

REPORT ON THE EVALUATION OF THE UNICEF SUPPORTED CHIKANKATA  
CBOSP & OVC TRAINING PROJECTS

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## **LIST OF ABBREVIATIONS**

<b>AMTS</b>	<b>AIDS Management &amp; Training Services</b>
<b>BCP</b>	<b>Behaviour Change Process</b>
<b>CBOs</b>	<b>Community Based Organisations</b>
<b>CBOSP</b>	<b>Community Based Orphan Support Programme</b>
<b>CEADW</b>	<b>Convention on the Elimination of All forms of Discrimination Against Women</b>
<b>CHIN</b>	<b>Children In Need</b>
<b>CPTs</b>	<b>Care and Prevention Teams</b>
<b>CRC</b>	<b>Convention on the Rights of Children</b>
<b>E.D</b>	<b>Executive Director</b>
<b>HBC</b>	<b>Home Based Care</b>
<b>HIV/AIDS</b>	<b>Human immuno-deficiency Virus/Acquired Immunodeficiency Syndrome</b>
<b>HQ</b>	<b>Headquarters</b>
<b>IGA</b>	<b>Income generating Activity</b>
<b>LARC</b>	<b>Link Association for the Relief of Children</b>
<b>OVC</b>	<b>Orphaned and Vulnerable Children</b>
<b>STDs</b>	<b>Sexually Transmitted Diseases</b>
<b>STIs</b>	<b>Sexually Transmitted Infections</b>
<b>SYB</b>	<b>Starting Your Business</b>
<b>UNICEF</b>	<b>United Nations Children Fund</b>

## EXECUTIVE SUMMARY

Chikankata has made significant progress since the last evaluation conducted by Catherine Poulter and James Sulwe (May 1997). This is in relation to the Community Based Orphan Support Project (CBOSP) and the Orphan and Vulnerable Children (OVC) Training project. The CBOSP has been running since 1995 while the OVC training is just about two years old. Both projects are run by Chikankata's Salvation Army Hospital. There has been an increase in activities as well as an increase in the number of communities participating in the CBOSP programme. From the previous two<sup>1</sup> to a total of five participating communities<sup>2</sup> at the time of this evaluation (May 2002).

The increase in the number of participating communities as well as the raised interest in the community members in project sites is a direct link to the community response towards the needs created by HIV/AIDS and issues of OVC. Ngangula has opened a community school<sup>3</sup> as a demonstration of community willingness and commitment to care for OVC<sup>4</sup>.

The affected communities acknowledge that HIV/AIDS affect them and that they need to be part of "the solution to the problem". The CBOSP project operating in five communities has a total population of 13,507 out of which 1,733 is an OVC population (representing 12.8 % of the total population) as at May 2002.

The successes scored in sensitizing the majority of the people in villages have resulted in the initiation of a number of activities that are aimed at improving the OVC situation using community efforts rather than individual household efforts.<sup>5</sup>

The Chikankata Hospital through its outreach programmes has played a very important role in raising awareness on HIV/AIDS in its catchment areas. Through the CBOSP, Chikankata has continued to enumerate Orphaned and Vulnerable Children.

Since the last evaluation in 1997 the OVC situation has continued to worsen. Although the 1997 report of Poulter and Sulwe observes some errors in OVC registration at the time, Ngangula had 104 registered orphans while Nameembo had 56, giving a total of

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<sup>1</sup> Ngangula and Nameembo at the last evaluation by Poulter and Sulwe (1997)

<sup>2</sup> Ngangula, Nameembo, Chaanga, Malala and Mukwela

<sup>3</sup> The community school was opened towards the end of 2001 to accommodate OVC who could not be supported by the CHIN committees in the government school.

<sup>4</sup> The community expressed a need to be provided with help in the construction of a bore hole at the school and possibly provision of roofing sheets for the classroom blocks being built through community effort. In addition a supply of basic school requisites such as books, pencils and chalk will contribute towards the basic education of the OVC.

<sup>5</sup> Community participation has, however, been affected by the high poverty and hunger levels caused by close to eight years of poor rain in the area. People have no basic income, which they used to derive from various farming activities.

160 between these two communities. The figures in each community in the catchment area show a general rise in the numbers of OVC.

The figures however, have been fluctuating for various reasons<sup>6</sup> hence sometimes affecting the total OVC numbers downwards. For instance the total figures have varied from 1,939 in November 2000 to 1,852 and 1,733 in February 2001 and November 2001 respectively. OVC weaned off by virtue of reaching the age of 18 will by then have been empowered through training in various practical skills such as Carpentry, Tailoring etc and therefore expected to sustain themselves. Two communities in Nameembo and Ngangula contributed 9 sewing machines and 2 sets of carpentry tools for children to use for income generation in 2001.

At community level there is evidence of commitment to improvement of the quality of life of OVC through initiation of Life and Practical Skills as well as Income Generating Activities within the communities<sup>7</sup>.

Through the training programme Chikankata has trained 154 OVC managers. These OVC managers have in turn trained other members of their organisations and thus there is evidence of multiplier effect from the training<sup>8</sup>. Chikankata plans to have achieved its objective of training up to 175 OVC managers by the end of 2002.

A number of organisations visited have performed very well after training from Chikankata. For instance, the Anglican Children's Project in Lusaka has developed a Child Abuse surveillance system and the results are overwhelming (see page 3). In Siavonga, a couple<sup>9</sup> that had been trained at Chikankata have initiated an interdenominational come together in which they congregate every three months to discuss and together generate solutions on the welfare of OVC in the community. In addition, this forum also raises food, clothes and take care of other needs for the needy OVC.

In Mazabuka, a participant<sup>10</sup> has initiated training workshops for colleagues involved in caring for street kids especially those in community schools. She has also initiated Behaviour Change Process Workshops for former street kids that have been enrolled in their Community school. She further introduced a street outreach programme upon return from training at Chikankata and through this was able to identify six cases of sexual child abuse involving four girls and two boys. The girls were all infected with STIs.

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<sup>6</sup> Sometimes OVC are removed from the registers when they reach the age of 18, sometimes they travel to go and live with relatives in other areas, sometimes a child dies

<sup>7</sup> The five communities through either the CPTs or their CBOSPs have been striving to see how they help the identified needy OVC through imparting various skills to them. They work in close collaboration with Chikankata Salvation Army Hospital in ensuring that the needs of OVC are taken care of

<sup>8</sup> See list of people interviewed in appendix 2.

<sup>9</sup> Mr. & Mrs. Namuyamba: They applied following their own realization that to look after orphans, they needed extra knowledge and skills. The Director (Mr Namuyamba) was further motivated by the fact that he was himself orphaned as a child.

<sup>10</sup> Mrs. E.N. Nzima: Was approached by the catholic church to assist set up the community school.

In Lusaka, participants from Anglican Children's Project are engaged in community mobilization and child abuse advocacy campaigns such as presentation of drama, theatre and group discussions especially in markets in nine communities (Chibolya, John Laing, Kamwala, Misisi, Chawama, Kabwata, Libala, Chilenje and Arrackan Barracks). Through drama and discussions, 19 cases of various types of child abuse have either been identified or reported to the outreach workers. Of the 19 cases 10 are sexual abuse cases involving all female children ranging from 6 months to 18 years of age.

In Kitwe, Mindolo Ecumenical Centre has started a project for orphans offering education and food at their centre. This was initiated after training from Chikankata, and so far the centre in less than a year caters for 450 OVC.

***Major constraints:***

- The major constraints in programme execution was seen in the apparent inability of the communities to select and run IGAs to the level of profits that could adequately cushion off some of the basic needs of the OVC such as school requisites. This was mainly due to lack of adequate skills in IGA selection and management coupled with inadequate initial capital.
- Community members lack skills in basic entrepreneurship and there is need to provide such skills in the near future. In addition, the communities do not have adequate resources to commence bigger and profitable IGA schemes. Entrepreneurial skills to project managers so that they could train community members.
- Inadequate transport affected the running of programmes especially the CBOSP before UNICEF provided the Toyota Hilux currently being used for CBOSP project activities. As a result of the lack of transport some activities though well planned could not be accomplished in the first, second and third quarter of 2001.
- A baseline study to establish the foundation data for the programme impact assessment was not conducted because there were neither the resources, terms of reference nor the human resource to spear head the exercise. It is hoped that this will be facilitated in the near future.
- Community members responsible for running CHIN programmes at village level have not all benefited from the Chikankata training programmes. There is need to acknowledge that they are best placed to apply the skills directly to the OVC. The course however appears to have been set for very literate candidates<sup>11</sup>.

## PURPOSE OF THE EVALUATION

The first evaluation was conducted in 1997 when only two communities (Nameembo and Ngangula) were involved in CBOSP activities. The number has since increased to five (to

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<sup>11</sup> It was observed that OVC programmes with access to resources are more advanced. This is evidenced from the levels of performance of OVC projects in, Siavonga, Mazabuka, Lusaka and the Copper belt. The projects in these areas are all fairly well funded.

include, Malala, Mukwela and Chaanga). This has resulted in the need for increased financial capacity, especially so with the introduction of an OVC course in 2000. Chikankata has submitted a project proposal in the hope that UNICEF could support both the CBOSP and OVC training in phase three. This evaluation therefore seeks to establish the basis for further support.

#### METHODOLOGY OF THE EVALUATION

The evaluation was carried out through a process of visitations to selected areas where in addition to physical tours, interviews were held with twenty-eight people that were directly or indirectly connected with the Chikankata projects.

#### SUMMARY OF THE MAIN RECOMMENDATIONS

- 1.1 UNICEF should reconsider its present policy of non-support to IGAs. It should provide 'start-up capital' for properly identified IGAs.
- 1.2 There is need to include some older OVC at community planning level. This will not only serve as a form of training for them but will also improve projects impact and success since OVC are the ultimate beneficiaries of the project.
- 1.3 In addition to any financial support that may be given to CHIN committees for IGAs it will be necessary to empower the women that are directly caring for orphans with basic seed capital for them to grow crops especially considering that most households have no food.
- 1.4 UNICEF should identify and engage an expert to carry out a baseline study. For the future benefit of the project, individual skills development and maximization on time, it is suggested that all project staff participate in this exercise.
- 1.5 There is need for Chikankata to work out an action plan to go round all communities on a re-sensitisation programme in order to raise the levels of cooperation from guardians and other OVC care givers.
- 1.6 Chikankata should work out a uniform CHIN committee structure for adoption by all villages involved.
- 1.7 Since the capacity already exists at Chikankata for OVC training the project Management team should make an effort to learn about and blend all the available models of care across the country with a view to strengthening the delivery packages.
- 1.8 Chikankata should identify trainable individuals in each community who through UNICEF could be sponsored for OVC training in order to bring skilled OVC care as close to the community as possible.

## 1. BACKGROUND INFORMATION

### **Introduction to the two projects:**

The Community Based Orphan Support Project (CBOSP), that is being employed by the Chikankata Health Services to mitigate the disastrous effects of the HIV/AIDS pandemic. The Pandemic has resulted in very large numbers of orphans that are being left behind by their parents when they die from AIDS. Most of the time the children are left with relative that are incapable of taking good care of these orphans in terms of not only food, but also basic needs such as shelter, clothing as well as education. The children therefore become vulnerable to various social vices such as crime, prostitution and so on.

Chikankata has been involved in the OVC support programmes since 1995 with Ngangula and Nameembo being the first beneficiary communities. In 1999, three other communities, Malala, Mukwela, and Chaanga were also incorporated in the programme.

The main objective of the CBOSP is to increase the community capacity to respond to the OVC crisis through a community-based system that utilizes the existing community resources and subsequently the welfare of the OVC.

Due to the increased need to provide more skilled service to the Orphaned and Vulnerable Children (OVC), an OVC training programme was initiated at Chikankata in 2000. Some gaps were identified in the management of OVC. They included those of mismanagement of OVC programmes, unsuitable care programmes, lack of community involvement in the management of OVC, lack of life skills among OVC and the scarcity of trainers in OVC issues. These issues, it was realized would be addressed through a suitably designed training intervention.

The main objective, therefore, of the OVC training was to improve the welfare of OVC at community level by providing training to individuals that were working on OVC programmes including those that were intending to start work in this area.

### **UNICEF support to the projects:**

UNICEF has been supporting the CBOSP activities in Chikankata from 1995. Initially only two communities Nameembo and Ngangula were chosen to pilot the project. The main goal of the project was to try and integrate identified needy children into a community support system using existing community resources and infrastructure. Prior to the CBOSP project there already existed CCBT that was providing Home Based Care (HBC) including education outreach programmes on HIV/AIDS a process that enhanced the implementation of the CBOSP activities.

The first evaluation was carried out on the CBOSP project in 1997 to ascertain the impact of the UNICEF assistance. Based on the results of the evaluation, the project was then expanded to three more villages, Mukwela, Malala and Chaanga. Support was in 2000

extended to training resulting into the commencement of the Orphaned and Vulnerable Children training programme. The two projects (CBOSP & Training) have therefore been running side-by-side since 2000. Chikankata has submitted a new proposal to UNICEF for an extension into phase two for continued technical and financial support.

This evaluation therefore seeks to assess the impact of UNICEF's assistance to Chikankata CBOSP and Training projects with a view to establishing the basis for further assistance and implementing strategy adjustments.

### ***Background on Chikankata Hospital***

Chikankata hospital is a mission hospital run by the Salvation Army. The hospital first opened in 1945 with the first site being at Bwenemuyama off the Siavonga road. This was later shifted after the local chief asked the mission to shift to the present site due to its centrality and high population.

