INDEPENDENT COSTING STUDY OF THE PEPFAR/OVC PORTFOLIO IN NIGERIA

November 2017

This publication was produced at the request of the United States Agency for International Development. It was prepared independently by Nkata Chuku, Beverly Stauffer, Tosin Adeyemo, Goddy Akhaluola, Erisa Danladi, Funke Falade, Tahirah Ikharo, Samuel Ogboo, and Seluman Lecky.
Cover Photo: School children in Nigeria benefit from USAID's PEPFAR/Orphans and Vulnerable Children program. Credit: USAID/Nigeria
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November 2017

USAID Contract No. AID-OAA-C-14-00067; Evaluation Assignment Number: 335

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Global Health Program Cycle Improvement Project
1331 Pennsylvania Avenue NW, Suite 300
Washington, DC 20006
Phone: (202) 625-9444
Fax: (202) 517-9181
http://ghpro.dexisonline.com/reports-publications

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

As part of the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR) Country Operational Planning (COP) process in Nigeria, the country teams estimate and document resources used to fund program activities based on historical expenditure or cost data. In Nigeria, expenditures for orphans and vulnerable children (OVC) partners have been used to generate unit expenditures (UEs) used to determine target-based budgets. Currently, there is no clear guidance to OVC partners on how to allocate shared costs across service types. PEPFAR Nigeria commissioned this costing study to obtain detailed OVC program costs across implementing mechanisms (IMs). This study explored: (1) current expenditures across the various IMs’ OVC service packages; (2) the average UE for the various OVC services packages; (3) allocation of shared expenditure across different service areas; (4) contextual factors affecting expenditures; (5) expenditures for a “gold standard” package of OVC services; and (6) recommendations for a framework to develop IM-level budgets for COP. The study covered October 2015 to September 2016, and collected cost data and contextual data from OVC implementing partners in seven states. The study noted a wide variation in the methods and assumptions for allocation of shared costs, and IMs do not usually allocate shared expenditures across the OVC service areas. Given this, the study found the average cost of providing services to one OVC to be $21.7 per year. The findings and recommendations from this study will be used to develop an effective budgeting tool for OVC programs taking into account contextual cost drivers, as well as the inputs required to deliver a “gold standard” package of services.
ACKNOWLEDGMENTS

This evaluation would not have been possible without the support, cooperation, and sharing of information and experiences, perceptions, and viewpoints of different stakeholders, providing vital material for this report’s findings and conclusions. The team wishes to acknowledge a debt of gratitude to all those, including community-based organizations implementing PEPFAR OVC programs, districts, and national leaders, US Government Implementing Partners, and other partners of the Government of Nigeria, who gave generously of their time, and shared their thoughts, at times extensively and with great depth. Special thanks are due to the leadership and staff of the following Implementing Partners: AIDS Prevention Initiative in Nigeria (APIN), Association for Reproductive and Family Health (ARFH), Catholic Caritas Foundation of Nigeria (CCFN), Catholic Relief Services (CRS), Center for Integrated Health Programs (CIHP), FHI 360, Friends for Global Health Initiative in Nigeria (FGHIN), Health Initiatives for Safety and Stability (HIFASS), Institute for Human Virology Nigeria (IHVN), Pro-Health International, Save the Children, and Widows and Orphans Empowerment Organization (WEWE). The data collectors who supported us in the field were indispensable and helped shape our interpretation of the information we received. The USAID staff who support and oversee PEPFAR and OVC deserve special mention for their time and sharing of their insights in the role of these programs with the evaluation team. In addition, we would like to thank USAID/Nigeria staff, including Tessie Philips-Ononye, Doreen Magaji, and Isa Iyortim; CDC/Nigeria staff, including Victor Atuchukwu, for setting a solid direction for the evaluation. And last, but certainly not least, the evaluation team would like to thank Melinda Pavin for her thorough technical reviews, Crystal Thompson for her administrative support throughout this evaluation, and Laurie Chamberlain, for her guidance with the editing and final production.
# CONTENTS

Abstract ............................................................................................................................................................. iii
Acknowledgments ........................................................................................................................................... iv
Acronyms ......................................................................................................................................................... vii
Executive Summary ......................................................................................................................................... ix
  Methodology and Limitations ............................................................................................................................ ix
  Findings.................................................................................................................................................................... x
  Conclusions and Recommendations ................................................................................................................... xiii
I. Introduction.................................................................................................................................................... 1
  Evaluation Purpose................................................................................................................................................ 1
  Evaluation Questions............................................................................................................................................... 2
II. Project Background ..................................................................................................................................... 3
  Background..................................................................................................................................................................... 3
  OVC Programming Design ................................................................................................................................... 3
  OVC Portfolio and Operational Models .................................................................................................................. 3
  OVC Program Foci for Study Year ........................................................................................................................... 3
III. Evaluation Methods and Limitations ....................................................................................................... 5
  Study Design................................................................................................................................................................... 5
  Study Location ............................................................................................................................................................... 5
  Study Population and Sampling ............................................................................................................................. 5
  Sampling........................................................................................................................................................................... 5
  Data Collection .................................................................................................................................................................. 6
  Data Quality Assurance .................................................................................................................................................. 7
  Data Analysis .................................................................................................................................................................... 7
  Limitations of the Study................................................................................................................................................... 7
IV. Findings ......................................................................................................................................................... 9
  Evaluation Question 1.................................................................................................................................................. 9
  Evaluation Question 2................................................................................................................................................... 11
  Evaluation Question 3................................................................................................................................................... 13
  Evaluation Question 4................................................................................................................................................... 14
  Evaluation Question 5................................................................................................................................................... 15
  Evaluation Question 6................................................................................................................................................... 19
V. Conclusions and Recommendations ........................................................................................................ 20
   Conclusions ........................................................................................................................................ 20
   Recommendations .......................................................................................................................... 20
Annex 1. Scope of Work ............................................................................................................................ 22
Annex 2. Categorization of IPs by Type of OVC Project ..................................................................... 41
Annex 3. Cost Drivers for OVC Services .............................................................................................. 42
Annex 4. Disclosure of Any Conflict of Interest .................................................................................. 45
Annex 5. Summary Bios of Evaluation Team Members ..................................................................... 54

TABLES
Table 1. Sample Population ...................................................................................................................... 5
Table 2. Mean Costs of Providing OVC Services in Nigeria, Oct. 2015 – Sept. 2016 (USD) .................. 9
Table 3. IPs’ Mean Costs of Providing OVC Services and the Number of Services Provided ........ 10
Table 4. Contribution of Cost Elements at the IP Level .................................................................... 10
Table 5. Comparison of Total Annual OVC Costs to Unit OVC Costs (USD) ................................. 10
Table 6. Weighted Mean Costs of Providing Unit OVC Services across SNUs ......................... 11
Table 7. Weighted Mean Unit Costs across OVC Services ............................................................... 12
Table 8. Percentage Contribution of OVC Services to Total Direct Cost ....................................... 12
Table 9. Inventory of Services and Interventions ................................................................................. 16

FIGURES
Figure 1. Correlation between the Number of OVC Reached and OVC Unit Costs ......................... 11
Figure 2. Methods for Allocation of Shared Expenditures across IPs .......................................... 13
ACRONYMS

AGYW Adolescent, girls and young women
APIN AIDS Prevention Initiative in Nigeria
ARFH Association for Reproductive and Family Health
ART Antiretroviral therapy
CBO Community-based organization
CCFN Catholic Caritas Foundation of Nigeria
CDC Centers for Disease Control and Prevention
CIHP Center for Integrated Health Program
COP Country Operational Planning
CRS Catholic Relief Services
DREAMS Determined, Resilient, Empowered, AIDS-Free, Mentored, and Safe Initiative
EA Expenditure Analysis
ECD Early childhood development
FCT Federal Capital Territory
FGD Focus group discussion
FGHIN Friends for Global Health Initiative in Nigeria
FHI 360 Family Health International 360
FMOH Federal Ministry of Health
FSW Female sex workers
FY Fiscal year
GHPro Global Health Program Cycle Improvement Project
HES Household economic strengthening
HH Household
HIFASS Health Initiatives for Safety and Stability
HTC HIV testing and counseling
HTS HIV testing services
IEC Information, education, and communication
IHVN Institute of Human Virology of Nigeria
IM Implementing mechanism
IP Implementing partner
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>KII</td>
<td>Key informant interview</td>
</tr>
<tr>
<td>LGA</td>
<td>Local Government Area</td>
</tr>
<tr>
<td>LoE</td>
<td>Level of effort</td>
</tr>
<tr>
<td>NDHS</td>
<td>Nigeria Demographic and Health Survey</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-governmental organization</td>
</tr>
<tr>
<td>NOMIS</td>
<td>National OVC Management Information System</td>
</tr>
<tr>
<td>OJT</td>
<td>On-the-job training</td>
</tr>
<tr>
<td>OVC</td>
<td>Orphans and vulnerable children</td>
</tr>
<tr>
<td>PEPFAR</td>
<td>President’s Emergency Plan for AIDS Relief</td>
</tr>
<tr>
<td>PHI</td>
<td>Pro-Health International</td>
</tr>
<tr>
<td>PLWHHA</td>
<td>People living with HIV/AIDS</td>
</tr>
<tr>
<td>PMP</td>
<td>Performance monitoring plan</td>
</tr>
<tr>
<td>PMTCT</td>
<td>Prevention of mother-to-child transmission</td>
</tr>
<tr>
<td>PSS</td>
<td>Psychosocial support</td>
</tr>
<tr>
<td>RH</td>
<td>Reproductive health</td>
</tr>
<tr>
<td>SMILE</td>
<td>Sustainable Mechanism for Improving Livelihoods and Household Empowerment</td>
</tr>
<tr>
<td>SMOH</td>
<td>State Ministry of Health</td>
</tr>
<tr>
<td>SNU</td>
<td>Sub-national units</td>
</tr>
<tr>
<td>SPRING</td>
<td>Strengthening Partnerships, Results, and Innovations in Nutrition Globally</td>
</tr>
<tr>
<td>STEER</td>
<td>Systems Transformed for Empowered Action and Enabling Responses for Vulnerable Children and Families</td>
</tr>
<tr>
<td>SVC</td>
<td>Save the Children</td>
</tr>
<tr>
<td>TWG</td>
<td>Technical Working Group</td>
</tr>
<tr>
<td>UE</td>
<td>Unit expenditure</td>
</tr>
<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
</tr>
<tr>
<td>USG</td>
<td>United States Government</td>
</tr>
<tr>
<td>VSLA</td>
<td>Village Savings and Loans Associations</td>
</tr>
<tr>
<td>WASH</td>
<td>Water, sanitation, and hygiene</td>
</tr>
<tr>
<td>WEWE</td>
<td>Widows and Orphans Empowerment Organization</td>
</tr>
</tbody>
</table>
EXECUTIVE SUMMARY

As part of the Country Operational Planning (COP) process, President’s Emergency Plan for AIDS Relief (PEPFAR) country teams estimate and document resources used to fund program activities based on historical expenditure or cost data. The PEPFAR Expenditure Analysis (EA) captures expenditures for all program areas, including orphans and vulnerable children (OVC) services, across implementing mechanisms (IMs). In Nigeria, expenditures for OVC partners from 2013 to present have been used to generate unit expenditures (UEs) used to determine target-based budgets. These UEs are not disaggregated by the different OVC services because denominator data for that is not collected. There is also no clear guidance to OVC partners on how to allocate shared costs across service types. As a result, there is limited understanding of what makes up the UEs across the different IMs. Another challenge with the EA is that it does not capture contextual factors to guide the use of the UE.

PEPFAR Nigeria commissioned this costing study to obtain and analyze detailed OVC program cost information across IMs, to help address the limitations above. PEPFAR provided the study team with six evaluation questions:

1. What are the expenditures currently being made by partners to provide the various service packages that they deliver to OVC?
2. What are the average, sub-national unit (SNU)-specific and partner-specific UEs for the various service packages being delivered to OVC?
3. How are partners currently allocating shared expenditures across the different service areas?
4. What contextual factors affect the expenditures incurred in providing these services across partners and regions?
5. What are the expenditures for a “gold standard” package of OVC services by intervention, across partners and regions?
6. What is the framework that the United States Government (USG) should use to develop IM-level budgets for Country Operational Planning?

METHODOLOGY AND LIMITATIONS

The study covered the period from October 2015 to September 2016. It collected cost data and contextual qualitative data, including inputs used to provide OVC services within the study year, regardless of when the inputs were procured. Inputs with a life span of more than one year were annualized, and costs shared between OVC and other programs were apportioned based on contribution to the overall portfolio. The study considered financial costs only, through the perspective of PEPFAR. Unlike the EA, which looked at total expenditure per partner at all levels within the fiscal year, this study used expenditure data from implementing partners (IPs) and a sample of their sub-awardees to determine the mean cost of all inputs used to provide OVC services during the study year.

The study team collected data from all seven states and 12 IPs identified by USAID and the Centers for Disease Control and Prevention (CDC). The table on the next page shows these states and IPs.

---

1 Expenditure Analysis of PEPFAR Programs Expenditure Tracking and Reporting Guidance 2016 also includes case management and early childhood development and separates primary from secondary education.
<table>
<thead>
<tr>
<th>States</th>
<th>IPs</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Benue</td>
<td>1. AIDS Prevention Initiative in Nigeria (APIN)</td>
</tr>
<tr>
<td>2. Cross River</td>
<td>2. Association for Reproductive and Family Health (ARFH)</td>
</tr>
<tr>
<td>4. Federal Capital Territory (FCT)</td>
<td>4. Catholic Relief Services (CRS)</td>
</tr>
<tr>
<td>5. Lagos</td>
<td>5. Center for Integrated Health Programs (CIHP)</td>
</tr>
<tr>
<td>7. Rivers</td>
<td>7. Friends for Global Health Initiative in Nigeria (FGHIN)</td>
</tr>
<tr>
<td>8.</td>
<td>8. Health Initiatives for Safety and Stability (HIFASS)</td>
</tr>
<tr>
<td>10. Pro-Health International (PHI)</td>
<td>10. Pro-Health International (PHI)</td>
</tr>
<tr>
<td>11. Save the Children (SVC)</td>
<td>11. Save the Children (SVC)</td>
</tr>
</tbody>
</table>

Twenty-eight community-based organizations (CBOs) were selected for the study: one for each IP with OVC program operations in more than one state, and two for each IP with operations in only one state.

Costs were classified either as site-level or above-site costs. Site-level costs are direct and indirect expenses CBOs incurred to provide services to OVC and households; above-site costs are direct and indirect expenses IPs at the central (in-country) and state levels to support the provision of OVC services. IMs’ average cost of providing OVC services within the study year was determined by summing all the site-level and above-site costs for each IM. For the calculation of average cost at each level, the numerator was the total cost and the denominator was the number of OVC served.

The study plan was ambitious, given the time and resources available. Therefore, the study team used purposive, rather than representative, sample sizing and random sample selection to determine how many and which CBOs should be selected. The study tried to mitigate this through a census of all the IPs and study states, to increase the chances of capturing variations. Because IPs do not organize their financial records in the manner required for ingredient costing, there was a lot of cost “lumping,” making it difficult to attribute some of the cost centers to specific interventions. Incomplete segregation between central- and state-level IP expenditures made it difficult to determine SNU costs. Differences in how interventions under the OVC service areas across IPs were categorized posed a challenge for accurately allocating costs to the correct service areas and articulating propositions for a “gold standard” package of OVC services.

FINDINGS

The study used a weighted mean to present mean costs, because costs were widely dispersed among the IPs. The weighted mean was computed by dividing the sum of the product of the mean costs and number of OVC served for each IP by the number of OVC served by all the IPs. This report uses the CBOs’ and IPs’ classifications of OVC services; these are different from the classifications in the PEPFAR EA, and were based more on the national classifications.

Evaluation Question 1
What are the expenditures currently being made by partners to provide the various service packages that they deliver to OVC?

The study found that the weighted mean cost of providing services to one OVC within the study year was N4,958² ($21.7). The mean costs across IPs ranged from N2,000 ($9) to N 27,838 ($122). Both site-level and above-site costs varied across CBOs, but the latter varied more widely. At the IP level, personnel accounted for the majority of OVC costs, followed by program activities. Scale played a role in the wide variations in mean costs. Two IPs that spent similar total amounts on their OVC programs

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² The Nigerian currency, naira, is denoted by an “N” in this report.
had radically different mean costs due to the large difference in the number of OVC they served during the study year.

**Evaluation Question 2a**
What are the average, SNU-specific UEs for the various service packages being delivered to OVC?

The centralized nature of most IPs made it difficult to disaggregate their national and state costs to determine their complete SNU costs (regional and state). To fulfill the requirements of this study, the weighted CBO mean cost in each state was used as a proxy for SNU costs. These are presented in the table below.

