FINAL REPORT OF THE REVIEW OF THE FAMILY PACKAGE PROJECT – RWANDA

August, 2010
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5  ABBREVIATIONS AND ACRONYMS

ANC          Anti Natal Consultation
ARV          Ant Retroviral Therapy
CBO          Community Based Organization
CF           Clinton Foundation
CNLS         National AIDS Commission
CRW          Contract Review Committee
CSOs         Civil Society Organisations
CUSB         Centre Universitaire de Sante Publique
FAO          Food and Agricultural organization
FP           Family Package Project
HAART        Highly Active Anti Retroviral Therapy
HIV          Human Immune Deficiency Virus
IF           Imbuto Foundation
IGA          Income Generating Activities
M2M          Mother to Mother
MDGs         Millennium Development Goals
MOH          Ministry of Health
MTCT         Mother to Child Transmission
NGO          Non Governmental Organization
OIs          Opportunistic Infections
PACFA        Prevention and Care of Families against HIV/AIDS
PANGAEMA     Publication Network for Geo-scientific & Environmental
PCA          Project Cooperative Agreement
PMTCT        Prevention of Mother to Child Transmission
RDB          Rwanda Development Board
RDHS         Rwanda Demographic and Health Survey
STIs         Sexually Transmitted Infections
TRACPLUS     Treatment Research and AIDS Centre
TWG          Technical Working Group
UN           United Nations
UNAIDS       United Nations for AIDS and Development
UNICEF       United Nations Children Fund
UNIFEM       United Nations Development Fund for Women
WFP          World Food Program
WHO          World Health Organization
6 ACKNOWLEDGEMENT

The review of the Family Package Project was commissioned by Imbuto Foundation supported by UNICEF – Rwanda. The team of consultants would like to express gratitude to the officials and staff met for the generous support, extended to us to accomplish this task. Special thanks go to the Permanent Secretary, Ministry of Health, and the UNICEF Country Representative in Kigali, Rwanda. Sincere thanks go to the UNICEF HIV and AIDS Section, Imbuto Foundation Family Package project staff for their crucial technical input.

We also extend our gratitude to the CNLS, TRACPlus, and members of the HIV Prevention Technical Working Group for providing valuable input enabling the review to remain true to the national context. Our gratitude is extended to partners like Clinton Foundation, UNIFEM, FAO among others not mentioned but whose contribution was equally important.

The review process was also made smooth by the commitment demonstrated by eight research assistants to collect reliable information from the 7 Family Package sites. We wish to commend their effort to this effect.

We are gratified at the great interest taken in the production of this report and anticipate that the proposals outlined herein will be taken into consideration.
7 EXECUTIVE SUMMARY

Introduction and Background Information
PMTCT activities started in Rwanda in 1999 with a piloting phase in Kicukiro health centre in Kigali City. Results from this pilot were impressive and the MoH sought to expand PMTCT nationwide and to subsequently integrate it into existing health structures. In this regard, the MoH mobilized partners to support the roll out plan. A steering committee was set up with involvement of all potential partners and a steadfast rollout process was embarked on. Since then, scaling-up of PMTCT programme has been gradually taking place. By the end of 2009, 373 sites were offering comprehensive PMTCT services compared to the initial package.

Acknowledging the effects of poverty, gender inequality and food insecurity as key drivers in the spread of HIV and AIDS, the “Family Package”, was designed under the initiative of the First Lady, to promote socio-economic empowerment, male involvement in PMTCT services, psychosocial support using support groups, sensitization on Family planning use of services, support with “Mutuelles de Santé” (community health insurance) membership for families and nutritional promotion through Income Generating Activities (IGAs) in addition to standard clinical PMTCT services. After 8 years of implementation, there was a need to carry out a review in order to document project achievements; highlight best practices and lessons learned; and formulate recommendations for improvement and scale-up of the project. In this regard a review of the Family Package project was carried out between April and May, 2010.

The specific objectives of the review were:

1) To assess the appropriateness of project’s model of care and support to address the PMTCT challenges
2) To assess the overall performance of the project in delivering planned outputs and identify potential best practices for replication
3) To determine the challenges faced during project implementation from program manager, care giver and beneficiary perspectives
4) To formulate recommendations with regard to FP model of care and support, and programmatic interventions with potential for scale-up and sustainability

Methodology
The evaluation employed both Qualitative and Quantitative approaches. Key evaluation questions were designed to assess if the model of care and support was appropriate, well implemented and sustainable. During the review process a literature and desk review was carried out and consultative meetings, Focus Group Discussions (FGDs) and interviews used as main methodologies to generate findings. Preliminary tools that allowed reviewers to gain insight into project intervention areas were developed and field visits were conducted in 7 sites. Key Informant Interviews were held with partners such as UNICEF, and UNIFEM, Clinton Foundation, World Vision, CNLS, a Head of PMTCT unit at TRACPlus and the Permanent Secretary of the Ministry of Health. In-depth interviews were conducted with Titulaires and head of the PMTCT department of each health facility where Family Package project was implemented. FGDs were conducted with two groups of beneficiaries, one group that comprised peer educators and another with beneficiaries drawn from associations/cooperatives at each facility. In total 14 FGDs in all seven FP sites.

1 Interviewed as the first coordinator PACFA and the first FP project officer
Findings

HIV test uptake among pregnant women attending ante natal care (ANC) in Family Package sites was higher as compared to the national average. In 2005, 98% in FP sites compared to national average of 89% of pregnant women attending ANC were tested. In 2008 and 2009, 100% of pregnant women were tested in FP sites compared with a national average of 97.9% in 2009.

The percentage of male partners attending ANC and testing for HIV in FP increased from 50% in 2005 to 82% in 2009. While this was much higher than the national average in 2005 and during the two years that followed, the national average caught up with FP sites average (82%) in 2009 (84%).

The proportion of HIV+ pregnant women in FP sites receiving ARV prophylaxis was consistently higher in FP sites compared to the national average. In 2009, this proportion in FP sites was 74% compared to 68% at the national level. 60% of infants born to HIV+ mothers get an HIV test at 6 weeks in FP sites compared to 54% nationally while 84% are tested at 18 months – a figure much comparable with the national average of 87%. The number of HIV+ mothers and infants lost to follow decreased respectively from 52 in 2007 to 26 in 2009 for the former and from 84 to 22 for the latter during the same period. In FP sites a total of 1,589 discordant couples are being followed up.

The review found that project planning and introduction process encouraged a participatory approach whereby stakeholders were brought on board; that the project was fully owned by all its stakeholders, at the national the local level. Further, the review noted that stakeholders demonstrated profound understanding of the project with beneficiaries (peer educators and members of the associations) being at the forefront in this regard. The project also addressed local needs and brought about palpable benefits to the health facilities, the beneficiaries and collateral benefits in communities in which they live.

Regarding project organizational and institutional framework, the review observed that despite registering progress, the project was implemented with limited staffing (one project officer was available). This minimized the amount of supervision from central level towards the sites, lead to inadequate recording of project activities and likely contributed to the observed insufficiency in training of beneficiaries and implementers (titulares and/or PMTCT heads). Although the review observed different areas in which target groups were trained in order to build their capacity, a lack of training material (such as curricula, training manuals) lead to inconsistency in the content of training delivered at different health centers.

The review noted that there was inadequate monitoring of the project previously and welcomed the fact that a monitoring officer has been hired to institute an effective monitoring system.
The review identified different aspects of the project it deemed to be sustainable. These include the way the project is well integrated within the existing health structures. In this regard, the project uses the same PMTCT national program, the same health infrastructure and same personnel. This potentially makes it for the project to be extended to new sites without having to incur heavy investments.

Also, the project implemented certain pioneering interventions which brought economic gains to beneficiaries which included providing loans for IGAs, loans to individuals who present sound project proposals. Loans once provided were used to start micro projects which generated income thus improving beneficiaries' livelihoods as well as those of their families.

Lastly, the cost of implementing the project was found to be minimal as the project spent $5 per beneficiary per year over a five period – a powerful finding that pins to potential for sustainability and scale up.

Conclusions

In Family Package sites, nearly all women attending ANC accepted to be tested for HIV and this level of performance has consistently been maintained above 98% from 2005 to 2007. In 2008 through 2009, all women attending ANC accepted to be tested for HIV. Male partners of women attending ANC who were tested for HIV in FP sites has also been higher than national average since 2005. The national average however caught up with the FP supported sites in 2009 (at 84%). Other indices such as the proportion of women receiving ARV prophylaxis and the infants receiving a virological test are either higher or comparable with the national averages as was shown earlier in this report.

These differences indicate that FP work in the sites it supports has contributed towards the achievement of PMTCT related outcomes in palpable ways. Even though the exact impact of FP interventions was not the focus of this assignment, the review observes with a fair amount of certitude that FP contributed to the observed differences between national averages and its sites.

As far as appropriateness and organizational framework of the project model is concerned, the review found many positives in the areas of stakeholder involvement, project ownership, planning and benefits the project brought to its target group helping them address their needs. On the other hand, there is still room for improvement through;

1. Promoting greater appropriation of the additional project interventions by health centers;
2. Strengthening health center capacity and empowering them to follow up additional project components such as IGAs and loans
3. Developing standard appropriate tools (planning, reporting, guidelines, training material, IEC) for use at the health center level.
4. Strengthening the Project M/E system
Finally, the review noted the following three main areas of the project which it deemed sustainable and therefore potentially allows for project transferability to other sites:

**Project Integration:** In many ways, the project is very well integrated with existing health structure functionally as well as structurally and requires no additional substantial investment to be initiated in new sites.

**Cost of the Project:** Based on the cost analysis conducted, the review observes that the cost of implementing this project model is minimal. Over a five year period, per capita expenditure per beneficiary per year was found to have been $5.

