Review of Survivors Fund (SURF)
HIV+ Survivors Integration Project (SIP)
Funded by Comic Relief People Affected by HIV Programme
2010 – 2012

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List of Acronyms and Abbreviations:

AVEGA Agahozo – Association of Widows of the Genocide
ACR – AVEGA Central Region
AER – AVEGA Eastern Region
AWR – AVEGA Western Region
CR – Comic Relief
CTP – Care and Treatment Project for HIV+ Women Survivors
DFID – UK Department for International Development
FARG – Government Assistance Fund for Survivors
GBV – Gender Based Violence
GoR – Government of Rwanda
HIV+ve – HIV positive
IGAs – income generating activities
MINISANTE – Rwandan Ministry of Health
MOU – Memorandum of Understanding
NGO – Non-Governmental Organisation
PLWHA – People Living With HIV/AIDS
SM – Solace Ministries
SURF – Survivors Fund
UOB - Urwego Opportunity Bank

Executive Summary

SIP has ably demonstrated the way in which judicious interventions in a complex policy and political context can mobilise potential within a disadvantaged population that is otherwise easily written off. SIP is important, not so much as a demonstration of what still remains to be done 18 years after the Genocide, but rather as a demonstration of just how much still **can** be done.

This end-term evaluation of the two year project is based on document review and seven days of fieldwork conducted in July 2012 in the final quarter of the project's life-span. The two evaluators met with beneficiaries and implementing staff in a series of individual interviews and group discussions. Additional data was collected by SURF staff on behalf of the evaluation team.

The political and policy context in Rwanda creates a number of important opportunities for promoting the interests of genocide survivors, even as it also demands that these be contextualized within the broader process of national unity and reconciliation.

Partner health clinics that had been established under previous grants as private facilities for genocide survivors were successfully integrated into the public health system. These clinics not only continue to provide a quality service to members of AVEGA and Solace Ministries, but are now also open to the general public. For survivors who are nearer to public health clinics than the partner ones, extensive psycho-social support and accompaniment has ensured that their transition from private to public based care has been smooth. Thanks to SIP, the widespread (and justified) fears that the end of the Care and Treatment Project would result in a decline in members' physical and psychological health, have not materialized.

The development of more carefully structured approaches to Income Generating Activities in collaboration with an independent micro-finance institution, appears on early indications to have been an extraordinary success, resulting in 100% repayments of loans, significant increases in member's daily consumption and monthly savings. Enhanced economic resilience has had significant positive impacts on women's self-confidence and self-esteem, with corresponding benefits in social dynamics. These successes depend to a certain extent on the participant's pre-existing physical and psychological resilience level, and work best when the participant already has some asset base and/or income generating activity. The need to provide ongoing support to weaker and more vulnerable survivors, and to consider having different types of IGA scheme according to different levels of physical and psychological well-being, needs to be considered.

The legal support component of the partners' wrap-around support to survivors has been largely funded from other sources, and as such was not a major component of SIP supported work. Nonetheless it appears to be somewhat weaker and less well developed than other dimensions of the partners' work, despite the fact that potentially it has major synergies with the income generating dimensions, insofar as IGAs are demonstrably enhanced if the participants have a pre-existing asset base.

Significant strides have been taken in the development of AVEGA, Solace Ministries and SURF Rwanda, with strengthened management capacity, and a healthy financial systems review of SURF Rwanda and AVEGA. Systematic assessments of other dimensions of the partner's work, such as human resources, team-building and

documentation, have yet to be conducted. However, many of the other recommendations of the 12 year review have been adopted and implemented. The establishment of a Forum of Partners to enable regular meetings between the partners has also seen the development of a clear and strategic advocacy agenda.

The report concludes with a number of recommendations structured in terms of health services, income generation, advocacy, and organizational development.

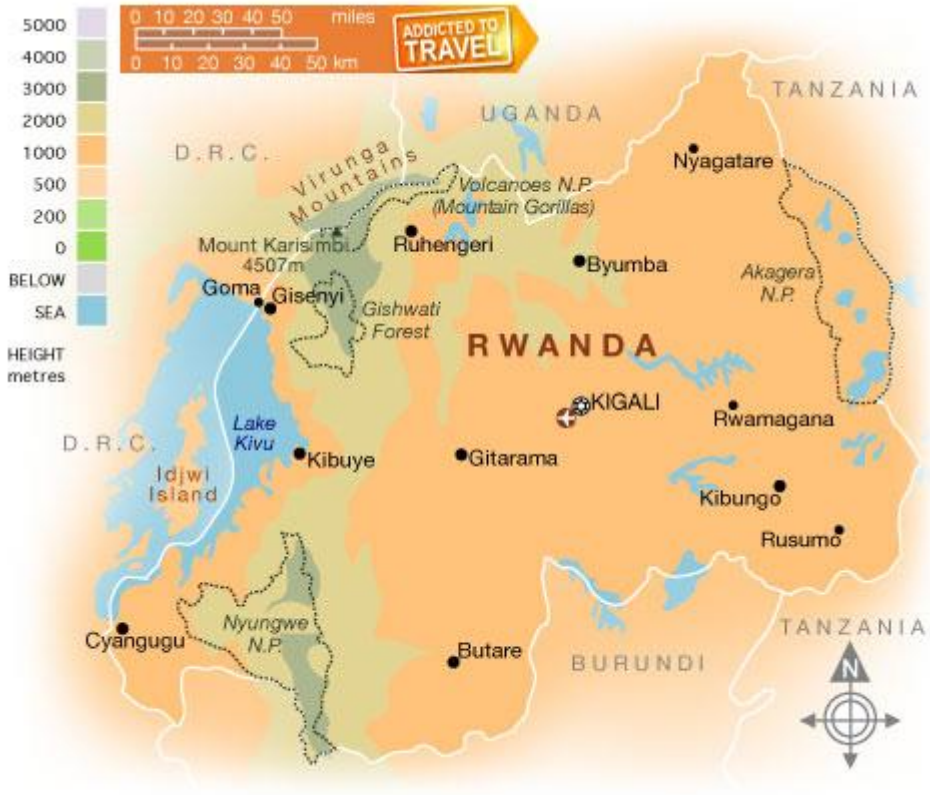

Figure 1: Map of Rwanda showing the locations of AVEGA Central Region and Solace Ministries in Kigali, AVEGA Western Region in Cyangugu, AVEGA Eastern Region in Rwamagana

Section 1: Introduction

The evaluation of any particular project needs to be situated and understood within the life-stories of the organisations implementing the project, how these in turn link to the lives of those touched by the project, and the wider socio-political environment.

In the case of the Comic Relief funded Survivors' Integration Project under review here, it has to be seen as the latest step in a long journey taken over the last eighteen years by the three partner organizations.

AVEGA was established in the immediate aftermath of the genocide by a group of 50 widows who recognised that there was no one left to care for them or their children. It was formally constituted in 1995 under the motto "united we stand", and currently incorporates 25,000 widows from across the country. It continues to be survivor-led and staffed, with major decisions made democratically at an annual national assembly. It is structured in terms of regional offices, namely AVEGA Eastern Region (AER) in Rwamagana, AVEGA Western Region (AWR) in Cyangugu and AVEGA Central Region (ACR) in Kigali, and as of this year, AVEGA Northern Region (ANR) in Gicumbi and AVEGA Southern Region (ASR) in Nyanza. The head office is located alongside the AVEGA Central Region offices in Kigali. Staffing in 2011 stood at 143 full-time and 32 part-time, and overall expenditure for 2010 stood at GBP 1,037,032.

Solace Ministries (SM) was set up in 1995 by Jean Gakwandi. Himself a survivor with a professional background in development he began supporting survivors in the immediate aftermath of the genocide. He recognised that most were traumatised – and that trauma was an issue for him too. Though a Christian organisation, SM does not discriminate against any clients on the basis of religion. They strive to follow their Christian values in a humane way, bringing comfort to those in need. Like AVEGA, Solace Ministries has succeeded in developing substantial infrastructure at its headquarters (offices, church, sound-studio and guest-house), as well as the CTP funded clinic in Kabuga, some 20 km outside Kigali. Staffing in 2011 stood at 25 full-time and 12 part-time, and overall expenditure for 2010 stood at GBP 562,128.

SURF was founded by Mary Kayitesi Blewitt OBE, a British citizen of Rwandan origin, and in 1997 was registered in the UK both as a charity and as a company limited by guarantee. SURF subsequently carried out ten Comic Relief funded projects. These were given an overall evaluation in early 2010, which concluded that "*the achievements of SURF as a catalyst and advocate on behalf of survivor organisations have been remarkable*," and recommended a number of changes in the working relationships between SURF's London and Kigali offices, as well as between SURF and its partners. The Director of SURF is based in London, and the SURF Rwanda office presently comprises of a National Coordinator, two programme managers, three project officers, accountant and administrator. Total expenditure in 2010 amounted to GBP 732,322.

1.1 Key Steps towards the Survivors' Integration Project (SIP)

The SIP project builds on two major projects involving SURF, AVEGA and Solace Ministries. The first of these was a five year (2000-2005) Comic Relief funded project to build the capacity of AVEGA and SM to provide support to 3,000 genocide widows and their dependents. The second, a five-year DFID-funded Care & Treatment Project, ran from 2006 – 2010, and scaled-up the capacity of AVEGA and SM to deliver support to 1,823 HIV+ women survivors, together with their 3,826 dependents. This included the establishment by AVEGA and Solace

Ministries of survivor dedicated health clinics and the organisational infrastructure to care for beneficiaries holistically (through income-generating activities (IGAs), psychosocial counselling and hardship support).