<table>
<thead>
<tr>
<th>Geopolitical Zone</th>
<th>States</th>
<th>Weighted Mean Cost: States</th>
<th>Mean Cost: Regions</th>
</tr>
</thead>
<tbody>
<tr>
<td>South South</td>
<td>Rivers</td>
<td>$9</td>
<td>$8.5</td>
</tr>
<tr>
<td></td>
<td>Cross River</td>
<td>$8</td>
<td></td>
</tr>
<tr>
<td>South West</td>
<td>Lagos</td>
<td>$10</td>
<td>$10</td>
</tr>
<tr>
<td>North Central</td>
<td>FCT</td>
<td>$12</td>
<td>$13</td>
</tr>
<tr>
<td></td>
<td>Benue</td>
<td>$11</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Nasarawa</td>
<td>$15</td>
<td></td>
</tr>
<tr>
<td>North West</td>
<td>Kaduna</td>
<td>$9</td>
<td>$9</td>
</tr>
</tbody>
</table>

The results show that states’ unit SNU costs, with the exception of Nasarawa state, ranged from $9 to $12 per OVC. The higher cost in Nasarawa ($15) reflected community volunteers’ allowances, which were used to service a relatively small number of OVC.

**Evaluation Question 2b**
What are the average, partner-specific UEs for the various service packages being delivered to OVC?

IPs surveyed generally provided a maximum of six OVC services across seven categories: health, education; household economic strengthening (HES); psychosocial support; nutrition; water, sanitation, and hygiene (WASH); and protection, which includes child, legal, and social protection. IPs did not have a formula or methodology for allocating shared expenditure to their OVC services, so this study allocated shared costs to the services in line with the percentage contribution of each service to the total direct costs the IPs incurred. As the table below shows, the study revealed that IPs spend most their OVC funding on HES (46 percent) education (16 percent), and health (14 percent).

<table>
<thead>
<tr>
<th>IP</th>
<th>Health</th>
<th>Education</th>
<th>HES</th>
<th>Psychosocial Support</th>
<th>Nutrition</th>
<th>WASH</th>
<th>Protection</th>
</tr>
</thead>
<tbody>
<tr>
<td>IP-1</td>
<td>0.8*</td>
<td>0.2</td>
<td>25</td>
<td>6</td>
<td>0.0</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>IP-2</td>
<td>7</td>
<td>0.4</td>
<td>2</td>
<td>2</td>
<td>2.8</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>IP-3</td>
<td>0.5</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>0.5</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>IP-4</td>
<td>2</td>
<td>0.8</td>
<td>24</td>
<td>4</td>
<td>1.2</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>IP-5</td>
<td>1</td>
<td>0.2</td>
<td>8</td>
<td>3</td>
<td>0.1</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>IP-6</td>
<td>0.4</td>
<td>10</td>
<td>9</td>
<td>0.2</td>
<td>0.1</td>
<td>-</td>
<td>0.1</td>
</tr>
<tr>
<td>IP-7</td>
<td>18</td>
<td>3</td>
<td>62</td>
<td>6</td>
<td>3.9</td>
<td>2</td>
<td>26</td>
</tr>
<tr>
<td>IP-8</td>
<td>1</td>
<td>2</td>
<td>7</td>
<td>0</td>
<td>0.1</td>
<td>-</td>
<td>0.2</td>
</tr>
<tr>
<td>IP-9</td>
<td>9</td>
<td>-</td>
<td>32</td>
<td>5</td>
<td>0.9</td>
<td>-</td>
<td>3</td>
</tr>
<tr>
<td>IP-10</td>
<td>3</td>
<td>-</td>
<td>16</td>
<td>2</td>
<td>-</td>
<td>-</td>
<td>0.3</td>
</tr>
<tr>
<td>IP-11</td>
<td>5</td>
<td>36</td>
<td>9</td>
<td>2</td>
<td>4.0</td>
<td>-</td>
<td>0.4</td>
</tr>
<tr>
<td>IP-12</td>
<td>5</td>
<td>0.1</td>
<td>1</td>
<td>8</td>
<td>-</td>
<td>-</td>
<td>1.0</td>
</tr>
</tbody>
</table>

**MEAN** | 4.3   | 5        | 17.7 | 2.9 | 1.23 | 0.4 | 3.2 |

*All amounts in USD.
**Evaluation Question 3**
How are partners currently allocating shared expenditures across the different service areas?

The study found that IPs do not usually allocate shared expenditures across the OVC service areas. However, IPs with integrated programs perform some allocation of shared expenditure between OVC and other service areas in the PEPFAR portfolio; IPs with multiple donor programs perform some allocation between PEPFAR and other donor grants. The figure at right depicts the methods IPs use for allocating shared.

**Evaluation Question 4**
What contextual factors affect the expenditures incurred in providing these services across partners and regions?

The study identified seven key contextual factors that affect the cost of implementing OVC programs:

1. The cost of doing business in Nigeria
2. Environmental conditions relating to geographical challenges (e.g., long driving distances and harsh terrain)
3. The socio-cultural context, such as the history of external aid, community penetration due to stigma, and influence of informal leaders/gatekeepers
4. Local stability/security
5. Health, WASH, and nutrition status (A high HIV burden and poor WASH and nutrition status increased programming costs.)
6. The strength of governmental child and social protection services primarily related to the existence and strength of these systems (e.g., safety nets)
7. Availability, affordability, and access to services

**Evaluation Question 5**
What are the expenditures for a “gold standard” package of OVC services by intervention, across partners and regions?

As the “gold standard” package has yet to be defined, the interventions IPs and CBOs reported were inventoried and grouped as being common or less common across IPs. This should provide some guidance as PEPFAR works to define the gold standard. This report includes tables of the inventory of services provided.

**Evaluation Question 6**
What is the framework that the USG should use to develop IM-level budgets for country operational planning?
The study team, at PEPFAR’s request, developed a Microsoft Excel-based template for retrospectively capturing detailed OVC costs. The template is designed to feed into the EA process with enough details to allow PEPFAR to better understand what is reported in the EA, and has built-in shared allocation formula. The template and user manual were submitted separately from this report.

CONCLUSIONS AND RECOMMENDATIONS

The study successfully identified and collected information on the type of PEPFAR-funded OVC services provided by IPs and their CBO sub-awardees, the resources and inputs they utilized, and the expenditures they incurred providing these services. It clearly identified program implementation and expenditure reporting challenges, and created an inventory of services provided and a database of detailed cost data for the PEPFAR OVC program in Nigeria. It provided information to answer the study questions, either completely or within the limits of the available data. Overall, it contributes to the program insight and guidance PEPFAR requires to improve budgeting for its OVC program, as well as highlights areas for improvement.

Use of Study Findings and Subsequent Studies: Though the weighted mean cost of providing OVC services within the study period provides a basis for improving cost per target allocation by PEPFAR, an analysis of cost-effectiveness will be more beneficial as it ensures that the costs being considered or used are those for the most effective programs. The findings of this study should be complemented by an evaluation of program effectiveness to clearly link outputs to outcomes and determine how the scope and quality of services implemented affect cost.

Shared Costs Allocation Principles: The study noted a wide variation in the methods and assumptions for allocation of shared costs, making it difficult to compare IPs’ costs. The study team recommends that the IPs should be given clear guidance on standard principles for allocating shared costs to the OVC program.

Allocation of Above-Site Costs to Different OVC Services: The study determined the cost per service area at the CBO level. It used the contribution of each service area to total service costs at the CBO level to apportion above-site costs to the services. This approach makes sense, given the integrated nature of spending at the IP level. If applied as a standard, it will be easier to understand and compare IPs’ costs.

Program Effectiveness and Efficiency: It is important for PEPFAR-Nigeria to follow up the study’s findings with a detailed review of those IPs whose average costs are outliers. This will help discern what is driving their costs, and ensure that program design and implementation align with guidelines and resources are being properly utilized.

Knowledge Management: PEPFAR-Nigeria should actively solicit and share national and global promising or best practices.
I. INTRODUCTION

As part of the Country Operational Planning (COP) process, President’s Emergency Plan for AIDS Relief (PEPFAR) country teams estimate and document resources used to fund program activities based on historical expenditure or cost data. This process, the PEPFAR Expenditure Analysis (EA), is essential for the United States Government (USG) to better understand what it spends to support the provision of HIV services to beneficiaries so it can improve program planning. One common approach to budgeting PEPFAR resources is to use historical unit expenditures that have been adjusted to create an applied unit expenditure (UE) or unit budget for budgeting purposes. The applied UEs are then multiplied by the corresponding number of targeted beneficiaries for the next year to create “target-based budgets.”

Under PEPFAR EA, partners and country teams capture expenditures for orphans and vulnerable children (OVC) services in health care access, educational support, psychosocial support (PSS), child protection, nutrition and food security, and economic strengthening interventions for OVC households (HHs). The PEPFAR-funded OVC portfolio provides a range of services that differ for beneficiaries and HHs, depending on child vulnerability, HIV/AIDS positivity of children and caregivers, HH composition, and a variety of socioeconomic and demographic factors. In Nigeria, the USG has gathered expenditures by implementing mechanism (IM) for OVC partners from 2013 to present, and these have been used to generate UEs that are disaggregated by sub-national unit (SNU). However, denominator data are not collected to produce UEs that are disaggregated by type of service. There is also no clear guidance to OVC implementing partners (IPs) on how to allocate shared costs across service types. As a result, there is limited understanding of the UEs for the packages of OVC services PEPFAR partners provide on OVC programs.

While PEPFAR EA is essential for USG resource tracking, national and IM UEs are not appropriate to determine partner-level budgets. To some extent, the current UEs from the EA reflect historical efforts by PEPFAR OVC partners to achieve their expenditure targets, with greater attention paid to the numbers reported than the quality of the service package. The absence of a clear definition of what constitutes a standard or “minimum package” of interventions has contributed to this trend. Another limitation of the EA is that it does not capture important contextual factors, which are equally relevant in the planning process.

The USG is concerned that components of the OVC service packages being offered in Nigeria are not consistent across IPs, and that IM-level and national-level UEs derived from the EA fail to capture the “gold standard” of OVC services. For this reason, it is necessary to devise an alternative approach to allocating resources, as well as identifying potential efficiency gains given existing resources.

EVALUATION PURPOSE

The purpose of this costing study is to obtain and analyze information that will help address the limitations of using the existing PEPFAR target-based budgeting approach using historical UE data for OVC, and to guide and inform a more refined IP-level budgeting process for the OVC program in Nigeria. Study findings are also expected to contribute to ongoing efforts to define a “gold standard” package of services by providing an understanding of the spread and scope of OVC services across partners and by looking at PEPFAR recommendations.

3 EA of PEPFAR Programs Expenditure Tracking and Reporting Guidance 2016 also includes case management and early childhood development, and separates primary education from secondary education.
**EVALUATION QUESTIONS**

The study used six evaluation questions. Question 2 was divided into two parts.

1. What are the expenditures currently being made by partners to provide the various service packages that they deliver to OVC?

2. What are the average, SNU-specific and partner-specific UEs for the various service packages being delivered to OVC?
   - Evaluation Question 2a. What are the average, SNU-specific UEs for the various service packages being delivered to OVC?
   - Evaluation Question 2b. What are the average, partner-specific UEs for the various service packages being delivered to OVC?

3. How are partners currently allocating shared expenditures across the different service areas?

4. What contextual factors affect the expenditures incurred in providing these services across partners and regions?

5. What are the expenditures for a “gold-standard” package of OVC services by intervention, across partners and regions?

6. What is the framework that the USG should use to develop IM-level budgets for Country Operational Planning?
II. PROJECT BACKGROUND

BACKGROUND

As described in the introduction, this study focused on researching expenditures by service categories; it was not intended as an in-depth review or evaluation of the OVC situation or the PEPFAR OVC portfolio. A certain level of understanding of PEPFAR programming during the study year was needed to guide the costing process.

This section presents what the study team learned by reviewing project documents and the initial inventory of interventions, and during discussions with USAID, OVC program staff at the Centers for Disease Control and Prevention (CDC), and IPs.

OVC PROGRAMMING DESIGN

The program’s primary objective, aligned with PEPFAR and national guidelines, is to ensure access of OVC and their HHs to care and support services relating to primary and secondary education; preventative health and health care; nutrition and food security; PSS; household economic strengthening (HES); and child, social, and legal protection (grouped together as “protection”). PEPFAR IPs4 provided OVC services across these intervention areas. The program utilizes a community-based approach in which volunteers provide in-home assessments and services, and links OVC and HHs to facilities, other community structures, or formal assistance programs. The majority of IPs noted leveraging public-private partnerships and linkages to provide OVC care and support services.

OVC PORTFOLIO AND OPERATIONAL MODELS

Of the 12 IPs PEPFAR selected for the study, six were funded through USAID and six through the CDC. During the study year, all but one IP managed OVC projects in partnership with local non-governmental organizations (NGOs) or community-based organizations (CBOs). These projects vary considerably in size, scope, coverage, and funding. Seven5 are integrated within comprehensive HIV/AIDS programming, and five are primarily6 stand-alone OVC projects.

OVC PROGRAM FOCI FOR STUDY YEAR

The COP15 states,

“The OVC service delivery package outlined in the National OVC Service Standards will be provided to OVC in scale up to saturation [local government areas] LGAs in [Fiscal Year] FY16. Children will receive need-based and age-appropriate interventions, including support to access healthcare; HIV testing and counselling; linkages to treatment and adherence support for HIV positive children; nutrition assessments and counselling; caregiver and community capacity-building for parenting, early childhood development, and child protection; household economic strengthening, prevention interventions for older OVC, and access to education.”

The COP15 noted several special aims, including to improve linkages to testing, treatment and care, and to recruit referral coordinators to facilitate access and adherence to antiretroviral therapy for HIV-positive children and caregivers. Other aims are to provide prevention messaging targeting adolescent

4 Of the 11 IPs submitting their inventory of interventions.
5 FHI 360, CRS’ Sustainable Mechanism for Improving Livelihoods and Household Empowerment (SMILE) project, and all the CDC-funded projects.
6 The study team was informed that additional funding has been provided to some IPs (e.g., prevention funds for working with key populations or for TB screening and follow-up).
OVC, especially girls, with linkages to adolescent-friendly reproductive health services, and to empower HHs and communities for better parenting and sustainable care and support to OVC. Another goal is to ensure that services are delivered within the HH and community with strong facility-community referral systems to provide HIV-positive OVC with seamless services from the health facility and within the community where they reside, and in LGAs receiving sustained support, where partners will focus on intensive HES interventions. HHs will be graduated out of the program in phases as their incomes rise.

In early discussions with the PEPFAR Technical Working Group (TWG) and IPs, it was anticipated that interventions and expenditures during the study year would be influenced by these foci as well as the specific mandates:

1. Newly enrolled OVC must be directly infected or affected by HIV/AIDS; thus, there will be considerable effort and expense to identify children linking to HIV testing and counseling (HCT) and treatment facilities and providing/support HCT.
2. Attention to HES as the strategy to graduate OVC.
3. Shift the focus from OVC to families, so more needs are attended to.
4. Push for strengthening the community/facility continuum of care and support, including case management.
5. Provide the standardized 10-hour training on gender norms and gender-based violence (GBV).
III. EVALUATION METHODS AND LIMITATIONS

STUDY DESIGN

This retrospective costing study covered the PEPFAR COP15, which spanned October 2015 to September 2016. The study utilized a mixed-methods design, with quantitative and qualitative approaches. It adopted a top-down approach to make the best use of available cost data and conduct meaningful analysis within the available time and resources. It also adopted an ingredient (input) costing approach. Data was collected on all inputs used to provide OVC services within the study year, regardless of when they were procured. Inputs with a life span of more than one year were annualized to obtain the amounts apportioned to the study year. Shared costs between OVC programs and other programs were apportioned based on program contributions to the overall portfolio. Unlike the EA, which looked at total expenditure per partner at all levels within the fiscal year, this study used expenditure data from IPs and a sample of their sub-awardees to determine the mean cost of all inputs consumed to provide OVC services within the study year. Only financial costs were considered, and the donor (i.e., PEPFAR) perspective was taken, so the focus was on the cost to PEPFAR of providing OVC services.

STUDY LOCATION

The study was conducted in seven states designated by USAID and the CDC: Benue, Cross River, Kaduna, Federal Capital Territory (FCT), Lagos, Nasarawa, and Rivers.

STUDY POPULATION AND SAMPLING

Cost and contextual data were collected from all 12 IPs and a sample of the CBOs they contracted to provide OVC services. Twenty-eight CBOs were selected, one for each IP with OVC program operations in more than one state, and two for each IP with operations in only one state (to provide some balance). Data was collected from the IPs’ central and state offices; for CBOs, data was collected in the states in which they worked. Key informants included management staff, OVC program staff, and finance and administration staff.

SAMPLING

A census approach for the IPs ensured that all were included in the study. A purposive, not representative, sampling method was used to select the CBOs. Each IP was asked to select the CBO that best represented its OVC program in terms of the number of implemented interventions. The mixed census and sampling approach was designed to create a complete inventory of each IP’s OVC services and ensure that the cost data for each captured the “standard” package and approach. Table 1 shows the study’s sample population, broken down by state.