**Interventions bringing economic gains to beneficiaries:** Lastly, the review documented benefits brought about by interventions of the project that translated into real economic gains by beneficiaries. These include IGAs, individual loans and paying premiums for beneficiaries to enrol into health insurance (mutuelles de santé), thus allowing them access to health care.

**Recommendations**

**Imbuto Foundation**

Strengthen and streamline the monitoring and evaluation system of the Family Package, through development of an M/E plan, definition of measurable indicators and data collection and reporting tools.

Advocate for greater integration of family package approach within the overall MoH National HIV policy frameworks and implementation strategies.

Devise mechanisms to increase appropriation of FP additional components by health center staff through increasing their participation in training, refresher courses and encouraging them to provide site leadership.

Review existing and adapt or develop documents with clear and smart project objectives, targets, including strategies, IEC materials, training packages.

Strengthen partnerships with all stakeholders to increase support to Family Package project in areas of funding to allow for effective implementation of the project interventions.

Develop strategies specifically targeting discordant couples in order to avert new infections within this sub group – allowing for further reduction of stigma and gender violence within families.

Consolidate and strengthen community involvement in PMTCT activities by all organised community groups. Peer or Mentor Mothers; Community health workers and the community leaders and other peer support groups should be supported more and their capacities improved to support PMTCT services. Partnerships and networking between health facilities and community support groups should be promoted by establishing linkages for follow up of PMTCT clients within the community for improved effectiveness of the programme.

Strengthen project management capacity (HR, Training) of family package project staff.

Design and implement a quasi-experimental study comparing PMTCT outcomes in sites implementing FP and those not implementing it, to determine the real impact of FP interventions towards provision of PMTCT services.
The proportion of association members eligible to who received loans was 33 %. The review revealed that those who did not access loans had IGA proposals that did not meet the funding criteria. The review recommends that beneficiaries be trained in micro project plan development to help beneficiaries develop proposals that meet the funding criteria and increase their chances of receiving these much needed loans.

**Health Facilitates**

The review found many benefits of the project towards the health facilities, the staff and their clients. Titulaires should use findings of this review to increase awareness of benefits of FP among the staff thereby improving project appropriation by the staff.

Strengthen male championships and involvement of male partners to provide care and support to the mother and child, by extending male involvement beyond attending the first ANC visit and get involved in the whole cascade of the PMTCT services

**TRACPlus**

Adopt integration of family package project components (Loans for IGAs, discordant couple counseling and Peer Education) in the current PMTCT program

The Ministry of Health, through TRAC Plus should advocate for funding from national level and other sectoral plans to support cooperatives and associations members as well as families infected and affected by the HIV epidemic.
8 BACKGROUND OF PMTCT AND FAMILY PACKAGE PROJECT

8.1 PREVENTION OF MOTHER TO CHILD TRANSMISSION (PMTCT)

PMTCT activities started in Rwanda in 1999 with a piloting phase in Kicukiro Health Centre in Kigali City. Results from this pilot were impressive and the MoH sought to expand PMTCT nationwide and to subsequently integrate it into existing health structures. In this regard, the MoH mobilized partners to support the roll out plan. A steering committee was set up with involvement of all potential partners and a steadfast rollout process was embarked on. Since then, scaling-up of PMTCT programme has been gradually taking place. By the end of 2009, 373 sites were offering comprehensive PMTCT services compared to the initial package which was limited to basic PMTCT health care services such as HIV testing, provision of ARV prophylaxis, infant feeding and follow-up exposed infants.

8.2 IMBUTO FOUNDATION

PACFA (Prevention and Care of Families against HIV/AIDS) now Imbuto Foundation, was established by the First Lady of Rwanda with a mission to support development of a healthy, educated and prosperous society. Over the last eight years, the organization has advocated consistently and implemented pioneering initiatives on Health, Education, and Economic empowerment, impacting on the lives of many families across Rwanda.

Imbuto Foundation seeks to realise this vision by implementing its activities under four units namely:

1) Health Unit
2) Socio-Economic Development Unit
3) Communication Unit
4) Finance and Administrative Unit

8.3 FAMILY PACKAGE PROJECT (FP)

The Family Package project (FP) falls under the Health Unit of Imbuto Foundation and aims to supplement the PMTCT national response in order to reduce HIV infection by building on the benefits of Prevention of Mother-to-Child HIV Transmission (PMTCT) national interventions. This is done by implementing its activities via seven core components – namely:

1. Counselling and psychosocial assistance;
2. Prevention of mother to Child transmission through various anti-retroviral therapy
3. ARV treatment for adults and children and treatment of STIs and OIs
4. Sensitization on Family planning use of services
5. Support with “Mutuelles de Santé” (community health insurance) membership for families
6. Follow up HIV exposed infant and
7. Nutritional promotion through Income Generating Activities (IGAs)

Acknowledging the trilogy of poverty, gender inequality and food insecurity as key drivers of the spread of HIV/AIDS, the Family Package project promotes socio-economic empowerment, male participation, psychosocial and nutritional support, in addition to standard HIV prevention services, care and treatment to families infected and affected by HIV and AIDS. Emphasis of Family Package on the entire family of PLWHA gives it a unique perspective and makes it a new approach as compared to standard PMTCT as shown in the table below.
Table 1: Building Blocks of FP Verses Standard PMTCT

<table>
<thead>
<tr>
<th>STANDARD PMTCT PACKAGE</th>
<th>FP ADDITIONAL COMPONENTS to STANDARD PMTCT PACKAGE</th>
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<tbody>
<tr>
<td>HIV counselling and Testing (including couples)</td>
<td>Counselling and psychosocial assistance</td>
</tr>
<tr>
<td>Immunological and clinical assessment</td>
<td>Sensitization on Family planning use of services</td>
</tr>
<tr>
<td>ARV prophylaxis including HAART</td>
<td>Support with “Mutuelles de Santé” (community health insurance)</td>
</tr>
<tr>
<td>Psychosocial support</td>
<td>membership for families</td>
</tr>
<tr>
<td>Infant ARV</td>
<td>Nutritional promotion through Income Generating Activities (IGAs)</td>
</tr>
<tr>
<td>Safe and assisted delivery</td>
<td></td>
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<tr>
<td>Infant feeding support</td>
<td></td>
</tr>
<tr>
<td>Exposed infant follow-up (EID, CTx, Growth Monitoring, EPI)</td>
<td></td>
</tr>
<tr>
<td>Care and treatment for mothers, partners and infected children</td>
<td></td>
</tr>
<tr>
<td>Family Planning integration</td>
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</table>

The Family Package project was first launched in February 2002 at Kacyiru Health Centre in Kigali City and is currently implemented in seven health facilities in all five provinces of Rwanda. The project targets to reach 52 health centres by the year 2012.

8.4 GEOGRAPHICAL SCOPE OF FAMILY PACKAGE PROJECT

The family package is implemented in 7 health facilities across Rwanda as shown by figure 1 below. Having been piloted in Kacyiru, the project was extended to other health centers using a phased approach to; CUSP, Matyazo (both in Southern Province), Muhura, Nyamata (both in the Eastern Province), Gisenyi (Western Province), between 2002 and 2007 and finally to Muhoza H/C (Northern Province) in 2009.

Figure 1: Number of PMTCT sites implementing the Family Package project (2002-2009)
Expected outcomes

The Family Package project was designed to influence on individual and household determinants to achieve the following outcomes:

1) Poverty mitigation: Increased socio-economical status of infected mothers, partners and their affected families
2) Reducing Gender inequality and stigma: Increased male involvement in PMTCT and reduced stigma in the community
3) Mitigating food insecurity: Increased nutritional status of infected mothers, partners and their affected families

On the sketch below, the review schematically demonstrates the relationship between each of the Family Package additional components with these key challenges: poverty, gender inequality and food insecurity.

Figure 2: Relationship between FP and expected outcomes
9 OBJECTIVES OF THE REVIEW

There were four objectives outlined by the project review team. These are:

5) To assess the appropriateness of project’s model of care and support to address the PMTCT challenges
6) To assess the overall performance of the project in delivering planned outputs and identify potential best practices for replication
7) To determine the challenges faced during project implementation from program manager, care giver and beneficiary perspectives
8) To formulate recommendations with regard to FP model of care and support, and programmatic interventions with potential for scale-up and sustainability

10 EVALUATION METHODOLOGY

To achieve the stated objectives, the review employed both qualitative as well as quantitative approaches. A desk review to allow for primary and secondary data collection was conducted and both TRACPlus and Imbuto foundation databases were used enabling reviewers to gain insight into program interventions. Consultative meetings with UNICEF, and Imbuto Foundation yielded information about the origin and evolution of the project.

Key Informant Interviews were held with partners who have supported the project since it began. Those interviewed included UN bodies such as UNICEF and UNIFEM, Clinton Foundation, World Vision, CNLS and the Head of the PMTCT Unit in TRACPlus as well as the Project Officer of Family Package Project. The Permanent Secretary of the Ministry of Health was involved in the initial project conceptualization and planning process and later became the first project officer and was therefore interviewed in this capacity. In-depth interviews were conducted with Titulaires and heads of the PMTCT departments of each health facility where Family Package project is implemented.

In addition, Focus Group Discussions (FGD) were conducted with two groups of beneficiaries, one group that comprised peer educators and another comprised of beneficiaries drawn from associations/cooperatives at each facility. The number of participants in each FGD was restricted to between 5 and 10 based on comparable variables like background, status, education, age group. In total 14 FGDs in all 7 sites were conducted.

10.1 QUALITATIVE METHODS

The review utilized a set key of questions which guided interviews conducted with key project players to assess project qualitative aspects. These key questions were used to guide development of a qualitative questionnaire which ensured structured interviews with respondents of interest.

