Final Evaluation of HelpAge International's Portfolio: Preventing HIV and AIDS and alleviating its Impact in Multigenerational Households

Final Evaluation Report

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Abbreviations

AFRIWAG	African Women AIDS Working Group
AIDS	Acquired Immune Deficiency Syndrome
ANOVA	Analysis of Variance between groups
ART	Anti-retroviral Therapy
BLF	Big Lottery Fund
CAFO	Community Aged Foundation
CCS	Christian Community Services
CDC	Center for Disease Control (United States)
CEO	Chief Executive Officer
CSO	Community Service Organisations
DAC	Development Assistance Committee
EAC	East Africa Community
EEPNA	Ethiopian Elders and Pensioners National Association
EWCARDC	East, West and Central Africa Regional Development Centre
FTE	Full time equivalent
GCU	Grants and Contracts Unit
HAK	HelpAge Kenya
HAPCO	HIV/AIDS Prevention and Control Office
HBC	Home Based Care
HIV	Human Immunodeficiency Virus
HR	Human Resources
IAP	Integrated AIDS Programme
IGA	Income generated activity
KAP	Knowledge, Attitude and Practice
M&E	Monitoring and Evaluation
MEL	Monitoring, Evaluation and Learning
MGH	Multi-generational households
MTCT	Mother to child transmission
MUSA	Muthande Society for the Aged
NGO	Non-government organisation
OECD	Organisation for Economic Co-operation and Development
OVC(Y)	Orphans and vulnerable children (and youth)
PLHIV	Person living with HIV
PRA	Participatory Rapid Assessment
RIATT-ESA	Regional Inter-Agency Task Team on Children and AIDS - Eastern and Southern Africa
SADC	Southern African Development Community
Sida	Swedish International Development Coordination Agency
TACAIDS	Tanzania Commission for AIDS
TEWOREC	Tanga Elderly Women's Resource Centre
THP	Traditional Health Practitioner
TV	Television
URAA	Uganda Reach the Aged Association
US	United States of America
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing

Executive Summary

HelpAge International (HelpAge) has been delivering HIV-related activities in some form or another for approximately 15 years. HelpAge received £4.97 million from the Big Lottery Fund towards a portfolio of nine projects in five sub-Saharan African countries between 2008 and 2013. The grant was later increased to £ 5.11 million as a result of the economic downturn experienced in most of the countries.

The aim of the portfolio was to reduce the impact of HIV and AIDS on multigenerational households (MGHs) in Sub-Sahara Africa by using an overall strategy which develops approaches that mainstream older people's needs and contributions in response to the HIV/AIDS epidemic

The portfolio had 4 outcomes in furtherance of its aim:

1. Outcome 1 – HIV and AIDS policy changes in four East/Southern African countries increasing older peoples' access to HIV prevention, care and treatment services will be implemented by the end of the portfolio;
2. Outcome 2 – By the end of the portfolio 60% of the target group in the 5 portfolio countries will have reported an increase in knowledge of HIV and AIDS and a greater confidence to protect themselves;
3. Outcome 3 – 75% of 10,200 people living with HIV receiving home care and services report an improvement in quality of care and services; and
4. Outcome 4 – 50% of MGHs affected by HIV in the portfolio have improved coping mechanisms to mitigate its impact by the end of the portfolio

Activities were delivered through 9 projects across 5 countries

- Project 1: (Ethiopia, Kenya, Tanzania and Uganda, Advocacy) Mainstreaming Ageing into HIV and AIDS Responses
- Project 2: (Ethiopia, Kenya, Tanzania and Uganda, Advocacy) HIV and AIDS Data Disaggregation
- Project 3: (Ethiopia, Kenya, Tanzania and Uganda, Prevention) Preventing HIV in Older People
- Project 4: (Kenya, Service Provision) Supporting Multigenerational Households through Economic Empowerment of orphans and vulnerable children in Kenya
- Project 5: (Uganda, Service Provision) Supporting Multigenerational Households through Protection of the Inheritance Rights of orphans and vulnerable children in Uganda
- Project 6: (South Africa, Service Provision) Strengthening the Role of Traditional Health Practitioners in South Africa
- Project 7: (Ethiopia, Service Provision) Strengthening Iddirs (Burial Societies) in Ethiopia

- Project 8: (Tanzania, Service Provision) Improving quality of Home Based Care to people living with HIV in Tanzania
- Project 9: (UK, Ethiopia, Kenya, Tanzania, Uganda, South Africa, Organisational Learning) Sharing Learning, Good Practice and Impact

Key findings from this evaluation are:

1. HelpAge has adapted existing models of intervention for its activities to provide some successful activities that have met most of its portfolio outcomes;
2. Older people have valued the knowledge that they have learned through HelpAge's prevention activities, however they still feel that HIV is more of an issue for younger people than for them. Trust in domestic relationships in the beneficiary groups in Kenya and Ethiopia emerged as an issue (although likely to be more widespread);
3. The quality of home-based care and services was rated highly. Clients of traditional health practitioners in South Africa confirmed that they had received improved services from their traditional health practitioners during consultations and Tanzanian and Ethiopian beneficiaries suggested that different mixes of components could create a quality care programme that they would consider appropriate to their needs;
4. At least 50% of the households targeted by projects 4, 5 and 7 have new coping mechanisms and the projects, despite some significant issues have been considered as valuable by the beneficiaries that participated in them;
5. Value for money achieved by the portfolio has been mixed while efficiency and portfolio management have presented issues for HelpAge and its partners;
6. The redesigned project 9 has provided some excellent learning tools and made the link between qualitative evidence gathering and communication and awareness raising more tangible; and
7. HelpAge's impact has been mixed. However it is possible to say that through the portfolio HelpAge is achieving at least part of its HIV Theory of Change at output, outcome and impact level.

We applied the OECD DAC criteria (results, relevance, effectiveness, efficiency and sustainability) to HelpAge's activities during our evaluation.

Results

Outcome 1

Advocacy has been one of the highlights of the BLF portfolio and HelpAge's success at setting up successful local and national advocacy groups has seen the introduction of structured, coordinated and to a degree sustainable local advocacy groups for older people's issues where previously there had not been much activity. These groups have not only advocated for policy change, but have also considered how policy might be implemented at a local level.

HelpAge staff and partner organisations in all four countries influenced key national policies, strategies, frameworks and curricula to include aspects of HIV and older people. Additionally HelpAge attended high-level national meetings and were represented on national HIV technical working groups. Senior government staff working in HIV recognized that HelpAge was visible in the sector advocating on older people's issues and had made a significant contribution. HelpAge works extensively with the EAC and SADC to advocate for the recognition of older people as carers for orphans and vulnerable children and for the recognition of older people as being at risk of infection within the HIV epidemic.

HelpAge have been active at the regional level in promoting data disaggregation for the collection of HIV data and in particular supporting the countries in the Big Lottery Fund portfolio as well as actively advocating at the regional level from Nairobi. The findings of HelpAge's advocacy work on data disaggregation at a country level are also helping to inform their work on data disaggregation at a global level.

Outcome 2

Prevention was considered to be the cornerstone of HelpAge's portfolio of HIV programming. Key to the success of this project would be the degree to which HelpAge and its partners could develop the knowledge of its target beneficiaries and influence their behaviour. The Peer Educators, Community Conversation facilitators, Home-Based Care givers and Traditional Health Practitioners have all played a role in supporting behaviour change amongst the beneficiaries, with the Peer Educators being especially valued by the beneficiaries. In general older people appear to be using abstinence and faithfulness as their main prevention techniques. While abstinence is more important to women and faithfulness appears to be more important to men, both genders are reporting that a lack of trust in their domestic relationships makes them feel more at risk of HIV infection. While condom use remains low overall, it has increased since 2008. Older age groups (70+) are less likely to attend VCT and men appear more likely to report that they have accessed VCT services. Findings on the change in HIV knowledge different between the survey results and the focus group discussions held during the evaluation. The focus group discussions held in the four main project countries suggested that most older people do value having this knowledge and knowing how to talk to their grandchildren about HIV, but that they continue to view HIV as an issue for younger people in general.

Outcome 3

Ethiopia and Tanzania implemented Home Based Care (HBC) programmes, while in South Africa, HelpAge's work with traditional health practitioners was initially described in terms of information provision and intended to have an impact on the quality of the services older people received from traditional health practitioners both at home and during their consultations with their traditional health practitioners. The evaluation found that HBC services were highly valued, the quality of care is considered very good or excellent,

beneficiaries would like their services to be extended and there are potential difficulties in sustaining the programme.

The quality of home-based care and services provided to beneficiaries has definitely increased and has been verified by the beneficiaries, although we are unable to say whether the outcome of 75% of 10,200 people living with HIV experiencing increased quality of care has been met, as there is no evidence to support how this figure was determined and one indicator alone (South Africa) has a target is excess of 10,200. The introduction of ART has had an impact on the kind of support households need.

Outcome 4

Activities that contributed towards outcome 4 focused on providing beneficiaries with knowledge, skills and opportunity to increase their own economic security and sense of identity. The interventions included legal support for land claims, will-writing and memory books, formalized training, business skills training and loans for small-scale income generation. Success has been varied and the income generation activities have presented the greatest challenge to the implementing partners, HelpAge and its beneficiaries; but have also provided the greatest successes. While will writing and memory books are interventions that are well utilized in Africa, and paralegal activity is recorded in other countries, neither had been implemented with older people in Kasese in the way that HelpAge designed. Equally, IGAs are not unknown to HelpAge, however the experiences of implementing IGAs in Ethiopia and Kenya provided new platforms for learning both successful and challenging lessons.

In Ethiopia the IGA loans programme was part of a larger project to strengthen the Iddirs; while in Kenya the focus was on the economic empowerment of orphans and vulnerable children in multigenerational households. These two projects provide us with contrasting views of project management and success. In Ethiopia beneficiaries reported genuine poverty reduction and significant increased asset ownership, whilst in Kenya the difficulties encountered in the first two and a half years, delayed and reduced the success that the project could have had during the lifetime of the portfolio. As a result the Kenyan IGA component has not had the same impact economically as the Ethiopian IGA component had for the Ethiopian beneficiaries. The IGA project in Ethiopia appears to have been the most successful element of the country-specific projects across the portfolio.

Outcome 4 intended to deliver improved coping mechanisms to the target beneficiary groups. Given the successes and the challenges for projects 4, 5 and 7 we can say that at least 50% of the beneficiaries targeted by these projects have new coping mechanisms in most cases. However there is an absence of robust baseline information in these communities for these projects so we cannot say whether these coping mechanisms are an improvement on any coping mechanisms that the communities may have already had in place.

Importantly the implementing partners in project 4, CCS, IAP and HelpAge Kenya all reported that they had observed a change in the attitude of those older people who had participated in the project, from dependency to self-sufficiency. That all three reported this independently is significant and suggests a real change that has permeated the community. No beneficiaries related this to us in these terms however, which means that while the implementing partners have observed this change, the beneficiaries only discussed the direct change they observed in their lives as they reported in the focus group discussions.

Relevance

HelpAge's activities were considered to most be relevant to the beneficiaries and the portfolio and its aims. The work with traditional health practitioners in South Africa however was found to be less relevant to the portfolio aims whilst being considered very relevant to the community. Taking the beneficiary viewpoint into account, 75% of beneficiaries that participated in the PRA exercises said that HelpAge and its partners were flexible and responsive as their needs changed during the project period, which suggests that HelpAge did try to make its interventions relevant to its beneficiaries.

HelpAge's regional focus was particularly relevant as it helped to highlight the issues for older people that it was tackling at a national and local level through the projects being implemented in each country.

The delivery of prevention information is relevant to promoting behaviour change of the beneficiary groups and to the portfolio aims. The beneficiaries specifically reported the changes that they believed they had experienced as a result of the prevention activities delivered by HelpAge and its partners, mainly through behaviour and attitude change. While HelpAge's interventions have been particularly relevant to the beneficiaries, the sustainability of these interventions is far from assured.

Participants in the focus groups in Ethiopia and Tanzania reported that HBC services provided a valuable service to those older people who were looking after orphans and vulnerable children or people living with HIV. While in South Africa the role of traditional health practitioners in the community is clearly important with more than one interviewee confirming that almost all members of the community will use a traditional health practitioner at some point, but most would deny doing so.

The work of the paralegals was very relevant as it aimed to protect the inheritance rights of orphans and vulnerable children. Gender was a key factor, as girls were not allowed to inherit land or property from their parents or grandparents. This same principle does not apply to sons in the family. Many older people and their orphans and vulnerable children are unable to defend themselves and prevent their land being grabbed. Cases taken to court to claim land back may be held up in the court system for a long time.

Both IGA projects were relevant to their communities. In Ethiopia, beneficiaries reported during the PRA exercise that they had been fully consulted on the proposed project and had helped to write the proposal that was eventually submitted as part of HelpAge's bid to BLF. While in Kenya, beneficiaries reported that they felt IAP and CCS consulted them before the project was implemented. Overall the beneficiaries felt included in the project consultation process and reported that the implementing partners had been flexible and responsive during the project.

Gender is a key reporting requirement for HelpAge and age disaggregation of data is a portfolio aim, however we did not find that HelpAge includes gender or age disaggregation in the design of its activities from a relevance perspective. In other words, activities were not designed to be gender specific or to focus on different age groups such as 50-59, 60-69, 70-79, etc.

Effectiveness

HelpAge is the only International NGO focusing on older people. While many of HelpAge's activities are not that different from other NGOs working in HIV and AIDS in Africa, HelpAge's focus on older people and their needs within the HIV epidemic is unique. This has enabled it to introduce proven prevention and service delivery techniques to older people, thereby extending the wider response to the HIV epidemic to include older people. HelpAge's unique offering in the international development sector has allowed it to attract significant funding and opportunity to engage with both national and international actors in every country within the portfolio remit.

HelpAge has used incremental innovation to help achieve effectiveness at a project level. For example, a key mechanism used by HelpAge as part of its strategy for mainstreaming issues related to HIV and AIDS and older people was the establishment of advocacy groups in each of the portfolio countries in 2008. This concept is not new, but HelpAge have successfully adapted it to its own beneficiary needs.

HelpAge also adapted its prevention activities from other, existing prevention methodologies already in use in the HIV sector and applied them to their core audience: older people. The use of techniques such as peer education and community conversations was especially effective in leading to a greater acceptance of the Peer Educators in a private domestic setting and a build up of trust in the Peer Educators, Home-Based Care givers and facilitators of community conversations.

Partnership working is integral to HelpAge's model for delivering activities and has been central to the successes and challenges experienced during the lifetime of the portfolio. As a network organisation that delivers activities through its partners, HelpAge's ability to meet its overarching aim for this portfolio is reliant on the capacity and skill of its partners. Some of HelpAge's partners have demonstrated experience and skill, which has allowed them to deliver projects with a degree of effectiveness. HelpAge

does provide capacity building support, however the management of capacity building does not appear to be joined up and can lack a sense of control. There may be lessons to be learned for HelpAge with respect to partner relationships including the need for thorough initial partner capacity assessment and having a capacity building plan and budget in place before partners begin implementing project activities. Understanding its organizational design and the relationship between the head office, the regional offices, the country offices and the implementing partner organisations more clearly (and making changes where appropriate) will have an impact on the design of future interventions and the role that partnerships will have to play in the delivery and management of activities. As a result HelpAge's partnership management and expectations (and therefore the capacity building focus for those partnerships) will also be affected and have to be improved.

Monitoring and evaluation has also been challenging. The M&E Framework focused on process and outputs, with only a few outcomes included. While the quantitative figures have mostly been provided for numbers of beneficiaries reached, comments in the cells on the spreadsheet suggest that not all the figures have suitable paperwork to back them up. In addition, not all the figures shown in the framework match the figures reported in the annual reports to the donor. Some activities have not been monitored between external evaluations, which do not provide sufficient opportunity for effective project management.

HelpAge's work on measuring impact is moving in the right direction and its Theory of Change on HIV is appropriate (although it could take more account of the central priority of social protection within HelpAge's strategies and how this work could affect its HIV strategies and build in a review loop). This work will be hampered however, unless HelpAge can resolve the data collection and analysis issues that appear to have dogged this evaluation and this portfolio of projects.

Project 9 in the BLF portfolio was focused on sharing learning and good practice arising out of the BLF portfolio; and specifically to disseminate learning in Africa to national and international NGOs and in the UK to policy institutes, academia and the UK government. A key output was the "Learning Briefs" which allowed implementing partners to record formally the learning that has arisen from the projects. The briefs were designed to encourage the collection of useful qualitative data that could inform project planning in a dynamic way and beyond the data collection already set out in the Big Lottery Fund project proposal. This approach is important as it goes beyond the quantitative limits of the M&E framework. The concept of the Learning Briefs has been shared more widely and the approach has been applied to other HIV work in HelpAge's network

The other significant output from project 9 was the annual MEL workshops, which have been implemented since year 2 of the portfolio period. These

workshops and their participatory approach have been highly valued by partners and appear to have contributed significantly to implementing partners' skills and capacity. However this has not necessarily transferred across to M&E data collection, which remained poor at a portfolio level. The main outcome of the workshop approach has been the change in the planning approach taken by teams as informed by their project site visits during workshops.

HelpAge states that gender and age are important in its reporting, however its activities and its M&E data collection for the portfolio does not prioritise gender and age disaggregated data. It also appears to be the case that gender and age do not feature in the design of the activities that have been delivered in this portfolio. This is curious given HelpAge's prioritization on disaggregated data in its reporting and as an aim for project 2 in the portfolio.

The value of the learning methodology used in the Big Lottery Fund portfolio is beginning to be recognised by those working in other thematic policy areas within HelpAge globally and to contribute towards institutional learning. The BLF learning project has had impact on broader organizational learning and communication.

Efficiency

HelpAge has managed to deliver its activities (including some unplanned activities) within budget. However it is not as efficient as it could be in delivering its projects generally, with management costs apparently duplicated in project and management budgets and very high unit costs. In its management of the portfolio HelpAge appears not to implement economies of scale to maximize its procurement, which, although a relatively small cost saving, would suggest that this is not done outside the portfolio either and that could have a larger significance. Partnership management and capacity building is undertaken, but more could be made of this activity, especially as HelpAge delivers all its projects through partnerships and some capacity building appears to fall between responsibilities in the regional office.

HelpAge's structure as a network organisation that delivers its activities through partners and includes those partners and other stakeholders in the design and consultation of activities, the projects are not as efficient in financial terms as they could be; because the costs of both HelpAge and its partner(s) has to be taken into account. This can appear to increase the management and staffing costs of a project as we have seen in the portfolio budgets.

From a value for money perspective HelpAge's BLF portfolio of projects to prevent HIV and AIDS and mitigate its impact in multigenerational households has been somewhat effectively, not efficiently and partly economically implemented. As a result this portfolio has only partly provided value for money to HelpAge and its donor, the Big Lottery Fund.

Sustainability

Sustainability for activities within the portfolio is mixed. Where activities have been well integrated or developed their own income generating potential (such as the IGAs in Ethiopia), they have also demonstrated some sustainability (albeit at a reduced level from the portfolio investment). Where implementing partners and country offices have held exit discussions with beneficiaries and participants, priorities for taking forward a reduced number of interventions have been agreed. While a plan to reduce the number of advocacy groups and introduce fundraising to the groups has commenced. Where some activities have been incorporated into government structures to ensure their survival (such as in Ethiopia), other interventions have not yet attracted additional support from local or national government (such as the paralegals in Uganda). HBC services face sustainability challenges, which could impact heavily on their effectiveness. Sustainability is patchy therefore and appears to be driven by the partners rather than by HelpAge. Although HelpAge is clear that sustainability has been a topic of regional workshops for approximately two years.

Conclusions

HelpAge has been successful in extending proven prevention, awareness and support techniques previously used with other communities and beneficiary groups to older people. This is an important contribution to the wider response to the HIV epidemic in Africa. HelpAge's intended aim was to reduce the impact of HIV in multi-generational households. From a value and impact perspective such an aim has the potential to increase both quality of life (well-being) and economic security. We have certainly found evidence that in some cases, HelpAge's activities have contributed to increased economic security (IGA activity in Ethiopia and paralegal activity in Uganda) and beneficiaries in all the portfolio countries reported results that can contribute towards increased well being and quality of life. However some of its interventions and strategies have been less than successful in either equipping households economic empowerment (as is the case in Kenya) or in fully addressing the beneficiaries' needs (as is the case in Tanzania).

In considering HelpAge's overarching aim for this portfolio: "to reduce the impact of HIV and AIDS on multigenerational households (MGHs) in Sub-Sahara Africa by using an overall strategy which develops approaches that mainstream older people's needs and contributions in response to the HIV/AIDS epidemic,"[1] we can say that:

- HelpAge's overall impact through the portfolio has been focused mainly on advocacy and specifically on the outcomes delivered in Ethiopia;
- HelpAge's beneficiaries are beginning to demonstrate the ability to mitigate the impact of HIV in their households, with the exception of Ethiopia where household resilience is clearly demonstrated;

[1] HAI Stage 2 Strategic Application

- HelpAge's incremental innovation of applying proven methods of HIV prevention and care specifically to older people is beginning to pay off. However it is not entirely the case that every project has delivered a model of good practice that can contribute to mainstreaming older people's needs and contributions in response to the HIV epidemic; and
- HelpAge's increasingly innovative approach to learning within the portfolio and their highly innovative approach to advocacy at a national and local level will continue to deliver increased impacts over time.

With this portfolio, HelpAge has gone some way towards meeting its intended aim of reducing the impact of HIV on multigenerational households in every country included in the BLF portfolio, however this aim has not been completely achieved and as was reported to us at the feedback workshop in Nairobi in 25 April 2013, HelpAge would need another 2 to 3 years to fully develop, evidence and write up the approaches used in this portfolio to have a suite of good practice approaches that can be fully rolled out in its other areas of operation.

Recommendations for the future

When we consider the future we can identify four features of this portfolio that HelpAge may wish to consider taking forward as general concepts for future programming and strategy development:

1. Incremental Innovation: This approach is a significant tool for further developing models of good practice that can help HelpAge to achieve its Theory of Change;
2. Mainstreaming HIV: Mainstreaming HIV into all of its activities, especially social protection, will allow HelpAge to take forward much of the HIV-specific learning from the portfolio into a broader programming remit and will also potentially address certain funding issues for some activities;
3. From the group to the individual: The trend observed in some of the projects of initiating interventions through groups (such as the community conversations) which lead to greater acceptance and participation at an individual level (such as the home based care services or peer education model) is potentially a methodology that should be studied and developed further;
4. Income generating activities: IGAs appear to be either implemented or planned in most countries in the portfolio as either an intervention or a source of sustainability. While we recognize the importance of these activities to HelpAge's beneficiaries, we would caution unbridled use of this intervention as a response to sustainability issues without the proper support, training and resourcing behind it, as it is a higher risk intervention for the beneficiaries.

Operational recommendations arising out of this evaluation

1. Partnerships

a. Capacity Building: HelpAge currently provides some capacity building within the context of its project partnerships. HelpAge should consider establishing a separate programme of work that is only about providing capacity building to its affiliates and members of the network. Although this programme would support one of the strategic aims of developing the network, it will also have a more immediate knock on effect of improving the quality of the partnerships and projects being delivered. This is especially important as HelpAge only works through partnerships;
b. Partnership Management: Partnership management processes appear robust, but do not appear to be implemented fully, with some responsibilities falling between the cracks. HelpAge should review its partnership management processes to ensure partners receive consistent support and monitoring whether from EWCARDC or HelpAge Country Offices;
c. EWCARDC to strengthen technical support to project partners by adopting the model used by the Advocacy Team partners as standard practice. This model is a direct relationship between the Advocacy and Communications team at EWCARDC and the advocacy groups, providing tailored technical support that included training and support during actual advocacy sessions and regular, close follow up to help build capacity and skills; and
d. EWCARDC should also consider reviewing the process by which capacity building support is provided and monitored and close some of the gaps in the process that allow issues to not be recognized quickly.

2. Organisational Development
    a. HelpAge should analyse its structures to explore whether there is duplication (e.g. staffing, reporting) between EWCARDC, its country offices and implementing partners and how this impacts on effectiveness. The results of this will have an impact on the design of future interventions and the role that partnerships will have to play in the delivery and management of activities. Understanding its organizational design more clearly and making changes as a result of that will impact on HelpAge's partnership management and expectations (and therefore the capacity building focus for those partnerships);
    b. HelpAge's regional policy on a 60%-40% project budget split appears excessive in relation to other organizational policies in the sector. This policy should be reviewed, whilst continuing to take into account the need for appropriate cost recovery from all budgets;
    c. HelpAge should consider making better use of its existing infrastructure (regional offices, country offices, affiliates, partners, etc.) to maximize economies of scale in procurement and supplier management;

d. The portfolio's unit costs are very high. HelpAge should consider undertaking a cost analysis exercise (possibly using a costing methodology such at that published by UNAIDS for costing facilities and services or the HIV-related Human Rights costing tool) to determine the full cost of its activities and use process mapping methodology to find ways to reduce cost across its activities; and
e. HelpAge needs to clearly define the roles and responsibilities of its regional offices versus its national offices so that each can articulate its own response in-country or regionally in an appropriate way.

3. Value for Money:
    a. HelpAge needs to determine what its organizational approach to the value for money agenda should be. There are a number of competing methodologies and points of view and HelpAge should determine the role that value for money will play in the organisation;
    b. Efficiency is an issue for HelpAge that it needs to pay greater attention to and understand how it impacts activities when it is designing and implementing projects and programmes; and
    c. HelpAge needs to match the skills and capacity of its regional and national offices with the requirements of its projects and programmes to ensure efficient and effective project delivery.
4. Data and Reporting
    a. Understand and articulate the flow of data from beneficiary level up through the organisation and how data is used at every level and what for, to ensure data is used to improve performance at every level in the organisation;
    b. Relate the data collected during projects, back to project design, for example: much data is collected and analysed according to gender and age, however gender and age do not appear to have any bearing on project design. Additionally data disaggregation is a key aim for this portfolio, but the disaggregation is not borne out in HelpAge's own programming;
    c. Improve reporting with respect to:
        i. Prevention activities (consistent with reports prepared for clinics, upward reporting in-country and local VCT services). Very detailed data is collected by HelpAge's implementing partners under their responsibilities to local and national government, this data is sometimes more comprehensive than the data that HelpAge requires, but can serve as a proxy for HelpAge's M&E requirements, thereby reducing the reporting burden on the partners. Additionally HelpAge's M&E framework did not require that all activity was collected and reported on, which meant that partners did not collect some data;

ii. Reporting of quantitative project deliverables on a regular basis and analysis of this data occurring as close to the beneficiary level as possible;
iii. Collect, analyse and review data more regularly, particularly with respect to prevention, to ensure that data has an early impact on project planning and priority behaviour changes relevant for HIV are targeted;

5. Activity specific:
    a. Data disaggregation:
        i. Mobilise other agencies to jointly gather more evidence on HIV and older persons for use in national advocacy activities
        ii. Step up the advocacy of big donors such as CDC to adapt the standard design of data collection formats to include data for older persons 50+.
    b. Adapt the existing posters on Peer Education to develop culturally specific hand-held portable 'flip-books' that can be easily carried by Peer Educators over longer distances and used informally in domestic settings and with illiterate communities. Flip-books are different from the current Peer Education manual tools in that they are more robust and smaller. Additionally flip-books can be designed to replace many individual tools, reducing the volume of what the Peer Educator has to carry;
    c. HelpAge's home-based care programme led to greater demands for additional services from the beneficiaries. HelpAge should consider developing or adopting broader-based models of home-based care and services that address a wider range of needs for older carers and MGHs, including HIV-specific support, that potentially also support HelpAge's priorities for older people's specific health issues and social protection;
    d. Where HelpAge is committed to implementing IGAs, it should provide dedicated technical support from EWCARDC for IGA projects as a greater need for them emerges among populations where HIV prevalence is high. Produce more detailed IGA implementation guidelines for older persons and suitable for use by IGA partners; and
    e. Improve the data collection and analysis of case reporting for paralegal activity to take proper account of successes and challenges and to contribute to a better analysis of the impact of this kind of activity.
6. Sustainability
    a. HelpAge should consider the issue of sustainability early on the in the project and so that project implementers such as Advocacy Group members, Peer Educators, Paralegals and HBCs are prepared for when the project funding comes to an end. We would not recommend the implementation of IGA

activities as a response to sustainability issues, as this is a high risk intervention that requires dedicated resources to support it successfully.

b. HelpAge should ensure that project partners are sufficiently capacity built (ref recommendation 1a) to support project activities independently once HelpAge's funding is withdrawn (either through the partners' own funds or their fundraising activities based on high quality data collected from the project as evidence of success); and
c. Undertake advocacy for sustainability jointly with partners at a national level to encourage local, regional and district administration structures to assume financial responsibility for some of HelpAge's activities or identify other sources of funding.

Recommendations for future studies

1. HelpAge may wish to explore further the issue of trust in domestic relationships as exposed by the results of the KAP survey in the questions relating to risk;
2. Understanding beneficiary motivation behind behaviour change would provide valuable evidence. HelpAge may wish to conduct such a study that could be used to inform a more tailored intervention design and potentially increase the positive impact of HelpAge's activities;
3. HelpAge may wish to consider commissioning a value for money or social return on investment analysis of the social benefits of collecting age disaggregated data at a national level for people over the age of 50 to support its advocacy strategy aimed at CDC and USAID at a national level;
4. The new Tanzanian national HBC curriculum is not yet published but it is likely that older persons will be included given HelpAge's involvement in the pilot. HelpAge should to follow up on this separately and an independent study on the potential impact of the national curriculum once published is worth considering; and
5. Our evaluation did not have sufficient time and budget to allow for a full impact evaluation of the Ethiopian IGA project. It could be useful for HelpAge to undertake a separate impact evaluation of the IGA activities in Ethiopia to fully understand the success at alleviating poverty and encouraging resilience amongst older people and their communities.

1 Background

In 1983 five organisations came together to form the HelpAge Network.[2] The network has been growing steadily since then and has eight regional offices and approximately 101 affiliates across the world.

HelpAge International (HelpAge) has been delivering HIV-related activities in some form or another for approximately 15 years. HIV is prioritized in its current strategy as HelpAge aims to enable older men and women and those supported by them to receive equal health, HIV and care services.

HelpAge runs few regional programmes like the portfolio evaluated here. Prior to the BLF portfolio, HelpAge had run a regional HIV programme in Africa funded by Comic Relief. While much of the work of the BLF portfolio has built on activities started under Comic Relief, a key finding of that programme was that HelpAge should focus its activities more and concentrate on fewer, deeper activities to gain better impact. This is a general trend across international development over the past five years.

HelpAge received £4.97 million from the Big Lottery Fund towards a portfolio of nine projects in five sub-Saharan African countries between 2008 and 2013. The grant was later increased to £ 5.11 million as a result of the economic downturn experienced in most of the countries. In delivering the portfolio HelpAge has worked with a number of partners in each country.

- Tesfa Social Development Organisation (Ethiopia)
- Uganda Reach the Aged Association
- Community Aged Foundation (Uganda)
- HelpAge Kenya
- Christian Community Services (Kenya)
- Integrated AIDS Programme (Assumption Sisters of Nairobi) (Kenya)
- AFRIWAG (Tanzania)
- Muthande Society for the Aged (MUSA) (South Africa)

Some of HelpAge's partners are also members of the HelpAge Network. Where HelpAge has country offices, these generally have operational oversight of the activities being delivered by the implementing partners.

HIV remains a significant issue in sub-Saharan Africa, although UNAIDS estimates that incidents of HIV have decreased in Eastern and Southern Africa by approximately 25%.[3] However adult prevalence is still 23.5million (15-49) in sub-Saharan Africa.[4] This statistic also underlines another key issue for HelpAge that it has built into the portfolio: data for HIV is largely disaggregated up to age 49 only, which ignores a growing number of people either growing old with HIV (due to increased access to ART) or becoming newly infected with HIV (due to low access to prevention technology or

[2] Age UK, HelpAge India, HelpAge Kenya, Help the Aged Canada, Pro-Vida Colombia
[3] UNAIDS, 2012, Global Report, Washington DC; Ethiopia and Kenya has seen a decrease either equal to or greater than 50%, South Africa and Tanzania have seen a decrease between 25% and 49% and Uganda has seen a decrease of less than 25%.
[4] Ibid

knowledge about HIV). Older people are also often missed out of policy statements and planning, although their role in looking after orphans and vulnerable children s has been widely known and acknowledged in the past.

This was the challenging environment that HelpAge was working in when it established the portfolio to prevent the spread of HIV and mitigate its impact in multi-generational households.

HelpAge's portfolio comprised 9 projects:

- Project 1: (Ethiopia, Kenya, Tanzania and Uganda, Advocacy) Mainstreaming Ageing into HIV and AIDS Responses
- Project 2: (Ethiopia, Kenya, Tanzania and Uganda, Advocacy) HIV and AIDS Data Disaggregation
- Project 3: (Ethiopia, Kenya, Tanzania and Uganda, Prevention) Preventing HIV in Older People
- Project 4: (Kenya, Service Provision) Supporting Multigenerational Households through Economic Empowerment of orphans and vulnerable children in Kenya
- Project 5: (Uganda, Service Provision) Supporting Multigenerational Households through Protection of the Inheritance Rights of orphans and vulnerable children in Uganda
- Project 6: (South Africa, Service Provision) Strengthening the Role of Traditional Health Practitioners in South Africa
- Project 7: (Ethiopia, Service Provision) Strengthening Iddirs (Burial Societies) in Ethiopia
- Project 8: (Tanzania, Service Provision) Improving quality of Home Based Care to people living with HIV in Tanzania
- Project 9: (UK, Ethiopia, Kenya, Tanzania, Uganda, South Africa, Organisational Learning) Sharing Learning, Good Practice and Impact

2 Methodology

The final evaluation used a mix of quantitative and qualitative methods to measure portfolio activity across Ethiopia, Kenya, Tanzania, Uganda and South Africa. We used this data collection to measure and assess the outcomes of the projects that had been delivered across the portfolio region and to consider what impact these projects may have had.

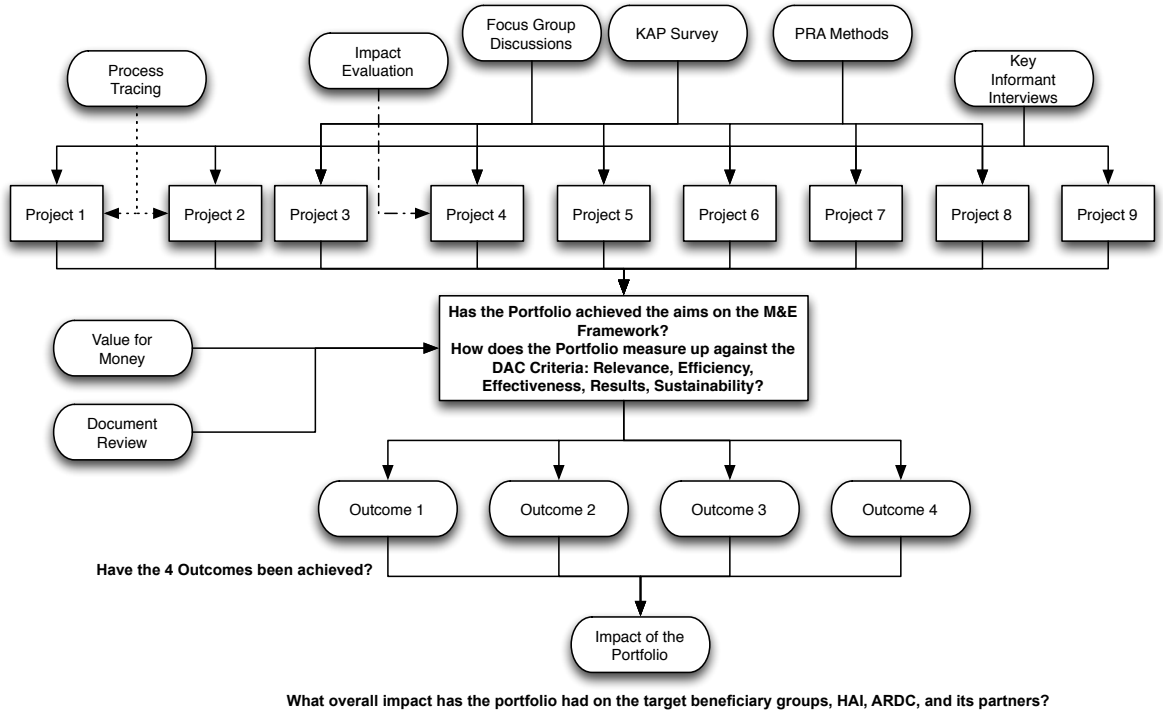

Figure 1: Methodology used in the Final Evaluation of Preventing HIV and AIDS and alleviating its Impact in Multigenerational Households

We visited all five countries to review the activities that had been delivered. All country visits have followed the same methodology, with the visit to Kenya including a more detailed impact evaluation approach as agreed with HelpAge.

In all five countries we ran the end line survey using the same knowledge, attitude and practice questions that were asked in the baseline and the mid-term. In addition in each country we included questions on peer education, home-based care, paralegal support and income generation activities, as was relevant to the country-specific projects that had been delivered. In Kenya we included an additional section that asked a series of livelihood questions as we were considering the impact of Project 4 (IGA activity) in more detail.

We surveyed a total of 2,084 households across all the portfolio countries:

Country	**Households**
Ethiopia	399
Kenya (Beneficiaries)	385
Kenya (Control)	385
Tanzania	393
South Africa[5]	124

[5] As was the case at the baseline and mid-term, we only surveyed traditional healers in South Africa. During the survey an unrelated incident resulted in some of the traditional healers refusing to participate in the survey and data collection. Only 41.8% of the planned sample size was surveyed.

The sample size for the survey was calculated using Yamane's (1967:886)[6] simplified formula for calculating sample sizes with a 95% confidence level and P = .5

$$n = \frac{N}{1 + N(e)^2}$$

Where n is the sample size, N is the population size, and e is the level of precision.

Activities were delivered in more than one area in each country. We allocated the number of households to be surveyed in each area based on the number of beneficiaries recorded in each area. Where activities were evenly distributed across different areas, we evenly distributed the households to be surveyed.

The evaluation design for the impact evaluation undertaken in Kenya was a non-randomised control design[7]. Since we were interested in understanding what had changed for beneficiaries targeted in the IGA intervention we deliberately identified households that had benefitted from the activities of Project 4. The aim of the impact evaluation in Kenya was to estimate the difference that HelpAge had made to the orphans and vulnerable children, older people and their households as a result of Project 4. To do this we would need to understand what would have happened to the beneficiaries had HelpAge never intervened (the counterfactual). To get this information from the beneficiaries (directly observed) is not possible, so the counterfactual cannot be directly observed, only estimated.

To estimate the counterfactual we identified a comparison group (control group) in Gatundu North that had sufficiently similar characteristics to the beneficiaries such as income and other characteristics such as education and asset ownership at the start of the project and used the same household survey with this group. Applying the same survey to the control group as to the beneficiary group would provide data that would form the basis of the estimation as to what would have happened had HelpAge not implemented its intervention in Thika. Having identified the control area of Gatundu North,

[6] Yamane, Taro, 1967, Statistics: An Introductory Analysis, 2nd Ed., New York: Harper and Row

[7] Except for specially designed pilots, randomised control evaluations are hardly ever applied to social interventions (especially in international development), as there is often a prohibitive cost of feasibility or ethical factor that constrains the evaluation. Additionally there is the issue of choice. People choose whether or not to participate in an intervention. Those that choose to participate are likely to be different from those that do not participate because of factors that are difficult to measure, such as motivation.

we selected actual households in the control area using cluster sampling methodology.[8]

We measured livelihood data that would enable us to determine how the income generation activities had changed the day-to-day lives of the beneficiary households.

Measuring Change in Livelihoods

The Livelihood Indicator: US$1.25 per capita per day
Measuring household wealth in resource-poor (particularly rural) settings is not straightforward, especially as the respondents tend to be self-employed. Self-reported wealth measures tend to be unreliable as the respondents often undertake a wide variety of activities to generate income.[9]

There is however a widely recognized, strong association between household income and consumption.[10] As a result the World Bank and others use a proxy measure formed by aggregating data on consumption and expenditure data to estimate the percentage of households living on more than US$1.25 per capita per day.[11]

Hence households are surveyed about their consumption and expenditure on food and non-food items[12] on a weekly, monthly and annual basis. Food and non-food items are then divided by the household size. It is however possible to underestimate the wealth of larger households with this method, so Deaton and Zaidi also propose an approach to calculating household size detailed in National Research Council (1995), where the household size is determined by determining the number of adult equivalents through the formula:

$$AE = (A + \alpha\ K\ )^{\theta}$$

Where *A* is number of adults in the household; *K* is the number of children in the household; α is the cost of a child relative to an adult; and θ controls the extent of economies of scale. For low-income countries, Deaton and Zaidi recommend that α be set at .25 or .33 and θ be set at .9.[13]

Ownership of Assets
Asset ownership is another way of measuring household wealth and is seen to complement the livelihood indicator. In the survey households were asked to select assets that they

[8] In cluster sampling, cluster, i.e. a group of population elements (in this case households) constitutes the sampling unit instead of a single element of the population (identifiable beneficiaries). This approach helps when the population is unknown and the random allocation of households helps to maintain impartiality.
[9] Morris, Saul, Calogero Carletto, John Hoddinott, and Luc J. M, Christianensen, 1999, Validity of Rapid Estimates of Household Wealth and Income for Health Surveys in Rural Africa: FCND Discussion Paper No. 72. Washington: International Food Policy Research Institute.
[10] Gujarati, Damodar N., 2003, Basic Econometrics: Fourth Edition. New York: McGraw Hill
[11] Deaton, A and S. Zaidi, 2002, "Guidelines for constructing consumption aggregates for welfare analysis," Working Paper No. 135. The World Bank, Washington, D.C.; Deaton and Zaidi also remark that empirical literature has shown that consumption is not linked to short term fluctuations in income and tends to be smoother and less variable than income. In resource-poor settings all income is consumed.
[12] Where possible non-food items are disaggregated on a gender basis
[13] Deaton, A and S. Zaidi, 2002, "Guidelines for constructing consumption aggregates for welfare analysis," Working Paper No. 135. The World Bank, Washington, D.C.

currently owned from a pre-prepared list and to recall whether they owned the asset or similar assets at the time of the baseline.[14] Thus reconstructing baseline data for this particular question in order to measure change over time.

Box 1: Basis for Impact Evaluation

Across all five countries we conducted focus group discussions with all the beneficiary groups representing the different activities conducted in each country. Details of the focus group discussions held are at appendix 6.9.

We also conducted participatory rapid assessment (PRA) exercises with some of the beneficiary groups in each country. This approach helped us to determine impact of the portfolio's activities for its stated beneficiary groups. Impact had not been fully considered during programme design in 2008 and even the revised M&E Framework does not refer to impact of the portfolio. So while it was not possible due to time and budgetary constraints to undertake detailed impact evaluations in every country, the PRA tool allowed us to rapidly get an estimate of impact and value priorities in each country.

The Big Lottery Fund changed its approach to impact in 2011 and has adopted a systems approach to impact, which is consistent with the Portfolio funding approach they took in the International Strategic funding round in 2008.[15]

Data collected during the survey was analysed using ANOVA (one-way) with post-hoc tests (Hartley Fmax, Cochran C, Bartlett Chi-square, Scheffe contrasts among pairs of means, Tukey-Kramer test for differences between means, Bonferroni test for differences between means, Fisher LSD) as appropriate using StatPlus software by AnalystSoft Inc. Pearson's Coefficient (linear correlation) was applied occasionally to determine linear trends as required.

Document reviews and financial analysis of budgets according to the 3E's value for money approach (as described in the Inception Report) was undertaken to support further evaluation for impact and change.

2.1 Limitations

There are no impact level indicators to consider for the Portfolio and only some outcome level indicators. While HelpAge have acknowledged that further work on impact is required, the agreed M&E Framework for the portfolio is lacking in this regard. In 2011 and 2012 HelpAge undertook further work on impact and an HIV Theory of Change that will be considered in this report.

[14] The assumption being that it is relatively easy to recall asset ownership over time.
[15] Big Lottery Fund, June 2011, Big Lottery Fund Research Issue 66, New tools for a new world (or why we need to rethink capacity-building), The Big Lottery Fund

The use of KAP surveys in international development health programmes has received criticism over the past twenty years.[16] With the main concerns being accuracy of reporting at the individual level[17], whether the data is truly appropriate for project planning[18], the challenges of collecting data in some settings[19] and a perceived failure to distinguish between the relevance of behavioural data for individuals and populations.[20] However, KAP surveys are still extensively used in international development health programmes. In order to ensure that we are able to evaluate change in the portfolio, whose outputs have been informed at the baseline and measured subsequently in the mid-term using a KAP survey, we have undertaken the endline survey using the same survey questions that were asked in 2008.

The KAP survey undertaken at the mid-term evaluation did not consider the change in beneficiary knowledge and behaviour as a result of the interventions as the survey was administered in the general population and not targeted on the beneficiaries. As a result the findings from the KAP survey in the mid-term have been excluded from analysis of the endline and only comparisons between the endline and baseline have been included.

However to take into consideration the limitations of the KAP survey as expressed above and to ensure that we can make some assessment of impact and value, we also used the PRA tool, focus group discussions and key informant interviews in each country.[21]

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[16] See Smith, H.L., 1993, On the limited utility of KAP style survey data in the practical epidemiology of AIDS, with reference to the AIDS epidemic in Chile, Populations Studies Center and Department of Sociology, University of Pennsylvania, Philadelphia, PA; Luaniala, A, 2009; How much can a KAP Survey tell us about people's knowledge, attitudes and practices? Some Observations from Medical Anthropology research on Malaria in pregnancy in Malawi, Anthropology Matters, Vol 11, No 1 (2009); Schopper, D et al, 1993; Sexual behaviors relevant to HIV transmission in a rural African population: How much can a KAP survey tell us? Social Science & Medicine, Volume 37, Issue 3, August 1993, Pages 401–412

[17] Schopper, D et al, 1993, Sexual behaviors relevant to HIV transmission in a rural African population: How much can a KAP survey tell us? Social Science & Medicine, Volume 37, Issue 3, August 1993, Pages 401–412

[18] Luaniala, A, 2009; How much can a KAP Survey tell us about people's knowledge, attitudes and practices? Some Observations from Medical Anthropology research on Malaria in pregnancy in Malawi, Anthropology Matters, Vol 11, No 1 (2009

[19] Ibid

[20] Smith, H.L., 1993, On the limited utility of KAP style survey data in the practical epidemiology of AIDS, with reference to the AIDS epidemic in Chile, Populations Studies Center and Department of Sociology, University of Pennsylvania, Philadelphia, PA

[21] See also Manderson, L., Aaby, P, 1992, An epidemic in the field? Rapid assessment procedures and health research Social Science & Medicine Volume 35, Issue 7, October 1992, Pages 839–850; PRA tools have developed to consider the beneficiary voice alongside data collected using tools such as KAP surveys, to provide a broader, more considered analysis.

3 Findings

In this section we consider the results achieved collectively by the nine projects that have been implemented by reviewing performance against the four portfolio outcomes, value for money and HelpAge's Theory of Change.

Key findings from this evaluation are:

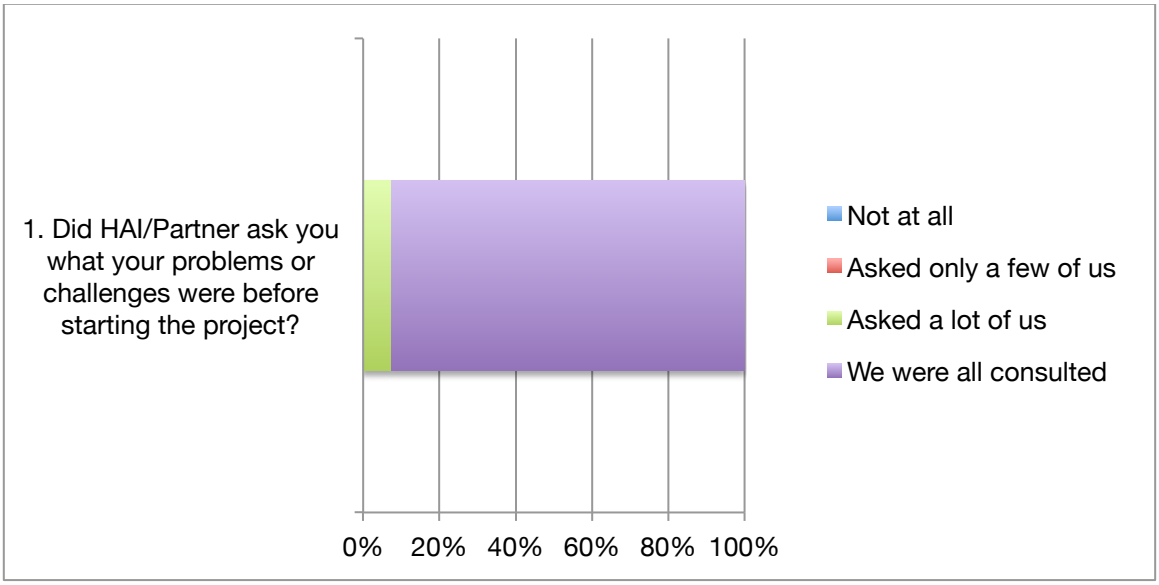
1. HelpAge has adapted existing models of intervention for its activities to provide some successful activities that have met most of its portfolio outcomes;
2. Older people have valued the knowledge that they have learned through HelpAge's prevention activities, however they still feel that HIV is more of an issue for younger people than for them. Trust in domestic relationships in the beneficiary groups in Kenya and Ethiopia emerged as an issue (although likely to be more widespread);
3. The quality of home-based care and services was rated highly. Clients of traditional health practitioners in South Africa confirmed that they had received improved services from their traditional health practitioners during consultations and Tanzanian and Ethiopian beneficiaries suggested that different mixes of components could create a quality care programme that they would consider appropriate to their needs;
4. At least 50% of the households targeted by projects 4, 5 and 7 have new coping mechanisms and the projects, despite some significant issues have been considered as valuable by the beneficiaries that participated in them;
5. Value for money achieved by the portfolio has been mixed while efficiency and portfolio management have been significant issues for HelpAge and its partners;
6. The redesigned project 9 has provided some excellent learning tools and made the link between qualitative evidence gathering and communication and awareness raising more tangible; and
7. HelpAge's impact has been mixed. However it is possible to say that through the portfolio HelpAge is achieving at least part of its HIV Theory of Change at output, outcome and impact level.

3.1 Results

This section deals with the actual deliverables under the portfolio which, whilst reported under the outcomes of the portfolio have been considered using the OECD DAC criteria.

HelpAge's activities were considered to most be relevant to the beneficiaries and the portfolio and its aims. The work with traditional health practitioners in South Africa however was found to be less relevant to the portfolio aims whilst being considered very relevant to the community.

In all the countries that participated in the portfolio 92.5% of beneficiaries felt that everyone had been consulted in the design of the country-specific projects.



Graph 1: PRA responses indicating relevance of the projects

In Ethiopia, for example, respondents specifically mentioned that they had participated fully as intended beneficiaries in the design of the proposal for project 7.[22]

3.2 Outcome 1 – HIV and AIDS policy changes in four East/Southern African countries increasing older peoples' access to HIV prevention, care and treatment services will be implemented by the end of the portfolio.

