# REPORT ON IMPACT EVALUATION OF THE PROJECT "ALL AGAINST AIDS", NGAOUNDERE, CAMEROON

## IMPLEMENTED BY EELC; 2009 - 2013

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# LIST OF ABBREVIATIONS

| | |
|---|---|
| AIDS | Acquired Immune Deficiency Syndrome |
| ARV | Antiretrovirals |
| DHS | Demographic and Health Survey |
| Digni | Norwegian Development Agency |
| EELC | Eglise Evangélique Luthérienne au Cameroun |
| FGD | Focus group discussions |
| HBCV | Home-Based Care Volunteer |
| HIV | Human Immunodeficiency Virus |
| IDI | In-depth interviews |
| IGA | Income generating activity |
| NGO | Non-governmental organisation |
| NMS | Norwegian Missionary Society |
| PLS | Projet de Lutte contre le VIH/SIDA |
| OVC | Orphans and Vulnerable children |
| PLWHA | People living with HIV&AIDS |
| PMTCT | Prevention of Mother-to- Child Transmission |
| SIK | Senter for interkulturellkommunikasjon (Center for Intercultural Communication) |
| VCT | Voluntary counselling and testing |

# EXECUTIVE SUMMARY

This is an end term impact evaluation report of Project "All against AIDS" commissioned by Digni in collaboration with the Norwegian Missionary Society (NMS) and Eglise Evangélique Luthérienne au Cameroun (EELC). The project was implemented by EELC, financed by Digni and the project grant managed by NMS. The evaluation was carried out by Mme Everlyne Nairesiae; an international development consultant in planning, monitoring and evaluation and a Senior Consultant at Social Economic and Environmental Transformation Organization of Kenya (SEETO Kenya); and Dr. Nsagha Dickson Shey; a project designer and public health expert in HIV&AIDS epidemiology, monitoring and evaluation; senior lecturer at the Department of Public Health and Hygiene, Medicine Programme, Faculty of Health Sciences University of Buea, Buea, Cameroon. Mme Everlyne Nairesiae was the evaluation team leader.

Phase three of the project purposed to follow-up people living with HIV&AIDS (PLWHA) providing trainings and facilitate establishment of income generating activities, and to build activities around the "Centre d'écoute". At the same time the project should continued with the sensitization of the population through the youth caravan and the supervision teams in the church districts of EELC. The project impact evaluation was conducted to assess the performance of the third phase of the project implemented during the period 2009 – 2013. Specifically, the evaluation objectives were to:

- Identify the results of the project and compare them to the indicators set out in the action plan.
- Evaluate the impacts of training programs for the beneficiaries undertaken by the project.
- Analyse the project relevance in terms of psychosocial support to people living with HIV&AIDS (PLWHA).
- Assess the capacity of the leaders of support groups of PLWHA to organize and educate their members in terms of positive behaviours in the context of AIDS
- Evaluate the relevance of the counselling Centre ('Centre d'écoute') as means of education, information and communication on health subjects and more specifically on HIV&AIDS.
- Assess the extent to which recommendations from the project evaluation (phase 1 and 2) conducted in March 2010, and Digni review report were utilized during implementation.
- To identify SIK, EELC and NMS's impact on the result, successes and limitations of the project.
- Provide the findings, conclusions and recommendations for future interventions

The evaluation employed participatory rural appraisal (PRA) and participatory learning and action (PLA), gender and human rights sensitive approaches. The evaluators developed evaluation tools; a guide to Focus Group Discussion (FGD), In-depth Interviews (IDI) and semi-structured questionnaire. The evaluation was highly interactive and participative, reaching out to

direct project participants (also referred to as beneficiaries) like groups of PLWHIV, Home Based Care Volunteers (HBCV), youth members of the Caravan Mobile, project staff , members of the general public from the project sites and EELC Church leadership including the Bishop. Data was collected through focus group discussions conducted with support groups of PLWHA and mobile caravan youth group, in-depth interview with key informants including HBCV, project staff, staff at EELC health department, EELC top leadership and government stakeholders; and a mini-survey reaching out to members of the general public living within the project sites. Observations and photography were also employed. The evaluation team visited communities in Tchollere and Pitoa in the Northern Region of Cameroon; Bertoua in the Eastern Region and Adamawa Region.

Findings of the evaluation shows that the project significantly achieved its planned objectives including mobilization of support groups of PLWHA; providing them with psychosocial support and trainings on HIV&AIDS issues; which also reached church leaders, animators group and hospital staff. Most support group members' were provided with financial seed capital to initiate income generating activities; and the mainstreaming of HIV&AIDS in the church structures with 52 articles containing HIV&AIDS messages developed to be integrated in the church sermons.

PLS project activities were undertaken according to the developed action plan; finances were well managed. The project had great success in mobilizing, educating and providing correct information on HIV&AIDS to local communities in the project sites including church congregants; and through its established health facilities/hospitals many more community groups of PLWHA and general public will continue to benefit. The Centre d'ecoute is a major success, providing meeting and training venue/spaces for PLWHA and others, serve as counseling, testing and treatment centre for PLWHIV. Activities of the Centre d'ecoute are sustainable and with capacity to continue these services with minimum challenges.

The support groups are yet to consolidate their activities, be cohesive and undertake their own independent activities from those of the project. The income generating activities are also not sustainable unless more financial support and targeted training is provided to ensure accompaniment of members of the support groups having existing businesses. The delivery of psychosocial support to PLWHA will need to be strengthened and embrace strategies that build members confidence to reduce high level of stigma faced by members' of support groups from within and outside their family circles. The project lack advocacy related activities and may need to invest more in members empowerment approaches for self representation in HIV&AIDS platform at local, national and international level.

Gender representation in project staffing and participants/beneficiaries trainings was well provided for in the implementation of the project. However, glaring gender gap was evident at the project steering committee which is made up of male members only; reflecting a similar gap at EELC senior positions of leadership. EELC has no gender and HIV&AIDS policies to guide/influence decisions on gender representation, and in the management of staff infected/affected with HIV&AIDS respectively.

NMS remains a strategic partner of EELC based on long term relationship with the church; a relationship that can be further developed to influence EELC capacity in fundraising for HIV&AIDS and other community empowerment projects. SIK remains a strategic partner to EELC and NMS owing to its capacity building background hence capable to provide

accompaniment and technical support to EELC or other NMS or Digni partners in HIV&AIDS and or other community empowerment projects to be established in future. This project has been relevant to the priority needs of the communities. The project activities are owned by EELC, government and the local communities including direct participants.

From the findings of this evaluation, comprehensive conclusions and recommendations are underscored in the subsequent sections of this report. Below are some of the conclusions and recommendations from this evaluation report:

- This project has been relevant to the priority needs of the communities.
- The project has been efficient as activities were implemented within the required project period. Financial management was up to standards with no cases of corruption/fraud or mismanagement reported during the project period.
- The EELC has adequately mainstreamed the current HIV&AIDS project within its structures and has capacity to sustainably continue the project; though in a smaller but strategic scale through the church structures and its leadership. However; the church should consider expanding the project to cover new sites within the current project sites/regions and outside the regions.
- The NMS remains a strategic partner to EELC and this relationship should continue and be further exploited for resource mobilization that goes beyond HIV&AIDS. NMS continues to provide a valuable link to Digni, which could further be exploited for more resources to facilitate similar HIV&AIDS projects in new project sites and or take up more empowerment programs in the current project sites.
- In view of the findings of this evaluation and in reference to recommendations of the evaluation conducted in 2010; the project has attained its objectives and it is time to refocus on more strategic priorities that affect communities that are linked to vulnerability to HIV&AIDS. This could include poverty reduction strategies; women and girls social, economic and political empowerment; gender based violence; youth economic empowerment programs; support for orphans and vulnerable children and elderly caregivers; environmental conservation and climate change issues.
- Despite the gap left by SIK in the implementation of the 3rd phase of the project, EELC/PLS project staff was able to successfully manage the implementation, monitoring and reporting of the project. However, technical accompaniment role of SIK, local or regional consultant will be required in the event EELC takes up new projects/thematic field whose skills/competence may not be resident within the organization.
- This project has had significant impact on the lives of many people directly and indirectly involved in the project; in terms of increased knowledge and information on HIV&AIDS, influenced adoption of positive behaviour; which in turn have contributed to the reduction of new infection and improved living standards of PLWHIV.
- Gender representation in project steering committee and decision making at EELC top leadership is wanting and need to be addressed. EELC also has no HIV&AIDS policy to aid decisions and support provided to human resource, church leaders or congregants infected/affected hence needs a policy direction.

- The project adequately used the recommendations of the evaluation report of 2010; which among other recommendations included adjusting its strategies to ensure grassroots mobilization and participation of PLWHA; influencing the EELC oversight for effective financial management, finalization and use of the centre d'ecoute and improve on communication at all levels of the project leadership and management.

The subsequent section of this report presents background information on Cameroon, HIV&AIDS in Cameroon; PLS project sites, the evaluation objectives and methodology used in the undertaking of this evaluation. The report comprehensively profile the successes and limitations of the project while examining specific findings, draws conclusions and give recommendations to project management staff, EELC, NMS and Digni.

# 1.0 ABOUT CAMEROON

Cameroon is situated in Central West Africa and north of the Equator. The country is bounded on the North by Chad; on the South by Equatorial Guinea, Gabon and Congo; on the West by Nigeria and on the East by the Central African Republic. Cameroon has a surface area of about 475,442 km $^2$ and a population of about 18 million people with an annual growth rate of about 2.8% [1]. Cameroon is undergoing a demographic transition and about 50% of the population now lives in urban areas. Administratively, the country is divided into 10 regions headed by governors. Each region is divided into divisions and subdivisions. Yaounde is the administrative capital while Douala is the economic capital. The average income per capita over the last five years ranges from US$ 600-650 [1]. The strong political will of the Government of Cameroon has been instrumental in the fight against the HIV/AIDS pandemic. The health system is decentralized and a multi-sector approach was adopted by the government to fight against the HIV/AIDS pandemic. In partnership with other development organizations, the Government has made considerable effort in the fight against HIV/AIDS. For example, the continuous decrease in the prices of ARV in Cameroon: 1999: 700 - 1000$ /patient/month; 2001: 300-600 patients on ART; 2005: 2,5$/patient/month: 15 000 patients on ARV and since May 1st 2007, there is free access to ART [2]. The Ministry of Public Health co-ordinates all health services in the country. The health system is organized into the central, intermediate and peripheral levels [1]. The Central level that outlines policies has three reference health institutions of Category I and three of Category II. At the Intermediary level are ten regional delegations of public health, ten regional Technical Groups for AIDS Control and nine regional hospitals and affiliated health structures, which coordinate policy implementation. Peripheral institutions are health districts, which implement health policies. In 2002, there were 150 such health districts and 1,388 health centers [3]. Currently there are an estimated 179 health districts in the country. Some health facilities are private institutions and others are faith-based. There is a national emphasis on preventive health services, which are available throughout the country to complete this national health structure [1]. The national social insurance scheme in Cameroon does not cover the health service even though private health insurance schemes are timidly being introduced since three years ago; patients have to pay for every aspect of services rendered.

