1. Introduction

1.1 Background
This report presents the process, findings, conclusions and recommendations of the independent Final Evaluation of the DanChurchAid (DCA) HIV/AIDS programme (2005-2009) in Zambia. The evaluation was conducted between September and November 2009 and involved the DCA Country Office and key implementing partners: the Churches Association of Zambia (CHAZ); Kara Counselling and Training Trust (KCTT); the Council of Churches in Zambia (CCZ), and the Girl Guides Association of Zambia (GGAZ). The geographic coverage of the programme was mainly in the Southern and Eastern Provinces but also nationwide through CHAZ partners.

The overall objective of the programme was “to contribute to increased claiming and upholding of the right to prevention, care, treatment, and knowledge for HIV/AIDS affected persons, especially the consequences for women, children and orphans as well as the negative impact HIV/AIDS has on the cultural socio-economic situation of the target population, alleviated”. The HIV programme had five (5) specific objectives as follows:

i. Risk-taking behaviour (sexual and non-sexual) for women, children and youth in rural and peri-urban areas, reduced;

ii. Access to counselling, care and treatment support, and socio-economic assistance for PLWHA, orphans and vulnerable children, increased and promoted;

iii. Churches and local NGOs’ role in the fight against HIV/AIDS and their ability to target key barriers in particular stigmatization, strengthened;

iv. DCA has been instrumental in facilitating increased capacity of partner organizations, in particular on rights based approach (RBA) and advocacy.

(Also see Annex 1: ToRs for details and programme objectives and accompanying indicators)

The overall DCA programme strategy was multi-pronged, multi faceted and responded to the HIV/AIDS challenge and associated problems in Zambia through the following thematic areas:

i. Primary prevention - which focused on awareness raising, increasing knowledge, and promoting behaviour change amongst the target population;

ii. Human rights, advocacy and gender issues – this dealt with stigma and discrimination, human rights and gender mainstreaming through education campaigns and advocacy at different levels;

iii. Home based care – this involved strengthening home based care services and facilities, and establishing community systems for provision of quality home based care services to people living with HIV/AIDS;

iv. Support for orphans and vulnerable children – this focused on addressing immediate and long term needs of children through general support that covered basic necessities, school requirements and income generating activities for households with orphans; and,

v. Capacity building of partners – which involved implementing rights based approaches, gender mainstreaming and advocacy.

In the period under review eight (8) key projects were implemented as follows: CHAZ Facilitating Community to Community Transfer of HIV/AIDS Responses (FCCT) (2005-2008); CHAZ Local Community Competence Building and HIV/AIDS Prevention in Zambia and Tanzania (LCCB) (2004-2007); CHAZ Pilot ART programme (2005-2008); CCZ Circles of Hope (2004-2007); 2nd Phase GGAZ AIDS Project (2005-2007); Umoyo Training Centre support for OVCs and female youths (2005-2007); Kwasha Mukwenu Women’s OVC support Group (2003-2006) and the Kara Children’s Day Care Centres (2006). In addition DCA implemented a number of cross-cutting capacity building interventions mainly in RBA, gender and advocacy. DCA also conducted and supported advocacy and networking activities of its partners.
1.2 Purpose and Methodology of the Final Evaluation

The evaluation purpose was “to assess the design, implementation, results, relevance, efficiency, effectiveness, impact and sustainability of the 2005-2009 HIV/AIDS programme, and determine whether DCA should initiate a new phase of its HIV/AIDS programme in Zambia for 2010-2013 and what changes should be made to the programme”. The evaluation’s three (3) specific objectives were to:

i. Assess the relevance, appropriateness and effectiveness of the current HIV/AIDS programme design and implementation. This objective included several sub-objectives and evaluation criteria which are outlined in detail in Annex 1: ToRs of this Report;

ii. Determine the quality and effectiveness of the DCA and partner programme monitoring and evaluation process;

iii. Examine DCA’s programme management and reporting capacity, including assessing whether the DCA country office allocation of resources to the PT4 programme is sufficient.

The evaluation design was based on a set of interview guidelines (frameworks) which structured and aligned the key evaluation questions to the ToRs, the programme’s LFA indicators and available sources of information. By and large the evaluation process was highly participatory and involved key programme staff, partners, beneficiaries and other stakeholders. In all, more than 170 people took part in the evaluation or were directly consulted. The evaluation work streams included: (i) in depth interviews with key informants – these were selected after thorough discussions with programme and partner staff and included DCA management and programme staff, Action by Churches Together and Association of Protestant Development Agencies (ACT/Aprodev) partner staff, partner project staff, beneficiaries and stakeholders. (ii) documentary review - a range of documents and reports were identified and reviewed; and (iii) project site visits for direct observations - visits were made to selected partner project sites in Southern and Lusaka provinces to illustrate differences in approach and diversity in the and response to the epidemic. Data was collected through focus group discussions (FGDs), interview guides, and e-mail and Skype interviews. A one-day partners’ self assessment workshop was conducted as part of the evaluation. Ex post evaluations were conducted for some projects such as the Kwasha Mukwenu and CHAZ ART pilot projects. Data Analysis was mainly qualitative but with considerations for quantitative analysis wherever necessary (See Annex 2: for detailed presentation of the Methodology and Approach).

This report is structured as follows: Section One is the Introduction, which provides the background and purpose of the final evaluation while Section Two is the Background, which briefly outlines the country context and the Programme’s contextual analysis, Policy and Development Context and stakeholder analysis. Section Three presents the Findings and Conclusions, in terms of relevance, efficiency, effectiveness, impact and sustainability and programme design. Other issues such as Crossing cutting capacity building, partner cooperation, programme management capacity, monitoring and evaluation, Country Allocation of Resources, Relevance of the Programme and Validity of the strategic approach are also dealt with in this section. Section Four presents the Lessons learned while Section Five outlines the Recommendations for the future direction of the HIV/AIDS programme in Zambia. In line with the ToRs an Evaluation Follow up Memo accompanies this Evaluation Report.
2. Background

2.1 Country Context
Zambia, with a population of 12.2 million, has not been spared from the HIV/AIDS epidemic which globally affects 40 million people. The epidemic continues to impact on various sectors of the economy and the well being of Zambian people and has been compounded by high national poverty and illiteracy levels estimated at 68 percent and 67.9% respectively. The general trend has been one of falling life expectancy. The UN observed that life expectancy at birth increased from below 50 years during the 1950-1955 period to above 50 years in 1985-1990 but thereafter it declined sharply falling to below 40 years during the 1995 to 2000 period. Median population projection variants assume life expectancy at birth will increase to almost 50 years by 2010. However, due to the impact of HIV/AIDS, life expectancy is expected to remain fairly low for some time to come. Table 2-1 below illustrates the Basic Development Indicators for Zambia.

Table 2-1: Basic Development Indicators for Zambia

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Estimates 2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pop mid 2009 (millions)</td>
<td>12.6</td>
</tr>
<tr>
<td>Births per 1000 population</td>
<td>45</td>
</tr>
<tr>
<td>Deaths per 1000 population</td>
<td>16</td>
</tr>
<tr>
<td>Rate of Natural Increase (%)</td>
<td>2.9</td>
</tr>
<tr>
<td>Life Expectancy</td>
<td>43</td>
</tr>
<tr>
<td>Percent of Population with HIV/AIDS</td>
<td>15.3 (14.3-GRZ)</td>
</tr>
<tr>
<td>GNI PPP per capita (US$) 2008</td>
<td>1,230</td>
</tr>
<tr>
<td>Percent Living on less than US$2/Day</td>
<td>82</td>
</tr>
</tbody>
</table>

Source: CSO, 2008; Population Reference Bureau, 2009, Washington DC

Social indicators continue to decline, particularly in measurements of life expectancy at birth (about 37 years) and maternal mortality (729 per 100,000 pregnancies). Per capita annual incomes are well below $921, placing Zambia among the world’s poorest nations. There is no compulsory education in Zambia although the first seven years of education are free. Literacy among women stands at 60.6% while for men stands at 81.6%. Infant mortality rate is 102/1,000. The country’s rate of economic growth cannot support rapid population growth or the strain which HIV/AIDS related issues (i.e. rising medical costs, decline in worker productivity) place on government resources.

About two-thirds of Zambians live in poverty. The situation is particularly difficult for women, who are left to head the households while male members of the family migrate to urban areas or out of the country. There is also an increasing trend in the region of women and girls being trafficked into forced prostitution or cheap labour. Unemployment is a contributory factor to high levels of poverty. It is estimated that unemployment is around 67% with the formal sector employing a workforce not exceeding 550,000 to support a population of 10.8 million people. Clearly, the larger part of the population has found themselves operating in the informal economy. However, it is those in formal employment who, after paying high taxes, are traditionally expected to support relatives (extended family) in rural areas by providing money and farming inputs. High unemployment levels are made worse by the declining standards in the nation’s education system.

1 CSO, 2004
2 UN, 2001, p. 474
2.2 Programme Context Analysis

Zambia has one of the highest rates of HIV prevalence in Southern Africa estimated at 14.3 percent among adults aged 15-49 years. As of 2007, at least one in every ten Zambians was carrying the deadly virus (CSO et al, 2009). The death toll due to AIDS has risen over the years and is expected to reach 1,260,000 by 2014. A high proportion of HIV positive individuals are in the 35-39 years age groups while 4.3 percent male and 8.5 female youths aged 15-24 years have HIV (PRB, 2009). HIV prevalence is twice as high in the urban (at 20 percent) than in rural areas (at 10 percent) (ZDHS, 2007). About 1 million people are living with the HIV virus of which over 300,000 require anti-retroviral therapy (ART) (NAC, 2007). As part of the Zambian government’s commitment to the World Health Organisation (WHO) 3-by-5 goal, free ARV’s have been included in the health service package. By the end of 2005, only close to half of the goal of 100,000 had been met.

Although the Government of the Republic of Zambia (GRZ) introduced universal access to ART in 2004 only a few patients could access the drugs at GRZ art centers. The subsequent increase in people going for voluntary counseling and testing (VCT) and knowing their status led to a corresponding increase in the demand for ARVs. GRZ was forced to prioritize VCT infrastructure upgrades along with expansion of ART centres throughout the country4 leading to dramatic growth in GRZ ART sites in rural and peri-urban areas from 2006. Due to scale of intervention non-state actors were not interested to go into ART but instead aligned their strategies to Home Based Care (HBC) and OVC support and capacity building. Some of the existing challenges of free ART policy at national level still remain unequal distribution of ART that favours Zambian urban middle class, poor infrastructure and poverty in the rural areas. Gender disparities exist in access in which men are the ones accessing ART in the hope that should the wife die, they can still look after the family4.

It is estimated that at least 14% of the child population in Zambia consists of other vulnerable children - street kids and young girls, dropping out of school, and who are exposed to rape, sexual abuse and drift into prostitution5. HIV/AIDS has contributed to the increase in the number of OVCs in Zambia. In 1999, the number of orphans was estimated at 520,000 (MoH, 1999, p. 35) while the Joint UN Program on HIV/AIDS estimated that there were 710,000 orphans in Zambia in 2005 (UN, 2006, p 507). The National AIDS Council (NAC) estimated 801,420 orphans during the same period (NAC, 2005, p. 24). The MoH has projected that the number of children orphaned due to HIV/AIDS would rise to 974,000 by 2014 while the UN projections are an increase from 700,000 to 1 320 026 in 2008 (UNGASS, 2007). Clearly Zambia’s well established extended family system is overstretched by the large numbers of orphans, a situation which is entrenching poverty in families. In 1999 one in six urban youths among the ages 15 – 19 years were HIV positive and by the age of 15, 37% boys and 27% of the girls had sex. Of this number 84% did not use a condom and faced the risk of infection (ZSBS, 1999). This situation has not changed much since information related to sexual reproductive health (SRH) is not readily accessible to many youths thus increasing their vulnerability while it is taboo to discuss sex with their parents.

A recent report of the NAC estimated that 82,700 Zambians will become newly infected with HIV in 2009, up from just over 70,000 in 2007 (NAC, 2009). The 2009 Zambia HIV Prevention Response and Modes of Transmission Analysis noted that the percentage of new HIV infections had stabilized, but the absolute number of new infections increased due to population growth. As many as 71 out of every 100 new infections occur as a result of sex with a non-regular partner, while people who reported having only one sexual partner accounted for around 21 percent of new infections. "This shows significant HIV

---

3 Ministry of Health, [MoH] 1999, p. 27
4 Also see National HIV/AIDS Strategy Framework (2006-2010)
5 DCA, 2005 HIV Program Document.
6 KCTT, Self Assessment Report 2009
risk even for those who are faithful. Low levels of male circumcision in most parts of the country and inadequate condom use, particularly among discordant couples remain the main drivers of the epidemic.