Central to HelpAge's ability to meet this outcome was the degree to which it was able to influence policy change at two levels: national and regional. This section considers what success HelpAge has had in achieving this outcome within the lifetime of the portfolio. The Big Lottery Fund portfolio aimed to influence national and regional policies and HIV responses in Ethiopia, Kenya, Tanzania and Uganda and at a regional level with SADC and the EAC; with the aim of increasing older person's access to HIV prevention, care and treatment services through the activities of Project 1 (mainstreaming ageing into HIV and AIDS responses) and Project 2 (HIV and AIDS Data Disaggregation). At the time the portfolio started it was generally acknowledged that older people were carers for orphans and vulnerable children, however most interventions were targeted at orphans and vulnerable children rather than older people, who in most interventions only benefitted indirectly. National AIDS Plans did not in general make specific reference to older people and their needs either as carers or as people living with HIV. Additionally HIV data collection was focused on the 15-49 year age group and older people were generally not included.

[22] Brady, R. 2013, Final Evaluation of HelpAge International's Portfolio: Preventing HIV and AIDS and alleviating its Impact in Multigenerational Households, Country Visit to Ethiopia, HelpAge International, London

HelpAge staff and partner organisations in all four countries influenced key national policies, strategies, frameworks and curricula to include aspects of HIV and older people. In some countries other broader issues were addressed including those relating to social protection. Additionally HelpAge attended high-level national meetings and were represented on national HIV technical working groups. Senior government staff working in HIV recognized that HelpAge was visible in the sector advocating on older people's issues and had made a significant contribution.

HelpAge's regional focus was particularly relevant as it helped to highlight the issues for older people that it was tackling at a national and local level through the projects being implemented in each country. HelpAge's partnerships (see below) helped to extend the relevance of HelpAge's focus on older people within a regional context and highlight similar issues for other groups. At a national and project level, HelpAge implemented the approach of using advocacy groups, one on one meetings with key authorities by partners both at national and local levels, lobbying together with older people with key authorities especially on particular days such as the International Day of Older Persons, and participating in technical working groups set up by the relevant government bodies including the national AIDS commissions and the national AIDS control programmes. This approach helped NGOs in each country to present a united voice on older people's issues, aiming to influence key decision makers for HIV and AIDS to recognise and address specific HIV needs at the national level and which would then have a direct positive influence on targeting them in local programme responses. In addition the Advocacy Groups' participation in determining how to implement regional strategies and plans has made this national approach relevant to HelpAge's regional priorities. The Ethiopian Government brought in the Charities and Societies Proclamation Law (CSO Law) in 2009, which makes it impossible for NGOs to advocate for policy change and is designed to strictly control civil society, especially Human Rights activities. However under the CSO Law means, while NGOs cannot advocate and lobby for change in policy, the people themselves still can. This meant that the approach by HelpAge of setting up advocacy groups became especially relevant after 2009 when the CSO Law was enacted.

3.2.1 Advocacy Groups

A key mechanism used by HelpAge as part of its strategy for mainstreaming issues related to HIV and AIDS and older people was the establishment of advocacy groups in each of the portfolio countries in 2008. This approach was also considered to be a capacity building approach[23] that would enable HelpAge's partners and local implementing partners to develop and implement advocacy and policy influencing strategies. These strategies were focused on influencing key national HIV policies, strategies, and frameworks

[23] HelpAge produced an Advocacy Trainers Handbook (Lackey, D et al, 2012, Advocacy Trainers Handbook: Case example HIV and AIDS. HelpAge International, Nairobi) that served as a guide to support partners in the development of an advocacy strategy and provided training and support directly from the regional office.

to include older people. This concept is not new, but HelpAge have successfully adapted it to its own beneficiary needs. Advocacy group members represented a broad range of civil society organisations (CSOs) as well as other key national stakeholders. In Ethiopia the Advocacy Groups had 17 CSO members, in Kenya 25 CSO members and 4 other members and in Uganda 10 CSO members.[24]

The advocacy groups were successful in Ethiopia, Kenya and Uganda but not in Tanzania where the quality of leadership was inadequate. It is evident that advocacy groups in Ethiopia, Kenya and Uganda have been very active and had a high visibility, and achieved a lot with little funds. The advocacy groups also achieved success in the implementation of the advocacy strategies, particularly gathering evidence (although this was also reported as being often the most challenging[25]), developing and delivering advocacy messages including policy briefs, posters and brochures and dissemination at national consultative meetings, international days for older people and HIV and AIDS, engaging with TV and radio (in Uganda advocacy group members were also using social media to promote their activities) and face-to-face meetings with decision makers among others, and success in getting inclusion of older people in national policies, plans of action, guidelines and then crucially implementation. Advocacy groups in Ethiopia and Kenya were particularly successful in achieving inclusion of older people in national HIV and AIDS strategic frameworks and action plans in relation to prevention, care and support, social protection and livelihoods.[26]

Other impacts reported in Uganda were that CSOs started mainstreaming issues related to older people into their own organisations, and as a result CSOs there are increasingly becoming recognized in the sector for their work with older people. They reported that this has had the knock on effect of improving their chances to find resources and improving partnership working between CSOs on older people's issues.

In all countries key informants viewed HelpAge International as the only international organisation working solely with older people and this high profile has been largely the result of HelpAge's advocacy efforts. Advocacy group members and key staff members of HelpAge International have participated in seminars and national and international HIV meetings and others relating to older people's issues. The Ugandan State Minister for Older Persons and Disability[27] described URAA's activities as 'punching' and a pressure group that was vital to strengthen political awareness of issues relating to OPs.

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[24] CSOs and Other Stakeholders Involved in HelpAge Advocacy Group Process 2008 – 2013
[25] Focus Group Discussion with Advocacy Groups, Addis Ababa, 20 February 2013
[26] HelpAge International, 2013, Position Paper: Advocacy Groups: CSO collaboration in addressing the impact of HIV and AIDS on older people in sub-Saharan Africa (Draft), HelpAge International, Nairobi
[27] Key informant interview with State Minister for Older Persons & Disability. 28 February

All advocacy groups had different advocacy objectives in-country and specific targets. In Ethiopia[28] the advocacy groups have been successful in their aim of raising the profile of the role that older people play as carers for people living with HIV and orphans and vulnerable children, and in particular in regard to the National Plan of Action for Ageing and HIV/AIDS. Their activities have also resulted in the recognition of the importance of the Ethiopian Elders and Pensioners National Association (EEPNA) at Federal level and their receipt of financial support from the Government for its strengthening. HelpAge also participates in exchange forums set up by the Federal HAPCO. The use of these advocacy groups was a particularly innovative methodology in Ethiopia given the strict advocacy laws that significantly reduced the ability of NGOs to advocate for change, however it was possible for local communities to advocate on their own behalf.

In Kenya the advocacy groups reported having more success at district than national level.[29] However the groups have had success at a national level too, as reported above and the advocacy groups that have been formed in Kenya were not formed with district level work in mind. The achievements of the advocacy groups in Kenya[30] included the production of policy documents relevant for older people on a range of HIV related issues including universal access, improving access to HIV treatment and care and support, and scaling up of the older people's cash transfer programme. Group members reported that they had increased their confidence and empowered them to engage in debates and working together with government to arrive at a joint position.

In Uganda[31] advocacy groups were initially established at the national level, groups at district level were established in 2011. In Year 2 a group for working of national data disaggregation for older people was also established. The groups successfully used several strategies including targeting influential people working in HIV in the sector with whom they had a series of on-going one-to-one meetings as well as facilitating the participation of older people in meetings at the national level to present their own issues. Advocacy group CSO members also reported that as a result of their activities they have started to mainstream issues relating to older people back into the activities of their own organisations. Evidence on older people and HIV was gathered at district level and used for advocacy at the national level.

All advocacy group members reported they had made personal development gains from being members of these groups including improving their

[28] Key informant interview with Federal HAPCO, 21 February 2013
[29] Focus group discussion with Advocacy Groups Leaders & Members of the Social Protection Advocacy Group, 13 February 2013; Conversation with an Intern at HelpAge Kenya, 13 February 2013.
[30] Focus group discussion with Advocacy Groups Leaders & Members of the Social Protection Advocacy Group, 13 February 2013
[31] Focus Group Discussion with URAA Advocacy Groups, Kampala. 28 February

knowledge and systematic approach towards advocacy and strategy development.

Some of the problems encountered by advocacy groups mentioned during the evaluation were the initial gathering the evidence, a lack of interaction between the district and national level, as well as issues of how they could sustain themselves after the Big Lottery funding stopped. Sustainability of the advocacy groups remains a major challenge, but the advocacy groups are actively attempting to address this issue, such as in Kenya, registering the advocacy groups as CSOs, which will enable them to raise funds.[32]

3.2.2 National and Local Advocacy

The advocacy strategy at national and local level, besides the advocacy group process, also included HelpAge programme staff and partners networking with national and local level decision makers and health service providers to ensure inclusion of older people in national and local level strategic plans and improving access to services. In Tanzania the HelpAge HIV and AIDS programme manager became a member, and, subsequent chairperson of the Tanzania National HIV and AIDS Commission (TACAIDS) Advocacy and Communications Committee, which has representation from civil society. The TACAIDS Head of Advocacy, Communications and Media had attended HelpAge regional consultative meetings on social protection, HIV and AIDS and older people and on media, HIV and AIDS and older people and became a champion for HelpAge and older people within TACAIDS.

A major achievement of the national level advocacy work in Tanzania was the success of having included in the Tanzania 2010 HIV and AIDS Policy a section (6.3) on HIV/AIDS and the elderly. The policy objective is to address elderly specific needs related to HIV in prevention, treatment and societal roles in care for orphans and vulnerable children and people living with HIV, and policy statements included:

- Develop age-sensitive prevention strategies and messages to reduce the spread of HIV
- Develop guidelines which ensure that carers of people living with HIV and orphans and vulnerable children are empowered to protect themselves and provide appropriate care
- Introduce social protection schemes for the elderly to enhance their ability to handle the effects of HIV and AIDS.

Also in Tanzania at district level the HelpAge partner AFRIWAG was successful in having six districts allocate home base kits for older HBC providers, as well as funding for economic empowerment activities for older people monitoring groups related to agriculture and pottery making in the case of Muheza District.

[32] HelpAge International, 2013, Position Paper: Advocacy Groups: CSO collaboration in addressing the impact of HIV and AIDS on older people in sub-Saharan Africa (Draft), HelpAge International, Nairobi

Advocating for age-friendly services has also achieved important change at health facility level. In Kenya this has centred on the HelpAge campaign Age Demands Action (ADA) that is focused around the International Day of Older People. The HelpAge Kenya partner organisation Christian Community Services (CCS) has prioritized its ADA advocacy activities on ensuring that older people do not have to queue when seeking health services at hospitals in Gatundu and Igegania. The hospital authorities agreed this and a signboard displayed in the outpatient department stating that older people do not have to queue. The next step was to have the two hospitals establish a separate consultation room for older people, and an age-friendly waiting room for older people attending physiotherapy clinics.

As a result of advocacy initiatives by AFRIWAG in Tanzania 21 health facilities, namely hospitals and health centres, in six districts in Tanga Region now have dedicated examination rooms for older people and attended by 22 health workers.[33] These advocacy achievements at local level in both Tanzania and Kenya were the result of active engagement and networking with local authorities and involving older people in the consultative process.

Similarly, in Uganda, advocating for equitable and quality health and HIV and AIDS care for older people through participating in both World Health and AIDS Days, URAA in partnership with Community Aged Foundation in Kasese have seen a change in the perception of health conventional workers towards older people. For example, Bwera, Kilembe and Kagando hospitals have established a special desk and waiting benches for older people as they come for treatment. Health staff has been assigned to assist older people. These hospitals have collected data on people aged 50 and over that are receiving ARVs and other health services. In Mukono district older people receive cards enabling them to access free health care at Mukono Hospital and other government health facilities. A health camp for older people has also been established taking place every Friday in the last week of the month. The Ministry of Health has replicated this model of health care for older people in Hoima and Luwero districts.

Policy influencing success at national level by URAA has included having the National Planning Authority recognize older people as a key vulnerable group in the Uganda Vision 2040 under Care and Protection for Vulnerable Population Groups. The policy document states that government will develop and implement social protection systems to respond to the specific needs of vulnerable groups including older people (page 60). URAA also engaged the Parliamentary Committee on Gender, Labour and Social Development through the National Coalition for Age Care Organizations to pass the National Council for Older Persons Bill in 2012 that will establish the Older Persons' National Council and monitor the implementation of the National Policy on Older People. The President of Uganda signed the bill.

[33] Email from the Regional Advocacy & Communications Manager, 2 May 2013, 10:53

The mid-term evaluation made a number of country-specific recommendations under outcome 1.

Mid-Term Evaluation Recommendation	Final Evaluation Commentary
Kenya	
There is need for the advocacy group members to participate more actively in decentralised level processes so as to ensure magnification and prioritization of older people's issues, possibly through the support of wider partners and players who are not necessarily partners in the programme.	Our understanding is that this has happened, but possibly not in the way intended by the mid-term evaluators, but rather as a way of getting policy change implemented at a lower government level, which could be used to influence policy change at a national level.
The established thematic advocacy groups meet together at least every 3 – 6 months to review progress and plan for the subsequent phase. Whilst these meetings are also intended to build the capacity of the advocacy groups, there is apparent need for more systematic technical capacity strengthening of the advocacy groups to provide impetus to teams in carrying out advocacy.	The advocacy groups reported that they had consistently received very good technical capacity building support for the duration of the five-year portfolio period and the evidence of policy change would support this.
There is need to include the senior leadership of the HelpAge partner organizations - CCS and IAP in trainings or in advocacy fora to enable them fully understand, appreciate and operationalize the advocacy activities	Our understanding is that IAP and CCS were not contracted to be involved in the advocacy work under outcome 1. In addition IAP and CCS regularly attended the M&E workshops and other regional meetings that HelpAge arranged to brief partners and share learning and best practice. IAP and CCS would have received information and learning on advocacy at these events.
There is need to work on a coordination structure to help in tying in the work of the different advocacy groups together, and for following up on progress made with activity implementation.	This recommendation appears to suggest a duplication of the activities of the Advocacy and Communication team at EWCARDC, which we would not sanction. We have not seen evidence that additional structures have been put in place.
Uganda	
URAA should exploit their recent inclusion in the Technical Working Group (TWG) on OVC to engage a wide range of stakeholders on issues of care and support provision to OVC by older people. Similarly, the association can exploit its membership in the Social Protection Sub-Committee to influence inclusion of the project site, Kasese, in the list of districts benefiting from cash transfer for older people	We have seen evidence of, and reported on the impact that URAA has had in its advocacy work with HelpAge and the advocacy groups. Specifically to advance the mainstreaming of care and support to older people who look after orphans and vulnerable children.
URAA should explore possibilities of reviving the Kasese District Health Advocacy group to add a voice for inclusion of older people's issues There is need to enhance capacity of partners to engage actively in advocacy at all relevant levels	We found that URAA had been very active in undertaking advocacy activities at a district level in Kasese. District level advocacy groups were established in 2011. Advocacy group members reported receiving good capacity building support from HelpAge.

Ethiopia	
The loose micro-macro linkage in policy influencing work should be addressed and evidence collected at project level used to inform advocacy and policy influencing initiatives at higher level. The Technical Working Groups should engage with government decentralised structures to analyze evidence and deliver messages to policy makers including those concerned with micro-credit.	We are not clear what this recommendation refers to. We saw evidence that the technical working groups were collecting evidence at a local level to support national advocacy work and that government departments and organisations had been influenced by the work of the technical working groups. This did not appear to be any different however before and after the mid-term evaluation.
There is need to review budgetary allocation for advocacy activities if major advocacy milestones are to be realised in a timely manner. It should be noted that while the project has advocacy specific milestones, other advocacy group members may not have such milestones and therefore are unlikely to assign reasonable budgets for advocacy activities.	This recommendation is unclear. It suggests that budgeting for activities is dependent on performance (performance-related budgeting). However we know that HelpAge budgets are designed on a zero-rated basis. This has not changed since the mid-term evaluation.
Tanzania	
The Tanga Advocacy Coalition requires regular support to not only cultivate common understanding but also come up with strategies for influencing change. HelpAge Tanzania should engage more closely with the group to guide it in developing its strategies and prioritizing advocacy issues. Currently it appears not to have a common understanding regarding key issues including its own objectives.	We have no indication that this has happened. We have seen evidence that the Advocacy Groups in Tanzania have been effective and HelpAge Tanzania was invited to sit on the board of the National Advocacy Advisory Body. So we are unsure that advocacy in Tanzania has been limited as a result of this recommendation not being fulfilled.
Since the concept of "Building Bridges" in HBC has not been introduced to most government staff working in Korogwe District, there is need not only to introduce it but also to advocate at all levels for its appreciation to enable ownership by the government structures. This will increase chances of scale up and greater participation and inclusion of older people	It is likely that the Building Bridges model has helped to influence the (as yet unpublished) new HBC national curriculum on the inclusion of older people. We have also seen evidence of the model being widely shared with government.

Table 1: Mid-term evaluation recommendations and our commentary on their implementation

3.2.3 Regional Advocacy

HelpAge's regional advocacy work pre-dates the BLF grant by approximately four years. HelpAge works extensively with the EAC and SADC to advocate for the recognition of older people as carers for orphans and vulnerable children and for the recognition of older people as being at risk of infection within the HIV epidemic.

HelpAge has had some success at SADC with getting older people recognized in its policies and statements. One clear example of this impact is the work that HelpAge undertook in collaboration with VSO RAISA. HelpAge and VSO RAISA teamed up to advocate for the inclusion of older people as carers in SADC's 2010-2015 HIV and AIDS Strategic Framework.

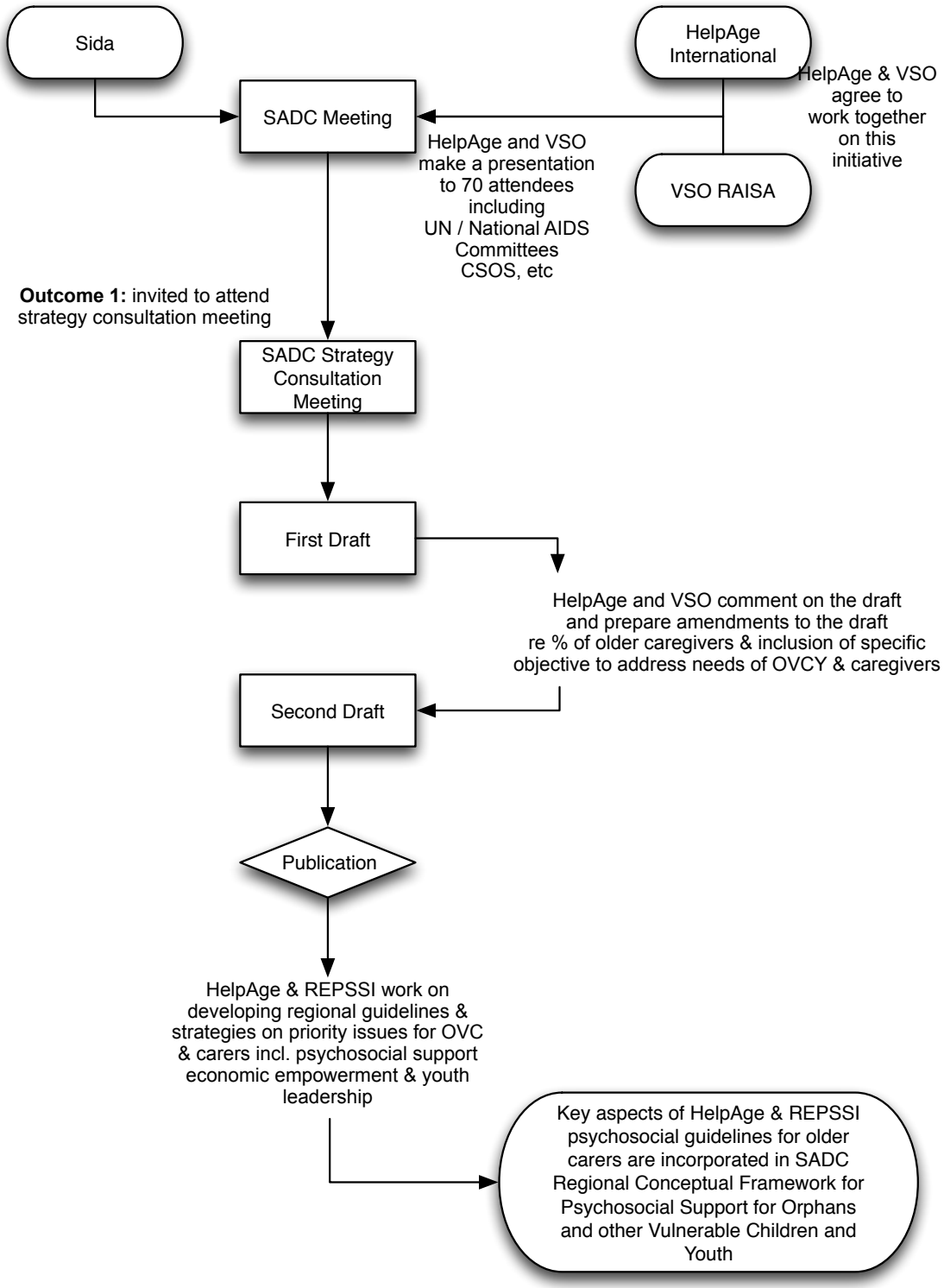

Figure 2: Process tracing the change to the SADC HIV and AIDS Strategic Framework 2010 - 2015 introduced by HelpAge and VSO

Through attending a series of meetings and making presentations, HelpAge and VSO RAISA were able to ensure the inclusion of a revised statement that recognized older people within the strategy and a specific objective to address the needs of orphans, vulnerable children and youth and caregivers: “Harmonised approaches and guidelines on social protection to reduce

vulnerability of OVCY and carers, particularly the elderly, to the impact of HIV and AIDS".[34]

Following on from the publication of the strategy, HelpAge worked with REPSSI to develop two publications to address the above objective:

- Psychosocial care and support for older carers of orphaned and vulnerable children: Programming guidelines; and
- Psychosocial care and support for older carers of orphaned and vulnerable children: Policy guidelines

These were shared with SADC and published in SADC's Regional Conceptual Framework for Psychosocial Support for Orphans and other Vulnerable Children and Youth.

Considering the process tracing map above we can say that at least 50% of the change to the Strategy was due to HelpAge, despite more than just VSO RAISA and HelpAge being present. This is largely due to the key role that both agencies were given in preparing the amendments to the draft Strategy and the clearly identifiable wording that was present in the Strategy that both agencies can claim.

Both agencies already had links into SADC prior to their partnership. Had one agency introduced the other to SADC then the balance may have tipped towards one or the other.

HelpAge's impact is enhanced further through its collaboration with REPSSI on developing the guidelines that were eventually adopted by SADC in its published Framework. Through its continual participation in the advocacy and guideline development process, HelpAge can claim significant attribution in this process.

An important barrier to getting the broader impact that had been hoped for however is the disjunction between the regional SADC level and the national level, where governments who are obliged to implement SADC policies into their national AIDS plans, are often very slow in doing so. This means that national advocacy in the form of the advocacy groups is vital to getting the implementation of the SADC regulations to ensure that HelpAge's regional advocacy activities have their broadest reach.

A second example of HelpAge's impact on a regional level from its engagement with SADC is what it has achieved being a member of SADC's OVCY Technical Group.

[34] Key informant interview with the Head of Advocacy and Communications and the Regional HIV & AIDS Coordinator, HelpAge, 12 February 2013; Key informant interview with the former Regional HIV & AIDS Policy Manager for VSO, 12 February 2013

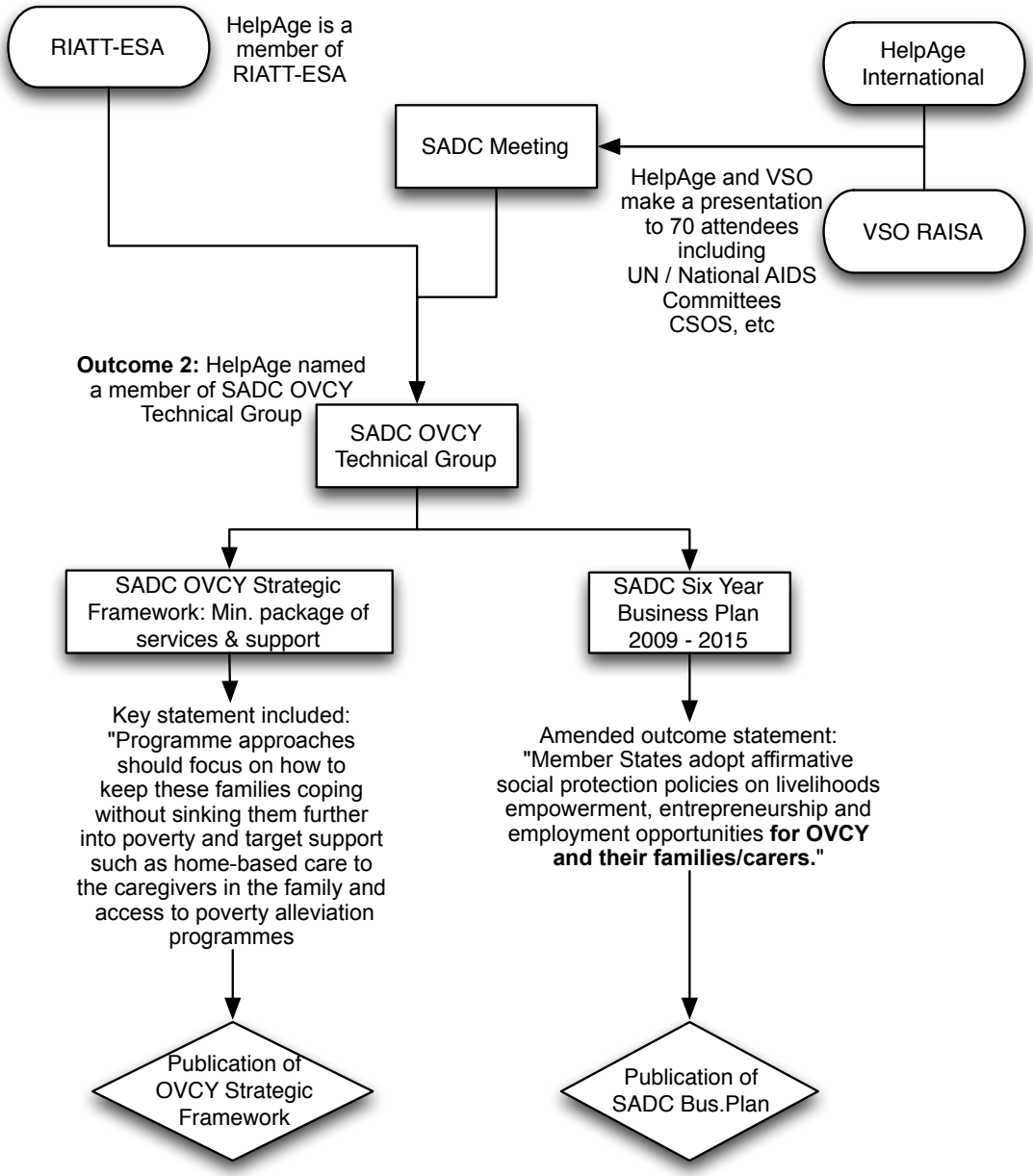

Figure 3: Process tracing the outcomes of HelpAge's membership of SADC's OVCY Technical Group

This membership was a result of HelpAge's presence at the same SADC meeting that led to its participation in the development of SADC's HIV and AIDS Strategy outlined above. As the process map in figure 3 shows, HelpAge's participation resulted in a key statement included in the published OVCY Strategic Framework and an amendment to an outcome statement in the SADC business plan.

Both these process map analyses highlight policy influencing by HelpAge at a regional level. As mentioned before the broader impact of this activity is at a national and local level. While beyond the scope and capacity of this evaluation, an analysis of how the national governments that participate in SADC have implemented these frameworks and business plans, specifically

looking at the sections that HelpAge has participated in, may be able to determine broader regional impact as a result of HelpAge's activities.

For the EAC HelpAge and VSO Jitolee partnered successfully to have a section (44.) on Support of community and home based caregivers included in The East African Community HIV and AIDS Prevention and Management Bill, 2010 which was passed by the East African Legislative Assembly in 2012. The regional HIV and AIDS bill supersedes national HIV and AIDS legislation. Section 44 calls on EAC Partner States to promote and support community and home-based care, and shall in particular- (a) develop a framework for the regulation and support of community and home-based programmes to ensure the respect of human rights and the provision of quality services.

Partnerships have also been important in HelpAge's regional activity generally in the same way that the VSO RAISA partnership helped HelpAge to achieve change at SADC. HelpAge is a member of RIATT-ESA[35] and has used its membership to promote research into the impact on older people of looking after orphans and vulnerable children.[36] HelpAge's membership of a children's task force is logical when you consider the approach that it takes to the issue: "helping children means looking at how you strengthen families".[37] This is also indicative of how HelpAge take a broader approach to older people's issues by considering the wider impact of supporting vulnerable older people at a household level. This approach allows them to participate in a wider number of fora and attract funding from beyond older people focused funding mechanisms.[38] Both a report and a briefing note have emerged from research promoted by HelpAge within RIATT-ESA and the briefing note is available to all RIATT-ESA members and is actively used at a regional level.[39]

In the same way that other RIATT-ESA members have benefitted from research promoted by HelpAge, so HelpAge has been able to benefit from its membership by having access to briefs and documents that have supplemented its own activities. For example, RIATT-ESA has also produced a regional briefing note on the SADC children's framework[40], which HelpAge and other RIATT members are using and rolling out at a national level. HelpAge has been accredited with being instrumental in opening up

[35] The Regional Inter-Agency Task Team on Children and AIDS – Eastern and Southern Africa was mandated by UNICEF to promote advocacy and knowledge management of issues affecting children affected by the HIV epidemic.
[36] RIATT-ESA, HelpAge International, 2011, Intergenerational issues between older caregivers and children I the context of AIDS in eastern and southern Africa, Johannesburg, 2011
[37] Key informant interview with RIATT-ESA Programmes Coordinator, 6 March 2013
[38] Key informant interview with the Regional Representative of HelpAge International, 13 February 2013
[39] Key informant interview with RIATT-ESA Programmes Coordinator, 6 March 2013
[40] RIATT-ESA, 2012, Children and youth orphaned or made vulnerable by HIV and AIDS in the Southern African Development Community (SADC), Johannesburg, 2012

the EAC to the children's framework through its existing links with the regional body.[41]

Our discussions with both VSO RAISA and RIATT-ESA highlighted the importance that its partners place on HelpAge's advocacy activities. HelpAge is considered to have reliable data and to be the only agency advocating for older people's issues at a regional (and at a national) level. HelpAge's partners considered that had the NGO not participated in regional advocacy (especially RIATT-ESA), there would have been less regional advocacy activity, fewer positive results and in the case of RIATT-ESA, it considered that its network would not have been as strong as it is.[42]

3.2.4 Data Disaggregation

Project 2 focused on the importance of advocating for the disaggregation of data for HIV for older people in four countries in the Big Lottery Fund portfolio including in Ethiopia, Kenya, Tanzania and Uganda. Historically in these countries data has been formally collected, analysed and reported for the age group of 15 - 49 years and this reflects the international level.

HelpAge have been active at the regional level in promoting data disaggregation for the collection of HIV data and in particular supporting the countries in the Big Lottery Fund portfolio as well as actively advocating at the regional level from Nairobi. HelpAge facilitated a Regional Consultative Meeting on HIV and AIDS data disaggregation in 2012 in collaboration with Handicap International and this was followed during the same year by supporting national meetings on data disaggregation in Kenya, Tanzania and Uganda[43]. These national meetings were attended by key national stakeholders in HIV and promoted the importance of collecting HIV data for older people.

In addition HelpAge also undertook a study of VCT centres in Ethiopia, Tanzania and Uganda to determine the level of access older people had to VCT centres and the test results for people aged 50 and over.[44] This study was able to determine the infection rates and access to services by older people at the 39 sites it surveyed. Although not yet, finalized, this study could help to advance the advocacy in Ethiopia, Tanzania and Uganda on this issue.

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[41] Key informant interview with RIATT-ESA Programmes Coordinator, 6 March 2013

[42] Key informant interview with RIATT-ESA Programmes Coordinator, 6 March 2013; Key informant interview with the former Regional HIV & AIDS Policy Manager for VSO, 12 February 2013

[43] HelpAge suggested that there had been previous meetings on data disaggregation before the 2012 meeting, however budgetary evidence suggests that this was the only meeting and we have not seen other evidence to support any previous meetings.

[44] HelpAge International, 2012, Voluntary Counselling and Testing Study: Utilisation of VCT services and test results for older people in Ethiopia, Tanzania and Uganda, HelpAge International, Nairobi

In Ethiopia[45] it was revealed during the evaluation that HIV data was collected for older people at sub-city level up to 70+. Nationally the government reports on HIV data for men up to 59 and women up to 49 years. Additionally it was confirmed that for reporting purposes data for adults over 50 years old is rolled into one figure. The reason given by the Federal Government is that their database (donated by US CDC and USAID) is not designed for more detailed information on this age group. The advocacy groups have been sourcing evidence from health centres at the local level as evidence when advocating for older people's issues.

In 2008, prior to the BLF portfolio, HelpAge Kenya was very active in its advocacy efforts to influence the Kenya National HIV & AIDS Indicator Survey (KAIS) 2007 and include data for the first time on older people from 50-64 years.[46] Following up on these activities, during project Year 1 staff from EWCARDC and HelpAge Kenya were invited to have direct input into the writing of this survey report with respect to older people.

Advocacy activities continued in Year 4 when HelpAge Kenya as a member of a technical working group joined others to advocate for the inclusion of HIV data disaggregated in five-year cohorts from 18 months to 64 years. HelpAge Kenya and the advocacy groups additionally analysed the gaps in the Kenya Ministry of Health HIV and AIDS reporting form used at health facilities and recommended that data collected from people 50 and older be included.

In Uganda[47] HelpAge International and URAA advocated together vigorously throughout the life the project but early on in Year 2 were unsuccessful in their attempts to get data for the 50 – 64 age group included in the Uganda AIDS Indicator Survey. However, their efforts, both under the BLF programme and a complementary Sida funded programme were later successful in that the Ministry of Health and Ugandan Bureau of Statistics agreed to extend data collection (and its analysis) to 59 for both men and women by 2011. URAA's original advocacy target was for data to be collected in 5-year cohorts from 55 to 74 years. HIV data collected by the Ugandan government for older people over 50 years has not been analysed. Project 2 has relevantly focused on advocating for the government to include and disaggregate data for those over 50 years.

In Tanzania[48] HelpAge International Tanzania has worked closely with other NGOs to advocate throughout the project life for TACAIDS and the National

[45] Key Informant interview with the Kolfe Keranio Sub-City AIDS Desk, 25 Feb 2013
[46] Key informant interview with the Professor of Populations Studies, University of Nairobi, 13 February 2013; Key informant interview with the Regional Head of Advocacy & Communications, 12 February 2013
[47] Khan, M. 2013, Final Evaluation of HelpAge International's Portfolio: Preventing HIV and AIDS and alleviating its Impact in Multigenerational Households, Country Visit to Uganda, HelpAge International, London
[48] Key informant interview with the Statistician, Bureau of Statistics, Ministry of Finance, Dar es Salaam Government of Tanzania. 25 February 2013

Bureau of Statistics to include HIV data collection for older people over 49 years and in project Year 4 they agreed to start discussions with a range of stakeholders to consider this. The government stated they were constrained by lack of budget to fund the collection and analysis of the extra data.

In project year 5 HelpAge International Tanzania held a national data disaggregation meeting attended by a wide range of stakeholders active at the national level mapping out future steps. The government committed to begin collection of data for older people in the next indicator survey. HelpAge International is seen to be am organisation working solely with older people and is attributed to having introduced the concept to the sector of including 50+ data. A key informant at the Tanzanian Bureau of Statistics stated there is still a need to advocate and influence the donors on the importance of collecting HIV data for older people and that the evidence base for this needs to be improved.

Data disaggregation is a broader issue than just older people and HIV. HelpAge and Handicap International (HI) have collaborated since 2008 on HIV data disaggregation and advocacy work in Kenya. HelpAge and HI both focus on Health Management Information Systems and the need to include older people and disability in future data collection. HI found that HelpAge was a step ahead in advocacy and helped HI with its modelling and being an advocate for disabled people. HelpAge also introduced HI to important contacts in government (especially the Kenya National Bureau of Statistics). Through attending the regional data disaggregation workshop HelpAge organised, HI was exposed to other ideas in other countries. HI felt that its collaboration with HelpAge had the following results:

- HI's advocacy skills were built up;
- HI's advocacy model at a national level was developed; and
- HI has a different entry point into government and a voice at a national level.

The findings of HelpAge's advocacy work on data disaggregation at a country level are also helping to inform their work on data disaggregation at a global level. At this level, HelpAge draw a distinction between the reporting and collecting of data. While in most countries, data for people over the age of 50 is collected at a local level, it is not always reported or analysed at a higher level in-country and the countries do not include it in their annual UNGASS reports as it does not meet any of the indicators that they are required to report on. Thus HelpAge's work is driven by the global indicators and its global advocacy priorities on data disaggregation are considered at every level. For example, as funders of national HIV databases provided to governments CDC and USAID are becoming the focus of HelpAge's country-level advocacy activities. Based on the evidence collected by the advocacy teams advocacy is focused on these donors changing data collection and analysis for people over the age of 50. The challenge for HelpAge is to come up with a response to the general reason provided by CDC and USAID for the limitations of the databases being provided: cost. This may be a matter

of determining the value of the data to be collected and analysed and determining the potential cost savings or opportunity costs presented by governments knowing and using this data. HelpAge may wish to consider commissioning a value for money or social return on investment analysis of this data in order to provide the evidence for this advocacy approach. HelpAge have also provided guidance to its partners on how to comment on the UNGASS reports generated by countries, in order to increase the presence of older people in global reporting. Success of this strategy has been seen outside the BLF-funded portfolio in Mozambique and Zambia, where those UNGASS reports now feature whole sections dedicated to older people as a result of advocacy by HelpAge.[49]

3.2.5 Summary

Advocacy has been one of the highlights of the BLF portfolio and HelpAge's success at setting up successful local and national advocacy groups has seen the introduction of structured, coordinated and to a degree sustainable local advocacy groups for older people's issues where previously there had not been much activity. These groups have not only advocated for policy change, but have also considered how policy might be implemented at a local level. HelpAge's ability to forge links with other, less obvious partners has helped to push forward the agenda of older people's issues and has resulted in some key regional and national successes. However the data disaggregation challenge remains and is one that HelpAge is advancing on a global level through its international advocacy, driven out of the Head Office in London.

3.3 Outcome 2 – By the end of the portfolio 60% of the target group in the 5 portfolio countries will have reported an increase in knowledge of HIV and AIDS and a greater confidence to protect themselves

Prevention was considered to be the cornerstone of HelpAge's portfolio of HIV programming.[50] As such it was delivered as a dedicated project (project 3) in four portfolio countries[51]. Prevention activity in-country included Peer Education, Community Conversations, radio and media campaigns, poster campaigns, etc. However HelpAge also considered that its country-specific projects (project 4 in Kenya, project 5 in Uganda, project 6 in South Africa, project 7 in Ethiopia and project 8 in Tanzania) also contributed to the delivery of this outcome, even though the focus of these projects was not prevention per se.

In this section we consider primarily the activities in project 3 and project 6 and relate the activities of the other projects to this outcome where possible.

Key to the success of this project would be the degree to which HelpAge and its partners could develop the knowledge of its target beneficiaries and

[49] Key informant interview with the HIV and AIDS Policy Advisor, 20 May, 2013
[50] HAI Stage 2 Strategic Application, 2008
[51] Ethiopia, Kenya, Tanzania, Uganda

influence their behaviour. The delivery of prevention information is relevant to promoting behaviour change of the beneficiary groups and to the portfolio aims. The beneficiaries specifically reported the change(s) that they believed they had experienced as a result of the prevention activities delivered by HelpAge and its partners, mainly through behaviour and attitude change.

HelpAge adapted its prevention activities from other, existing prevention methodologies already in use in the HIV sector and applied them to their core audience: older people. This incremental innovation approach has been successful in enabling HelpAge to make best use of proven techniques in its approach to sharing information with its beneficiaries.

The use of techniques such as peer education and community conversations was especially effective in leading to a greater acceptance of the Peer Educators in a private domestic setting and a build up of trust in the Peer Educators, Home-Based Care givers and facilitators of community conversations.

However from the start beneficiaries and some trainees for interventions such as community conversations were wary of the messaging and approach that was used.[52] The response to this resistance appeared to be a common approach across most of the countries: Peer Educators are able to speak to groups of beneficiaries first, whilst at the same time HIV is spoken about in public meetings such as the Community Conversations, churches, funerals, etc.

Peer Educators in Kenya reported that this trust brought with it an anticipation that the Peer Educators could help with other issues besides HIV and AIDS. Older people who participated in focus groups in Kenya also suggested that the model of Peer Education should be extended to other topics that would be useful to them. This demand for greater engagement was experienced in other portfolio countries and influenced the inclusion of some additional topics in the Peer Education manual (see below for more details on the manual). Peer Educators were also the first people to be tested for HIV, as examples to the rest of the community that testing was safe and appropriate.[53] Whereas in Uganda, Peer Educators have become de facto members of village health teams (part of the formal government health service delivery structure).[54]

HelpAge's study of VCT centres in Ethiopia, Tanzania and Uganda provided older people with an opportunity to suggest ways that these services could be improved. The three main responses were:

- Inclusion of food supplements with starting ART;

[52] Focus Group Discussion with Community Conversation Facilitators, 25 February 2013; Focus group discussion with Peer Educators, 15 February 2013
[53] Focus group discussion with Peer Educators, 15 February 2013
[54] Focus Group Discussion with Peer Educators, Bugoye sub county, Kasese District. 6 March

- Provision of special days for HIV and AIDS services for older people;
- Provision of older counsellors for older people.[55]

The data for that study was collected in 2009/2010 – mid-way through the portfolio period. What we saw in our final evaluation was:

- Older people still thought that nutrition was an important factor and wanted for information and support on the issue[56];
- Some health facilities have made efforts to prioritise older people and ensure that they do not have to wait to be seen[57]; and
- The Peer Educators model is highly valued by older people and seen as a potential model for other interventions (see above)

HelpAge also developed a Peer Education Manual as an output from the project 3 activities. Although most interventions would have been designed so that the manual that supported the intervention was developed ahead of the roll out of the project at a regional level, HelpAge is clear that the manual reflects the lessons learned through the activities in Ethiopia, Kenya, Tanzania and Uganda and will form part a future strategy on learning as well as being used in the field where Peer Education activities are implemented. The manual is comprehensive and could be implemented immediately. However future use of the manual outside of Africa may require not only translation, but also cultural adaptation, which will require funding and may slow down the cascading of this knowledge across the HelpAge Network.

Once the manual was produced, HelpAge financed the retraining of the Peer Educators to ensure consistency of the approach across its portfolio countries. While appropriate, this was an extra cost that had not been foreseen.

The measure of the success of the prevention activities across all the countries is in the change in knowledge and behaviour of the beneficiaries with whom Peer Educators and others have been working. To this end, HelpAge developed three indicators to measure this change over time:

Indicator	**Target**		**Progress at Nov 2012**
Percentage of target group (older people and their dependents) who know the basic facts on HIV and AIDS	60% (overall)	Kenya: 44%	75%
		Uganda: 40%	98%
		Tanzania: 43%	27%
		Ethiopia: 46%	19%
Percentage of older people who have received a HIV test in the	50% (0verall)	Kenya: 14%	15%
		Ethiopia: 31%	79%

[55] HelpAge International, 2012, Voluntary Counselling and Testing Study: Utilisation of VCT services and test results for older people in Ethiopia, Tanzania and Uganda, HelpAge International, Nairobi

[56] This was reported in all the portfolio countries

[57] Key informant interview with the HIV Coordinator local CACC (Constituency AIDS Control Council), 15 February 2013

last 12 months and who know their results		Uganda: 38%	63%
		Tanzania: 31%	31%
Percentage of target group (older people and their dependents) who have practiced safe sex in the past six months	40% (overall)	Kenya: 24%	4%
		Ethiopia: 26%	3%
		Uganda: 20%	48%
		Tanzania: 16%	7%

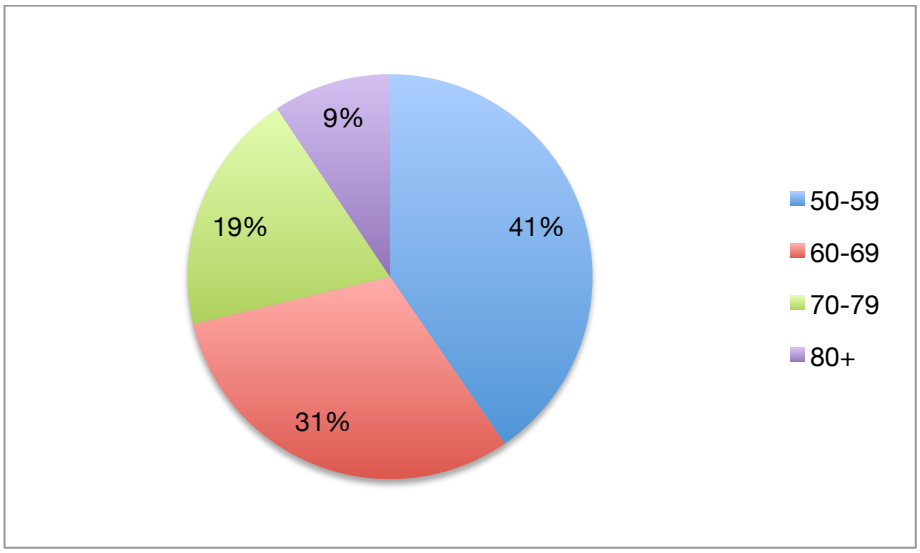
Table 2: Indicators from the M&E Framework on beneficiary knowledge

HelpAge had run a baseline KAP survey in 2009 and repeated it in 2011 to gauge change in the impact of its activities.[58] We ran the survey again as the endline and analysed the data, comparing responses with the baseline where available in each country. A limitation of this approach has been that HelpAge did not measure the knowledge and behaviour change amongst its beneficiaries outside of the mid-term and endline surveys. This meant that HelpAge and its partners were not able to identify and respond to any changes amongst its beneficiaries that may have affected the final results.

The baseline study reported that it used Descriptive Analysis to analyse the data collected in 2008. We agreed with HelpAge that our approach would be to use ANOVA, Pearson and other tests (see Methodology section) and that analysis would be on the basis of the responses to each question, rather than the respondents, as not every respondent answered every question. HelpAge also requested that we disaggregate our findings by gender, age and country. HelpAge do not appear to have targeted specific activities or interventions to focus on gender or age-group. So it is likely that this analysis is more useful for future planning than as part of an evaluation of the Portfolio.

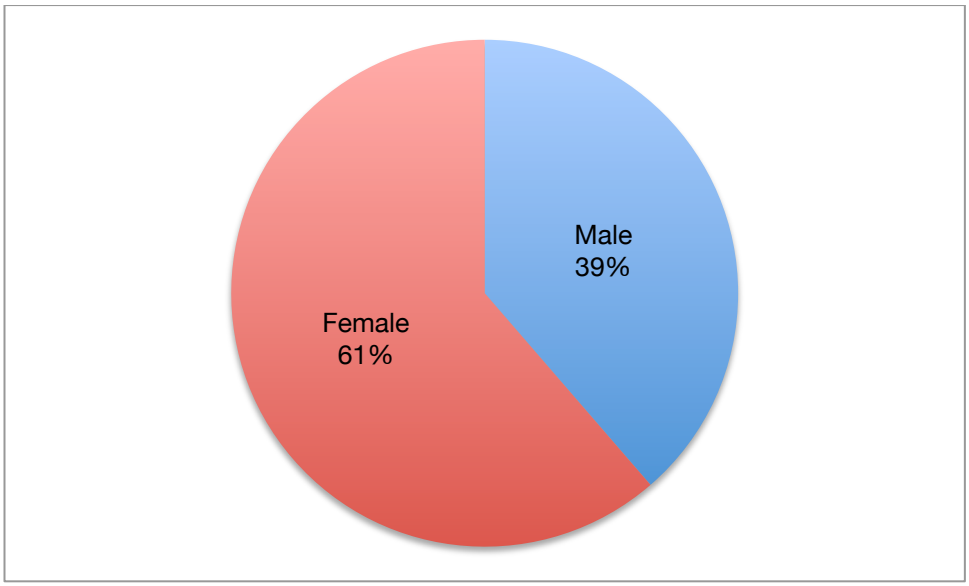
The majority of the respondents to the survey were between 50 and 69 (see graph 2 below). This is significant as 25 years ago when HIV first rose to prominence in Africa, these respondents would have been 25 – 44 years old, the age groups that were the focus for all the HIV prevention activities in the early part of the global response to HIV and AIDS in Africa. This would also suggest that respondents should have prior knowledge of HIV and should have some understanding of behaviour that could prevent the spread of HIV.

[58] See section 2.1 for further explanation on why the midterm survey results are not used for comparison in this evaluation



Graph 2: Age of respondents across Ethiopia, Kenya, Tanzania and Uganda, disaggregated

More women than men were interviewed for the endline survey across Ethiopia, Kenya, Tanzania and Uganda, which was in contrast to the baseline survey findings, where more men than women were interviewed. This may have had an impact on the results, however without access to the baseline data to interrogate alongside the endline data, we are unable to draw any further conclusions on the relevance of gender to the differences observed in the baseline and endline data.