Table 1. Sample Population

<table>
<thead>
<tr>
<th>State</th>
<th>Funding Agency</th>
<th>IP</th>
<th>CBOs Sampled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lagos</td>
<td>USAID</td>
<td>Association for Reproductive and Family Health (ARFH)</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Save the Children (SVC)</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Family Health International 360 (FHI 360)</td>
<td>1</td>
</tr>
<tr>
<td>CDC</td>
<td></td>
<td>AIDS Prevention Initiative in Nigeria (APIN)</td>
<td>1</td>
</tr>
</tbody>
</table>
DATA COLLECTION

Quantitative cost data was collected using a customized Microsoft Excel-based input tool designed to contain the detailed OVC services inventoried from IPs. For each service, cost input factors (e.g., transportation, hall rentals, and food) were pre-identified and programmed into the tool, with provision for additional factors as necessary. This made it easier at each level to enter data by sub-service and service areas and analyze using those categories. Questionnaires were used to collect qualitative data from IPs, CBOs, and beneficiaries on program/implementation approaches and contextual factors affecting costs. A team of at least two trained enumerators visited each IP at their central and state offices and CBOs at their state offices to train them on the costing tool, collect available cost data, and fill out the questionnaires for qualitative data. The costing team obtained data from the CBOs’ financial records and entered it into the Excel tool. The IPs entered the data for state- and national-level costs directly, and data validation sessions were held with each IP after their submissions had been reviewed. In addition to the questionnaires, IPs were emailed a self-administered survey to provide more in-depth information about their OVC programs. They submitted this information with their costing data.

Primary data collection was complemented by secondary data from project reports, as well as USAID and CDC reports. Desk research included review of the following:

- EA data from few of the CDC and USAID IMs
- OVC project reports where submitted by USAID and CDC IPs
- PEPFAR OVC guidance
DATA QUALITY ASSURANCE

In addition to a core team of senior-level researchers, experienced research assistants with strong data extraction and spreadsheet skills were engaged to assist with collecting data from CBOs. The core team collected financial and contextual data from the IPs and supervised the research assistants in all study states. All team members were provided didactic and on-the-job training on the quantitative and qualitative tools. Each enumeration team had at least two members, and a study core team member led each state team.

DATA ANALYSIS

Quantitative analysis was conducted using a Microsoft Excel spreadsheet. Qualitative data were collated across enumeration teams and analyzed along thematic areas of interest. Data from the different sources were triangulated to deepen understanding and interpretation. Capital costs were annualized over the useful life of the capital input.

Costs were classified as either site-level or above-site. Site-level costs are direct and indirect expenses CBOs incurred to provide services to OVC and their HHs. Above-site costs are direct and indirect expenses IPs incurred at the central and state levels to support the provision of OVC services; these were limited to in-country expenses. Though above-site costs encompassed all the areas in the EA, they were classified differently for this study to capture activity-related expenses as IPs documented them and to encourage the IPs and CBOs to think though the activities that drive cost and ensure they were captured to the greatest extent possible. Classifications included integrated supportive supervision visits, monitoring and evaluation, training, meetings, and health systems strengthening support to national and state governments.

Shared costs were identified as expenses that supported both OVC and other programs.

Each IP’s average cost of providing OVC services, within the study year, was a summation of all the site-level and above-site costs. This was determined by adding the average unit OVC cost of CBOs funded by that IP and the average unit OVC cost for the IP at the state7 and central levels. In calculating average cost at each level, the numerator was total cost and the denominator was the number of OVC served.

LIMITATIONS OF THE STUDY

The study encountered several limitations. These are presented below to provide a context for the use of findings and draw lessons for future studies.

Study Scope and Plan: The scope asked for a review of expenditure data and a determination of average costs, but these did not include a cost-effectiveness analysis or a review of individual IP performance. The study’s scope was quite ambitious and strained available resources. To manage time and resources, the study used purposive, not representative, sample sizing. A random sample selection was used to determine how many and which CBOs to choose. The short timeframe also made it difficult to validate submitted data down to source documents. The study tried to mitigate this through a census of all the IPs and study states, to increase the chances of capturing the variations.

7 For IPs that had expenditures well disaggregated between their central and state offices. For others, the consolidated IP expenditure for central and state offices was used.
**Data Availability and Validity:** As IPs do not organize their financial records in the manner required for ingredient costing, there was a lot of cost “lumping,” which made it difficult to attribute some of the cost drivers to specific interventions. Incomplete segregation of central- and state-level expenditures was common among IPs, due to varying levels of decentralization. The study used only CBO-level data to compare the states’ average costs. Because the study coincided with the final development of the COP17, key informants/stakeholders were not always available.

**Non-standardized Categorization of Interventions:** Review of the inventories and expenditure data noted differences in how interventions under the different OVC service areas were categorized. This posed a challenge for accurately allocating costs to the right service areas and articulating propositions for a “gold standard” package of OVC services; therefore, the team also used PEPFAR guidelines as a benchmark.

Non-standardized Approach for Allocation of Shared Expenditures: This made comparing IPs difficult.

**Absence of Quality and Effectiveness Data for Complete Interpretation:** Data on the quality and effectiveness of interventions was not available, so the study used only cost data to make determinations about implementing approaches and gold standards. This made the team’s job difficult. The absence of effectiveness data also made it difficult to explain the wide variation in unit costs across IPs, as the team could not determine the quality and penetration of services provided.

**Determination of Gold Standards:** Because PEPFAR had not defined a gold standard, the study relied on PEPFAR reference materials to analyze interventions.
IV. FINDINGS

A weighted mean was used to present mean costs across IPs at the national level and across CBOs at the state and regional levels. The study team used a weighted mean due to the wide dispersion of costs among IPs, and because it helps reduce the distortion of the mean caused by outlier IPs, which make up a relatively small portion of the total OVC served. The weighted mean was computed by dividing the sum of the product of the mean costs and the number of OVC served for each IP by the number of OVC served by all the IPs. As described in Section III, the mean cost per IP represents an aggregation of mean unit costs each IP incurred at the CBO, state, and national level.

The OVC service types in this report reflect the classifications used by the CBOs and IPs. The classifications differed from those in the PEPFAR EA, and were based more on national classifications.

EVALUATION QUESTION I

What are the expenditures currently being made by partners to provide the various service packages that they deliver to OVC?

Review and analysis of IPs and CBOs expenditure data collected by this study found that the weighted mean cost of providing services to one OVC during the study year was N4,9588 ($21.7). The mean costs incurred by the IPs in providing a package of services to one OVC ranged from N2,000 ($9) to N27,838 ($122). The results are in line with costing studies conducted in other Sub-Saharan African countries, including Botswana, Uganda, and Rwanda. As in Nigeria, the IPs in these countries incurred a wide range of costs servicing OVC. While site-level costs showed some variability across IPs, a wider dispersion was noted for above-site costs, which IPs incurred for personnel, recurrent, and capital expenditures, and service support activities. These costs may be directly attributable to the OVC program or shared with other programs/grants. Table 2 shows the variation in mean costs across IPs.

Table 2. Mean Costs of Providing OVC Services in Nigeria, Oct. 2015 – Sept. 2016 (USD)

<table>
<thead>
<tr>
<th>IP</th>
<th>Mean Cost: CBO</th>
<th>Mean Cost: State</th>
<th>Mean Cost: National</th>
<th>Total Mean Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>IP-3</td>
<td>4</td>
<td>2</td>
<td>3</td>
<td>9</td>
</tr>
<tr>
<td>IP-8</td>
<td>5</td>
<td>-</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td>IP-12</td>
<td>15</td>
<td>-</td>
<td>-</td>
<td>15</td>
</tr>
<tr>
<td>IP-5</td>
<td>8</td>
<td>-</td>
<td>7</td>
<td>15</td>
</tr>
<tr>
<td>IP-2</td>
<td>14</td>
<td>-</td>
<td>3</td>
<td>17</td>
</tr>
<tr>
<td>IP-10</td>
<td>13</td>
<td>7</td>
<td>1</td>
<td>21</td>
</tr>
<tr>
<td>IP-6</td>
<td>20</td>
<td>-</td>
<td>6</td>
<td>26</td>
</tr>
<tr>
<td>IP-1</td>
<td>16</td>
<td>4</td>
<td>13</td>
<td>33</td>
</tr>
<tr>
<td>IP-4</td>
<td>21</td>
<td>-</td>
<td>12</td>
<td>33</td>
</tr>
<tr>
<td>IP-9</td>
<td>16</td>
<td>-</td>
<td>34</td>
<td>50</td>
</tr>
<tr>
<td>IP-11</td>
<td>18</td>
<td>11</td>
<td>27</td>
<td>56</td>
</tr>
<tr>
<td>IP-7</td>
<td>18</td>
<td>-</td>
<td>104</td>
<td>122</td>
</tr>
</tbody>
</table>

8 The Nigerian currency, naira, is denoted by an “N” in this report.
There were several reasons for the variation in costs, including an IP’s scale of operations, the number of services provided in the OVC package, and the type of interventions provided in access to health care, education, food and nutrition, protection (child, legal, and social), and HES. There was no direct relationship between the number of services provided and the weighted mean cost per OVC. The IPs with the highest mean costs provided a total of five services each, while some with lower mean costs provided up to six services.

Table 3. IPs’ Mean Costs of Providing OVC Services and the Number of Services Provided

<table>
<thead>
<tr>
<th>IP</th>
<th>No. of OVC Services Provided</th>
<th>Mean Costs (USD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>IP-8</td>
<td>6</td>
<td>10</td>
</tr>
<tr>
<td>IP-5</td>
<td>6</td>
<td>15</td>
</tr>
<tr>
<td>IP-2</td>
<td>6</td>
<td>17</td>
</tr>
<tr>
<td>IP-6</td>
<td>6</td>
<td>26</td>
</tr>
<tr>
<td>IP-4</td>
<td>6</td>
<td>33</td>
</tr>
<tr>
<td>IP-3</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>IP-1</td>
<td>5</td>
<td>33</td>
</tr>
<tr>
<td>IP-9</td>
<td>5</td>
<td>50</td>
</tr>
<tr>
<td>IP-11</td>
<td>5</td>
<td>56</td>
</tr>
<tr>
<td>IP-7</td>
<td>5</td>
<td>122</td>
</tr>
<tr>
<td>IP-12</td>
<td>4</td>
<td>15</td>
</tr>
<tr>
<td>IP-10</td>
<td>4</td>
<td>21</td>
</tr>
</tbody>
</table>

The study team noted that the number and type of interventions provided within the services may be a more important driver of mean costs among the IPs. For example, an IP might have provided five services but implemented a more interventions within those services than an IP that provided six services. The type of intervention implemented was also critical in determining the cost. In providing HES services, the unit cost for providing Village Savings and Loans Associations (VSLA) services is likely to be less than the unit cost for providing cash grants. Overall, the results indicate that the IPs provide different OVC services (i.e., types, scale, scope, and quality), which makes it difficult to directly compare services and costs without a detailed program effectiveness and quality review.

As Table 4 shows, personnel accounted for the majority of OVC costs at the IP level, followed by program activities.

Table 4. Contribution of Cost Elements at the IP Level

<table>
<thead>
<tr>
<th>Personnel Costs</th>
<th>Capital Expenditure</th>
<th>Recurrent Expenditure</th>
<th>Program Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>58%</td>
<td>4%</td>
<td>17%</td>
<td>22%</td>
</tr>
</tbody>
</table>

Costs incurred per OVC were also affected by the IPs’ scale or efficiency. Two IPs that spent similar total amounts on their OVC programs, CIHP and PHI, had radically different unit costs due to the disparity in the number of OVC they served during the study year (Table 5).

Table 5. Comparison of Total Annual OVC Costs to Unit OVC Costs (USD)

<table>
<thead>
<tr>
<th>IP</th>
<th>Total Annual Cost</th>
<th>No. of OVC Reached</th>
<th>Unit OVC Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>IP-11</td>
<td>1,621,455.12</td>
<td>57,975</td>
<td>56</td>
</tr>
<tr>
<td>IP-7</td>
<td>1,624,559.39</td>
<td>6,326</td>
<td>122</td>
</tr>
</tbody>
</table>

Figure 1 illustrates the relationship between scale and cost per OVC for the study. It demonstrates that the more children reached, the lower the cost per child for the full complement of services provided.
During the study year, two program structures were identified among the IPs. Forty-two percent of the IPs implemented stand-alone programs with scopes covering only OVC services, and 58 percent had their OVC programs integrated as a component of comprehensive HIV/AIDS prevention, treatment, and care programs. The study found that the stand-alone programs had slightly lower costs (weighted mean of $21) than the integrated programs (weighted mean of $23). The slightly higher costs of the latter were attributable to the scale of their total shared costs: The portion allocated to the OVC programs was more substantial than the entire shared expenditures for the stand-alone programs.

**EVALUATION QUESTION 2**

The study team split the question to reflect its two distinct parts.

*Evaluation Question 2a. What are the average, SNU-specific UEs for the various service packages being delivered to OVC?*

Cost data was obtained from the national, state, and community levels with the aim of disaggregating average costs by national and sub-national levels (i.e., regional and state) for each IP. Because most IPs were centralized, it was difficult to disaggregate national and state costs to determine their complete sub-national unit costs. To fulfill the requirements of this study, the weighted CBO mean cost in each state was used as a proxy for SNU costs (Table 6). The weighted mean costs per state were aggregated into geopolitical zones to determine if there were significant regional differences.

**Table 6. Weighted Mean Costs of Providing Unit OVC Services across SNUs**

<table>
<thead>
<tr>
<th>Geopolitical Zone</th>
<th>States</th>
<th>Weighted Mean Cost: States</th>
<th>Mean Cost: Regions</th>
</tr>
</thead>
<tbody>
<tr>
<td>South South</td>
<td>Rivers</td>
<td>$9</td>
<td>$8.5</td>
</tr>
<tr>
<td></td>
<td>Cross River</td>
<td>$8</td>
<td></td>
</tr>
<tr>
<td>South West</td>
<td>Lagos</td>
<td>$10</td>
<td>$10</td>
</tr>
<tr>
<td>North Central</td>
<td>FCT</td>
<td>$12</td>
<td>$13</td>
</tr>
<tr>
<td></td>
<td>Benue</td>
<td>$11</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Nasarawa</td>
<td>$15</td>
<td></td>
</tr>
<tr>
<td>North West</td>
<td>Kaduna</td>
<td>$9</td>
<td>$9</td>
</tr>
</tbody>
</table>

The results show that states’ SNU costs ranged from $9 to $12 per OVC. The higher cost in Nasarawa ($15) reflected community volunteers’ allowances, which were used to service a relatively small number of OVC. In the North Central region, which includes Nasarawa, mean cost per OVC were relatively
higher ($13) than in the other regions. At $8.5 per OVC, the South South region had a relatively lower mean cost.

**Evaluation Question 2.b. What are the average, partner specific UEs for the various service packages being delivered to OVC?**

The IPs generally provided a maximum of six services within the OVC program, across seven categories: education; health; HES; nutrition; water, sanitation, and hygiene (WASH); PSS; and protection, which includes child, legal, and social protection. The study examined the unit costs the IPs incurred providing each of these services. In determining this, it was noted that CBOs and IPs did not have a formula or methodology for allocating shared expenditure to their OVC services. Therefore, for this study, shared costs were allocated to the different services in line with the percentage contribution of each to the IPs’ total direct costs. Table 7 shows the IPs’ unit costs for delivering OVC services, and Table 8 highlights the percentage contribution of each service cost to the IPs’ total direct costs.