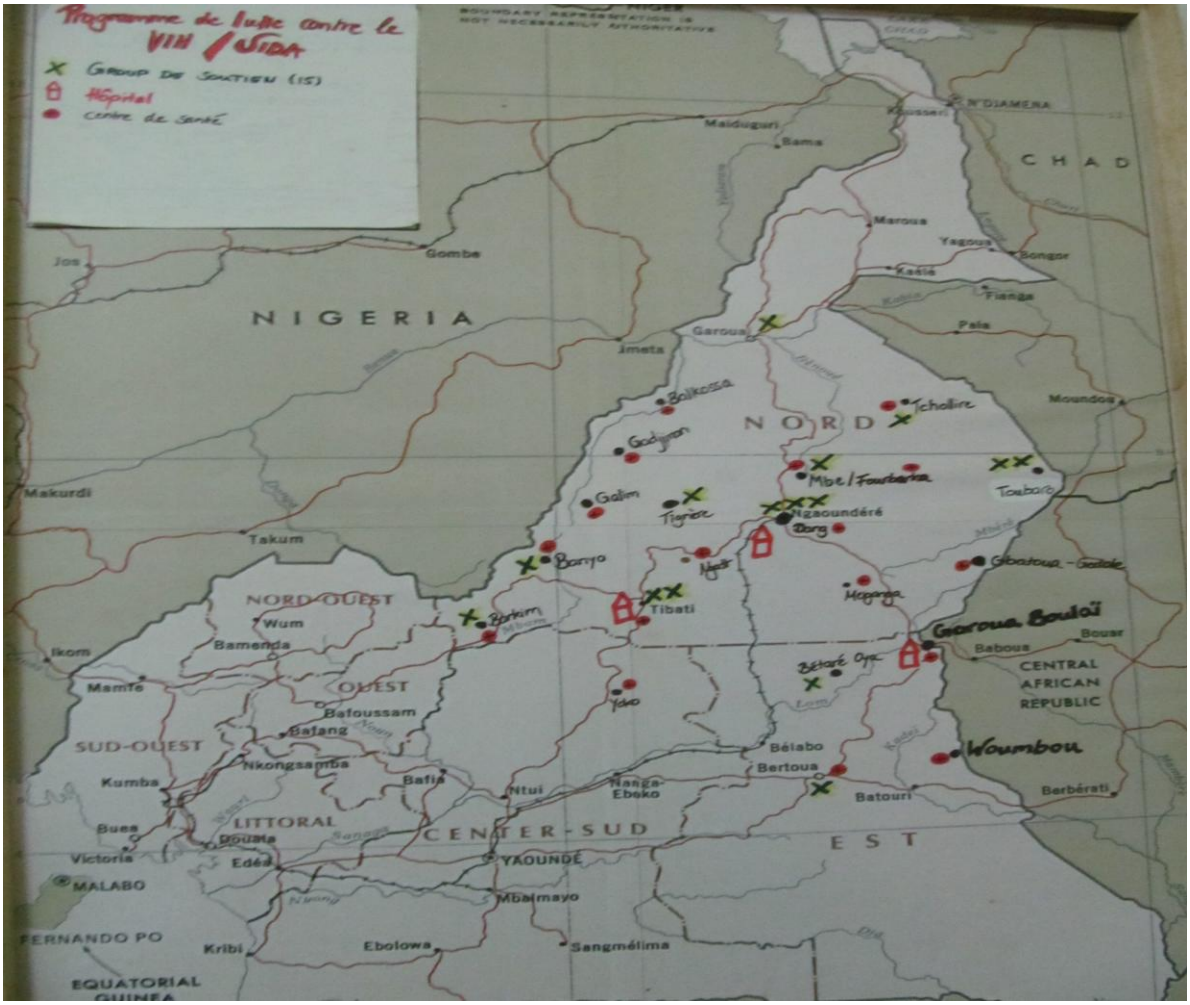
## 1.1 STATUS OF HIV AND AIDS IN CAMEROON

The prevalence of HIV in Cameroon was 5.1% in 2010 with significant regional discrepancies; two thirds of those currently infected are youths and 60% of annual infections fall within this category of citizens [4]. The estimated number of people living with HIV&AIDS for 2002 was 920,000, of which 69,000 were children (compared to 22,000 in 1999) between 0-14 years and 860,000 were aged 15-49years including 500,000 women [5]. HIV&AIDS pose serious social, cultural and economic hardship to its victims including orphans and vulnerable children (OVC) [6]. In 1995, 7,900 people died from AIDS in Cameroon; and the annual number rose to 25,000 in 2000. Out of, 200,000 orphans and vulnerable children in Cameroon reported in 2010, 300,000(25%) were AIDS orphans [7]. Other orphans and the number of children orphaned by AIDS have increased dramatically from 13,000 in 1995 to 304,000 in 2010 [7]. By 2020, this number is projected to rise to 350,000. OVC due to HIV/AIDS are a major public health problem in Cameroon [6] as the HIV prevalence continues its relentless increase with 141 new infections per day [7].

The current national HIV prevalence in Cameroon is 4,3% with lots of Regional variations. Information from the Ministry of Public Health show that the HIV prevalence is still high in two of the PLS project Regions. Adamawa and the East Regions still high values compared to the North Region. Key contributing factors include illiteracy, poverty, low level of education, cultural barriers like early marriages and social stigma. The major PLS project sites are trans-border towns with many heavy truck drivers as shown in the map below. The recent fighting in the Central African Republic is a major predisposing factor for HIV in the East Region as most refugees entering Cameroon settle in this Region.

## 1.2 THE PROJECT SITES

Cameroon is divided into 10 administrative Regions. However, PLS is implemented in mainly 3 Regions: Adamawa, North, East with scanty operations in Central Cameroon. The project activities have mainly been implemented mainly in Adamawa Region, with the project coordination office located in Ngaoundere, the Regional capital. Administratively, Adamawa is divided into 5 Divisions, 18 Sub-divisions, 3 Administrative Districts and 21 councils. The map below depicts the PLS project sites.




Map Showing PLS Project Sites

The Adamawa Region is bordered to the north by the North Region and to the south by the East, Central, West and North West Regions; and to the east by the Central African Republic; and the West by the Federal Republic of Nigeria. The predominant religions in the project area are Islam, traditionalist and Christianity and the main sources of livelihood are livestock and crop farming, fishing and artisan jobs. Even though the 'All Against AIDS' project is managed from the EELC church Headquarters in Ngaoundere in the Adamawa Region, the project is also implemented in the North Region (Headquarters in Garoua) and the East Region(Headquarters in Bertoua).

# 2.0 PROJECT "ALL AGAINST AIDS" (PLS)

The All against Aids (PLS) project was initiated in 2002. The project was applied for by Senter for interkulturell kommunikasjon (SIK) to Digni formally known as NORAD-BN (Bistandsnemnda/BN) and got funded for the years 2002-2005 (also referred to this report as phase 1). From 2004, Digni decided that Norwegian Mission Society (NMS) should be the responsible partner towards Digni, and that SIK provide accompaniment in the monitoring and

follow-up of the project. The first phase of the project was from 2002/3-2005, and the second phase was from 2006-2008.

During the first and second phase of the project (2002-2008), many people living in Adamawa including the EELC Church congregants who formed larger a proportion of the target group had limited knowledge of what HIV&AIDS was all about; neither did they recognise it as a disease. People were ignorant about HIV&AIDS and the general level of knowledge on infection, treatment, prevention, care and support of PLWHA was inadequate. It is on this backdrop that this project was presented and funding secured from Digni. The project specific objectives then were to:

- Stabilize and reduce the number of HIV&AIDS infection in the areas covered by EELC.
- Create awareness on the existence and the nature of HIV&AIDS.
- Change attitudes and behaviours related to sexual relations.
- Make people aware of how to prevent themselves from being infected, through abstinence, fidelity and other prevention methods.
- Make people aware of how to associate with and care for people with HIV&AIDS which in turn will change their attitudes towards HIV-positives

Phases 1 and 2 of the project went through a final evaluation in March 2010, commissioned and financed by Digni. A report of the said evaluation is available and can be accessed through the EELC/PLS project management team.

A third phase of the project 'All against AIDS' was approved as a five-year-project (2009-2013) by Digni. The project purposed to support follow-up of people infected and affected by HIV/AIDS, and to build some activities around the "Centre d'écoute". At the same time the project aimed to continue sensitization of the population by strengthening the activities of the youth caravan and the supervision teams in the Church districts of EELC.

The project implementation and management structure was sustained with EELC in Cameroon as the implementing organization, NMS as the grant manager and Digni as the donor. However, SIK did not continue with its project accompaniment role as previously done in phase one and two of PLS project.

# 3.0 OBJECTIVES OF THE EVALUATION

This is a summative evaluation report conducted in February 2014. The evaluation was conducted to assess performance of the third phase of the project implemented during the period 2009 - 2013.Project evaluation is an important component of a project management cycle, it is considered to be an important learning tool for project receiving communities, managers and donors. Specifically, the evaluation objectives were to:

- Identify the results of the project and compare them to the indicators set out in the action plan.

- Evaluate the impacts of training programs for the beneficiaries undertaken by the project.
- Analyse the project relevance in terms of psychosocial support to people living with HIV&AIDS (PLWHA).
- Analyse the capacity of the leaders of support groups of PLWHA to organize and educate their members in terms of positive behaviours in the context of AIDS
- Evaluate the relevance of the counselling Centre ('Centre d'écoute') as means of education, information and communication on health subjects and more specifically on HIV&AIDS questions
- Assess to what extend the recommendations in the evaluation report from March 2010, and Digni reports from 2010 have been followed-up.
- To identify SIK, EELC and NMS's impact on the result, successes and limitations of the project.
- Provide the findings, conclusions and recommendations for influencing sustainability, exit and draw lessons for future interventions.

# 4.0 EVALUATION METHODOLOGY

The evaluators used the following participatory learning and rural appraisal approaches; gender and human rights sensitive methods for the evaluation. Key activities included the review of project documents including project proposal, annual reports, plans, training manuals, and other relevant government and agency documents; development of the evaluation tools; and data collection through in-depth interviews, focus group discussions, field observations, mini-survey; and held an interactive stakeholders workshop in which preliminary findings were shared. Interaction with the project participants took place in Ngaoundere (Adamawa Region), Tchollire and Pitoa (North Region) and Bertoua (East Region); project sites sampled for the evaluation and believed to represent the reality of the communities and outcomes of the project.

Since the evaluation was seen as a learning process for all stakeholders, project workers and the target group of the project were involved in the evaluation process to ensure a mutual understanding of the challenges and solutions of the project, local ownership to the proposed changes, recommendations and proper follow- up after the evaluation. PLS team of staff and NMS representative offered immense support to the evaluators through communication, coordination, and logistics for transport and data collection exercise; and ensured sufficient materials were available to effectively complete the assignment.

## 4.1 Population and Sampling Procedures for the Evaluation

The following categories of persons were purposively selected for in-depth interviews, focus group discussions and randomly selected participants for the mini-survey. The selection criteria took into account availability of key informants, direct project participants/beneficiaries and accessibility.

- Church Leadership - [Bishop and assistant Bishop, and the General Secretary of the EELC,
- Project administration- [project coordinator, assistant project coordinator, project financial manager, secretary of the project]. The views of the NMS representative and SIK were sought and provided via email.
- Staff of other structures under the church - [the Hospital in Ngaoundere].
- Direct Beneficiaries of the project (project participants) including associations of PLWHA, youth in the mobile Caravan and home based care volunteers.
- Partners and collaborators [Government officer at the National AIDS Control Committee of Adamawa Region was interviewed]
- Members of the public (randomly sampled and reached through the mini-survey questionnaire)

### 4.2 Evaluation Tools and Administration

The consultants developed various tools, which provided both qualitative and quantitative data. The tools included a semi-structured questionnaire used for the mini-survey to measure knowledge, attitude and behaviour including stigma; a guide to focus group discussion and in-depth interviews. Observation of assets in the field and photography was also used to capture visual images that demonstrate the situation on the ground including Centre de'coute and income generating activities (IGA). A workshop was also organized in Ngaoundere to share preliminary findings with EELC, PLS team, health stakeholders, youths, women, men and PLWHA.

The two consultants carried out the data collection. To enhance participation of the project staff in the evaluation exercise, the tools were shared and reviewed by the evaluation team including the NMS representative to ensure reliability and common understanding of the research approach and objectives. The project staffs were involved in disseminating and administration of the mini-survey questionnaires in the sampled project sites visited.

*The evaluation team realized the following data collection outcomes:* 4 focus group discussions (Ngaoundere with the Youth Caravan, association of PLWHA in Tchollere, Pitoa and Bertoua. Fifteen (15) in-depth interviews were conducted reaching the project coordinator, 3 project staff, Ministry of Public Health, Coordinator of AIDS, Ngaoundere; leader of association of PLWHA (Ngaoundere), nurse in charge of Antenatal Care (ANC), EELC Hospital Ngaoundere and doctor in charge of treatment/PMTCT and ARTs, Ngaoundere. In-depth interviews with the director EELC health Board, Secretary General of EELC, the Assistant Arch Bishop and the Arch Bishop of EELC were also conducted.

Questionnaires were sent via e-mail to key partners including SIK, Digni and NMS grants department. SIK was able to respond to the questionnaire and their views in cooperated in this report. Although, the role of SIK in the current project under evaluation changed from the previous one, the organisation was engaged in the undertaking a mid-term review of the project in 2012; and therefore, their participation in this evaluation was sought.

Further, a total of 91 out of a target of 100 questionnaires target by a mini-survey were administered to sampled members of the public and some project beneficiaries including HBC volunteers. During the exercise, Ngaoundere in the Adamawa Region had 25respondents; Tchollere in North Region had 26respondents; Pitoa in the North Region had 16respondents and Bertoua in the East Region had 24 respondents. The number was considered statistically significant for analysis and findings used for triangulation of the evaluation findings.

### 4.3 Data Analysis

Data was entered on Microsoft Excel and exported into STATA for analysis. Data collected was analyzed using qualitative and quantitative methods and presented in tables/charts. This report therefore, presents the findings of the evaluation in the subsequent sections including observations made by the evaluators.

### 4.4 Limitations of the Evaluation

Project design: There was no reliable baseline data of the project to effectively allow comparison of the before and after project implementation situation. However, clarity of the annual activity plans with indicators envisioned served as a guide to the evaluation team.

The objectives did not respect the "SMART" format very well. However, the evaluators were able to understand the specific objectives and results posted.

Long distances covered to project sites and limited time: namely Ngaoundered to Pitoa, Tchollire and Bertoua made it challenging for the evaluation team to cover project locations previously included in the 2010 sample sites including Meiganga, Touboro, Tibati and parts of Center Region including Yaounde where a few project activities like training of church leaders were undertaken.

Views sought via e-mail to NMS grants management office staff and Digni were not received, hence views presented in this report are limited to data gathered from other evaluation participants, staff of EELC/PLS, other staff of EELC and its leadership and NMS representative in Cameroon.

# 5.0 RESULTS OF THE PROJECT PLS EVALUATION

The results/findings of this evaluation are based on the original project objectives/purpose and indicators of results posted at the inception of the project in 2009. In addition, the findings are premised on the context of the project sites in which it was implemented, new and emerging issues which could have had significant impact on the project. The results of this evaluation are prepared and presented in thematic sections as below.

## 5.1 Demographics Information

The project evaluation used a participatory approach to reach out to community beneficiaries (project participants) including association of PLWHA, youth, community home based care volunteers, members of the general public, project staff, staff from health department at EELC and its leadership; and government officials. In a mini-survey, ninety-one community members including members of the public and indirect beneficiaries of the project in Ngaoundere (Adamawa Region), Pitoa (North Region), Tchollire (North Region) and Bertoua (East Region) were interviewed on key project success determinants, involvement and change they have interacted with as a result of this project initiative.

### 5.1.1 Age and Gender Distribution

The ages of the participants varied from 10 to 60 years; the mean age was 29 as shown in table 1 below with majority fallings within the reproductive age. The distribution of the participants according to gender and locality is shown in Table 1.