Although Zambia has recorded successes in its prevention of mother-to-child transmission (PMTCT) program, ensuring a safe blood supply, and behavior change communication (BCC) campaigns, the NAC recommended urgently focusing future prevention efforts on curbing common practices such as having multiple concurrent partners, transactional sex and inter-generational sex. "Multiple concurrent partnerships are the leading cause of HIV infection in Zambia. Within these relationships, correct and consistent use of condoms remains dismally low despite condoms being readily available, in most cases free of charge," However, the report revealed that the annual estimated requirement was 200 million male condoms and 2 million female condoms, yet only 96 million male and 500,000 female condoms were available. The high number of new infections was due to the poor uptake of HIV/AIDS services and reluctance to change risky behavior.

An estimated 99 percent of Zambians have knowledge of HIV/AIDS although the figures are lower among women and men who have never had sex and those with less education (ZDHS, 2007). Knowledge of HIV/AIDS is also higher in urban than rural areas. Despite this and existence of information on VCT, few people are testing for HIV. In 2006 only 13.4% knew their HIV status (ZSBS, 2006). Zambia has exhibited some changes in social norms relating to sexual behaviour, such as postponement of the age at first sex from 16.5 to 18.5 years among young people aged 15-24 between 2003 and 2005. However, multiple and concurrent partnerships still pose as a major challenge for HIV prevention activities, with 17% of women and 38% men reporting they had sex in the previous 12 months with someone who was not their spouse.

2.3 Policy and development context

In order to mitigate the impact of HIV/AIDS, GRZ has put in place a number of interventions including HIV prevention, care and support programs including PLWHA and orphan support, home based care, nutritional support, support for care givers, and palliative care including, pain management and prophylactic treatment for opportunistic infections (OIs). The government is however constrained by limited financial and technical resources to effectively roll out HIV/AIDS programs in Zambia. The GRZ has nevertheless responded by developing appropriate policies and strategies to fight the HIV/AIDS epidemic.

The GRZ has developed and implemented various policy and guideline documents to mitigate the impact of HIV/AIDS and to guide implementation of HIV/AIDS related programs. These include the MoH 2006-2010 National Health Strategic Plan, the National AIDS Council (NAC) 2006-2010 HIV/AIDS Strategic Framework and the 2005 HIV/AIDS/STI/TB policy. It has been observed that “there exists in Zambia a prominent need to link the usually well-prepared policies and strategies with concrete action through financial allocations and actual initiatives” (DCA, 2005). The evaluation team restates that the gap between the policy level and the implementation level has not been sufficiently closed since most plans and documents, even the critical ones like the FNDP, remain largely unimplemented. This has significant ramifications for the target groups, general public and vulnerable groups mostly rurally based with low access to information, public service and legal protection.

Responses to the HIV/AIDS pandemic internationally, regional and national have varied. DCA Zambia has made efforts to streamline its efforts to suit the global, regional and national response through the

---

7 Quoted in IRIN PlusNews, 2009
8 NAC, 2009
9 ZDHS, 2007
10 DCA, Programme Document, 2005

5
2005-2009 HIV/AIDS program strategy (Also See section 1.1 above). The response integrates well into various policies, strategies and programs that have been made by the government as well as other international agencies. The National HIV/AIDS/STI/TB policy provides the directive and the foundation for the HIV/AIDS response in Zambia. The broad objectives identified under this policy that are aligned to DCA’s interventions include: to ensure that Zambia complies with international practices in its interventions against the HIV/AIDS pandemic and treatment of infected and affected people; to effectively mainstream equity considerations and gender in HIV/AIDS programs and activities and to fully exploit the potential of faith-based organizations in the fight against HIV/AIDS.

Other objectives of this policy are to ensure that rights of HIV-infected and affected people are protected and stigma and discrimination are eliminated; to protect the rights of children and young people and to avail them access to HIV/AIDS prevention and care services; to create a supportive environment for the effective prevention of HIV/AIDS; and to equip Zambians, and especially the youth, with knowledge and life-saving skills as a way of preventing HIV infection and to sensitize communities on the importance of VCT as a means of knowing ones status. The policy also aims to minimize vertical transmission of HIV from the mother to the child; increase the availability and accessibility of antiretroviral drugs and their safe and equitable distribution; strengthen treatment, care and support structures for infected and affected people; and, to mitigate the high risk of HIV infection common among vulnerable groups.

As a way of implementing the policy, the Zambian government developed a National strategy under six broad themes namely; intensifying prevention, expanding treatment care and support, mitigating the socio economic impact, strengthening the decentralized response and mainstreaming HIV and AIDS, improving the monitoring of the response and integrating advocacy and coordination of the multi sectoral response. These six themes have been further broken down into twenty eight strategic objectives. These correlate with the actual National HIV/AIDS/STI/TB Policy (2005) and DCA’s interventions to a large extent as they directly relate to prevention of further transmission of HIV, strengthening care and support especially home based care, promoting positive living for PLWHA, providing support to orphans and vulnerable children. Although it must be mentioned that further interventions should include aspects of strategic objective sixteen of the National HIV and AIDS strategy that aims at promoting programs of food security and income/livelihood generation for PLWHA and their care givers and families.

Policy guidelines are in place for PMTCT, Counselling and Testing (CT) and ART while a PMTCT scale up plan, laboratory Standard Operating Procedures (SOPs), and various national training manuals have been developed. The NAC 2009-2011 draft HIV Prevention Strategy is also in its finalization stage while Monitoring and Evaluation (M&E) systems are in place for data collection and monitoring of national HIV/AIDS activities. GRZ with the help of collaborating partners has developed and implemented national anti retroviral (ARV) drugs and HIV Test kit quantification, procurement and distribution systems. The development of national laboratory and OI drug systems is underway. Both the MoH and NAC emphasize equity of access to cost effective and quality health care services by all Zambians and that are as close to the family as possible. This vision is achieved through its principles of good Leadership, Accountability, Partnership and Sustainability.

The Fifth National Development Plan (2006-2010)

The FNDP has a chapter that fully lays out how government plans to address the HIV/AIDS challenge. The chapter reveals that the vision of government is ‘to have a nation free from the threat of HIV and AIDS by 2030’. The overall objective for the HIV/AIDS sector under the FNDP is “to prevent the spread of HIV and provide appropriate care, support and treatment to HIV and AIDS infected persons and those affected by HIV and AIDS, TB, STIs and other opportunistic infections by the year 2010. The Development Plan further states that government shall strive to integrate VCT, PMTCT and anti-
retroviral therapy into the public health care delivery system and in private health care services. This objective will be realized through various sub objectives that include intensifying prevention of HIV infection, providing appropriate care, support, and treatment to HIV and AIDS infected persons and those affected by HIV, provide improved care and support services for orphans and vulnerable children and others affected and at risk. GRZ has started preparing the Sixth National Development Plan (SNDP) through consultations with key stakeholders.

**Human Rights, Gender and Advocacy**

The National HIV/AIDS STI/TB policy attests to the fact that there is a correlation between the HIV/AIDS pandemic and the abuse of human rights. As human rights are governmental obligations toward individuals, advocacy must also focus on ensuring that laws, policies and programs provide an enabling environment for the protection of rights and fulfillment of obligations by government. The government has adopted as one of the guiding principles of the National HIV/AIDS STI/TB policy, to promote and protect of human rights. According to the policy, an effective response to the epidemic requires that the Zambian rights to equality before the law and freedom from discrimination are respected protected and fulfilled. This approach is also reflected in the National HIV/AIDS Strategy Framework (NHASF -2006-2010) that has adopted a similar guiding principle.

Efforts must also be made to ensure that governments actively fulfill their obligations of promoting and protecting human rights, including ensuring legislative, administrative, budgetary and other measures are in place. It is fundamental to establish if the Zambian legislation adequately protect the rights of people living with and affected by HIV and AIDS. It follows that people who are mostly affected by HIV may progress toward the realization of their rights and better health if the enabling conditions exist to alleviate the impacts of personal, societal, and economic issues on their lives. Therefore it is fundamental to promote community advocacy to create awareness on not only the modes of transmission but on human rights and the rights of people with AIDS. Advocacy should thus be focused at lobbying the government to provide an enabling to ensure that people are able to uphold their rights, particularly those living with HIV/AIDS.

GRZ has recognized the need for equal and quality participation of women and men in national development and hence has developed and adopted a National Gender Policy (NGP, 2000). The NGP provides a framework for promoting gender equality, affirmative action, empowerment, gender mainstreaming and SRH and for addressing gender gaps and imbalances, among other issues. Gender is a cross cutting issue and therefore implementation of the NGP requires the commitment, participation and contribution of everyone. It is in this regard that DCA has committed to integrating gender perspectives in its work plans and that gender considerations are mainstreamed in service delivery and advocacy work.

**Millennium Development Goals**

The Millennium Development Goals (MDGs) that directly relate to DCA’s response to HIV/AIDS pandemic is Goal Six which is the combating HIV/AIDS, malaria and other diseases. Indicators that relate to the achievement of this objective include halting and begin to reverse the spread of HIV/AIDS and achieve by 2010 universal access to treatment for HIV/AIDS for all those who need it. Other goals that may be related to the response include the eradication of extreme poverty and hunger, promotion of gender equality and empowerment of women and reduction of child mortality.
2.4 Assumptions and Risks at Programme Design

The two assumptions predicted at programme design stage related to: i) a continuation in political commitment and will of government and other stakeholders; and ii) continuation in the flow of resources meant for HIV/AIDS in Zambia. Since 2005 the political will and commitment to implement HIV/AIDS programs has remained firm and a marked increase in community and institutional motivation to fight HIV/AIDS has occurred. Reported incidences of bad governance (especially fraud in the MoH) resulted in withdraw of donor funding to the health sector. Such events had negative implications since there were fewer resources to consolidate gains made in the fight against AIDS including those made by DCA and its partners.

The passing of the NGO Bill in September 2009 was a significant shift in GRZ policy as it implied more controls and stifling of independent operations of NGOs. Although the Bill may not directly affect DCA, it creates uncertainty on future operations of all NGOs especially those dealing with advocacy, human rights and governance issues. It also has implications on the choice of partners with of whom DCA may associate with and who could be targeted or not be allowed to work in certain areas by GRZ. The following quote Civicus commenting on the Zambia Non-Governmental Organizations Bill, 2009, sums up the situation:

“The Bill imperils the freedom of association by creating a highly restrictive regulatory regime for non-governmental organizations (NGOs) that serves to impede rather than enable freedom of association. Some of the concerns raised by civil society organizations in respect to the earlier version of the Bill drafted in 2007 have been addressed in the 2009 version. Nevertheless, key provisions of the Bill restrict the independence of NGOs and subject them to excessive and unwarranted controls. Significantly, the Bill creates an NGO Registration Board with overreaching mandate, which is under the firm control of the Government. In sum, the Bill will severely limit civil society space and impede the activities of NGOs, which not only play an important role in democratic development and nation building, but also render invaluable support and services to the people of Zambia” (Civicus, 2009).

Risks anticipated at Programme Design Phase

Three major risks were foreseen at the programme formulation phase, namely: i) the presidential and general elections of 2006; ii) the continued economic decline in Zambia and its impact on people’s ability to provide a spirited and voluntary fight against HIV/AIDS; and iii) that the burden of PLWHA and OVC may hinder communities’ effective response to the pandemic as they focus more on the immediate needs within their households. Two important observations are that before and during election political leadership focused more on elections and spent substantial amount of GRZ resources on election at the expense of the health and other sectors. Economic decline, compounded by the global economic crisis, resulted in reduced GRZ budgetary funding to the health sector as a whole. Reduced funding and shifting donor emphasis from HIV/AIDS to other sectors may in the long term affect the gains made through DCA support, as NGOs cut down on spending in developing countries. Harsh local economic conditions also resulted in beneficiaries demanding ‘some form of payment’ in return for their labour. The advent of ART has helped to reduce the burden of PLWHA and OVCs as more people are surviving and living longer and there are more resources to scale up the community response.

---

11 DCA HIV Programme Document, 2005
12 ibid, 2005, p. 55
2.5 Stakeholder Analysis

The HIV programme could not have been success without the cooperation and collaboration of various implementing partners and stakeholders. To a greater extent, DCA and its partners managed to engage with organizations with varied interests and expectations who were also contributing to the fight against HIV/AIDS. First and foremost have been Government Stakeholders that are responsible for developing national support structures and policies, planning frameworks, guidelines and protocols to which the DCA programme has been aligned. DCA has maintained, through its partners, indirect working relationship with GRZ institutions such as the National AIDS Council, Ministry of Finance and National Planning (MFNP), Ministry of Education (MoE); Ministry of Health, Ministry of Youth, Sport and Child Development (MYSCD); Ministry of Community Development and Social Welfare (MCDSW); Ministry of Agriculture and Cooperatives (MACO) and Gender and Development Division (GIDD), inter alia.

