

ZIMBABWE

Ministry of Labour
and Social Services



National Action Plan for
Orphans and Vulnerable Children



Our Children, Our Future

Zimbabwean Good Practices Responding To The Needs Of Orphans And
Vulnerable Children

The “Zvandiri” Programme, Africaid
and
The Kapnek Trust Early Childhood Development Centres



SAHAIDS Southern Africa
HIV and AIDS Information
Dissemination Service



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Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral therapy
ARV	Antiretroviral
CASP	Child Adherence Support Project
CPC	Child Protection Committees
DAC	District AIDS Committee
ECD	Early Childhood Development
HIV	Human Immunodeficiency Virus
MoESC	Ministry of Education, Sport and Culture
MoHCW	Ministry of Health and Child Welfare
MSF	Medicins Sans Frontieres
NAC	National Action Committee
NANGO	National Association of Non Governmental Organisations
NAP	National Action Plan (for Orphans and Vulnerable Children)
OVC	Orphans and Vulnerable Children
PLHIV	People Living With HIV
PMTCT	Prevention of Mother to Child Transmission
PoS	Programme of Support
PSS	Psychosocial Support
PVO	Private Voluntary Organisation
RDS	Regai Dzive Shiri (reaching our goals slowly but surely in the Shona language)
SAfAIDS	Southern Africa HIV and AIDS Information Dissemination Service
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
UZ	University of Zimbabwe
ZNASP	Zimbabwe National HIV and AIDS Strategic Plan

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1. Executive summary

This document represents part of a SAfAIDS project implemented in collaboration with the Ministry of Labour and Social Services (MoLSS), which documents Good Practices in OVC programming in Zimbabwe. The goal of the project is to scale-up information generation and dissemination and thereby encourage the replication of Good Practices in the care and support of orphans and vulnerable children (OVC) in Zimbabwe. The two programmes, coined as Good Practices, and documented here are:

- Africaid's Zvandiri Programme – Providing psychosocial support to children and adolescents living with HIV; and
- Kapnek Trust's – Early Childhood Development (ECDs) Centres.

The Zvandiri Programme focuses on providing psychosocial support to young people living with HIV through their support groups, which are present in most districts of Harare. Kapnek ECD Centres focus on pre-school children in the Zvimba area of Zimbabwe and provide them with food, health care and educational interventions.

The framework for the documentation was adapted from the SADC Framework for HIV and AIDS Best Practice documentation which was elaborated on by SAfAIDS. This is a practical guide to facilitate the sharing of Good Practices in programming among Member States in order to scale up interventions based on what is known to work.

The documentation and sharing of Good Practices encourages the replication of small, successful interventions on a larger scale and involves the rigorous interrogation of a project in seven key areas; effectiveness, ethical soundness, cost effectiveness, relevance, replicability, innovativeness and sustainability. How well a project scores in each of these critical areas determines whether or not it can be classified as a Good Practice. The programmes documented here therefore represent some of the very best work being done on the ground in Zimbabwe in the care and support of OVC.

Both programmes obtained excellent scores as Good Practices using the Best Practice criteria (Africaid's Zvandiri Programme, 92% and Kapnek Trust's ECD programme, 97%). They are characterised by commendable management systems, skilled and conscientious staff, a close working relationship with Zimbabwe Government Ministries and partners, detailed attention to ethical issues and a commitment to the use of participatory programme implementation strategies.

2. Introduction

2.1 Context

In June 2005, the Government of Zimbabwe endorsed the National Action Plan (NAP) for Orphans and Vulnerable Children (OVC). In an effort to complement current Government efforts in OVC programming and to address perceived information gaps, Southern Africa HIV and AIDS Information Dissemination Service (SAfAIDS), in partnership with the National Association of Non-Governmental Organisations (NANGO), is implementing an information and communication project on behalf of the NAP for OVC Secretariat. As part of this project, SAfAIDS documented the Good Practices in OVC programming to promote information sharing and cross learning among all stakeholders responding to the needs of OVC.

The goal of this project is to scale up OVC information generation and dissemination in Zimbabwe. The target population is orphans, their carers, the communities and organisations that are working with orphans. The project aims to support OVC aged between 10 and 17 years from rural, peri-urban and urban areas. SAfAIDS serves as the publication house for OVC information and education material while NANGO provides the platforms for disseminating information and mobilising the communities for advocacy activities. The project aims to distribute materials to all ten provinces in Zimbabwe using a cascading model through NANGO members and networks.

In line with this objective, SAfAIDS sent out a call for Good Practices in OVC interventions which were relevant also to HIV and AIDS programming. Organisations responded to this call by submitting concept notes to be considered for documentation. A preliminary rigorous exercise was carried out to determine which organisations were suited for documentation as Good Practices.

To assess an organisation in terms of Good Practice, its activities are analysed on the assumption that organisational success depends on:

- Good management practice, for example, organisations need to have clearly defined goals and transparent financial management and tracking systems, among others.
- Commitment to the democratic principles of participation; for instance communities are part of the planning process and have power to influence the activities of the organisation, ensuring community support and programme relevance.
- Cutting-edge, advanced understanding of the specific circumstances of the intervention, in this case, the provision of services to OVC. For example, the understanding that research has shown it is best to provide OVC with home-based care rather than institutionalised care wherever possible: that it is better to support OVC whilst they are living with relatives in the community setting, rather than placing them in orphanages or places of care.

Some might argue that community participation and cutting-edge interventions are merely aspects of good management, but here they have been separated for emphasis. After analysis, the documentalists presented the findings in this report. Readers will hopefully take this information and use it creatively in their own work with OVC.

2.2 Good Practice documentation: sharing ‘what works’

Those of us working to reduce the impact of the HIV epidemic will know that resources are limited and therefore the efficient use of available resources is essential. The application of inefficient or ineffective interventions and the process of trial and error that accompanies the implementation of novel projects or programmes can result in the wastage of time and money. The documentation of ‘Best or Good Practices’ is an attempt to avoid such waste by allowing organisations to learn from the successes of others. The need to scale up our activities has made the sharing of ‘Best or Good Practices’ a greater imperative than ever because it reduces the chances of large-scale replication of error and re-invention of the wheel.

SADC’s Strategic and Business Plans on HIV and AIDS both advocate the sharing of Best Practices between and within Member States (SADC, 2008). A call for the scaling up of ‘Best Practice’ in southern Africa was officially made in the Maseru Declaration on Combating HIV and AIDS where it was recognised that:

“...within the SADC region there have been successes and Best Practices in changing behaviour, reducing new infections and mitigating the impact of HIV and AIDS, and that these successes need to be rapidly scaled up and emulated across the SADC region.”

In response to these calls, and growing evidence that organisations need to learn from each other’s experiences, UNAIDS and SADC began documenting ‘Best Practices’ in 1997 with their ‘Best Practice Collection’. The Best Practices reported in this publication are modelled on the original SADC HIV and AIDS Best Practice Framework.

‘Good’ versus ‘Best’ Practice

Whilst ‘Best Practice’ has been widely used as the terminology to describe an exemplary programme, there are concerns that the term ‘Best’ is exclusive and implies a rigid system that cannot be improved upon. SAfAIDS and the Zimbabwe Government discussed this view and chose to use the term ‘Good’. The ‘Best Practice’ criteria nevertheless remain relevant and it is reasonable to assume that, for the purposes of this report, the terms ‘Good Practice’ and ‘Best Practice’ can be used interchangeably.

The seven SAfAIDS Best Practice criteria and definitions

The SAfAIDS Framework for Best Practice (see note about the interchangeable use of ‘Good Practice’ and ‘Best Practice’ above) defines the primary objective of a Best Practice document based on the SADC framework of HIV and AIDS Best Practices as a “practical instrument that facilitates sharing within and between Member States in order to assist local authorities to scale up interventions based on what is known to work – through documenting, understanding, and appreciating good experiences; facilitating learning of what works and what does not; sharing experiences; and assisting replication of small and successful interventions on a larger scale” (SADC, 2006).

Reproduced below are the seven criteria and their definitions as provided by SADC (2006) and as adapted in this documentation for OVC programmes.

1. Effectiveness

A Best Practice must have clear objectives guided by identified community needs obtained through a baseline study and it must have evidence that it is achieving these objectives. The community should participate at every stage of the project, from its inception to its implementation, monitoring and final evaluation.

2. Ethical soundness

An ethical practice is one that upholds social principles and professional conduct. An intervention is a Best Practice if it does not violate human rights, respects confidentiality as a principle, embraces the concept of informed consent, applies the “do no harm” principle, and works together towards the protection of the interests of vulnerable groups.

3. Cost effectiveness

Cost of delivery for a cost effective programme is proportionate to available resources; that is, “the capacity to produce desired results with a minimum expenditure of energy, time or resources”. The intervention should have in place cost saving and reduction systems. The programme should provide a standard package of HIV prevention, treatment or care at a reasonable cost. This should result in an improvement in the quality of life of an increased number of community members. Efficiency measures the capacity of a programme to produce desired results with the minimum expenditure of energy, time and resources.

4. Relevance

All interventions, including those related to HIV or OVC, need to take cognisance of the specific context in which they are taking place, noting cultural, religious and other norms, as well as political systems and the socio-economic environment in so far as they affect vulnerability, risk behaviour, or the successful implementation of a response.

5. Replicability

Inherent in a Best Practice is its ability to be copied or adapted, and its need to discover interventions that set an example.

6. Innovativeness

A Best Practice may demonstrate a unique and/or more cost effective way of implementing a programme or responding to an issue. The programme itself could also be unique.

7. Sustainability

Sustainability is the ability of a programme or a project to continue and to continue to be effective, over the medium and long-term. This can be strengthened through community ownership of the project and through skills transfer. Sustainability should take into cognisance financial sustainability, marketing and awareness building of the project.

SAfAIDS has pioneered the documentation of HIV Best Practices in the region and for this project, in order to ensure that the documentation process captured those elements specific to Best Practice on OVC, SAfAIDS felt it necessary to add additional OVC-specific criteria and these are described on the next page.

The SAfAIDS OVC-specific Good Practice criteria

The criteria specific to OVC programmes were determined after a review of the OVC literature for southern Africa. It was felt that a document written by Strebel (2004) summarised an excellent understanding of OVC Good Practice interventions. Strebel arrived at her criteria after taking a comprehensive look at OVC interventions in Botswana, South Africa and Zimbabwe. Her criteria assessed the way OVC were cared for (primarily through home-based community supported care), the ability of the organisation to address stigma in the community attached to HIV orphans and the involvement of the community in identifying OVC. SAfAIDS also added a direct observation criterion concerning the general state of well-being of the children. It was assumed that the health and happiness of the children would be a key, evidence-based, indicator of the success of the OVC intervention.

2.3 Background and literature review

Status of HIV in Zimbabwe

Zimbabwe has one of the highest rates of HIV seroprevalence in southern Africa, although this has shown a decline in recent years, reducing from 33.7% in 2001 to 14.3% in 2009 (MoHCW, 2009). HIV, exacerbated by severe economic hardship, has had devastating effects. Between 2002 and 2006, the population is estimated to have declined by four million people. Since 1990, infant mortality has doubled. Average life expectancy for women, who are particularly vulnerable to HIV in Zimbabwe, has been estimated to be 34. Officials from the World Health Organization have admitted that the actual number may be as low as 30 (Avert, 2010).

Status of OVC in Zimbabwe

Orphans have been defined as children of 18 years old or below, who have lost one or both parents. Vulnerable children are defined as children under 18 years of age, who are living with terminally ill parents, or old, frail or disabled parents, or whose family have taken on the extra burden of caring for orphans themselves. It has been estimated that the percentage of children living in Zimbabwe who are orphans will rise to 34% by the end of 2010 (Chandiwana, 2009).

A review of the status of orphans in various districts in Zimbabwe by Chandiwana (2009) revealed that the main threats to orphans include:

- A shortage of material resources such as food, school stationery, clothing, shelter, blankets, school uniforms and sanitary wear for girls
- Child labour
- Lack of access to school
- Rape
- Sexual, emotional or physical abuse

The large number of OVC in Zimbabwe has had a huge impact on the resource base of communities, placing a significant strain on the extended family, especially on grandparents (Chandiwana, 2009; Strebel, 2004). In some parts of the country, such as Zvimba, as many as 75% of the school-going population are classified as OVC.

Trends in OVC programming in southern Africa

The region's high HIV burden has, among other impacts, resulted in an increasing number of children being orphaned and made vulnerable. Overall HIV prevalence in many countries in the region is in excess of 20%, while in Zimbabwe, prevalence in the adult population (15-49 age group) has fallen from an estimated high of 24,6% in 2003 to 13,7% in 2009. As a result, Zimbabwe had an estimated 1,025,472 orphans by 2008. Because of the magnitude of the OVC problem in southern Africa and because of the needs of children themselves, who do best in a stable home environment, the intervention of choice (wherever possible) is currently perceived to be home-based community-supported care. Orphanages are considered a last resort. Therefore, most OVC programmes have in place systems to support families and communities in their response to OVC (such as income generating activities, training of guardians in child care, nutrition, drug adherence, and so forth).