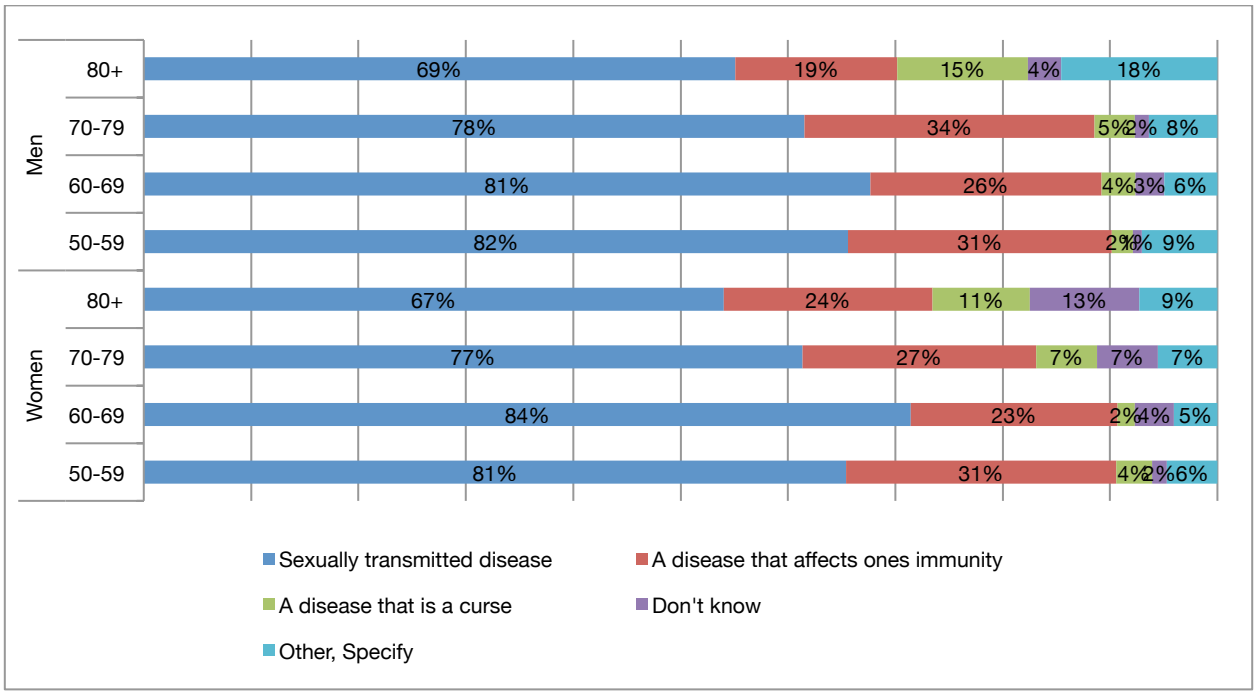
Graph 3: Gender disaggregation of respondents across Ethiopia, Kenya, Tanzania and Uganda

The results of the endline survey suggested that knowledge of HIV and how it is transmitted had reduced since the baseline was run. However this was not always supported by what we learned during the focus group discussions and the key informant interviews; and reported behaviour changes seem to

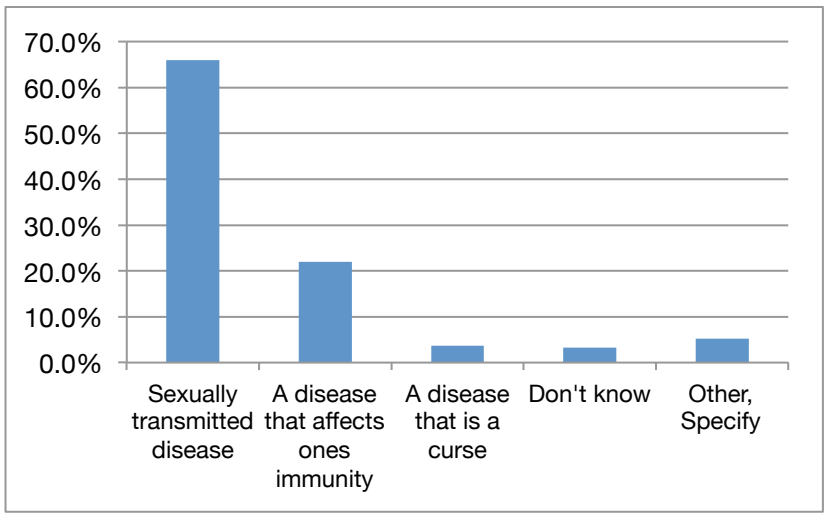
suggest that some knowledge transfer has taken place and that beneficiaries have internalized HIV prevention messages to a certain degree.

Our analysis of the results of the endline survey is focused on those questions and data that are related directly to the prevention outcomes listed in the M&E Framework.

Respondents were asked their understanding of HIV:



Graph 4: Survey responses to "What do you understand by HIV?" disaggregated by gender and age.

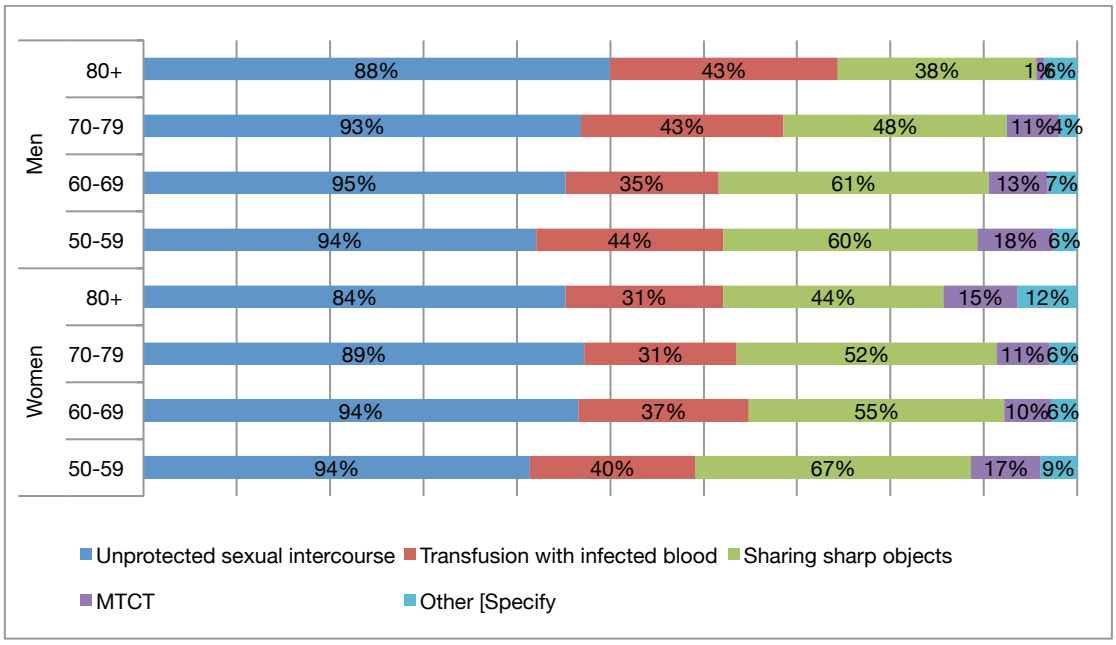


Graph 5: Mean awareness of what HIV is across Ethiopia, Kenya, Tanzania, and Uganda survey respondents

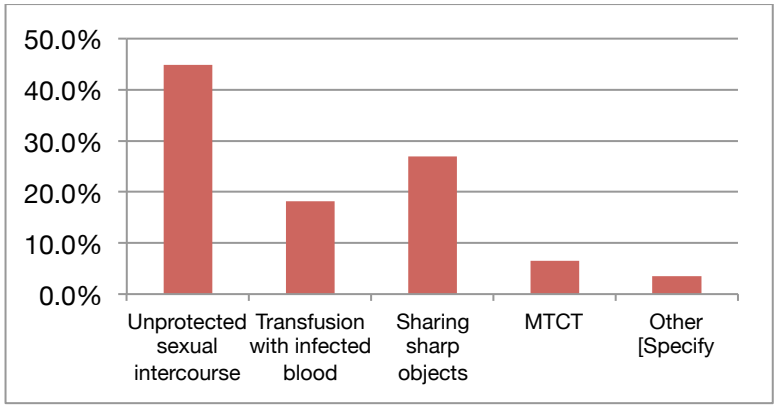
An average of 66% of the responses across Ethiopia, Kenya, Tanzania and Uganda reported HIV to be a sexually transmitted infection. While 21.9% of all responses across all countries identified HIV having an affect on the

immune system. Therefore more respondents to the endline than the baseline were able to identify that HIV is a virus that attacks the immune system ("a disease that affects one's immunity").

Knowledge of how HIV is transmitted was standardized across the age groups questioned and there was no indication that different age groups identified different routes of transmission.



Graph 6: Survey responses to "How is HIV transmitted?" disaggregated by gender and age

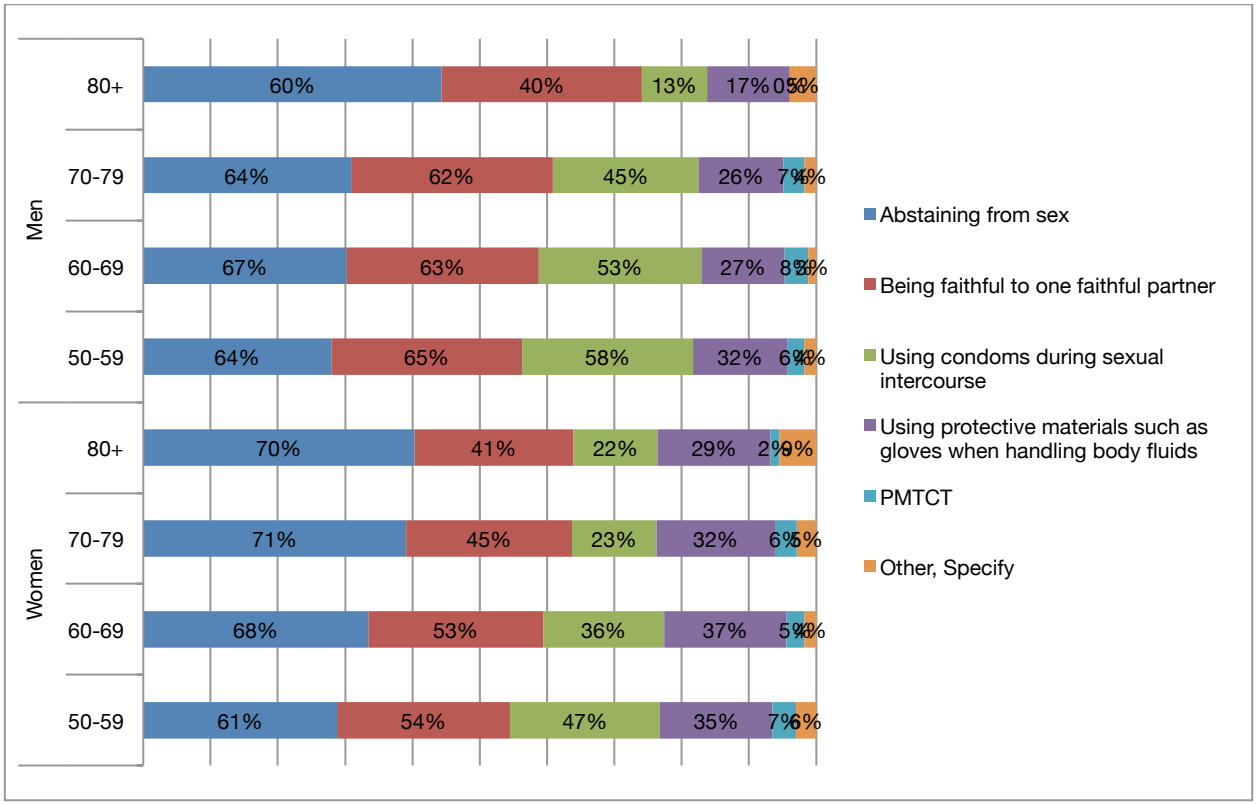


Graph 7: Mean awareness of how HIV is transmitted across Ethiopia, Kenya, Tanzania, and Uganda survey respondents

However, overall 44.9% of all responses across Ethiopia, Kenya, Tanzania and Uganda reported that unprotected sex could lead to infection with HIV. This is possibly the most important statistic, especially with regard to the main focus of prevention messaging about sexual practice. Older people in the portfolio countries demonstrated a decent knowledge of HIV during the focus group discussions, however they continually suggested that it was

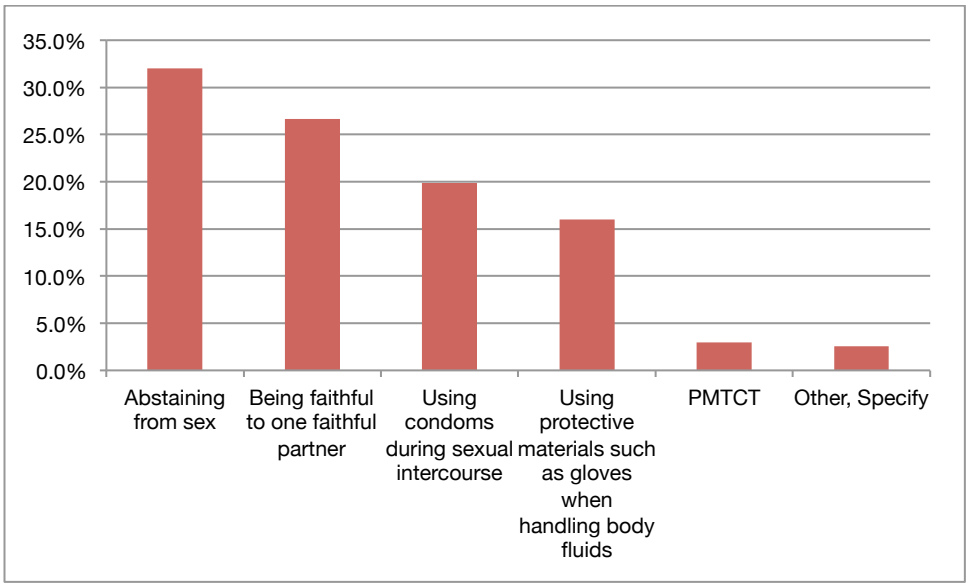
important that they had the knowledge as they could speak to their children about it, rather than it have an impact on their own behaviour.[59]

Older people also consistently reported that abstinence and faithfulness were the two main approaches to HIV prevention. Interestingly, while all older people reported that abstinence was the main way to protect against infection of HIV (graph 8 and graph 9), their own behaviour generally suggested that they were being faithful to one faithful partner (graph 10 and graph 11).



Graph 8: Survey responses to "How can one prevent being infected with HIV?" disaggregated by country

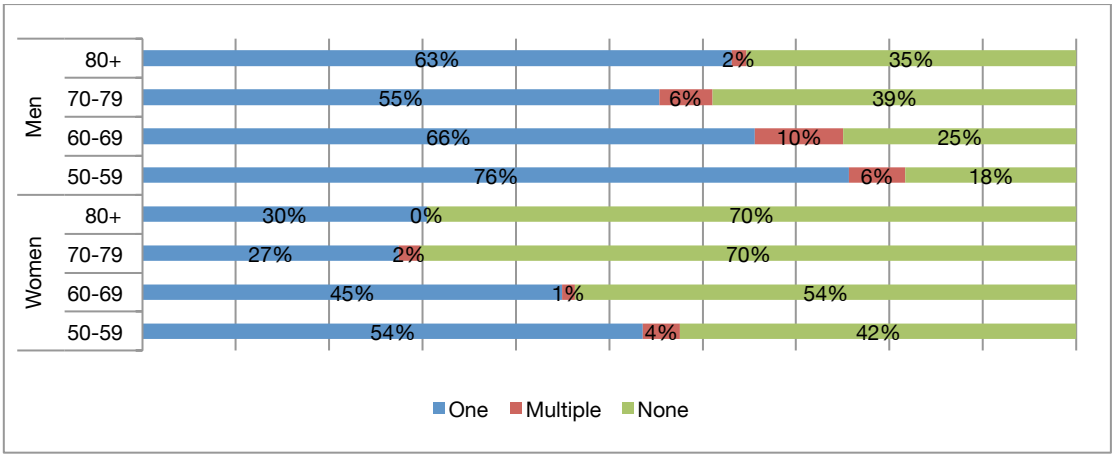
[59] Focus group discussion held with older women who received Peer Education 15 February 2013; Focus group discussion with Older Men who had received Peer Education, 15 February 2013



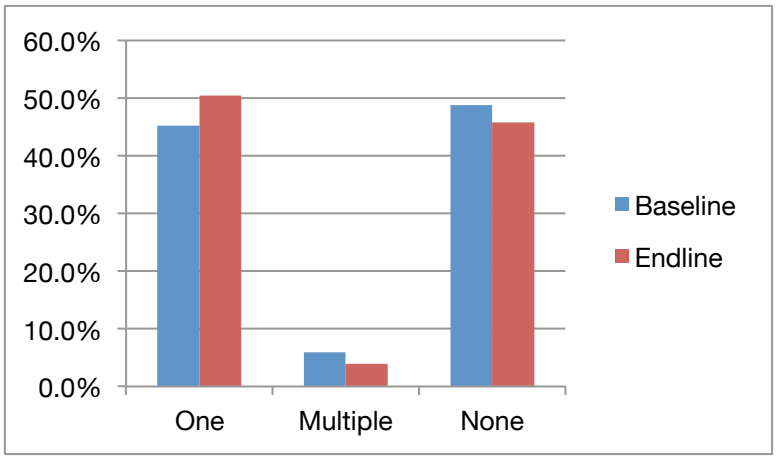
Graph 9: Mean awareness of how to prevent HIV across Ethiopia, Kenya, Tanzania, and Uganda survey respondents

However the responses provided by different age groups and genders in graph 10 and graph 11 highlights the different priorities for individuals.

More men between 50 and 59 reported being faithful to one partner, than did women between 50 and 59. Whereas women over the age of 70 were more likely to report that they had no sexual partner. Generally men reported being more sexually active than women in the same age groups. Whilst not reported directly by the men in any conversation, these results do suggest that older men are sleeping with women below the age of 50. Where older men are reporting faithfulness, these results might also suggest that they are faithful to a woman much younger than themselves. Further detailed study on the sexual practices of older men and women would be needed to determine whether this trend is observed more generally and whether the hypotheses presented above are true.

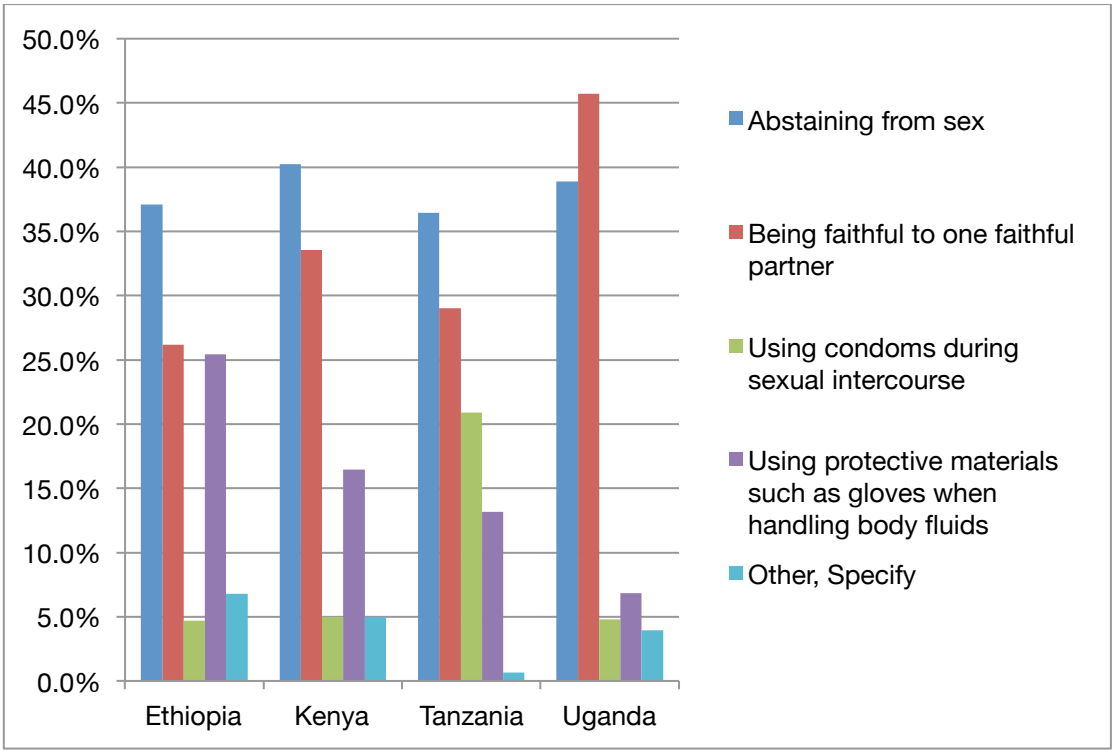


Graph 10: Survey responses to "How many sexual partners do you have?" disaggregated by age and gender



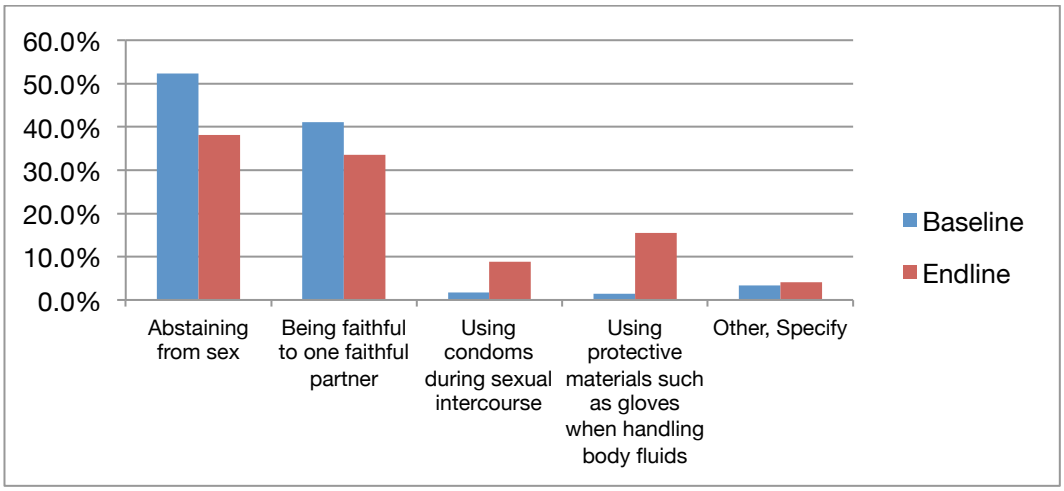
Graph 11: Mean percentage of the number of sexual partners compared to the Baseline across Ethiopia, Kenya, Tanzania, and Uganda survey respondents

The general trend across all the portfolio countries is towards one sexual partner and a reduction of multiple partners and fewer respondents reporting no sexual partners. Although for most women over the age of 60 that responded to the survey, abstinence is more important. In some countries too, such as Kenya, the trend is towards abstinence.[60] Abstinence was also reported as the main protection method that was being used (see graphs 12 and 13 below). Although in Uganda faithfulness was the main approach reported, in general across all four countries, faithfulness remained the second choice option, similar to the baseline.



Graph 12: Survey responses to "What do you do to protect yourself?" disaggregated by country

[60] Focus group discussion held with older women who received Peer Education 15 February 2013; Focus group discussion with Older Men who had received Peer Education, 15 February 2013



Graph 13: Mean percentage of respondents' ways that they protect themselves compared to the Baseline across Ethiopia, Kenya, Tanzania, and Uganda

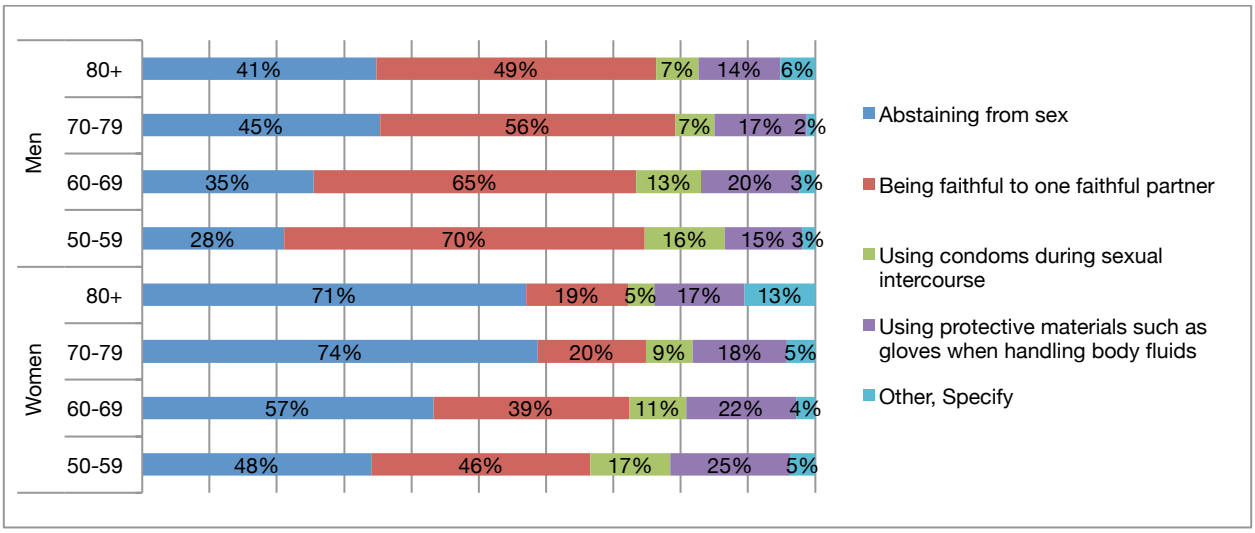
This trend towards either one faithful partner or abstinence is a major trend across the respondents and together with the responses to perceptions of risk below suggests that abstinence and faithfulness are the two main prevention strategies that older people who responded to the survey are using. During the evaluation feedback session with HelpAge and its partners, some participants hypothesized that this could be the result of cultural attitudes towards condoms, age and respondents' awareness of their HIV status after having accessed VCT services.[61] This might be worth further investigation to ascertain whether this complex mix of cultural attitudes and prevention messaging has resulted in older people taking a risk-averse approach to HIV-prevention. Graph 13 above does also show an increase in condom use and an increase in use of protective materials amongst the respondents to the survey.

We disaggregated these responses by gender and age.

	Women				Men			
	50-59	60-69	70-79	80+	50-59	60-69	70-79	80+
Abstaining from sex	48%	57%	74%	71%	28%	35%	45%	41%
Being faithful to one faithful partner	46%	39%	20%	19%	70%	65%	56%	49%
Using condoms during sexual intercourse	17%	11%	9%	5%	16%	13%	7%	7%
Using protective materials such as gloves when handling body fluids	25%	22%	18%	17%	15%	20%	17%	14%
Other, Specify	5%	4%	5%	13%	3%	3%	2%	6%

Table 3: Survey responses to "What do you do to protect yourself?" disaggregated by age and gender

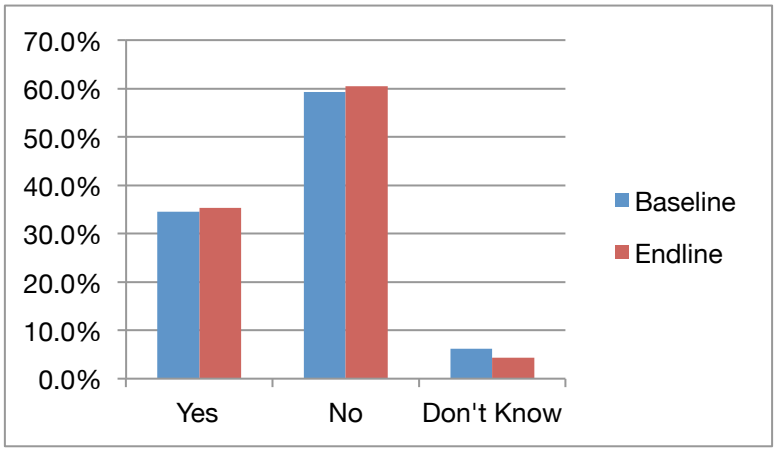
[61] Evaluation Feedback Workshop Session, Nairobi, 25 April 2013



Graph 14: Survey responses to "What do you do to protect yourself?" disaggregated by age and gender

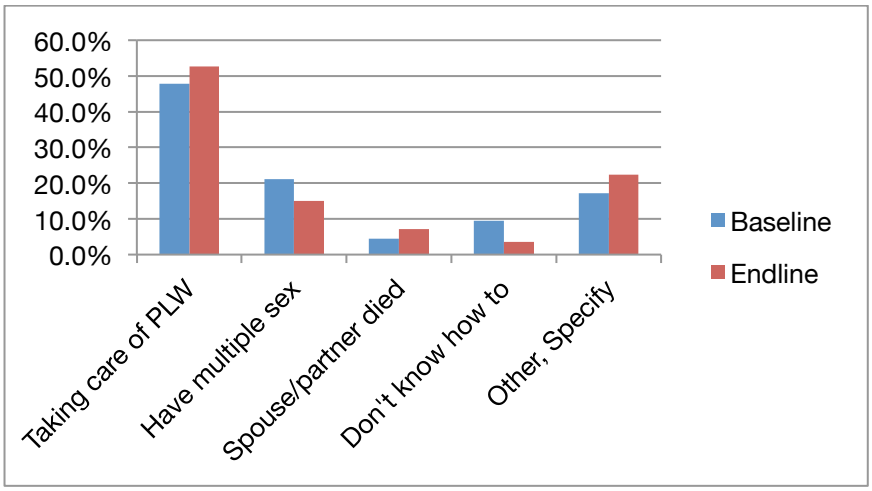
While faithfulness is cited by men as being the most used protection method, women cited abstinence. Those women who reported their marital status as being "widow" were also more likely to report abstaining from sex as their main protection method.

In general, most respondents did not think that they were at risk from HIV.



Graph 15: Mean perception of risk of infection with HIV compared to the Baseline is across Ethiopia, Kenya, Tanzania, and Uganda survey respondents

Where they did think they were at risk from HIV, it was mainly because they were looking after someone living with HIV. Risk of infection was not associated with personal risk-taking behaviour (although "accidental infection" featured highly amongst the other reasons given for being at risk).



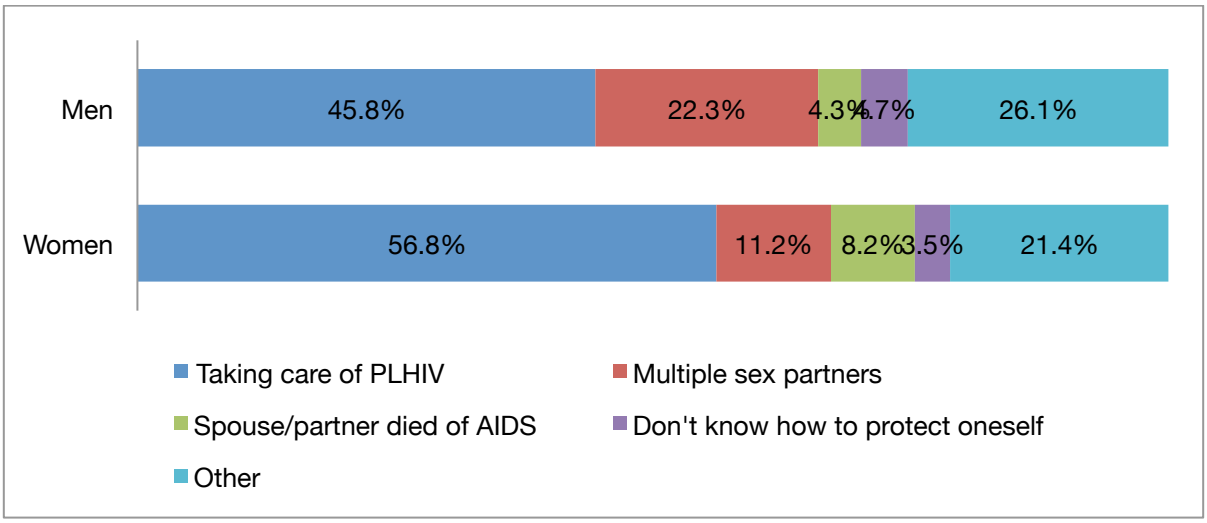
Graph 16: Mean perception of source risk of infection with HIV compared to the Baseline is across Ethiopia, Kenya, Tanzania, and Uganda survey respondents

When we disaggregated these responses by country and gender we found the follow results:

Women	**Ethiopia**	**Kenya**	**Tanzania**	**Uganda**
Taking care of PLHIV	49.3%	51.9%	77.5%	48.8%
Multiple sex partners	11.9%	5.6%	10.0%	17.5%
Spouse/partner died of AIDS	9.0%	2.8%	10.0%	11.3%
Don't know how to protect oneself	4.5%	1.9%	3.8%	3.8%
Other	26.9%	38.9%	0.0%	20.0%
Men	**Ethiopia**	**Kenya**	**Tanzania**	**Uganda**
Taking care of PLHIV	46.7%	33.3%	78.8%	24.3%
Multiple sex partners	20.0%	16.7%	11.0%	41.4%
Spouse/partner died of AIDS	0.0%	0.0%	8.5%	8.6%
Don't know how to protect oneself	0.0%	13.3%	2.5%	2.9%
Other, specify	40.0%	40.0%	0.0%	24.3%

Table 4: Perception of Risk by gender and country

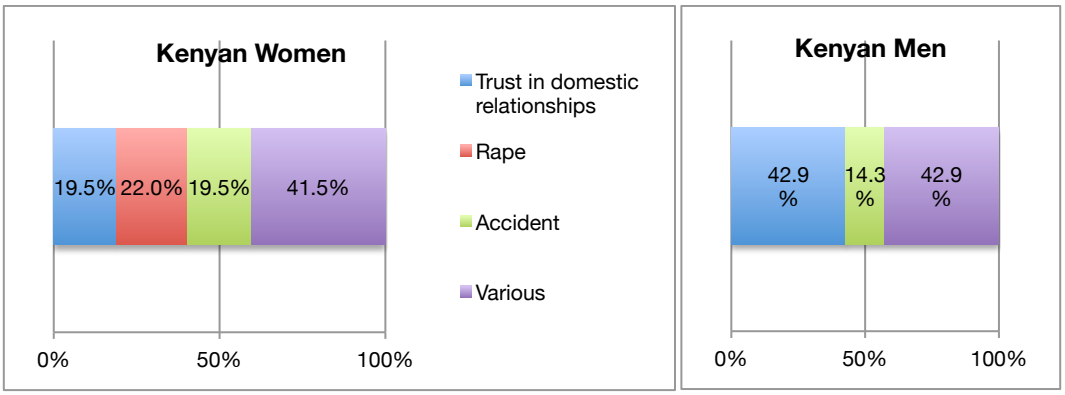
We also considered the average across the four countries, which highlights that for both men and women, looking after people living with HIV was still considered to be the main risk to infection with HIV. However "other" scored highly across three of the four countries and highly for both genders.



Graph 17: Perceptions of Risk disaggregated by gender

As part of the more detailed impact evaluation in Kenya we interrogated the results for "Other, Specify" in more detail. We found that trust in domestic relationships emerged as a key issue for the respondents.

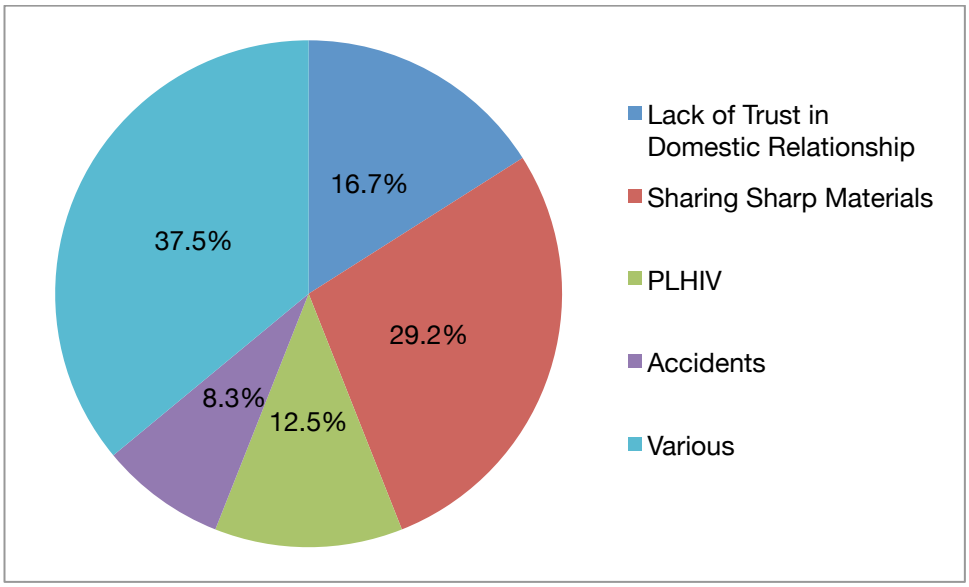
We further disaggregated this data by gender to see whether one gender was reporting trust in domestic relationships as an issue more than the other.



Graph 18 & 19: Responses amongst Kenyan Women to Q19 "Other, Specify" and responses amongst Kenyan Men to Q19 "Other, Specify"

Interestingly, lack of trust in relationships was more of an issue for men, while women reported rape as more of a concern than lack of trust in their relationships. However the sample of men who responded to "other, specify" is so small as to not be statistically significant and the difference between those women who reported lack of trust and rape to be an issue is 2.5%, which is a very narrow margin. Additionally, the women did not specify whether it was rape in general, rape by their partners or rape by a third party that most concerned them. Lack of trust had not previously emerged as an issue amongst the beneficiary groups.

While we did not have enough data to properly interrogate the "Other, Specify" results in Uganda, in Ethiopia, a different picture emerged:

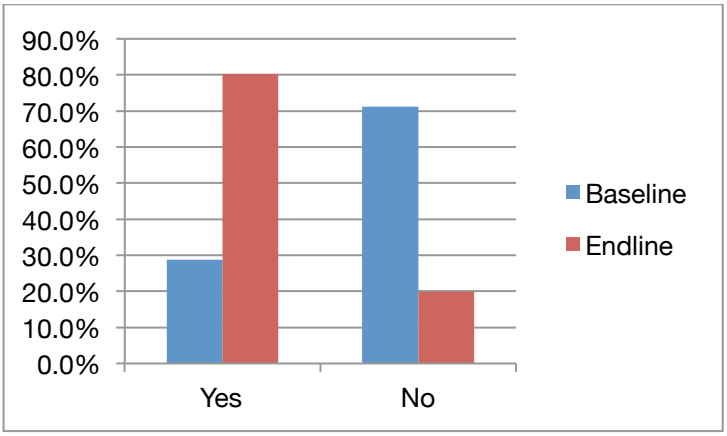


Graph 20: Responses to "Other, specify" in Ethiopia

Remarkably the use of sharp objects was the main reason for risk of infection amongst Ethiopian respondents, whilst lack of trust in relationships was a secondary factor. Although, only women reported that lack of trust was an issue. For some respondents, that they were already living with HIV was considered enough to put them at risk.

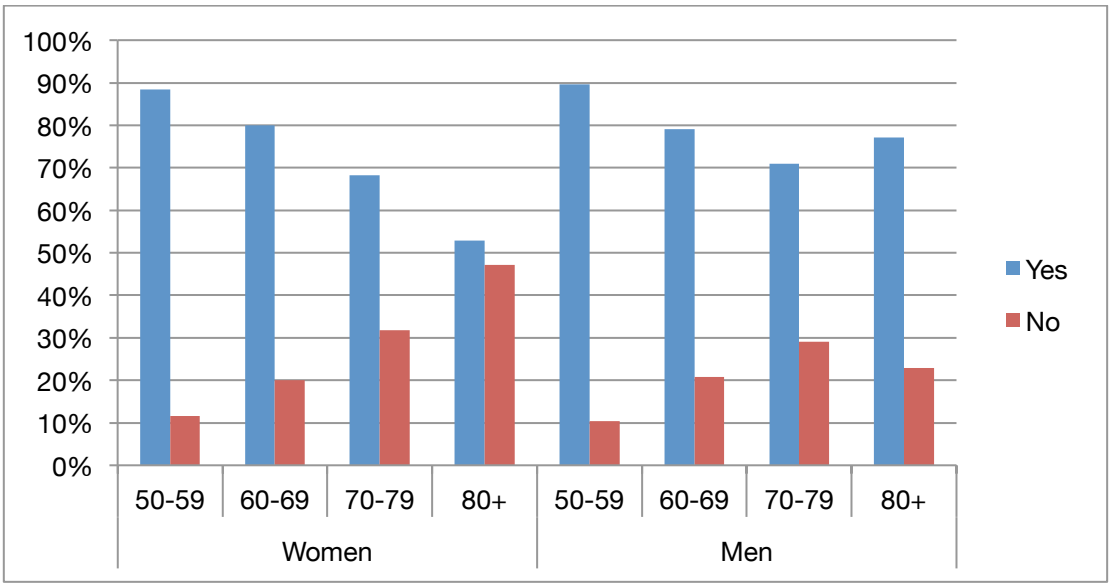
Where respondents did not feel that they were at risk, most reported that their reduced level of risk was due to either being faithful or abstaining from sex.

The other key factor that can be used to measure awareness of HIV and how it can affect you personally is the willingness to be tested for HIV and whether those who have been tested know their status. Here HelpAge's results across all four portfolio countries is significant and shows a major change in behaviour and attitude from the baseline. Across all four countries 80.2% of respondents had been tested.



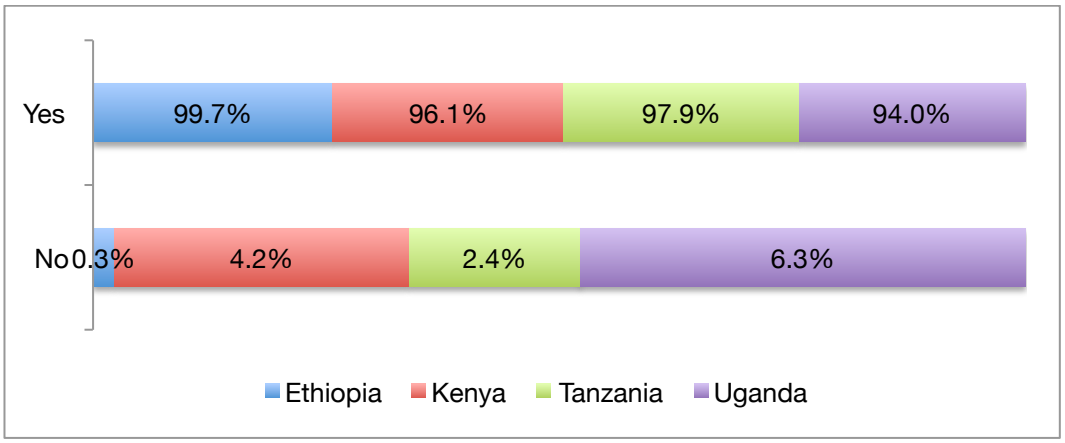
Graph 21: Mean percentage of respondents who have been tested for HIV compared to the Baseline is across Ethiopia, Kenya, Tanzania, and Uganda survey respondents

Younger people were more likely to report having been tested for HIV than older people were. In general, men were more likely to reported having been tested, except amongst 60-69 year olds where 80% of women and 79% of men reported that they had been tested for HIV.

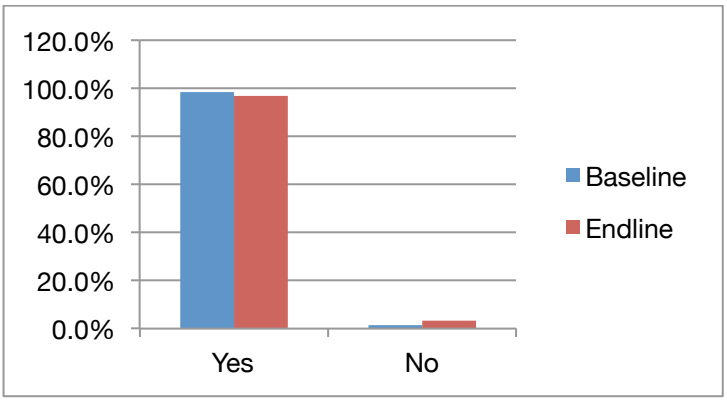


Graph 22: Survey responses to "Have you ever been tested for HIV?" disaggregated by age and gender

Of those who had been tested across Ethiopia, Kenya, Tanzania and Uganda, 96.9% knew their status.

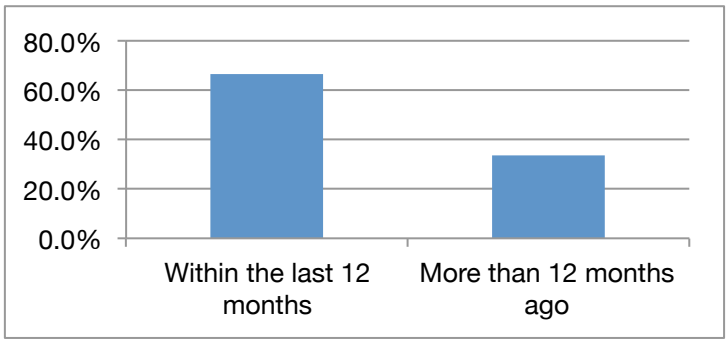


Graph 23: Survey responses to "Do you know your status?" disaggregated by country



Graph 24: Mean percentage of respondents who have been tested for HIV, who know their status compared to the Baseline is across Ethiopia, Kenya, Tanzania, Uganda survey respondents

Most of the respondents had been tested within the last year, although this does not prove frequency of testing and whether the test in the last year was the only test in the past 5 years that the respondents had taken (there is no baseline data available for this question, although it was asked).

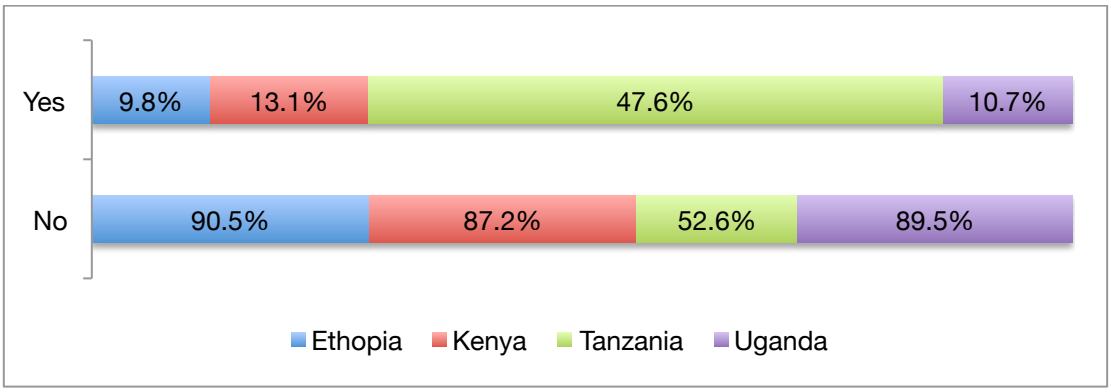


Graph 25: Mean percentage of respondents who have been tested for HIV within the last 12 months and more than 12 months ago, across Ethiopia, Kenya, Tanzania, Uganda survey respondent (Baseline data not available)

HelpAge also undertook a VCT study in Ethiopia, Uganda and Tanzania during a six-month period between 2009 and 2010. During the study older people were asked to participate in exit interviews from VCT centres in the three countries. Most of the respondents (69.4%) had reported feeling prepared for the VCT tests, however few of the respondents (20%) received information relating to sexual relationships, stigma, discrimination, etc. Most respondents (62%) were generally satisfied with the VCT services.[62]

Respondents to the endline survey were also asked about condom use. Most significantly, condom use has not increased substantially over the lifetime of the project, with most respondents that they still tend not to use condoms.

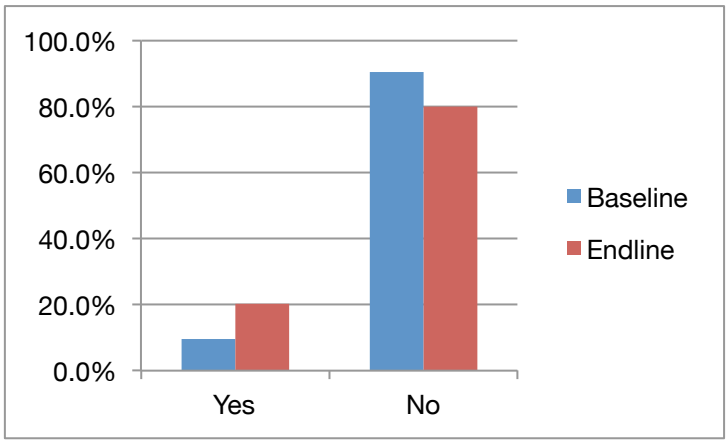
[62] HelpAge International, 2012, Voluntary Counselling and Testing Study: Utilisation of VCT services and test results for older people in Ethiopia, Tanzania and Uganda, HelpAge International, Nairobi



Graph 26: Survey responses to "Have you ever used a condom?" disaggregated by country

Only in Tanzania, was the variance between those who reported using and not using condoms low: only 5% more of the respondents in Tanzania said they had not used a condom. By comparison 80.7% more people in Ethiopia reported not using condoms.

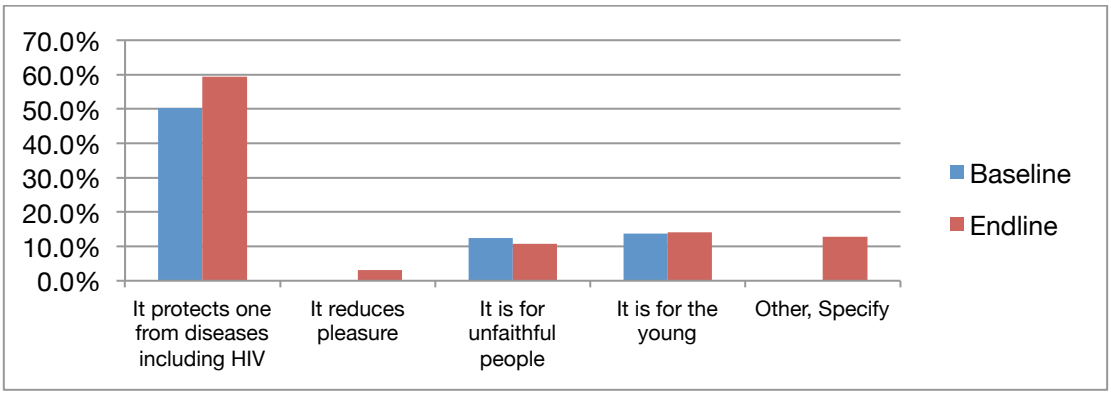
However overall, across the portfolio there has been an increase of 10.8 percentage points in the number of respondents now reporting that they use condoms. This is just over double the percentage of respondents who reported condom use at the baseline.



Graph 27: Mean percentage of respondents' that have used a condom compared to the Baseline across Ethiopia, Kenya, Tanzania, and Uganda

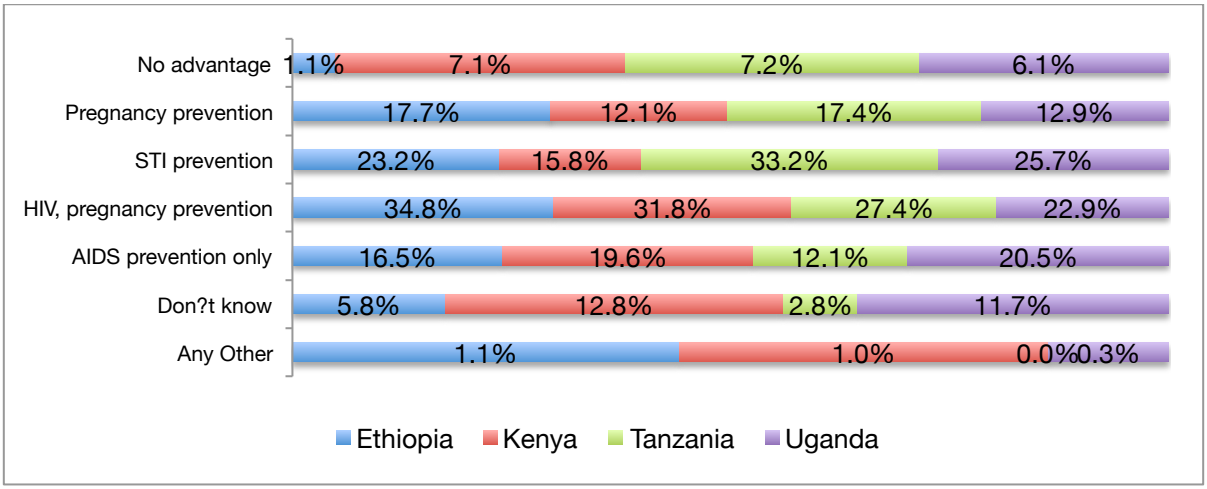
Most people who responded to the surveys across Ethiopia, Kenya, Tanzania and Uganda gave the opinion that condoms protect individuals from infections such as HIV. However there was also a slight increase in the number reporting that condoms are for the young and notably a small decrease in the percentage of respondents that thought condoms were for unfaithful people. This is an interesting response as during some focus group discussions with older men particularly, participants suggested that they do not use condoms because they are married and that condom use is associated with sex workers and people cheating on their partners.[63]

[63] Focus group discussion with Older Men who had received Peer Education, 15 February 2013

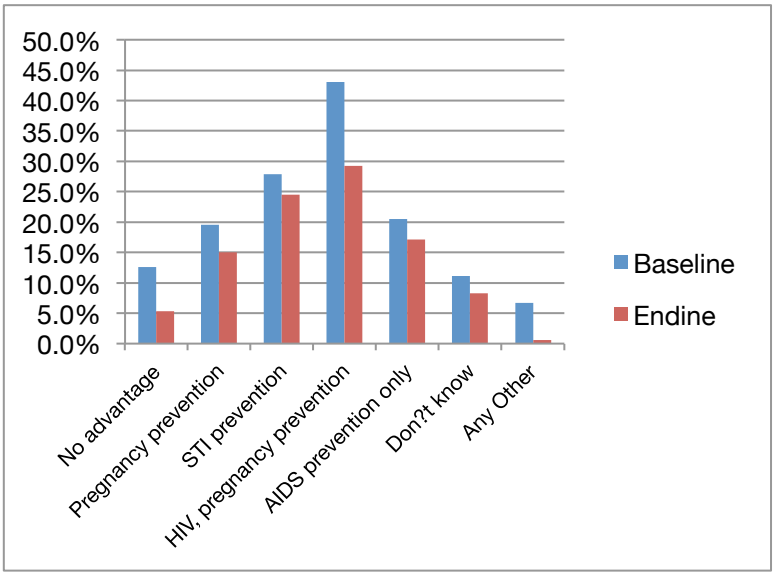


Graph 28: Mean percentage of respondents' opinion about condoms compared to the Baseline across Ethiopia, Kenya, Tanzania, and Uganda

The main advantage of condom use was considered to be HIV prevention and pregnancy prevention by 29.2% of all respondents in the portfolio (see graphs 29 and 30 below).