DCA directly worked with a number of Faith based, non-faith based and inter-faith organizations mainly involved in advocacy, lobbying and HIV/AIDS programming. CHAZ, which is responsible for over 50% of formal health care in rural areas of Zambia and about 30% of health care in the country and is a major national service provider in the health sector, has been the major implementing partner of DCA. CHAZ is not only an NGO, advocate and service provider on behalf of GRZ but also a distributor of GFATM funds to FBOs and manages large donor funding portfolios including Global Fund, PEPFAR, DCA, CORDAID, EU and the Royal Netherlands Embassy. CHAZ has effectively used its strategic position to influence national stakeholders and duty bearers play an active role in different networks including the GFATM Country Coordinating Mechanism (CCM), the Civil Society Poverty Reduction (CSPR) network, the Health Innovation Fund and NAC partnership.

CCZ is another major faith based implementing partner of DCA especially in provision of OVC support, fighting stigma and discrimination of PLWHA through Support Groups, general training and financial empowerment of women and their rights, and provide training for church leader training on HIV/AIDS. It seeks to promote cooperation and fellowship between Christians, works with churches and local congregations nationally and has a strong national voice in addressing general issues of the public. It is a member of the World Council of Churches (WCC), All African Conference of Churches (AACC) and the Nordic supported Fellowship of Councils of Churches in Southern Africa (FOCISA) which is influential in Africa and globally. A core group is responsible for cross regional dialogue in relation to HIV/AIDS.

DCA has often interacted with the CSPR mainly in national discussion on public resource allocation and monitoring of the spending on HIV/AIDS. CSPR is a key monitor of how duty bearers are accountable to the general public. DCA has also linked directly or indirectly through partners with the Zambia National Aids Network (ZNAN), which like CHAZ, is a principal recipient of GFATM funds and sub-grants to local NGOs that are not faith based. The interface has been in the areas of information exchange and resource mobilization national HIV/AIDS policy level lobbying and advocacy. DCA has also good working relations with the Non-Governmental Organisations Coordinating Council (NGOCC), which is an umbrella organisation for NGOs and CBOs working with gender and developmental challenges. DCA main interest is that NGOCC involved in advocacy on gender issues and that it coordinates gender related programmes, designs and implements training programmes for women’s organisations in Zambia and with over 70 member organizations, it is generally a focal point.

13 Also see Section 2.3: Policy and Development context above
14 ZNAN, MFNP, MoH and CHAZ are the four recipients of GFATM-funds. CHAZ receives these funds on behalf of the FBO community.
15 FOCISA collaborates with five councils of churches in the five Nordic European countries which initiated a joint process of theological reflection on the experience of HIV and AIDS-related stigma and discrimination.
for the women's movement in Zambia. Together with GIDD, NGOCC is the rotational chair of the Gender Forum.

DCA has also closely worked another group of who included traditional leaders and healers, school teachers, elderly women and men. Traditional leaders and chiefs are custodians of customary law and so are constitutionally required to play a central role in the communities. DCA has engaged traditional leaders due to the linkage between gender inequality, customary law and HIV/AIDS. They have significant influence in addressing and changing harmful cultural practices such as inheritance, initiation ceremonies, early marriages, and sexual cleansing. As duty bearers they are a natural focal point at community level where DCA and its partners engaged them in constructively supporting HIV/AIDS work and in redefining the harmful cultural and social practices. Other stakeholders who have had a bearing on DCA interventions included traditional healers, traditional birth attendants, spiritual healers, diviners and herbalists.

Teachers also have great influence on perception and community attitude on HIV/AIDS. The role of school teachers is vital in relation to the access to information for children while elderly women are also very important actors as educationist of especially girls and thereby they influence the opportunities of changing cultural and social practices and information on sexual and reproductive rights. DCA has also equally emphasized the participation of men and young boys in the programme due to their position as moral duty bearers. Males are also victims of traditional practices, gender roles and expectation but they hold a better opportunity of changing the traditional gender roles and thereby improving the position of women at household and community level. DCA recognized the need to engage with the private sector such as the Zambian Business Coalition on HIV/AIDS but during programme implementation this did not occur as envisaged since the areas of interface with the private were not clearly defined.

---

16 DCA, 2005 Programme Document
3. Findings and conclusions

This section presents the main findings and conclusions of the evaluation based on standard ToRs\textsuperscript{17} and the programme’s evaluation criteria. Issues of the programme’s relevance, efficiency, effectiveness, impact and sustainability are discussed in the findings and in subsequent sections of the report. The findings are supported with evidence mainly drawn from data collected during fieldwork, direct observations, key informant interviews and documentary review including thorough analysis of the programme’s LFA indicators. The findings are systematically presented as follows:

1. Achievements and Impact of the Programme
2. Cross cutting Capacity Building Issues
3. Programme Reporting, Monitoring and Evaluation
4. Programme Management Capacity
5. DCA Country Allocation of Resources
6. Relevance and Quality of Programme Design
7. Validity of the Programme Strategic Approach

3.1 Achievements and Impact of Programme

To measure the overall impact, that is, the extent to which the programme achieved its set goals, objectives, output and outcome indicators, the evaluation focused on progress made, achievements and results of the program’s immediate objectives during the period 2005 to 2009 as set out in the programme’s LFA. Programme impact was measured in terms of the changes in the four key programme intervention areas of primary prevention; human rights, gender and advocacy; home based care and OVC support and capacity building of partners outlined in the DCA HIV programme strategy.

3.1.1 Prevention, knowledge building and behaviour change

Under the intervention area: “Prevention, knowledge building and behavior change including knowledge and practice of ABC” achievements were measured against the key LFA objective, namely: “Risk taking behavior (sexual and non-sexual) for women, children and youth in rural and urban areas reduced” with the following LFA indicators addressed:

1. Targeted communities are knowledgeable about the modes of HIV transmission and can identify ways infection can be prevented.
2. Increased number of people exercising their right to voluntary counselling and testing services
3. Increased number of girls and adolescence women claim their sexual and reproductive rights.
4. Increased number of community members sensitized on gender inequalities by churches and local NGOs. (this indicator is dealt with under Section 3.2.4)

To address the LFA indicator: “targeted communities are knowledgeable about the modes of HIV transmission and can identify ways infection can be prevented” and other indicators, we evaluated a number of projects including: i) the Danida funded Facilitating Community to Community Transfer of HIV/AIDS responses (FCCT) project (2005-2008); ii) the EU funded CHAZ Local Community Competence Building and HIV/AIDS prevention (LCCB) programme (2005-2007); and the Girl Guide AIDS Project - Phase 3 (2005 to date). Others were the CCZ Circles of Hope and Kara Umoyo and Day Care centre projects integrated HIV prevention strategies.

\textsuperscript{17} See Annex 1 for detailed ToRs
Overall we found that all DCA partners were involved in primary prevention albeit using different strategies and approaches. The main interventions focused on awareness raising, increasing knowledge and promoting behaviour change including promotion of ABC. DCA had to a large extent also succeeded in increasing the number of people treated for STIs, reached with IEC materials and messages, and pregnant women served with ART prophylaxis to reduce MTCT as the following sections shows. There was marked increase in the number of pregnant women accessing PMTCT services in the target areas due to the establishment of PMTCT centres, post-test clubs for members, community sensitization on CT targeting mainly women and girls and pregnant mothers and training of health workers and Traditional Birth Attendants (TBAs) as ToTs in PMTCT. Other strategies used included basic counseling and use of PMTCT motivators and training of community volunteers in behavior change, particularly male involvement in PMTCT, couple counseling sessions and mobile VCT services to increase access to CT. A significant achievement was the involvement of traditional leaders and chiefs and males in PMTCT. Pregnant women, who previously feared revealing their HIV status to their husbands, started doing so and husbands became more supportive. The evaluation team witnessed a training session of male involvement in PMTCT conducted at Chikankata in September 2009.

Significant achievements were made in increasing knowledge about HIV/AIDS through BCC and the simultaneous distribution of IEC materials and condoms. For example in 2008 CHAZ reached a total of 80,960 people mainly in rural areas with IEC materials, which represented 88.4 per cent increase from 2007. CHAZ reported that there was “some semblance of behavioural change” which was reflected in reduction in risky decision making; increased claim making capacity of young girls and communities challenging cultural practices such as sexual cleansing, wife inheritance, tattooing, dry sex etc through involvement of traditional leaders, chiefs and headmen. Traditional leaders were actively involved in

---

18 CHAZ FCCT project Bi Annual Report, 2007
19 EU/DCA, LCCB project, 2007
20 CHAZ Bi-Annual Report, 2007
21 FCCT, PCR, 2007, p. 4
BCC as reflected in actions of chiefs around Mikinge MH and Mtendere (Siavonga) where Senior Chief Sikoongo completely banned harmful traditional practices.

**Reduction of Risky Behaviour among the Youths**

DCA to a large extent succeeded in helping to reduce risky behavior among youths in its catchment areas. This was achieved mainly through knowledge and information dissemination by applying strategies such as Peer Education and Anti-AIDS clubs in schools. Appropriate messages, including ABC, were disseminated which contributed to breaking of structural barriers related to knowledge, attitudes, perceptions and beliefs (KABP); reduction of misconceptions about prevention and transmission of HIV/AIDS, abstinence and delay of sexual debuts and consistent use of condoms by youths. Appropriate HIV/AIDS messages that focused on the ABC principle, specific risky behaviours were disseminated to the youths. These messages took into account cultural, age and gender, sexual practices and occupation and settings of the youths. The emphasis was on the way HIV and STIs were transmitted and prevented, the importance of VCT, cognizance of risky or non risky behaviour, attitudes and determinants of such risk. The messages were first tested before communication to youths and other target groups.

Messages were communicated through appropriate channels including music, sports and schools activities, complementary radio spots, training and health information cards, multimedia campaigns, youth group education and prevention sessions, and training of peer educators among the youths. Messages were also passed on during distribution and promotion of condoms and referrals to VCT services. All DCA partners widely used the print and electronic media (mainly radio broadcasts and sometimes sponsorship of TV spots on abstinence and delay or consistent condom use), drama groups, newspapers and local folk media to promote behavioral change, awareness and sensitization about HIV and safe sexual behavior. Publications (newsletters, pamphlets etc) and magazines e.g. the GGAZ's Guide voice magazine were used for information dissemination. Of significance is that messages and a range of print materials have been translated in seven local languages for illiterate youths.

Messages were getting through to more youths in both rural and urban areas who are frequently discussing HIV/AIDS issues. Many children and youths in the target areas have learnt about abstinence and are exposed to behaviour change strategies and are aware of the effects of HIV. The following HIV messages were recorded from girl children and youths supported by GGAZ in Livingstone:

| “HIV virus is sexually transmitted; AIDS is caused by HIV virus; AIDS has no cure; Unprotected sex is when one takes no measures to protect against HIV when having sex; Blood transfusion is another mode through HIV virus can be transmitted; PMTCT is another through which infant get infected; AIDS can be prevented by abstinence and the use of condoms; Used objects such as razor blades and syringes can cause HIV infection; You cannot get HIV through handshakes; AIDS does not choose and You cannot tell by looking” FGD with beneficiaries Livingstone, September, 2009 |

Overall we found that there was less emphasis on youth negotiation, refusal and assertion skills, promotion of delayed sexual intercourse, negotiation of condom use, respect for partners’ sexual choices and ability of youths to understand the situation of PLWHA (i.e. messages that are sensitive to HIV+ perspective). Further most youths were still generally lacking in knowledge about adolescent SRH and socio-cultural and gender norms (including avoidance or subverting gender stereotypes) and their contribution to risky behavior. The changes in most social norms that were part of the socialization

---

22 CHAZ, FCCT project, 2007; EU/DCA/ LCCB project, 2006
process of adolescents and young people were slow and that less widely known social and cultural practices with potential to transmit HIV/AIDS continued to be practiced without any modifications.23

DCA partners used various strategies and types of messages to communicate to the youths. CHAZ for example promoted a more holistic approach and did not restrict themselves to the abstinence and faithfulness like CCZ and GGAZ, whose emphasis was more on abstinence and were reluctant on condom in the belief that such action would promote unnecessary early sexual debut or encourage risky behavior among youths and young girls respectively. It was observed that CCZ resented acknowledgement of the need for member churches to actively support the use of condoms which was a reflection of “inbuilt schisms between HIV/AIDS and theology”.24 However, by upholding Christian and organizational values, some partners were missing opportunity of a holistic prevention approach since prior research25 had shown that many youths were still sexually active and so lack of emphasis on condom use placed them at high risk of contracting HIV. The opposition to condom use by some DCA partners could be seen as an obstacle towards addressing one of the root causes of HIV-infections and thereby not preventing further mystification and stigma in the local church communities26. Another challenge regarding BCC has been the weakness in advocacy components of some partners. Effective advocacy and capacity development are required before BCC and AIDS education can take effect.

Youth self-organising activities
With regard to youth self-organising activities, DCA and partners succeeded in promoting AIDS talks, peer education, drama performances; youths’ citations of personal experiences and testimonies of being infected with HIV or coming from homes affected by HIV/AIDS and youth debates in Anti-AIDS Clubs. Peer education was effectively used by DCA partners to promote non risky behavior and for building confidence among the youth. Trained peer educators were able to organize advocacy meetings with parents, teachers, and formal and informal community leaders and act as role models to other young people by exhibiting positive behavior, maturity and leadership skills. Anti clubs managed by youth peer educators in schools were more effective as they provided a youth friendly, safe and supportive environment. Youths were encouraged to organize youth conferences, VCT campaigns and National VCT days.