They also tend to embark on broad engagement with other community services and networking, such as with social services. Furthermore, the welfare of OVC is linked to the removal of the stigma attached to HIV, since most southern African orphans have lost parents to the disease or are living with HIV themselves. Therefore, an important aspect of improving the welfare of OVC is to reduce the level of HIV stigma in the community.

There is also a general acceptance that there must be strong community involvement, preferably including the children themselves, in the amelioration activities and in the development of the criteria for identifying those children in need of support (Babcock, 2007; Greifinger & Dick, 2008). In addition, the fact that it is mostly women, and often, elderly women, who care for OVC, means there is a regional trend to tailor interventions to specifically support this group. Helping OVC is seen as inseparable from helping their guardians. Training for the guardians in various aspects of childcare and community living is a common characteristic of programmes working with OVC in southern Africa; it is also assumed that the children need care and support even before they lose their parents.

There has been a recent focus on psychosocial support as an important component of any programme looking to improve the quality of life of OVC (Strebel, 2004; Boler and Carroll, 2003). However, despite this focus on psychosocial support and community involvement, the acknowledgement that the orphans' most immediate needs are often for basics (food, shelter and clothes) has not been lost.

Below is a diagram showing the stages of Best or Good Practice documentation and how SAfAIDS uses this process to build the capacity of partners and to encourage the replication of Good Practices in programming.

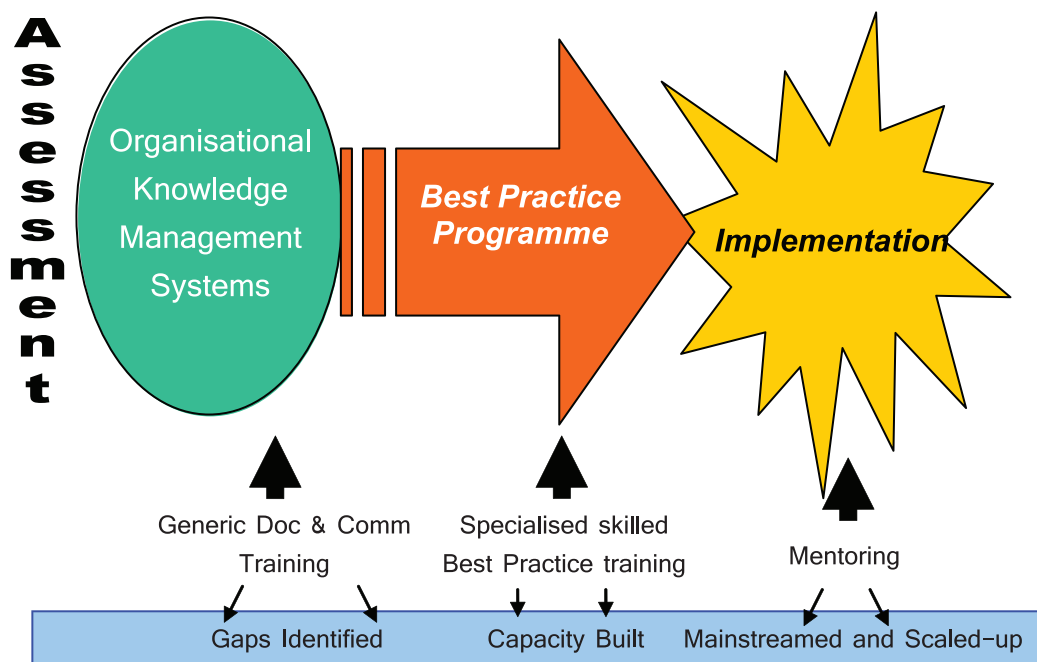


Figure 1: SAfAIDS Best Practice Documentation Model

3. Methodology

The process of documenting a Good Practice for dissemination purposes is essentially a matter of research. The documentalists therefore used typical qualitative research methods such as interviews, document reviews and direct observation to collect the data, which was then analysed using the Good Practice criteria.

3.1. Good Practice documentation questions

The key questions asked in the Good Practice documentation process are designed to uncover the critical aspects of an OVC programme; to determine whether or not the Community Based Organisation (CBO) is following appropriate standards of engagement, as well as feeding into national strategic frameworks and Government commitments. Other essential elements are how innovative the programme is with regard to the challenges faced by the community in which it operates, as well as its long term sustainability and the degree of community and OVC participation. Full details are given in Annex 1 but in sum these are:

1. Does the organisation fulfil the standards of Good Practice, namely, good management, community participation and cutting-edge interventions?
2. If so, how does the organisation achieve the standards of Good Practice?

3.2. Initial stage of documentation

An initial call for submissions for Good Practices was sent across Zimbabwe via electronic forums, news print and other databases. A selection committee of experts was then convened to review the received submissions using the SAfAIDS Best Practice criteria to guide their deliberations. The National AIDS Council, NANGO and members of civil society were represented in this selection committee. After this rigorous selection process, two projects/programmes were approved for the Good Practice documentation. These were:

1. Africaid - 'Zvandiri' Programme which provides community psychosocial support for children and adolescents living with HIV in Zimbabwe, and
2. Kapnek Trust - Early Childhood Development (ECD) centres as entry points for community-based interventions addressing orphans and vulnerable children.

This report presents the findings of the documentation of these two projects.

3.3 Field work

Having identified the projects to be documented, a liaison person was identified in each of the selected organisations who was also part of the documentation team. This person was given the responsibility of facilitating the necessary meetings and visits by the documentalists. The documentalists spent five days in each organisation reviewing literature, making direct observations, taking photographs where possible and carrying out interviews and focus group discussions. Out of these five days, one day was spent at the organisations' head offices in Harare, and the rest of the time was spent at the field sites.

The documentalists made efforts to interview as wide a range of relevant stakeholders as possible; from beneficiaries and programme implementers, to significant community members; among them teachers, nurses, headmen (traditional leaders), and relevant representatives from Government (see Annex 3 for a list of interviewees). The document analysis consisted of examining a variety of materials, including concept notes, annual reports, monitoring and evaluation (M&E) instruments and evaluations (see Annex 4 for a list of the documents examined).

The interviews were guided by interview instruments for:

- programme beneficiaries (OVC and their care-givers)
- programme implementers
- key informants (among them representatives from line ministries, churches and schools working in the community).

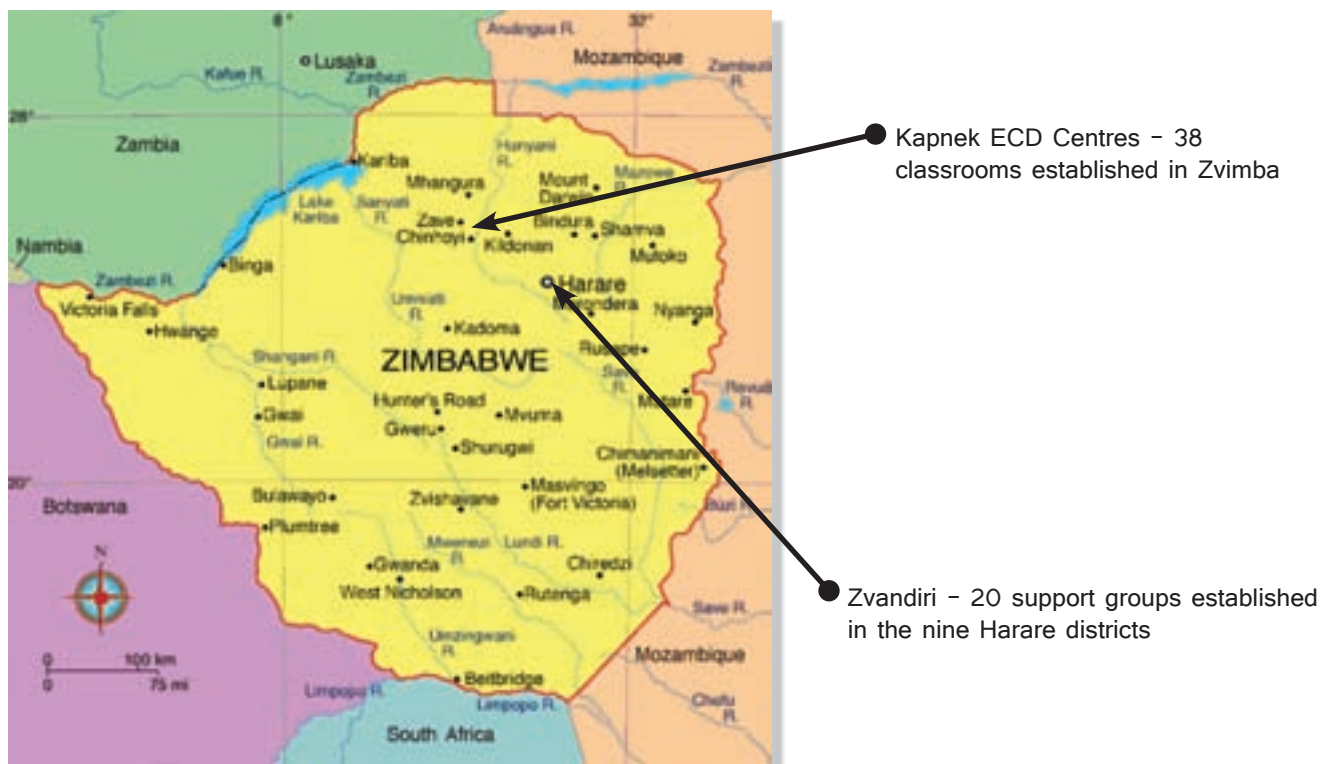


Figure 2: Field sites of the Zvandiri Support Groups and the Kapnek ECD Centres

These interview instruments can be found in Annex 1 at the end of this report.

3.4. Analysis and write-up

The data analysis consisted of assessing the organisations against the Good Practice criteria already determined, and giving them a percentage score (see the Score Card provided in Annex 2). For each criterion, the documentalists answered the question of whether the organisation had achieved it using the scale: No (0 points), Almost (3 points) and Yes, definitely (5 points). Given that there were 30 criteria in all, a perfect score would result in 150 points. In practice, some criteria were not relevant and therefore the perfect score had to be adjusted accordingly. For example, if only 28 criteria were relevant, the perfect score would be $28 \times 5 = 140$. The percentage score for the organisation was then determined and compared to the scoring scale as follows:

- 75% and above: Good Practice – should be documented
- 60–74%: Good Practice – can be documented with slight adjustments
- Below 60%: Potential Good Practice for future documentation

The Score Card analysis allowed the documentalists to answer, with some degree of objectivity, the key question: Does the organisation fulfil our standards of Good Practice? The write-up involved reporting the organisation's Good Practice score and answering the question: How does the organisation achieve good management, community participation and cutting-edge understanding and delivery of the intervention?



AFRICAID 

4. The Zvandiri Programme: Providing psychosocial support to children and adolescents living with HIV

4.1. Programme start-up and description

In 2004, Margie Pascoe¹, a medical doctor, and Nicola Willis², a nurse, were working with children living with HIV at clinics in Harare. Daily they interacted with children who were suffering from some of the hardest blows that life could present. For example, many of the children had lost one or both of their parents, and all of them were facing the harsh reality of their own serious ill health. It became apparent that although antiretroviral therapy (ART) was performing medical miracles, there was no psychosocial support for these children. Their most common experience was that they felt “all alone”. They could rarely find emotional support, as they were afraid to tell others of their situation due to their fear of stigma and discrimination. They also existed in a frightening vacuum of information, since few were fortunate enough to have the mechanisms of HIV infection and ART explained to them in terms that they could understand.



Figure 3: The Zvandiri team

Out of their compassion for the suffering of these children, and with negligible funding, Margie Pascoe and Nicola Willis decided to establish a support group for OVC living with HIV. Their inaugural meeting was held late in 2004, for 20 OVC living with HIV. The objective of the support group was to provide psychosocial support to the children by, amongst other things, providing them with a community of accepting friends and by giving them the knowledge they would need to take control of their own health.

The support group, for children and youth over the age of seven, met at the initiators' houses on the weekends. These meetings were then, as they are now, joyous occasions. In between moments of heartfelt sharing and getting to grips with the technical aspects of HIV, the children had the freedom to ‘be themselves’, to have fun and to enjoy each other’s company. A key commitment from the beginning was that the children should play a strong leadership role in the organisation. For example, the children themselves chose the name Zvandiri (which means simply “as I am”). They also designed the programme’s logo, a cave with the sun rising above it (see above), representing the hope that Zvandiri gives – the movement out of darkness and into light. Furthermore, the children were consulted about the content of the education and the nature of the entertainment that the support groups would provide. For example, they were asked what they wanted to learn and what sorts of games and activities they would like to do.

