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LEARNING GROUP 3: EXPANDING ACCESS TO SERVICES AND PROTECTING HUMAN RIGHTS

Photo by Laurie Wen

Community-Centered Integrated Services for Orphans and Vulnerable Children in Rwanda

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List of Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy for HIV (triple therapy)
ARV	Antiretroviral drugs for treatment and/or prophylaxis of HIV virus
CBO	Community Based Organization
CCM	Country Coordinating Mechanism
CDC	Centers for Disease Control and Prevention
CHAMP	Community HIV/AIDS Mobilization Project
CNLS	*Commission Nationale de Lutte Contre le Sida*
CSO	Civil Society Organization
DACC	District AIDS Control Committee
DFID	UK Department for International Development
EDPRS	Economic Development and Poverty Reduction Strategy
FBO	Faith Based Organization
GDP	Gross Domestic Product
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GoR	Government of Rwanda
HIV	Human Immunodeficiency Virus
IMCI	Integrated Management of Childhood Illnesses
M&E	Monitoring and Evaluation
MAP	Multi-Country HIV/AIDS Program
MDG	Millennium Development Goal
MIGEPROF	Ministry in charge of Gender, Child Protection, and Family Promotion
MINELOC	Ministry of Local Affairs
MOU	Memorandum of Understanding
NACC	National AIDS Control Commission
NGO	Non-governmental organization
NIPS	Nkundabana Initiative for Psychosocial Support
NOVIB	*Nederlandse Organisatie Voor Internationale Bijstand* (Oxfam, Netherlands)
OVC	Orphans and Vulnerable Children
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PITC	Provider Initiated Testing and Counselling
PLWHA	People Living With HIV/AIDS
PMTCT	Prevention of Mother-To-Child Transmission
PRSP	Poverty Reduction Strategy Paper
RALGA	Rwandan Association of Local Government Authorities
RWN	Rwanda Women's Network
SIAPAC	Social Impact Assessment and Policy Analysis Corporation
TRACPlus	Treatment and Research AIDS Center Plus
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations Children Fund
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
WHO	World Health Organization
VCT	Voluntary Counseling and Testing

Executive Summary

Background: A community-centered program supported by Rwanda's national government aims to provide a "minimum package" of services for OVC, including comprehensive access to health services, assistance with school fees, child protection services, as well as nutritional, psychosocial, and economic support. While strong political will exists to protect and support this population, the mobilization of resources has become increasingly difficult given the magnitude of children's needs throughout the country, which has endured the long-term effects of the 1994 genocide and the ongoing impact of the HIV/AIDS epidemic, resulting in nearly 3 million orphans and vulnerable children in a total population of 9 million individuals nationwide.

The overall goal of this case study is to provide in sufficient detail the process that follows from initial ideas/ vision, government policy development, the creation of national strategic plan of action, local (district-level) program and work plan development, and ultimately program implementation, including monitoring and evaluation (M&E). A detailed description of the M&E system is offered as an example of how information generated at the local level can potentially inform changes in the strategic plan to improve overall program performance.

There are innumerable examples in global health of how 'good ideas' stay in the board room or conference hall and never reach those in need. The Rwanda OVC case is an example of sound ideas of public service translated into action. By offering a detailed description and outlining the architecture of this process, readers can glean from the case what may be replicated in other settings, in terms of content, process, or both. Therefore, the target audience of this case includes other policy makers, government officials, decision makers for multilateral and bilateral organizations, program developers, and implementers.

Methods: Several different sources of information were used to develop this case study. These sources include primary policy documents from NACC, documents from the Rwandan NACC website, and other sources from the gray literature. A comprehensive review of government documents was performed based on these sources. In addition, documents and websites from non-governmental organizations working in Rwanda were reviewed. Primary data were collected through semi-structured interviews with key informants from governmental and non-governmental agencies in Rwanda. Key informants were from the National AIDS Control Commission (NACC), representatives from two district offices in Rwanda (one high-performing and one low-performing in terms of services provided to OVC) as well as five civil society organizations: CARE International, Haguruka, Imbuto Foundation, Rwanda Women's Network, and World Relief. District leaders were interviewed in order to describe relevant national policies and program implementation.

Results: Findings indicate a number of key elements that have promoted advancement of the program, including: a clear vision at the outset that informed the OVC policy and framework for the strategic national plan of action with clear objectives; sustained political will and leadership at the national level; a comprehensive, multi-sector orientation; a holistic approach to services for OVC; a focus on transparency as well as decentralization of authority, planning, and responsibility at the district level; a monitoring and evaluation system that is broadly accessible and focuses on district level capacity building and analysis of the data at the local level to inform programmatic improvements; and involvement of children to inform recommendations for OVC policy and programming.

Ongoing challenges include: communication and coordination of program activities between the national and district levels as well as among district level organizations; difficulties in providing all elements of the "minimum package;" ensuring that all OVC are identified and assisted; and concerns regarding the level of resources available being outstripped by the number of orphans and other vulnerable children and the magnitude of their needs.

Policy/action implications and conclusions: Linkages to facilitate navigation of children within the system should be strengthened and documented so that they can be applied elsewhere. Future efforts should focus on employing mechanisms to coordinate, follow-up, and evaluate implementation of the OVC package. Continued engagement of OVC programmatic advancements in economic development activities will prevent marginalization of the program. Additional inputs for the M&E system will provide opportunities for increased capacity building at the district level and further authority and advance program development at the local level. Technical and financial stability of support for OVC and vulnerable families should be given high priority, and planning for future financing will be essential for sustained success of the program.

In summary, the purpose of this case study was to describe the framework or architecture of a program from the outset, starting with the initial vision and ending with program implementation. The vision of aggressively moving Rwanda's economic situation out of poverty is an underlying force that drives the process and it is this vision that characterizes the type of leadership that is motivated by the democratic process and the promotion of human rights, particularly of those most vulnerable. The mechanics of operationalizing the vision of offering orphans and vulnerable children the services and resources they are entitled to were initiated with policy development, which provided the framework for the national strategic plan of action. The guiding principles of the strategic plan were based on content from Rwanda's National Policy on OVC (2003) and the UN Convention on the Rights of the Child (GoR, 2006).

However, in the Rwandan case, the process did not 'stop' with the national strategic plan; implementation was possible because this national plan was translated into district-level plans in which district officials were responsible for program plans, implementation, and evaluation. In terms of future progress of this ambitious plan, feedback from program implementers indicated a need to strengthen efforts of communication, capacity building, transparency and coordination between national and local/district levels of operation. As more capacity building occurs at the district level, the local government will be able to develop a more coordinated response (e.g. across government entities and CSOs) to address the needs of OVC, since they may vary in different geographical areas of Rwanda.

Rwandan policy makers were able to set the agenda with development partners, such as PEPFAR, Global Fund, World Bank, etc., given the fact that they had engaged local communities as well as orphans and vulnerable children to offer feedback on how OVC could be assisted. Policy makers developed the "minimum package" program in part based on this feedback and negotiated with development partners to fund this program, rather then allowing outside funders to set the agenda. As a result, the Rwandan government was able to make its own decisions on allocation of this external funding and also was able to develop a monitoring and evaluation system that mirrored their internal goals and objectives for the OVC program. In the immediate-term, this has sustained the system and program activities. It is clear that greater external funding for the program is needed currently to meet the great need of OVC; however, as Rwanda transitions into its vision of a middle-income nation, it is anticipated that more resources will be generated internally by the very youth who benefited from the existing program.

1. Introduction, Overview, and Justification for the Study

> *Rwanda has a very specific OVC situation, and I think we could help other countries that aren't developing as rapidly as we are—as we're* trying *to do. When people are empowered, confident in themselves, they are more creative. It's not the people in high places but the beneficiaries who quickly find ways to use these models.*
>
> Rwandan district authority

The 1994 genocide in Rwanda has left an indelible mark on the country. In late 2007, there were an estimated 3.4 million children aged 0-17 in Rwanda, that is, over one-third of a total population of 9 million. Of these children, 825,000, or 24% of the children in Rwanda, were orphans and 2 million (59%) were deemed as vulnerable children (SIAPAC, 2008). Although it is likely that Rwanda's comprehensive HIV/AIDS response has prevented the pandemic from spreading at rates similar to other countries in sub-Saharan Africa, HIV/AIDS remains a significant contributor of vulnerability to children, being responsible for over one-fifth of orphans throughout the country (SIAPAC, 2008).

Vulnerability of children and families in Rwanda is primarily the result of overwhelming poverty and the inability of caregivers to meet basic needs, such as food security, clean water, and housing (SIAPAC, 2008). It is well known that social supports often serve as a protective factor from the deleterious consequences of vulnerability. The reality is, however, that many orphans and vulnerable children (OVC) do not have the opportunity to maintain social supports they would expect if they were able to continue their schooling, remain connected with their families or communities, or live with surrogate adults who are able to care for them. The two main issues in this challenge are access to basic services and the sheer magnitude of the problem. What does this mean for Rwanda?

Faced with an emergent generation of "vulnerable" adults, the Government of Rwanda (GoR) has recognized the urgent need to reach these orphans as well as other children made vulnerable by the genocide, poverty, and HIV/AIDS. Strong political will has played a central role in the GoR's attempt to raise the status of the most vulnerable populations. In the past five years, a coherent response to support OVC has emerged, first through the broader HIV/AIDS response and then in the 2003 National Policy on OVC, culminating with the Strategic Plan of Action for Orphans and Other Vulnerable Children, 2007-2011 (GoR, 2006). GoR and its partners are currently developing a national strategic plan for social protection that targets all vulnerable groups, but OVC make up the largest segment of the population that would benefit from this plan.

The strategic plan recently called for a situation analysis of OVC program aims in order to improve its evidenced-based planning, strengthen the OVC response, and include the beneficiaries as participants in planning interventions. This plan has also mandated the provision of a "minimum package of services" to OVC. The minimum package, which includes access to basic health care, nutritional support, formal and non-formal education and training, protection, and psychological and socioeconomic services, is now in its second year of implementation.

