* On behalf of the Inter Agency Task Team on Children and HIV and AIDS. World Vision and UNICEF.

[17] The Republic of Uganda (2013). HIV and AIDS Uganda Progress Report, p. vii.

[18] Focus group discussions with Para Social Workers and Community Development Officers.

[19] Definition of post-exposure prophylaxis (PEP) from http://www.cdc.gov/hiv/basics/pep.html

to promote coordination by USAID could incentivize partners to align work plans and foster new types of collaboration between implementing partners, particularly OVC and care and treatment partners.

Conclusion

The portfolio review highlighted the need for USAID Uganda to maintain a holistic intervention approach to reduce vulnerability and assist children and families affected by HIV and AIDS. This includes a judicious mix of household economic strengthening, linkages to care and treatment programming, and continued investment in systems strengthening. It is an opportune time for USAID Uganda to develop and promote a more unified understanding of systems strengthening and child protection amongst all OVC partners, building on the experience of SCORE and SUNRISE-OVC, across all of the components outlined above. Ensuring OVC programming priorities, approaches and interventions are shared and understood across national government bodies, UNICEF and all USAID implementing partners has the potential to further maximize UASID investments, helping the Uganda social welfare system to partner with civil society and more effectively meet the needs of OVC throughout the country.

II. Background Information

HIV and AIDS continue to be a major contributing factor to vulnerability in Uganda. The key drivers of HIV incidence in Uganda include a limited understanding of personal or partner HIV status, high risk sexual behaviors such as early sexual debut, multiple partners and transactional cross generational and/or commercial sex.[20] The 2011 AIDS Indicator Survey in Uganda reported HIV prevalence at a national average of 7.3%; with higher rates among women.[21] The overall HIV burden is estimated to have increased during the period 2007-2013 from 1.2 million to 1.6 million persons living with HIV (PLHIV).[22] This is a combined result of both new infections and improved treatment resulting in longer lifespans of those living with the disease. Of PLHIV in Uganda, 93% are aged 15 and above and 56% are female.[23] Although Uganda still has significantly high rates of new infections, there has been a notable decline from 154,589 new infections in 2011 to 140,908 in 2013.[24] Interestingly, the decline in the number of new child cases of HIV has been more striking, falling from 27,660 in 2011 to 9,269 in 2013.[25]

Children under the age of 18 years constitute 57.4% of Uganda's 30.7 million people.[26] Ongoing economic challenges, internal migration, family break down and HIV and other illnesses have resulted in a significant number of vulnerable children. A staggering 96 percent of Ugandan children are considered to have some degree of vulnerability, with 43% (7.3 million) considered moderately vulnerable and 8 percent (1.3 million) considered critically vulnerable.[27] These children have faced significant shocks and adversities, but have typically lacked access to a spectrum of supports and services. In addition, many have been unable to access the traditional mechanisms of extended family care that were available prior to the epidemic. A recent situation analysis on Child Poverty and Deprivation reveals that 3.7 million children below five years of age (half the under-five population) live in poverty, and around 1.6 million live in extreme poverty. Furthermore, 38% of children aged 6-17 in Uganda live in poverty, and around 18% live in extreme poverty.[28]

[20] The Republic of Uganda (2013). *HIV and AIDS Uganda Progress Report.*
[21] *Ibid.,* p. vii.
[22] *Ibid.,* p.vii
[23] *Ibid.,* pg.vii
[24] *Ibid.,* pg.vii
[25] *Ibid.,* pg.vii
[26] Uganda Bureau of Statistics (2010). Uganda National Households Survey 2009/2010: Socio-Economic Module (Abridged Report), Kampala, Uganda.
[27] *Ibid.*
[28] MGLSD, UNICEF and EPRC (2015). *Situation Analysis of Child Poverty and Deprivation in Uganda*. Kampala: Ministry of Gender, Labour and Social Development, Uganda; UNICEF, Uganda, Economic Policy Research Centre, Uganda.

Table 1: Regional Distribution of Vulnerable Children in Uganda (%)[29]

	Critically Vulnerable	Moderately vulnerable	Generally vulnerable	Total vulnerability
Central	7.8	33.6	52.7	94.1
Eastern	7.5	45.5	43.8	96.8
North	9.3	53.6	35.9	98.8
Western	8.1	41.1	45.1	96.1
Average	8.1	42.9	45.1	96.1

Many children who do reside with extended family are also highly vulnerable to abuse, neglect and exploitation, stigma and discrimination.[30] The 2009 Situation Analysis estimated that 14 percent (approximately 2.43 million) of the 17.1 million children in Uganda below the age of 18 years have lost one or both parents, with almost half as a direct result of HIV. Orphanhood rates increase with age and children are more than two times more likely to report having lost a father than a mother at any given age. Orphan status is significantly higher in Northern Uganda (at least 16.8% of children in the region have lost a parent) than in the rest of the country.[31] Further, about 33% of households in Uganda have an orphan or foster child living in the household.[32] The same study also indicated that about 63% of these orphans live with non-family caregivers that often exhibit vulnerabilities such as poverty or older age.[33] Children outside of family care are especially vulnerable and the numbers in this situation continue to rise. There are an estimated 32,130 children between the ages of 10 to 17 who are heading households, while over 40,000 children live in institutions and approximately 10,000 live on the streets with no adult care.[34]

USAID has played a critical role in supporting an integrated response to the wide-range of vulnerabilities faced by orphans and vulnerable children in Uganda. Working within the framework of the USAID Orphans and Vulnerable Children Strategy for Uganda, USAID and is implementing partners have taken a three pronged approach to strengthening the response aimed at the household, community and district/national level.

Portfolio Review

The objective of the OVC Portfolio Review was to utilize up to date information collected through desk review and key informant interviews, to answer the following questions:

1. What are the strengths, weaknesses, threats and opportunities associated with the Strategy described in the Results Framework for USAID/Uganda's OVC Portfolio (see Figure 1)?

[29] Uganda Bureau of Statistics (2010). Uganda National Households Survey 2009/2010: Socio-Economic Module (Abridged Report), Kampala, Uganda.

[30] Roby, Shaw and George. Perceived food and labor equity and school attendance among Ugandan children living in kin care. (2013). *International Journal of Social Welfare*

[31] MGLSD, UNICEF and EPRC (2015). Situation Analysis of Child Poverty and Deprivation in Uganda. Kampala: Ministry of Gender, Labour and Social Development, Uganda; UNICEF, Uganda, Economic Policy Research Centre, Uganda.

[32] Uganda Ministry of Health, ICF International. UGANDA AIDS INDICATOR SURVEY 2011.Calverton Maryland, USA, 2012.

[33] USAID Orphans and Vulnerable Children Strategy (n.d.).

[34] *Ibid.*

2. How might the Strategy be improved or strengthened (within the parameters of current PEPFAR priorities)?
3. How do current mechanisms support achievement of these results?
4. What are the strengths, weaknesses, threats and opportunities associated with these mechanisms?

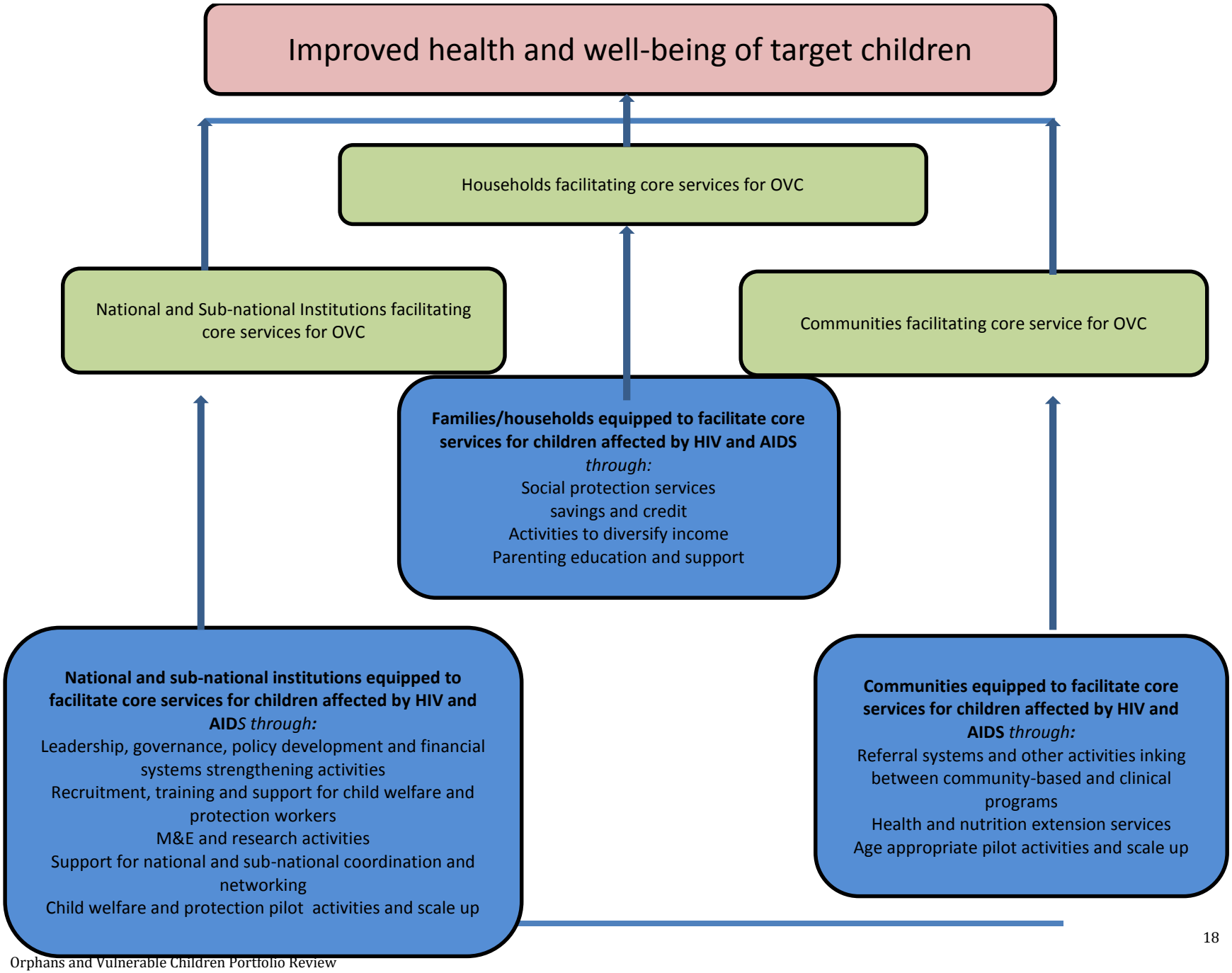
The team from USAID also requested in the first in country briefing meeting with the 4Children team that 4Children pay particular attention to issues related to targeting, case management and referral mechanisms, graduation, links with care and treatment partners and overall coordination amongst implementing partners. The portfolio review primarily focused on these issues but key findings and recommendations are framed within the broader questions outlined above. The Scope of Work for the USAID Orphans and Vulnerable Children Portfolio Review is included in Annex 1.