Key Evaluation Questions

1. Project Appropriateness
   – How appropriate was the model of care and support?
   – Was the package well defined from the start?
   – Were there clearly defined project objectives to be achieved?
   – Was the project development process inclusive (full involvement of key stakeholders in the planning process)?
Did all stakeholders (project initiators, donor agencies, implementers and beneficiaries) understand the project?

2. Project Implementation
   – How was the implementation of the project?
   – Was the project implemented successfully?
   – Do implementation arrangements (plans, strategies, communication, structures...etc) respond to the needs on the ground, are they in place?
   – Did the project achieve its objectives?
   – Are there best practices/lessons to learn from?

3. Project Sustainability
   – Did the project increase beneficiaries’ self reliance?
   – Which sustainable activities has the project supported?
   – Are IGAs acting as a source of livelihoods to the beneficiaries?
   – Have project interventions and activities been well integrated with the rest of MoH interventions and activities?
   – How did Family Package program create linkages with other stakeholders implementing PMTCT?
   – Are there adequate personnel with required skills to ensure project implementation?

10.2 QUANTITATIVE ASSESSMENT

Quantitative approaches were used to assess performance by considering variables and outputs of the national PMTCT program and Family Package project. These were then used to determine outcomes as outlined below.

Table 3: Quantitative variables and indicators from routine PMTCT program

<table>
<thead>
<tr>
<th>INDICATORS/OUTCOMES ASSESSED</th>
<th>Variable collected and used to calculate routine PMTCT indicators</th>
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<tr>
<td>Standart PMTCT indicators</td>
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<tr>
<td>– Proportion of pregnant women attending ANC tested for HIV</td>
<td>– Number of women attending ANC</td>
</tr>
<tr>
<td>– Proportion of HIV+ pregnant women who received ARV prophylaxis</td>
<td>– Number of women tested HIV+</td>
</tr>
<tr>
<td>– Proportion of infants born to women living with HIV who received a virological test within 6 weeks of birth</td>
<td>– Number of women on ARV prophylaxis</td>
</tr>
<tr>
<td>– Proportion of infants born to women living with HIV who received a virological test at 18 months</td>
<td>– Number of women delivering in the health center</td>
</tr>
<tr>
<td>– Proportion of male partners of pregnant women attending ANC tested for HIV</td>
<td>– Number of infants tested HIV at six weeks</td>
</tr>
<tr>
<td></td>
<td>– Number of children born of HIV+ mothers tested at 18 months</td>
</tr>
<tr>
<td></td>
<td>– Number of HIV+ women using modern family planning methods</td>
</tr>
<tr>
<td></td>
<td>– Number of women lost to follow up</td>
</tr>
<tr>
<td></td>
<td>– Number of children lost to follow up</td>
</tr>
<tr>
<td></td>
<td>– Number of infants tested HIV+ at 18 months</td>
</tr>
<tr>
<td></td>
<td>– Number of male partners attending ANC tested for HIV</td>
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</table>
Evaluation of Family Package output indicators
Additional FP variable were assessed using a set of variables were collected through Imbuto Foundation’s data management system or the health facility registers. Variables used to generate family package indicators and determine FP effectiveness are shown below.

Table 4: Quantitative variables and indicators from routine Family Package project

<table>
<thead>
<tr>
<th>INDICATORS /OUTCOMES ASSESSED IN QUANTITATIVE ANALYSIS FOR FAMILY PACKAGE PROJECT</th>
</tr>
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<tbody>
<tr>
<td><strong>Family Package indicators</strong></td>
</tr>
<tr>
<td>– Proportion of male peer educators in the 7 family package implementing sites</td>
</tr>
<tr>
<td>– Proportion of Family Package program members eligible to loans who receive them</td>
</tr>
<tr>
<td>– % of reimbursement from Rotational Loans for IGAs</td>
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11 REVIEW FINDINGS

11.1 QUANTITATIVE PMTCT FINDINGS

In the following section, the review shows findings of project performance which are presented as trends and compares evolution in FP sites versus the national averages.

11.1.1 HIV TESTING OF PREGNANT WOMEN DURING ANC

Figure 3: % of pregnant women who accepted HIV test in FP sites versus national average

The graph above shows trends of HIV testing uptake among pregnant women attending antenatal care (ANC) in Family Package sites versus national average from 2005 to 2009. Almost all pregnant women accepted HIV testing in FP sites as compared to the national average. As far back as 2005, the percentage of pregnant women attending ANC in FP sites who were tested for HIV was 98% compared to national average of 89%. Since then FP sites maintained this level of performance and tested 100% of women in 2008 and 2009. Meanwhile, the national average has progressively increased over the same period of time reaching 97.9% in 2009.

Whereas the increase for national average is largely due to the MoH commitment and issuance of a ministerial instruction to health facilities in 2007 to test all pregnant women attending ANC for HIV, in FP sites other factors were responsible for the observed higher and consistent performance (2005-2009). The Family Package emphasizes a peer educators approach – a model that builds capacity of HIV infected project beneficiaries by training them on various HIV issues including ANC. These are then encouraged to mentor their peers and educate the community on HIV-related issues. It is this that greatly contributed towards creation HIV awareness at the community level.
which explains the impressive and consistent performance observed in the FP sites. This was captured from participants during the review:

“Our neighbours these days increasingly come to us asking about FP and advice on HIV which we have happily provided”

(Focus Group Discussion with peer educators at Matyazo HC)

11.1.2 MALE PARTNERS OF PREGNANT WOMEN ATTENDING ANC AND TESTING FOR HIV

Male partners’ HIV test uptake was higher in Family Package sites from 2005-2007, as compared to the national average. Starting from 2008-2009, HIV test uptake by male partners of pregnant women in FP sites became comparable to the national average (80% in FP sites compared to 77 at the national level in 2008, and 82% in FP sites compared to 84% at national level in 2009). Since the inception of the PMTCT program, the MoH has made a recommendation to health facilities to develop mechanisms aimed at attracting male partners to accompany their wives for ANC and to test for HIV. At the beginning, the level of male participation was very low but picked up over time due to awareness created through different educational programs put in place by the health facilities and their partners – explaining the growing trend from 2005-2009. In the FP sites, this national effort was boosted further by direct implication of males as peer educators. This is shown in figure 11 which indicates that more than a third of peer educators trained by the FP are actually males. Involvement of male peer educators contributed to creation of positive perceptions towards male participating in ANC with their spouses. This was captured from participants during the review:

“Those of us who still have our male partners have been encouraged to bring them to join the association. Together, we and our partners are working to confront our challenges and develop our families”
**11.1.3 PREGNANT WOMEN RECEIVING ARV PROPHYLAXIS**

Figure 6: % of pregnant women receiving ARV prophylaxis

Source: Rwanda National PMTCT program, 2005-2009; Denominator: Total Number of pregnant women attending ANC Nationally and in 7 FP sites testing HIV+ who receive ARV prophylaxis according to the national recommendations.

Figure 7: disaggregated % of pregnant women receiving ARV prophylaxis by site

Figure 4 above shows that ARV prophylaxis initiation is higher in Family Package sites as compared to the National average (2005-2009) even if there is a declining trend from 2007 to 2009. In figure 5, disaggregated data of pregnant women receiving ARV prophylaxis in 2008 and 2009 is presented. In this graph, highlights potentially explaining the observed decline are revealed. First, it is shown that 4 sites did not necessarily perform well on this indicator and provoked a general decline of the trend in the seven sites. In two of these 4 sites that did not perform well, Family Package had been only recently introduced (2007) and the PMTCT program itself was relatively new. But the figure reveals another important finding – which is that in 2008, all women testing HIV+ at CUSP were transferred to Kabutare Hospital to receive prophylaxis because the facility lacked ARVs. It is not clear what caused the decline at Kacyiru HC which otherwise is the best supported. One possible explanation increased availability of ARV prophylaxis services to many health centers. When this happens, women who tested in another site (Kacyiru in this case) prefer to receive ARV prophylaxis services at facilities nearer to their homes when these services suddenly become available there. As a result, the numerator reduces while the denominator remains the same. The resulting proportion then becomes falsely low because some women who tested HIV+ at a site receive ARV prophylaxis at another site.
11.1.4 DISCORDANT COUPLES IN FP SITES

Figure 8: Number of discordant couples in FP sites

Source: Rwanda National PMTCT program, 2003-2009

Figure 6 shows the number of discordant couples in FP sites since 2003. A total of 1,589 discordant couples are being followed up within these sites – highlighting a potential for an increased risk of new HIV infections in these couples, many of whom still live with their partners.

11.1.5 EXPOSED INFANT TESTING

Figure 9: % of infants born to HIV+ mothers and tested at 6 weeks

Source: Rwanda National PMTCT program, 2007-2009; Denominator: Total Number infants born to HIV+ pregnant women Nationally and in 7 FP sites testing HIV+ who received a virological test 6 weeks after birth.
The above figure shows the % of infants born to HIV+ mothers in the 7 implementing sites versus the national average tested at 6 weeks from 2007 to 2009. PCR was first introduced in Rwanda in 2007 but was then limited to the Rwanda National Reference Laboratory in Kigali. It became more available to peripheral sites in 2009 via district hospitals where blood samples are sent from health centers to be tested. The increasing trend of PCR testing between 2008 and 2009 relates to this fact. In 2009, all FP sites were able to benefit from increased availability of PCR and accordingly (more infants) 60% of infants born to HIV+ mothers were tested for HIV at 6 weeks of age.