Graph 29: Survey responses to "What is the advantage of condom use?" disaggregated by country



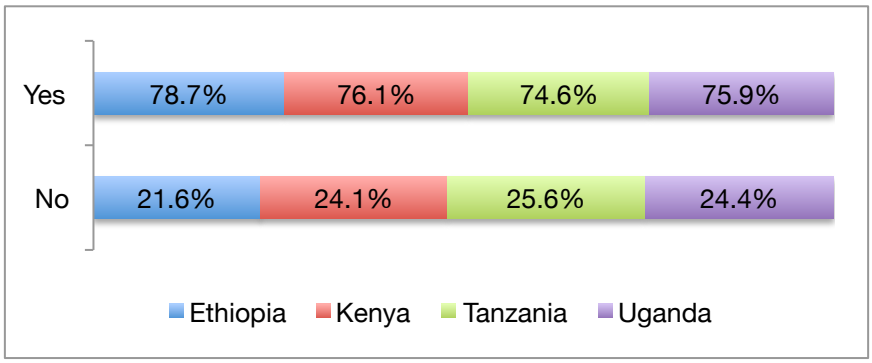
Graph 30: Mean percentage of respondents' opinion about the advantage of condom use compared to the Baseline across Ethiopia, Kenya, Tanzania, and Uganda

When we looked for linear correlation to better understand the results around condom use, we found that those respondents who reported that HIV was

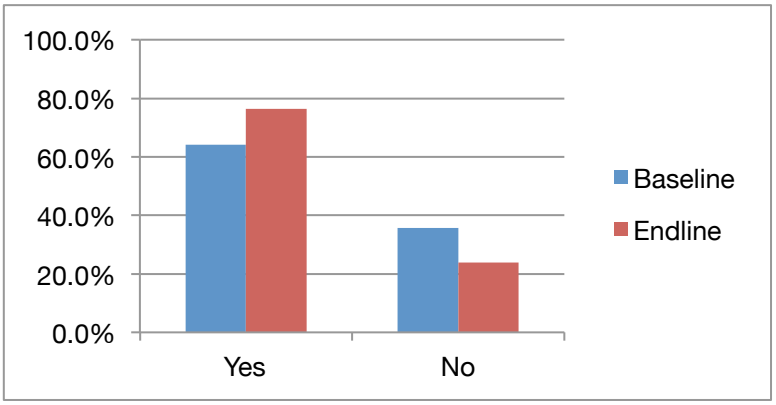
a sexually transmitted infection that could be transmitted through unprotected sex were more likely to report that they had not used a condom.[64]

Finally the respondents were asked whether they discussed HIV within their households and what they discussed. These responses were considered to be an indication of confidence to discuss the issue and an ability to pass on knowledge acquired from either a Peer Educator or other mechanism.

At the endline 12% more respondents reported discussing HIV within their own households than had done so at the baseline. Perhaps significantly, the individual country responses at the endline are relatively similar for both those households reporting that they do discuss HIV and those households that reported that they do not discuss HIV. This is the only response that is so evenly balanced across the different countries.



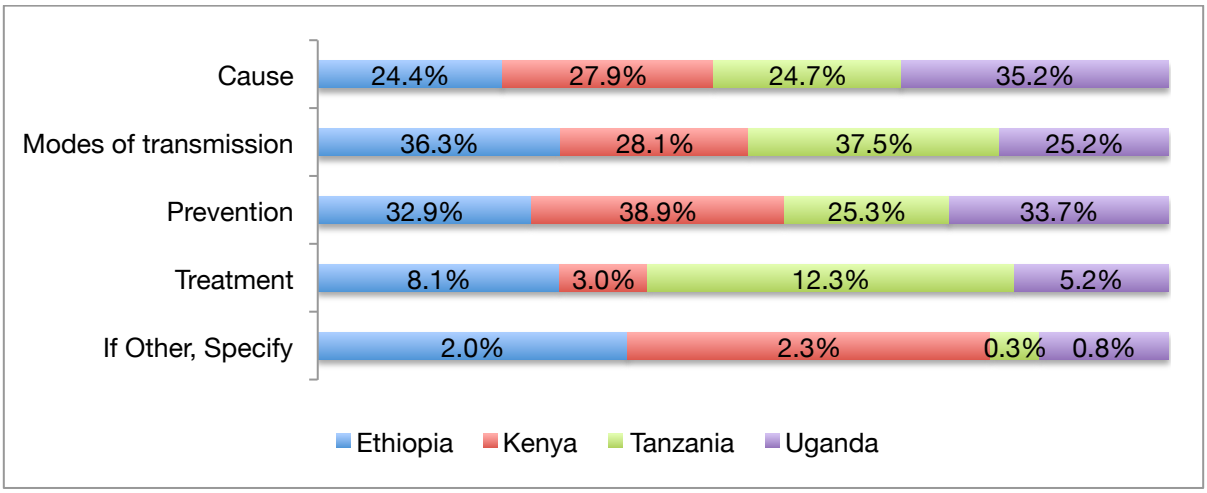
Graph 31: Survey responses to "Do you openly discuss HIV/AIDS with members of your household?" disaggregated by country



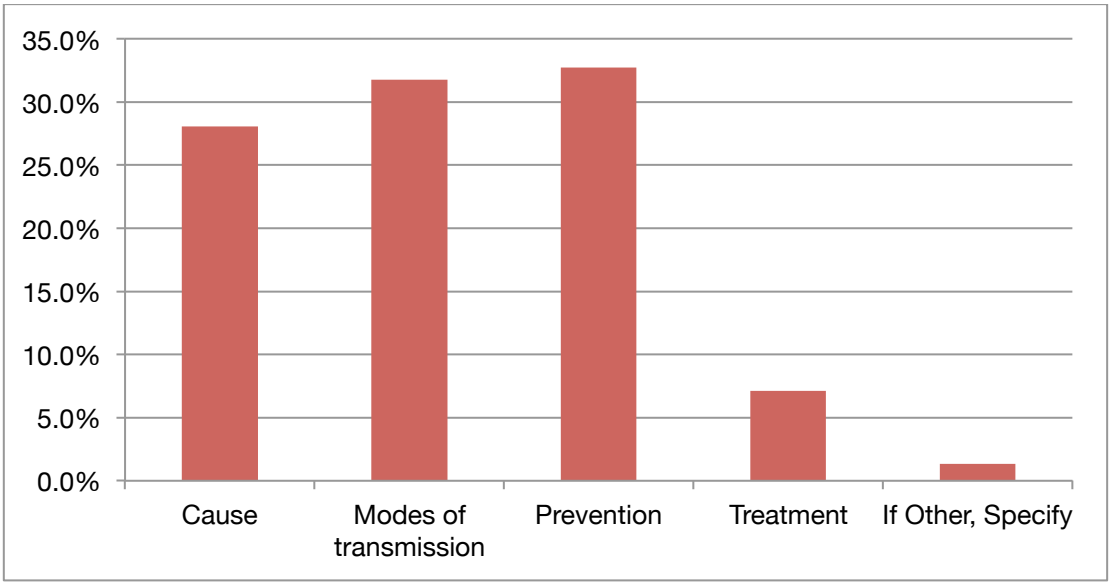
Graph 32: Mean percentage of respondents who openly discuss HIV within their own household compared to the Baseline across Ethiopia, Kenya, Tanzania, and Uganda

There is a fairly even split between discussing the causes of HIV how it is transmitted and prevention of HIV in households across the portfolio, with slightly more households reporting that they discuss prevention more than the other topics.

[64] Only in the survey results for Uganda was there no correlation between respondents reporting that HIV could be transmitted through unprotected sex and reporting lack of condom use.



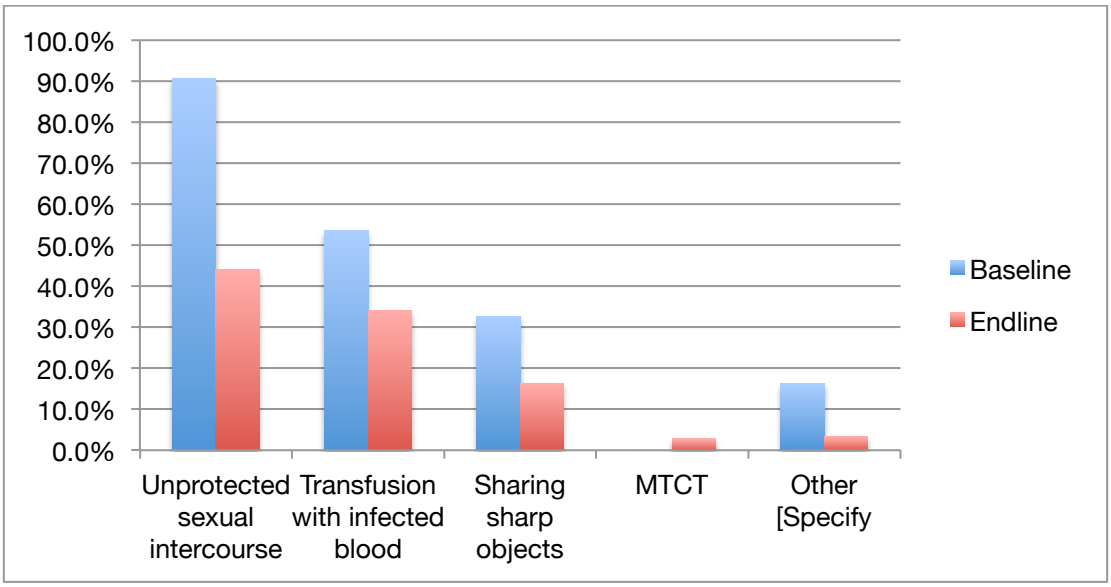
Graph 33: Survey responses to "What do you discuss about HIV/AIDS?" disaggregated by country



Graph 34: Mean percentage of the types of topics respondents openly discuss within their own household compared to the Baseline across Ethiopia, Kenya, Tanzania, and Uganda

While project 3 was implemented in Ethiopia, Kenya, Tanzania and Uganda as a dedicated project, in South Africa prevention messaging was integrated into project 6, which focused on working with traditional health practitioners to improve their knowledge and skills to better support their clients both in their surgeries and in their clients' homes. The intervention in South Africa focused on those types of traditional health practitioners that came into contact with their clients directly and therefore had the highest risk of infection.

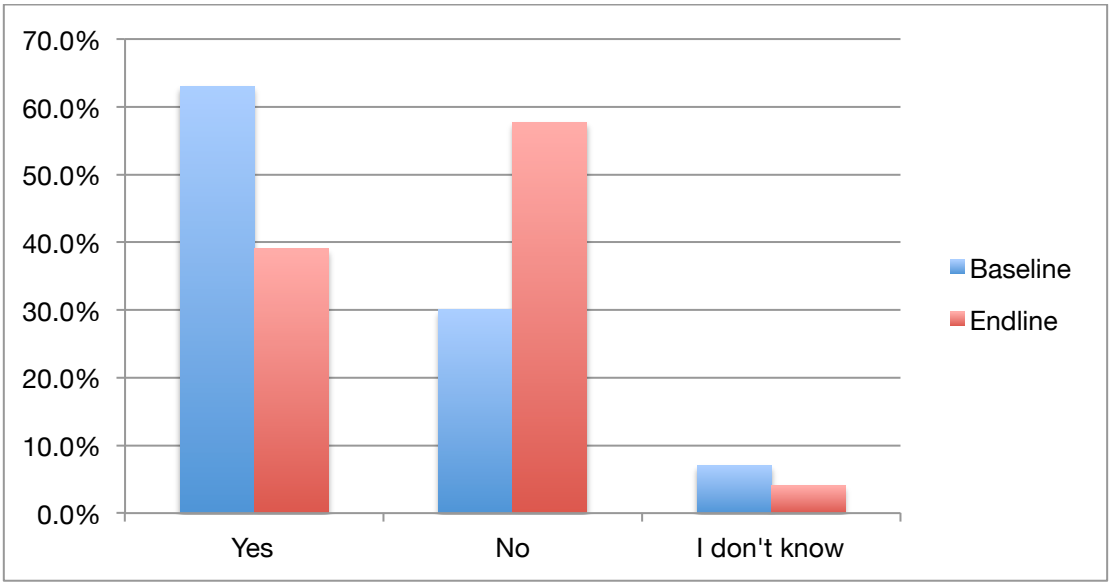
The KAP survey was also run in South Africa, however the survey was only aimed at the Traditional health practitioners that had participated in the project, which mirrored the approach taken at the baseline and the mid-term evaluation.



Graph 35: Survey responses to Q14: "How is HIV transmitted?"

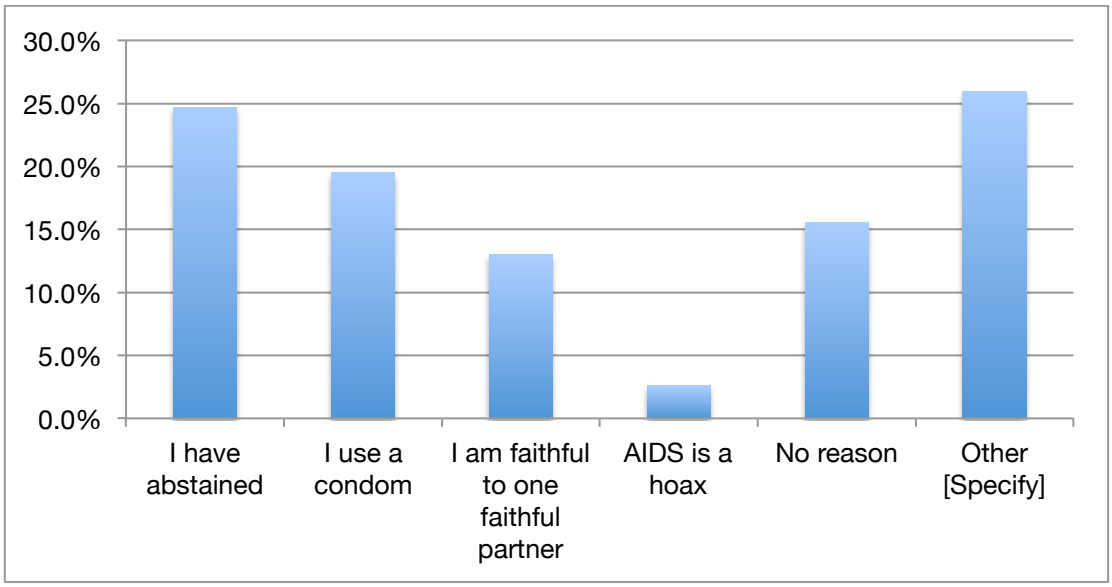
As with respondents in other countries endline data suggests a reduction in general knowledge of methods of transmission amongst the traditional health practitioners that responded to the survey. Although unsafe sex remains the main cited route of HIV infection and unlike the baseline, MTCT is referenced by a small group of traditional health practitioners. Given the training and the reference to razors amongst both the traditional health practitioners and their clients in the focus groups, it is surprising that more traditional health practitioners did not mention sharing sharp objects during the endline.

There is a significant change however between the baseline and the endline when traditional health practitioners responded to the question of whether they thought they were at risk of testing positive for HIV themselves.



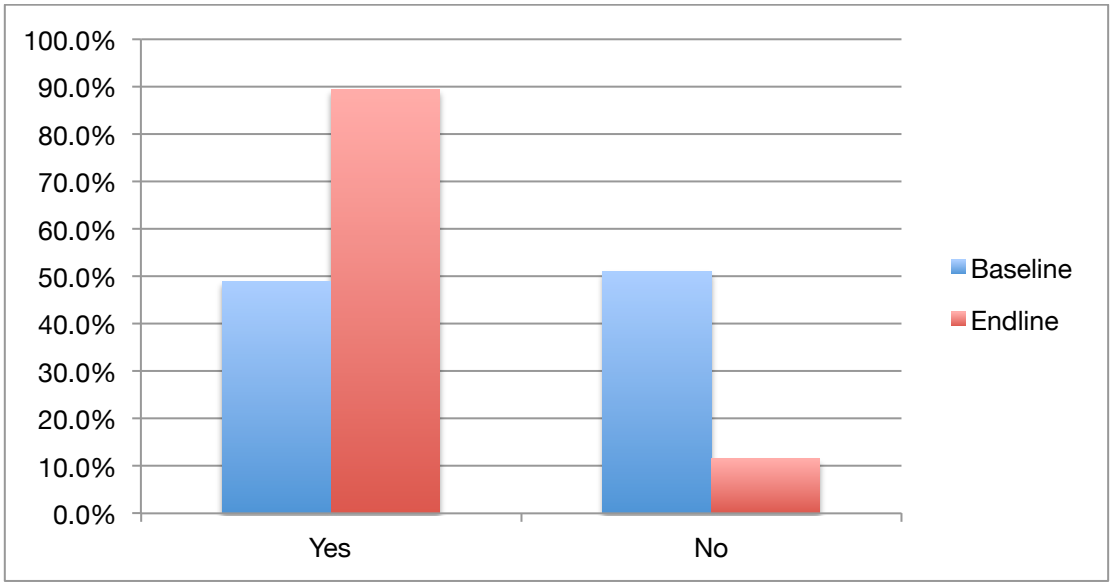
Graph 36: Survey Responses to Q18: "Do you consider yourself at risk of infection (re-infection) with HIV?"

Of those who felt they were no longer at risk, the ABC approach was often cited. However "other [specify]" was the dominant response to the question. Unfortunately the data of what those other reasons were was not recorded, so we are unable to determine whether there were any trends in those responses that could inform future project activity.



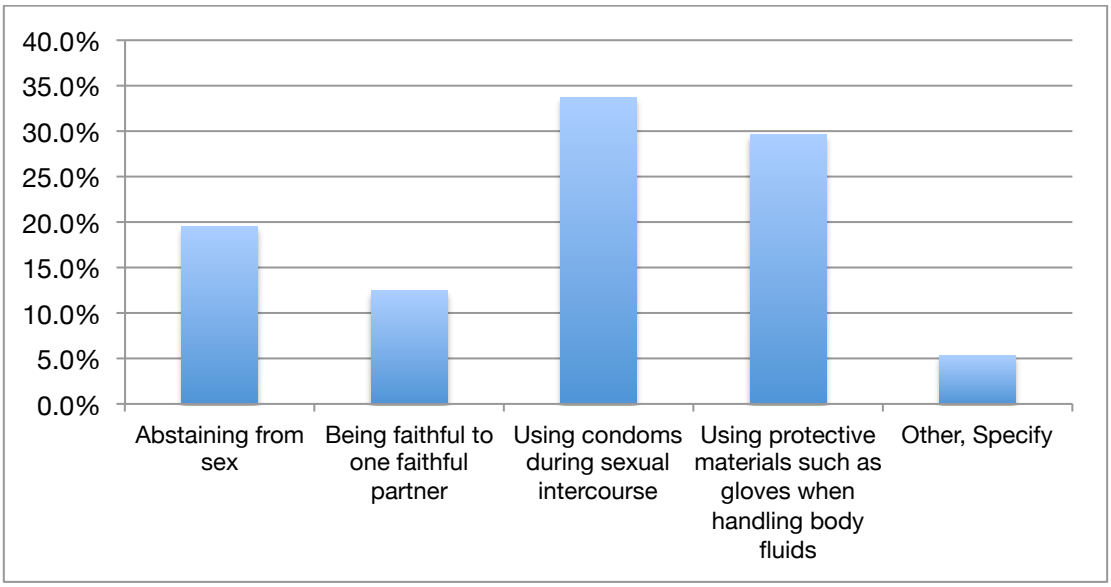
Graph 37: Survey responses to Q20: "Why do you consider yourself out of risk?"

As with other countries in the portfolio South African traditional health practitioners reported a significant increase in testing:



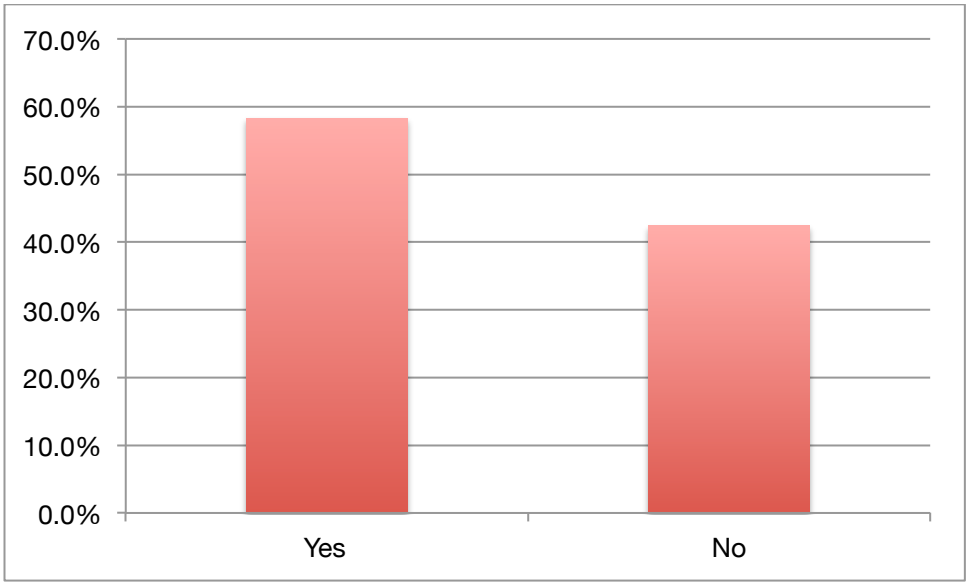
Graph 38: Survey responses to Q25 "Have you ever been tested for HIV?"

Traditional health practitioners also demonstrated an awareness of how to protect against HIV infection.



Graph 39: Survey responses to Q30 "What do you do to protect yourself against HIV?"

As in most other countries, the results of questions 20 and 30 in the survey combine to suggest that traditional health practitioners have a good knowledge of HIV prevention. However this did not prevent 42.5% of respondents from reporting that they did not use condoms themselves. What is clear however is that respondents in South Africa were the only group where the majority of respondents had used condoms.



Graph 40: Survey responses to the question "Have you ever used a condom?"[65]

Older people's reference to HIV knowledge as important for communicating to their households, their own preference for abstinence and faithfulness and their low perception of risk, combined with a high percentage of VCT access and status knowledge might suggest that the following thought process may

[65] There was no baseline data available for this question to compare the endline results with

have taken place, guided by Peer Educators, Home-Based Care Givers, traditional health practitioners and Facilitators of Community Conversations:

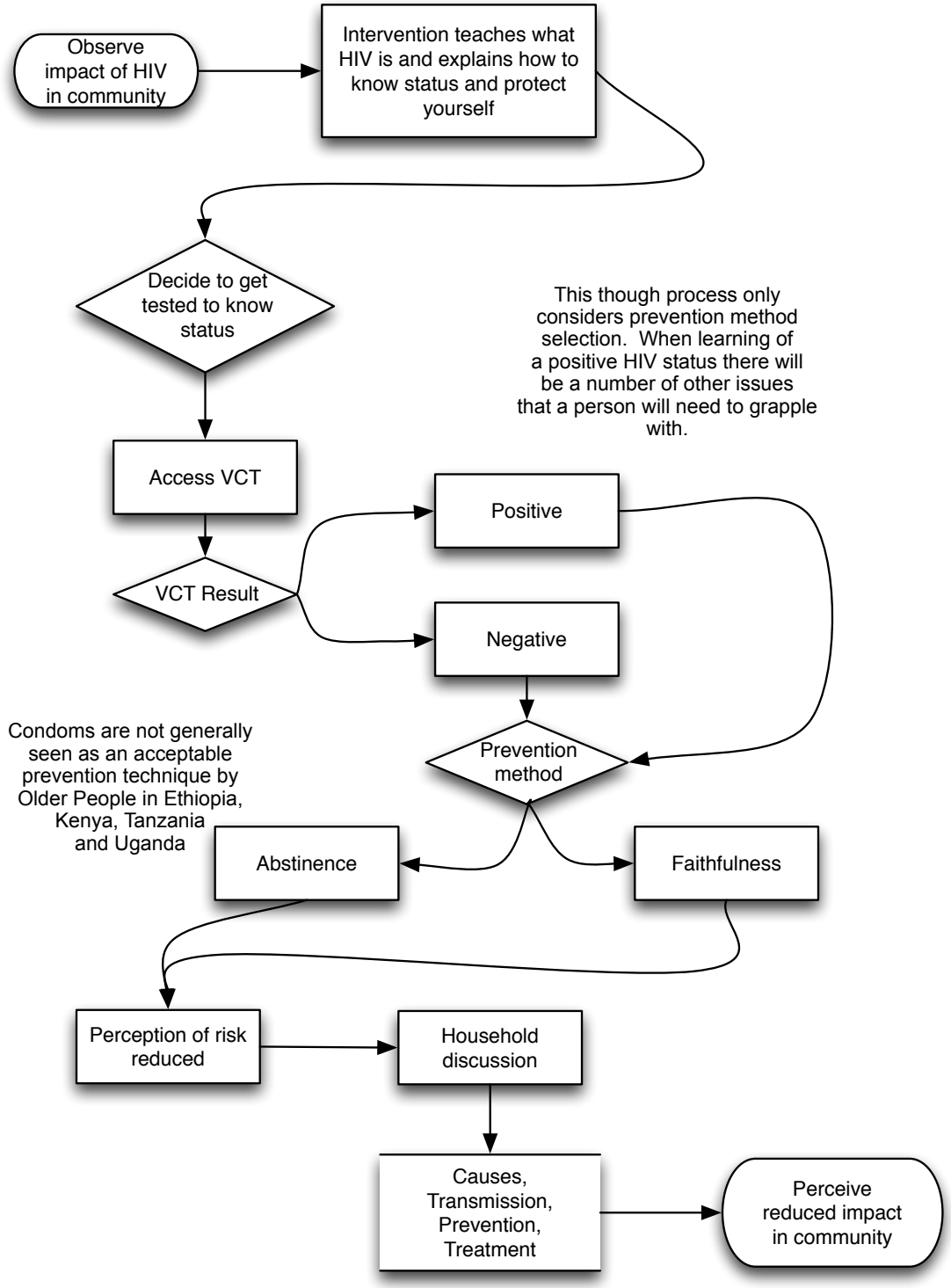


Figure 4: Potential decision making process affecting the behaviour of beneficiaries receiving prevention messages

This hypothesis is unproven and was discussed with the project teams during the evaluation feedback workshop.[66] It might however help to explain the increased behaviour change and apparent reduced knowledge results

[66] Evaluation Feedback Workshop Session, Nairobi, 25 April 2013

seen in the KAP survey. In considering this hypothesis we investigated trends in the survey results to understand whether respondents were more likely to be tested as a result of their knowledge of HIV or a visit from a Peer Educator. In all countries those respondents that reported a Peer Educator had visited them were more likely to have also reported being tested for HIV. In addition, those respondents that reported that HIV affected the immune system were more likely to report that they had been tested for HIV. We also looked for a correlation between knowledge and behaviour. In Ethiopia, Kenya and Tanzania, respondents who reported knowing that unprotected sex could lead to HIV infection were also more likely to report that they had abstained from sex as a means of protecting themselves. However in Uganda there was no such correlation and respondents who reported knowing that unprotected sex could lead to HIV infection, were less likely to report abstinence as a preferred means of protecting themselves. These linear correlations between the results of the survey suggest that the decisions people take affecting behaviour change as outlined above might be proven in a dedicated study on the subject. Understanding beneficiary motivation behind behaviour change would provide valuable evidence that could be used to inform a more tailored intervention design and potentially increase the positive impact of HelpAge's activities.

Outcome 2 relied heavily on volunteers to train as Peer Educators, Community Conversation facilitators or as Home-Based Care Givers. In Ethiopia project 3 was delivered using the same delivery mechanism (the Iddirs and Iddir Leaders) as project 7 (income generation activities). While HelpAge will support paying a stipend to its volunteers, it does not yet have a policy of paying Home-Based Care Givers, Peer Educators, etc. a salary. While this approach does help to keep the costs down, it does reduce the longer-term sustainability of the projects as the individuals who are working as volunteers in the projects will lose the stipend that they were receiving. In addition, although laudable, the emphasis on training older people to be volunteers does come with the risk of wearing the volunteer group out or indeed some volunteers dying. Such factors were seen in Tanzania and are mentioned in the M&E Framework; and are more likely when working with older people and need to be taken into account during project design.

In some instances the support network that surrounded these volunteers is also at risk as the portfolio comes to an end, as the smaller community-based implementing partners may not have the financial resources to continue to support the scale of volunteering seen during the project period. The Peer Educators and Home-Based Care givers did report that they were likely to continue to provide the support that they had as they had found it beneficial to themselves and to their households; as well as being a "good thing" to be doing in the community. Good will is indeed valuable, but further support and consideration of how to make the projects sustainable was needed much earlier on in the project planning process.

The approach in Ethiopia of using pre-existing community infrastructures such as the Iddirs, who have income that is independent from the project already and are not reliant on project funds for survival, shows the strongest likelihood of some sustainability (albeit not at the same level as previously supported by the project). Sustainability of the Home-Based Care givers is discussed further under Outcome 3.

The mid-term evaluation made some recommendations on outcome 2:

Mid-Term Evaluation Recommendations	**Final Evaluation Commentary**
Peer education training was halted sometime back pending the development of a peer education curriculum for older people. HelpAge should hasten the development of a peer education manual that will allow for staggered training of older people who have challenges sitting through whole-week training, and also provide for incorporation of adult learning approaches, both these in addition to the routine technical content.	The Peer Education manual was produced after the mid-term evaluation. HelpAge reported to us that the manual was an output of the prevention project, which makes this recommendation appear somewhat contradictory.
The portfolio should facilitate creation of community level supervisory structure which could include experienced and committed peer educators trained as TOTS. Provision of regular refresher trainings to existing volunteers to equip them with skills on older people friendly approaches	Training of trainers and the trainer of trainers concept was evidenced in a number of projects and appeared to have always been planned as part of the projects, with budget allocations for this training always in place. The same is true of refresher training for Peer Educators. Hence we are unsure what this recommendation refers to.
Similarly, peer educators should be equipped with information and skills to be able to influence many older people to go for counselling and testing since peer educators report prevalence of fear for HIV testing among older people.	We understand that this is an intended outcome of the Peer Education activity and was included in the early (pre-mid-term) reporting on portfolio progress.
The peer educators should be equipped with skills to handle hostile cases that sometimes manifest amongst men. Where possible, the peer educators can be supported for exchange visits to learn from their colleagues in other parts of the country or region.	We understand that such training was included in refresher training.

Peer educators can be supported to engage with media; in countries like Uganda, the project can approach the government to access free interactive talk show airtime where selected peer educators can participate	We are not aware that such support to engage with the media has happened.
Across the board, and especially in Uganda, the Portfolio should engage closely with health facilities to organize outreaches for VCT so as to take services closer to older people, especially those residing in hard-to-reach hilly areas like Rwenzori, and who have difficulties navigating the steep terrains.	We do not believe that VCT outreach is within the scope and remit of HelpAge's prevention programme or budget. We did not see evidence of such an outreach programme. However each country found ways to address access to VCT services and HelpAge is finalizing a report on the issue.
The project should establish strong linkage between peer educators and health facility staff to ensure timely technical support, which is currently erratic.	We understand that such links have been formed between HBC givers and Health Facility staff, but saw no evidence of a link between Peer Educators and Health Facility staff.

Table 5: Mid-term evaluation recommendations and our commentary on them

3.3.1 Summary

This outcome is about achieving an increase in awareness about HIV and AIDS and increased understanding in how to protect yourself. In general older people appear to be using abstinence and faithfulness as their main prevention techniques. While abstinence is more important to women and faithfulness appears to be more important to men, both genders are reporting that a lack of trust in their domestic relationships makes them feel more at risk of HIV infection. While condom use remains low overall, it has increased from the baseline. The focus group discussions held in the four main project countries suggested that most older people do value having this knowledge and knowing how to talk to their grandchildren about HIV (something they learned from the Peer Educators or community conversation facilitators), but that they continue to view HIV as an issue for younger people in general.

The Peer Educators, Community Conversation facilitators, Home-Based Care givers and Traditional Health Practitioners have all played a role in supporting behaviour change amongst the beneficiaries, with the Peer Educators being especially valued by the beneficiaries. While HelpAge's interventions have been particularly relevant to the beneficiaries, the sustainability of these interventions is far from assured.

3.4 Outcome 3 – 75% of 10,200 people living with HIV receiving home care and services report an improvement in quality of care and services

Ethiopia and Tanzania implemented Home Based Care (HBC) programmes as part of the Big Lottery Fund portfolio, while in South Africa, HelpAge's work with traditional health practitioners was initially described in terms of information provision[67] and intended to have an impact on the quality of the services older people received from traditional health practitioners both at home and during their consultations with their traditional health practitioners. Projects 4, 6 and 8 contributed towards this outcome. The evaluation found that HBC services were highly valued, the quality of care is considered very good or excellent, beneficiaries would like their services to be extended and there are potential difficulties in sustaining the programme.

Participants in the focus groups in Ethiopia and Tanzania reported that these HBC services provided a valuable service to those older persons who were looking after orphans and vulnerable children or people living with HIV (see boxes 2 and 3 below).[68] While in South Africa the role of traditional health practitioners in the community is clearly important with more than one interviewee confirming that almost all members of the community will use a traditional health practitioner at some point, but most would deny doing so.[69]

Project 8 has implemented a relevant and proven HBC model in three districts in Tanga Region to support older persons as primary carers. The model aimed to improve the skills of older carers to provide care for people living with HIV and in particular with relation to HIV and AIDS related illnesses, as well as developing their counselling skills and ability to deliver psychosocial support for people living with HIV. In particular it aimed to improve access for carers and people living with HIV to health care services in these districts including voluntary counselling and testing (VCT) and anti-retroviral treatment (ART). The model is very relevant given that baseline data[70] collected during Year 1 in the three districts showed that only

HBC services have been provided by Iddirs, which are a community structure unique to Ethiopia. Unlike many other CBOs and NGOs, Iddirs are independent, developed and led from the grassroots, the ground up. This means they have a significant level of trust from the community that very few other organisations can point towards or enjoy.

Iddirs had already identified the impact that HIV was having on their organisations[71] and were aware that they needed to change and adapt to survive. Tesfa had already started working on the HIV and AIDS impact long before the BLF-funded portfolio began[72] and was aware of the work required within Iddirs and

[67] The data collected on Project 6 throughout the lifetime of the portfolio referred to the number of individuals who have received information messages from traditional health practitioners as an indicator of people living with HIV who had received information and care from traditional health practitioners.

[68] Focus Group held in Tanzania with beneficiaries who were older persons being supported by Home Based Carers. 23 February 2013; Focus group discussion with HBC givers, 23 February 2013

[69] Key informant interview with Project Manager, 28 February 2013; Key informant interview with the Head of the THP Unit at eThekwini Municipality, 5 March 2013

[70] Preventing HIV/AIDS and alleviating its impact in multigenerational households, Kenya, Uganda, Tanzania, Ethiopia & South Africa baseline survey report. Gerald Kinondo et al. HelpAge International.

[71] Focus Group Discussion with Peer Educators, 23 Feb 2013; Key Informant Interview with Country Director, HelpAge International Ethiopia

[72] See section 1.3. Tesfa also worked closely with ACORD in its early years on HIV and AIDS in Addis Ababa.

20% of people reported they knew of HBC services available to people living with HIV. The model uniquely included older people as HBC givers and served to break from the past where HBC givers were younger people. Additionally the model proposed the formation of support groups for older carers to help them to share information and learning. This structure is relevant given that only 17% of those interviewed in the baseline survey reported they knew of support groups for people living with HIV.

Project 8 also aimed to review the existing national HBC guidelines in order to establish the relevant gaps with respect to older persons and both advocate and work towards their inclusion as HBC givers.

Box 2: Relevance of HBC services in Tanzania

within the communities in Kolfe Keranio.

Most significantly, project 7 was designed in collaboration with the Iddirs and its members and to a large degree appeared to meet the priorities of the Iddirs (with the exception of general support and assistance for older people living in poverty).

While Tesfa and HelpAge were not able to be as flexible as they would have liked to be within project 7[73]; the projects implemented can be considered to be relevant to the beneficiary groups they were intended for.

Box 3: Relevance of HBC services in Ethiopia

In South Africa, however, traditional health practitioners and their clients note that the traditional health practitioners get consulted by all members of the community equally, not just older people and that older people do not make use of traditional health practitioners more often than other members of the community or other age-ranges in the community.[74]

There is clearly some residual benefit in that the clients of properly trained traditional health practitioners are more likely to be properly referred to local clinics, get better services during a consultation and get improved dispensary advice from traditional health practitioners (which should result in fewer side effects for the client); and properly trained traditional health practitioners can provide better information about HIV during their consultations. The clients of the traditional health practitioners that participated in the focus group discussion were clear that a person on ART was not advised to take prescriptions provided by the traditional health practitioners as this might work against the ART,[75] and neither the traditional health practitioners nor their clients confirmed that the traditional health practitioners actually provide condoms during consultations. Therefore the impact that training traditional health practitioners is likely to have on multi-generational households to either prevent HIV or reduce the effects of HIV are likely to be limited.

The Home Based Care (HBC) model developed in Tanzania by HelpAge supported older people to become HBC givers. The Big Lottery Fund enabled HelpAge International to replicate this HBC model with 680 trained

[73] Tesfa was aware it could not meet all the need in the community as it arose during the project. A committee was established to prioritise the most important needs as they arose and attempts to meet those needs either within the project or from other sources were made.

[74] Focus group discussion with traditional health practitioners, 4 March 2013; Focus Group Discussion with older people and people living with HIV who are clients of traditional health practitioners, 2 March 2013

[75] Focus Group Discussion with older people and people living with HIV who are clients of traditional health practitioners, 2 March 2013

HBC givers in three districts in the Tanga Region including in Tanga Municipality, Mkinga District and Korogwe District where the government was not providing a service. The model was innovative in that these older HBC givers supported older vulnerable people in communities to improve their skills and knowledge of HIV, care of orphans and vulnerable children and people living with HIV and link them to other service providers in the area. This aimed to fill a gap where many older people were excluded from existing HIV programme targeted at younger people. Prior to 2008 this HBC model had been developed and extensively tested by HelpAge in collaboration with other partners (including Sida) and including in Tanga Region.[76] Research findings[77] had identified gaps in support for older people as carers.

In both Ethiopia and Tanzania the trainings of HBC givers were facilitated by either government or government accredited trainers and using government-approved manuals. The qualifications and status of the project trained HBC givers were on a par with those who had been trained and employed by government. In Tanzania the project had close collaboration with the Ministry of Health & Social Welfare who provided accredited trained facilitators to train 100 trainers of trainers who in turn trained the HBC givers. In Ethiopia HBC givers were provided with 21 days training that included assignments to local hospitals or clinics before going into the community. This is a standard HBC training process for HBC in Ethiopia. The HBC givers in this programme also received refresher training every 4 – 6 months.

Prior to the South African Act 22 (2007) The Traditional Healers Act formally recognizing the right of traditional healers to practice, traditional health practitioners had practiced at the fringes of society and this had meant that their training in western medical approaches had been severely limited. Since the ratification of the Act, training on a number of topics has been more widely available through organisations of traditional health practitioners. Those traditional health practitioners that do not belong to some sort of umbrella organisation generally do not receive any additional or professional development training. The training that traditional health practitioners have received and do receive from their organisations includes: updates on new diseases, diarrhoea, TB, diabetes, skin disorders, counselling, etc. This training is only theoretical.[78]

After discussion between the traditional health practitioners and MUSA it was agreed that the training would be provided to those practitioners who offered Herbal Healing and Bone Setting as these were the two practices that came into contact with their clients' bodies.[79] There were challenges in getting these two types of traditional health practitioners to work together as there

[76] Building Bridges. A home based care model for supporting older carers of people living with HIV. HelpAge Guidelines
[77] The Cost of Love: Older people in the fight against AIDS in Tanzania. HelpAge International, 2004
[78] Key informant interview with a member of the THP Council, 2 March 2013
[79] Key informant interview with Project Manager, 28 February 2013

were animosities between the different types of traditional health practitioners; however MUSA insisted on training the two groups together as there was no difference in the awareness training between the types of traditional health practitioners.[80] The training was conducted over five days intensively and covered:

1. Prevention
2. Awareness
3. Recording clients information; and
4. Data collection for basic statistics

Training included some practical elements and some provisions such as disposable gloves were provided to the traditional health practitioners. This practical element was different from the theoretical training that they received from their own organisations and was highly valued by the traditional health practitioners.[81] It must be noted however that the traditional health practitioners reported that the training was not five consecutive days[82] but rather one day a month, with the training often having to be repeated during a year so that all the traditional health practitioners could attend the training at a time that suited them.[83]

In Ethiopia in Kolfe Keranio the HBC givers have a ratio of 1 HBC giver to 15 members of the community and in Tanzania it was planned that each HBC giver would cover 15 multigenerational households (and beneficiaries reported they received on average 2 visits a month from an HBC giver).

The project fulfilled its objective of training 680 HBC givers in Tanzania across the three districts in Tanga by the end of the project and made a big contribution to increasing the overall coverage of district HBC services (in Karogwe District 75% of HBC givers were from the project), although training was delayed during the project life, which had a knock on effect in the implementation of project activities. There was no refresher training done for HBC givers. While in Ethiopia, HelpAge and its implementing partner exceeded their target for training HBC givers, but did not appear to reach its target for multi-generational households receiving HBC services from Iddirs.[84]

Focus group discussions[85] were held in Tanzania during the evaluation with project beneficiaries who were older carers being supported by HBCs. Many present in these discussions said their homes were very overcrowded and that they were looking after many people including their own children, grandchildren and relatives (who were sometimes living with HIV), as well as neighbours. Findings showed it was also common in communities that

[80] Ibid
[81] Key informant interview with a member of the THP Council, 2 March 2013; Focus group discussion with traditional health practitioners, 4 March 2013
[82] Something also reported by the project manager, Key informant interview with Project Manager, 28 February 2013
[83] Focus group discussion with traditional health practitioners, 4 March 2013
[84] M&E Framework, updated at Nov 2012; the data for Tanzania includes HBC givers who have died or moved away. A note on the M&E Framework suggests that 602 are still active.
[85] Focus group discussion with project beneficiaries who were older people caring for people living with HIV, 22 February 2013

grandmothers look after their vulnerable grandchildren whose parents had gone to the city to work (but who were not orphans). Beneficiaries reported that the services provided by the HBC givers were addressing their felt needs and had had many positive impacts – they felt they had been well cared for by HBC givers who they reported visited an average of twice monthly. In particular they valued the information on HIV and AIDS passed on to them by HBC givers and which they mentioned they disseminated widely to their grandchildren and people living with HIV they were caring for. HBC givers supported them looking after people living with HIV and helped them with their medication including advice on the importance of taking ARTs and the correct time.

Beneficiaries particularly found support useful from HBCs who accompanied them on hospital visits (and sometimes giving them a lift on their bikes) and for regular medical check ups. They considered that where they were accompanied to hospital by HBC givers they received better treatment from the hospital staff. HBC givers also provided beneficiaries with physical support to help move bedridden patients to sit outside, help with airing their mattresses as well as for cleaning houses. Beneficiaries reported that the HBCs sometimes gave them money, food or other items out of their own pockets and that some of them experienced difficulties meeting their rent payments.

Box 4: The positive impact of HBC services on older people caring for PLHIV

In Tanzania[86] focus groups held with beneficiaries (see box 4) during the evaluation showed that they most appreciated advice from HBC givers on taking ARTs, as well as their help in looking after bedridden patients and with physical tasks in the home. They particularly valued HBC givers' help to accompany them to the hospital, as they perceived the health workers gave them better treatment.

Beneficiaries stated that one of their main problems was to provide good quality food for people living with HIV they were looking after and in particular the expense incurred and providing a balanced diet. They emphasised that IGAs would help them to generate money to pay for food costs.

We also considered the view of the HBC givers in our evaluation. HBC givers in Ethiopia[87] still consider the services they provide for older people to very life-saving and important to counter fear, stigma and lack of knowledge on HIV and they said that they personally had learnt much from the people they worked with. Importantly, both men and women had been trained as HBC givers in Ethiopia. The men who participated in the focus group discussion did report some initial discrimination against them from both the community and the household that they were trying to help, but this did dissipate after a while when their ability to support the household was demonstrated.[88] In Tanzania HBC givers considered that as a result of their services their clients were less isolated from their families and less stigmatised by communities and were more integrated into family life so that family relationships had improved. Additionally they considered the knowledge of beneficiaries had improved and their counselling services had helped those clients who

[86] Focus Group held in Tanzania with beneficiaries who were older people being supported by Home Based Carers. 23 February 2013
[87] Same as above
[88] Focus group discussion with HBC givers, 23 February 2013

suffered from depression. A key informant interview[89] in Tanzania stated that without the HBC givers' services many orphans and vulnerable children may have ended up in orphanages or living on the streets. The HBC givers considered that some people living with HIV who were project beneficiaries had begun to be more active, taking initiatives such as starting up their own IGAs (selling cakes and vegetables, cleaning clothes and premises). Additionally they had started to organize themselves into income generating groups so they could better position themselves to be eligible for government loans (and which older people generally found harder to access).

In both Tanzania and Ethiopia HBC givers reported experiencing initial resistance from some households to let them into their homes as those looking after people living with HIV feared discrimination. HBC givers displayed persistence and patience during follow up visits in getting to know their clients. Additionally they both reported that other difficulties included being constantly asked by their clients for money, food, items and medical drugs (as their clients had high levels of poverty). Many who were poor themselves found this process hard to manage. In Tanzania the HBC givers were provided with bicycles to share and allowances to enable them to travel to visit their clients. HBC givers reported that they found it initially hard to share one bike between three of them but they adapted as time went on. During the evaluation many reported that their bikes had worn out and that in their experience the average life of a bike was 3 years. Other difficulties were that they found it hard to work as a volunteer over a long period of time and that at the end of the project given their age, they were experiencing increasing difficulty in walking long distances to visit clients. Additionally the contents of the HBC kits they received in 2010 were quickly used up and generally not replaced (although they had support from the District Home Based Coordinator for some replacements only sporadically where there were leftovers from other donations).

In Tanzania the component of the programme relating to support groups for HBC givers did not appear to take off. The project had facilitated the formation of the groups with members names listed but activities were hampered by HelpAge's difficulties with its implementing partners and particularly where their funding was stopped. Once formed support group members viewed the structures as ideal to start IGAs.

The value of the project's HBC model for older people in Tanga, Tanzania has been recognized by other donors (including national & international agencies), and who through their joint partnership and the Rapid Funding envelope have supported its replication in 5 more districts in Tanga including in Sonega, Njombe, Kibaha, Kinondoni and Arumeru. Their support has further contributed to increasing the coverage of HBC services in Tanga Region. Additionally the US agency TOLEDA supported 30 HBCs already

[89] Key informant interview with the Acting Programme Manager, HelpAge International Tanzania.

trained by the project with blood pressure measuring machines, thermometers and stethoscopes and which they accompanied with training.

Both the Tanzania and Ethiopia HBC programmes could be improved by the supply of rubber gloves for older people caring for people living with HIV and more home based care kits. Although the local district government in Tanzania has supplied some home based care kits this has been sporadic and not on a regular basis.

Additionally in Ethiopia HBC givers made suggestions that their service could be expanded beyond HIV services to include support for orphans and vulnerable children (including educational support) and the empowerment of women. The HBC givers did not specify what that support would look like in detail. However the results of the quality of care survey conducted (see section 3.4.1 below) suggest that beneficiaries prefer practical help and support that is focused on older people.

Since the introduction of ART there is an additional need for HBC services to have a stronger focus on drug adherence for HIV, accessing drugs for opportunistic infections related to HIV and further support for nutrition and setting up IGAs. Part of the duties of the HBC givers in Ethiopia was to support adherence to ART. A Health Facility in Kolfe Keranio reported that HBC givers often attend clinic with their patients to ensure they pick up their ART prescription and the clinic relies on the HBC givers to follow up on patients that have defaulted on their ART.[91] Focus group discussions in Tanzania showed that support for ART was valued by recipients of HBC services. Beneficiaries would however benefit from a stronger focus on drug adherence for HIV (and TB where relevant), infection treatment, monitoring clients checks and psychosocial care and support as there are now fewer bedridden people living with HIV since the introduction of ARTs to the area.

There were strong linkages between the project and local government. An example in the initial stages of project implementation shows that government staff identified vulnerable households in communities and HBCs followed up by supporting the older persons living there. There was a good close working relationship between the HBCs and the district HBC Coordinator (who was employed by the National Aids Control Unit, Ministry of Health), and in particular who supervised them. HBCs regularly sent their reports to the HBC Coordinator as well as to AFRIWAG.

The project benefited from engaging and linking up with key government officials at the very start of the project and with a view to promoting sustainable activities. District officials were appreciative of the project HBC coverage and confirmed they found HBC services to be appropriate as they considered older persons to be trusted carers for Orphans and vulnerable children and people living with HIV. [90]

Box 5: Linkages between project and local district government

[90] Key informant interview with Tanga District Administrator, Community Development Officer and Acting District Medical Officer. 20 February 2013.
[91] Key informant interview with Health Facility in Kolfe Keranio, 25 February 2013

In Tanzania project planning would benefit from closer planning with other agencies operating in Tanga and who are providing HBC services, such as the Red Cross, to avoid duplication (see box 5).

HelpAge International and its partners were successful in Tanzania in participating in all stages of the national process to review the national HBC curriculum and were particularly active at the national level. As a result of these advocacy activities and being the only organisation working solely on older persons issues, the government invited partners to participate in a pilot exercise for the national curriculum in Tanga Region and with a view to testing and incorporating the model for older persons for the first time. The new national curriculum is not yet published but it is likely that older persons will be included given HelpAge's involvement in the pilot. Since this curriculum was not available to us during our evaluation we cannot comment further on what could be a significant impact. HelpAge would have to follow up on this separately and an independent study on the potential impact of the national curriculum once published is worth considering.