**Table 1: Age distribution of respondents in the mini-survey**

| Age range (years) | No of Respondents | % |
|---|---|---|
| 10 – 19 | 16 | 18 |
| 20 – 29 | 32 | 35 |
| 30 – 39 | 31 | 34 |
| 40 – 49 | 10 | 11 |
| 50 – 59 | 1 | 1 |
| >60 | 1 | 1 |
| Total | 91 | 100 |

**Table 2: Gender Distribution of Respondents by Location: Mini-Survey**

| Locality | Male<br>No (%) | Female<br>No (%) | Total<br>No (%) |
|---|---|---|---|
| Bertoua | 13(23.21) | 11(31.42) | 24 (26.37) |
| Ngaoundere | 17(30.36) | 8(22.86) | 25 (27.47) |
| Pitoa | 11(19.64) | 5(14.29) | 16(17.58) |
| Tchollire | 15(26.79) | 11(31.43) | 26(28,57) |
| Total | 56 (61.54) | 35 (38.46) | 91(100) |

On the overall gender distribution, most of the respondents reached during the evaluation exercise were female respondents (72%). More female came out to participate in the focus group discussions and were willing to be interviewed about HIV. However, there were more male (62%) respondents reached by the mini-survey compared to women (38%) as most men showed willingness to give confidential information to the field assistants; and less attracted to group activities including the associations of PLWHA as shown in the tables below.

## 5.2 Knowledge on HIV&AIDS

### 5.2.1 Modes of HIV Transmission and Prevention Methods

The evaluation sought to establish the level of community knowledge on modes of HIV transmission. Most participants (90%) in the focus group discussion who constituted members of the PLWHA and the youth in the caravan mobile had correct knowledge on modes of HIV transmission. This finding differs significantly with the results of the mini-survey conducted with general public and other project beneficiaries. Of the 91 community members interviewed during the mini-survey, 74 (81%) had correct knowledge on the modes of transmission of HIV including heterosexual sex compared to only 17(19%) who stated wrong answers. The distribution of the respondents' knowledge on the modes of transmission of HIV conducted through the mini-survey is presented in Table 3.

**Table 3: Knowledge on the modes of HIV transmission by locality**

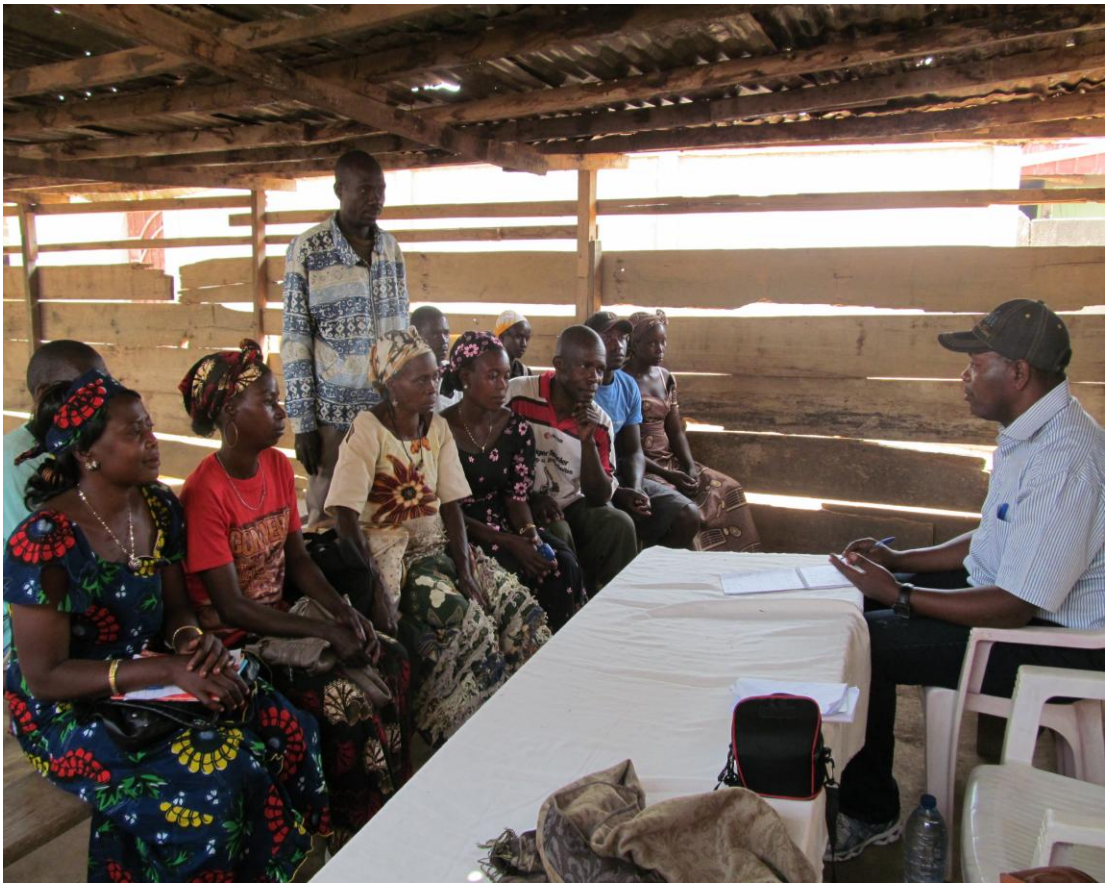
| Locality | Know<br>No (%) | Don't know<br>No (%) | Total<br>No (%) |
|---|---|---|---|
| Bertoua | 20 (27.03) | 4 (23.53) | 24 (26.37) |
| Ngaoundere | 24 (32. 43) | 1 (5.88) | 25 (27. 47) |
| Pitoa | 7 (9. 46) | 9 (52.94) | 16 (17.58) |
| Tchollire | 23 (31.08) | 3 (17.65) | 26(28.57) |
| Total | 74 (81.32) | 17 (18.68) | 91 (100) |

Further, the evaluation examined respondents' knowledge on the HIV prevention measures. Comparatively to responses received on the modes of HIV transmission, most participants (94%) in the focus group discussion showed high level of knowledge and understanding on HIV prevention measure and exposure risk factors. Equally, majority of the respondents' in the mini-survey [82 (90%)] knew the methods of HIV prevention with only 9 (10%) stating wrong methods. Participant's knowledge on HIV prevention as per locality is presented in Table 4 below.

**Table 4: Participant's knowledge on HIV prevention by location**

| Locality | Know<br>No (%) | Don't know<br>No (%) | Total<br>No (%) |
|---|---|---|---|
| Bertoua | 21 (25.61) | 3 (33.33) | 24 (26.37 ) |
| Ngaoundere | 23 (28.05) | 2 (22.22) | 25 (27. 47 ) |
| Pitoa | 15 (18.29) | 1 (11.11) | 16 (17.58 ) |
| Tchollire | 23 (28.05) | 3( 33.33) | 26 (28.57) |
| Total | 82 (90.10 ) | 9 (9.89 ) | 91( 100) |

As observed in the above findings, the variation of responses received from participants of the focus group discussions could be attributed strongly to the trainings on HIV&AIDS received from the project. The PLWHA associations reported to have participated in formal and informal training sessions on HIV&AIDS in which transmission; prevention, treatment, care and management issues were tackled.



**Members of a support group participating in focus group discussion during data collection in Bertoua**

Most of the respondents reported to have received such trainings from the project while others have had such informal sessions in local health facilities and treatment Centers. Members of the youth mobile caravan reported to have been trained as trainers and imparted with knowledge about HIV&AIDS which they then went on to disseminate in various institutions of learning, churches and members of the public. It is therefore observed, that most project beneficiaries and community members have correct knowledge about HIV transmission and prevention measures.

### 5.2.2 Uptake of HIV Screening

A review of HIV voluntary counselling and testing activities conducted during the project period shows more people turned out for HIV test at the beginning of the project and gradually the number declined on annual basis. A summary of the HIV test results per project location for the period 2009 - 2011 is presented in the Table 5 below. This table shows that more females than males were tested positive for HIV in all EELC project sites from 2009-2011.

**Table 5: HIV Testing in EELC Project Sites 2009-2013**

| Location | Period 2009-2011 | | Men tested | Women tested | Total Tested | Men positive for HIV | | Women positive for HIV | | Total HIV positive | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Yes/ No | Date | No | No | No | No | % | No | % | No | % |
| ADAMAWA REGION | | | | | | | | | | | |
| -Nyambaka | YES | 2009 | 316 | 394 | 710 | 6 | 1.9 | 6 | 1.5 | 12 | 1,69 |
| -Tibati | | 2009 | 339 | 304 | 643 | 11 | 3.2 | 40 | 3.6 | 51 | 7,9 |
| -Touboro | | 2009 | 330 | 372 | 607 | 19 | 5.8 | 57 | 15.3 | 76 | 10,83 |
| -Bankim | | 2009 | 120 | 119 | 239 | 1 | 0.8 | 11 | 9.2 | 12 | 5,02 |
| -Tignere | | 2011 | 99 | 162 | 261 | 4 | 0.4 | 10 | 6.2 | 14 | 5,36 |
| -Banyo | | 2011 | 116 | 166 | 282 | 5 | 4.3 | 14 | 8.4 | 19 | 6,73 |
| -Ngaoundere | | 2010<br>2011 | 499<br>37 | 548<br>63 | 1047<br>100 | 139<br>2 | 2.8<br>5.4 | 317<br>1 | 57.8<br>1.6 | 4563 | 43,53<br>3,0 |
| -Mbe | | 2009 | 101 | 249 | 350 | 8 | 7.9 | 19 | 7.6 | 27 | 7,71 |
| NORTH REGION | | | | | | | | | | | |
| -Pitoa | YES | 2010 | 114 | 92 | 206 | 7 | 6.1 | 12 | 13.0 | 19 | 9,22 |
| -Tchollire | | 2010 | 252 | 180 | 432 | 12 | 4.7 | 19 | 10.6 | 31 | 7,17 |
| EAST REGION | | | | | | | | | | | |
| -Bertoua | YES | 2010 | 128 | 155 | 283 | 17 | 13,3 | 25 | 16.1 | 42 | 14,84 |
| -Betare-Oya | | 2011 | 202 | 211 | 413 | 18 | 8.9 | 25 | 11.8 | 43 | 10,41 |

Of the 91 respondents in the mini-survey, 67 (74%) accepted that they had been tested for HIV compared to 24(26%) who had never been tested for HIV status. Reasons advanced for not being tested for HIV status include fear of being found HIV positive and ignorance of the available ART, care and support system in hospital and community. Women have high changes of having been tested for HIV, as is a requirement for those pregnant during ANC in heath facilities, a reason that could explain the gender variations. The distribution of HIV testing by gender and project sites is shown in Table 6 and 7 below.

**Table 6: Distribution of HIV Tests Conducted by Gender**

| Total | Tested<br>No (%) | Not Tested<br>No (%) | Total<br>No (%) |
|---|---|---|---|
| Males | 38 (56.72) | 18(75.0) | 56 ( 61.54) |
| Females | 29 (43.28) | 6(25.0) | 35 ( 38.46) |
| Total | 67 (73.63%) | 24(26.37) | 91(100) |

**Table 7: Distribution of HIV Test Conducted by Project Site**

| Locality | Tested<br>No (%) | Not Tested<br>No (%) | Total<br>No (%) |
|---|---|---|---|
| Bertoua | 19 (28.36) | 5 (20.83) | 24 (26.37) |
| Ngaoundere | 21 (31.34) | 4 (16.67) | 25 (27. 47) |
| Pitoa | 7 (10. 45) | 9 (37.50) | 16 (17.58) |
| Tchollire | 20 (29.85) | 6 (25.00) | 26 (28.57) |
| Total | 67 (73.63) | 24 (26.37) | 91 (100) |

### 5.2.3 Results of HIV Testing

Results of HIV tests conducted at the Protestant Hospital in Ngaoundere under EELC management shows a total of 7,610 people tested in 2009 - 2013 as shown in table 8 below. Of the people tested, 402 (5.3%) persons tested positive for HIV. This statistics is higher than and does not compare with national government statistics, which place HIV prevalence in Cameroon at 4.3%. However, it is also worth noting that the uptake of HIV test went down gradually over years and this could have also affected the number of those testing positive for HIV.

**Table 8: HIV Test Results 2009 - 2013 - Ngaoundere Protestant Hospital**

| Year - HIV Test | Total No. of People Tested | No(%) of People Tested Positive |
|---|---|---|
| 2009 | 2067 | 151(7.3) |
| 2010 | 1825 | 105(5.8) |
| 2011 | 1724 | 86(5.0) |
| 2012 | 1178 | 30(2.5) |
| 2013 | 816 | 30(3.7) |
| Totals | 7610 | 402(5.3) |

Regional variations in HIV prevalence was also observed as noted in the national and regional statistics. Data was further analyzed to check regional disparities based on respondents' information on their HIV tests and results as profiled in the mini-survey. Of the 91 participants, 66(73%) who said to have previously taken an HIV test; 61 (92%) of them were HIV negative; while 5 (7.6%) had tested positive. According to this finding, it is indicatively possible that there are regional variations of HIV prevalence with some below and or higher than the national figures.

### 5.2.4 Prevention of Mother-to-Child Transmission of HIV

Discussions with members of the PLWHIV associations and health officials at Ngaoundere hospital indicated improved knowledge, information and uptake of PMTCT. Some of the PLWHIV association members have been beneficiaries of PMTCT and some had delivered healthy children and such statistics was positively growing by day. This finding is further confirmed by the mini-survey, which reveals an increase in knowledge on PMTCT among members of the general public. In the mini-survey with 89 (97. 80%) of the 91 participants who responded to a question on knowledge about PMTCT, 70 (79%) had knowledge of PMTCT compared to 19(21%) who did not. The distribution of knowledge on PMTCT according to the project sites is shown in Table 9 below.