Both these projects were structured around the recognition that the women they worked with were multiply stigmatised as survivors of genocide, survivors of rape, and living with HIV/AIDS. This informed the model of comprehensive, multi-dimensional, or 'wrap-around' support to survivors; home-based care, counselling, nutritional supplements, legal aid, access to health clinics that offer a "safe, ideal space" to seek treatment, including psychosocial support, and Income Generating Activities (IGAs).

The independent end-term evaluation of CTP in March 2010 concluded that the project had been a success overall, but noted significant challenges and weaknesses in the IGA component of the work. The 12 Year Review of all Comic Relief funded activities up to end 2009 recommended;

> "considered reflection on the current state of Rwanda's recovery, and how survivors and their organisations best and most strategically position themselves within the national framework of unity and reconciliation and the Government's best efforts to ensure a de-ethnicised national consciousness and identity".

The review went on to argue that

> "Donors need to be persuaded that survivor organisations are engaging in those processes in a manner which while critical is also constructive. That survivors continue to require organisations to champion their best interests within these processes is evident. All organisations also need to clearly analyse the changing needs of their respective constituencies and what these imply for programming over the coming five years".[1]

1.2 Overview of Survivors Integration Project (SIP)

The CTP approach focused intensively on the complex of needs of its beneficiaries. Although by the end of the project in 2010, 948 HIV+ women survivors (more than half the primary beneficiaries) had joined the public health system, the project had not focused specifically on overcoming the social isolation of these survivors from the broader community, and many survivors continued to access the AVEGA and SM clinics for psychosocial support, despite receiving ARVs from public health services.[2] Furthermore, it had not been able to reach out to an estimated 500 survivors in the western region who were not on treatment at all.

By the time of the 12 year review, there was some recognition of the need for interventions to enable greater reintegration of survivors into the broader community to ensure the longer-term sustainability of beneficial impacts. The need for integration was given further impetus by national policy shifts promoting inclusion and down-playing historical divisions within society.

[1] Dolan, C & Gatete K, January 2010

[2] The reintegration dimension was however recognised in the design of CTP IGAs, whereby groups were encouraged to ensure a mixture of HIV+ survivors (60%), as well as some local supporters from the survivors' communities (see *CTP Review Report, 2009: p12)*

In light of all these experiences and developments, Comic Relief in 2010 funded a two-year follow-up to CTP in the form of the HIV+ Survivors Integration Project (SIP), with money going to SURF, AVEGA and Solace Ministries. Work began on 1st September 2010, with funding available from 1st October 2010. The project, which closes on 30th September 2012, has targeted 2000 survivors and their dependents.

The challenge confronting SURF and partners in designing the health-related component of SIP was two-fold: on the one hand HIV+ women genocide survivors continued to be resistant to accessing treatment in public health clinics, citing concerns over the quality and confidentiality of the services, as well as fears that they would be further stigmatised, possibly by clinic staff with associations to genocide perpetrators. On the other hand, Government had made it clear, in the final phases of CTP, that for the clinics to receive any sustained government support, they would have to be fully integrated into the health system, and therefore open to all members of the public, regardless of their personal history in relation to the Genocide.

The challenge confronting the IGA component of SIP was to address the weaknesses in the CTP-funded IGA projects. The most major of these was that beneficiaries had treated the IGA loans to be grants; only 27% of loans were recovered, and no clear steps were taken to recover the balance; whether or not this should be taken as an indicator of dependency on the part of survivors is debatable, but it certainly did not paint them as an attractive client base for microfinance institutions.

A number of additional challenges in the IGA component of CTP were identified during a review conducted by SURF staff in November 2010 as follows:

- lack of sufficient group managerial skills
- lack of basic infrastructure and transportation
- direct and indirect competition with formal enterprises
- lack of access to credit services
- lack of IGA specific staff in AVEGA, SM and SURF[3]

The review recommended that 'IGA should be run through formal financial institutions to enable more beneficiaries to be reached and to enable beneficiaries to become accustomed to bank services'.[4]

This SIP project, which was implemented in Kigali, Rwamagana, and Cyangugu, was thus designed with the following aims:

- To ensure the successful integration into the public health system of 875 HIV+ women survivors who had been beneficiaries of CTP and had been identified as needing additional support, as well as a further 500 HIV+ survivors in the western region of Rwanda that CTP did not reach.

[3] SURF, IGA Review, November 2010, p 4
[4] Idem

- To empower economically active HIV+ women survivors to build livelihoods to better support themselves and their own dependents, in part by ensuring that the associations of economically active HIV+ women survivors would be viable over the medium to long term,

- To strengthen home-based care and enforce the legal rights of older HIV+ women survivors, particularly land-rights for those who rent their land for farming

- To improve the life prospects of dependents of HIV+ women survivors, mainly orphans of the genocide and children born of rape, through improved access to education and HIV prevention, as well as counseling to those infected/affected by HIV.

- To ensure that the clinics owned and managed by AVEGA and SM are sustainable following their integration into the national health system, by maximising revenue from the MINISANTE for treating Mutuelle holders (survivors and non-survivors alike), by ensuring that standards of care remain at the consistently high level established through CTP, and by providing access to training for clinic staff, as well as business support for clinic administration.

- To facilitate reconciliation and integration of survivors and non-survivors through a sustainable model of shared service provision

- To strengthen the capacity of AVEGA and SM to advocate for their members to ensure that the GoR and other primary stakeholders involved in healthcare delivery in Rwanda are informed and persuaded of the case for special treatment required by the target group

1.3 Theory of Change, and how it differs from Care & Treatment Project (CTP)

The ***Theory of Change*** of SIP, which substantially distinguishes it from CTP, has several dimensions:

- Separate facilities and interventions for survivors and non-survivors are not viable in the long-term, and private clinics established under CTP must be linked into the national health system to ensure partial cost recovery and sustainability of services

- Bringing survivors and non-survivors together around their shared need for HIV support services can, if well managed, generate a change in their social relationships towards greater reconciliation and co-existence

- Income generating activities that both allow repayment of capital as well as develop savings, can and must enable economically active HIV+ survivors to become self-sufficient and independent of unconditional grants; the nature of economic activities should itself contribute to alleviating social isolation and trauma and thereby contribute to integration

In summary, SIP was structured around a theory of change prioritising *enhanced sustainability of services to survivors, increased integration of survivors into their communities, and diminished dependency of survivors on ongoing material support.*

1.4 Political, economic, and social issues affecting the HIV support work of AVEGA and SM

A progressive post-genocide leadership has been at the helm of an impressive recovery away from the destructive effects of the war and genocide and towards consistent stability and growth. Despite obvious impediments to economic growth, including a high population density, a troubled past, and a land-locked location in the midst of a war-torn region, Rwanda has been able to maintain steady economic growth, and has lifted one million people out of poverty in five years. The aftermath of the horror of genocide has catalysed the resolve of the Rwandan people to endure the pain and work harder, which itself has enhanced Rwanda's recovery story, arguably one of the most remarkable turnarounds of a people and nation in recent history.

Today Rwanda has reached a critical stage as all prerequisites are in place for the country to take off and propel itself to new heights of development, and to break out of cycles of poverty. The publication of the third Integrated Household Living Conditions Survey (EICVIII), preceding the elaboration of the next poverty reduction strategy EDPRS-2 (PRSP-3), showed great improvement in living conditions of Rwandans, a reduced gap between the rich and poor[5] as a result of government driven pro-poor initiatives such as the *one cow per poor family*, the *Ubudehe*[6] - direct money transfer, and the District loan scheme (*Umurenge SACCO*[7]). These saw poverty levels drop from 57% to 45% between 2006 and 2011, while extreme poverty levels fell from 40% in 2000/2001, to 36% in 2005/2006 and 24% in 2011/2012. This impressive 2.5% annual poverty reduction rate is an accomplishment only comparable with the best performing nations in the world such as Vietnam, Thailand and China.

On the flip side however, the registered growth has not spread fairly across the entire country and population. The EICV III[8] reported persistent poverty levels among those relying exclusively on farming wage labour. While government programmes can provide quick wins to the rural poor, they do not necessarily meet the needs of the most vulnerable people. Eighteen years down the line, the country has arguably recovered on most aspects but the human rehabilitation of survivors will take much longer. The 1994 genocide of Tutsi has had a devastating impact upon Rwanda's human, social and economic fabric, and in some cases, permanently impeded their capacity to cope with and take advantages of the gains offered by progress. To date, there is evidence that poverty in Rwanda impacts heavily on women and other vulnerable groups including survivors, orphans, widows, disabled and the elderly.

Vulnerable survivors in particular, have specific impediments that undermine their competitiveness, access to services and appropriate care. Attempts to bring them into inclusive medical and economic programmes have not always been successful. In response, survivor organisations have been effective in identifying their specific needs and going the extra mile of providing adapted and specialised services that can address their needs with or without the support of the state, for example by providing home based care, safe housing, education and hardship allowance to survivors who most needed them.

[5] The gini-coefficient has reduced from 0.52 to 0.49

[6] A poverty reduction approach which aims to enhance monetary capacity of the rural poor through direct cash transfer; cash for [public] work, and financial support through a community micro-credit scheme

[7] A microcredit scheme, component of Ubudehe approach.