Table 4: Number of children tested for HIV at 6 weeks in FP sites

<table>
<thead>
<tr>
<th>Facilities</th>
<th>2008</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of infants expected to test at 6 wks</td>
<td>Number tested at 6 wks</td>
</tr>
<tr>
<td>Gisenyi</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Kacyiru</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Matyazo</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Muhura</td>
<td>21</td>
<td>27</td>
</tr>
<tr>
<td>Nyamata</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>CUSP</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Source: Rwanda National PMTCT program, 2007-2009

Throughout 2008 only one health facility (Muhura) out of the 7 FP implementing sites had CPR and capable to carry out HIV test on children at 6 weeks. In 2009 other facilities were able to perform the test as CPR became more and more available. Out of the total children tested within the two years, no child tested HIV.
In the above figure, a comparison is made between the % of infants born to HIV+ mothers tested at 18 months at the national level and in the 7 FP sites. Whereas this was lower for FP sites in 2007, their average performance is comparable with the national average in 2008 and 2009. Community based interventions initiated by the FP program through the peer educator program contributed to this positive trend. By conducting home based visits to families of people living with HIV, peer educators ensured greater acceptance and adherence to the PMTCT program by these people. This fact was echoed by health providers who commend the work of peer educators that has brought about reduction in the bulk of work they (health providers) would otherwise be required to perform in the communities.

“Peer educators do a commendable work in their communities and this has led to a diminution of our work concerning the follow-up of HIV patients”

(Key informant interview with Health Providers at Gisenyi)
11.1.6 FOLLOW UP HIV+ MOTHERS AND EXPOSED INFANTS

Figure 11: Number of HIV+ women and infants born to HIV+ mothers lost to follow up

The number of HIV+ mothers and infants born to HIV+ mothers lost to follow up has progressively reduced in the FP project sites as is shown in the above graph. According to this graph the number of HIV+ mothers lost to follow up has reduced almost four times from 84 in 2007 to 22 in 2009. On the other hand the number of infants lost to follow up has been reduced by 50%, from 52 in 2007 to 26 in 2009. Again peer educator program and their implication in the follow up of PLWHA families at the community level has had commendable contribution to this outcome. This was captured from interview with peer educators during the review:

“We follow up HIV+ mothers and children born to these mothers so that they can continue to respect the advice given to them by health provides”

(Focus Group Discussion with peer educators at CUSP)
11.2 QUANTITATIVE FAMILY PACKAGE SPECIFIC FINDINGS

In this section, indicators specific to FP project assessed are presented. They include beneficiaries of the mutuelles and loans for IGAs both of which constitute critical components of the FP project. The rest of the data sets highlighted in the methodology was not available and therefore could not be assessed.

11.2.1 BENEFICIARIES ENROLLED IN MUTUELLE DE SANTE

Figure 12: Shows number of beneficiaries enrolled in mutuelle de santé in the seven FP sites

![Chart showing number of beneficiaries enrolled in mutuelle de santé from 2007 to 2009.]

Source: Family Package Program, 2007-2009

Since its introduction as a FP component in 2007, a total of 6,743 clients and their family members have been supported by FP to enroll into Mutuelle de Santé. Supporting beneficiaries of the FP to enroll into mutuelles de santé has been of great benefit. It enabled its beneficiaries to access healthcare whenever they needed it. Since this support is extended to the entire family, it means that even HIV free members of the family can access health. This has therefore alleviated the health cost burden that a family would experience if any of its members were to fall seek. More importantly however, health insurance makes it possible for HIV+ beneficiaries to get treatment for opportunistic infections – a common ailment among HIV+ people. This was captures during interview with both health providers and beneficiaries:

“Mutuelle works well here and people use it...Family package pays for premiums for its members to join mutuelles” (Key Informant Interviewee at Nyamata Health Center).

A Key Informant Interviewee at CUSP echoed related sentiments about supporting beneficiaries to join mutuelles and highlighted how the system helps beneficiaries to receive treatment for opportunistic infections:

“For treatment of STIs and OIs, these beneficiaries have been lucky because they use their mutuelles when they must receive related treatment” (Key Informant Interviewee at CUSP).
11.2.2 ROTATIONAL LOANS PROVISION

Figure 13: Proportion of Family Package Project beneficiaries receiving loans

Source: Family Package Program, 2007-2009

For beneficiaries to be given individual loans, they must come up with a proposal of their project idea and fulfill the eligibility criteria of members who are extremely poor. The proposal is evaluated by association members who received training support from Family Package. The evaluation determines whether it is a viable project or not, and whether the loan will potentially be recovered so that it can be extended to other beneficiaries in a rotating manner. The above figure shows the 33.3% of members fulfilling the eligibility criteria have already received loans. The remaining 66% did not receive loans either because they did not apply for it or their proposals did not qualify. The review deems this as a potential area of increased support to ensure that members become capable of coming up with convincing micro projects which can qualify for the loan.

Figure 14: Percentage of reimbursement of rotational loans for IGAs

Source: Family Package Program, 2002-2009
The figure above illustrates the rate of rotational loans reimbursement for IGAs by site. The average rate of loan reimbursement for all the facilities is at 90% except for Gisenyi. For this site, the recovery rate was 49.3% due to a lack of follow up of loaned beneficiaries. Upon realization of this, loaning was suspended and FP encouraged beneficiaries to first establish a follow up system that would enable satisfactory loan recovery. At the time of the review this effort was underway and loaning is expected to be restarted in the near future.

Family Package started operating at Muhoza HC in 2009 and therefore implementation of loans scheme has not yet started. The review noted great acknowledgement towards the loan and enthusiasm towards them as a source of improvement of beneficiaries’ livelihoods as was captured during the interview:

"Beneficiaries are given small loans to start income generating activities so that they improve their nutrition and other social aspects... they were also advised to grow «kitchen gardens» so that they can have a balanced diet”

(Key Informant Interviewee at Muhura Health Center)

11.3 QUALITATIVE FINDINGS

11.3.1 PROJECT APPROPRIATENESS, IMPLEMENTATION AND SUSTAINABILITY

In the following section of this report, the review sought to determine whether or not the project model was appropriate, assed the implementation process and explored potentials for project sustainability. Accordingly, review criteria were defined for:

1. Project appropriateness as:
   (i) Stakeholder involvement to plan for project initiation at a new site
   (ii) Project ownership/level of understanding by field implementers (PMTCT head & titulaires and beneficiaries
   (iii) How the project activities addresses local needs
   (iv) Benefits of the project at different levels; namely,
       a. Health center; beneficiaries and community

2. Project implementation as:
   (i) Overall organizational and institutional framework:
       a. Staffing
       b. Capacity building
       c. Monitoring and evaluation

3. Project sustainability as:
   (i) Degree to which the project fits well with exiting structure and how they reinforce mutually
   (ii) Interventions with a direct sustainable nature such as loans and IGAs and how they affected beneficiaries livelihoods and improved their socio-economic status
   (iii) Mutuelles de Santé and whether or not it brought sustainable benefits to beneficiaries
11.3.1.1 Project Appropriateness

11.3.1.1.1 Did the project planning and introduction process encourage a participatory holistic approach with its stakeholders?

The review found that implantation of the project is done through a series of definite steps defined by FP comprised of:

- Formal introduction of the project to the local leaders and clinical staff aimed at sharing the concept with them;
- Assessment of the facility to identify local needs;
- Setting up of the association (an already existing association is strengthened);
- Peer educators specific training (including a HC representative) on their roles;
- Peer Educators’ selection (at the end of the training); and,
- Project commencement at a new health center;

Once the project is up and running at a new health center, follow up visits are conducted through quarterly meetings between FP staff, health providers and beneficiaries including peer educators. Peer educators also meet with the titulaire or PMTCT head monthly for follow up on their activities. However the review noted that documentation of these meetings was insufficient or lacking as evidenced by absence of meeting agendas or minutes.

The review was also able to establish appreciable levels of stakeholder involvement at all levels as a cornerstone of FP project since initial planning and design. Involved partners ranged from national level partners such as MoH, CNLS and TRACPlus to district and health center authorities such as COSA and COGE, PLWHA and community leaders. In addition, FP project actively engaged with its international partners such as PANGAE, UNICEF and Clinton Foundation and together developed cooperation agreements in which areas of partnerships were clearly outlined and project objectives defined.

As far as planning is concerned, the review generally noted that FP sought to promote engagement of all its partners. In some health centers where titulaires reported limited knowledge of the planning process (such as Matayzo and Kacyiru) the review established that the titulaires had been appointed long after the FP had been initiated at the sites. This challenge can easily be resolved in future if FP staff provided a briefing about the project to new titulaires in the event of staff turn over.

11.3.1.1.2 Is the project owned by all its stakeholders, national or local level?

To a greater extent, primary project beneficiaries (peer educators and members of the associations of families LWHA) fully owned the project in that they were the drivers of the project at the health centre and community levels. The review noted the following as some of the telling examples of ownership of the project by its primary beneficiaries:

- Beneficiaries choose the president of their association which usually is based at the health center level.
  - The president makes management and organizational decisions, calls up meetings on a quarterly basis;
- The president liaises between the community and the health center, often communicating important issues raised by the members of the association;

- Peer educators are encouraged to devise solutions to their problems and those of the association members. For example, the review found that peer educators at different sites had developed a recording system for members of their associations. The record included members of the association and their family members and this was under the custodian of the presidents of the associations – helping them to keep track of the growing association membership.

- Beneficiaries regularly attended quarterly meetings in which they share experiences many of which were attended by Imbuto Foundation representatives from Kigali.

11.3.1.1.3 Do stakeholders (national or local) understand/know the project?

As might be anticipated from the above outlined findings, stakeholder knowledge of the project ranged widely.

At the national level, government representatives interviewed (MoH, TRACPlus and CNLS) demonstrated appreciable amount of understanding of the Family Package project. In fact, the current Permanent Secretary in the MoH spearheaded the project design and planning and became the first FP project officer when it was introduced at Kacyiru Health center – and therefore demonstrated comprehensive understanding of the project.