USAID OVC Strategy

The current USAID OVC Strategy for Uganda includes a Results Framework that has as its purpose to provide at least 967,187 additional OVC access to and utilization of core services for improving health, nutrition, education and psychosocial wellbeing of children and prevention of and response to violence, abuse, exploitation and neglect. The overall goal of the current USAID Orphans and Vulnerable Children Strategy is: *Improved health, nutrition, education, and psychosocial wellbeing, and reduced abuse, exploitation and neglect among children affected by HIV and AIDS.* The Results Framework for the USAID Orphans and Vulnerable Children Program in Uganda, below, illustrates the priority programming areas, approaches and interventions (see Annex 2).[35]

[35] USAID. OVC Strategy for Uganda.

Figure 1: USAID UGANDA OVC Program –Results Framework



The current partners of key projects in USAID Uganda's OVC portfolio are highlighted in the table below.

Table 2: Description of current USAID OVC Implementing Partners

Nr.	Project	Organization	Primary Focus
1.	SUNRISE-OVC: Strengthening the Ugandan National Response for the Implementation of Services for OVC	International AIDS Alliance	A system-strengthening project aimed at building the capacity of local government and civil society to adequately respond to the needs of OVC in 80 districts in Uganda.
2.	SCORE: Sustainable COmprehensive REsponses (SCORE) for Vulnerable Children and their families	AVSI International Service Volunteers Association	Focused on addressing economic vulnerabilities through household economic strengthening activities combined with other community-based services.
3.	PIN: Production for Improved Nutrition	RECO Industries	The goal of this activity is to reduce the burden of under-nutrition in Uganda through strengthening the capacity of a local/regional company to become a sustainable manufacturer and distributor of therapeutic and supplementary foods to meet national and/or regional demand.
4.	SDS: Strengthening Decentralization for Sustainability	CEM: Cardno Emerging Markets	Aimed at supporting decentralization process of health and social welfare through grant making and also including strengthening local government structures including governance.
5.	MEEPP: Monitoring and Evaluation of Emergency Plan Progress	URC-CHS: University Research Company-Center for Human Services	Supports M&E of PEPFAR and improving the reporting system for selected key indicators in the Uganda National HIV/AIDS Strategic Plan (NSP) and the Performance Monitoring and Management Plan (PMMP). Designed to improve and maintain a comprehensive PEPFAR program performance management system including results reporting to the Office of the Global AIDS Coordinator (OGAC) and to support the Government of Uganda's (GOU) national monitoring and evaluation system for the overall HIV/AIDS response.
6.	Uganda Private Health Support Program	CEM: Cardno Emerging Markets	Promoting access to high impact HIV/AIDS prevention, care and treatment services through 56 PNFP facilities/organizations. Five intervention areas including: sustained access to quality HIV/AIDS chronic care and treatment services; PMTCT, HCT, safe medical circumcision and vocational, apprenticeship and nutrition programs for orphans, vulnerable children (OVC) and their caregivers.

7.	STAR-EC: The Strengthening TB and HIV & AIDS Responses in East-Central Uganda (STAR-EC)	JSI: John Snow International	A five-year program to increase access to, coverage of and utilization of quality comprehensive HIV/TB prevention, care and treatment services within nine districts in the East-Central region of Uganda. The STAR-EC project has been provides comprehensive TB and HIV/AIDS services targeting adults & children living with HIV/AIDS and/or tuberculosis (TB) and populations at greater risk of transmitting and acquiring HIV infection e.g. commercial sex workers; fisher folks, truck drivers, etc.
8.	Advocacy for Better Health	PATH	PATH, in partnership with Initiatives focused on empowering Ugandans—with emphasis on women, young people, persons with disability (PWD), and most-at-risk populations (MARPs)—with skills, tools, and systems to more effectively advocate for accessible, high-quality health and social services.
9.	Targeted HIV/AIDS Services	JCRC: Joint Clinical Research Center	Ensure the provision of HIV/AIDS care and treatment, laboratory, PMTCT and TB/HIV services within public, regional, referral, and district hospitals; enhance the quality of HIV/AIDS care and treatment, laboratory, PMTCT, and TB/HIV services at regional, referral, and district hospitals; and increase stewardship by MOH to provide sustainable and quality HIV/AIDS care and treatment, laboratory, PMTCT, and TB/HIV services within the public health system.
10.	SUSTAIN: Strengthening Uganda's Systems for Treating AIDS Nationally	URC-CHS: University Research Company-Center for Human Services	URC is working with the Ugandan MoH to ensure continued provision and sustainable scale-up of comprehensive HIV and AIDS services for people living with HIV and AIDS at 10 regional referral and six general hospitals. Services include base care package for PLHA, antiretroviral therapy, PMTCT, lab services, HCT, and safe medical male circumcision.
11.	CHC: Communication for Health Communities	FHI-360:	Designing and implementing high-quality health communication interventions to improve the knowledge, attitudes, norms, behaviors and demand for services related to HIV, TB, malaria, nutrition, maternal and child health and family planning. Also focused on improving the coordination of health communications interventions and increasing research and KM to enhance health communications.

12.	Community Connector	FHI-360: Family Health International - 360	Community Connector assists local governments in improving the nutrition of women and children and the livelihoods of vulnerable populations by implementing interventions that integrate nutrition and agriculture at the community and household levels. The project focuses on the role of women in the household, food security and the use and distribution of resources.
13.	ASSIST: Applying Science to Strengthen and Improve Systems (ASSIST) Project	URC-CHS: University Research Company-Center for Human Services	This project is focused on promoting the Continuum of Response (COR) within HIV programming The approach seeks to provide clients and their families with essential prevention, care/support and treatment services to reduce HIV transmission and disease progression and to maximize health outcomes. Following diagnosis of HIV, the next step along the COR cascade is living persons with HIV to care and treatment.

III. Methodology

Portfolio Review Team composition: The eight-person team that reviewed the USAID OVC Portfolio was drawn from the 4Children consortium and three evaluators from the Makerere University School of Social Work. Members of the team had diverse expertise including qualitative and quantitative methods, monitoring and evaluation, PEPFAR OVC programming, HIV care and treatment, child protection, social welfare system strengthening, and alternative care. Planning for the evaluation began in January 2015 with a series of preliminary teleconferences and email exchanges between USAID and the 4Children team leaders. The purpose of these exchanges was to (1) understand USAID's expectations for the portfolio review; (2) receive a portfolio overview from the USAID team; and (3) collect key project documentation that would be used by the team leaders to inform the portfolio review design. Based on these conversations, the team leaders adopted a primarily qualitative approach for the portfolio review. Primary qualitative data was collected from project stakeholders including USAID, implementing OVC partners, UNICEF, care and treatment implementers, national and district level government, and TSOs.

Desk review: A desk review of relevant literature included more than 75 documents such as annual reports from USAID-funded projects, Uganda Government policies and guidelines related to HIV, OVC and child protection, statistical data from national and international sources, and other relevant programmatic and/or peer reviewed literature. See Annex 3 for full list of reviewed documentation.

Primary Qualitative Data Collection: As the team was simultaneously conducting the SUNRISE OVC Final Project Evaluation as the OVC Portfolio Review, the team combined information needs of both assignments. Interviews were held with approximately 75 people representing the following:

- Ministry of Gender, Labor and Social Development Officials
- District Officials including the Chief Administration Officer, District Community Development Office, Probation and Welfare Officer and the sub county Community Development Officer
- Community leaders, caregivers, para social workers and children
- International NGOs focusing on OVC
- National NGOs focusing on OVC
- USAID HIV/AIDS care and treatment implementing partners
- USAID child survival and maternal health implementing partners

- UNICEF
- TSO representatives
- UNICEF
- USAID mechanisms receiving OVC funds (see Annex 4 for a list of organizations and individuals that participated in key informant interviews and focus group discussions).

Tool development: Prior to arrival in the field, the evaluation team leaders prepared draft key informant interview and focus group discussion guides (see Annex 5). These were later reviewed and revised to reflect the updated information needs provided to the 4Children team by USAID. Throughout the two-week data collection process, information needs were constantly revised and updated based on the cumulative knowledge gained as the team undertook the process.

Limitations: While the methodology used provided a great deal of rich information, there were some important limitations. The first was the limited time available to conduct site visits to all OVC implementing partners. Where possible, the team took advantage of their visits to the field for the SUNRISE evaluation, which happened at the same time, and spoke with local government officials, care and treatment facilities and other implementing partners. Additionally, the team was not able to meet with every OVC implementing partner but in as many instances as possible met with project management in Kampala.

IV. Key Findings

The 4Children team primarily focused on the specific issues of targeting, case management and referral mechanisms, graduation and links with care and treatment partners whilst also thinking about a SWOT analysis of the OVC strategy itself. A very general SWOT analysis of the current strategy, make up of the portfolio and current context related to OVC in Uganda is also included in Table 3, whilst more detailed findings regarding the specific topic areas requested by USAID Uganda, are highlighted below.

Given that these are some of the main factors that enhance or limit coordination between and amongst IPs, the findings have been utilized to inform practical recommendations for the overall USAID OVC Strategy as well as more specific actions that aim to enhance overall coordination of efforts and an enhanced understanding by all actors involved as to the primary objectives of OVC programming in Uganda.

As per discussions with the USAID Uganda team during the initial briefing, the team did not spend a significant amount of time assessing the existing strategy (as per the original SoW) but instead prioritized topic areas requested by the USAID team. However, within the process of meeting with key informants, conducting the desk review and understanding the Ugandan contexts as it relates to OVC, the following rapid findings using a SWOT analysis approach were identified regarding the existing USAID OVC Strategy.

Table 3: Rapid SWOT Analysis of Existing USAID OVC Strategy for Uganda

SWOT	Key Findings
Strengths	▪ Very well rounded selection of programming foci and approaches. ▪ Wide range of partners with varying types of expertise. ▪ Notable achievements within systems strengthening, especially at district level (see

	SUNRISE –OVC final evaluation for more details). ▪ Clearly reflects GoU priorities for OVC as illustrated the national policy framework. ▪ Programming areas that reflect priorities highlighted in the PEPFAR Guidance for OVC Programming.
Weaknesses	▪ Large number of implementing partners that appear to inhibit coordination and standardized definitions, tools and approaches (see findings, below, for more details). ▪ No clear strategy or mechanism for a DOP-like structure at national level. ▪ Inconsistent geographic alignment of system strengthening initiatives and household strengthening interventions may result in missed opportunities to promote a synergistic relationship and help show complementarity.
Opportunities	▪ Continued focus on systems strengthening approach has potential to result in long-term sustainability and government ownership. Further analysis of combination approach that includes 1) system strengthening; 2) household economic strengthening; and 3) government grants has potential to produce better outcomes and contribute to the evidence base. ▪ Interest from implementing partners and care and treatment partners to better link HIV/Health and social welfare/child protection. ▪ Significant opportunities for operational research that could help inform policy and practice within Uganda and beyond and result in better health and protection outcomes for children.
Threats	▪ HIV and social welfare sectors continue to work in isolation if coordination is not actively sought and actors held accountable. ▪ District government ownership and management of system only reaches so far and is inhibited by budget limitations if national level government is not actively engaged in the process nor properly strengthened to be able to advocate for increased resources towards social welfare and child protection systems. ▪ Dependence on front line social service workforce i.e., para professional volunteers is not sustainable if appropriate technical support and supervisory structures are not strengthened and expanded at the same time.