Sustainability of the work of the HBC givers in Tanzania was considered to be dependent on the commitment and ability of the local government to support their activities, although local government had limited funding to pay salaries. The government currently supports a Home Base Care Coordinator to work at district level and with a large remit to oversee all the HBC givers in the district.

The HelpAge International Country Programme Director for Tanzania reported that a scoping study has not yet been initiated to map out how the activities will continue after the ending of the Big Lottery funding,[92] nor technical support been forthcoming for this from the HelpAge Regional Office. It is evident that the HIV Programme Manager from HelpAge Tanzania has made rigorous and continued efforts throughout his time in post to strengthen links and engage with the local district authorities in the project areas to update them on the project's prevention and HBC activities and with a view their sustainability after the end of the project. However, although the district authorities appeared to be very positive about these activities they had not made any concrete financial commitments to carry on support.

In Ethiopia the HBC programme was not considered sustainable on its own and would be merged with the government-run Health Extension Workers (HEW) programme, previously shown to have a significantly lower ration of worker to community members. This is a concern for HelpAge as the current ration of 1:15 in the HBC programme may be eroded, however it is unlikely that it can sustain the HBC programme on its own.

The Mid-Term Evaluation did not provide any recommendations for Ethiopia in relation to the HBC component, while the only relevant recommendation

[92] Key informant interview with the HelpAge International Tanzania Country Programme Director, 26 February 2013

made for the THP project was for the formal health care sector, which is outwith this evaluation to review. The table below considers recommendations from the Mid-Term for Tanzania:

Mid-Term Evaluation Recommendations	Final Evaluation Commentary
Recommendation: to explore ways of economic empowerment for both persons living with HIV and HBC givers	We have not been provided with evidence to show this has been undertaken, however key informant interviews revealed some consideration has been given to this since the Mid Term Evaluation
Recommendation: to conduct an assessment of livelihoods among primary carers, orphans and persons living with HIV.	We have not been provided with evidence to say this has been undertaken
Recommendation: the project should engage with stakeholders to harmonise the understanding of the HBC package.	HelpAge and AFRIWAG have engaged actively with the Tanzanian government, who included them in a pilot to test the HelpAge HBC model in Tanga, with a view to including it in the national HBC curriculum
Recommendation: to improve AFRIWAG's contribution to data reporting on HBC activity at district level.	There has been collaboration between AFRIWAG and the district HBC Coordinator in Korowgwe District to better coordinate reporting of the activities of HBC givers supported by the project and this has included discussions on the disaggregation of data by age.
Recommendation: to establish a supervisory structure of focal persons to supervise CHBC givers, orphans and vulnerable children, people living with HIV and older persons in general.	AFRIWAG has closely supervised and supported the HBC givers since the Mid Term Evaluation.
Recommendation: to build the capacity of AFRIWAG to enhance its HBC technical capacity	HelpAge undertook capacity building of AFRIWAG in response to difficulties with the partnership and transparency issues.

Table 6: Mid-Term Evaluation Recommendations for Tanzania

3.4.1 Quality of Care

This outcome aimed to achieve coverage of quality HBC provision of 75% over a defined beneficiary group of 10,200. However M&E data collection does not appear to be consistent across both the countries that implemented HBC provision, with Ethiopia reporting actual numbers and Tanzania only reporting a percentage, without reference to an actual number or how the percentage is derived.

The M&E Framework for South Africa suggests that 30,624 people living with HIV in the six areas of KwaZulu-Natal where the traditional health practitioners were trained have received information and care from traditional health practitioners. However this data cannot be verified as the traditional health practitioners are now withholding data claiming confidentiality. What is also unclear from the M&E Framework is whether the numbers reported annually for people living with HIV reached by traditional health practitioners are new individuals or whether they include individuals who are receiving information and care year-on-year from their traditional health practitioner.

Without being able to determine that, it is difficult to draw any conclusion from the reported figures. The clients did however verify that the quality of the consultations with traditional health practitioners had improved. HelpAge reported in its December 2012 Trip Report that it had agreed a sampling method with MUSA for measuring quality of care amongst people living with HIV who were clients of the traditional health practitioners who were trained in the project. Six questions would be asked of 30 clients (with the assumption that those 30 clients will represent 30 traditional health practitioners – 1 client per traditional health practitioners). Aggregate scores of 75% or more across the 30 clients would be interpreted as meaning that all the clients in that area were receiving quality services. This data was not provided during the evaluation.[93] While the approach is sound, the sampling size is potentially too small and should include both people living with HIV who are clients of the traditional health practitioners and clients of the traditional health practitioners who are HIV negative, as the training provided to the traditional health practitioners will benefit all their clients, not just those living with HIV.

All three projects appear to have fallen short of the target set for them, as measured on the M&E Framework:

Indicator		Target	Baseline	Progress to date
Tanzania	Percentage increase of PLHIV who receive quality HBC services	75%	N/A	25%
Ethiopia	Number of MGHs receiving HBC services from Iddirs societies	1,500	N/A	803
South Africa	Number of PLHIV that receive information and care from THPs	36,750	N/A	30,624

Table 7: Targets for increase in quality of care

In addition there is no evidence of any baseline survey or on-going monitoring on quality of care to compare against to determine whether the care provided at the end of the project was an improvement on the care provided at the beginning of the project. However in Tanzania, an assessment of HBC quality of care was carried out as a one-off exercise in year 5, although we have not received a report on this assessment. Therefore we are unable to say whether this outcome has been met.

In South Africa, clients of traditional health practitioners reported that they had seen the impact of the traditional health practitioner training during their consultations. Box 6 below highlights the key impacts witnessed. The traditional health practitioners also verified these changes separately.

Key changes reported by both the traditional health practitioners and their clients were:

1. Hygiene: traditional health practitioners washed their hands before and after each

[93] Additionally, quality of service provision was not mapped at the baseline; therefore percentages marking improvements would not be useful indicators of change.

consultation. Where cutting was prescribed, each patient either provided or was issued with their own razor blade.[94] Traditional health practitioners used disposable gloves.

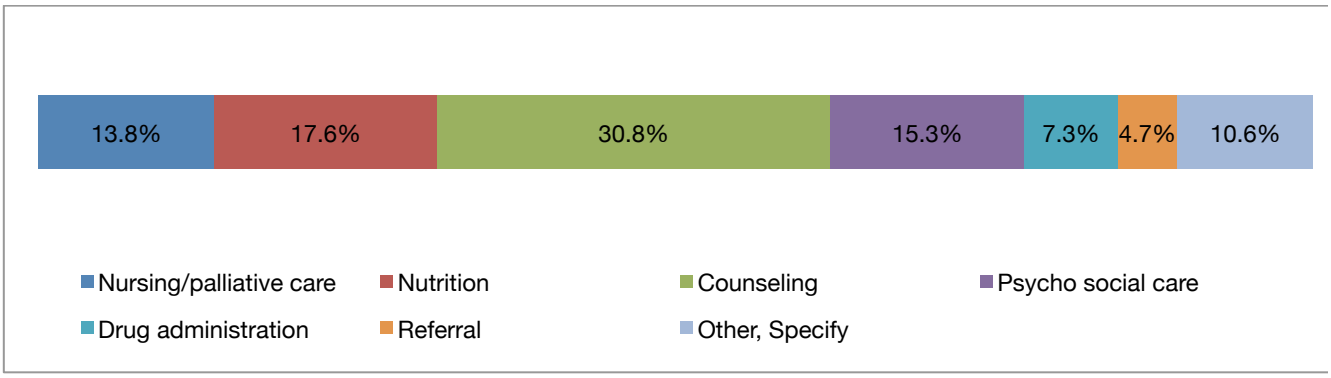
2. Dispensing 'muti': Medication was labelled using writing and different coloured tops[95] and put into plastic packaging to ensure that the packaging could not break if dropped. This was a significant improvement as clients reported regularly forgetting which medication was topical and which was to be ingested. Mistakes were common, which resulted in clients being rushed to the clinics or hospitals for treatment. Medication is also correctly measured out before being packaged with the dosages identified clearly.
3. Registration: traditional health practitioners now record who visits them, what they diagnosed and what treatment was prescribed to the client.
4. Referral: traditional health practitioners now feel able to refer clients to the local clinics and health centres. MUSA has improved the relationship between traditional health practitioners and the clinics by training the traditional health practitioners to identify when they are able to diagnose a condition and when it is more appropriate to send the client to the clinic for diagnosis and treatment. The Clients of traditional health practitioners reported that they are also required to get a letter from the clinic detailing the diagnosis and any prescribed medication for their traditional health practitioner to see. Previously traditional health practitioners may have referred their clients to another traditional health practitioner if necessary, but never to a mainstream clinic or health centre. While traditional health practitioners are now prepared to make this referral, they never get referrals made to them from the clinics. Additionally traditional health practitioners are not able to follow up with their clients who may be hospitalized for treatment.
5. People living with HIV: previously it would have been rare for traditional health practitioners to treat someone with HIV or to admit that they themselves were HIV positive. Now traditional health practitioners can provide some support to people living with HIV. Traditional health practitioners' clients are aware already of the potential difficulties in taking traditional remedies alongside their ARTs. MUSA's training however appears to have addressed this, with clients reporting that traditional health practitioners will not prescribe medication that could impact on the ART their clients are receiving.
6. HIV Knowledge: Clients reported that traditional health practitioners do talk to them about HIV, how to prevent it and how to manage it, especially the importance of nutrition in living with HIV.[96]

Box 6: Impact of training provided to traditional health practitioners

In Ethiopia and Tanzania we asked three survey questions on quality of care to gauge what beneficiaries experienced.

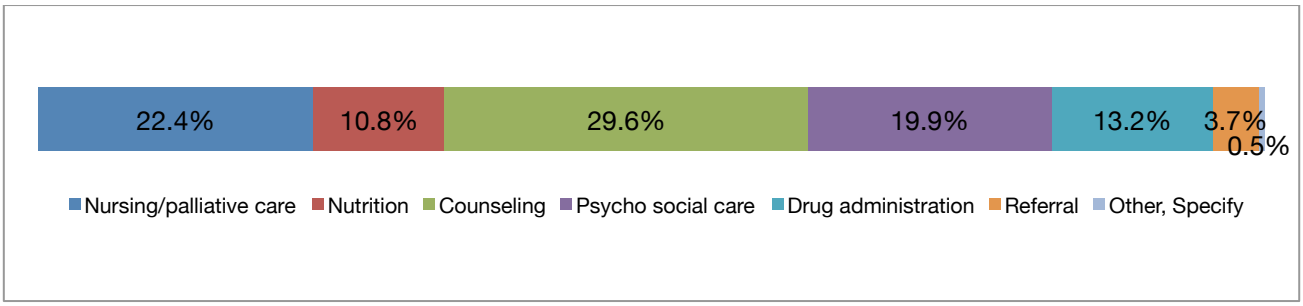
In Ethiopia the endline survey undertaken during the evaluation showed that most respondents reported they had received counselling support followed by nutrition and psychosocial care. Few reported that referrals were made however it is known that referrals are made as HBC givers work with the local health facilities following up on lapsed adherence to treatment.

[94] Sometimes whole families were prescribed cutting and in such a case, each family member had their own blade.
[95] For illiterate clients
[96] Focus Group Discussion with older people and persons living with HIV who are clients of traditional health practitioners, 2 March 2013; Focus group discussion with traditional health practitioners, 4 March 2013



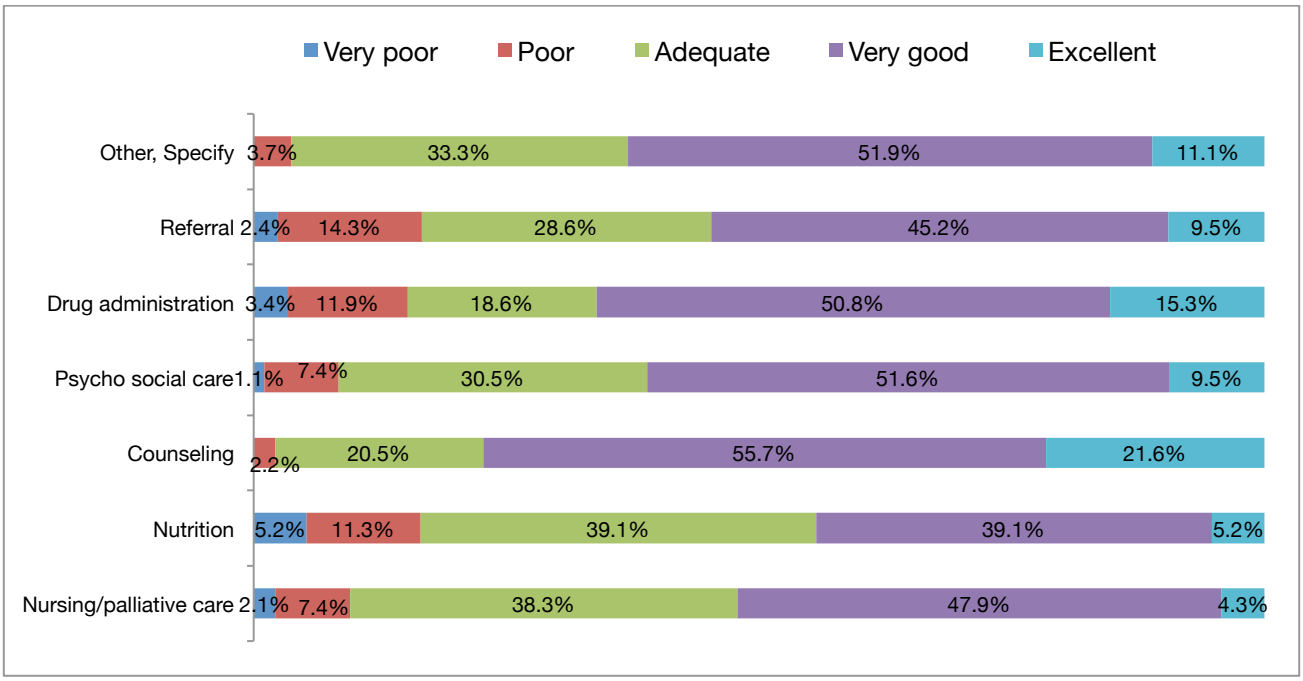
Graph 41: Ethiopia KAP Survey Result: "What services did s/he provide? "

In Tanzania the endline survey showed that of those who had received a visit to their household by an HBC giver the majority of services provided were counselling, nursing/palliative care and psychosocial care. They considered that fewer services for nutrition and drug administration were provided. HBC givers were reported to have made few referrals.



Graph 42: Tanzania KAP Survey Result: "What services did s/he provide? "

In Ethiopia respondents rated the HBC services they had received as either adequate or very good. Counselling services received the highest ratings, which were mostly perceived to be excellent and very good. Respondents reported referrals as the least accessed service.



Graph 43: Ethiopia KAP Survey Result: "How would you rate the quality of the service? "

In Tanzania the majority of recipients found the quality of services they received to be very good or excellent and in particular drug administration, psychosocial care, counselling and palliative care were the most appreciated. It appeared as if nutrition services were the least appreciated. In the Focus Group Discussion with older carers who had been supported by HBC givers conducted in Tanzania, older carers considered that the lack of good food for people living with HIV in their households was a big problem.

One participant reported that 'Food is getting to be the biggest problem as people living with HIV need to eat good quality food.' She could not afford to cook a separate, different meal for the person with HIV and continue to meet the food requirements of her family. She knows she should provide a variety of food to the person living with HIV, such as bananas, but she has only beans. She knows that patients need to eat five times a day but she can hardly afford to feed her family twice a day[97].

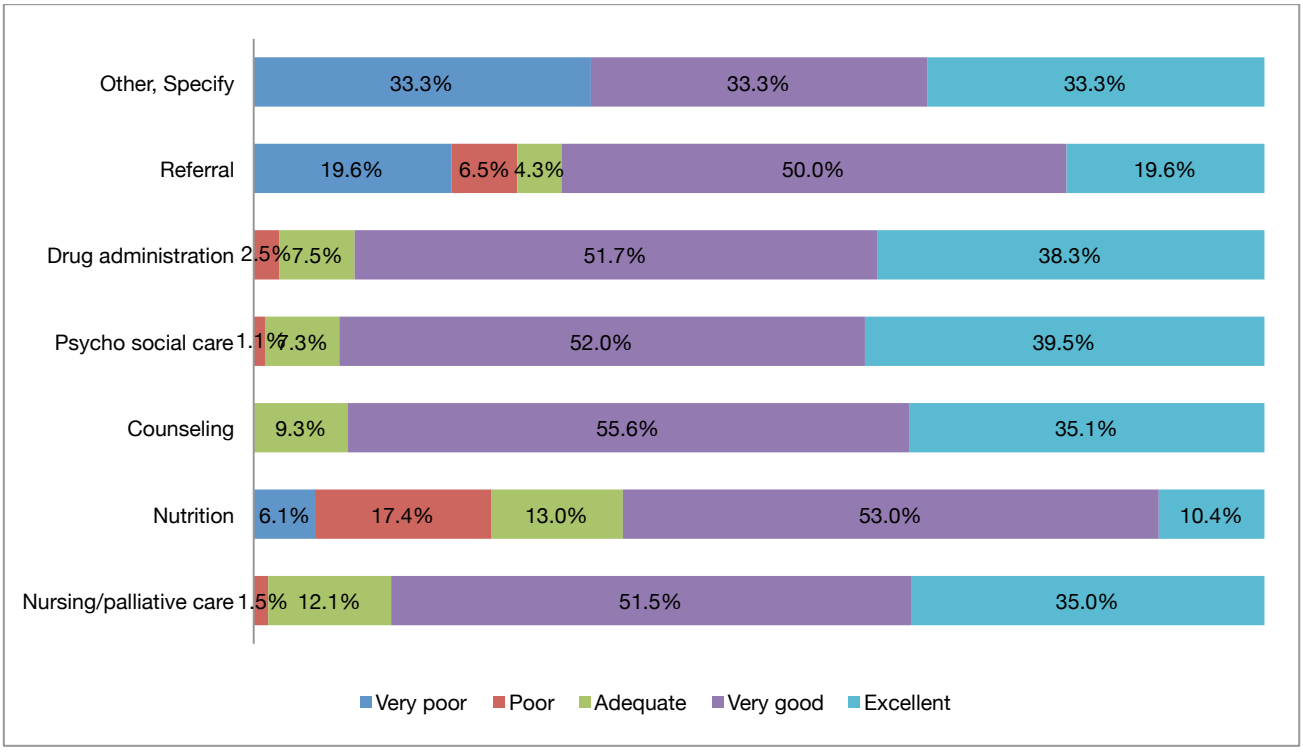
In a Social Return on Investment evaluation conducted for the International HIV/AIDS Alliance in Zambia it was demonstrated that the effect of keeping families together by keeping people living with HIV within the family group has the unintended effect of increasing poverty in the household in the short term. In that evaluation it was demonstrated that households can take up to six years to recover from the unintended poverty produced by having to provide better nutrition to people living with HIV.[98]

Box 7: Feedback on Nutrition from Focus Group Discussion with Older Carers Supported by HBC Givers

[97] Focus Group Discussion with older carers who are being supported by HBC givers, 21 February 2013

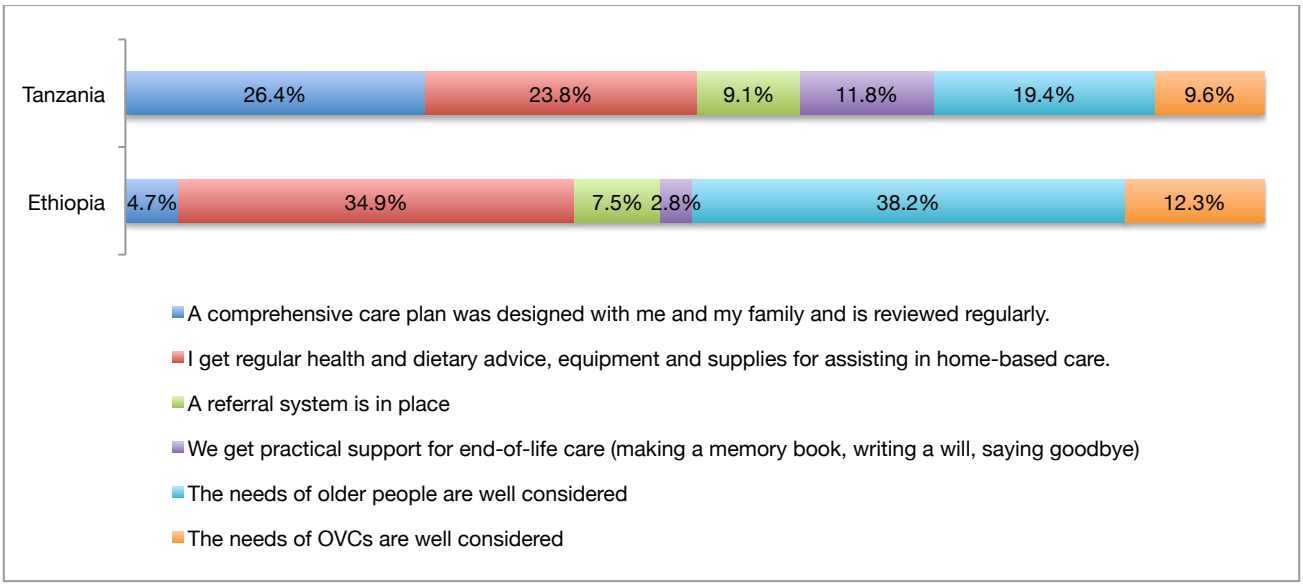
[98] Brady, R, 2011, The True Cost of Stigma, Evaluating the Social Return on Investment of the stigma and discrimination component of the Alliance's Africa Regional Programme II, International HIV/AIDS Alliance, Brighton

Although patients require a variety of food they are often compelled to eat a reduced diet because the household cannot afford the variety. Participants also reported that the ART drugs were too powerful and food was not sufficient. They cited an incident where someone died recently because of this. The carers reported that they need more money for food. Some HBC givers supply older carers with milk, fruit, soap – but the older carers reported that they still needed more food from HBC givers.



Graph 44: Tanzania KAP Survey Result: "How would you rate the quality of the service? "

Finally respondents were asked what quality of care meant to them:



Graph 45: KAP Survey Result: "What does quality of care mean to you?"

Each country demonstrated different priorities for care, with Ethiopian priorities being weighted towards practical support for older people, while the Tanzanian response would suggest a broader requirement for most types of care offered.

3.4.2 Summary

The quality of home-based care and services provided to beneficiaries has definitely increased and has been verified by the beneficiaries, although we are unable to say whether the outcome of 75% of 10,200 PHIV experiencing increased quality of care has been met, as there is no evidence to support how this figure was determined and one indicator alone (South Africa) has a target is excess of 10,200. HBC services face sustainability challenges, which could impact heavily on their effectiveness. Whereas the training of traditional health practitioners in South Africa is evidently important, its relevance may be of broader significance that an HIV programme focused on the needs of older people. The introduction of ART has had an impact on the kind of support households need. In some instances in Ethiopia there is evidence that ART support has been incorporated into the role of HBC givers, and in Tanzania HBC givers were found to be advising beneficiaries on taking ARTs.

3.5 Outcome 4 – 50% of MGHs affected by HIV in the portfolio have improved coping mechanisms to mitigate its impact by the end of the portfolio

Activities that contributed towards outcome 4 focused on providing beneficiaries with knowledge, skills and opportunity to increase their own economic security and sense of identity. The interventions included legal support for land claims, will-writing and memory books, formalized training, business skills training and loans for small-scale income generation. Success has been varied and the income generation activities have presented the greatest challenge to the implementing partners, HelpAge and its beneficiaries; but have also provided the greatest successes. This outcome is supported by projects 4, 5 and 7 in Kenya, Uganda and Ethiopia respectively. While will-writing and memory books are interventions that are well utilized in Africa, and paralegal activity is recorded in other countries, neither had been implemented with older people in Kasese in the way that HelpAge designed. Equally, IGAs are not unknown to HelpAge, who implements over 19,000 such activities globally, however the experiences of implementing IGAs in Ethiopia and Kenya provided new platforms for learning both successful and challenging lessons.

Project 5 in Uganda has been implemented by paralegals together with memory book and will writers with the aim of supporting multigenerational households through protecting the inheritance rights of orphans and vulnerable children in Kasese District. It is the first project of its kind in the district.

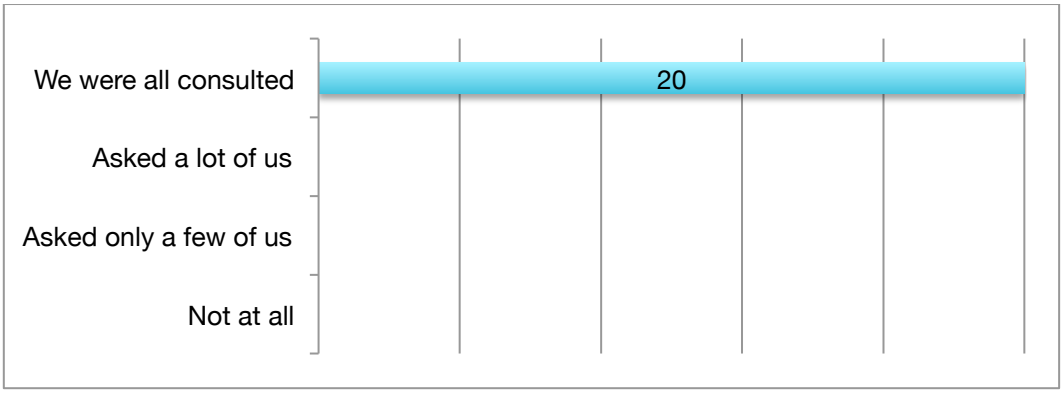
Paralegals were supported to work with multigenerational households to resolve civil cases at community level, especially supporting orphans and vulnerable children to claim their inheritance (mainly land and houses) that had been taken from them at the time of their parents' death.

The choice of Kasese District in Uganda was very relevant for projects 3 and 5 to be implemented given its high HIV prevalence compared to other districts and the presence of many orphans and vulnerable children, whose inheritance rights were under threat whilst being cared for by older people.

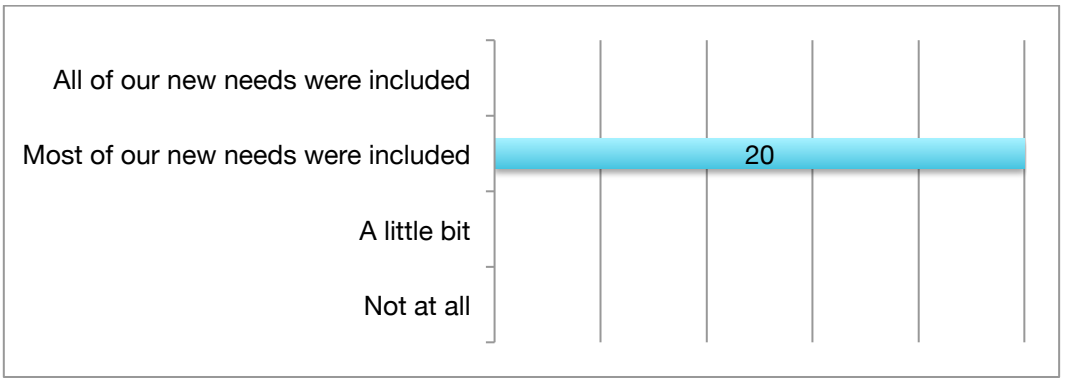
Project 5 was very relevant for Kasese District as it aimed to protect the inheritance rights of orphans and vulnerable children by implementing support through a trained network of paralegals. Trained memory book and will writers also aimed to support households and orphans and vulnerable children to trace their parentage, and helped them in their entitlement to inheritance rights and by writing wills secure their future inheritance. The ownership of land in Kesese District was perceived to be in increasingly short supply and there was a mobile border population between Uganda and neighbouring Democratic Republic of Congo.

The implementing partner CAFO in Kasese District had relevant previous work experience with its focus on older people issues.

A PRA exercise was undertaken as part of the evaluation (see Appendix 6.9) and beneficiaries reported that they had been fully consulted by CAFO on the nature of their problems before this project started and that most of their new needs during the project life had been included. They explained however, that there was still a real need for more paralegals in their neighbouring areas in order to cover all the villages in the sub counties.



Graph 46: Responses to question 1 in the PRA exercise with older people who participated in project 5



Graph 47: Responses to question 2 in the PRA exercise with older people who participated in project 5

URAA felt also that they were fully involved in the development of the Big Lottery Fund proposal, which they considered to be an open process involving all partners. They undertook a needs assessment in the form of a mini baseline survey and attended a planning meeting in EWCARDC at the start of the programme.[99]

Gender is a key factor, as girls are not allowed to inherit land or property from their parents or grandparents. A household consisting only of orphans and vulnerable children girls would on the death of their grandparents be obliged to leave the family home which could then be grabbed by another branch of their family leaving them impoverished. This same principle does not apply to sons in the family. Many older people and their orphans and vulnerable children are unable to defend themselves and prevent their land being grabbed. Cases taken to court to claim land back may be held up in the court system for a long time.

The Inspector of Police (Community Liaisons Office) from Kasese State Police estimated[100] that from 2010 to 2012 there were around 30% fewer civil cases in Kasese District as a direct result of the paralegal work done in the community. He perceived their role as 'half way lawyers' tackling civil cases, mediating in local disputes and counselling of community members. He appreciated their work, which he considered to have made a contribution to the decreasing crime trend in the district since 2008, and to improving the welfare of older people who are particularly vulnerable to crime and abuse. Prior to 2008 the police had been concerned about the protection of older people but he considered that due to project activities fewer were being physically hurt and abused. He noted an increase in the number of orphans and vulnerable children benefiting from claiming their inheritance rights. The police in Kasese District have allowed and been supportive of the work of the paralegals but there is a clear understanding that criminal cases remain the responsibility of the police. The effect of the paralegal's activities has been to free up police time and money enabling them to plan other important activities.

Box 8: Inspector of Police (Communities) Supports the Paralegal component

The work of the paralegals has very effectively implemented Project 5 in the project areas in Kasese District. They have formed an active and effective network helping older people to resolve civil cases at community level.

[99] Key informant interview - Head of Programmes, URAA, Kampala. 27 February
[100] Key informant interview with Inspector of Police (Community Liaisons Officer), Kasese Police, Kasese District. 6 March

Key informants, such as the Inspector of Police (Communities) highlighted in Box 8, interviewed during our evaluation suggested that a significant benefit of the work of the Paralegals had been an improved economic situation for older people due to feeling more secure. Importantly older people reported that they were less fearful of going to court as a result of the Paralegals' work and that they trusted the police sufficiently to consider them their first port of call for resolving disputes.[102] The evaluation showed that they have a have a clear mandate to work and have strong support from the local district authorities, members of the legal profession including the District Magistrate and the police (see box 9)

The District Magistrate in Kasese[101] reported being very supportive of the project and mentioned its relevance as in 2008 it coincided with an attempt by the district to set up a similar programme. The Magistrate also reported that as a result of the paralegals work his case-load had been significantly reduced by an estimated 50% during 2012. His average case-load of 100 cases has been reduced to 50 as a result of project activities.

Additionally he considered that the paralegals have contributed to reducing the large backlog of civil cases in the district. The resolution of cases at community level has meant that they do not reach an overcrowded court and has freed up the Magistrate's time and give existing cases more attention. Such is the Magistrate's confidence in the ability of the paralegals that he actively refers some of his cases back to them to resolve at community level and encourage people to settle cases before they come to court. The Magistrate said that he 'appreciated all the tremendous work done by the project'.

Box 9: District Magistrate in Kasese

CAFO and URAA[103] have since the inception of the project actively engaged a wide range of stakeholders including the District Magistrate, State District Attorney, police, District Administration, Local Councils, and departments such as community development including their probation department. Other organisations that have participated in the project through training and technical support included the Foundation for Human Rights Initiative, Christian Lawyers Fraternity. This active engagement by CAFO and URAA with stakeholders at the start of the project has paid off, as much buy-in to the project has been achieved.

Many of these stakeholders have participated in workshops for the paralegals, given additional talks and taken on a mentoring role. There is an increasing recognition that the work of the paralegals has made a real contribution to the district. The Vice Chairman of Kasese District said 'the extent of justice to older people has been felt'.

The Mid-Term Evaluation recommended that the Paralegals "form groups and exploit existing opportunities in the community to create awareness on orphans and vulnerable children inheritance issues." The model of support groups has been effective. Paralegals have formed support groups both for themselves to discuss their own work and for other older people as a forum

[101] Key informant interview with Kasese District Magistrate (Grade 1). 5 March.
[102] Focus group discussion with beneficiaries of paralegal activities, Karambi sub county, Kasese District, 4 March
[103] Key informant interview with URAA Programme Manager, Kesese District. 6 March

for disseminating information on legal matters.

The Paralegals focused on resolution, where cases came up and where beneficiaries approached paralegals for help with specific issues. The Paralegals were actively and constantly disseminating information on inheritance issues among their meetings with beneficiaries as well as disseminating to the Peer Educators (who wanted to learn more). Community trust in paralegals was also evident as they were increasingly being called on to settle domestic disputes.

As part of Project 5 people living with HIV were trained in memory book and will writing activities. A focus group discussion[104] held during the evaluation revealed positive impacts from these activities. Memory book writing helped older people to support orphans and vulnerable children to identify and trace their unknown relatives (and lost fathers in particular) and also their clan. In some instances this helped orphans and vulnerable children to realise their inheritance rights, which in some cases resulted in an economic benefit. The process of memory book and will writing involved the whole family unit cooperating together, which reportedly helped to improve the peace of mind of older people and people living with HIV who were beneficiaries. This helped to lesson people's internal stigma and release some of the negative emotions felt of their past history. The fact that the memory book trainers were themselves living with HIV facilitated open discussions with beneficiaries.

During the evaluation there were instances reported of single mothers who had either died of AIDS-related illnesses or gone to live in a city and left their children in the care of their grandparents. This project effectively supported those orphans and vulnerable children to locate their clan, which was integral and central to their identity and peace of mind.

One beneficiary who acquired a will and was present at the focus group[1] considered that her family 'was protected as her children did not have to fight against those grabbing the property'. Another stated that the will writing activities for older people helped prepare the whole family for their death leaving her feeling relaxed and having peace of mind that her children would be protected when she died.

Box 10: Beneficiary reports on Will writing effectiveness

Community members reportedly benefited from having wills and the accompanying peace of mind that their legal affairs were in order. Additionally there was a reduction in disputes in court over land, reduction in property grabbing belonging to orphans and vulnerable children and a decrease in the violence and visible fighting that sometimes accompanied land disputes and property grabbing. Memory book trainers' support for will writing had a reported knock on effect in the reduction of cases arriving at Local Government 1 level.

Beneficiaries also reported that as a result of the project communities now had the confidence to feel that inheritance was one of their rights and prior to

[104] Focus group discussion with trainers on memory books & wills, Munkunyu sub country, Kasese District, 5 March

that the community's attitude was that 'if you are poor you don't win the case but if you are rich you win the case'. Such was the popularity of the memory books they have been called 'The Guiding Book for OVCs' in Kasese District. Mention was made that before the project orphans and vulnerable children were 'double orphans' who had lost both parents and land.

Memory books also reportedly helped reduce the stigma of orphans and vulnerable children whose parents had died of AIDS-related illnesses (and who also might potentially be living with HIV).

According to the data provided in Table 8 below, Project 5 activity has secured the future for at least 2,799 households in the area. The sensitization of households on legal issues is important as a mechanism for ensuring that household inhabitants know their rights and feel confident enough to exercise them.

There have been a total of 492 memory books and 318 wills produced. Table 8 below shows the numbers of legal cases solved (and referred on) by paralegals in the community as well as the memory books and wills produced. Although checked with the project team in Uganda, this table represents our best estimate of Project 5 activity that has taken place in Uganda during the portfolio period and the data included originates both from the BLF Annual Reports, URAA and the HelpAge Uganda Country Office.

The original BLF project M&E Framework had initially planned that the reporting of both memory books and wills would lumped together and this is evident in the reporting for Years 1 and 2. However, this was later revised to make the reporting of memory books and wills separate.

The total of memory books and wills reported in the BLF M&E Framework does not tally with the figures in the table. This together with an inconsistent reporting terminology makes it hard to compare data over the project years e.g. in Year 4 it is not clear if cases taken on were resolved. There were no case details available for the resolved orphans and vulnerable children's inheritance cases.

BLF Annual Reports	**Cases received or solved in community by paralegals**	**Cases referred to court**	**Memory books & wills produced**
Year 1	-	-	56 memory books or wills
Year 2	- 481 cases resolved - 504 OVCs have had their property & other inheritance rights addressed - A total of 377 households sensitised on OVC inheritance	51 cases successfully concluded in favour of OPs and OVCs under their care	168 memory books or wills

	rights, OPs rights and will writing and other legal issues.		
Year 3	- Received a total of 1,212 cases - 1,098 cases resolved at community level Cases included 357 land cases, 179 OVC inheritance rights violations, 512 domestic violence cases and 164 other property inheritance issues. - 2,649 members of MGHs sensitised	- 78 cases successfully resolved in favour of OPs and OVCs under their care - 36 cases still being followed up	- 86 memory books written[105] - Groups of (average of 40 members) have been sensitised on memory books and will making.
Year 4	1,626 cases taken on by paralegals from MGHs. (25% were land cases, 27% other property issues, 20% OVC rights violation issues and 28% domestic violence related conflicts)	87 cases referred[106]	167 memory books written[107] 110 wills made[108] - Of those people trained in memory book writing 97% have written memory books and 64% have written wills.
Year 5 (Q1)	- 233 cases resolved by paralegals - Paralegals undertaken 162 sensitisation sessions reaching 265 households (including for 84 land issues, 51 child rights violations, 172 other property issues)	32 cases referred and resolved in court.	100 Memory books written[109]
Year 5 (Q2)	- Paralegals received 62 land cases, 79 family social understandings, 44 child rights violation cases and 76 family property issues. - Paralegals sensitised 376 family groups on legal issues	15 cases referred and resolved to court	*It was reported that from 2008 to 2013 the project had supported the total production of 492 memory books and 318 wills.*[110]

Table 8: Project 5: Legal cases undertaken by paralegals and memory book & wills produced from 2008 – 2013

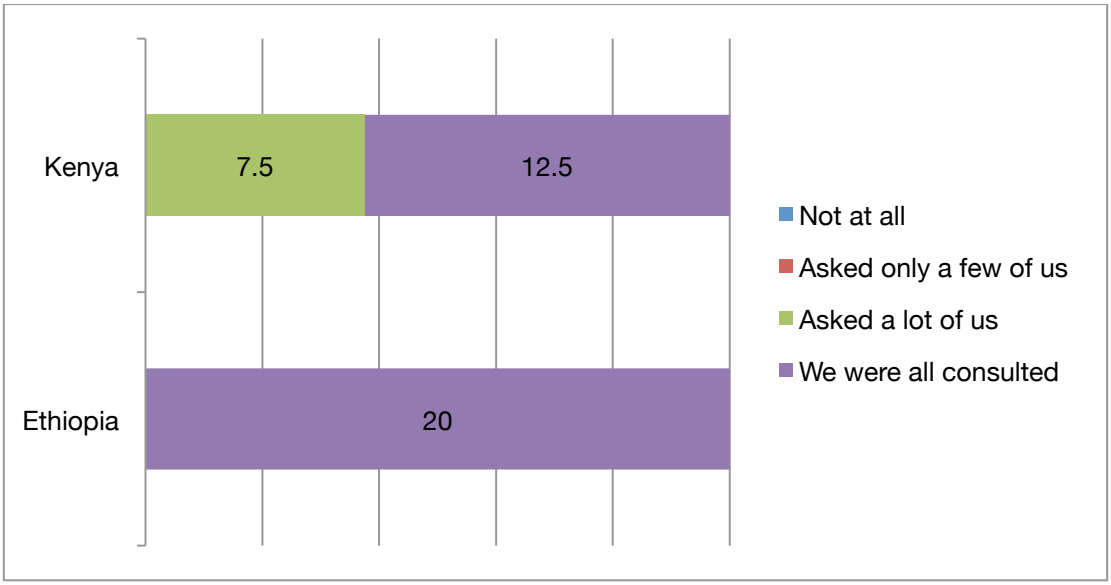
The Mid-Term Evaluation also recommended that there was a "need to establish a framework for continuous, or regular provision of supervisory

[105] URAA feedback, provided 6 May 2013
[106] Ibid
[107] Ibid
[108] Ibid
[109] URAA feedback, provided 6 May 2013
[110] M&E Framework, updated Nov 2012; URAA feedback, provided 6 May 2013

technical support." We are not provided with such a framework for monitory supervisory technical support. However we understand that there was an active programme of key legal speakers being asked to come to Paralegal meetings/forums and give talks to support and improve their technical legal knowledge. URAA were actively promoting this engagement between Paralegals and the legal system in Kasese.

In Ethiopia and Kenya, IGA activities were implemented. In Ethiopia the IGA loans programme was part of a larger project to strengthen the Iddirs; while in Kenya the focus was on the economic empowerment of orphans and vulnerable children in multigenerational households. These two projects provide us with contrasting views of project management and success. In Ethiopia beneficiaries reported genuine poverty reduction and significant increased asset ownership, whilst in Kenya the difficulties encountered in the first two and a half years, delayed and reduced the success that the project could have had during the lifetime of the portfolio. As a result the Kenyan IGA component has not had the same impact economically as the Ethiopian IGA component had for the Ethiopian beneficiaries.[111]

However economic performance is not the whole story in these two contrasting projects. This outcome is about improving coping mechanisms and the participants in the PRA exercises provided some useful insights.

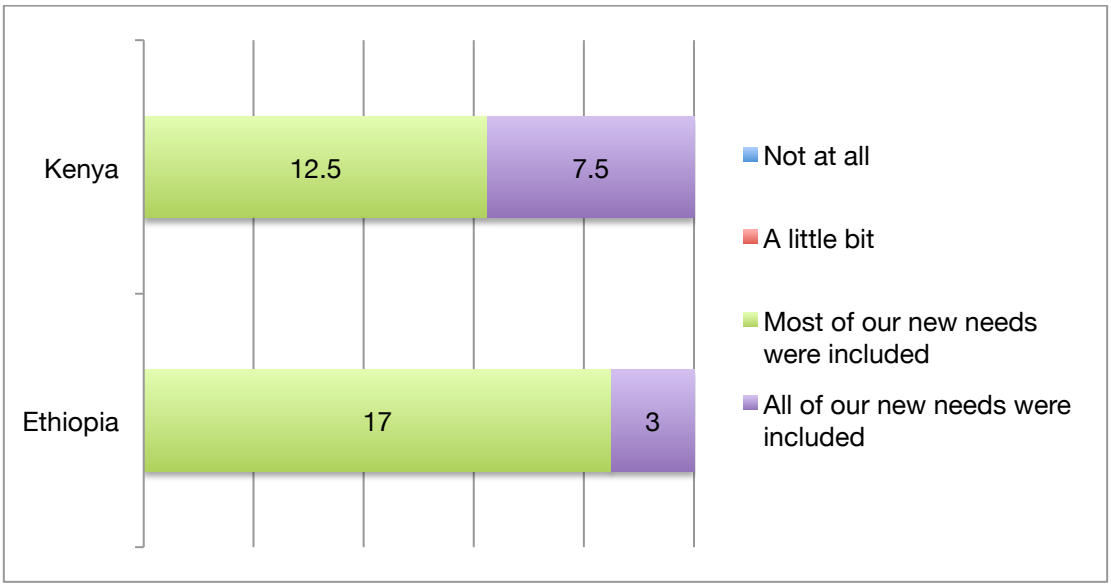


Graph 48: Responses to questions 1 & 2 in the PRA exercise with older people and OVCs who participated in project 4 & 7

Both projects were relevant to their communities. In Ethiopia, beneficiaries reported during the PRA exercise that they had been fully consulted on the

[111] Brady, R. 2013, Final Evaluation of HelpAge International's Portfolio: Preventing HIV and AIDS and alleviating its Impact in Multigenerational Households, Country Visit to Ethiopia, HelpAge International, London; Brady, R. Khan, M, 2013, Final Evaluation of HelpAge International's Portfolio: Preventing HIV and AIDS and alleviating its Impact in Multigenerational Households, Country Visit to Kenya, HelpAge International, London

proposed project and had helped to write the proposal that was eventually submitted as part of HelpAge's bid to BLF.[112] While in Kenya, beneficiaries reported that they felt IAP and CCS consulted them before the project was implemented.

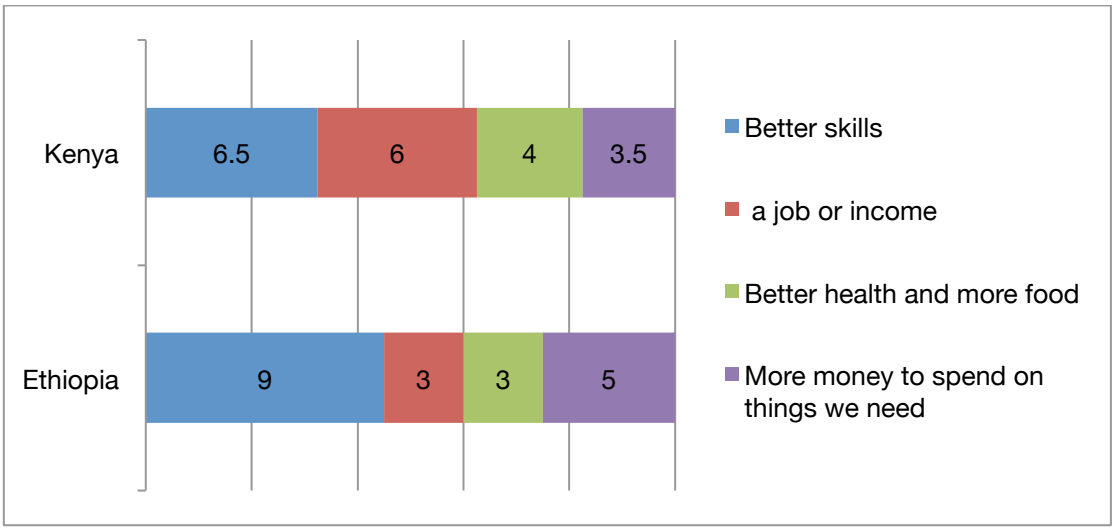


Graph 49: Responses to questions 2 in the PRA exercise with Older People and OVCs who participated in project 4 & 7

However, beneficiaries in Kenya did not feel that IAP and CCS had been entirely mindful of their needs throughout the life of the project. The reason given was that some beneficiaries had chosen cows for their IGAs that had subsequently died and had then requested that project staff cancel their loan, as they were unable to make any profit. However, they felt staff had not taken their request into consideration. Beneficiaries however reported the great assistance project staff had given them when their cows fell sick. The orphans and vulnerable children in Kenya had viewed themselves as the main beneficiaries of the project (whose aim was stated as their economic empowerment) and felt that as a result they had been reasonably well consulted on the project and that IAP and CCS had been flexible in accommodating their changing needs.[113] This was also confirmed by the orphans and vulnerable children during the focus group discussion with them where one participant suggested that the implementing partners had been "like parents" to him and had supported him through his studies with not only the course fees but additional living costs too.[114]

[112] PRA exercise with IGA recipients and Community Conversation participants, 23 February 2013
[113] PRA exercise with orphans and vulnerable children who participated in Project 4, 16 February 2013.
[114] Focus group discussion with orphans and vulnerable children who participated in Project 4, 16 February 2013

Overall the beneficiaries felt included in the project consultation process and reported that the implementing partners had been flexible and responsive during the project.



Graph 50: PRA responses to the question "What has the project helped you to achieve?" in Ethiopia and Kenya[115]

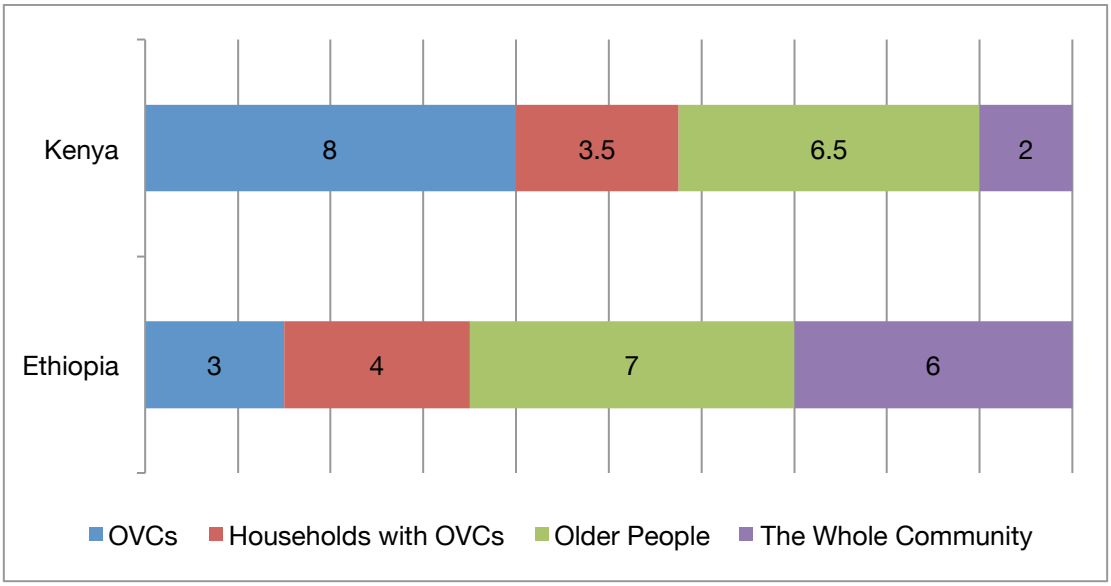
While improved skills was considered an important achievement in both countries, the Ethiopians felt that they also had more money to spend on the things that they needed, which the Kenyans ranked as the lowest achievement. Improved skills were seen as something that you could take with you and would be with you forever. The Stage 2 application describes the project 4 objective for orphans and vulnerable children as being to provide life-skills training and business start up capital with the intention that orphans and vulnerable children could "initiate their own IGAs or to gain paid employment."[116] The orphans and vulnerable children that had been trained at the polytechnic reported in the focus group discussion that they did not have jobs as a result of their training (see box 11 below). In other words learning better skills had not yet translated into increased security.