[8] Integrated Household Living Conditions Survey III

While it has been the government's strategy to downplay the survivors' lobby capacity in the interest of reconciliation, this has been an obstacle to their assertiveness to engage government on issues that affect their rights.[9] Almost two decades after the genocide however, the context is sufficiently conducive for survivor's organisations to expand a traditional service delivery role to also include a policy influencing dimension, to ensure that practical achievements are leveraged and consolidated and that survivors are empowered and resilient enough to participate according to their capacity, but also that policies are shaped in a manner that responds to their specific needs, enabling them to cope with the rapidly shifting Rwandan society and economy. At policy level, given that all actions implemented by SURF's partners thus far are consistent with the government's Economic Development and Poverty Reduction Strategy (EDPRS II)[10], strategic advocacy should be feasible, particularly insofar as Government objectives include: Promotion of off-farming employment; Promotion of micro enterprise, Compulsory Universal free education and Universal health care.

Further policy developments of relevance to survivors are the proposed social pension pilot to be launched in 2012, the National Social Protection Strategy, Vision Umurenge 2020, and the ongoing land registration process which is due to be completed by 2014. A further area for legal advocacy is the matter of ensuring that compensation awards made during the Gacaca process, which amount to millions of FRW, are duly enforced and paid out.

1.5 Evaluation Methodology

The evaluation was conducted by a team of two independent external evaluators, who were previously responsible for the 12 year review which informed the SIP project. Extensive background documentation was provided to the lead evaluator by the Director of SURF, and this was subsequently shared with the second evaluator. Field-work was undertaken over a seven day period in the three project sites (Kigali, Rwamagana, Cyangugu), in the final quarter of the final year of the project.

The evaluation began with an introductory consultation meeting with SURF, AVEGA and Solace Ministries. The meeting, held at Solace Ministries, discussed the aims of the process, identified respondents, and established schedules for visits and interviews. The evaluators travelled to Cyangugu the following day, conducting two interviews with individual beneficiaries, followed by a focus group discussion with beneficiaries, and ending with a focus group discussion with project staff.

In Kigali, the evaluators met with a range of staff in the AVEGA offices, as well as beneficiaries in their respective places of work (market places, own homes). They also met with staff and individual beneficiaries of Solace Ministries at the SM offices. A visit was made to the SM clinic at Kabuga where a number of beneficiaries and staff were interviewed. A one day visit was made to Rwamagana, involving interviews with staff and beneficiaries, as well as a focus group discussion with one of the income generating associations in Gahengeri , Bicumbi sector.

[9] Some known genocide suspects have held government positions and, under State protection, have eluded justice, while sentenced perpetrators who have been pardoned with no consultation with survivors have in some cases fallen into recidivism and killed survivors upon return to the community

[10] The current EDPRS (2008 – 2012) is due to expire in December, and a new five year EDPRS, which will impact on allocation of resources and funding to all sectors affecting survivors – including education, shelter, health, and livelihoods - is currently under discussion.

An evaluation de-brief was given to representatives of all three organisations on the final day of the fieldwork. The draft report was also shared with SURF, AVEGA, SM, and Comic Relief, and comments were addressed as appropriate.

The full schedule of visits, interviews and focus group discussions, is set out in Annex 2. In summary, in addition to group discussions with staff of Solace Ministries, AVEGA Eastern, Western and Central Regions, a total of 15 individual interviews were conducted with staff of AVEGA, SM and SURF. Four Focus Group Discussions were held with beneficiaries, as well as individual interviews with eight beneficiaries. Time did not allow the interviews with external actors (e.g. local authorities, Ministry of Health, etc.) that were foreseen in the evaluation TOR, though one was held with a member of UNDP.

In addition to the evaluators' own fieldwork, they requested that the SURF IGA staff re-interview by telephone 20 out of the 99 beneficiaries who had been surveyed as a baseline prior to the beginning of SIP. The purpose of this was to assess the impact of the IGAs on their day-to-day living expenses and on their capacity to save.

Section 2: Key Findings

2.1 Project Outputs & Impacts

2.1.1 Integration of HIV+ve Survivors into Public Health system

The SIP project set itself ambitious targets with regard to the integration of HIV+ve survivors into the Public Health System, namely that 70% of those who at the end of CTP were not yet integrated would have improved physical and mental health by the end of SIP, as would 70% of those already integrated. With hindsight, perhaps a more important indicator would have been that 90% of those who at the end of CTP continued to fear a transition to the Public Health System would have successfully effected this transition before the end of SIP.

While the evaluators spoke to a handful of survivors who continue to travel extra distances in order to access the partner's clinics, in the vast majority of cases integration appears to have worked successfully. At the end of CTP AVEGA had 1433 HIV +ve survivors on its books, with a further 948 HIV +ve members already integrated into the Public health system. In other words, users of private clinics greatly outnumbered those integrated into the public system. Solace Ministries similarly had 170 members attending its own clinic, and 83 already integrated into the public system.[11]

By the time of SURF's report to Comic Relief for the year 2010-2011, the relationship between private and public system users had been reversed:

> 'A notable achievement is that there are now more HIV+ve women survivors choosing to receive treatment from their local clinic than travelling to a partner clinic. Such a scenario was remote at best at the point of closure of CTP before funding from CR had been secured'. [12]

The following table shows how the transition has reduced numbers attending the AVEGA Clinic in Rwamagana[13]:

District Beneficiaries live in	Number attending AVEGA Clinic under CTP	Number attending AVEGA Clinic under SIP
Ngoma	54	1
Rwamagana	109	62
Bugesera	45	15
Kirehe	61	0
Kayonza	43	6

For those who continue to access SM and AVEGA clinics rather than their local public health clinic, some of the reasons relate to the sense of family and safety that they have developed with clinic staff and fellow patients; as

[11] An important change under SIP for users of the SM Clinic was that SM would no longer pay them a transport allowance for attending the clinic. As such, while anybody could still come to the clinic for treatment, the fact of having to pay their own transport acted as a disincentive for all except those most reluctant to go to the public clinics.
[12] SURF, 30 September 2011, Annual Narrative Report to Comic Relief
[13] Figures provided by AVEGA Community Development Workers during group discussion, 15 July 2012

one beneficiary who had followed SM to its new clinic stated, *'They have helped us so much, that's why we trust them, that's why we follow them up wherever they go*'.[14] Other reasons include fears about whether the quality of care would be comparable, and, in one case, a refusal to let clinic staff in her locality know that she was HIV +ve; to do so would, in the mind of this individual, be to let the perpetrators in her community know that they had succeeded in doing her harm.

Survivors have adapted quickly, and we came across no reports of abuse by public health staff. In one interview, a staff member of AVEGA remembered being called by a health centre because a beneficiary who had been transferred there was not appearing. After a home visit and discussion the doctor was sent to visit her at home, followed by the counsellor to convince her to go to the health centre. The beneficiary changed her mind and returned to the public health clinic.[15] Where beneficiaries who have transferred to the public system report secondary effects from changes in HIV medication, the AVEGA doctor has been able to conduct follow up to resolve the issue.[16] According to staff in AVEGA central, none of the CTP beneficiaries who transferred to public clinics have stopped adhering to their treatment.

At the AVEGA Eastern Region clinic, the evaluators met with members of mixed groups of former CTP beneficiaries with new non-survivor PLWHA users of the clinics. Each of the four groups comprises 15 members. All agreed (the two categories were interviewed separately), that the opening up of the clinic to non-survivors has led to improved social relationships at the clinics and at home.

In one case, a non-survivor client of the AVEGA East clinic declared that she had been living in the same neighbourhood with a survivor but only got to befriend her after they had met at the clinic on one of their routine consultations. Others declared that they visit each others' homes and at times help each other out when they are down with opportunistic diseases.

The success of this transition appears to be dependent on a number of factors. With regard to former CTP members generally, the careful preparation of beneficiaries, coupled with their greater physical and psychological resilience as a result of CTP, accompaniment of survivors in the early stages of integrating into the public health system[17], ongoing availability of home-based care by AVEGA & SM staff, and the strength of survivor support groups in their home areas, have undoubtedly all played an important part. For users of CTP clinics, the creation of mixed user groups described above has also been important in enabling survivors and their non-survivor neighbours to find some common ground.

For the staff of CTP-established clinics, the transition has been aided by careful preparation, the fact that the process is in line with the national policy of unity and reconciliation, and the fact that, in all three former CTP

[14] Interview with two beneficiaries, SM Clinic, 18 July 2012
[15] Odette Kayirera, AVEGA, 13 July 2012
[16] AVEGA Central group discussion with staff, 17 July 2012
[17] On this last point see SURF response to Comic Relief, January 2012

clinics (Rwamagana, Kigali, Kabuga), salaries have been topped-up to maintain them at the level they were at during CTP, a level which is higher than that provided by the Ministry of Health.[18]

It is important to note that the provision of extensive counselling to many CTP beneficiaries, which facilitated their transition from accessing partner clinics to using public health clinics, was funded through FARG. Equally, the top-up of salaries for former CTP clinic staff, which was motivated by the desire of partners to retain existing staff, was funded by the partners themselves. In other words, the health integration component of SIP was not a stand-alone achievement, but depended on the creation of strategic synergies using alternative funding sources.

