Issue Date: **March 30, 2009**
Closing Date: **April 20, 2009**
Closing Time: **17:00 Hours Rwanda Time**

Subject: **USAID-RWANDA-696-09-004-DRAFT-RFA - Future Request for Applications "SOCIAL SERVICES FOR VULNERABLE POPULATIONS" (SSVP)**

Ladies/Gentlemen:

USAID/Rwanda announces its intention to invite comments and suggestions on a draft Program Description for the implementation of the program entitled **"Social Services for Vulnerable Populations**" in Rwanda. This program will have approximately a base funding of US$12 million per year for the entire SSVP program to be implemented over five (5) years through a cooperative agreement type award. Therefore, the total estimated cost of the award may be as much as US$60 million.

The final version of the Request for Applications (RFA) is projected to be issued in early May 2009. USAID/Rwanda invites comments and suggestions on the attached draft program description from firms and organizations eligible to compete, experts in the area of SSVP and other interested parties. U.S. and non-U.S. based organizations may be eligible and are strongly encouraged to review the document, provide comment, and consider submitting applications in response to the resulting final solicitation. The purpose of posting this draft program description is to enhance the quality of the RFA. Comments and suggestions received may be considered as the RFA is finalized.

THIS IS NOT A REQUEST FOR APPLICATION. PLEASE DO NOT SUBMIT AN APPLICATION IN RESPONSE TO THIS DRAFT AS IT WILL NOT BE CONSIDERED.

We are soliciting comments and suggestions from interested parties, in order to further refine this draft program description. Your comments will be appreciated and considered as we finalize the RFA for the proposed cooperative agreement. Comments may or may not be incorporated in the program description. USAID/Rwanda will entertain suggestions/comments to the draft program description until the Closing Date and Time stated above. USAID reserves the right to incorporate and/or to reject suggestions and comments on the draft program description. **USAID/ Rwanda will not be able to respond to questions or requests for clarifications resulting from this notice until the final RFA is issued.**

The period of performance is expected to be five years. No information on Pricing, Competition, Instructions to Applicants or Evaluation Criteria is available at this time. Please refrain from submitting questions or requests for clarifications in regard to these sections, as responses will not be provided. When the RFA is issued, any amendments thereof will be posted on www.grants.gov, and interested parties should check the website regularly.

Issuance of this draft program description does not constitute an award commitment on the part of the Government, nor does it commit the Government to pay for any costs incurred in the preparation or submission of comments/suggestions or an application. Furthermore, the Government reserves the right to defer issuance of the RFA solicitation or not to issue an RFA, if such action is considered to be in the best interest of the Government.

Please submit your comments/suggestions electronically to the Regional Agreement Officer, Marcus A. Johnson, Jr. at marcusjohnson@usaid.gov with a copy to the Senior A&A Specialist, Aster Kebede at askebede@usaid.gov. The email subject line should read **"USAID-RWANDA-696-09-004-DRAFT-RFA"**.

Thank you for your interest in USAID/Rwanda programs.

Sincerely,

/s/

Marcus A. Johnson Jr.
Regional Agreement Officer
USAID/EAST AFRICA

THIS IS A DRAFT DOCUMENT THAT IS BEING POSTED TO SOLICIT COMMENTS AND SUGGESTIONS PRIOR TO POSTING THE ACTUAL REQUEST FOR APPLICATIONS (RFA).

DRAFT PROGRAM DESCRIPTION
SOCIAL SERVICES FOR VULNERABLE POPULATIONS

A.1. Introduction

The goal of the *Social Services for Vulnerable Populations Project* is to reduce the risk and impact of HIV/AIDS and other health conditions on most vulnerable populations in Rwanda, especially people living with HIV/AIDS (PLHA), orphans and vulnerable children (OVC) and their families**.** The project builds upon USAID support to the Government of Rwanda (GOR) to support these vulnerable populations to access health and social services that enable them to live productive lives. The project will work in the health areas of HIV/AIDS care, prevention and treatment, family planning/reproductive health (FP/RH), maternal/neonatal/child health (MNCH), child survival (CS), malaria and nutrition. In addition to linking PLHA, OVC and other vulnerable families to basic health care, it will also link with support services that mitigate the impact of HIV disease, including services that promote or support education, economic empowerment, and legal protection.

The *Social Services for Vulnerable Populations Project* will operate in a subset of the 30 districts, to be determined together with the Government of Rwanda and depending on the availability of funds. Project districts will be selected through a consultative process post award, and will be based on criteria that include continuation of current integrated health and social service delivery activities, opportunities for increased program linkages between clinic and community-based programs, and government expression of interest and commitment. The awardee and current project-holders will jointly devise workable approaches to transition beneficiaries and caregivers from the current projects to the follow-on effort at community, household, family, and individual levels.

The design of this new award benefited from the 2008 preliminary draft of the Health Sector Strategic Plan II (2009-2012), the 2008 Rwanda Community Health Needs Assessment report, and findings of the 2007 Interim Demographic and Health Survey. To be consistent with GOR policies and guidelines, consultations were made with the Ministry of Health (MOH) Community Health desk, MOH leadership at the central and decentralized levels, Ministry of Gender and Family Promotion (MIGEPROF), and current providers of OVC and PLHA services. Available policy documents for the GOR were referenced to ensure consistency with national goals. Electronic copies of these documents will be made available through USAID/Rwanda.