1. Social Service Systems and Child Protection Capacity

Strengthening the social service system to deliver comprehensive and quality services to OVC is a primary objective of OVC programming globally, and is included as a specific focus of the USAID Uganda OVC Strategy. Strengthening the social service system requires a thorough understanding of several issues including: the unique and mandated role of government to oversee, coordinate and manage the system to ensure that interventions are sustainable; the active and planned engagement of civil society to support government within that systems especially in the provision of social services; and a range of interventions aimed at strengthening the different components that make up the system, not in isolation but in a coordinated fashion. A system strengthening approach is relatively new within the OVC sector and so growing pains are to be expected by both USAID as well as implementing partners.

From interviews conducted with many of the OVC implementing partners (IP) it was clear that there is tremendous variance in regards to how a system strengthening approach is understood and valued as well as what is meant by the term child protection. For example, in some cases, implementing partners were only vaguely familiar with the role of para social workers and their role as a bridge between the informal and formal sectors. Similarly, there were also different degrees to which IPs understood, supported and valued the role of government within a systems framework. The evaluation team also found that there were differences in how child protection was understood ranging from child friendly

schools to a general promotion of children's basic rights. Occasionally there was reference to protection from violence, abuse, neglect and exploitation, but it was rare when all three were mentioned together and almost never did the IP definition include both prevention and response. This variance and lack of definitional clarity was particularly noted among non-OVC focused implementing partners that have OVC among their target populations, but not as their primary mandate.

The USAID Mission in Uganda is in a unique position to support transition to a standardized approach and understanding by all OVC implementing partners of both a social service system strengthening approach and child protection that is consistent with the PEPFAR Guidance for Orphans and Vulnerable Children Programming. It should be an expectation of all USAID funded OVC implementing partners that a solid understanding of and practice that illustrates a system strengthening approach and child protection as highlighted in the aforementioned PEPFAR Guidance, including the presence of a child safeguarding policy within every USAID OVC project. Uganda is particularly fortunate to have the presence of Makerere University in country. Makerere University has an established and well-recognized child protection training curriculum that could be utilized as a foundation for promoting this standardized understanding and approach to child protection within OVC programming, including the role of a child protection system within the larger social welfare system. Having standardized terminology and understanding of these key concepts that are also contextually appropriate and expecting IPs to actively ensure that this standardization occurs within their own organizations and projects will be an immediate way in which to help develop a strong and coordinated foundation for OVC programming.

Amongst the non-OVC projects where smaller amounts of OVC funds were integrated, there are clear opportunities to promote training around social services systems strengthening and child protection. If USAID continues to integrate OVC funds into larger non-OVC projects, then it may be worthwhile for COPs and/or DCOPs to participate in a one-day management level orientation to social services strengthening and child protection. This orientation would need to be developed and it may be efficient for Makerere University or other organizations to adapt its existing training into a one-day management overview.

2. Targeting and enrollment

Targeting and enrolment are key processes involved in identifying households and children that will be served by a specific project or intervention. USAID has their own geographic targeting process that has identified the most HIV affected areas of Uganda. As noted in the OVC Strategy: *"This strategy employs a geographic targeting approach that estimates the burden of OVC and HIV care to identify high-priority districts where portfolio investments could be best concentrated to achieve maximum impact on children and leverage synergies with the continuum of HIV prevention, care, and treatment."* [36]

Key informant interviews with IPs identified that a range of different approaches and tools are used by IPs to identify beneficiaries. This includes community mapping, such as what was utilized in the SUNRISE project, to identify households that communities classified as vulnerable. In some cases IPs were using results of the community mapping, for example SCORE and TASO, and then supplementing it with other tools that were internally developed or government tools such as the Vulnerability Index (VI). Local government officials at district and sub-county levels typically used the Child Status Index and Child Protection Registration forms in line with the MGLSD Guidelines for Operationalizing the Three Factor

[36] USAID. OVC Strategy for Uganda.

Criteria for OVC Identification, Vulnerability Index and Child Status Index (CSI) Tool issued in 2013.[37] Children who have suffered child protection violations might be referred through another mechanism. Similarly, there were also cases of children or caregivers being referred for social services by care and treatment facilities. The Community Connector project, funded by Feed the Future, used a tiered geographic targeting and age based criteria primarily focused on the combined issues of food insecurity and households with children under five years of age.

It would be useful to further explore which targeting tools are paying particular attention to the ability to identify the most vulnerable households within targeted communities and their effectiveness in reaching the most vulnerable households/children. MEASURE Evaluation has recently completed an evaluation of the vulnerability index that identified minor adjustments that the evaluation team understood are being addressed. Once this process is finalized it would be useful to review existing targeting approaches utilized by IPs and strongly encourage them to use the government-endorsed tools such as the community mapping data, CSI and the VI. Given that a significant part of OVC programming in Uganda has focused on supporting and strengthening government to take a stronger role in coordinating the system, having USAID-funded implementing partners utilizing the tools would be an important step in fostering recognition of the government's role within the system and the importance of using recognized and endorsed tools. At the same time, USAID and IPs are also in the unique position to constructively engage with government and other partners around utilization of the tools. For example, USAID could facilitate the formation of a technical working group focused on sharing experiences around the use of the tools. The opportunity to leverage the experiences and expertise of the IPs as a means of ensuring constant review and adaption of tools is an excellent means of encouraging continued collaboration between government and civil society, encourage government to embrace its coordination role, and foster a participatory quality improvement process.

Table 4: Targeting tools utilized by USAID Implementing Partners

Implementing Partner	Community mapping	Vulnerability Index	Child Status Index	Child Protection Registration form	Facility based targeting	Other/own tools
SUNRISE	x		x			
MUWRP		x			x	
TASO		x				
PIN		x				
Baylor		x			x	
Uganda Private Health Support Program		x				
SCORE						x
Local Government	x		x	x		
Community Connector						x

[37] MGLSD. Guidelines for Operationalizing the Three Factor Criteria for OVC Identification, Vulnerability Index and Child Status Index Tool.

NB: Not all OVC partners listed on pages 15-16 were interviewed or do not include targeting in their project design.

3. Graduation

Graduation is the process of finding pathways to move households or children from receiving services to no longer receiving services. Similar to targeting, there appears to be a wide range of approaches utilized by IPs for graduation. It appeared that the graduation process was very much related or directly linked to the specific intervention and/or age of the child. For example, some IPs may have committed to support a child through a certain level of schooling. In other cases, organizations had funding for five years and were prepared to offer support only during that time. Programs with a more defined approach to graduation typically included a household economic strengthening (HES) component. More specifically, graduation was based on reduced household economic vulnerability and an increased ability of the household to meet their basic needs. Household readiness for graduation was assessed using a combination of the Vulnerability Index and CSI or a project-specific vulnerability assessment tool. There were also other organizations that did not appear to have any kind of graduation process or procedures.

Many IPs, CSOs and even local government officials saw linkages between poverty, risk and vulnerability, and child protection concerns. They noted that household economic strengthening, appropriately designed, can mitigate child protection concerns and HIV by reducing family stressors and by providing resources that families can use to benefit children.[38] For example, as family income grows, global evidence suggests that families are less likely to rely on child labor and more likely to enroll their children in school.[39] Evidence also suggests reductions in early sexual behavior or child marriage (see text box), especially when girls are provided with access to education.[40] HES is only one component of a spectrum of preventive and responsive child protection approaches and services, and should be accompanied by measures to make local knowledge, attitudes and practices more protective in nature.

Relationship between child marriage and economic vulnerability: In most cases, anecdotal evidence from para social workers revealed that girls were being pressured into early marriage as a result of economic challenges faced by their family/household. Permitting a girl to enter into marriage often brings in some kind of material resources to her family household (e.g., goats from the groom's family). At the same time, the child bride normally leaves the household to live with the groom, thus reducing the number of people in the household requiring food, shelter, etc. Finally, most girls also leave school when they marry, which is another cost savings as books and uniforms no longer need to be purchased. As such, it is logical to hypothesize that addressing the household economic vulnerabilities would then most likely lead to an improved situation whereby the option of child marriage would not be so appealing. Although there was only anecdotal evidence provided on the links between HES and decreased child protection risks or violations during this review, there is a growing evidence base that

[38] Key informant interviews with implementing partners; Cluver, Lucie et al. *Assembling an effective paediatric HIV treatment and prevention toolkit.* The Lancet Global Health , Volume 2 , Issue 7 , e395 - e396. http://www.thelancet.com/journals/langlo/article/PIIS2214-109X(14)70267-0/fulltext

[39] DFID, HelpAge, Home and Homes for Children et al. Joint Statement on Child Sensitive Social Protection. http://www.unicef.org/aids/files/CSSP_joint_statement_10.16.09.pdf; UNICEF & ODI. *Promoting synergies between child protection and social protection*. 2009. http://www.unicef.org/wcaro/wcaro_UNICEF_ODI_5_Child_Protection.pdf

[40] International Center for Research on Women. *Solutions to End Child Marriage. A Summary of the Evidence.* http://www.icrw.org/sites/default/files/publications/19967_ICRW-Solutions001%20pdf.pdf; UNICEF & ODI. *Op cit.*

supports the linkages and increased recognition by policy makers, practitioners and communities as to the benefits of a two pronged approach that addresses both economic and child protection vulnerabilities simultaneously.

A persistent challenge for many community development officers was limited economic strengthening options for the most vulnerable households who did not have the resources or capacity to participate in village savings and loan (VSL) groups and/or were not eligible for the government's Social Assistance Grants for Empowerment (SAGE) or community driven development (CDD) programs due to geographic, age or income restrictions. This gap appears to be a specific issue facing some of the most vulnerable families targeted by the projects and does require additional exploration as to how best to ensure that this group is able to access the services that they need to participate in VSLs.

USAID and the Government of Uganda may want to consider convening a technical working group to assess the complex set of issues involved in graduation. This assessment could include defining graduation in its different contexts, how to measure it, and what level of resiliency can be anticipated over what period of time. Furthermore, given the increasing focus on social protection within HIV and AIDS programming,[41] it might also be worthwhile for USAID to increase its role within the national social protection platform and actively engage with key donors such as DFID and World Bank to ensure that USAID initiatives are in line and that components of the social welfare system supported by USAID are linked and coordinated with larger national level social protection interventions.[42]

4. Case management systems and referral mechanisms

Case management systems: Case management is a core component of a social service system designed to effectively prevent and respond to children and families' vulnerabilities. Case management can be understood as the process of assessing, referring and monitoring the delivery of services in a timely, context-sensitive and individualized manner.[43] Similar to targeting and graduation, there appears to be a wide range of case management and referral processes and procedures utilized by IPs. There is no one unified approach to case management, including an understanding of what it means, across the OVC portfolio. For example, there are absences of unique identifiers, case files and/or procedures for guarding/storing case files. There are limited to no electronic case files, thus hampering the ability to do trend analysis or identify promising interventions that could help inform policy and programming. Although the OVC MIS has been a significant part of OVC efforts over the past several years, it is not designed as a case management tool. The OVC MIS is a start to tracking children reached. It is not unreasonable to suggest that over time, the OVC MIS will evolve into a more sophisticated system, which will yield useful information to continue to inform current interventions targeting OVC.