2.1.2 Supporting Income Generating Activities

The development of a new model of IGA which addresses the challenges identified in the model used under CTP, has perhaps been the most noteworthy achievement of the SIP project. The review of the CTP model had identified lack of sufficient group managerial skills within the IGA groups, a lack of basic infrastructure, transportation, access to credit services, and lack of IGA specific staff in AVEGA, SM and SURF, as some of the obstacles to its success. The IGA model under SIP set out to tackle all these weaknesses, and had ambitious targets, as it aimed to ensure that 50% of the 2,318 HIV+ve AVEGA members would have 'an income that enables self-sufficiency by the project's end', and 65% of the 253 HIV+ve Solace Ministries members. IGA staff, including a cohort of interns, were appointed by all partners, and undertook an intensive training and induction programme coordinated by SURF. A rigorous weekly skills training programme comprising 38 modules on group dynamics, market research, value chain analysis, profit and loss, and bookkeeping, was put in place for group members.

Finding a micro-finance institution that was willing to work with this relatively high risk category of loan recipients, was a relatively long process.[19] Eventually, a partnership agreement was signed between SURF and Urwego Opportunity Bank (UOB), under which IGA groups could access loans at an interest rate of 2.5% a month, 0.5% less than its standard rate of 3% a month. SIP also provided a FRW 25 million Loan Guarantee Fund to UOB, and set aside a FRW 10 million Compensation Fund through which up to 70% of the loan recipients' interest payments could be reimbursed to them upon completing their payments (this provision was not routinely made known to the women at the start of the project, even though it effectively reduced the final interest rate to 0.75%/month (less than half the going rate for micro-finance credit), and thereby should have rendered the UOB loan considerably more attractive to users than those available from competing microfinance institutions). It was explained to the evaluation team, that the rationale for not making the plan for reimbursement known to participants, was to condition them to manage payments on a par with independent clients of UOB. However, the partners recognise with hindsight that, had this process been undertaken more transparently it would probably have resulted in higher levels of satisfaction with the UOB loan options; new groups are now routinely informed of the possibility of the reimbursement to incentivise repayment.

[18] In AER's Rwamagana Clinic, all the nurses left at the end of CTP and became counsellors, which is a better paid position. The new nurses receive 150,000 RWF per month, compared to the standard government salary for nurses of 90,000 RWF. (interview with AVEGA eastern region counsellor, 15 July 2012)

[19] According to SURF's own profiling, the HIV+ve women have an average age of 49, are heads of households expending US $ 0.40/day/person, and have relatively low levels of education (77% no higher than four years of secondary education).

The basic model is that project staff work with existing associations for a period of six month on skills training (once a week), at the end of which they introduce the UOB loan officers to review loan requests. Before an application for a loan is approved, group members have to generate savings of 10% of the loan they are seeking, to deposit with UOB.[20] Once this is done and the loan is approved and given to the group, members repay on a biweekly basis, to the visiting loan officer. The groups vary in size, but can number over 30 members, and the repayment periods range from five to six months. One beneficiary summarised the learning as follows:

> *I have learned how to approach clients, how to buy without being ripped off, and how to sell so that I cover my costs and get some benefit*.[21]

In Phase 1 77% of beneficiaries identified received training. UOB began to accept and evaluate proposals in September 2011, and 47% took loans before the end of the year. In Phase 2 63% of the beneficiaries identified received training and 42% took bank loans.[22] In Phase 3 the proportion of beneficiaries receiving training rose to 91%, but loans had not yet been issued at the time the data was collected.[23] From these early loans, it appears that rural groups are more likely to opt for group projects, while in urban areas individual members tend to take a portion of the monies loaned to the group to further their own existing business interests. The way in which the loans allow individuals to significantly scale up their level of activity was evident in one beneficiary group, which had come together with a contribution of 5,000 FRW per person, and when they first engaged with AVEGA had a total savings of 100,000 FRW. After the training, the group members took loans from UOB ranging from 100,000 to 500,000 FRW.[24] The majority of individual recipients of loans were able to report a clear indicator of change in their economic status and place in economic systems. The woman who had gone from selling bananas to beer makers, to brewing beer herself, was typical in this regard.[25]

For those who have been through the training and received loans, the early signs are that this process takes them considerably closer to achieving economic self-reliance. The small telephone survey of 20 beneficiaries that SURF conducted for this evaluation in July 2012 suggests that the improvements in regular income have been remarkable, particularly changes in income: The cumulative average spending per week of the 20 respondents had increased by 57%, from FRW 9,650 per respondent, in 2011, to FRW 15,125 per respondent in 2012. At the same time, the cumulative average saving per month of the 20 respondents had increased 263%, from FRW 11,400 per respondent per month in 2011, to FRW 41,420 per respondent per month in 2012. 17 of the 20 respondents reported making a net profit, 17 reported increased trust in others, and 15 reported increased confidence in accessing healthcare.[26]

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[20] In some instances where an individual is unable to raise the 10% by herself, fellow group members have clubbed together to provide her with the necessary deposit (IGA Officer, AVEGA Central, 17 July 2012)

[21] IGA training beneficiary, Kigali, 17 July 2012

[22] Not all those who received training took loans; some already had economic activities which the training helped them to manage more effectively, and others had existing credit which they had not yet repaid, so bank refused to give them another credit (Group Discussion with AVEGA Central staff, 17 July 2012)

[23] SURF, July 2012, Spreadsheet of SIP IGAs and their locations

[24] Interview with IGA group, Mumyembe Kimihura, 17 July 2012

[25] Interview with IGA group members, Gitambi, 15 July 2012

[26] SURF, July 2012, Main Findings of SIP Survey Respondents

The other major and prominent success of this model to date has been the loan repayment rate. For the first three groups, repayments were 100% of loans;[27] this compares to a repayment of 27% of loans made under CTP.[28] Initial indications for repayments from Phase 2 were also of 100% repayment rates.[29] Whereas under CTP, 73% of loan monies were never paid back, and thus became *de facto* one-off grants, under SIP the credit offered is all being paid back and thereby opening up the prospects of further loans from financial institutions, as well as related activities such as rotating credit schemes. As one senior staff member noted:

> *I remember past experience in the use of money; they wasted money because we used a wrong methodology - but this time they are really 100% responsible for that money. This time we made people repay everything and it works better. They also put their contribution; if the project asks 2 million, they have to put 10% of the total budget. That has been happening, you can see it on our reports. It is an approach we shall continue to use in WSEP and other projects*.[30]

Such has been the consistency of repayments to date, that SURF recently requested that the Loan Guarantee Fund be redeployed to fund further training of IGA groups who did not benefit during the SIP funding period. In the correspondence with UOB, the following statement stands out as summarizing how important SIP has been as a model for working with a population that otherwise has a very low credit-worthiness even for micro-finance institutions:

> *"UOB has been impressed by the progress of SIP to date, the model of training and support provided to the groups of members of AVEGA and SM, and the repayment rate of the participants in the programme to date. This is testament to the training and follow-up provided by the IGA programme team of the partnership of SURF, AVEGA and SM. The challenge now ahead is to manage the transition of the current groups that access loans through the LGF into becoming independent clients of UOB. The aim of the programme has always been that once the groups complete three cycles of loans, UOB will conduct an independent assessment to determine if they can be taken as UOB's independent clients without the support of LGF. We are now nearing the point of completing three cycles for the first phase groups that accessed loans at the start of our partnership."*[31]

An equally important, but perhaps less visible success of this process, has been the transformation in loan-takers' self-perception and self-confidence. Whereas in previous visits to Rwanda, the evaluators had found deeply entrenched and internalised gender expectations (especially among rural women) that women should have nothing to do with money and should therefore not take loans, these have been substantially overcome by this project, as suggested by the following exchange during an interview with AVEGA Central staff:

> *Q: can you say that the project has helped them to be dynamic?*

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[27] SURF, July 2012, Spreadsheet of SIP IGAs and their locations
[28] Enfield S, August 2010, Project Completion Report, p. 18
[29] SURF, July 2012, Spreadsheet of SIP IGAs and their locations
[30] Odette Kayirera, 13 July 2012
[31] Email from Jeffrey J. Lee, President and CEO, Urwego Opportunity Bank, dated 20th September 2012

A: today there is a member of a group who has been able to go to Uganda to buy things and sell here. If an old woman of 50 can go outside the country…. …traditionally women in Rwanda were scared of taking credit. Currently the Rwandan woman has understood that she can participate in economic activities.[32]

The level of initiative in many instances is high, as indicated by one survivor who sells charcoal in Kigali:

Sometimes I have gone looking for charcoal, rather than waiting for it to be delivered. Found it in southern and western provinces. Went there, loaded it onto trucks, and brought it back. I go to the forest, buy a forest, bring in guys to chop it, they make the charcoal from there, and bring it back to Kigali. The cost of making it is 4.000, and I sell here at 5,500. If I put it in a depot I can sell it at 6,500 or 7,000.[33]

Women survivors have gained self-confidence in working with financial institutions, and a blanket refusal to even think about taking credit has been replaced with a medium-long-term vision amongst many individuals of how they can use loans to build up their capital and savings. Those who received the training are also able to apply the skills developed to other issues as well, as in the case of one survivor who, following the business skills training, gained sufficient insight into key administrative and bureaucratic procedures that she was able to register her own house properly.[34] While the majority of beneficiaries are women, male survivors engaging in the IGA programme also report enhanced self-esteem ('we used to sell on the street; now we have space on the market, have an employment card') and respect in the community.[35]

As a result of the combination of increased credit-worthiness, increased income, and increased self-esteem, there has been a diversification of survivors' livelihoods and asset-base/capital, including subsistence farmers gaining a foothold in the off-farm economy. Even as these successes have reportedly strengthened a sense of group belonging among survivors, they have also generated increased openness to interaction with non-survivors.[36]

The contrast with the preceding CTP project is striking. For the senior counselor at Solace Ministries, the IGAs also helped '*from counselling perspective, because previously they (survivors) sat at home thinking about the genocide, but now they are working, their thoughts are not stuck on genocide, but looking forwards*."[37] According to AVEGA Central staff;

On the psychosocial side CTP left some dependency. The difference with SIP is that each person knows that she can succeed in her life, with work, with integration into society. In CTP each person was just thinking of themselves, now they are capable of helping one another.[38]

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[32] AVEGA Central staff, 17 July 2012
[33] Interview with IGA Group, Mumyembe-Kimihura, 17 July 2012
[34] SURF, February 2012, Feedback on GR002-01910-DQUI Annual Report
[35] Interview with two male beneficiaries of SM IGAs, 18 July 2012
[36] SM alerted the evaluators to one SM beneficiary whose husband is in prison as a genocide perpetrator
[37] SM Senior Counsellor, 13 July 2012
[38] AVEGA Central staff, 17 July 2012

Notwithstanding these considerable and important successes, two important lessons need to be drawn from this process. Firstly, from the evaluators' interviews with beneficiaries, it appears that, by and large, the women who chose to benefit from the training and the loans already had pre-existing sources of income, and that the projects were instrumental in either supplementing these or in enabling them to invest in scaling-up their existing activity. None of our respondents claimed that the project on its own could enable self-sufficiency, but the project undoubtedly enhanced their economic resilience.