How does this national implementation of OVC policy and strategies translate into supporting children? This case study assesses and describes how actors at the decentralized level, i.e., district authorities and community-based organizations (CBOs), coordinate efforts to provide services to help alleviate the suffering of children and families at risk, given existing economic and human resource constraints. The overall goal of this case study is to provide in sufficient detail the process that follows from initial ideas/ vision, government policy development, national strategic plan of action, local (district-level) program and work plan development, and ultimately program implementation, including monitoring and evaluation (M&E). A detailed description of the M&E system is offered as an example of how information generated at the local level can potentially inform changes in the strategic plan to improve overall program performance. There are innumerable examples in global health of how ‘good ideas’ stay in the board room and never

reach those in need. The Rwanda OVC case is an example of sound ideas of public service translated into action. By offering a detailed description and outlining the architecture of this process, readers can glean from the case what may be replicated in other settings, in terms of content, process, or both. Therefore, the target audience of this case includes other policy makers, government officials, decision makers for multilateral and bilateral organizations, program developers, and implementers. The lessons learned highlight certain factors that facilitate successful implementation of OVC support in Rwanda, as well as ongoing implementation challenges.

1.1 Methodology

Several different sources of information were used to develop this case study. These sources include primary policy documents from NACC, documents from the Rwandan NACC website, and other gray literature (such as that found on the "AIDSportal" website). A comprehensive review of government documents was performed based on these sources. In addition, documents from non-governmental organizations working in Rwanda were reviewed. Field staff interviewed key stakeholders in Rwanda to describe the policy development as well as the program implementation of the Rwandan OVC program.

Primary data were collected through semi-structured interviews with key informants from governmental and non-governmental agencies in Rwanda. Key informants were from the National AIDS Control Commission (NACC), representatives from two district offices in Rwanda (one high-performing and one low-performing in terms of services provided to OVC), as well as five civil society organizations: CARE International, Haguruka, Imbuto Foundation, Rwanda Women's Network, and World Relief. District leaders were interviewed in order to describe relevant national policies and programs. Civil society organizations were selected based on their active participation in offering care and support for OVC in the selected districts and staff members were interviewed to describe service provision at the grassroots level. In addition to primary data collection, relevant websites from organizations that support children in high HIV-burden areas were also reviewed as part of the formative research stage and qualitative data collection.

The two districts were selected based on a mapping exercise conducted in 2007 by the Rwandan Association of Local Government Authorities[1] (RALGA). The HIV/AIDS Program Officer at RALGA provided a summary of the three districts that fared the best and the worst based on the following criteria: available services; effective identification of OVC and their needs; and capacity to engage more implementers (see Table 1). Of the three highest-performing districts, Kamonyi in the Southern Province was selected because of its high number of OVC yet overall good performance (See comments in Table 1); its proximity to Kigali was also an advantage due to time constraints for conducting fieldwork. Of the low-performing districts, Nyarugenge in Kigali Province was chosen because it had few OVC interventions and few implementers (See comments in Table 1).

Interviews were recorded with a digital voice recorder and subsequently transcribed word for word. Interviews conducted in French were transcribed and then translated into English. The transcriptions were then coded thematically to facilitate organization and writing of the case study.

[1] RALGA's mission is to "strive for and build an efficient, effective, transparent, and accountable local government system in Rwanda." (http://www.ralga.org.rw/)

Table 1. Evaluation of OVC Interventions according to District

	Districts					
	Kayonza	**Kamonyi**	**Gicumbi**	**Nyaruguru**	**Nyarugenge**	**Musanze**
Performance	**High**	**High**	**High**	**Low**	**Low**	Low
Services Available						
School fees and school materials/ Supplies	√	√		√	√	
Professional training		√				
Health insurance	√	√		√	√	
Nutritional support	√	√		√	√	
ARVs	√					
PMTCT						
VCT, AIDS awareness/ prevention groups						√
Housing						
Capacity building						
Income-generating activities	√	√		√		
Effective Identification of OVC and Their Needs						
Children's committees at all decentralized levels			√			
Participation of OVC in identification of their problems			√			
Capacity to Engage More Implementers						
Presence of a large number of partners operational in the district	√		√			
Comments	Largest number of implement-ers and variety of services offered	Large number of OVC (30,000) but maintains satisfactory level of service provision to OVC	First and only district to implement children's committees at all decentralized levels	Few implementers (5). Needs significantly outweigh available resources. Largest number of OVC (36,317)	Few services for OVC and few implementers	Yet to establish an OVC database to enable planning of OVC interventions. Insufficient OVC services

2. Development Context

Aside from being a tremendous human tragedy, the 1994 Rwandan genocide exacerbated development constraints that had existed previously in Rwanda. What was already a poor economic infrastructure was virtually destroyed. Vast tracts of land and livestock were decimated, GDP was halved in a single year, and 80 percent of the population was plunged into poverty. The nation was robbed of a generation of trained teachers, doctors, public servants, and private entrepreneurs. After the genocide, the government was faced with the dilemma of how to mend the social, economic, and political fabric of the country (Government of Rwanda, 2000).

2.1 Decentralization

To counter the exclusion and oppression that led to one million deaths in 1994, those who were rebuilding Rwanda proposed establishing a pro-poor, decentralized, and participatory approach in all social programs. In 2000, the Rwandan Government adopted a Decentralization Policy that reorganized the country into 30 administrative districts with five provinces: Kigali, Eastern, Southern, Western, and Northern (Binagwaho, Spring, and Kourouma, undated). MINELOC, the Rwandan Ministry in charge of local government, community development and social affairs, defines the district as "a legal decentralized agency responsible for overall coordination of economic development." Each district is made up of individual sectors, which are responsible for service delivery, coordination and management of basic services, fundraising, monitoring, education and social affairs (including social protection), housing, and infrastructure (SIAPAC, 2008). Sectors are in turn divided into cells, which are responsible for community mobilization, and cells are further divided into villages.

Districts play an important role in the decentralization process. They act as intermediaries between civil society organizations (CSOs) [of which both CBOs and non-governmental organizations (NGOs) are a part] and the central government. Districts manage all community activities, including the OVC response, in their respective geographic areas. The district is in charge of planning, fundraising with the central government, allocating funds, handling financial transfers for the central government, and overseeing service delivery by sector agencies. The government's position is that a decentralized "learning by doing" approach will increase CSOs' capacity to meet objectives at the grassroots level. The main goal of decentralization is therefore to enhance opportunities for involving community-level actors and CSOs in national development priorities. The decentralization process promotes capacity building at the local level that can serve to ensure allocation of resources directly towards services for OVC. Local officials who are responsible for district-level OVC activities are elected by the general population. Therefore, communities are actively engaged and can withdraw support of elected officials who are not following through with OVC programmatic initiatives or choose to re-elect those who are making progress (GoR, 2006).

2.2 Vision 2020

In response to the emergency situation that Rwanda faced post-genocide, the government, in collaboration with the Ministry of Finance and Economic Planning, embarked on "Vision 2020," the country's development planning and policy framework for future strategies, plans, programs, and policies. Finalized in 1999, the document outlines a plan to tackle poverty and transform the country into a middle-income economy by the year 2020 (Government of Rwanda, 2000).

2.3 Poverty Reduction Strategy

In 2002, the government published its first Poverty Reduction Strategy Paper (PRSP) to plan for the period up to 2005. The PRSP, developed in a post-conflict context, focuses on issues related to reconstruction. Two priority areas that are related to Vision 2020 are particularly relevant to the country's OVC response: (1) poverty and vulnerability reduction and (2) institutional capacity building and social capital formation. Vulnerability and poverty reduction includes social

protection, in line with the explicit national priority for attaining "sustainable progress to ensure that social protection is accessible to all, with an emphasis on the existing poor and vulnerable." Further, the second economic development policy reduction paper (EDPRS) outlines the need to address children's issues coherently, and in a way that reinforces the social inclusion of OVC in society, specifically with regard to improving access to education (SIAPAC, 2008).

The EDPRS for 2008-2012 seeks to redefine some of the initial priorities that had reflected concerns of a more transitional nature, to policy focused on promoting sustainable development; issues pertaining to OVC have been integrated into this broader strategic economic development plan. In essence, it provides a medium-term framework for achieving the country's long-term development objectives, as embodied in Vision 2020 and the Millennium Development Goals. As such, the wider goal of the EDPRS is to achieve sustainable economic growth and social development, ultimately improving the quality of life for Rwandan citizens. The paper calls for a clear pro-poor focus in public spending, with improved targeting of basic health care, education, and other core services (Bigsten and Isaksson, 2008). Specifically, the EDPRS addresses issues such as gender, HIV/AIDS, and environmental protection, and outlines a focused strategy for integrating HIV/AIDS concerns into all sectors, which has had a positive impact on OVC access to care and treatment for HIV/AIDS. A cross-cutting issue of the EDPRS has been to emphasize social inclusion as a way to ensure equity of service delivery to all vulnerable groups, including OVC.

3. Rwanda's AIDS Response

In Rwanda historically, commitment to fighting HIV/AIDS at the central government level has been strong. In 2001, at the African Head of States meeting in Abuja, they signed a declaration recognizing HIV as a high priority. A few months later, at the 2001 United Nations General Assembly Special Session (UNGASS) on HIV and AIDS, 189 Member States, including Rwanda, adopted the Declaration of Commitment to HIV and AIDS, a framework for reversing the epidemic by 2015. This commitment encompasses global, regional, and country-level responses with regard to prevention, care, treatment, and impact mitigation. The signatory countries agreed to develop and implement national policies and strategies to build and strengthen governmental, family, and community capacities to provide a supportive environment to OVC infected or affected by HIV. In order to monitor the progress in achieving concrete, time-bound targets set forth in the Declaration, countries report on a core set of indicators at the national level (Government of Rwanda, 2008a).