A.2. Activity Objective

The Activity Objective of the *Social Services for Vulnerable Populations* project is to **Increase the use of health and related social support services among the most vulnerable, including PLHA, OVC and their families, to mitigate the impact and reduce the risk of HIV and other health threats.** This Activity Objective will be accomplished through the achievement of the three results listed below. The detailed Program Description with results framework, sub-results and expected outcomes is provided in Section A.6.

Result 1: Increased access to a network of high-quality preventive, curative and social services at the household and community level for the most vulnerable.

Result 2: Strengthened stability of families and communities through economic strengthening, food security and education.

Result 3: Strengthened capacity of local government, civil society and community groups to support the most vulnerable children and families in a sustainable manner.

A.3. Guiding Principles

- Plan, design, and implement all activities to promote the sustainability of the project and its interventions through widespread buy-in of activities; transfer of critical and relevant skills and knowledge; use of enabling strategies that encourage a learning-by-doing approach; and use of existing talent, resources, mechanisms, and forums for project interventions whenever possible in order to **take advantage of and build on local knowledge and capacities**;

- **Link clinic-and community-based services within both health and social service networks** to improve access to basic primary preventive health, basic care, education, protection, food security, and economic strengthening

- **Be responsive to designated GOR actors**, such as the Ministry of Health and the Ministry of Gender and Family Promotion (MIGEPROF), and relevant GOR priorities, as outlined in relevant policy or planning documents, such as Vision 2020, the Economic Development and Poverty Reduction Strategy (EDPRS), HSSP II, National OVC Policy and others;

- **Work in close coordination and collaboration with** other donors, USAID implementing partners, local partners, and other relevant stakeholders;

- **Model the principles and practices of accountability and participation** to help build the resilience and capacity of vulnerable populations so that they themselves are better able to: improve their health and socio-economic status; be involved members of their communities; and reduce stigma and discrimination;

- **Support dissemination of lessons learned and best practices**—as well as the use of networks for exchange, peer learning and problem solving—to all stakeholders as possible and appropriate;

- **Promote gender through the planning, management, and implementation of all project activities.** Girls and women often face a disproportionate level of risk and vulnerability for exploitation, physical and sexual abuse, trafficking, HIV infection and burdens of caring for family members;

- **Seek, develop, and maintain private and/or public sector partnerships** that augment project interventions and/or sustain them beyond the life of the project; and,

- **Support a client-focused/family-centered approach** to promote comprehensive family-centered care, decrease potential stigma, and reduce the stress on already vulnerable families and households.

A.4. Background

Rwanda is a small landlocked country with a per capita GDP of approximately $260, making it one of the world's poorest countries. Around 60 percent of the population lives below the poverty line. The country's economy is based on agriculture, mostly at a subsistence level. Its population of more than nine million is concentrated in a land area of 23,336 sq. km., making it the most densely populated country in

Africa at an estimated 349 people per sq km, yet it is also one of the least urbanized countries on the continent.

The state-orchestrated genocide in 1994 has left a disruptive legacy. Today Rwanda has hundreds of thousands of orphaned children and tens of thousands of people in jail. Life expectancy at birth in Rwanda is around 45 years, about the same as during the 1970s. Subsistence farming dominates Rwanda's economy, employing 80 percent of people and providing around 40 percent of GDP. Tea and coffee are the main cash crops and usually generate over 80 percent of export earnings. An estimated 95 percent of energy consumed in Rwanda comes from wood, peat and charcoal. Electricity demand is rising fast, but is constrained by the available supply, though there are plans to increase this.

In keeping with the government's liberal orientation, economic policy is intended primarily to ensure macroeconomic stability, conditions for continued fast economic growth and poverty reduction. Real GDP growth averaged around six percent from 2004-07. Since 1994 the services sector has been growing at a faster rate than the overall economy, and it now contributes over 40 percent of GDP. It is largely driven by the telecommunications sector, although transport, tourism and retail also play a role.

The HIV/AIDS epidemic continues to affect the lives of millions across the world, threatening the public health and well-being of entire societies while rolling back decades of progress in economic and social development. Among those most affected by the disease are people living with HIV/AIDS (PLHA), orphans and vulnerable children (OVC), and their families.

In Rwanda, HIV prevalence is estimated at 3% among 15-49 year olds. The prevalence among women is higher (3.6%) than men (2.3 %) and is higher in urban vs. rural areas. According to UNAIDS estimates, approximately 150,000 Rwandans were living with HIV/AIDS in 2008, of which some 17,000 were children aged 0-14, primarily due to mother to child transmission. In addition to the more than 60,000 PLHA on ART, 89,000 PLHA that were not yet eligible for ART are being reached with basic health care and support services.