However, there was such a high demand for the services of the support group that it quickly became clear that they needed to decentralise. Discussions were held with the Provincial Director of the National AIDS Council, District AIDS Action Coordinators, Social Services and City Health staff who agreed to allocate community halls and clinics for the use of support groups in each of the nine districts of Harare. The support groups were officially registered with the National AIDS Council (NAC) and community entry and operations was facilitated together with the District AIDS Co-ordinator (DAC). Africaid was established as a Private Voluntary Organisation (PVO) to allow the organisers to source funding.

¹ Presently the chairperson of the Africaid board. ² Presently the director of Zvandiri.

Initially, funding for the support groups was from private individuals and, even today, the Africaid head-office rental is a gift from an individual. Maruva Trust (initially Africaid UK) was set up in the United Kingdom as a registered charity with the specific aim of supporting the work of Africaid in Zimbabwe. Additionally, funding was obtained from the British Council and more recently from the United States Agency for International Development (USAID).

The organisers liaised closely with Government authorities to ensure that their work was in line with Government policy. Specifically, this meant working with the Ministry of Health and Child Welfare (MoHCW) and the City of Harare Municipality. Because Africaid was dealing with vulnerable children, they realised that their activities needed to be conducted with a high degree of attention to ethical issues. Additionally, they made sure that the relevant authorities were provided with regular reports and copies of their training materials. This was necessary as these authorities were responsible for the well-being of the children within their jurisdiction and therefore needed to be kept well-informed about Africaid's activities.

Whilst the support groups were growing in number around the Harare region (to date there are 20) the number of clinics/hospitals taking Africaid's lead was also growing. Many of the Harare City Hospitals set up their own support groups or began referring children living with HIV to the Zvandiri groups. A list of the Africaid support group leaders and their phone numbers can still be found at Harare Hospital. A Medicins Sans Frontieres (MSF) clinic not far from Harare also began a Zvandiri support group. In particular, Africaid works closely with Newlands Clinic to ensure that children receive integrated health and psychosocial support services at clinic and community level.

Africaid has also partnered with the Regai Dzive Shiri (RDS) research project. This project is in its final stages and will provide scientific data and evidence-based recommendations on the community support required by children and adolescents living with HIV, with special reference to behavioural interventions, including improved mental health and adherence to ARVs. It will compare those communities that have received the Zvandiri model intervention (see Figure 9) with those communities that have not. The results will provide evaluation data that will not only benefit Zvandiri, but will feed into international academic research on the subject of psychosocial support for people living with HIV (PLHIV).

During the five years that Zvandiri has been in existence, its activities have expanded to include community support groups and outreach, life skills training, youth groups and vocational training, one-on-one counselling and educational materials development, each of which is described in more detail below.

As a result of the programme's success, and in order to assist other organisations to replicate it, Africaid has developed the Zvandiri model, which summarises their activities. See Figure 5.

Community support groups and outreach

"At the Zvandiri support groups we have learned lessons about life, such as the way to cope with HIV, adherence and re-infection. We are now able to keep ourselves healthy."

- Participant in a focus group discussion of beneficiaries, a youth group member, (20 years old).



Figure 4: Support group leaders discuss issues in the Zvandiri House garden



Figure 5: The entrance to Zvandiri House

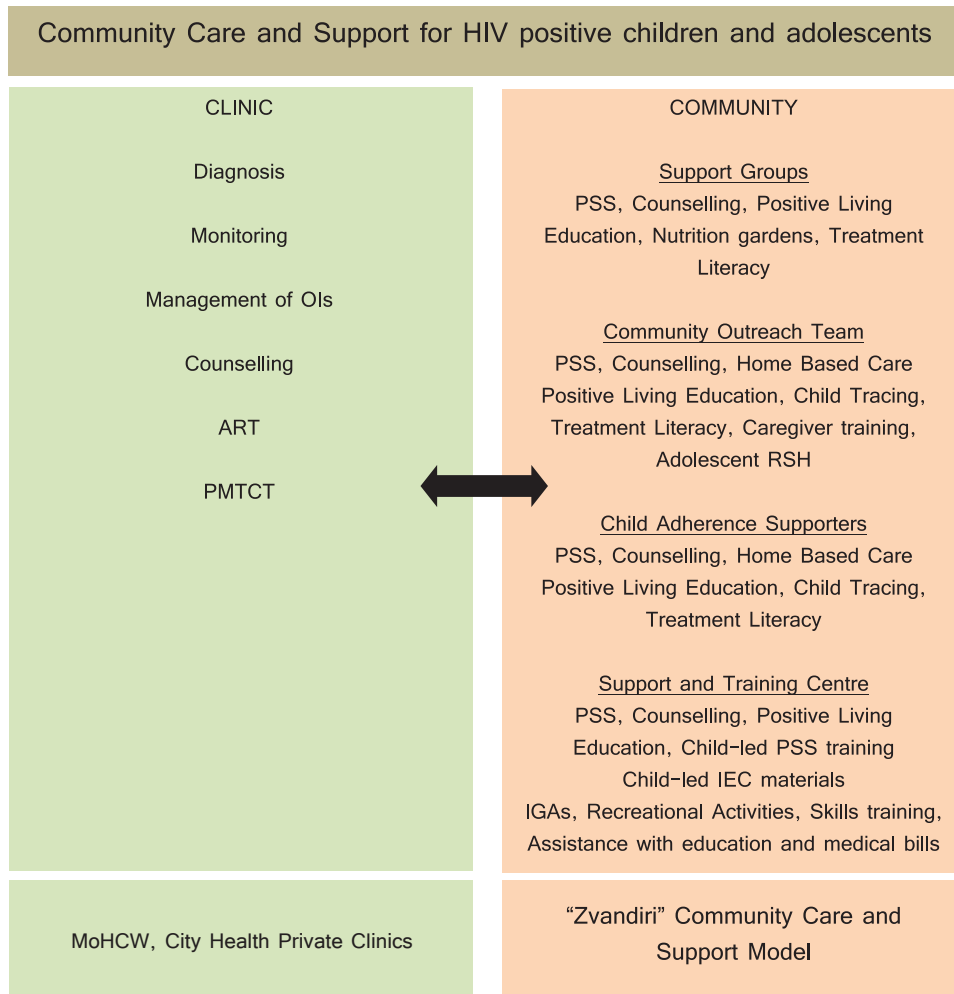


Figure 6: The Zvandiri model of psychosocial support to children living with HIV

The 20 support groups remain the core activity of the Zvandiri programme. They meet each week and on one Saturday of each month. These groups are led by professional counsellors, nurses, doctors, pharmacists, social workers and teachers.

In the interviews with Zvandiri staff, it was stressed by several people that an important aspect of the success of these support groups was the high calibre and professionalism of the leaders - "We need the right people".



Figure 7: One of the community halls in which Zvandiri runs its support groups

Therefore, although there were many people who were willing to run the support groups, only people professionally trained to deal with children and their psychosocial issues were given this responsibility.

Zvandiri has a community outreach team of two dedicated people who provide the administration necessary to organise the support groups and deliver training messages. A key Zvandiri strategy is to ensure that the support group leaders are well-prepared and have a unified vision before holding a support group session. Therefore, if there is a certain issue that needs to be dealt with, such as the issue of faith healing (certain churches encourage people living with HIV to stop taking their drugs, and instead have faith in their healing through God alone), then the leaders get together and arrive at a Zvandiri policy with regards to the issue. The leaders base their response on this policy. If a particular educational message is to be given out, again, the leaders meet and decide how to deliver the message and what the content should be.

For instance, there was a situation where pillboxes were donated to the organisation. The leaders held a preparatory session on the message they should give as they delivered the pillboxes to the children. In this way, Zvandiri is able to achieve consistency in its method and messaging.

Another key strategy is the well-established and carefully nurtured referral system. This system exists to facilitate the referral of youth living with HIV to the support groups by the clinics. Similarly, the support groups refer youth in need of medical attention to the clinics.

Africaid's experience is that support groups alone do not meet the needs of the children they aim to assist. Children attending support groups require community follow up, whether in the home or at a clinic, by professional counsellors and nurses; to follow up on issues identified through the support groups.

Africaid's community outreach team visits children each day in different communities, to provide counselling, health assessments, clinical monitoring, adherence, support and follow-up of children deferring from clinic appointments or support.

Africaid's latest project, falling under the umbrella of community support and outreach, is its Child Adherence Support Project (CASP), in which a group of ten young adults have been trained as adherence counsellors (or 'peer treatment buddies'). All of these youth were themselves once members of the support groups. The MoHCW has also commissioned Africaid to train youth living with HIV as 'paediatric HIV adherence counsellors' to support the MoHCW's projects.

Youth groups and vocational training

"Through the Zvandiri youth group we have learnt so many lessons, like career guidance and C.V. writing. Africaid provided for us."

- Participant in a focus group discussion of beneficiaries, a youth group member, (20 years old).

When the Zvandiri children turn 18, they take the next step and join the Zvandiri youth group. This currently has a membership of about 50 young adults between the ages of 18 and 22 years. Their major challenge is finding a way to earn a living. This is difficult enough in Zimbabwe, given its current economic challenges, but often these youth have the added disadvantage that their education has been interrupted by ill health. Most of the youth group members therefore do not have the training that would help them to obtain formal employment. Zvandiri finds opportunities for the youth to gain the experience and training that will benefit them in their search for jobs. Some of these opportunities are listed below.

Vocational courses

Zvandiri has supported the youth to attend vocational courses. So far, they have funded youth to be trained as hairdressers, nurse aides and first aiders. In the words of one of the youth who has benefited from such training, after he was asked what it was that he liked about Zvandiri:

*I like everything about Zvandiri - EVERYTHING!
Right now I like the dancing and the first aid training course.*

- Member of the Zvandiri Youth Group, (19 years old).

Youth editorial team

Another way to train youth is to get them involved in apprentice-type activities or attachments. During their visit to Zvandiri House, the documenting team met the child-led editorial team that, with the help of a local journalist and a graphic designer, had been given the responsibility of producing the monthly newsletter called Zvandiri News. Before now, the newsletter was produced by the Africaid team, although it contained articles written by the children. The teenagers in the Editorial Team were receiving training in conducting interviews, writing articles and newsletter design and layout. The documentalists were able to view the newsletter in its early stage of production. It was full of interesting information, stories by the children and colourful graphics and pictures. The first edition was to be produced in October 2009. By the end of the year-long attachment, the youth involved would be better prepared to look for work in this field.

Dance group

"I had a passion for dancing and I just thought it was to be a dream until Zvandiri put that dream into reality. I felt so fulfilled when the reality of dancing came into existence.

I thank Zvandiri for making the star in me."

- Zvandiri dance group member, (19 years old).

The youth group is also providing 15 of its members with the opportunity to be trained by the dance group, Tumbuka. Tumbuka is a world-renowned, Zimbabwe-based dance company. The Zvandiri dancers meet once a week at the National Ballet and recently they gave a very successful performance before an international audience. It is uplifting to hear the personal stories of these dancers, several of whom were quite ill until recently.

Peer counsellors

As already mentioned, some of the youth have been trained as child counsellors for the CASP. They are eloquent, dedicated young people with the knowledge and experience that come from living with HIV themselves and having benefitted from the psychosocial support offered by Zvandiri. They were initially given a week of attachment training at Newlands Clinic, followed by a week of counselling training at Zvandiri House. Their role is then to provide daily community-based counselling and support to children facing difficulties with adherence to their ARVs. The peer counsellors have been welcomed into the clinics by the City Health Department and they are working together with clinic staff to identify and counsel children struggling with adherence. Below is an excerpt from a weekly report given by a CASP peer treatment buddy:

"What a great week. Had our usual meetings, that's when I discovered that one of our communities needed support and thought of helping out...so we visited Warren Park community. How exciting it was with a lot of challenges as well as a good working environment. Taught some kids on adherence. Had a great time with small kids. The Soldier Game is proving to be a success as many lessons about HIV and AIDS are easier to understand."

- CASP peer treatment buddy.

Research assistants for Regai Dzive Shiri

Zvandiri has also contributed to the Regai Dzive Shiri research by providing youth research assistants. These youth research assistants collect data from their peers using a computerised, touch screen system. Not only will the information provided by RDS be useful for Zvandiri, but its youth have gained important skills through their attachment to the project.

Zvandiri House: one-on-one counselling and more

Zvandiri House provides a warm, friendly atmosphere for children and adolescents. There is a trained counsellor in a private office available for one-on-one counselling sessions. There is also a small library with relevant HIV literature and a comfortable veranda on which to sit and meet friends. The garden is also available to the youth, who play ball games there, or just relax in the quiet shade. Many of the youth come from difficult home environments so the quiet, safe space offered by Zvandiri House provides essential respite for them.