The main challenge with youth activities was sustainability, especially of Anti-AIDS clubs. Poor organization, insufficient training and sensitization of peer educators, high turn-over of club members who either graduated or dropped out of school and lack of operational funds and IGAs affected these clubs. An external review commissioned by DCA in 2006 found that the CHAZ youth prevention component was “…the weakest part of its community approach – especially the AIDS clubs, which seemed not to have reached their potential”.27 Effective peer education and youth education in schools were seen as important strategies to strengthen youth self organizing activities.

The programme’s emphasis on Life skills education and training had a positive contribution to shaping attitudes and developing interpersonal skills of youths. All DCA partners have been active in building life skills, in some cases based on Christian values, especially for OVCs. For example through its life skills and empowerment component, GGAZ was able to provide guidance to young girls on abstinence, faithfulness and to a lesser extent on condom use. Training methods were youth-centred, gender sensitive, interactive and participatory while some partners use Anti AIDS clubs as platforms for Life Skills Education and training. One challenge noted, however, is that some partner organizations

---

23 EU/DCA, LCCB project, 2006
24 DCA HIV Programme Document, 2005
25 DCA/UNZA/INESOR, 2006
26 ibid, 2005
27 Danida/NCG, 2006
generally lack good infrastructure outlay and specialized life skills educators and so need support in this area. An earlier review found that the District Education Boards (DEBS) were implementing a Girls Friendly School Programme that had significant importance in life skills building and developing HIV/AIDS competences of young school girls. It was recommended that the Girls Friendly School concept be included in the youth prevention strategies. We also found this concept (and that of girls information corners and girl friendly spaces) relevant and appropriate to the DCA youth prevention strategy and so uphold the recommendation.

Access to Voluntary Counselling and Testing Services
DCA played a significant role in introducing and scaling-up of VCT services especially in both rural and peri urban areas where government infrastructure was generally inadequate and a large gap for these services existed. VCT services were promoted in the belief that knowledge of HIV status could encourage young and older people to avoid risky sexual behavior and promote positive living among those already infected and thus help avoid escalation of the HIV/AIDS epidemic. Before the DCA programme intervention baseline data revealed that many young people, community leaders and actors did not know what VCT was. People also revealed that VCT services were only available at the Hospitals and not at health centres that were closer to most people. Through a number of clinics and hospices VCT was provided to high-risk and vulnerable groups, and youths. CHAZ piloted VCT services including mobile interventions in rural areas. There was general acceptance from the people who turned out in numbers to receive VCT.

There was a significant increase in access to VCT in CHAZ’s catchment areas as the number of centres grew from 5 to 24 centres between 2004 and 2006. In 2008 CHAZ counseled and tested 57,357; distributed 58,256 condoms and sensitised 29,303 people. A total of 7,405 people underwent counselling and testing while 5169 received STI treatment. There was a corresponding increase in uptake of condoms and number of people demanding and accessing VCT services and a reduction in STI incidence. For example, Mbereshi MH, which used to record high incidences of STIs soon after the Umutomboko ceremony, recorded a marked reduction in STIs and HIV prevalence after sensitization campaigns. Due to access to VCT more people started accessing ART, became productive again and experienced less stigma and discrimination. More people were accessing CT services before marriages and traditional cleansing, which was an indication of a break in harmful cultural practices. Generally increase in VCT services contributed to reduction in risky behaviour since people were better informed and made appropriate decisions about some risky decisions such as tattooing, wife inheritance, testing before marriage and traditional sexual cleansing. Other strategies included promotion of national VCT days and VCT campaigns in schools in collaboration with the Ministry of Education.

Kara provides VCT through its network of Hospices, Drop-in and Day Care centres. We visited Kara Choma where it was revealed that the number of people accessing VCT services in Choma had increased significantly and that this was due to easy access to ART after VCT. Many people were encouraged to go for VCT after seeing improvements in the quality of life of previously sick people. Another positive development is that a total of 83 children at Ambuya Day Care Centre were put on

28 The Girls Friendly School concept is not included or described as a prevention strategy in any DCA programme documents but was seen as significant by a review team commissioned by DCA in 2006 (Danida/NCG Report, 2006).
29 Danida/NCG, 2006
30 EU/DCA LCCB project, 2006
31 FCCT project, 2006
32 Ibid, 2006
34 CHAZ Bi Annual Report, 2007
35 Focus Group Discussions with Beneficiaries, September 2009
ART after undergoing VCT. A CCZ supported PLWHA support group in Lusaka peri-urban claimed that more people were going for VCT after witnessing improvements in health of HIV+ people in their communities. Although CCZ and GGAZ provide counseling services including psychosocial support (PSS) to PLWHA and young people respectively but they do not have diagnostic laboratories for testing. CCZ and GGAZ planned to initiate VCT services in future as demand was increasing.

Some of the challenges faced by partners included inadequate equipment like HIV testing kits, CT expertise and low number of VCT facilities especially in rural areas. Although mobile VCT clinics have improved access VCT in rural areas remains a huge challenge. It was there were more people accessing VCT services in urban and peri-urban areas than in rural areas due to proximity to facilities. Recent research has revealed that while condom use was emphasized in VCT services, only fewer target groups received counseling on reducing their number of sexual partners and fewer were advised to disclose their HIV test results to partners. This is more especially in a country like Zambia with a generalized epidemic where multiple concurrent sexual partners are a significant driver of new infections. Further there is over emphasis on the risk of contracting HIV through blood, which is not a major driver of Zambia’s HIV epidemic, and of living positively with HIV, even before a client’s status was known. It was also found that VCT services were mainly accessed by the most educated segments of the population and that VCT was failing to reach many women and men who had no or only primary education. There were also concerns about quality of VCT services provided and whether the costs of training were justified since there was no difference in quality of services in the private and public sectors. All in all a renewed focus on adapting counseling to the realities of Zambia’s HIV epidemic could improve the efficacy of VCT in all areas.

**Girls and adolescence women claim their Sexual and Reproductive rights**

All DCA partners integrated SRH in their project interventions. They did not only address women’s and girls’ SRH rights but also gender imbalances that influenced behavioural change. Young girls including OVCs and adolescent women participating in GGAZ projects as girl guides, in CHAZ projects on CPTs, in Kara Umoyo life skills training projects and in CCZ PLWHA support groups, were to a large extent empowered with knowledge of SRH. The LCCB project emphasized and succeeded to a greater extent in empowering youths with appropriate knowledge of risky sexual behavior, human rights, their duties and responsibilities, including avoiding sex before marriage and importance of accessing VCT as well as medical, emotional, and spiritual well being.

We visited children supported by GGAZ, and asked if they knew their SRH rights. They acknowledged that they were aware of their Sexual Reproductive Health rights and were empowered with appropriate information on HIV/AIDS. They said, for example, that they had a right to say no to sexual advances and to report matters of sexual abuse to elders and to refuse to be married off by their parents or guardians. This had resulted in reduced pregnancies while girls who got pregnant were aware of their right to go back to school and complete education. It was clear, however, that there was need for further sensitization and training of young girls and their teachers in SRH and human rights. Males were being involved in sexual reproductive health and Maternal Child Health and Family Planning (MCH/FP) mainly by CHAZ.

The measurement of programme’s impact on behavioural change was not easy due to insufficient empirical evidence and relevant information from partners. Previous national surveillance surveys had reported reductions in national prevalence rates but this was not sufficient indication of behaviour

---

36 Ibid, 2009
37 Private Sector Partnerships One (PSP-One) project, USAID, 2009
38 EU/DCA, LCCB project 2006
39 Focus Group Discussion with GGAZ girl guides in Livingstone, September 2009
Realising this gap, DCA commissioned applied research with the aim of generating evidence on the impact of its programmes and as part of health systems strengthening components of the CHAZ FCCT and LCCB projects. In this respect, the research conducted by UNZA’s INESOR helped to generate evidence on progress made in prevention efforts and documented DCA’s impact. The recommendations were widely used and shared among churches in Zambia and those in Uganda. In keeping with the NAC’s HIV/AIDS Policy emphasis on research and the need for evidence-based HIV/AIDS programming, there was need for DCA and partners to conduct more empirical studies on behaviour change and prevention efforts especially among the youth.

3.1.2 Integrated HIV/AIDS Care and Support
Under the programme intervention: “Integrated HIV/AIDS care and support”, achievements and impact were measured against the objective: “to determine access to care, counselling, treatment, support and socio-economic assistance for PLWHA, orphans and vulnerable children”. The LFA indicators assessed under this objective were:

| Number of PLWHA accessing support from home-based care and community support groups; |
| Number of orphans and vulnerable children supported and empowered with life skills and –knowledge; |
| Number of referrals to governmental service deliverers enhanced, particularly of OVC; |
| Number of PLWHA claim right to ART; |
| Number of vulnerable women economically strengthened through income generating activities. |

With regard to the number of PLWHA accessing support from home-based care and community support groups, DCA succeeded in establishing Home Based Care (HBC) groups that provided care and support for terminally ill people through a network of community volunteers who also provided counselling, immune-positive nutritional diet and PSS. HBC was used as a strategy to link the hospital system and HIV+ individuals especially in rural areas. Different HBC strategies were deployed by DCA partners such as the CHAZ Care and Prevention Teams (CPTs), Kara Hospices and Day Care Centres and CCZ PLWHA support groups. GGAZ was also to some extent conducting HBC through its network of Volunteers (Guides). Overall all partners had established an effective HBC outreach program which not only identified the needy and most vulnerable individuals but also placed them under care and support or referred them to Hospitals or Hospices. In the case of Kara HIV+ orphaned children were taken care of in the Day Care centres.

The CHAZ supported CPTs, consisted mainly of women who helped to identify and provide support to sick people including counseling, training and community sensitization. CPTs were trained on different strategies that they applied in the community and that led to many sick people coming out in the open and receiving counseling and testing (CT) services. CPTs sensitized communities on HIV/AIDS transmission, prevention and care as well as on human rights and gender issues taught and taught good hygiene practices and nutrition, provided psycho-social support and monitored ART adherence. The impact of HBC groups like those in Chikankata, was reduction stigma in the communities, mitigation of health and socio-economic impact of HIV/AIDS and improvement in the quality of life of PLWHA and sick OVCs. The main challenge was long term sustainability of HBC intervention, which DCA partners were partially addressing through Income Generating Activities (IGAs).

40 ZBSS, 2007
41 CHAZ Bi Annual Report, 2007
42 The key projects supporting HBC activities were CHAZ AIDS Prevention Programme; Kara Hospices and Day Care Centres and the CCZ Circles of Hope Project
Access to Treatment

The DCA support for increasing access to ART in the early stages of the programme was very important as it helped to fill a large gap in provision of ART especially to people in rural and peri-urban areas. This intervention came at an opportune time when GRZ was starting to roll out universal access to ART (circa 2004) but still few people had access to designated government ART centers. For example by the end of 2005, only close to half of the national goal of 100,000 PLWHA on ART had been met. The intervention was also introduced at a time when more and more people were going for VCT, knowing their status and were demanding ART services. Although from 2006 the number of ART sites grew dramatically in government hospitals and clinics, the sheer scale of services and financial resources required to roll out ART was so huge that it could not be dealt with sufficiently by GRZ alone.

Provision of ART was achieved through the CHAZ ART pilot project (2005-2007) which was implemented at Chipembi and Fiwale RHCs. DCA support consisted of basic logistics and equipment support, procurement and supply of ARV drugs, reagents and drugs for OIs and STIs and test kits. By 2008 at least 3,985 PLWHAs were accessing ARVs with support from DCA with additional support from the Global Fund and Catholic Relief Services (CRS). The major impact of the DCA ART intervention was mainly improvement in the health status and quality of life of PLWHA. It was observed at Mtendere in Siavonga, for example, that people had become “better in terms of health and [had] gone back to their work and [became] more socially and economically active”.43 PLWHA on ART became sexually active, were marrying again and having children. A significant reduction in stigma was observed as more people were going for VCT services; there was more openness in discussion and disclosure of HIV+ status. There was also renewed hope for those who knew or were afraid to reveal their status.

A notable impact of HBC was the reduction in the pressure on HBC care givers and number of visits made by community volunteers due to reduction in the disease burden. Going for VCT was associated with getting ARVs, which was consistent with reduction in stigma in communities. An effective exit plan for the CHAZ pilot ART programme was put in place as more HIV+ people were referred to and

43 FCCT Bi Annual Report, 2007, p. 12
registered at government ART centres before the project closed. CHAZ has since re-aligned its ART interventions to mitigation of opportunistic infections (IO) through provision of drugs such as Cotramiziole (Septrin). The main challenges encountered by the partners were keeping track of people who had benefited from the ART programme, adherence support, dealing with drug resistance and access to nutritional, livelihood and psychosocial support. It was also observed that the link between the ART programme and DCA’s Food Security programme was not fully exploited to provide additional nutritional support to PLWHA.