The National AIDS Commission (CNLS) demonstrated sound understanding of the project concept and has an ongoing collaboration with Imbuto Foundation’s FP via the HIV prevention TWG in which both are active members. Also, TRACPlus has consistently related with the FP on technical aspects by outlining policies, guidelines implemented by the project in its sites.

Regarding other partners, the review noted that there have been collaborative initiatives between FP project with UN agencies. The Agaseke women project for instance was a joint initiative where FP received support from UNIFEM to train project beneficiaries to make baskets. WFP was a key supporter of the FP nutritional food supplementation to families living with HIV until this was integrated with IGAs in an effort to ensure a sustainable source of food. UNICEF and Clinton Foundation (phasing its support this year) were the most consistent financial supporters of the project. These organizations supported these FP initiatives with clear understanding of the project concept, objectives and were quick to highlight some of the quick wins the project brought about.

"Providing of consistent peer-led counseling services at Kacyiru Health center and nutritional rehabilitation of vulnerable clients has provided the base for growth and development of other programs; e.g. IGAs" (Key Informant Interviewee Clinton Foundation)

From the above interactions, joint initiatives and collaborations, the review generally noted sufficient understanding and knowledge of the project by its national level stakeholders. However, this could be strengthened further by sharing information using more formalised channels like sharing monthly, quarterly and annual progress reports evidence of which the review could not establish.
Titulaires and PMTCT Heads
The titulaires and/or heads of PMTCT provide oversight of the project at the local level. During the review, their knowledge of the project varied from one facility to another. While the majority (titulaires and Heads of PMTCT from 5/7 sites), clearly explained to the reviewers the project concept as an “Imbuto Foundation initiative aimed at helping HIV positive mothers, their children and families attain a better life”, those from the remaining health centers (Nyamata and Gisenyi) were not in position to explain the focus of the project and objectives.

At Gisenyi health center the titulaire though Family Package is equivalent to Imbuto Foundation and vice versa while in Nyamata the titulaire demonstrated limited knowledge of the project including its target group:

“Really, we do not differentiate Imbuto Foundation from Family Package, all we know is they help families” (Key Informant Interviewee Gisenyi)
“What I know is that it an organization which assists PLWHA” (Key Informant Interviewee Gisenyi)

And therefore, whereas the level of knowledge about the project by implementers (titulaires and heads of PMTCT) is generally satisfactory, the findings at Gisenyi and Nyamata were an issue worth noting. In both these health centers, FP started in 2007. During this period, titulaires were not changed and the review estimated this to be ample time to understand the project. That they don't understand the project potentially represents a major impediment to project progress. Every effort thus should be made to engage management of these two health centers by increasing direct communication with them to encourage them to embrace project activities at their sites.

Beneficiaries (Peer educators & members of association)
The review noted that the knowledge and understanding of the project demonstrated by beneficiaries was exceptionally impressive despite their apparent low education levels. Beneficiaries have deep appreciation of the project interventions and are committed to contribute towards achieving its goal of “providing care and support to HIV positive women, their children and families”. Respondents in the FGDs provided a clear narration on the objectives of the project and easily linked its benefits to poverty mitigation through IGAs.

Vivid accounts of how individual respondents came to learn and join the FP association emerged during FGDs, and included the following:

- During a visit to the health centre for ANC;
- During a visit by Imbuto Foundation staff to the H/C when they asked to meet HIV positive pregnant women already in association and from where information spread;
- Through peer educators and association members education sessions at the community level

Beneficiaries recognize their role and contribution as mobilizing and assisting HIV positive persons to accept their status and encouraging those who do not know their status to go for the HIV test. They eloquently pointed out their functions that include; home visits, ensuring good ARV adherence, sensitization of association /cooperative members and the community on HIV prevention and spread as well as encouraging beneficiaries to enroll into IGAs and start micro projects.
Respondents underlined some gaps which included insufficient project documents such as; reading materials, plan of actions and emphasized a need for increased support even then remaining determined to carry out their roles and functions.

11.3.1.1.4 Does the project activities response to local needs?

The review identified many project outputs as a result of activities carried out during the project life which directly or indirectly addressed their needs. In the following table, some of the major project outputs are linked to the project outcomes of poverty mitigation; Reducing stigma and gender inequality; plus mitigation of food insecurity.

**Table 5: Project outputs and how they impacted on the project outcomes**

<table>
<thead>
<tr>
<th>1: Mitigating Poverty</th>
<th>2: Reducing gender inequality and stigma</th>
<th>3: Mitigation of food insecurity</th>
</tr>
</thead>
<tbody>
<tr>
<td>– Beneficiaries acquired knowledge and skills on setting up &amp; managing IGAs</td>
<td>– P/E and associations assisted beneficiaries to accept their serological status and moved out of isolation by supporting each other psychologically and spiritually</td>
<td>• Income generated through IGA and individual loans enables beneficiaries to provide for their basic needs including food</td>
</tr>
<tr>
<td>– Beneficiaries gained a source of income through IGAs</td>
<td>• Inclusion of male peer educators encouraged other men to participate in the ANC/PMTCT programs</td>
<td>• Project initially provided nutritional support to house holds affected by HIV (now through IGAs families have provide for their own food)</td>
</tr>
<tr>
<td>– Through the credit scheme members in associations &amp; cooperatives accessed loans to set up micro project thus improving their livelihoods and those of their families</td>
<td>• Through associations members were sensitized and learnt how to live positively</td>
<td></td>
</tr>
<tr>
<td>– FP paid Mutuelles de santé (health insurance) for beneficiaries enabling them access to healthcare services</td>
<td>• Sensitization in the community on HIV:</td>
<td></td>
</tr>
</tbody>
</table>

This was captured during the interviews with respondents:

*The project helps families by paying for their health insurance (mutuelles de santé), school tuition for their children and fight against stigma” (Key Informant interviewee at Kacyiry Health center)*

11.3.1.1.5 Does the project bring benefits to different levels where it is implemented?

The review identified many project benefits many of which were direct benefits to the project target group, but also FP interventions had a positive collateral effect on the health centers and communities as summarized in the table below.
Table 6: Showing benefits brought about by Family Package project by level

<table>
<thead>
<tr>
<th>Health Facilities</th>
<th>Beneficiaries</th>
<th>Community</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Workload reduced due to:</td>
<td>1. Training enabled beneficiaries to attain life skills on:</td>
<td>1. Beneficiaries conduct health education activities in the community improves awareness on many health issues.</td>
</tr>
<tr>
<td>1. Follow up of HIV pregnant women their by peer educators</td>
<td>• Positive living</td>
<td>2. Increased peer support among beneficiaries and peer educators at the community level has led to:</td>
</tr>
<tr>
<td>2. Follow up of infants born to HIV+ mothers by peer educators</td>
<td>• Use of small loans</td>
<td>• More respect to health center visit appointments</td>
</tr>
<tr>
<td>2. Increased peer support among beneficiaries and peer educators at the community level has led to:</td>
<td>• Setting up and managing IGA projects and some of the existing IGAs noted are;</td>
<td>• Improvement adherence to ARV therapy</td>
</tr>
<tr>
<td></td>
<td>• Grinding mill</td>
<td>3. Community is sensitized on HIV prevention and testing</td>
</tr>
<tr>
<td></td>
<td>• Sawing and knitting</td>
<td>3. Stigma reduction as a result of awareness creation efforts by association members</td>
</tr>
<tr>
<td></td>
<td>• Weaving</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Farming by rearing of Rabbits, Goats and chicken</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Knitting, making baskets and beads</td>
<td></td>
</tr>
<tr>
<td>3. The project has constructed hall for IGAs at Kacyiru Health center</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Many of these benefits were also captured during FGDs with beneficiaries during the review, more especially on stigma reduction, and how the community has finally come to embrace PLWHA:

“At first some discriminated against us, some felt sorry for us and were very supportive, but now, community members come to us seeking advise regarding HIV testing and asking about how our association works”, (FGD at CUSP).

Picture 1: A beneficiary sells juice to a client at Kacyiru Health Centre

Picture 2: Clients buying some products from the canteen, and Rt a photocopy machine being used

In the pictures above some examples (pictures 1, 2) of Income Generating Activity projects implemented in Kacyiru health center are shown. In the remaining 6 Family Package implementing sites, many such initiatives can be found as a testimony to palpable benefits the project has brought to its beneficiaries. Although many of these initiatives were proposed by Imbuto Foundation staff,
beneficiaries are encouraged to come up with their own ideas of IGAs which suit their local needs. The canteen in Kacyiru (now an approved cooperative) for example is a great source of income for cooperative members as it is located in close proximity with not only the health center but also the Police hospital both of which provide good market potential.

In Matyazo health center (picture 3), a different but equally rewarding IGA of a grinding mill has been initiated by association members (on the way to becoming a cooperative). This grinds cassava, maize and other cereals into flour for beneficiaries to feed their families and for the community members to generate money. As they operate these projects, beneficiaries create a forum to share life experiences which relieves them of their social and psychological stresses. Also, through the credit scheme many members accessed small loans and set up micro project that have improved their livelihoods and those of their families.

### 11.3.1.2 Organizational and Institutional Framework

#### 11.3.1.2.1 Did staffing levels allow for effective project implementation?

The review noted that FP has one permanent project officer reporting to the head of the Health Unit who in turn reports to the Director General of Imbuto Foundation. The FP project officer is responsible for planning, coordinating, training, monitoring, and supervision of project activities in all the seven sites. In addition the officer takes up other tasks as assigned including project administrative work at the central level. Given the above situation, the review deems staffing at the project level to be less than adequate. As will be described below, this has implications on the way the project is implemented even at the site level.