The projects and the Mission Hospital is run by an Executive Director who reports to the Salvation Army HQ. He also reports to the Ministry of Health with regard to routine hospital business and training functions related to health. In spite of this dual reporting system there is evidence of co-ordination and smooth running of both the projects and the Hospital. Whenever a project is initiated it is presented to the hospital executive council of the Salvation Army while training and health service needs are channeled through the Ministry of Health. The Executive Director performs his routine functions through seven Managers (Administration, Clinical care, AIDS Management Training, Education, Community Health and Technical services).

### ***Main objective of the Assessment***

Primary objective was to assess the model of care, how many children have been reached as a result of the care, with what care and the cost per child for providing that care.

### **Specific objectives:**

#### ***CBOSP***

1. Assess progress made to date against each objective and the overall effectiveness focusing on phase 1 and 2 of support by UNICEF and determine whether the programme is on track and susceptible to achieve its final objectives.
2. Identify and comment on any constraints that affected the project if any and propose corrective actions.
3. Provide technical guidance to the CBOSP team on how to plan for the next phase of the project based on the lessons learnt in phase 1 and 2.
4. Provide guidance to the CBOSP team on tools that need to be developed for phases 3 especially for data collection.

#### ***TRAINING CENTRE***

5. Assess effectiveness of the training and how training has benefited organizations that participated in it.
6. Assess whether there is any acquired knowledge to improve the caring practices and awareness of children's rights by participants.

7. Assess the materials developed by the training team, including training manual and data collection/analysis tools.
8. Assess sustainability components of training programme.

## **2. METHODOLOGY**

This evaluation was carried out through conducting interviews with 28 people connected either directly or indirectly to the Chikankata projects. In all the cases, the method of information gathering involved observations, site visits, personal interviews and focus group discussions based on structured questions contained in my designed evaluation instrument.

The areas visited in Chikankata, Southern Province, included Ngangula, Mukwela, and Malala. Other areas in the Province were, Siavonga and Mazabuka. In addition time was allocated for the hospital project site in Chikankata where interviews were conducted with the Executive Director of the hospital, the Manager AIDS Management and Training Services (AMTS), the Training and Technical Assistance Coordinator and the CBOSP coordinator. This exercise was infused to gather information on project management issues as well as any other relevant information related to the running of the projects.

Further visits were made to the Copperbelt where some beneficiaries from the OVC Chikankata training operate. Whilst on the Copper belt efforts were made to visit the Rainbow model of the Association of Pope John the 23<sup>rd</sup>. The purpose of this visit was to compare the Chikankata model to that of the Rainbow with a view to identifying pertinent differences and similarities between the two models. In addition, participants from Lusaka that had attended the OVC course at Chikankata were also visited in order to establish how they were utilizing the knowledge and skills that had been learnt during the OVC course.

### ***2.2 Limitations to the evaluation***

With respect to coverage, a variety of destinations were visited and fairly rich information obtained. However, prior communication with centres to be visited was not always possible and therefore some interviews were done with key informants. It was however, evident that where more than just the key informant was available, more information was gathered.

### 3 OBSERVATIONS AND FINDINGS ON PHASE 1 & 2

#### 3.1 Chikankata Management System and Capacity

Chikankata hospital run by an Executive Director and assisted by six Managers in charge of various departments (Administration, Clinical Care, AIDS Management and Training, Education, Community Health and Technical Services). Like government hospitals, Chikankata staff establishment has also to an extent been affected by government's Public Service Reform Programme in which there has been down-sizing in the number of employees in certain departments especially projects. A total of 120 staff including general workers is now based at Chikankata. 66 of these are nurses, 5 doctors and 7 Clinical Officers. The number of nurses represents 75% of the required posts while the current posts for Doctors have all been filled by the 5 existing.

The day-to-day conduct of business is carried out through a management team comprising six unit heads. These hold two meetings per month and are chaired by the Executive Director with the Human Resource officer as secretary. All resolutions arising from these meetings are then presented to the Internal Hospital Management Board comprising the ED and the six Managers. According to the ED this system has helped in not only solving problems faster but also in internal policy formulation.

The hospital has an approximate annual budget of K600m to meet the health and training services. Government contribution amount to 40% of the total budget while 60% is generated from various sources. Until recently the Salvation Army used to give grants to the hospital but its policy towards direct investment in health services has since change. Therefore, currently the hospital is experiencing inadequacy of funds to meet all its operations. This has to an extent affected timely project implementation. Whenever funds are received priorities are taken based on the existing strategic plan. Generally medical supplies take precedence followed by other services such as electricity and water.

Auditors sent by the Salvation Army Headquarters, Delloite and Touche audit the hospital. Until recently friends of the hospital from Spain carried out this function on a standing arrangement basis.

Through this system of management, projects have been carried out according to the hospital's plan. The Executive Director assumes an overall advisory role. He has been able to provide advice on projects based on prevailing demands on the market in order to sustain the operations of the AIDS management and Training Services (AMTS). The AMTS is considered an important hospital investment that contributes up to 90% of it's generated income into hospital operations while it retains 10% back into improvement of the seminar centre.

### **3.2 Review of Key recommendations of the 1997 Report**

The evaluation report of 1997 by Catherine Poulter and James Sulwe made a number of recommendations for the attention of both UNICEF and Chikankata. This report has reviewed some of the key recommendations from this report, particularly citing those that may not have been fully addressed (see annex 5).

### **3.3 PROJECT I: THE CBOSP**

The Community based orphan support programme (CBOSP) has a clear and focused goal that is stated as follows:

*“To increase community capacity to respond to the OVC crisis through a community based system (chin committees) that utilize community resources in order to improve the welfare of OVC”.*

Given this goal observations were made with respect to efforts being made of both the Chikankata Health Service-CBOSP and the communities within the catchment area (Ngangula, Nameembo, Mukwela, Malala and Chaanga).

Over the period under review (2000 to 2002) activities were based on the following components:

#### **a. Community mobilisation and information**

This component was carried out using six activities:

*i) To conduct baseline survey*

This activity could not take because of lack of logistics, which included the unavailability of terms of reference. In addition there was no body in Chikankata that could competently undertake the exercise at the time. This should, however, be conducted as soon as these logistical constraints are taken care of.

*ii) To provide and enhance Community sensitization*

The OVC concept has been well understood by the five communities of Chikankata's catchment area. This is observed through various community activities such as IGA activities conducted in all the five communities and the commencement of a Community school in Ngangula. It is nevertheless observed that there is need to strengthen community participation through regular monitoring visits and meetings so that members continue to contribute willingly to the cause of OVC without expecting outside rewards<sup>12</sup>. In Mukwela, the CHIN secretary expressed worry at the rate executive members were

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<sup>12</sup> This is however a challenge that UNICEF and any other donor will have to consider as almost everyone in the five catchment areas are poor. The more time they spend attending to community work, the more they expose and put their own households to risk of poverty and abuse.

resigning. There appeared to be a leadership problem in this community because members did not see their immediate benefit by being in the committee and also they did not have mutual trust for one another<sup>13</sup>. On the contrary it was found that Ngangula community was very well organized with successful IGA activities<sup>14</sup> taking place.

Only two child rights and OVC sensitization meetings were held in Ngangula and Mukwela out of the planned four<sup>15</sup>. With the availability of a vehicle it was mentioned that all planned meetings will be accomplished.

### *iii. OVC registration*

Although the OVC registration has been regularly maintained, the CBOSP is unable to obtain regular update profiles of the OVC situation in the communities. In spite of the concept of OVC being understood some of the community members looking after OVC do not see the benefit of having these children registered. They, therefore, do not have them registered as they see registration as a sheer waste of time. This activity is related to strengthening sensitization strategies and also community involvement in searching for sustainable solutions. Based on the information obtained the following profile was obtained between September 2001 and January 2002:

	NGANGULA		NAMEEMBO		MALALA		CHAANGA		MUKWELA	
	SEP-NOV 01	DEC TO FEB 02	SEP- NOV 01	DEC TO FEB 02	SEP- NOV 01	DEC TO FEB 02	SEP- NOV 01	DEC TO FEB 02	SEP- NOV 01	DEC TO FEB 02
<b>OVC REACHED</b>										
Total OVC	332	230	280	170	250	35	52	0	94	8
Guardian	48	66	10	10	76	13	13	0	31	3
Kept by other relatives	1	1	10	0	-	0	0	0	0	0
Education provided to	57	8	0	0	-	0	0	0	0	0
Counseling provided to	4	0	2	7	-	0	0	0	0	0
<b>BASIC SUPPORT PROVIDED</b>										
Total	146	89	232	110	72	0	11	0	76	1
Clothes support to	58	28	54	39	38	0	0	0	38	0
Food to	13	38	4	4	0	0	1	0	5	0
Shelter to	1	0	0	0	0	0	0	0	0	0
Blankets to	0	0	0	0	0	0	0	0	0	0
Books/ pens to	48	11	125	25	0	0	0	0	0	1
School fees to	2	0	12	8	0	0	0	0	0	0
Med fees to	14	20	7	4	3	0	0	0	0	0
<b>ADVOCACY SERVICE</b>										
Total beneficiaries	74	40	22	19	42	0	2	0	4	0
Against property grabbing	6	14	4	4	0	0	0	0	0	0

<sup>13</sup> Some members felt that the way the Tuck shops were being run was not transparent and that others might be benefiting from it individually

<sup>14</sup> Ngangula runs a tailoring club for women who make school uniforms both for sale and also for the OVC whose parents/guardians are unable to acquire some for them. Ngangula's Tuck shop is also one of the successful ones. The community has also started keeping goats (see also page 10)

<sup>15</sup> This is an area requiring more attention in order to lessen undue expectations from the community members for their contribution towards OVC activities.

On education	63	25	2	2	40	0	0	0	0	0
On child abuse	0	1	13	6	1	0	0	0	2	0
On family conflicts	5	0	3	7	1	0	0	0	2	0

From the above figures it is clearly observed that there was inadequate advocacy activities in the areas visited compared to the provision of basic needs. This could be a skills based constraint on the part of community leaders

***iv). Health Education Talks***

Between September 2000 and August 2001, 2747 pupils had benefited from HIV/AIDS/STDs talks. Twenty-eight (28) education talks out of the 40 planned were conducted. This represents 70 % achievement. The shortfall was alluded to the spill over into December school holidays<sup>16</sup>. Chaanga and Mukwela had 7 and 5 sessions respectively followed by Ngangula and Nameembo with 4 each. Malala only had 3 sessions. It was not possible to reach any pupil in the second quarter (December 2000 to February 2001) because all pupils were on vacation when it is difficult to mobilise them. From the total number of pupils talked to one sees a fairly broad coverage considering the sparse population of the Catchment area, of course this is notwithstanding the fact that there was still 12 more meetings that were not conducted.

Although, a total of 2747 pupils were reached there was no information as to what proportion this number represented of the total pupil population in the area.

***v). Child to child clubs and community visits.***

Visits to Twenty (20) child-to-child clubs were planned. However, only 12 (60%) of these were successfully undertaken with the higher number being in the first quarter (September – November 2000). Out of these Malala and Nameembo had the least visits (1) while Chaanga had the highest, with a total of five visits. Four community visits were planned out of which three were successfully conducted. Chikankata, at the time was facing transport problems and therefore regular visitations to ensure that all planned for meeting were held were not always possible.

***vi). Community to Community visits***

All communities were involved in this exercise. This involved visitations between Mukwela and Nameembo; Ngangula and Malala; Malala and Chaanga. The planned visit between Nameembo and Ngangula, however, could not materialize but would still have to be conducted in the near future.

***b. Community and human resource development***

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<sup>16</sup> It is difficult to conduct activities during school holidays unless well planned because this the time pupils and teachers rest

This component was addressed through five activities that had provision for imparting basic knowledge and skills to the OVC. This component was adequately addressed as all training activities were achieved.

40 OVC were trained in tailoring and carpentry. This comprised 19 females and 21 males from the five communities. The females were trained in Tailoring while the males were trained in Carpentry.

Two five day courses were conducted covering children's rights, child abuse, assertiveness, decision making, HIV/AIDS/STDs, family life, (good morals) self help, OVC participation in various activities and peer pressure management. This training only provided for 41 OVC from two communities, Nameembo and Malala<sup>17</sup>.

Five refresher workshops for CHIN committees were held to strengthen the skills in handling issues of OVC. The workshops were conducted in the five respective communities and a total of 88 participants benefited<sup>18</sup>. The successful holding of all the planned five workshops indicate commitment on the part of both Chikankata and village committees in attending to OVC problems despite some of the problems<sup>19</sup> mentioned above in some community committees.

A total of 15 teachers, three from each of the five communities were invited to attend the child-to-child workshop for teachers. Seven (7) of these managed to attend. The workshop focused on developing skills that are essential in promoting child-to-child clubs in schools. There was representation from each community except Nameembo.

IGA activities have generally not done very well in all communities. However, as mentioned above, Ngangula reported good progress. Currently Ngangula has bought goats and each of the sixteen sub-communities have been given one to look after. In addition to this project the community runs a Tuck shop through the CHIN committee<sup>20</sup>. The community has also started pig rearing. However, like other communities the shops were found to be inadequate for purposes of looking after OVC. There are also problems associated with looking after the little financial proceeds from the Tuck shops.