In the last few years Rwanda has made great strides in reducing its infant and child mortality rates. According to the interim demographic and health survey completed in 2008 (I-RDHS 2008) the infant mortality rate is 62 deaths per 1,000 live births, and the child mortality rate is 103 deaths per 1,000 live births. This is compared to rates of 86 and 152, respectively, in 2005. Although these results represent a major reduction in Rwanda's mortality rates compared with the 2005 and 2000 demographic and health surveys, it still means that one out of every sixteen children dies before their first birthday, and one in ten die before the age of five.. At the same time, 2005 data show that 45% of children under five suffer from chronic malnutrition and 19% are severely malnourished, an increase over previous rates. Malaria remains one of the leading causes of morbidity and mortality among adults and children.

The context of orphans and other vulnerable children in Rwanda is complex due to the 1994 genocide, the civil war, the loss of parents to AIDS and other causes, and extreme poverty. Around 60 percent of the Rwandan population lives below the poverty line and 90% of those who are poor live in rural areas. As of late 2007, there were an estimated 3.4 million children aged 0-17 in Rwanda. According to the 2005 Rwanda DHS, 28 percent of all Rwandan children under the age of 18 are orphaned or vulnerable. More than 87% of households with orphans and/or vulnerable children received no external support of any kind (emotional, medical or social). For households with chronically ill persons, the percentage receiving no external support was also more than 87%. While data on child headed households is difficult to collect, about 71,000 children are estimated to be living in child headed (and/or sibling headed) households. A situation analysis of OVC conducted by UNICEF and MIGEPROF also found a high level of violence against OVC.

Although the GOR prioritizes family care over formal care for children, about 4,000 children were still living in orphanages in 2005. Immediately following the genocide, the number of orphanages in Rwanda increased fourfold. However, efforts to place children with kin or foster families have reduced this number dramatically. In 2001, systematic data was collected on the characteristics of children living in 24 Un-Accompanied Children centers including those for whom a family reunification or placement was not successful. The data revealed that while the majority of children had entered centers for reasons related to war and genocide, the main cause for more recent entrance (1998 or later) was poverty.

A.5. Relationship of *Social Services for Vulnerable Populations* to Government of Rwanda Policies and the U.S. Foreign Assistance Framework

Alignment with Government of Rwanda (GOR) policies

The GOR's draft Health Sector Strategic Plan (HSSP) II 2009 – 2012 is the most recent comprehensive document of all policies to date related to health. It supports major strengthening of interventions categorized along two axes: *client-centered service delivery* and *support services* (health systems). The HSSP II describes 12 objectives across these two axes:

Service Delivery:

1. Expand and strengthen FP/RH/MCH/Nutrition services
2. Promote and sustain a culture of healthy lifestyles and prevent disease
3. Consolidate gains in and further expand and improve treatment and care of infectious diseases
4. Develop and/or expand health services for non-communicable diseases

These services are provided at different levels of the health care system: community, health posts, health centers, district hospitals and referral hospitals; and by different types of providers: public, confessional, private-for-profit or NGO, and trained volunteer.

Support Services:

1. Develop, update, monitor and evaluate evidence-based policies and plans
2. Guarantee financial accessibility to health services for all people in Rwanda
3. Improve the availability, quality and rational use of Human Resources for Health (HRH)
4. Improve geographical accessibility of the population to health services
5. Ensure (universal) availability and rational use at all levels of quality drugs, vaccines and consumables
6. Ensure the highest attainable quality of health services at all levels
7. Promote and inculcate a culture of research
8. Ensure that health interventions are responsive to people's needs, managed efficiently and transparently, and that all actors are participating in planning and evaluation in a well coordinated manner

These services are mainly provided at the national and district level, mostly by the public system (MoH and District Health Units), but also by others.

In March 2007, the MOH finalized the *National Community Health Policy*, and is finalizing the community health strategy, guidelines and operational procedures. The policy defines three types of volunteer community health workers (CHWs) – *Agent de Sante Binome* (male and female community health worker), *Animatrice de Sante Maternelle* (maternal community health worker), and *Agent de Sante Communautaire* (community health worker specializing in HIV/AIDS and other palliative care).

In Rwanda, support services for OVC are delegated to a number of different line ministries, with the lead agency being the Ministry of Gender and Family Promotion (MIGEPROF). The Ministry of Local Government (MINALOC) has established a *National Policy for Orphans and Vulnerable Children,* which

governs policy for a range of vulnerable children, including those specifically orphaned due to AIDS, and MIGEPROF has established a corresponding Action Plan. The National AIDS Control Commission (CNLS) has also developed a national policy and action plan for AIDS which is in the process of being updated. The Ministry of Education (MINEDUC) is also critical as its 2004-2008 Education Sector Strategic Plan includes promoting the "catch up education for out of school children, early childhood development, special education for children with special needs, protective measures particularly for girls and psychosocial support for OVC". In addition, District Education Funds support OVC to access education.

Primary school enrollment has risen for all children due to the introduction of universal primary education (UPE) in 2003. Net enrollment in primary school currently stands at 95.1% for girls, and 93.3% for boys. UPE has increased the pupil teacher ratio to 74:1 (i.e. 74 pupils for each teacher). The number of pupils has outgrown the infrastructure available and unqualified teachers have been laid off even though they have considerable experience. The recent move to English as a medium of instruction and the double-shifting in the newly introduced 9-year basic education (six years primary school and three years secondary) has increased capacity gaps in teachers and teaching aids. Secondary enrollment rates are 56.6% for boys, and 52.7% for girls, however, the available infrastructure in secondary school is not able to accommodate all the pupils transitioning from primary to secondary hence the introduction of double shifting. In 2006, the GOR joined the Education for All Fast-Track Initiative to increase school retention, but infrastructure, resources, organizational and human capacity continue to be challenges to delivering the minimum quality education to all children.