As part of support extended to Kacyiru health center which is regarded as model site, the FP hired a full-time staff who oversees FP activities there. And although this staff’s salary is fully paid by FP, technically, the employee belongs to Kacyiru health center and is answerable to the tituliare – just like other health center employees. In the remaining six sites, implementation of project activities is placed under the responsibility of the heads of the PMTCT who are not remunerated for the this extra responsibility. As a result, some of them do not necessarily find an incentive of diligently executing this duty. For the above two reasons, the review found that the project has been affected in the following ways:
1. Inadequate supervision of existing IGAs projects by the heads of the PMTCT and/or the titulaires has often left beneficiaries without optimal guidance on exactly what they are expected to accomplish. Further, the review found that there was need for increased follow up of the project activities at the site level from the project head quarters, which has been limited to quarterly meetings. The quarterly meetings which brings together a staff from FP with beneficiaries of the project at the site allows a collective look at issues they (beneficiaries) have been facing and explores possibilities for remedy. Beneficiaries however feel that timing is too far apart and that more support would be relished. In the FGP discussion with peer educators, the issue of increased supervision and follow up was captured:

“It would be beneficial if FP staff visited us more regularly and consistently, so that they can give us advice” (FGD with peer educators at Nyamata health center)

2. Inadequate recording of project activities and beneficiaries at the site level hence hindering monitoring of project achievements and bringing about inconsistency in the recording tools used, and information recorded across health centers. This was captured during the review:

“As a health center we keep no records about family package members... only the association keeps a list of its membership” (Key Informant interview at CUSP);

“We do not have standard registers for that purpose (registering FP members), we use block notes, or blank paper sheets to record the information about FP clients (Key Informant interview at Gisenyi)

3. The low level of staffing probably contributed to the observed insufficient training and refresher training sessions which was an expressed need by health center staff, peer educators and beneficiaries – especially on management of IGA as was captured during the review:

“There is a need for more training of staff about family package project and its interventions and additional training to beneficiaries” (Key Informant Interview, Nyamata health center)

“In this health center, we work as a team and we always rotate our staff. Everyone would benefit from training about FP project and its interventions” (Key Informant Interview, CUSP)

11.3.1.2.2 Was there an appropriate monitoring and evaluation mechanism?

Although proper plans to implement the project model were developed with support from PANGAE at the inception of the project, some key elements essential for effective monitoring and evaluation were overlooked during the design and planning process of FP project. The FP project was implemented largely leveraging on the existence of the national PMTCT plan. The review team was informed that the project was now supported by a Monitoring and Evaluation Officer who was streamlining the system of data collection and use. Previous lack of monitoring and evaluation tools made it difficult to supervise, monitor as well determine project progress.

The review identified a need for development of key project tools that can then serve as references by project staff for consistent delivery of project outputs. These include project strategic plan, operational plans, monitoring and evaluation plan, guidelines, as well as standardized reporting
tools all of which will contribute towards an effective monitoring and evaluation process. In absence of these, the review noted that some key data might not have been captured hence, making it difficult to accurately assess and quantify project achievements.

The review also identified a need to have sufficient amount of Information Education and Communication (IEC) materials to ensure effective project advocacy.

11.3.1.2.3 Did the project build capacity of implementers?
Family Package recognises the importance of building capacity for its staff. At the project level, this was largely accomplished using on-the-job training of its officer, facilitating the officer to participate in meetings, workshops and conferences and encouraging active membership into PMTCT steering committee from which her knowledge about national PMTCT program was enhanced.

At the health center level, training focused mainly on peer educators. The training covered areas such as management of IGAs, financial management and health education on HIV prevention through VCT and PMTCT, stigma and discrimination, psychosocial support, follow up of HIV positive women and infants, nutritional support as well as family planning, among others. In turn, peer educators relayed information obtained from the training to members of associations/cooperatives through sensitization and orientation.

Beneficiaries from Muhura HC reported having received training on psychosocial support, management of Micro-Projects, and on HIV prevention. Gisenyi and Muhaza beneficiaries confirmed they received training on family planning, in micro projects along with talks regarding family package project implementation.

The review noted the following as some of gaps to be addressed:
1. Consistency of the training: There has been little consistency in training beneficiaries from site to another. For example, in Muhura respondents mentioned that they received training on “Clinical Psychology, Micro-projects and prevention of HIV among the youth”, At Gisenyi on the other hand, respondents mentioned that they were trained on “Family planning & micro projects” while in Muhaza, they said “they attended a talk on family planning” all delivered by FP
2. It was noted that training packages (such as curricula, training manuals) had not been developed to support the project to train different levels of staff together with target groups – a factor which probably explains training inconsistency described above.
3. Whereas the quarterly meetings were used as forums for refresher trainings, the allocated time seemed insufficient. The review observed that there is need to set aside and focus time specifically for refresher training. In addition, the Titulaires and PMTCT Heads felt that their inclusion in training as well as orientating them on FP would better equip them to support the peer educators and the project as whole.

Despite the efforts to build capacity of those involved with the project, some of the above findings pointed to the need to consolidate the current achievement. There were also some specific needs identified. For instance, Titulaires and Heads of PMTCT indicated they needed specific training to
improve their knowledge and skills to enable them implement FP activities – more specifically the IGA component.

11.3.1.3 Project sustainability

This was one of the challenging aspects of this review owing to complexity of definition of sustainability itself but also due to the local context in which the project operates. Conventionally, sustainability is often defined in terms of; Institutional sustainability, Economical and financial sustainability, and Ecological sustainability. For this review an analysis along these lines was deemed impractical and to an extent unrealistic.

For instance, until now even with extraordinary progress Rwanda has made, the national budget is still nearly 50% dependent on external aid according to the 2010-2011 national budget. Even with this amount of dependence on external aid, it would be unfair for one to conclude that Rwanda as a nation is not sustainable. Instead another aspect that would need more focused attention and scrutiny would be; what has Rwanda done with this money? Is the money facilitating progress or not? Is the money helping to steer Rwandans towards economic emancipation and helping them advance towards a better future? Is it helping the nation to build better and stronger institutions and so on?

By thinking along this axis, a new more realistic and contextualized line along which to assess Rwanda’s sustainability can be clearly drawn. This analogy on Rwanda fits well with the FP since one (the FP) operates within the context of the other (Rwanda). It is against this background that the review assessed sustainability of the FP project using the following set of questions:

1. Did the project fit well with exiting structure and have the two been mutually reinforcing (project integration/institutional sustainability)
2. Did the project implement interventions with an economic nature which helped to further beneficiaries’ livelihoods (Interventions bringing economic gains to beneficiaries or economic sustainability)?
3. Was the cost of implementing the project reasonable (Cost of the Project)?

11.3.1.3.1 Project Integration

As might have been previously highlighted FP project fitted well both functionally and in terms of infrastructure with Rwanda MoH health system set up since its inception.

- The project uses the same health center infrastructure and usually requires no additional investment in this regard. In few health centers with acute lack of space the IGA component might need infrastructural expansion, otherwise, the remaining components of the project are usually well accommodated in the existing health center rooms. This was captured during the review:

“*When the project was introduced to our health center, we welcomed them and provided them with space for a weaving micro project*” (Key Informant Interviews, Matyazo, Muhura).

- Introduction of the project in a new health center does not necessitate hiring of new staff, or buying of new equipment. The existing health center staff (head of PMTCT or titulaire are entrusted with the task) is trained and entrusted with the implementation of the project. Staff then receive support from FP staff through quarterly meetings and periodic field visits.
• The FP concept seeks to reinforce the national PMTCT program (as earlier highlighted) by creating and supporting a community but more specifically a family centered approach that tackles the HIV challenge in a holistic manner. The interventions have benefitted health centers, the community in many already outlined different ways.

• The FP additional none clinical components are fully owned by beneficiaries and community. Associations of beneficiaries (part of the community) create awareness in their communities and in so doing, encourage people to test for HIV, contribute to reduction of stigma and improve PMTCT and ARV treatment program adherence.

Given above factors, clearly the project and the health system in which it operates mutually reinforce one another. The health system provides tools for project to operate, which range from policy down to infrastructure and HR. On the other hand the project, by creating a functional support group program (peer educators) provides the system with a unique community-health center interface in which beneficiaries are key players.

11.3.1.3.2 Interventions bringing economic gains to beneficiaries

One of the goals of the FP is to reduce poverty among families affected by HIV/AIDS. This can not be achieved without promoting some sort of economic gain for the target group. In the previous sections of this report, benefits of IGAs and individual loans and testimonies of beneficiaries whose lives have changed for the better as a result of these interventions were outlined. At this point, it suffices to mention that the project has promoted initiatives with economic benefit as follows:

• Created and supported various IGAs in the 7 FP implementing sites which in turn helped members of the associations and their families. Some of the IGA supported so far include; making of dolls, making of baskets, weaving and knitting, creating of a canteen at Kacyiru, and grinding mill at Matyazo and others, which so far benefited 1,018 association members.

• Provided rotational loans to many individual beneficiaries who presented viable micro projects allowing them to cater for their family needs like proving for food, education for their children, clothing...etc.

• Paid health insurance for 6,743 beneficiaries in 2007 through 2009, hence allowing access to healthcare. With insurance availed to these beneficiaries, they spent less on healthcare and certainly made indirect financial gains by averting lost productivity due ill health.

• Helped associations (is still doing so) to form cooperatives from associations. Once the associations become cooperatives, they then become eligible to access bank loans which in long term will translate into real economic gains for members. Such two cooperatives include the canteen at Kacyiru and the grinding mill at Matyazo health centers.

Although, not all the members have benefited from IGAs or have been given small loans mainly because they were not necessarily eligible, to many beneficiaries, IGA and loans have been a real privilege.