[41] Ambassador Birx. Social Protection in the PEPFAR program. (2014). http://www.unaids.org/sites/default/files/media_asset/Item9_Social%20Protection%20in%20the%20PEPFAR%20Program%2034th%20PCB.pdf

[42] International Monetary Fund. The case for establishing a comprehensive social protection system in Uganda. 2014. http://www.imf.org/external/country/UGA/rr/2014/103014.pdf

[43] Global Protection Cluster. *Interagency Guidelines for Case Management and Child Protection: The Role of Case management in the Protection of Children – A guide for Policy and Programme Managers and Caseworkers. 2014*; Davis, R., for USAID. *Case Management Toolkit: A User's Guide for Strengthening Case Management Services in Child Welfare*. (2014).

The evaluation team found that SUNRISE-OVC, because of its focus on system strengthening, paid particular attention to the issue of case management, including supporting district and sub-country government staff to utilize the CSI, and utilizing home visiting forms and other relevant forms that would assist in the case management process. There were inconsistencies observed in how the different cadres of the workforce utilized the tools. For example, in some sub-counties para professionals were able to provide written information to help inform case management (i.e., number of homes visited, number of cases referred), but in others this was challenging due to limited resources such as a lack of notebooks and pens. It appears that most CDOs are utilizing the CSI for assessment and ongoing monitoring, including when a household is ready to graduate from the program, but the thoroughness of the reports, where the data are stored and how detailed reports are varies from district to district. It does appear, however, that SUNRISE has been instrumental in disseminating and encouraging the use of the government endorsed case management book at district and sub-county level. Based on discussions with Probation and Welfare Officers and CDOs, this represents an improvement over the previous situation where records were kept in notebooks that could easily be misplaced.

Although this is a noted improvement, there are still identified shortcomings in the existing approach. Notably the case management record book relies on the client to remember if she/he has been to the office before so that the PWO or CDO can scan and identify the case in order to complete the actions taken column. In some cases, if the client doesn't come back, some Probation Officers reported that they assume the case has been resolved. A notable exception was when the life of the child was in danger and closer follow-up seems to have been provided. Users must document actions taken and closed cases in the same column, making it difficult for them to quickly scan their book and identify open and closed cases. In addition, case numbers were typically assigned by incident, rather than by child or household, making it difficult to identify repeat visits from the same child or household. Although case files were not able to be viewed in all projects, the ones that were viewed showed variance in terms of maintaining record confidentiality. In short, the system is getting better, but there is more to be done to improve the existing system utilized by government structures and promoted under the SUNRISE project. Of particular interest would be further review related to the quality of information collected and identification of promising practices amongst IPs (or others) that could then be promoted and used as models to be adapted.

Some TSOs have taken the initiative to launch their own case management model such as the case of Bantwana, who have adapted their case management model developed in Zimbabwe to the Ugandan context, including several communities in Namutumba. In this case they have equipped child protection committees with case management books and lock boxes to facilitate case management at the community level.

Noting that there is both a basic understanding of the important role of case management within child protection, social welfare and OVC programming, USAID has the opportunity to increase this foundational component of a systems approach by promoting a standardized understanding of case management by IPs, promote utilization of government endorsed tools for case management, initiate or support the development of standard operating procedures for case mangement that could be utilized by both IPs and government. Additionally, USAID could help identify or review existing case management processes and procedures to identify promising practices and support on going quality improvement and adapation.

Referral mechanisms: Referral mechanisms are the processes or procedures that exist to ensure that

referrals within and between and across sectors occur and are monitored. Effective referral systems are necessary to support effective case management by skilled service providers responding to complex individual child or family vulnerabilities.[44] Case management and referral mechanisms are interlinked and the success of one is dependent on the other. A good case management system must include clear and coordinated referral procedures to ensure that the case plan developed, including the services to be delivered, are done so in a coordinated, timely and child sensitive manner. 4Children reviewed existing referral mechanisms and found that most IPs have some sort of referral system in place, although it varied in how it was documented, monitored and adapted based on user feedback. Almost all partners spoke of the benefits of a referral system both in terms of improving programming for the beneficiaries, helping to better understand the of their beneficiaries and what services they could and could not provide and where to get them.

The portfolio review found that all mechanisms had some kind of referral system in place that linked health facilities, CSOs, and/or government services providers but the effectiveness of those systems varied. Existing referral mechanisms are both formal and informal. Similarly, most districts had also completed a community mapping exercise that included identifying existing services within the district.[45] The formal referral mechanisms, for example, are utilized by the government and involve the DOVCC at district level, the SOVCCs at sub county level and the various staff within the social welfare system such as PWOs, CDOs and service providers. This system also has recognized and endorsed formats such as those utilized by the CDOs. There were some complaints about the inadequacies of the government form, resulting in some of the IPs developing their own version of referral forms.

Referrals can also be informal, as in the case of personal networks or "word of mouth" referrals. At the community level, where most referrals originate, para social workers used written referrals, verbal referrals or in many cases physically accompanied the client to the service. This was especially the case in situations where the client was a victim of a child protection violation such as defilement, early marriage or abuse, and was not comfortable or able to go to a government office by him or herself.

Completion of the referral varied across the projects reviewed and depended upon a number of factors including:

- Whether or not the service was perceived as tangible by the client;
- Geographic location and ability to reach the destination where the service was offered;
- Trust in the ability of government to provide a quality service;
- Bottlenecks created by clients who have not "graduated" from the intervention and therefore do not allow for new clients to receive services; and
- Selection criteria that limits the ability of certain children or family members to receive services (i.e., below the age of five; pregnant, etc.).

Creative solutions to challenges with referrals: Key informants mentioned that documenting and monitoring referrals was especially difficult because of a limited understanding by clients and some service providers as to the importance of properly filling out a referral form. Several mentioned the challenges involved in tracking down referral forms and following up with clients and service providers. This process was both time consuming and required human resources to do so. Therefore, this is an area

[44] *Ibid.*

[45] This was a key activity of the USAID-funded SUNRISE-OVC project.

of concern considering that key staff are spending precious time chasing down referral forms when they could be engaged in provision of direct services. There should be a balance between ensuring that referrals result in a tangible benefit to the child and family while not diverting limited human and financial resources away from service provision. One district had found a creative solution to the process. The Probation Officer uses the pink carbon copy from the government referral form pad with the bottom part of the original form stapled to it – demonstrating evidence of a completed referral. This information then is entered by hand in to the case management book pictured above as well as the OVC MIS. [46]

In the specific case of referrals from health facilities to communities there was great variance that appeared to be influenced by the level and type of facility and whether it was government or private/faith based. Some facilities were equipped with an OVC focal point or a social worker that could be tasked with improving this aspect of the program, while lower level facilities may only have a counselor. In discussions with health facilities only some of them seemed to have clear procedures in place to refer cases of abuse, especially sexual and gender based violence against girls and women, to the police.

Referral remains a challenge, and it may be worth identifying existing positive case studies to better understand and learn from what is working in some locations and why challenges persist in others. There are tools, such as MEASURE Evaluation's toolkit, that can be used to assess and monitor referral networks. Testing this toolkit in several locations may help to provide more insights. The USAID OVC strategy recommends a review of current referral and coordination mechanisms, which would be an opportunity to look into this matter and provide opportunities for improvement. It would also help inform the eventual development of standard operating procedures for case management, including referral mechanisms.

5. HIV and OVC

The portfolio review paid particular attention to the issue of HIV within OVC programming. Specifically, issues of identification of pediatric cases, adherence, disclosure and stigma and the linkages between HIV and child protection violations—especially sexual abuse—were explored with key informants. A growing evidence base demonstrates the linkages between HIV and child protection related adversities. For example, there appears to be an association between HIV infection and early sexual debut and/or sexual violence. There is also the increased likelihood of children in households affected by HIV of contracting the disease. Children affected by HIV in turn face protective challenges such as stigma or lack of family or suitable alternative care. [47,48] Both OVC and care and treatment programs need to identify areas of intersection, whereby both can leverage their comparative expertise to ensure that more children and families are reached with care and treatment services. It is important that OVC programs identify key entry points wherein issues of HIV can be better addressed presents an excellent

[46] It is not clear how much time lapses between the completion of a referral and submission into the OVCMIS as it was beyond the scope of this review. However, looking into this area could prove useful information and highlight potential opportunities to strengthen the social welfare system, in particular referral mechanisms and data collection and submission procedures.

[47] Long, S. & Bunkers, K. (2013). *Op cit.*

[48] Wamala, E. (2015, Feb. 16). How poverty and stigma are hindering HIV treatment for Uganda's adolescents. http://ovcsupport.net/how-poverty-and-stigma-are-hindering-hiv-treatment-for-ugandas-adolescents/

opportunity for the OVC portfolio to align with the global care and treatment agenda and prevention interventions.

Case identification

Care and Treatment partners believe that they are implementing exhaustive efforts to identify HIV+ children. These efforts include: near universal testing in pediatric wards, increasing provider initiated testing and counseling (PITC), following up on HIV Exposed Infants (HEI) at reproductive child health clinics (whose mothers gave birth at home) and increasing HIV testing during antenatal visits. Despite these efforts, the care and treatment partners are finding very low prevalence of HIV amongst children to the point where they are questioning whether the HIV+ children exist at the UNAIDS estimated levels.

Contrasting this, some OVC partners state that they know of HIV+ children in communities who have not been tested or do not make their way into the care and treatment folds. Stigma has been cited as the primary cause. Even when parents are aware of their own HIV status, they often fear community members knowing that infection exists within the children of the family. However, while the OVC partners know of children living with HIV in communities, who often do not make their way into treatment, it should be noted that that, according to IPs these numbers have dramatically decreased since the roll out of ART and PMTCT services.

Disclosure and Adherence

The OVC partners also relayed stories of children, whose status is known, not accessing treatment or not properly adhering to treatment due to lack of knowledge within families on drug use and correct dosage. Key informant interviews provided insight into the fact that some children have been known to fail on second line treatment regimes due to poor attention by parents to ensure appropriate drug adherence, particularly in young children.[49]

Most OVC partners expressed concern at the manner in which HIV status of parents, as well as, children is disclosed to children. Inadequate knowledge on how to communicate with children on this topic in an age appropriate manner remains problematic. One particular area to explore is how the issue of disclosure, specifically, might be integrated into positive parenting and ECD interventions especially those focused on positive communication strategies.[50] The issue of disclosure to children seems to be an area where there could be stronger linkages established between the health and OVC sectors.