Educational material development

When trying to educate and share information around the issues that arise when youngsters are living with HIV, the technical information must be packaged in such a way that it can be easily understood, since children and young people have relatively little knowledge about their bodies and disease processes. In addition, the information that needs to be imparted is often complicated from a social or relationship point of view; for example, how does one address the issue of discrimination with a young child? The staff at Zvandiri House are always on the lookout for new, effective ways to educate and share information with their young members. When the resources are not available, they simply devise their own. Two innovative examples of resources they have developed are: a book entitled *Our Story*; and *The Soldiers Game*.

Our Story

In 2006, Zvandiri collected the stories and testimonies of several children and put them together in an illustrated book called *Our Story* (See Figure 8). After an initial print run funded by Maruva Trust, the United Nations Children's Fund (UNICEF) funded a second print run and a national tour of HIV paediatric sites. During this awareness raising tour, the Zvandiri children acted as child ambassadors and the *Our Story* books were distributed. In the words of Margie Pascoe, "There is nothing more powerful than a child ambassador". In the interviews with those children whose stories were included in the book, their pride in being able to say "This is our book. We wrote it", was tangible.



Figure 8: The front cover of *Our Story*

The Soldiers Game

Knowledge is power. Understanding a disease that affects oneself is an important step in dealing with it. However, to fully understand HIV and AIDS requires a relatively detailed understanding of the biological aspects of the disease, such as the way the immune system works and the way that antiretroviral medicines (ARVs) act to control the infection. The Zvandiri team came up with a novel way to put this information across to children by developing The Soldiers Game (See Figure 9). Initially conceived in *Our Story* as a tale of soldiers battling HIV (the soldier is a striking Ndebele warrior), The Soldiers Game was later developed as cards or, alternatively, beaded wire as used at Newlands Clinic. The components of the game include soldiers (the T4 cells), red balls (virus), blue balls (drug resistant virus) and three-sided shapes (ARVs). The Soldiers Game is a fun, non-threatening way to explain to children how the virus works.



Figure 9: OVC play The Soldiers Game with cards



Figure 10: OVC play The Soldiers Game with beaded wire figures

4.2. Elements of Good Practice

Zvandiri scored an admirably high 92% in the scoring exercise. It therefore is classified as a Good Practice.

Effectiveness

"At Zvandiri, whatever is planned, gets done."

- Participant in a focus group discussion of programme implementers, a support group leader, Newlands Clinic

The visit to Zvandiri allowed the documentalists to witness first hand the effectiveness of the organisation. From the youngest child interviewed through to top government officials and funders, people shared stories of the success of the organisation (see section on success stories).

- The Zvandiri project has a sense of community ownership and community participation; the beneficiaries (children) of the project have seen and express their appreciation and the value they find in being part of the Zvandiri project. The various facets of the project such as psycho-social support and vocational training add to the well being of the children as well as educating them on HIV and treatment issues. Children have been trained to be peer counsellors and this has proved very useful as new children joining the group find it easier to cope with their situation. These children have no difficulty identifying with the Zvandiri project.

*“Zvandiri helps kids build self-esteem and to live positively.
I am now more than happy, but when I first joined,
I had lots of questions running through my heart. Zvandiri
gave me the answers to my questions
and helped me get through the difficult times. In Our Story, we wrote our
stories in our own words. So Zvandiri has empowered us in many ways.”*

-Participant in a focus group discussion of beneficiaries,
a youth group member, (21 years old).

- It is clear that membership of Zvandiri has given the children confidence as well as enhancing their life skills and ability to cope with life's knocks.
- The constant feedback provided to the programme's management as a result of the participatory management style ensures that the needs of the beneficiaries are always at the forefront and that programmes can be adjusted as the need for change is identified.
- The responsiveness of Support Group Leaders to new policy measures on topical issues also ensures effectiveness. The fact that such policies are established after open debate and agreement on the final organisational position also ensures that policies are effectively communicated to beneficiaries and other stakeholders.
- One statistic that gives an important measure of Zvandiri's effectiveness is that they have a retention rate of about 85%. This means that only 15% of the children who have joined Zvandiri have, for some reason, dropped out. Furthermore, unfortunately, many of the children who make up the 15% were lost due to death.

Zvandiri has also implemented an effective monitoring and evaluation system which ensures that feedback is incorporated promptly and effectively, as well as that available funding is used to maximum advantage. Monitoring and evaluation is an essential aspect of ensuring an organisation's effectiveness as it identifies the gaps and inefficiencies in the implementation of the intervention.

Ethical soundness

“I admire Africaid. They have children on their Board. This is child participation in action. In all their activities, they are very aware of the rights of the children.”

- UNICEF focal person.

Because of the discrimination that children often experience if they are living with HIV, as well as the special concerns that come with dealing with children, Africaid has many ethical issues to consider.

Some of the strategies Africaid uses to ensure ethical soundness include:

- **Significant child participation**, ensuring that the organisation only carries out activities that the children feel happy with. The depth of this participation is evident in the way that the children have made some important, organisational decisions. For example, the children decided that only children living with HIV could join the organisation.
- **Strict adherence to confidentiality**, such that, for example, Zvandiri does not widely advertise itself, and membership is through referrals from other members living with HIV or through the medical system. This was a clearly expressed requirement from the children, who wanted Zvandiri to ensure confidentiality by avoiding having strangers walking in who might recognise them.
- **Parental involvement** in the organisation and in any communications with the children. Ensuring signed consent forms for the children's participation at Zvandiri by parents or guardians.
- The insistence that only **professionals trained to deal with children are given the role of support group leader** and, further, monitoring and assessment of these leaders to ensure that any who are not coping with their position are replaced.

- Careful attention is paid to **transparency and communication**, for example, providing relevant ministries with monthly reports and copies of training materials.
- **Development of Zvandiri policies** on controversial issues ensures that all the support group leaders are giving the same, thoughtfully prepared positions.
- **Bringing the leaders together regularly** and training them on the recommended way to present educational content, so that there is consistency in the information delivered. Training sessions are held on the first Saturday of every month. Recent topics included: how to identify malnourished children; how to teach children about good nutrition; and the use of cotrimoxazole.
- **Willingness to seek advice from other professionals** on issues outside their skills area, for example, Zvandiri has previously contacted the children's advocacy organisation, Childline, for help on dealing with child abuse.
- Commitment to equality; all children, no matter their gender, religion, ethnicity or ability, are welcome at Zvandiri.

Cost-effectiveness

How much does a dose of love cost? Fortunately, nothing!

However, there is a cost – both financial and in terms of time – in getting the right people together to ensure that the children can receive the psychosocial support that they need. By being careful to select staff with the right qualifications, attitudes and experience, as well as by applying a standard training programme, Zvandiri ensures that staff turnover is low and that job satisfaction is high. This contributes to the programme's cost effectiveness. Because Zvandiri is not providing materially for the children, but rather socially and spiritually, its overheads are low compared to many other organisations. This makes it remarkably cost effective. Initially, the organisation survived on the goodwill of only a handful of concerned individuals.

Zvandiri's integrated approach also ensures cost effectiveness. The children wrote their own story and are now producing their own newsletter; in many organisations these tasks would be done by 'experts' or consultants. The young people are becoming peer educators and gaining new life skills at the same time.

Zvandiri project uses already existing building structures to implement some of their activities, among these are the Warren Park Community hall which is used to hold community support groups. This is cost effective for both the organisation and community in that the organisation does not have to begin construction of new structures. Community members do not have to travel long distances to attend support group meetings, hence there is effective use of time and resources. The organisation owns their office premises and do not have to worry about rentals.

Relevance

The way that Zvandiri ensures its relevance to the children, through a strong focus on child participation, has already been mentioned. That it is relevant is made clear by the fact that it was originated when the urgent need for psychosocial support for children living with HIV was identified by health practitioners working with children living with HIV. In the interviews, there was complete agreement amongst both beneficiaries and key informants that the organisation's activities were hugely relevant to their needs. As one child said, "I met children who were positive like me. That was when I realised I was not the only one who is living positively." What more evidence of relevance to their beneficiaries can there be, than to help a child in emotional pain and isolation meet other children in the same position?

"At first, I thought I was in darkness. I used to get sick all the time. I thought I was going to die, because in those days I did not have hope that I could live a long life. I met children who were positive like me. That was when I realised I was not the only one who is living positively... I was like an unprotected flower with yellow leaves due to lack of support. I am now glowing with life and happiness because I have got help and support from Zvandiri".

-Zvandiri beneficiary.

This statement is indicative of the relevance of the Zvandiri project as it is making a difference to children living with HIV. It is bringing about positive change that increases the children's life spans, as well as contributing to improving their quality of life.

The psychosocial support adds to the relevance of the Zvandiri project as it provides a sense of belonging for the affected children. The vocational training programme also facilitates children acquiring life skills that they can use to support themselves for the rest of their lives.

Zvandiri also has a responsibility to be relevant to Zimbabwe Government policy and in this its relevance is also not in question. The project's activities are directly related to the Zimbabwe National Action Plan for Children (NAP, 2004) strategic areas for OVC, with special reference to the section headed "Psychosocial Support and Health". For example, as suggested by the NAP, Zvandiri is committed to child participation, education on ARV adherence, protecting children's rights and providing extra curricular activities, such as life skills and vocational training.

Zvandiri also fits well into the Zimbabwe National HIV and AIDS Strategic Plan (ZNASP). Their activities are relevant to the ZNASP sections headed; "Prevention of New Infection"; "Treatment and Care"; and "Mitigation and Support". Zvandiri closely follows the ZNASP guiding principles, for example, ZNASP encourages a participatory approach (meaningful involvement of PLHIV) and stresses the importance of assisting vulnerable groups, as well as taking cognisance of gender issues, evidence-based strategies and international goals and principles (ZNASP, 2006).

Replicability

The speed with which Zvandiri grew from a single support group to over 20 groups is evidence that it can easily be replicated. Replication is simplified because the material requirements of the support groups are minimal and the methodology is simple and easy to follow. Zvandiri is currently working on what it calls the Zvandiri Model. This outlines its main characteristics and will facilitate replication. Already, many clinics have successfully replicated the Zvandiri support groups for themselves.

Innovativeness

Zvandiri has been highly innovative in a number of ways, for example:

- It was the first organisation in Zimbabwe to start a programme of psychosocial support for children living with HIV. The inclusion of adolescents was particularly novel, as this group has tended to be overlooked.
- It has developed its own, unique, training and edu-taining materials such as the book, *Our Story*, and *The Soldiers Game*.
- It has taken the idea of child participation further than most organisations, even to the extent of making a child representative part of the Zvandiri board, and training youth as adherence counsellors.
- The use of memory books and art as methods for helping children to deal with bereavement is well known, but Zvandiri also uses needlework, such as tapestry and cross-stitch to achieve a similar goal. This has the added advantage of giving the children sewing skills that could be expanded into livelihood skills later in life.

Zvandiri staff achieve their innovativeness by seeing the gaps in care and support for children and adolescents living with HIV and acting to fill them. They identified the need for psychosocial support and acted to address it. There was a lack of HIV training materials for children, so they made their own.

Sustainability

There are many ways to look at sustainability. One is to consider whether the organisation will be able to continue as it is. Another, is to consider if it would continue if existing funding was stopped. In terms of the first criteria - continuing as it is - Zvandiri is ensuring that it remains popular with funders by carefully following and meeting donor requirements. These include ensuring their relevance to their beneficiaries, good management, transparent expenditure and sound ethical practices. As for continuing should funding cease, Zvandiri has also emphasised the training of peer educators who will be able to carry on with the work on their own, or establish new organisations to provide psychosocial support. In addition, as the children grow older, Zvandiri has grown with them, developing income generating projects, training them as peer educators - all low-cost processes that are likely to ensure the sustainability of the programme for generations to come. Also, Zvandiri's past experience of managing to function on very little funding suggests that it would continue even if funds suddenly became unavailable.

The organisation also plans to capture data via a computer package, such as PASTEL, to improve its accounts management. Having ready access to financial information through an accounts management system potentially improves sustainability because it ensures correct use of funds and assists with planning and monitoring activities. It should also reassure potential donors that funds are being appropriately used and the necessary financial reports can be readily made available.

4.3 SAfAIDS' OVC-specific elements of Good Practice

*"Kids just stand up and say to a crowded group. Look at me.
Do I look sick? Having HIV is not all that you are."*

- Participant in a focus group discussion of programme implementers, Newlands Clinic.