11.3.1.3.3 Cost of the Project

In this section, the review explored the cost of implementing the project by computing different monies available and their sources. Also, we attempt to analyze what the money was used for, by separating expenditures by activities. Lastly we calculated the per capita expenditure on each beneficiary as a means of determining the cost of the project, per person as shown.
Table 7: Showing FP sources of funding (2005-2009)

<table>
<thead>
<tr>
<th>Partner</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>UNICEF</td>
<td>16,719,000</td>
<td>17,779,835</td>
<td>29,157,000</td>
<td>23,854,640</td>
<td>48,873,589</td>
<td>136,384,064</td>
</tr>
<tr>
<td>Clinton F.</td>
<td>900,000</td>
<td>5,234,000</td>
<td>41,300,000</td>
<td>16,255,836</td>
<td>11,624,836</td>
<td>38,147,672</td>
</tr>
<tr>
<td>MINECOFIN</td>
<td>--</td>
<td>27,000,000</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>27,000,000</td>
</tr>
<tr>
<td>RIEPA</td>
<td>--</td>
<td>3,900,000</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>3,900,000</td>
</tr>
<tr>
<td>CNLS</td>
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<td>--</td>
<td>832,000</td>
<td>--</td>
<td>--</td>
<td>832,000</td>
</tr>
<tr>
<td>Global Fund</td>
<td>--</td>
<td>--</td>
<td>4,104,000</td>
<td>4,528,000</td>
<td>4,854,000</td>
<td>13,486,000</td>
</tr>
<tr>
<td>Grant (M. Fisher)</td>
<td>--</td>
<td>--</td>
<td>1,641,000</td>
<td>--</td>
<td>--</td>
<td>1,641,000</td>
</tr>
<tr>
<td>Other (Operation fund)</td>
<td>6,955,836</td>
<td>6,955,836</td>
<td>8,606,316</td>
<td>10,654,500</td>
<td>--</td>
<td>33,172,488</td>
</tr>
<tr>
<td>Total</td>
<td>24,574,836</td>
<td>60,869,671</td>
<td>48,473,316</td>
<td>55,292,976</td>
<td>65,352,425</td>
<td>254,563,224</td>
</tr>
</tbody>
</table>

The above table shows partners who funded Family Package project starting in 2005 through 2009. UNICEF and Clinton Foundation provided financial support consistently from 2005 to 2009. Over the course of that time, the project received a total of 254,563,224 Frw from different donors.

Figure 14: Shows FP funding by source

A pie chart showing Family Package project funding sources

According to the above pie chart, UNICEF provided most of the funds to Family Package project contributing up to 54% of the total funds from 2005 to 2009, followed by Clinton Foundation that contributed up to 15% of the total budget during the same period.
### Table 8: Showing Family Package project expenditure lines

<table>
<thead>
<tr>
<th>Activity</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Activities</td>
<td>10,409,000</td>
<td>1,769,085</td>
<td>26,174,000</td>
<td>18,404,640</td>
<td>17,590,569</td>
<td>74,347,294</td>
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<tr>
<td>Loans</td>
<td>2,000,000</td>
<td></td>
<td>6,000,000</td>
<td></td>
<td></td>
<td>8,000,000</td>
</tr>
<tr>
<td>IGAs</td>
<td>4,310,000</td>
<td>19,910,750</td>
<td>54,560,000</td>
<td>600,000</td>
<td>19,475,000</td>
<td>49,751,750</td>
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<tr>
<td>Nutritional Support</td>
<td>3,434,000</td>
<td>2,333,000</td>
<td>6,350,000</td>
<td></td>
<td></td>
<td>12,117,000</td>
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<tr>
<td>Construction</td>
<td>27,000,000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>27,000,000</td>
</tr>
<tr>
<td>Health insurance</td>
<td></td>
<td>4,104,000</td>
<td>4,528,000</td>
<td>4,854,000</td>
<td></td>
<td>13,486,000</td>
</tr>
<tr>
<td>Salaries</td>
<td>900,000</td>
<td>1,800,000</td>
<td>1,800,000</td>
<td>87,583,6</td>
<td>23,432,856</td>
<td>36,688,692</td>
</tr>
<tr>
<td>Other (Operation Fund)</td>
<td>6,955,836</td>
<td>6,955,836</td>
<td>8,606,316</td>
<td>10,654,500</td>
<td></td>
<td>33,172,488</td>
</tr>
<tr>
<td>Total</td>
<td>24,574,836</td>
<td>60,869,671</td>
<td>48,473,316</td>
<td>55,292,976</td>
<td>65,352,425</td>
<td>254,563,224</td>
</tr>
</tbody>
</table>

The above table shows Family Package line expenditures (2005-2009). The table provides details of project activities, amount of funds spent on each activity in a given year and the sum used during the whole period (2005-2009). The majority of the funds were used on project activities.

**Figure 15: Pie Chart** showing Family Package line expenditure

A pie chart to show the % of funds spent on activities

In the above pie chart, 70% of funding went to project intervention related activities while only less that 30% was used on other operations and salaries.

**PER CAPITA EXPENDITURE ON BENEFICIARIES**
The total amount funds available over 5 years was 254,563,224 Frw = USD 465,381 (Exchange rate taken at BNR average rate of 1$=547 Frw through 2006-2008). Over the same period the number of house hold members of Family package grew to 19,068. On average therefore, amount of money spent per beneficiary over 5 years is 13,350 Frw (24.4$). In other words, the project spent $5 per beneficiary per year. Based on this analysis, review concluded that the cost of the project is quite minimal compared to delivered outputs. The review finds many aspect of this project sustainable, and these should be the ones to focus on during scaling up.

12 LESSONS LEARNED AND CHALLENGES NOT ENOUGH

Over the course of the project implementation, FP encountered challenges, some related to the level of funding and others to programming.

12.1 CHALLENGES RELATED TO THE LEVEL OF FUNDING

1. The project lacked sufficient funds to hire additional staff at the head quarter level. Donors were more willing to provide funds to carry out project activities than they were in providing funding for additional staff salaries. Even as the project expanded to other sites, the number of staff remained the same, thus exerting an increasing amount of workload and adversely affecting the support extended to the sites.

2. Low level of staffing at the project level impacted the level of follow up of the project activities on the ground – hence, onsite, some implementers (titulaires/head of PMCT) did not clearly understand Family Package specific components.

3. In some of the health centers, there was insufficient space to accommodate additional Family Package components. Even though infrastructure was beyond the project scope and in some sites advocacy activities mobilized enough funds to set up desired infrastructure (Kacyiru for example), in other sites like Muhoza where space was limited, IGA activities were negatively affected and could not start.

4. Follow up, assessment of needs in order to formulate strategies to respond to those needs is not easy due to the limited staff.

12.2 PROGRAMMATIC CHALLENGES

1. There were no appropriate tools (guidelines, strategies, training manuals reporting formats...etc) which are essential for implementation of any project. As a result Titulaires and PMTCT heads lacked proper references to execute FP specific components. This was further compounded by the fact that some Titulaires and Heads of PMTCT were not necessarily orientated on the FP and in few cases not included in the initial training about the project.

2. The M/E system was not strong enough to allow consistent and reliable data collection for use in evidence based decision making.

3. Due to lack of appropriate tools (examples enumerated above), some aspects of the project were not systematically implemented from site to site. Inconsistency in the content of training was one such example.

4. The level of education of most of the beneficiaries was another challenge facing the project. Many of the beneficiaries have limited or no education and this impacted on their comprehension of the project and affected the way IGAs were administered since these are overseen almost entirely by members of the association.
5. Some site level implementers did not necessarily appropriate the project to themselves. They continued to regard its additional components as belonging to FP hence impacting progress.

12.3 LESSONS FOR REPLICATION

• Beneficiaries are key players in the project. At the health center level, they organize themselves into associations/ cooperatives; support each other in managing IGAs. Within their communities, they encourage their neighbors to test for HIV making them role models of positive change and contribute to reducing stigma and discrimination
• The peer educator/association approach is effective in the mobilization of discordant couples, creates awareness in the context of preventing HIV/AIDS spread, and greatly alleviates stigma
• Peer educators played a key role in encouraging male involvement in ANC and contributed towards increased acceptability of HIV testing
• Loans to members were a critical motivator and enabled them to initiate IGAs, becoming self-reliant and uplifted members livelihoods (plus those of their families)
• Activities of additional Family Package components are mutually reinforcing with those of the health center. The work accomplished by peer educators improved quality of care provided by the health center (e.g. patient follow and adherence to treatment)
• Benefits of building capacity of peer educators ramify beyond association members and health facility. Through creating awareness of the peer educators, the community in which they live is educated on different health issues such as HIV, PMTCT, Family planning, nutrition.
• Skills gained by association members are useful for their life. Using these skills, they make products which they sell to gain sustainable income to support themselves and their families
### STRENGTHS AND WEAKNESSES