**OVC care and support**

Other indicators measured were the number of OVCs supported and empowered with life skills and knowledge and the number of referrals to governmental service deliverers enhanced for OVCs. We found that overall DCA had a long history of supporting OVCs in Zambia dating back to the 1990s. OVC support focused on education scholarships to vulnerable children (GGAZ) and nutritional support for HIV positive children (Kara). DCA partners used different strategies and approaches in OVC support although the same basic criteria for selection was applied, which was the degree of vulnerability resulting from the loss or sickness of the parents due to HIV/AIDS. Once selected OVCs were provided with direct support, which included life skills training; payment of school fees, fees for student teachers especially in Community Schools. They were also supported with school requisites such as uniforms, books and sanitary towels (for girls), blankets and foodstuffs. Many traumatised children received psychosocial support while HIV+ children are referred to hospices or received home based care. In order to harmonise and coordinate efforts, DCA partners, through the partner platform, established an OVC task force to enhance their advocacy work and leverage resources for OVCs.

The evaluation team visited and interviewed OVCs supported by GGAZ, Kara Choma Day Care centre and Hospice and Kara Umoyo Training Centre. It was learnt that GGAZ had cumulatively supported 384 OVCs since the project started while Kara Umoyo Training Centre supported an estimated 80 female OVCs and vulnerable female youths every year. Kara Choma provided support to OVCs under its Day Care centres. CHAZ supported a total of 59,398 OVCs mainly through the CHAZ St Edmunds OVC centre and its network of CHIs. In 2008 a total of 1,831 OVCs were provided with school fees, books and shoes, which represented an increase of 11.5% compared to 1,642 OVCs in 2007. CHAZ had anticipated that expenses for supporting OVCs would increase significantly in the coming years and this was found to be the case during the evaluation.

Achievements made under the OVC Scholarship program included significant improvement in mental, physical and psychosocial wellbeing of children; empowerment of OVCs with life skills and provision of opportunities for them to continue their education or realise their right to education. An increasing number of OVCs were getting into secondary and tertiary education institutions while some OVC were even performing so well that they were selected to University. Life skills empowerment through skills development was another major achievement particularly with regard to Kara Umoyo and GGAZ projects. The following remarks by the DEBS summed up the view of GRZ on DCA support: “The government appreciates the cooperation from DCA which comes to the districts through the partners. DCA is complementing government efforts in providing a holistic education system that includes awareness of HIV/AIDS by young people. The government appreciates the support from DCA, in particular the (OVC) scholarship program which has assisted the most vulnerable to attain some level of education.”

---

44 GGAZ/Kara Self Assessment Reports, 2009  
45 CHAZ FCCT Bi-Annual Report 2007  
46 Interview with DEBS, September 2009
With regard to OVC support, the main challenges encountered by all partners included the growing number of OVCs requiring both secondary and tertiary education, declining support budgets and increasing costs of OVC support and high expectations for OVC support from the communities. There was lack of continuity in OVC education as many dropped out of school at the end of scholarship support. The existing partners’ OVC referral system to other NGOs and GRZ institutions was not very effective and there were no viable OVC adoption programs and bursary schemes to support further education. Available resources were over-stretched as there were too many OVCs to support. As a result OVC support was not holistic and was sparing and the quality of service was compromised.47

Scholarship beneficiaries who completed primary or secondary education were unable to proceed for further education due to insufficient funding.

Other challenges related to OVC support included early pregnancies and marriages, which resulted in sponsored girls dropping out of school, and insufficient follow up (or tracking of girls) who had completed school or who shifted from one school (or district) to another.48 Schools benefiting from the scholarship program did not frequently submit reports which made it difficult to ascertain progress made [in class] by OVCs. There was, however, a demonstrated willingness by some guardians to support OVCs in their care although their main challenge was poverty and lack of resources to fend for OVCs and their own children. At some point the lack of guidelines for OVC support was a hindrance to an effective response. However partners like CHAZ had since developed OVC guidelines (with support mainly from the Global Fund) to provide guidance and a coordinated response in OVC support.49 These guidelines were, however, not yet shared among DCA’s partners.

47 CHAZ FCCT Bi Annual Report, 2007
48 Kara Umooyo, 2009
49 CHAZ Annual Report, 2008
**Income Generating Activities (IGAs)**
The success of DCA supported IGAs and their impact on vulnerable groups, including women groups, PLWHA support groups and OVCs and communities as a whole, was well reflected in all partners’ project interventions. In terms of outputs CHAZ funded a total of 128 IGAs that not only benefited OVCs but also volunteers working as care givers. A total of 120 programme staff from CHIs/FBOs were trained in entrepreneurship skills while 1750 copies of the Credit and IGA Management Guidelines were translated and distributed to IGAs across the country. CHAZ also trained IGA implementers and AIDS Field Officers (AFOs) in Credit and IGA Management, recruited Community Based IGA officers and sourced and disbursed seed funds to CHIs and FBOs.

A report described CHAZ’s IGAs as comprising “...smaller amounts of money made available for “merry go round” micro finance arrangement”. However, the same report acknowledged that IGAs “…makes it possible for the community to some extent to support PLWHA and orphans”.

At Mtendere in Siavonga, 30 Volunteers were trained by CHAZ in IGAs while exchange visits among IGAs were promoted to share experiences e.g. between Mishikishi and Fiwale MH, with the latter being regarded as best practice in IGA. CHAZ developed a new IGA strategy that stressed transparency and accountability as well as monitoring of CHIs and FBOs implementing IGA schemes and facilitated and printed Credit and IGA management training manuals and guidelines. The Kulijata women’s IGA Group, visited by the evaluation team in Chikankata, was established to respond to the high number of deaths, PLWHAs and OVCs in the community. The group started a Savings Club before accessing a loan from DCA. The proceeds were used to support OVCs and sick people in the community. The group also received training and started community sensitization in HIV/AIDS. IGA manuals were used by IGA members.

DCA’s support to Kara Umoyo enhanced entrepreneur skills in young girls (including HIV+ girls and adolescent OVCs), who subsequently were empowered with life skills in agriculture, tailoring, sewing and knitting, and catering. Kara Umoyo supported follow-up training programs for its graduates and helped them secure employment after graduation. It was found, however, that there were few employment opportunities for Kara graduates. This was resolved through a sustainability plan, which involved gardening and farming activities as well as establishment of Graduate Guardian Council enterprises (GGCE).

With regard to the CCZ, it was found that PLWHA support groups had access to IGA loans and were involved in gardening and poultry keeping which enabled them to provide better nutrition to sick members. It was, however, observed that CCZ IGAs were not well developed and viable ventures compared to those implemented by CHAZ or Kara Umoyo. In this regard there was need for more exchange visits between the partners to share experiences in IGA management and between the IGA groups. It was also revealed that DCA did not support GGAZ in IGAs although significant need existed especially amongst guardians of OVC scholarship recipients.

As a result of IGAs support there was a marked improvement in the quality of life of IGAs members through better nutrition and management of Opportunistic Infections (IOs). The nutritional status of PLWHA improved since food was readily available from communal gardens, piggery and poultries projects. There was a growing realisation of having sustainable communities in the wake of HIV/AIDS and more people were joining and forming IGAs groups. The number and quality of IGAs in project sites increased and improved as more IGAs groups opened bank accounts and were provided with loans for ongoing business activities. Maintaining bank accounts resulted in proper accountability of IGA funds and greater creditworthiness of IGAs groups who were able to repay loans which were loaned to

---

50 Ibid 2008
51 CHAZ FCCT Bi Annual Report, 2007
52 Danida/NCG report (2006)
53 Following the recommendations of a Kara Umoyo Mid Term Review, 2008
other groups. There was a reduction in the number of CPTs and HBC volunteer drop-outs as well as improvements in livelihoods of PLWHA and OVCs.

In some cases IGAs integrated AIDS education, support for PLWHA and OVCs, and sharing of experiences on living with HIV which helped to reduce stigma. Men who previously used to shun HBC responsibilities were attracted to HBC, CPT and IGA groups due to the benefits of IGAs. Profits from IGAs were channelled to support OVCs mainly in form of clothing, beddings and Insecticide Treated Nets (ITNs), school fees, blankets, soap, sugar, maize meal, cooking oil, and blankets. Assistance was also in form of transport for collection of CD4 count results, support for funeral expenses and rentals for OVC housing. Profits were also used to support HBC, PLWHA and TB clients and to provide shelter for the aged. For example three (3) houses were built for PLWHA in Fiwale while at Chipembi, the Tioneni IGA group, composed of widows, constructed a house for a 76 year old widow who also took care of 26 Orphans.¹⁴

Generally IGAs were used to promote sustainability of project interventions at grassroots level. IGA skills gained provided some financial sustainability to the target groups and it was possible to pay teachers’ allowances in Community Schools. Employment opportunities were created for out-of-school OVCs as hammermill operators and grocery assistants and in tailoring and carpentry. IGA graduates started their own businesses and employed other youths while CPT groups running hammermills employed other community members. The success of IGA interventions had a positive on other donors who provided more resources to the communities to support OVCs, HBC and other activities. For example, Health Communications Partnership (HCP) donated a hammermill at Katondwe MH while Community Response to AIDS (CRAIDS) trained CPT’s 16 AIDS AFVs and community volunteers in IGA management. The Stephen Lewis Foundation donated 26 herds of cattle to Mukinge MH that had a multiplier effect of enhancing OVC support.

¹⁴ CHAZ FCCT Bi Annual Report, 2007
The common challenges faced included lack of capacity IGA group members and long term sustainability of IGAs. For example, the Kulijata IGA group was openly concerned with the sustainability of the IGA once DCA loans came to an end while other groups reported inadequate funds to support the high demand for IGAs from communities, increase in number of beneficiaries (HBC clients and OVCs) requiring support from IGA groups; and poor repayments of loans to enable redistribution. Seed funds were generally inadequate while part of the profit was spent on OVCs and PLWHAs leaving little for re-investment. Other challenges included poor record keeping and reporting especially by community volunteers; poor monitoring and lack of accurate information on performance and impact of IGAs. Although some IGA groups (e.g. at Fiwale) were doing well and could provide best practice example to others, very few exchange visits took place due to lack of funds.

3.1.3 HIV/AIDS initiatives strengthened through focus on stigmatisation
Under the programme intervention “HIV/AIDS initiatives strengthened through focus on stigmatisation” achievement and impact were assessed against the objective “Churches and local NGOs’ role in the fight against HIV/AIDS and their ability to target key barriers in particular stigmatisation strengthened”. The LFA indicators measured were:

i. Number of PLWHA actively involved in DCA supported HIV/AIDS activities.
ii. Number of support groups established by churches and local NGOs.
iii. Increase in quantity and quality of church HIV/AIDS activities.
iv. Increased advocacy by churches on HIV/AIDS and human rights issues such as churches publicly opposing condemnation of PLWHA.

In order to assess the successes made in reducing stigma, we measured the number of PLWHA who were actively involved in DCA supported HIV/AIDS activities and number of support groups that were
established by churches and local NGOs. We also determined whether there was an increase in quantity and quality of church HIV/AIDS activities and determined the depth of advocacy activities on HIV/AIDS and human rights issues led by churches. The outcomes focused more on the quality of life of PLWHA. The overall DCA HIV/AIDS strategy emphasized increase in church leadership in selected countries and programmes’ public support to effective methods of protection against HIV infection and positive actions to fight stigmatization.

Being a church based organization DCA promoted effective methods of protection against HIV infection and positive actions to fight stigmatization. Specific strategies used by DCA and partners in fighting stigma included i) advocating for more HIV/AIDS activities being carried out within the churches; ii) connecting church representatives at community level to HIV/AIDS issues and encouraging them to condemn stigma in society and within churches. DCA recognised that stigmatisation of PLWHA was a major barrier in the fight against HIV/AIDS and therefore focused on fighting stigma and discrimination through advocacy and information dissemination initiatives involving church leaders and pastors, HBC, CPTs and any other means in its interventions. The DCA strategy was to support the vital role of churches in advocacy initiatives: indirectly through the fight against stigma and silence and directly through condemnation. Overall as a result of the DCA intervention there has been an increase in the number of HIV/AIDS support groups in both churches and local NGOs and more PLWHA are accessing ART.

The main DCA partner in achieving this programme objective was CCZ, although all partners played a significant role in reducing stigma within their catchment areas. Through the CoH project, CCZ targeted PLWHA in church congregations as well as church ministers and leaders as main duty bearers in the fight against HIV/AIDS. The CoH focused on capacity building of church members to provide care and support to PLWHA and empowering PLWHA with income generating skills. With a network of 3,800 church members, CCZ played a key role in addressing HIV/AIDS and its consequences, particularly in addressing stigma in congregations. It also supported terminally ill with foodstuffs, transport to clinics to obtain ART and educational support for their children, mainly through a network of church based care givers and PLWHA Support groups. The Support Group concept worked very well as members were able to encourage and support each other in times of need and serious illness and provided safe spaces for PLWHA who were able to come out in the open and obtain counseling and testing and psychosocial support.