Internationally, there is some agreement about what good quality OVC interventions in southern Africa should look like. Not all organisations will necessarily achieve all the needs of OVC, but Zvandiri appears to be a model that achieves a large number of them. For example, Zvandiri supports home-based care of OVC, although it also works with orphans in institutions, such as the Emerald Hill Orphanage. It supports families and communities in their response to OVC through its presence in the communities (such as the community halls) and through its engagement with parents and guardians and its home visits. Zvandiri engages broadly with other community services, such as clinics, and also networks with other relevant organisations, such as the MoHCW and Childline. Zvandiri links its efforts to care for OVC to efforts that deal with HIV prevention, by providing training for the children and adolescents on infection and re-infection. Zvandiri also caters for bereavement, both for children whose parents have already passed away and for children whose parents are currently terminally ill, for example, through their use of memory books. The psychosocial and developmental needs of OVC are well taken care of, since addressing these needs is the main function of Zvandiri.

Finally, perhaps the most striking characteristic of the Zvandiri children is their general state of well-being. They are happy, confident and refreshingly open. The atmosphere at Zvandiri House is reminiscent of a loving, safe home. The children run up to the staff and give them warm-hearted, welcoming hugs, which are affectionately reciprocated. This is perhaps the greatest testament to the claim that Zvandiri is indeed a Good Practice.

Recently, the Zvandiri management team have put together their lessons learned to devise a model of psychosocial support (PSS) that they are calling the Zvandiri Model.

4.4 Success stories

In the interviews, many success stories were described. Below are just four examples:

The girl who could not walk

A Zvandiri support group was being conducted in a hospital ward. A young girl was carried to the support group on her grandmother's back, because she was too weak to walk. The support group leader wondered, "Shouldn't this child have remained at home?". However, because there were beds in the ward, the child was able to lie down and to participate in the session. Since then, the girl's health has improved vastly, thanks to ARVs. She is now strong and jovial. She often recalls that first day more than two years ago, when she attended the Zvandiri support group. "Do you remember, my first day?" she asks. Her story has become a great source of hope for new members.

The boy who broke down

A boy, aged 14 years old was told that he was HIV positive. He thought he would die and that no-one could ever love him. He thought that he would be hated by everyone. When he came to the support group he was "a real mess". That was on a Saturday. By the Monday, "He was a different boy". He had gained strength from meeting the other children and had realised that he did not have to die.

The mother who wouldn't tell

A boy living with HIV had been receiving treatment for three years at the Newlands Clinic. However, his family were very afraid of the HIV label and his mother, a banker, refused to tell him of his status. She told him that the tablets he had to take were vitamins. One day, the boy said, "I am not going to take vitamins anymore, look how strong I am!" In the end, his mother agreed that he had to be told, but could not do it herself. The doctor had to tell him that he was HIV positive. Afterwards, he sent for his mother, and said, "Mom, it is not the end of the world. I have one question. Why did they have to tell me, not you?". This boy, with the support of Zvandiri, has broken the stigma of HIV in his family. Although he is very short, permanently undersized from the effects of HIV, he is confident and happy and has become an amazing advocate for people living with HIV.

In the words of a Zvandiri child

"At first, I thought I was in darkness. I used to get sick all the time. I thought I was going to die, because in those days I did not have hope that I could live a long life. My life was full of misery. I was in pain at that time. But when I joined Zvandiri support group I saw the light. I never thought that I would find joy and happiness in Zvandiri support group. I met children who were positive like me. That was when I realised I was not the only one who is living positively. I once had a wound but it was healed. I was shown and given love. Now I am living a happy life. Now I am taking my ARVs. God has done miracles in my life. And also by joining the support groups I was taught many things. I learnt lots of experiences.

I was like an unprotected flower with yellow leaves due to lack of support. I am now glowing with life and happiness because I have got help and support from Zvandiri".

The fact that child support groups have already been established under the auspices of the City Health authorities and in the hospitals, as well as by another leading international NGO are all tributes to Zvandiri's success and the esteem in which it is held by those working in the field. In time it is likely that PSS groups for children living with HIV will be an accepted part of a national programme.

4.5 Challenges

Despite its evident success, Zvandiri has faced several challenges along the way. These include:

- There is still a great deal of stigma attached to being HIV positive. This has been a challenge, especially to the children, many of whom have not disclosed their status to the broader community. It is an added consideration for the Zvandiri staff that their activities must never jeopardise their members' confidentiality. However, as the children grow more confident and begin to act as peer educators, this situation will clearly change. Already children have the confidence to stand up in public and say "look at me – do I look sick?"
- Zvandiri provides only psychosocial support. Sometimes it is very hard to stand by and watch the hardships that the children suffer due to a lack of resources, and be unable to help. Under normal circumstances, referrals could be made to Social Welfare, but unfortunately this government department does not have the resources to provide this assistance at present.
- Initially, funding was in short supply. However, recently, Zvandiri has been able to find adequate funding.
- The process of registering Africaid as a PVO took much longer than expected. This affected both access to funding sources and the credibility of the organisation to potential international partners

4.6 Lessons learnt

I have learnt that a child who comes depressed will one day put a smile on its face. A hug goes a long way. It is not about just talking, it's about love – love from the support group leaders – it's about being in a family and having something to look forward to.
–Support group leader.

Being HIV positive does not have to be a disability. These children are full of life, multi-talented. Sometimes they are wise beyond their years.
– Support group leader.

Some of the lessons learnt included:

- Meaningful involvement of children in projects that affect them helps ensure the effectiveness and sustainability of projects
- Great things can be achieved from humble beginnings. One does not need a lot of money to offer the service of psychosocial support. Ordinary people with a dream really can make a difference and make their dream a reality
- It seems that most of the implementers, when asked about the “lessons learnt”, wanted to share that their greatest lesson was that there really was hope for these children. Working in the support groups has changed their lives too
- It is important to follow protocol carefully, especially when dealing with children. The organisation is now benefiting from the initial hard work of setting up transparent reporting systems and liaising with MoHCW officials, thereby ensuring trust amongst the stakeholders.

4.7 Way forward and conclusion

It should be noted that Africaid's growth and success have come at an extremely difficult time in Zimbabwe's socio-economic and political situation. This makes its situation even more commendable and points to the clear need in Zimbabwean communities that the organisation has filled. Had the times been more normal, it is probable that Zvandiri would have been even more successful and its philosophy adopted more widely and more quickly.

Because of its success, Zvandiri is now being called on to expand its activities. As a representative from UNICEF said, “They are becoming a national programme”. For example, Zvandiri has recently obtained funding to set up support groups in Marondera and it will be assisting the MoHCW to train their peer educators.

Zvandiri is an inspiration. The staff members have used their passion for the well being of children living with HIV to create a safe environment for those children. They have been rewarded with empowered, emotionally strong children, who are full of hope and who are able to take responsibility for their own adherence to life-long medication.



5. Kapnek Trust - Early Childhood Development (ECD) Centres

5.1 Programme start up and description

Jimmy Kapnek was a magnanimous, far-sighted man who had made his fortune in mining. He wanted to use his wealth to contribute to the development of the country. Therefore in 1910, he initiated what eventually became the University of Zimbabwe and was also instrumental in setting up the medical school there. Following his death in the 1960s, the Kapnek Trust was set up. With the advent of HIV, the Trust decided to divert resources to understanding and treating the impacts of HIV. At this time, the Kapnek Trust contributed significantly to HIV research in southern Africa. Unfortunately, by the 1990s, the Trust no longer had sufficient funds to continue as it had.

Rather than stop functioning altogether, the remaining Kapnek family members and the Kapnek Board, based in California, USA, decided to carry on the Kapnek legacy. They turned to donors for help with funding. A key moment in the story of the Kapnek Trust occurred in 2000, when a grant was received from USAID to establish Prevention of Mother to Child Transmission (PMTCT) services. It was also at this time that the current head of Kapnek Trust, Dr. Greg Powell, joined the organisation. As a paediatrician, he brought with him his special interest in children's rehabilitation.

Consequently, after 2000, the Kapnek Trust took on a new identity, but the themes of education and health remained the focus of its activities. When considering how best to help Zimbabwe, aside from the PMTCT aspect of their work, the management of the Kapnek Trust felt that a significant impact would be made through the education of pre-school children – a particularly vulnerable group. The aim was to provide 'respite centres' for the children and their caregivers. These centres would give the children food, professionally monitor the children's health and provide them with the mental stimulation they needed to achieve their optimum potential. Any children with disabilities would also be provided with rehabilitation therapy. Additionally, the parents themselves would be given training to help them understand the importance of education for their children (including HIV education), birth certificates, sound health and nutrition.

The Kapnek Trust Early Childhood Development Centres started in 2004, in a small way, in Zvimba (see Figure 1). A participatory process of engagement with the local communities led to the setting up of the first three ECD centres. These were established wherever there was space, at times even under a tree. Coincidentally, around this time the Ministry of Education, Sports and Culture (MoESC) introduced preschool (ECD) classes (called Grade 0) in primary schools. This opened up the opportunity for Kapnek Trust to assist the MoESC in introducing ECD into the schools.

After successful negotiations with the MoESC, Kapnek Trust identified derelict classrooms in the Zvimba primary schools and renovated them for use as ECD centres, though they remained within the jurisdiction of the MoESC management structures. Kapnek Trust offered training to school head teachers on the need for ECD centres and facilitated the setting up of pre-school management committees. To date, 36 schools in Zvimba have a Kapnek Trust-supported ECD centre.

The Kapnek Trust made a decision early on not to treat orphans and vulnerable children differently from other children. In fact, as a head office staff member of Kapnek Trust pointed out, technically, in such a resource-poor setting, all the children are OVC. In some of the schools, 75% of the children were orphans, having lost one or both parents. Such is the devastating effect of HIV on the families in Zvimba.

The Kapnek Trust ECD programme carries out, or facilitates, the following activities: renovation of derelict classrooms; parent/guardian education; in-service training for ECD paraprofessional teachers; donation of grade one classroom resources; payment of school fees, text book donations, and provision of playground equipment; it encourages the establishment of community-based Child Protection Committees (CPC); carries out supplementary feeding and routine health care; and ensures that children obtain birth certificates. These activities are described in detail on the next page.

Renovation of derelict classrooms

“The children at Kapnek have a classroom. Shelter is one of our human rights. They are protected from the other kids in the environment. Without a classroom, children do not feel secure. They NEED this component.”

– UNICEF focal person.

The renovation of classrooms is a particularly busy part of the Kapnek Trust suite of activities and this was especially so in 2008, when a total of 15 classrooms were renovated. Figure 11 shows one of the early Kapnek Trust classrooms. The trademark colour of the classrooms is pink. There is a high level of community involvement in the construction work.

For example, in one instance the community provided the labour to dig a 5 x 5 x 3 metre hole for a large pit latrine in just one week. The parents also provide river sand, bricks, firewood and accommodation for the builders.

Ensuring children have birth certificates

Having a birth certificate is a basic human right. Kapnek Trust discovered that the main obstacles to children obtaining birth certificates were: lack of awareness of their importance; lack of knowledge on how to get one; and the challenges of obtaining transport to travel to the relevant government facilities. In collaboration with the MoESC, Kapnek Trust has worked hard to ensure that all the children of Zvimba have a birth certificate. Their role is simply to assist the parents to obtain the certificates. So far, about 400 children have obtained their birth certificates with Kapnek Trust’s assistance.



Figure 11: One of the first ECD classrooms renovated by Kapnek Trust

Education interventions

The Kapnek Trust Early Childhood Development (ECD) programme takes a holistic approach to education and tries to provide education to all those involved in the children’s lives, from head teachers and ECD teachers themselves, to parents and guardians. It also acknowledges the importance of the availability of teaching resources and playground apparatus. The main education-related activities of the programme are detailed below.