Secondly, it is evident that to engage on this rigorous training programme, and to then take on a loan with a biweekly repayment schedule, requires a degree of physical and psychological resilience which not all survivors currently enjoy or are likely to enjoy in future. The evaluators were struck by the nickname apparently given to UOB clients, namely '*Kataryama'*, meaning 'Those who do not sleep'; it is not self-evident that the stress of rapid repayment will sit comfortably with medical advice to PLWHA to ensure they get adequate rest.

Furthermore, loan recipients who default are liable to lose their existing assets, and this is a considerable disincentive to some. One loan recipient reported how three women and one man in his group refused to take a loan because

> *'They were scared of the repayment. They didn't even have any property to be taken.*
>
> *Q: So what was the fear?*
>
> *A: They were scared that they (UOB) would take even the mattress on which they were sleeping.*[39]

The first of these findings has important implications for the legal support work; the fact that having existing assets greatly leverages the results that can be obtained from the IGA training and loans, should add extra urgency to the pursuit of land-titles, as well as the attempt to see other properties returned and Gacaca compensation awards enforced.

The second point emphasises the fact that a 'one size fits all' approach to Income Generating Activities cannot adequately accommodate the varied situations of genocide survivors.[40] In Solace Ministries, for example, of the first group of 47 trained, 37 formed themselves into five groups. Of the 37, ten already had individual loans from UOB, 11 agreed to seek credit from UOB, and the other 16 took loans from other banks with lower interest rates or sold their own properties in order to raise some capital.[41] As Solace Ministries Counsellor noted:

> *"what really bothers us is the elderly women who cannot work. We have tried putting them together, to follow up closely, but we have some who are really old, have no children, can't work, sometimes handicapped, their legs, or arms or head were cut, they have psychological problems…"*[42]

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[39] Interview with two male beneficiaries of SM IGAs, 18 July 2012

[40] The need to develop and/or access financially rigorous but less relentlessly demanding schemes (without falling into the trap of CTP style loans which were understood by the recipients to be grants), was recognised towards the end of the project, with two groups choosing to access loans through Umurenge SACCO, which had a less taxing repayment schedule.

[41] Solace Ministries IGA officer, 13 July 2012

[42] Solace Ministries Senior Counsellor, 13 July 2012

As such, the reality of leveraging and capitalising existing degrees of entrepreneurship among genocide survivors, and the potential of IGAs to do this, needs to be placed more squarely alongside the need for sustainable alternatives for the most vulnerable survivors (e.g. a national pension scheme, home-based care etc), alternatives which the partner organisations only began to advocate for towards the end of the project.

It is noteworthy that Solace Ministries, using the money recovered from CTP loans, in 2011 established its own Solace Fund for Community Development. Loan approval is from a central committee in SM, and recovery of loans is managed by the community leadership of the 59 SM communities. Repayments are monthly over a period of 8 – 18 months. The Fund currently has around FRW 26,744,000 capital. SM staff believe that this somewhat gentler approach is more appropriate for working in rural areas than the rigours of the UOB approach.[43]

2.1.3 Providing legal support to survivors

The thinking behind including legal support as part of 'wraparound' support to survivors was with a view to pursuing land claims. This would be particularly important for widowed HIV+ve survivors who were too weak to engage in physical work or IGA projects directly, but who could nonetheless use their land as a source of income. Due to time constraints the evaluators were unable to meet with the legal officer in AVEGA east, though the legal officer for AVEGA central was present for a part of the group discussion.

Although the Annual Narrative report to Comic Relief for 2011 makes no mention at all of legal work, Solace Ministries gave figures of 190 cases worked with, and 24 cases ongoing, but this work was not funded out of SIP monies. At the beginning of 2012, a small number of cases which were considered to be "winnable" and potentially precedent-setting were identified and funded by SURF, in partnership with AVEGA and Solace Ministries. The high cost (around £500) of each case has limited the reach of this potentially highly important component of work. The extent of the unmet need for legal support was noted in the narrative report of June 2012 by a legal assistant in AVEGA, describing how in a period of 3 months he had 'documented' a total of 288 cases, of which the majority (168) related to enforcement of Gacaca rulings, 15 to enforcement of other rulings, 45 to succession issues, 36 to land matters, and 24 to other property issues.[44] While the number of cases is significant (not least in terms of what it reveals about a disturbing lack of follow through on Gacaca cases, including a failure to enforce awards made),[45] it is also evident from the report that the staff member concerned, who described his clients as 'Widows, orphans of Genocide, and some few men', was considerably frustrated by his inability to do more than document the cases and offer advice to the complainants. He ends with the recommendation that

> 'It is better to think how this coming period (if it is possible) can be more helpful than the last one, because to receive and document the cases without any follow up is nothing for the clients'.

[43] Solace Ministries Director, 18 July 2012. It was not clear what repayment rate has been achieved on loans made by the Fund.
[44] AVEGA, 6 June 2012, June Report on legal work
[45] Research published by the Legal Aid Forum in June 2012 determined that 92% of all genocide-related judgments yet to be enforced have exceeded the three-month time limit prescribed by law with some claimants having waited more than 15 years (see http://survivors-fund.org.uk/news/enforcement/).

Solace Ministries, which every Friday runs a legal desk in partnership with Kigali Bar Association, described how the majority of legal cases revolve around advocating and mediating, rather than court appearances. Furthermore, in both Solace Ministries and AVEGA, it was explained to the evaluators that the legal support was not funded by Comic Relief, but rather by the Sigrid Rausing Trust and REDRESS. This is largely reflected in the SIP budget, under which only AVEGA received Comic Relief monies for the salary of a legal officer ((GBP 11,464 over the two years of the project), but Solace Ministries received none.

In 2011, AVEGA was funded by UN Women on a project about legal access to justice for HIV+ve survivor women, regarding land, property, inheritance. The project trained 1200 paralegals and documented 6,448 cases of widows with judicial problems. Project staff engaged with local authorities to try and resolve the issues. Seven were taken to court due to the complexity of the matter. This project was given a further round of UN Women funding in 2012.[46] AER reported having 74 para-legals based out of its offices.

2.1.4 Linking private clinics into public health system in sustainable fashion

The indicator of sustainability adopted in the SIP project was that, by the end of the project, the Ministry of Health would provide 80% of budgets, and the clinics would raise at least 25% of their costs. This indicator seems to have been more than successfully accomplished:

CLINIC	Period	Income (FRW)	Expenditure (FRW)	Income as % of costs
Ntarama Health Centre	Jan – Jun 2012	14,168,678	51,407,760	27.5
AER Clinic	Jan – August 2012	13,506,508	44,687,514	30.2
AVEGA Kigali Clinic	Jul 2011 – Jun 2012	16,154,658	30,495,023	52.9

Management training for clinic staff of partner clinics was provided by Global Fund and Ministry of Health. Staff at the SM clinic had not received any management training, but were receiving support with financial management from SM Headquarters staff.[47]

While the clinics were undoubtedly linked into the public system in terms of being accessible to the general public and being partially resourced by the Ministry of Health, they remained privately owned clinics and thus at liberty to establish their own salary scales. Whereas one of the major fears in the run up to integration was that staff salaries would be reduced to those of staff in public clinics, and that this would lead to a loss of experienced and well-liked health workers, this problem was averted by SURF's decision – at the request of the partners – to top-up the salaries of clinic staff in a (successful) bid to retain them. The question of where future

[46] Odette Kayirera, AVEGA, 13 July 2012

[47] SM Clinic Staff interview, 18 July 2012

top-ups might come from was not addressed during the evaluation field-work, though it may be possible to do so through the income that the clinics are now generating.

2.1.5 Improving the life prospects of dependents of HIV+ women survivors

Under the SIP project, AVEGA supported 842 HIV+ beneficiaries across the association (Central, Western, Eastern), with 1,231 dependents. Additionally, both AVEGA and SM support children born of rape (FARJ does not provide support for children born after July 1994).

