

Concern Worldwide Rwanda

TUBUNGANIRE

HIV and AIDS CAPACITY BUILDING PROJECT

In

Districts of Gakenke (Northern Province), Huye & Nyaruguru (Southern Province), Rwanda

End of Programme Evaluation

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Acronyms

AAC	Anti-Aids Clubs
AIDS	Acquired Immune Deficiency Syndrome
ANC	antenatal clinics
ARBEF	Association Rwandaise pour le Bien Etre Familial
ART	Antiretroviral Therapy
ARV	Antiretroviral
CDLS	District AIDS Commission
CHW	Community Health Worker
CNLS	National AIDS Commission
CS	Civil Society
CWW	Concern Worldwide
DED	German Development Service
DHS	Demographic and Health Survey
FIM	Food Incomes and Markets
HBC	Home Based Care volunteers
HC	Health Centre
HAP	Humanitarian Accountability Partnership
HIV	Human immunodeficiency virus
IGA	Income Generating Activity
M&E	Monitoring and Evaluation
MTR	mid-term review
NGO	Non-governmental organisation
NSP	National Strategic Plan
OVC	Orphans and Vulnerable Children
P4	programme participant protection policy
PAM	Programme Alimentaire Mondial (World Food Programme)
PE	Peer Educators
PLHIV	people living with HIV
PM&E	Planning, monitoring and evaluation
PMTCT	Prevention of Mother to Child Transmission
RDHS	Rwanda Demographic and Health Survey
STD	Sexually Transmitted Disease
UNGASS	United Nations General Assembly 26th Special Session
USD	United States Dollar
VCT	Voluntary Counselling and Testing

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Executive summary

Introduction

Tubunganire ('working together') was a four year HIV and AIDS capacity building project working in 8 sectors spread across 3 of the 30 districts in Rwanda which ended in December 2010. Concern Rwanda's main partner was the Association Rwandaise pour le Bien Etre Familial (ARBEF) though in Nyaruguru the programme also worked for a short period with IVPF. It targeted people living with HIV (PLHIV), orphans, unmarried mothers and widows, as the direct beneficiary group with the whole population of programme areas as indirect beneficiaries.

The goal was to reduce the transmission of HIV and minimise the socio-economic impact of AIDS among 3 targeted communities in the Northern and Southern Provinces of Rwanda. The purpose was to strengthen the capacity of NGO partners and local authorities in order to optimise the utilisation of HIV and AIDS-prevention services and to fight against HIV and AIDS-related stigma and discrimination. There were three outputs: 1) Technical and institutional capacity of NGO partners strengthened in the provision of HIV and AIDS preventative services; 2) AIDS Commissions (CDLS) in 3 Districts strengthened in the planning and monitoring of HIV and AIDS related activities; and, 3) HIV and AIDS infected and affected groups empowered to challenge stigma and discrimination through relevant, community-based social and economic support mechanisms.

This review was carried out over a two week period in July-August 2011 by a team consisting of staff from ARBEF and Concern Rwanda led by an external consultant. The review faced a number of challenges including changes to the programme approach that were not fully reflected in the programme documentation and logframe, a lack of substantive quantitative data, and not being able to collect data on trends from CDLS within the timescale. A decision was therefore made, in consultation with Concern Rwanda, to focus on learning lessons and drawing conclusions from the data that was possible to collect within these constraints.

The programme has concentrated on setting up cell level structures to support HIV&AIDS prevention and care. There are 3 kinds: Anti-Aids Clubs (AAC) which raise awareness about HIV&AIDS and carry out sensitisation and mobilisation activities; Peer Educators (PE) selected from the direct beneficiary group to visit nearby households for interpersonal communication on prevention and care, as well as condom distribution; and, Home Based Care volunteers (HBC), again selected from the direct beneficiary group to support PLHIV, particularly those that are bedridden. A total of 3383 people were directly involved in these community level structures. In addition the programme carried out mobile VCT in collaboration with sector level health centres. The programme operationalises the GIPA principle through inviting PLHIV to take leading roles in the community response to HIV&AIDS.

Key findings

This evaluation concluded that the programme was relevant in that it did address issues identified in the baseline such as lack of knowledge on HIV&AIDS, high levels of stigma, weak community support structures, lack of uptake of services and risky behaviours. It was also aligned to Rwanda's National HIV&AIDS Strategic Plan 2005-9, though it wasn't revised to bring it in line with some elements of the new National Plan introduced in 2009. The programme also followed the principle of the 'Three Ones.

All anti-aids clubs visited were still active and most were judged to be likely to continue in the medium to long term. Members in the active clubs showed good basic knowledge on HIV&AIDS which they shared more widely in the community. Being part of the group and having a recognised public role, had considerable effect in developing solidarity, confidence and status of members from all four targeted groups, not just PLHIV. However clubs faced a number of challenges including accessing updated information and weak linkages with the health centre and sector level social affairs. Some had lost members since the programme stopped suggesting a certain lack of ownership of the club and its objectives.

All peer educators visited were still active and it appeared likely that they would continue operating in the medium to long term. Volunteers enjoyed helping others and appeared to be successfully reaching their peer groups with advice and support. They faced similar challenges to the AAC, though for them updated information is more critical. In particular they faced challenges in reaching out to men, and consistent access to condoms.

All of the HBC volunteers visited were still active and bedridden PLHIV were being visited on a regular basis, encouraged to go for testing and to adhere to taking their ARV. Some HBC volunteers had trained additional volunteers, a positive sign for sustainability. HBC volunteers also struggled with links to local government and health centres not always being defined or strong, and as a result also lacked access to updated information, particularly on possible side effects of ARVs. Being HBC volunteers has given them a social purpose and status in the community, but as wider support is quite weak, the burden is in many cases falling mainly on those who are already vulnerable. Poverty of PLHIV remained a key challenge meaning they are not always able to put into practice what they know about positive living or prevention of transmission.

Less progress can be seen against outputs 1 and 2 which received less emphasis. ARBEF has developed capacity in some specific areas through the programme and used this experience to inform new work. In its first two years the programme contributed to Gakenke CDLS's bottom up development of its strategic plan and supported CDLS them to initiate a Joint Action Forum on the HIV and AIDS response at both District level and in the 3 sectors where the programme was working. In the last two years the programme has met its obligations in terms of reporting to and coordinating with the CDLS in each district, but has not gone beyond this to influence the CDLS or to develop its capacity in any significant way.

There is considerable anecdotal evidence of significant reduction in stigma in the programme areas, though how much of this is attributable to the programme was impossible to assess in such a short time in the field. Key areas of change include: people are more willing to visit PLHIV; mixed groups of PLHIV and others work together; there are less judgemental attitudes towards PLHIV; there is less family conflict as a result of members knowing their status; and PLHIV are willing to give testimony in public, and some have achieved public standing in the community.

There was also considerable anecdotal evidence from both community leaders and club members that they were seeing some change in behaviour, such as increased uptake of VCT and use of condoms. Quantitative data tends to support to uptake of VCT, however challenges remain. Furthermore whether mobile VCT has a long term effect in encouraging utilisation in areas where it is not possible to access VCT at the local health centre has to be questioned. Access to condoms remains a serious challenge. The programme distributed them directly via peer educators with the supply increasing from 2007 to 2009, but being massively curtailed in 2010 to encourage people to get their condoms from sources that

would continue post programme. The information collected suggests that for this strategy to have been effective, more emphasis on links to providers would have been required. Consistent anecdotal evidence suggests that though some people would make the effort to get condoms on a regular basis from either the health centre or through purchase, the effort required would put many off, in particular unmarried women. Our findings suggest that condom use in the programme areas has increased, but remains sporadic at best.

Minimising the socio-economic impact of AIDS happened via three routes: referral of 287 PLHIV to Concern's Food Incomes and Markets programme where beneficiaries were reported to increase their average monthly income by 60-100%; communal work, income generating activities and savings initiated by the community structures set up by the programme; and support of goods or labour for up to 929 PLHIV per year by the AAC and HBC. This help, though limited in scale, clearly made an immense difference for some people.

The programme spent a total of Euro 745,107 over the period 2007-10 with direct expenditure taking 44.3% of this. Spending peaked in 2008 and by 2010 had fallen considerably. Cost per direct beneficiary (ie members of AAC, HBC volunteers or PE) was a total of 220 Euro over the 4 years, an average of 55 Euro per year. Cost per indirect beneficiaries (i.e. those reached with sensitisation and prevention messages) averaged out at 1.16 Euro per year in Huye which is broadly comparable to the cost per head of overall prevention programmes in Rwanda.

Conclusions and lessons

Overall there is anecdotal evidence to suggest that within programme areas there has been considerable progress against a number of issues identified in the baseline. The extent to which this is attributable to *Tubunganire* is challenging to assess as there are many other sources of information on HIV&AIDS within Rwanda, however a case can be made that the programme has contributed to positive shifts in: knowledge on HIV&AIDS; reduction in levels of stigma; community support structures; reduction in risky behaviours; and, demand for VCT. However none of these can be considered sustainable in the long run unless there are systems in place to give information and support on an ongoing basis.

Sustainability and linkages

The community level structures worked best where there were strong links with, and good leadership from, local leaders who showed an interest in what they were doing. It would be possible to plan this more systematically.

HIV&AIDS programme need to be designed from the start with exit strategies in mind and focused more on the need for support and prevention services to be provided in a continuous manner. It is important that local ownership and partnership with health structures is planned from the start and built in throughout the programme cycle.

This may include an advocacy element, which was missing in *Tubunganire*, to collate evidence on challenges in access and provision of services while supplying them in the short term. To do this it should be possible to make more use of the complementarity of skill sets and experiences that Concern Rwanda and partners have, for example ARBEF's strength in service delivery, combined with Concern's access to networks and potential for influence at district/hospital level.

Ensuring clubs stay focused on task

There can be some conflict of interest between groups focused on group activities such as savings and IGA and benefits for their members, and those looking outwards to provide a service or benefit to the community. Whilst there must be benefits to members, or they will not remain involved, it is important that the balance doesn't tip over so that the group's primary purpose becomes about income generation rather than HIV&AIDS prevention and support. This may mean further orientation, or bye-laws within clubs to ensure that the club is clear about, and stays focused on, its primary purpose. Strong links to eg the local health centre can help reinforce this.

Targeting

The programme successfully targeted groups who were particularly vulnerable to the impact of HIV and potentially vulnerable to becoming infected i.e. orphans, widows, unmarried mothers and PLHIV, the majority of whom are women. This evaluation shows that there are benefits for marginalised women in terms of recognition and status in the community from their membership of self-help groups. It should be possible to build on this, whilst spreading the burden more equitably within the community by working to develop stronger wider support links for the community structures set up by the programme.

Furthermore, because of the way targeting was done the programme faced challenges in reaching other groups. Consistent feedback suggested that men were not being reached and were less likely than women to either take preventive measures, seek VCT, be open about their status, or seek care unless they were very ill.

Monitoring and evaluation

The programme collected basic quantitative data and had developed, but not really used, a more comprehensive monitoring framework towards the end of the programme. Monitoring and evaluation needs to be an integral part of the programme from the outset. Where possible indicators should align with data already being collected by the government to make it possible and economic to collect. It is important to find appropriate methods for assessing and understanding behaviour change, and should be possible to identify and collect some local health statistics that can act as a proxy for changes in sexual attitudes and behaviour. These should be collected on an on-going basis to track trends over time and help inform decision making, ideally in collaboration with local leaders so they are empowered to track the progress of sensitisation and prevention work in their communities.

It is important that monitoring and evaluation processes also allow for programme design to adapt both as a result of how work is going on the ground and taking into account the emerging picture of HIV&AIDS in Rwanda as new data and approaches become available and best practice evolves.

Feedback mechanisms and protecting participants

There were no clear complaints mechanisms in programme areas. At the very least programme participants should be given a printed paper with basic information about what they can expect from the programme and a telephone number they can call in confidence if they have any concerns. This should be re-iterated verbally on a regular basis. The issue is a clear example of the importance of implementation of the various Humanitarian Accountability Partnership mechanisms to which Concern is committed and which Concern Rwanda now has clear plans to roll out.

Working in partnership

Concern staff have faced some challenges in adapting from their traditional experience as direct implementers to working in partnership where their role changes to being one of mentoring, guiding and advising partners. Part of successfully working in partnership is systematically considering and building strategies that build on the specific strengths of different organisations. Concern Rwanda needs to work with staff to develop the understanding and skills to see their role more broadly. This would include keeping abreast of debates and innovations within their field of expertise, building strong links and relationships with institutions like CDLS, and generating robust evidence to leverage broader influence at both programme and national level.