**Table 7. Weighted Mean Unit Costs across OVC Services**

<table>
<thead>
<tr>
<th>IP</th>
<th>Health</th>
<th>Education</th>
<th>HES</th>
<th>PSS</th>
<th>Nutrition</th>
<th>WASH</th>
<th>Protection</th>
</tr>
</thead>
<tbody>
<tr>
<td>IP-1</td>
<td>0.8*</td>
<td>0.2</td>
<td>25</td>
<td>6</td>
<td>0.0</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>IP-2</td>
<td>7</td>
<td>0.4</td>
<td>2</td>
<td>2</td>
<td>2.8</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>IP-3</td>
<td>0.5</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>0.5</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>IP-4</td>
<td>2</td>
<td>0.8</td>
<td>24</td>
<td>4</td>
<td>1.2</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>IP-5</td>
<td>1</td>
<td>0.2</td>
<td>8</td>
<td>3</td>
<td>0.1</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>IP-6</td>
<td>0.4</td>
<td>10</td>
<td>9</td>
<td>0.2</td>
<td>0.1</td>
<td>-</td>
<td>0.1</td>
</tr>
<tr>
<td>IP-7</td>
<td>18</td>
<td>3</td>
<td>62</td>
<td>6</td>
<td>3.9</td>
<td>2</td>
<td>26</td>
</tr>
<tr>
<td>IP-8</td>
<td>1</td>
<td>2</td>
<td>7</td>
<td>0</td>
<td>0.1</td>
<td>-</td>
<td>0.2</td>
</tr>
<tr>
<td>IP-9</td>
<td>9</td>
<td>-</td>
<td>32</td>
<td>5</td>
<td>0.9</td>
<td>-</td>
<td>3</td>
</tr>
<tr>
<td>IP-10</td>
<td>3</td>
<td>-</td>
<td>16</td>
<td>2</td>
<td>-</td>
<td>-</td>
<td>0.3</td>
</tr>
<tr>
<td>IP-11</td>
<td>5</td>
<td>36</td>
<td>9</td>
<td>2</td>
<td>4.0</td>
<td>-</td>
<td>0.4</td>
</tr>
<tr>
<td>IP-12</td>
<td>5</td>
<td>0.1</td>
<td>1</td>
<td>8</td>
<td>-</td>
<td>-</td>
<td>1.0</td>
</tr>
<tr>
<td><strong>MEAN</strong></td>
<td><strong>4.3</strong></td>
<td><strong>5</strong></td>
<td><strong>17.7</strong></td>
<td><strong>2.9</strong></td>
<td><strong>1.23</strong></td>
<td><strong>0.4</strong></td>
<td><strong>3.2</strong></td>
</tr>
</tbody>
</table>

**Table 8. Percentage Contribution of OVC Services to Total Direct Cost**

<table>
<thead>
<tr>
<th>IP</th>
<th>Health</th>
<th>Education</th>
<th>HES</th>
<th>PSS</th>
<th>Nutrition</th>
<th>WASH</th>
<th>Protection</th>
</tr>
</thead>
<tbody>
<tr>
<td>IP-1</td>
<td>2%</td>
<td>1%</td>
<td>76%</td>
<td>18%</td>
<td>0%</td>
<td>0%</td>
<td>3%</td>
</tr>
<tr>
<td>IP-2</td>
<td>41%</td>
<td>2%</td>
<td>12%</td>
<td>12%</td>
<td>16%</td>
<td>12%</td>
<td>6%</td>
</tr>
<tr>
<td>IP-3</td>
<td>8%</td>
<td>50%</td>
<td>17%</td>
<td>17%</td>
<td>8%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>IP-4</td>
<td>6%</td>
<td>2%</td>
<td>73%</td>
<td>12%</td>
<td>4%</td>
<td>0%</td>
<td>3%</td>
</tr>
<tr>
<td>IP-5</td>
<td>7%</td>
<td>1%</td>
<td>52%</td>
<td>20%</td>
<td>1%</td>
<td>0%</td>
<td>20%</td>
</tr>
<tr>
<td>IP-6</td>
<td>2%</td>
<td>51%</td>
<td>45%</td>
<td>1%</td>
<td>1%</td>
<td>0%</td>
<td>1%</td>
</tr>
<tr>
<td>IP-7</td>
<td>15%</td>
<td>2%</td>
<td>51%</td>
<td>5%</td>
<td>3%</td>
<td>2%</td>
<td>22%</td>
</tr>
<tr>
<td>IP-8</td>
<td>10%</td>
<td>19%</td>
<td>68%</td>
<td>0%</td>
<td>1%</td>
<td>0%</td>
<td>2%</td>
</tr>
<tr>
<td>IP-9</td>
<td>18%</td>
<td>0%</td>
<td>64%</td>
<td>10%</td>
<td>2%</td>
<td>0%</td>
<td>6%</td>
</tr>
<tr>
<td>IP-10</td>
<td>14%</td>
<td>0%</td>
<td>75%</td>
<td>9%</td>
<td>0%</td>
<td>0%</td>
<td>1%</td>
</tr>
<tr>
<td>IP-11</td>
<td>9%</td>
<td>64%</td>
<td>16%</td>
<td>4%</td>
<td>7%</td>
<td>0%</td>
<td>1%</td>
</tr>
<tr>
<td>IP-12</td>
<td>33%</td>
<td>1%</td>
<td>7%</td>
<td>53%</td>
<td>0%</td>
<td>0%</td>
<td>7%</td>
</tr>
<tr>
<td><strong>MEAN</strong></td>
<td><strong>14%</strong></td>
<td><strong>16%</strong></td>
<td><strong>46%</strong></td>
<td><strong>13%</strong></td>
<td><strong>4%</strong></td>
<td><strong>1%</strong></td>
<td><strong>6%</strong></td>
</tr>
</tbody>
</table>

The study revealed that IPs spend the highest proportion of their funding on HES services. The focus interventions within these services were provision of unconditional cash transfers, provision of apprenticeship or technical and vocational training, purchase of livelihood inputs, and facilitation of
VSLAs. Health and education services also accounted for a significant portion of the total unit costs for OVC (14 percent and 16 percent, respectively). Interventions within health services focused on HTC services and escort services to facilities. Education interventions were mostly centered around payment of school fees, provision of block grants, and school supplies.

In all, five IPs implemented six of the seven OVC services, five implemented five services, and two implemented a maximum of four services. (See Table 3.) All 12 IPs were involved in the implementation of at least one health, HES, and PSS intervention during the study year.

Two IPs provided 12 interventions (the highest number recorded), and eight IPs with per-unit OVC costs above the weighted mean provided 10 to 12 interventions. It is pertinent to note that the type, scope, and quality of the interventions within the same service varied considerably among IPs, and did not allow for direct comparison of service costs.

**EVALUATION QUESTION 3**

*How are partners currently allocating shared expenditures across the different service areas?*

As discussed above, IPs do not have a formula or clear methods for allocating their shared expenditures to the OVC services. To estimate costs related to each service, the study adopted a methodology for allocation of shared costs based on the percentage contribution of the services to the total direct costs incurred.

However, the study did find that IPs with integrated programs perform some allocation of shared expenditure between OVC and other service areas in the PEPFAR portfolio, and IPs with multiple donor programs perform some allocation between PEPFAR and other donor grants. Figure 2 depicts the methods IPs use for allocating shared expenditures.

**Figure 2. Methods for Allocation of Shared Expenditures across IPs**

The LoE basis considers the proportion of time each staff member spent on the OVC program during the COP year in relation to the total time available for active work during the same period. The LoE basis was largely used for allocating the costs of shared services personnel, technical staff with cross-portfolio roles, and part-time staff.

The portfolio size basis allocates shared expenditures to the OVC program in consideration of the proportional contribution of the program to an IP’s overall portfolio.

In utilizing the head count, shared costs are allocated to the OVC program based on the proportion of staff fully engaged on the program compared to the total number of staff engaged by the IP.
Office space involves the allocation of shared expenditures based on the proportion of the total floor space/area occupied by the OVC program relative to the total floor space/area occupied by the IP.

**EVALUATION QUESTION 4**

*What contextual factors affect the expenditures incurred in providing these services across partners and regions?*

IPs and CBOs were also asked during meetings and interviews or through surveys about factors that caused or contributed to their implementation costs during the study year. The key findings are discussed below.

**Cost of Doing Business in Nigeria:** IPs and CBOs working in all regions frequently noted Nigeria’s economic situation, with rising inflation and currency devaluation, as a major factor affecting costs of commodities and consumables such as fuel during the study year. Specifically, those working in urban centers noted increased costs related to staff salaries, office space, and training venues. Several CBOs noted increased costs of living and transport as a reason why community volunteer home visitors were dissatisfied with their stipends. This resulted in higher attrition, which drove costs for training new volunteers. IPs and CBOs in Nasarawa, Benue, and Cross Rivers emphasized poor electricity supplies—a common and chronic problem in Nigeria—as driving the costs of operating offices dependent on fuel-driven generators.

**Environmental Conditions:** IPs and CBOs frequently mentioned geographical and environmental conditions. These included long driving distances when working with hard-to-reach populations and in areas with low population densities; rough terrain; poor road/transport systems; seasonal conditions that affected travel, such as flooding in riverine areas; and vehicle expenses, including the additional costs of water transport. Environment and transport were highlighted issues in Nasarawa, Benue, Kaduna, Cross Rivers, and rural parts of Lagos and the FCT. A CBO in Lagos also noted that the environment affects recruiting and retaining skilled personnel, particularly the costs of relocating staff and associated high attrition.

**Socio-cultural Context:** Noted factors included that communities with a history of external aid were more likely to be dependent and less actively engaged in finding solutions or meeting expectations. As one IP said, “they see our USAID car [and] they expect handouts.” IPs and CBOs also noted that it could be challenging to enter some communities due to distrust of external assistance or stigma related to HIV/AIDS, which affected beneficiaries’ willingness to access HIV testing services (HTS) or to enroll in the project. Also, the strong influence of informal leaders/“gatekeepers” required solid stakeholder analysis and considerable engagement efforts. These factors are primarily related to entry into scale-up communities and relate to cost of activation, greater mobilization, advocacy, organizing effort, and expense (e.g., start-up workshops and identification and preparation of community volunteers). Two IPs/CBOs in Lagos noted that adolescent programming costs were higher in areas where youth were engaging in high-risk sexual activity, such as commercial sex work, and that more focus was needed on provision of PSS, access to healthcare (e.g., treating sexually transmitted infections, contraception, pregnancy care, and HIV prevention).

**Local Stability/Security:** A CBO in Lagos and one in Kaduna, as well as an IP office in the FCT, noted the challenges of entering and working in areas with unrest and insecurity. Associated costs included security measures, such as hiring escorts or vehicles instead of using motorcycles. In Lagos, a CBO noted the problems associated with demolition of houses and shops and high mobility resulted in greater expenses in tracking and monitoring OVC HHs. OVC programming in areas with displacement or resettlement were likely to have higher HH support costs.
**Health, WASH, and Nutrition Status:** In Rivers, the effect of poor health status, especially the HIV/AIDS burden, drives the costs of OVC programming,\(^{10}\) including referrals and escort services. This was particularly significant in scale-up LGAs. It is likely that WASH conditions and the prevalence of food insecurity and infectious diseases such as malaria, which may be seasonal, will drive costs of prevention, emergency HH assistance, and early identification/referrals in some locations.

**Strength of Governmental Child and Social Protection Services and/or Local Charities:** This primarily related to the existence and strength of child protection (government) and social protection, including safety nets provided by government or local faith-based or other charities. As one IP noted, “the weaker the systems, the more we [the project] need to do.”

**Availability, Affordability, and Access to Services:** The availability of education and health institutions, the level of service, or school fees and access — distance/transport and perhaps social factors such as internal or external stigma — were likely to affect the costs of assisting OVC core services such as education, health, and food or housing assistance (i.e., safety nets). The 4Children study showed that 27.5 percent of people living with HIV/AIDS (PLWHA) accessed HIV services outside the LGA where they lived. This may be due to availability or access issues, including concerns about confidentiality or stigma.

**EVALUATION QUESTION 5**

*What are the expenditures for a “gold-standard” package of OVC services by intervention, across partners and regions?*

As the “gold standard” package has yet to be defined, interventions reported by IPs and CBOs were inventoried and analyzed for alignment with 2012 PEPFAR OVC guidance and other key documents, including “Technical Considerations Provided by PEPFAR TWG for COP15”; the 2015 and 2016 COP Guidance; 2014 Standards for Improving Lives of Vulnerable Children in Nigeria; OVC DREAMS Core Package of Interventions Summary; and the 4Children Case Management Package. All IPs and CBOs in the study reported interventions addressing access to education, health, nutrition, HES, and protection.

While the types of interventions IPs and CBOs reported many similarities, review of the reported expenditures often found wide variations for specific activities and cost inputs. This might be due, in part, to how CBOs classify the different activities they implement, “lumping” of cost input factors for different activities, and poor financial reporting systems. There were also variations in IP sub-contracting and implementation approaches. For example, most IPs funded CBOs for all implementation-level activities, including procurements, while it was sometimes noted that IPs directly procured items needed at the community level, managed cash transfers, or directly conducted skills-training for community volunteer home visitors. Most IPs and their partner CBOs noted leveraging, public-private partnerships, and linkages to provide OVC care and support services.

**Review of OVC Interventions**

Table 9, which begins on the next page, lists common and less common interventions reported by IPs and CBOs.

\(^{10}\) It is possible that areas with higher HIV/AIDS or TB rates may have more extensive resources while areas with lower diagnosis/rates may have greater unmet need for services. This would affect the level of support needed with OVC funding.
### Table 9. Inventory of Services and Interventions

<table>
<thead>
<tr>
<th><strong>HES Interventions</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Interventions Commonly Implemented (&gt;6 of the IPs)</strong></td>
<td><strong>Interventions Less Commonly Reported</strong></td>
</tr>
<tr>
<td>• Local market analysis</td>
<td>• Linkages to credit</td>
</tr>
<tr>
<td>• HH economic/livelihood assessment</td>
<td>• Linkages with government schemes</td>
</tr>
<tr>
<td>• Financial assistance to HHs, including cash transfers or direct income-generating activity inputs</td>
<td></td>
</tr>
<tr>
<td>• Business planning</td>
<td></td>
</tr>
<tr>
<td>• Skills-training</td>
<td></td>
</tr>
<tr>
<td>• HH home gardening</td>
<td></td>
</tr>
<tr>
<td>• Emergency aid — consumption support</td>
<td></td>
</tr>
<tr>
<td>• Joint planning for HES assistance and referrals</td>
<td></td>
</tr>
<tr>
<td>• Monitoring of HH plan — benchmarks and progress</td>
<td></td>
</tr>
<tr>
<td>• Financial literacy for caregivers</td>
<td></td>
</tr>
<tr>
<td>• Facilitation of Group Savings and Lending Groups</td>
<td></td>
</tr>
<tr>
<td>• Linkages with other HES services (NGO/private sector)</td>
<td></td>
</tr>
<tr>
<td>• Access to vocational training and apprenticeships for caretakers and out-of-school OVC</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Interventions Less Commonly Reported</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Value chain development</td>
<td></td>
</tr>
<tr>
<td>• Financial literacy training for adolescents</td>
<td></td>
</tr>
<tr>
<td>• Savings and loan groups for adolescents</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Education Interventions</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Interventions Commonly Implemented (&gt;6 of the IPs)</strong></td>
<td><strong>Interventions Less Commonly Reported</strong></td>
</tr>
<tr>
<td>• Advocacy for schooling, enrolment, re-enrolment (HH level and, if prevalent, community campaigns)<strong>11</strong></td>
<td>• Life skills training, including age- and sex-appropriate sex education for adolescents</td>
</tr>
<tr>
<td>• Advocacy for school waivers</td>
<td>• Infrastructural improvements (e.g. WASH for healthier/gender-friendly learning environment).</td>
</tr>
<tr>
<td>• Direct assistance with school fees, transport, uniforms, or school supplies</td>
<td>• Linkages or provision of aid/services for children with disabilities<strong>15</strong></td>
</tr>
<tr>
<td>• School/home visits to monitor attendance and assist with homework</td>
<td></td>
</tr>
<tr>
<td>• Block grants to schools</td>
<td></td>
</tr>
<tr>
<td>• Tutoring, remedial learning<strong>12</strong></td>
<td></td>
</tr>
<tr>
<td>• Tracking performance<strong>13</strong></td>
<td></td>
</tr>
<tr>
<td>• Access to early childhood development and education for most vulnerable HHs</td>
<td></td>
</tr>
<tr>
<td>• Caregiver/Parent-teacher conferences<strong>14</strong></td>
<td></td>
</tr>
<tr>
<td>• Girls/boys clubs, peer education at schools</td>
<td></td>
</tr>
</tbody>
</table>

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11 Associated costs are largely for personnel and are not reflected in direct cost.

12 May be after school, off-site, or at home — but all are provided by skilled tutors or instructors.

13 Recommend including on National OVC Management Information System (NOMIS).

14 Based on the information provided, it was unclear if this was being supported in the study year. If not, it should be considered.

15 Only one CBO reported addressing special needs of children with disabilities with aid from the private sector.
### Health and Nutrition Interventions

#### Interventions Commonly Implemented (>6 of the IPs)

- HH assessments and monitoring — health status, nutrition/diet, and WASH
- Education and social and behavior change communication\(^{16}\) relating to child health, nutrition, and WASH during home visits
- Advocacy and agreement for waived or discounted fees
- Funds for urgent healthcare
- Promotion and referral to HCT
- Follow up of referrals and promoting adherence to treatment
- Linkages and referrals to health and nutrition services including HIV/AIDS testing and TB screening, treatment, care and support, and nutrition assessment
- Linkages to or provision of growth monitoring and referral
- Follow up of malnourished OVC, reinforcement of dietary recommendations
- HH dietary planning using local and enriched foods.