3.1 National AIDS Control Commission

In accordance with the "Three Ones" principles—which suggest that every country should have one national coordinating body, one strategic national plan of action, and one monitoring and evaluation framework—the National AIDS Control Commission (NACC; *Commission Nationale de Lutte Contre le Sida* in French, CNLS) was created in 2001. Reporting directly to the Office of the President, this body's core function is the coordination of all HIV/AIDS activities in Rwanda. The NACC ensures multi-sector coordination through the implementation of the National Multisector HIV and AIDS Policy and its Strategic Plan (2005-2009) (described below). It does this by harmonizing the strategies and activities of institutions involved in HIV service delivery; educating the public to carry out AIDS control activities, such as prevention and HIV testing; and mobilizing funds for AIDS control both nationally and internationally (Lee, Rhatigan, Kim & Porter, 2008). The NACC monitors OVC interventions in the field of HIV implemented through various "umbrella" organizations, discussed below.

3.2 Umbrella organizations

To ensure civil society participation in the national HIV/AIDS response, between 2003 and 2005 the NACC and development partners (e.g. World Bank, Global Fund, PEPFAR, and others) supported the establishment of 12 civil society "umbrella" organizations. These umbrella

organizations, often called simply “umbrellas,” have legal status and are organized into advocacy groups in specific sectors to support the AIDS response (for example, the RRP+ Network of People Living with HIV/AIDS, the National Women’s Council, and the National Youth Council). This multi-sector approach is broad and beyond involvement of NACC and MIGEPROF, engages sectors that address economic development, social protection, education access, legal support, child labor practices, and rehabilitation of child soldiers. The mission of the umbrellas is to identify the needs of their respective sectors and to mobilize support to fulfill these needs. Their primary responsibilities are to distribute resources efficiently and equitably within the community and to assist their constituency with planning activities and capacity building. Each umbrella supports its constituency by enabling members to gain access to resources for quality prevention, care and treatment, and support services. For example, it might facilitate the link between individuals living with HIV and available resources for their medical, psychosocial, and economic needs. Each umbrella elects representatives from the community, district, and government to serve on its board, which represents the interests of their respective sectors with regard to the national AIDS response. The boards are *de facto* members of all AIDS coordinating bodies to facilitate civil society’s participation in advocacy and programming, as well as to ensure that all decisions take their constituencies’ interests into account. The board of the most influential “umbrella” includes PLWHA, youth, women, representatives from religious institutions and also involves members of all AIDS management committees, such as the Country Coordinating Mechanism (CCM) for the GFATM and the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR) steering committee. Members of this board are aware of the budgeting process as well as HIV/AIDS program expenditures.

NACC mobilizes technical and financial resources for the umbrellas and oversees their activities. To realize these objectives, an umbrella signs a memorandum of understanding (MOU) with the NACC that explains the obligations and rights of both parties in joint partnership in the fight against HIV/AIDS. The umbrella therefore agrees to support NACC in planning, coordinating, and monitoring implementation of the AIDS response in its constituency. In turn, NACC helps the organization function as an autonomous legal body, and uses it as a vehicle to disseminate information quickly to communities. While there is currently no umbrella organization specifically for OVC, the government takes a multisectoral approach to OVC-related issues and therefore some umbrella organizations contribute to OVC activities (Government of Rwanda, undated).

3.3 National HIV/AIDS Policy and Strategic Plan

The National Policy on HIV/AIDS, developed in 2005, defines the principles on which the national response to HIV/AIDS is based. It also acts as an advocacy tool in the fight against HIV/AIDS by involving leaders at the political, administrative, and community levels, including religious leaders. The definition of elements included in the National Policy on HIV/AIDS led to a national strategic plan, which addresses prevention, care, and treatment of HIV/AIDS. The Strategic Plan (2005-2009) encompasses the government's support of decentralization, a mechanism that facilitates the involvement of a range of government ministries, NGOs, PLWHA, FBOs, and the private sector in national development priorities. A key component of the AIDS response is therefore to empower civil society by including community-level actors in both the design and implementation of AIDS-related interventions.

The plan further highlights the fact that AIDS and OVC interventions cannot be mutually exclusive domains. For example, it states that intervening in favor of OVC can: 1) aid in prevention of mother-to-child transmission of HIV (PMTCT) efforts; 2) reduce risk of transmission among OVC through primary prevention strategies; and 3) help reduce the spread of HIV through poverty reduction strategies, such as offering income-generating projects to child-headed households. The plan also defined intervention areas for OVC support and set goals for number of children reached in five categories: primary school (53,000), secondary school (40,000), nutritional support (18,000), job training (100,000), and national health coverage (*mutuelle de santé*) (all OVC) (Government of Rwanda, 2006).

3.4 Children and the AIDS response

In 2004, during the mid-term review of the National AIDS Plan, the NACC and partners acknowledged that children were being overlooked in the country's AIDS response. Disaggregation of data on treatment during 2003-2004 showed that children under 15 years of age were being underrepresented (less than 1 percent) in the number of people on HIV treatment. The first Children's Summit, which coincided with the 10th anniversary of the genocide in 2004, spurred President Paul Kagame, government ministers, and CSOs to sign a commitment to focus on six priority concerns for children. Developed in part by children themselves, the commitment included combating HIV and strengthening interventions for children. That same year, initiatives such as the formation of the Children and AIDS Steering Committee and the National Pediatric Conference for Children Infected and Affected by HIV/AIDS facilitated scale-up in prevention, treatment, and supportive services for children with HIV; by 2007 15% of people on ART were children and PMTCT coverage was greater than 50% (Binagwaho, Muita, Assimwe, undated). In addition to HIV treatment and PMTCT, advancements have been made in child protection, care, and support, as well as other aspects of HIV prevention.

Activities to continue to engage children have been pursued, such as a second National Children's Forum in 2006. These forums allow for active participation of children where they have the capacity to inform recommendations for OVC policy and programming. The children raised a broad range of concerns including basic needs such as food, shelter, and clothing. They found that provision of school fees, including school materials and clothes allowed them greater access to education. Availability of health services and access to psychosocial support were also deemed helpful. For girls, safety and security was an important issue, particularly for those who were heads of households. Finally, children and youth expressed interest in economic activities or initiatives that would promote self-sufficiency and independence, such as improving access to land and livestock. Based on feedback from children, the Strategic Plan of Action for OVC focused on addressing the following issues: economic hardship; psychosocial distress; lack of love and affection; withdrawal from school; risk of violence and exploitation; malnutrition and illness, including increased risk of HIV infection; and gender dimension/ discrimination (GoR, 2006). Children also participated in the EDPRS development.

4. The OVC Response

The government, under the leadership of the Rwandan Ministry in charge of Gender, Child Protection, and Family Promotion (MIGEPROF), developed its first national policy for OVC in 2003. This document was a first step towards a comprehensive framework to assist the government and development partners in planning, implementing, and monitoring programs and policies in favor of OVC through a multisectoral, integrated response. Specifically, the policy established objectives and proposed strategies to address problems OVC faced through:

- a systematic coordination of services and programs
- the prioritization of major areas of work
- a better geographical distribution of services available for orphans and other vulnerable children
- identifying gaps in services
- improving and/or establishing services for children who are not adequately served
- planning for future financing from outside as well as inside Rwanda
- avoiding overlap of services
- improving the allocation of budgetary resources on a rational basis
- appropriate use of human and financial resources
- identifying gaps in human resources
- the establishment of a comprehensive monitoring and evaluation system

- assessing the impact of programs and services ensuring technical and financial sustainability of programs (Government of Rwanda, 2003).

4.1 Strategic Plan for OVC

The Rwandan Ministry in charge of Gender, Child Protection, and Family Promotion (MIGEPROF) is responsible for implementing both the National Policy on OVC and Strategic Plan for OVC 2007-2011. The Strategic Plan, adopted in 2007, is aligned with the EDPRS and is intended to draw on resources consonant with Vision 2020, the Millennium Development Goals, and UNGASS.

The vision of the Strategic Plan is to enable OVC to reach their full potential and have the same opportunities as all other children to participate in home and community life. The main objective of the Strategic Plan is to "protect the rights of the child and to ensure the physical and psychosocial long-term development of orphans and other vulnerable children." The objective of the plan underscores the focus on OVC as having unassailable rights, and therefore worthy to participate as decision-makers who merit respect. It also recognizes their need for assistance that would enable them to become productive adults who contribute to society. The Plan's six strategic objectives are as follows:

1. To create a supportive environment for OVC through increased awareness on all matters concerning OVC by addressing children, parents, caregivers, service providers, decision-makers, and the general population
2. To ensure a protective environment for OVC through enhanced policy, legislation, procedures and regulations
3. To provide protection, care, and support to OVC by establishing and strengthening family and community-based support structures
4. To ensure access to essential services for OVC, including housing, education, health, and nutrition, social protection, water and sanitation, and birth registration
5. To build and strengthen the capacity of government, civil society, and service providers to respond to the situation of OVC
6. To establish coordination, implementation, and monitoring and evaluation mechanisms (GoR, 2006).