In-service training for ECD paraprofessional teachers

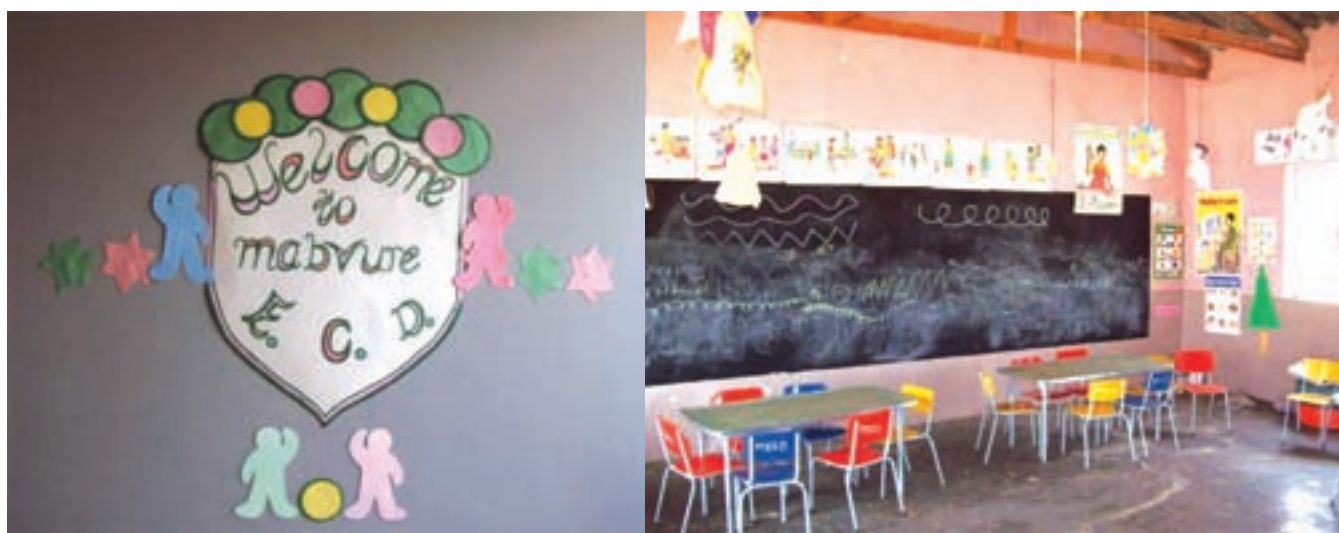


Figure 12: Mabvure ECD classroom

Kapnek Trust has hired two ECD consultants to carry out five training sessions per month. Training includes basic ECD concepts, such as how to develop and make educational materials and how to teach through play. Most of the ECD teachers are volunteers from the community, for example grandmothers. Thanks to the skills gained in these workshops, ECD classrooms are bright and cheerful, with walls covered in interesting and eye catching visual aids (see Figure 12). The ECD teachers receive token stipends from the School Development Committees because, as teachers without diplomas, the MoESC is not in a position to remunerate them.

Parent/guardian education

*"The parents are very interactive, very curious.
They debate amongst themselves."*

- Head office member of Kapnek Trust.

Well-attended, monthly parents' meetings are held at each of the ECD centres. Here, caregivers can learn about ECD-related issues such as parenting skills, nutrition, family planning, prevention of HIV infection and re-infection, school-home relations, immunisation and record keeping, child development and the prevention of mother-to-child transmission of HIV. The parents are involved in setting the curricula for these training sessions and learn about the topics that they feel are most important. A parenting training manual has been developed that incorporates all the topics that are being taught. This manual was developed after widespread consultation with all the relevant stakeholders and it is hoped that it will be utilised as a guiding tool long after Kapnek has left.

Grade 1 classroom resource donations

The ECD classrooms, filled with books, paper, pencils and learning aids, are noticeably different from the Grade 1 classrooms which have very little in the way of equipment. As a result Kapnek Trust felt it was necessary to reduce this gap and has since attempted to provide more resources to Grade 1 classrooms.

School fees

Any child who is not in school because their parents cannot pay fees is eligible to have their school fees paid by Kapnek Trust, using funding from a German donor. Currently, the Trust pays school fees for more than 3,000 OVC, both for primary and secondary education. School fees for physically challenged children are also paid by Kapnek Trust, despite these being more expensive because of such children's special needs. Figure 13 shows some of the school-going children being supported by Kapnek Trust.

Text book donations

Kapnek Trust has now supplied the schools in their programme with enough text books for the children to have one each. They no longer have to share a single text book with perhaps a whole class of children, as is sometimes the case in other rural schools. This has contributed to the increased pass rate for the grade seven classes. The MoESC personnel ensures that these books are well kept and are covered to ensure they are durable.

Figure 14 shows proud MoESC staff with the Kapnek Trust-donated textbooks they are about to distribute.



Figure 13: Children who benefit from Kapnek Trust school fees



Figure 14: Textbooks from Kapnek Trust, ready for distribution



Figure 15: Playground equipment made by the parents

Playground equipment

Parents are fully involved in the construction of playground equipment required under the Kapnek Trust project. In fact, Kapnek Trust provides only the basic carpentry training needed, along with some of the materials and the parents do the rest. In all the five schools that the documentation team visited, they were taken on a guided tour and the pre-school playground was always a highlight. Figure 15 shows some of the brightly painted, well-constructed playground equipment.

Community-based Child Protection Committees (CPC)

Kapnek Trust has also facilitated the establishment of volunteer, community-based Child Protection Committees (CPC), whose members include child representatives. The CPCs take on the task of identifying children who are abused, neglected, malnourished or physically challenged. They ensure fair distribution of any donated food or clothes. They identify children who have dropped out of school and act as advocates to their parents, to ensure that the children return to their studies. They also take child abusers to the police and have them charged for their crimes.

Supplementary feeding and routine health care

Every weekday, the preschool children at the ECD are provided with a nutritious high-protein (corn-soya blend) porridge meal and a drink of mahewu (malted sorghum). The mothers have a roster for volunteering with the feeding programme.

Kapnek Trust also provides transport for local clinic staff, ensuring they visit the ECD centres regularly to check on the children's health and administer immunisations. If required, children with particular physical challenges are also provided with special rehabilitation therapy, such as physiotherapy and with wheelchairs where necessary.

5.2 Elements of Good Practice

Below is the report from the Good Practice scoring exercise carried out by SAfAIDS on the Kapnek Trust ECD programme. The exercise resulted in an excellent score of 97% (Refer to Annex 2 for the Score Card). This means that the Kapnek Trust ECD programme is truly a Good Practice.

Effectiveness

"One mother came to cook every day for a whole year to show her appreciation of Kapnek."

- Headmaster, a Zvimba school.

"Their greatest success is their inclusion of the local community."

- Focal person, teacher, a Zvimba school.



Figure 16: Preschoolers attending an ECD centre in Zvimba

Kapnek Trust has managed to achieve the goals it set itself and has been rewarded with the community's admiration and support. Kapnek Trust is perhaps best seen as a capacity builder. It provides training and technical/structural support, the absence of which prevents communities from achieving their desire of education for their children.

The benefits of Kapnek Trust's intervention were clearly evident to the documenting team. The proof lay in the beautifully decorated and well-finished ECD classrooms, the happy, healthy children, the proudly presented text books, the integration of the physically challenged into the classes and the warm welcome that the team received from the school administration. One of the headmasters interviewed mentioned that there had been a large increase in school enrolments thanks to Kapnek Trust's activities, while another mentioned how Kapnek Trust had been a true 'God-send' during the period of spiralling inflation.

Ethical soundness

“Because of the way Kapnek have empowered others to run their programmes, we have seen great impact of their activities.”

– Remedial tutor, a Zvimba school.

Ethical soundness is largely a function of careful engagement with the communities, making sure that their needs are being met and that they are, in essence, in charge of the intervention which affects their lives and the lives of their children.

The documenting team could not fault Kapnek Trust on this point. For every activity, there was evidence of community involvement. This included regular meetings with the communities and a very close working relationship with the MoESC. Kapnek staff make it a habit to drop in at the MoESC offices every time they go into the field to give updates and to confirm with the authorities that everything is in order. Additionally, Kapnek Trust makes sure that its representatives are present at relevant stakeholder meetings, such as the monthly meeting of the District AIDS Committee.

Because Kapnek Trust has the policy of assuming that all children are vulnerable and all children get nutritional support, regardless of their HIV status, the issue of confidentiality is not of great significance. However, if for some reason it is necessary for someone to disclose their status, this is treated with the utmost professionalism.

In terms of gender equality, both men and women are present at all Kapnek Trust meetings and committees. Likewise, there is a fairly equal distribution of boys and girls in the ECD centres. However, there is evidence of gender division of labour along cultural lines amongst the parents and guardians, with men being more involved in construction projects and women more involved in cooking and child-care activities.

Although the primary focus of the ECD centres is on the preschoolers, Kapnek Trust also helps older children by providing text books and the payment of school fees. Indirectly, the parent training sessions also helped these older children by developing better caring skills in their parents.

Cost-effectiveness

“Our ECD centres are very cost-effective. We are here to support the Ministry’s activities.”

– Head office member of Kapnek Trust.

One of the ways to be cost effective, as the quote above implies, is to avoid doing everything by one’s self. Kapnek Trust reduces overhead costs by playing the role of supporter and facilitator. For example, rather than build classrooms from scratch, it takes pre-existing, unused, derelict ones and renovates them. Rather than bringing in its own clinical staff, it provides transport for government clinicians to visit the children. The parents and teachers themselves form the management committees, also reducing the staff budget. This allows Kapnek Trust to use its limited resources in high impact ways, for example, in the provision of food and text-books. Its training of paraprofessionals was another high impact investment, as it allowed these volunteers to deliver a high quality of service to OVC.

Another way that Kapnek Trust ensures cost-effectiveness is by running a ‘tight ship’. All expenditure is carefully monitored and requires head-office approval. The annual cost per child is USD24-30 and about only 15-25% of the budget goes to administration of the programme (depending on the donor requirements). A major cost area is fuel. To keep this low, project officers try to co-ordinate their visits, so it is often the case that just one vehicle at a time will travel into the field, perhaps carrying three staff members on different missions.

In terms of procurement, Kapnek Trust staff try to obtain good quality for a good price. To achieve this, they have developed a suppliers’ list and negotiated with many of their suppliers to give them a discount because of their charitable nature.

Another cost saving intervention is the use of interns in each department to do some of the work. This is a win-win situation; the interns get training and experience and the organisation gets relatively inexpensive labour. Kapnek Trust is audited annually. Significantly, due to the existence of the Kapnek Trust Fundraising Board in the USA, they carry out the exacting American audit process.

Relevance

Kapnek Trust is highly relevant in a number of ways:

- It supports the Ministry of Education, Sports and Culture initiative to bring preschool into mainstream education
- It has many points of entry into the ZNASP, for example: its in-service training teaches the paraprofessionals to provide psychosocial support to the children; it is providing nutritional support to the affected and infected; it is educating parents about issues such as PMTCT, infection and re-infection; it supports women's rights (for example, training on inheritance); and it caters for the marginalised through the identification of physically challenged children for rehabilitation
- It fits into the NAP for OVC by ensuring that OVC access all basic social services
- It is guided by the community itself, ensuring its continued relevance.

Replicability

The concept of Kapnek Trust's ECD centres is an easily replicable one. This is because, in theory, it is not highly resource dependent and throughout the rural areas of Zimbabwe (even throughout southern Africa), there are likely to be derelict classrooms that can be renovated.

The participatory processes involved in the construction of Kapnek Trust's ECD centres are also easily replicated. These include working closely with government authorities and involving the communities at each stage of programme initiation and implementation.

Innovativeness

Kapnek Trust is strikingly innovative. To begin with, it has the ability to creatively identify opportunities and then take full advantage of them. As an example, it was a significant creative moment when Kapnek Trust saw the opportunity to work with the MoESC to help develop the ECD centres. It was also a creative moment when they noticed the frequent occurrence of derelict classrooms at schools and realised that these could be converted relatively inexpensively into ECD centres. Another creative move was to realise that the skills were available in Zimbabwe to provide the children with many of their needs. For example, the nurses were already present at the clinics and government officers were already available to process birth registrations. What was needed was only the transport to get the relevant people to where they needed to go. Thus, an important function of Kapnek Trust has simply been one of providing logistical support and facilitation.

On another level, Kapnek Trust has shown innovativeness in the way it has engaged communities to make available the resources that children need for their education. Kapnek Trust rarely buys teaching aids. Instead, they have trained parents and teachers to make their own.

Sustainability

"Kapnek have taught people how to construct items such as toys, gym equipment and visual aids – so when they decide to leave us, we will be equipped to do it ourselves."

– Deputy Head, a Zvimba school.

One of the many benefits of using community participation is that it helps a programme achieve sustainability, as the community develops the skills to do the work themselves. Kapnek Trust is a good illustration of this kind of sustainability. Instead of developing dependence by bringing in ECD materials from outside, they have made use of local skills and readily available materials to develop home-grown equivalents of the materials found in any ECD classroom around the world. Their work with Government has also demonstrated to Ministry officials the great things that can be achieved with relatively little financial input. Recently, the MoESC decided that it should carry out the training of the paraprofessionals, one step towards them finding the confidence to take on this role. In essence, if Kapnek Trust is successful, it will work itself out of a job.

The capacity of the schools has been enduringly improved, in that the paraprofessionals have been trained in ECD. These teachers are also a source of inspiration to the other teachers. Certain structures have been set up which can be maintained, such as the Pre-school Management Committees and the Child Protection Committees. The classrooms themselves are lasting legacies which require minimal up-keep.

5.3 SAfAIDS OVC-specific elements of Good Practice

“The health of the kids is relatively good. Those children who do not attend the ECD clinics, perhaps they live too far away, look sickly in comparison.”

– A member of staff, Mpumba school.