#### Interventions Less Commonly Reported

- Facilitation of enrollment in government health or insurance plan
- Promotion and assistance to access of Adolescent reproductive health (RH) and HIV prevention services\(^{17}\)
- Linkages with nutrition initiatives (e.g. the Strengthening Partnerships, Results, and Innovations in Nutrition Globally (SPRING) project to incorporate nutrition education in OVC activities including support groups such as prevention of mother-to-child transmission (PMTCT))

### PSS Interventions

#### Interventions Commonly Implemented (>6 of the IPs)

- Home visits — ongoing assessment and “counseling” for caregivers or OVC referral as needed for professional counseling
- Parenting education for caregivers
- Facilitation of caregiver forums
- Post-GBV support and linkages with professional counseling as needed

#### Interventions Less Commonly Reported

- Mentor programs for OVCs
- Mobilization of social and play resources to ensure inclusion of OVC
- Adolescent-focused social activities — “safe spaces” if needed for highly vulnerable adolescent girls
- Linkages to support groups (e.g. Mother to Mother or PLWHA (including groups for HIV-positive OVC))
- Facilitation of community mobilization and action to address harmful social practices and gender norms, and prevention of GBV and discrimination

### Child Protection Interventions

#### Interventions Commonly Implemented (>6 of the IPs)

- Support for strengthening local structures\(^{18}\) and coordination between social, health, legal aid, and police to carry out functions (e.g. raising awareness of child protection laws, investigation, reporting and follow up of child abuse and neglect and rape

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\(^{16}\) Insecticide-treated bednets targeting children under 5, immunizations, good handwashing practices, proper disposal of excreta, deworming, and rapid identification and treatment of common childhood illnesses, including oral rehydration salts and zinc for diarrhea cases.

\(^{17}\) Only one IP noted condom distribution for youth.

\(^{18}\) All reported supporting local child protection committees, and several also mentioned child protection networks.
Legal Protection Interventions

<table>
<thead>
<tr>
<th>Interventions Commonly Implemented (&gt;6 of the IPs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Access to birth certificates</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Interventions Less Commonly Reported</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Legal aid for assistance with wills or succession planning or adoption</td>
</tr>
</tbody>
</table>

Social Protection Interventions

<table>
<thead>
<tr>
<th>Interventions Commonly Implemented (&gt;6 of the IPs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Development of OVC data management system</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Interventions Less Commonly Reported</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Facilitate linkages to safety net and government schemes for widows, orphans, and the very poor</td>
</tr>
<tr>
<td>• Need-based skills-training for social service workforce</td>
</tr>
<tr>
<td>• Support for local charities serving vulnerable HHs (e.g. food banks, clothing drives, shelter aid)</td>
</tr>
</tbody>
</table>

Follow-up: Current Changes in Interventions

In addition to the data from the study year and document review, follow-up surveys and discussions were held with IPs and CBOs about changes in the current year (i.e., the post-study period). The following are the key findings with cost implications.

Case Management: The majority of IPs noted increased support for referral coordination processes and further development of traditional volunteer home visitors to become “community case managers.” Concerning the case management model, several noted that it might be necessary to pay higher stipends because time demands are greater and more advanced qualifications are needed. A large project noted the importance of having more qualified volunteers in overseeing “community structures,” such as child protection committees.

Adolescent Programming: Concerning health, two IPs noted increased targeting of high-risk female adolescents. Two also noted targeting children of female sex workers (FSW) and work this year on developing linkages and referrals for adolescent, girls, and young women (AGYW) to access RH/HIV services. Two comprehensive HIV/AIDS projects noted building capacity for providing adolescents with HIV counseling and for staff providing HIV/RH services.

In education/PSS, several IPs noted more segmentation based on age and sex in their PSS, as well as inclusion of HIV prevention topics. Two IPs said they developed youth peer educators/promoters for in- or out-of-school settings.

For HES, two IPs said they started VSLA groups for older associations, including one that emphasized women. Another IP noted initiating cash transfers for OVC who were starting businesses, increasing efforts to return out-of-school youth to school, and linking to vocational training (government or other programs). Others noted more work in peer education and strengthening HIV prevention efforts.

Last, the SMILE project reported that it piloted programs focused on adolescents in six LGAs.

Early Childhood Development: A large project reported that early childhood education was a new direction, though it did not specify its interventions. Another IP said it produced early childhood information, education, and communication (IEC) materials during this year.

Education: Block grants are being scaled up. The Systems Transformed for Empowered Action and Enabling Responses for Vulnerable Children and Families (STEER) project noted that this not only helps with access for OVC, but supports school renovations needed for a healthier learning environment.

19 This function was not included in the “gold standard” framework.
SMILE reported using block grants to promote re-enrollment and progression, with special attention to older female OVC.

**EVALUATION QUESTION 6**

*What is the framework that the USG should use to develop IM level budgets for Country Operational Planning?*

At PEPFAR’s request, the study team developed a Microsoft Excel-based template for retrospectively capturing OVC costs. The template also provided assumptions that can be used for IM-level budgets to ensure standardized allocation principles. The template is designed to feed into the EA process, but with enough details to allow PEPFAR to better understand what is reported in the EA. A user manual accompanied the template.
V. CONCLUSIONS AND RECOMMENDATIONS

CONCLUSIONS

The study successfully identified and collected information on the types of PEPFAR-funded OVC services IPs and their CBO sub-awardees provided, the resources and inputs utilized, and the expenditures incurred. It clearly identified program implementation and expenditure reporting challenges, and created an inventory of services and a database of detailed cost data. It provided information to answer the study questions completely or within the limits of the data available. Overall, it contributed to the program insight and the guidance PEPFAR requires to improve budgeting for its OVC program.

The review and analysis of expenditure provided a clear indication of the range of unit costs IPs incurred providing OVC services. The results noted there was not a standardized methodology or basis for allocating shared costs across partners, which made it difficult to compare unit costs. A key observation that has implications for the annual expenditure analysis is the different service categorizations IPs use. For example, provision of food packages and home gardening categorized under nutrition/food security or HES, support for vocational training for OVC categorized under education or HES, and early childhood development and life skills training categorized under education, health, or PSS. This lack of a standardized definition or application of definitions of service areas created wide variability in service delivery approaches and packages.

The study team concurs with the PEPFAR TWG that a greater understanding of the contextual factors specific to states, LGAs, and communities is needed to assure appropriate programming design and allocation of funding. Social, cultural, and economic factors pose barriers to education and health-seeking behavior, and contribute to household vulnerability, but are not well-articulated. More time and resources are needed for the IPs and CBOs, who are closer to the realities of OVC, HHs, and communities to conduct situation analyses, including the use of the National OVC Management Information System (NOMIS) to map areas with the highest HH vulnerability, and identify barriers (e.g., social and economic) and lack of equity to education and health care services. These factors have implications for programming, budgeting, and operations (i.e., how to most efficiently and effectively work in hard-to-reach communities.

Overall, the interventions IPs and CBOs reported were aligned with PEPFAR guidelines. Using the lens of the DREAMS core package, interventions focused on adolescents appeared to be underdeveloped during the study year. Non-allowable costs or non-core interventions were noted but infrequent. The wide variation in cost drivers for IPs and CBOs (Annex 3) raises questions about what is actually being done (i.e., ensuring that above-site interventions and costs are captured) and how activities are being implemented (i.e., the implementation/operational models and programmatic approaches being used).

Although there was no indication that IPs systematically analyzed their activities, they were aware that the needs and vulnerabilities varied in certain areas and populations, such as street children, migrant populations, children of key populations, or areas with high rates of child labor for HH livelihoods.

RECOMMENDATIONS

Use of Findings and Subsequent Studies: Though the weighted mean cost of providing OVC services during the study period provides a basis for PEPFAR to improve its cost-per-target allocation, a cost-effectiveness analysis will be more beneficial, as it ensures that the costs being considered or used are devoted to the most effective programs. This study’s findings should be complemented by an evaluation of program effectiveness to clearly link outputs to outcomes and determine how the scope

20 With the following “gold standard” framework, standardized categorization is provided based on PEPFAR guidance.
and quality of services implemented affect costs. One critical input to achieve this is to define a standard package of services that outlines the minimum type, scope, and quality of services that should be delivered to one OVC and the minimum outcomes that should be expected. There is a direct relationship between total costs and the number of OVC served; therefore, to ensure efficiencies of scale, PEPFAR can consider using the number of OVC the mid-range cost IPs serve as a minimum target.

**Shared Costs Allocation Principles:** The study noted variations in the methods and assumptions for allocation of shared costs, making it difficult to compare IPs’ costs. The study team recommends that IPs be given clear guidance on standard principles for allocating shared costs to the OVC program. The guidance should consider key assumptions and formulae for allocating these costs across the grants each IP is implementing and within the overall PEPFAR grant itself. The adoption of a similar set of allocation principles across IPs will enable a degree of standardization that allows for meaningful comparison of cost data. This study developed a retrospective reporting framework on OVC services that will embed agreed-upon allocation principles and facilitate the implementation of this recommendation; IPs have been oriented on this framework. The template utilizes contribution to total portfolio size as a basis for allocation of shared costs. Although this method has shortcomings, such as sometimes not representing a program’s actual LoE, it is simple to use, data is always available to determine the allocation factor, and it is not subject to individual interpretation.

**Allocation of Above-Site OVC Costs to Different OVC Services:** No IP had a formula for allocating above-site costs — or even CBO indirect costs — to the different OVC service areas. This study determined the cost of each service at the CBO level and used those figures to total service costs (also at the CBO level) to apportion above-site costs. This approach is logical given the integrated nature of spending at the IP level. If applied as a standard, it will make costs across IPs easier to understand and compare.

**Program Effectiveness and Efficiency:** It is important for PEPFAR-Nigeria to follow up this study with a detailed review of those IPs whose average costs are outliers. This will help clarify what is driving IPs’ costs, and ensure that their program design and implementation align with guidelines and that they are utilizing resources properly. It would be of interest to look more closely at the outliers in program approach, such as IPs and CBOs not reporting livelihood inputs or cash transfers or financial assistance to access education. It is important to understand if this reflects their strategy, informs their project design, or is perhaps specific to their organizational culture. Closer review of activities and implementation/operational models is recommended when refreshments, accommodation, per diem, or transportation are the leading cost drivers. The study team recommends that OVC programming become more outcomes-based, and that results be used to review and compare the cost-effectiveness of IPs’ and CBOs’ approaches and interventions.\(^\text{21}\)

**Knowledge Management:** PEPFAR-Nigeria should actively solicit and share national and global promising or best practices, such as leveraging, not procuring, the activities and practices of communities and IPs/CBOs, and promoting HIV prevention and sexual and reproductive health among adolescents.\(^\text{22}\) The team also recommends expanding NOMIS to manage outcome data (e.g., changes in HH livelihoods, school progression, community donations, and action) and to use these as strategic data for improving the Nigeria OVC program and for sharing success stories.

\(^{21}\) For example, are block grants more efficient than direct assistance with school fees or cash transfers to HHs? Are there differences in outcomes, such as school attendance, performance, or progression?

\(^{22}\) For example, HIV prevention/sexual and reproductive health interventions being conducted by APIN. This includes the Champagne CBO’s work with pregnant teens, HIFASS (e.g., the U.S. Embassy-funded project for slum girls implemented by Neighborhood Care Foundation, WEWE, CHIP, Caritas GO-Girl clubs in schools), and FHI 360 (noting results of the adolescent reproductive health needs study they conducted this year).
ANNEX 1. SCOPE OF WORK

Assignment #: 335 [assigned by GH Pro]

Global Health Program Cycle Improvement Project (GH Pro)
Contract No. AID-OAA-C-14-00067

EVALUATION OR ANALYTIC ACTIVITY STATEMENT OF WORK (SOW)

Date of Submission: 12-08-2016
Last update: 03-2-2017

I. TITLE: Independent Costing Study of the PEPFAR OVC Portfolio in Nigeria

II. Requester / Client

☐ USAID Country or Regional Mission
Mission/Division: PEPFAR Nigeria / OVC TWG (Interagency)

III. Funding Account Source(s): (Click on box(es) to indicate source of payment for this assignment)

☐ 3.1.1 HIV
☐ 3.1.2 TB
☐ 3.1.3 Malaria
☐ 3.1.4 PIOET
☐ 3.1.5 Other public health threats
☐ 3.1.6 MCH
☐ 3.1.7 FP/RH
☐ 3.1.8 WSSH
☐ 3.1.9 Nutrition
☐ 3.2.0 Other (specify):

IV. Cost Estimate: Note: GH Pro will provide a cost estimate based on this SOW

V. Performance Period

Expected Start Date (on or about): March 3, 2017
Anticipated End Date (on or about): July 28, 2017

VI. Location(s) of Assignment: (Indicate where work will be performed)
Six states in Nigeria: Kaduna, FCT, Nasarawa, Benue, Lagos, Cross River, Rivers

Type of Analytic Activity (Check the box to indicate the type of analytic activity)

EVALUATION:

☐ Performance Evaluation (Check timing of data collection)
☐ Midterm ☐ Endline ☐ Other (specify):

Performance evaluations focus on descriptive and normative questions: what a particular project or program has achieved (either at an intermediate point in execution or at the conclusion of an implementation period); how it is being implemented; how it is perceived and valued; whether expected results are occurring; and other questions that are pertinent to program design, management and operational decision making. Performance evaluations often incorporate before-after comparisons, but generally lack a rigorously defined counterfactual.

☐ Impact Evaluation (Check timing(s) of data collection)
☐ Baseline ☐ Midterm ☐ Endline ☐ Other (specify):

Impact evaluations measure the change in a development outcome that is attributable to a defined intervention; impact evaluations are based on models of cause and effect and require a credible and rigorously defined counterfactual to control for factors other than the intervention that might account for the observed change. Impact evaluations in which comparisons are made between beneficiaries that are randomly assigned to either a treatment or a control group provide the strongest evidence of a relationship between the intervention under study and the outcome measured.
OTHER ANALYTIC ACTIVITIES
☐ Assessment
   Assessments are designed to examine country and/or sector context to inform project design, or as an informal review of projects.

☐ Costing and/or Economic Analysis
   Costing and Economic Analysis can identify, measure, value and cost an intervention or program. It can be an assessment or evaluation, with or without a comparative intervention/program.

☐ Other Analytic Activity (Specify)

<table>
<thead>
<tr>
<th>PEPFAR EVALUATIONS (PEPFAR Evaluation Standards of Practice 2014)</th>
</tr>
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<tbody>
<tr>
<td><strong>Note:</strong> If PEPFA-funded, check the box for type of evaluation</td>
</tr>
<tr>
<td>☐ Process Evaluation (Check timing of data collection)</td>
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<tr>
<td>□ Midterm            □ Endline           □ Other (specify):</td>
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<tr>
<td>Process Evaluation focuses on program or intervention implementation, including, but not limited to access to services, whether services reach the intended population, how services are delivered, client satisfaction and perceptions about needs and services, management practices. In addition, a process evaluation might provide an understanding of cultural, socio-political, legal, and economic context that affect implementation of the program or intervention. For example: Are activities delivered as intended, and are the right participants being reached? (PEPFAR Evaluation Standards of Practice 2014)</td>
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<tr>
<td>☐ Outcome Evaluation</td>
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<tr>
<td>Outcome Evaluation determines if and by how much, intervention activities or services achieved their intended outcomes. It focuses on outputs and outcomes (including unintended effects) to judge program effectiveness, but may also assess program process to understand how outcomes are produced. It is possible to use statistical techniques in some instances when control or comparison groups are not available (e.g., for the evaluation of a national program). Example of question asked: To what extent are desired changes occurring due to the program, and who is benefiting? (PEPFAR Evaluation Standards of Practice 2014)</td>
</tr>
<tr>
<td>☐ Impact Evaluation (Check timing(s) of data collection)</td>
</tr>
<tr>
<td>□ Baseline          □ Midterm          □ Endline          □ Other (specify):</td>
</tr>
<tr>
<td>Impact evaluations measure the change in an outcome that is attributable to a defined intervention by comparing actual impact to what would have happened in the absence of the intervention (the counterfactual scenario). IEs are based on models of cause and effect and require a rigorously defined counterfactual to control for factors other than the intervention that might account for the observed change. There are a range of accepted approaches to applying a counterfactual analysis, though IEs in which comparisons are made between beneficiaries that are randomly assigned to either an intervention or a control group provide the strongest evidence of a relationship between the intervention under study and the outcome measured to demonstrate impact.</td>
</tr>
<tr>
<td>☐ Economic Evaluation (PEPFAR)</td>
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<tr>
<td>Economic Evaluations identifies, measures, values and compares the costs and outcomes of alternative interventions. Economic evaluation is a systematic and transparent framework for assessing efficiency focusing on the economic costs and outcomes of alternative programs or interventions. This framework is based on a comparative analysis of both the costs (resources consumed) and outcomes (health, clinical, economic) of programs or interventions. Main types of economic evaluation are cost-minimization analysis (CMA), cost-effectiveness analysis (CEA), cost-benefit analysis (CBA) and cost-utility analysis (CUA). Example of question asked: What is the cost-effectiveness of this intervention in improving patient outcomes as compared to other treatment models?</td>
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VII. Background
Background of project/program/intervention:
As part of the Country Operational Planning (COP) process, PEPFAR country teams estimate and document resources used to fund program activities based on historical expenditure or cost data. This process, the PEPFAR Expenditure Analysis (EA), is essential for USG to better understand what the USG actually spends to support the provision of HIV services to beneficiaries, in order to improve program planning. One common approach to budgeting PEPFAR resources is to use EA to develop unit expenditures (UEs) for “target-based budgeting,” by which available unit expenditure data is adjusted to reflect program activities planned in the next year and then multiplied by the corresponding number of targeted beneficiaries.
Under PEPFAR EA, partners and country teams capture expenditures for orphans and vulnerable children (OVC) services that target OVC needs in the areas of health care access, educational support, psychosocial support, child protection and food and nutrition, as well as economic strengthening interventions for OVC households. The PEPFAR-funded OVC portfolio provides a range of services which differ by composition for beneficiaries and households, depending on child vulnerability, HIV/AIDS positivity of children and caregivers, household composition, and a variety of socioeconomic and demographic factors. In Nigeria, the USG has gathered expenditures for OVC partners from 2013 to present by implementing mechanism (IM), and these have been used to generate UEs which are disaggregated by SNU. However, denominator data is not collected in order to produce UEs that are disaggregated by type of service. There is also no clear guidance to OVC partners on how to allocate shared costs across service types. As a result, there is limited understanding of the UEs for the various packages of OVC services provided by PEPFAR partners on OVC programs.