1. Introduction

Tubunganire ('working together') was a four year HIV and AIDS capacity building project working in 8 sectors spread across 3 of the 30 districts in Rwanda. The programme started in 2006 with partner identification and selection, then programme work started in Huye (Southern Province) and Gakenke (Northern Province) in 2007 and in Nyurunguru (Southern Province) in 2008. A joint baseline was carried out for the Food Incomes and Markets (FIM) programme and HIV&AIDS programme in 2007 and a mid-term review (MTR) for the HIV&AIDS programme in 2008. The programme ended in December 2010. The main partner within the programme Concern was the Association Rwandaise pour le Bien Etre Familial (ARBEF) though in Nyaruguru it also worked for a short period with IVPF.

The **project goal** was to reduce the transmission of HIV and minimise the socio-economic impact of AIDS among 3 targeted communities in the Northern and Southern Provinces of Rwanda. The **purpose** was to strengthen the capacity of NGO partners and local authorities in order to optimise the utilisation of HIV and AIDS-prevention services and to fight against HIV and AIDS- related stigma and discrimination. There were three outputs as follows:

Output one: Technical and institutional capacity of NGO partners strengthened in the provision of HIV and AIDS preventative services.

Output two: AIDS Commissions (CDLS) in 3 Districts strengthened in the planning and monitoring of HIV and AIDS related activities.

Output three: HIV and AIDS infected and affected groups empowered to challenge stigma and discrimination through relevant, community-based social and economic support mechanisms.

The programme was targeted on people living with HIV (PLHIV), orphans, unmarried mothers and widows, as the direct beneficiary group as these were seen as the most vulnerable to the impact of HIV&AIDS. The whole population of the 8 programme sectors were indirect beneficiaries.

2. Background

Demography and vulnerability

Rwanda is a small, densely populated, landlocked African country, bordered by Burundi, the Democratic Republic of Congo, Tanzania, and Uganda. The population of approximately 9 million is relatively young with 43.5% of the entire population under 15 years old and 55.2% in the 15-49 year age bracket. Rwanda has one of the highest fertility rates in sub-Saharan Africa, with 6.1 children per woman¹.

Rwanda's gross domestic product (GDP) per capita was US\$ 272 in 2009; 57% of the population lives below the national poverty line and 37% live in extreme poverty².

Vulnerable households (headed by women, widows and children) represented 43% of all households in 2006 (against 51% in 2001) and were concentrated in rural areas. Poverty

¹ Rwanda National Strategic Plan on HIV and AIDS, 2009-2012

² Rwanda National Strategic Plan on HIV and AIDS, 2009-2012

among vulnerable households is around 60%³. Women have access to less land, less time available for labour and fewer employment opportunities than men⁴.

HIV&AIDS Situation

HIV prevalence surveillance in antenatal clinics (ANC) has been carried out since 1988. The RDHS survey of 2005 survey found HIV prevalence of 3.0% in the general population aged 15 - 49. The total estimated number of people living with HIV in Rwanda was about 169,200 in 2009, including about 22,200 children⁵. The estimate for ANC 2007 was higher than that for ANC 2005 (4.3% compared to 4.1%), showing no improvement in the situation during this period. There was low HIV prevalence among young people aged 15-24 compared to the general population. However, young women are far more often infected than men by HIV: respectively 3.9% versus 1.1% in urban areas and 1% versus 0.3% in rural areas⁶.

Women are disproportionately affected by HIV infection. In addition HIV positive women are more likely to be in extreme poverty than HIV positive men (50.2% live on less than 1US\$ a day compared to 38.6% of PLHIV men); and the proportion of HIV positive people who have not had any formal education is also higher among women (18.5%) than men (12.2%). Around 20% of people living with HIV of either sex are unemployed and not working at all⁷.

According to the ANC data from 2007, HIV prevalence is much lower for married women (2.5%) than for separated (14.6%), widowed (9.7%), single (6.8%), divorced (6.4%), and cohabiting (5.9%) women. The pattern for women in the DHS survey is similar, although in the case of that survey HIV prevalence was higher among widows than separated or divorced women⁸.

Behavioural studies show a mixed picture, with different sources showing very different results in terms of reported knowledge, condom use, and partner exchange rates. According to UNGASS, young people in general cannot be considered a risk group, though many infections do occur in this age group⁹. According to the 2010 RDHS data on national transmission knowledge and behaviours virtually all women and men in Rwanda say that they have heard of HIV&AIDS with knowledge not varying by background characteristics. As HIV prevention initiatives in Rwanda focus on faithfulness (having only one sexual partner) and condom use it asked a series of questions with regards to these behaviours and found:

Less than one percent of women (0.6 percent) and only 4 percent of men age 15-49 say that they had 2 or more sexual partners in the past 12 months prior to the interview. The proportion of women with 2 or more sexual partners in the past 12 months is higher among women who have no education (0.9 percent), live in urban areas (1.1 percent) and Kigali City (1.2 percent), and are divorced, separated or widowed (2.0 percent). Similarly, the proportion of men with 2 or more sexual partners in the past 12 months is higher among men who live in urban areas (5.6 percent) and in Kigali City (5.8 percent) and the West province (5.2 percent), and are divorced, separated or widowed (10.6 percent). The proportion of men with 2 or more sexual partners in the past 12 months varies little by level of education. More

³ UNGASS date

⁴ Concern Rwanda country strategy 2006-10

⁵ EPP/Spectrum national estimates, 2010

⁶ UNGASS date

⁷ Rwanda Stigma Index Survey, Preliminary Data (2008) cited in NSP 2009-12

⁸ The Data Synthesis (or Triangulation) project, TRACPlus (2008)

⁹ UNGASS date

men age 25 or older have 2 or more sexual partners than those age 15-24. Even though an overwhelming majority of women and men say that the risk of getting the AIDS virus can be reduced by using condoms every time they have sexual intercourse, only 29 percent of women and 28 percent of men reported using a condom during their last sexual intercourse.
(DHS 2010 p.26-29)

According to a 2008 study¹⁰ cited in NSP 2009-12 over 40% of people living with HIV had been excluded from a social gathering in the past year, over 50% had been insulted or threatened, and over 20% had been physically assaulted. In all cases women living with HIV were more affected than men. In each case, HIV status was perceived as being the cause of discrimination or abuse by the majority of respondents. In addition, 24% of respondents reported that their HIV status had caused their family to be discriminated against.

The Rwandan National Strategic Plan on HIV&AIDS 2009-12 suggests that 2.2% of heterosexual couples are HIV sero-discordant (around 60,000 couples), putting the HIV-negative members of these discordant couples at high risk for HIV infection. It comments that very few programs exist that aim to identify and work with discordant couples for HIV prevention and predicts that new infections will most likely be related to low condom use among steady sero-discordant couples

Another group that is often marginalized and underserved by HIV prevention programs is people living with disabilities, which is a large population in Rwanda, estimated at about 5.02% of the general population¹¹.

Many households, particularly the most vulnerable, have experienced labour constraints due to the effects of HIV and AIDS. They may also have sold off livestock and other assets to cope with the mounting expenses associated with caring for chronically ill household members, and may face challenges in ensuring adequate nutrition for those infected by HIV and AIDS¹².

There are about 1,350,800 orphans and vulnerable children in Rwanda between the ages of 0 and 17. It is estimated that AIDS accounts for nearly a fifth of these: the number of children (0-14 years old) having lost one or both parents because of HIV was estimated to be about 203,000 in 2008¹³.

Government Response

The percentage of the total government budget spent in the health sector increased from 8.2% to 9.1% in 2006-2007, an increase of US\$ 6 to US\$ 11 for total health spending per capita.¹⁴

The Government of Rwanda has shown strong commitment to addressing HIV and AIDS and its consequences. Among adults (15+ years old), about 75,000 were estimated in need of ART in 2008, and more than 57,000 (76%) received treatment¹⁵. This compares to 40 000

¹⁰ Rwanda Stigma Index Survey, Preliminary Data (2008)

¹¹ Draft Report of the Government of Rwanda in Collaboration with the African Decade of Persons with Disabilities, cited in <http://www.msc.st/docs/HRBA-Disability-Rwanda-revised-2011-01-30.doc>

¹² Concern Rwanda country strategy 2006-10

¹³ Rwanda National Strategic Plan on HIV and AIDS, 2009-2012

¹⁴ Rwanda National Strategic Plan on HIV and AIDS, 2009-2012

¹⁵ Rwanda National Strategic Plan on HIV and AIDS, 2009-2012

people receiving it in 2006, some 50% of those needing it, which was also up from only 8000 receiving it in 2005¹⁶. The number of patients lost to follow up stayed about constant: 5% in 2005 and 7% in August 2008. Moreover there was significant reduction in the real cost of accessing ARV services by PLWHA with the introduction of Mutuelles de Santé covering for ARV treatment. Opportunistic Infection treatment was included into other services packages offered by community based health insurance.

The number of centres for testing and treatment (ART and also PMTCT) increased significantly between 2001 and 2006 from 11 to 234 and 4 to 138 respectively¹⁷. In 2008 56% of HIV-positive pregnant women received a prophylaxis regimen. It is estimated that 11% of infants born to HIV positive mothers are HIV infected¹⁸.

Coordination of response

Rwanda adheres to the “Three Ones” principles: the existence of one national coordinating body, one strategic national plan of action and one national monitoring and evaluation framework.

In January 2006 as part of the ongoing decentralisation policy which commenced in 2001, the Rwandan Government changed the territorial administration structures. Thus the current District and Sectoral administration was still relatively new at the time of *Tubunganire* starting. The coordination of all HIV and AIDS-related activities is the responsibility of the National AIDS Commission (CNLS). Under the AIDS Commission all stakeholders are organised into umbrella organisations and clusters to facilitate collaboration and coordination: NGOs, PLWHA, Public Sector, Private Sector and Donors. The CNLS has branches in all 30 Districts (CDLS). One appointed staff member acts as a technical assistant in charge of coordination, planning and monitoring HIV and AIDS activities. There is also a steering committee consisting of 7 members headed by the District Mayor, as well as a technical committee. Every year, the CDLS facilitate a participatory process to develop an Annual Action Plan for their districts including planned activities, performance indicators, annual targets, and a budget for HIV-related activities that will be implemented over the course of the year.

According to the national response strategy, despite the national-level activities put in place for data and information dissemination, districts report limited access to information and very rarely, if ever, use the information available to inform planning and decision making;

The programme area

Wide availability of HIV&AIDS services are evident in the programme area, where all 8 sectors have health centres, all but one (built in 2009) predating the programme. Only two, both in Huye, do not yet have HIV&AIDS services (VCT, PMTCT, ARV), but one of these expects to have these by the end of 2012.

According to UNGASS North Province has relatively low HIV prevalence, but in most ANC sites it is increasing. Risk behaviours such as multiple sex partners are relatively low, but usage of services like testing and condoms are low in most locations. Although many sites are isolated, it is considered that rapid urbanization in this province may explain increasing HIV prevalence¹⁹. South Province has low overall HIV prevalence, though once again the ANC

¹⁶ Concern Rwanda country strategy 2006-10

¹⁷ Concern Rwanda country strategy 2006-10

¹⁸ Rwanda National Strategic Plan on HIV and AIDS, 2009-2012

¹⁹ Rwanda National Strategic Plan on HIV and AIDS, 2009-2012

2007 study indicated recent increases. The presence of the National University of Rwanda in the province, as well as the existence of transport routes, seasonal workers and commercial centers, may be the key factors contributing to the epidemic in the province²⁰.

Total expenditure on HIV and AIDS in Rwanda increased by about 33% from USD 74.6 million in 2007 to USD 110.8 million in 2008 (see Table 1). Expenditures on care and treatment rose from US\$ 27 million in 2007 to 44 US\$ million in 2008 with the largest portion of the funds directed towards to hospital care, ARVs and nutritional support associated to ARV therapy. However the 2009-12 National Plan for response to the epidemic faced some financing shortfalls at the time of publication.