Kapnek Trust is a model of international trends in caring for OVC. It is supporting home-based community-supported care of OVC. It has a dynamic, effective programme of support for families and communities in their response to OVC (such as training of guardians in child care, nutrition and drug adherence). There is demonstrably broad engagement with other community services and a strong commitment to networking. The communities themselves help identify those children in need of support, through the CPC. The gendered nature of childcare is recognised and, therefore, Kapnek Trust has training sessions on a variety of gender issues. For example, they recently ran a training session on the importance of protecting women’s inheritance rights. Strategies are also in place to tackle the psychosocial and developmental needs of OVC (for example, counselling training for caregivers is essential).

The general state of well-being of the children under the care of the organisation is reasonably good, despite the harsh environment in which they are living. The children are cheerful and ever ready to burst into song.

5.4 Success stories

Some success stories captured during the documentation process are as follows:

A small miracle

At one of the Kapnek Trust schools, the documenting team were introduced to a girl called Justine. She was born with Down’s Syndrome and when she first came to the attention of the school she was unable to speak or walk. Everyone thought she would never be able to do these things. However, thanks to the ECD programme and the special rehabilitation therapy that she received through Kapnek Trust, she is now able to do both. She is a very loving, happy child – mobile and communicative. In Figure 17 she is pictured with her mother



Figure 17: Justine with her mother

The advantage of being trusted

Kapnek Trust has made it a point to work in unison with the objectives of the MoESC. It sees itself as a volunteer extension of the Ministry’s work, rather than a stand-alone development organisation. The advantage of taking this line is that all the stakeholders in Zvimba have trust in Kapnek. Consequently, during the NGO ban, which was effected during the period of political unrest in 2008, Kapnek’s activities were largely unaffected, with the exception of the paraprofessional training, which was impacted by the blanket ban on public gatherings.

The Certificate of Good Practice from the Ministry of Education

Almost the first thing that happened after the documenting team had been introduced to the Kapnek Trust staff was that they were shown the Certificate of Good Practice that Kapnek Trust had received from the Ministry of Education. This certificate is prominently displayed on the wall of the Kapnek Trust Programmes Manager’s office. As an almost unprecedented gesture from the Ministry, it is a great honour and proof that Kapnek Trust has truly achieved its aims of supporting the Ministry’s goals.

5.5 Challenges

All organisations face some challenges along the way. Kapnek Trusts' challenges include the following:

- During the period of hyperinflation, when suppliers almost entirely stopped providing goods, Kapnek Trust had to be highly innovative, sourcing its materials regionally if necessary. They were able to negotiate the disbursement of their funding in United States dollars, which cushioned them from some of the negative effects of hyperinflation
- The newly formed basket fund for OVC had initial teething problems that resulted in some NGOs who had already been promised funding having to reapply and/or having their funding reduced. This has resulted in Kapnek Trust having a temporarily reduced cash flow
- The volunteer paraprofessionals are paid a very small stipend by the School Development Committee, which obtains its funds from the parents. However, most parents are too poor to pay their school fees and consequently these amazingly dedicated women have not received any remuneration for several months, yet they continue to come to work. However, they too face poverty and need to sustain themselves. Small as it was, the stipend made it possible for them to spend their time in the classrooms, rather than in the fields, growing food. If there is no financial support for them at all, they may be forced to stop work and return to their farming activities.

5.6 Lessons learnt

Some of the lessons learnt include:

- The importance of being flexible and acting decisively to take advantage of opportunities when they present themselves
- The value of working closely with both Government and local communities
- Organisational need to define their focus clearly, keeping it uncomplicated and easy to replicate and scale up
- Organisational dealing with OVC need to have a holistic approach, which takes into consideration the material needs of OVC, as well as their emotional and intellectual needs, enabling effectiveness of the intervention.

5.7 Way forward and conclusion

The Kapnek Trust's ECD centres in Zvimba are now well-established and are moving ahead with their own momentum, since they are a part of the school management team. This is one of the greatest marks of success for a development project, since it demonstrates the principle of sustainability. If, for some reason the Kapnek Trust were to stop their activities in Zvimba, these ECD centres should, in theory, be able to continue.

The achievements of the Kapnek Trust in Zvimba are remarkable. A whole generation of children in this area has benefited from their intervention. We can perhaps expect that these children will have greater chances of success later in life and that their achievements will contribute to the development of the nation and region as a whole.

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Annex 1: Interview guides

Tool 1: Interview Guide for Key Informants

EFFECTIVENESS

1. What is the purpose or aim of the project/programme?
2. How does the project/programme goal or aim relate or fit into the national HIV and AIDS strategic plan (ZNASP) and the National Action Plan for OVC?
3. What are the strategies to achieve the goal? (probe for implementation plans, services rendered and defined target groups – geographic and demographic catchments)
4. How are the project/programme services accessed by beneficiaries? (probe for clarity on community outreach plan or disbursement/distribution plan,)
5. What systems are in place to ensure effective implementation? (probe financial, programming, procurement, human resource allocation, equipment, staff development, skills transfer and project sustainability)
6. How does the project/programme approach integrate into other programmes i.e. inclusion of other services, multitasking? (to see if programme is vertical or not and assess multiplier effect)
7. How were project/programme priorities determined? (probe for information on needs assessments, community and other stakeholders involvement, is project addressing urgent needs of community?)
8. How is the community involved in the project/programme? (participation in planning, monitoring, implementation and evaluation– probe for information on mechanisms put in place to solicit for feedback from community groups – probe for other ways that community contributes to the project, assess project acceptability – social, political, cultural and religious)
9. How does the project/programme take into cognisance gender dynamics at community level? (probe for composition of structures, participation and beneficiaries)
10. How is the project/programme monitored? (ask for monitoring tools if any and frequency e.g. coverage, reporting forms, tally sheets, monitoring committees, quality assurance or quality bench marks)
11. How is the project/programme evaluated? (measurement of impact – probe for knowledge of main indicators and baseline information, frequency of conducting evaluations)
12. Who are the implementers of the project/programme? (probe for information on sectoral expertise amongst staff, volunteers, out sourcing as necessary, adequacy of staff, roles and responsibilities)

ETHICAL SOUNDNESS

13. How does the project/programme ensure inclusion of vulnerable groups? (probe for value statement on how interests of young people, women, children living with disabilities and children living with HIV are taken care of)
14. What policies are in place to ensure that the project/programme upholds and respects human rights? (probe for policy or consideration of confidentiality, informed consent and safety issues)
15. What policies are in place to ensure continuity of services? (probe for systematic weaning or phase out strategies, skills transfer)
16. What policies are in place to ensure equitable distribution of services? (probe for information on whether those with greatest need are accessing the service)
17. How is the project/programme audited and who does the auditing? (probe for transparency i.e. project/programme allowing for both internal and external programme and financial audits, frequency of audits)

REPLICABILITY

18. What are some of the success stories that can be shared?
19. What are some of the project/programme challenges?
20. What are some of the lessons learnt? And how have these learning points been used to strengthen the project/programme?
21. What plans are in place to scale up the project/programme? (to reach more beneficiaries or to have more impact on currently reached beneficiaries)

SUSTAINABILITY

22. How is the project/programme vision aligned to current trends? (national and regional trends, epidemic, economic, developmental – political correctness– MDGs, Universal access etc)
23. What is the funding pattern of donors? (basket funding, % of funding from local sources and donors)
24. How does the project/programme strategy ensure financial sustainability? (probe for information on fundraising strategies, user fees, community initiatives)
25. What do you see as the future of the project/programme?

INNOVATIVENESS

26. What do you think is the most unique aspect of this project/programme?
27. Ask for any other additional information deemed relevant but not covered in the questions.

*Introduce the purpose of the FGD, and get verbal consent. Assure FGD members that the information they shall share shall be treated anonymously.

EFFECTIVENESS

1. What is the purpose or aim of the project/programme? (goal, objectives)
2. How were you involved in the establishment of the project/programme? (conceptualisation, consultations, needs assessment, prioritisation of needs, relevance to needs, usefulness, timeliness of project/programme, planning)
3. What do you think are the benefits of this project/programme for you as women/men/children, young people and for your communities?
4. How do you view this project/programme? (is this YOURS, ownership, or imposed, or donor driven, or neutrally accepted because there is no choice)
5. How do project/programme services/activities cater for the needs of different age-groups, sexes, and social classes within your community?
6. How does the project/programme take into cognisance gender dynamics in your community? (probe for composition of structures, participation and beneficiaries – girls, boys, women & men, benefits)
7. How has access to project/programme services/activities been influenced by the economic or political trends in your community?
8. How are project/programme implementers working with you to determine project/programme needs to meet your needs?
9. How are you participating in the project/programme implementation and checking that the project/programme is progressing well (monitoring and evaluation processes)?
10. How do you share your feedback or feelings about the services/activities you are receiving, with project/programme implementers? How often?
11. How does your community contribute towards the services/activities that this project/programme offers? (cash, kind, other support, e.g. advice and networking)
12. Describe the process that takes place for community members to access the services and activities provided by the project/programme? (probing should be specific to the good practice you are documenting, this will measure how implementers are 'doing things' e.g. are human rights being adhered to, etc.)
13. What factors hinder children from accessing the services, or engaging in the activities that this project/programme is offering?
14. What would you like to be done in this project/programme, to be of greater benefit to your community?

COST EFFECTIVENESS

15. Are services provided in a timely manner?
16. Is there an increase in the number of children and families in this community whose lives have been changed as a result of benefiting from the programme?
17. Is there a positive life story that you can share with us?
18. The way the service is provided, is it cost effective? How can it be improved?
19. Do you find that the project has adequate personnel providing the service? (Numbers and skills)

RELEVANCE

20. What are the views of your traditional and religious leaders on this project/programme? (was project introduced to traditional systems, consensus sought, part of consultative process, commitment, support offered by traditional systems)
21. Are all the services provided necessary? If not which ones should be provided?

ETHICAL SOUNDNESS

22. Are your rights and others' respected in this programme, why?
23. In your opinion, is the distribution of services between men and women, rich and poor, married and unmarried, adults and children fair?
24. Is there transparency in the operations of this organisation?
25. Do you feel that the organisation and its staff are accountable to beneficiaries?
26. Are people treated with respect, and are their opinions listened to by programme staff?

INNOVATION

27. In your opinion, is this programme creative and innovative, different from other projects?
28. Can you share with us a story that demonstrates this innovation?

SUSTAINABILITY

29. In the absence of donor support, do you think this programme should continue? Why? (are there skills in the community? Is the community contributing to the programme in cash or kind?)
30. Is the programme well known to the community?
31. What are some of the challenges faced by yourselves in this programme and how have these challenges been addressed by yourself and the NGO?

*After adequate introduction and explanation of purpose of exercise, point out that interview may take up to one hour. There may be need to have some documents handy to clarify issues during or after the interview.

EFFECTIVENESS

1. What is the purpose or aim of the project/programme?
2. How does the project/programme goal (or aim) relate to, or fit into, the National HIV and AIDS strategic plan (ZNASP) and the National Action Plan for OVC?
3. What are the strategies to achieve the goal? (probe for implementation plans, services rendered and defined target groups – geographic and demographic catchments)
4. How are project/programme services accessed by beneficiaries? (probe for clarity on community outreach plan or disbursement/distribution plan)
5. What systems are in place to ensure effective implementation? (probe financial, programming, procurement, human resource allocation, equipment, staff development, skills transfer and project sustainability)
6. How does the approach of the project/programme approach integrate with other programmes i.e. inclusion of other services, multitasking? (probe to see whether programme is vertical, assess multiplier effect – ‘does one stone kill many birds?’)
7. How were project/programme priorities determined? (probe for information on needs assessments, community and other stakeholders involvement, is the project addressing the urgent needs of the community?)
8. How is the community involved in the project/programme? (participation in planning, monitoring, implementation and evaluation– probe for information on mechanisms put in place to solicit for feedback from community groups and for other ways that community contributes to the project, assess project acceptability – social, political, cultural and religious)
9. How does the project/programme take into cognisance gender dynamics at community level? (probe for composition of structures, participation and beneficiaries)
10. How is the project/programme monitored? (ask for monitoring tools if any and frequency e.g. coverage, reporting forms, tally sheets, monitoring committees, quality assurance mechanisms or quality bench marks)
11. How is the project/programme evaluated? (measurement of impact – probe for knowledge of main indicators and baseline information, frequency of conducting evaluations)
12. How is monitoring and evaluation data used? (frequency of use for project review, timely dissemination to relevant stakeholders)
13. Who are the implementers of the project/programme? (probe for information on sectoral expertise amongst staff, volunteers, out-sourcing as necessary, adequacy of staff, roles and responsibilities)

ETHICAL SOUNDNESS

14. How does the project/programme ensure inclusion of vulnerable groups? (probe for value statement on how interests of young people, women, children living with disabilities and children living with HIV are included)
15. How are human rights upheld or respected during establishment and implementation of the project/programme? (probe for policy or consideration of confidentiality, informed consent and safety issues)
16. How is continuity of services, support or care ensured after end of current funding cycle? (probe for systematic weaning or phase-out strategies, skills transfer mechanisms)
17. How is equitable distribution of services ensured? (probe for information on whether those with greatest need are accessing the service)
18. How is the project/programme audited and who does the auditing? (probe for transparency i.e. project allowing for both internal and external programme and financial audits, frequency of audits)

COST EFFECTIVENESS

19. How are project/programme resources distributed? (admin versus programme costs)
20. How is the service – cost measured within this project/programme? (probe for methods of tracking inputs, outputs in relation to outcomes so as to enable calculation of cost per client)
21. To what extent are available resources adequate to support delivery of project/programme services? (probe for adequacy of human and financial resources, equipment and supplies)
22. What are the cost saving and cost reduction measures of the project/programme? (use of low cost, improvised substitute, engaging volunteers for some of the services, does it have an increased financial burden on beneficiaries?)
23. To what extent does cost sharing take place in the project/programme? (user fees, payment of some of the services e.g. training, transport)
24. What is included in the minimum package of the service/s provided by the project/programme? (compare with the standard package policy for the country, procedure guides)
25. How timely is the delivery of services?