While PEPFAR EA is essential for USG resource tracking, national and IM UEs are not appropriate to determine partner-level budgets. To some extent, the current UEs generated from EA are a reflection of historical efforts by PEPFAR OVC partners to stretch resources to reach large numbers of children, with greater attention being paid to the numbers reported than to the quality of the service package they receive. The absence of a clear definition of what constitutes a standard or ‘minimum package’ of interventions has contributed to this trend. Another limitation of the EA is that it does not capture important contextual factors, which are equally relevant in the planning process.

USG has concerns that some of the OVC service packages being offered in Nigeria are not of sufficient quality, and that IM-level and national-level UEs derived from EA fail to capture the ‘gold standard’ of OVC services. For this reason, it is necessary to devise an alternative approach to allocating resources for these programs, as well as to identifying potential efficiency gains given existing resources.

Strategic or Results Framework for the project/program/intervention (paste framework below)
If project/program does not have a Strategic/Results Framework, describe the theory of change of the project/program/intervention.

What is the geographic coverage and/or the target groups for the project or program that is the subject of analysis?

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

This activity will help address these limitations and guide and inform a more refined partner-level budgeting process for the OVC program in Nigeria. It will tie in with ongoing efforts to determine a “gold standard” package of services linked to standard ranges and categories of child and household vulnerability.

The study will collect expenditure data on the various service packages (including staff time/salary, travel and transportation, and other resources) required to support OVC in a sampling of USAID and
CDC sites, and service provision data for the various packages. It will examine how partners are currently allocating expenditures across the various services areas as part of the expenditure analysis process, and will also document key contextual factors that contribute to cost drivers at specific sites/facilities. A brief qualitative component of this study will focus on helping to better explain why these contextual factors influence costs.

The study will also focus on how the findings can be used to develop a more effective budgeting tool for OVC programs that takes into account contextual cost drivers as well as the inputs required to deliver a ‘gold standard’ package of services.

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

| PEPFAR/Nigeria OVC Interagency Technical Working Group (TWG) |

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

| The study findings will be used to determine budgeting for OVC programs |

**Evaluation/Analytic Questions & Matrix:**

a) Questions should be: a) aligned with the evaluation/analytic purpose and the expected use of findings; b) clearly defined to produce needed evidence and results; and c) answerable given the time and budget constraints. Include any disaggregation (e.g., sex, geographic locale, age, etc.), they must be incorporated into the evaluation/analytic questions. **USAID policy suggests 3 to 5 evaluation/analytic questions.**

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

c) State the application or use of the data elements towards answering the evaluation questions; for example, i) ratings of quality of services, ii) magnitude of a problem, iii) number of events/occurrences, iv) gender differentiation, v) etc.
<table>
<thead>
<tr>
<th>Costing Study Questions</th>
<th>Suggested Methods for Answering This Question</th>
<th>Sampling Frame</th>
</tr>
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<tbody>
<tr>
<td>1</td>
<td>What are the expenditures currently being made by partners to provide the various service packages that they deliver to OVC?</td>
<td>IP program and financial records</td>
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<tr>
<td>2</td>
<td>What are the average, SNU specific and partner specific UEs for the various service packages being delivered to OVC?</td>
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<td>3</td>
<td>How are partners currently allocating shared expenditures across the different service areas?</td>
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<td>4</td>
<td>What contextual factors affect the expenditures incurred in providing these services across partners and regions?</td>
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<td>5</td>
<td>What are the expenditures for a “gold-standard” package of OVC services by intervention, across partners and regions?</td>
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<td>6</td>
<td>What is the framework that the USG should use to develop IM level budgets for Country Operational Planning?</td>
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Other Questions [OPTIONAL]  
(Note: Use this space only if necessary. Too many questions lead to an ineffective evaluation or analysis.)

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

**General Comments related to Methods:**  
The analysis will include a selected list of IPs and associated SNUs that are directly involved in providing OVC services. IPs will be selected to represent different models of OVC service provision as well as a mix of geographic and urban/rural spread. It is estimated that there will be 4-6 IPs that will be interviewed to collect the required data.

**Document and Data Review** (list of documents and data recommended for review)  
This desk review will be used to provide background information on the project/program, and will also provide data for analysis for this costing study. Documents and data to be reviewed include:
- The consultant(s) will receive EA data from PEPFAR/Nigeria on all sixteen CDC and USAID Implementing Mechanisms (IMs) that currently provide support for OVC services in Nigeria. This data includes estimates of total PEPFAR expenditures and beneficiaries served as
provided by PEPFAR IPs. This EA data will provide the background for the analysis and will help to prepare the costing framework for the subsequent interviews and data collection with the IPs selected to participate in the study.

- Description of OVC activities
- OVC Project Reports
- PEPFAR OVC Guidance
- DREAMS guidance
- PEPFAR Nigeria Gender Analysis Report 2016
- OVC portions of Nigeria COP15 and COP16
- OVC modules of the Community SIMS tool,
- Expenditure analysis for OVC for FY15 and 16 (will be provided by PEPFAR Team)
- Other key partner-specific documents will be provided to the consultants by partners

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

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<thead>
<tr>
<th>Data Source (Existing Dataset)</th>
<th>Description of Data</th>
<th>Recommended Analysis</th>
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**Key Informant Interviews** (list categories of key informants, and purpose of inquiry)

1. As a first step, a quick round of conversations with partners or an informal poll, will provide some information about the scope and depth of expenditures. This will enable the consultants to finalize the framework for the in-depth analysis.

2. To better understand the expenditures, PEPFAR funded OVC implementing partner staffs and their CBO sub-partners will be interviewed. The selected IPs (and their CBOs), in advance of any interviews, will receive a list of questions that will be asked, so they can be prepared for the interviews to be conducted. Interviews are expected to last from 2-4 hours (although there may be the need for follow-up interviews) and will include both IP programmatic and financial staff. The purpose of these quantitative and qualitative interviews will be to identify the expenditures incurred in the last year on OVC services by partner, and to identify factors that drive costs at the partner-level. USAID, CDC and PEPAR OVC staff will provide background information and a recommended list of persons to be interviewed. It is anticipated that government agencies will not be interviewed as part of this costing work, but beneficiaries may be included. The list of informants will be finalized during the Team Planning Meeting.

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

**Group Interviews** (list categories of groups, and purpose of inquiry)

**Client/Participant Satisfaction or Exit Interviews** (list who is to be interviewed, and purpose of inquiry)

**Survey** (describe content of the survey and target responders, and purpose of inquiry)
As a first step, a quick survey will provide some information about the scope and depth of expenditures which can then be followed up with interviews.

☐ **Facility or Service Assessment/Survey** *(list type of facility or service of interest, and purpose of inquiry)*

☐ **Observations** *(list types of sites or activities to be observed, and purpose of inquiry)*

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

The analysis will involve both a review and summary of USG expenditure data at the state level (FY15 and 16). The analysis will interrogate what services are provided by IPs to beneficiaries in the selected communities, at what cost, over what periods of time, and with what frequency. In order to define UEs by service type, data on beneficiaries served with each service type will also be gathered. Expenditures will be categorized by the standard PEPFAR EA cost categories including the following illustrative elements:

- direct expenditures per category for each service type
- amount of human resources applied for each service type
- amount of additional resources required for each service by cost category (e.g. travel, supplies, etc.)
- level of above site organizational (head office)/program management support per service type, by cost category
- Any other cost categories not captured by the PEPFAR EA categorization

☐ **Data Abstraction** *(list and describe files or documents that contain information of interest, and If impact evaluation – Is technical assistance needed to develop full protocol and/or IRB submission?*

- Yes
- No

List or describe case and counterfactual

<table>
<thead>
<tr>
<th>Case</th>
<th>Counterfactual</th>
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IX. Human Subject Protection

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

An Informed Consent statement included in all data collection interactions must contain:

- Introduction of facilitator/note-taker
- Purpose of the evaluation/assessment
X. Analytic Plan
Describe how the quantitative and qualitative data will be analyzed. Include method or type of analyses, statistical tests, and what data it to be triangulated (if appropriate). For example, a thematic analysis of qualitative interview data, or a descriptive analysis of quantitative survey data.

The analysis will focus only on USG expenditures that are required to support the identified services, and will not include expenditures incurred by other donors or the Government of Nigeria.

Expenditures will be disaggregated by service type and cost categories, including but not limited to the PEPFAR EA cost categories, and will indicate the following illustrative elements:
- direct expenditures per category for each service type
- amount of human resources applied for each service type
- amount of additional resources required for each service by cost category (e.g. travel, supplies, etc.)
- level of above site organizational (head office)/program management support per service type, by cost category
- Other (disaggregated by categories as appropriate)

The analysis will involve both a review and summary of expenditure data at the state level (FY15) and a review of the results from the interview and data collection with IPs about the community and beneficiary expenditures. For example, the analysis will note how total and unit expenditures vary by a variety of contextual factors, to be determined by the PEPFAR Nigeria/OVC TWG and the consultant(s). These contextual factors could include geographic area (e.g., urban, rural and deep rural), the vulnerability of children and caregivers in that region, and other socioeconomic and demographic factors. In addition to an analysis of the quantitative data, the consultant(s) will also analyze qualitative data provided by IPs and the existing EA data.
All analyses will be geared to answer the evaluation questions.

XI. Activities
List the expected activities, such as Team Planning Meeting (TPM), briefings, verification workshop with IPs and stakeholders, etc. Activities and Deliverables may overlap. Give as much detail as possible.

**Background reading** – Several documents are available for review for this analytic activity. These include PEPFAR OVC and other guidelines, PEPFAR/Nigeria Gender Analysis, Nigeria COP, OVC modules of the Community SIMS, and the expenditure analysis for OVC, among others. This desk review will provide background information for the Costing Team, and will also be used as data input and evidence for the analysis.

**Team Planning Meeting (TPM)** – A four-day team planning meeting (TPM) will be held at the initiation of this assignment and before the data collection begins. The TPM will:
- Review and clarify any questions on the SOW
- Clarify team members’ roles and responsibilities
- Establish a team atmosphere, share individual working styles, and agree on procedures for resolving differences of opinion
- Review and finalize analytic questions
• Review and finalize the assignment timeline
• Develop data collection methods, instruments, tools and guidelines
• Review and clarify any logistical and administrative procedures for the assignment
• Develop a data collection plan
• Draft the evaluation work plan for USAID’s approval
• Develop a preliminary draft outline of the team’s report
• Assign drafting/writing responsibilities for the final report

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

• Costing Analysis launch, a call/meeting among the USAID and CDC OVC team (including PEPFAR Nigeria OVC Team, EA advisors in country and Washington/Atlanta backstops), GH Pro and the Team Lead to initiate the evaluation activity and review expectations. The PEPFAR Nigeria team will review the purpose, expectations, and agenda of the assignment. GH Pro will introduce the Team Lead, and review the initial schedule and review other management issues.

• In-brief with PEPFAR Nigeria OVC Team, as part of the TPM. At the beginning of the TPM, the Costing Team will meet with the PEPFAR Nigeria team to discuss expectations, review evaluation questions, and discuss workplan, methodology ideas and intended plans. The Team will also raise questions that they may have about the project/program and SOW resulting from their background document review. The time and place for this in-brief will be determined between the Team Lead and USAID prior to the TPM.

• Workplan and methodology review briefing. At the end of the TPM, the Evaluation Team will meet with the PEPFAR Nigeria Team to present an outline of the methods/protocols, timeline and data collection tools. Also, the format and content of the Costing Analysis report and budgeting tool(s) will be discussed.

• In-brief with USG Implementing Partners (IPs) to review the cost analysis plans and timeline, and for the IPs to give an overview of their activities to the Costing Team.

• The Team Lead (TL) will brief USAID weekly to discuss progress on the evaluation. As preliminary findings arise, the TL will share these during the routine briefing, and in an email. There will also be a mid-term discussion to confirm methodology and effect course correction if necessary.

• A final debrief between the Costing Analysis Team and the PEPFAR Nigeria OVC Team will be held at the end of the evaluation to present preliminary findings, costing framework and matching budgeting tool. During this meeting a summary of the data will be presented, along with high level findings and draft recommendations. For the debrief, the Evaluation Team will prepare a PowerPoint Presentation of the key findings, issues, and recommendations. The evaluation team shall incorporate comments received from the PEPFAR Nigeria OVC team during the debrief in the evaluation report. (Note: preliminary findings are not final and as more data sources are developed and analyzed these finding may change.)

• A training session on the budgeting tool that responds to the developed costing framework for the PEPFAR OVC TWG.

Site Visits and Data Collection – The Costing Team will conduct site visits for data collection. Selection of sites to be visited will be finalized during TPM in consultation with the PEPFAR/Nigeria OVC team. The Costing Team will outline and schedule key meetings and site visits prior to departing to the field.
**Costing Analysis Report** – The Costing Team under the leadership of the Team Lead will develop a report with findings and recommendations (see Analytic Report below). Report writing and submission will include the following steps:

1. Team Lead will submit draft report to GH Pro for review and formatting
2. GH Pro will submit the draft report to USAID and CDC
3. USAID and CDC will review the draft report in a timely manner, and send their comments and edits back to GH Pro
4. GH Pro will share USAID and CDC’s comments and edits with the Team Lead, who will then do final edits, as needed, and resubmit to GH Pro
5. GH Pro will review and reformat the final Costing Analysis Report, as needed, and resubmit to USAID and CDC for approval.
6. USAID and CDC may require GH Pro to submit a summary re-formatted version for 508 compliance and post it to the DEC.

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

**Data Submission** – All quantitative data will be submitted to GH Pro in a machine-readable format (CSV or XML) and in excel. The datasets created as part of this costing study must be accompanied by a data dictionary that includes a codebook and any other information needed for others to use these data. It is essential that the datasets are stripped of all identifying information, as the data may be public once posted on USAID Development Data Library (DDL).

Where feasible, qualitative data that do not contain identifying information should also be submitted to GH Pro.

### XII. Deliverables and Products

Select all deliverables and products required on this analytic activity. For those not listed, add rows as needed or enter them under “Other” in the table below. Provide timelines and deliverable deadlines for each.