Children born of rape; The AVEGA report of April 2011 indicates that a total of 249 children born out of rape were being supported with school fees and materials, and of these, 6 also received legal support, 67 a hardship allowance, 9 nutritional support, and 5 psychological support. The AVEGA West report of August 2011 notes that 105 children born of rape were identified and received scholastic materials, uniforms and mattresses, while 34 secondary school students received transport support and toiletries.[48]

Solace Ministries provides counselling and material support to 97 children born of rape, but using funding from Foundation Rwanda.

Orphans

As with legal support, this area of activity was largely funded from outside of the SIP grant, in this case largely by FARG, and as such staff tended not to discuss it as they did not see it as integral to SIP.

2.1.6 Strengthening the capacity of AVEGA and SM to advocate for appropriate healthcare for members

AVEGA participates in the Joint Action Development Forum (JADF) in those districts it operates in. In this forum, all the partners (Local/ International NGOs, Civil society, local Government, Religious Institutions, Cooperatives) come together to discuss the relationship between them in supporting beneficiaries.[49] Advocacy at a national level has been slower to develop. However, in response to the 12 year review, and on the basis of ongoing discussions in the Forum of Partners meetings which are held three times yearly, Survivors Fund (SURF) has identified advocacy capacity as a priority, and a number of steps have been taken to develop this. In December 2011 a legal advocacy coordinator was appointed within SURF Rwanda as an interim measure, even as partner capacity is being built up. Initiatives such as Project Umubano advocacy practicum in July 2012, is a further step in this direction. AVEGA's advocacy on older widows and shelter is reflected in news coverage.[50]

Plans are also in place for SURF to fund the recruitment of advocacy interns at three of SURF's partner organisations, including AVEGA, to enable them to have persons focused on advocacy campaigns related to;

a) Enforcing payment of reparations (including Gacaca compensation awards)

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[48] AVEGA West narrative report, October 2011
[49] AVEGA, October 2011, SIP Narrative Report, All regions
[50] See for example http://www.newtimes.co.rw/news/index.php?a=55575&i=15044 and http://www.newtimes.co.rw/news/index.php?a=57068&i=15084 and http://www.newtimes.co.rw/news/index.php?i=15090&a=57260

b) Influencing the Economic Development and Poverty Reduction Strategy which is to be finalised in November 2012 (EDPRS II – 2013-2018)

c) Informing the National Social Protection Strategy (NSPS) which will be restructured in a rolling fashion from now up to 2016

d) Ensuring AVEGA, or other representative survivor's organisation, is represented on the Board of the Government Assistance Fund for Survivors (FARG) as it continues to disburse funding for shelter, counselling, livelihood activities, and healthcare

e) Calling for a Social Pensions for Elderly Genocide Widows (over 70 years of age) which pays GBP 21 per month to all that qualify by July 2013

f) Engaging with a range of Government Sector Working Groups, particularly those related to Justice and Healthcare, by January 2013

If these campaigns develop well and are effective, they will undoubtedly inform responses to other draft laws, and create substantial advocacy capacity within the partner organisations.

2.2 Project Process

2.2.1 Inclusivity (IGA Groups, Access to Health Care)

Compared to observations made during the 12 Year Review done in late 2009, when the ending of CTP loomed large in people's minds, and there was a general belief that integration of survivors with non-survivors, whether in health services, income generation, or in society generally, was impossible, the generalised fears have not materialised and inclusivity has increased in both IGA groups and the health care system.

Certain practices have undoubtedly enhanced inclusivity;

- Requesting IGA groups to include non-survivors[51]
- Establishing joint clinic user-groups to work through any tensions between survivor and non-survivor users.[52] [53]
- Instilling the principle that survivors who are benefiting should share some of the benefits with non-survivors. For example, SM survivor beneficiaries who were given cows subsequently donated milk once

[51] This is a slow process; in AER, for example, IGA staff reported that only 10 out of 297 IGA group members (i.e. 2.3%) are non-survivors. In the words of one staff member, "to convince them to work with non-survivros is a long process. In most cases they don't understand well, but they try, because it is the policy". (group discussion with IGA staff, AER, 15 July 2012

[52] In the AER Clinic in Rwamagana, non-survivor HIV+ve clinic users outnumber survivors, 125: 87 (Interview with AER Counsellor, 15 July 2012)

[53] Former CTP members in Rwamagana explained how the mixed user group functions to create new relationships: *"We didn't know each other before; didn't know that they (non-survivors) were ill (with HIV). When we met here we understood that we all had the same problem. Even now it has strengthened our relationship. We visit each other. Q; do you help each other out when you have a problem? A: yes, we help each other out Q: for example? A: one of them passed away and we helped, came here and requested the coffin, participated in organising the ceremony. We receive food here and when we come to receive we share that"* (17 July 2012).

per week to address kwashiorkor (resulting from protein deficiency) in the non-survivor population. Similarly, under an AVEGA bee-keeping project, honey from the bees is given to non-survivor neighbours, and under a project funded by Good Gifts, and named 'A Gift to Your Neighbour', the offspring of livestock such as goats, cows, and chickens are given to neighbours.

- Helping women to break out of self-restricting models of themselves as women; by engaging with microfinance institutions, women survivors have also become more self-confident and therefore better able to insert themselves into the wider society

2.2.2 Monitoring and Support

The follow up of IGAs by SURF staff has been systematic (e.g. they have complete list of beneficiaries, repayments, outstanding loans, points scored etc), as has the ground-level follow-up by SM and AVEGA staff. This is further complemented by the weekly visits of UOB loan officers as they collect repayments.

2.2.3 AVEGA & SM management capacity, technical expertise, staffing levels, approach to working with its membership in implementing SIP

Both AVEGA and Solace Ministries are gifted with strong directors who have been closely involved in their respective organisations for many years. The coordinator of AVEGA West is well-established, while those of AVEGA East and AVEGA Central are newer to their roles. Neither of the latter has any formal management training, with the AER coordinator having previously worked as a psychologist at the AER clinic, and the ACR coordinator having worked previously as the Personal Assistant to the director.

In terms of technical expertise, the fieldwork did not allow sufficient time to do a meaningful human resources audit. Certainly all programme staff appear well able to explain their work, and to know their achievement and challenges, and to be able to articulate these verbally, though, as noted elsewhere and in the 12 year review, written documentation is generally quite weak. Commitment levels appear good, and are shaped by the staff's own experiences as survivors. They may, however, over time become demotivated by salary levels (AVEGA), and as the organisations grow, it will be important to ensure that an ethos of recruiting from within the survivor population goes hand in hand with ensuring that technical competencies are also assured.

One of the recommendations of the 12 Year Review, namely for "a systematic assessment of partner needs with regard to key areas of capacity, including but not limited to: proposal development, fund-raising, financial and narrative reporting, documentation, research, team building" had not been adopted, with the exception of a financial systems review of SURF Rwanda and AVEGA by Health Poverty Action in July 2010, which found that "The first constraint was the lack of qualified accountants amongst the staff, SURF Rwanda being the only exception". This in turn was linked to a lack of clear and effective financial procedures manuals.[54]

The follow-up report of December 2011 notes that in the course of the year SURF Rwanda had adopted the UK office's Financial procedure manual as well as procurement and inventory management guidelines, and was keeping its asset listing up-to-date. Documentation of payments had begun to be rigorously enforced, though

[54] Health Poverty Action, July 2010, December 2011

internal audits were yet to be put in place. From January 2011 onwards, there were standard financial reports for partners.

The report noted a number of ongoing weaknesses in AVEGA systems, including the lack of a separate Finance Manual, and lack of central internal audits, but also that positive steps had been taken towards establishing the organizational budget in 2010, beginning regular bank reconciliations and updating of the asset register. In July 2012, AVEGA agreed a new comprehensive finance and procedures manual. This followed on from the issuing in March 2011 of new manuals for child protection, code of conduct, gender policy, conflict resolution and fund-raising.

Overall there is a greater sense of dynamism within AVEGA than in 2009, and a relatively highly centralised management process. This is in line with the HPA report's July 2010 recommendation that in terms of financial processes, "The AVEGA Central office should have more involvement in overseeing the two regional branches in order to ensure consistency among the different offices." The same principle almost certainly applies to other dimensions of work, including human resources, grants management, procurement, and IT policy. It will, however, be important to ensure that centralized management and the need to establish a common organizational culture across multiple offices, does not result in micro-management.

During visits to the different offices and clinics, our observations of interactions between staff and beneficiaries were consistently positive, and the language of being part of one 'family' is used frequently. Perhaps the inter-relations between different skill-sets need to be further explored and articulated. For example, counsellors who are familiar with the pattern of psychological response to commemoration activities should be interacting with the staff working on IGA programmes so that such patterns can be taken into account and accommodated in the design of training, loan repayment schedules, etc. The 2011 commemoration period , for example, was one of the factors that led to the start of the IGA programme being post-poned.