Table 1: Breakdown by AIDS Spending Categories in Rwanda for the period 2006 – 2008 (US\$)²¹

Spending category	2006	2007	2008	% variation from 2007 to 2008
Prevention programmes	20,878,368	17,115,251	29,308,085	+42%
Care and treatment component	27,142,088	27,793,912	44,670,057	+38%
Programme management and administration strengthening	25,828,454	10,790,812	13,272,550	+19%
Incentives for human resources	416,132	5,839,282	4,915,545	-19%
Social protection and social services excluding OVC	5,634,419	579,841	1,283,576	+55%
Orphans and vulnerable children	7,033,937	9,358,637	12,850,247	+27%
Enabling environment and community development	196,058	2,310,109	2,868,683	+19%
HIV and AIDS related research	485,344	777,094	1,642,853	+53%
Total	87,573,532	74,564,938	110,811,596	+33%

3. Methodology

The review team consisted of an external consultant, Jennifer Chapman, who was joined by Gregoire Gabiro, David Mudagu and Sudi Iyamuremye of ARBEF and Therese Nyiransengimana of Concern Worldwide Rwanda. The team worked together to develop the key questions for the review and plan and carry out the field work over a period of two weeks.

The methodology of the review included:

- Review of key documentation available in English
- Developing key questions
- Interviews and discussions with staff in Concern Worldwide Rwanda
- Interviews with ARBEF staff
- Interviews with CDLS at the district level
- Field visits to 10 sampled cells covered by the programme, where focus group discussions were held with Anti-Aids Clubs, Peer Educators, and Home Based Care providers/*comite de soutien*.
- Interviews with Health Centre staff and local leaders at sector and cell level, both in the programme area and in a non-programme sector
- Collection of quantitative data
- Team analysis workshop
- Literature review
- Review of financial data

²⁰ UNGASS Rwanda Report 2010

²¹ Rwanda National Strategic Plan on HIV and AIDS, 2009-2012

- Review of monitoring data

A full list of those interviewed and the field work undertaken can be found in Appendix 1.

The review was challenging for a number of reasons. There were a number of changes to the programme after the MTR that have not been reflected in the programme documents or the logframe. The emphasis on one out of the three components of the original design as described in the next section, means it was not possible to evaluate the overarching goal to which all 3 components should have been contributing in the usual output to purpose to goal rationale. While action plans and partnership agreements reflected the recognition at management level that the programme was being redirected in light of financial changes and internal capacity, in future, consideration should also be given to amending broader programme frameworks. It would also be worthwhile in programme design and through the programme cycle to include opportunity to review indicators – more on the programme M&E plan and implementation will be discussed later.

The evaluation also faced a lack of substantive quantitative data. While the programme did undertake a baseline study in two of the three Districts and there was a clear reporting structure with certain output level indicators regularly documented (e.g. number of people tested or trained) and annual reviews were conducted, the M&E system was not as rigorous as it might have been to allow the collection and analysis of robust outcome and impact level data. While attempts were made to improve on the routine data collection through application of the Concern PM&E guidelines developed midway through the programme, staff report that this faced challenges linked to partner capacity and motivation to apply a new tool midway through implementation. As the programme did not conduct an end of programme survey due to resource limitations, this evaluation has to rely on existing data supplemented by what we could collect through the field work we were able to undertake in the limited time available. As the programme was operational at Sector level we have tried to find data at two levels:

- Trends in data within a sector where the programme is working
- Comparative data for sectors where the programme is not working.

We had expected to be able to collect year by year data by sector from CDLS which would have allowed some analysis of trends in programme areas, compared to non-programme areas that were only receiving the support from the government and via channels such as radio which were also available in the programme area, but this has not been forthcoming. What we were able to do was to collect some data from some health centres, though not all visited were able or willing to supply this²².

Given the lack of existing quantitative data, and the need for translation, field time was also extremely short for an end of programme evaluation of this type.

4. Programme approach

Of the three outputs the focus of implementation has largely been on the third for the following reasons:

- Staffing and internal capacity challenges. As highlighted in the MTR, managing the programme within the FIM management structure as originally envisaged, proved

²² Some HC visited were very busy. Collecting this data involves manually leafing through monthly reports from the past 5 years and adding together figures. It takes considerable time.

challenging. On the basis of the MTR recommendations Concern Rwanda attempted to recruit a specific programme manager for Tubunganire, however this was unsuccessful due to recruitment challenges which Concern Rwanda attributed to '*a high local demand for a limited pool of capacity in this field by organisations which offer a more competitive remuneration package*'.

- Financial constraints: During the programme, Concern Rwanda reacted to the wider financial difficulties facing Concern Worldwide by restructuring its staff, thereby reducing the number of people directly allocated to Tubunganire to one based in Huye. Whilst this was said to prove '*somewhat feasible*' in terms of supporting partners in the component focusing on community initiatives; it meant there was significantly less scope for engagement with district level authorities and close interaction with partner animators.

The programme has largely concentrated on setting up community level structures to support HIV&AIDS prevention and care. There are 3 kinds at the cell level:

Anti-Aids Clubs (AAC): These clubs were formed to raise awareness about HIV&AIDS and to carry out sensitisation and mobilisation activities. There are one or two per cell. In Gakenke these are formed from youth, in Huye they are formed from 10 representatives each from four categories identified as being most vulnerable: widows, child headed households, unmarried mothers and PLHIV who are willing to be active, in Nyaruguru they were formed from existing Anti-Aids clubs with members of these four categories invited to join. All have been supported with small amounts of capital to set up income generating activities.

Peer Educators (PE): These were selected from each of the 4 different categories identified as most vulnerable. They are trained and their role is interpersonal communication with households near to where they live on prevention and care, as well as condom distribution. They meet regularly at the cell level where there are around 10. In Huye and Nyaruguru these were initially separate from the Anti-aids clubs, in Gakenke they were part of clubs. They have been mentored to set up a savings and loans schemes.

Home Based Care volunteers (HBC): Two volunteers were selected per village from the 4 categories according to their perceived capacity, behaviour and responsibility they are. They work as individuals to support PLHIV, particularly those that are bedridden. They meet as a group at the cell level where they were mentored for savings and loans.

In Huye the work of these community based structures was coordinated and supervised by a 'pilot committee' which covers the sector and has around 19 members including:

- The person responsible for social affairs at the sector level,
- The executive secretary of the cell level (who is also a peer educator)
- Representatives from anti-aids clubs and peer educators.

In addition the programme carried out mobile VCT in collaboration with sector level health centres.

Table 2 summarises the approach in each District.

Table 2: Summary of approach in each District

	Huye	Nyaruguru	Gakenke
Scope	3/14 sectors Jan 2007 – Dec 10 ARBEF	2/14 sectors Jun 2008 – Dec 09 IVPF Jun-Dec 2010 ARBEF	3/19 sectors Jan 2007 – Dec 10 ARBEF
AAC	New groups of unmarried mothers, OVC, PLHIV & widows	Existing groups. Added members from 4 categories	Youth
Peer educators & HBC	Separate groups. 4 categories	Separate groups. 4 categories	One group 4 categories
VCT	Mobile VCT in collaboration with health centres		

The programme works directly with 3383 beneficiaries who are members of AAC, Peer Educators or Home Based Care Volunteers in the 3 Districts (see Table 3). These are a mix of orphans, PLHIV, widows, unmarried mothers and youth.

Table 3: Members of Community Support Structures

	AAC	Peer educators	HBC	Total direct beneficiaries
No trained	83 clubs with 2905 members	511	89	3383
No active Dec 2010	79	399	76	

The programme directly targets all those who are PLHIV, unmarried mothers, widows and orphans. These total 25,143 in the whole programme area²³

The number of indirect beneficiaries is the total population of the sectors reached. Using 2007 data this would be a total of 144 910 potential indirect beneficiaries²⁴.

The programme operationalises the GIPA principle through inviting PLHIV to take leading roles in the community response to HIV&AIDS.

Changes made in response to the MTR

The MTR carried out in 2008 found that local authorities were not really involved in the community level structures. In response in 2009 and 2010 ARBEF carried out training at cell

²³ Huye: 10,498 (Mbazi, Simbi and Rwaniro), Gakenke: 8,546(Cyabingo, Kivuruga and Rusasa sectors), Nyaruguru: 6,099 (Rusenge and Nyagisozi Source: District Development Plan, Huye 2007; District Development Plan, Nyaruguru 2007; District Development Plan, Gakenke 2007; District and sector statistics.

²⁴ Huye: 55,283(Mbazi, Simbi &Rwaniro sectors) Nyaruguru: 36,344(Rusenge & Nyagisozi sectors) Gakenke: 53,283(Cyabingo, Kivuruga & Rusasa sectors. Source: District Development Plan, Huye 2007; District Development Plan, Nyaruguru 2007; District Development Plan, Gakenke 2007; District and sector statistics.

and village level for Village chief and Executive secretary of the cell. This covered an overview on HIV&AIDS and what their role could be as local authority in fight against AIDS. It also connected them with the community level structures established by the programme so they could support them.

The MTR also found that little progress, or activity had been done against output 2 and suggested that MOU should be drawn up with CDLS at District level. After further discussion this was not carried out as the programme lacked any budget to undertake any joint activities, and it was considered that the CDLS, in any case, by this time had a lot more capacity than at the commencement of the programme, making this output less relevant. The programme has, however, continued to liaise and report to the CDLS.

As the partnership with IVPF was discontinued at the end of 2009 due to audit irregularities, in addition to problems with their management and approach ARBEF became the only relevant NGO for Output 1. Following on from the MTR a more comprehensive grant agreement was developed between ARBEF and Concern Worldwide Rwanda, but capacity building remained ad-hoc rather than strategic.

The MTR recommended that more emphasis should be put on reaching men. This was done to some extent in some places, by recruiting additional male peer educators such as the Executive Secretary of the Cell (Huye).

The MTR also recommended that the HIV&AIDS programme should recruit an overall programme manager. There were two attempts to do this, both of which failed to appoint. Instead a project officer was appointed in 2008, who, since the departure of the FIM coordinator in November 2009 has reported directly to the ACDP. This does mean that since the November 2009 there has been one person with the overview of the programme.

5. Relevance

The programme was relevant in that it did address issues identified in the baseline i.e.:

- Lack of knowledge on HIV&AIDS
- High levels of stigma (self and external)
- Weak community support structures
- Risky behaviours
- Weak demand for VCT
- Difficulty of access to male condoms

The programme was aligned to Rwanda's National HIV&AIDS Strategic Plan 2005-9. In 2009 this was replaced by the National Strategic Plan on HIV and AIDS 2009-12 (NSP). This is the reference document for all sectors, institutions and partners involved in the fight against HIV and AIDS. This sets out overarching aims for 2012 of: halving the incidence of HIV in the general population; reduced morbidity and mortality among people living with HIV; and, that people infected and affected by HIV have the same opportunities as the general population. The programme is also broadly aligned to this more recent strategy in that it supports these overarching aims²⁵.

The programme also followed the principle of the 'Three Ones'²⁶ and liaised with the CDLS and submitted data via the government monitoring system as appropriate.

²⁵ But see comments in Lessons section

²⁶ One agreed AIDS action framework, as the basis for coordinating the work of all partners; one national AIDS coordinating authority, with a broad-based multi-sectoral mandate; and one agreed country-level monitoring and evaluation system

6. Targeting

The programme directly targets all PLHIV, orphans, single mothers and widows in the programme area. These were selected as being the groups most at risk of contracting HIV and/or being vulnerable to its effects. As explained by a staff member of ARBEF:

These groups, because of the problems they had would involve themselves in sexual issues. They were most vulnerable and at high risk of getting infected. Unmarried mothers didn't get care and protection from parents so were at risk of going into sex. The orphans also because of no protection would also end up in sex to reduce their grief. Widows also did not have husbands and people to support them. (ARBEF)

In Huye people out of each of these categories were chosen on the basis of people who would be active and good at communicating with others to form the Anti-AIDS clubs.

The person would be vulnerable but had to be also active and go in front of a crowd and be able to speak out and a person who wants to join. (ARBEF)

In Gakenke the AAC targeted youth, and in Nyaruguru worked with existing AAC that mainly worked with youth.

In all areas the HBC volunteers and peer educators were selected from these four vulnerable groups.

The programme had a range of aims meaning that targeting fits better for some than others:

- For prevention, these 4 categories worked well in terms of identifying people who were able to reach out to their peers but tended to miss out men who are not PLHIV or orphans, and dis-cordant couples who are identified as one of the major risk categories in the National Strategic Plan 2009-12. It is also not clear that disabled people were targeted in a systematic manner. They also do not allow for reaching youth that are just becoming sexually active (other than OVC). There was some attempt to reach men after the MTR.
- In reducing stigma, giving these 4 categories of people, all of whom are marginalised in different ways, a public role appears to have worked well in developing their confidence and reducing self stigma, as well as increasing their social standing and reducing external stigma directed at PLHIV and unmarried mothers.
- For HBC and other support to PLHIV, PLHIV are in a good position to offer support and advice to other PLHIV as they can understand and empathise with their concerns and act as positive role models, but there is a risk of increasing the workload of those who are already vulnerable.
- For IGA: A small number (287) of PLHIV were identified for support via the FIM programme, who were identified as those who were particularly needy. AAC were trained in savings and supported with advice, and some small funding, to set up IGA. However as the groups targeted the articulate in the 4 categories, or youth, rather than the poorest, the IGA support via the AAC is not necessarily reaching those most in need. Though some groups are using some of their income to support the very needy in their communities on a small scale.