None of the other communities visited was satisfied with their IGAs (e.g. Tuck shops). It was observed that it would be worth to invest in crop growing and animal keeping rather than just Tuck shops<sup>21</sup>. However, these activities require a relatively substantial amount of either real seed capital or actual seed money to kick-start them or improve them. In all

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<sup>17</sup> There was observed need to extend the same training to the other three communities.

<sup>18</sup> This activity is supposed to be on-going so that community members could appraise themselves on the management trends of OVC.

<sup>19</sup> Problems of inadequate transport, culminating in failure strengthen the monitoring of activities.

<sup>20</sup> Other communities also have Tuck shops. Chikankata is in the process of buying 50 goats for Nameembo, which they will keep as part of their IGA activity. It is expected that when the goats start multiplying families looking after OVC will benefit.

<sup>21</sup> There is need to minimise pressure on Tuck shops if profits are to be realised as the number of OVC depending on them are massive and the goods in them are minimal.

the villages visited there is potential for identifying CHIN plots for crop growing as well as animal keeping<sup>22</sup>.

Chikankata hopes that the next farming season will improve IGAs since agricultural ventures have already been planned for.

**c. Monitoring & Evaluation:**

The records inspected showed that there was monitoring of CHIN activities going on in the communities. However, feedback of activity evaluation needs to be communicated back to respective communities promptly so that the communities could refocus their plans. An example in this respect is the continued existence of Tuck shops as primary IGAs that are not successful in generating income that may improve OVC care. This is notwithstanding the fact that initial capital for a Tuck shop is high compared to that of animal rearing. Chikankata should be in a position to assess the viability of these ventures and provide more informed guidance based on market survey principles, labour requirements and management inputs required in an IGA. The failure in making informed IGA choices is partly due to inadequate entrepreneurial skills on the part of the CHIN committee members and minimum guidance by Chikankata.

Although there has been consistent OVC registration, there is still need to improve sensitization of the community to raise the levels of cooperation from guardians and other caregivers. Some members of the community are still harboring traditional myths and misconceptions about death of a parent and orphan-hood. As such these must be reached and talked to on a person to person basis. At the time of this evaluation the following OVC returns were obtained as most recent:

<b>Community</b>	<b>Quarter1 From Sept-Nov 00</b>	<b>Quarter 2 From Dec 00- Feb 02</b>	<b>Quarter 3 From Mar-May 01</b>	<b>Quarter From Jun-Aug 01</b>
Ngangula	640	610	515	537
Nameembo	450	420	399	309
Malala	295	277	301	303
Mukwela	250	225	238	264
Chaanga	300	320	320	320
<b>Total</b>	<b>1935</b>	<b>1852</b>	<b>1773</b>	<b>1733</b>

It was found that in certain cases figures rose significantly between quarters while in some they dropped a bit due to weaning off of those OVCs attaining the age of eighteen while others leave the communities.

**Meetings for CHIN committees:**

<sup>22</sup> There is commitment by members towards achievement of the two activities. Skills must however be improved to include ‘Starting Your Business’ (SYB). This is the only way IGA activities will be sustainable.

General meetings of the CHIN committees were held monthly subject to availability of transport. Membership of the CHIN committees varied depending on size of the community. For instance Ngangula has sixteen members whereas Malala has twenty-two and Mukwela eleven members in the committee. Through these meetings an inventory of OVC members was obtained and it was found that there was a total of 1733 OVCs by November 2001 in a catchment area with a population of 13,507 (total population in all 5 communities). This represents 12.8% of the population. Through the same meetings it was possible to mobilize some resources such as 1485 kg maize, 29 clothes, 18 pumpkins, 2.5 kg groundnuts and beans, two sewing machines and K 3,023,500.00 cash for improving the living standards of the OVC.

Although a total of 33 out of 60 planned monitoring visits were carried out between 2000 and 2001 it was not apparently clear as to what corrective action was taken towards the unsatisfactory performance of Tuck shops in Chaanga and the organizational problems that existed in Mukwela.

#### ***d. Programme Management & Administration***

There is commitment and will to execute designed programmes at both Chikankata as well as at community level. This is complemented by the existence of structures in communities such as CHIN committees and smaller village sub-committees. The project management structure is adequate to achieve set objectives. However, a lot more needs to be done to encourage active participation particularly regarding the running and administration of IGAs.

#### ***CONSTRAINTS IN OVERALL CBOSP EXECUTION***

The major constraints in programme execution was seen in the apparent inability of the communities to select and run IGAs to the level of profits that could adequately cushion off some of the basic needs of the OVC such as school requisites. This in certain cases resulted in loss of interest and continued commitment to the activities by members. In Mukwela and Malala it was observed that there was no meaningful IGA taking place. The Tuck shop in Mukwela was running almost at a loss, while in Malala a new shop was under construction. The picture was slightly better in Ngangula where there was successful goat rearing schemes, carpentry works, and tailoring.

There is need to conduct regular training interventions on the basis of business management skills such as “starting your Business” (SYB). Knowledge of basic business skills is missing in community members spoken to and as such this could explain their failure to conduct simple market surveys for IGAs.

Inadequate transport was also reported as a big constraint especially before UNICEF donated the Toyota Hilux currently being used for CBOSP project activities. As a result of this handicap some activities though well planned could not be accomplished in the

first second and third quarter of 2001. Further IGA start-up capital was too meager in all communities and this resulted in communities resorting to Tuck shop activities.

## **PROJECT II: THE OVC TRAINING**

The Department of AIDS Management and Training Services (AMTS) at Chikankata has been involved in conducting training in AIDS Management since 1990. In addition an intensive-counseling course is also offered to enable workers deal with infected or affected persons by HIV/AIDS on a daily basis. While the ultimate beneficiary for the course is intended to be OVC eligibility to attend the course is that one must have attained grade twelve.

The orphaned and Vulnerable Children programme was conceived following Chikankata's realization that inspite of the fact that the institution was offering courses in the AIDS Management and intensive counseling, there were observable gaps regarding the OVC situation in Zambia. The gaps included:

- Unsustainable care programmes
- Lack of community involvement in the Management of OVC
- Absence of life skills among OVC
- Scarcity of trainers in OVC issues.
- Mismanagement of OVC programmes

The OVC training is intended to feed directly into the CBOSP/CHIN project. From September 2000 to the time of this evaluation a total of 154 participants from within and outside Zambia and from different backgrounds successfully underwent training on this course. Participation fee for Zambian participants was subsidized by UNICEF while each participant contributed K 300,000 towards the total cost of the training. The total number of intakes since 2000 to February 2002 is 7. This achievement translates to an average of 22 participants per course. From the training and intake lists inspected it was found that both men and women have attended the course.

The total number of participants projected to be trained by the end of 2002 is 175. This means that there is an equivalent of only one more training of 21 participants before this target is reached. By implication, therefore, the project is likely to achieve its set target before the end of the year (2002).

Based on all the observations made, the programme content, facilitation teaching and learning aids, assessment and evaluation schemes for the course are adequate. There is need however, to take due consideration to the fact that the course duration has been reported as a constraint. Since adult learning approaches have been adopted for course delivery, it follows that time of delivery must not be a source of depression for participants. It may be necessary to consider extending it to three weeks. Before then the

project management may verify this concern through a simple “needs assessment” questionnaire for previous participants to answer.

This evaluation addressed the following training and related components:

**a) *Programme aim & goal***

Aim: *To improve the welfare of OVC at community*

Goal: *To train 80 people per year in the community based OVC care*

***The content***

The curriculum content adequately addresses the issues that commonly affect the OVC. To be eligible to attend the course, though, one should have a minimum of grade 12 certificate. This requirement excludes the majority of village community members and yet the course would be of great benefit to them. It would be helpful for the community if the entry requirement was reviewed in order to cater for trainable and literate CHIN committee members.

**c) *Programme evaluation strategies and Assessment schemes***

The formative and summative evaluation strategies and learner assessment schemes have been clearly defined including the certification and accreditation.

The learning strategies conform to faculty skills development and adult learning schemes and therefore are appropriate.

**d) *Course duration vs content***

Based on the findings obtained from past participants, it was found that although the course had the right content the period was too short within which to cover it. It was generally felt that two weeks was not enough as it forced participants to have very little time to assimilate what was learnt before the next session. Therefore most respondents felt that the programme should be extended to at least three weeks within which could be included practical field visits to selected outreach areas than presently available.

**e) *Learners' assessment of programme***

***i. At learning level***

The participants interviewed in Siavonga, Mazabuka, Copperbelt and Lusaka expressed satisfaction with the programme overall presentation except for the duration. Two of the participants that had attended the OVC course expressed reservation with the way the topic on IGA was presented. They indicated that the facilitator had not adequately

prepared for his presentation making it difficult for them to understand what he was teaching.

## ***ii. Impact of training***

As earlier pointed out, former participants were visited at their respective organizations and projects in order to assess the impact of the training. The Towns visited included Siavonga (Namumu Orphanage), Mazabuka (Luyobolola Community School), Lusaka (Anglican Children Project, & UTH), Ndola (Rainbow Project/LARC), Luanshya, Kitwe and Chingola. Luanshya and Kitwe participants were not at station at the time of the visit although a coordinator at Pastoral and Clinical Care Centre at Kitwe was interviewed. The most prominent lessons and reactions were evident at Siavonga's Namumu Orphanage, Mazabuka's Luyobolola Community School and Lusaka's Anglican Children's Project:

All the former participants visited were already putting in practice what was learnt during the course. Only one participant in Chingola had not yet directly employed the skills<sup>23</sup>. By virtue of her job as a nurse however she had started making use of her earned skills by looking after one double orphan and a former street child that had been hospitalized for a long time and was in a debilitating condition. In addition she and her colleague are in the process of initiating a rehabilitation centre. They however require help.

### ***a) Siavonga's Namumu Orphanage***

#### ***Motivation and impact of training:***

This is an orphanage initiated and managed by a husband and wife as Director and deputy respectively through a management committee with a total number of 11 members. Both the Director and his wife have attended the Chikankata training with the wife having recently attended the OVC course. The Director stated that one of his motivation for establishing the Orphanage was that he himself had been raised as an orphan and that since he new what it felt like to be an orphan he has decided to devote his time looking after other orphans. Through the skills gained during the training, the couple has been able to share their experience with not only their own church members (United Church of Zambia) but also with other denominations and non-churchgoers on the OVC situation.

A day before our visit the couple had invited people in the Siavonga community to a church meeting at which the plight of the OVC in Siavonga was shared and donations made and later given to the most needy of the community. Although this meeting was held at the UCZ, it was for both Christians and non-Christians. The couple shared with the invited people on the importance of helping the needy, particularly the OVC. It was agreed at this meeting that such gatherings would be held every after three months in order to strengthen advocacy on OVC.

#### ***The Project:***

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<sup>23</sup> This was because this participant was at the time erecting a structure that was to accommodate activities aimed at improving child welfare (OVC)

At the time of our visit, an Orphanage was under construction with some structures almost complete. Construction work for the complex was initiated through the Presbyterian Church of the United States of America following a visit in 1997 and the subsequent realization of the need to extend help to the OVC and underprivileged of society. The outreach foundation of the USA provided an initial resource of US \$ 25,000 towards the construction works. Standing on a 15-acre plot currently are 1 hostel, 1 Chapel 1 Piggery with a total of 31 pigs, and 1 kitchen. The entire complex is expected to house in addition to IGAs that are already in place, a Community school (already running using unfinished structures), Pastoral Care, Skills Training and other related OVC programmes. Retired teachers are currently teaching at the community school that opened on 5<sup>th</sup> March 2002 on voluntary basis.

Water is a problem and several sites for borehole drilling have been identified and the committee is currently busy soliciting for possible donors to help meet the cost of drilling. Electricity installation also requires external assistance.

The first hostels that have been constructed have a capacity to accommodate 40 OVC. The intention of the centre is to initially host 40 boys and forty girls. All these will depend on the initial goodwill of the donors. Meanwhile the OVC situation in Siavonga catchment area (soon to include Chirundu) is estimated at over 1,000 with new cases appearing daily. Siavonga has an approximate total population of 60,000. The Catholic Church is assisting in dealing with cases of OVC by providing care to 300 of them. The Namumu Director's household has adopted six children between the ages of 5 to 15 years. All these orphans were adopted from different households and are now living under one roof as members of one family. The couple is supporting these six children from their own resources. All the children are in school.

The centre has plans to expand on its skills training programmes to include Carpentry, Metal fabrication, Domestic Science and other skills that may be found necessary for OVC.

***b) Mazabuka's Luyobolola Community School***

***Conception of the Community school***

The school was established in April 2001 after the realization by the Mazabuka catholic diocese that the problem of street kids and children out off school was growing in the town. One of the catholic fathers, working with one of the church members, Mr. Kamona began mobilizing kids from shop corridors to the church for various lessons. At inception only one kid was recruited but within one week the number rose to 15.

Currently, the school has recruited a total of 321 pupils from both the street and or surrounding communities<sup>24</sup>. These children range from 6 to 17 years of age with different educational levels including those that have never been in school.

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<sup>24</sup> Children at the Luyobolola community school come from various social backgrounds. Some are street children, others are orphans, while others are either problem children or come from very poor households and their parents or guardians are unable to send them to government schools.

### ***Observed impact of OVC training within the Mazabuka Community schools***

Arising from this heavy burden of handling such a diverse group of young boys and girls, Mrs. E.N. Nzima, a teacher and member of the church was asked if she could spare some time to help organize the school. Mrs. Nzima accepted and since then has become the Coordinator of the school, assisted by Mr. Kamona and eleven other untrained volunteer teachers.