PLWHA support groups promoted self care as in positive living, prevention of infection and re-infection, and entrepreneurship skills. A referral system was developed for PLWHA to access government operated ART centres and to monitor the treatment of OIs. A significant reduction in stigma was reported with rural areas recording fewer cases compared to urban areas. More than 70 PLWHA support groups were established with a membership of 1500 and with an average of 21 members in each support group had but some had as many as 50 to 70 members, which was an indication of the levels of sensitization of PLWHAs achieved in DCA target areas. A major challenge in the work of support groups was lack of transport and money for them to provide adequate services to sick people. The problems of support groups were more severe in rural than in urban areas due to long distances. Funding to CCZ PLWHA support groups (e.g. in Luanshya) was irregular and this had led in interruption in care and support for the sick. Despite the reduction in stigma accounts of some PLWHA
show that the practice is still preponderant in target communities. Denial by church leaders and members of the existence of HIV/AIDS and PLWHA in churches was another major challenge. Although significant achievements were made, stigma and discrimination was not totally eliminated from the communities.

A PLWHA Support Group in George Compound explained that they conducted home visits to assess the vulnerability of the families, encouraged members to stick to one support group and then assisted affected families to take care of terminally ill people. The Support Group also reported a reduction in stigma due to sensitization campaigns in the community and changing attitudes of family and communities members. Sick people were coming out in the open to disclose their status and to seek medical attention which resulted in reduction of deaths and number of orphans in the community. PLWHA Support group also testified that “we are now able to walk and talk and live freely in their communities without fear of stigma”. The attitude of community members towards participation of PLWHA in community life was changing although there was no empirical data to support these accounts. The contribution of CCZ to the lives of PLWHA is also reflected in this statement by a support group member in Kabwe, Zambia: “We have benefited from CCZ, they have improved our outlook on life and how we take care of our bodies, that is, the value of different food stuffs to our bodies. We have also learnt on how to administer medicines (ART) even to children”. One of the main challenges identified was that Support Group project activities were not regularly monitored and that communication between CCZ and support group members was only through Coordinators who often misused their positions and had become too powerful.

Other DCA partners were also in the fore front of fighting against stigma and discrimination. For example CHAZ, through its vast network of Church Health Institutions mainly Mission Hospitals and Rural Health centres, CBOs and FBOs, deployed CPTs and care givers to fight stigma in the community. The CPTs reported that sick people were increasingly identifying themselves with Support Groups and communities were increasingly becoming more accommodative of HIV+ people. Kara Umoyo and Kara Choma were also fighting stigma and discrimination through their community outreach programmes and network of Hospices and Day Cay Centres. Kara has used information initiatives and education of parents, guardians and community members to fight stigma. Similarly GGAZ implemented an integrated approach to the fight against stigma and discrimination in all its programmes mainly relying on a network of Volunteers (senior Guides), and care givers to fight stigma. Volunteers interviewed reported a marked reduction in stigma and discrimination and that increasing numbers of PLWHAs were coming out in the open about their HIV/AIDS status.

Churches were also at the frontier of the fight against stigma and used their decentralized structures and outreach programmes to conduct advocacy work at community level. Church efforts had resulted in increase in PLWHA disclosing their status, standing forward and publicly disclosing their status. The effect was a significant reduction in stigma in churches and the community. Pastors and clergymen were making announcements about the existence and benefits of PLWHA support groups which attracted many sick people to come out in the open and were publicly condemning stigmatisation and discrimination of PLWHA which resulted in increased visibility of HIV/AIDS in congregations and greater interaction with the community. However, it was found that some church leaders and pastors still had great difficulties in reconciling or combining HIV/AIDS facts and theology, particularly those issues touching on morality such as sex.

---

60 CCZ/DCA/NCA, 2009  
61 ibid, 2009  
62 CHAZ FCCT Bi-Annual Report, 2007  
63 CCZ/NCCA/DCA Report, 2009  
64 CCZ Self Assessment Report, 2009
3.1.4 Human Rights, Gender and Advocacy Work

Under the programme intervention “human rights, advocacy and gender issues promoted by the Church and partners”, achievements and impact were measured against the objective: “DCA has been instrumental in facilitating increased capacity of partner organizations, in particular on rights based approach (RBA) and advocacy including gender mainstreaming. The LFA indicators assessed were:

- Church leaders and partners apply skills obtained on RBA, gender and advocacy to activities, monitoring and evaluation;
- HIV/AIDS Partner Platform established and functional with increased advocacy and networking activities.

In Zambia the HIV/AIDS epidemic has posed many human rights challenges with the majority poor not having access to quality healthcare. And yet the right to health is very closely linked to people’s fundamental human rights including: the right to dignity, the right to educational information on health, and the right to the highest possible standards of health are examples. DCA has since 2002 promoted RBA in all its programme interventions using its overall strategy of promoting “increased capacity of DCA staff and partner organizations to address the challenges of HIV/AIDS in a rights-based and gender mainstreamed way within the framework of the Millennium Development Goals”. DCA’s overall country programme objective is to contribute:“to increased claiming and upholding of the right to prevention, care, treatment, and knowledge for HIV/AIDS affected persons”. DCA’s emphasis on human rights and gender equality is on the premise that these provide protection and improved welfare for all individuals, who are then able to respond to HIV infection and its adverse effects. The programme intervention focused on fighting stigma and discrimination by promoting human rights and gender mainstreaming mainly through education campaigns and advocacy work at different levels.

**Church Leaders apply RBA, gender and Advocacy to activities, monitoring and evaluation**

One of DCA’s programme strategies was to increase church leaders’ capacity in human rights and advocacy by: “ensuring an increase in church leadership…, and programmes’ public support to effective methods of protection against HIV infection and positive actions to fight stigmatization”. Church leaders and churches played an influential role, which coupled with their strong voice and stance on matters related to human rights and HIV/AIDS, contributed to reduction of stigma and discrimination in their congregations and communities. DCA supported church leaders through training in advocacy and HRG, which enabled them apply new knowledge in congregational activities and awareness creation as well as in monitoring activities. Church leaders effectively used their strategic positions, roles and responsibilities to promote human rights and gender equality within church congregations and in the communities. Church leaders were also using PLWHA support groups to disseminate messages of change in attitudes, perceptions and beliefs based on Christian principles, norms and values and so became more accountable and were upholding the rights PLWHA. They were also more willing than ever to help the sick and orphans in the community.

Through their positive messages, church leaders helped congregational members to break structural barriers, stereotypes, stigma and discrimination thereby enabling PLWHA to improve their self-esteem and to claim their rights including their right to dignity. Many PLWHA in churches no longer feared

---

65 DCA HIV program document, 2005
66 Danida/NCG, 2006
67 DCA, HIV Programme Document, 2005
68 DCA, 2006
69 ibid, 2006
70 DCA/CWS-NCCA/CCZ Report, 2009
isolation or blame which encouraged them to come out in the open, reveal their status and seek HIV/AIDS care. Sick people were in control and making important decision regarding their health and status. The church also actively promoted theological reflection on the experience of HIV and AIDS-related stigma and discrimination. Through their unique position churches and church leaders were fighting stigma among the church members by talking openly about HIV/AIDS and launching campaigns in churches like AIDS Sundays as well as openly demonstrating compassion for PLWHA.

In terms of HRG the main challenge faced by church leaders was to understand and internalise new and often complex HRG concepts. As a result of inadequate knowledge many clergy did not properly defend or advocate for the rights of their congregational members. Secondly stigma and discrimination were still evident and ingrained in churches and some church leaders and members were still in a state of denial about the effects of HIV/AIDS. In George Compound, a support group reported that faith leaders were not fully upholding the rights of PLWHA but instead were even infringing on some their rights by diverting materials donated to church congregations for PLWHA to other uses. Some partners had taken a stance on HIV/AIDS issues such as resisting notions that churches could actively support the use of condoms. This was seen as a very positive step in the direction of enabling the churches to combat HIV/AIDS on a more realistic and impact-oriented level and was a more pragmatic stance towards the inbuilt schisms between HIV/AIDS and theology.

**Partners apply RBA, gender and Advocacy to activities, monitoring and evaluation**

DCA adequately supported its implementing partners to apply RBA, gender and to conduct advocacy work through their interventions. Pilot RBA interventions were implemented through the CHAZ FCCT project (2005-2008) and LCCB project (2005-2007) and later by other DCA partners. Prior to these interventions, the incidence of HIV/AIDS in DCA’s catchment areas was disproportionately high among groups whose rights were not adequately protected and that suffered discrimination especially among girls and women. It was also found that the main drivers of human rights violations and gender inequality were social and cultural practices, inadequate information, non-observance of human rights, discriminatory measures and coercive actions that tended to drive the HIV/AIDS pandemic underground.

DCA introduced new concepts of human rights and gender equality in areas where previously people were not aware or familiar with these new concepts. By promoting RBA, changes were introduced at the community level that helped reduce cases of stigmatization and discrimination and elimination of gender insensitive marriage customs. Communities were also empowered with knowledge of basic human rights and HIV/AIDS and competences were built among community actors, traditional leaders, opinion makers and young people in promotion of human rights and gender equality. People who previously never discussed concepts of human rights and gender equality acquired new knowledge and applied this knowledge in their communities. The effect of DCA’s intervention was increased awareness of basic concepts of human rights in all target groups. Social problems were discussed in terms of violation of human rights including restrictions imposed on young people as violations of human rights.

People who did not see public services, including health care, as entitlements started claiming their rights to better services or treatment from the Government. Duty bearers also began claiming their rights. Community members also realized that it was their duty to provide support to the needy and less fortunate, such as the widows and orphans. The problems of stigmatisation and discrimination against people living with and affected by HIV/AIDS, property grabbing and early marriages and poor access to

---

71 CCZ PLWHA Support Group FGD observation, September 2009
73 ibid, 2006
74 CHAZ EU LCCB project, 2007
education for orphaned and vulnerable children were discussed in terms of violation of human rights. Another problem addressed by the project was failure by the local justice system and institutions to engage with the concepts of human rights and gender equality. This was mainly due to lack of exposure to these concepts and poor observance of human rights in the public institutions including the health institutions. It was observed that Duty bearers rarely questioned gender insensitive customs and practices which resulted in most of the traditional practices going on unabated.

People started to discuss violation of human rights and possibilities of preventing the violations of human rights in their areas. There was growing recognition that human rights were violated in some of the social and cultural practices. As a result, debates relating to how these practices might be carried out without infringing on the rights of any of the people involved were for the first time going on. Harmful traditional practices were being eliminated e.g. sexual cleansing was being modified to take account of the risk of transmission of HIV and the possible violating of the right to life. Most families were consequently sending the person to be cleansed and the person selected to perform the ritual to the health institutions for HIV tests. In cases where either the person that has to be cleansed or the one selected to perform the ritual was HIV positive, sexual cleansing was substituted with other forms of cleansing ranging from using herbs, mealie meal and the “kalungu”75. The project helped to minimize the dispossession of widows and orphans of property when their spouses and parents died which left them destitute. DCA built on the advocacy work of the Young Women Christian Association (YWCA), which had waged an advocacy campaign in the mid 1990s to ensure observance of the Intestate Succession Act of 1989. At Chikankata Mission Hospital and the general catchment area cases of property grabbing from the widowed and orphaned children reduced as these were widely seen as a violation of human right.

DCA’s partners did not fully succeed in building enough capacity for community actors and leaders to actively start advocating for specific rights that were being violated in the community. The exclusion of OVCs from secondary schools on account of not being able to pay school and boarding fees was not questioned by individuals or institutions although clearly this was their right to education. There were a few isolated cases of some community leaders and actors intervening in a few cases of early marriages but not all cases of early marriages and violations of children’s rights to education were challenged by institution, organisation or an individual. Gender insensitive customs, such as property grabbing, early marriages and sexual cleansing had certainly not ended. During the field visit to Chikankata, the evaluation team was told the following story which revealed that human rights of women were still been violated in the community:

“A young woman was recently stopped from cutting vegetables when preparing food at a funeral by one of the mourners…on the premise that she was HIV/AIDS positive and should therefore not cut the vegetables as everyone else at the funeral would be infected. The girl reported the case to the CPT who intervened and spoke to the mourner urging him to stop discriminating people who were positive as the virus was not spread by cutting vegetables”. CPT member’s observation, Chikankata, September, 2009

Clearly the way forward was to build on the achievements made in the LCCB project and other DCA interventions until a culture of respect for human rights became entrenched in the targeted communities. This would, however, require a long time for people to internalise such value loaded and unfamiliar concepts as human rights. Most traditional customs were gender insensitive and so the knowledge of human rights helped to slowly change these customs indicating also a need for sustained

75 see Mulenga, 2005 cited in LCCB End of Term Evaluation, 2007
efforts and continuity in promotion of human rights at community level. A significant reduction in cases of stigmatisation and discrimination against people living with and affected by HIV/AIDS was reported which was not due to respect for human rights, but rather the knowledge of HIV/AIDS.