<table>
<thead>
<tr>
<th>Deliverable / Product</th>
<th>Timelines &amp; Deadlines (Estimated)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Launch briefing call</td>
<td>March 7, 2017</td>
</tr>
<tr>
<td>In-brief with USAID, CDC and PEPFAR OVC TWG</td>
<td>March 13, 2017</td>
</tr>
<tr>
<td>Workplan and methodology finalization briefing with USAID, CDC and PEPFAR OVC TWG</td>
<td>March 17, 2017</td>
</tr>
<tr>
<td>Workplan with timeline submission for approval</td>
<td>March 20, 2017</td>
</tr>
<tr>
<td>Draft analytic protocol with data collection tools</td>
<td>March 20, 2017</td>
</tr>
<tr>
<td>In-brief with USG OVC IPs</td>
<td>March 21, 2017</td>
</tr>
<tr>
<td>Routine briefings</td>
<td>Weekly</td>
</tr>
<tr>
<td>Final Analytical protocol with data collection tools</td>
<td>March 20, 2017</td>
</tr>
<tr>
<td>Preliminary review of data based on data collected to date: disaggregated by service and cost category, for the various service packages as delivered by partners at the selected sites</td>
<td>April 18, 2017</td>
</tr>
<tr>
<td>An analysis and quantification of the main contextual drivers of expenditures by PEPFAR IPs that influence the cost of OVC services by partner.</td>
<td>April 18, 2017</td>
</tr>
<tr>
<td>A draft budgeting tool for OVC programs, using the data from the study to inform the COP.</td>
<td>April 19, 2017</td>
</tr>
</tbody>
</table>
### Deliverable / Product | Timelines & Deadlines (Estimated)
--- | ---
- Out-brief with USAID, CDC and PEPFAR OVC TWG with PowerPoint presentation, and training on use of budgeting tool | May 3, 2017
- Draft report: full report + summary report for public distribution | Submit to GH Pro: May 17, 2017
  | GH Pro submits to USAID & CDC: May 23, 2017
- Final report: full report + summary report for public distribution | Submit to GH Pro: June 7, 2017
  | GH Pro submits to USAID & CDC: June 13, 2017
- Raw data (cleaned datasets in excel, and CSV or XML, with data dictionary) | June 8, 2017
- Final formatted pdf report to USAID & CDC | June 30, 2017
- Summary Posted to the DEC | July 28, 2017
- Other (specify): |

### Estimated USAID review time
Average number of business days USAID and CDC will need to review deliverables requiring USAID review and/or approval? **5** Business days

### XIII. Team Composition, Skills, and Level of Effort (LOE)
**Evaluation/Analytic team:** When planning this analytic activity, consider:
- Key staff should have methodological and/or technical expertise, regional or country experience, language skills, team lead experience and management skills, etc.
- Team leaders for evaluations/analytics must be an external expert with appropriate skills and experience.
- Additional team members can include research assistants, enumerators, translators, logisticians, etc.
- Teams should include a collective mix of appropriate methodological and subject matter expertise.
- Evaluations require an Evaluation Specialist, who should have evaluation methodological expertise needed for this activity. Similarly, other analytic activities should have a specialist with methodological expertise.
- Note that all team members will be required to provide a signed statement attesting that they have no conflict of interest, or describing the conflict of interest if applicable.

**Team Qualifications:** Please list technical areas of expertise required for this activity:
- List desired qualifications for the team as a whole
- List the key staff needed for this analytic activity and their roles.
- Sample position descriptions are posted on USAID/GH Pro webpage
- Edit as needed GH Pro provided position descriptions

**Overall Team requirements:**
The study team will include appropriate methodological and subject matter experts in costing and OVC programs. The Team should include: 1) an economist with specialization in social welfare, public or health economics; and 2) an individual with extensive OVC programming experience, preferably experience working in PEPFAR OVC programs. Strong knowledge of the PEPFAR EA methodology is recommended. Additional team members can include a financial analyst, a research/logistics assistant, and others as appropriate.

**Team Lead/OVC Specialist:**
**Roles & Responsibilities:** The team leader will be responsible for (1) providing team leadership; (2) managing the team’s activities, (3) ensuring that all deliverables are met in a timely manner, (4) serving as a liaison between the USAID, CDC and the evaluation/analytic team, and (5) leading briefings and
presentations. S/He will also provide expertise on OVC programming. S/He will participate in all aspects of the assignment, including planning, data collection, data analysis and report writing.

Qualifications:

- Minimum of 10 years of experience in public health or health economics (or related field), which includes experience in implementation of health activities in developing countries, including at least 8 years’ experience with OVC and HIV projects
- Demonstrated experience leading health sector studies or evaluations, utilizing both quantitative and qualitative methods
- Expertise in the full range of OVC program activities, particularly those supported with USG funding
- Knowledge of the OVC programming priorities
  - Education
  - Psychosocial Care and Support
  - Household Economic Strengthening (HES)
  - Social Protection
  - Health and Nutrition
  - Child Protection
  - Legal Protection
  - Capacity Building
- Familiar with PEPFAR guidelines and policies, including
  - PEPFAR Guidance for OVC Programming
  - PEPFAR Next Generation Indicators Reference Guidance
  - PEPFAR Monitoring, Evaluation, and Reporting Indicator Reference Guide
  - PEPFAR Evaluation Standards of Practice
  - Capacity Building and Strengthening Framework
  - Gender Strategy
  - Country Operational Plans (COP)
  - Site Improvement through Monitoring System (SIMS)
  - Expenditure Analysis
- Excellent interpersonal skills, including experience successfully interacting multiple USG programming partners (i.e., USAID, CDC, State Department, DOD etc.), and their implementing partners (IPs)
- Excellent skills in project management
- Excellent organizational skills and ability to keep to a timeline
- Good writing skills, with extensive report writing experience
- Experience working in the region, and experience in Nigeria is desirable
Key Staff 1
Title: Economist (Costing Expert)
Roles & Responsibilities: Serve as a member of the OVC Costing Analysis team, providing technical expertise to evaluate the USG OVC project expenditures. S/he will provide technical expertise for the expenditure and value for money analysis. S/He will participate in all aspects of the assignment, including planning, data collection, data analysis and report writing.

Qualifications:
- At least 8 years of experience working with costing analyses or related work in developing country settings/context
- Knowledge of PEPFAR Expenditure Analysis is desirable
- Experience should include in depth understanding of evaluating programs from a cost efficiency perspective
- Experience working with projects to extract expenditure data, including categorizing these expenditures into useful categories of project implementation
- Experience assessing value for money on health and development projects, including determining areas for investment that lead to best development outcomes
- Experience working with USAID and/or CDC health programs is desirable
- Familiarity with PEPFAR OVC programs and guidelines is desirable
- Excellent interpersonal skills, including experience successfully interacting with implementing partners and USG representatives
- Proficient in English
- Good writing skills, with experience producing evaluation and/or technical report
- Experience working in Nigeria is desirable

Other Staff Titles with Roles & Responsibilities (include number of individuals needed):

Field Coordinator /Research Assistant (local consultant) will support the Costing Analysis Team with all logistics and administration to allow them to carry out this assignment, as well as assist with data collection as needed. The Field Coordinator will have a good command of English and other relevant local language(s). S/He will be familiar with communications with US government agencies in Nigeria, such as, USAID, CDC, State Department, DOD. S/He will also have knowledge of key actors in the health, educations and social service sectors, donors and other stakeholders. To support the Team, s/he will be able to efficiently liaise with hotel staff, arrange in-country transportation (ground and air), arrange meeting and workspace as needed, and ensure business center support, e.g. copying, internet, and printing. S/He will work under the guidance of the Team Leader make preparations, arrange meetings and appointments. S/He will conduct programmatic, administrative and support tasks as assigned and ensure the processes moves forward smoothly. S/He will also assist in data collection and translation of data collection tools and transcripts, as needed.

Financial Analyst (local consultant, as needed) to assist the Costing Analysis Team with collection and analysis of financial data. S/He should have basic familiarity with financial records and processes utilized by USG implementing partners. Familiarity with the PEPFAR Expenditure Analysis process is desirable. The local Financial Analyst will have a good command of English and other relevant local language(s). S/He will also assist the Team and the Logistics Coordinator, as needed, and will report to the Team Lead.

Will USAID and CDC participate as an active team member or designate other key stakeholders to as an active team member? This will require full time commitment during the evaluation or analytic activity.

☐ Yes – If yes, specify who:
☐ Significant Involvement anticipated – If yes, specify who: Tessie Philips-Ononye (USAID), Victor Atuchukwu (CDC)
☐ No
**Staffing Level of Effort (LOE) Matrix:**
This optional LOE Matrix will help you estimate the LOE needed to implement this analytic activity. If you are unsure, GH Pro can assist you to complete this table.

a) For each column, replace the label “Position Title” with the actual position title of staff needed for this analytic activity.
b) Immediately below each staff title enter the anticipated number of people for each titled position.
c) Enter Row labels for each activity, task and deliverable needed to implement this analytic activity.
d) Then enter the LOE (estimated number of days) for each activity/task/deliverable corresponding to each titled position.
e) At the bottom of the table total the LOE days for each consultant title in the ‘Sub-Total’ cell, then multiply the subtotals in each column by the number of individuals that will hold this title.

LOE in **days** for each Evaluation/Analytic Team member
*(The following is an Illustrative LOE Chart. Please edit to meet the requirements of this activity.)*

| Activity / Deliverable | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 |
| Team Lead / OVC Specialist | 0.5 | 1 | 5 | 5 | 5 | 4 | 4 | 4 | 0.5 | 0.5 | 0.5 | 1 | 1 | 1 | 2 | 2 | 2 | 1 | 1 | 1 | 1 | 1 |
| Costing Specialist | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 |
| Logistics & Research Coordinator | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 | 0.5 |
If overseas, is a 6-day workweek permitted  □ Yes  □ No

**Travel anticipated:** List international and local travel anticipated by what team members.

| This assignment requires travel to 7 states spread across North, South, West of Nigeria: Sundry sites in Kaduna, FCT, Nasarawa, Benue, Lagos, Cross River, Rivers |

**XIV. Logistics**

**Visa Requirements**
List any specific Visa requirements or considerations for entry to countries that will be visited by consultant(s):

**Visas are required for travel to Nigeria**

List recommended/required type of Visa for entry into counties where consultant(s) will work

<table>
<thead>
<tr>
<th>Name of Country</th>
<th>Type of Visa</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nigeria</td>
<td>□ Tourist  □ Business □ No preference</td>
</tr>
</tbody>
</table>

**Clearances & Other Requirements**

**Note:** Most Evaluation/Analytic Teams arrange their own work space, often in conference rooms at their hotels. However, if a Security Clearance or Facility Access is preferred, GH Pro can submit an application for it on the consultant’s behalf.

GH Pro can obtain **Secret Security Clearances** and **Facility Access (FA)** for our consultants, but please note these requests processed through USAID/ GH (Washington, DC) can take 4-6 months to be granted, with Security Clearance taking approximately 6 months to obtain. If you are in a Mission and the RSO is able to grant a temporary FA locally, this can expedite the process. If Security Clearance or FA is granted through Washington, DC, the consultant must pick up his/her badge in person at the Office of Security in Washington, DC, regardless of where the consultant resides or will work.

If **Electronic Country Clearance (eCC)** is required prior to the consultant’s travel, the consultant is also required to complete the **High Threat Security Overseas Seminar (HTSOS)**. HTSOS is an interactive e-Learning (online) course designed to provide participants with threat and situational awareness training against criminal and terrorist attacks while working in high threat regions. There is a small fee required to register for this course. [Note: The course is not required for employees who have taken FACT training within the past five years or have taken HTSOS within the same calendar year.]

If eCC is required, and the consultant is expected to work in country more than 45 consecutive days, the consultant may be required to complete the one-week **Foreign Affairs Counter Threat (FACT) course** offered by FSI in West Virginia. This course provides participants with the knowledge and skills to better prepare themselves for living and working in critical and high threat overseas environments. Registration for this course is complicated by high demand (consultants must register approximately 3-4 months in advance). Additionally, there will be the cost for additional lodging and M&E to take this course.

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

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

Before Field Work

- **SOW.**
  - Develop SOW.
  - Peer Review SOW.
  - Respond to queries about the SOW and/or the assignment at large.
- **Consultant Conflict of Interest (COI).** To avoid conflicts of interest or the appearance of a COI, review previous employers listed on the CV's for proposed consultants and provide additional information regarding potential COI with the project contractors evaluated/assessed and information regarding their affiliates.
- **Documents.** Identify and prioritize background materials for the consultants and provide them to GH Pro, preferably in electronic form, at least one week prior to the inception of the assignment.
- **Local Consultants.** Assist with identification of potential local consultants, including contact information.
- **Site Visit Preparations.** Provide a list of site visit locations, key contacts, and suggested length of visit for use in planning in-country travel and accurate estimation of country travel line items costs.
• **Lodgings and Travel.** Provide guidance on recommended secure hotels and methods of in-country travel (i.e., car rental companies and other means of transportation).

**During Field Work**
- **Mission Point of Contact.** Throughout the in-country work, ensure constant availability of the Point of Contact person and provide technical leadership and direction for the team’s work.
- **Meeting Space.** Provide guidance on the team’s selection of a meeting space for interviews and/or focus group discussions (i.e. USAID space if available, or other known office/hotel meeting space).
- **Meeting Arrangements.** Assist the team in arranging and coordinating meetings with stakeholders.
- **Facilitate Contact with Implementing Partners.** Introduce the analytic team to implementing partners and other stakeholders, and where applicable and appropriate prepare and send out an introduction letter for team’s arrival and/or anticipated meetings.

**After Field Work**
- **Timely Reviews.** Provide timely review of draft/final reports and approval of deliverables.

**XVI. Analytic Report**
Provide any desired guidance or specifications for Final Report. (See **How-To Note: Preparing Evaluation Reports**)

The final report will include summary of findings from historical EA data, an assessment of costs for selected partners and sites, as well as an analysis and quantification of the main contextual drivers of expenditures by PEPFAR and IPs that influence the cost to support OVC services by partner. In addition to the quantitative analysis, there will also be a qualitative assessment that summarizes many of the key issues driving the cost of providing OVC services by the IPs. Finally, the report will present a potential framework for more refined budgeting for OVC services using EA data in addition to findings from this study. This budgeting framework can be used to create a tool that complements other existing PEPFAR Budgeting Tools (PBAC) to accurately budget for OVC services to the partner level. This full report is intended for internal use by the USAID and CDC/Nigeria and USG Nigeria OVC Interagency Team, and will not be posted to the DEC.

USAID may request a Summary document for public distribution, and possible posting to the DEC. This will be discussed during the in-brief with USAID and CDC, and confirmed at the debrief presentation with USAID and CDC/Nigeria.

Although this is not an Evaluation Report, GH Pro requests that it adheres to the **USAID Criteria to Ensure the Quality of the Evaluation Report (USAID ADS 201):**
- Evaluation reports should be readily understood and should identify key points clearly, distinctly, and succinctly.
- The Executive Summary of an evaluation report should present a concise and accurate statement of the most critical elements of the report.
- Evaluation reports should adequately address all evaluation questions included in the SOW, or the evaluation questions subsequently revised and documented in consultation and agreement with USAID.
- Evaluation methodology should be explained in detail and sources of information properly identified.
- Limitations to the evaluation should be adequately disclosed in the report, with particular attention to the limitations associated with the evaluation methodology (selection bias, recall bias, unobservable differences between comparator groups, etc.).
- Evaluation findings should be presented as analyzed facts, evidence, and data and not based on anecdotes, hearsay, or simply the compilation of people’s opinions.
- Findings and conclusions should be specific, concise, and supported by strong quantitative or qualitative evidence.
- If evaluation findings assess person-level outcomes or impact, they should also be separately
assessed for both males and females.

- If recommendations are included, they should be supported by a specific set of findings and should be action-oriented, practical, and specific.

**Reporting Guidelines:** The full OVC Costing Study Report should be a comprehensive analytical evidence-based report. It should detail and describe results, effects, constraints, and lessons learned, and provide recommendations and identify key questions for future consideration. The report shall follow USAID branding procedures. *The Summary report will be edited/formatted and made 508 compliant as required by USAID for public reports and will be posted to the USAID/DEC. The report will include a budgeting tool and guidance on how to use the tool.*

The **Summary Report** should exclude any potentially procurement-sensitive information. As needed, any procurement sensitive information or other sensitive but unclassified (SBU) information will be submitted in a memo to USAID separate from the Evaluation Report.

All data instruments, data sets (if appropriate), presentations, meeting notes and report for this evaluation/analysis will be submitted electronically to the GH Pro Program Manager. All datasets developed as part of this costing study will be submitted to GH Pro in an unlocked machine-readable format (CSV or XML). The datasets must not include any identifying or confidential information. The datasets must also be accompanied by a data dictionary that includes a codebook and any other information needed for others to use these data. Qualitative data included in this submission should not contain identifying or confidential information. Category of respondent is acceptable, but names, addresses and other confidential information that can easily lead to identifying the respondent should not be included in any quantitative or qualitative data submitted.