A *National Policy on Gender-Based Violence and Violence against Children* and corresponding *Strategic Plan on Gender-Based Violence and Violence against Children* are currently in the process of development.

In 2006 the GOR instituted a Community Based Health Insurance (CBHI) scheme, which is more commonly referred to as "*Mutuelles de Santé*". *Mutuelles* attempt to reduce the financial barrier in accessing health care by co-financing services between the beneficiary and the GOR. The very poor are exempt from payment (paid by GOR, Global Fund and NGOs) but still need to pay a small entry fee to participate. Participation in *mutuelles* has been made mandatory and thus uptake and demand for health services has increased dramatically.

In 2007, the GOR also published its *Decentralization Strategic Framework*, which outlines a phased approach to allocating increased governing power to districts, sectors and cells. This shift in authority for budgeting, reporting and managing to decentralized levels has important implications for the health system and health governance in Rwanda. For example, one important aspect is the directive from the Ministry of Finance and Economic Planning (MINECOFIN) and the Ministry of Local Government (MINILOC) for all associations which engage in income generating activities to form cooperatives, including those for CHWs, OVC, and PLHA. Given the changes in decentralized administrative functions and responsibilities, and the new focus on community health, it is a critical moment for USG and other donors to assess their contribution to the health sector and determine strategic steps forward. Of particular relevance and importance to the *Social Services for Vulnerable Populations* project will be the planned establishment of "social affairs" personnel by the GOR at the district, sector and cell levels in order to better link health and social services delivery.

A comprehensive policy on basic care and support for people living with HIV and AIDS is currently under development with support from a USAID clinical partner and inputs from the African Palliative Care Association (APCA) and Mildmay International.

The Economic Development and Poverty Reduction Strategy (EDPRS) 2008-2012 is the GOR's medium-term strategy for economic growth, poverty reduction and human development. The EDPRS outlines priorities in:

> Education: "In education and skills development, the emphasis is on increasing the coverage and the quality of nine year basic education, strengthening technical and vocational education and training, and improving the quality of tertiary education."
> Health: "In health, the objectives are to maximize preventative health measures and build the capacity to have high quality and accessible health care services for the entire population in order to reduce malnutrition, infant and child mortality, and fertility, as well as control communicable diseases. This includes strengthening institutional capacity, increasing the quantity and quality of human resources, ensuring that health care is accessible to all the population, increasing geographical accessibility, increasing the availability and affordability of drugs, improving the quality of services in the control of diseases and encouraging the demand for such services."
> Social Protection: "In social protection, the objective is to achieve effective and sustainable social protection for the poor and vulnerable. The sector will provide social assistance to the most needy while supporting the able-bodied to progress out of extreme vulnerability and poverty into more sustainable means of self-support."

Vision 2020, finalized in 2000, formulates long-term development goals for Rwanda. It puts forward development objectives based around the six pillars of good governance, agricultural transformation, private sector development, human resource development, infrastructural improvements, regional and international economic integration, and the cross-cutting issues of gender equality, environmental protection and ICT development, as well as specific targets for a wide range of key indicators relating to these fields. It also employs a Community Driven Development (CDD) approach for achieving its development objectives. CCD aims to empower communities and local governments with resources and authority to take control of their development, taking a bottom-up approach and treating communities as partners in development.

Alignment with U.S. Government (USG) strategies

In Rwanda, the U.S. Agency for International Development (USAID) focuses on health; economic growth; and democracy and governance.

Improving Health Care: In the area of health, USAID programs work to reduce maternal and neonatal mortality; improve the quality and sustained use of family planning; reduce malnutrition among children; provide treatment and prevent the transmission of HIV/AIDS, tuberculosis, and malaria; and ensure access to decentralized health care.

In 2004 Rwanda began full implementation of the President's Emergency Plan for AIDS Relief (PEPFAR), and the U.S. is Rwanda's largest funder of HIV/AIDS programs. Under PEPFAR, USAID supports prevention of mother-to-child transmission of HIV/AIDS; provision of voluntary counseling and testing services, care, and treatment; and provision of psycho-social services to people living with HIV/AIDS, orphans, and other vulnerable people. Under the President's Malaria Initiative (PMI), which began in Rwanda in 2007, USAID's program—implemented in close coordination with Rwanda's government--focuses on malaria in pregnant women; indoor residual spraying of homes in designated districts; distribution of long-lasting, insecticide-treated bed nets; life-saving drug therapy; and case management of malaria at health facilities and the household level.