During the focus group discussion with the orphans and vulnerable children who had received training at the Polytechnic, the group reported that it was important to them to train and receive a certificate from the Polytechnic that verified they had the skills as this was seen as ticket to getting a job. However none in the group that had graduated from the Polytechnic reported finding paid employment that related to their training. One participant was working as an intern (paid stipend only) for a government ministry, while his class mate did farming, casual work and looked for work on construction sites to make money while trying to save enough money to start his own car mechanic business.[117] None of the orphans and vulnerable children regretted attending the Polytechnic despite not having a job, but they did report that the benefits were limited, as a lot of money had been spent on courses and materials without the end result being a job.[118] The participants recommended

[115] The results shown here for Kenya are aggregated from the two PRAs that were undertaken there. As highlighted elsewhere
[116] HAI Stage 2 Strategic Application
[117] Focus group discussion with orphans and vulnerable children, 16 February 2013
[118] Ibid

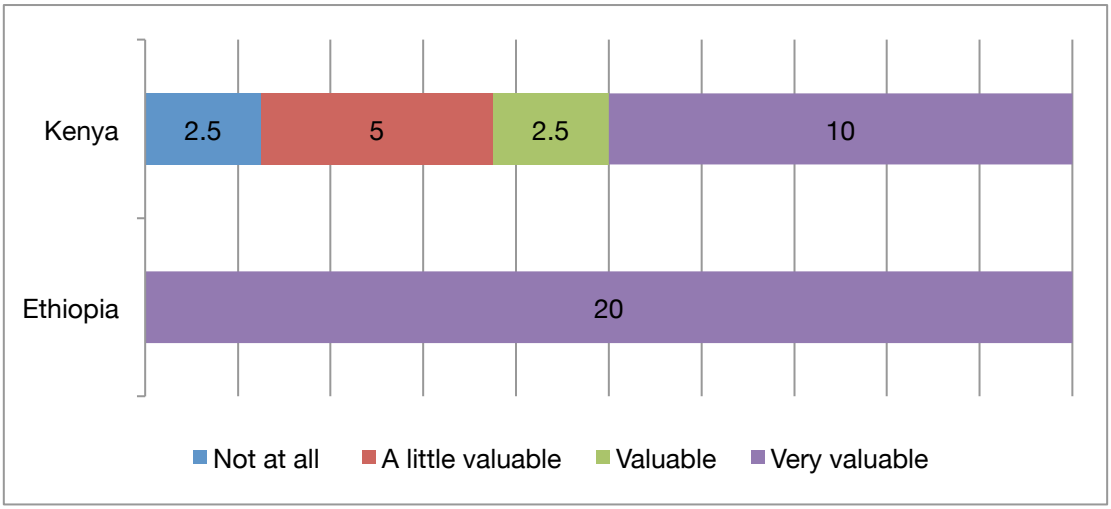
that the vocational training at the Polytechnic should be linked with businesses where they can get hands-on work experience and make links with businesses that might employ them after they had finished their studies. Additionally they suggested that financial support was provided to allow them to start their own businesses.

Box 11: Feedback on training received at the Polytechnic from the focus group discussion with OVCs in Kenya



Graph 51: PRA responses to the question "Who has benefitted from the project?"

When considering where most benefit had been received the Ethiopians felt that older people had received most of the benefit, whilst Kenyans felt that despite not having found jobs or permanent employment, the orphans and vulnerable children that had been trained had received the most benefit. The Ethiopians also felt that the community as a whole had benefitted, which might be partly due to the fact that the IGA loans scheme was only part of a broader scheme that included HBC givers, leadership training for Iddir leaders, etc.



Graph 52: PRA responses to the question "How valuable was the project for older people?"

The starkest contrast between the two groups of beneficiaries may be seen in their consideration of how valuable the projects had been for older people (see the graph above). Due in part to the difficulties in project 4, the Kenyans felt that some of the older people had not had any value out of the project, whilst the Ethiopians considered that the project was very valuable to older people, especially as it had reduced poverty for older people, which they could verify.

The IGA project in Ethiopia appears to have been the most successful element of the country-specific projects across the portfolio. Our evaluation did not have sufficient time and budget to allow for a full impact evaluation of the Ethiopian IGA project. It could be useful for HelpAge to undertake a separate impact evaluation of the IGA activities in Ethiopia to fully understand the success at alleviating poverty and encouraging resilience amongst older people and their communities.

The success of the Ethiopian IGA activities appears to be a combination of good training for candidates for loans, excellent follow up of loan recipients on an on-going basis, pre-existing structures (Iddirs) to manage the loan facilities, a pre-existing tradition of 100% repayment amongst the community and micro-financing skills within Tesfa's staff.[119]

In a focus group discussion the recipients of the loans described how their selection for training on IGAs was dependent on whether they had previously demonstrated an ability to work and repay the loan, some previous work experience, the seriousness of their family problem, that they were members of an Iddir that was a member of Tesfa and in Burayou, the Peer Educators were selected initially to undergo IGA training.[120]

Between year 1 and year 5[121] of the programme 465 business loans were issued totalling ETB1,058,000 (GB£37,933.05); of this ETB945,000 (GB£33,881.60) is capital from the BLF grant and ETB113,000 (GB£4,051.45) is capitalized interest earned on the loans issued over the lifetime of the project.

Over the five-year period, renovating homes for rental income and making Injera for sale proved to be the most popular businesses to invest in. In an expanding city such as Addis Ababa, this focus on providing the basics for people moving to the city ensures a degree of predictability in future income, allowing individuals to better plan their expenditure. What is also noticeable about the types of businesses that were started is the focus on the retail sector, which makes up the bulk of the businesses. However of significance is the number of businesses that are about adding value to a product. In his

[119] Admittedly there was high turnover of project staff in the first two years, but this had settled down by year 3 and does not appear to have affected either loan issue or loan repayment.
[120] Focus group discussion with IGA/Loan beneficiaries, 25 February 2013
[121] To February 2013, the date of the country visit

book *'How Rich Countries Got Rich and why Poor Countries stay Poor'* Eric Reinert outlines the importance of adding value to a product as an important contributing factor to creating lasting wealth in an economy.[122] What we can observe about the businesses from this perspective is that a significant number are engaged in adding value either to raw materials by processing them (butter, cheese, Injera, Alcohol, timber, etc.) or by enhancing existing products (mending old clothing, tap water re-selling, scrap metal, restaurants, small-scale shops). Although these businesses are subject to the vagaries of economic cycles like anywhere else, the value generated by these businesses is greater in net terms because the businesses have set about adding value to products or materials, rather than simply selling on the raw material in its natural state to others. An indicator of this value generation is whether asset ownership has increased or not; and during the focus group discussion and the PRA exercise, beneficiaries highlighted that they had been able to increase their asset ownership and improve their overall quality of life.[123]

Other aspects of project 7 in Ethiopia that have contributed to establishing coping mechanisms in the community have been the HBC givers component and the training for Iddir leaders. Key informants and the focus groups considered that training for Iddirs had been the most important aspect of the project as it formed the basis for all other components. A total of 600 Iddir leaders from 60 Iddirs were trained. With each Iddir having between 50 and 500 households as members, we can estimate that an average of at least 16,500 households may have benefitted from their Iddir leaders having improved skills. However the data reported in the M&E Framework updated at November 2012 does not support this hypothesis.

The table below is an extract from the M&E Framework updated at November 2012, which suggests that 1,250 households have directly received HBC services and loans for small businesses (Indicator 7.4 and 7.5 are measuring the same households), while 67,480 individuals have participated in community conversations (average 40 participants per session). We do not know whether every individual who participated in a community conversation was from a different household. If that were true, the reach of the community conversations would only serve to underline the view of the stakeholders that it is a successful mechanism that should be retained in the future.

[122] Reinert 2007, How Rich Countries got Rich and why Poor Countries stay Poor, Constable, London

[123] Focus group discussion with IGA/Loan beneficiaries, 25 February 2013; PRA exercise with IGA recipients and Community Conversation participants, 23 February 2013

Indicator		Target	Baseline	Progress to date
7.1	Number of Iddirs/CBO/Youth clubs members trained in HIV prevention and HBC	600 Iddirs leaders 400 members from 25 CBOs 300 youth from 10 youth groups Overall target is 1300	0	600 IL 447 CBO members 300 youth from 10 youth groups Overall =1347
7.2	Number of community conversations on HIV prevention facilitated	1,200	0	1,687
7.3	Number of MGHs receiving HBC services from Iddirs societies	1,500	0	803
7.4	Number of MGHs receiving loans to start up small businesses	466	0	447
7.5	Number of MGH IGA set up and running by the end of the project	466	0	447

Table 9: Indicators for Project 7 from the M&E Framework as at November 2012

Iddir leaders were involved in cascading training to other trainers and identifying members to be trained for Peer Education, HBC, Community Conversations and to receive IGA loans and training. Importantly, Iddir leaders also received training relevant to running their Iddirs.

For the Iddir leaders and the Federal HAPCO, the significant outcome from this project has been the leadership training and the change in Iddirs to engage in more social welfare activities.[124] Strengthening the Iddirs with this type of training was a core aspect of the work in Ethiopia as it formed the basis for the advocacy groups, the selection of Peer Educators, Community Conversation Facilitators, Home-based Care givers and recipients of IGA loans. The success of projects 1, 3 and 7 relied on the training provided to Iddir leaders being successful. In that sense the most important added value of the BLF funding has been the significant change that has been brought about within the Iddirs as a result of the training provided under project 7.

Alula Pankhurst, chair of Tesfa is also an expert on Iddirs and suggests that the relative informality of the Iddir structure allows it to challenge social issues (such as HIV) more easily that more formal organisations or indeed the need for legislation to support social change.[125] Hence capacity building these organisations through providing leadership training as described earlier will provide a lasting impact on the structures that support Ethiopian society in Kolfe Keranio and Burayou. That this training is considered important beyond the boundaries of the project has been verified by government (Federal HAPCO) and the community (Iddir leaders) as well as HelpAge and Tesfa.

Box 12: Added value of the BLF funding to the development of Iddirs in Ethiopia

Given the central role Iddirs have in urban Ethiopian society, such training is significant and will have an impact beyond the scope of the project. An

[124] Focus group discussion with Iddir Leaders, 25 February 2013; Key informant interview with Federal HAPCO, 21 February 2013

[125] Key informant interview with Chair of Tesfa, 23 February 2013

example of this is the broadening remit of Iddirs, made possible by the changes they made to their by-laws to allow them to do more social protection work, as a result of the training under project 7 (see box 12).[126]

The programme in Ethiopia also responded to the specific recommendations at the Mid-Term Evaluation to look at the allocation of the interest between being recapitalized and contributing towards administration costs. As highlighted in greater detail in the country report beneficiaries of the loan scheme in Ethiopia paid 8% interest on their loans. Originally this interest was allocated as:

- 3% interest towards administration costs; and
- 5% interest was recapitalized

Following the Mid-Term Evaluation this was altered to:

- 5% interest towards administration costs; and
- 3% interest was recapitalized.

The country office and Tesfa viewed this change as appropriate to their needs during the portfolio period.[127]

The Mid-Term Evaluation made a series of very specific recommendations for Project 4 in Kenya, which had not had significant success in years 1 and 2 of the portfolio. The evaluation and these recommendations led to the redesign of project 4, which has impacted on the results for this project due to time lost to the restructure:

Mid-Term Evaluation Recommendation	Risk Impact	Final Evaluation Comment
Capacity enhancement on IGA and MF will be key for IAP and CCS, as well as the CBOs that they work with	Medium	A consultant was appointed who worked with IAP, CCS and HelpAge Kenya to develop their capacity on IGAs. The consultant also helped to build the capacity of beneficiaries directly (reported)
HAK should consider the best model of oversight. There are 2 options: a) To develop the capacity within HAK b) To outsource MFI oversight services	High	HelpAge Kenya developed the capacity in-house and appointed a Micro-Finance Officer
Management Information System (MIS) for the IGA portfolio will tremendously aid both the IAP and CCS in the day to day management and facilitate Strategic Decision making	High	We saw no evidence of a bespoke MIS for the IGA activities. HelpAge's M&E Matrix does have figures for loans issued for all five years, which suggests some sort of system is operational. It is reported that IAP and CCS sourced loan-tracking software, but a lack of computer skills meant that the software is not used.
HAK should revisit the operations model and consider mainstreaming the project manager budgetary allocations and decision making.	High	The project manager was accounted for in HelpAge's budgets for all five years, suggesting that this position was not paid for from HelpAge Kenya's unrestricted or

[126] Focus group discussion with Iddir Leaders, 25 February 2013
[127] Key informant interview with Tesfa Programme Officers, 20 February 2013

Mid-Term Evaluation Recommendation	Risk Impact	Final Evaluation Comment
Including the project manager as a mandatory signatory to the bank account is a viable option in mainstreaming control on the part of the project manager		core funding. HelpAge Kenya's board have not yet authorized the project manager to be a signatory on the bank account.
Establish a monitoring and evaluation framework to measure achievement of the project's objectives in line with the fund's core mission.	High	No M&E framework for impact on poverty or poverty eradication was evidenced during the evaluation. Given the focus on data collection at a process level for the portfolio M&E framework it is questionable whether HelpAge Kenya would have had the capacity to support an additional M&E framework
Conduct in depth review the current IGA model with the aim of improving inadequately performing components.	High	HelpAge and its implementing partners considered very carefully the model for the IGAs in Kenya and took lessons from the more successful programme in Ethiopia. The development of CBOs below IAP and CCS and the development of self-help groups along the lines of the Iddir groups are evidence that HelpAge and its partners have worked to transform the implementation design
Consider formalizing the IGA projects' risk assessment process and incorporate the resulting analysis in IGA implementation and monitoring plan with the purpose of ensuring that the objectives of the IGA projects will be achieved.	Medium	We saw no evidence of a risk assessment process for IGAs or a specific IGA monitoring plan.
Prioritize risks according to impact and likelihood. For example, the project should identify the risks which could be classified as having high impact, and high likelihood of occurrence to give the needed attention to such risks.	Medium	We saw no evidence of a risk assessment process for IGAs or a specific IGA monitoring plan.
The existing OVC selection criterion should be reviewed with the aim of establishing an objective assessment while ensuring consistency in dispensing the criteria/tool.	High	The OVC were reviewed and no loans to OVC were issued until Year 5 (according to the annual and quarterly reports to the donor). HelpAge Kenya reported that it and IAP and CCS no longer have a role in selection as this is now done by the CBOs set up below IAP and CCS
Beneficiaries should be exposed to a 360 degrees IGA selection mapping and basic business skills	High	The self-help groups are used to select and monitor those who receive loans, whilst more formalized training on business skills is provided through the CBOs that report to IAP and CCS
CCS to develop a policy on response time to queries from umbrella CBOs regarding funds beneficiaries.	Medium	We have not seen such a policy
The fund managers (HAK) should consider revising the relevant clause in the agreement to reflect that the LIPs shall monitor or verify the application of any amount disbursed to beneficiaries.	High	We are not aware that this amendment has been made. HelpAge Kenya report that it was not considered practical for them to do this and it was left to the CBOs to have the freedom to decided loan amounts
The respective program officer assigned to the project should carry out continuous field monitoring activities and issue reports which should be shared with	High	As far as we are aware, regular monitoring and sharing of monitoring information has taken place

Mid-Term Evaluation Recommendation	Risk Impact	Final Evaluation Comment
respective LIPs (IAP or CCS) for implementation of suggested recommendations if any.		
HAK should assess the level of engagement and the workload of the existing IGA monitoring and consider more in-depth monitoring and coaching of IGA management, especially for older people.	High	

Table 10: Mid-Term Evaluation Recommendations and our observation on their implementation

In Kenya, we also undertook an impact evaluation on Project 4. As mentioned in section 2, we were interested in understanding whether the project had resulted in the beneficiaries having higher consumption and expenditure due to increased wealth.

In order to evaluate the impact of this project in detail we included an additional section on Livelihoods in the endline survey and asked both the beneficiaries and the control group to respond to the questions. The analysis of this data will provide us with the opportunity to measure the average estimated difference between the beneficiaries and the control group with regard to their current livelihood situation, as a means of describing the change that happened in the beneficiary group as a result of the project (see the section on Methodology for more detail on the evaluation design).

Measuring Change in Livelihoods

The Livelihood Indicator: US$1.25 per capita per day

Measuring household wealth in resource-poor (particularly rural) settings is not straightforward, especially as the respondents tend to be self-employed. Self-reported wealth measures tend to be unreliable as the respondents often undertake a wide variety of activities to generate income.[128]

There is however a widely recognized, strong association between household income and consumption.[129] As a result the World Bank and others use a proxy measure formed by aggregating data on consumption and expenditure data to estimate the percentage of households living on more than US$1.25 per capita per day.[130]

Hence households are surveyed about their consumption and expenditure on food and non-food items[131] on a weekly, monthly and annual basis. Food and non-food items are then divided by the household size. It is however possible to underestimate the wealth of larger households with this method, so Deaton and Zaidi also propose an approach to calculating

[128] Morris, Saul, Calogero Carletto, John Hoddinott, and Luc J. M, Christianensen, 1999, Validity of Rapid Estimates of Household Wealth and Income for Health Surveys in Rural Africa: FCND Discussion Paper No. 72. Washington: International Food Policy Research Institute.

[129] Gujarati, Damodar N., 2003, Basic Econometrics: Fourth Edition. New York: McGraw Hill

[130] Deaton, A and S. Zaidi, 2002, "Guidelines for constructing consumption aggregates for welfare analysis," Working Paper No. 135. The World Bank, Washington, D.C.; Deaton and Zaidi also remark that empirical literature has shown that consumption is not linked to short term fluctuations in income and tends to be smoother and less variable than income. In resource-poor settings all income is consumed.

[131] Where possible non-food items are disaggregated on a gender basis

household size detailed in National Research Council (1995), where the household size is determined by determining the number of adult equivalents through the formula:

$$AE = (A + \alpha\ K\ )^{\theta}$$

Where *A* is number of adults in the household; *K* is the number of children in the household; α is the cost of a child relative to an adult; and θ controls the extent of economies of scale. For low-income countries, Deaton and Zaidi recommend that α be set at .25 or .33 and θ be set at .9. [132]

Ownership of Assets

Asset ownership is another way of measuring household wealth and is seen to complement the livelihood indicator. In the survey households were asked to select assets that they currently owned from a pre-prepared list and to recall whether they owned the asset or similar assets at the time of the baseline.[133] Thus reconstructing baseline data for this particular question in order to measure change over time.

Box 13: Basis for impact evaluation

General characteristics of the households in the survey:

	Beneficiaries	*Control*	*Variation*
Grandparents Male	1.	1.01	0.01
Grandparents Female	1.02	1.03	0.01
Parents Male	1.48	1.31	-0.17
Parents Female	1.32	1.27	-0.05
Grandchildren Male	2.04	1.71	-0.33
Grandchildren Female	1.92	1.6	-0.31
Great Grandchildren Male	1.67	1.71	0.04
Great Grandchildren Female	1.76	1.46	-0.30
Other Male	1.88	1.33	-0.55
Other Female	1.62	1.29	-0.32
Total Mean	**15.71**	**13.73**	**-1.98**

Table 11: Characteristics of Household population (Means) for Beneficiaries and Control Group who participated in the survey

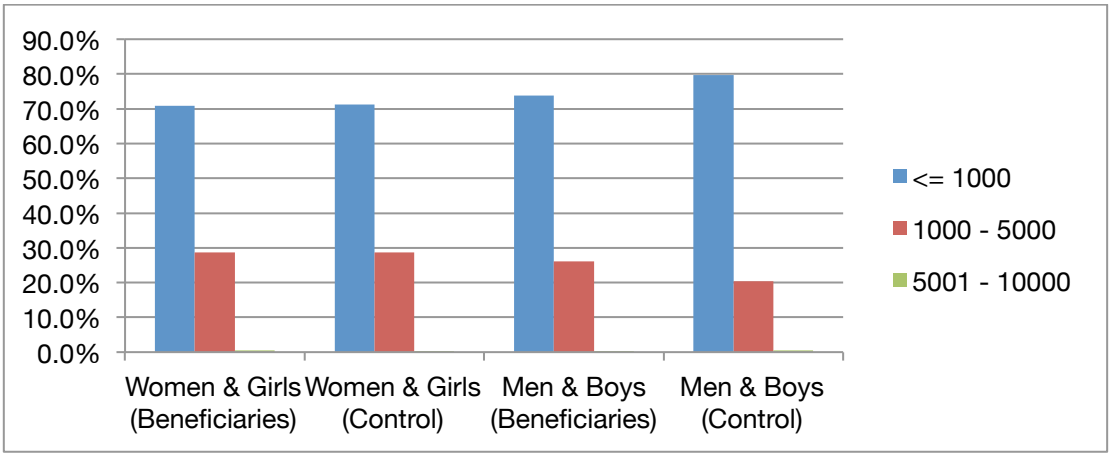
Based on the formula $AE=(A+\alpha K)^{\theta}$ explained in box 13 above and using the data collected in the household survey, we have calculated the average household size as:

- Beneficiary Households (AE=estimated adults) 7.4
- Control Households (AE=estimated adults) 7.3

The control group households were slightly smaller on average than the beneficiaries. The beneficiary households tended to have more male grandchildren than any other category. While the beneficiary households do report spending more on men and boys than women and girls, the control group spends even more on men and boys than the beneficiaries.

[132] Deaton, A and S. Zaidi, 2002, "Guidelines for constructing consumption aggregates for welfare analysis," Working Paper No. 135, The World Bank, Washington, D.C.

[133] The assumption being that it is relatively easy to recall asset ownership over time.



Graph 53: Weekly expenditure on women & girls and men & boys

We asked the households what food items from a pre-prepared list they had purchased over the past month and how much they had paid for those items.

Vegetables	Grains	Meat	Fruit	Other
Tomatoes	Maize Meal	Lamb	Bananas	Milk
Beans	Sorghum/Millet	Beef	Avocados	Alcohol
Cabbage	Wheat Flour	Chicken	Pineapples	
Kale	Rice	Goat	Mango	
Onions	Kasavas	Pork	Paw Paw	
Pumpkin	Arrow root	Rabbit		
Potatoes	Green Maize			
Peas				
Carrots				
Sweet potatoes				

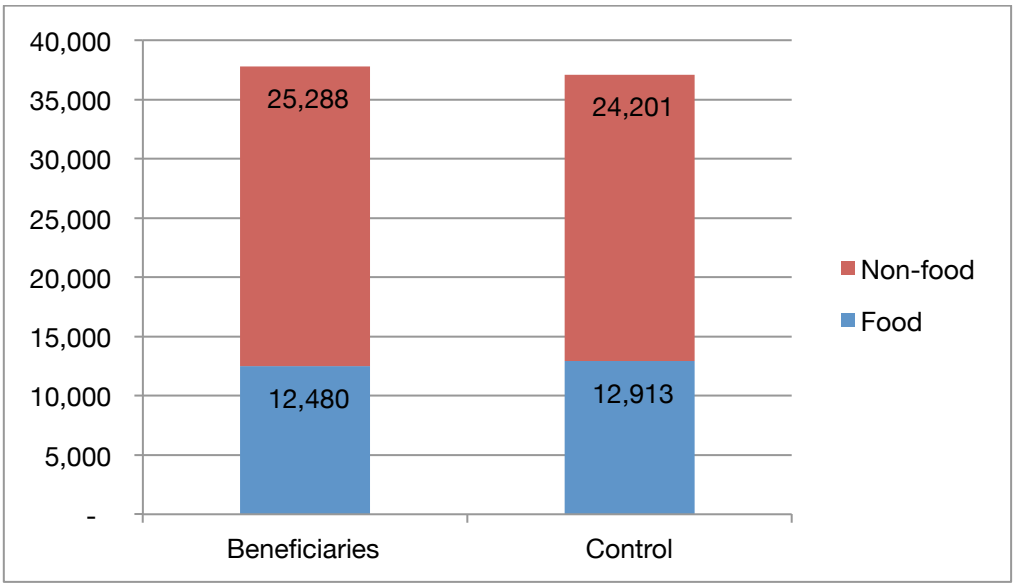
Table 12: Households were asked which food items they had purchased in the past month

We also asked households which of the following non-food items they had purchased over the past month and what they had paid for them:

Transport	Toothpaste	Water
Healthcare visits	Soap	Electricity
Women's clothes	Light bulbs	Education expenses
Women's shoes	Candles	Medicine
Girl's clothes	Fuel	Airtime for phone
Girl's shoes	Batteries	Charging phone battery
Men's' clothes	Kerosene	Rent on a small house
Men's shoes	Gas	Rent on a medium house
		Feed for animals

Table 13: Households were asked which non-food items they had purchased in the past month

We found that average monthly expenditure on food and non-food items only were Ksh37,768 for the beneficiaries and Ksh37,114 for the control group. The beneficiaries spent Ksh654 more per month than the control group.

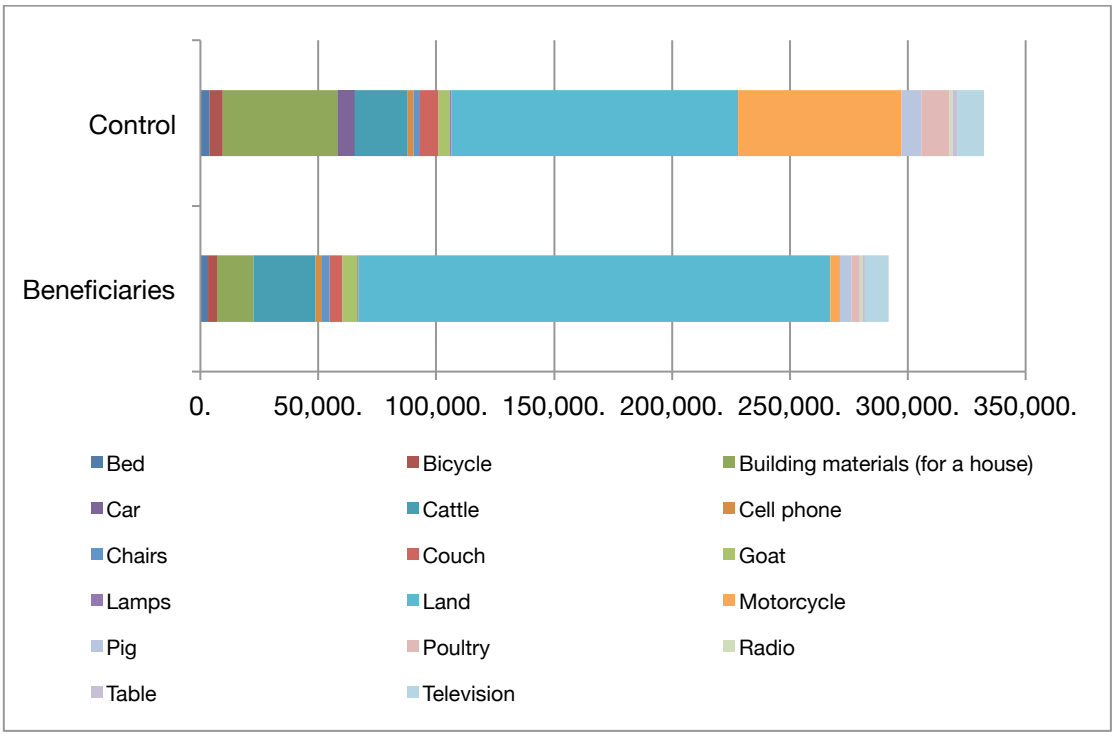


Graph 54: Average monthly household expenditure on food and non-food items

However this is not the full story. Households also purchased some items on an annual basis. Households were also asked to report on what non-food items from the following list they had purchased during the past year:

Cell phone	Cattle	Lamps
Land	Pig	Table
Building materials (for a house)	Goat	Chairs
Bicycle	Poultry	Couch
Motorcycle		Bed
Car		Television
		Radio

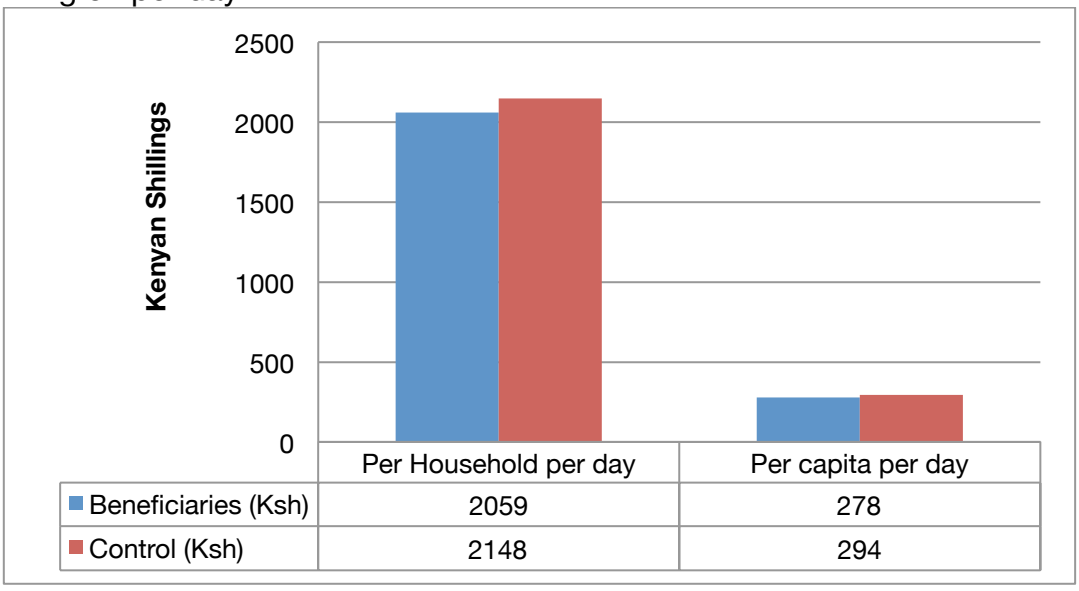
Table 14: Households were asked which non-food items they had purchased in the past year



Graph 55: Average annual expenditure on big-ticket items

In this case the control group reported spending Ksh40,479 per household per year than the beneficiaries.

Using the proxy aggregate measure promoted by the World Bank, we have calculated how much each household and each person in the household is living on per day:



Graph 56: Per household per day and per capita per day living

In US dollars the amount per capita per day that the households are living on is:

	Beneficiaries	Control	Variance
Per capita per day	US$3.27	US$3.46	US$0.19

Table 15: per capita per day in US$[134]

With a variance of only US$0.19 in favour of the control group we cannot say that the interventions applied by HelpAge and its implementing partners has resulted in an increase in economic empowerment based on the Livelihoods indicator only.

We also investigated asset ownership amongst the households in 2013 against asset ownership (reconstructed) in 2009. We asked the respondents to list the assets that the household currently owned and their condition and to list the assets that the household owned in 2009 and their condition then. We collated the assets into three different groups to ensure that we did not compare asset poor with asset rich (extremes) and determined the mean asset ownership for each group in 2013 and 2009. We have excluded animals from this analysis as many respondents used the IGA loans to purchase cows, so including an asset purchased as part of the project would skew the results:

Asset Rich	**2013**	**2009**	**Variance**
Beneficiaries	10.79	9.	1.79
Control	10.76	8.88	1.88
Variance	**0.03**	**0.12**	**-0.09**

Asset Middle	**2013**	**2009**	**4.00**
Beneficiaries	1.08	0.5	0.58
Control	0.37	0.38	-0.01
Variance	**0.71**	**0.12**	**0.59**

Asset Poor	**2013**	**2009**	**4.00**
Beneficiaries	0.37	0.19	0.18
Control	0.14	0.1	0.04
Variance	**0.23**	**0.09**	**0.14**

Table 16: Mean Asset ownership – Beneficiaries and Control Group, 2013 v 2009

The largest variation between the beneficiary group and the control group in 2013 is in the Asset Middle group, which shows a mean variance of 0.71, however in the Asset Rich and Asset Poor groups there is less variance.

Between 2009 and 2013 the Asset Rich Control Group experienced higher growth than the Asset Rich Beneficiary Group. However the Asset Middle Beneficiaries experienced substantial growth, whereas the Asset Middle Control Group virtually stood still (although if depreciation was applied, then they are likely to be worse off than they were in 2009). The Asset Poor

[134] Exchange rate: Ksh1 = US$0.0118 (7.04.2013 19:28), PPP not applied.

Beneficiaries also experienced growth during the project period. The Asset Middle Beneficiary group appeared to outperform the Asset Middle Control group.

Importantly this result suggests that the beneficiaries in the middle are beginning to demonstrate asset growth and mobility which, had the impact evaluation been undertaken in two to three years time, may have translated into the kind of poverty reduction that was observed in Ethiopia over the lifetime of the portfolio.

This analysis suggests that approximately one third of the beneficiaries are somewhat better off now than in 2009 and better off now than the control group; whilst two thirds of the beneficiary group are either marginally better off or the same as the control group. Therefore we cannot say that the interventions delivered by HelpAge and its partners during the lifetime of the portfolio have resulted in significant economic empowerment based on asset ownership.

Finally we considered two further measures, which although less scientific, do provide an indication of whether our measurements on livelihoods and asset ownership were accurate and appropriate.

We asked the data collectors to observe the materials used for the roof, floor and walls of the home. With more basic materials allocated a lower ranking (1) and more complex materials allocated a higher ranking (3 – 5).

		Beneficiaries	**Control**
Roofing	*Cardboard or plastic sheeting*	0.5%	4.4%
	Corrugated Iron	**98.4%**	**95.3%**
	Roof tiles	1.3%	0.6%
Flooring	***Bare ground***	**50.4%**	41.4%
	Wood	0.3%	0.6%
	Tiles/ Cement	49.6%	**58.3%**
Walls	*Wood*	6.9%	12.0%
	Corrugated Iron	10.8%	**37.0%**
	Bricks	20.9%	9.4%
	Breeze blocks	15.1%	4.1%
	Walls are plastered	**30.4%**	28.4%
	Walls are painted	16.1%	9.4%

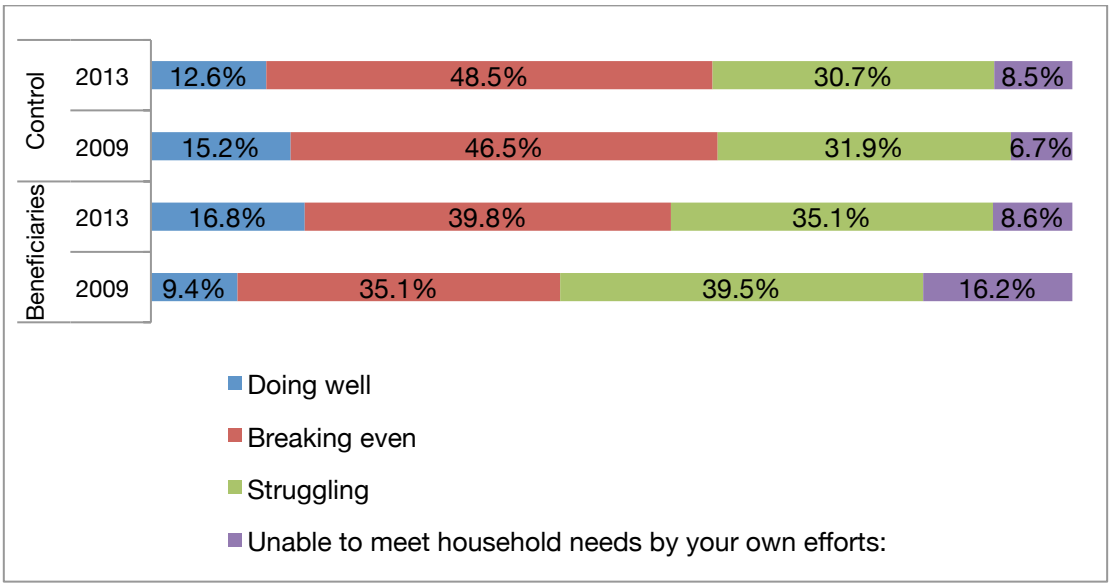
Table 17: Materials used to build homes of households

Overall the beneficiaries scored higher by one point than the control group in terms of net worth as determined by building materials, largely due to the majority of respondents being observed to plaster their walls. This is not a significant variance between the groups that can suggest the impact of increase consumption or expenditure in the beneficiary group.

The households were asked to consider how well they were doing in respect to meeting basic needs and were asked to express this in terms of one of

four statements. They were also asked to consider how well they were doing in respect of meeting basic needs in 2009 in terms of the same statements.

- "Doing well: able to meet household needs by your own efforts, and making some extra for stores, savings, and investment."
- "Breaking even: Able to meet household needs but with nothing extra to save or invest."
- "Struggling: Managing to meet household needs, but depleting productive assets and/or sometimes receiving support."
- "Unable to meet household needs by your own efforts: dependent on support from relatives living outside of your household or the community, government and/or some other organisation – could not survive without this outside support."



Graph 57: Household Survey responses to whether households are able to meet their basic needs

While 4.7% more beneficiaries stated they were breaking even in 2013 than in 2009, only 2% more members of the control group were breaking even in 2013 than in 2009. Significantly, 7.4% more beneficiaries reported doing well in 2013 than in 2009.

The beneficiaries have reported a general improvement across all four categories from 2009 to 2013.

	Beneficiaries		
	2009	2013	Variance
Doing well	9.4%	16.8%	7.3%
Breaking even	35.1%	39.8%	4.7%
Struggling	39.5%	35.1%	-4.5%
Unable to meet household needs by your own efforts	16.2%	8.6%	-7.6%

Table 18: Beneficiaries meeting their basic needs

This means that the beneficiaries perceive an overall 2.9% improvement between 2009 and 2013. The control group on the other hand have demonstrated a general net decline of -1.5% between 2009 and 2013.

	Control		
	2009	2013	Variance
Doing well	15.2%	12.6%	-2.6%
Breaking even	46.5%	48.5%	2.0%
Struggling	31.9%	30.7%	-1.2%
Unable to meet household needs by your own efforts	6.7%	8.5%	1.8%

Table 19: Control group meeting their basic needs

This represents an overall positive difference between the beneficiaries and the control group of 4.3%.

Importantly the implementing partners, CCS, IAP and HelpAge Kenya all reported that they had observed a change in the attitude of those older people who had participated in the project, from dependency to self-sufficiency. That all three reported this independently is significant and suggests a real change that has permeated the community.[135] No beneficiaries related this to us in these terms however, which means that while the implementing partners have observed this change, the beneficiaries only discussed the direct change they observed in their lives as they reported in the focus group discussions.

3.5.1 Summary

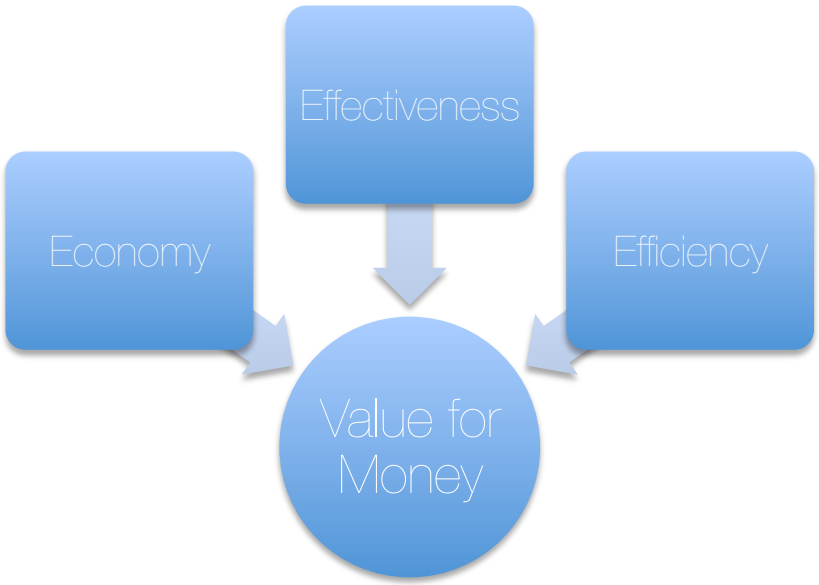
This outcome considers improved coping mechanisms having been achieved amongst the beneficiary groups. Given the successes and the challenges that we have discussed both here and in the country reports for projects 4, 5 and 7; we can say that at least 50% of the beneficiaries targeted by these projects have new coping mechanisms in most cases. This is based on the figures reported for projects 4, 5 and 7 and taking into consideration the successes and challenges reported and evidenced during this evaluation. However there is an absence of robust baseline information in these communities for these projects so we cannot say whether these coping mechanisms are an improvement on any coping mechanisms that the communities may have already had in place. In some instances, such as the paralegal work in Kasese, key informant interviews suggest that there was no such service or support in place before the project started.[136] If this is the case, then the baseline was likely to be zero, in which case the current coping mechanisms do represent an improvement. Whether or not the coping mechanisms introduced by HelpAge through these projects were new or not, is moot when the positive responses provided by the beneficiaries are considered. As shown through the discussion of the PRA exercises and key informant interviews in this section, beneficiaries found the projects to be valuable for most older people and the skills they learned during the project will support them for a long time.

[135] Key informant interview with IAP Project Officers, 16 February 2013; Interview with CCS Project Officers, 16 February 2013; Key informant interview with the Country Programme Manager, HelpAge Kenya, 18 February 2013

[136] Key informant interview with Inspector of Police (Community Liaisons Officer), Kasese Police, Kasese District. 6 March

3.6 Value for Money

We also consider HelpAge's projects and activities from a Value for Money perspective. The Value for Money methodology that was agreed at the inception period was the 3E's approach: Economy, Efficiency, and Effectiveness.



Effectiveness: Successfully achieving the intended outcomes from an activity Economy: Minimising the cost of resources used for an activity Efficiency: Maximising output for a given input or minimizing input for a given output

This section sets out our findings under these three headings. In summary our value for money opinion of the portfolio can be summed up as:

- HelpAge has managed to deliver its activities (including some unplanned activities) within budget;
- HelpAge is not as efficient as it could be in delivering its projects generally, with management costs apparently duplicated in project and management budgets and very high unit costs;
- In its management of the portfolio HelpAge appears not to implement economies of scale to maximize its procurement, which, although a relatively small cost saving, would suggest that this is not done outside the portfolio either and that could have a larger significance; and
- Partnership management and capacity building is undertaken, but more could be made of this activity, especially as HelpAge delivers all its projects through partnerships and some capacity building appears to fall between responsibilities in the regional office.

As a result we can say that HelpAge's BLF portfolio of projects to prevent HIV and AIDS and mitigate its impact in multigenerational households has been somewhat effectively, not efficiently and partly economically

implemented. As a result this portfolio has only partly provided value for money to HelpAge and its donor, the Big Lottery Fund.

3.6.1.1 HelpAge's relationship to the Big Lottery Fund

The Big Lottery Fund grant for preventing HIV and AIDS and mitigating its impact in multi-generational households is one of three grants from the BLF that HelpAge is currently managing.

Over six years the total grant is worth £5.1m to HelpAge. This is an increase from the original award of £4.97m. This increase was negotiated with the donor as a result of the impact felt by HelpAge in the portfolio from the economic downturn between 2008 and 2010. The additional funding was allocated to projects 1, 2, 3, 4, 7 and 9. This funding was designed to cover the shortfall experienced due to substantial hikes in inflation rates in portfolio countries, increases in fuel and commodity prices, increases in staff salaries and increased office running costs.[137]

We have available to us the audited financial accounts for HelpAge to 31 March 2012. We have used these to understand the importance of this BLF grant to the financial health of HelpAge.

	2009 £000's	2010 £000's	2011 £000's	2012 £000's	Total to 2012 £000's	% BLF to other
BLF Contract IS/2/010281292	938	759	1,243	1,094	4,034	
Total Grants Received for International Programmes	13,578	15,383	17,847	13,322	60,130	6.7%
Total Annual Income	17191	21495	25963	26717	91,366	4.4%
Total Annual Expenditure	16,566	19,725	24,496	27,784	88,571	4.6%

Table 20: BLF Contract IS/2/010281292 in relation to other international programme income and total annual income and expenditure

This BLF grant represents approximately 4.5% of both income and expenditure over the past four years for HelpAge International. During this time, HelpAge has also managed up to five BLF grants per year, indicating a healthy relationship between the funder and HelpAge. While HelpAge did report a higher than expected turnover of grant officers at BLF, HelpAge's overall experience of managing BLF grants over the years appears to have stood them in good stead.

3.6.2 Efficiency

We have considered how efficient HelpAge and its partners have been in delivering the portfolio across all five countries. We have considered cost control and financial processes and policies during this evaluation in order to understand how efficiently HelpAge and its partners control their budgets and the issues that they have had to face during the portfolio lifetime.

[137] Economic downturn request application "Changes to your grant", March 2010

3.6.2.1 Financial Analysis

We understand that the organisation (like many others) had to reforecast its budgets in 2010 to take account of the financial downturn and how this affected its operations. So we have used the budgets revised in 2010 as a basis for comparison with the most recent budgets available to us.

Project	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Total (as at 2012)	Total (as at 2010)	Variance
Revenue	660,912.00	757,415.00	923,529.00	766,355.00	917,576.57	101,709.51	4,127,497.07	4,176,238.36	-48,741.28
Capital	67,002.00	6,463.14	24,878.00	14,937.00	1,852.03	0.00	115,132.17	117,613.14	-2,480.97
Total	727,914.00	763,878.14	948,407.00	781,292.00	919,428.60	101,709.51	4,242,629.24	4,293,851.50	-51,222.25
Management									
Revenue	147,331.00	123,297.00	173,990.00	172,853.00	182,085.15	68,634.97	868,191.12	816,969.00	51,222.12
Capital	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Total	147,331.00	123,297.00	173,990.00	172,853.00	182,085.15	68,634.97	868,191.12	816,969.00	51,222.12
Grand Total	**875,245.00**	**887,175.14**	**1,122,397.00**	**954,145.00**	**1,101,513.75**	**170,344.48**	**5,110,820.36**	**5,110,820.50**	**-0.13**

Table 21: Variance between budgets approved at 2010 and budget approved at 2012

HelpAge's regional financial policies manual for EWCARDC sets out guidance that total project cost should not be "less than 60% of the total budget cost and administrative costs not more than 40%."[138] The table above highlights that 83% of the total grant was spent on project costs and 17% on management costs. The variance between the total amount in the budget between 2010 and 2012 is minimal, which suggests very tight financial control.

However the project costs shown above also contain management costs in addition to the management costs reported separately. We do not dispute that it is important that NGOs do cost recovery and that some management costs are essential parts of delivering project activity. We have separated out the costs that were included in the project budgets into revenue (project activities with or on behalf of beneficiaries), project-related management (salaries and overheads considered to be project expenditure and not already recorded under management costs). To do this we relied on the names of the budget lines in the project budgets to determine those budget lines that were project-related management and those that were project activity (revenue) and capital. In most cases it was a straightforward exercise as budget lines were named:

- Vehicle insurance;
- Stationary and consumables-ARDC;
- CEO-HAK;
- Finance Officer – URAA; etc.

In appendix 6.8 we have listed all the budget lines that were included in the disaggregated project-related management line below. HelpAge expressed some concern at this approach and would possibly disagree with some of

[138] HelpAge Financial Policies and Procedures Manual, December 2010

this analysis, however we believe this represents a useful view of the budget from an efficiency perspective.

Project	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Total (as at 2012)
Revenue	430,941.65	535,967.88	656,930.25	482,062.04	599,489.85	36,108.77	2,741,500.44
Project-related Management	229,970.35	221,447.12	266,598.75	284,292.96	318,086.72	65,600.74	1,385,996.64
Capital	67,002.00	6,463.14	24,878.00	14,937.00	1,852.03	0.00	115,132.17
Total	727,914.00	763,878.14	948,407.00	781,292.00	919,428.60	101,709.51	4,242,629.24
Management							
Revenue	147,331.00	123,297.00	173,990.00	172,853.00	182,085.15	68,634.97	868,191.12
Capital	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Total	147,331.00	123,297.00	173,990.00	172,853.00	182,085.15	68,634.97	868,191.12
Grand Total	**875,245.00**	**887,175.14**	**1,122,397.00**	**954,145.00**	**1,101,513.75**	**170,344.48**	**5,110,820.36**
Project Activities with or on behalf of Beneficiaries	49.2%	60.4%	58.5%	50.5%	54.4%	21.2%	**53.6%**
Management & Project Management & Capital	50.8%	39.6%	41.5%	49.5%	45.6%	78.8%	**46.4%**

Table 22: Portfolio budget with project management costs highlighted

This layer of management costs, while necessary to the delivery of the project activities in each country highlights the actual expenditure on salaries and overheads required to deliver the results reported in this evaluation. Additionally, if this measure of management costs is used, then HelpAge does not meet its regional policy of a 60-40 split of costs between project activities and management. HelpAge's view is that as a strategic grant, one of the purposes of the BLF funding was to provide funding to more generally fund organizations to deliver their mandates. Therefore higher management costs might be seen in strategic grants than would be the case with more straight forward project funding. HelpAge also suggested that the 60-40 split is not a HelpAge policy across the board, rather only applicable to its core grant from Age UK. However the 60-40 split features in guidance for managing budgets and work plans for Partnership management[139] and is therefore applicable to the budgets prepared for the portfolio activities.

The project management costs include costs for country offices, partners' management costs and EWCARDC. The management costs listed separately also contain costs for country offices, partners and EWCARDC, as well as UK head office costs.

While there is always a debate between the degree of allocation of costs between regional offices, country offices and secretariats[140] and no magic solution for such debates, as part of its commitment to the International Transparency and Accountability Initiative, HelpAge needs to ensure that

[139] HelpAge Financial Policies and Procedures Manual, December 2010
[140] HelpAge would not be alone in this debate. The balance of resources between the different layers within an NGO preoccupy most international NGOs

costs are as transparent as possible. As demonstrated in table 22 above, there are two different sets of management costs, with sometimes the same post being allocated a budget line in the project costs and the management costs, for example: the CEOs of URAA, MUSA and HelpAge Kenya all received an allocation in the project budget and an allocation in the management budget. In addition the financial policy and procedures manual encourages the maximization of indirect cost recovery[141], however a policy of 40% management costs permissible in a partner's project budget is unlikely to encourage efficiency savings in the long run. This allocation of costs from both project and management budgets towards the costs of the country offices, HelpAge's partners and the EWCARDC suggests a less then efficient approach to delivering activities.

3.6.2.2 Unit Cost Analysis

Although overall, HelpAge managed it costs within a revised budget, the actual cost of reaching the beneficiaries was not as efficient as possibly it could have been. We have considered the unit costs of reaching some of the target beneficiaries:

Beneficiaries		Amount[142]	Unit Cost £	Total Cost £
Ethiopia	Iddir Leaders & recipients of step-down training	6600	8.72	57,555.93
	CBO members	447	28.72	12,838.87
	Youth Group members	300	57.23	17,167.50
	Training for IGAs	447	115.72	51,726.59
Kenya	OVCs who have received vocational training	259	363.42	94,125.51
	OVCs and MGHs who received training for IGAs			
	Number of OVCs who receive training in marketing and financial management of IGAs	*587*		
	Number of MGHs who have received training for IGAs	*666*		
	Total	1253	24.22	30,350.85
South Africa	Traditional Healers	1134	76.02	86,211.57
Tanzania	Number of people participating in annual consultative dialogue with NAC on HBC curriculum review	123	137.98	16,971.79
	Number of older people trained as HBC caregivers	680	233.02	158,455.42
	Number of support groups established in three districts for older people caregivers	273	234.52	64,025.13

[141] HelpAge Financial Policies and Procedures Manual, December 2010

[142] Beneficiary numbers were taken from the M&E Framework as at November 2012, except for the Iddir Leaders beneficiary number. HelpAge Ethiopia was able to verify that the Iddir Leaders and those who the leaders had trained were all funded through the same budget line. This has highlighted that not all beneficiary numbers are reported in the M&E Framework, this may affect other unit cost calculations in this table.

Uganda	Paralegals (Total)			
	Mobilising & training Paralegals	*360*	*166.65*	*59,992.93*
	On-going technical assistance	*360*	*234.17*	*84,300.00*
	Total	360	400.81	144,292.93
	PLHIV	515	31.66	16,304.35

Table 23: Unit costs of delivering training for beneficiaries across all portfolio countries[143]

Unit costs for activities to reach beneficiaries range from £8.72 to £400.81.[144] There is no trend to suggest that it is more economical for HelpAge to implement activities in one country over another. The broadest range of unit costs within one country is in Uganda, where unit costs can range from £31.66 to £400.81 per beneficiary (a difference of £369.15 between activities). There is also no trend suggesting that one activity is more cost-effective to implement than another activity across all portfolio countries.