7. Key achievements

The normal approach in an evaluation is to assess the programme against its goal, purpose and outputs, but as explained earlier, these were not adjusted when the programme adjusted its approach. As a result, working systematically through these, will not give a fair

reflection of the achievements of the programme. Instead the approach this report takes is to summarise the key achievements of the programme by starting with output 3 where work was focussed, and then to make some overall comments about the other two outputs, the goal, and the purpose.

7.1 Output three: HIV and AIDS infected and affected groups empowered to challenge stigma and discrimination through relevant, community-based social and economic support mechanisms.

As described in section 4, there were 3 main approaches at community level: Anti-Aids Clubs, Peer educators and home based care.

7.1.1 AntiAids Clubs

The team visited 10 AAC out of 79 known to be active in December 2010. These were purposively sampled from a range of geographical areas and to include a mix of strong, medium and weak ones. Support from the programme had ended 7 months prior to the visit. All the clubs still existed and 8 out of 10 were judged to be likely to continue in the medium to long term (see table 4).

Table 4: Summary of AAC capacity and linkages²⁷

Rating\activity	AAC
0 No longer exists	
1 Still exists but activities/ members reducing and unlikely to be sustained	Rugango Nyagisozi
2 Active and stable but lacks support Not linked to health centre or social affairs. Undertake sensitisation activities on sporadic basis. Membership stable.	Mwurire
3 Active with some sign of being able to maintain group. But support is sporadic rather than regular Some form of income or support, but no regular links to health centre or social affairs. Undertake sensitisation activities on regular basis. Membership stable or growing.	Gisakura Mwoya Rugimbu Muramba Rukore
4 Group active and linked in to wider systems Reports on regular basis to social affairs or health centre and receives support from them. Undertake sensitisation activities regularly and frequently. Membership growing or renewing itself.	Rusagara Sereri

In all clubs members showed good basic knowledge on HIV&AIDS transmission and prevention, which most attributed at least partly to their membership of the club though radio was also said to have played a part. Some also indicated that their knowledge on reproductive health in general had increased (eg youth in Muramba and Rukore). They shared this information more widely in the community through activities such as plays and songs.

Members of all ages, both men and women, reported increased confidence and ability to make informed choices on sexual matters including abstinence, the use of condoms and deciding whether and when to get pregnant, and indicated that they were putting this into practice at least some of the time. It was notable that women’s confidence to negotiate the use of condoms had increased considerably since the MTR. In 2008 most women interviewed knew about condoms and could even access them, but felt unable to do much more than making them visible and hoping the man would choose to use it: directly asking

²⁷ Developed by team at analysis workshop

him to wear one was difficult for most. In 2011 most women interviewed felt able to ask their partner to use a condom, perhaps alluding to it indirectly.

Nowadays women will ask men to wear a condom. Sometimes say the problem is that they are not getting enough condoms. Mentioning the word condom, they don't consider it that clean, so nicknamed it. Eg a wedding gown, and when the guy comes and says can I have a wedding gown? (Peer educators and HBC, Gisakura)

Asking did not always lead to them being used, especially if the man was drunk.

Every member of the club has agreed if they are to have sex they will use condoms and they are no longer shy to go and buy. They talk about it and encourage each other. (AAC Sereri)

The groups successfully bring together PLHIV and other groups in the community. As in the MTR, field work indicated that being part of the group and having a recognised public role, had considerable effect in developing solidarity, confidence and status of members from all the four disadvantaged groups, not just PLHIV.

'Before the project started the unmarried girls would be fearful even families would chase them from houses... Now they are free, open to the world, they don't feel as left behind.'
(Mwurire)

Among the women it brought back their motivation to live, and their focus. They now believe they can achieve something e.g. rearing different animals. Through that they have developed confidence. They are now recognised in the community even more than women who have husbands (ARBEF)

Most of the clubs either worked each others' land in turn together, which was said to be less time consuming, or cultivated some communal land. Some groups have also set up savings schemes for members and/or set up small IGA like selling beans (Rusagara) had secured the promise of 17 cows from a local NGO ARCT RUHUKA and aspired to form a cooperative to access additional resources.

The savings or IGA can finance sensitisation work (one sold 4 rabbits to buy equipment needed for a play), can motivate members and may help with issues such as nutrition (three visited – Sereri, Rusagara and Rukore - had bought one pig for each member, and another two had bought rabbits – Muramba and xx), or access to health by eg paying health insurance fees for members.

An old childless lady, said without the people in the club she doesn't know what she would do as they help with cultivation and go with her and with them she is able to earn a living. Also they have a savings and credit group. ... A widow said she has a child in secondary. Without that savings and credit she doesn't know if she would have been able to send the child to school. (AAC, Gisakura)

ARBEF consider that club activities such as group cultivation and savings can support group cohesion:

Clubs will last for a long time because of cooperatives they made and the small IGA will make them stay focussed (ARBEF staff)

There was some indication that accessing assets such as pigs, could help the status of some of those marginalised within their families:

When I took the pig home, they stopped despising me and saying I was not worth anything as I was doing something productive. (unmarried mother. Club anti-aids MWURIRE)

However there was also some indication that they could be leading to the most marginalised dropping out. For example Gisakura has dropped from 40 to 25 members. When asked why the other stopped the response was:

Some left the club as said did not have the means to get the amount of saving that was required. We usually contributed 600 per month and those would say they could not afford that kind of amount (AAC, Gisakura).

Sometimes a person would be poor and not have the equipment to play a part in different activities. E.g. if we go to cultivate and a person didn't have hoe, they wouldn't feel so much of a member and might leave (Rukore)

Clubs were appreciated by social affairs at sector level who have the responsibility of mobilising and sensitising the community on HIV&AIDS, though the amount of support the clubs received varied greatly. Clubs such as Sereri were invited to talk to the community about HIV&AIDS at meetings or after communal work. There tended to be weaker links with the health centres, and only two clubs, Rusagara and Sereri, were well linked with both social affairs at the cell and sector level and able to get updated information.

The different groups set up are very much helping us in our work. It is easier to sensitise the people. We have different activities to take place eg if we need to build a house for a poor person the people already have that sense of helping each other. When there are different competitions having to take place, it wont be too much work for us, as we know there is already a club. (Social affairs cellule Rusagara)

Though the most of the AAC are active and appear sustainable, they also face a number of challenges:

- Though basic information is good, they lack regular means to access updated information.
- Though it was positive that clubs also contained men, there were considerable gender issues within the clubs, with most leadership positions being taken by men and men tending to speak on behalf of the group.
- With two exceptions, most clubs had weak linkages with the health centre and social affairs at the sector level.

Some have lost members since they stopped getting regular support which suggests a certain lack of ownership of the club and its objectives:

Some also left saying that the organisation stopped so why should we keep going to the club, didn't see the essence of going when there were no sponsors. (AAC, Gisakura)

The number of members of the club has decreased. They were 16 and are now 12. 7 girls and 5 boys. Why do people leave? People saw that no one following up activities after ARBEF left so just decided to go. (AAC Sereri)

The AAC in Nyaruguru, which were set up before the programme started working with them, faced particular issues. They reported that they had actually been weakened by their experiences with IVPF. One IVPF staff member was said to have defrauded them of a considerable amount of money from their group savings scheme, and made a whole range of promises that had not been kept. This had left a legacy of suspicion with in the group and has led to one particularly active woman, trained as a peer educator, had being marginalised by the community. As a result of this a number of members had left the club.

It was strong in the past. ... They even had a programme of savings where could give money and lend to each other. But they no longer do it. There is no trust. They no longer cultivate together, so they no longer have activities which make them come together. They only meet when the sector level say they need a club to do eg a play. They are no longer active as they were. (AAC, Nyagisozi Cell, Nyagisozi Sector)

7.1.2 Peer educators

All of the peer educators visited were still active and it appeared likely that this structure would continue operating in the medium to long term. See Table 5 for a summary.

Table 5: Peer Educator Sustainability

Rating\activity	PE
0 No longer exists	
1 Still exists but activities/ members reducing and unlikely to be sustained	
2 Active and stable but lacks support Unable to access condoms or up to date information	Mwurire Rugango Nyagisozi Muramba
3 Active with some sign of being able to maintain group. But support is sporadic rather than regular Able to train new peer educators, occasionally able to access condoms and up to date information	Rusagara Mwoya Sereri Rugimbu Rukore
4 Group active and linked in to wider systems Reports on regular basis to social affairs or health centre and receives support from them. Access to condoms and up to date information on a regular basis. Able to replace or add peer educators	Gisakura

They appeared to be successfully reaching their peer groups (female youth, widows, orphans and PLHIV) with advice and support and it was clear that the members enjoyed helping others. During the programme they had also played a key role in distributing male condoms. Some groups visited had trained additional peer educators themselves, which is a good sign for sustainability.

Peer educators talked about how being a peer educators had helped them to gain hope and change their own behaviour:

I had 5 children while still a girl. Since the programme started, I haven't had another child. When I have sex I protect myself (38 year old unmarried mother & peer educator, Nyagisozi)

It was also clear from the stories peer educators told that they were trusted by their peers who felt able to approach them for advice. In Mwoya, Mbazi, Rugimbu and Sereri club members or local leaders mentioned that the number of unplanned pregnancies among orphans, widows, unmarried mothers and PLHIV had decreased as a result of the work of peer educators, though in some places there was a suggestion that youth pregnancies had increased.

For example one unmarried lady used to give birth every 2 years. But now her youngest child is in 2nd year of primary school. (Peer educators & HBC, Rugimbu)

When we first addressed ourselves to PLHIV they didn't want to listen to us. They didn't want to stop sex. They did not see use of going for ARV. E.g. when we went to unmarried mothers and told them they should stop giving birth as having so many children would be a problem, they would tell us "actually this child will be my saviour and someone in the future to help me". Even the PLHIV mothers would want to get pregnant. They would say maybe this child I bear now will be fine and be the one who will support me and take care of me in my final days. Now it has changed. (Peer educators and HBC in Sereri)

The challenges faced were in many ways similar to those faced by the AAC, though for peer educators lack of access to updated information is more critical as they will be expected to answer specific questions. Areas where they particularly lacked information included on discordant couples, where most didn't understand how it was possible for couples to be discordant if they had had children together, and how MTCT works and is prevented (though they knew to tell PLHIV to go for advice if they wanted children).

In particular peer educators faced challenges in reaching out to men, who they said were unlikely to want to talk with them, unless they were PLHIV who were very sick. Another key challenge was the lack of consistent access to condoms.

'When we had the condoms it was easy to distribute as people trusted us. Now people say they cant go to the shop and buy them as people will think they are just into sex. For example if it is a lady without a husband.... '(Peer educator Mwurire)

7.1.3 Home based care

In some areas the home based care volunteers were the same as the peer educators, in some places different. This report deals with them as a separate heading and focuses on the services that the HBC volunteers offer.

Again all of the HBC visited were still active and were successfully reaching PLHIV with psycho-social and practical support (see table 6).

Table 6: Home Based Care Sustainability

Rating\activity	HBC
0 No longer exists	
1 Still exists but activities/ members reducing and unlikely to be sustained	
2 Active and stable but lacks support Not linked to health centre or social affairs. Unable to access support for bed ridden	Mwurire Rugango Rugimbu
3 Active with some sign of being able to maintain group. But support is sporadic rather than regular Able to train new HBC, occasional access to support for bedridden or PLHIV	Rusagara Mwoya Nyagisozi Sereri Muramba Rukore
4 Group active and linked in to wider systems Reports on regular basis to social affairs or health centre and receives support from them. Able to access condoms and up to date info on regular basis. Able to replace or add HBC	Gisakura

In cells with active HBC groups bedridden PLHIV were being visited on a regular basis, being encouraged to go for testing and adhere to taking their ARV, and being accompanied on visits to hospital or the health centre. Volunteers were clear about the benefits of accessing care for PLHIV:

'I was one of the bedridden two years ago, but I am now healthy and act as an example. We accompany those sick to hospital. We used to use my bicycle.... 10 have gone to hospital in 2011. Of these 4 we had to carry the whole way.' (male PLHIV Rusagara)

'We thank Concern. Some were really sick, you are taking them from the grave. They can now work for themselves. We are very thankful.'