#### Table 9: Strength Weakness Opportunities and Threats Analysis

<table>
<thead>
<tr>
<th>STRENGTHS</th>
<th>WEAKNESSES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Imbuto Foundation</strong></td>
<td><strong>Imbuto Foundation</strong></td>
</tr>
<tr>
<td>– Family Package has a high level of engagement giving it strong potential for increased support and funding</td>
<td>– Donor agencies were not willing to support staff salaries making it difficult for the project to have adequate staff</td>
</tr>
<tr>
<td>– Family Package does not implement a parallel program. The project seeks to supplement the national PMTCT program</td>
<td>– Inadequate training of beneficiaries to meet the funding criteria for IGAs</td>
</tr>
<tr>
<td>– The project provides strong advocacy derived from Imbuto Foundation's wide network of partners</td>
<td>– Inadequate project documentation and inappropriate record keeping to enable project evaluation</td>
</tr>
<tr>
<td>– Loans provided by Family Package project have enabled beneficiaries to start IGA's that have improved their financial status</td>
<td>– Limited level of supervision from the national level towards the sites due to low level of staffing</td>
</tr>
<tr>
<td>– Family Package project is well integrated within existing health systems from which it leverages resources and with which they create synergies to deliver better health services</td>
<td><strong>Site level</strong></td>
</tr>
<tr>
<td>– Site level</td>
<td>– Site level</td>
</tr>
<tr>
<td>– Family Package project community aspect enjoys a great amount of support and involvement by its beneficiaries</td>
<td>– There was inadequate or no space for IGAs at some facilities</td>
</tr>
<tr>
<td>– Due to community presence of, beneficiaries the community has easy access to health information. This has improved their health seeking behaviour and adherence to treatment</td>
<td>– Lack of motivation and commitment towards the project by some health providers hindered progress of the project in some sites</td>
</tr>
<tr>
<td>– Beneficiaries have received psychosocial support thus enhancing awareness and reducing stigma</td>
<td>– Site level</td>
</tr>
<tr>
<td>– Acceptance of HIV status has brought harmony within the families and community and members feel they are not isolated anymore</td>
<td>– Site level</td>
</tr>
<tr>
<td>– Increased male support and participation to ANC as well promotes increased male championship in PMTCT</td>
<td>– Site level</td>
</tr>
<tr>
<td>– Creation of IGA and capacity building on IGA management has improved lives of many beneficiaries of the project</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>OPPORTUNITIES</th>
<th>THREATS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Imbuto Foundation</strong></td>
<td><strong>Site level</strong></td>
</tr>
<tr>
<td>– Imbuto Foundation has strong partnerships both nationally and internationally from which the project leverages support - financial or otherwise.</td>
<td>– Lack of motivation and commitment towards the project by some health providers hindered progress of the project in some sites</td>
</tr>
<tr>
<td>– There is potential for experience sharing among members of HIV prevention TWG in which FP is represented</td>
<td>– Site level</td>
</tr>
<tr>
<td>– Site level</td>
<td>– Site level</td>
</tr>
<tr>
<td>– There is potential for easy expansion of the project to other sites in the country as no substantial investments are required</td>
<td>– Site level</td>
</tr>
<tr>
<td>– Presence of other organizations (donors) in sites where FP is implemented provides an opportunity for increased cooperation to solve some of the challenges already enumerated</td>
<td>– Site level</td>
</tr>
</tbody>
</table>
13 CONCLUSION

In Family Package sites, nearly all women attending ANC accepted to be tested for HIV and this level of performance has consistently been maintained above 98% from 2005 to 2007. In 2008 through 2009, all women attending ANC accepted to be tested for HIV. Male partners of women attending ANC who were tested for HIV in FP sites has also been higher than national average since 2005. The national average however caught up with the FP supported sites in 2009 (at 84%). Other indices such as the proportion of women receiving ARV prophylaxis and the infants receiving a virological test are either higher or comparable with the national averages as was shown earlier in this report.

These differences indicate that FP work in the sites it supports has contributed towards the achievement of PMTCT related outcomes in palpable ways. Even though the exact impact of FP interventions was not the focus of this assignment, the review observes with a fair amount of certitude that FP contributed to the observed differences between national averages and its sites.

As far as appropriateness and organizational framework of the project model is concerned, the review found many positives in the areas of stakeholder involvement, project ownership, planning and benefits the project brought to its target group helping them address their needs. On the other hand, there is still room for improvement through;

5. Promoting greater appropriation of the additional project interventions by health centers;
6. Strengthening health center capacity and empowering them to follow up additional project components such as IGAs and loans
7. Developing standard appropriate tools (planning, reporting, guidelines, training material, IEC) for use at the health center level.
8. Strengthening the Project M/E system

Finally, the review noted the following three main areas of the project which it deemed sustainable and therefore potentially allows for project transferability to other sites:

**Project Integration:** In many ways, the project is very well integrated with existing health structure functionally as well as structurally and requires no additional substantial investment to be initiated in new sites.

**Cost of the Project:** Based on the cost analysis conducted, the review observes that the cost of implementing this project model is minimal. Over a five year period, per capita expenditure per beneficiary per year was found to have been $5.

**Interventions bringing economic gains to beneficiaries:** Lastly, the review documented benefits brought about by interventions of the project that translated into real economic gains by beneficiaries. These include IGAs, individual loans and paying premiums for beneficiaries to enrol into health insurance (mutuelles de santé), thus allowing them access to health care.
14 RECOMMENDATIONS

Imbuto Foundation

Strengthen and streamline the monitoring and evaluation system of the Family Package, through development of an M/E plan, definition of measurable indicators and data collection and reporting tools.

Advocate for greater integration of family package approach within the overall MoH National HIV policy frameworks and implementation strategies.

Devise mechanisms to increase appropriation of FP additional components by health center staff through increasing their participation in training, refresher courses and encouraging them to provide site leadership.

Review existing and adapt or develop documents with clear and smart project objectives, targets, including strategies, IEC materials, training packages.

Strengthen partnerships with all stakeholders to increase support to Family Package project in areas of funding to allow for effective implementation of the project interventions.

Develop strategies specifically targeting discordant couples in order to avert new infections within this sub group – allowing for further reduction of stigma and gender violence within families.

Consolidate and strengthen community involvement in PMTCT activities by all organised community groups. Peer or Mentor Mothers; Community health workers and the community leaders and other peer support groups should be supported more and their capacities improved to support PMTCT services. Partnerships and networking between health facilities and community support groups should be promoted by establishing linkages for follow up of PMTCT clients within the community for improved effectiveness of the programme.

Strengthen project management capacity (HR, Training) of family package project staff.

Design and implement a quasi-experimental study comparing PMTCT outcomes in sites implementing FP and those not implementing it, to determine the real impact of FP interventions towards provision of PMTCT services.

The proportion of association members eligible to who received loans was 33 %. The review revealed that those who did not access loans had IGA proposals that did not meet the funding criteria. The review recommends that beneficiaries be trained in micro project plan development to help beneficiaries develop proposals that meet the funding criteria and increase their chances of receiving these much needed loans.

Health Facilitates

The review found many benefits of the project towards the health facilities, the staff and their clients. Titualiares should use findings of this review to increase awareness of benefits of FP among the staff thereby improving project appropriation by the staff.
Strengthen male championships and involvement of male partners to provide care and support to the mother and child, by extending male involvement beyond attending the first ANC visit and get involved in the whole cascade of the PMTCT services

**TRACPlus**

Adopt integration of family package project components (Loans for IGAs, discordant couple counseling and Peer Education) in the current PMTCT program

The MoH through TRACPlus should advocate for funding from national level and other sectoral plans to support cooperatives and members of association members as well as families infected and affected by the HIV epidemic.
REFERENCES

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Rwanda National Strategic Plan on HIV and AIDS 2009-2012

http://www.who.int/mediacentre/

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Bokea C and Ikiara M; Socio economics of the lake Victoria Fisheries; the Macro-Economy of the export fishing industry in lake Victoria (Kenya). April 2000

Patient Monitoring Guidelines for HIV Care and Anti-Retro Viral Therapy, WHO, 2006

Evaluation of HIV Care and Treatment in Ante Natal Care, Settings and Adherence to Short Course Ante Retro Viral Prophylaxis for PMTCT-Francistown-2009


Monitoring and Evaluation Strengthening tool, January, 2007

Family Health International Institute for HIV and AIDS, August 2007


Http://www.Pepfar.gov/pepfar/press/79671.htm (accessed 09/03/09), it was also evaluated with PEPFAR funding Horizons:
15 APPENDICES

1) Terms of References
2) Letter of authorization to conduct data collection exercise for the review
3) Quantitative and qualitative tools
4) Clinton Foundation Support document, 2010
5) Minutes for meeting, family package project assessment
6) Internal Memo requesting for additional staff to assist in data collection exercise
7) Field Photos
8) Matrix Summarizes Quantitative Findings

10 Matrix Summarizes Quantitative Findings

<table>
<thead>
<tr>
<th>Quantitative Findings Matrix</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of Pregnant Women Accepting HIV Test In FP Sites</td>
</tr>
<tr>
<td>% of Pregnant Women Receiving ARV prophylaxis In FP Sites</td>
</tr>
<tr>
<td>% Of Men Accompanying Partners To Receiving PMTCT</td>
</tr>
<tr>
<td>Women Testing HIV In ANC (National Av.)</td>
</tr>
<tr>
<td>Up take of ARV Prophylaxis in the 7 FP sites</td>
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Facilities

<p>| 2008 | 2009 |</p>
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<thead>
<tr>
<th>Health Facility</th>
<th>Number of Infants Tested at 6 Wks</th>
<th>Number Tested at 6 Wks</th>
<th>% Tested</th>
<th>HIV+</th>
<th>Number of Infants Tested at 6 Wks</th>
<th>Number Tested at 6 Wks</th>
<th>% Tested</th>
<th>HIV+</th>
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<td>0</td>
<td>0</td>
<td>0</td>
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<td>21</td>
<td>55</td>
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</tr>
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<th>Beneficiaries Receiving Mutual Cards In 7 Family Package Implementing Sites</th>
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<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
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<td>2427</td>
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<th>Trained Peer Educators</th>
<th>Female</th>
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<tr>
<td></td>
<td>Male</td>
<td>32.5</td>
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**Percentage of facilities that reimburse Rotational Loans for IGAs**

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<tr>
<th>Health Facility</th>
<th>Percent</th>
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<tbody>
<tr>
<td>Matyazo</td>
<td>99.9%</td>
</tr>
<tr>
<td>CUSP</td>
<td>99.9%</td>
</tr>
<tr>
<td>Kacyiru</td>
<td>92.0%</td>
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<tr>
<td>Muhura</td>
<td>99.9%</td>
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<tr>
<td>Nyamata</td>
<td>96.0%</td>
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<tr>
<td>Gisenyi</td>
<td>49.3%</td>
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<tr>
<td>Average</td>
<td>89.5%</td>
</tr>
<tr>
<td>Matyazo</td>
<td>99.9%</td>
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