Sexual Violence and HIV

Most OVC partners adequately understood the links between sexual violence and HIV transmission. There appeared to be a clear understanding that a case of child sexual abuse requires both a legal (i.e., police) and medical response, but there remains confusion by key stakeholders about the need to initiate PEP within the 72 hour window. This appears to be an area that could benefit from continued

[49] Agwu AL and Fairlie L. Antiretroviral treatment, management challenges and outcomes in perinatally HIV-infected adolescents. *Journal of the International AIDS Society* 2013, 16:18579 http://www.jiasociety.org/index.php/jias/article/view/18579 | http://dx.doi.org/10.7448/IAS.16.1.18579

[50] Long & Bunkers. *Prevent and protect: coordinating HIV and child protection to keep children safe, healthy & resilient. Promising practices: building on experience from Nigeria, Zambia and Zimbabwe.* In press. UNICEF and World Vision

awareness raising amongst those that directly engage with children, especially those that are not part of the health system such as para social workers, CDOs and PWOs.

Coordination

The coordination between the community-based OVC and facility-based care and treatment partners appears to be very limited. Without external prompting or requirements, the two programs appear to operate independently with little intentional overlap or coordination. In order to develop a more productive working relationship and more seamless interface between the facility and community, it is recommended that someone who understands both the community and facility assist the two groups to find their points of intersection.

Interestingly, one example of establishing linkages between community based OVC programming and health facilities in a project piloted by Bantwana. Utilizing private funds to integrate their portfolio of OVC systems strengthening and care and treatment projects, Bantwana has purposefully created synergies between OVC programming and health facilities. For example, Bantwana put coordination interns or 'locums', recent graduates, at both health centers and social welfare offices, tasking them with managing referrals and linking clients requiring additional service from the social welfare office to the health center or vice versa, later embedding these volunteers within the system. Integrating the two programs has also enabled local government to use the DOVCC to ensure OVC have access to PEP free of charge, as mandated by law, after several complaints of health workers charging underage patients in Kamuli. As the Bantwana Care and Treatment staff explained:

> "*We have created a forum whereby health workers can provide information and informally "train" the para social workers how to look for and refer and identify HIV-related issues (e.g., illness, stigma, adherence issues) when doing home visits to households that are part of their case load. The same is done by para social workers that help "train" health workers how to identify potential violence, abuse, neglect and exploitation in households where HIV is an issue.*"

These initiatives are an excellent and cost effective means of establishing concrete linkages between the two sectors and helping to improve cross identification and referrals; an issue that has been recognized, at the global level, as needing improvement.[51]

Care and treatment partners were receptive to an increased use of para social workers at the facility. This could include discussions on child protection and violence during the clinic when patients often spend hours waiting for their appointments. Similarly, there also seems to be a notable opportunity to integrate early childhood development and positive parenting activities into this time and space as well. Para social workers armed with increased knowledge on HIV transmission, identification of HIV in families and the basics of ART and adherence could be a powerful vehicle in communities to increase pediatric enrollment into care and treatment as well as support health workers, where possible, to follow up issues of adherence and retention. Conversely, the facility staff should be able to refer cases of violence to the social welfare workers, whether formal district/sub-county staff or the para social worker.

[51] Long & Bunkers (in press). *Op cit*.; Long & Bunkers (2013). *Op cit.*

6. Coordination: USAID, Implementing Partners and the Government of Uganda

USAID projects have advanced coordination efforts between themselves and government at the district level, especially through the establishment of the District OVC Committees (DOVCCs) and the District Operational Plan (DOP). The DOVCCs bring together representatives of different government bodies, civil society members and the private sector to discuss issues related to children. It is an excellent platform to identify room for potential linkages with other initiatives and activities and to ensure that USAID-funded projects are aware of and when possible, working together with other actors. Furthermore, the DOPs have been instrumental in bringing together all USAID funded projects that are implementing in the district. As with the DOVCCs, the DOPs present a unique opportunity to ensure coordination and information sharing between district government and USAID implementing partners as well as amongst USAID IPs. However, there remain significant gaps to ensuring full alignment into government processes. Alignment into the overall district development plans requires continued attention to the planning cycles of governments. A pathway to sustainability is to ensure that projects work within government planning cycles for the fiscal year, which begins on July 1st. This requires an adjustment in preparation and mind-set to understand the planning cycle and ensure adequate participation in the process.

It appears that USAID is optimally positioned to create a functioning coordination mechanism at the national level with an overarching vision for collaboration among USAID IPs. Although there are meetings with all USAID funded projects on a regular basis it appears that creating a time and space for only OVC IPs and USAID to meet would be beneficial. Similarly, actively engaging interaction and regular communication with national level government, USAID and OVC IPs is also an important means of ensuring that key messages, activities and USAID programming priorities are understood by national level government and that government priorities including tools are also well understood by OVC IPs.

V. Recommendations

The recommendations provided below address key findings of both the SWOT analysis of the USAID OVC Strategy for Uganda as well as the specific technical areas requested by the Mission. Recommendations were developed in a way to address both issues in a holistic and coordinated manner rather than separately.

1. **Provide a common language, understanding and approach towards social service system strengthening and child protection amongst USAID and implementing partners that reflect global guidance and national laws, policies and tools.**
    a. Develop a standardized description of a social service systems strengthening approach based on 2012 PEPFAR OVC Guidance, inclusive of a standardized or agreed upon child protection training for all USAID funded OVC implementing partners.
    b. Encourage IP management participate in a brief management-level orientation on social services, system strengthening and child protection that would assist them to give appropriate support to staff, utilizing existing expertise within Makerere University, Africhild Research Centre and other technical experts.
    c. USAID should consider requiring IPs to use standardized national tools to ensure consistency in targeting methods and reporting across projects whilst also providing venues to leverage IP expertise through constructive engagement with government in an effort to enhance national tools.

2. **Actively promote further discussion and IP engagement with government around the issue of**

graduation.

a. USAID and the Government of Uganda may want to consider convening a technical working group to think through the complex set of issues involved. This could include defining graduation in its different contexts, how to measure it, and what level of resiliency can be anticipated over what period of time.
b. Graduation strategies should be part and parcel of IP sustainability plans.
c. Convene a multi-sectoral technical working group on graduation with the objective to clarify definitions and updated guidelines and tools based on IP experience in Uganda and elsewhere.
d. To facilitate graduation, ensure robust household economic strengthening is included in mechanisms to support vulnerable children and households.

3. **Identify, better understand and promote effective models of case management and referral mechanisms amongst implementing partners, other service providers and government as well as amongst social welfare and health/HIV sectors.**
    a. Conduct operations research to identify the best referral models/forms, document and scale, including the Bantwana case management model.
    b. Support the development and roll out of agreed upon and evidence-based standard operating procedures for case management.
    c. Encourage IPs to use existing tools (e.g., MEASURE and QI) to assess, monitor and improve referral networks.
    d. Define the business processes for case management prior to adopting an electronic case management system or adapting the OVC MIS. There may be lessons learned from Child Helpline.

4. **A growing evidence base illustrates the linkages between HIV affected and infected children and increased vulnerability to child protection risks as well as the increased risk of HIV faced by child survivors of child protection violations. USAID Uganda is in a unique position to strengthen and facilitate improved coordination between OVC and social welfare system strengthening efforts and care and treatment partners and promote synergies between child protection and HIV programming, wherever possible.**
    a. Ensure facility-based counselors/social workers have linkages with community-based service providers.
    b. Leverage existing PLHIV support groups, expert clients, VHTs and para social workers to encourage parents/caregiver to access HCT and ART for children.
    c. Add a module into the child protection and para social worker trainings to ensure Community Development Officers (CDOs) and para social workers have basic knowledge in PEP, ART adherence, disclosure, stigma, available resources and identification of children at risk of HIV and HIV+ children.
    d. Encourage care and treatment partners to include a social work position within health facilities and/or to actively link with para social workers, CDOs and PWOs to foster cross referral of potential child protection cases identified in HIV/health clinics and/or HIV cases identified by child protection sector. This can and should include the development of a training module for doctors, nurses and other health facility staff to recognize signs of abuse or neglect in children.
    e. Support care and treatment providers to develop and implement child safeguarding policies as is expected by OVC partners.

5. **Increase access to HIV testing, treatment and care especially amongst children and adolescents.**
    a. Encourage care and treatment partners to better understand the role that the care environment and neglect has on adherence amongst children and adolescents. For example, many children are living with extended family or elderly caregivers and because of stigma and/or neglect are not able to receive medical care and treatment. Many of these families are vulnerable and could be part of the social worker's caseload thereby requiring improved coordination and communication between the social welfare and health sectors.
    b. Support child and adolescent friendly clinics and support groups.
    c. Support the recruitment and training of clinic-based staff with skills to work with children and adolescents.
    d. Leverage expert clients, para social workers, VHTs and other community-based structures to support adherence.

6. **Strengthen coordination mechanisms amongst USAID, Implementing Partners and the Government of Uganda.**
    a. Using its convening power, USAID could create a collaboration and coordination platform leveraging the strengths of each mechanism to advance OVC objectives (as a complement to the National OVC Steering Committee).
    b. Create opportunities for joint work planning across USAID OVC and USAID non-OVC mechanisms and the GOU.
    c. Continue to support DOVCCs and DOPs as an effective means of coordination at the district level.

7. **Aim to reduce the number of implementing partners focusing on those with the technical skills and foci identified in the PEPFAR Guidance for OVC Programming, with particular focus on those that have experience and expertise in system strengthening, household economic strengthening, child protection, workforce development and case management and referral systems.**
    a. Try to avoid funding small, OVC components as additions to larger non-OVC focused project and instead focus on funding of projects within projects that are led by organizations with experience and expertise that is relevant to OVC priority areas.
    b. Encourage implementing partners to engage with and seek information from globally recognized entities with technical expertise e.g., Global Social Service Workforce Alliance, RIATT, etc.

VI. Lessons Learned

- A system strengthening approach, although well-known and understood within the health sector is relatively new within the social welfare and child protection fields. There remains significant variance in how IPs understand and appreciate a system strengthening approach thus inhibiting, in some cases, coordination amongst partners and with government structures.
- Related to this IPs have varying degrees of understanding as to what child protection is. There is confusion between child rights, child safeguarding and child protection. Furthermore, there does not seem to be a clear understanding by all IPs of government's mandated role in a child protection system to provide oversight, coordination and a legal and policy framework.
- There is a continuing need for improved coordination between the OVC and care and treatment partners. This is especially true when looking at increasing the ability to identify, test and improve adherence rates in children and adolescents. Working together and recognizing that

para social workers, as front line workers engaged with vulnerable families within the communities, should be better utilized and understood by the health sector to help identify and refer cases of children and adolescents. Similarly, recognizing that neglect and stigma of children, especially those living with extended family, elderly caregivers or child headed households, is a significant factor in testing, treatment and adherence. Therefore, working together with the social welfare sector is critically important in identifying where those children are and responding to these issues with both medical and social services.

- It is important to ensure that there is child protection and system strengthening technical expertise engaged in project evaluations for OVC partners, including those where an OVC component is embedded within a larger project. This inclusion presents an important opportunity to ensure that the evaluation includes a child protection/OVC lens and that learning from the evaluation can be utilized to improve and inform future efforts.
- USAID should utilize its convening power to ensure that OVC programming priorities, approaches and interventions are shared with national level government bodies and UNICEF to ensure that coordination of efforts in areas such as social protection, child protection system strengthening, adolescents and children without parental care are proactively identified and coordinated whenever and wherever possible.