Due to sensibilisation the number of people taking medication is increased, not because the number of sick increased, but they are no longer fearful of going for testing. Stigma has obviously reduced. It is not as much as before. (HBC Rugango)

You are not able to now find someone bedridden in this cell. They know about ARV. (Peer educators & HBC, Rugimbu)

People are no longer shy are outspoken about suffering from HIV. That is why go for ARV. Number of women who get pregnant, PLHIV women getting pregnant has decreased. All the changes they get is from knowledge they get from project. (Peer educators and HBC, Gisakura)

Some groups had decided there was too much work for the original volunteers and had themselves trained additional volunteers, which is a positive sign for sustainability. The members also made it clear that they enjoyed their work and that there were benefits for themselves including solidarity, a sense of purpose, and a greater focus on nutrition and cleanliness and caring for themselves.

We no longer have grief among us, we visit each other, and have a spirit of togetherness. There is also community solidarity where we help each other. Eg we cultivate for each other, build toilets for each other. What we also gained is enough knowledge on HIV&AIDS and people diagnosed go for treatment at earlier stage, rather than getting to sick level. (HBC Rugango)

This group also talked about how being HBC volunteers had supported them to make changes in their own lives. One PLHIV male widower talked about how he had decided not to get remarried, a very unusual decision in the culture. Some of the PLHIV women described what had changed for them:

We have changed and now have good conduct in our daily life. .. before we would go in bars, drink and get drunk and even go home with men and have sex. Now we have changed. We now have hope in ourselves and for the future. Before we had lost hope so we wouldn't go to land and cultivate. Before had lost hope just went to bars and drank. Would think why should I do it, my life will be over soon. (women PLHIV, Sereri)

The same group of women went on to explain that in the past, if they did go and do any farming, they might have sex with men in return for doing the heavy agricultural work that they lacked strength for. But that now they are able to avoid this by helping each other:

After harvesting something and making up a bundle, we wouldn't have strength to carry it home. We would call a man and ask him to carry and in return he would ask us to sleep with him. The project came and we are now together and help each other, we no longer have to ask for help from men who in return ask for sex. (Peer educators and HBC in Sereri)

HBC volunteers gave particular support to the newly diagnosed and encouraged them not to give up hope and to go for treatment.

The PLHIV HBC help the newly diagnosed, to follow up, take to hospital, to show where can get treatment. They escort them and help out. The numbers going for medicine have increased, as more people know their status. Those who knew but didn't want to go are now going, they are no longer fearing. (AAC Rusagara)

They faced similar challenges to the peer educators, key being that their links to local government and health centres were not always very defined or strong.

We had requested to be linked to the community health worker. ARBEF asked the person in charge of social affairs at the sector level to link us on 1st Dec 2010 (AIDS day), but nothing has yet been done. ... Now the programme is finished we don't get any support in providing HBC. (AAC Rusagara)

As a result they lacked access to updated information, particularly on possible side effects of ARVs. The poverty of those they visited remained a key challenge, as it was during the MTR. During the programme they occasionally got access to provisions such as nutritious food or soap, but now the programme has ended this is very rare, except for those with strong links to social affairs or health centres.

We continue to visit people in houses and do their laundry, or bathe them. But in the past ARBEF gave us some medicine for wounds or bed sores, now we cant get. Also before we would have good anti-bacterial soaps. Currently there are 17 bedridden from HIV related illness (3 men and 14 women). As they are no longer getting their requirements the number is going up. They are no longer getting specialist food. A year ago there were 12 bedridden, two years ago it was 19. 10 out of the 17 are on ARV, which is all that are needed to. (AAC Rusagara).

Poverty means that PLHIV are not always able to put into practice what they know about positive living or prevention of transmission. Many of those on ARV struggle to get good nutrition, thus acerbating side effects.

People who don't have enough food, take ARV inconsistently. The side effects are really bad when you take without having enough food. They complain about being very weak and needing to sleep the whole time. We cant do anything. In the past we would get food supplements but these are now finished. In the past PAM (the World Food Programme) was supplying. Now some cases can get, but there is no real programme doing it. It is sporadic. It is the biggest problem. If people have access to food, then the current situation of access to HIV services could be a success. (AAC Muramba and Rukore)

One PLHIV woman, a HBC volunteer, who had a 3 month old baby had sought PMTCT when she found she was pregnant and the baby to date had tested positive, but she was desperately worried about being unable to afford to stop breastfeeding when the baby reached 6 months.

The system of mobilising marginalised groups to offer the HBC has given members a social purpose and status in the community. But as the wider support for the HBC volunteers is quite weak, the burden is in many cases falling mainly on those who are already vulnerable.

7.2 Output one: Technical and institutional capacity of NGO partners strengthened in the provision of HIV and AIDS preventative services.

There has been less attention given to, and less results against output one. Relevant NGO partners would be IVPF and ARBEF. Concern carried out an audit of IVPF in late 2009 as part of a process to evaluate the 6 partner organisation's financial systems. As a result of this audit which revealed significant problems with IVPF, the partnership was discontinued, and it is not clear that IVPF still operates as an NGO.

ARBEF is a much more established organisation that was founded in 1986, which already had considerable capacity. It is the only Rwandan NGO focussing on the full range of reproductive health, and has a wide range of funders. A capacity assessment did take place at the start of the programme, but the MTR concluded it was not very effective and did not provide a baseline against which to assess progress. At the time of the MTR ARBEF suggested that the programme had supported them to:

- Understand and adopt a range of new approaches to HIV and AIDS prevention work such as locating animators in communities rather than in urban based clinics, using mobile VCT clinics to reach remote communities and the use of community mobilisation to raise demand for services and encourage behaviour change complemented by service delivery.
- Be more aware of the importance of working in collaboration with others, rather than working on their own to provide services. For example putting more attention into liaising with local authorities and other NGOs, and involving community groups more. They are also working more closely with health centres to build their capacity for sustainable provision.
- Improve their capacity to work in partnership.
- Operationalise their strategic objective to shift their focus from largely Family Planning to also working more on HIV and AIDS.
- Develop staff skills, particularly in facilitation, the use of peer educators, planning using a logical framework and developing a M&E plan. Skills such as financial management and mainstreaming developed through partnership with Concern were said to be being used in other ARBEF projects. Training in Stepping Stones was said to be particularly useful in helping staff work on behaviour change.
- Access transport and computers, and, for the duration of the programme, increase human resources through the employment of animators.

The MTR also suggested that the relationship was tending towards more of a sub-contract than a full partnership and focused on the grant and how it was used, with Concern usually taking the initiative on issues.

The MTR recommended a more systematic approach to achieving output one, but this was not done, though *'needs were identified in regular meetings and workshops were conducted on a regular basis. It was not done systematically' (Concern)*. Some efforts were made such as joint development of partnership principles and their inclusion in the agreement which was provided in French and the instigation of an annual review process which discussed both programme outcomes and the strengths and weaknesses of the partnership approach.

This evaluation found that most of the points above had been developed further, and that ARBEF had used its experience in this programme to inform new proposals for work which integrate HIV&AIDS work with family planning work, for example a new project starting in the East Province funded by the Global Fund. ARBEF has also retained most of the staff from the programme and redeployed them in other work so it can continue to make use of their skills. There were areas where more could be done, such as not only recognising the need for, but also systematically planning for, working with local authorities. Also the work within the programme remained separate from the other services that ARBEF is providing in the programme Districts, and though links remain on a personal basis, ARBEF is currently not supporting the structures set up under the programme.

7.3 Output two: AIDS Commissions (CDLS) in 3 Districts strengthened in the planning and monitoring of HIV and AIDS related activities.

The MTR found that the programme had participated and contributed to Gakenke CDLS bottom up development of its strategic plan. By 2008 CDLS had the appropriate structures with sub-groups each with their clear responsibilities such as prevention, HBC and support, resource mobilisation. The programme had also supported CDLS in Gakenke to initiate a Joint Action Forum on the HIV and AIDS response at both District level and in the 3 sectors where the programme is working. These were said to be very successful in promoting synergy among stakeholders, though not all the NGOs working on HIV and AIDS in the District attended. There was less progress at the time of the MTR in Huye, and the relationship showed some tension.

Since the MTR there has been little emphasis on output 2. One member of staff comments:

When the project was designed there was really a big need for support in PM&E at CDLS level. Over the time of the programme, the nation really improved M&E. It is not to do with the programme though. They now have good plans, good M&E, good indicators. They receive more support from national level and the activities are more coordinated than in 2004. So it became less relevant. (Staff)

Given this lack of emphasis, and the short time frame available for field work, the evaluation did not spend a lot of time looking at detail of the CDLS and how it operates, though interviews were held with the CDLS coordinator in both Huye and Gakenke (the one in Nyaruguru was not available). It was clear that the relationship with the CDLS coordinator in Huye had much improved since the MTR and that they appreciated the support that the programme had given them to undertake specific activities linked to their priorities. In reference to support provided for the OVC monitoring exercise at the end of 2010 the comment was made:

Now we are able to identify OVC. Now we know how many there are and where they are so we can target them when we have a new activity.

CDLS in Gakenke clearly worked well with ARBEF, but complained of some lack of clear communication with Concern Worldwide. Overall it is clear that the programme has met its obligations in terms of reporting to and coordinating with the CDLS, but that in the last two years it has not really gone beyond this to influence the CDLS or to develop its capacity in any significant way.

Whilst the CDLS itself may not require urgent support at District level, the underlying concept that structures and systems for coordination could be strengthened remains valid. More is said on this in the challenges section.

7.4 Impact

The output to purpose to goal logic does not match well with what has actually been done in the programme, in that it assumes that key to achieving the goal is the strengthening of NGO and local authority capacity (the purpose), yet these have received very little attention. Despite this some effects can be seen at goal level, largely as a direct results of output 3.

This section therefore looks at the following, all of which are embedded within the purpose and goal:

- Reduction in AIDS related stigma and discrimination
- Optimising the utilisation of HIV&AID prevention services and reducing the transmission of HIV
- Minimising the socio-economic impact of AIDS

7.4.1 Reduction in AIDS related stigma and discrimination

It is clear that the clubs have had a large effect on self-stigma and other stigma for the members themselves. This section looks at the wider impact on stigma in the programme area. Overall there is considerable anecdotal evidence of significant reduction in stigma, though how much of this is attributable to the programme, and how much to other forms of sensitisation (eg radio) or access to ARV was impossible to assess in such a short time in the field. Key areas of change include:

People in general are more willing to visit PLHIV

One Executive Secretary at the Cell level commented:

When the project just started if you asked people to show you a place where a PLHIV lived to go and visit, people would just point and not go with you. Now if they are asked they can go to visit with you as they have learnt to accept them in the community. ...[this happened] because of different teachings they got from AAC and people started taking ARV so it gave much more hope for future. (Exec secretary, Nyagisozi Cell, Nyagisozi Sector)

The same story was found in Rusagara who talked of PLHIV 'no longer having grief as they have people to be with them', and in Gisakura 'nowadays PLHIV have a lot of people come to visit them so it helps them to be encouraged,' though there were said to be still a minority who would not visit.

Some people who are open about their status have achieved public standing within the community

In the past people would hide their status, but now many are prepared to talk about it openly, and have found that by doing so their standing in the community has actually enhanced. One woman PLHIV peer educator talked about how 'Even the executive secretary has my mobile number and gets in touch.'

There are mixed groups of PLHIV and others working together

Informants commented on how it was no longer unusual now to have meetings or clubs where PLHIV mixed with other people:

Before the people would not be very confident to attend different meetings or be in associations of PLHIV. Now they willingly attend which shows they have accepted to be with PLHIV. (Exec Secretary cell level and chef de village, Rukore and Muramba)

There are less judgemental attitudes towards PLHIV

At the MTR a common complaint was about PLHIV who chose to get pregnant despite their status, with a strong implication that this was an irresponsible act. In the field work this time, the attitude towards PLHIV who chose to get pregnant was much more supportive:

Before PLHIV would hide it if they were pregnant . Now they do say it and will go to ensure the baby is not sick. Eg there was a PLHIV woman who really needed a child, she went to the doctor to say and the doctor helped and the baby is OK. (HBC Rugango)

There is less family conflict as a result of members knowing their status

Informants from a number of cells talked about the reduction in family conflict that used to occur as a result of one member finding out, and disclosing their PLHIV status.