From a more strategic perspective, and looking to the future role and activities of AVEGA, the evaluators were encouraged by the fact that the organisation is beginning to think about how it should adapt to the aging of its original constituency (women genocide survivors), and beginning to look at the issue of widows more broadly. The Executive Director observed that:

> *At last congress we started talking about including the descendents of the elderly widows. Perhaps also more and more we are thinking of changing the mission of the organisation; for example, this year we did a project with organisations which advocate for widows; widows of AIDS, widows of war, widows… We worked with Rwanda Women's Network which advocates for vulnerable women. We did a project for international day of the widow.*

Clearly SIP has had an influence on this thinking. According to another AVEGA staff member,

> *Our beneficiaries today are 'le peuple rwandaise'. We have a health centre which welcomes everyone. My colleague has a project which welcomes vulnerable people, without looking at their origins. These activities show that ten or fifteen years from now, some people will remain, they could be the children of our members, who can supervise these activities. So I don't think AVEGA will close its doors, it will continue, it will work for Rwandan society… … AVEGA has experience with widows of genocide, but can*

also help widows of HIV and other illnesses. With its experience we can work with widows of other causes to overcome their problem.[55]

2.2.4 Sustainability of Impact (livelihood development programme, transition into public health system

Livelihoods: the three-cycle model is important in establishing sustainability (only after two or three rounds can the loan-makers be sure that people are not using other assets to pay off their loan). As set out above, the initial findings of the phone survey suggest that participants in the loan-schemes are managing to both increase their regular expenditure levels by an average of 57%, and at the same time, have managed to increase their savings rate by an average of 263%. As such they are able to increase consumption immediately, but at the same time build towards a far stronger and more resilient financial future. As the correspondence with UOB demonstrates, the micro-finance institution itself is giving close consideration to transitioning successful loan recipients to loans independent of the loans guarantee fund, and this would be a clear indicator of sustainability of impact.

However, as noted above, these successes cannot be replicated with all survivors. The recommendation of the 12 year review continues to hold true, namely that "*donors must be lobbied to recognise that needs are very context and history specific. While some survivors are able to move on and regain full control over their lives, others will remain vulnerable."*[56]

Access to Health Services: the use of public health systems, and in particular access to ARVs and treatment for opportunistic infections, is sustainable for those survivors and their dependents who have overcome their fears of joining public systems alongside non-survivor peers. In other words, beneficiaries of CTP and SIP are now reasonably assured of sustained access to the necessary health services.

However, the job of persuading survivors who have not yet accessed services to try and do so (and this will undoubtedly prove to be the case as the new offices of AVEGA become more established), continues to require the kind of 'wraparound' support which was the trademark of both CTP and SIP. In the absence of sufficient funding for such support services to be provided comprehensively by AVEGA and Solace Ministries, advocacy to the Ministry of Health to provide the 'wrap around' elements will need to be done *(it is noteworthy that this does not feature explicitly on the list of planned advocacy campaigns outlined above)*.

2.2.5 How the findings and recommendations of the Review of CR funded projects of SURF have been applied, and what issues still remain to be addressed.

While not all recommendations have been fully adopted, many of the most urgent ones were taken seriously; our concerns at the working systems and relationships within SURF appear to have been addressed. The London-based director is much more visibly in control of the overall functioning of SURF, there are more systematic communications between London and Kigali, and the Director plays an active oversight function, liaising closely with the programme managers.[57] The legal status of SURF in Rwanda, which at the time of the 12 year review was somewhat unclear, has been clarified. SURF is now registered as an international NGO in

[55] AVEGA Central Staff, 17 July 2012
[56] Dolan C & Gatete K, January 2010, p. 13
[57] The Rwanda-based Programme Manager, for example, reported twice monthly skype calls with the SURF Director (Interview 15 July 2012)

Rwanda, with SURF Rwanda a fully owned and controlled subsidiary of SURF UK. In 2012, accounts were consolidated for the first time. These steps have helped the relationships between SURF Rwanda and partners, with improved communication all round. Specifically, a 'Forum of Partners' has been established, which meets three times a year (the first meeting was in March 2010, within two months of the final review report), and has become an important space for discussion of strategic issues, such as the key advocacy campaigns to pursue (see above). Furthermore, an MOU between SURF and AVEGA was signed on 18 July 2011, "to improve and establish a stable and conducive relationship and collaboration between SURF and AVEGA as an entity". It commits the two parties to working as partners, rather than as donors and beneficiaries, and commits SURF to working with AVEGA as a whole, rather than bypassing the central office to work directly with regional branches.

SURF Rwanda has thus responded to the recommendation that "*The M & E function of SURF Rwanda needs to be re-defined and probably re-affirmed through an internal review and planning exercise",* and has moved into a more constructive and supportive monitoring role for SURF staff, and moved away from becoming an implementer in competition with Rwandan survivor organisations.

In terms of programming in synergy which the changing policy environment, the challenges of integrating survivors had been confronted resolutely through the SIP project, with strategic use of unrestricted income to smooth out hurdles which the Comic Relief funding alone could not address. The recommendation that "*Any strategic review must consider whether the reach of survivor organisations should extend to hitherto under-addressed areas of the country"*[58] appears to have been addressed through the opening of two new AVEGA offices under a new DFID grant in 2012.

The recommendation that "*Partner organisations need to be more demanding in terms of their understanding of resource flows and information"*[59] was addressed under improved financial systems arising from HPA review, as was the warning that procedural mistakes by SURF Rwanda could seriously jeopardize the working relationship with the partners.

The following are recommendations that had not been fully addressed but still appeared pertinent to the evaluators:

- *Further capacity building on different aspects of the project cycle needs to be conducted (with beneficiaries).* Not apparent in terms of projects being developed by the partner organizations, but evident in the training conducted for IGA groups. However, SURF has facilitated training for the partners since the evaluation, such as on SPSS (statistics software package) and report writing, though further support would be beneficial.

- *Systematic assessment of partner needs with regard to key areas of capacity, including but not limited to: proposal development, fund-raising, financial and narrative reporting, documentation, research,*

[58] Idem, p 20
[59] Dolan C & Gatete K, January 2010, p 21

team building. Not apparent except for financial and narrative reporting, though day to day monitoring by SURF staff is taking place.[60]

- *As well as M & E in the conventional sense, partners should receive training on how to capitalize on their considerable achievements through careful documentation and the use of multi-media, whether to their membership or to their supporters and donors.* [61] AVEGA has begun to utilise multi-media, such as the production of a documentary film in July 2012 on the situation of older genocide widows, to advocate for that population. However, further training and support would be beneficial, not least in terms of basic documentation. Several of the documents provided to the evaluators, for example, were undated, making it difficult to use that documentation either for planning purposes or for advocacy.

- *The reviewers strongly recommended that Comic Relief consider funding a one week strategic planning workshop for all the partners it has funded through SURF to date. Key discussions in the course of that week would include:*

    - *understanding the changing context of Rwanda*
    - *what that contextual analysis implies for interest groups such as the survivor organisations*
    - *where their priorities should lie over the coming five years*
    - *what their key advocacy messages should be at this point in post-Genocide developments*
    - *how best they should structure the relationships between themselves with a view to increasing mutual support (e.g. should AVEGA Central be a regional office similar to AVEGA East and West offices, while AVEGA National takes on an overall co-ordination role?).*[62]

While this recommendation was not adopted in the strict sense of holding a one-week planning workshop, a more sustainable response to this recommendation was found in the establishment of regular 'Forum of Partners' meetings in which strategic matters are discussed. A further intensive period of review could nonetheless be beneficial

2.2.6 The approach of Comic Relief to the project

Given the weaknesses in documentation which became evident to the evaluators, the clear structuring of reporting requirements from Comic Relief is an asset, as it compels the grant recipients to report on dynamics that would otherwise not be captured.

The only complaint noted by the evaluators was that Comic Relief has never visited the project and as a result may not fully appreciate the complex relationship between meeting survivor needs and working within government policy parameters.

From the evaluators' perspective, it appears that Comic Relief could usefully work with its partners to document the complexities of working with survivors, including the paradox that this single category can contain diametrically opposite needs (e.g. some survivors will need life-long support, others will benefit from rigorous

[60] Idem, p 19
[61] Idem, p 20
[62] Idem, p 24

training and support to enable them to regain their independence), and the challenges and dilemmas that this may create for donors need to be more clearly articulated.

Equally, Comic Relief would do well to document and highlight the way in which well structured interventions, such as the IGA training and loan support, can mobilise latent potential within disadvantaged groups, populations which can otherwise be easily written off as meriting at best a lifelong 'holding operation'. Comic Relief should also publicise the important *gender gains* derived from these approaches, in terms of the evident ways in which the IGAs have substantially transformed the women's self-perceptions and provided them the confidence to engage with the formal financial sector and with their wider communities.

It might be added that while the two year time span of SIP was adequate for the component focused on integration of CTP clinics into the public health system, it was too short for the IGA component to be rolled out to all the potential beneficiaries within the partner organisations, or for its benefits to be conclusively demonstrated.

The above notwithstanding, the model of IGA established under SIP has enabled SURF to pursue an additional three year grant from DFID to extend this approach to the two new AVEGA offices in the southern and northern regions of the country.[63]

[63] SURF, 30 September 2011, Annual Narrative Report to Comic Relief

Section 3

3.1 Lessons

SIP has demonstrated the complex interplay between policy and political context and the way in which judicious interventions can mobilise potential within a disadvantaged population that is otherwise easily written off. SIP is important, not so much as a demonstration of what still remains to be done 18 years after the Genocide, but rather as a demonstration of just how much still ***can*** be done.

Specifically, private clinics can be integrated into public health systems, and the patients of such clinics can, with the right degree of accompaniment, integrate into public clinics nearer to their homes. However, this aspect of the SIP project has been successful in part because alternative/additional funding was available to ensure that the 'wraparound' support dimension could be continued, even though the Comic Relief funding to SIP did not cover certain activities that were built into the SIP project, notably legal support, and top-ups to salaries of private clinic staff.

A significant proportion of genocide survivors, despite an average of 49 years and despite many having been HIV +ve for many years, can, with adequate training and ongoing support from loan officers, engage in meaningful income generating activities and sustain loan repayments in a way which qualifies them for future loans independent of supporting projects, and which substantially enhances their economic resilience.