When the Coordinator realized the need for extra skills in handling the OVC, she went to Chikankata for the OVC course and upon return has been able to better cope with the various emotional, social and psychological issues affecting the pupils. Mrs. Nzima has been able to blend skills acquired at Chikankata with her teaching methods, and has offered workshops to eleven volunteer teachers who by background are not trained teachers. Teachers from other community schools under the diocese were also trained through her at the same workshop and this brought the total number of participants to 40. Although there had been efforts to attract children from the street this was not systematic and therefore Mrs. Nzima also put in place a street outreach programme.

To further alleviate the growing problem of OVC in Mazabuka, the Catholic Church has opened four Community schools<sup>25</sup> to enable the less fortunate to at least attain basic education. The are schools located around town and are as follows: Kaleya, Ndeke, Chaanga and Luyobolola.

Most of the OVC have a street background and as such one of the biggest problems experienced with these pupils is that of diseases including sexually transmitted infections<sup>26</sup>. Recently, 28 pupils suffered from mumps<sup>27</sup>. The infection spread very rapidly among the kids because of congestion in classrooms.

One of the girls was recruited at her early stage of pregnancy and the coordinator had to assume the role of guardian in ensuring that she attended all Antenatal sessions during her pregnancy. She has since given birth and is due to resume her classes at the community school soon. At the same time, the coordinator will have to ensure that the baby is looked after properly while the mother is away at school.

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<sup>25</sup> The community school is undergoing continuous development with an Art lab, Classroom block and a third complete building. One classroom was at slab level.

German Technical Assistance to Zambia (GTZ) assisted in the acquisition of large variety of books through the donation of K7.0 million while well wishers from Italy through the church also donated a photocopier and computer. The Coordinator made an earnest appeal for any help that would go towards catering for the welfare of this large number of needy children.

<sup>26</sup> At the time of the evaluation 10 had been treated for STIs.

<sup>27</sup> Mazabuka general hospital does not offer any concessions to the pupils when they are sick and this is becoming an area of concern to the school administration because of its limited financial resource base. Despite the difficulties faced by the community school, the coordinator indicated the need to conduct *general medical screening to street children for cases such as, Malaria, Bilharzia, worms etc. using blood, urine and stool examinations.*

### ***Behaviour change interventions:***

Other than academic lessons provided to pupils, two ***Behaviour Change Process (BCP)*** workshops have been held in order to try and regulate behavior of some boys and girls that were identified with personality problems. These workshops are on going and structured in levels from simpler topics to more complex ones. Individual counseling is also undertaken. Based on these activities, there has been observed change in some kids while others still need further working with because they perhaps spent longer periods in the streets and hence more time would be needed to change deep rooted anti-social behavior developed over the time.

### ***c)The Anglican Children Project-Lusaka***

The Anglican Children's Project (ACP) started in 1996 with the mission of ***building the capacity of Orphans and Vulnerable Children through increased intervention by involving various stakeholders including the children themselves.***

The set ACP developmental objective is “ ***to raise the capacities of OVC and their families in responding to their needs through community based and other interventions.***” Based on this objective families have been assisted with ways of coping and how to handle OVC through training in IGA management, psycho-socio counseling and through focus group discussions.

The project is organized and run via five Community Care and Prevention Committees<sup>28</sup> that are spread around the city of Lusaka. The Project Coordinator and his staff are responsible for facilitation and coordination at the project office. Through this model communities are directly involved in identifying activities and as such have embraced the project vision and objective since they feel they are part of it. The model also identifies cases of child abuse<sup>29</sup>.

The model employs three strategies in mobilizing OVC:

- i. **Withdrawing:** Involves actual following up of street kids, abused children and OVC in their sleeping places at night and convincing them to register with any designated project shelter if they are not comfortable with going to ACP. During the first three days after registration, the kid is counseled and provided with food.
- ii. **Rehabilitation:** This stage involves tracing the street kids, abused children, orphans and other vulnerable children, profiling them and providing counseling and any other required help with a view to enhancing child reform.

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<sup>28</sup> Each of these five committees also have their own sub Care and Prevention Team committees

<sup>29</sup> Six Caregivers were sent to Chikankata for OVC training in June 2002 to gain further skills in dealing with OVC. Upon return from training the participants facilitated the formation of CPTs in various communities; 6 in Chelston, 5 in Matero, and 2 in Chilenje/Kabwata. One of the participants, Mrs. M. Zulu, is coordinating OVC activities in a total of 9 communities; Chibolya, John Laing, Kamwala, Misisi, Chawama, Kabwata, Libala, Chilenje and Arrackan Barracks. She admits that the OVC course has enhanced her ability to relate better with both her colleagues and the OVC.

**Reintegration:** Involves putting the street kid/abused child/OVC back into normal life activities through engagement in various constructive activities such as vocational skills and entry into school.

### ***Improved Skills of OVC management following OVC Training***

- iii. One of the participants, Mrs Zulu admitted that following her OVC training she has been able to raise her own understanding of the OVC situation as well as carry out her duties with empathy. She has used the skills to conduct many workshops on OVC care in her community.

### ***Project Capacity & Resource Base***

At the moment the project site located at Chelston has two accommodation blocks, one for males and another for females. The total number of OVC is 45, 31 males and 14 females. The facility is under pressure to enroll more OVC into boarding but cannot due to its small size. All the OVC have been placed in various government schools though it is increasingly becoming difficult to support them adequately with school needs.

Through ILO assistance, the project also operates a withdrawal and rehabilitation project for street children and child prostitutes, which has attracted 150 children. The ILO assisted with the process of street kid and child prostitution withdrawal from streets and later provided basic help to meet school fees and Skills training for 1 year in the catchment area for 150 children. Out of the 150, only 50 that were above school going age were supported in Skills Training; tailoring and Tie and Dye.

At the time of the evaluation, Management pointed out that for a year the ILO has not supported the project and fears what will happen to the 150 children in school after the lapse of ILO's assistance if some other help is not accessed.

### ***Constraints of the project***

The project covers the whole Lusaka. However, it has been difficult to reach all these areas without adequate means of transport. Management feels that if transport were provided, accomplishment of its activities would be very easy.

### ***d) Needy Ministries at Emasdale Baptist Church-Lusaka***

This project has been running on care and voluntary basis for 3 years. The current Coordinator, Mrs. E. Masebe, is a qualified nurse, a trained counselor and has undergone OVC training course at Chikankata.

In the last few years Mrs. E. Masebe has been involved with the underprivileged through her facilitation with Care International and at her own church project. She admits that after her OVC training she has been able to look and respond to the problem of OVC much more objectively including added approaches to counseling of OVC. Through the

church she is currently involved in mobilizing various forms of assistance such as food and clothing for over 20 needy people that the church has identified. Under this project the focus is not only the OVC but adults that the church has categorized as being in the most disadvantaged positions and requiring help.

***Programme sustainability:***

Based on the reported number of applicants and those that actually attend the course, there is evidence that the course has had the desired impact to organizations and individuals, locally and abroad. This implies that as long as the curriculum remains as relevant as it has been reported to be, the programme will continue running.

The course fees chargeable should also be able to drive the programme without risks of collapse and it is hoped that if both the training standards and the environment remain high the programme should sustain itself well into the future.

**THE RAINBOW MODEL OF CARE ON THE COPPER BELT**

The Copperbelt has been running OVC and other related programmes through various organizations such as the Inter-denominational congregations, non-governmental organizations and the Church itself. During this evaluation the Rainbow model, which is run through Pope John 23<sup>rd</sup> was analysed with a view to compare and contrast it with the Chikankata model of care.

**The Association Pope John the 23<sup>rd</sup> founded the Rainbow project in 1986** with the project site at the Franciscan Centre Chifubu in Ndola. The model has formulated four goals:

- ❑ To respond to the emerging situation of OVC mainly due to HIV/AIDS pandemic, through a strategic plan.
- ❑ To reach and help a large number of children.
- ❑ To keep children in a related or non-related family by supporting these families psychologically and economically (micro-credit) programme to alleviate poverty.
- ❑ To make the nation aware of this humanitarian emergency.

The goals set to be achieved through three objectives:

- To create in each compound a net of answers to the different needs of the OVC and the families caring for them.
- To link the organisations that are participating in the project in order encourage networking and working together.
- To increase the activities that these organisations are already doing.

The Rainbow model focuses on poverty alleviation by categorizing its beneficiaries into two main groups. These are the direct and indirect beneficiaries:

- i. Direct beneficiaries to include:
  - ✓ Orphans and Vulnerable Children
  - ✓ Families Caring for Orphans and Vulnerable Children
  - ✓ Poor and handicapped people
  
- ii. Indirect beneficiaries:
  - ✓ Associations groups and NGO working on the field
  - ✓ Primary and secondary schools
  - ✓ Micro economy of the area

The poverty alleviation programme is organised into seven distinct but related components:

- Perception of needs in which information is obtained on the ground from the people directly affected. It also involves physical searches of children in distress and based on data obtained, linking some of these children to the Social Welfare department or to other NGOs.
- Reducing poverty levels of families affected by HIV/AIDS and OVC through micro-credit support schemes for short and long-term activities.
- Education support to the children that fall out of school by finding places in formal or community schools for those with no opportunity to attend formal school.
- Nutritional support in which priority has been placed on those children that either through the death of their parents are left in the hands of poor and vulnerable Care givers such as grandparents.
- First Aid home Family: This is an effort to rehabilitate and shelter those street kids that may have been left roaming the street after their parents or guardians' death. This is being done in conjunction with the social welfare department.
- Information and advocacy: This component emphasises on raising awareness of both the OVC, their Care givers as well as the general public and ultimately the government on the rights of the OVC.
- Adoption and fostering: This is meant to identify and if possible organise families that have the will and desire to adopt OVC that have come from the First Aid homes.

All these components are facilitated through teamwork approach.

#### ***a. Comparison of Rainbow and Chikankata models***

##### ***The Model:***

The Chikankata model of OVC care is based on the traditional extended family system of caring for the orphaned children. Therefore, there are no foster homes in these communities but instead relatives such as uncles, Aunties, and Grandparents are directly responsible for taking care of the OVC. Children therefore grow up in a biological family setting. Other models such as the Anglican Children's Project and the Rainbow model have created homes where children that may have no parental care are kept under one

roof regardless of whether they have traceable extended families or not (e.g. street kids and abused children).

The CBOSP Chikankata model of care is workable and in its form sustainable. The CBOSP team should as a matter of programme enrichment consider visiting Ndola to study the Rainbow IGA management system (which provides interest free loans to OVC Care givers) with a view of incorporating the micro-credit scheme at Chikankata.

### ***Similarities:***

- Both models focus on community based care of the OVC
- Both models strive to enhance the way of life of the OVC through health shelter and food provision
- Both models engage the community in OVC work
- Both models try to empower older OVC with skills

### ***Differences***

- The Chikankata model strives to engage OVC in the discussion of their welfare whilst the Rainbow model mainly engages adults to find solutions for the OVC they are looking after.
- The Rainbow model seems to be broader than the Chikankata model in the sense that its mandate includes provision of micro-credit facilities that eventually will benefit the entire household. The micro-credit is administered through organizations that are part of the rainbow model of care. The Chikankata model targets households and OVC directly through their CPTs or CHIN committees<sup>30</sup>.
- The Rainbow model operates through various organizations while the Chikankata model is a model that works through community committees all belonging to one singular organization.
- The Rainbow model has an advantage of being in an urban setting where most of the constraints such as transport, relative distances between and among networking communities, ease with which community members are sensitized and so on are not as prominent as those in Chikankata. Chikankata is in a rural setting and affected by all the aforesaid. Therefore based on location and scope of operation the two may not be readily comparable
- The rainbow model encourages and supports IGA<sup>31</sup> at a larger scale and provides seed money to organisations that are part of the model
- The Chikankata model has the advantage of having all its activities structured and organised in a more traceable and manageable system
- The Chikankata model has a structured training component

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<sup>30</sup> The Chikankata model operates through Care Prevention Teams and Children in Need committees, which are community based and part of the organ of one organization.

<sup>31</sup> One prominent feature seems to be the organization and execution of Income generating Activities. The approach is two pronged; ***income generating and micro finance services***. It is intended that the micro finance will eventually improve programme sustainability, livelihood of those involved as well as promote crop production. From the start the recipients get involved in IGAs. In the mean time they are given mealie meal, medical care and educational support of the children until such time when they are able to sustain their IGAs into profitable ventures. This system has been reported to working well for this model of care.

***OBSERVATIONS ON THE CURRENT PROJECT PROPOSAL DOCUMENT  
(PHASE TWO EXTENSION INTO YEAR 3)***

The Overall objective of this document, “*To ensure increased optimum quality of life for children infected or affected by HIV/AIDS and contribute to the prevention of new incidences of HIV infections thereby reducing the possible numbers of HIV/AIDS orphans in Zambia,*” adequately incorporates the objectives of both the CBOSP and the OVC projects. It is therefore suggested that the next justifying paragraph be deleted (page 10 of project document) as it seems to dilute the intent in the overall objective.

The Overall Objective appears under OVC training when it is supposed to stand alone to encompass both CBOSP and OVC. It would be clearer if Part One, (The OVC Training) is clearly titled to separate it from the background. Its objectives would then stand out clearly.