VII. Conclusion

The portfolio review provided an opportunity to meet with implementing partners, learn from their experiences and identify successes and challenges within the framework of the existing USAID OVC Strategy for Uganda. There are many positive elements to the existing strategy as well as to the existing programming efforts. The current strategy relies on a wide range of highly qualified technical experts as implementing partners although the number could be reduced to help support more standardized approaches, utilization of common approaches, tools and terminology. The system strengthening approach that has as its long term objective to strengthen the ability of government, at all levels, to provide oversight, collect, analyze and use data to inform policy and practice, to coordinate key actors and ensure proper service delivery is an important and necessary component of the strategy that reflects global and national priorities. Given that system strengthening requires a long-term approach, it is highly recommended that USAID continue moving forward with this approach and support future programming that builds off of what has been accomplished to date, including supporting government structures at all levels. Of particular importance is to continue to provide support to MGLSD to build its own capacity to be able to successfully advocate for increased presence of and resources towards social welfare and child protection.

It is an opportune time for USAID Uganda to develop and promote a more unified understanding of system strengthening and child protection amongst all OVC partners. This understanding will work to enhance mutual respect, increased appreciation for system strengthening approaches and interventions hopefully result in an improved understanding of how and why civil society and government can and should work together to better serve vulnerable children and families.

The portfolio review also highlighted the need for USAID Uganda to maintain a holistic intervention approach to reduce vulnerability and assist children and families affected by HIV and AIDS. This includes a judicious mix of household economic strengthening (HES) interventions, including income/asset transfers for the most vulnerable households. Building upon the global evidence base that supports a combined approach of HES and social service system strengthening, USAID Uganda is in an excellent position to promote this approach and encourage future implementing partners to build off of and learn

from the experiences of SUNRISE and SCORE, for example.

Finally, this review has demonstrated the important need to enhance coordination, collaboration and knowledge management amongst implementing partners (both OVC and care and treatment) and between USAID and the implementing partners. Without robust coordination and collaboration between mechanisms, opportunities for synergies are lost. A knowledge management approach that incentivizes learning and sharing amongst all partners working in OVC presents a huge opportunity to maximize USAID investments.

Annexes

Annex 1: Scope of Work for USAID Orphans and Vulnerable Children Portfolio Review

Background

USAID has asked 4Children to evaluate its portfolio of OVC programs prior to awarding two new large OVC awards in Uganda.

The overall purpose and expected results of the current OVC portfolio are: *At least 967,187 additional OVC access and utilize core services for improving health, nutrition, education, and psychosocial well-being and reducing abuse, exploitation and neglect in the Central and Western Regions of Uganda.*

> *Result 1: OVC caregivers have the parenting skills and economic resources to increase access core services*
> *Result 2: Government, civil society and communities increase and improve core services for OVC and their caregivers*
> *Result 3: Coordination of community-based clinical and socio-economic services is improved*

First, 4Children is to conduct a performance evaluation of two USAID OVC programs in Uganda (SCORE and SUNRISE) to determine their effectiveness in meeting approved targets. Then, using those evaluations and other sources, 4Children will conduct an overall assessment of USAID/Uganda's OVC portfolio. In its review, 4Children will cover the following questions articulated by USAID:

1. What are the strengths, weaknesses, threats and opportunities associated with the Strategy described in this Results Framework?
2. How might the Strategy be improved or strengthened (within the parameters of current PEPFAR priorities)?
3. How do current mechanisms support achievement of these results?
4. What are the strengths, weaknesses, threats and opportunities associated with these mechanisms?

4Children will look at which mechanisms beneficiaries themselves regard as most useful, as well as which mechanisms provide "bang for buck". In addition to other areas of programming for OVC, the 4Children team will assess:

- Targeting and enrollment
- Case management
- Graduation
- Economic activities for destitute HHs, HHs struggling to make ends meet, and HHs ready to grow
- Parenting programs
- Child safeguarding
- Psychosocial programs for OVC
- Initiatives to strengthen leadership and governance, coordination and networking, financing, social service workforce, and information systems for OVC
- Programming to prevent and respond to violence against children

- Referral systems and other mechanisms to connect health facilities and social service programs, including for very young children
- Early childhood development programming and mechanisms for coordinating health and social services for very young children

Reporting and Work Relationships

The 4Children Uganda assessment team will be led by Karen Doll, Senior Program Manager at IntraHealth. Kelley Bunkers, the 4 Children Child Protection and Systems Strengthening Technical Director, will be the 4Children team liaison and will report on behalf of the team to Shannon Senefeld, 4Children Project Director. Shannon Senefeld, in turn, will liaise with USAID/W and 4Children partners about the progress of the assessment team. Other team members include Dan Oliver, 4Children Evidence Building Technical Director, and Carrie Miller, CRS Senior Technical Advisor for OVC Economic Strengthening.

While in Uganda, the 4Children assessment team will coordinate with USAID/Uganda for meetings, liaising as necessary with the CRS office for logistical support.

Activities to be conducted by the assessment team

- Consult with USAID/W and USAID/Uganda on final portfolio review parameters and reporting format, including the USAID-generated list of review questions (Attachment One)
- Conduct a desk review of relevant USAID and Government of Uganda documents, including the Uganda National Household Survey and "The Four P's" document for portfolio review
- Develop review methodology
- Per methodology, determine desired in-country meetings/assessment activities
- Brief local assessment team members on review scope and methodology
- Conduct interviews with key stakeholders on performance of SUNRISE project: including SUNRISE AORs, implementing partners' leadership and project staff, relevant members of the Government of Uganda, beneficiaries/project participants of SUNRISE, and external stakeholders
- Collect and analyze performance data, as available, from implementing partners
- Develop performance evaluation SUNRISE
- Consult with key stakeholders of other USAID OVC programs as relevant
- Develop report on overall performance of USAID/Uganda OVC programming

Activities to be performed by USAID in support of 4Children:

- Provide guidance on evaluation parameters and format
- Assist with designing and setting up in-country schedule
- Meet with assessment team as required by review methodology
- Other support as needed

Deliverables:

- Performance evaluation of SCORE
- Performance evaluation of SUNRISE
- Report on overall performance of USAID/Uganda OVC programming

Place and period of performance:

Uganda, February 2015.

The activity is expected to take approximately 15 days of work in country, plus three days per team member of preparation time, five to ten days per team member for report writing, and three days for administrative work to set up and close out the activity.

ATTACHMENT ONE: Questions to consider for OVC Portfolio Review in Uganda

Results Framework for Uganda OVC Portfolio
Purpose: At least 967,187 additional OVC access and utilize core services for improving health, nutrition, education, and psychosocial well-being and reducing abuse, exploitation and neglect in the Central and Western Regions of Uganda

Result 1: OVC caregivers have the parenting skills and economic resources to increase access core services

- *OVC caregivers increase expenditures on food, education, health*
- *OVC caregivers demonstrate improved parenting skills*
- *OVC perceptions of wellbeing increase and distress decrease*

Result 2: Government, civil society and communities increase and improve core services for OVC and their caregivers

- *Leadership and governance structures, the social service workforce, financing and information management are strengthened*

Result 3: Coordination of community-based clinical and socio-economic services is improved

- *All OVC and their caregivers enrolled in OVC programs know their status and adherence to treatment improves*
- *More OVC and their caregivers (particularly those under 8 and over 14) access health and nutrition services*

Potential Review Questions

1. What are the strengths, weaknesses, threats and opportunities associated with the Strategy described in this Results Framework?

2. How might the Strategy be improved or strengthened (within the parameters of current PEPFAR priorities)?
3. How do current mechanisms support achievement of these results?
4. What are the strengths, weaknesses, threats and opportunities associated with these mechanisms?
5. The following areas of programming will be assessed:

- Targeting and enrollment
    - What criteria are used for targeting? Is it sufficient?
    - Who are the key target groups served by OVC programming? What are the ages, gender, living situations (family, street, orphanage), and HIV status, etc of children served? What are the education levels, income levels, and marital status, etc of

caregivers?
    - How are children prioritized for services
    - What are the primary challenges faced by children served by the OVC portfolio? Do girls face different challenges than boys? How are they different?
    - What opportunities exist for flexible enrollment as new HIV + children are identified?
- Case management
- Graduation
    - How do different OVC projects address graduation? What are the strengths/weaknesses of these graduation models?
- Economic activities for destitute HHs, HHs struggling to make ends meet, and HHs ready to grow
- Parenting programs
- Psychosocial programs ups for OVC
- Initiatives to strengthen leadership and governance, coordination and networking, financing, the social service workforce, and information systems for OVC
- Programming to prevent and respond to violence against children
- Referral systems and other mechanisms for connecting health facilities and social service programs
    - What are referral tools/mechanisms? What are the strengths/weaknesses of these tools/mechanisms and how could they be improved?
    - Do partners follow up on referrals to ensure that services are received? If yes, how?
    - Do partners have a method of providing feedback to other organizations that they refer clients to?
    - How many partners have formal MoUs?
- Early childhood development programming and mechanisms for coordinating health and social services for very young children
- Mechanisms for coordinating health and social services for very young children
- Engagement with faith-based communities and private sector
- Coordination with other USG projects (e.g. PEPFAR, USAID health, education, Feed the Future and other economic programming, DCOF funded projects, DOL funded child labor projects)
- Coordination with projects funded by other donors
- Coordination with government initiatives
- Relationship with government
    - Under what circumstances do projects interface with government? Which government officials from which departments/offices?
    - What are the strengths/weaknesses of this relationship? How could this relationship be improved?
    - What is the role of government vis a vis the OVC Portfolio?
- Child Safeguarding
    - How many partners/which have rules in place to protect children from being harmed or treated inappropriately by staff and volunteers? (Are rules in writing? How do staff/volunteers become aware of rules? Do children and caregivers know that these rules exist?)
    - If a staff member or volunteer suspects that a child is being mistreated (at home, school or other), what steps do partners take to address cases of abuse? How many/which partners have addressed cases of abuse and how were the cases handled?
    - What steps, if any, do partners take in the event a caregiver dies, is abandoned, or is unsafe at home?

- Project based M&E systems (including the appropriateness of indicators for measuring impact)
    - What M&E data do partners collect? How do they report on results? To whom? How often and in what form?
    - How much time do partner staff/volunteers spend collecting and reporting on data?
    - How is data used to support programming?
    - Does data support casework?
    - What data is most useful/least useful?
    - Is there any other data not currently collected that would be useful?

- How many/which partners are familiar with these sources of guidance: core, near-core, non-core activity guidelines, 2012 PEPFAR Guidance for OVC Programs, and COP15 Technical considerations? To what degree is the portfolio adhering to the guidance.

6. What are some key achievements of HKID funded USAID mechanisms?
7. Which activities implemented by mechanisms do beneficiaries consider most useful/least useful?
8. Which activities are most likely/least likely to be sustained beyond the life of OVC projects?
9. What are the greatest challenges faced by OVC mechanisms/partners?