**Table 9: Distribution of knowledge on PMTCT by Project Sites**

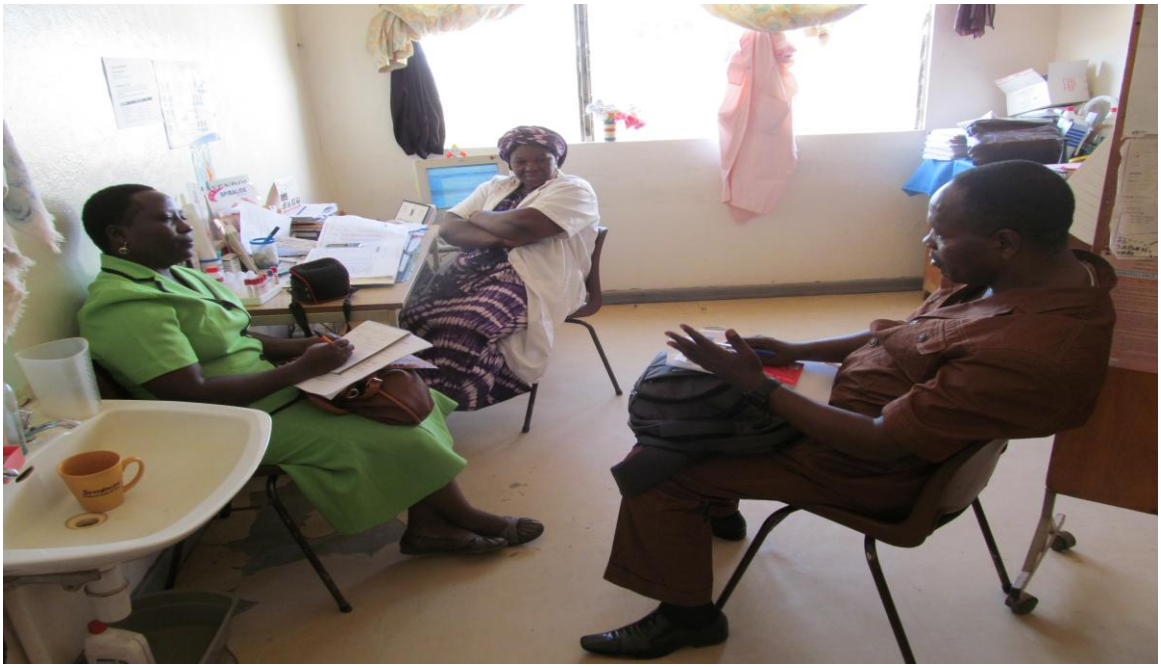
| Locality | Know<br>No (%) | Don't know<br>No (%) | Total<br>No(%) |
|---|---|---|---|
| Bertoua | 19 (86.36) | 3(15.79) | 22(25.29) |
| Ngaoundere | 23 (92) | 2(10.53) | 25(28.09) |
| Pitoa | 9 (56.25) | 7(36.84) | 16(17.97) |
| Tchollire | 19 (73.08) | 7(36.84) | 26(29.21) |
| Total | 70(78.65) | 19(21.35) | 89(100) |

With reference to precautions taken to prevent mother- to- child transmission of HIV, 87 out of 91 community members reached by the mini-survey responded. A total of 59 (68%) participants stated that they seek medical assistance in health facilities during ANC or take treatment as precautionary measures for PMTCT; while 28 (32%) do not know what to do/have never done anything about this before. Knowledge on precautionary measures against PMTCT according project sites is shown in Table 10 below.

**Table 10: Knowledge on Precautions against PMTCT by Project Sites**

| Locality | Know<br>No (%) | Don't know<br>No (%) | Total<br>No(%) |
|---|---|---|---|
| Bertoua | 17 (28.81) | 6 (21. 43) | 23 (26.44) |
| Ngaoundere | 17 (28.81) | 8 (28.57) | 25 (28.74) |
| Pitoa | 7 (11.86) | 9 (32.14) | 16 (18.39) |
| Tchollire | 18 (30.51) | 5 (17.86) | 23 (26.44) |
| Total | 59 (67.82) | 28 (32.18) | 87 (100) |

From the focus group discussions with PLWHA associations and health officers, it was evident that there has been great increase in access to information on PMTCT mainly from health facility and through this project.



**Consultants in an in-depth interview with Mrs Marie Bilum, the nurse in charge of antenatal care at Ngaoundere Protestant Hospital**

## 5.3 Exposure to HIV - Risk Factors/Behaviours

### 5.3.1 Risk associated with sharing sharp objects and HIV transmission

Of the 91 respondents, only 78 (86%) responded on the role of sharp objects in HIV transmission. Of the respondents, 68 (87%) knew that sharing sharp objects like needles and razorblades could contribute to HIV transmission compared to 10(%) who had no knowledge.

The distribution of knowledge on the role of sharp objects in the transmission of HIV according to project site is shown in Table 11 while the distribution of the same according to gender is shown in Table 12 respectively.

**Table 11: Distribution of knowledge on sharp objects in HIV transmission by project sites**

| Locality | Know<br>No (%) | Don't know<br>No (%) | Total<br>No (%) |
|---|---|---|---|
| Bertoua | 21 (30.88) | 3(30.00) | 24(30.77) |
| Ngaoundere | 20 (29.41) | 2(20.00) | 22(28.21) |
| Pitoa | 9 (13.24) | 1(10.00) | 10(12.82) |
| Tchollire | 18 (26.47) | 4(40.00) | 22(28.21) |
| Total | 68(87.18) | 10(12.82) | 78(100) |

**Table 12: Distribution of knowledge on sharp objects in HIV transmission by gender**

| Total | Yes<br>No (%) | No<br>No (%) | Total<br>No (%) |
|---|---|---|---|
| Males | 40 (59.70) | 7(63.63) | 47(60.26) |
| Females | 27 (40.3) | 4(36.36) | 31(39,74) |
| Total | 67( 85.9) | 11(14.1) | 78(100) |

### 5.3.2 Practice of having multiple sexual partners

The evaluators examined knowledge of HIV risk factors and community members' sexual practices. Respondents were asked to indicate if they have/ recently had multiple sexual partners. Findings show some respondents' 25 (27%) have recently had multiple sexual partners while a majority 66 (73%) do not have multiple sexual partners. Responses on practice of having multiple sexual partners by location are further provided in Table 13 below.

**Table 13: Responses on multiple sexual partners by project locations**

| Locality | Yes- Practice<br>No (%) | No-Don't Practice<br>No (%) | Total<br>No (%) |
|---|---|---|---|
| Bertoua | 8 (32.00) | 16(24.24) | 24(26.37) |
| Ngaoundere | 8 (32.00) | 17(25.76) | 25(27.47) |
| Pitoa | 2 (8.00) | 14(21.21) | 16(17.58) |
| Tchollire | 7 (28) | 19(28.79) | 26(28.57) |
| Total | 25 (27.47) | 66(72.53) | 91(100) |

### 5.3.3 Sexual relationship of older persons with youths (intergenerational sex)

Analysis show the practice of sexual relationship among older persons with young people is below average. Only 81 of the 91 respondents' responded to this question; with 33 (40.74%) stating it was common practice in their communities; while 48(59.26%) were of the view that this practice is not there. More analysis of the practice of sexual relationships of older persons with youths in the project area is shown in Table 14 below.

**Table 14: Elderly Persons' Sexual Relations with Youths by Location**

| Locality | Know<br>No (%) | Don't know<br>No (%) | Total<br>No (%) |
|---|---|---|---|
| Bertoua | 9 (27.27) | 10 (20.83) | 19 (23.46) |
| Ngaoundere | 11 (33.33) | 12 (25.00) | 23 (28.40) |
| Pitoa | 4 (12.12) | 9 (18.75) | 13 (16.05) |
| Tchollire | 9 (27.27) | 17 (35.42) | 26 (32.10) |
| Total | 33 (40.74) | 48 (59.26) | 81 (100) |

### 5.3.4 Sexual relationship of youth with elderly persons

Most community members [51(61%)] indicated that the practice of sexual relationship with elderly persons by youths was non-existence; but 33 (39%) confirmed that this practice was still common and that young girls were more vulnerable. The findings of the mini-survey results on the practice of sexual relationships among youth with elderly persons by location are shown in Table 15 below.

**Table 15: Youth sexual relationships with the elderly persons by location**

| Locality | Know<br>No (%) | Don't know<br>No (%) | Total<br>No (%) |
|---|---|---|---|
| Bertoua | 9 (27.27) | 14(27.45) | 23(27.38) |
| Ngaoundere | 7 (21.21) | 14(27.45) | 21(25.00) |
| Pitoa | 5 (15.15) | 9(17.65) | 14(16.67) |
| Tchollire | 12 (36.36) | 14(27.45) | 26(30.95) |
| Total | 33(39.29) | 51(60.71) | 84(100) |

Findings on sexual relationship between the old and younger persons or vice versa could be motivated by a number of factors including extreme poverty and lack of basic essentials mainly among young girls.

**Members of the support group in Pitoa engaged in a focus group discussion with the consultants**

Findings from the focus group discussions pointed to high level of illiteracy among women and girls with cases of girls practicing prostitution and receiving sexual favours from elderly-rich men in the community as a means of helping themselves economically. Although statistics to back this findings could not be established at the time of carrying out the evaluation, there are reasons to worry and need to invest more in girls and youth empowerment programs in these communities; addressing social and economic issues, gender based violence and protection needs. Such cases were largely reported in Ngaoundere, Pitoa and Bertuoa; largely of urban characteristics.

### 5.4 Condom Use During Sex

According to most participants in the focus group discussions, they indicated regularly use condoms with their sexual partners. However, some expressed concern and indicated to have limited knowledge of how young couples wanting to have children could go about treatment and support available for them.

**Group photo of members of support group and consultants in Tchollire after a focus group discussion**

This observation was further confirmed by the mini-survey conducted with members of the public showing that the practice of condom use during sexual relationships is somewhat common in the area with 47(57%) participants indicating use; while 35(43%) said they do not use condoms. Findings of the mini-survey on the practice of condom use by location are shown in Table 16 below.

**Table 16: Practice of Condom Use by Location**

| Locality | Yes<br>No (%) | No<br>No (%) | Total<br>No (%) |
|---|---|---|---|
| Bertoua | 15 (31.91) | 8 (22.86) | 23 (28.05) |
| Ngaoundere | 15 (31.91) | 7 (20.00) | 22 (26.83) |
| Pitoa | 4 (8.51) | 8 (22.86) | 12 (14.63) |
| Tchollire | 13 (27.66) | 12 (34.29) | 25 (30.49) |
| Total | 47 (57.32) | 35 (42.68) | 82 (100) |

Further interrogation on the practice on condom use during sexual relationships by gender shows, high uptake of condoms among men [27(57%)] than women [20 (43%)] as shown in Table 17 below.

**Table 17: Condom Use by Gender**

| Gender | Yes<br>No (%) | No<br>No (%) | Total<br>No (%) |
|---|---|---|---|
| Males | 27(57.45) | 22(62.86 ) | 49(59.76) |
| Females | 20(42.55) | 13(37.14 ) | 33(40.24) |
| Total | 47(57.31) | 35 (42.68) | 82(100) |

The practice of the use of condoms during sexual relationships among females is shown in Table 18 with women in Bertoua and Tchollire showing higher uptake than the other project sites**.**

**Table 18: Practice of condom use during sexual relationships among females by project sites**

| Locality | Yes<br>No (%) | No<br>No (%) | Total<br>No (%) |
|---|---|---|---|
| Bertoua | 9 (45.00) | 1(7.69) | 10(30.30) |
| Ngaoundere | 4 (20.00) | 3(23.08) | 7(21.21) |
| Pitoa | 1 (5.00) | 4(30.77) | 5(15.15) |
| Tchollire | 6 (30.00)) | 5(38.46) | 11(33.33) |
| Total | 20(60.61) | 13(39.39) | 33(100) |

More men in Ngaoundere [11(40.74%)] had higher uptake of condoms compared to other project as shown in Table 19 below.

**Table 19: Practice of condom use during sexual relationships among males by project sites**

| Locality | Yes<br>No (%) | No<br>No (%) | Total<br>No (%) |
|---|---|---|---|
| Bertoua | 6 (22.22) | 7 (31.82) | 13 (26.53) |
| Ngaoundere | 11 (40.74) | 4 (18.18) | 15 (30.61) |
| Pitoa | 3 (11.11) | 4 18.18) | 7 (14.29) |
| Tchollire | 7 (25.93) | 7 (31.82) | 14 (28.57) |
| Total | 27 (55.10) | 22 (44.90) | 49 (100) |

**Frequency of condom use among females and males in the project sites**

A total of 47 (57%) of 82 participants indicated that they use condoms during sexual relationships. Of these, 31 (66%) expressed the views that they use condoms sometimes with only 16 (34%) of respondents' indicating used condoms all the time.

In view of the above findings, we deduce that men were the main decision makers in determining condom use. In this case, more women could be vulnerable to sexual abuse if they resist unprotected sex; while some may not have adequate negotiation skills for safe sex. Comparatively, participants from the association of PLWHIV displayed confidence and courage to make decision around their sexual life; which could be attributed to high knowledge of the risk associated with unprotected sex including HIV transmission, re-infection and prevention measures; and while some were shy to speak about the subject.

Reasons advanced by the respondents for the use of condom were to avoid contracting HIV and other sexuality transmitted infections or infecting others. On the other hand, reasons advanced for not using a condom included; being faithful to one partner, need for children/get pregnant. Some indicated abstaining from sex and some responses indicated less satisfaction during sexual intercourse. From these findings, it evident that the communities are aware and more cautious of their behaviour on multiple sexual partners while some use condom to reduce new HIV infection.

## 5.5 Knowledge and Training on Home Based Care

Out of 91 respondents in the mini-survey, only 71 (78%) responded to questions on home-based care for PLWHIV. General knowledge on home –based care was poor with only 15 (21%) understanding what this was all about; compared to 56 (79%) who did not know what home based care is. Only 8 % of the respondents' who answered the question had received formal or

informal training on home-based care and support. The distribution of general knowledge on home based care in the different project sites is shown in Table 20.