Promoting Rural Economic Growth: USAID's economic growth program expands agribusiness opportunities in the specialty coffee and the dairy sectors. For example, in 2000 no specialty coffee was

exported from Rwanda; in 2007, annual export revenue from this sub-sector has grown to $8 million; and Rwandan specialty coffee has been featured by Starbucks and Green Mountain Coffee as their "best of the best." In the dairy sector, USAID provides technical assistance to the Rwandan dairy industry to enhance its competitiveness through increased efficient and profitable flow of quality milk, dairy products and related inputs and services through the dairy value chain. In addition, the program seeks to expand access to economic opportunities for vulnerable populations through integrating people living with HIV/AIDs, orphans and other vulnerable children into dairy-related income-generating activities. USAID supports Rwanda's eco-tourism in Nyungwe National Park by working to increase the number of visitors to the park, conserve the biodiversity, and improve the livelihoods of Rwandans surrounding the park.

In Rwanda, USAID also provides food assistance to food insecure households. The assistance provides a safety net to HIV/AIDS-infected people, orphans and other vulnerable people. Food aid activities contribute to employment, improved agricultural technologies, agri-business development, incomes, and food security. To date, over 850,000 Rwandans have benefited from the U.S. food assistance.

Promotion of Democracy and Governance: USAID's democracy and governance program supports the decentralization process through strengthening the capacity of local governments and communities to improve health service delivery in twelve districts in Rwanda. It also supports conflict mitigation and reconciliation activities, such as National Unity and Reconciliation, Conflict Transformation Radio, and the development of permanent debate platforms at the national, provincial, and local levels, as well as the Rwandan diaspora, in post-conflict dialogue. In the Justice sector, USAID supports the provision of legal aid services and works to strengthen the legislative process.

The MCC Threshold Program was developed to address Rwanda's MCC Ruling Justly indicators, specifically Political Rights, Civil Liberties, and Voice and Accountability. The Rwanda Threshold Program will build the capacity of civil society organizations; improve the impartiality, efficiency, and independence of the judiciary; facilitate the implementation of Rwanda's legislative reform agenda; build the capacity of the media sector; and improve the internal investigation functions of the Rwandan National Police. Rwanda's Threshold Program is being implemented by USAID/Rwanda in partnership with the GOR.

In the United States Foreign Assistance framework, this activity falls *primarily* under Investing in People (IIP), Program Areas 3.1: Health; 3.2: Education; and, 3.3: Social and Economic Services and Protection for Vulnerable Populations. Some activities may also fall under Economic Growth, Program Area 4.7: Economic Opportunity.

The *Social Services for Vulnerable Populations* project is expected to network, coordinate and collaborate in its efforts with USG-funded programs, not only in health, but also including MCC Threshold program civil society strengthening, economic growth activities and education.

A.6. Current activities for provision of care and support services to vulnerable populations in Rwanda

The key donors working to provide care and support services to OVC, PLHA, and their families in Rwanda include the UN Agencies, World Bank, Global Fund and other bilateral donors, such as Belgium, Germany, Switzerland and England. All development partners have signed on to support a sector-wide approach (SWAp) in health to ensure better coordination and collaboration of all health activities.

Orphans and Vulnerable Children

The USG in Rwanda is the primary donor in OVC service provision and focuses on children aged 0-17 affected by HIV/AIDS. USG assistance reaches OVC with a menu of services that mirrors the minimum package stipulated by the GOR, including school fees, vocational training, health insurance, food security and nutritional support, psychosocial support and HIV prevention education.

The USG OVC strategy places a strong focus on leveraging other sectors to provide services and do wrap-around programming. Wrap-around activities include collaboration with the Presidential Malaria Initiative, Food for Peace (Title II) for nutrition and food security, and the Ambassador's Girls Scholarship Program. In addition, there are several new wrap-around opportunities in the design and procurement phases including a program to increase youth employment. HIV prevention and testing and counseling activities are also integrated into OVC activities thereby linking OVC programming with other USG/PEPFAR-funded activities.

The USG and its partners actively participate in a country-based OVC Technical Working Group which coordinates programming across USG and other partners, and has recently supported the GOR in the creation of an OVC vulnerability criteria algorithm and a situation analysis. The group is also supporting the process of training partners on the use of the Child Status Index (CSI), a child-centered tool used to monitor and evaluate the well-being of children who are affected by HIV and are receiving services directly or indirectly through OVC programs. The CSI provides direct information on child progress, program successes, and areas for improvement in domains critical for child survival and well-being.

The USG currently has four main partners providing OVC service delivery. The Community HIV/AIDS Mobilization Project (CHAMP) is the USG's main implementing partner. CHAMP is lead by CHF International, in collaboration with Catholic Relief Services (CRS), Johns Hopkins University's Center for Communication Programs (JHU/CCP), Social Impact (SI), and 13 Rwandan Partner Organizations. Additional USG-supported OVC programs are managed by Africare, Catholic Relief Services (CRS) and *Associazione Volontari per il Servizio Internazionale* (AVSI), which receive funding through the centrally procured PEPFAR Track One Initiative. The CHAMP program will end in September 2009, and the Track One program in June 2010. These OVC partners work primarily in the following areas: care coordination and referral, education (primary, secondary), income-generating activities (IGA) for youth and caregivers, food security and nutrition, health care access, psycho-social support, legal and child protection, and limited support to shelter. To date, the USG has invested in several discrete activities to support child protection and more broadly social welfare services. Child protection committees were established in seven districts by CHAMP, sensitization on children's rights is offered by most of the OVC partners, and access to legal services has been offered through *Haguruka* and *Avocats Sans Frontières*.