To advance the national plan of action for OVC (GoR, 2006), six priorities were emphasized, including a focus on: 1) data collection and situation analysis; 2) development of coordination, implementation, and monitoring mechanisms, including the establishment of the National Council for Children, decentralizing coordination committees and the strengthening of children's forums; 3) capacity building at all levels; 4) survival of the most vulnerable through continued support of existing interventions; 5) monitoring and evaluation of standardized national monitoring and evaluation strategy and tools; and 6) resource mobilization, including development of strategies and mechanisms to ensure that funds are mobilized and are channeled to communities promoting transparency and accountability. An essential component of the strategy was a mandate for the formation of child protection committees. The role of these committees, which are presided over by local authorities and composed of children, volunteers, and members of NGOs, is to prevent any type of child abuse, report and intervene on existing cases and follow-up to ensure that abused children have access to all the services they need. Through this plan, the country has also established within MIGEPROF the OVC Technical Working Group, a specific political body for protecting OVC with a view to strengthening coordination, coherence, and comprehensiveness of the OVC response. The Technical Working Group also serves as a venue for discussing best practices in responding to the needs of OVC. Members include all stakeholders, including NGOs, funders, and central government and local authorities. Through the Strategic Plan, the government, in collaboration with the OVC Technical Working Group and other stakeholders, such as PEPFAR, the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM), and the Multi-Country HIV/AIDS Program (MAP) defined a "minimum package" of services to support OVC. The framework used to develop the minimum package is intended to be

both practical and holistic, and is designed to address a large majority of both the immediate and long-term needs of OVC. During the development phase of the package, however, some development partners faced constraints with regard to what it should consist of and how it should be operationalized. After three years, the parties reached a consensus on the definition of the minimum package. This is outlined below.

4.2 Intervention Areas

The Strategic Plan requires that six intervention areas, listed below, are covered by the minimum package. These are the fundamental elements required for a child to become a healthy and productive adult in Rwanda:

1. Basic healthcare
2. Nutrition
3. Formal and non-formal education and training
4. Child Protection
5. Psychosocial services
6. Socioeconomic services

The position of the government and stakeholders is that access to these essential services puts OVC on equal footing with other children in their ability to grow up in a safe and nurturing environment free from stigma and discrimination, and that these components are vital to children's well-being and survival. The first component, access to basic healthcare services, would be provided through Rwanda's mutual health coverage, PMTCT services, and antiretroviral therapy (ART) for infected children and/or their caregivers. Other services covered under the rubric of health would also include access to preventive care, the integrated management of child health (IMCI) package, hygiene education, reproductive health services, and HIV/AIDS prevention services, including voluntary counseling and testing (VCT). Nutrition, the second component of the package, includes food assistance, nutritional counseling and education, and therapeutic nutrition for malnourished children and/or children on ART. The third component, formal and non-formal education, includes assistance with school fees and supplies; vocational training and starter kits (for example, tools for carpentry or a sewing machine for tailoring); and literacy and remedial classes. Fourth, the minimum package ensures protection against all forms of abuse and violence. It stipulates the code of conduct for community volunteers who work with OVC. Legal assistance and shelter are also included under protection. Fifth, psychosocial support is guaranteed, including subsidized consultation fees and access to specialized care. Finally, socioeconomic support consists of facilitating income-generating activities for families, association members, and communities (Binagwaho et al, undated).

To be eligible to receive the minimum package, the child must meet certain vulnerability criteria. According to the national policy, a qualified child must be between zero and 18 years of age and be "exposed to conditions which do not permit him to fulfill his fundamental rights for his harmonious development" (Government of Rwanda, 2003). He or she must also meet the definition of "vulnerable." In Rwanda, vulnerable children are defined according to two categories of criteria (A and B) (Dushimimana et al., 2008):

<u>Category A: Children at high risk of vulnerability</u>

- Children from families with unsafe housing that cannot protect them from bad weather
- Children from families without enough land and/or employment or other sources of reliable and sufficient income
- Children from child-headed households
- Children living in households with a single adult (widows and widowers, divorced/separated persons who are not remarried or are not living with another adult,

single parents/caregivers, and the elderly), as well as families that have been brought back together after the trauma of separation
- Children whose parents/caregivers fight
- Children whose parents/caregivers fail to fulfill their duties towards their children because of other factors (e.g., alcohol abuse, lack of desire to care for the child, etc.)
- Children with one or more parents/caregivers who suffer from chronic or intermittent poor health, including those who are physically or mentally disabled
- Children who have one or more parents/caregivers who are HIV-positive

Category B: Clinically vulnerable children

- Malnourished children
- Children with problems related to education (not in school, poor attendance, drop-outs, poor performance)
- Children suffering from chronic or intermittent poor health
- HIV-positive children
- Children who are emotionally traumatized
- Children who are sexually or otherwise physically or emotionally abused
- Children who live or work on the street, including children involved in sex work
- Children who abuse alcohol or drugs
- Girls who are teenage mothers

The goal of using the above criteria is to improve the capacity of communities to exercise ownership of OVC programs and promote a sense of belonging of OVC in the community. In general, the government aims to ensure that OVC receive the package through at least the end of secondary school. The holistic quality of this minimum package makes it unique compared to some social support packages implemented in other resource-poor settings. In theory, the package cannot be provided piecemeal, nor can one or more of its components be provided independently of the others, unless the child already has access to one or more of these services. For example, according to the policy, a child who does not have adequate nutrition and does not attend school must receive both of these services. OVC services are linked so that children in need of multiple elements of the package can receive them from different providers through a referral system. Once a child is identified, he or she is evaluated to determine what components of the package are needed (Thurman, Pells, and Ntaganira, 2006). Although the primary target group for the OVC program consists of children under the age of 18, a secondary target group includes those who support OVC, such as caregivers, volunteers, and local workers who are responsible for providing and ensuring access to adequate care for OVC (GoR, 2006).

5. Implementation

Implementation of the minimum package in Rwanda is characterized by a participatory approach. By intentionally involving local authorities, CBOs, NGOs, churches, volunteers, funders, and beneficiaries themselves, corruption is minimized; fostering a sense of ownership of OVC programs by local stakeholders facilitates their implementation. In this context of diversity, multiple stakeholders decide how OVC are identified, what entities offer what services, and how services are coordinated among a network of providers. But how does the district identify OVC, their specific needs, and resources to help them? Decentralized leadership plays a critical role in this process.

> *All implementers in the health sector, poverty reduction sector, commercial sector, churches, NGOs, private business—you name it—they know how many orphans are in a given district, how many households have people living with HIV, how many households are without food or shelter.*
>
> Staff member, Rwanda Women's Network

5.1 Identification of OVC and Development of Work plans

Identification of OVC is currently being updated according to the new vulnerability criteria outlined above (Dushimimana et al., 2008). A new monitoring and evaluation tool is being developed—the Child Status Index that is currently being adapted to the Rwandan context will provide information on the child with respect to the six domains outlined by the minimum package.

As mentioned above MIGEPROF, with assistance from the OVC Technical Working Group, is responsible for coordinating the nation's OVC response. The central authority therefore has the "big picture" of the OVC situation, and aims to ensure that resources and services are distributed equitably to CSOs throughout the country. At the district level, oversight of service provision is the responsibility of members belonging to the Joint Action Forum. The purpose of the Joint Action Forum is to convene district authorities, stakeholders, and community actors to discuss problems that arise in the district. The Joint Action Forum ensures that OVC issues are on the district's agenda and that the poorest and most marginalized children have access to fundamental social services within their communities. At the decentralized level in some districts, child protection committees to identify gaps in service delivery have proven instrumental in developing solutions to OVC problems, as noted above. Each of the 30 districts develops its own OVC response according to local priorities and outlines these plans in its annual work plan. In order to develop an effective work plan and budget, however, district authorities must first know how many OVC there are at the district, sector, cell, and village levels. As one district authority stated in our interviews:

> *We can't be everywhere at once in the district. Leadership helps us monitor how these children are being taken care of. It's the population itself that manages the lists of OVC. But, we have meetings where the whole population is there. It's very difficult to deceive people; we can't deceive people; this is transparency. We don't go into the villages and see who is or isn't vulnerable; it is the local population that does this.*

Data on the number of OVC for the district's annual work plan originate at the village level, where children are selected to receive support based on criteria established by the community. Once the selection is made, this information is communicated to the appropriate person at the cell level (i.e. social worker).

> *When they make the selection of children at the village level, they are supposed to call all influential people in the village. This means church leaders, traditional healers, and local authorities. They make a public announcement on a certain day. People come and witness this, which lends transparency to the exercise.*
>
> Staff member, World Relief

The cell is the next largest administrative unit, comprised of 400 - 1650 households. Each cell elects community leaders, such as pastors or village authorities to be in charge of specific issues, such as gender, education, security, social affairs, or civic data (birth, death, and marriage records). Issues related to OVC, such as provision of national health insurance schemes (*mutuelles de santé*), nutritional support, or housing, are the responsibility of those in charge of social affairs. A social worker (*agent social*) facilitates access to OVC services and performs follow-up visits. The social worker also keeps a list of OVC in the cell area and passes it on to the next level: the sector.

Approximately 10-15 cells make up a sector. Similar to the cell, the sector has an executive committee headed by a sector coordinator. The committee is composed of nine elected staff members with roles similar to those at the cell level. Similar to the cell level, at the sector level the social worker is responsible for all OVC-related matters and keeps a list of OVC, which she or he gives to the district. Thus the district is aware of the number of OVC and what kinds of support beneficiaries are receiving.

In order to develop its annual work plan, district authorities must also know exactly which implementers are providing what types of support to OVC and what their action plans include. Any organization that wants to work with OVC must first approach the committee member in charge of social affairs at the sector level, who will help coordinate the intervention. To support coordination efforts, the ideal situation is for civil society organizations to collect and centralize information on their constituency's activities for quarterly reports to the district based on the geographic area where they are operational.

Implementers' activities are aggregated into work plans according to sector. Each district aims to reach two targets outlined in the work plan by the end of a year: the number of beneficiaries and also the budget for OVC. The mayor of each district consolidates these plans and then sends them to the central government. The sector plans are subsequently consolidated at the national level.