**Table 20: Knowledge on Home Based Care by Project Sites**

| Locality | Know<br>No (%) | Don't know<br>No (%) | Total<br>No (%) |
|---|---|---|---|
| Bertoua | 7 (46.67) | 11(19.64) | 18(25.35) |
| Ngaoundere | 5 (33.33) | 14(25.00) | 19(26.76) |
| Pitoa | 1 (6.67) | 14(25.00) | 15(21.13) |
| Tchollire | 2 (13.33) | 17(30.36) | 19(26.76) |
| Total | 15(21.13) | 56(78.87) | 71(100) |

The findings further reveal that only 34 (48%) of the respondents' are aware of such community based home care services while 37 (52%) are not. Only 8% of the respondents' indicated having participated in voluntary home-based care support activities. Types of support provided by home-based caregivers as profiled by the survey findings and HBCV interviewed include: moral support 25(81%), financial support 2(6%) and other home care support 4(13%) cited. The distribution of knowledge on assistance given to PLWHA at home is shown in Table 21 below.

**Table 21: Knowledge on type assistance given to PLWHA at home by project site**

| Locality | Know<br>No (%) | Don't know<br>No (%) | Total<br>No (%) |
|---|---|---|---|
| Bertoua | 12 (35.29) | 8 (21.62) | 20 (28.17) |
| Ngaoundere | 11 (32.35) | 5 (13.51) | 16 (22.54) |
| Pitoa | 5 (41.71) | 5 (13.51) | 10 (14.08) |
| Tchollire | 6 (17.65) | 19 (51.35) | 25 (35.21) |
| Total | 34 (47.89) | 37 (52.11) | 71 (100) |

In view of the above findings, this evaluation attributes limited knowledge on home-based care giving to limited access to such information at the community level and few services provided through formal structures like hospital, limited number of trained home-based caregivers by this project hence their work not visible at local level; and the limited number of bed-ridden PLWHA

requiring such attention and support. Table 22 below shows records of HBCV participation in HIV&AIDS activities according to administrative regions and project sites.

**Table 22: HBCV Records by Region and Project Sites**

| REGIONS | Project site | Women volunteers | Men volunteers | Total |
|---|---|---|---|---|
| ADAMAWA | -Nyambaka | 4 | 4 | 8 |
| | -Tibati | 4 | 4 | 8 |
| | -Touboro | 4 | 4 | 8 |
| | -Bankim | 4 | 4 | 8 |
| | -Tignere | 4 | 4 | 8 |
| | Meiganga | 4 | 4 | 8 |
| | -Banyo | 4 | 4 | 8 |
| | -Ngaoundere | 6 | 6 | 12 |
| | -Mbe | 4 | 4 | 8 |
| | -Nyambaka | 4 | 4 | 8 |
| | -Tibati | 4 | 4 | 8 |
| NORTH | Garoua | 4 | 4 | 8 |
| | Pitoa | 4 | 4 | 8 |
| | Tcholliré | 4 | 4 | 8 |
| | Touboro | 4 | 4 | 8 |
| EAST | Bertoua | 4 | 4 | 8 |
| | Betare-Oya | 4 | 4 | 8 |
| | Garoua-Boulai | 4 | 4 | 8 |

While drawing relationships, the finding shows a strong relationship between training on home-based care and capacity and interest in helping patient at home. However, high level of stigma could also have challenged those infected and ailing from AIDS from disclosing their status and willingness to openly accept to access HBC. Out of 91 respondents to the mini-survey, 89 (97.80 %) responded to the question of whether they knew PLWHA in their communities, 57 (64%) indicated knowledge of PLWHA in their communities; while 32 (36%) did not. The analysis show there is a strong relationship (strongly significant) between knowing PLWHIV in the community and assisting PLWHA at home.

### 5.6 Support Groups of People Living with HIV&AIDS

This project aimed at improving the living standards of PLWHA through access to psychosocial support, information access on HIV&AIDS, organizing in groups and economic empowerment to enable access to treatment; and strengthening their leadership.

Most of the support groups were formed in 2009 - 2012 with mobilization mainly done through the local churches as shown Table 23 below. Support groups had an average of 16 members. The retention of the group membership is good although cases of some leaving the group for lack of financial motivation were noted. The group members have received informal training sessions given by staff on HIV&AIDS, nutrition and income generating activities. The project also provided some materials like blankets, soap, body oil and toothpaste to members of the support group to compliment their needs. This was also done once in a while to motivate members' participation in-group activities.

Group activities included regular meetings for members, individual income generating activities and at least one group in Tibati reported to have organized and publicly participated in the celebration of International AIDS Day in 2012. An exchange visit between support groups (4 support groups met in Tibati in 2012, 5 support groups in Pitoa in 2013 was conducted to share their experiences/lessons learnt and to address stigma and disclosure. A support Group of PLWHA in Tibati has in a few years now been participating in the World AIDS Day celebrations with some of its members able to speak openly about their HIV&AIDS. A few of the group had made their little savings before and after starting their income generating activities to support each other in the event of sickness. However, only one group at the time of this evaluation had such savings in place.

**Table 23: Support Group Distribution by Region and Year Established – 2009 – 2013**

| REGIONS | SG NAME AND LOCALITY | BIRTH DATE | IGA funds RECEIVED/year |
|---|---|---|---|
| ADAMAOUA | AFEDYS in NGAOUNDERE | 2010 | YES/2009 |
| | AFSOSODY in NGAOUNDERE | JANUARY 2005 | YES/2009 |
| | ESPERENCE in TIGNERE | JUNE 2011 | YES/2012 |
| | SOK-DAGA in MBE | 2009 | YES/2010 |
| | MANDERE in NGAOUNDERE | APRIL 2008 | NO |
| | ESPOIR in BANYO | MAY 2011 | NO |
| | ZOUDOUK in TIBATI | SEPTEMBER 2009 | YES/2010 |
| | ESPERENCE + in TIBATI | OCTOBER 2006 | YES/2010 |
| | MAINTENANT in BANKIM | NOVEMBER 2010 | NO |
| NORD | SOMI in TOUBORO | OCTOBER 2009 | YES/2010 |
| | ESPOIR in PITOA | MAY 2010 | YES/2013 |
| | NARRAL in TCHOLLIRE | MAY 2010 | YES/2013 |
| | KAWTAL YIIDE in TOUBORO | OCTOBER 2009 | YES/2010 |
| EST | MOINAM in BETARE-OYA | MAY 2011 | NO |
| | IL EST TEMPS in BERTOUA | NOVEMBER 2010 | YES/2012 |
| TOTAL | | 15 | 11/15 |

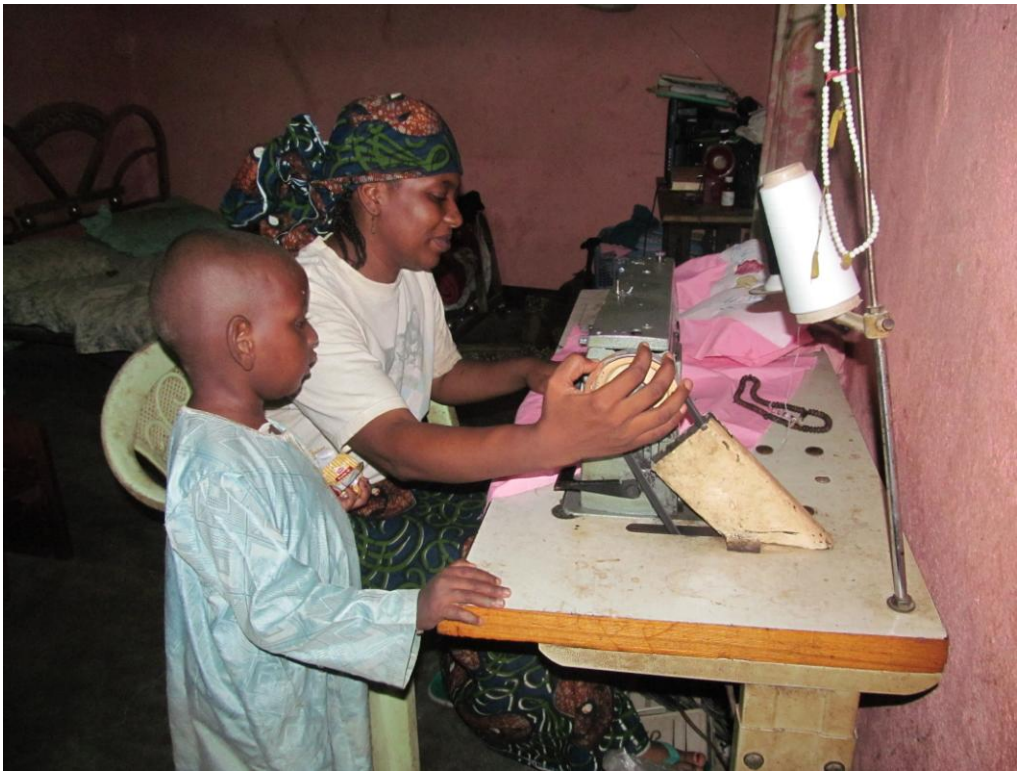


**Photo of one of the support group leaders interviewed during the evaluation exercise**

Leadership by PLWHA and in the management of support group in critical. This will not only support group members' activities; but also help them motivated to participate in local and national platforms on HIV&AIDS advocacy for health and other resource needs they may have. From evaluators observation during focus group discussions conducted with PLWHA leaders and association members, none of the support groups or its leadership had the capacity essential to help them move to the next level of independence of the group management. This remains a big challenge to the project and support groups' sustainability.

Most of the support groups are still at the developmental and norming stages of development. The groups lack clear vision, plans and confidence in their group activities and leadership. High level of stigma seems to curtail their sharing of HIV status with family members including spouses. However, support group members have received psychosocial support, which have enabled a number of discordant couples disclose their status and some agreeing to participate in the group activities. This is commendable and more psychosocial support efforts need to be encouraged.

## 5.7 Stigma and Discrimination

There has been a significant reduction of stigma associated with HIV&AIDS among most project participants and members of the public. Members of the support group were seen to be more interactive and open about their status while with fellow members; unlike when with family and members of the public. Most PLWHA noted that stigma is still high and they are still challenged to go public on their HIV status. To estimate the level of stigma, the evaluators sought to find out the perceptions and behaviours that could perpetuate stigma and discrimination of PLWHA as shown in the results captured below.

### 5.7.1 Readiness to eat from the same bowl with PLWHA

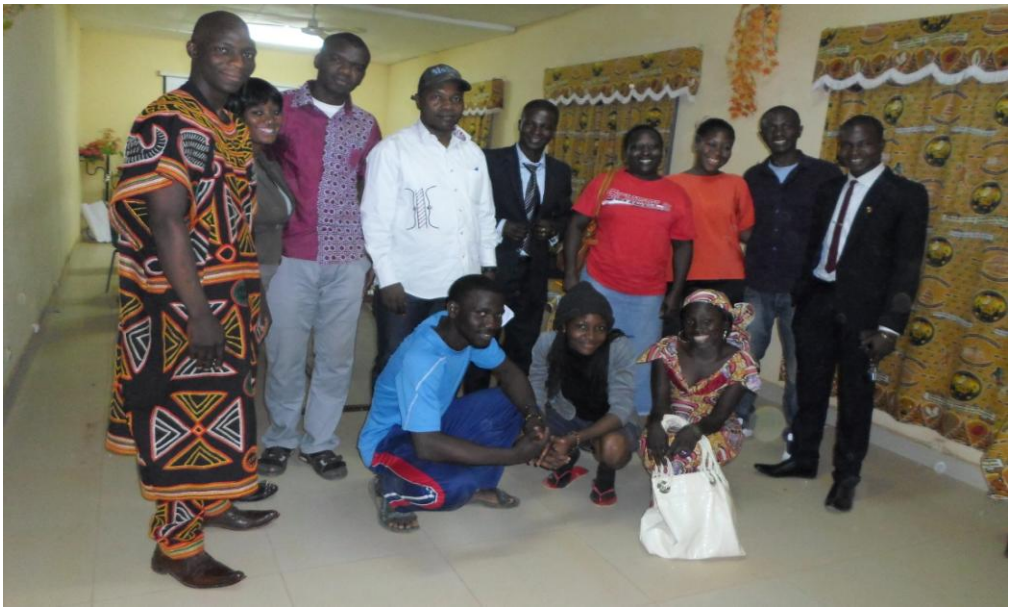
Only 88 (97%) of 91 participants who responded to the attitudinal question on whether they could eat with PLWHA from the same bowl. A total of 75 (85.2%) people accepted they could share a meal from the same bowl with PLWHA compared to 13(%) who said they could not share a meal with PLWHA.

### 5.7.2 Living with PLWHA in the house

Out of the 88 respondents', most participants [79 (90%)] accepted that they can live with PLWHA in the same household compared to 9(10%) who opposed such company. Comparatively with the findings of the evaluation 2010; there is a significant positive change in attitude that embraces people living with HIV&AIDS.

## 5.8 Sensitization on HIV&AIDS

There is evidence of sensitization activities having been carried out in various parts of the project sites. The sensitization were well organized and targeted communities including youth in and out of school, university students, church leaders - women, youth and pastors as well as members of the general public.