Each of the two Parts of the document should have clear immediate (specific) objectives. From the document it appears that the objectives for CBOSP have been lumped together with objectively verifiable indicators (OVIs) and are called ‘Outcomes.’ They must be separated especially for the purposes of the project evaluation. The objectives can then be tagged with activities, which in the document are well laid out.

The following suggested specific objectives are derived from indicators & Outcomes on page 10 of the document (They should come before indicators):

***Objective 1. Conduct training of 240 OVC managers and other stakeholders in Zambia.***

***Objective 2: Deploy Chikankata CH & D and AMTS in communities once every three months for at least two days in each community to monitor progress and take care of any other arising matters.***

***Objective 3: Support two members of staff<sup>32</sup> twice every year to two different training workshops abroad to provide and strengthen their facilitation.***

***Objective 4: To raise the number of CBOs and NGOs involved in effective running of the community base programmes mitigating the impact of HIV/AIDS on orphans and vulnerable children.***

Since activity 1 of objective 1 has already been achieved, this could be modified to read; *Revise the Curriculum for OVC based upon the experiences within and outside Chikankata catchment area.* This activity takes into account the fact that Chikankata is now well placed to offer not only training based on local experience but also from outside its area of operation. In order to improve the focus for the renewed phase of the project it

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<sup>32</sup> *The staff members will be one from Chikankata CH & D and the other from AMTS. Attendance should be availed to all staff in the respective departments and should not favor some staff.*

is suggested that a logical framework (as an Annex) of the entire project be given at the end as suggested below:

**Logical Framework for the CBOSP & OVC training projects.**

<i>Objectives</i>	<i>Activities</i>	<i>Objectively Verifiable Indicators (OVIs)</i>	<i>Means of Verification (MoV)</i>
<p><b>Developmental Objective:</b> To ensure increased quantity of life for children infected and affected by HIV/AIDS and contribute to prevention of new incidences of HIV infections thereby reducing the possible numbers of HIV/AIDS orphans in Zambia.</p>	<p>1. Manage and co-ordinate CBOSP project activities</p> <p>2. Provide training to various interest groups in the area of OVC.</p>	<p>1. All CBOSP activities successfully managed and co-ordinated.</p> <p>2. more than 80 % of all yearly targets for OVC training achieved.</p>	<p>1. Viable IGAs, CPTs and cared for OVC</p> <p>2. Participant lists</p>
<p><b>Immediate (Specific) Objectives:</b></p>			
<p>1. Conduct training of OVC managers and other stakeholders.</p>	<p>1.1 Develop &amp; revise the curriculum for OVC course based on the experiences in the Chikankata area &amp; outside Chikankata.</p> <p>1.2 Conduct four two-week courses/year for 25 pax each in Community Care for OVC.</p>	<p>1.1.1 Relevant curricula developed and in use.</p> <p>1.2.1 At least three two week courses/year done.</p>	<p>1.1.1.1 curricula documents</p> <p>1.2.1.1 Participants lists</p>
<p>2. Deploy Chikankata CH &amp; D and AMTS in communities for at least one day/month to tap experiences.</p>	<p>2.1 Provide on-site follow-up visitations to former course participants for verification of applicability of lessons learnt.</p>	<p>2.1.1 At least 75 % of visitations achieved &amp; programme impact assessment done.</p>	<p>2.1.1.1 Visitation returns and quarterly reports.</p>
<p>3. Strengthen facilitation skills of Chikankata CH &amp; D and AMTS.</p>	<p>3.1 Programme staff to participate in relevant community and HIV/AIDS workshops and conferences at local and international levels</p>	<p>3.1.1 At least each project staff will have attended two workshops during the project period.</p>	<p>3.1.1.1 Individual workshop reports.</p>
<p>4. Raise the number of CBOs and NGOs involved in effective running of community based programmes mitigating the impact of HIV/AIDS on orphans and vulnerable children.</p>	<p>4.1 Network and create partnership with other CBOs NGOs and government institutions.</p>	<p>4.1.1 At least each community has both CBOs and NGOs that recognise and deal with issues of HIV/AIDS.</p> <p>4.1.2 All relevant government institutions recognise the need for care of OVC</p>	<p>4.1.1.1 increased level of activities in communities.</p> <p>4.1.1.2 Relevant government institutions have developed deliberate policy.</p>
<p>5 Establish Child rights clubs</p>	<p>5.1 Facilitate formation of clubs in school and communities</p>	<p>5.1.1 At least 5 clubs are formed in the entire catchment area</p>	<p>5.1.1.1 Registers of members</p>
<p>6. Conduct basic management skills workshops</p>	<p>6.1 Identify participants in communities (CBOs &amp; CHIN committees)</p>	<p>6.1.1 At least one committee in every community trained.</p>	<p>6.1.1.1 Register of participants.</p>

**LESSONS LEARNT**

UNICEF’s mandate of protecting children’s rights and making crucial differences in their lives from birth through to adolescence is a clear and concise one as it falls in line with the Convention of the Rights of Children (CRC). In the Chikankata situation, however,

there is need for UNICEF to consider intensifying both the direct support to the OVC as well as raising the abilities and capacities of the OVC immediate family or community.

It was discovered, for instance that while most communities were keen to forge ahead with IGAs towards improving the OVC situation, there was serious limitation with initial capacity in terms of both financial and material resources. In most cases there was simply no start-up capital that could provide meaningful IGA.

The inability on the part of family households to contribute fully to the CHIN programmes has also brought worry on the part of the Hospital management as this threatens project implementation and success. The Executive Director at Chikankata made a strong appeal to UNICEF to reconsider its position by first empowering the woman in the catchment area. He said it would be difficult to realise tangible results if the most important Caregiver, the woman was not empowered first. He said, '*denying a woman is infact denying the OVC*'. This is because they inevitably assume the role of mothers to OVC and for that matter should be provided with basic means of income at individual family level.

Chikankata should play a major role in guiding communities in selecting viable IGAs for presentation to UNICEF for possible initial support. The scheme should be run on a revolving fund basis as an interest free micro-credit facility as is the case under Rainbow project on the Copper belt.

### **Management capacity**

There is presently a sound management system at the hospital to facilitate all project programmes successfully. However, there is need for the Salvation Army to give more support and attention to the CBOSP staff in order to make progress in that area. Despite the Salvation Army making visible achievement in the training component, there appears signs of frustration in the CBOSP component. The CBOSP component was the first project to be supported by UNICEF and support has been channelled to this area for more than 6 years<sup>33</sup>. There is need for Chikankata to strengthen its monitoring role in order to achieve its intended goals in its catchment areas.

### ***Four components of the CBOSP***

#### *Community mobilisation and Awareness*

There has been notable progression from the first phase into the second phase. However, there is still need to carry out activity 1 (Baseline Study) under this component in order to gather pertinent information on what was pre-existing for purposes of continuation or modification of the project.

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<sup>33</sup> Indeed one has to consider factors such as delayed release of funds by UNICEF, late liquidation on the part of Chikankata and communication/transport difficulties by Chikankata with the various catchment project communities

OVC registration has been an ongoing activity and has progressed satisfactorily. There is however need for further improvement. CHIN committees and the CPTs need to combine efforts in collecting more detailed profiles on OVC. Although, committee members are able to state the numbers of OVC<sup>34</sup> within their communities there isn't accurate data in terms of the financial cost of looking after orphans. The cost of education varied from school to school and it was not easy to compute an average cost especially considering that school age OVC ranged from grade 1 through to senior secondary.

The OVC registration may further be improved by profiling the income base of Caregivers, parents or guardians for ease of providing assistance based on varying levels of poverty. The overall success of the OVC registration and profiling is very much dependant on the monitoring capacity of the CBOSP/CHIN co-ordinator with the availability of a vehicle this activity should improve<sup>35</sup>.

In the entire Chikankata population of 70,000 people a total of 2,747 pupils were given health education talks in all the communities. It is hoped that these talks will be a regular activity in the communities as they play a vital role in educating the pupils on sexuality especially HIV/AIDS and STIs. There is need to estimate the total number of pupils within the catchment area so as to easily assess the levels of success or otherwise of each educational activity.

#### *Community and Human resource Development*

Of all the components planned for this activity recorded the highest success. All the activities were executed, in some cases achieving 100% performance. For instance the two planned Life Skills' workshops were both conducted. What remained, however, was extending these to the other three communities that were not included in the initial plan.

Because these sessions have direct bearing on child rights, deliberate repeat sessions should be planned for in future, covering a variety of issues. The Mazabuka's Luyobolola scheme called **Behaviour Change Process (BCP)**, a programme designed following Mrs Nzima's return from her OVC course at Chikankata could be studied and its levels adopted in all communities to form part of life skills.

**Micro-business skills & IGAs:** Since all communities are adequately motivated to improve the OVC quality of life through various IGAs there is need to improve this area by conducting more community based training workshops on the selection and management of IGAs. Developed proposals by Chikankata show that serious agriculture activities have been planned and are included in the next phase. These will be more effective if they are complemented with skills training of those to be directly in charge of such ventures. At the moment the activities seem to be run mostly by those that are only committed but unskilled. IGAs have a higher chance of success if CHIN committee members could at least be given basic skills in **"Starting Your Business" (SYB)**.

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<sup>34</sup> As also stated

<sup>35</sup> There is further need to provide bicycles to the Care Prevention Teams and the CHIN committees to enhance their monitoring roles

Tuck shops though providing items that everyone wants to buy do not seem to be the best IGA for the level of income generation expected. They are under utilised due to financial constraints. The profit margins are too low, the Tuck shops are small and there are narrow product ranges. Although Tuck shops may be a part of the entire IGAs they should not form the core business.

Since the project document has identified agricultural activities it may be necessary for UNICEF to support such IGA initiatives at least for one or two seasons. For this project to work each community should identify a CHIN dedicated farm plot for it to own and control. All community members will have to work together to plough it and decide the range of crops to plant with due regard to the recurring drought situation in the area.

Animal and chicken rearing should also be encouraged. However, certain skills will be required for such animals as pigs and hybrid chickens. When this activity finally takes off, it will be necessary for those rearing pigs to network with Namumu orphanage in Siavonga where this activity is successful.

### *Monitoring and Evaluation*

There is need for the CBOSP Co-ordinator to be alert as written quarterly reports are gathered in order to capture some of the changing responses in the communities towards CHIN activities. Situations such as the one that existed in Mukwela where CHIN committee members expressed distrust towards one another needs close monitoring and immediate intervention. The CBOSP Co-ordinator and his team can only capture problems through personal and regular visits. To discourage unwarranted expectations by those placed in leadership committee positions constant sensitisation must also be encouraged.

Generally the monitoring process is adequate and is carried out every quarter and findings entered on a standard evaluation form. The quarterly review form however must include a title for '*problems or constraints met during the reporting phase*'. This will help project management address needful issues at an early stage.

### *Programme Management*

There does not seem to be any issues related to poor project management. The project once in a while suffers from delayed financial grants from UNICEF. This could improve for the better if Chikankata improved on its obligation to liquidate monies advanced. The evaluation notes the untimely release of funds by UNICEF, which affect project implementation of activities. Equally it notes that the delay in releasing funding is largely related to late liquidation of funds by Chikankata itself. Given the improved accounting system at Chikankata it is expected that problems of liquidation will be a thing of the past.

The structures for programmes' implementation in communities are in place. However, it is noted that they are not uniformly organized. For instance in Ngangula 16 villages had small subcommittees that later sent representatives to the main committee while there was only one large committee of village representatives in Malala. In Malala there was a risk of a village representative not articulating a common view at committee meetings since there was no forum for smaller group consensus. Such variances may create problems when these communities decide to network and share ideas. It is necessary therefore that Chikankata works out a uniform CHIN committee structure for adoption by all the villages.

## **5.0 RECOMMENDATIONS AND CONCLUSION**

### **5.1 CBOSP PROJECT**

- 5.1.1 In order to improve the selection, implementation and management of IGAs there is need to provide training to all CHIN committee members with SYB knowledge. UNICEF may consider sponsoring such training, whose duration should not be less than 40-hours (5 days).
- 5.1.2 Communities in consultation with together with Chikankata CBOSP project facilitators should identify more viable IGA projects that require minimum human and financial inputs but of higher profit potential in respective communities.
- 5.1.3 UNICEF should reconsider its present policy of non-support to IGAs. It should provide 'start-up capital' for properly identified IGAs. This support could be

- either in kind or in monetary form as used on the Copperbelt by Rainbow or LARC.
- 5.1.4 The CHIN activity register should provide for a column in which respondents can insert major activity constraints faced over a given quarter. This will serve as an early warning system as well as identify inadequacies in the project along the way.
  - 5.1.5 There is need to include some older OVC at community planning level. This will not only serve as form of training for them but will also improve projects impact and success since OVC are the ultimate beneficiaries of the project. Of course the nature of meetings they attend may be discretionary depending on agenda items.
  - 5.1.6 In addition to any financial support that may be given to CHIN committees for IGAs it will be necessary to empower the women that are directly caring for orphans with basic seed capital for them to grow crops especially considering that most households have no food.
  - 5.1.7 Chikankata needs to establish a profile register for the Caregivers' income base so that whenever limited resources are to be given, they be appropriated based on established hierarchy of need within the community.
  - 5.1.8 UNICEF should identify and engage an expert to carry out a baseline study. For the future benefit of the project, individual skills development and maximization on time, it is suggested that all project staff participate in this exercise.
  - 5.1.9 There is need for Chikankata to work out an action plan to go round all communities on a re-sensitisation programme in order to raise the levels of co-operation from guardians and other OVC care givers.
  - 5.1.10 Chikankata should work out a uniform CHIN committee structure for adoption by all villages involved.
  - 5.1.11 The OVC register should include age, sex, number of OVC within household of a particular OVC as well as source of daily livelihood and source of income of the bread winner in the household.