> *You have to declare what you're going to do because your quarterly work plans will always be subject to the annual work plan you've provided. At the end of the year, people meet again with the district authorities to evaluate the past year and also look at peoples' plans for the coming year. The sector authorities are present so they will be able to attest to what has worked and what hasn't. What do we need to do differently? What can we do better? What can be replicated elsewhere?*
>
> Staff member, Rwanda Women's Network

5.2 Civil Society Organizations

While the district is essential for generating annual plans to assist OVC as well as to provide oversight, CSOs are responsible for implementation. The NGOs that participated in the interviews for this case study, which are discussed in more detail below, all offered some elements of the minimum package of services for OVC and caregivers. Several of these NGOs acted as coordinating mechanisms for service delivery via grassroots organizations, while others worked directly with beneficiaries.

5.2.1 CARE International

CARE International began working in Rwanda in 1984. Locally, the NGO is probably most recognized for its successful Nkundabana[2] Initiative for Psychosocial Support (NIPS) project for OVC, which has been operational since 2003. This project added educational and psychosocial support to its initial package of services for OVC, which included food, income generating activities, and HIV/AIDS prevention training. NIPS is a community-based approach to support OVC and operates in five districts and two towns of the former Gitarama province. The program's goal is to ensure that "vulnerable children are economically productive and contribute positively to the peace and reconciliation for the future of their country" (Thurman, Pells, Ntaganira, 2006).

> *We, and other big actors—CHAMP, Global Fund, PEPFAR—need to be looking at targeting. What CARE is doing—the way we actually use vulnerability as a targeting mechanism rather than coming up with preconceived ideas, that is, 'let's target this or that group.' That's a best practice, I would say.*
>
> Staff member, CARE International

Nkundabana are trained community volunteers who provide guidance and care for children living without adults through ongoing accompaniment. Originally CARE implemented NIPS with child-headed households, but then quickly realized that vulnerability is a more effective criterion than living arrangements for targeting the neediest children and families. After the community defines vulnerability criteria, CARE then does a mapping of households that matches these criteria. This process has enabled identification of the most vulnerable children. Community acceptance and support of the Nkundabana are integral to the success of the program.

[2]Literally "I love children" in Kinya-rwanda

The model is also successful because it follows the basic principle of working in child protection—with the direct participation of the child. Initially, OVC from three different households agree on two people in the community whom they would like to have as an Nkundabana. Two others are chosen as "candidates" in case the children's first choices do not accept. CARE then approaches the first choice Nkundabana with local authorities to explain what the children expect of him/her, what his/her role would be, and ask if he/she is willing to participate. If this individual agrees, CARE and local authorities provide trainings for the Nkundabana.

> *What we've noticed is that households that get support from Nkundabana actually have more capacity to take advantage of other services, particularly access to school. Children with psychosocial problems, trauma—even if they have the ability to go to school, don't have regular attendance because they have other problems and there is no one to help them. What we've seen is that when there is support from a community mentor—an Nkundabana—school attendance and performance is really good.*
>
> Staff member. CARE International

Besides psychosocial support, CARE provides some, but (due to budget constraints) not all of the OVC services of the minimum package. Currently, all of its funding comes from private donors from the United States and European Union.

CARE relies on referral networks to complete the minimum package. Nkundabana are connected to other service providers, so they are instrumental in finding other support for children. However, coordination of services, according to a staff member, is one of the biggest challenges to implementation. While the system for assisting OVC in Rwanda is generally well structured, many children still fall through the cracks:

> *We could do much better than what we're doing now if there were better coordination mechanisms in place at all levels. We have a minimum package, but so far, we haven't really been successful at implementing it. Not even 1% of children have access to the full package.*
>
> Staff member, CARE International

To exemplify the coordination challenge, a CARE staff member referred to the ongoing development of the social protection strategic plan which (it is anticipated) will benefit many OVC. To succeed, this implementation strategy will require the participation of innumerable ministries (health, education, protection, labor). One staff member of CARE suggests that competing priorities among the ministries have impaired the necessary participation at planning meetings:

> *It's very important to have them [all the ministries involved in implementation] take part in the development phase [of the social protection strategic plan]. It's really been a challenge. MINELOC invites these ministries, including MIGEPROF, and at least at the meetings where I've been present, I haven't seen any of these ministries sitting at the table!*
>
> Staff member, CARE International

CARE does not see its role—nor that of other NGOs—as direct service providers. CARE's approach is to develop and test models in the community. If these models prove successful, CARE advocates for their integration into the national strategy, as it has done with NIPS.

5.2.2 Haguruka

Created in 1991, Haguruka is a small NGO based in Kigali with offices in Butare and Gitarama. Its mission is to promote and defend the rights of women and children primarily through training, socio-legal assistance, public awareness, socioeconomic assistance, advocacy and research. According to Haguruka, there is a lack of knowledge in Rwanda about children's rights and OVC

problems in general. According to a Haguruka staff member, "*Changing the way people think is a long process. Sometimes you don't see things moving quickly*."

> *We see that once these children [OVC] are living in the same conditions as other children, they start behaving like other children.*
> Staff member, Haguruka

Children who use Haguruka's services include those who are trying to reclaim property that is theirs by right, victims of physical or sexual violence, or girls who have been forced into marriage. All of the organization's activities take place at the district level such as, for example, accompanying a child to court or to a consultation with a district authority. The organization has a wide reach, providing legal services to all of Rwanda with the help of 383 paralegals throughout the country.

In 2007, Haguruka offered legal protection to 124 OVC. While it does not support many children in ways other than legal assistance, it does offer other components of the minimum package, namely socioeconomic support. According to the same staff member quoted above, *"We can't say that an OVC has legal rights and not give him or her anything to eat, or the chance to go to school, or receive health care*." In 2007, Haguruka paid school fees or offered support for 65 primary school students, 22 secondary school students, and 5 vocational school students. The main reason that the latter figures are small in comparison to the need is because Haguruka is not financially capable of offering support to more OVC:

> *There are some families that can't even pay 100 Rwf for transportation from their house to the courthouse. If they're not able to pay transportation costs, they're certainly not able to pay lawyers' fees. We pay for very few OVC because we don't have the means to pay for everyone*.
>
> Staff member, Haguruka

Currently, Haguruka receives funding from NOVIB, Cordaid, Trocaire, CARE International, the European Union, Canada, CHAMP, several embassies, and will soon be receiving monies from the Global Fund. Funding is executed through a donor "round table" to which Haguruka invites all of its technical partners. At the round table, the organization presents its action plan. If the donors accept it, they put money into a "basket fund." The challenge has been to tailor Haguruka's services to meet specific guidelines that donors stipulate in terms of planned interventions and expected outcomes.

5.2.3 Imbuto Foundation

> *The number of children is enormous. The needs are enormous. We don't have enough financial and human resources to fulfill these needs. We try to offer a minimum package, but why shouldn't we offer a 'normal' package?*
> Staff member, Imbuto Foundation

Originally the Protection and Care of Families against HIV/AIDS (PACFA) was started by the First Lady Jeanette Kagame in 2001; this program changed its name to Imbuto Foundation in 2007. Meaning *seed* in Kinya-rwanda, Imbuto's mission is to improve the living conditions of all vulnerable persons, especially children and families. The program has three major focus areas: HIV/AIDS, education and socioeconomic development. According to one staff member, "*We aim to contribute to the government's efforts to improve the well-being of the population with regard to prevention and access to care and treatment for HIV/AIDS*." The foundation offers a "Family Package," which builds on the benefits of its initial interventions to prevent mother-to-child transmission of HIV by extending basic care and support to families living with HIV. Since its inception, the Package has more than 3,500 beneficiaries.

One of Imbuto's largest projects that target OVC is the Education Programme. This initiative offers scholarships to OVC who had dropped out of school and want to resume their secondary education. Imbuto pays the school directly by depositing the money into the school's bank

account. Imbuto staff meet with students at school to make sure that they understand what is being provided, such as school materials, uniforms, transportation costs, and also what is expected of them in terms of performance and commitment. Students must maintain at least a 70% average in school to stay in the program. This project is funded through Rwandan and international private donors.

The GFATM-supported community-based health insurance project facilitates access to basic health care to vulnerable children and families through payment of health coverage schemes (*mutuelles*). In 2007, there were 233,959 orphans and people living with HIV/AIDS over the entire country who have benefitted from the project. The foundation also seeks funding from private donors as well as UNICEF, UNAIDS, UNFPA, and DFID.

According to Imbuto, its seat at the OVC Working Group has given the foundation a voice in the policies that affect the population it serves. This Working Group presence is also a practical way to synchronize OVC services with other providers when funding is limited. Referrals to the district or another NGO, therefore, are key to securing for OVC other elements of the minimum package:

> *A way to avoid duplication is to work with the district—the local authorities. For example, if CHAMP is doing a specific activity in a given district, then we don't need to provide this service. That way, we know these children are accounted for. A child could write directly to us and say he needed help when in actuality he was receiving it from another association. It would be a free-for-all.*
>
> Staff member, Imbuto Foundation

Imbuto had a different understanding of the minimum package than did the other NGOs interviewed for this study, stating that MIGEPROF's policy was that any organization that worked with OVC had to offer at least three components of the minimum package. The remaining three services, according to a staff member, could be provided by other organizations through a referral network.

5.2.4 Rwanda Women's Network

Rwanda Women's Network (RWN) coordinates 50 women's grassroots organizations in nine districts that are dedicated to promoting and strengthening strategies that empower Rwandan women. Strategies include social support for victims of gender-based violence, HIV/AIDS services, and training. Six groups work specifically with OVC—three in Kigali and three in the Southern province. In addition to coordination, RWN also pays school fees and provides scholastic materials and startup kits for young adults who complete their vocational training. Over 1,240 OVC have been able to go to primary school and 420 to secondary school through assistance provided by RWN. In 2008, RWN has supported 90 child-headed households. In addition to education, RWN facilitates nutritional support and daily care, such as cleaning and moral support, to vulnerable families through home visits by community volunteers.