3.6.3 Economy

HelpAge has a full financial processes and procedures manual that is reviewed regularly. The financial processes manual provides guidance on processes such as procurement, budgeting, donor reporting and exchange rates.[145] Importantly for value for money we consider procurement, budgeting and as it is central to HelpAge's model, partnership management.

Staff can procure supplies and consumables through relevant budget holders and there are separate procurement processes that are also reviewed regularly and are comparable to best practice procurement practices of three quotes from preferred suppliers, although the described process appears to rely heavily on paperwork such as tables and spread sheets to support decision-making. This does support accountability and transparency, but the trade-off is reduced capacity as more staff time is spent tracking processes. However there is no obvious evidence to support that HelpAge is taking advantage of potential economies of scale through refined procurement processes that promote either savings that can be made through purchases being made closer to project sites rather than centrally at EWCARDC or vice versa if the transportation costs can be off set. Equally it is not fully evident that procurement policies take account of ethical issues such as climate change, carbon off-setting or supporting local suppliers where possible.

[143] Some of the beneficiary numbers reported in the M&E Framework do not match the beneficiary numbers reported in the annual reports to the donor, although we have some concerns over the accuracy of the reporting, we have used the available beneficiary counts in the M&E framework for the unit cost calculations. As a result the actual unit cost could go up or down once beneficiary numbers are confirmed.

[144] This calculation only considers the relevant budget lines in the project budget for project 8. Full cost recovery analysis would include further indirect costs and overheads associated with the training, such as venue costs and staff costs, which would increase these unit costs further.

[145] HelpAge Financial Policies and Procedures Manual, December 2010

Budgeting in HelpAge is based on a zero-based budgeting approach and all activities and services should be evaluated every year before budgets for the following year are set. This process was also applied to the BLF portfolio, with an annual budget review process built in.[146] The M&E Framework shows that not all activities were reviewed non-financially on an annual basis[147], which suggests that budget planning may not have been fully informed regarding the performance of each activity in the portfolio in the previous year.

Partnership working is integral to HelpAge's model for delivering activities. HelpAge have in place very robust financial policies and procedures governing the partnership agreements that are put in place for project delivery, which include procurement requirements to an international standard, cost management requirements and policies.

Partnership management is split between the Grants and Contracts Unit (GCU) and the Finance and Administration Department (with no mention of the role of the Portfolio Manager – or any project manager in the management of the partnership). However financial monitoring appears to be the responsibility of both financial and programme staff. While the processes themselves appear to be very robust, there is a complicated ownership structure of the relationship between a partner and HelpAge, which does allow for the potential for issues and process ownership to fall between the cracks with each party assuming that another has ownership or obligation to respond to an issue. The monitoring responsibilities for partners are also clearly outlined in the financial policies manual.

The role of the country office is not specified in the process, but can be assumed reasonably to be the same as the regional office. With the lack of clarity in ownership of partnership processes evident from the financial policy manual there is potentially increased lack of clarity with the participation of a further management layer in the form of the country office.

HelpAge have had some significant partnership issues during the portfolio, especially in Tanzania (see section 3.1.3 for a more detailed explanation of the challenges experienced there). The issues raised in the Tanzania experience of partnership management need to form the core of broader learning for the organisation on how to improve its partnership management and support.

In addition, HelpAge's structure as a network organisation that delivers its activities through partners and includes those partners and other stakeholders in the design and consultation of activities, the projects are not as efficient in financial terms as they could be; because the costs of both HelpAge and its partner(s) has to be taken into account. This can appear to

[146] Key informant interview with management accountant, HelpAge International (UK Office), 12 April 2013
[147] ME Matrix Updated Nov 2012

increase the management and staffing costs of a project as we have seen in the portfolio budgets. HelpAge already does provide some capacity building support to its partners and we discuss this process in more detail under section 3.6.3. However if HelpAge considered that capacity building was sufficiently important to set up as a stand-alone, on-going programme, funded either centrally or through a combination of project and strategic funding with the aim of developing its partners so that they could be eventually independent of HelpAge financial support, the analysis over time would look significantly different.

3.6.4 Effectiveness

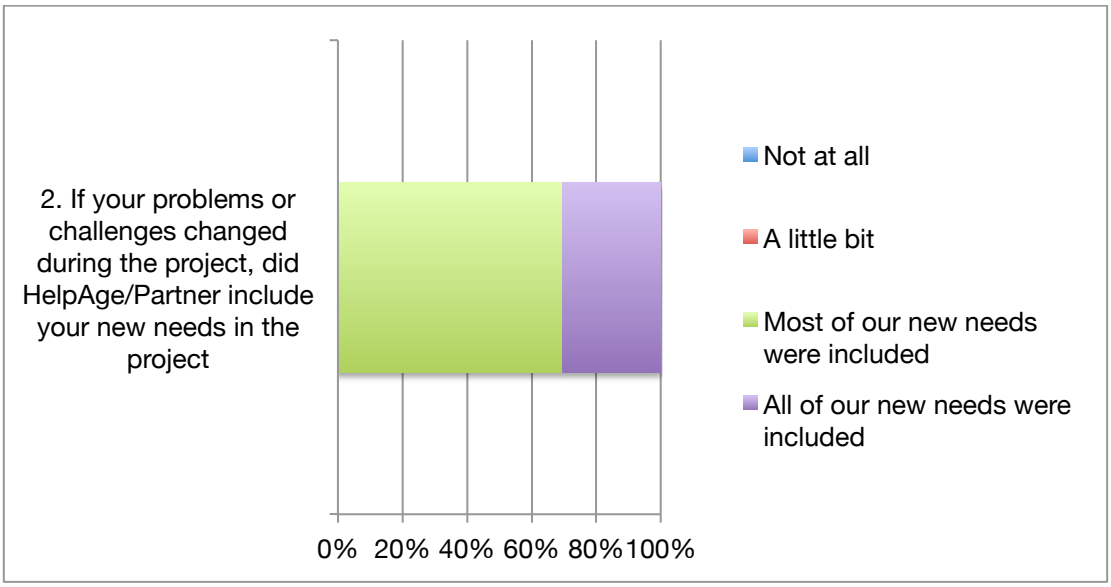
Here we will consider how effective HelpAge International has been in designing, implementing, managing and delivering the portfolio across all five countries. This will include consideration of HelpAge's distinctive offer, partnership relationship management and organizational effectiveness (management, project management, M&E processes). Normally this section would also include a detailed discussion on the results of activities in order to determine how effective HelpAge has been in delivering those activities. However sections 3.3 to 3.5 discuss the results of HelpAge's activities in detail and we will not duplicate those discussions here.

HelpAge is the only International NGO focusing on older people.[148] While many of HelpAge's activities are not that different from other NGOs working in HIV and AIDS in Africa, HelpAge's focus on older people and their needs within the HIV epidemic is unique. They have also been able to focus on the needs of older people through social protection as well as through more traditional support programmes. HelpAge's unique offering in the international development sector has allowed it to attract significant funding and opportunity to engage with both national and international actors in every country within the portfolio remit.

3.6.4.1 Beneficiary view of HelpAge and its Partners

Taking the beneficiary viewpoint into account, 75% of beneficiaries that participated in the PRA exercises said that HelpAge and its partners were flexible and responsive as their needs changed during the project period. This, together with the high level of beneficiary consultation reported under results in section 3.1, suggests that HelpAge did try to make its interventions relevant to its beneficiaries.

[148] This was evidenced in all five countries in multiple key informant interviews with both partners and other stakeholders.



Graph 58: PRA responses indicating flexibility in HelpAge and its partners' approach to the country-specific projects

3.6.4.2 Partnership management & capacity building

HelpAge requires that all its partners undergo a partnership assessment process that can be self-administered by the partner or administered by HelpAge either with or without partner participation. An improvement plan is then put in place as a result of the assessment process. For organisations that receive more than £10,000 from HelpAge, they also have to go through a Mango Financial Health Check process. The Mango health check is designed to be self-administered. The delivery of the resultant improvement plans does not appear to be a requirement or condition of grant payment in the partnership agreement. The process to monitor how organisations are progressing with these delivery plans is considered to be a part of the capacity building process that HelpAge engages with, with its partners. It is a multi-channel process. Figure 5 below shows that project monitoring trips are also used to monitor the capacity building plans agreed with the partner. Project staff are accompanied by other staff from the regional office (finance, HR, etc.) that are usually requested to work with the partner on capacity building issues in relation to the plan agreed. An important caveat however is that when agreeing the agenda for the visit between HelpAge and the partner, if the partner does not raise issues to be addressed, HelpAge is unable to cater for those issues in the subsequent visit. As a result, when HelpAge arrives on site with the partner, it may identify issues that need to be addressed, which the partner has not seen.[149]

HelpAge staff are able to report back on every aspect of the monitoring trip and as figure 5 below shows, there are three different mechanisms that HelpAge staff can use to report back. Trip reports are shared across EWCARDC and emails are sent outside of the trip reports to appropriate staff or departments if issues on capacity building have arisen during the visit and

[149] Key Informant Interview with the portfolio manager (Skype), 29 April 2013

reports are made by and to the contract manager responsible for tracking the capacity building plan.

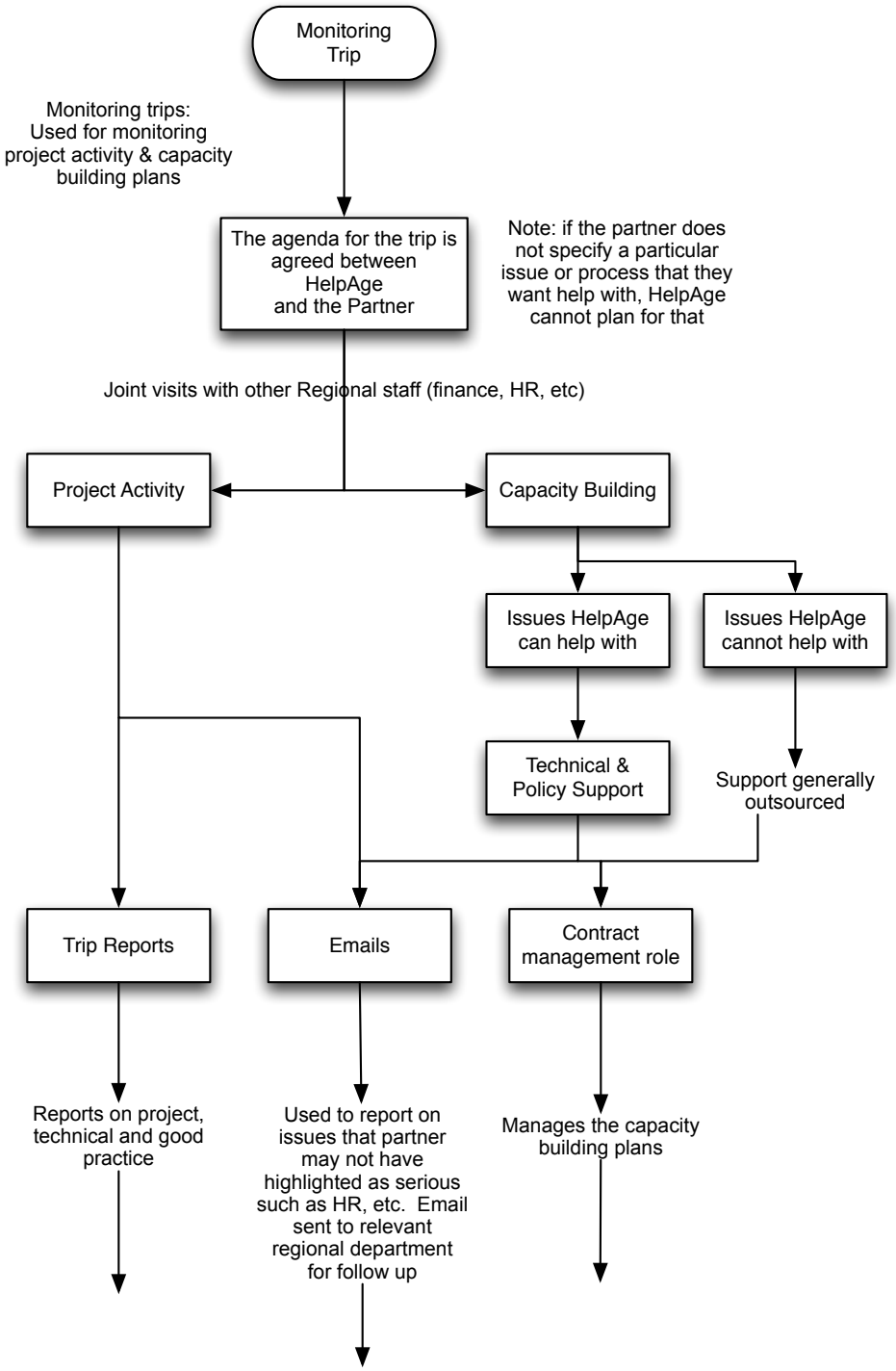


Figure 5: Process to monitor capacity building activity

However the reporting process is not always joined up and once a project manager has reported onwards the wider issues of capacity building that fall outside of the project management remit directly, then the contract manager rather than the project manager is considered responsible and at that stage they should enable other HelpAge staff members to get involved in capacity

building activity.[150]This allows for issues to fall between responsibilities and potentially allows capacity building challenges to go unrecorded. Additionally the reliance on partners to raise issues that they might be having is a weakness in the process that means HelpAge cannot always provide timely support.

More frequent trips to partners to monitor capacity building specifically were suggested as a potential change to the process to make it more robust, along with improved capacity enhancements upfront to partners to allow them to better deliver project activities agreed with them.[151]

The partnership agreement focuses on the project delivery, quite rightly. However the data and reporting requirements are mixed between regular project reporting and annual general reporting. HelpAge also requires input into the appointment of their partners' auditors where HelpAge has provided more than 30% of the partners' annual income. Such a clause appears onerous in a project partnership agreement and potentially puts HelpAge at risk of appearing to assume fiduciary responsibility for their partners.[152] HelpAge also requires a high standard in procurement processes and transparency in financial processes and transactions.

The most serious partnership issues that HelpAge encountered during the lifetime of the Portfolio were in Tanzania. During our evaluation it emerged that a capacity assessment had not been undertaken for HelpAge's first implementing partner TEWOREC at the start of project activities. The partnership with TEWOREC was terminated for performance and transparency issues, which may have been highlighted earlier had a capacity assessment of TEWOREC been made. HelpAge's second partner AFRIWAG was found to have financial irregularities during another NGO's audit process, some AFRIWAG staff were fired and HelpAge funding suspended pending further investigation. During this period the implementation of project activities was overseen by HelpAge Tanzania based in Dar es Salaam. These issues suggest that the partnership processes in place are not being regularly and consistently applied.

The partnership between HelpAge and AFRIWAG has since been resumed following agreement by AFRIWAG to:

- Repay the missing funds;
- Review the constitution;
- Review the board and management structure;
- Improve the reporting mechanism of management staff to the board;

[150] Ibid

[151] Key Informant Interview with the portfolio manager (Skype), 29 April 2013

[152] The appointment of auditors is usually the responsibility of the members, general assembly or trustees of an organisation. By insisting on input into this process under certain conditions, HelpAge may be inadvertently insisting on the same rights as a trustee or member of their partner organisation and therefore under some of the legal systems where they operate may be at risk of having the same responsibilities.

- Improve communication channels and strategic and annual planning process; and
- Review the HR manual.

The issues relating to fraud at AFRIWAG were investigated by the Regional Office and an agreement put in place whereby they agreed to repay the missing funds and address their governance issues. During the evaluation AFRIWAG board members and senior staff were interviewed and articulated that regular auditing needs to be undertaken to improve accountability issues.[153] Staff interviewed also considered that the initial project proposal did not fully cover all the AFRIWAG project activities and staffing costs (and in particular for the accounting staff) in order to adequately manage the Big Lottery Funds.

Staff from HelpAge Regional Office and HelpAge Tanzania engaged constructively with AFRIWAG during their frequent visits to AFRIWAG in this difficult period and had a strong will to address the problem by offering their support. They appeared to manage a difficult problem well and this was appreciated by AFRIWAG.[154] The difficulties experienced with partner governance appeared to contribute to a delay in implementing project activities in the target districts and particularly with respect to rolling out training and management of the support groups; and as a result the effectiveness of the projects being implemented was compromised.

Although not as significant as the issues in Tanzania, HelpAge also experienced capacity and skills issues in Kenya with its implementing partners who eventually required external assistance and capacity building in order to continue delivering the project (see section 3.5 on Outcome 4).[155] This is another example of where the partnership capacity assessment process appears not to have picked up a significant capacity or skills gap that was essential to the successful delivery of the project.

There may be lessons to be learned for HelpAge with respect to partner relationships including the need for thorough initial partner capacity assessment and having a capacity building plan and budget in place before partners begin implementing project activities. The plan could usefully include initial priority areas for capacity building to be undertaken intensively as well as longer-term inputs. Additionally close monitoring of partner work is a priority. In other words, ensuring that the processes described in the financial policy and procedures manual are implemented consistently and robustly and possibly building on these processes to ensure that the health and ability of partners is prioritized.

[153] Key informant interview with AFRIWAG board members & senior management staff
[154] Ibid
[155] Brady, R. Khan, M, 2013, Final Evaluation of HelpAge International's Portfolio: Preventing HIV and AIDS and alleviating its Impact in Multigenerational Households, Country Visit to Kenya, HelpAge International, London

3.6.4.3 Income Generating Activities

In its most recent annual report, HelpAge highlights a significant achievement in having 3,950 OPAs with 90,000 members involved in IGAs across the world,[156] as part of its global action 1: enabling older women and men to have a secure income. It is surprising therefore that EWCARDC does not have a dedicated micro-finance or IGA specialist position identified within its staff structure.[157] While some members of the current staff structure may have appropriate skill sets to draw on, the current structure and design of EWCARDC does not appear to provide an opportunity to make use of those skills as part of current role descriptions. The experiences of this portfolio with IGAs as described under outcome 4 have highlighted how important it is to have appropriate skills in the regional office as well as in the implementing partners.

IGAs can be extremely successful as we have seen in Ethiopia, but they are high-risk interventions that can also go very wrong and leave beneficiary groups worse off than they were before the intervention, with the potential to damage the longer-term relationship with that beneficiary group. During our evaluation we came across requests for IGAs to be implemented in South Africa[158] and Tanzania[159], and we discovered that IGAs were also introduced in Uganda[160] as an unplanned part of the portfolio activities in that country.

When introducing these IGAs in Uganda it was not clear what the training or support was from the implementing partners. CAFO did have a track record in IGA implementation, however it is not clear that this had been taken into account, assessed and considered sufficient for the purposes. There was no reporting on these IGA activities to the donor.

We were unaware of the existence of these groups before we reached Uganda and the country team there had little available information on them. HelpAge has subsequently told us that these organizations were self-formed and self governed with rules and regulations set by the members with minimal push from the partners and they have registered the groups which are now recognized by government and could be used to channel government and other resources for service to the community which is partly to address the issue of sustainability. Like the Iddirs, they are social groups that have some social expectations that members cannot afford not to adhere to as they have larger implications socially, something that has larger implications on sustainability.[161] We have not however been able to verify any of this information about the IGA activity in Uganda.

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[156] HelpAge International Annual report and financial statements, 31 March 2012
[157] EWCARDC Organogram - Jan 2013
[158] Focus group discussion with traditional health practitioners, 4 March 2013
[159] Key informant interview with the Acting HIV Programme Manager, HelpAge International Tanzania Office: 26 February 2013
[160] Key informant interview with URAA Programme Manager, Kasese District. 6 March
[161] Feedback to Draft 2 of the Final Evaluation Report, May 2013

As HelpAge has outlined above, IGAs are also seen as a potential response to the issue of sustainability of projects. The apparent wide-spread reliance on IGAs for sustainability is a concern for us and we would not advise that IGAS are considered as a solution to sustainability concerns without the proper training and support mechanisms in place. If IGAs were implemented for sustainability in a HelpAge project, we would consider that the onus is on HelpAge to provide proper support for such activities to give them the best chance to succeed. The opportunity costs associated with IGA failure may be very high indeed.

3.6.4.4 M&E management

In concert with the challenges with implementing partners described above, monitoring and evaluation has also been challenging. The M&E Framework provided to us for the evaluation was, as described to us in the inception meetings, focused on process and outputs, with only a few outcomes included. Very little work had been done in the redesign of the framework in year 1 to include outcome and impact data collection or processes. While the quantitative figures have mostly been provided for numbers of beneficiaries reached, comments in the cells on the spreadsheet suggest that not all the figures have suitable paperwork to back them up. In addition, not all the figures shown in the framework match the figures reported in the annual reports to the donor.[162] Some activities have not been monitored between external evaluations, which do not provide sufficient opportunity for effective project management.

Where absolute figures (as opposed to percentages) are used in the M&E Framework, these are not always consistent with the figures reported to the donor in the quarterly and annual reports. In addition, some data appears o be lost or missing but as in the case of the Uganda data on paralegals and will writing, with additional data being included by the country teams upon review of our country report. Notes in the M&E Framework suggest that some beneficiaries have either died or moved away (such as in the case of older people trained as HBC givers in Tanzania) but the total including those who have died or moved away is still reported; and perhaps most significant, there is no monitoring of prevention data amongst beneficiaries during the portfolio except for the baseline and mid-term, which means that HelpAge would not have been able to track and identify and respond to issues that were affecting its activities.

3.6.5 Project 9 – organizational learning

Project 9 in the BLF portfolio was focused on sharing learning and good practice arising out of the BLF portfolio; and specifically to disseminate learning in Africa to national and international NGOs and in the UK to policy institutes, academia and the UK government. It was intended that Project 9 would contribute towards all four Big Lottery Fund portfolio outcomes. We

[162] See Brady, R. Khan, M, 2013, Final Evaluation of HelpAge International's Portfolio: Preventing HIV and AIDS and alleviating its Impact in Multigenerational Households, Country Visit to Kenya, HelpAge International, London for an example of this issue

have not discussed it under the different outcomes but instead in relation to HelpAge's organizational effectiveness, focusing this discussion on the learning rather than the outcomes. The project was originally intended to be delivered jointly by Help Age EWCADRC in Nairobi (40%) and the Head Office in London (60%).

HelpAge developed an evidence and learning framework approximately six years ago, just before the start of the BLF portfolio period, which was being developed by a cross-organisational working group. However organizational redevelopment had hindered the development of the learning agenda in HelpAge, as there had been a loss of staff and the Policy and Communications Department at Head Office had been split during the reorganization. A new team called the Policy, Influencing and Learning Team has been formed that will be taking the learning agenda within HelpAge forward. The BLF portfolio offered HelpAge an opportunity to work on a dedicated learning project, which was considered a great opportunity.[163]

However the original design for project 9 started with the dissemination of evidence based on portfolio activities, but had not considered how that evidence would be gathered. In year 2 HelpAge took the opportunity provided by a BLF visit to recommend that project 9 be redesigned to allow learning evidence to be collected and some dissemination to take place. A learning strategy was developed that looked at the outputs across 5 years and the methodology of how to deliver those outputs. BLF accepted this proposal and subsequently project 9 and its outputs looked very different to the original proposal. The project now emphasises the need to document learning and supports partners to collect data, analyse it and document it.

A key output was the "Learning Briefs" which allowed implementing partners to record formally the learning that has arisen from the projects. This approach also allowed an on-going conversation between the implementing partners across the portfolio and encouraged the partners to view each other as support for problem solving and advice. The briefs were designed to encourage the collection of useful qualitative data that could inform project planning in a dynamic way and beyond the data collection already set out in the Big Lottery Fund project proposal. However the briefs are shared mostly internally to the portfolio team. This approach is important as it goes beyond the quantitative limits of the M&E framework. The concept of the Learning Briefs has been shared more widely and the approach has been applied to other HIV work in HelpAge's network.

The other significant output that was implemented was the annual MEL workshops, which have been implemented since year 2 of the portfolio period. During our evaluation the partner staff teams have provided feedback on the value of these workshops and the participatory approach, which appears to have contributed significantly to implementing partners'

[163] Key informant interview with the HIV and AIDS Advisor, HelpAge International, 27 March 2013

skills and capacity. However this has not necessarily transferred across to M&E data collection, which remained poor at a portfolio level (see section 3.6.4.4 above).

The main outcome of the workshop approach has been the change in the planning approach taken by teams as informed by their project site visits during workshops. For example, experiencing how a community conversation in Ethiopia worked encouraged other partners to think about how they could implement that approach in their country.[164]

Project 9 was also used for funding appropriate research and case study gathering to supplement other data flows through the organisation. For example, the Peer Education guidelines were developed under project 9. An initial review revealed that Peer Education was being implemented differently in each country, however project 9 provided an opportunity to generate guidelines on Peer Education that could be used across HelpAge's network. This product is seen as a significant development for HelpAge generally with fundraising potential. At the document launch at a Peer Education conference in Nairobi in 2012 interest in the Peer Education guidelines was expressed from NGOs more broadly.[165]

The value of the learning methodology used in the Big Lottery Fund portfolio is beginning to be recognised by those working in other thematic policy areas within HelpAge globally and to contribute towards institutional learning. The BLF learning project has had impact on broader organizational learning and communication. Once the redesigned project 9 was fully functional and data was flowing from the partners and country offices, it was possible for HelpAge to use that data to have an impact. This has been seen in the number of HIV-related content on HelpAge's website. For example, the animated film "Age, sex and HIV: Older women's stories" was a new departure for HelpAge from its traditional approach to film making. In addition the HIV blog that HelpAge ran was the third most visited page on HelpAge's website.[166]

To mark the 30th anniversary of HIV and AIDS HelpAge produced a photo gallery of pictures of older persons which was accessible through their website[167]. It portrayed some of the experiences of the portfolio beneficiaries including home based carers and older people who were looking after people living with HIV.

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[164] Ibid
[165] Ibid
[166] Key informant interview with the HIV and AIDS Advisor, HelpAge International, 27 March 2013
[167] http://www.helpage.org/what-we-do/hiv-and-aids/30th-anniversary-of-hiv-and-aids-reflections-on-the-epidemic/

HelpAge also produced a virtual Project Scrapbook[168] that included stories of beneficiaries of the Big Lottery Fund portfolio. Stories illustrate the effect of income generating projects on the livelihoods of beneficiaries from Kenya, the work of home based carers in Tanzania, and in Uganda the impact of the paralegals supporting parents and grandparents to make a will to protect their inheritance rights and memory books to help orphans and vulnerable children remember their parents.

Another high point for the learning agenda within the BLF portfolio was HelpAge's facilitation and participation in a pre-conference meeting on HIV & Ageing in Africa at the International Conference on AIDS and Sexually Transmitted Infections in Africa (ICASA) in December 2011 in project Year 4 (run jointly with WHO, UNAIDS and Sydney School of Public Health). This was attended by a range of high-level HIV stakeholders. One of the outcomes of the meeting was a statement on HIV & Ageing and which was taken forward to the main ICASA conference.[169] This event was also developed into a HelpAge webpage. This is also an example of how HelpAge has been able to use activities within the portfolio to leverage funding from other organisations to support its activities, with UNAIDS and WHO jointly funding the pre-conference.

In addition VSO also reported that it had absorbed some of the learning from HelpAge's HIV-exclusive programming,[170] while earlier we reported that Handicap International had been able to increase its advocacy capacity and improve its advocacy model through its relationship with HelpAge. These are early examples of how HelpAge is able to extend its learning into other INGOs in the sector.

The prioritizing of learning in HelpAge is gathering pace. The reorganization of the Secretariat has allowed learning to be included in departmental descriptions. This is a key development for HelpAge, which has not always had the funding to prioritise learning in the way that it may have wanted to in the past. The redesign of project 9 and the subsequent outputs and outcomes described above reinforce this new learning priority.

3.6.6 Summary

In summary we can say that HelpAge's BLF portfolio of projects to prevent HIV and AIDS and mitigate its impact in multigenerational households has been somewhat effectively, not efficiently and partly economically implemented.

Partnerships are the core to HelpAge's implementation model, yet the management of partners is muddied and significant failings were missed,

[168] http://www.helpage.org/what-we-do/hiv-and-aids/tackling-the-impact-of-hiv-and-aids-in-africa-project-scrapbook/
[169] HelpAge International - IS2010281292 Year 4 End of Year Report_FINAL
[170] Key informant interview with the former Regional HIV & AIDS Policy Manager for VSO, 12 February 2013

which may have been spotted if the robust partnership processes in HelpAge's financial policies and procedures manual had been implemented effectively. Organisationally, EWCARDC appears not to have some crucial technical positions on site that may have helped in the management of the portfolio activities and identified technical failings earlier. Understanding its organizational design is crucial to addressing the efficiency, economy and partnership concerns expressed in this section. Understanding its organizational design and the relationship between the head office, the regional offices, the country offices and the implementing partner organisations more clearly (and making changes where appropriate) will have an impact on the design of future interventions and the role that partnerships will have to play in the delivery and management of activities. As a result HelpAge's partnership management and expectations (and therefore the capacity building focus for those partnerships) will also be affected and have to be improved.

However, by redesigning project 9, HelpAge has successfully transformed the learning agenda for the portfolio and influenced project planning and communication. Notable outputs from this activity are the "learning briefs" concept and the annual MEL workshops. Project 9 has also demonstrated that once evidence gathering is in place and working, evidence gathered can be used successfully to increase awareness and influence policy.

As a result this portfolio has only partly provided value for money to HelpAge and its donor, the Big Lottery Fund.

3.7 HelpAge's Theory of Change

In 2011 and 2012 HelpAge developed a Theory of Change for its HIV work globally:

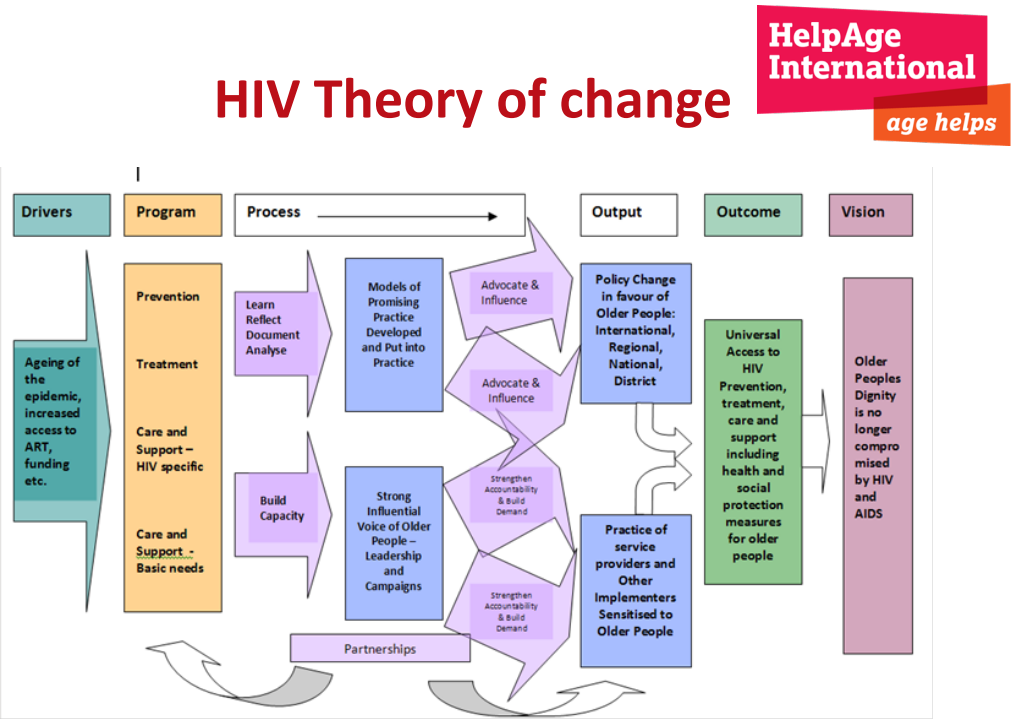

Figure 9: HelpAge's HIV Theory of Change, January 2012

This Theory of Change was not in place when the portfolio began and we have already illustrated that the data and evidence collected during the portfolio period was mainly at an output level (with some outcome data being recorded), which is not sufficient to measure whether or not the portfolio has contributed towards delivering the Theory of Change. However we have been able to consider (and have already discussed in sections 3.3 – 3.5) what impact overall HelpAge has had through the portfolio activities.

The portfolio is also viewed as an opportunity to develop models of good practice that could be rolled out as scaled up versions.[171] This is also articulated in the Theory of Change as an element of the process. HelpAge's use of incremental innovation to adapt existing successful models to its needs has enabled HelpAge to move towards developing its own models of good practice, but the team at EWCARDC agree that most activities would benefit from another 2 to 3 years of solid evidence gathering before the current activities could be ready to be scaled up and rolled out.[172]

This evaluation has seen that HelpAge has been successful in achieving impact in its advocacy activities and the target beneficiaries have overall valued the projects that they have participated in. While the issues in Kenya in the first two and a half years combined with a lack of employment opportunities might help to explain why we had not seen more significant

[171] HAI Stage 2 Strategic Application; meeting with HelpAge team on 25 April 2013
[172] Meeting with HelpAge team on 25 April 2013

impact in economic empowerment of orphans and vulnerable children in project 4, what was reported to us independently by all the implementing partners there was a change in attitude amongst the beneficiaries from dependency to self-sufficiency.

Added to this we have reported in section 3.4 on beneficiary attitudes towards the HBC component in Ethiopia and Tanzania, and we have demonstrated how households are beginning to be able to mitigate the impact of HIV through IGAs and paralegal support. Taking all this into account, we can say that HelpAge is achieving at least part of its HIV Theory of Change at output, outcome and vision level. There is some way to go yet on the capacity building element of the Theory of Change, not only of communities, but also of organisations that support those communities.

3.7.1 Impact Indicators

When the portfolio was designed, impact was not considered in the design of the projects or the M&E framework. In 2012 however HelpAge did some work to better understand the impact that it is having.[173]

The impact indicators that HelpAge established were:

- Improved health and emotional wellbeing of MGHs
- Improved health and emotional wellbeing of people living with HIV
- Improved health and emotional wellbeing of people living with HIV and caregivers
- Increased property and asset security for orphans and vulnerable children and MGHs and improved emotional wellbeing
- Reduced incidence among older people
- Reduced incidence among older people and their dependents
- Reduced incidence, improved health and emotional and economic wellbeing among older people
- Reduced poverty in MGHs

In our inception report, we stated that during our evaluation we would consider:

- Reduced incidence of infection
- Improved health status
- Improved emotional wellbeing
- Improve economic wellbeing
- Increased asset security for orphans and vulnerable children

The challenge during this evaluation was the lack of impact-level data collection. We addressed this by using tools such as PRAs and the non-randomised control evaluation. The focus groups also provided us with additional information that we have been able to use in considering impact.

[173] See Copy of ME framework - mapping impact Apr 2012, which plots potential impact against the M&E framework

Under section 3.5 we have already demonstrated that HelpAge's activities have contributed towards improved economic well being in Ethiopia; and over time it is likely that similar results will be demonstrated in Kenya following the successful redesign of that project. We have also discussed how the paralegal activity and the will writing and memory book activity in Uganda has contributed towards the economic security of older people and multigenerational households, as well as towards increased asset security for orphans & vulnerable children.

In section 3.4 we reported on how the training provided to traditional health practitioners in South Africa was having a knock on effect to their clients, providing them with improved health and general wellbeing through improved consultation practices; and the value that clients put on the HBC services that had an affect on their wellbeing (although unmeasured).

In Kenya all the implementing partners reported that they considered the most significant change coming out of activities there to be the change in mind-set that they observed in the community from one of dependence to one of self-sufficiency (see section 3.5). Although unmeasured (and hard to measure) the affect of such a mind-set change would be to bolster both economic and emotional wellbeing.

The one challenge that HelpAge faces is proving that a reduced incidence of infection amongst the communities that it works with is due to its interventions. Partly because HelpAge has not collected, or required to be collected, any data on reduced incidence of infection[174]; but also because reduced incidence is already being reported for the region at a UN level, which suggests that it is the result of a combination of all NGOs' and Governments' activities.

HelpAge's intended aim was to reduce the impact of HIV in multi-generational households. From a value and impact perspective such an aim has the potential to increase both quality of life (well-being) and economic security. We have certainly found evidence that in some cases, HelpAge's activities have contributed to increased economic security (IGA activity in Ethiopia and paralegal activity in Uganda) and beneficiaries in all the portfolio countries reported results that can contribute towards increased well-being and quality of life.

HelpAge states that gender and age are important in its reporting, however its activities and its M&E data collection for the portfolio does not prioritise gender and age disaggregated data. It also appears to be the case that gender and age do not feature in the design of the activities that have been delivered in this portfolio. This is curious given HelpAge's prioritization on disaggregated data in its reporting and as an aim for project 2 in the portfolio.

[174] We appreciate that the work on impact has been developed after the M&E Framework was agreed, however this underlines HelpAge's current challenges with data collection, analysis and communication of data.

HelpAge's work on impact is moving in the right direction and its Theory of Change on HIV is appropriate (although it could take more account of the central priority of social protection within HelpAge's strategies and how this work could affect its HIV strategies and build in a review loop). This work will be hampered however, unless HelpAge can resolve the data collection and analysis issues that appear to have dogged this evaluation and this portfolio of projects.

3.7.2 Data

HelpAge's M&E Framework focused mainly on output level activities (with some outcome level indicators only). It contained 9 outcomes (one for each project) with a series of indicators for each outcome. However the portfolio had 4 overarching outcomes, none of which were articulated in an M&E Framework or linked in any obvious way to any of the outcomes shown in the M&E Framework for the portfolio. While the HelpAge team and the partners were clear as to which project contributed to which of the 4 overarching outcomes, this was not reflected in the M&E activity.

In the feedback workshop with HelpAge and its partners on 25 April 2013, the partners were clear that they considered they were collecting data on portfolio activities mainly to report to the donor. In a study funded by BLF, Comic Relief, DFID and supported by Bond, the consultancy ITAD suggested that data collection for donor reporting may be the lowest level of effectiveness required for organisations to function.[175]

HelpAge appears not to distinguish between the type of data it requires at different levels of the organisation for different functions and requirements. Data has different roles to play at different levels of the organisation:

Strategic Development	↕	Impact level data that is analysed to understand gaps in provision and emerging trends in need
Annual business planning		Outcome level data that is analysed to provide evidence that supports annual planning activity
Regular Project / Portfolio Management		Output and Outcome level data that can be analysed to identify issues that need to be addressed on a regular basis and require management intervention
Day-to-day project delivery		Process and Output level data that can be analysed in the field to support daily decision making

Table 24: Data requirements at different levels in an organisation

It is important that HelpAge understands the different roles that data has to play in the organisation and designs its data collection and analysis accordingly. Improving the type of data collected and the depth of analysis of data on a regular basis will enable HelpAge to begin to measure its impact more meaningfully.

[175] ITAD, 2013, The Cost of Effectiveness, Bond, Comic Relief, Big Lottery Fund, Department for International Development (unpublished)

4 Conclusions and lessons learnt

HelpAge's overarching aim for this portfolio as expressed in its Stage 2 application was "to reduce the impact of HIV and AIDS on multigenerational households (MGHs) in Sub-Sahara Africa by using an overall strategy which develops approaches that mainstream older people's needs and contributions in response to the HIV/AIDS epidemic."[176]

HelpAge has been successful in extending proven prevention, awareness and support techniques previously used with other communities and beneficiary groups to older people. This is an important contribution to the wider response to the HIV epidemic in Africa. However some of its interventions and strategies have been less than successful in either equipping households economic empowerment (as is the case in Kenya) or in fully addressing the beneficiaries' needs (as is the case in Tanzania).

The implementation of the BLF portfolio was not smooth in the early part of its lifetime, with some activities requiring a period of redesign and the baseline survey taking place in the first year, delaying the implementation of some activities. While some projects did not need a redesign and could begin implementation in 2009, projects in Kenya, Ethiopia and Tanzania and Project 9 across the portfolio had some sort of revision or redesign in the first part of the portfolio period. While HelpAge are clear that this cannot be ascribed to staff turnover and lack of institutional knowledge in the organisation, our evaluation came up against regular comments that suggested that some staff turnover and new appointments early in the portfolio lifetime, coupled with either missing data or a lack of knowing where to find information and data had the effect in some cases of staff feeling like they were "starting again" when they entered their posts. All the changes that have taken place in the portfolio have produced better interventions, however it has come at the cost of efficiency and reduced effectiveness.

HelpAge's advocacy activities have perhaps been the most successful element of the portfolio, at both a national level and a regional level. The advocacy groups approach has been innovative and successful, providing structure and focus to local and national advocacy in the four countries that it has been implemented under BLF. This approach is also somewhat sustainable, with the groups undertaking their own fundraising for future activities and planning to continue to meet together after the BLF portfolio period HelpAge have also developed guidelines for implementing this approach that could be shared more broadly both within the network and beyond.

Prevention in the portfolio is a curious tale: on the one hand there is the success of the Peer Educators and Community Conversation facilitators (to the point that key stakeholders in Ethiopia viewed community conversations

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as only one of two interventions that should be continued[177]) and on the other hand there does not appear to be an increase in general HIV knowledge, there is consistent low use of condoms and an attitude prevalent amongst some older people that HIV remains an issue for younger people. What also emerged from the survey was that trust in domestic relationships appears to be a significant issue. Peer Education and the Community Conversation approach has been successful at providing older people with the tools to talk about HIV and raise the awareness that older people are at risk of HIV. This can also be seen in the significant improvement in the numbers of beneficiaries attending VCT services. VCT access was a key communication in the Peer Education and Community Conversation messaging. The results however do show the people over the age of 80 are less likely to go for testing, which suggests that the attitude reported to us that HIV is an issue for younger people, might have some resonance in older people's behaviour over a certain age.

Home-based care was delivered in two of the five countries in the portfolio. While the quality of the home-based care was clearly reported on by the beneficiaries, the HBC givers also reported that they, like the Peer Educators, were increasingly asked to support households in other matters unrelated to the portfolio. This highlights the degree of trust the beneficiaries have placed in the HBC givers and the Peer Educators. It also highlights how beneficiary needs changed during the portfolio lifetime. While most beneficiaries told us that HelpAge and its partners had been flexible in accommodating new needs where possible, HBC components were clearly affected by the introduction of ART. In Tanzania there is a strong likelihood that the national HBC curriculum has been influenced to include a component on older people.

The implementation of income generation activities in this portfolio was also a tale of two parts: significant success in Ethiopia, and significant challenges in Kenya. IGA interventions are not new for HelpAge and it has a global history in implementing such activities. While there is a Livelihoods advisor at the head office[178] and a similar post has been introduced at HelpAge Kenya as part of the redesign of project 4 and the capacity building of the implementing partners, there does not appear to be a dedicated post for micro-finance at the EWCARDC. This is a significant gap, given the priority of IGA activity in the Africa strategy. While some existing staff do have micro-finance experience, it is not part of their current role descriptions and therefore they have little time or formal opportunity to feed into such projects, except where issues arise that the EWCARDC have to respond to quickly.

HelpAge suggests that it places significant emphasis on increasing older people's access to social protection mechanisms to support economic security, which is reflected in its current organizational design priorities. Social protection is also an important part of the Africa strategy, but should

[177] The other being the IGAs
[178] Key informant interview with Head of Programmes, 29 April 2013

not detract from the equal priority given to IGAs in the Africa strategy, which should be equally resourced if that part of the strategy is to be achieved.

Partnership working has been central to the successes and challenges experienced during the lifetime of the portfolio. As a network organisation that delivers activities through its partners, HelpAge's ability to meet its overarching aim for this portfolio is reliant on the capacity and skill of its partners. Some of HelpAge's partners have demonstrated experience and skill, which has allowed them to deliver projects with a degree of effectiveness. However where partners have not been able to deliver activities (for whatever reason) HelpAge has sometimes been slow to react. When it did react though, HelpAge made every effort to rectify issues or contract in support for partners to ensure that the activities got back on track as quickly as possible. HelpAge's approach to partnership capacity evaluation with a default first line self-assessment approach has let it down in some instances during the portfolio. HelpAge does provide capacity building support, however the management of capacity building does not appear to be joined up and can lack a sense of control.

Like other parts of the portfolio, the learning project, project 9 was redesigned in the first half of the portfolio. That was a significant redesign that meant that learning within the portfolio was more appropriately addressed and taken account of. Key outputs that made a difference to project planning and implementing partners' management of their activities were the learning briefs and the annual MEL workshops. The workshops in particular are an excellent example of the kind of organizational capacity building that we would suggest HelpAge engages in more. It has shown to have a clear benefit to both the activities and the partner organisations. The link between evidence gathering and powerful communication has been proven with this project, especially the web-based and social media aspect, which HelpAge appears to have embraced.

As with most elements of the portfolio, value for money derived from the portfolio and its activities has been mixed. Whilst we acknowledge that the portfolio implementation probably predates the value for money agenda in HelpAge, our approach used in this evaluation of the 3Es has highlighted some of the issues discussed above. Efficiency and economy were the main areas that reduced the potential for value for money in the portfolio. However value for the beneficiaries was generated at a household level and overall the target beneficiaries did feel that the interventions were valuable to them. This is a good indication that HelpAge is on the right track with the nature of its interventions, but needs to do more to make its own operation more efficient and effective. Value for money is an emerging issue that will continue to require HelpAge to focus on the areas evaluated in this review.

Efficiency has been an issue for HelpAge during the portfolio period. Whilst, like all organisations, it needed to review its activities during the height of the global economic downturn and looked for ways to deliver agreed activities;

the regional policy of allowing up to 40% of project costs to be spent on salaries and overheads, etc. has allowed a significant amount of the grant to be spent on non-beneficiary related activities, with some staff positions getting allocations from both the project budget and the management budget. While partnership working does increase the costs of project delivery, where HelpAge has also made use of a country office or an intermediary partner like HelpAge Kenya or URAA, costs have been higher than perhaps was necessary. In general there is a lack of clarity about ownership of activities and responsibility within the portfolio management approach that comes partly as a result of a similar lack of clarity in ownership of activities described in HelpAge's regional policies and procedures and partly from a capacity issue, with the portfolio management team being quite small for such a broad portfolio. We are not convinced that EWCARDC has matched existing staff and skill sets with its strategic priorities in an organizational structure that responds to those priorities.

Sustainability for activities within the portfolio is mixed. Where activities have been well integrated or developed their own income generating potential (such as the IGAs in Ethiopia), they have also demonstrated some sustainability (albeit at a reduced level from the portfolio investment). Where implementing partners and country offices have held exit discussions with beneficiaries and participants, priorities for taking forward a reduced number of interventions have been agreed. While a plan to reduce the number of advocacy groups and introduce fundraising to the groups has commenced. Where some activities have been incorporated into government structures to ensure their survival (such as in Ethiopia), other interventions have not yet attracted additional support from local or national government (such as the paralegals in Uganda). Sustainability is patchy therefore and appears driven by the partners rather than by HelpAge or the EWCARDC. Although HelpAge is clear that sustainability has been a topic of regional workshops for approximately two years.

In considering HelpAge's overarching aim for this portfolio: "to reduce the impact of HIV and AIDS on multigenerational households (MGHs) in Sub-Sahara Africa by using an overall strategy which develops approaches that mainstream older people's needs and contributions in response to the HIV/AIDS epidemic,"[179] we can say that:

- HelpAge's overall impact through the portfolio has been focused mainly on advocacy and specifically on the outcomes delivered in Ethiopia, which has demonstrated significant impact and was not subject to a redesign phase;
- HelpAge's beneficiaries are beginning to demonstrate the ability to mitigate the impact of HIV in their households, with the exception of Ethiopia where household resilience is clearly demonstrated;
- HelpAge's incremental innovation of applying proven methods of HIV prevention and care specifically to older people is beginning to pay off.

[179] HAI Stage 2 Strategic Application

However it is not entirely the case that every project has delivered a model of good practice that can contribute to mainstreaming older people's needs and contributions in response to the HIV epidemic; and

- HelpAge's increasingly innovative approach to learning within the portfolio and their highly innovative approach to advocacy at a national and local level will continue to deliver increased impacts over time.

With this portfolio, HelpAge has gone some way towards meeting its intended aim of reducing the impact of HIV on multigenerational households in every country included in the BLF portfolio, however this aim has not been completely achieved and as was reported to us at the feedback workshop in Nairobi in 25 April 2013, HelpAge would need another 2 to 3 years to fully develop, evidence and write up the approaches used in this portfolio to have a suite of good practice approaches that can be fully rolled out in its other areas of operation.

5 Recommendations

5.1 Recommendations for the Future

When we consider the future we can identify four features of this portfolio that HelpAge may wish to consider taking forward as general concepts for future programming and strategy development:

1. Incremental Innovation: This approach takes known successful interventions that have been applied either in another country or with another type of beneficiary and adapts and applies those same interventions to your beneficiary groups. Incremental innovation is a significant tool for further developing models of good practice that can help HelpAge to achieve its Theory of Change;
2. Mainstreaming HIV: The trend towards mainstreaming HIV into health and development initiatives (rather than maintaining HIV as a stand alone programme) is taking place across the developing world. Mainstreaming HIV into all of its activities, especially social protection, will allow HelpAge to take forward much of the HIV-specific learning from the portfolio into a broader programming remit and will also potentially address certain funding issues for some activities;
3. From the group to the individual: The trend observed in some of the projects of initiating interventions through groups (such as the community conversations) which lead to greater acceptance and participation at an individual level (such as the home based care services or peer education model) is potentially a methodology that should be studied and developed further.
4. Income generating activities: IGAs appear to be either implemented or planned in most countries in the portfolio as either an intervention or a source of sustainability. While we recognize the importance of these activities to HelpAge's beneficiaries, we would caution unbridled use of this intervention without the proper support, training and resourcing behind it, as it is a higher risk intervention for the beneficiaries.

5.2 Recommendations arising out of this evaluation

Operational recommendations arising out of this evaluation are:

1. Partnerships
    a. Capacity Building: HelpAge currently provides some capacity building within the context of its project partnerships. HelpAge should consider establishing a separate programme of work that is only about providing capacity building to its affiliates and members of the network. Although this programme would support one of the strategic aims of developing the network, it will also have a more immediate knock on effect of improving the quality of the partnerships and projects being delivered. This is especially important as HelpAge only works through partnerships;

b. Partnership Management: Partnership management processes appear robust, but do not appear to be implemented fully, with some responsibilities falling between the cracks. HelpAge should review its partnership management processes to ensure partners receive consistent support and monitoring whether from EWCARDC or HelpAge Country Offices;
c. EWCARDC to strengthen technical support to project partners by adopting the model used by the Advocacy Team partners as standard practice. This model is a direct relationship between the Advocacy and Communications team at EWCARDC and the advocacy groups, providing tailored technical support that included training and support during actual advocacy sessions and regular, close follow up to help build capacity and skills; and
d. EWCARDC should also consider reviewing the process by which capacity building support is provided and monitored and close some of the gaps in the process that allow issues to not be recognized quickly.

2. Organisational Development
   a. HelpAge should analyse its structures to explore whether there is duplication (e.g. staffing, reporting) between EWCARDC, its country offices and implementing partners and how this impacts on effectiveness. The results of this will have an impact on the design of future interventions and the role that partnerships will have to play in the delivery and management of activities. Understanding its organizational design more clearly and making changes as a result of that will impact on HelpAge's partnership management and expectations (and therefore the capacity building focus for those partnerships);
   b. HelpAge's regional policy on a 60%-40% project budget split appears excessive in relation to other organizational policies in the sector. This policy should be reviewed, whilst continuing to take into account the need for appropriate cost recovery from all budgets;
   c. HelpAge should consider making better use of its existing infrastructure (regional offices, country offices, affiliates, partners, etc.) to maximize economies of scale in procurement and supplier management;
   d. The portfolio's unit costs are very high. HelpAge should consider undertaking a cost analysis exercise (possibly using a costing methodology such at that published by UNAIDS for costing facilities and services or the HIV-related Human Rights costing tool) to determine the full cost of its activities and use process mapping methodology to find ways to reduce cost across its activities; and
   e. HelpAge needs to clearly define the roles and responsibilities of its regional offices versus its national offices so that each can

articulate its own response in-country or regionally in an appropriate way.