USG OVC partners have also provided a standard package of uniform and school supplies for primary school, with more dispersed attention to after school programs and other remedial interventions. In addition to support for primary school, orphans and vulnerable children have been supported to attend secondary school or vocational training, including the provision of "start-up kits" upon completion of vocation training.

The Global Fund to fight AIDS, Malaria and Tuberculosis (GFATM) and UNICEF also support OVC care activities. UNICEF focuses mainly on central level TA/systems strengthening, and provides no direct services. Both UNICEF and CHAMP second OVC advisors to MIGEPROF. In Round 7, the GFATM is supporting MIGEPROF to implement the National Plan of Action for OVC; build the capacity of district and sector authorities to plan, monitor, and enable decentralized OVC activities; support PLHA umbrella organizations to strengthen OVC advocacy oversight, monitoring and evaluation activities; and support OVC in targeted districts with primary education costs and vocational training and apprenticeship.

People Living with HIV/AIDS (PLHA)

The USG supports access to a comprehensive range of basic care and support services to PLHA, including clinical and non-clinical interventions, at both the facility and community level. To date, the majority of prevention, care, and treatment services for PLHA have been provided in the health facility setting. Clinical services include the provision of cotrimoxazole for eligible adults, CD4 testing and clinical staging, diagnosis and treatment of common opportunistic infections (OIs), adherence counseling, clinical monitoring, nutritional assessment and support, prevention counseling, and referrals to community-based care and support services. Social care services have been primarily provided through community-based activities, some clinic-based partners have supported provision of *mutuelles*, transportation, income generation through PLHIV associations, and linkages to food support.

Clinic-based care is being supported by PEPFAR in 23 districts in Rwanda. PLHA who have been enrolled into care need psychosocial support and basic health care to delay progression of HIV disease, to stay in care programs until such a time as they may need ART, and to engage in normal life activities that allow them to live independent productive lives. They also need a support system at the community level. For this to happen, clinic-based care providers must work hand in hand with community providers, to identify infected individuals, provide the necessary psycho-social and medical care and assist the infected person and his or her family to settle within the community.

A.7. Detailed Program Description

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<tr><td colspan="3">Activity Objective: Increase the use of health and related social support services among the most vulnerable, including PLHA, OVC and their families, to mitigate the impact and reduce the risk of HIV and other health threats.</td></tr>
<tr>
<td>Result 1: Increased access to a network of high-quality preventive, curative and social services at the household and community level for the most vulnerable.

1.1: Mutuelle coverage among the most vulnerable, PLHA, OVC and their families, improved.

1.2: Increased timely and appropriate health seeking behavior among the most vulnerable children and families.

1.3: Referral systems and structures linking health and related social services improved and expanded.

1.4: Psycho-social interventions and life skills improved and expanded.</td>
<td>Result 2: Strengthened stability of families and communities through economic strengthening, food security and education.

2.1: Economic security of most vulnerable children and families strengthened through increased access to market-linked interventions and mechanisms appropriate to the poorest.

2.2: Increased enrollment and retention in primary and secondary education among the most vulnerable children.

2.3: Increased food security and improved nutrition among most vulnerable children and families.</td>
<td>Result 3: Strengthened capacity of local government, civil society and community groups to support the most vulnerable children and families in a sustainable manner.

3.1: Increased capacity and expansion of services to protect the most vulnerable children and families from abuse, neglect, exploitation, stigma and discrimination.

3.2: Increased capacity of key government entities responsible for monitoring and providing services for vulnerable populations at all levels.

3.3: Strengthened capacity of local civil society organizations to manage and provide services to vulnerable populations.

3.4 Increased income generation capacity of cooperatives through market-linked interventions and support to cooperative service providers.</td>
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</table>

Result 1: Increased access to a network of high-quality preventive, curative and social services at the household and community level for the most vulnerable.

Care for PLHA should begin at the time of infection. Since this is unknown, access to counseling and testing is essential, so that care can begin with an early diagnosis. Much remains to be done to ensure that all PLHA begin to receive care and support as close as possible to the time of infection, and not only in advanced stages of HIV/AIDS. Breaking the transmission chain of HIV depends heavily on the ability of prevention programs to reach and impact people already infected with the disease. Likewise, successful ARV treatment requires adherence to therapy, and both require strong linkages between the health facility, and the community to ensure a continuum of care. It is important that HIV-exposed and infected children and OVC have access to immunization and other critical child survival services. Vulnerable populations, especially OVC and PLHA, need access to other social support services, including psychosocial support services and life skills for young people.

This project will primarily focus on ensuring access to the non-clinical components of community care, such as *mutuelles*, psycho-social support and improving the linkages and referrals between health and other services. Since the training, supervision and support of community health workers will be the responsibility of the health facility (per the GOR's Community Health Policy), this project will not directly support, but will need to link to and work closely with CHWs.

Sub-result 1.1: *Mutuelle* coverage among the most vulnerable, PLHA, OVC and their families, improved.

Families will be encouraged and supported to participate in the national community-based health insurance scheme or *mutuelles.* Based on availability of funding, some children and their families may receive *mutuelles* through the project. Other potential sources for *mutuelle* coverage, such as Global Fund, should be explored and linked to as appropriate. It is critical that the project ensures coverage on a family basis and not for only one member of the household. The project may also provide in selective cases transport costs and co-payments for the most vulnerable.