> *Discussions of experience, technical know-how—such statements will always come up. But in terms of HIV and OVC programs, what's being done at the community level has nothing to do with technical expertise because you are talking about how to help those who are bedridden to clean their bodies, be by their side to cook a small pot of porridge, give moral support to the young ones when an old person is dying. This has more to do with the human and moral approach to helping someone during hard times.*
>
> Staff member,
> Rwandan Women's Network

RWN tracks the progress of beneficiaries directly and through caregivers who provide direct services. For example, RWN has regular meetings with OVC to discuss daily school life and also collect reports on children from school authorities at the end of each term. RWN photocopies these reports, enters relevant information into its database, and then sends the child back to school with the report. RWN never directly provides cash, so the database allows RWN staff to

quickly access information on what school the student is attending, the cost of school fees per term, the school's bank account number, etc. A bank slip is issued for each child for whom school fees are paid. If a child fails a term, RWN can rapidly learn why because of its ongoing communication with schools.

> *For services we cannot handle, referrals are made to the district health center. Or if it's a legal issue we cannot handle, we always do a referral. The only constraint in this area is that when you talk about legal services, these are the most expensive. If you cannot afford a lawyer, we can always rely on paralegals. They generate the necessary documents to file the documents that are required to file the case in a court of law.*
>
> Staff member, RWN

RWN receives funding from (among others donors) CHAMP and the Firelight Foundation. Repeating what most other NGOs reported who interviewed for this report, RWN often has to negotiate donor restrictions on the age cap (usually 18, as per the US or European law) for assisting OVC. One staff member stated that in the Rwandan context, a 25-year-old may still in essence be a child if he or she has not been given opportunities to develop into a productive adult. For example, after the genocide, many children interrupted their schooling to take care of siblings. Some seek OVC support to return to school once they are in their early twenties. Unfortunately, many of these young adults are denied access to OVC services because of such stringent donor criteria.

Keenly aware of the day-to-day problems vulnerable women and children face, RWN is also disturbed by how much technical consultation and research have eaten into budgets. As one staff member noted in an interview,

> *You see how many millions are being put into HIV/AIDS or malaria in sub-Saharan Africa, but when you scrutinize the heart of the problem—now I'm talking about providing drugs, mosquito nets, treating people—you find that maybe 15-20 percent really gets there, and the rest has gone into technical expertise, consultancy, and the story ends. People are dying here! In terms of advocacy there is a need to tie this research—these studies—into the reality on the ground.*
>
> Staff member, RWN

5.4.5 Rwanda World Relief

Rwanda World Relief is a direct service provider in 12 districts across the country. An explicitly religious organization, has been "working with churches to change lives and bring hope to Rwanda"since 1994 (Rwanda World Relief, 2008). Services for OVC include prevention, care, and treatment for HIV/AIDS, payment of school fees, and vocational training.

> *At the beginning of the year, we give the district our action plan. So, if we assisted 200 OVC in the district, they're aware of this.*
>
> Rwanda World Relief

Religious leaders in the community are a pillar of the organization, and World Relief considers them integral to the identification of OVC as well as to implementation. World Relief engages community health workers in collaboration with a group of 6-9 pastors at the district level to identify OVC in the community. Community leaders then attest that these children are truly in need of services. According to a staff member, *"We don't give money directly to children because they could use it for other things, so we deposit it in the school's bank account*." The NGO then sends personnel to the schools to make sure beneficiaries are attending. Trained volunteers also conduct follow-up visits to children's homes during vacation. Other interventions for OVC include health insurance (*mutuelle de santé*), HIV prevention services, psychosocial support, and camps where children can participate in three days of recreational activities.

The primary challenge is lack of sufficient funding, given the number of children who require assistance. World Relief is supported by churches in the US and Rwanda and by PEPFAR. Although it is a faith-based organization, it cannot use money for evangelism. Like many NGOs that support OVC, World Relief does not provide the minimum package, but recognizes that if a child is having psychological problems, for example, he or she will not be able to function well in school. For this reason, the organization chooses to offer several services to fewer OVC rather than a single support mechanism to many.

6. Monitoring, Evaluation, and Program Oversight

In recent years, Rwanda has had to design and implement a new monitoring and evaluation (M&E) system to support two fundamental shifts in its health system. First, as mentioned above, Rwanda has decentralized authority for HIV/AIDS care and other health services to the district level. Second, the government has enacted an ambitious plan to rapidly scale up the availability of ARVs throughout the country. To facilitate decentralization, it was necessary to provide ongoing, up-to-date programmatic information to policymakers at the district level. To effectively scale-up ART entailed several challenges in ensuring a consistent supply of drugs and laboratory supplies, and in monitoring patient adherence. Addressing these issues was critical to avoiding drug resistance and delivering safe and effective long-term care.

6.1 The previous M&E system

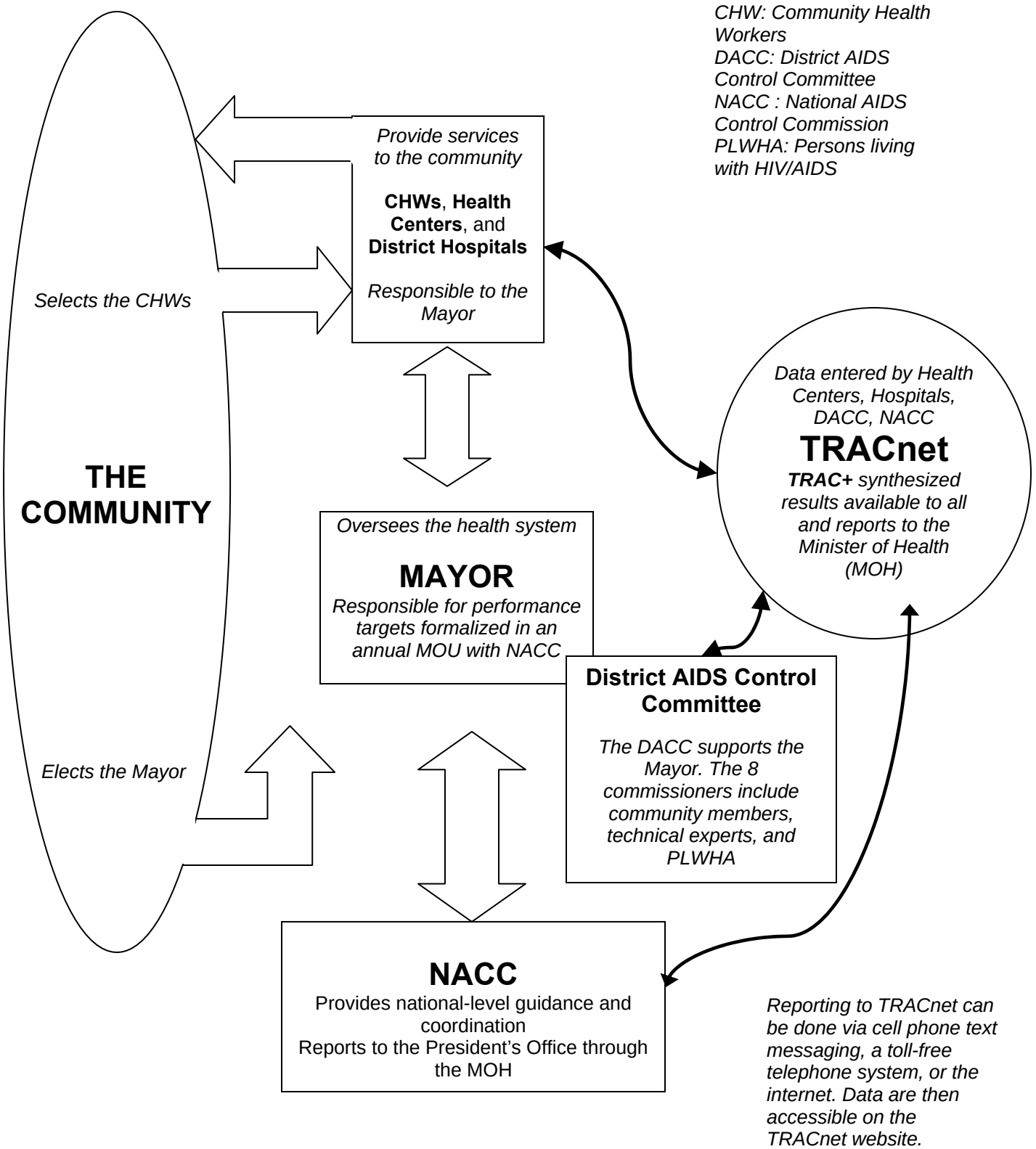
Before the 2006 national re-organization, there were 12 provinces and 106 administrative districts. Health districts were defined separately, often covering more than one administrative district and sometimes also spanning provincial boundaries. Planning as well as monitoring and evaluation were carried out at the provincial level by two staff members in each province (Binagwaho, Banamwana et al. 2007). Information was conveyed with paper reports that care providers filed and forwarded up the chain of command.

The traditional system of paper-based reports was inadequate for several reasons. First, it was time-consuming and costly for staff members at all levels to keep their own records and then make copies for forwarding. Second, there were long delays—often weeks—associated with forwarding the reports and with collating the information. Third, gaps in the system rendered analyses incomplete and posed challenges for interpretation and policymaking. Fourth, the flow of information tended to be uni-directional, meaning that district officials received very little support from the national level, where M&E activities were based. Both the district and the national levels were thus constrained in their abilities to advance the health system and improve program performance (Voxiva 2007).

6.2 A new organizational structure

The national decentralization plan reconfigured the previous 12 provinces and 106 districts and towns to a more manageable 5 provinces and 30 districts. Health districts—previously defined independently—were aligned with the administrative districts, each of which is headed by a mayor. Decision-making authority and responsibility for all HIV/AIDS issues were devolved to these districts. The mayor of each district is ultimately responsible for ensuring the delivery of HIV/AIDS services to citizens. Mayors and representatives from Rwanda's NACC sign a Memorandum of Understanding (MOU) for each specific project to formalize and publicize this responsibility (Binagwaho, Banamwa et al. 2007). The relationships between entities responsible for monitoring and evaluation of HIV/AIDS services are shown in Figure 1, below.