10. What are lessons learned from HKID funded USAID mechanisms?
11. Are there any gaps in OVC programming? What areas of programming are not currently addressed by HKID funded USAID mechanisms but should be? In what ways might the OVC Portfolio be expanded to address these areas? Which mechanisms might be most appropriate to address these areas of programming?
12. Which mechanisms give us the biggest bang for our buck?
13. Is there any duplication (e.g. advocacy activities, quality improvement, nutrition and HES programming, programming for adolescents, faith-based, and private sector engagement under OVC Regional Projects and the smaller Health Advocacy Program, services through faith-based programming, ASSIST, PIN, RHU project, and Private Health Support Program)? What are opportunities for further streamlining the program to ensure greatest efficiencies?
14. Any other recommendations?

Annex 2: Results Framework for USAID Orphans and Vulnerable Children Portfolio Review

<table>
<tr><td colspan="3">Goal/Impact: Improved health, nutrition, education, and psychosocial wellbeing, and reduced abuse, exploitation and neglect among children affected by HIV and AIDS</td></tr>
<tr><td colspan="3">Outcome: Improved facilitation of core services at household, community and national levels for children affected by HIV and AIDS</td></tr>
<tr><td colspan="3">Outputs: Households, Communities and National and Sub-national institutions equipped to facilitate core services for children affected by HIV and AIDS</td></tr>
<tr><td rowspan="2">Development Hypothesis:

If children affected by HIV/AIDS are cared for by strong and financially stable families, make more regular use of essential health and nutrition services, and have access to a more effective protection system, they will grow into healthy, educated young adults free from violence and HIV.</td><td colspan="2">Goal Level Indicators:</td></tr>
<tr><td>Percent of children:
malnourished
<5 years with recent diarrhea
<5 years with recent fever
who are too sick to participate in daily activities
reporting irregular food intake
1-5 years fully immunized
with basic shelter
with basic social support
who have a birth certificate / identification card
>5 years currently enrolled in school
>5 years regularly attending school
>5 years who progressed in school over time</td><td>Percent of households:
in which caregiver reports basic social support
able to access money to meet important family needs
that are food insecure due to lack of resources
in which caregiver reports basic social support
able to access money to meet important family needs
that are food insecure due to lack of resources
Percent of target population
that views violence, exploitation, abuse, or neglect of children as less acceptable after participating in or being exposed to U.S. government programming</td></tr>
</table>

Output 1: Families/households equipped to facilitate core services for children affected by HIV and AIDS **Development Hypothesis**: If households reduce their socioeconomic vulnerability and improve their functioning, then they be better equipped to facilitate core services for children affected by HIV and AIDS	**Activity 1.1**: Increasing access to consumption support among critically vulnerable households caring for children affected by HIV and AIDS **Activity 1.2**: Increasing access to savings and credit among more vulnerable households caring for children affected by HIV and AIDS **Activity 1.3**: Increasing and/or diversified income among moderating vulnerable households caring for children affected by HIV and AIDS **Activity 1.4**: Increasing functioning among caregivers caring for children affected by HIV and AIDS	**Key Interventions**: - Support Village Savings and Loan Associations and complimentary parenting education and support groups - Support Farmer Field Schools - Promote outgrower/outsourcing approaches to private sector engagement - Facilitate cooperative agriculture input purchases - Support Microfranchising - Promote matched savings and asset building approaches such as Child Savings Accounts/Child Development Accounts - Provide consumption support/graduation approaches for critically vulnerable families

Output 2: Communities equipped to facilitate core services for children affected by HIV and AIDS **Development Hypothesis:** If communities improve linkages between community-based and clinical programs and increase access to health and nutrition services and integrated age services, then they will be better equipped to facilitate core services for children affected by HIV and AIDS	**Activity 2.1**: Improving linkages between community-based and clinical programs for identification, treatment and retention of HIV+ children and caregivers caring for children affected by HIV and AIDS **Activity 2.2**: Increasing access to health and nutrition services among households caring for children affected by HIV and AIDS **Activity 2.3:** Increasing access to integrated age-appropriate services for adolescents and very young children	**Key Interventions**: - Map essential services - Establish local referral and coordination mechanism between OVC service providers, health and nutrition service providers, and other key service providers - Train OVC service providers in Middle Upper Arm Circumference (MUAC) - Train OVC service providers to promote knowledge of Insecticide Treated Nets (ITN), safe water, HIV Counseling and Testing - Facilitate access to free Insecticide Treated Nets (ITN) and safe water products for critically vulnerable households - Integrate HIV Prevention and RH services within formal and informal education programs for adolescents - Use Early Childhood Development platforms to establish innovative mechanisms for linking OVC, PMTCT and Pediatric AIDs program

Output 3: National and sub-national institutions equipped to facilitate core services for children affected by HIV and AIDS **Development Hypothesis**: If national and sub-national institutions have stronger leadership, governance, and financing, a better performing workforce, more effective information management and accountability systems, better coordination and networking mechanisms and increased availability of good service models and delivery mechanisms, then they will be better equipped to facilitate core services for children affected by HIV and AIDS	**Activity 3.1**: Strengthening leadership, governance and financing at MGLSD, NCC, and other national and local-level national and local levels to plan and manage child welfare and protection services **Activity 3.2**: Improving performance among child welfare and protection workers **Activity 3.3**: Strengthening child welfare and protection information management, accountability, and evidence building systems **Activity 3.4**: Improving child welfare and protection coordination and networking mechanisms **Activity 3.5**: Increasing availability of good child welfare and protection models and delivery mechanisms	**Key Interventions**: - Support for OVC planning and integration - Advocacy for more workers - Advocacy for increased financing - Improve the relevancy, accuracy and use of OVC MIS data - Improve formal coordination and referral systems - Monitor quality of OVC services, deliver integrated services, and promote alternative care - Support development of research strategy and plan - Support Violence Against Children Study and Advocacy

Annex 3: List of documentation reviewed

1. 4Children. Draft *Program Guidance for 4Children.* (2014).
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Annex 4: KII & FGD Participant Lists

First Name	Last Name	Position/Title	Organization	District
Eunice	Kagoya	Interns/Volunteers	Bugiri District	Bugiri
Ketty	Muzaki	Interns/Volunteers	Bugiri District	Bugiri
Silvia	Mirembe	Interns/Volunteers	Bugiri District	Bugiri
Byakika	Yakubu	DOVCC Chair	Bugiri District	Bugiri
Edith	Nalukwembbe	Secretary, GLSD	Bugiri District	Bugiri
George	Omuge	CAO	Bugiri District	Bugiri
Shafiq	Butanda	District PWO	Bugiri District	Bugiri
Stephen	Magero	DCDO	Bugiri District	Bugiri
Tabitha	Bwizanganya	Data Entry Clerk	Bugiri District	Bugiri
Dan	Kudaga	Parish Chief Uwemba	Bulida Sub County	Bugiri
Ronald	Ssenyonjo	CDO	Bulida Sub County	Bugiri
Andrew	Ochieng	SCORE	SCORE	Bugiri
Lydia	Nabiyre	Nursing Officer	Uwemba S/C Health Center	Bugiri
Stella	Nabiyere	Nursing Officer Lead	Uwemba S/C Health Center	Bugiri
Emma	Kaihura	M&E officer	Africare	Kampala
Esther	Karamagi	Acting COP	ASSIST	Kampala
Juliana	Nabwire	QI Advisor	ASSIST	Kampala
Grace	Kemimrembe	DCOP	Community Connector	Kampala
Benjamin	Aisya	M,E &L	Community Connector	Kampala
Charles	Sserwanja	HIV/Public Health	IRCU Faith-Based HIV-AIDS	Kampala
Joshua	Kitakule	COP	IRCU Faith-Based HIV-AIDS	Kampala
Agnes	Wasike	National CP Coordinator	MGLSD	Kampala
Harriet	Atim	Program Officer	MGLSD	Kampala
Jane	Ogwang	Sr Probation Officer	MGLSD	Kampala
Lydia	Najamba	OVC Coordinator	MGLSD	Kampala
Mortiz	Magal	OVC Department Head	MGLSD	Kampala
Obadiah	Kushemeirwe	OVC MIS Coordinator	MGLSD	Kampala
Onduri	Machula	Act. Dir., Soc.Protection	MGLSD	Kampala
Barbara	Amuron	Chief of Party	MEEPP	Kampala
Sarah	Kyokusingura	Sr M&E Advocacy Advisor	MEEPP	Kampala
Boniface	Mugisha	TM, Livelihoods	PIN	Kampala
Brian	Rubwojo	Chief of Party	PIN	Kampala
Jarvice	Sekajja	OVC Specialist	PIN	Kampala
Massimo	Lowicki	Chief of Party	SCORE	Kampala
Saul	Langol	Dep. Chief of Party	SCORE	Kampala
Robert	Kalemba	Director, Sustainability	SDS	Kampala
Madina	Nakibiringe	Senior Grants Manager	SDS	Kampala
Ella	Hoxha	Chief of Party	SDS	Kampala
Annet	Kaobusngye	Dep.Chief of Party	SUNRISE	Kampala

Fred	Ngaribano		SUNRISE	Kampala
Grace	Mayanja	Chief of Party	SUNRISE	Kampala
Herbert	Tumuhimbise	Senior Technical Advisor	SUNRISE	Kampala
Patrick	Ssemanda	Sr. M&E Officer	SUNRISE	Kampala
Richard	Ekodeu	TA Qual. Ass. &Standards	SUNRISE	Kampala
Basil	Kandyomunda	Senior Consultant	SUNRISE (Consultant)	Kampala
Michael	Etokoit	Chief of Party	TASO	Kampala
Aida	Girma	Country Director	UNICEF	Kampala
Sylvia	Pasti		UNICEF	Kampala
Wilboard	Ngambia	Social Policy Analyst	UNICEF	Kampala
Catherine	Muwanga	AOR	USAID	Kampala
Edton Babu	Ndyabahika	Deputy Country Director	World Education	Kampala
Mark	Riley	Child Protection Expert	Consultant	Kampala
Judith	Kinue	Friend 1	Child Care Institution	Mpigi
May	Caplin	CEO	Child Care Institution	Mpigi
Sarah	Kasozi	Administrator	Child Care Institution	Mpigi
Sarah	Kiyingi	Friend 2	Child Care Institution	Mpigi
Luwakanya	Johnmary	LCV Chairman	Mpigi District	Mpigi
Mataringaya	Willy	CAO	Mpigi District	Mpigi
Mwanje	Anthony	DCDO	Mpigi District	Mpigi
Nabuuma	Annet	Senior Probation Officer	Mpigi District	Mpigi
Dr. Kasendwa	Patrick	Medical Director	Nkozi Hospital	Mpigi
William	Mbwonigaba	Team Lead	Save the Children	Mpigi
William	Etwop	M&E	Save the Children	Mpigi
Kyobe	Anny	CDO	Sub-County	Mpigi
Sarah	Nakandi	Sub-County Chief	Sub-County Local Gov't	Mpigi
Babirye	Aisha	Acting Manager	Bushfire Ministries (CCI)	Namatumba
Bernard	Ogwang	CAO	District Government	Namutumba
Esther	Nandase	Probation Officer	District Government	Namutumba
Samuel	Livango	DCDO	District Government	Namutumba
Kwajja	Bumali Hissa	CDO	Sub-county Government	Namutumba
Eric Robert	Kamunvi	TSO Representative	World Education	Namutumba
Specioza	Namakula	TSO M&E	World Education	Namutumba
Kamwesigje	Necvilleus	OVC Coordinator	STAR-EC	Kampala
Mr. Johnson ,	Mutungwanda	ACAP	District Government	Kasese
Wilson	Asaba	Chairperson DOVCC	District Government	Kasese
Kitanywa	Sowedi	Sr. PWO	District Government	Kasese
Ben	Birungi Henry	DCDO	District Government	Kasese
Florence	Ayo	TSO representative		Kasese
Nzirambi		Child Care Institutions	NOTDEC	Kasese
Kamwesigje	Necvilleus	OVC Coordinator	STAR-EC	Kampala