Families who are living with PLHIV are now at peace with each other. Before they were always fighting and misunderstandings. Now as we keep counselling they are no longer having misunderstandings. (AAC Rusagara)

Some peer educators are also PLHIV. Before their families would reject them, but that has now stopped so it is giving them more hope... From the trainings we had from ARBEF we were able to unite the families. Even in a couple found suffering from HIV normal breakups are not happening so the families still live together. Sometimes the women are the ones who have the motivation to get tested and tell their husband they have HIV. In the past the husband would mostly abandon the lady and go somewhere else or would always be fighting in the house, but now there is peace in the family. (Peer educators and HBC, Gisakura)

PLHIV are willing to give testimony in public

In all areas visited there were now people who were prepared to talk openly about their status or that of their relatives:

People are now are able to talk to say that they are suffering from HIV&AIDS, before they wouldn't dare say it. When we have meetings at cell level they will give testimony. (Peer educators & HBC, Rugimbu)

In the past when someone would die from AIDS the family would not say the cause of death. Now we have had 3 examples at the cemetery when talking about history of person they would also say what they suffered from and the family would advise people to protect themselves from HIV&AIDS. (Executive secretary and chef of villages Gisakura cell)

Though there has obviously been a lot of changes on the issue of stigma, probing reveals that it still exists to some extent in some areas. PLHIV informants from Muramba and Rukore talked about how people would point when they went past and talk about them being 'rotten inside'. Furthermore self-stigma among men remains a key issue, with a number of men being reported as refusing to disclose or be open about their status, even with their wives, and not seeking treatment. One man was reported to have moved to another area after finding out that he was PLHIV, so that he could find sexual partners who didn't know about his status.

7.4.2 Optimising the utilisation of HIV&AID prevention services and reducing the transmission of HIV

While the previous section looked at whether club members were actually taking steps to protect themselves against the risk of transmission of HIV this section looks for indications of behaviour change in the wider community. There was considerable anecdotal evidence from both community leaders and club members that they were seeing some change in behaviour. As we do not have figures for % of young women and men 15-24 who are HIV affected at the sector level²⁸ we look at the data we do have: VCT testing and condom distribution, and triangulate this with the qualitative data collected during field work.

VCT

Table 7 shows the number of people tested for VCT via the mobile services funded by the programme.

Table 7: Mobile VCT supported by programme

	2007	2008	2009	2010	Total	Comments
# People tested VCT.	701 500 female, 201 male.	7580 5326 female, 2,254 male	6072: 3437 female, 2635 male.	3517 2270 female, 1247 male	17,870: 11,533 Female 6,337 male	In 2007 Activities were done in the last quarter only. People were oriented to health centre where HIV services were available.
Positive	12: 8 female, 4 male	90: 37 male, 53 female.	57pos : 22 male , 35 female	51: 19 male, 32 female	210: 82 males and 128females	

This shows mobile testing reached a peak in 2008. The idea was that having seen VCT testing at work in their own communities, people would be more open to undertaking it at the local health centre in future.

Mobile VCT was seen as a means of awareness raising and sensitisation: *'If the service is new and people are not very well aware we are able to bring it closer. Sensitisation is done by one of our peer educators. When they can see that it is not dangerous and that results come out of it. And that those that test positive receive support and continue their lives. We think that if they have had the opportunity to see how VCT can work in a local area, it is easier to convince them to go to the Health Centre' (Concern)*

Table 8 shows figures for all VCT (mobile and on site) carried out by 3 Health Centres in Huye, and one in Nyaruguru.

Table 8: VCT testing from 4 Sectors²⁹

VCT testing								
District	Sector	2007	2008	2009	2010	2011 * 2	Popln 2007*	Notes
Huye	Mbanzi health centre via mobile VCT^	485	1025	341	180	38	25525	Mobile VCT only
	% popln Mbanzi	1.9	4.0	1.3	0.7	0.1		
Huye	Simbi HC		831	2389	2975	3502	22876	Testing at HC and mobile
	% popln Simbi		3.6	10.4	13.0	15.3		

²⁸ UNGASS core indicator for impact

²⁹ In Simbi and Kigoma this data was collected from the monthly reports the HC makes. In Mbanzi it was collected from the record book for mobile VCT.

Huye	Kigoma HC	6735	5157	5372	5203	6422	18557	Testing at HC and mobile
	% popln Kigoma	36.3	27.8	28.9	28.0	34.6		
Nyaruguru	Maraba Health Centre		1266	1910	1936	2528	n/a	

^ not clear all were actually tested in 2009

* Figures taken from baseline

NB Data for January – June of 2011 was doubled for comparative purposes.

The yellow cells (Mbazi, Simbi and Maraba) are programme areas and the blue cells (Kigoma) a non-programme comparative where there are HIV&AIDS clubs, which were initially started by DED and are now supported via the HC.

It can be seen that VCT has effectively stopped in Mbazi as the health centre is not able to yet carry out VCT itself. It is not possible to estimate how many of the population have been mobilised to go elsewhere, but the timing of the intervention seems to have been less than optimum. The rationale of carrying out mobile VCT was to get people to be used to it so they would then take up. However ideally this would have led up to, and have been linked to the launching of VCT at the local clinic.

In contrast Simbi and Maraba show rising trends with the number of VCT rising in absolute numbers year by year and also as a % of head of population in Simbi (though this has not been adjusted for population growth which would reduce this trend). This suggests that around 15% of the population are going for tests each year. This can be broadly compared with government data³⁰ from 2005 for the whole country which found that 11.6% of women and 11% of men age 15-49 had been tested in the last 12 months and knew their status. But falls well short of the government target that by 2012 35% of women and men aged 15-49 will have received an HIV test in the last 12 months and know the results.

This positive picture, is put into perspective by the data from Kinyamakara HC in Kigoma. We visited this location on the advice of the CDLS expecting to find a sector that had not received support on HIV&AIDs except through the government. However we found that DED had been supporting the HC up until 2008. The DED and the HC working together set up AAC that are run from the HC. The HC itself also puts its own resources into carrying out mobile VCT when it can. Here it can be seen that using the population figures from the baseline³¹ VCT is reaching a considerably higher proportion of the population, and from what we were told, this has been without outside support since 2008.

Mobile VCT was said to be popular and to increase the number of people taking the test, but whether it has a long term effect in areas where it is not possible to access VCT at the local health centre has to be questioned³². In Mwirire if people now want VCT they have to go to Huye as the sector health centre does not yet provide it. The peer educators comment:

‘Some mothers maybe say they want to take the child for a test. But the hospital is too far and they have no money for the trip. When they see the expense, they just leave it. It has affected the numbers going for VCT, they are getting lower’. They also suggest it has reduced the number of men going for VCT: *‘Usually when ARBEF came (with mobile VCT) the men*

³⁰ This is only indicative as the government data is for women and men who are 15-49 whereas this data is for all VCT tests.

³¹ The health centre gave a different figure for the population currently, but to compare like with like we are using the population data from the baseline for all the sectors. This is only indicative as it is possible that some inhabitants of these sectors travel outside the sector for tests, particularly in Mbanzi where the Health Centre does not offer VCT on a regular basis. It is also possible that some people from outside the sector in Simbi and Kigoma travel in for tests.

³² Only one out of sectors was in this position at the time of the programme ending.

were the hardest to convince. Now when we say go for a test they say they wont. Here they would sneak into the room when no-one was watching’.

Some health centres are continuing mobile VCT with sponsorship from elsewhere, or utilising their own funds. The Health Centre at Simbi is planning to integrate it into mobile visits for giving give vaccination and supervising people taking medication.

Demand for condoms

The programme distributed condoms directly via peer educators as shown in table 9. It can be seen that the supply of condoms increased from 2007 to 2009, but was massively curtailed in 2010. The rationale for this was that during the final year of the programme people should be encouraged to source condoms from sources that would continue post programme. However the information collected suggests that for this strategy to have been effective, more emphasis on links to providers would have been required.

Table 9: Condoms distributed by programme

	2007	2008	2009	2010	Total	Comments
Male condoms distributed by peer educators.	106,974	159,600	174,334	12,740	453,648	Condoms were given by ARBEF, CDLS, Health Centre

It can be seen from this table that there was an increased number of condoms distributed between 2007 and 2010. To put this in perspective, if we take the total population of the programme area³³ of approximately 158 000, then assume approximately a third are sexually active³⁴ (i.e. around 50 000 people or 25 000 couples), at its peak this allows for 7 condoms per couple per year, unlikely to be sufficient for consistent utilisation. Of course the programme would not be the only source of condoms in the area.

Anecdotal evidence suggests changes in attitude towards condom use within the programme area, although national data is still suggesting that Rwanda faces a challenge in achieving widespread behaviour change³⁵:

Before when you would buy a condom and it would fall out of your pocket people would see it and start teasing you. Now they see it as something normal. Now even girls who used to be shy can come and ask me for a condom. This shows how behaviour has changed. (Exec Secretary cell level and chef de village, Rukore and Muramba)

Behaviour among people really has changed. They can go to get condoms. There is a lady responsible. Everyone in the cell knows who has them. Everyone says just go to her as she collects from HC centre and she distributes (AAC, Gisakura)

Nowadays the women, are not shy to admit they need condoms or to go and ask. Said maybe a lady can come in the evening and say I really do need a condom as I have a visitor. If she is really confident enough to say that she is going to have sex and will protect herself. Also the PLHIV pregnant women keep showing reports of last visit to hospital showing progress. (Peer educators and HBC, Gisakura)

³³ This is only an approximate figure as explained in footnote 22.

³⁴ 43.5% of the population is under 15 and few of these will be sexually active. 55.2% of people are aged 15-49 but not all of these will be sexually active.

³⁵ DHS 2010

There are evident changes. The people in area now use condoms in large numbers. When I leave condoms in toilets I will find them finished in very short time. (Social Affairs level Sector, Cyabingo sector)

Our field work suggested that indeed there was a demand for condoms among club members, but that a regular source of them remained a problem for many people in places other than Gisakura. PLHIV who were on ARV were said to be able to collect them when collecting their medication, married couples were said to be able to get them through family planning services, but others in the target group (youth, unmarried mothers, widows) found regular access problematic.

Consistent anecdotal evidence suggests that though some people would make the effort to get condoms on a regular basis from either the health centre or through purchase, the effort required would put many off, in particular unmarried women. Our findings suggest that condom use in the programme areas has increased, but remains sporadic at best.

When we had the condoms it was easy to distribute as people trusted us. Now people say they cant go to the shop and buy them as people will think they are just into sex. For example if it is a lady without a husband.... (Peer educator Mwurire)

There is a pharmacy near by where you can get condoms. You have to buy. But they are not used as much. It is the mindset. People feel that they cant go and buy a condom. People haven't accepted to use condom. Even in family planning they prefer to use other methods. ... They haven't put it into mind they can use. Or still think it is not good, might get torn or might get into the ladies stomach and cause infection. They haven't yet understood. (Exec secretary, Nyagisozi Cell, Nyagisozi Sector)

Comparing with adults the youth are the ones who buy more. Sometimes the Red Cross also gives out but it is not regular. Before when used to give condoms for free, the women would get for free. But we don't know of any woman who goes to buy. [Do men?] Men buy them but not as the youth. What they do is sometimes send children to buy. (Peer educators & HBC, Nyagisozi Cell, Nyagisozi Sector)

Reaching men

In all prevention and care services, we received consistent feedback that men are less likely to access them than women, are less likely to be open about their behaviour and still suffer considerable self-stigma

Men are still resistant in using condoms as they will not attend different trainings and not be present in different activities. They are the ones to ask the women for sex. They will be the ones to bring up the idea. It is not easy for the women to tell them what to use. They still act as a very big barrier as women still don't have a choice on that. (Exec Secretary cell level and chef de village, Rukore and Muramba)

Men still don't take part in the activities. They can't admit they have HIV&AIDS. E.g. there was a PLHIV man from Ngoma sector in Huye District who shifted and went to another sector to look for a wife where he was not known. Another man went somewhere and was with a woman, he came across someone who knows his status and was winking at that lady to not tell [the new woman] about his status. He wanted this new woman to get involved with him, yet he knew his status. Even in the VCT mobile programme the women always go in larger in numbers compared to the men. (Pilot committee, Mbazi)

Likewise the social affairs, Cyabingo sector said that at the start of last year they had 316 new cases of HIV diagnosed, but only 218 of these turned up for their follow up appointments. She commented it was mainly men who didn't turn up. The executive secretary of one of the cells went on to say that there were 9 men diagnosed in the cell as positive who refused to use condoms with their wives. Similar issues were reported in Rugimbu where a PLHIV man was refusing to use a condom with his discordant wife.