Figure 1: M&E FEEDBACK LOOPS IN RWANDA'S HIV/AIDS SYSTEM



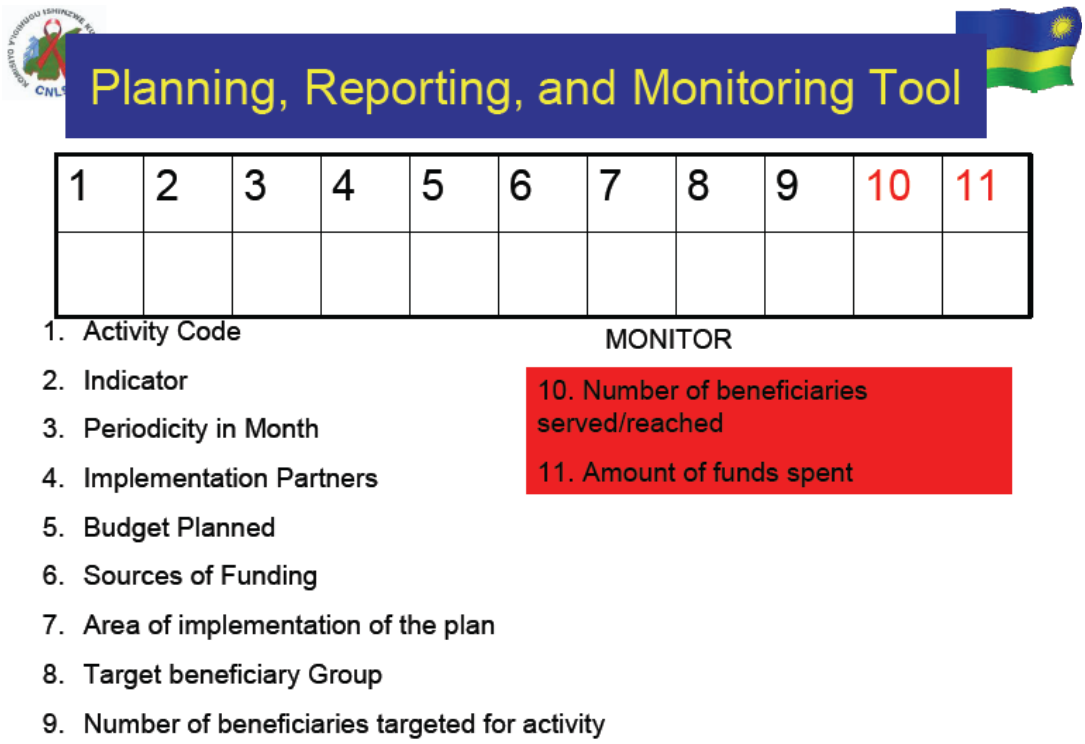
In each district an eight-member District AIDS Control Committee (DACC) supports the mayor. DACC members are drawn from the government and civil society, and include persons living with HIV. NACC provides two M&E experts to each DACC (Banamwana 2007; Banamwana, Afrika et al. 2007). Several technical subcommittees also report to the DACC (provincial-level staff members are not involved in this process because authority has been completely transferred to the districts). Initially, the DACCs did not have enough information to advise the mayors; this highlighted the need for an M&E system that could allow for collection of information nationally at the NACC and also provide information at the district level (Binagwaho, Banamwa et al. 2007). An M&E system had been established for HIV/AIDS activities at the national level, but at the outset there was none at the district level (Taratibu, Banamwana et al. 2007).

6.3 A new M&E system: CNLSnet and TRACnet

In preparation for the decentralization laws, which went into effect in the second quarter of 2006, NACC and TRACPlus (the Treatment and Research AIDS Center Plus), began working on an M&E system in 2005. NACC worked on a web based system for the non-health related and TRACPlus created the health-related part for the HIV and AIDS programs. The objective was to support planning and reporting M&E systems that would meet national- and district-level needs, and to provide a standard, comprehensive framework that could encompass all HIV/AIDS activities (Binagwaho, Banamwana et al. 2007). NACC created a web-based management information system as a planning and reporting tool and called it CNLSnet. To monitor and coordinate the rapid scale-up of ARV care and equip the district health facilities to manage and implement programs effectively. TRACPlus created TRACnet, a new health information management system. CNLSnet and TRACnet were developed by the government with PEPFAR in collaboration with Measure for CNLSnet and for TRACnet it was with CDC, university partners, local telecommunications companies, and Voxiva, an international telecommunications firm (Assimwe, Cishahayo et al. 2007).

A codified list of 600 intervention activities was developed and standardized planning and reporting formats were developed by the NACC. The government of Rwanda broadly engaged stakeholders in the development of these tools to ensure that all technical and managerial needs would be met once the system was implemented (Binagwaho, Banamwana et al. 2007). Technical and financial assistance was provided by the MEASURE Project, including training in CNLSnet database development for NACC staff and two members of each DACC and training in the use of TRACnet for ARV treatment providers. Reports are provided by implementers and compiled electronically under the responsibility of the mayors at the district level and submitted to NACC on a quarterly basis (Binagwaho, Banamwa et al. 2007).

CNLSnet managed by NACC for non-health related activities and TRACnet managed by TRACPlus make key HIV/AIDS information accessible to users at the local, district, and national levels, including summaries of program indicators, drug inventories at the point of care, patient registries, lab results, and offer group and individual communication mechanisms as well as management dashboards (Voxiva 2007). Using standard tools, users at the local and district levels report their activities in the first nine cells of the sample form shown below. At the central level, costs and benefits are analyzed using cells 10 and 11:



Source: Banamwana 2007

Users at all levels may access CNLSnet and TRACnet via the World Wide Web, but because internet connections are not consistently available in most rural areas, data may be retrieved and reported using other parts of the communications infrastructure, as well. When TRACnet was under development, it was observed that the cellular telephone network had good coverage and that many Rwandans were comfortable communicating via text messages. A bilingual English/French interface was developed to facilitate reporting via the Web, via a toll-free telephone system, and by cell phone text message (Voxiva, 2007). All 184 of Rwanda's ARV sites use TRACnet; via the internet or via telephone system (TRACPlus, undated).

On a quarterly basis, mayors submit reports to the central government (NACC) describing program progress on achieving targets and budget management. Each district compiles a district-wide aggregate report. The NACC then uses this information to develop a semi-annual report as well as the national annual HIV/AIDS M&E report, which feeds into the broader UNGASS report (Binagwaho, Banamwana et al. 2007).

6.4 M&E in practice

Representatives from NACC perform quarterly field visits and offer feedback to front-line staff working with communities and CNLSnet providers and TRACPlus do the same for health services providers and TRACnet users. These representatives travel to one province every quarter and visit all project sites within that province. These site visits are collaborative in nature and are planned jointly by the NACC, mayors, development partners and other stakeholders in each district. Ideas are exchanged openly, and progress and challenges are discussed. Initial meetings are held at the district level with the NACC, TRACPlus, key local leaders, and other civil society stakeholders. Meeting attendees then break into smaller groups to visit sites that are involved with HIV programming within all of the district's sectors. The group reconvenes after the site visits to discuss achievements and difficulties, and identifies potential solutions to problems observed. An action plan is developed with an accompanying timeline, and commitments are made to accomplish the activities which are intended to improve the system (Binagwaho and Karwera 2007).

In addition, the NACC visits any project sites that appear to present challenges, offer complaints or are not achieving the program targets. During the final quarter of the year, the program's central administration (based in Kigali) is reviewed, including performance of NACC, TRACPlus and the "Central d'achat des médicaments essentiels, consommables et équipments médicaux au Rwanda" [CAMERWA]. An annual data audit is performed to verify the accuracy of the information (Binagwaho, Banamwana, & Scialfa, 2007). Districts are selected randomly for this audit.

In addition, as part of capacity building, in each district, two DACC staff persons and program implementers are trained in M&E, on inputting the data electronically and use of the CNLSnet. Continual training has been necessary to maintain a high performance level (Binagwaho, Banamwa, Taratibu, 2007). Although the data collected in CNLSnet are analyzed centrally at present, there are plans to also decentralize this, and to build capacity for district offices to analyze their own data, so that any challenges or setbacks can be identified and resolved more quickly. Currently, the NACC actively shares analysis reports with provinces and districts and convenes a workshop to present data nationally with implementing partners.

The mayors are responsible of the data collection process that generates information for the following indicators: school drop-out rate; health insurance coverage (mutuelle); and child mortality rates, among others. Analysis of the data allows for feedback at the district level and promotes program planning that can be based on empirical evidence and meet the changing needs of the populations affected by the epidemic.

Annual meetings are convened nationally, with the President of Rwanda presiding, to review overall progress in development efforts. Any obstacles in offering HIV-related services are discussed within the broader context of economic development in the country. District officials, including mayors, are required to attend and report on progress in the past year. Approximately 800 individuals attend these meetings, including ministers, ambassadors, and heads of public institutions across all sectors (Binagwaho & Karwera, 2007). Attendees include all levels of the government, and the meetings are also aired on national radio and television. This allows for public participation, facilitating a democratic process. For example, if constituents find that their district is falling behind or not achieving program targets, they can play an active role by not voting for the incumbent mayor at the next local election. This democratic incentive system has many advantages, and allows for greater transparency and accountability. Districts are ranked according to the program performance for that year. In addition to the annual meeting, there are quarterly meetings at which the Prime Minister presides. These meetings focus on program and implementation challenges, with the goal of trouble-shooting and developing strategies to address presenting problems.