3. Value for Money:
    a. HelpAge needs to determine what its organizational approach to the value for money agenda should be. There are a number of competing methodologies and points of view and HelpAge should determine the role that value for money will play in the organisation;
    b. Efficiency is an issue for HelpAge that it needs to pay greater attention to and understand how it impacts activities when it is designing and implementing projects and programmes; and
    c. HelpAge needs to match the skills and capacity of its regional and national offices with the requirements of its projects and programmes to ensure efficient and effective project delivery.
4. Data and Reporting
    a. Understand and articulate the flow of data from beneficiary level up through the organisation and how data is used at every level and what for, to ensure data is used to improve performance at every level in the organisation;
    b. Relate the data collected during projects, back to project design, for example: much data is collected and analysed according to gender and age, however gender and age do not appear to have any bearing on project design. Additionally data disaggregation is a key aim for this portfolio, but the disaggregation is not borne out in HelpAge's own programming;
    c. Improve reporting with respect to:
        i. Prevention activities (consistent with reports prepared for clinics, upward reporting in-country and local VCT services). Very detailed data is collected by HelpAge's implementing partners under their responsibilities to local and national government, this data is sometimes more comprehensive than the data that HelpAge requires, but can serve as a proxy for HelpAge's M&E requirements, thereby reducing the reporting burden on the partners. Additionally HelpAge's M&E framework did not require that all activity was collected and reported on, which meant that partners did not collect some data;
        ii. Reporting of quantitative project deliverables on a regular basis and analysis of this data occurring as close to the beneficiary level as possible;
        iii. Collect, analyse and review data more regularly, particularly with respect to prevention, to ensure that data has an early impact on project planning and priority behaviour changes relevant for HIV are targeted;
5. Activity specific:
    a. Data disaggregation:

i. Mobilise other agencies to jointly gather more evidence on HIV and older persons for use in national advocacy activities
ii. Step up the advocacy of big donors such as CDC to adapt the standard design of data collection formats to include data for older persons 50+.

b. Adapt the existing posters on Peer Education to develop culturally specific hand-held portable 'flip-books' that can be easily carried by Peer Educators over longer distances and used informally in domestic settings and with illiterate communities. Flip-books are different from the current Peer Education manual tools in that they are more robust and smaller. Additionally flip-books can be designed to replace many individual tools, reducing the volume of what the Peer Educator has to carry;
c. HelpAge's home-based care programme led to greater demands for additional services from the beneficiaries. HelpAge should consider developing or adopting broader-based models of home-based care and services that address a wider range of needs for older carers and MGHs, including HIV-specific support, that potentially also support HelpAge's priorities for older people's specific health issues and social protection;
d. Where HelpAge is committed to implementing IGAs, it should provide dedicated technical support from EWCARDC for IGA projects as a greater need for them emerges among populations where HIV prevalence is high. Produce more detailed IGA implementation guidelines for older persons and suitable for use by IGA partners; and
e. Improve the data collection and analysis of case reporting for paralegal activity to take proper account of successes and challenges and to contribute to a better analysis of the impact of this kind of activity.

6. Sustainability
    a. HelpAge should consider the issue of sustainability early on the in the project and so that project implementers such as Advocacy Group members, Peer Educators, Paralegals and HBCs are prepared for when the project funding comes to an end. We would not recommend the implementation of IGA activities as a response to sustainability issues, as this is a high-risk intervention that requires dedicated resources to support it successfully.
    b. HelpAge should ensure that project partners are sufficiently capacity built (ref recommendation 1a) to support project activities independently once HelpAge's funding is withdrawn (either through the partners' own funds or their fundraising activities based on high quality data collected from the project as evidence of success); and

c. Undertake advocacy for sustainability jointly with partners at a national level to encourage local, regional and district administration structures to assume financial responsibility for some of HelpAge's activities or identify other sources of funding.

5.3 Recommendations for Future Studies

During our evaluation we have seen instances where additional research might benefit HelpAge to understand better the impact it is having in specific communities or the situation that its beneficiaries are in and as a result design more relevant interventions:

1. HelpAge may wish to explore further the issue of trust in domestic relationships as exposed by the results of the KAP survey in the questions relating to risk;
2. Understanding beneficiary motivation behind behaviour change would provide valuable evidence. HelpAge may wish to conduct such a study that could be used to inform a more tailored intervention design and potentially increase the positive impact of HelpAge's activities;
3. The challenge for HelpAge is to come up with a response to the general reason provided by CDC and USAID for the limitations of the databases being provided: cost. This may be a matter of determining the value of the data to be collected and analysed and determining the potential cost savings or opportunity costs presented by governments knowing and using this data. HelpAge may wish to consider commissioning a value for money or social return on investment analysis of this data in order to provide the evidence for this advocacy approach;
4. The new Tanzanian national HBC curriculum is not yet published but it is likely that older persons will be included given HelpAge's involvement in the pilot. HelpAge should to follow up on this separately and an independent study on the potential impact of the national curriculum once published is worth considering; and
5. The IGA project in Ethiopia appears to have been the most successful element of the country-specific projects across the portfolio. Our evaluation did not have sufficient time and budget to allow for a full impact evaluation of the Ethiopian IGA project. It could be useful for HelpAge to undertake a separate impact evaluation of the IGA activities in Ethiopia to fully understand the success at alleviating poverty and encouraging resilience amongst older people and their communities.

6 Appendices

6.1 Ethiopia Country Report

See separate file

6.2 Kenya Country Report

See separate file

6.3 South Africa Country Report

See separate file

6.4 Tanzania Country Report

See separate file

6.5 Uganda Country Report

See separate file

6.6 Inception Report

See separate file

6.7 Advocacy Groups funded by BLF

This Appendix includes the Advocacy Group members (including CSOs and others) for Kenya, Ethiopia and Uganda that are funded by BLF.

Kenya (25 CSO members, 4 other members)

- **Four advocacy, groups established in 2010, based in Nairobi, HelpAge International partner, lead organizations, funded by BLF**
  - HelpAge International partner: HelpAge Kenya
  - HIV Prevention: Movement of Men Against AIDS in Kenya (MMAAK)
  - Care and Support:
  - HIV and AIDS Treatment and Health: Greater Love for Women and Men Organisation (GLOWAMO)
  - Social Protection and Livelihoods: The Association of People with AIDS in Kenya (TAPWAK)

- **CSO Members of the Advocacy Groups**
  1. KESPA
  2. Senior Women Citizens for Change, SWCC
  3. Kenya Orphans Support Organization, KOSO
  4. Movement of Men Against AIDS in Kenya, MMAAK
  5. Integrated AIDS Program, IAP Thika
  6. Health Education Africa Resource Team, HEART
  7. Christian Community Services, CCS – Thika
  8. Mt. Kenya A.I.S
  9. Greater Love of Women and Men Organization, GLOWAMO
  10. KARIKA Ageing and HIV/AIDS Program
  11. The Association of People with AIDS in Kenya, TAPWAK
  12. Kenya Network of Women with AIDS, KENWA
  13. Women Fighting AIDS in Kenya, WOFAK
  14. Foundation of People with AIDS In Kenya, FOPHAK
  15. National Organization of Peer Educators, NOPE
  16. Youth Education Network, YEN
  17. HelpAge Matiliku
  18. Health Systems Partners, HESPA
  19. Embakasi Deaf Women Organization
  20. Community Nurturing International
  21. Network of Men with AIDS, NETMA+
  22. Uzima Foundation
  23. HelpAge Kenya
  24. AGAPE African Woman
  25. Nairobi Urban Women Organization on Housing, NURWOH

- **Other Advocacy Group Members**
  1. Radio Waumini
  2. GIZ
  3. FEP Media
  4. City Council of Nairobi

Ethiopia (17 CSO members)

- **Four advocacy groups established in 2008 and expanded to five groups in 2009, two based in Addis Ababa and three based at regional level, HelpAge International partner, lead organizations, funded by BLF**
  - HelpAge International partner: HelpAge International Ethiopia
  - HIV and AIDS Prevention (Addis Ababa): Ethiopia Elderly Persons National Association
  - HIV and AIDS Care, Support and Treatment (Addis Ababa): Tesfa Social and Development Association (TSDA)
  - HIV and AIDS Care, Support and Treatment (Southern Region): Medhin Ethiopia HIV Positive Older People Association
  - Health (Eastern Region): Dawit Elderly Support Association
  - Livelihood, Poverty and IGA (Oromia Regional State): Rift Valley Children and Women Development Association

- **CSO Members of the Advocacy Groups**
  1. World Vision Ethiopia
  2. Friendship for Integrated Development Association
  3. Integrated holistic Urban Development
  4. Keste Demana Older People's Association
  5. Addis Ababa Older People's Association
  6. Enredada Older People's Association
  7. St. George Older People's Association
  8. Wud Argawian Association
  9. Awassa Iddir Union
  10. Christian Child Fund
  11. Biruh Tesfa Association
  12. Kelem Pastoralist
  13. Ethiopia Elderly Persons National Association
  14. Tesfa Social and Development Association
  15. Medhin Ethiopia HIV Positive Older People Association
  16. Dawit Elderly Support Association
  17. Rift Valley Children and Women Development Association

Uganda (10 CSO members)

- **Three advocacy groups established in 2008, based in Kampala, HelpAge International partner, lead organizations, funded by Sida/NORAD**
  - HelpAge International partner: Uganda Reach the Aged Association
  - HIV and AIDS National Advocacy Group: Uganda Network of AIDS Service Organizations
  - Health, HIV Care, Support and Treatment National Advocacy Group: Mildmay International Uganda
  - Social Protection/Livelihood National Advocacy Group: Reach One Reach One Ministries (ROTOM)

- **One district level advocacy group** established in 2010, based in Kasese District and funded by BLF

CSO Members of the Kampala-based Advocacy Groups

1. Uganda Network of AIDS Service Organizations (UNASO) – Lead Agency HIV&AIDS National Advocacy Group
2. Mildmay International Uganda – Lead Agency Health, HIV Care, Support and Treatment National Advocacy Group
3. Reach One Reach One Ministries (ROTOM) – Lead Agency Social Protection/Livelihood National Advocacy Group
4. National Association of Women in Uganda (NAWOU)
5. National Community of Women Living with HIV&AIDS (NACWOLA)
6. AIDS Information Centre (AIC)
7. The AIDS Support Organization (TASO)
8. Spreading AIDS Information and Learning (SAIL) Uganda
9. Coalition for Health Promotion and Social Development (HEPS-Uganda)
10. Send a Cow

Other National Advocacy Group Members

1. Ministry of Health (MOH)
2. Ministry of Gender, Labour and Social Development (MGLSD)
3. Uganda AIDS Commission (AC)
4. Media (UBC FM and Star FM)
5. Kyambogo University
6. Medical Research Council (MRC)
7. Baylor College of Medicine

CSO Members of the Kasese District Advocacy Group (5 CSO members, 2 other members)

1. Uganda Christian Lawyers Fraternity
2. Foundation for Urban and Rural Development
3. CAFO
4. Obusinga Bwa Rwanzururu
5. Uganda Reach the Aged Association

Other Kasese District Advocacy Group Members

1. Kasese District Local Government (2)

Tanzania

In Tanzania leadership issues within the advocacy groups was a major constraint in the groups becoming active.

6.8 Budget Lines and their Codes included in Table 22 in section 3.6.2.1 Financial Analysis

Activity	PARTNER	Code
Vehicle insurance (6% purchase price)	ARDC	10.1p1
Vehicle running cost	ARDC	10.2p1
Baseline survey	ARDC	10.4p1
Portfolio manager HIV/AIDS ARDC	ARDC	11.1p1
Project Coordinator -ARDC	ARDC	11.2p1
Project Officer - ARDC	ARDC	11.5p1
Finance Officer-ARDC	ARDC	11.3p1
Driver - ARDC	ARDC	11.4p1
Regional Representative - ARDC	ARDC	13.1p1
Regional Programme Manager - ARDC	ARDC	13.2p1
Regional finance manager-ARDC	ARDC	13.3p1
M & E - ARDC	ARDC	13.4p1
Administrative Assistance	ARDC	13.5p1
Communications officer	ARDC	13.6p1
Rent-ARDC	ARDC	13.30p1
Rates and Utilities, security ARDC	ARDC	13.31p1
Communications (tel, fax, email, courier)-ARDC	ARDC	13.32p1
Stationary and consumables-ARDC	ARDC	13.33p1
Equipment repairs & Maintenance-ARDC	ARDC	13.34p1
Bank charges-ARDC	ARDC	13.35p1
Transport costs-ARDC	ARDC	13.37p1
Regional Advocacy Manager - ARDC	ARDC	13.38p1
Regional Advocacy - ARDC	ARDC	13.39p1
Vehicle insurance (6% purchase price)	ARDC	10.1p2
Vehicle running cost	ARDC	10.2p2
Baseline survey	ARDC	10.4p2
Portfolio manager HIV/AIDS ARDC	ARDC	11.1p2
Project Coordinator -ARDC	ARDC	11.2p2
Project Officer - ARDC	ARDC	11.5p2
Finance Officer-ARDC	ARDC	11.3p2
Driver - ARDC	ARDC	11.4p2
Regional Representative - ARDC	ARDC	13.1p2
Regional Programme Manager - ARDC	ARDC	13.2p2
Regional finance manager-ARDC	ARDC	13.3p2
M & E - ARDC	ARDC	13.4p2
Administrative Assistance	ARDC	13.5p2
Communications officer	ARDC	13.6p2
Rent-ARDC	ARDC	13.30p2
Rates and Utilities, security ARDC	ARDC	13.31p2
Communications (tel, fax, email, courier)-ARDC	ARDC	13.32p2
Stationary and consumables-ARDC	ARDC	13.33p2
Equipment repairs & Maintenance-ARDC	ARDC	13.34p2
Bank charges-ARDC	ARDC	13.35p2
Transport costs-ARDC	ARDC	13.37p2
Regional Advocacy Manager - ARDC	ARDC	13.38p2

Regional Advocacy - ARDC	ARDC	13.39p2
Project Officer-HAK	HAK	11.2p4
Micro Finance Officer	HAK	11.6p4
CEO-HAK	HAK	13.9p4
Finance Officer-HAK	HAK	13.15p4
Partner's staff & running costs-	HAK	13.29p4
Rent-HAK	HAK	13.30p4
Rates and Utilities, security HAK	HAK	13.31p4
Communications (tel, fax, email, courier)-HAK	HAK	13.32p4
Stationary and consumables-HAK	HAK	13.33p4
Equipment repairs & Maintenance-HAK	HAK	13.34p4
Bank charges-HAK	HAK	13.35p4
Transport costs-HAK	HAK	13.37p4
Project Officer-URAA	URAA	11.2p5
CEO-URAA	URAA	13.11p5
Finance Officer-URAA	URAA	13.16p5
Programme manager - URAA	URAA	13.20p5
Partner's staff & running costs-	URAA	13.29p5
Rent URAA	URAA	13.30p5
Rates and Utilities, security-URAA	URAA	13.31p5
Communications (tel, fax, email, courier) URAA	URAA	13.32p5
Stationary and consumables-URAA	URAA	13.33p5
Equipment repairs & Maintenance-URAA	URAA	13.34p5
Bank charges-URAA	URAA	13.35p5
Transport costs-URAA	URAA	13.37p5
Project Officer-MUSA	MUSA	11.2p6
Trainer	MUSA	11.7p6
CEO-MUSA	MUSA	13.10p6
Finance Officer-MUSA	MUSA	13.12p6
Rent-MUSA	MUSA	13.30p6
Rates and Utilities, security-MUSA	MUSA	13.31p6
Communications (tel, fax, email, courier)-MUSA	MUSA	13.32p6
Stationary and consumables-MUSA	MUSA	13.33p6
Equipment repairs & Maintenance-MUSA	MUSA	13.34p6
Bank charges-MUSA	MUSA	13.35p6
Transport costs-MUSA	MUSA	13.37p6
Project Officers -HAI Ethiopia	HAETH	11.2p7
Project Officer-TSDA	TSDA	11.2p7
Country Director-B HAI Ethiopia	HAETH	13.7p7
Finance Officer-HAI Ethiopia	HAETH	13.13p7
Contract Manager - HAIE	HAETH	13.17p7
Programme Assistant - HAIE	HAETH	13.18p7
Driver - HAIE	HAETH	13.19p7
Partner's staff & running costs-	TSDA	13.29p7
Rent-HAETH	HAETH	13.30p7
Rates and Utilities, security-HAIETH	HAETH	13.31p7
Communications (tel, fax, email, courier)-HAETH	HAETH	13.32p7
Stationary and consumables-HAETH	HAETH	13.33p7

Equipment repairs & Maintenance-HAETH	HAETH	13.34p7
Bank charges-HAETH	HAETH	13.35p7
Transport costs-HAETH	HAETH	13.37p7
Project Officer-HAI Tanzania	HAIT	11.2p8
Project Officer-Tz Partner	Tz PARTNER	11.2p8
20% HIV/AIDS PO salary contribution - HAIT	HAIT	11.6p8
100% PO salary support-TzPartner	Tz PARTNER	11.7p8
Country Director-B HAI Tanzania	HAIT	13.8p8
Finance Officer-HAI Tanzania	HAIT	13.14p8
Partner's staff & running costs-	Tz PARTNER	13.29p8
Rent-HAIT	HAIT	13.30p8
Rates and Utilities, security-HAIT	HAIT	13.31p8
Communications (tel, fax, email, courier)-HAIT	HAIT	13.32p8
Stationary and consumables-HAIT	HAIT	13.33p8
Equipment repairs & Maintenance-HAIT	HAIT	13.34p8
Bank charges- HAIT	HAIT	13.35p8
Transport costs HAIT	HAIT	13.37p8
UK HIV Project Officer	HAUK	9.9p
Vehicle insurance (6% purchase price)	ARDC	10.1p9
Vehicle running cost	ARDC	10.2p9
Baseline survey	ARDC	10.4p9
Portfolio manager HIV/AIDS ARDC	ARDC	11.1p9
Project Coordinator -ARDC	ARDC	11.2p9
Project Officer - ARDC	ARDC	11.5p9
Finance Officer-ARDC	ARDC	11.3p9
Driver - ARDC	ARDC	11.4p9
Regional Representative - ARDC	ARDC	13.1p9
Regional Programme Manager - ARDC	ARDC	13.2p9
Regional finance manager-ARDC	ARDC	13.3p9
M & E - ARDC	ARDC	13.4p9
Administrative Assistance	ARDC	13.5p9
Communications officer	ARDC	13.6p9
Rent-ARDC	ARDC	13.30p9
Rates and Utilities, security ARDC	ARDC	13.31p9
Communications (tel, fax, email, courier)-ARDC	ARDC	13.32p9
Stationary and consumables-ARDC	ARDC	13.33p9
Equipment repairs & Maintenance-ARDC	ARDC	13.34p9
Bank charges-ARDC	ARDC	13.35p9
Transport costs-ARDC	ARDC	13.37p9

6.9 Data Collection Tools

In this evaluation we used four main data collection tools:

1. The endline survey
2. Focus group discussions
3. PRA exercises
4. Key informant interviews (see appendix 6.10)

Sample of Endline Survey:

Household Questionnaire

Questionnaire # Date ……Interviewer Name.....

Country.....District..... Area……,……..

1. Age

50-59…… 1 [ ]
60-69…… 2 [ ]
70-79…… 3 [ ]
80+…… 4 [ ]

2. Sex

Male …… 1 [ ]
Female…… 2 [ ]

3. Religion

Islam …… 1 [ ]
Christian…… 2 [ ]
Traditional/African …… 3 [ ]
Any other [Specify]…… 4 [ ]

4. Level of education

College…… 1 [ ]
High school …… …. 2 [ ]
Primary…… 3 [ ]
Non formal …… 4 [ ]
None…… 5 [ ]

5. What is your marital status?

Married…… 1 [ ]
Single …… 2 [ ]
Separated …… 3 [ ]
Widow/widower…… 4 [ ]

6. What is your source of income?

Employed…… 1 [ ]
Casual …… 2 [ ]
Business …… 3 [ ]
Farming…… 4 [ ]
Pension …… 5 [ ]
Relatives support…… 6 [ ]
Other [Specify]…… 7 [ ]

7. How long have you lived here?

< 1 year…… 1 [ ]
1 year – 5 years…… 2 [ ]
> 5 years…… 3 [ ]

8. Who is the head of the household?

Grandparent…… 1 [ ]
Parent…… 2 [ ]
Grandchild…… 3 [ ]
Other, Specify…… 4 [ ]

9. Number of household members

Grand parents 1.Male |___|___| 2.Female |___|___|
Parents 1.Male |___|___| 2.Female |___|___|
Grandchildren 1.Male |___|___| 2.Female |___|___|
Great Grandchildren 1.Male |___|___| 2.Female |___|___|
Other, Specify……

10. Number of OVC (under 18) within the household

Number of Males

0…… 1 [ ]
1 …… 2 [ ] Age |___|___|
3 …… 3 [ ] Age |___|___|, |___|___|, |___|___|
4+…… 4 [ ] Age |___|___|, |___|___|, |___|___|, |___|___|, |___|___|

Number of Females

0…… 1 [ ]
1 …… 2 [ ] Age |___|___|
3 …… 3 [ ] Age |___|___|, |___|___|, |___|___|
4+…… 4 [ ] Age |___|___|, |___|___|, |___|___|, |___|___|, |___|___|

11. Number of OVC (between 18 &25) within the household

Number of Males

0…… 1 [ ]
1 …… 2 [ ] Age |___|___|
3 …… 3 [ ] Age |___|___|, |___|___|, |___|___|
4+…… 4 [ ] Age |___|___|, |___|___|, |___|___|, |___|___|, |___|___|

Number of Females

0…… 1 [ ]
1 …… 2 [ ] Age |___|___|
3 …… 3 [ ] Age |___|___|, |___|___|, |___|___|
4+…… 4 [ ] Age |___|___|, |___|___|, |___|___|, |___|___|, |___|___|

KNOWLEDGE OF HIV, SOURCES OF INFORMATION, ATTITUDE,PRACTICES &BEHAVIOUR

13. What do you understand by HIV?

Sexually transmitted disease …… 1 [ ]
A disease that affects ones immunity…… 2 [ ]
A disease that is a curse…… 3 [ ]
Don't know…… 4 [ ]
Other, Specify…….....5 [ ]

14. How is HIV transmitted?

Unprotected sexual intercourse…… 1 [ ]
Transfusion with infected blood…… 2 [ ]
Sharing sharp objects……..... 3 [ ]
MTCT…… 4 [ ]
Other [Specify]…….…… 5 [ ]

15. How can one prevent being infected with HIV?

Abstaining from sex …… 1 [ ]
Being faithful to one faithful partner…….. 2 [ ]
Using condoms during sexual intercourse……..…. 3 [ ]
Using protective materials such as gloves when handling body fluids…….. 4 [ ]
PMTCT……..…. 5 [ ]
Other, Specify…… 6 [ ]

16. Where do you mostly get information about HIV & AIDS?

Spouse……..……. 1 [ ]
Relatives……..... 2 [ ]
Friends……. 3 [ ]
Health Facility personnel…… 4 [ ]
Church/Mosque/Temple…….. 5 [ ]
Media/Radio/Newspaper/TV…… 6 [ ]
NGO/CBO staff/Seminar…….. 7 [ ]
Traditional Health Practitioner…….. 8 [ ]
Other, Specify…… 9 [ ]

17. Which of these sources do you value most regarding information on HIV & AIDS?

Spouse……. 1 [ ]
Relatives…… 2 [ ]
Friends……. 3 [ ]
Health Facility personnel……. 4 [ ]
Church/Mosque/Temple…….. 5 [ ]
Media/Radio/Newspaper/TV…… 6 [ ]
NGO/CBO staff/Seminar……. 7 [ ]
Traditional Health Practitioner……. 8 [ ]
Any Other [Specify]…… 9 [ ]

18. Do you consider yourself at risk of infection (re-infection) with HIV?

Yes ..... 1 [ ]
No..... 2 [ ]
Don't know..... 3 [ ]

19. If Yes, why do you consider yourself at risk?

Taking care of PLW..... 1 [ ]
Have multiple sex partners..... 2 [ ]
Spouse/partner died from AIDS..... 3 [ ]
Don't know how to protect oneself..... 4 [ ]
Other, Specify..... 5 [ ]

20. If No, why do you consider yourself out of risk

I have abstained..... 1 [ ]
I use a condom..... 2 [ ]
I am faithful to one faithful partner..... 3 [ ]
AIDS is a hoax..... 4 [ ]
No reason..... 5 [ ]
Other [Specify]..... 6 [ ]

21. How many sexual partners do you have?

One..... 1 [ ]
Multiple..... 2 [ ]
None..... 3 [ ]

22. Do you know where you can find out your HIV STATUS?

Yes..... 1 [ ]
No..... 2 [ ]

23. If yes, where?

Health facility..... 1 [ ]
VCT site..... 2 [ ]
Community centre..... 3 [ ]
Other, Specify..... 4 [ ]

24. How long does it take to get to the above site from where you live?

Time in hours |___|___|

25. Have you ever been tested for HIV?

Yes ..... 1 [ ]
No..... 2 [ ]

26. If yes, do you know your status?

Yes ..... 1 [ ]
No..... 2 [ ]

27. If yes, when were you tested?

Within the last 12 months..... 1 [ ]
More than 12 months ago..... 2 [ ]

28. If yes, what did you learn from the experience?

I know how to protect myself from infection..... 1 [ ]
I know how to live positively..... 2 [ ]
I know how to care for others..... 3 [ ]
It has made no difference to me..... 4 [ ]
Other, Specify..... 5 [ ]

29. If No, what is the reason for not testing?

Do not see the need..... 1 [ ]
I fear being seen by friends/relatives..... 2 [ ]
I fear the results..... 3 [ ]
I do not have time..... 4 [ ]
Never been told about it..... 5 [ ]
The VCT site is too far..... 6 [ ]
I have heard bad things about the VCT site..... 7 [ ]
No reason..... 8 [ ]
Other, Specify..... 9 [ ]

30. What do you do to protect yourself against HIV?

Abstaining from sex…… 1 [ ]
Being faithful to one faithful partner…… 2 [ ]
Using condoms during sexual intercourse…….. 3 [ ]
Using protective materials such as gloves when handling body fluids…. 4 [ ]
Other, Specify…… 5 [ ]

31. Where are condoms available in this community?

Health facility…… 1 [ ]
Kiosk…….. 2 [ ]
Pharmacy/Chemist…… 3 [ ]
Bar/Restaurant/Lodging……. 4 [ ]
Do not know…… 5 [ ]
Other, Specify…… 6 [ ]

32. Have you ever used a condom?

Yes…… 1 [ ]
No…….. 2 [ ]

33. What is your opinion about the condom?

It protects one from diseases including HIV……..... 1 [ ]
It reduces pleasure…….. 2 [ ]
It is for unfaithful people…….. 3 [ ]
It is for the young…….. 4 [ ]
Other, Specify…… 5 [ ]

34. What is the advantage of condom use

No advantage…… 1 [ ]
Pregnancy prevention…….. 2 [ ]
STI prevention…… 3 [ ]
HIV, pregnancy prevention…… 4 [ ]
AIDS prevention only…… 5 [ ]
Don't know…… 6 [ ]
Any Other…… 7 [ ]

If Other, Specify……

35. Do you openly discuss HIV/AIDS with members of your household?

Yes…… 1 [ ]
No…… 2 [ ]

36. If Yes, what do you discuss about HIV/AIDS?

Cause……. 1 [ ]
Modes of transmission…….. 2 [ ]
Prevention……. 3 [ ]
Treatment…… 4 [ ]
If Other, Specify……. 5 [ ]

37. If No, why not?

Not appropriate to discuss HIV issues with household members…….. 1 [ ]

I don't feel comfortable discussing it…… 2 [ ]

I don't know enough about it…… 3 [ ]

Other, Specify…… 4 [ ]

38. What are the behaviors associated with people your age (or older people) in this community that may put you at risk of HIV infection?

Alcohol and substance abuse…… 1 [ ]

Having multiple sexual partners…… 2 [ ]

Men marrying much younger women…… 3 [ ]

Rape cases……. 4 [ ]

Wife inheritance…… 5 [ ]

Care/nursing of PLWH…… 6 [ ]

Other, Specify……. 7 [ ]

39. Has any older person visited you to talk about HIV disease?

Yes…….. 1 [ ]
No…… 2 [ ]

40. If yes, what did he/she talk to you about HIV disease?

Causes……... 1 [ ]
Modes of transmission…….. 2 [ ]
Prevention…….. 3 [ ]
Sources of information…… 4 [ ]
Service access and utilization…… 5 [ ]
If other, Specify…… 6 [ ]

41. What services do you know that are available to PLWH?

ART…… 1 [ ]
Opportunistic infections treatment…… 2 [ ]
PMTCT…… 3 [ ]
Home based care…… 4 [ ]
Other, Specify…… 5 [ ]

42. Do you know of any support groups for people infected or affected by HIV?

Yes…… 1 [ ]
No…… 2 [ ]

43. Has any trained HBC provider ever come to visit your household?

Yes …… 1 [ ]
No…… 2 [ ]

44. If yes, which organization did he/she come from?

……

45. If Yes, what services did s/he provide?

Nursing/palliative care…… 1 [ ]
Nutrition…… 2 [ ]
Counselling…… 3 [ ]
Psycho social care…… 4 [ ]
Drug administration…… 5 [ ]
Referral…… 6 [ ]
Other, Specify……..... 7 [ ]

45a. For each of the services you said you received, how would you rate the quality of the service

Service	Very poor	Poor	Adequate	Very good	Excellent
Nursing/palliative care	11[ ]	12[ ]	13[ ]	14[ ]	15[ ]
Nutrition	21[ ]	22[ ]	23[ ]	24[ ]	25[ ]
Counselling	31[ ]	32[ ]	33[ ]	34[ ]	35[ ]
Psycho-social Care	41[ ]	42[ ]	43[ ]	44[ ]	45[ ]
Drug administration	51[ ]	52[ ]	53[ ]	54[ ]	55[ ]
Referral	61[ ]	62[ ]	63[ ]	64[ ]	65[ ]
Other, Specify	71[ ]	72[ ]	73[ ]	74[ ]	75[ ]

45b. Which of the following statements reflects what "quality of care" means for you? (choose as many as you like)

"A comprehensive care plan was designed with me and my family and is reviewed regularly." 1[ ]

I get regular health and dietary advice, equipment and supplies for assisting in home-based care." 2[ ]

"A referral system is in place" 3[ ]

"We get practical support for end-of-life care (making a memory book, writing a will, saying goodbye)" 4[ ]

"The needs of older people are well considered" 5[ ]

"The needs of OVCs are well considered" 6[ ]

46. Please, describe which health needs relating to HIV&AIDS are provided by HBC service in this community

47. Are there any services provided to the members of your family, including children? If yes, describe the services to members of your family?

48. In your view what things could the HBC service provide but are not being provided?

49. How does your family help you to have your needs met?

50. How does the rest of the community help/support you?

51. Could you please give some ideas about how HBC service could be provided in a better way?

52. Do you personally know anyone who has HIV or has died from AIDS?

Yes..... 1 [ ]
No..... 2 [ ]

53. If a member of your family become sick with the AIDS virus, would you be willing to care for him or her in your household?

Yes..... 1 [ ]
No..... 2 [ ] Don't
Know..... 3 [ ]

54. If you knew that a shopkeeper or food seller had the AIDS virus, would you buy products from them?

Yes..... 1 [ ]
No..... 2 [ ] Don't
Know..... 3 [ ]

55. If a member of your family got infected with the AIDS virus, would you want it to remain secret?

Yes..... 1 [ ]
No..... 2 [ ] Don't
Know..... 3 [ ]

56. Has anyone in your household, including yourself, been very sick or bedridden for a period of three or more months, or has anyone died after being sick for more than three months?

Yes…… 1 [ ]
No…… 2 [ ]

57. Over the past 12 months, how many people age 18+ years in your household were sick or bedridden for three or more months?

……..

58. For the sick person/people, did your household receive help or care from any of the following?

Hospital /Clinic staff…… 1 [ ]
Relative (s) …… 2 [ ]
Friend(s) …… 3 [ ]
Religious organization …… 4 [ ]
Community group …… 5 [ ]
Organization or worker …… 6 [ ] Other (specify)
…… 7 [ ]

59. n/a

60. n/a

61. n/a

62. n/a

63. n/a

64. n/a

65. n/a

66. n/a

67. Is your household benefiting from any income generating activity that is supported by a grants or a loan scheme?

Yes ……..…. 1 [ ] No
…… 2 [ ]

68. If yes, which organization is providing the grants/loan scheme?

……..

69. If yes, has the loan scheme helped you in any way?

Yes ……..…. 1 [ ] No
…… 2 [ ]

70. What advice would you give to help households with orphaned and vulnerable children and youth?

Thank you

Focus Group Discussions:
Ethiopia

1. Focus Group discussion with Advocacy Groups, 20 February 2013

2. Focus Group Discussion with Peer Educators, 23 February 2013
3. Focus group discussion with HBC givers, 23 February 2013
4. Focus Group discussion with Iddir Leaders, 25 February 2013
5. Focus Group Discussion with Community Conversation Facilitators, 25 February 2013
6. Focus Group discussion with IGA/Loan beneficiaries, 25 February 2013

Kenya

1. Focus group discussion with Advocacy Groups Leaders & Members of the Social Protection Advocacy Group, 13 February 2013
2. Focus group discussion with Peer Educators, 15 February 2013
3. Focus group discussion with Older Men who had received Peer Education, 15 February 2013
4. Focus group discussion with older women who received Peer Education, 15 February 2013
5. Focus group discussion with orphans and vulnerable children, 16 February 2013

South Africa

1. Focus Group Discussion with older people and people living with HIV who are clients of traditional health practitioners, 2 March 2013
2. Focus group discussion with traditional health practitioners, 4 March 2013

Tanzania

1. Focus Group Discussion with HBC givers at Korogwe: 21 February 2013
2. Focus Group Discussion with people living with HIV receiving support from HBC givers: 21 February 2013
3. Focus Group Discussion with older care givers being supported by HBC givers: 22 February 2013
4. Focus Group Discussion with beneficiaries who have received peer education in Mkinga: 23 February 2013
5. Focus Group Discussion with Peer Educators in Mkinga: 23 February 2013

Uganda

1. Focus Group Discussion with Uganda Advocacy Group members: 28 February 2013
2. Focus Group Discussion with Paralegals in Karambi sub county, Kasese District : 4 March 2013
3. Focus Group Discussion with older people supported by Paralegals in Karambi sub country, Kasese District: 4 March 2013
4. Focus Group Discussion with trainers of memory books & wills, Munkunyu sub country, Kasese District: 5 March 2013
5. Focus Group Discussion with Peer Educators in Bugoye sub county, Kasese District: 6 March 2013

6. Focus Group Discussion with beneficiaries of Peer Education in Bugoye sub county, Kasese District: 6 March 2013

PRS Exercises:

Ethiopia

1. PRA exercise with IGA recipients and Community Conversation participants, 23 February 2013

Kenya

1. PRA exercise with orphans and vulnerable children who participated in Project 4, 16 February 2013
2. PRA exercise with older people who participated in Project 4, 16 February 2013

South Africa

1. PRA with Older People who are clients of traditional health practitioners, 4 March 2013

Tanzania

1. PRA (Participatory Rapid Appraisal) for older people living with HIV who are receiving HBC services and older caregivers receiving support from HBC givers in Mkinga, Tanzania

Uganda

1. PRA undertaken with older people who have been supported by paralegals in Karambi, Kasese District, Uganda, 4 March 2013

Sample of PRA Exercise:

PRA exercise with IGA recipients and Community Conversation participants, 23 February 2013 (Ethiopia)

1. Did Tesfa ask you what your problems or challenges were before starting the project?	Not at all	Asked only a few of us	Asked a lot of us	We were all consulted
				20
2. If your problems or challenges changed during the project, did Tesfa include your new needs in the project	Not at all	A little bit	Most of our new needs were included	All of our new needs were included
			17	3
3. Who has benefitted from the Project	OVCs/HVCs	Households with OVCs/HVCs	Older People	The Whole Community
	3	4	**7**	6
3a. How valuable is the project to OVCs/HVCs	Not at all	A little valuable	Valuable	Very valuable
		5	6	**9**
3b. How valuable is the project to Households with OVCs/HVCs	Not at all	A little valuable	Valuable	Very valuable
			8	**12**

3c. How valuable is the project to older people	Not at all	A little valuable	Valuable	Very valuable
				20
3d. How valuable is the project to the whole community	Not at all	A little valuable	Valuable	Very valuable
				20
4. How easy is it to access the project staff?	Not at all	Somewhat easy	Easy	Very easy
				20
5. How wisely has the money been spent on this project	Not at all	Somewhat wisely	Wisely	Very Wisely
				20
6. What has the project helped you to achieve?	Better awareness of HIV & AIDS	A regular source of income	Better health and more food	More money to spend on the things that we need
	9	3	3	5

6.10 List of people and organisations interviewed

Ethiopia:

1. Key informant interview with Ethiopia Country Director and BLF Project Manager, 20 February 2013
2. Key informant interview with Tesfa Programme Officers, 20 February 2013
3. Key informant interview with Addis Ababa HAPCO, 20 February 2013;
4. Key Informant Interview with the Federal Ministry of Health, 21 Feb 2013;
5. Key informant interview with Federal HAPCO, 21 February 2013
6. Key informant interview with the Kolfe Keranio District Administrator, 23 February 2013
7. Key informant interview with Chair of Tesfa, 23 February 2013
8. Key Informant interview with the Kolfe Keranio Sub-City AIDS Desk, 25 February 2013
9. Key informant interview with Health Facility in Kolfe Keranio, 25 February 2013
10. Key Informant interview with Burayou Health Officer, 26 February 2013
11. Key Informant interview with GP at a private clinic, Burayou, 26 February 2013
12. Key Informant interview with Tesfa Management Team, 26 February 2013

Kenya:

1. Key informant interview with the Regional Head of Advocacy & Communications, 12 February 2013
2. Key informant interview with Program Officer Civil Society (NACC), 12 February 2013
3. Key informant interview with the Professor of Populations Studies, University of Nairobi, 13 February 2013
4. Conversation with an Intern at HelpAge Kenya, 13 February 2013
5. Key informant interview with CEO of NEPHAK 13 February 2013
6. Key informant interview with CEO TAPWAK 13 February 2013
7. Key informant interview with the Programme Manager for Integrated Aids Programme, Kenya, 14 & 15 February 2013
8. Key informant interview with the Coordinator for DASCO (District AIDS Council) in Gatundu South, 15 February 2013
9. Key informant interview with the District Officer, Mangu, 15 February 2013
10. Key informant interview with the HIV Coordinator local CACC (Constituency AIDS Control Council), 15 February 2013
11. Key informant Interview with CCS Project Officers, 16 February 2013
12. Key informant interview IAP project officers, 16 February 2013
13. Key informant interview with the Country Programme Manager, HelpAge Kenya, 18 February 2013
14. Key informant interview with the Portfolio Manager, 21 February 2013
15. Discussion with the M&E Regional Advisor, 26 April 2013

South Africa

1. Key informant interview with the General Manager of MUSA and the Project Manager of Project 6, 28 February 2013
2. Key informant interview with Project Manager, 28 February 2013
3. Key Informant Interview with Traditional Health Practitioner and Council Member 2 March 2013
4. Key Informant Interview with Traditional Health Practitioner 4 March 2013
5. Key informant interview with the Head of the THP Unit at eThekwini Municipality, 5 March 2013

Tanzania:

1. Key informant interview with the Assistant Commissioner for Social Welfare, Family & Child Welfare, Dar es Salaam: 19 February 2013
2. Key informant interview with the former HIV Programme Manager, HelpAge International, (Tanzania), Dar es Salaam: 20, 21, 22 February 2013
3. Key informant interviews with the Director, Community Development Officer and District Medical Officer, Korogwe Town Council, 21 February 2013
4. Key informant interview with the District HBC Coordinator at Korogwe District Hospital: 21 February 2013
5. Key informant interview with the Regional Coordinator Tanga Red Cross, Tanga Town: 22 February 2013
6. Key informant interview with the Programme Manager, Tree of Hope, Tanga Town: 22 February 2013
7. Key informant interviews with AFRIWAG Board and Project Accountant: 22 February 2013
8. Key informant interviews with AFRIWAG Field Office and Project Officer, 22 February 2013
9. Key informant interviews with Doctor and HBC Coordinator at District Hospital: 23 February 2013
10. Key informant interview with Field Officer, AFRIWAG, 23 February 2013
11. Key informant interview with the Director Policy, Planning & Research, TACAIDS, Dar es Salaam: 25 February 2013
12. Key informant interview with a Statistician, Bureau of Statistics, Ministry of Finance, Dar es Salaam: 25 February 2013
13. Key informant interview with the HIV/AIDS Programme Coordinator, HelpAge International, 26 February 2013
14. Key informant interview with the Executive Director, WAMATA: 26 February 2013
15. Key informant interview with the Country Programme Director Tanzania, HelpAge International: 26 February 2013
16. Key informant interview with the Acting HIV Programme Manager, HelpAge International Tanzania Office: 26 February 2013

Uganda:

1. Key informant interview with the Head of Programmes, URAA, Kampala: 27 February 2013
2. Key informant interview with a Board Member of URAA, Kampala: 27 February 2013
3. Key informant interview with the Country Director of HelpAge International Uganda: 27 February 2013
4. Key informant interview with the Technical Officer in Charge of Vulnerable Groups, Directorate of Health, Kampala: 27 February 2013
5. Key informant interview with the Technical Officer in Charge of Monitoring & Evaluation, Department of Ministry of Gender, National Implementing Unit for OVCs: 28 February 2013
6. Key informant interview with the State Minister of Older Persons and Disability: 28 February 2013
7. Key informant interview with the National HIV/AIDS Coordinator Civil Society: 28 February 2013
8. Key informant interview with the Project Assistant for SIDA, URAA: 28 February 2013.
9. Key informant interview with Karambi Parish Administrator, Kasese District: 4 March 2013
10. Key informant interview with the Magistrate for Kasese District: 5 March 2013.
11. Key informant interview with the Chief Administrative Officer, Kasese Town: 5 March 2013.
12. Key informant interview with the Vice Chairman for Kasese District, Kasese Town: 5 March 2013.
13. Key informant interview with the District Community Development Officer, Kasese Town: 5 March 2013
14. Key informant interview with the Inspector of Police (Community Liaisons Officer, Kasese Police, Kasese District: 6 March 2013
15. Key informant interview with a retired Senior Health Educator, Kasese District Health Promotion Department, Kasese District: 6 March 2013
16. Key informant interview with the Head of Programmes, CAFO, Kasese: 6 March 2013
17. Key informant interview with the Programme Manager, URAA, Kesese Town: 6 March 2013
18. Key informant interview with the Director General of the Board of CAFO, Kasese Town: 6 March 2013

United Kingdom

1. Key informant interview with EWARDC Head of Programmes, 25 March 2013
2. Key informant interview with the HIV and AIDS Advisor, HelpAge International, 27 March 2013
3. Key Informant interview with the Management Accountant, HelpAge International, 12 April 2013

6.11 List of reviewed documentation

1. HelpAge Financial Policies and Procedures Manual, December 2010
2. Copy of ME Framework – mapping impact Apr 2012, internal document
3. HelpAge International - IS2010281292 Quarterly Report May-Jul 08
4. HelpAge International - IS2010281292 Q2 Report Aug-Oct 08 2
5. HelpAge International - IS2010281292 Quarterly Report 3 FINAL
6. HelpAge International - IS2010281292 Q4 report
7. HelpAge International - IS2010281292 Annual Report Year 1
8. HelpAge International - IS2010281292 Quarterly Monitoring Report Y2 Q1
9. HelpAge International - IS2010281292 Y2 Q2 report
10. HelpAge International - IS2010281292 Y2 Q3 report
11. HelpAge International - IS2010281292 Y2 Q4 report June 23RD 2010
12. HelpAge International - IS2010281292 Year 2 Annual Report
13. HelpAge International - IS2010281292 Quarterly Report May-Jul 10
14. HelpAge International IS2010281292 Q2 - Yr 3 Report
15. HelpAge International IS2010281292 Q3 - Yr 3 Report
16. HelpAge International_IS2010281292 Q4 - Yr 3 Report
17. HelpAge International - IS2010281292 Year 3 Annual Report
18. HelpAgeInternational_IS2010281292 Q1 - Yr 4 Report
19. HelpAge International_IS2010281292 Q2 - YR 4 Report – Final
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21. Helpage International-IS2010281292Quarterly Monitoring Report Q4Y4
22. HelpAge International - IS2010281292 Year 4 End of Year Report_FINAL
23. HelpAge International_IS2010281292 Q1 - YR 5 Report_FINAL
24. HelpAge International_IS2010281292 Q2 - YR 5 Report_FINAL
25. Outcomes and Milestones - Year 4
26. Outcomes and Milestones - Year 5
27. Outcomes and Milestones sent to BIG
28. Stage 1 Application Form
29. Stage 1 HAI Budget submitted post assessment
30. Stage 1 HAI Budget submitted pre assessment
31. Stage 1 HAI Section 3
32. Stage 1 HAI Strategic Document
33. HAI Stage 2 Strategic Application
34. HAI Stage 2 Strategic Milestones
35. Corporate Indicators on health and HIV
36. EWCARDC Organogram - Jan 2013
37. Final Africa Strategy 2010-2015
38. HIV theory of change
39. ME Matrix Updated Nov 2012
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41. HelpAge MTE Final Report - June 2011
42. HAPCO-MoWA OVC standard service delivery, February 2010
43. Analysis of Key National Policies and Strategies of Ethiopia for Inclusion of Older People, March 2009
44. Final Draft of the Road Map- for SPM II August 24 2010
45. Strategic Plan II for Intensifying multisectoral HIV and AIDS Response in Ethiopia 2010/11 – 2014/15
46. Regional Data Disaggregation Consultative Meeting Report, April 2012
47. HIV and AIDS Peer Education Manual for Older People, June 2012
48. http://www.helpage.org/where-we-work/africa/kenya/ Accessed 31 March 15:02
49. http://www.helpage.org/who-we-are/who-we-are/our-history/ Accessed 31 March 2013, 15:30
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55. Baynham, N. 2012, Mapping and Review of HelpAge International's Rural and Urban Livelihoods Programmes, HelpAge International, London
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Financial Budgets

61. HelpAge IS2010281292 Revised budget July 09
62. Economic downturn detailed budget Mar 10
63. Detailed Budget - June 2010
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66. Summary budget - Year 5
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6.12 Bibliography

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6.13 Management response to findings

See separate file

Glossary

Abstinence
To choose to not have sex

Accidental infection
To be accidently infected with HIV

ANOVA – Analysis of Variation
ANOVA is a collection of statistical models used to analyse the differences between group means and their associated procedures (such as "variation" among and between groups), in which the observed variance in a particular variable is partitioned into components attributable to different sources of variation. In its simplest form, ANOVA provides a statistical test of whether or not the means of several groups are all equal, and therefore generalizes *t*-test to more than two groups. The name is derived from the fact that in order to test for statistical significance between means, we are actually comparing (i.e. analysing) variances.

ART – Antiretroviral Therapy
A combination of antiretroviral drugs which suppresses the retrovirus HIV that causes AIDS. Standard antiretroviral therapy (ART) consists of the combination of at least three antiretroviral (ARV) drugs to maximally suppress the HIV virus and stop the progression of HIV disease.

Asset Rich
To be rich in that which is capable of being owned or controlled to produce value and that is held to have positive economic value that can be converted into cash.

Asset Middle
To have moderate wealth in that which is capable of being owned or controlled to produce value and that is held to have positive economic value that can be converted into cash.

Asset Poor
To be poor in that which is capable of being owned or controlled to produce value and that is held to have positive economic value that can be converted into cash.

Cash Transfer Programme
Programmes that transfer cash to eligible people or households

Community Conversations
A methodology that involves trained local facilitators, who help the community to generate insights on the underlying factors fuelling the spread of HIV and AIDS in the community.

Cost Recovery
The method of recovering an expenditure that a business or organisation takes on.

Counterfactual (Counterfactual Analysis)
A comparison between what actually happened and what would have happened in the absence of an intervention. The 'counterfactual' measures what would have happened to beneficiaries in the absence of the intervention, and impact is estimated by comparing counterfactual outcomes to those observed under the intervention.

Data Disaggregation
The recording of data about individuals or single entities; for example, a person's age, sex, income, or occupation, or the registration number of a vehicle to reveal the significance of particular factors

Descriptive Analysis
Descriptive analysis is the discipline of quantitatively describing the main features of a collection of data, or the quantitative description itself. The process provides simple summaries about the sample and about the observations that have been made.

Domestic Relationships
Relationship between men and women in the home

Economies of Scale
Economies of scale are the cost advantages that organisations obtain due to size, with unit costs generally decreasing with increasing scale as fixed costs are spread out over more units of output. Often operational efficiency is also greater with increasing scale, leading to lower variable cost as well.

Faithfulness
Staying sexually faithful to one partner

Home-based Care
The provision of care to people living with HIV in their home and which combines a range of services

Home-based Care Kits
The provision of materials and drugs home based care services for people living with HIV

Impact evaluation
Impact evaluation assesses the changes that can be attributed to a particular intervention, such as a project, program or policy, both the intended ones, as well as ideally the unintended ones.

Income Generating Activities

Supporting people undertake activities to secure income to alleviate poverty

Incremental Innovation
An improvement to an existing project methodology that aims to improve it

Innovative Methodology
A new and more effective methodology, usually for project delivery or planning

Memory Books
Books that are produced by people with HIV who wish to record their own and their family history

Paralegal
A person who has received some training in legal matters but who is not a fully trained lawyer

Participatory Rapid Appraisal
A quick appraisal method that enables community members to share their knowledge to gain insight into the potential impact an intervention has had and enabling this information to be included in all the different stages of the project cycle.

Personal Risk-taking Behaviour
To undertake risky practices which put one at risk of contracting HIV.

Pearson's Linear Coefficient
A statistical test which measures the strength of a linear association between two variables.

Process Tracing Map
A qualitative analysis method that involves mapping out the potential causal paths that may have led to an outcome.

Scoping Study
Study to map out and include all different possible interventions

Social Protection
Preventing, managing and overcoming situations that adversely affect people's well-being.

Social Return on Investment
Social return on investment (SROI) is a principles-based method for measuring extra-financial value (i.e., environmental and social value not currently reflected in conventional financial accounts) relative to resources invested. It can be used by any entity to evaluate impact on stakeholders, identify ways to improve performance, and enhance the performance of investments.

Value for Money
Value for money (VFM) is a term used to assess whether or not an organisation has obtained the maximum benefit from the goods and services it both acquires and provides, within the resources available to it. Some elements may be subjective, difficult to measure, intangible and misunderstood. Judgement is therefore required when considering whether VFM has been satisfactorily achieved or not. It not only measures the cost of goods and services, but also takes account of the mix of quality, cost, resource use, fitness for purpose, timeliness, and convenience to judge whether or not, together, they constitute good value.

Zero-based Budgeting
A method of budgeting whereby cash flow budgets are newly prepared (zero base) every year and with no balance carried forward