Anticipated **outcomes** include:

- Increased demand for *mutuelles* among most vulnerable families as a result of education and outreach activities.
- Increased *mutuelle* coverage among the most vulnerable children and families due to savings and income generation activities, and/or links to other resources.

Sub-result 1.2: Increased timely and appropriate health seeking behavior among the most vulnerable children and families**.**

Under this sub-result, community intermediaries (organizations and volunteers working on behalf of OVC and PLHA groups) complement the efforts of community health volunteers by reinforcing health messages and encouraging appropriate health seeking behaviors. Community intermediaries will integrate healthy living within other activities such as home visits, afterschool programs, day care, and by helping to identify and refer children and families to available health services. Integration with USG and other partners supporting service delivery (and systems strengthening) in health facilities will be imperative to ensure effective and timely referrals. Critical importance should be placed on improved care seeking behavior that is appropriate both to age and risk including and especially adults and children living with HIV, pregnant women, and children under five.

Anticipated **outcomes** include**:**

- Community intermediaries support children and families to practice basic preventive health care at home (including clean water, hygiene, nutrition, and use of LLITNs).
- Community intermediaries support children and families to recognize early signs of morbidity, and complications of morbidity, and to seek appropriate health services.

Sub-result 1.3: Referral systems and structures linking health and related social services improved and expanded.

Under this sub-result, referral structures and systems that ensure continuity of care across health and related social services are strengthened and expanded. Services relevant to family and child well-being are identified and mapped at local levels. Actors from district to village level receive capacity building in the establishment, management and oversight of referral systems according to their responsibilities. As needed, referral protocols, training aids and other supportive media are created (and or replicated) and disseminated to all actors.

Anticipated **outcomes** include:

- Community intermediaries identify and refer children at risk of morbidity, complications of morbidity, and mortality in a timely manner to health services
- Civil society, community organizations and local multi-sectorial committees involved in social affairs (health, gender, OVC, CDLS, etc.) collaborate regularly to assure smooth and effective referrals between providers.
- Most vulnerable children and families have increased access to a comprehensive range of social and health services, linked through referral systems that prevent overlap and gaps in services, and avoid unnecessary costs to users and providers.
- Creation of referral networks and a mapping of social service providers who complement basic health care, such as organizations that provide school fees for OVC, nutrition services, psycho-social support, market-linked IGAs, etc.

Sub-result 1.4: Psycho-social interventions and life skills improved and expanded.

Under this sub-result, vulnerable populations will be supported by interventions that help them to cope with difficult circumstances including but not limited to death and other loss, disclosure, stigma and discrimination. Vulnerable children will be supported by interventions that facilitate a transition to responsible, independent, risk-free living through an interactive training process that builds the skills of learners to adopt healthy behaviors. This includes training in a variety of interpersonal and psychosocial skills that may include: verbal and nonverbal communication, negotiation and conflict management, persuasion, decision-making, critical thinking, self esteem/confidence building, goal setting, coping, positive thinking, and time management.

Anticipated **outcomes** include:

- Increased ability to adopt healthy behaviors
- Enhanced ability to work with others and develop relationships through effective communication, cooperation, and negotiation
- Skills in resilience and self-confidence to assist with dealing with personal challenges
- Increased ability to assess personal strengths and abilities, problem solve to follow a course of action, identify resources, and learn how to access those resources
- Enhanced ability to identify and pursue personal goals that match current interests and develop specific strategies to achieve those goals

Result 2: Strengthened stability of families and communities through economic strengthening, food security and education.

Almost all coping with problems occurs within households, and thereafter to varied levels within extended families and among friends and neighbors. Most coping is local, and it relies on kinship and friendship networks, and other means of local support, particularly churches and local authorities. By strengthening households and communities, vulnerable populations will have the skills, resources and support necessary to improve their living situation.

Sub-result 2.1: Economic security of most vulnerable children and families strengthened through increased access to market-linked interventions and mechanisms appropriate to the poorest.

Under this sub-result, vulnerable families (including and especially PLHA, youth headed households, OVC caregivers) are supported in viable household economic strengthening activities that are appropriate to their age, skills, and experience; and which are linked to the local market potential for revenue and sustainability. These activities can include participation in cooperatives, savings and loan schemes or vocational training. Applicants are encouraged to consider public-private partnerships.

Anticipated **outcomes** include:

- Vulnerable families are better able to meet their own needs economically, in spite of changes in the family situation due to HIV/AIDS and other shocks.
- Returns on investments by individuals and families in terms of time, labor and other inputs, are improved.

Sub-result 2.2: Increased enrollment and retention in primary and secondary education among the most vulnerable children.

Under this sub-result, enrollment and retention in primary and secondary school would be increased through a combination of interventions focused on improving procurement practices; and expanding remedial support for those most likely to drop out and fall behind. Support at primary level can include a standard package of uniform and school supplies but should also focus on strategies to improve quality, retention and completion. In addition to primary school, orphans and vulnerable children should be supported to continue for secondary education or vocational training as appropriate. The project is encouraged to develop creative solutions to increasing access of OVC to secondary education, beyond payment of scholarships.