Funding is linked with program performance; that is, less funding is allocated to districts or institutions that are not performing as well as others. The evaluation is based on measurable progress in terms of whether targets for indicators are met. A key advantage of the part of the M&E system developed by the NACC is that it is in response to needs identified by the national government and not in response to donor requirements (e.g. PEPFAR) or other international reporting obligations (e.g. MDGs, UNGASS). Capacity building to achieve this was obtained through support from the MEASURE Evaluation Project (Banamwana 2007; Binagwaho, Banamwa et al. 2007).

6.5 Ongoing challenges

Rwanda's M&E system faces ongoing challenges in several important areas. Although the system already encompasses all health centers and DCCA by leveraging the existing communications infrastructure, the costs of connectivity are still high. These costs are expected to rise sharply as districts and health centers transition to the web-based DCCA to CNLSnet and TRACnet interface. Building staff capacity, and purchasing, maintaining, and upgrading computer

systems will all require additional resources. As more DCCA and health centers report more data, greater server capacity will be needed, and increased database size and complexity will require more specialized technical skills. Further challenges lie in expanding CNLSnet and TRACnet to include more indicators, and extending access to staff through all levels of the health system (Banamwana 2007; Binagwaho, Banamwa et al. 2007).

6.6 Monitoring and evaluation for OVC programming

The M&E efforts for OVC programming build on existing systems as far as possible and indicators for OVC program outcomes are integrated into the broader M&E strategies. Indicators have been agreed upon for national use and have been informed by OVC, their families, and their communities. The conceptual framework allows for three levels of indicators which address issues of process, outcome, and impact of the program. Monitoring of process indicators includes, for example, documenting the number of trainings, type(s) of trainees, and the number of individuals trained. Whereas outcome indicators focus on, for example, equity in access to services for OVC (compared to non-OVC). Impact indicators document whether the actual situation of OVC has improved or not (i.e. demonstrating the result of a given program) (GoR, 2008b).

In particular, the M&E system is designed to not only assess the number of program activities, but includes assessment of program impact; in this regard the M&E system serves as a program management tool, allowing staff to phase out activities that are not performing well and scale up projects that are having an impact. The M&E system has a "results" orientation that is linked with the goals and objectives of the strategic national plan of action. In addition to service coverage, the system also attempts to monitor quality of care (e.g. whether services are being offered according to national and international standards) (GoR, 2008b).

Indicators serve a core function of the M&E system, since quantitative changes can be monitored over time to track progress of various program activities. In this regard, outcome and impact indicators are more useful to examine changes over time. Examples of process indicators include: number of cells with functioning Child Protection Committees; number of meetings to disseminate information on OVC and prevention of HIV in communities; and number of high level meetings conducted to discuss OVC issues, etc. Outcomes are measured according to the following indicators, among others: percent of OVC whose households receive free basic external support in caring for the child; percent of households that are child-headed; percent of all children ages 0-17 living outside of family care; the ratio of double-orphaned children to non-orphaned children who are currently attending school; and proportion of OVC who have at least one adult who provides consistent love and support. The main impact indicators are: improved quality of life of OVC according to the Child Status Index; and percent of children who are vulnerable according to UNAIDS OVC M&E guide definition (GoR, 2008b, p. 15-16).

Data collection reporting tools capture the key elements of these indicators and are structured forms including the OVC Periodic Summary Form and the District Level OVC Summary Form. Data quality and management occur at the district level with the goal of analysis being performed as close to the source as possible (GoR, 2008b). This strategy is fairly unique and consistent with the overall decentralized approach of the program and also promotes use of the data for program management purposes. In this regard the OVC M&E system is consistent with the broader HIV/AIDS M&E system.

7. Lessons Learned

In describing the roles and approaches of authorities at the decentralized level and NGOs working to improve the lives of OVC, it became clear that certain specific factors helped to facilitate the implementation of support mechanisms for this population. These factors are listed and discussed below. Some of the ongoing challenges in these areas are also identified.

1. Political will to address the OVC problem
Rwanda has demonstrated its commitment to supporting children and families that have been made vulnerable due to the genocide, HIV/AIDS, and overwhelming poverty by recognizing the importance and relevance of community-based support of OVC in its policy and programming. All ministries engaged in OVC work, whether directly or tangentially, should recognize the importance of their individual participation in development of OVC planning going forward.

2. Decentralization of the program
Decentralization of responsibility of OVC programmatic activities (e.g. concrete work plans developed at the district level) has facilitated success through promoting local ownership, enhancing district autonomy, and engaging communities, including vulnerable children themselves.

3. Strong, widely accepted program leadership
Robust leadership at all levels (from the national coordinating authority to the decentralized level) has fostered transparency and accountability in the system in financial as well as programmatic terms. This process has engendered in local actors a sense of responsibility for and motivation to assist OVC. Strong leadership has encouraged participation in open forums to exchange ideas and solve problems collaboratively. These findings suggest that MIGEPROF should focus on initial consultation with leadership at the district level on programmatic decisions concerning OVC. Packaging this information in a way to make it accessible to communities, particularly illiterate populations, is an ongoing challenge for leadership at the decentralized level.

4. Linking OVC programming with poverty reduction and economic development
A central priority of Rwanda's national government is poverty reduction and economic development. The OVC policy and program initiatives were spearheaded in this context, promoting uptake and expansion of new OVC efforts. The OVC efforts are implemented within the context of the EDPRS. It is necessary to make OVC plans a reality and an essential part of the district development plan.

5. Trust and buy-in of local stakeholders and beneficiaries
Gaining the trust of people in the community and beneficiaries can be achieved by promoting active participation of the child in OVC support services. Child-centered committees at the decentralized level and children's involvement in the Nkundabana initiative have shown success and sustainability. The high level of community involvement promoted program follow-through and fostered accountability for achieving program targets.

6. Strategic alliances
Networks of service providers at all levels with informed knowledge of OVC problems and experience are integral to helping children navigate the referral system as well as reducing the number of children who receive duplicate services and children not accessing services. Multiple support mechanisms delivered simultaneously allows children to fare better overall; for example, children who receive psychosocial support tend to have better performance in school. Reliance on volunteers to deliver services to OVC is an integral part of service delivery, but this also poses a challenge in terms of their level of commitment. Harmonization and dissemination of best practices across NGOs and district offices and have not yet occurred on a broad scale. Competing priorities of involved ministries and other key stakeholders may have slowed the rate of progress in this regard.

7. Development of comprehensive programs to address root causes of the problem
Comprehensive programs that address underlying causes of OVC problems exist in Rwanda. The use of a community-centered definition of vulnerability as a targeting mechanism has enabled service providers to reach a greater number of OVC. However, set criteria are needed for determining when children and families have "graduated" from a support program

or entered into a less/more severe state of vulnerability. The minimum package of services in its entirety has not been implemented widely enough due to budget constraints and coordination challenges. This is in part due to the fact that one organization cannot typically offer all six elements of the minimum package. Donors should lessen restrictions on use of funding for operating costs (such as not allowing compensation for community volunteers or motorbikes for transportation) and eliminate the beneficiary age cap in order to make services more accessible to OVC.

8. Challenges of maintaining the monitoring and evaluation system
The monitoring and evaluation system is an excellent example of data collection used for the purpose of improvements in program implementation. In this sense it is a strong system. The main challenge will involve maintaining and building capacity of the system in terms of cost, staff training, and equipment/software upgrades. Thus far, it appears as if the technical expertise is available but it's unclear if there will be adequate funding in the future to sustain the system.

9. Leadership and future financing of the initiative
Feedback from the field interviews indicates that the need is far greater than the current program capacity. Strong leadership and advocacy have allowed the OVC program to advance to its current form and it is anticipated that these strengths will serve to enhance future funding to sustain and expand the program. Allocation of additional funds will allow for a greater likelihood of all elements of the "minimum package" being offered to all OVC and promoting dissemination and uptake of "best practices."

In summary, the purpose of this case study was to describe the framework or architecture of a program from the outset, starting with the initial vision and ending with program implementation. The vision of aggressively moving Rwanda's economic situation out of poverty is an underlying force that drives the process and it is this vision that characterizes the type of leadership that is motivated by the democratic process and the promotion of human rights, particularly of those most vulnerable. The mechanics of operationalizing the vision of offering orphans and vulnerable children the services and resources they are entitled to were initiated with policy development, which provided the framework for the national strategic plan of action. The guiding principles of the strategic plan were based on content from Rwanda's National Policy on OVC (2003) and the UN Convention on the Rights of the Child (GoR, 2006).

However, in the Rwandan case, the process did not 'stop' with the national strategic plan; implementation was possible because this national plan was translated into district-level plans in which district officials, such as the local mayors, were responsible for program plans, implementation, and evaluation. The process of decentralization was facilitated by raising local awareness through information campaigns, fostering capacity building as the local level by supporting local community-based organizations and structures, and establishing mechanisms for coordination, to ensure program consistency, prevent duplication, and identify gaps in services. In terms of future progress of this ambitious plan, feedback from program implementers indicated a need to strengthen efforts of communication, capacity building, transparency and coordination between national and local/district levels of operation. As more capacity building occurs at the district level, the local government will be able to develop a more coordinated response (e.g. across government entities and CSOs) to address the needs of OVC, since they may vary in different geographical areas of Rwanda.

Rwandan policy makers were able to set the agenda with development partners, such as PEPFAR, Global Fund, World Bank, etc., given the fact that they had engaged local communities as well as orphans and vulnerable children to offer feedback on how OVC could be assisted. Policy makers developed the "minimum package" program in part based on this feedback and negotiated with development partners to fund this program, rather then allowing outside funders to set the agenda. As a result, the Rwandan government was able to make its own decisions on allocation of this external funding and also was able to develop a monitoring and evaluation

system that mirrored their internal goals and objectives for the OVC program. In the immediate-term, this has sustained the system and program activities. It is clear that greater external funding for the program is needed currently to meet the great need of OVC; however, as Rwanda transitions into its vision of a middle-income nation, it is anticipated that more resources will be generated internally by the very youth who benefited from the existing program.

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