### XVII. USAID Contacts

<table>
<thead>
<tr>
<th>Primary Contact</th>
<th>Alternate Contact 1</th>
<th>Alternate Contact 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:        Tessie Philips-Ononye</td>
<td>Kelly Badiane</td>
<td>Isa Iyortim</td>
</tr>
<tr>
<td>Title:       Program Manager, OVC; Gender POC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Email:       <a href="mailto:tphilips-ononye@usaid.gov">tphilips-ononye@usaid.gov</a></td>
<td><a href="mailto:kbadiane@usaid.gov">kbadiane@usaid.gov</a></td>
<td><a href="mailto:iiyortim@usaid.gov">iiyortim@usaid.gov</a></td>
</tr>
<tr>
<td>Telephone:   234(09)461 9394</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cell Phone:  234 803 450 7819</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
List other contacts who will be supporting the Requesting Team with technical support, such as reviewing SOW and Report (such as USAID/W GH Pro management team staff)

<table>
<thead>
<tr>
<th>Technical Support Contact 1</th>
<th>Technical Support Contact 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name: Lily Asrat</td>
<td></td>
</tr>
<tr>
<td>Title: Senior Evaluation Advisor</td>
<td></td>
</tr>
<tr>
<td>USAID Office: USAID, Office of HIV/AIDS</td>
<td></td>
</tr>
<tr>
<td>Email: <a href="mailto:aasrat@usaid.gov">aasrat@usaid.gov</a></td>
<td></td>
</tr>
<tr>
<td>Telephone: 571 551-7192</td>
<td></td>
</tr>
<tr>
<td>Cell Phone: 571-451-6079</td>
<td></td>
</tr>
</tbody>
</table>

XVIII. Other Reference Materials
Documents and materials needed and/or useful for consultant assignment, that are not listed above

XIX. Adjustments Made in Carrying out This SOW after Approval of the SOW
(To be completed after Assignment Implementation by GH Pro)
## ANNEX 2. CATEGORIZATION OF IPS BY TYPE OF OVC PROJECT

### IPs Implementing OVC as Part of Integrated Projects

<table>
<thead>
<tr>
<th>IP</th>
<th>Mean Cost ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>APIN</td>
<td>4</td>
</tr>
<tr>
<td>FGHIN</td>
<td>10</td>
</tr>
<tr>
<td>FHI360</td>
<td>20</td>
</tr>
<tr>
<td>CCFN</td>
<td>21</td>
</tr>
<tr>
<td>IHVN</td>
<td>29</td>
</tr>
<tr>
<td>CIHP</td>
<td>56</td>
</tr>
<tr>
<td>PHI</td>
<td>122</td>
</tr>
</tbody>
</table>

### IPs Implementing OVC Stand-Alone HIV/AIDS Programs

<table>
<thead>
<tr>
<th>IP</th>
<th>Mean Cost ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIFASS</td>
<td>15</td>
</tr>
<tr>
<td>CRS</td>
<td>17</td>
</tr>
<tr>
<td>ARFH</td>
<td>33</td>
</tr>
<tr>
<td>SVC</td>
<td>39</td>
</tr>
</tbody>
</table>
ANNEX 3. COST DRIVERS FOR OVC SERVICES

In this section, key findings are presented relating to the analysis of the cost drivers as reported by the CBOs. Given the non-availability of State-specific data from the IPs, we were unable to determine sub-national level costs and had to use the CBO costs as a proxy.

**General Findings**

- As expected, given that OVC programming is a care and support project and human resource-dependent, personnel ranked as the largest cost driver overall except for two CBOs where their highest expenditures were livelihood inputs.\(^{23}\) Analysis of personnel expenditures by intervention was not possible given the lack of detailed time sheets or accounting system.

- Transportation, too, is a major and frequently top cost driver; the lack of sufficient funding for transportation was a common complaint of CBOs.

**Education-Specific**

- There was considerable variation in expenditures and cost drivers reported by IP partner CBOs given differing interventions (block grants, direct payment of fees, conditional cash transfers,\(^{24}\) or provision of supplies versus advocacy for school waivers. In terms of States, Kaduna was most striking, with only one IP providing direct financial assistance (block grant). Also noted as interesting, was that CBOs with two large OVC projects did not report any education expenditures. This is likely because the IP, CIHP made those expenses directly from their office.

- In addition to direct support, major cost drivers included transportation and supplies or materials.

- No expenditures were noted specific for early childhood development (ECD).

- Expenditures are not accounted for according to level or type of formal education; this is challenging for reporting using the EA categories.

**Health and Nutrition-Specific**

- Major cost drivers for health were most frequently: transportation, supplies/materials, medicines and hospital bills, and refreshments. Other expenditure categories included: accommodation/per diem and training materials. Two CBOs (different IPs) noted expenditures for escort services. More information is needed to understand the CBOs not reporting transportation costs and for those where refreshments were cost drivers for assisting OVC HHs to access health services.

- For nutrition, transportation, supplies/materials, and refreshments (food and drinks) were most frequently reported, followed by training materials. No expenditures for nutrition were reported by 14 CBOS. Five of the CBOs mentioned providing food packages under nutrition, with expenditures ranging from 12,000 to 210,000 Naira—these may be specific to micro nutrient needs of HIV positive persons, or for malnourished children otherwise better categorized under HES.

- In looking at the potential for differences in cost between IPs with stand-alone and comprehensive HIV/AIDS, the picture was mixed. Following the calculation of a weighted mean, the costs of stand-alone OVC programs were slightly higher than those with integrated programs.

- While not verifiable, given that costs are not disaggregated by LGA, it is expected that there were higher costs in scale up LGAS because of the significant emphasis on HCT support.

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\(^{23}\) For example, underdeveloped or potentially non-core activities or with associated non-allowable costs.

\(^{24}\) Only noted by one CBO.
• Only in Nasarawa (two CBOs), FCT (one CBO) and in Cross Rivers (one CBO) — these representing three IPs, were WASH expenditures reported. 25.

**HES-Specific**
- Livelihood inputs and/or cash transfers were most frequently reported as highest HES expenditures by CBOS (or IPs if directly provided), followed by transportation and refreshments, then supplies and accommodation/per diem—these primarily related to development of savings and loan groups and HES-focused training activities. For four CBOS, accommodation and per diem expenditures ranked the highest expenditures.
- In early review of the 2016 Expenditure Analysis, a large IP noted that HES expenditures are likely to be higher in rural project areas, e.g. more expensive inputs to improve agriculture-related livelihoods and the greater uptake/popularity of savings and loan groups in rural as compared to urban communities. The costing study did not find discernable difference between rural and urban specifically
- All IPs noted that HES expenditures were higher in “sustained” LGAs with the emphasis on graduating OVC households. The costing study was not able to verify this as expenditures were not segmented according to LGA.

**PSS-Specific**
- Most frequently reported cost drivers were transportation, refreshments followed by supplies/materials, training supplies.
- No regional differences were noted, though a CBO in Lagos had higher expenditures compared to other IPs—costs were related to refreshments for kids and adolescent girls clubs and caregiver activities.

**Child, legal and social protection-specific**
- All reported IPs developing local child protection mechanisms.
- The major cost drivers for protection (child, legal and social) were meeting expenses, e.g. refreshments and transportation (personnel). Accommodation and cost of supplies or training materials were mentioned but less common. No regional differences were noted.

**“Cross-cutting” expenditures**
In collecting and analyzing expenditure data, the following were noted as cross cutting expenditures: a) Transportation and refreshment for advocacy and penetration of communities; b) Transportation for monitoring and supervisory visits; c) Step down integrated OVC training for CVs (transportation, refreshment, accommodation and training materials); and d) Transportation costs for recruitment and monthly meetings with CVs.

Common interventions were reported relating to the strengthening of the case management processes during this study year aided by guidelines developed by the PEPFAR-funded 4Children project. With the review of the 2016 Expenditure, there was a wide variation in proportion of funds assigned to Case Management. Early discussions found a lack of definition and consensus as to what interventions should be included as specific to case management. In discussions with IPs and CBOS, they indicated contextual factors discussed under study question four—relating to community entry, engagement, network development, identification, assessment and enrollment of OVC and their HHs, and the initial care planning. IPs and CBOs interviewed or surveyed noted disparity of salaries and volunteer stipends. In follow-up interviews with CBOs representing 8 of the IPs, key findings were: during the study year, the

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25 Water and sanitation as contextual factors were not noted by IPs/CBOS—but this may be an indication that this does drive costs in specific areas.
community volunteer home visitors had similar assigned tasks but stipends varied from 3500 to 15,000 Naira/month and with some CBOs also providing transport payments for escort services or to attend the monthly review meetings. With CBOS who are funded by more than one IP, the discrepancy of salaries for staff and volunteers assigned to the specific projects, e.g. SMILE, SUSTAIN, or STEER creates significant discord and dissatisfaction.
ANNEX 4. DISCLOSURE OF ANY CONFLICT OF INTEREST

GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT PROJECT

USAID NON-DISCLOSURE AND CONFLICTS AGREEMENT

USAID Non-Disclosure and Conflicts Agreement- Global Health Program Cycle Improvement Project

As used in this Agreement, Sensitive Data is marked or unmarked, oral, written or in any other form, "sensitive but unclassified information," procurement sensitive and source selection information, and information such as medical, personnel, financial, investigatory, visa, law enforcement, or other information which, if released, could result in harm or unfair treatment to an individual or group, or could have a negative impact upon foreign policy or relations, or USAID’s mission.

Intending to be legally bound, I hereby accept the obligations contained in this Agreement in consideration of my being granted access to Sensitive Data, and specifically I understand and acknowledge that:

1. I have been given access to USAID Sensitive Data to facilitate the performance of duties assigned to me for compensation, monetary or otherwise. By being granted access to such Sensitive Data, special confidence and trust has been placed in me by the United States Government, and as such it is my responsibility to safeguard Sensitive Data disclosed to me, and to refrain from disclosing Sensitive Data to persons not requiring access for performance of official USAID duties.

2. Before disclosing Sensitive Data, I must determine the recipient’s “need to know” or “need to access” Sensitive Data for USAID purposes.

3. I agree to abide in all respects by 41, U.S.C. 2101 - 2107. The Procurement Integrity Act, and specifically agree not to disclose source selection information or contractor bid proposal information to any person or entity not authorized by agency regulations to receive such information.

4. I have reviewed my employment (past, present and under consideration) and financial interests, as well as those of my household family members, and certify that, to the best of my knowledge and belief, I have no actual or potential conflict of interest that could diminish my capacity to perform my assigned duties in an impartial and objective manner.

5. Any breach of this Agreement may result in the termination of my access to Sensitive Data, which, if such termination effectively negates my ability to perform my assigned duties, may lead to the termination of my employment or other relationships with the Departments or Agencies that granted my access.

6. I will not use Sensitive Data, while working at USAID or thereafter, for personal gain or detrimentally to USAID, or disclose or make available all or any part of the Sensitive Data to any person, firm, corporation, association, or any other entity for any reason or purpose whatsoever, directly or indirectly, except as may be required for the benefit USAID.

7. Misuse of government Sensitive Data could constitute a violation, or violations, of United States criminal law, and Federally-affiliated workers (including some contract employees) who violate privacy safeguards may be subject to disciplinary actions, a fine of up to $5,000, or both. In particular, U.S. criminal law (18 USC § 1905) protects confidential information from unauthorized disclosure by government employees. There is also an exemption from the Freedom of Information Act (FOIA) protecting such information from disclosure to the public. Finally, the ethical standards that bind each government employee also prohibit unauthorized disclosure (5 CFR 2635.703).

8. All Sensitive Data to which I have access or may obtain access by signing this Agreement is now and will remain the property of, or under the control of, the United States Government. I agree that I must return all Sensitive Data which has or may come into my possession (a) upon demand by an authorized representative of the United States Government; (b) upon the conclusion of my employment or other relationship with the Department or Agency that last granted me access to
GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT
PROJECT

Sensitive Data; or (c) upon the conclusion of my employment or other relationship that requires access to Sensitive Data.

9. Notwithstanding the foregoing, I shall not be restricted from disclosing or using Sensitive Data that:
   (i) is or becomes generally available to the public other than as a result of an unauthorized disclosure by me; (ii) becomes available to me in a manner that is not in contravention of applicable law; or (iii) is required to be disclosed by law, court order, or other legal process.

ACCEPTANCE

The undersigned accepts the terms and conditions of this Agreement.

Signature Date

Dr Nkata N. Chuku

Name Title

16.12.2017
GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT
PROJECT

Sensitive Data; or (e) upon the conclusion of my employment or other relationship that requires
access to Sensitive Data.

9. Notwithstanding the foregoing, I shall not be restricted from disclosing or using Sensitive Data that:
(i) is or becomes generally available to the public other than as a result of an unauthorized disclosure
by me; (ii) becomes available to me in a manner that is not in contravention of applicable law; or (iii)
is required to be disclosed by law, court order, or other legal process.

ACCEPTANCE
The undersigned accepts the terms and conditions of this Agreement.

Beverly Stauffer

Signature

Date

02/21/17

Name

Title
GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT
PROJECT

Sensitive Data; or (c) upon the conclusion of my employment or other relationship that requires
access to Sensitive Data.

9. Notwithstanding the foregoing, I shall not be restricted from disclosing or using Sensitive Data that:
(i) is or becomes generally available to the public other than as a result of an unauthorized disclosure
by me; (ii) becomes available to me in a manner that is not in contravention of applicable law; or (iii)
is required to be disclosed by law, court order, or other legal process.

ACCEPTANCE
The undersigned accepts the terms and conditions of this Agreement.

Signature

Date 3/31/2017

Name Adeyemo Oluwatson Adeolu

Title Dr
GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT
PROJECT

Sensitive Data; or (e) upon the conclusion of my employment or other relationship that requires
access to Sensitive Data.
9. Notwithstanding the foregoing, I shall not be restricted from disclosing or using Sensitive Data that:
(i) is or becomes generally available to the public other than as a result of an unauthorized disclosure
by me; (ii) becomes available to me in a manner that is not in contravention of applicable law; or (iii)
is required to be disclosed by law, court order, or other legal process.

ACCEPTANCE
The undersigned accepts the terms and conditions of this Agreement.

Signature

Date

Name

Title

3/24/2017

Mr.
GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT PROJECT

Sensitive Data; or (c) upon the conclusion of my employment or other relationship that requires access to Sensitive Data.

9. Notwithstanding the foregoing, I shall not be restricted from disclosing or using Sensitive Data that: (i) is or becomes generally available to the public other than as a result of an unauthorized disclosure by me; (ii) becomes available to me in a manner that is not in contravention of applicable law; or (iii) is required to be disclosed by law, court order, or other legal process.

ACCEPTANCE
The undersigned accepts the terms and conditions of this Agreement.

[Signature] 03/01/2017
Signature Date

[Name] Title

Danladi Eriza Sarki Ms
GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT PROJECT

Sensitive Data; or (c) upon the conclusion of my employment or other relationship that requires access to Sensitive Data.

9. Notwithstanding the foregoing, I shall not be restricted from disclosing or using Sensitive Data that: (i) is or becomes generally available to the public other than as a result of an unauthorized disclosure by me; (ii) becomes available to me in a manner that is not in contravention of applicable law; or (iii) is required to be disclosed by law, court order, or other legal process.

ACCEPTANCE
The undersigned accepts the terms and conditions of this Agreement.

__________________________  ________________________
Signature                  Date

March 7, 2017

__________________________  ________________
Name        Title
Tahirah Ikharo      Ms.
Sensitive Data; or (c) upon the conclusion of my employment or other relationship that requires access to Sensitive Data.

9. Notwithstanding the foregoing, I shall not be restricted from disclosing or using Sensitive Data that: (i) is or becomes generally available to the public other than as a result of an unauthorized disclosure by me; (ii) becomes available to me in a manner that is not in contravention of applicable law; or (iii) is required to be disclosed by law, court order, or other legal process.

ACCEPTANCE
The undersigned accepts the terms and conditions of this Agreement.

Signature

Date 31/03/2017

Name DR. OGBODU, Samuel Onyema

Title Medical Doctor/ Data Collector, GHT, PEPFAR

Dexis Consulting Group
GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT PROJECT

Sensitive Data; or (c) upon the conclusion of my employment or other relationship that requires access to Sensitive Data.

9. Notwithstanding the foregoing, I shall not be restricted from disclosing or using Sensitive Data that: (i) is or becomes generally available to the public other than as a result of an unauthorized disclosure by me; (ii) becomes available to me in a manner that is not in contravention of applicable law; or (iii) is required to be disclosed by law, court order, or other legal process.

ACCEPTANCE
The undersigned accepts the terms and conditions of this Agreement.

Signature  

Date  

Name  

Title  

01/04/17

Lecky Salzman  

Mr.
ANNEX 5. SUMMARY BIOS OF EVALUATION TEAM MEMBERS

**Nkata Chuku**, Evaluation Team Leader and Costing Specialist. A medical doctor and health systems strengthening specialist with expertise in cost effectiveness analysis, Dr. Chuku served on FHI 360's senior management team and is the founder of a development sector consultancy firm.

**Goddy Akhaluola**, Data Collector. A professional accountant with more than 17 years’ experience. Mr. Akhaluola has extensive experience managing development project finances for a number of international NGOs.

**Oluwatosin Adeyemo**, Data Collector. A qualified physician and public health professional who has managed projects and implemented M&E systems.

**Erisa Danladi**, Qualitative Study Analyst. Holds a Master’s in Dramatic Literature and Criticism, and a Bachelor’s in Theater Arts.

**Olufunke Falade**, Costing Associate. An accomplished management consultant and a Certified Project Management Professional.

**Tahirah Ikharo**, Logistics Coordinator. A trained communications specialist and program manager.

**Samuel Ogboo**, Data Collector. A medical doctor who has participated in several research projects with different organizations in Nigeria.

**Lecky Seluman**, Data Collector. Experienced with Finance and Administration, which he has applied to work with international development organizations in Nigeria.

**Beverly Stauffer**, OVC Specialist. Public health specialist focusing on monitoring and evaluation. Ms. Stauffer has an extensive international resumé with work focusing on PEPFAR and orphans and vulnerable children, and has consulted for multiple GH Pro assignments.
For more information, please visit
http://ghpro.dexisonline.com/reports-publications