Nsubuga	Hood	DCDO	District Government	Bundibigyo
Zakayo	Kisungu	ACAO/DOVCC Chair	District Government	Bundibigyo
Simon	Musiga	PWO	District Government	Bundibigyo
Edmond		DCDO	District Government	Bundibigyo
Joseph	Maate	CDO	Sub-county Government	Bundibigyo
Geofrey	Muntangie	ACDO	Sub-county Government	Bundibigyo
Veronica	Kugonza	Secretary for gender	District Government	Bundibigyo
David	Opwonya	Dep. CAO/ DOVCC Chair		Gulu
Isaac Netwton	Ojok	District Vice-chairperson		Gulu
Jessica	Anena	PWO		Gulu
Cosmas	Opio	CDO	Bungaatira Sub-county	Gulu
Micheal	Ongan	TA Capacity building		Gulu
Fred Peter	Okello	TA- M&E		Gulu
Jimmy	Okello	PM, Family Strengthening	SOS Children's Village	Gulu
Sarah	Nayiga	Programme Director	SOS Children's Village	Gulu
Beatrice	Ochan	Family Care Manager	SOS Children's Village	Gulu

Focus Group Discussions (FGD)	District	Sub-County
National Child Serving CSOs	Kampala	
USAID Health Projects	Kampala	
Int'l Child Serving CSOs	Kampala	
USAID Integrated Health Projects	Kampala	
USAID Care and Treatment	Kampala	
TSO Meeting I 2.9	Kampala	
TSO Meeting II 2.19	Kampala	
INGOs	Kampala	
Children (Aged 12-15 years)	Mpigi	
Children (Aged 16-17 years)	Mpigi	
DOVCC	Mpigi	
Community Leaders	Mpigi	Kilingente
Parasocial Workers	Mpigi	Kilingente
Caregivers	Mpigi	Kilingente
SOVCC	Namatumba	Magada
DOVCC	Namatumba	
Community Leaders	Namatumba	Magada
Caregivers	Namatumba	Magada
Paraprofessionals	Namatumba	Magada
Children	Namatumba	Magada
DOVCC	Bugiri	

Community Leaders	Bugiri	
Caregivers	Bugiri	
Para Social Workers	Bugiri	
Children	Bugiri	
DOVCC	Kasese	
SOVCC	Kasese	
Caregivers	Kasese	
Children	Kasese	
DOVCC	Gulu	
SOVCC	Gulu	
Caregivers	Gulu	
Para social workers (PSWs)	Gulu	
Children	Gulu	
DOVCC	Bundibugyo	
SOVCC	Bundibugyo	
Caregivers	Bundibugyo	
Para social workers (PSWs)	Bundibugyo	
Children	Bundibugyo	

Annex 5: Key informant interview guides

Key Informant Interview Guide for District Chief Administrative Office (CAO)
Name
Title
Date

Introduction
4Children is a USAID funded global project, meaning we are not specific to one country. 4Children is a consortium of organisations led by CRS. USAID Uganda has asked us to carry out two assignments in Uganda. One is an evaluation of the SUNRISE project. Our team is collecting information from other districts (ADD NAMES) and from many different people who have been in engaged in or have received services from this project. We hope to use this information to provide us with important feedback that will help inform and guide the next phase of programming. We want to build on what is going well and learn from and improve upon the things that are not going as well as we would like.

Additionally, USAID has asked us to do a review of the USAID OVC portfolio, which includes the SUNRISE project and many other initiatives related to OVC.

Portfolio Review
- What are the critical issues related OVC and child protection that you feel must be addressed (or continue being addressed) in the next five years?
- How are these reflected in the district development plans and budget allocation?
- What are the primary gaps related to OVC and child protection in your district?

Key Informant Interview Guide for TSO
Name
Title/Organization
Date

Introduction
4Children is a USAID funded global project, meaning we are not specific to one country. 4Children is a consortium of organisations led by CRS. USAID Uganda has asked us to carry out two assignments in Uganda. One is an evaluation of the SUNRISE project. Our team is collecting information from other districts (ADD NAMES) and from many different people who have been in engaged in or have received services from this project. We hope to use this information to provide us with important feedback that will help inform and guide the next phase of programming. We want to build on what is going well and learn from and improve upon the things that are not going as well as we would like.

Additionally, USAID has asked us to do a review of the USAID OVC portfolio, which includes the SUNRISE project and many other initiatives related to OVC.

Portfolio Review
- What are the critical issues related OVC and child protection that you feel must be addressed (or continue being addressed) in the next five years?
- Are these reflected in the legal and policy framework?
- Are these reflected in the work that USAID is supporting?
- What are the primary gaps related to OVC and child protection in Uganda?
- How would you describe the current status of social work within Uganda at this point in time? Have there been important developments in this area? Please describe? What do you see as the continuing gaps in this area?
- How would you describe the relationship (i.e., the "links between") USAID supported work in the area of OVC and national government bodies mandated with protecting the health, education and protection of children—especially those affected by HIV and other adversities.
    - What are the gaps?
- Is there any support related to OVC and child protection from the US Government that you would like to be different?

Key Informant Interview Guide for Care and Treatment Facility
Name
Title
Date

Introduction
4Children is a USAID funded global project, meaning we are not specific to one country. 4Children is a consortium of organizations led by CRS. USAID Uganda has asked us to carry out two assignments in Uganda. One is an evaluation of the SUNRISE project. Our team is collecting information from other districts (ADD NAMES) and from many different people who have been in engaged in or have received services from this project. We hope to use this information to provide us with important feedback that will help inform and guide the next phase of programming. We want to build on what is going well and learn from and improve upon the things that are not going as well as we would like.

Additionally, USAID has asked us to do a review of the USAID OVC portfolio, which includes the SUNRISE project and many other initiatives related to OVC.

Today I would like to cover issues around both the SUNRISE evaluation and the portfolio review with you.

Pediatric HIV

- As we are looking at OVC issues and the linkages between care and treatment and OVC programming, we would like to know what challenges you are facing with increasing pediatric enrollment into care and treatment?
- What challenges do you face with adherence amongst children?
- What challenges do you face with defaulting amongst children?
- What techniques do you use to improve adherence and to trace defaulters particularly children?
    - Most facilities should be taking a family approach and will tell you that they work with the parents/caregivers and the child together

Potential linkages with OVC programs and paraprofessional Social Workers

- In the case of SUNRISE, nearly 11,000 of para professional social workers have been trained in areas related to child protection and working with families and communities. This cadre could be an added benefit to identify adults and children in the community living with HIV and assist to bring them into treatment facilities. What advantages would you see? What would be the challenges?
- Do you have any examples of collaboration with the paraprofessional social worker or the CDO/probation and welfare officer
- Could there be any role for the para professional to work on issues of adherence or care and treatment defaulting? What would be the challenges?
- At facility level, when you see signs of abuse and violence in women or children, what do you do? Do you refer them to the CDO or to the Police? What challenges do you face in this kind of referral? What would be the solutions that you would propose?
- What are the other social issues that you have referred to a CDO or probation and welfare officer?

Key Informant Interviews Makerere University
Name
Title/Position
Date

4Children is a USAID funded global project, meaning we are not specific to one country. 4Children is a consortium of organisations led by CRS. USAID Uganda has asked us to carry out two assignments in Uganda. One is an evaluation of the SUNRISE project. The SUNRISE project is in its fifth year of implementation. Are you familiar with the SUNRISE project? If not, I am happy to give a quick summary. SUNRISE is a USAID funded social welfare systems strengthening project.

Additionally, USAID has asked us to do a review of the USAID OVC portfolio, which includes the SUNRISE project and many other initiatives related to OVC. Today I would like to cover issues around both the SUNRISE evaluation and the portfolio review with you. First, if you agree, I would like to begin with the questions related to the **SUNRISE project.**

PORTFOLIO REVIEW

- What do you understand as the primary focus of the government in terms of OVC? Does this coincide or reflect USAID programming in their area of OVC?
- How would you describe the current status of social work within Uganda at this point in time? Have there been important developments in this area? Please describe? What do you see as the continuing gaps in this area? Are they being addressed by government, USAID or other donor funding? What would you say are the most critically important issues around social work for the next 3-5 year period?
- How often have you had engagement with USAID? Has the input of the University been solicited during planning processes
- Is there any support related to OVC and child protection from the US Government that you would like to be different?

Key Informant Interview Guide UNICEF
Name
Title/Position
Date

4Children is a USAID funded global project, meaning we are not specific to one country. 4Children is a consortium of organisations led by CRS. USAID Uganda has asked us to carry out two assignments in Uganda. One is an evaluation of the SUNRISE project. The SUNRISE project is in its fifth year of implementation. Are you familiar with the SUNRISE project? If not, I am happy to give a quick summary. SUNRISE is a USAID funded social welfare systems strengthening project.

Additionally, USAID has asked us to do a review of the USAID OVC portfolio, which includes the SUNRISE project and many other initiatives related to OVC. Today I would like to cover issues around both the SUNRISE evaluation and the portfolio review with you.

PORTFOLIO REVIEW

- What are the critical Government priorities related to OVC in general and child protection specifically? Are these clearly articulated in the existing legal and policy framework? Have these priorities changed or evolved over the past five years?
    a. Where do you feel that UNICEF, together with the government have had the most success in addressing or fulfilling these OVC priorities? Have USAID projects been engaged in these efforts? Please provide examples.
- What are the primary gaps related to OVC and child protection for which the Ugandan Government would like continued or additional development partner assistance?
    a. What are the gaps currently not filled by any development partner?
- How would you describe the current status of social work within Uganda at this point in time? Have there been important developments in this area? Please describe? What do you see as the continuing gaps in this area? What is the structure of social work in Uganda?
- How would you describe the relationship (i.e., the "links between") USAID supported work in the area of OVC and national government bodies mandated with protecting the health, education and protection of children—especially those affected by HIV and other adversities.
    a. What are the gaps?
- How often does USAID interface with Government, UNICEF and other donors during planning processes of government and USG? How would you describe this collaboration? What are the existing coordination mechanisms at national level and are UNICEF and USAID actively engaged? If not, do you have suggestions for how to strengthen this coordination?

    Is there any support related to OVC and child protection from the US Government that you would like to be different.