7.4.4 Minimising the socio-economic impact of AIDS

The programme's goal was to help minimise the socio-economic impact of AIDS. This happened via three routes:

- referral of some PLHIV to the FIM programme,
- communal work, IGA and savings of the AAC, HBC and PE
- Support of PLHIV by the AAC and HBC

PLHIV referred to the FIM programme

The number of PLHIV referred to the FIM programme was limited by the programme's budget. There were 2 cohorts 2007 (2008 in Gakenke) and 2009. The second cohort was in new areas. In total 287 PLHIV were supported by the FIM programme.

Data supplied by Concern Rwanda suggests that average monthly incomes of direct beneficiaries of the FIM programme who were supported in either agriculture or IGA rose from 5000-8000 Rwf to 10000-20000 Rwf. Incomes are notoriously difficult to assess for small holder farmers or small traders so these figures should be treated with some caution. However, even after allowing for inflation of 6% these figures suggest an increase of around 60-100% which is significant, but, if they do not have additional income, still leaves participants in the category of the poor or extreme poor on the basis of income analysis only.³⁶

Communal work, IGA and savings of PLA belonging to the AAC, HBC and PE

Those PLHIV who are members of the AAC, HBC volunteers or PE would benefit, as would other members, from any IGA or savings scheme that the group undertook. This is described in more detail in section 7.1.1. It should be noted that club members were not selected as being the most vulnerable in community, but as being the most able to communicate and support others in the community among the 4 targeted groups (PLHIV, widows, unmarried mothers, child headed households) certain vulnerable categories.

Support of PLHIV by the AAC and HBC

Table 10 shows the number of times that PLHIV were supported by the community level structures set up by the programme. As the same households could be counted more than once in these figures, it is not possible to extrapolate from this the absolute number of PLHIV supported. What we can say is that at a maximum this is reaching 929 different PLHIV a year, who may also be members of the clubs, but it is likely to be somewhat less than this.

³⁶ According to UNDP (http://www.undp.org/rw/Poverty_Reduction.html) Poverty in Rwanda is measured using a poverty line which represents the cost of an adult's basic needs: enough food to provide 2,500 calories per day, and some basic non-food items. The poverty line was RWF 250 per day in January 2006. Any person who consumes less than this amount is classified as poor. Similarly, extreme poverty line covers food costs only, and were RWF 175 per day in 2006. Using an inflation rate of 6% per year would put these figures at 355 RWF per day for poor to 248 RWF for extremely poor, this translates to a monthly figure of around 10600 RWF for poor and 7500 for extreme poor. However as this figure is for one adult only, then any household earning with 2 or more adult members earning the upper of these figures would remain poor, and if earning the lower of these figures, extremely poor.

Table 10: Support through local solidarity mechanisms

	2007	2008	2009	2010	Total	Comments
# of times people were supported through local solidarity mechanisms including HBC.	55	162	929	506	1652	According to ARBEF staff the same household could receive support twice or three times according to their needs. So these figures represent number of times that people were supported rather than No of people supported

This support took different forms in different places and at different times, but examples given included:

- Cultivating
- Building houses or toilets
- Buying livestock
- Contributing food
- Buying school materials

This help, though limited in scale, clearly makes an immense difference for some people:

There was a handicapped widow, old, we helped. We would cultivate for her, but this wasn't enough so we also contributed food. Before harvest we each give her 2 kg beans. We do every year. (Peer educators & HBC, Rugimbu)

The extent of this support was sometimes constrained by the resources of the club members:

We built houses for 2 of our members. But we still haven't finished as they need doors, windows and cement for floors. (Club Anti-SIDA Rusagara)

In some cases the clubs were able to access, or inspire support for PLHIV from the wider community. For example the Social affairs officer of Rusagara cell talked about how they had opened up a donations box at the cell office, so that visitors could make donations to support PLHIV. However in most cases, the burden of caring for PLHIV has remained with the various clubs set up by the programme. In Gisakura PLHIV were able to access some help with food from the health centre.

8. Financial Analysis

The programme has spent a total of Euro 745,107 over the period 2007-10 as shown in table 11. Spending peaked in 2008 and by 2010 had fallen considerably.

Table 11: Expenditure and budget in Euros

All figures in Euros					Total
	2007	2008	2009	2010	2007-10
Direct Expenditure	69185	103624	86914	70353	330076
Direct Support Cost	35765	74458	48325	13942	172490
Indirect Support Cost	49214	60569	76136	56621	242540
Expenditure Total	154164	238651	211375	140917	745107
Project Budget	197537	289714	201589	128624	817464

Table 12 shows spend broken down by category. It can be seen that direct expenditure formed 44.3% of the total expenditure over the whole period. In the final year of operation this rose to almost 50%. Indirect support costs also rose as a proportion of the whole for the final two years.

Table 12: % Expenditure and spend by category

	2007	2008	2009	2010	Total 2007-10
Direct Expenditure	44.9%	43.4%	41.1%	49.9%	44.3%
Direct Support Cost	23.2%	31.2%	22.9%	9.9%	23.1%
Indirect Support Cost	31.9%	25.4%	36.0%	40.2%	32.6%
Expenditure Total	100.0%	100.0%	100.0%	100.0%	100.0%
% of budget spent	78.0%	82.4%	104.9%	109.6%	91.1%

Cost per direct beneficiary (i.e. members of AAC, HBC volunteers or PE) was a total of 220 Euro over the 4 years as can be seen from table 13, an average of 55 Euro per year. To put this in context the GDP per capita in 2010 was 540 US\$ (approx 380 Euro) and the national spending on health per capita was estimated to reach approximately \$47 (33 Euro) per capita in 2008³⁷.

The number of people getting direct or indirect support through the programme is hard to estimate as the data collected on community support to PLHIV or people affected by AIDS (Table 10) counts support to households not individuals and is likely to include double counting. Also it doesn't distinguish between different types of support. At the absolute most it reached 929 households in 2009. If these were treated as separate individuals who are different from the direct beneficiaries, then the number of people receiving some sort of direct or indirect support from the programme in 2009 would be 4312 (i.e. the 3383 direct beneficiaries plus the 929 people directly supported by the AAC or HBC) which would make the cost per beneficiary fall to 49 Euro that year. The true cost per person receiving direct or indirect support is likely to lie between these two figures (i.e. 49-62 Euro in 2009).

Table 13: Cost per beneficiary

All figures in Euros	2007	2008	2009	2010	Total 2007-10
Cost per direct beneficiary	46	71	62	42	220

Cost per indirect beneficiaries (i.e. those reached with sensitisation and prevention messages which is taken to be the whole population of the programme area) can be seen for Huye in table 14³⁸.

Table 14: Cost per Indirect Beneficiary

Huye (Mbazi, Simbi and Rwaniro)

Population in 2007 ³⁹	66691				Euros
	2007	2008	2009	2010	2007-11
Expenditure Total (Euros)	74567	89598	78247	65711	308123
Cost per head popln (Euros)	1.12	1.34	1.17	0.99	4.62

³⁷ Health and the MDGs Revisited Chris Lane November 2009

<http://siteresources.worldbank.org/HEALTHNUTRITIONANDPOPULATION/Resources/281627-1095698140167/RwandaFiscalSpace.pdf>

³⁸ Note population in Rwanda is growing rapidly, so the actual spend per head of population will be slightly lower.

³⁹ From baseline

There was a total of 4.62 Euro per head of population in the 3 sectors in Huye which averages out at 1.16 Euro per year. As the message that is reaching the wider population in Huye is largely about prevention, this can be compared against the total expenditure for prevention work (Table 1). This was for approximately US\$ 17,115,000 in 2007 and US\$ 29,308,000 in 2008 (approximately 12 million and 20.5 million Euro at current exchange rates). If we use a total population figure of 9 million this equates to a spend per head on prevention of HIV&AIDS of 1.3 Euro in 2007 and 2.3 Euro in 2008. Thus the cost of the programme per head in Huye is broadly comparable to the cost per head of overall prevention programmes in Rwanda.

9. Conclusions and lessons

9.1 Progress against baseline

Overall there is anecdotal evidence to suggest that within programme areas there has been considerable progress against a number of issues identified in the baseline. The extent to which this is attributable to the Tubunganire programme is challenging to assess as there are many other sources of information on HIV&AIDS within Rwanda, however a case can be made that the programme has contributed to positive shifts in the following areas:

- Lack of knowledge on HIV&AIDS
- High levels of stigma (self and external)
- Weak community support structures
- Risky behaviours
- Weak demand for VCT

However a number of challenges that were identified in the baseline and proposal remain including:

- Regular and easy access to male condoms
- Risky behaviours by men in particular
- Wider community support structures, in particular linking with newly developed and already existing structures (e.g. palliative care CHWs)

These are compounded by an overall context of high levels of poverty and vulnerability which influence life choices and make access to food and sufficient nutrition to support adherence ongoing challenges.

Furthermore none of the achievements against the baseline situation can be considered sustainable unless there are systems in place to give information and support on an ongoing basis. The NSP rightly emphasizes the importance of continuity of prevention efforts and comments that *'behaviour change is not a once-off process, and just like the provision of treatment to people living with HIV, HIV prevention efforts in communities need to be maintained over time, and they need to be adapted and updated'*⁴⁰. It identified poor continuity of service delivery as a key risk and pointed out that threats to continuity in prevention include: condom stock-outs and sporadic CSO outreach programming, from lack of continuous funding. Both of these remain challenges in the programme area. It goes on to point out that *'lack of continuity in community programs can also reduce the effectiveness of treatment – for instance if there are interruptions in the provision of treatment adherence support, and nutritional support, as well as social support for orphans and vulnerable children'*.

⁴⁰ Rwanda National Strategic Plan on HIV and AIDS, 2009-2012

This section looks in more detail at some of the lessons that can be drawn from the programme.

9.2 Sustainability

The evaluation showed that AAC and community based projects can be effective in the prevention of HIV&AIDS & the support of PLHIV. The community based structures are giving support and hope at the community level and some of them, but not all, appear to be sustainable at least in the medium term. However they lack the following:

- Access to updated information except on an ad-hoc basis⁴¹ (radios, individuals going for treatment)
- Regular and reliable access to condoms
- Access to supplies for HBC eg soap, ointment for sores etc, food supplements for the bedridden (they had these in the past from ARBEF)
- Ongoing support and guidance
- Close linkage and integration with existing services.

Some are linked with local government leaders e.g. social affairs who give them some support and encourage them and may use them for mobilisation and activities. Some are not. Linkages with the health structure are weaker, though some of the AAC include the community health volunteers as members, this was not planned systematically. The programme made some attempt to build links through training local government leaders in 2009 and 2010, but turnover meant that by the time of the evaluation many of the people in these roles had changed. But training government officials part way through a 4 year programme is not adequate to generate ownership. As put by one member of staff:

'The thing that worries me most is that the local leaders at cell level left implementation to ARBEF. I think that now ARBEF is gone it will be hard for them' (ARBEF staff)

Another commented:

I don't think we had a good exit strategy. We went and told people we were leaving, but we did not leave in a way that they were strong enough to work on their own and stay strong. (ARBEF staff)

There were attempts to hand over the work to others during the last year of the programme:

In the last year of working we would reduce visits. We held meetings between the leaders and other partners to tell them are leaving to see what they can do follow up with them. (Analysis workshop)

But our field work showed that this attempt to hand over responsibility during the last year, met with mixed results and led to the conclusion that it has to be built in from the start. It is important that work is done to promote local ownership and partnership with health structures throughout the programme cycle. This might mean approaching work much more

⁴¹ Concern Worldwide's Metaevaluation of HIV&AIDS evaluations states that 'the idea that increasing knowledge and understanding are sustainable must be contested, especially in relation to HIV and AIDS where some basic facts may be "constant" but medical knowledge about avoiding transmission, dealing with and avoiding opportunistic infections etc are changing all the time. People need to know where they can go and get up to date information in order to ensure their understanding is sustained'.

in partnership so that the programme doesn't reach a point of formal 'handover' but rather phases out support over time. If a handover approach is planned, then it is important that there strong relationships have been invested in and developed, along with understanding of what the programme was doing so that handover responsibilities can be allocated.