Other partners such as Kara and GGAZ targeted also made significant achievements in introducing new concepts of human rights to vulnerable young girls in addition to sex education and life skills development. Kara for example managed to a certain degree to merge the objectives of previous phases with new elements; most notably human rights, gender and advocacy trainings. Kara managed to have air at least six (6) radio programs on Human rights although funding for this activity ended abruptly and so the outcome was not fully achieved as anticipated. The challenge Kara faced was that rights-based and gender indicators were not adequately reported on partly due to inadequate capacity to implement and capture this and partly to the limited ability of Kara to grasp new concept of human rights. It was also possible that the HRG indicators may not have been well defined.

DCA promoted activities aimed at strengthening empowerment of girls, female adolescents and adult women as well as reaching out to men with relevant IEC materials on human and gender rights with regard to HIV/AIDS. Through its network of Churches, CHIs, Youth and Church Groups and Anti-AIDS Clubs, CHAZ exposed young people to concepts of human rights and gender equality. HRG trainings were conducted and new approaches to gender mainstreaming introduced. Some partners felt that the training approach was not holistic as it did not lead to long term empowerment of girls and women with information and tools for behaviour and attitude change. The full participation and partnership of both women and men was necessary in productive and reproductive life including shared responsibilities for protection, care and mitigation against HIV/AIDS. DCA made no distinction between PLWHA women and men, OVC boys and girls, men and boys, since all were equally involved with a view to securing their support in attainment and protection of girls and women’s rights. Another strategy involved use of church pastors, traditional leaders, elderly women and local community leaders in sensitizing people on gender issues and to influence and contribute to behaviour change (and negative stereotypes) among men.

DCA partners dealt adequately with factors that debilitate women’s participation at many levels of society such as traditional and cultural practices and policies and legislation, which did not allow full expression of women’s potential and abilities. Gender based and sexual violence (GBSV) is another form of low status of women and gender discrimination in communities and is still common place in Zambian communities. It was observed that DCA partners had not adequately incorporate issues of GBSV, especially the relationship between sexual violence and reproductive health. Issues such as risks to injury and exposure to STIs and HIV as a result of GBSV were not fully covered. Overall it was observed that achieving change in gender relations at community level would require policy and program actions that could improve women’s access to secure livelihoods and economic resources, alleviate their excessive responsibilities with regard to house chores and eliminate legal barriers.

DCA partners like GGAZ have engaged traditional leaders as natural focal points and duty bearers at community level. Although traditional leaders are constructively supporting HIV/AIDS work in their areas, there is still need for more advocacy work to influence, particularly, in redefining the harmful cultural and social practices. The dual nature of the Zambian legal framework makes it difficult to interpret especially in relation to division of powers between customary and statutory law. The traditional leaders would in some instances be legal duty bearers and in other moral duty bearers. In addition, the traditional leaders not only constitute a legal hindrance/possibility, they also represent a central media for communicating and thereby introducing a change in gender perceptions, especially in

---

76 DCA Project Completion Report, 2007
77 DCA, 2005
addressing the sexual and reproductive rights. In one area visited, Chikankata, it was found that people still practiced polygamy and that girls who got pregnant early dropped out of school and became more vulnerable to HIV/AIDS.

DCA has consistently sought the cooperation and involvement of Chiefs and Traditional Authorities in Human Rights and gender, HIV/AIDS, SGBV and SRH issues through training and workshops. Traditional leaders were well positioned to help eliminate harmful cultural practices such as early marriages, traditional sexual cleansing ceremonies and defilement young children. Chiefs had the opportunity to change customary laws and to enact new rules to curb harmful practices. For example, one villager was discouraged from marrying off his young daughter and the child was later removed from the marriage and brought back to school. There was need to capitalize on good and positive aspects of traditional institutions and structures to increase advocacy work since traditional authorities had the potential to reach out to many in the target population.

With regard to advocacy work, DCA carried out a powerful and broad based global advocacy, which was also spelled out at a strategic level in policies and strategies. DCA helped to strengthen partners’ capacity to engage effectively in advocacy e.g. in MDG-campaign calls for greater resource allocation to gender, poverty reduction and HIV/AIDS as well as in support towards elaboration and implementation of focused advocacy strategies for partners. Networking has strengthened the advocacy work carried out by DCA’s partners in respect of coordination with other stakeholders. DCA’s partners integrated the rights-based approach and gender focus in projects and opportunities for advocacy initiatives and by jointly identifying specific advocacy themes. In the early phases of the programme, advocacy work among DCA’s partners was not strong in spite of their nationwide coverage, influence in public policy making and citizen advocacy. Subsequently DCA increased its advocacy work in Zambia by supporting its partners (notably CHAZ, CCZ and GGAZ) to develop Advocacy Strategies and by allocating 26,500DKr to the Jesuit Centre for Theological Reflection (JCTR) in 2006 for advocacy work.

The DCA HIV programme, by design, had no direct links with the MoH and NAC which to some extent limited its advocacy work and potential to influence GRZ policy and decisions. However, through its partners like CHAZ, DCA was able to indirectly influence policy decisions of MoH, NAC, District Health Management Teams, District HIV/AIDS Task Forces, and other relevant government agencies. CHAZ had an influential position in GRZ circles, which made it an authoritative policy and advocacy organization at national level. CHAZ had through dialogue and on many occasions successfully influenced GRZ to increase spending on health particularly on HIV/AIDS. It was noted however that all DCA partners had an opportunity to influence national policy through well-targeted interventions and increased advocacy activities.

**HIV/AIDS Partner Platform**

DCA ably supported the establishment and strengthening of the HIV/AIDS Partner Platform, which met at least twice a year. DCA was represented on the platform by the HIV programme officer and Country Representative. The Partner Platform was effectively used by DCA to promote networking, collaboration, learning and sharing of experiences and best practice. It also helped the partners to avoid overlap, promoted collaboration and cooperation and ensured a coordinated DCA response to HIV/AIDS in Zambia. The platform also provided a window of opportunity for DCA partners to identify common interests and to work together on some common goals. It created space for effective dialogue built on mutual and cordial exchange of information sharing and updates on development trends and changes in the context of HIV/AIDS. The platform promoted transparency and

---

78 DCA, 2005
79 Danida/NCG, 2006
80 DCA Program Budget, 2009
accountability through partner self evaluation, introspection and sharing of experiences. The platform was used for joint advocacy initiatives e.g. in 2005 DCA partners decided to focus on advocacy initiatives around stigmatisation, access to ART, OVCs and joint training programmes. The partner platform was also effectively used for harmonisation of the programme’s M&E and for resolution of outstanding issues that required a common stance amongst DCA partners such as advocacy on OVCs.

Overall the partner platform enhanced a desired level of synergy for a coordinated DCA response. A number of challenges were observed including the need to make the partner platform a more effective mechanism for joint advocacy work, networking and partnership building. Some partners were inexperienced in networking, teamwork and ability to sustain partnerships while the terms of reference, modes of participation and lines of communication were not clear to all partners. Only DCA partner organizations participated in the partner platform although the intention was to include non DCA partners for networking purposes. In the same vein there was provision for the PTA to participate in at least one partner platform meeting but this did not occur during the programme’s life span. It was also felt that there was a missed opportunity for partners, through the platform, to engage more with GRZ and its agencies although partners like CHAZ were active participants in GRZ programmes.

3.1.5 Balance between Advocacy, Empowerment and Service Delivery
In this section an assessment of the balance between DCA’s advocacy work, empowerment and service delivery is presented. Comparison was made of the partners’ service delivery levels, advocacy of duty bearers and the level empowerment of target groups. Generally DCA programme components were deliberately planned to reinforce each other and to achieve an optimal level of synergy. Specific partner interventions were built around a continuum of prevention, care and support and treatment as well as economic empowerment, OVC support and elimination of practices and behaviours that put women at risk and increase their vulnerability. The programme had an advocacy component that was aimed at influencing policies and implementation.

DCA sufficiently supported its partners to implement HIV/AIDS interventions to meet the immediate needs of target groups and to prevent and mitigate the impact of HIV/AIDS. Due to high HIV sero-prevalence levels and morbidity rates in target communities the demand for services has always been high. As a result partners have tended to focus more service delivery that is, outputs, quantity or number of activities and number of people reached rather than on the quality of results or services, that is, the outcomes of their interventions. CHAZ and CCZ have made some progress in balancing service delivery and advocacy especially in relation to increased access to ART and reduction in stigma and discrimination, particularly in rural areas while Kara (and to some extent GGAZ) spearheaded life skills education and empowerment. All partners have promoted OVC free education and empowerment. DCA, through its partners, made some head way in influencing national level duty bearers and policy. Partners supported empowerment of men and women, as well as young people with knowledge and skills and with IGAs. Empowerment and autonomy of women and the improvement of their political, social, economic and health status was a highly important end in itself.

3.1.6 Cross Cutting Capacity Building Issues
This section focuses on assessment of DCA partners’ capacity and competencies to implement the Programme. One of the fundamental requirements of the partnership with DCA was adequate capacity of a partner to implement programme activities and ability to take on responsibilities assigned by DCA to ensure overall programme success. In line with its objective of “facilitating increased capacity of partner organizations, in particular on rights based approach (RBA), advocacy and M&E.” DCA has supported Training of Trainers (ToT) workshops; training in basic financial management, Monitoring and Evaluation; advocacy, human rights and gender. DCA has effectively transferred knowledge and skills
through a number of training programs conducted by partners and CHIs and CBOs, with minimal supervision. DCA’s support for partner’s organizational development (OD) processes resulted in demonstrated improvements in organizational effectiveness and efficiency in service delivery. However, some partners still lacked basic skills in Grant and Report Writing, Communication, Participatory M&E, Documentation, IGA management, Counseling, Psycho-social Support and general project cycle management skills. For example, the quality of reports from some partners has been poor resulting in DCA demanding revisions and delays in disbursement. Further capacity building was required in advocacy, human rights and gender and financial management for partners. Since DCA invested so much in training and capacity building during the programme’s life span, the partners should in future invest their own resources in further training and capacity building.

CHAZ expanded in scope and complexity and now has a range of very experienced multidisciplinary HIV/AIDS expert groups – both at HQ at the strategic level in Lusaka and at mission clinics and hospitals all over Zambia. CHAZ HIV/AIDS staff are experienced medical doctors, nurses, midwives, clinicians and pharmacists and include staff specialized in development and education. DCA has provided sufficient support to CHAZ which has strengthened its competencies in both management and HIV/AIDS. CHAZ is also able to draw from large pool of HIV/AIDS skills and expertise now available in Zambia. Due its demonstrated capacity to implement a decentralized healthcare delivery system, CHAZ was selected to be one of the four Principal Recipients (PRs) of the Global Fund for TB, Malaria and HIV/AIDS in Zambia. This places CHAZ in vantage positing to interact with and influence government policy at the highest level.82 CHIs and local communities’ knowledge and skills in project management were enhanced and competencies build to respond effectively to AIDS particularly an increase was recorded in clients reached in HBC, provision of ART and adherence support. The FCCT enabled the transfer of HIV/AIDS programming expertise from implementing CHIs to other CHIs and CBOs that were either beginning or scaling up community based interventions.

The capacity built in the CHIs, CPTs and communities in HIV management was a sustainability factor in the programme. Most CHIs are now able to carry out project activities independently of CHAZ. CHIs are able to share programming experience and use exchange visits as the main medium of transfer of expertise.83 CHAZ experienced some challenges regarding retention of HIV/AIDS competences in the wake of high competition from INGOs and donor programs like PEPFAR or UN projects, which offered better packages. Late disbursements of funds to CHAZ by cooperating partners, high staff turnover in CHIs, late or non submission of reports by CHIs and failure by CHIs/FBO managements to take corrective measures on inadequacies identified in their institutions and closure of Global Fund Grants (for HIV, TB and Malaria Round 1) affected sustainability of interventions.84

A major impact of competence building has been the transfer of skills from CHAZ to CHIs, FBOs and CBOs. For example the FCCT project (2005-2008) succeeded in transfer of HIV/AIDS programming expertise from CHIs to other CHIs and CBOs through exchange visits and other medium of knowledge transfer. The FCCT also assisted to build capacities of institutions that lacked financial support for AIDS related activities. Area of focus included workshops and ToTs for health and community workers, AFO and community volunteers in counseling, IGA management and Syndromic Management of Sexually Transmitted Infections (STIs). As a result all target CHIs/FBOs have become focal centres for training of district health workers and for promotion of community based health and social support strategies.85

82 CHAZ Annual Report, 2008; Danida/NCG, 2006; FCCT, PCR, 2007, p.5
83 FCCT Bi Annual Report, 2007, p. 6
84 CHAZ Annual Report, 2008
85 CHAZ FCCT Bi Annual Report, 2007
For some partners it was found that the technical capacity and competence to implement HIV/AIDS interventions was insufficient. For example the GGAZ HIV/AIDS focal point person was overstretched due to the large number of activity based and mobile oriented projects in communities. Insufficient staff at site level made implementation and monitoring of project activities difficult. Kara had qualified staff that were training young girls including OVCs in life skills (tailoring, sewing and knitting, carpentry, and farming) and provided training in peer education. It was observed, however, that although Kara’s graduates received a holistic education, the training covered a lot of subjects in a short space of time to allow students to master their trade. This prompted Kara to find places elsewhere for further training for its graduates, which had proven a major challenge given the insufficient opportunities in similar organizations. This resulted in a number of graduates remaining unemployed and inactive for long periods of time. Kara had no comprehensive plan, inadequate resources and facilities for further training of Kara graduates while establishing GGCE at community level was also a major challenge. Overall in the past five years there have been many significant changes in the HIV/AIDS context, target group environment and in priorities of partners and other stakeholders. As a consequence changing contexts all partners reported having the requisite but not adequate capacity to manage and implement DCA supported projects.