## **5.2 OVC TRAINING**

- 2.1.1 The OVC course should continue in its form but consideration should be made on its duration.
- 2.1.2 Since the capacity already exists at Chikankata for OVC training the project Management team should make an effort to learn about and blend all the available models of care across the country with a view to strengthening the delivery

packages. This will involve physically travelling to the Copperbelt to learn about the Rainbow model.

- 2.1.3 Although the Rainbow model has been implemented successfully, there is need to encourage the Caregivers on the Rainbow model to undergo formal training at Chikankata in OVC. This will in future improve networking and common approach to problems affecting OVC care.
- 2.1.4 Chikankata should identify trainable individuals in each community who through UNICEF could be sponsored for OVC training in order to bring skilled OVC care as close to the community as possible.

### **5.3 CONCLUSIONS**

The OVC care model at Chikankata has progressed as planned with observable improvements since its inception in 1995. The UNICEF input has provided adequate financial support, though at times this support was rendered late. The hospital management always came to the rescue of the project activities whenever committal of funds by UNICEF was delayed. This was on the understanding that such expenditures would no doubt be offset in due course. This indicates a good and trusted working relationship between Chikankata management and UNICEF.

The combined efforts of the Chikankata project management team and the participating communities through their CPTs and CHIN committees have resulted in many targets being met. This is evidence of a sound relationship between the project and the people, a necessary ingredient in the ultimate success of the entire programme.

It is hoped that in the coming phase Chikankata will be more proactive in strengthening its existing programmes by initiating long distance network system with OVC care givers on the Copperbelt so that cross cutting issues may be incorporated in the training programmes.

Generally the OVC training has been well received by organizations and individuals. At the time of curriculum review it may be necessary to include aspects of the training that will have been obtained from various caregivers. The programme should be able to sustain itself beyond the project life through course fees currently in place.

## **APPENDICES**

Terms of Reference

**Terms of Reference For The Evaluation of The UNICEF Supported Training And CBOSP Chikankata Projects**

### **BACKGROUND**

Chikakanta Mission founded in 1946 has an international reputation for HIV care and prevention and for having and for having trained over 2000 people in Zambia and many other countries in the region such as Malawi, Uganda, Zimbabwe, Botswana, and Namibia. The training offered is in the areas of AIDS management strategies, and OVC care. Chikakanta is located in rural Southern Province and consists of a general hospital, 4 rural health centres, a training school for nurses, a nutrition centre, a home craft centre,

a multi-purpose training centre, a recording studio, a community development programme and a secondary school.

A Home Based Care (HBC) team was formed in 1987 after the hospital recognised that AIDS was causing both medical and social problem. This team was initiated to offer support to the parents and their families and to educate the communities about caring for people living with HIV/AIDS and the prevention of further spread of the virus. However the increase in the number of patients further forced the hospital team to come up with another strategy. The emphasis shifted to developing care and prevention teams (CPT) in the individual communities surrounding the mission.

IN December 1994, UNICEF showed interest in working with Chikankata and this resulted into a UNICEF funded community based orphan support project (CBOSP) IN 1995. Two communities were chosen to pilot the project and these were Nameembo and Ngangula, which are approximately 25-35 kms from the Chikankata mission. By this time CCBT had already started working in these areas providing a HBC and education outreach on HIV/AIDS. UNICEF agreed to support the project with materials to rehabilitate existing community resources (e.g. schools health clinics) in return for free education and medical care for orphans. UNICEF also supported the CCBT to work with the CPTs to develop an orphan register and a database on orphans, and to train 22 headmasters and teachers from CHIN committees in the problems of orphans, orphan enumeration, monitoring and evaluation of the problem.

In the initial agreement the project was to commence in January 1995 and operate for one year. However, payment of the first instalment of the UNISEF funds was only made in September 1995. The second instalment for Phase 1 was not released until November 1996 due to delays in accounting for use of project funds largely due to staff turnover both at UNISEF and Chikakanta. The goal of the project was to integrate identified needy children into a community support system **using existing** community resources and infrastructure. In November 1996, UNICEF received two proposals from the CBOSP for the construction of hammer mills in the 2 communities as part of phase 11 of the project, UNICEF and the CCBT at Chikankata agreed to conduct an evaluation of the first phase of the project, to assesses the impact phase 1 and determine the best way forward with phase 2 of the project. The first evaluation looked at:

- . Community participation and impact of phase 1 activity.
- . Project sustainability and replicability.
- . Provide recommendations for phase 2

In phase 2 of the project, it was proposed that the CPTs would receive further training to help them identify and manage income-generating project to provide long-term support to orphans and other children in need.

Since in principle Chikankata had been working with UNICEF from 1995 the first evaluation was conducted in the early part of 1997, and this resulted into the project being expanded to three more villages. Currently the project operates in villages namely Nameembo, Malala, Ngangula, Mukwela and Chaanga. In 2000, a new component was added to support the training centre to provide training on OVC, which was and is still being supported by UNICEF. Chikankata has now submitted another proposal for both the CBOSP and the training centre on OVC for the third phase. In order to decide what of programmes to support, it is imperative that UNICEF evaluates their work and outputs achieved. This will make it easier to understand what has transpired since 1997 and give us direction on the steps to take from the current support.

A consultant has been identified to support Chikankata and the UNICEF Child Protection Section in evaluating CBOSP and training projects, particularly in its second phase, and to provide technical information and guidance for approaches the next phase of the programme. The consultant has been selected using the UNICEF agreed upon terms (competitive bidding).

## **GENERAL OBJECTIVES OF THE ASSESSMENT**

To examine the actual achievements of the project, in relation to the objectives sets out in the project proposal of the Chikankata CBOSP and training projects. This is with a view to documenting progress, experience and lessons learnt and identifying issues and challenges to be addressed before any further support can be made.

### **GENERAL OBJECTIVES:**

Primary objective is to assess the model of care, how many children have been reached as a result of the care, with what care and the cost per child for providing that care.

### **SPECIFIC OBJECTIVES:**

#### **CBOSP**

1. Assess progress made to date against each objective and the overall effectiveness focusing on phase 1 and 2 of support by UNICEF and determine whether the programme is on track and susceptible to achieve its final objectives.
2. Identify and comment on any constraints that affected the project if any and propose corrective actions.
3. Provide technical guidance to the CBOSP team on how to plan for the next phase of the project based on the lessons learnt in phase 1 and 2.
4. Provide guidance to the CBOSP team on tools that need to be developed for phases 3 especially for data collection.

#### **Training Centre**

5. Assess effectiveness of the training and how training has benefited organizations that participated in it.
6. Assess whether there is any acquired knowledge to improve the caring practices and awareness of children's rights by participants.
7. Assess the materials developed by the training team, including training manual and data collection/analysis tools.
8. Assess sustainability components of training programme.

#### **Sustainability and Replication**

9. Assess linkages of the CBOSP to other community capacity building projects.
10. Assess resources and management structure both human and financial, used to achieve Phase 1 and 2 objectives, particularly pertaining to project sustainability and community republication.

11. Assess how UNICEF's contribution was used for the CCPT activities in conjunction with contributions from other donors.

12. Assess documentation of the results of phase 1 and the extent to which results are shared with the neighbouring communities.

### **Recommendation for Phase 3**

13. Make recommendations on how the projects can be strengthened, identify process and impact indicators to facilitate the CBOSP process.

14. Make recommendation on how to strengthen training linkages for the training centre (phase 2).

15. Make amendments to the current project proposal if need be, and assess the in-house monitoring evaluation indicators with a view to strengthening them to promote future effective measurement of progress especially in building community consensus in phase 3.

16. develop process and outcome indicators for monitoring of CBOSP, with the number of OVC reached and types of services provided.

17. Make clear recommendations for each role player for instance the CPTs Chikankata staff and donors.

## **METHODOLOGY**

The assignment will be carried out in close consultation with UNICEF. The consultants will be responsible for the following tasks.

- Review key documentation pertaining to CBOSP (initial and current project proposals, quarterly progress reports, workshop reports, etc).
- Develop a methodology and tools for continuous assessment for both the training and CBOSP project in conjunction with Chikankata and UNICEF.
- Hold meetings / discussions with stakeholders, caregivers (parents and guardians) and the training and CBOSP managers and senior management at Chikankata and UNICEF.
- Conduct interviews with at least ten participants of the Chikankata OVC workshops (this will be limited to districts 10 Copper belt district participants and 10 Lusaka district participants for logistical reasons) and how the Chikankata model compares with Rainbow in the copper belt.
- Collect, analyse and write up of the findings of the evaluation with UNICEF and Chikankata and any other stakeholder as deemed necessary.

### **Duration**

The assessment will be carried over a period of one-month maximum starting 15<sup>th</sup> April and 30<sup>th</sup> May 2002.

The consultant will be requested to work with minimal supervision within the specified time schedule.

The consultant will also be requested to develop a work plan before starting his/her assignment.

**Deliverables**

The consultant will submit an evaluation report (hard copy + diskette) to UNICEF.

The report format will contain:

- An executive summary, which is no longer than three pages.
- Objectives of the evaluation.
- Methodologies used in evaluation.
- A chapter with all findings, including monitoring indicators, and specific recommendations on project design to improve effectiveness.

The appendix will have the following: terms of reference with all tool used for the evaluation, list of people spoken to, stakeholders consulted, etc.

\*UNICEF provided transport and DSA for the consultant to enable him travel to and from Chikankata and from the Copper belt.

## Appendix 2

### List of people/organizations visited

NAME	ADDRESS/ORGANISATION
1. Mr M. Mweemba	Community health worker- Ngangula
2. Mr Mweene	CHIN sub committee member- Ngangula
3. Mrs Chikolo	Widow & CHIN participant-Ngangula
4. Mr Mwiinga	CHIN committee member- Ngangula
5. Mr Chikolo	CHIN committee member- Ngangula
6. Mr O. Mwiinga	CHIN committee Secretary
7. Mr V. Mwiinga	CHIN committee member
8. Mrs E.N. Nzima	Co-ordinator- Luyobolola community school, Mazabuka
9. Ms C. Mwalilino	Nchanga General Hospital
10. Mrs V. Kasochi	Co-ordinator- Home Care Programmes Clinical Pastoral Care, Kitwe Central Hospital
11. Ms G. Gozza	Association Pope John the 23 <sup>rd</sup> - Rainbow Project- Ndola Catholic Diocese
12. Mr M. Namuyamba	Director- Namumu Orphanage Centre- Siavonga
13. Mrs Namuyamaba	Deputy Director- Namumu Orphanage- Siavonga
14. Mr J. Sianjoka	Site Project Supervisor-Namumu Orphanage Centre, Siavonga
15. Mr A. Mupachilimo	Piggery manager Namumu Orphanage Centre- Siavonga.
16. Mr C. Munshya	Chairman- LARC/Acting Project Coordinator for CBR, Ndola.
17. Mr Ngulube	LARC liaison Co-ordinator, Ndola
18. Mr F. Mwale	Head-Anglican Children Project, Chelston, Lusaka
19. Mr Nyambe	Estate Manager- Luyobolola Community school, Mazabuka.
20 Mrs Zulu	Anglican Children Project, Chelston, Lusaka.
21. Mr J. Kamona	Maths/English teacher Luyobolola community school, Mazabuka
22. Mrs E. Masebe	School of Nursing, UTH, Lusaka
23. Mr Simanvwa	Executive Director- Salvation Army Hospital, Chikankata
24. Mr W. Silomba	Manager-AMTS, Chikankata
25. Mr B. Njovu	Training & Technical Assistance Coordinator, Chikankata
26. Mr P. Hachintu	CHIN Programme Co-ordinator
27. Mrs A. Sampa Kamwendo	Child Protection Officer, UNICEF, Lusaka

### Appendix 3

#### Analytical Matrix of Findings at Chikankata

ANALYTICAL MATRIX OF FINDINGS FOR THE UNICEF SUPPORTED TRAINING & CBOSP CHIKANKATA PROJECTS							
I) INFORMATION ON UNICEF MANDATE & OPERATIONS							
PARAMETER	UNICEF						
YEAR OF OPERATIONS COMENCEMENT IN ZAMBIA	Has been working in Zambia since 1967 to-date						
WHY/MANDATE	To support the Republic of Zambia in protecting the rights of a child as well as raising quality of their life from birth to adolescence.						
MAJOR BENEFICIARY / TARGET GROUP	Children and women through activities based on The Convention on the rights of a children and The Convention on the elimination of all forms of discrimination						
GENERAL RESPONSE TO	Through support of basic education sub-sector investment programme (BESSIP) and policy of educating our future under						
HIV/AIDS IN ZAMBIA	three components of Learning achievement project, HIV/AIDS, and Life skills project						
AS RELATES TO CHILD/ & SCOPE	Through Child protection, strengthening the capacities of OVC Care givers, Households, the community, institutions and The government. Also support to various arms of the law with regards to child and women's rights.						
II) INFORMATION ON THE ORGANISATIONAL SET-UP OF PROJECT HEADQUATERS & CENTRES (AS RELEVANT)							
PARAMETER							
INSTITUTION	The Salvation Army						