The original proposal for the HIV&AIDS programme gave more focus on developing capacity and structures for HIV&AIDS prevention and support. In practice the programme has largely delivered the prevention and support itself though setting up, supporting and mentoring community based structures. Though it has worked through a local NGO, this is not an NGO that is operational in the programme sectors on an on-going basis (currently ARBEF has no staff working in the sectors covered by the programme, and the evaluation provided the first opportunity to visit the community structures since the programme had ended). As put by one member of staff:

Every project should have a start and an end. But it stopped when it was very active and had raised to a climax and then just stopped. We weren't surprised, but we had come from a phase when it was hard. Then we reached a point where everything was going well and it just stopped. I think it should have continued (ARBEF).

The conclusions from this evaluation are not that the programme should necessarily have continued, but that it should have been designed from the start with the exit strategy in mind and focused more on the need for support and prevention services to be provided in a continuous manner. As put in CWW's HIV&AIDS Strategy there is a need to:

Link all activities to relevant referral services, e.g., condom distribution..., medical care, VCT, ... , PMTCT, etc, and to advocate and make linkages for the provision of services and the allocation of resources in underserved areas.

Indeed the programme lacked an advocacy element which could, for example, have both drawn evidence from the programme on issues such as lack of regular access to condoms, the demand for them, and the best routes to supply them, and then used this evidence to influence the government policy on condom supply while continuing to supply them in the short term. Similarly in one sector the programme worked to increase demand for VCT through providing mobile services, but this was not linked to advocacy to ensure that the local HC had the necessary facilities by the end of the programme. As a result the VCT service abruptly stopped and there could be an 18 month gap before it is restarted.

This links with the possibility of making more use of the complementarity of skill sets and experiences that Concern Rwanda and ARBEF have. ARBEF's strength in service delivery, combined with Concern's access to networks and potential for influence at district/hospital level could have supported approaches that addressed issues of sustainability from the start.

9.3 Community structures and links with local leadership and health services at facility and community level

Whilst it is useful to have specific groups focused on different tasks (mobilisation and sensitisation, HBC, Peer education), the evaluation showed that it is not necessary for these to be separate groups. It would be possible to have one AAC with separate committees within it. This would aid in coordination and linking with the local authorities, and minimised the risk of having a number of unconnected initiatives at grassroots level.

The community level structures worked best where there were strong links with, and good leadership from, local leaders who showed an interest in what they were doing. It would be possible to plan this more systematically:

Before when we were implementing the project the local leaders were not very much part of the project. The meetings were just to tell them about the project not to really make them part of the project. Now I would give them activities or link them in different areas so they are more included (analysis workshop).

There were some attempts to link with HC, for example in Gakenke there would be an annual meeting between the HC, ARBEF and the peer educators. But this is not the same as building strong links from the start. Two HC visited said that the programme worked separately with the HC and with the community and weren't encouraging the community structures set up through the programme to link with either the health centre or the community operations managed within the Ministry of Health Structure such a community health workers for palliative care. One of the Health Centres visited indicated a desire to strengthen these links and the NSP 2009-12 offered the ideal entry to building these links as it states:

Many interventions described in this new HIV strategy have both a clinical health facility based aspect and a community based aspect. Rather than seeing them as separate interventions, the strategy adopted by this NSP is to link them to ensure a continuum of intervention from the health facility to the community. ... [An] important strategy is to establish a coordination mechanism between the community mobilization system implemented by community based organizations (associations of people living with HIV and AIDS, NGOs, faith based organizations) and the community health workers' interventions supervised by the health centre.

9.4 Targeting

The programme successfully targeted groups who were particularly vulnerable to the impact of HIV and potentially vulnerable to becoming infected i.e. orphans, widows, unmarried mothers and PLHIV, the majority of whom are women. Concern's meta-evaluation on HIV&AIDS found:

Women's willingness to actively volunteer in support or self help groups is clear from the reviews; however programmes need to make more effort to ensure that this bias does not mean that the burden on women is increased.

This evaluation shows that there are benefits for marginalised women in terms of recognition and status in the community from their membership of self-help groups. It should be possible to build on this, whilst spreading the burden more equitably within the community by working to develop stronger support links for the community structures set up by the programme.

Furthermore, because of the way targeting was done the programme faced challenges in reaching other groups. Consistent feedback suggested that men were not being reached and were less likely than women to either take preventive measures, seek VCT, be open about their status, or seek care unless they were very ill. Though it appeared that progress was being made in supporting women to negotiate safe sex with their partners, this is a challenging area, and many are unable to do this, or unable to do it on a regular basis.

Not fully involving men runs counter to CWW's HIV&AIDS strategy:

The involvement of men in HIV prevention programmes is critical to better address power inequalities and to reduce men's vulnerability and that of women to HIV infection. Fathers need to be included in prevention-of-mother-to child transmission programmes. Greater involvement of men can help to reduce the spread and impact of HIV and AIDS among women and men. Men and boys can be engaged to promote gender equality and to help address gender based violence associated with HIV transmission. (CWW AIDS strategy)

Not including men also weakens the programmes' ability to reach out to discordant couples – which is where the NSP predicts most new infections will arise.

There was some anecdotal evidence from Huye, where the AAC were set up from the vulnerable categories that prevention messages were not reaching all youth as there was said to be a rise in teenage pregnancies. It is important that some focus on membership renewal is built into such clubs. 13 year old children at the start of the programme, could be starting to become sexually active 3 or 4 years later, and if the club remains focused on its original members, it is unlikely to reach them. It might be that clubs can set up a youth committee, a proportion of whose older members stand down each year to be replaced by younger representatives.

9.5 Ensuring clubs stay focused on task

There can be some conflict of interest between groups focused on group activities such as savings and IGA and benefits for their members, and those looking outwards to provide a service or benefit to the community. Whilst there must be benefits to members in being involved, or they will not remain involved, it is important that the balance doesn't tip over so that the group's primary purpose becomes about income generation rather than HIV&AIDS prevention and support. Indeed benefits do not necessarily have to be material, as important can be status and recognition in the local community, access to knowledge, or a sense of purpose in life. Similarly it is important that a focus on IGA or savings doesn't exclude the poorer members of the group or act as a barrier to new members joining as they would have to match the savings already accrued.

This may mean further orientation, or bye-laws within clubs to ensure that the club is clear about, and stays focused on, its primary purpose. Strong links to eg the local health centre can help reinforce this.

9.6 Monitoring and evaluation

The programme had collected basic quantitative data on number of people in clubs, numbers trained, numbers supported by HBC, numbers going for mobile VCT and condoms supplied. A more comprehensive monitoring framework had been developed towards the end of the programme, but not really used.

Monitoring and evaluation needs to be an integral part of the programme from the outset, staff consider that this is likely to be the case in future programmes with the introduction of Concern Worldwide's new PM&E guide and the commitment by Concern Rwanda to improve M&E overall. In doing this where possible indicators in the monitoring framework should align with data already being collected by the government to make it possible and economic to collect the data⁴². However indicators also need to be suitable for a 4 year programme. For example UNGASS recommends that transmission reduction is tracked

⁴² Ideally this would also mean automatically aligning with UNGASS best practice

through percentage of young women and men aged 15–24 who are HIV-infected, which gives a better indication of new infections than the more general prevalence level currently in the programme logframe.

In work of this kind it is important to find appropriate methods for assessing and understanding behaviour change. As put by CWW's HIV&AIDS meta-evaluation: *'It is not adequately addressed through asking people if they have changed their behaviours, as this will, at best, test, understanding of what are risky or harmful practices and not much more... There is a need for greater use of "proxy indicators" of changing behaviour.'* It should be possible to identify and collect some local health statistics that can act as a proxy for changes in sexual attitudes and behaviour e.g. STD rates, numbers of teenage pregnancies, age of first pregnancy, VCT rates, % of people turning up for post positive test appointments etc. But these should be collected on an on-going basis to track trends over time and help inform decision making. Ideally this could be done in collaboration with local leaders so they are empowered to track the progress of sensitisation and prevention work in their communities. It is not possible to systematically collect this kind of data in 2 weeks of field work during an evaluation.

Although the programme is unlikely to be the only influence on such changes, it does help to triangulate qualitative data collected during interviews. It may also be possible to compare this data with trends in other similar non-programme areas.

It is important that monitoring and evaluation processes also allow for programme design to adapt both as a result of how work is going on the ground and taking into account the emerging picture of HIV&AIDS in Rwanda as new data and approaches become available and best practice evolves.

9.7 Feedback mechanisms and protecting participants

Concern has a strongly disseminated and widely known programme participant protection policy which is to be lauded. All CWR staff and partner organisations are signatories to the P4 and the country programme management and staff are committed to applying and promoting the values and behaviours associated with this document. Despite this, a number of programme participants and other community members in Nyaruguru were defrauded of considerable savings, reported to be more than a million RWF from 153 people in 2 cells, as a direct result of trusting someone working in partnership with Concern on the programme. They say that this money was handed over in different phases, some in order to buy shares in Dutereimbere cooperative and some for other activities, including the purchase of cattle.

The incident happened some time ago, and the evaluation team only spent one afternoon in the area, so it is not possible to reconstruct exactly what happened or how it could have been prevented. However documentation of the investigation undertaken by Concern and discussions with the community explains additional issues which came to light:

It was confirmed that programme participants were requested to sign for a higher amount than they actually received as transport allowance for trainings. On March 17th one co-operative member declared 'when you are poor and someone asks you to sign for an amount of money and gives you a lower amount you accept because you are poor'.⁴³ This practice does not reflect Concern Worldwide's organizational commitment to community accountability, nor does it comply with the organization's 'Programme Participant Protection Policy' which prohibits exploitation of beneficiary communities. [.....] Overall the

⁴³ Name has not been inserted as discussions were held on a confidential basis.

*investigation has revealed poor financial systems and inadequate accountability to beneficiary communities on the part of IVPF. In the process of this investigation we observed a lack of willingness to share information and a disregard for the entitlements of community members. This has made it impossible for Concern Worldwide to continue working with IVPF and in turn meet our organizational commitments to transparency and accountability.*⁴⁴

While the case came to light as a result of audit irregularities and was handled through a process of investigation and steps taken to end the partnership, staff explain that there were limitations on Concern's ability to seek redress for individual community members. Despite efforts on the part of the Programme Officer to follow up with the community and local authorities to bring the process to a conclusion a sense of disappointment was still apparent among programme participants at the time of the evaluation.

It is important that due consideration is given to the lessons that can be learnt from this. There were no clear complaints mechanisms in programme areas, and it is possible, but by no means certain, that such a mechanism could have alerted Concern to the issue at an earlier stage. At the very least programme participants should be given a printed paper with basic information about what they can expect from the programme and a telephone number they can call in confidence if they have any concerns. This should be re-iterated verbally on a regular basis. The issue is a clear example of the importance of implementation of the various Humanitarian Accountability Partnership mechanisms to which Concern is committed. In 2009 Concern Worldwide Rwanda undertook a HAP baseline and subsequent to this an accountability action plan was drafted which includes the development of an information sharing strategy for communities and the implementation of a complaints response mechanism.

The country programme team acknowledge that this event has prompted them to look carefully at the process of partnership selection and indeed the partnership approach more broadly. This is reflected in the strategic plan for 2011-2015 which states: *CWR decision to work with partners will depend on the continued existence of reliable local partners. If reliable CS partners are not present where we work, programmes will be implemented directly, while continuing to look for possibilities to invest in local partner capacity development.*⁴⁵

In line with integration of the HAP principals to programme design senior Concern staff comment that there is much greater consideration given to Concern visibility in a partnership relationship and the importance of maintaining substantial direct engagement between Concern and the community even when local organisations are the first point of contact for service delivery.

It is also possible that the reduction in Concern staff prevented the problem from being identified more quickly (from 2009 there was only one staff member working on the programme for all 3 programme areas). Whilst it would appear that this was adequate to support the established partner ARBEF, who had their own systems for supervision, more regular visits to programme areas may be useful with new and untested partners.

44 Letter to local authorities re IVPF Concern Worldwide Rwanda 2010

45 CWR Strategic Plan Version 3, February 2011

9.8 Working in partnership

Concern staff have faced some challenges, as is to be expected, in adapting from their traditional experience as direct implementers to working in partnership where their role changes to being one of mentoring, guiding and advising partners. Part of successfully working in partnership is systematically considering and building strategies that build on the specific strengths of different organisations. In this case ARBEF have the experience and skills in service delivery, whereas Concern is linked in to international and national networks and debates on HIV&AIDS issues.

Concern Rwanda needs to work with staff to develop the understanding and skills to see their role more broadly. This would include keeping abreast of debates and innovations within their field of expertise, building strong links and relationships with institutions like CDLS, and generating robust evidence to leverage broader influence at both programme and national level.