Anticipated **outcomes** include:

- Vulnerable children have access to school materials and education.
- Vulnerable children successfully complete primary education.
- Vulnerable children are supported to remain in school.

Sub-result 2.3: Increased food security and improved nutrition among most vulnerable children and families.

Under this sub-result, vulnerable children and families attain skills and knowledge that lead to greater food security; and greater understanding of the interplay between diet, nutrition and hygiene, especially as related to the special nutritional needs of PLHA (and other chronically ill persons), pregnant and lactating women, and children under five. Where practical, interventions that result in multiple benefits (increased

food security, improved nutrition, and strengthened household economic security) are supported, such as training in kitchen /backyard gardens, seed and small animals distribution, nutrition and hygiene education and counselling, cooking demonstrations, nutrition assessments and BMI monitoring (MUAC).

Anticipated **outcomes**:

- The most vulnerable children and families ability to utilize food and increase production of macro and micro nutrients.
- Increased food availability and income among highly vulnerable households (including and especially OVC and PLHA).

Result 3: Strengthened capacity of local government, civil society and community groups to support the most vulnerable children and families in a sustainable manner.

At the state and local level, strong political commitment, effective social sector policies based on local input, reliable and valid data, significant community participation and advocacy, and access to resources will create and maintain a supportive environment for the delivery, and ultimate use, of quality social sector services that benefit most vulnerable children and families.

To date, program beneficiaries have been identified through a community driven process that begins at the village level with community members identifying those considered most vulnerable. Local PLHA support groups participate in the identification of OVC to ensure that those known to be directly affected by HIV are represented. The lists of vulnerable children are then given to the cell and sector level where they are matched with service delivery groups including PEPFAR OVC partners. Despite the potential for unfair processes in regard to secondary school fees this process appears overall to be working well with observable equality across geographic areas and gender groups. Identification of OVC and PLHA program beneficiaries through other HIV services including testing and care sites does not appear to be a systematic practice across partners, and is an area requiring strengthening in order to ensure PLHA and their families are linked to key social services in the community.

Sub-result 3.1: Increased capacity and expansion of services to protect the most vulnerable children and families from abuse, neglect, exploitation, stigma and discrimination.

Under this sub-result, support will be provided for policy development and action planning for child protection and protection against sexual and gender-based violence among vulnerable populations. The community-level structures to prevent SGBV and protect children (e.g. child protection committees) will be expanded and strengthened. Tools and protocols and tools that will enable to successful implementation, tracking and improvement of child protection and SGBV services will be developed or expanded. Health facilities, schools, civil society organizations, community volunteers, community health workers and others will be trained to identify and care for SGBV/child abuse survivors and link them to legal services.

Anticipated **outcomes** include:

- Protocols and tools for prevention and care of child abuse/SGBV survivors, developed and used.
- Community support structures recognize signs of abuse and are linked to support resources.
- The most vulnerable children and families are prioritized according to need for available social and health support through both community and clinical identification processes.

Sub-result 3.2: Increased capacity of key government entities responsible for monitoring and providing services for vulnerable populations at all levels.

Under this sub-result, MIGEPROF, MOH and possibly MINEDUC, will receive technical assistance to ensure proper identification, service provision and monitoring for most vulnerable populations. District teams, health facility staff and community leaders will also receive support to ensure better provision of services.

Anticipated outcomes include:

- Reduced duplication of effort as program implementation is in line with identified needs.
- More appropriate services are provided to most vulnerable populations.
- OVC services are being monitored.
- Successful practices are shared and replicated.

Sub-result 3.3: Strengthened capacity of local civil society organizations to manage and provide services to vulnerable populations.

Under this sub-result, programming for vulnerable populations will use a model of service delivery through local civil society organizations. Capacity will be built through needs-based technical assistance in the areas of human and financial resources management, strategic planning, quality assurance, fundraising, organizational governance, and grants management.

Anticipated outcomes include:

- CSOs' capacity to manage programs has improved.
- Local partners are able to solicit support, and facilitate links between Rwandan organizations and international humanitarian and charitable assistance organizations and corporate, private and public foundations.
- Community volunteers and organizations are trained to support the identification of children and families eligible for government assistance grants and facilitate their application.
- Community, faith and civil society partners (business associations, women's and youth groups, faith based organizations) are able to mobilize resources from locally based private and public sectors, as well as the community at large through advocacy and fund-raising.

Sub-result 3.4: Increased income generation capacity of cooperatives through market-linked interventions and support to cooperative service providers.

Under this sub-result, increased income generation capacity of cooperatives contributes to the stability and well-being of vulnerable groups (e.g., PLHA associations, youth and caregiver OVC groups, etc.), and motivates and appreciates the efforts of volunteers (e.g., community health workers, OVC and other community volunteers).

Anticipated **outcomes:**

- Cooperatives maximize income returns on the investment of their time, labor and other inputs.
- Cooperatives are economically viable to the benefit of their membership, and to the benefit of vulnerable community members served by volunteers.
- Reduced vulnerability of members as a result of social networks and economic empowerment provided by cooperatives.
- Cooperatives have the necessary financial and management skills to operate transparently and fairly and to the benefit of their members.