ADEQUACY OF FUNDS	adequate but health service not adequate	Support comm. resource base (IGAs)	Support comm. resource base (IGAs)	Support comm. resource base (IGAs)	Support comm. resource base (IGAs)	Support comm. resource base (IGAs)	obtained per community capacity building
MAJOR COST CENTRES	Clinical Health Services & Projects	Continued IGAs Support.	Continued IGAs Support.	Continued IGAs Support.	Continued IGAs Support.	Continued IGAs Support.	Community capacity building
METHODS/MEANS OF ACCOUNTABILITY OF FUNDS	Internal monitoring External audits	Use of relevant Forms. Monthly stock Taking.	Use of relevant Forms. Monthly stock Taking.	Use of relevant Forms. Monthly stock Taking.	Use of relevant Forms. Monthly stock Taking.	Use of relevant Forms. Monthly stock Taking.	Loan returns Monitoring.
PERSONS RESPONSIBLE FOR BUDGETING	Management Board	CHIN Committee	CHIN Committee	CHIN Committee	CHIN Committee	CHIN Committee	Project management
RESPONSIBILITY FOR & COMMITMENT OF FUNDS FOR ACTIVITIES	Territorial Commander GRZ	CHIN Committee Treasurer	CHIN Committee Treasurer	CHIN Committee Treasurer	CHIN Committee Treasurer	CHIN Committee Treasurer	Project Management
FINANCIAL AUDITING DONE BY	Independent, International & Salvation Army HQ	Chikankata	Chikankata	Chikankata	Chikankata	Chikankata	Not stated
<b>III) INFORMATION ON THE AVAILAIBLE RESOURCES(AS RELEVANT)</b>							
<b>PARAMETER</b>	<b>CHIKANKATA</b>	<b>NAMEEMBO</b>	<b>MALALA</b>	<b>MKWELA</b>	<b>CHAANGA</b>	<b>NGANGUL A</b>	<b>COPPER BELT</b>
	<b>HOSPITAL</b>						
NO. OF HOSPITAL TRG							
SITES BY PROGRAMME	4						

CLASS ROOM SPACE AT AMTS & ADEQUACY	30 persons at a Time.						
AVAILABILITY OF LIBRARY ( AT AMTS & OTHER TRG SITES (?ADECUACY)	3 sites						
PARTICIPANTS HOSTELS ADEQUACY & STD	30 single rooms available						
ADEQUACY OF ADMIN/ RECEPTION FACILITY AT AMTS	Sufficient						
AVAILABILITY OF PARTICIPANTS' CAFETERIA/ SOCIAL AMENITIES	Sufficient including Swimming pool, T. Tennis, Squash Darts, etc						
SPECIAL FACILITIES							
	<b>III) INFORMATION ON THE AVAILABLE RESOURCES(AS RELEVANT)</b>						
<b>PARAMETER</b>	<b>CHIKANKATA</b>	<b>NAMEEMBO</b>	<b>MALALA</b>	<b>MKWELA</b>	<b>CHAANGA</b>	<b>NGANGULA</b>	<b>COPPER BELT</b>
	<b>HOSPITAL</b>						
	CBOSP	CHIN Committee	CHIN Committee	CHIN Committee	CHIN Committee	CHIN Committee	Many compounds within Rainbow Catchment area.
EXISTING IN OUTREACH CENTRES CONTRIBUTING TO OBJ.	MCH						

ATTAINMENT							
LEVELS OF COMMUNITY COMMITMENT/ IN CAREING FOR THE FACILITIES	Full support	Very adequate	Very adequate	Very adequate	Very adequate	Very adequate	Report indicates full community support
COST TOWARDS OUT REACH CENTRE FACILITY							
EXEPECTED FACILITY IMPROVEMENT AT OUT-REACH CENTRES							
NO OF PARTICIPANTS IN CENTRE		14 in Main Comm	20 CHIN	20 CHIN	16 CHIN	16 CHIN	committee members
		Committee & 56 in zone committees	committee members	committee members	committee members		
SOURCE OF FACILITATORS & SPECIALTIES	Nurses, Teachers Drs, Social workers Administrators						
	<b>III) INFORMATION ON THE AVAILAIBLE RESOURCES(AS RELEVANT)</b>						
<b>PARAMETER</b>	<b>CHIKANKATA</b>	<b>NAMEEMBO</b>	<b>MALALA</b>	<b>MKWELA</b>	<b>CHAANGA</b>	<b>NGANGUL A</b>	<b>COPPER BELT</b>
	<b>HOSPITAL</b>						
FURTHER TRAINING OPPORTUNIT	Available and adequate	OVC, Drug Abuse Survival Skills,	OVC, Drug Abuse Survival Skills,	OVC, Drug Abuse Survival Skills,	OVC, Drug Abuse Survival Skills,	OVC, Drug Abuse Survival	No Information



PROJECT(S)/ PROGS		mobilization	mobilization	mobilization	mobilization	mobilization	
CBOSP/IGA IN CENTRE							
	2	1	1	1	1	1	No information
TOTAL NO PROJECTS							
VIABILITY OF PROJECTS SO FAR	Both are very viable	Viable	Viable	Viable	Viable	Viable	
PARTICIPATION CRITERIA	Community-CBOSP	Community sensitization + mobilization	Community sensitization + mobilization	Community sensitization + mobilization	Community sensitization + mobilization	Community sensitization + mobilization	Community sensitization + mobilization
	Above grade 12 for Training (OVC)						
GENDER PROFILE IN PROJECT (S)	Well balanced	Well balanced	Well balanced	Well balanced	Well balanced	Well balanced	
MAJOR ACHIEVEMENTS	CPTs formed +sup	OVC support by	OVC support by	OVC support by	OVC support by	OVC support by	
IN PHASE 1 & 2(BY OBJ.)	ported by comm.	CHIN/CPTs	CHIN/CPTs	CHIN/CPTs	CHIN/CPTs	CHIN/CPTs	
	Awareness raised	IGA shops built	IGA shops built	IGA shops built	IGA shops built	IGA shops built	
	OVC supported						
FACTORS TOWARDS ACHIEVEMENTS	Community structures built up	CPT concept trg effort & Member commitment	CPT concept trg effort & Member commitment	CPT concept trg effort & Member commitment	CPT concept trg effort & Member commitment	CPT concept trg effort & Member commitment	
FAILURES RECORDED	IGA implementation						
		IGAs	IGAs	IGAs	IGAs	IGAs	



ADEQUACY/RELEVANCE							
OF TRG PROGRAMMES	Very adequate &						
TO COMMUNITY NEEDS OF OVC	relevant						
PARTICIPATION CRITERIA	Above grade 12						
GENDER PROFILE IN TRAINING PROGS	More women than men						
MAJOR ACHIEVEMENTS	1. OVC training programme carried out at National level						
IN PHASE 1 & 2(BY OBJ.)	2. Over 100 participants trained/year						
FACTORS TOWARDS ACHIEVEMENTS	1. Availability of funds and other resources						
	2. Commitment of all staff involved						
FAILURES RECORDED	Not able to get all the 25 participants as planned for per course						
REASONS FOR THESE FAILURES	When would be participants that have been reserved places back out at last minute						
SUGGESTIONS FOR BETTER PERFORMANCE IN TRG IN FUTURE	Last minute backing out may be stopped if participants are asked to pay no refundable fees						

STRATEGIES FOR	1. Participants already contribute 300,000 to total cost						
SUSTAINABILITY OF	2. Evidence of direct application of concepts learnt exists in many Zambian communities e.g. Namumu orphanage & Mindolo etc						
TRAINING BEYOND UNICEF SUPPORT							
TOTAL NO. OF AIDS MGT PARTICIPANTS IN LAST 5-10 YEARS	3,700						
TOTAL NO. OF OVC FACILITATORS	154						
PARTICIPANTS IN THE LAST 5-10 YEARS							
POTENTIAL FOR TRAINEES TO GET INTO FORMAL/GAINFUL EMPLOYMENT FOLLOWING ATTAINMENT OF THE ABOVE SKILLS PROGS	No information						
<b>V) INFORMATION ON RELATIONSHIP BETWEEN CHIKANKATA HOSPITAL &amp; THE SURROUNDING COMMUNITIES</b>							
<b>PARAMETER</b>	<b>CHIKANKATA HOSPITAL</b>	<b>NAMEEMBO</b>	<b>MALALA</b>	<b>MKWELA</b>	<b>CHAANGA</b>	<b>NGANGULA</b>	<b>COPPER BELT</b>
SIZE OF COMMUNITY SERVED	Zambia & beyond	4000 people	1800 people	1500 people	2000	4207	No information

USUAL ACTIVITIES		Community Development	Community Development	Community Development	Community Development	Community Development	Community Development
TAKING PLACE IN		MCH	MCH	MCH	MCH	MCH	MCH
COMMUNITY BEFORE		OVC Registration	OVC Registration	OVC Registration	OVC Registration	OVC Registration	OVC Registration
CHIKANKATA ARRIVED		OVC Visits	OVC Visits	OVC Visits	OVC Visits	OVC Visits	OVC Visits
		Advocacy	Advocacy	Advocacy	Advocacy	Advocacy	Advocacy
		IGAs	IGAs	IGAs	IGAs	IGAs	IGAs
ACCEPTANCE LEVELS OF CHIKANKATA IDEAS		All communities have accepted the concepts introduced	All communities have accepted the concepts introduced	All communities have accepted the concepts introduced	All communities have accepted the concepts introduced	All communities have accepted the concepts introduced	All communities have accepted the concepts introduced
STRATEGIES USED TO CONVINCE COMMUNITY ABOUT VALUE OF CHIKANKATA PROJECTS		Project knowledge Reinforcement. Community facilitation involvement	Project knowledge Reinforcement. Community facilitation involvement	Project knowledge Reinforcement. Community facilitation involvement	Project knowledge Reinforcement. Community facilitation involvement	Project knowledge Reinforcement. Community facilitation involvement	Project knowledge Reinforcement. Community facilitation involvement
COMMUNITY POPULATION TOTAL		4000	1800	1500	2000	4207	
Accurate information on the number of Males, Females, Female Children or Male Children was not available at time of this evaluation							



## Appendix 4

### 1. Evaluation Instrument

**EVALUATION INSTRUMENT OF THE UNICEF SUPPORTED TRAINING AND  
CBOSP CHIKANKATA PROJECTS  
DESIGNED BY: Daniel Fwambo**

**(I) INFORMATION ON UNICEF MANDATE & OPERATIONS**

<b>Parameter</b>	<b>Information Required</b>	<b>Methods of collection</b>	<b>Sources of collection</b>	<b>Questions</b>
General Mandate	-Scope of UNICEF support -Major beneficiaries -Limits of support	-interviews Literature review	Senior officers Child protection unit -Documents	-Why was UNICEF established and when? -What major areas of human endeavour is UNICEF mainly involved in? -What has UNICEF done to uplift the quality of life of the child in Zambia in line with its mandate? - To what extent has UNICEF assisted member countries share good experiences/ achievements by one country on the welfare and rights of a child?
Response to HIV/AIDS pandemic	-General response -As affects the child (scope)	-interviews -Literature review	Senior officers Child protection unit -Documents	-What is UNICEF's general response to the HIV/AIDS scourge in the world? -What is the scope of UNICEF's response to HIV/AIDS with regard to the child in the world and Zambia specifically?
Future outlooks of UNICEF	-To child welfare in general -In response diseases affecting children vis-à-vis HIV/AIDS	Interviews Literature review	Senior officers Child protection unit	- Does UNICEF foresee a shift in its own current policy on the rights and privileges of the child in view of effects brought about by the HIV/AIDS scourge.

**(II) INFORMATION ON THE ORGANIZATIONAL SET UP OF PROJECT HEADQUARTERS**

<b>Parameter</b>	<b>Information Required</b>	<b>Methods of collection</b>	<b>Sources of collection</b>	<b>Questions</b>
Institutional Background	-Owner of the institution -Reasons for establishing the institute	Unstructured/structured Questions-interview	Head of institution Senior staff	-Who owns the institution? -When was the institution established? -Why was the institution primarily established?
Organisational Structure	-Kind of structure	Unstructured/structured Questions-interview	Head of institution Senior staff Organograms	-How is your organisation structured? -Are all positions provided for filled? -What is the chain of command in your institution? -Does each position have a written and defined job Description?
Communication	-Channels of communication -Decision making process -Means of communication	Unstructured/structured interviews	Head of Inst. Senior staff	-How do you communicate with your members of staff and vice visa? -How are major decisions made? -How are policies formulated and revised and by who?