**Youth members of the mobile caravan posing for a photo after a focus group discussion**

The sensitization activities were mainly conducted by the youth through the mobile caravan. Youth were trained as trainers and prepared adequately to undertake sensitization activities and responded to questions on HIV&AIDS that were asked by community and or schools pupils/students. As a result of this activity, more people are reached with correct HIV&AIDS information, get opportunity to ask questions and got answers. The strategy ensured reach of remote areas covered by the project through early mobilization and public activities. With increase in correct information about HIV&AIDS, there has been a higher level of uptake of PMTCT services, counseling and testing for HIV as reported by youth members of the caravan team, health officials and church leaders. Stigma reduction has also been slightly impacted by this activity, as people get to understand the modes of HIV transmission and prevention measure; diffusing fears of contracting the disease when interacting with PLWHA in the community, household level or workplace. Table 24 below shows the location where sensitization on HIV&AIDS took place during the project period and the number of people reached - both male and female participants.

**Table 24: Participation during sensitisation campaigns by Region and project sites**

| LOCALITY | | Year of sensitisation (2009 - 2013) | Number of people sensitised |
|---|---|---|---|
| Adamawa Region | -Classical High SchoolNgaoundéré | 2010, 2012, 2013 | 2210, 3500, 3875 |
| | -Tibati High School | 2010 | 6200 |
| | - Bankim High School | 2011 | 4560 |
| | -CPDM Party House Ngaoundéré | 2012 | 1200 |
| | -Ceremonial | 2009, 2012 | 350 |
| | GroundNgaoundéré | 2012 | 1800 |
| | - Bilingual High SchoolMeiganga | 2009, 2010, 2011, 2012, 2013 | 20080, 1990, 2300, 2500, 30100 |
| | -EELC parishes | | |
| North Region | -Touboro | 2010 | 450 |
| | -Pitoa | 2011 | 300 |
| | -Garoua | 2009, 2011 | 900, 200 |
| | -Tcholliré | 2011 | 600 |
| East Region | -Technical High School Bertoua | 2013 | 650 |
| | -Betaré-Oya | 2011 | 500 |
| | -Garoua-Boulai | 2010 | 400 |

This is one of the successful activities of the project. However, notable challenges including vast geographical coverage by the project and lack of proper means of transport challenged them logistically to effectively cover some project sites. Further, there is limited participation of youth out of schools in the activities of the caravan team; posing risk of transitioning knowledge, skills and strategies to younger/new youth to take over/continue such activities as most of those involved are in college/university students facing time constraints. Further, the link of the sensitization efforts to the local church structures was weak and need to be strengthened to tap into the vibrant youth leadership in the church and others at the community level.

### 5.9 Training,Training Mannuals and Reports

The design of the project provided for training opportunities including HIV&AIDS, PMTCT, HBC, leadership and business development skills. The PLS staff organized various trainings, which happened at the community level while some including the leadership and training for HBCV took place in Ngaoundere. The trainings aimed at increasing knowledge and understanding of HIV&AIDS among church leaders (pastors, women and youth leaders), PLWHA association members and their leadership, health staff and the animation team. The trainings modules and manuals were borrowed from various sources and customized to the needs of the specific groups including manuals from CARE. Issues of HIV facts, transmission, prevention, treatment, care and support were covered. On leadership, the project team used other manuals/aid books including "Against AIDS" and Grace Assistance and Justice. The manuals used for training on HIV/AIDS were adequate but no manuals were available on psychosocial support for PLWHIV. Lack of a guide/manual on psychosocial support could have affected the quality of training, mentorship and support provided to PLWHA. Table 23 below shows a description of the trainings conducted and manual/aid material used for references.

**Table 25: Trainings conducted by type and training manual used**

| Training Conducted | Availability of training report | Training Manual Used |
|---|---|---|
| Training of volunteer community (HBCV) | Yes | Manual of the CARE project |
| Training on leadership:<br>Churches,<br>Teachers,<br>Support groups<br>PLWHA<br>Members of the sensitization Animation team | Yes | -Book of activities 'Against AIDS'<br>- Manual of the Animation Team<br>- Grace Assistance and Justice |
| Training of singers | No | Manual of the CARE project |
| Training of youths of the mobile caravan (HIV themes) | No | Manual of the CARE project |
| Psychosocial support | No | None |

Various trainings and sensitization conducted on HIV&AIDS, PMTCT, ART, sexuality and nutrition during the project period have greatly contributed to behaviour change, which have seen an increase in knowledge about the HIV&AIDS and awareness on risky behaviours like early marriages and intergenerational sex. In addition, trainings on leadership, democracy, HIV&AIDS (benefited support group leaders, pastors, and youth and women leaders; youth mobile caravan. PMTCT – reached the lab technicians, counsellors, volunteers and midwives and statisticians.

As a result of the information given through the trainings, there has been a reduction of unwanted pregnancies and sexually transmitted diseases including HIV and stigma reduction. Specifically, the trainings and sensitization activities have contributed to the following key results:

- There is increase in knowledge about HIV&AIDS (prevention and modes of transmission) – trainings and sensitization activities (e.g. Mobile Caravan sensitization in churches, schools and public places)
- Increased positive attitude towards people living with HIV&AIDS (PLWHA) – by volunteers, family members and members of the general public due to access to correct information

- Increase number of PLWHA accessing ART services – as mobilized and supported by the project
- Psychosocial Support: members within the groups are gradually gaining confidence about living positively with HIV, have shared their status with family members who also support them when in need.
- Music CDs and videos developed by members of the youth caravan were and used during community outreach activities. Playing the music on church radio in Ngaoundere and others stations can further disseminate HIV&AIDS information to members of the public.

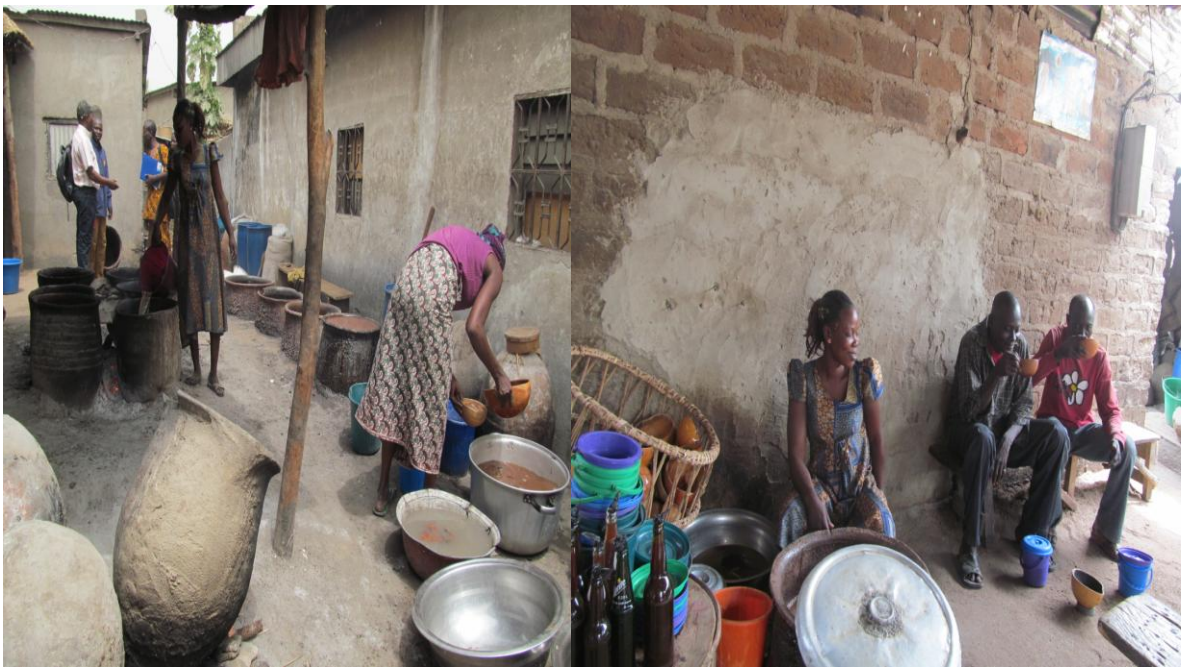
It is however, observed that most training were conducted by the project staff; who could be limited in knowledge and expertise in specific fields required to deliver such trainings. The trainings on leadership was critical and presented PLWHA and church leaders a greater opportunity to locate their role in the fight against HIV&AIDS and ways of supporting those affected and infected in the community. Despite the PLWHA association leaders indicating that they had been trained as leaders, they displayed limited leadership capacity including articulation of their roles in aiding the group, counsel and support fellow members towards achieving intended goals. Most PLWHA support group did not any work plans or a forecast of future activities. Support group members' efforts and motivation was mainly felt at individual level; and most relied on PLS project staff for direction. Some of the leaders are less committed or not in touch with the group activities; with some isolated cases of mismanagement of the group finances by some of them.

The EELC church will be capable of continuing with teachings and sensitization on HIV&AIDS and psychosocial support because the capacity of church leaders, pastors, women and youth leaders has been strengthened in many training sessions. Compact Discs (CD) with music carrying HIV&AIDS messages produced by the youth caravan could be played on the EELC radio and other local radios stations to continue sensitization work. However, sensitization through outreach activities to the community will only happen through church organizing and mobilization as is likely to be hampered by lack of a project vehicle taking into consideration that the project sites are many (approx. 350) kilometres apart even within the same region.

### 5.10 Income Generating Activities

The project supported PLWHA to initiate small business enterprises also referred to in this report as Income Generating Activities (IGAs). Members of the support groups were targeted by this activity with the aim of strengthening their economic capacity to access treatment/ ART when sick and pay for CD4 counts in addition to meeting their nutritional needs. The project staff made inception meetings and provided the respective association members with information that helped them review their business plans. The staff then assessed their business plan, members own contributions and provided varying financial support based on the business plans. Most active members of the support groups/association of PLWHA received financial support to either boost already existing business or to initiate new ones. Most business activities include vending of farm products like vegetables and fruits, selling of grains, fish, farming activities, tailoring and

dress making, jewellery and livestock keeping, and motorbike transport. Some of the business activities e.g brewing and selling of local beer (BiliBili- as known in the local language) could further expose the women to sexual violation by their clients; while those engaged in charcoal business are not promoting environmental conservation issues.



**Photos: Local brewing and selling point as an income generating activity for one female support group member**

Most (70%) business activities have been in existence for about 6 months - 2 year with members reporting to have benefited from this activity. However, most members expressed fear that most business are at the verge of collapsing as they use most of the profits made and at times the business capital is used to pay transport cost to and from hospital when need treatment for other opportunistic infection and also support their loved ones; pay school fees for their children and meeting general household needs. It was not established for how long either of this businesses will survive the test of time as the participants made request for extra and slightly higher financial support to boost their business. Most (90%) members of the support group who received IGA support have not made any financial savings to cushion themselves against costs for treatment in the event the fall ill or other needs related to their health. This is likely to influence failure of their business as they rely totally on the business capital and little profits made for their survival. This could challenge their future capacity to access treatment and some may fail to adherence to treatment due to lack of financial capability.

In view of the performance of the IGAs, the evaluators established that members of the support group were not adequately prepared before receiving the financial support. Capacity strengthening through sessions on financial literacy, business development and management, risk assessment and management were done informally with limited content covered and or time invested in this could have been too short to enhance positive attitude towards doing business

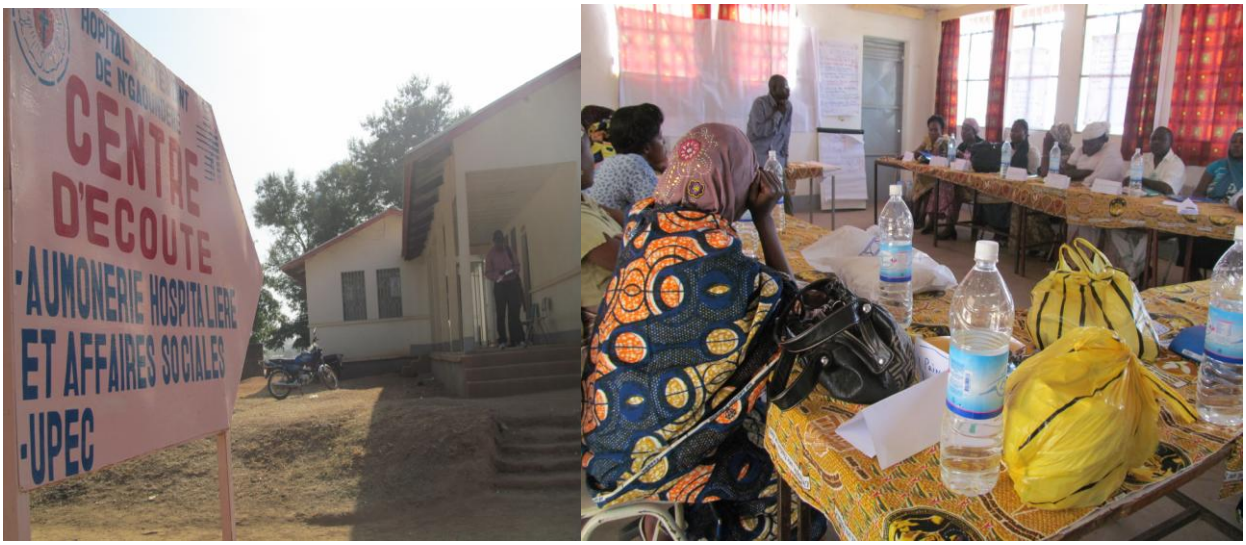
compared to the need for project handouts. The content of the informal sessions offered by the project staff mainly offered encouragement and moral support; but did not adequately tackle the practical/technical content of the said subjects to enable the members discern their interest and capably develop viable business plans. Such training capacity could be sourced from the relevant ministry or business entities or experienced resource persons; when not available within EELC. Such training and mentorship can further be done now with the existing group members with IGAs to reduce risk of losing their businesses. Close monitoring and accompaniment of individuals who have established businesses need to be enforced to offer mentorship and guide those in need at the right time. Linking this initiative with church structures needs to be strengthened to facilitate access to technical and moral support from within the region; rather than relying on the project staff based in EELC project office in Ngaoundere.