REPLICABILITY

26. How are project/programme activities and processes documented? (get copies of reports, case studies collected, documentaries, manuals, books, etc)
27. What are some of the success stories that can be shared to depict positive impact or influence of the project/programme services on beneficiaries?
28. What are some of the project/programme challenges?
29. What are some of the lessons learnt from this project/programme, and how have these been used to strengthen the project/programme?
30. What plans are in place to scale-up the project/programme? (to reach more beneficiaries or to have more impact on currently reached beneficiaries, quality & quantity)

INNOVATIVENESS

31. What do you think is the most unique aspect of this project/programme?
32. Ask for any other additional information deemed relevant but not covered in the questions above.
33. Share with us a success story that demonstrates the success of your programme.

SUSTAINABILITY

34. How is the project/programme vision aligned to current trends? (national and regional trends, epidemic, economic, developmental – political correctness- MDGs, universal access etc)
35. How is the project/programme marketed to stakeholders? (assess for active education and awareness building amongst stakeholders, language and medium used, are you getting the expected responses?)
36. How does the project/programme strategy ensure financial sustainability? (probe for information on fundraising strategies, user fees, community initiatives)
37. What do you see as the future of the project/programme?

Annex 2: Score Card (Based on the Good Practice Criteria)

SCORE CARD

Name of Project/Programme or Practice and Project/Programme implementing the practice

.....

	Variable	Data Source	No	Almost	Yes - definitely
			0 POINTS	3 POINTS	3 POINTS
A. RELEVANCE (2)					
1	Project/programme/practice complements the National Action Plan for Orphans and Other Vulnerable Children (NAP for OVC)	Literature/ Organisation Documents			
2	Project/programme results correlate with original objectives OR practice is in line with project/programme objectives	Literature/ Organisation Documents			
3	There is a sense of community/children's involvement and community/children's ownership with regard to project/programme or practice	Literature/ Organisation Documents			
4	Project/programme or practice seems to have clear and effective M&E procedures and impact evaluation systems in place, such that data is analysed regularly and results used to make meaningful adjustments to project/programme or practice	Literature/ Organisation Documents			
5.	Project/programme has well articulated goal/s and target/s and clear implementation plan/s and strategies are in place to achieve the proposed objectives. OR practice has a clear purpose and the reason for implementation of given practice in order to achieve programme/project goals is explicit	Literature/ Organisation Documents			
B. ETHICAL SOUNDNESS (2)					
6	The practice or project/programme activities are ethically sound, e.g. with regard to: respecting confidentiality; respecting and protecting the interests of vulnerable children; equitable distribution of resources	Literature/ Organisation Documents			
7	The practice or project/programme seems to be transparent	Literature/ Organisation Documents			
C. COST EFFECTIVENESS (2)					
8	Project/programme/practice is deemed cost effective with regard to cost of delivery of the project/programme services vs. available resources and degree of impact vs. input costs. OR: practice is deemed cost effective with regard to project/programme service delivery vs. cost of implementation of practice	Literature/ Organisation Documents			

	Variable	Data Source	No	Almost	Yes - definitely
			0 POINTS	3 POINTS	3 POINTS
9	Service delivery occurs in a timely manner. OR practice encourages timely delivery of project/ programme services or does not hinder service delivery in any way	Literature/ Organisation Documents			
D. RELEVANCE (2)					
10	The project/programme or practice takes into account specific contexts of target area/group	Literature/ Organisation Documents			
11	Project/programme or practice activities are relevant to community needs and are socially and culturally acceptable	Literature/ Organisation Documents			
E. REPLICABILITY (3)					
12	Project/programme can be replicated (in part or in totality) in similar contexts or adapted if necessary. OR practice can be replicated for use within similar projects/programmes or adapted if necessary	Literature/ Organisation Documents			
13	Practice or project/programme exhibits evidence of proper documentation in terms of goals, processes, methods, evaluation, cost and resources	Literature/ Organisation Documents			
14	Other groups and locations would benefit from the implementation of a similar project/programme or other projects/programmes would benefit from the implementation of a similar practice	Literature/ Organisation Documents			
F. INNOVATIVENESS (3)					
15	Project/programme or practice is unique/ new either in concept/ implementation strategy/ use of available resources/ reaching beneficiaries or is new to the country/ region or community	Literature/ Organisation Documents			
16	Project/programme or practice is contributing to the base of knowledge	Literature/ Organisation Documents			
17	Project/programme or practice approach and systems are scientifically/ and economically sound	Literature/ Organisation Documents			
G. SUSTAINABILITY (3)					
18	Project/programme activities are sustainable (skills/knowledge transferred) and long-term plans are achievable and in line with national trends as well as development patterns of OVC programming OR practice is sustainable and plans to continue practice are in line with national trends as well as development patterns of OVC interventions	Literature/ Organisation Documents			
19	Project/programme or practice is financially sustainable	Literature/ Organisation Documents			
20	Marketing and awareness building is evident and project/programme or practice is actively and appropriately marketed to stakeholders and funders	Literature/ Organisation Documents			

	Variable	Data Source	No	Almost	Yes - definitely
			0 POINTS	3 POINTS	3 POINTS
H. CRITERIA SPECIFIC TO OVC ORGANISATIONS (10)					
21	Is the intervention of choice (wherever possible) home-based community-supported care?	Concept papers; interviews			
22	Is there effective support of families and communities in their response to OVC? (such as income generating activities, training of guardians in child care, nutrition, drug adherence, etc)	Concept papers; interviews			
23	Is there broad engagement with other community services and networking?	Concept papers; interviews			
24	Is the stigma of HIV being addressed at the level of the community?	Concept papers; interviews			
25.	Did the communities help develop the criteria for identifying those children in need of support?	Concept papers; interviews			
26	Is the gendered nature of community care needs being recognised so that the intervention incorporates the needs of women?	Concept papers; interviews			
27	Do the interventions for OVC link to and include efforts that deal with HIV prevention?	Concept papers; interviews			
28	Do the responses to the problems encountered by HIV-affected children begin before parents die? (here, early identification is crucial)	Concept papers; interviews			
29	Are there strategies in place to tackle the psychosocial and developmental needs of OVC (for example, counselling training for caregivers is essential)	Concept papers; interviews			
30	What is the general state of well-being of the children under the care of the organisation?	Direct observation; interviews			
TOTAL number of questions (30)					
SUBTOTALS			x0	x3	x5
GRAND TOTAL (possible perfect score is 150)					
PERCENTAGE SCORE					

Scoring Scale:

75% and above: Good Practice – should be documented and shared widely

60-74%: Good practice - can be documented with slight adjustments

Below 60%: Potential Good Practice for future documentation

Annex 3: List of interviews and focus group discussions

Zvandiri, Africaid

Focus group discussions (9)

Description	Number of individuals
Implementers, head office management, director, programme officers, counsellors, monitoring and evaluation officer	6 female
Beneficiaries, CASP members, Zvandiri House	6 female
Beneficiaries, CASP members, Zvandiri House	4 male
Beneficiaries, dance group, Zvandiri House	5 male
Beneficiaries, children grades 3 - 7, Warren Park	3 male, 5 female
Beneficiaries, children, United Church of Christ, Mbare	2 male, 4 female
Beneficiaries, guardians, United Church of Christ, Mbare	4 female
Beneficiaries, children and guardians, Hopley Farm	9 adults; 12 children
Implementers, support group leaders, nurses, Newlands Clinic	4 female

Interviews (9)

Description
Finance officer, Zvandiri House
Warren Park support group leader
Focal person, UNICEF
Provincial AIDS district co-ordinator, MoHCW
Child representative on Africaid board
Provincial M & E officer, MoHCW
Chairperson of Africaid board, medical doctor, Newlands Clinic
Professional councillor, Epworth, MSF
Medical doctor, Epworth, MSF

Kapnek Trust, ECD centres

Focus group discussions (13)

Description	Number of individuals
Implementers, programmes officers, Kapnek Trust head office	5 male, 1 female
Implementers, finance managers for ECD centres	3 male
Kapnek Trust finance staff, head office	2 female
Stakeholders, Head, Deputy Head, Teacher in Charge, Mabvure	2 male, 2 female
Beneficiaries, parents and guardians, Mabvure	About 20 male and female
Stakeholders, Head, Deputy Head, Teacher in Charge, Focal Person, Goredema	2 male, 1 female
Beneficiaries, parents and guardians, Goredema	About 20 male and female
Acting Headmaster, Chairperson of the School Development Committee, Teacher in Charge, Focal person, Murombedzi	2 male, 2 female
Beneficiaries, parents and guardians, Murombedzi	About 15 male and female
Headmaster, Deputy Head, Teacher in Charge, Focal Person, Kawondera	2 male, 2 female
Beneficiaries, parents and guardians, head man, Kawondera	More than thirty male and female
Headmaster, Deputy Head, Representative from the School Development Committee, Teacher in Charge, Mpumbu	3 male, 1 female
Beneficiaries, parents and guardians	About 20 male and female

Interviews (11)

Description
Director Kapnek Trust, Milton Park
Kapnek Trust programmes manager, Milton Park
UNICEF focal person, Avenues
Zvimba district education officer
Zvimba remedial officer
Zvimba district administrator
Zvimba district social welfare officer
Ward 9 councillor, Goredema
Headman, Mabvure
Chairman, Child Protection Committee, Goredema
Member Child Protection Committee, Mpumba

Annex 4: List of relevant documents

Kapnek Trust ECD centres

- JF Kapnek, 2009. Budget Summary.
- JF Kapnek, 2009. Annual Review.
- JF Kapnek, 2008. Summary Report of Paraprofessional Training.
- JF Kapnek, 2008. Items distributed to ECD centres.
- JF Kapnek, June 2009. Child Protection Committee, Monthly Report.
- JF Kapnek, September 2009. Early access to birth registration report.
- JF Kapnek, Jan–March 2009. Birth Registration Statistical Report.
- JF Kapnek, 2009. Detailed Budget and Expenditure Sheet.
- JF Kapnek, Jan 2009. Health and Nutrition Assessment Workshop Report.
- JF Kapnek, Health and Nutrition Statistical Assessment Report.
- JF Kapnek, 2008. Murewa Children Follow-up Report.
- JF Kapnek, October 2008. Attendance at ECD Teacher Training Workshop.
- JF Kapnek, undated. Parenting Support Programme, Facilitator Report Form.
- JF Kapnek, August 2009, Parenting Support Programme Session Notes.

Zvandiri, Africaid

- Africaid. 2009. “Zvandiri” Programme Overview.
- Africaid. 2009. Community Psychosocial Support for HIV Positive Children and Adolescents in Zimbabwe.
- Africaid. 2009. Children First Progress Report.
- Africaid. 2009. “Our Story” Book Treatment Literacy Project.
- Africaid. August 2009. Support Group Leader Monthly Report.
- Africaid. Undated. Registration Consent Form and Biographical Details of New Members.
- Africaid. September 2009. Child Adherence Support Programme Weekly Reports.
- Africaid. 2009. Monitoring and Evaluation Information Capture Templates.
- Africaid. 2009. Database Page of Income and Expenditure.
- Maruva Trust. Web page available at: <http://www.africaid.co.uk/> [Accessed November 2, 2009].



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Signature of Witness

Date

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SAfAIDS Regional Office:
479 Sappers Contour, Lynnwood,
Pretoria 0081, South Africa
Tel: +27-12-3610889, Fax: +27-12-3610899
Email: reg@saf aids.net

SAfAIDS Zimbabwe Office:
17 Beveridge Road, P.O. Box A509, Avondale, Harare, Zimbabwe
Tel: +236-4-336193/4; Fax: +263-4-336195
Email: info@saf aids.net
Website: www.saf aids.net