Such an approach, which establishes working relationships between survivors and microfinance institutions, can not only give survivors a new sense of purpose and possibility, and thereby break them out of any dependency syndrome, but in the process also it can help women escape from deeply entrenched gender norms inhibiting them from engaging in the formal monetary economy, and thus contribute to their integration within a still troubled social and political environment.

For those who complete IGA training and take loans, it appears that the Compensation Fund was not strictly necessary, as they were able to deal with the relatively high interest rates demanded by UOB.

However, as with any such category, needs are diverse, and the high intensity approach adopted under SIP will not work for all survivors, some of whom are not sufficiently physically or psychologically robust for such an approach, but may be able to sustain a somewhat 'softer' approach. Furthermore, the particularities of survivor groups need to be accommodated within the business models of micro-finance institutions. For example, levels of trauma during the annual Genocide commemoration period are likely to affect repayment regularity.

Designing the project with an awareness of major policy developments has enabled several synergies between Government initiatives and the project:

- The *Mutuelle de Santé* (public health insurance) has revolutionised access to health care
- The policy of Unity & Reconciliation has provided a national framework (and a protection mechanism) for the integration elements of the project

- The attempt to diversify survivors' income through provision of credit to Income Generation Activities structured through groups, is consistent with policy of increasing off-farm employment (VUP Umurenge), and the agriculture policy

- The creation of entrepreneurship among vulnerable sections of the population is in line with EDPRS (Economic Development & Poverty Reduction Strategy), as well as the *Ubudehe* policy (community development and poverty alleviation)

- The process of regularisation of land tenure can contribute in securing tenure of survivors

3.2 Challenges and Issues

The steps to be taken to either sustain private clinic staff at existing salary levels (which are higher than the public health system salaries), or bring them down in line with the existing public health system scales, have not been clarified.

There is clear correlation between a survivor's level of physical and psychological stability and the likelihood of her enrolling for a loan (and the amount), indicating that a 'one-size fits all' approach needs revisiting.

The quality of documentation from the partner organisations is relatively poor, and creates an obstacle to the quick identification of successes. For example, many of the documents submitted to the evaluators were not dated, the periods covered were not clearly stipulated, and the figures did not always add up.

3.3. Recommendations

Health Care

- Optimise opportunities offered by government policies, but also advocate more visibly on the basis of lessons learned from the CTP-SIP process

Income Generating Activities

- Use the Project Loan Guarantee Fund to extend the IGA training component of SIP by eight months

- Develop a three–layer loan scheme which has the UOB model (tough), SACCO (medium), and Solace Fund (appropriate for most vulnerable), and explore ways of giving survivors a choice of Microfinance Institution to work with, possibly combined with a psychological and physical assessment process

- Set up extension services and ongoing training to leverage business efforts, but bear in mind that as number of groups grows, so does need for extension services

- Clarify to survivors the exact interest rate of their loan repayment, and that, if they complete repayments, SURF will in turn return up to 70% of the interest payments to them

- Complete the end-line survey of the SIP project by re-interviewing the remaining 79 of those who were surveyed as a baseline in 2011 (i.e. complete the process begun during evaluation in July 2012)

- Connect legal measures to reclaim land and properties, and to enforce compensation payments, with IGA projects and training

Advocacy Opportunities and Needs

- In addition to the campaigns already identified, more training on civic participation to enable competition for civic positions at the grassroots level which would allow survivors to influence policy and decision making at local level, including monitoring of *Imuhigo* (Performance Contract).
  There should also be a campaign focused specifically on enforcement of payment of Gacaca compensation awards.

Organisational

- Establish consistent frameworks for figures (and definitions), and rigorously improve documentation practices

- As AVEGA grows and the new offices become more firmly established, it will be important regularly to review and adapt the management relationships and systems between centre and regional offices, and to establish benchmarks against which decentralisation of certain areas of management decision-making can be implemented

- Conduct a review of salary scales across a range of related organisations to ensure that partner salaries are competitive and able to retain staff.

- Junior and mid-level staff should be encouraged to express themselves and take responsibility

- Use the Forum of Partners to explore the extent to which stigma and marginalisation of survivors have resulted in technical capacity gaps, the challenges this creates for survivor organisations, and the steps that could be taken to address them (e.g. Solace Ministries collaborates with Kigali Bar Association to ensure that its legal clinic is well supported)

- "a systematic assessment of partner needs with regard to key areas of capacity, including but not limited to: proposal development, fund-raising, financial and narrative reporting, documentation, research, team building" (restated from 12 year review)

- Encourage Comic Relief to visit the projects and document the fruits of its extensive support; since 2003 when the last visit was done, there has been a quantum shift in the scale and depth of the activities, as well as the organisational capacities of AVEGA, Solace Ministries and SURF.

Annex 1: Evaluation & Fieldwork Schedules

ACTIVITY	WK 1	WK 2	WK 3	WK 4	WK 5
I. Set-up (SURF & Rwanda Coordinator)					
• Negotiating and agreeing contract					
• Agree implementation plan					
II. Document Review					
• Agree on documents to be reviewed					
• Make relevant documents available					
• Review of documents					
III. Data Collection & Analysis					
• Design methodology and tools					
• Data collection					
• Data analysis					
IV. Report Findings & Writing					
• Presentation of findings					
• Initial draft of report for comment					
• Final draft of report					

Daily Fieldwork Schedule

Thursday 12th
Principal Evaluator travels to Kigali

Friday 13th
am – Entry conference with all partners, held at Solace Ministries
pm – Opening meetings with individual staff

Saturday 14th
Am: Further document review in morning and interview of 2 SURF staff
Pm; Travel to Cyangugu 1pm, fieldwork in with AVEGA Western Region, Cyangugu 3pm - 11pm

Sunday 15th
am – Flight to Kigali
pm – Meeting with SURF Rwanda Team

Monday 16th
am – Meeting with ACR Team, Tour of Kigali Clinic,
pm - Field visits to IGA Associations (interviews with beneficiaries)

Tuesday 17th
am – Travel to Rwamagana, Meeting with AER Team, Tour of Clinic

pm – Field visits to IGA Associations (interviews with beneficiaries), Return to Kigali

Wednesday 18th
am – Meeting with SM Team, Tour of Kabuga Clinic
pm - Field visits to IGA Associations (interviews with beneficiaries), Any additional meetings required,

Thursday 19th
am – Preparation of debriefing presentation
pm – Debriefing presentation

Friday 20th
Writing up day; any additional follow-up meetings
UN Women on inheritance rights for HIV+ women (AVEGA)

Annex 2: List of Interviews and Focus Group Discussion

12 07 13 SM IGA Officer
12 07 13 SM Senior Counsellor
12 07 13 Programme Manager, WSEP, AVEGA Central
12 07 13 Odette Kayirere, AVEGA
12 07 14 AWR beneficiaries (2 male)
12 07 14 AWR beneficiary (female)
12 07 14 AWR Staff group discussion
12 07 14 SURF IGA Officer
12 07 14 SURF Project Officer Assistant
12 07 15 SURF Programme Manager
12 07 15 SURF Rwanda Representative
12 07 15 Meeting with AER IGA Beneficiaries (8 women, 4 men)
12 07 15 AER CDWs
12 07 15 AER Counsellor
12 07 15 AER IGA Staff
12 07 15 AER Coordinator
12 07 15 IGA beneficiaries, Gitambi
12 07 17 Former CTP Clients
12 07 17 Group Discussion, AVEGA Central staff
12 07 17 IGA Beneficiaries, AVEGA Central
12 07 17 IGA Group, Mumyembe-Kimihura
12 07 18 group discussion with SM Staff
12 07 18 discussion with 3 SM sponsored tertiary students
12 07 18 discussion with two beneficiaries who transferred to SM clinic rather than attend public clinics
12 07 18 discussion with two male beneficiaries of SM IGAs

Annex 3: Documents Reviewed

AVEGA, December 2011, SIP Report for September 2010 – December 2011, All AVEGA Regional Offices

AVEGA, 6 June 2012, Narrative Report on legal support

AVEGA, undated, spreadsheet of Gacaca compensation decisions which have yet to be enforced

AVEGA, Comic Relief Partner Evaluation Form – Interim Report, September 2010 to April 2011

Comic Relief, 2011 Consolidated Annual Data Report Form for SIP

DFID Health Resource Centre, 2009 Annual Review – Care & Treatment Project

Dolan, C & Gatete K, January 2010, *Review of Comic Relief funded Programs of SURF in Rwanda, implemented in partnership with Local Survivor's Organisations 1996-2008*

Enfield, S, August 2010, Draft Project Completion Report, Care & Treatment of Genocide Survivors Infected by HIV/AIDS

Health Poverty Action, July 2010, SURF Partner Organisations Systems Review Report

Health Poverty Action, December 2011, Follow-up of HPA Systems Review

Solace Ministries (undated), '*Health & Relief: Strategic Plan for Future of Solace Clinic and Medical Services*

SURF, 1 October 2010, SIP Entry Meeting Report

SURF, November 2010, IGA Review

SURF, 21 March 2011, Training report SURF Business and Cooperative Development Training

SURF, 30 September 2011, Annual Narrative Report to Comic Relief

SURF, 25 October 2011, Strategy Planning Workshop Outline

SURF, 26 October 2011, SIP Review Feedback

SURF, 31 January 2012, Feedback on GR002-01910-DQUI Annual Report

SURF, July 2012, Main Findings of SIP Survey Respondents