### 5.11 Use of Centre D'Ecoute

The centre is a major success of this project. The centre houses three chaplains trained as HIV&AIDS counsellors who provide counselling on daily basis to those infected and affected by HIV&AIDS; and those in need of voluntary counselling and testing. Lab technicians are also stationed there to take blood samples for screening at the hospital lad.

The centre also serves as the HIV&AIDS treatment centre. HIV management cases and provision of ART services including ARVs is done at the centre; serving as an annex to the Ngaoundere Protestant Hospital owned and managed by EELC. Counsellors, lab technicians and other support staff working in the centre are paid by EELC.

Other social services provided here include space for meetings mainly for PLWHA support groups/associations, seminars and trainings rooms for youth who were involved in the project, HIV&AIDS education; as well as meeting point for orphans and vulnerable children reached by the health department of the EELC. Centre is now fully operational and in good use as the picture taken during the evaluation period shows a seminar going on in the meeting room.




**Photos of Centre de'coute and a training going on at the time of the evaluation**

The Centre de'coute is now serving as safe space for PLWHA; providing them with ample space for their associations/support group meetings essential for their sharing and psychological well being. The centralization of testing, treatment, management, care and support for PLWHA at the Centre has made it easy for the hospital staff to manage such cases, keep records and address their special needs.

### 5.12 Provision on Gender Issues

The project made deliberate efforts to provide for gender representation in trainings with at 50 female and male representations. Trainings targeted pastors, women and youth leaders in the church, leaders of support groups made efforts to ensure both gender was represented. However, most support groups have more female members compared to men. The support group membership could have been difficult to influence, as membership was voluntary and largely informed by individual member willingness to share their HIV status.

The project has 3 male staff (coordinator, assistant coordinator and the finance manager); while the project psychosocial advisor is female.

The project management committee is made up of male members and none of them is of female gender. This shows a glaring gender gap in EELC top leadership of the project structure and this need to opened up to include women in senior church positions. EELC should consider developing a gender policy to enforce such provisions and provide for affirmative action that could facilitate progress towards achieving this goal.

The youth were active participants in the project; while the children were reached through church and school sensitization activities on HIV&AIDS.

There was no evidence of involvement of persons with disability at the level of project management structure, staff, and church or community participants. People who are differently able (Disabled persons) need to be reached and their needs profiled because leaving them out could make them vulnerable to HIV&AIDS.

### 5.13 Strategic Partnerships in the Fight against HIV&AIDS

#### 5.13.1 Government of Cameroon / National AIDS Control Committee (NACC)

The activities of the project 'All Against AIDS' by EELC are in line with the National AIDS Control Committee (NACC) in Cameroon, the official organ of the Ministry of Public Health in-charge of AIDS. The National Government AIDS Coordinators in the ten Regions of Cameroon are appointed by the Minister of Public Health with recommendations from NACC.


**Photo: In the middle is Dr. Onana Ewane Coordinator of National AIDS Coordination Council in Adamawa Region after an in-depth interview with consultants in his office in Ngaoundere**

The evaluation reveals that the relationship between PLS/EELC and NACC in Adamawa has not been fully explored and tapped for the benefit of the project. There has been some interaction with the Regional Delegation of Public Health, Regional Technical Group for the fight against HIV&AIDS, and Ministry of Public Health. As noted in the PLS evaluation report of 2010, there was need to enhance collaboration between EELC/PLS project leadership and the NACC office in Adamawa region which was previously strained. In an interview with NACC coordinator of Adamawa, he observed and noted with concern that his office was not informed about the PLS project activities. He, however, confirmed that his office was working closely with Hospital Protestant of Ngaoundere and even supporting it with HIV testing kits and treatment drugs; and whose reports have been in cooperated as best practices in the NACC annual regional reports. He registered his willingness and commitment to work closely with PLS project team to support its efforts in the fight against HIV&AIDS and noted his readiness to give recommendation of PLS/EELC to other funding bodies if such an opportunity arises. It will be strategic and beneficial for PLS/EELC to work closely with NACC not only in Adamawa but also in the North and East Regions.

### 5.13.2 Donor Agencies and Civil Society Organizations

The project had previous relationship with CARE, UNICEF Cameroon and Lutheran World Federation, who supported activities on sensitization, HIV testing, care for PLWHA and support for Orphans and Vulnerable Children (OVC) and production of a guide for pastors on HIV&AIDS. At the time of this evaluation, PLS project had no direct interaction with the said organizations or development agencies. There were limited efforts to reach out to other development partners (local donors and development agencies) for financial, material and technical resources including from the Ministry of health. PLS/EELC can benefit more and expand its project resource/financial base by establishing new partnerships with like-minded organizations including active participation in national and regional networks of organizations addressing HIV&AIDS. This potential is yet to be explored to add value to her HIV initiatives as well as build synergy.

### 5.13.3 Role of SIK in the Project

In phase 1 and 2 of the PLS project, SIK was instrumental in influencing the design of the project to not only meeting the objectives of the project, but also participation of the church leaders in facilitating the achievement of the project results. SIK then, played a role in monitoring the financial aspects of the project to ensure proper management and also intervened to provide technical support to financial issues that emerged from the auditors and from the donor.

The design of the PLS project phase 3 under evaluation, SIK did not provide any technical accompaniment support to the project as done in phase 1 and 2. EELC has however, maintained cordial relationship with SIK as a capacity strengthening institution in programming and financial management issues. SIK conducted a participatory PLS project mid-term review in 2012 and provided recommendations to the project progress. SIK remain a strategic partner of EELC/PLS project; and SIK indicated readiness to support or accompany future development activities of the EELC including PLS project. SIK previous experience with PLS/EELC development and church based activities continue to be a resource, which could be tapped in the future; based on the established needs of similar projects.

Despite limited involvement of SIK in phase 3 of the project, PLS team of staff was able to manage the implementation, monitoring and reporting of the project with limited challenges while utilizing the lessons and capacity gained during the previous phases.

### 5.13.4 Norwegian Mission Society and Digni

Norwegian Mission Society (NMS) has been the grant manager of the PLS project. Digni, formally known as NORAD-BN was the financier of the project. EELC/PLS and NMS has had cordial relationships in the management of the project. Communication between NMS and EELC over the project planning, financial issues, monitoring and reporting has been prompt. EELC/PLS project staff was able to handle all communication and responded to questions arising from reports from NMS in time.

However, there were concerns about delay and budget cuts in financial year 2012 and 2013, which made it difficult to meet the expectation of the planned activities; necessitated scaling down the activities and delay in paying staff salaries. NMS staff assigned to supervise the grant in some occasions were changed and this caused delay in communication between the two parties and resulted to breakdown of communication as they did not have full view of the project plan and changes made during the project implementation period. Although the impact was directly felt in the general management of the project, the impact did not have a significant effect to the attainment of the project results. Transition and induction of new grant management staff at NMS needs smoothly transitioned in the future to support and sustained positive progress and communication.

EELC/PLS project management did not have a direct communication with Digni; as all project management issues were handled by NMS on behalf of Digni. No issues of concern were raised on the part of Digni financial responsibility to the project and the relationships at all levels are cordial.

### 5.14 EELC Structure and Influence on Project Performance

The EELC structure has the Bishop as the helm of the Church leadership and the Executive Board as the highest decision making level in the church. The EELC structure is well organized because the EELC Arch Bishop is the Chair of the 'All Against AIDS' project steering committee and works in collaboration with the project coordinator.

**The EELC Bishop Rev Dr Ngozo Ryben during an in-depth interview with evaluators in his office**

There are four departments in the church namely; the evangelical, communication, education and heath with each headed by a director. Each departmental director is in charge of all the projects/programs within the respective department and work with a project coordinating committee in the implementation of the project. All decisions concerning the work or human resource in the department is under the OSEELC Board through the executive committee or the steering committee for the project in this case, PLS.

The church has a new Bishop who recently took the helm of its leadership. For the last six month of his work in this position, he has been informed and involved in the project. The office of the Bishop has had positive influence to the church leaders/pastors and its congregants who are the major target of the church development projects.

The operation of the EELC is guided by a constitution. This constitution serves as a reference point for leaders and management providing directions on legal procedures and operational principles that govern the church and her members. From this constitution, various policies including the human resource and operating procedures are laid out.

While examining the EELC efforts in the fight against HIV&AIDS and in reference to the recommendations of the PLS evaluation report of 2010, the church leadership has made positive steps towards supporting staff and pastors who are either affected and infected with HIV&AIDS by declaring that all persons are equal before God and deserved equal treatment according the teachings of the Bible.

Although the EELC Constitution is not clear on what should constitute such a support/treatment of members of the church and pastors/church leaders who are infected or affected with HIV, such declaration calling for solidarity and support to those affected and infected with HIV is in its self a positive step. This has seen reduction of stigma and discrimination of PLWHA in the church.

The EELC church modified a major criterion for admission into its Bible Training Colleges cancelling the rejection of students who were HIV positive. As profiled in the evaluation report of 2010, discrimination of persons infected with HIV by EELC from joining the evangelical training colleges was noted with great concern. This restriction has been lifted and prospective candidates do not need to go through a medical test as previously required to prove their HIV status. This is commendable step towards fighting stigma and discrimination of PLWHA by EELC. To ensure this effort is sustained and can stand a test of time, the EELC will need to consider developing a HIV&AIDS policy, which will affirm its position and give parameters for support of PLWHA within its human resource and church fraternity.

### 5.15 General Administration of the Project

This project is in line with the EELC priorities of meeting the needs of the people they serve; the spiritual, mind and body. The fight against HIV is based on the conviction that the church can influence spiritual, social and economic development. The project was implemented and guided by the EELC strategic plan with the health department assuming management responsibility of the project. The role of the EELC Bishop in the project had a positive political influence on the

rest of the church leadership and the congregants to join hands in the fight against HIV and acceptance of the church to address issues that promote stigma and discrimination of PLWHA.

The objectives of this project are also in line with national priorities under the ministry of health, which aims at reducing the effects of HIV among the country population. These objectives are also in line with the international goals including the millennium development goals (2000) and other international human rights instruments championing access to health care for all, education and elimination of discrimination of all kinds including stigma associated with HIV&AIDS.

The staff that coordinated the project had professional qualification and information on HIV&AIDS, attributed to their previous work experiences and time spent in the implementation of the project. This presented an important opportunity to guide and share correct knowledge to the project participants. For those staff that did not have this advantage, they benefited from the project trainings, exposures and interactions they gained from those with these skills.

Upon receipt of project funds, the project coordination team (based in Ngaoundere) reviewed the planned activities and undertook planning for and mobilization of communities for implementation. All staff (project coordinator, assistant project coordinator, finance officer and the project secretary) took the center stage in executing the activities. This project was managed and coordinated through the health department of the EELC. Most staff involved in the project had professional qualifications and medical experience and this made it easy for them to implement the project activities. The project coordinator also serves as the director of the health department at EELC. This ensured efficiency in information prepared and delivered to the target group through this team.

Although the project lost one of the key staff; assistant project coordinator to a road accident in early 2012, the team was able to hire and replaced the position in good time. The project was slight affected by loss of institutional memory including files and project details of previous activities. This was however, not significant to have interfered with the project outcomes.

In September 2012, the project coordinator took leave of absence. EELC hired a new project coordinator who also doubled as the head of health department. The new coordinator did not however, was not handed over the coordination of the project as was getting towards the end. The new coordinator provided overall supervision and supported the project team to the completion of the project period. The evaluation team did not establish whether the head of health department will assume coordination of PLS project; if the project was to be extended of EELC will adopt new project management structure.

### 5.16 project Financial Management

Project financial management and operational procedures were well handled with the oversight of the project management committee, internal control and external audits. The finance manager made budget follow ups against specific budget lines to ensure they were justified while the accounting system used was up to date. The finance manager was involved in project activity planning and advised on expenditure against budget lines and other financial matters/standards.

Within the EELC church, there is an anti-corruption committee headed by a lawyer with other pastors and women as members who ensure church finances and project funds are used for the intended purpose. At the EELC Health Board, regular audits have been conducted both for hospital finances and the PLS project. In view of internal and external audits conducted during the project period; no fund mismanagement or misplacement was recorded. However, the external audit advised on the need to strengthen project cash flow monitoring. Reacting to this recommendation, it was observed that the project finance manager experienced some challenges in monitoring the cash flow, as a cashier at EELC kept the money withdrawn from the bank. This challenge was however addressed in good time, and the finance office was able to adequately track cash flow through weekly and monthly checks.

Financial reports were developed and sent to NMS in a timely manner. However, changes made on the financial reporting template by NMS was noted and when such change happened, no capacity building and accompaniment was provided to project finance office by NMS to ensure requisite skills for correctly use of the templates. This was previously a role previously played by SIK. However, this function was removed from the 3rd phase of the project, as SIK accompaniment support was not provided. Despite this challenge, the project finance management office was able to learn and correctly use the new financial templates. To enhance efficiency of financial monitoring and reporting, NMS should consider providing induction session for project finance manager/staff on such new templates and or provide for an accompaniment support function as previously provided by SIK or localized support to aid the process. The EELC finance manager has requisite skills and experience in handling project finances; financial systems and operational procedures adequate to ensure effective delivery of his function.

### 5.17 Project Ownership, Sustainability and Exit Strategy

From the evaluation, the following were observed:

The EELC leaders and the communities own this project. EELC, through its leadership and the church structures have fully been involved in the project implementation, monitoring and management. The project has supported the development of 52 verses with HIV&AIDS messages to be in cooperated in the church sermons in its attempt to mainstream HIV&AIDS in its work. This shows great level of ownership by the church and its leadership; and this effort is truly sustainable.