**(III) INFORMATION ON THE AVAILABLE RESOURCES**

<b>Parameter</b>	<b>Information Required</b>	<b>Methods of collection</b>	<b>Sources of collection</b>	<b>Questions</b>
1. Funds	-How funds are secured -How funds are	Unstructured interview/structured	-Chikankata hospital Director -AMTS	HOSPITAL DIRECTOR -What is the main source of funding for

	<p>managed</p> <ul style="list-style-type: none"> <li>-Distribution of funds</li> <li>-Accountability</li> <li>-Preparation of budget</li> <li>-Approval and commitment of funds</li> </ul>		<p>Manager/Project Manager</p>	<p>the hospital.</p> <ul style="list-style-type: none"> <li>-Is the funding adequate to meet all your operational needs? If no how much is required and how do you normally get round this shortfall.</li> <li>-Generally how do you distribute the funds?</li> <li>-What form of financial assistance do you provide to the Outreach Community programmes vis-à-vis HIV/AIDS related activities.</li> <li>-What role does your office play in assisting the AMTS sustain itself financially?</li> <li>-To what extent does your office influence AMTS and its related programmes in budgeting and financial accountability (commitment and approval of funds)?</li> <li>-What level of compliance and/or co-operation exists regarding financial practices?</li> <li>-How are your accounts Audited and by who?</li> </ul> <p>AMTS MANAGER/PROJECT MANAGER</p> <ul style="list-style-type: none"> <li>-What major factors influence your annual budgeting?</li> <li>-To what extent are your budgets approved and commitment to the same by management achieved?</li> <li>-Do you normally attain all your set targets from your approved budgets?</li> </ul>
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				<p>-If no, how do you go round the shortfalls?</p> <p>-How dependant is your regular operations on Donor support?</p> <p>-What mechanisms have you put in place to account for donor money? What has been the Donor's position on your system of accountability?</p>
<p>Infrastructure</p>	<p>Number, size and condition of:-</p> <ul style="list-style-type: none"> <li>-Hospital Training sites</li> <li>- Classrooms</li> <li>- Library</li> <li>- Hostels</li> <li>- Administration block</li> <li>- Cafeteria /Social Amenities</li> <li>- Ablution blocks</li> <li>- OUTREACH CENTRES</li> </ul>	<p>Unstructured/structured /observation</p>	<p>AMTS MANAGER/PROJECT MANAGER</p>	<ul style="list-style-type: none"> <li>- How many Lecture rooms do you have?</li> <li>-What are their sizes?</li> <li>- What are their state of condition?</li> <li>- How many hostels, ablution blocks, libraries do you have?</li> <li>-Are these adequate to meet your current programmes and future projections?</li> <li>-How much assistance do you receive from other training wings within the hospital with regard to some of these training facilities when you are in need?</li> <li>-What recreation facilities have you put in place for your participants?</li> <li>-Are they adequate and if not what reflections have you received from your participants over the time?</li> </ul> <p>OUTREACH CENTRES</p> <ul style="list-style-type: none"> <li>-What facilities exist in the outreach areas that help you carryout your programmes?</li> <li>-Who put them in place?</li> <li>-How committed are</li> </ul>

				<p>the community members in looking after, maintaining and even putting these infrastructure in place?</p> <p>-How far have these facilities been a cost on your operations?</p> <p>-What improvements would you wish to see put up in these centres?</p>
5. Human Resources	<ul style="list-style-type: none"> <li>-Number of participants involved</li> <li>-Facilitator numbers and profile</li> <li>-Training opportunities for facilitators</li> <li>-</li> <li>-Involvement of staff in project development strategies etc</li> </ul>	Structured/unstructured	<ul style="list-style-type: none"> <li>-AMTS Manager/Project Manager</li> <li>-Vice Principal</li> <li>-Staff</li> </ul>	<ul style="list-style-type: none"> <li>-Do you have any continuous skills development for the facilitators.</li> <li>-How many officers have benefited from your retraining interventions?</li> <li>-What is the actual facilitator establishment?</li> <li>- What are the levels of retention of facilitators and how do you motivate them to stay on?</li> <li>-Are they full-time paid staff or volunteers on part-time.</li> <li>-What is the channels of communication between management and facilitators with regard to project development inputs?</li> <li>- What is the gender balance among facilitators and how is it so?</li> </ul>
6. External Support (other than UNICEF)	<ul style="list-style-type: none"> <li>-Source of support</li> <li>-type of support</li> <li>-Frequency of support</li> <li>-Adequacy of this support</li> </ul>	<ul style="list-style-type: none"> <li>- Structured/unstructured interviews</li> </ul>	<ul style="list-style-type: none"> <li>-Principal(Head of institution)</li> <li>-Owner</li> </ul>	<ul style="list-style-type: none"> <li>-Do you receive any external support in your institution (Yes/No)</li> <li>-If yes, who offers this support?</li> <li>- What is the frequency</li> <li>-What type of support</li> </ul>

	-Relevance of the support -length of support			- Is that adequate? -If not, how do you meet the short fall or How does the institution sustain itself? -What is the relevance of the support to your Programmes? -If you have been receiving support, for how long has It been going on? -Are they're any donors that may have withdrawn their support? If yes why?
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**(IV) COLLECT INFORMATION ON PROGRAMME ACTIVITIES AND THEIR SUSTAINABILITY**

<b>Parameter</b>	<b>Information Required</b>	<b>Methods of collection</b>	<b>Sources of collection</b>	<b>Questions</b>
1. IGA/CBOSP Programmes	-Types of programmes -No. of programmes -Viability of programmes -Participation criteria -Programme responsiveness to gender and community needs	- Unstructured/structured interviews	-AMTS Manager/Project Manager –Facilitators -Participants	-What type of IGA programmes do you offer? -Do you think the income generated contributes adequately towards sustenance of the projects? - What modalities are in place for sharing the income generated and how adequate are these ? -What is the response to the programmes by the community? - Are the older OVCs ever involved directly or indirectly in IGAs as skills development strategy ? -How many males and females are involved in

				<p>IGA?</p> <ul style="list-style-type: none"> <li>-What major achievements have you scored in phase 1 and 2 (Refer to immediate objectives)</li> <li>-What factors helped you achieve them?</li> <li>-What did you see as your failures?</li> <li>-What do you think made you fail (Risk factors-internal &amp; external?)</li> <li>-What areas of improvement would you want to see in order for you to get the best results in phase 3?</li> <li>What strategies do you have in place to sustain the CBOSP activities in the event that UNICEF stopped supporting them in future?</li> </ul>
<p>Training Programmes</p>	<ul style="list-style-type: none"> <li>-Nature of training(actual programmes)</li> <li>-Type of curriculum</li> <li>-Problems solved by these training interventions</li> <li>-Adequacy of programmes to community needs</li> </ul>	<p>unstructured</p>	<ul style="list-style-type: none"> <li>-AMTS Manager/Project Manager</li> <li>-Facilitators</li> <li>-Community Participants</li> </ul>	<ul style="list-style-type: none"> <li>-What training programmes are you running now?</li> <li>-Do you have plans to introduce new training interventions? If yes which ones?</li> <li>-What kind of curricula is you following for your programmes?</li> <li>-What community concerns or problems are the training programmes solving?</li> <li>-Are these programmes meeting all community expectations?</li> <li>What major achievements have you scored in phase 1 and 2(Refer to immediate objectives)</li> <li>-What factors helped you achieve them ?</li> <li>-What did you see as your failures?</li> </ul>

				<p>What do you think made you fail(Risk factors-internal &amp; external ?          What areas of improvement would you want to see in order for you to get the best results in phase 3 ?</p> <p>What strategies do you have in place to sustain the training programmes in the event that UNICEF stopped supporting you in future?</p>
Past Performance	<ul style="list-style-type: none"> <li>-In take in the last five to 10 years</li> <li>-Graduates in the last five years</li> <li>-Formal/informal employment</li> </ul>	Unstructured/structured	<ul style="list-style-type: none"> <li>-AMTS Manager/Project Manager</li> <li>-Facilitators</li> <li>-(Participants if possible)</li> </ul>	<ul style="list-style-type: none"> <li>-How many participants in total have passed through your courses in the last 5 to 10 years?</li> <li>-What is the breakdown per programme?</li> <li>-What follow-up mechanisms have you put in place for your programme graduates?</li> <li>-What common feedback do you receive regarding suitability/adequacy or otherwise of the programmes you run?</li> <li>-Where do you draw your participants from?</li> <li>-Are you aware of any of your participants that through your courses may have advanced professionally?</li> </ul>

**(V) INFORMATION ON RELATIONSHIP BETWEEN CHIKANKATA HOSPITAL AND THE SURROUNDING COMMUNITIES**

<b>Parameter</b>	<b>Information Required</b>	<b>Methods of collection</b>	<b>Sources of collection</b>	<b>Questions</b>
Nature and Size of community	<ul style="list-style-type: none"> <li>-Size of community served</li> <li>-Activities taking place within the community</li> <li>-Relevance of programmes offered by the institution to activities undertaken by the community.</li> </ul>	structured/unstructured interviews/Observations	<ul style="list-style-type: none"> <li>-People in the community</li> <li>-Facilitators</li> <li>-Headmen</li> <li>-Participants</li> <li>-AMTS Manager/Project Manager</li> </ul>	<ul style="list-style-type: none"> <li>-What is the population of the surrounding community?(Total and then village by village)</li> <li>-What types of activities are the communities generally involved in?</li> <li>-To what extent is the community involvement in their own activities?</li> <li>-How relevant are the programmes introduced to the activities undertaken by the community and how willing are the community members to adapt to new projects ?</li> </ul>

**(VI) INFORMATION ON INFLUENCE OF LOCATION VARIOUS PROJECT CENTRES ATTAINMENT OF PERFORMANCE TARGETS**

<b>Parameter</b>	<b>Information Required</b>	<b>Methods of collection</b>	<b>Sources of collection</b>	<b>Questions</b>
Location and accessibility	<ul style="list-style-type: none"> <li>-Location of Community</li> <li>-Means of transport to and from the project centres</li> <li>-Distance from the institution to the surrounding community</li> </ul>	structured/unstructured/physical visits	<ul style="list-style-type: none"> <li>-Community participants</li> <li>-Travel experience</li> <li>-Members of staff</li> <li>-Facilitators</li> <li>-Participants</li> </ul>	<ul style="list-style-type: none"> <li>-How far is the village from project administration point?</li> <li>-Does this distance render activity implementation significantly difficult? If so how?</li> <li>-What criteria were used to identify this as a project active site?</li> <li>-Why is it located where it is?</li> <li>- What mode of transport is used to get to this site</li> </ul>

				<p>and how often?</p> <p>-Are there any complaints from either the facilitators or the beneficiaries regarding the Location of the project site and if so what is the nature of complaints?</p>
<p>Basic Services within the community</p>	<p>Availability of water, electricity, communication facilities e.g. telephones ,or courier systems</p>	<p>Unstructured/structured observation</p>	<p>-Participants -Facilitators</p>	<p>-What is the source of drinking water? -How secure is this source? -Is the village serviced by electricity (Solar or hydro)? If no is it the feeling of all stakeholders that its availability could have helped the attainment of some activities? -Do you have telephones, faxes etc? -What form of communication do communities have with Chikankata as well as among themselves (for networking if at all it exists)</p>

## Appendix 5:

Review of key recommendations of the 1997 report

### REVIEW OF KEY RECOMMENDATIONS OF THE 1997 REPORT

Key recommendations included the following: (Recommendation in italics followed by comment)

- *The CHIN committees should be helped to improve their registration procedures, monitoring and more importantly, the prioritisation of need. This will help them to plan and so also to avoid charges of favouritism.*  
This recommendation was addressed. Specific forms have been designed and used in the profiling of OVC. However, there is still need to improve on the details of information collected. For instance, it is necessary to rank the households that are keeping the OVC in terms of basic sources of income/livelihood, size of household and the relationship between OVC and guardian, as this will further assist CHIN committees in more rational appropriation of assistance.
- *CHIN committees should also be helped to develop strategies to help guardians of “Children In Need” to help themselves. This will maximise resources and allow the recipients to be part of the solution.*  
This area has not been adequately addressed. Although there is evidence of Income Generating Activities taking place in communities, Chikankata management strongly advocated for improved direct assistance to guardians through provision of initial capital at household level and particularly so, to women guardians. Once these were empowered the OVC would also directly be empowered.
- *Several community members suggested that efforts should be made to involve the village headmen directly in the work of the communities, rather than merely informing them of developments.*  
This was addressed as it was found that headmen were actively involved in CHIN committee activities.
- *Future training should be carried out in the communities rather than inviting a few individuals to be trained at the mission hospital. This will be more cost effective, but more importantly will enable more community members to be involved.*  
This kind of training has been initiated at community level. For instance five refresher workshops for CHIN committees were held. There is still room for improvement in this area though. It is necessary for instance to identify some active and literate community members for possible OVC training components. The surrounding community has not benefited from the OVC training because it has been designed for grade 12 school leavers and above but it is possible that some components of the course could be adapted for people with basic literacy.
- *The management at Chikankata Mission need to ensure that any further funds from UNICEF are accounted for at the prescribed times. The reorganisation of the administration section at Chikankata (and the computerisation of accounts) should make this much easier to achieve.*

This has been achieved and consequently Chikankata strongly appealed to UNICEF for an improvement in the time it takes to release funds for various planned for activities.

- *UNICEF will need to be more actively involved in consultations during the development of phase 2 of the CBOSP and should take a more active and ongoing role in monitoring the implementation of the project. UNICEF should clearly communicate what kind of activities the organisation can and cannot support, from the outset, to avoid setting unrealistic expectations in the communities. UNICEF should also be realistic about the kind of technical and material assistance that it can provide to the CBOSP, so that activities are not stalled or delayed in phase 2.*

The most outstanding issue under this recommendation has been the UNICEF's refusal to provide start-up capital for IGA projects. It has been found that there is need for UNICEF to review this position. Currently, the IGAs are not viable as most of the communities are only engaged in Tuck shop business. These were found to be inadequate given the immense needs of OVC. Therefore, there is need for UNICEF to provide initial capital to support such projects as crop growing, animal keeping and other similar projects.