The Centre d’ecoute is fully operational and uniquely positioned to provide services and serve as safe space for PLWHA in Ngaoundere and its environs. The structure is permanent, very sustainable and if well maintained can be available for many years. The activities taking place at the centre are also sustainable as linked and managed under the EELC hospital; presenting opportunities to diversity its services to better the lives of PLWHA and other patients served in the hospital. The staffing of the centre are paid by EELC and if the activities of the centre are well managed, such finances could be mobilized through subsidised services provided through this facility. Care must be taken by EELC to ensure the main objective of the centre is not lost for a commercial gain.

Established support groups for PLWHA are based on community mobilization and support system. The members of the support group are holding together; though faced with some cohesion challenges; are part of a larger community. Their activities (if held together) will continue to make them more resilient in addressing challenges associated with positive leaving.

Income generating activities initiated and supported by the project for PLWHA are largely not sustainable. Competing interest for little profit made from the IGAs for health and other needs are likely to eventually "eat up" the business capital; which will make in unlikely for such activities to survive. However, the support provided, sessions on income generating activities and encouragement PLWHA have already received will continue to inspire lasting positive attitude towards self initiative for economic empowerment; and if some fail could have a chance of picking up again.

As a result of the project success, EELC leaders, members of the communities and project participants can confidently face the challenges posed by the disease now and in the future. However, the society is dynamic and this might require continuous and targeted initiatives which expand on the gains made so far and explore new opportunities to strengthen the community resilience to the disease while linking poverty, women and girls empowerment to gender issues, environment and climate change vulnerabilities to such diseases; youth empowerment, social inclusion in decision making and participation in decision making.

EELC has so far demonstrated capacity to take over this project mainly as a mainstream component alongside its evangelical/church, education, communication and health structures. However, the project has not laid out plans and mechanisms in place to support the mainstreaming of this project. While acknowledging this limitation, the church could find it challenging to sustain the scale of the project due to financial constraints. Particularly, the support groups which are yet to consolidate their activities, leadership and reach a great level of independence might suffer a risk of collapse; their IGAs if not closely accompanied and monitored, sensitization activities by the youth mobile caravan will also be challenged to continue.

The training offered on HIV&AIDS to various church leaders and groups enabled transfer of knowledge on HIV transmission, prevention, treatment, management, care and support. The knowledge gained is sustainable but need to be refreshed to accommodate new learning and emerging trends in HIV& AIDS. The churches and health facilities provide unique structures to continue presenting this opportunity alongside projects such as PLS.

At the time of this evaluation, the project is still dependent on one single donor (Digni through NMS) presenting greater financial limitation to the continuity of the project work on similar or different scale. EELC through its leadership and the Health Board must come up with a clear lobbying and advocacy agenda to profile the work of the organization and enhance internal capacity for program development and fundraising.

# 6.0 LESSONS LEARNT

- Established infrastructure (Centre d'Ecoute) has demonstrated the power of safe space for treatment, psychosocial care and support for PLWHA in the area (though only located in Ngaoundere).

- Support groups remain a powerful community structures that continue to demonstrate ability for members psychosocial support for positive living for PLWHA and need to be promoted. It however, takes time and investment (moral support and financial) to see for such group to mature to an "independent group".

- High level of stigma remains the major obstacle to the fight against HIV&AIDS. However, exchange visits among support group members (strong and weak groups) could help address fear and stigma barriers.

- Members and leaders of support groups need more empowerment to increase their capacity to manage and guide the groups, participate in project decision making and undertake HIV&AIDS public advocacy issues.

- Financial literacy and more training on small enterprise activities is required to influence great performance of the IGAs established, sustainability and reduce dependency on handouts by PLWHA.

- Mainstreaming of HIV&AIDS in church structures done by the project that reach out to and involved church leadership, pastors, women and youth representatives greatly influenced its success and anchor its sustainability/continuity.

- The geographical coverage of the project is vast (though strategically located) strains effective monitoring and support made available by the project team to the local communities involved/PLWHA support group including mentorship required for success.

- Currently, there is limited support to children born with HIV and those orphaned or living with grant parents. The attention has mainly focussed on adult PLWHA both at the community and health centres. Attention to support children born with HIV and increasing uptake of PMTCT services is of dire need to reduce new infections.

- There is need to involve more youth out of schools (motorbike riders, reaching girls and boys with empowerment efforts for income generating activities and or vocational skills could be complementary.

- Limited collaboration with government structures (HIV&AIDS Regional Coordinator and other stakeholders working on HIV&AIDS) continues to limit opportunities for synergies and access to complementary resources required for the project.

- The inter-religious approach to mobilization of PLWHA, sensitization and training which involved Muslim leaders and their members was successful and influenced the good will towards the project across religious groups.

# 7.0 CONCLUSIONS FROM THE EVALUATION

The following are the conclusions made from the findings of this evaluation.

- This project has been relevant to the priority needs of the communities. The EELC leaders and respective community groups own the project including member of the church, PLWHA associations, HBCV and youth groups.

- The project has been efficient as activities were implemented within the required project period. Project reports (narrative and financial) were shared with NMS and Digni in time and issues raised received adequate responses within the required time.

- Financial management was up to standards with no cases of corruption/fraud or mismanagement reported during the project period. Audited accounts (internal and external) are available; with matters arising from the audits receiving adequate attention and oversight by the EELC health Board.

- The EELC has adequately mainstreamed the current HIV&AIDS project within its structures and has capacity to sustainably continue the project; though in minimum scale. However; owing to the large coverage of EELC church in Cameroon and based on the lessons learnt in the implementation of PLS project; the church should consider up scaling the project to cover new sites within the current regions and outside the regions.

- The NMS remains a strategic partner to EELC and this relationship should continue and be further exploited for resource mobilization and capacity strengthening in fundraising through seconded staff; volunteer support or consulting services procured to aid this support for EELC benefit beyond the current funding source/Digni.

- In view of the findings of this evaluation and in reference to the evaluation conducted in 2010; the HIV&AIDS project has greatly attained its goals and it is time to refocus on more strategic priorities that affect communities that are linked to vulnerability to HIV&AIDS. This could include poverty reduction strategies; women and girls social, economic and political empowerment; youth empowerment programs; support for orphans and vulnerable children and elderly caregivers; environmental conservation and climate change issues.

- The NMS continues to provide a valuable link to Digni, which could further be exploited for more resources to facilitate similar HIV&AIDS and empowerment programs for community development.

- Despite the gap left by SIK in the implementation of the 3$^{rd}$ phase of this project; EELC/PLS project staff was able to successfully manage the implementation, monitoring and reporting of the project. However, technical accompaniment role from SIK, local or regional consultant will be required in the event EELC takes up need project/thematic field whose skills/competence will not be resident within the organization.

- This project has had significant impact on the lives of many people directly or indirectly involved in the project in terms of increase in knowledge and information on HIV&AIDS, influence in behaviour change which in turn contributed to the reduction of new infection and improved the living standards of PLWHA.

- The project adequately used the recommendations of the evaluation report of 2010; which among other recommendations included adjusting its strategies to ensure local grassroots mobilization and participation; influencing the EELC oversight for effective financial management and communication issue.

# 8.0 RECOMMENDATIONS

The following are recommendations from this evaluation. The recommendations have been broken down and addressed to project management and coordination team, EELC top leadership, NMS and Digni. The recommendations provided are not conclusive by themselves and will require a review and consultation at all levels for consensus and decision making in their uptake and implementation.

## 8.1 Project Management and Coordination

- It is highly recommended that HIV&AIDS project should consider more effort in fighting stigma, uptake of PMTCT, support OVCs affected and infected with HIV including children born with HIV, support to elderly caregivers, PLWHA and strengthening capacity of PLWHA in lobbying and advocacy issues.

- Make deliberate efforts to link the PLS project and support church structures and increase church leadership capacity in mainstreaming of HIV&AIDS in their church activities including the use of the 52 church sermon articles developed through the project.

- Provide refresher trainings for PLWHA support groups on aspects of HIV&AIDS and stigma reduction in their communities to ensure high level of outputs (in number of people trained) as well as reduction of cost for the same, e.g. transport and accommodation.

- Make deliberate efforts that gear towards consolidating support groups through capacity building on group formation, organising dynamics, leadership, advocacy and management. Encourage peer learning and exchange between the weak and strong groups; and provide them with opportunity that nurture leadership e.g. participation in church, regional and international advocacy forums on HIV&AIDS.

- Provide tailor-made training on financial literacy, business development skills and choice of business ventures to PLWHA support group members; ensure accompaniment and mentorship for their business activities.

- Complementary financial supports made for PLWHA IGAs that factor in their own contribution should be promoted. However, adequate preparation of the beneficiaries must be done and confirmed including their level of commitment. Financial support

should not be used as a mobilization strategy for the formation of support groups; but such groups should be founded on the principle of moral and psychosocial support amongst its members with a individual and group vision.

- Continue reaching out and involve members of other religious groups; encourage such participation for purpose of reaching out to many people within the community and ensure goodwill towards the project.
- Strengthen monitoring and evaluation of the project activities for learning, documentation and decision-making. A data management system for beneficiaries will be required to ensure protection of data and ease access of such information when required.
- Strengthen the financial monitoring and reporting at all levels for accountability. Financial reports should be shared with the project management board and updates provided as may be required.
- The project management structure has the capacity to manage a HIV&AIDS or other health oriented projects and therefore should be maintained. However, in the event a new project is designed and addresses other thematic issues; the staff skills may need to be reviewed for either capacity strengthening or replacement as may be deem fit for the success delivery of that project.
- Strengthen and promote interdepartmental consultation and involvement in the mobilization of communities, influence cross learning, mainstreaming of HIV&AIDS, and broadening contribution towards achievement of the project objectives as well as sustainability.
- Hold annual stakeholders meeting with relevant government offices, development agencies and civil society groups to share progress, achievements and challenges in the HIV sector and develop joint plans for addressing the needs. This will ensure the project is well profiled nationally and increase resource mobilization and synergy across all partners.
- Strengthen gender mainstreaming in all aspects of the project through representation by number as well as empowerment of women and men, boys and girls; and persons who are differently able (with disability) participation in the project activities.

### 8.2 EELC Top Leadership

- Continue to encourage, support and enforce the mainstreaming of HIV&AIDS information in the church structures, which enjoy local/grassroots coverage and proactive participation of pastors, women and youth leaders in such activities.
- The project coordination should continue to be implemented under the health department and unless otherwise determined by EELC Board that such capacity is not resident within

the health department to handle such or other projects; a new implementation structure may be agreed upon.

- There is need to strengthen internal fundraising capacity through PLS project management team and other departments of the church. This will help EELC to diversify her project funding partners by developing and submitting project proposals to other funding bodies such as Bill Gates Foundation.
- The church should consider developing a HIV&AIDS, and Gender policies for the church to affirm commitment and provide affirmative action towards HIV and gender issues including participation in decision-making.
- The Church has the potential to profile the gains of this project through website, social media and reach out to more partners and donors in and outside Cameroun to support more resources.
- EELC remains a well-placed actor in Adamawa to run HIV projects. It also has the potential of transforming its HIV interventions, scaling up and implementing new projects that are community empowering. EELC need to review its strategic priorities in meeting community needs and in undertaking such development work. Such project ought to be community and rights based driven; and with high funding traction.
- We recommend that this evaluation report be shared with relevant stakeholders at EELC including the project team. About the language of the report, the document could be translated into French; NMS or a local consultant could facilitate this for easy accessibility across board.

### 8.3 Norwegian Mission Society

- In view of the findings of this report, NMS and EELC should consider a joint consultative process to explore new dimensions into the PLS project and map new project areas for possible fundraising beyond the current HIV&AIDs Project.
- NMS established funding relationship with Digni present an opportunity to pursue similar project (on HIV&AIDS) and or others; which could be of benefit to EELC and the constituency it serves.
- NMS is a close, long-term partner of EELC and provides guidance and financial resources that complements the church projects and administrative costs. There is need to invest more on strengthening staff fundraising technical capacity to from local donors and international donor agencies to upscale its development work.
- The exclusion of SIK in the project accompaniment role during the implementation of the 3rd phase of PLS project was acceptable. However, NMS should find a way within its staff capacity, local or regional consulting service mechanism that could provide support to PLS team when a technical need arises. This accompaniment could include financial

technicalities in reporting, the project management strategies, advocacy issues and others as may be requested from time to time.

- Strengthen communication between the NMS project officer in-charge of the grant and the coordinating team at EELC particularly grants management function. This will clarify delays in funding or allow sufficient consultation if review of budgets. Staff transition and induction should also be given adequate time and new staff supported to understand the project development issues.

### 8.4 Digni

- In view of the findings of this evaluation and the great success achieved by this project so far, it is highly recommended that continuity of HIV&AIDS initiatives consider more targeted efforts in fighting stigma, improve PMTCT, support OVCs affected and infected with HIV including children born with HIV, support to elderly caregivers, PLWHA organizing, lobbying and advocacy capacity.

- Consider establishing a new 5 years grant opportunity for EELC community empowerment project (through NMS) that builds on the gains of the PLS project and reduces community vulnerability to contracting HIV&AIDS. Areas to consider include women and girls empowerment, sexual and gender based violence; PLWHA organizing-lobbying and advocacy issues; youth empowerment; OVC and elderly caregivers support; environment and climate change issues; among others.

- There is dire need for a project vehicle to ease coordination and mobility in the implementation and monitoring of project activities across the regions. This will significantly enhance the efficiency of this project operation.

- Make it flexible to review the activity plans and funding decisions through consultative processes at all levels while taking into account the changing and challenging nature of HIV, diversity in community needs and transformation processes which could require a shift of strategies within the project period against the original activity and financial plan approved by Digni.

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**Photo of an evaluation planning session conducted between the evaluators, PLS staff and NMS**