Voluntarism was one of the competence building strategies DCA and partners applied effectively and successfully at community level. Partners like GGAZ and CHAZ relied to a large extent on community volunteers to implement and monitor project activities particularly care and support. In the HIV/AIDS community approach taken by CHAZ, volunteers from the villages comprised the core staff for HBC activities and support provided to orphans. Many of these volunteers (approx. 50,000 people and mainly women) had worked for several years in CHAZ programmes.\textsuperscript{86} CHAZ developed Volunteer Policy and Guidelines outlining the strategies for effective voluntarism. More than 30 volunteers were directly interviewed and they revealed that voluntarism was an effective means of sustaining HIV/AIDS interventions such as HBC and IGAs. Volunteers lived within the communities and were complementing the partners’ manpower requirements at community level. The key challenges regarding ‘voluntarism’ were lack of motivation and incentives, inadequate counseling rooms, protective clothing, and transport, which resulted in divided loyalties as some volunteers preferred to work for NGOs that offered better incentives. External incentive schemes tended to negate the spirit of voluntarism and made volunteers understand that they were part of a project structure as opposed to a community response. Lack of ownership was another problem as Volunteers would disband the moment projects ended. There was need for a cohesive community response, creation of community led volunteer incentives and mechanisms for volunteer retention.

\textbf{3.1.7 Partner Cooperation}

DCA has developed a global Partnership Policy to guides for the formation and strengthening of partnerships based on mutual ownership, accountability, participation, equality, harmonisation and alignment. DCA’s partnership policy not only enables it to enter into cooperation agreements with FBOs but also with inter-faith and non religious organisations on HIV/AIDS issues. There is a good balance in the current choice of partners which is a mix of FBOs (CHAZ and CCZ) and inter-faith organizations (GGAZ and KCTT). DCA’s ultimate choice of PT4 partners was mainly influenced by the partners’ development vision, philosophy, values and principles, and track record in HIV programming, community outreach and partners’ objectives were aligned to DCA’s program strategic objectives. In line with the “program approach”, adopted by DCA in 2005, support is not on a project-by-project basis but from a programmatic perspective. This enabled DCA to focus more on broad policy and strategic issues regarding programme implementation while at the same time maintaining close interaction with partner organizations. This also engendered a good degree of autonomy and flexibility which enabled partners to set their own priorities and decision makings concerning their projects thereby enhancing

\textsuperscript{86} Ibid, 2006
ownership and partner’s increased responsibility for planning and resource utilization. A major challenge observed was that of ensuring and sustaining effective partner cooperation and collaboration.

The partnership between DCA and CHAZ started in 1993, providing support for HIV/AIDS education; capacity building for health institutions and communities to provide care and support services including home based care, STI treatment, and counselling and testing; orphan support; and prevention activities. CHAZ accounts for approx. 80% of the total sum being invested in HIV/AIDS activities in Zambia. With its mission hospitals and clinics covering 35% of urban health services and 50% of rural health services, CHAZ occupies a significant place in the HIV/AIDS sector and is a high profile actor at the NGO scene in Zambia. DCA support has enabled CHAZ to develop a HIV/AIDS Strategic Plan 2006-2010 which is under review. CHAZ complements government efforts in the delivery of quality health care by bringing into the health sector: human, material and financial resources, innovation, and care. CHAZ’s member institutions are mostly situated in rural areas where government services are few or sometimes non-existent. CHAZ is a principal recipient for the Global Fund. CHAZ holds a board membership and participates in several technical groups of the NAC. CHAZ is highly regarded by the NAC for its Christian value base, which is important in prevention of HIV. CHAZ has strong links with MoH, DHMT, DATFs and other NGOs, FBOs and private sector firms.

Since 2002, DCA has supported CCZ, an ecumenical umbrella organization of the Christian Churches in Zambia that seeks to promote cooperation and fellowship between Christian people and organizations. Project activities include establishing groups of PLWHA (including Circles of Hope), supporting the Makeni HIV/AIDS Resource and Training Centre, training for church leaders in psychosocial counseling, HBC, and HIV/AIDS advocacy, and formation of support groups for PLWHA within the churches, through the Circles of Hope project which has an income generating component. DCA started working with GGAZ in 2000 in cooperation with the Green Girl Guides in Denmark. GGAZ is a voluntary non-profit making and non-partisan organization for girls and young women, established in 1924 with 15,000 active members. GGAZ accounts for approx. 18% of the total sum being invested in HIV/AIDS activities in Zambia through non-formal educational programs and life skills, confidence building and responsible citizenship. The current GGAP project, which runs up to 2010, supports peer education, OVC scholarships, and HBC and human rights activities.

The partnership with Kara Counselling and Training Trust (KCTT) dates back to 1998. DCA contribution to the Kara budget is presently at 40% which is mainly used for VCT, counseling training, peer education, HBC, and supporting hospice services. The Umoyo Training Centre, which started in 1996, supports girl orphans and vulnerable children some from a background of abuse (about 80 girls are enrolled at Umoyo every. Training includes skills and entrepreneurship training, provision of scholarships for further training and empowerment of the girls, HIV education and provision of health care services. KCTT also runs three day care centres for HIV/AIDS children who are mostly orphans. The day care centre activities include provision of medical check-ups, ART, food supplementation, education and psychosocial support. The objective of this program is to improve children's mental, physical and psychosocial wellbeing including, placing children back into school.

3.1.8 Linkages and Networking
DCA has been committed to profiling its partners and itself as serious actors in HIV/AIDS work and to actively participate in and influence discussions on HIV/AIDS both globally and in Zambia. To this end, DCA strives to establish and be part of a strong network of NGOs that are at the frontier of the fight against HIV/AIDS. The assessment of DCA’s linkages and networking was made at two levels: at national and local levels. At national level DCA collaborates with ACT/Aprodev partners in the regular

---

87 Danida/NCG, 2006
88 DCA Program Budget, 2009
exchange of information and expertise on HIV/AIDS. There is also shared and common interest in RBA, advocacy work and to some extent HIV/AIDS programming (with Christian Aid). For example in 2006 DCA and ACT/APRODEV partners jointly supported CCZ in capacity building in RBA while in 2005 DCA hosted HIV/AIDS workshop which included participants from sister organisations. DCA has ably played its role as facilitator of resources and technical backstopper to partners and has helped strengthen partners’ capacities in RBA, gender issues and advocacy. DCA also offered in-house capacity building, local and regional workshops and a RBA course in 2006. DCA programme staff shared with partners their technical knowledge in RBA and gender.

DCA participated in meetings and various fora including the sub-committee on Livelihoods, HIV/AIDS and ART under the INGO-Forum. It is also a member of CSPR network and has participated in PRSP and monitoring of budgetary allocations for HIV/AIDS. DCA (through PT1) has been active on the Gender Forum and coordinated well with government on gender issues. DCA partners were involved in Technical Committees of National AIDS Council (NAC) and various donors and stakeholders in HIV/AIDS. DCA partners also participated in national, regional or international networks (including Vision and Plan for 2006-2010. Through its partners DCA has also been part of large global and regional networks such as the FOCCISA and the International Conference on AIDS and STIs in Africa (ICASA) through which DCA extended its network to 15 African partner organizations on HIV/AIDS. DCA also organized a follow up HIV/AIDS African Workshop that was held in Lusaka in November 2005.\textsuperscript{89} The Workshop objectives included exchange of ideas among the partners in Africa; networking; and sharing of the DCA’s HIV/AIDS policy and advocacy strategies.\textsuperscript{90} DCA’s partners have benefited from the FOCCISA’s Nordic cooperation, which has produced the “One Body” initiative that aims at providing church leadership theological legitimacy to fight against stigmatization of PLWHA.\textsuperscript{91}

CHAZ collaborates with the Global Fund and Catholic Relief Services (CRS) on roll out of ART and has links with the private sector firms and communities that surround its sites. CHAZ sent an emissary of the Global Fund to the USA on two occasions to lobby US FBOs to increase funding to Global Fund in Zambia. CHAZ has also been represented at Annual General Meeting of the Regional AIDS Training Network. DCA’s partners like GGAZ have forged closer links and networks with other NGOs like the YWCA and YMCA for counseling; the Legal Clinic for legal assistance and FAWEZA for shelter. Other NGO networks include Save the Children (Child Rights, basic education and HIV/AIDS) and the Southern Africa AIDS Trust (SAT) and Zambia National Association of AIDS Networks (ZNAN) on prevention and advocacy issues. GGAZ also collaborates with NGOCC on SRH, PSS initiatives, RESPI and UNICEF on Internally Displaced Children (IDPs).

CCZ has links with different organizations who are actively involved in sensitizing people on the dangers of HIV/AIDS and teaching PLWHA to cope with their status. These include Afya Muzuri, Treatment Advocacy Literacy Campaign (TALC), Zambia Interfaith Networking group on HIV/AIDS (ZINGO) in food stuffs, Family Health Trust (FHT) and Copperbelt Health Education Project (CHEP) in education), World Vision International (material assistance) and Development Aid from People to People (DAPP) in clothing. CCZ also collaborates with NZP+ to support the functions of PLWHA support groups, promote VCT and PMTCT education and the Zambia Alliance for People living with HIV/AIDS. The benefits of these networks are that DCA partners were able to tap into expertise, experience and resources of other organizations.

\textsuperscript{89} ICASA 2003  
\textsuperscript{90} Ibid, 2006, p.14  
\textsuperscript{91} Danida/NCG, 2006
3.2 Programme Management Capacity

3.2.1 Overview
DCA’s programme management capacity was evaluated in terms of organizational capacity, governance and strategic leadership and human and other core resources. Good management ensures that proper weight is given to each facet of programme mission fulfillment. In this respect, DCA has administered and managed the HIV/AIDS programme in a way that supports its overall mission and programme strategy. DCA has strived to attain a balance in its core programme components including planning, implementing and monitoring with available resources. Programme management capacity is well correlated with performance that is also highly visible outside of DCA’s organizational set up. DCA’s success in implementing this programme could be attributed to the existence of a balanced, deep and broad leadership. Strategic leadership and guidance has been adequate to steer the programme on its right course to achieve the programme strategy.

3.2.2 Programme level Staff, Capacity and Competencies
The HIV programme has been administered and efficiently managed by the decentralized Zambia regional office whose management staff comprise the Country Coordinators (CC) and Program Type Adviser (PTA) -a specialist in HIV/AIDS both based at DCA H/Q in Copenhagen while at country office key staff include the Regional Representative (RR) and the HIV/AIDS Programme Officer. HIV/AIDS programme staff are supported by a part time Programmes Assistant (PA). The programme received adequate support from the Finance and Administrative Controller, Assistant Program Officer for Finance and Administrative Assistant and the Logistics Officer/Driver, mainly in budgeting and fund administration, procurement and asset management and logistics.

The technical capacity existed with DCA but the number of staff required to efficiently implement the HIV/AIDS programme was in our view inadequate. This was mainly due to the large HIV/AIDS programme portfolio (comprising eight (8) project interventions implemented by four (4) equally large partner organizations) with many tasks of tracking, monitoring and evaluation of project activities. DCA also faced a high turn-over of its HIV/AIDS staff, with at least four (4) programme officers having left since the programme started in 2005. This high attrition rate not only affected stability and continuity at programme level but also efficient administration and implementation of the programme. Partners were also affected as a result of inconsistencies in information flow to and from DCA and delayed implementation of cross-cutting activities as new programme officers had to adjust to the new environment. A self assessment exercise would help to ascertain the real and potential causes of high staff turnover at country office level. Further the Programme Assistant was often delegated with work and responsibilities from other programme types (PT1 and PT3) as well as from the RR. This inevitably increased the workload of the Programme Officer, and when the Programme Assistant was busy with other PT activities. There is need to recruit a full time Program Assistant to strengthen the technical expertise of the HIV/AIDS programme.

It was also found that DCA did not support long term training although it encouraged its staff to pursue career development opportunities at their own cost. This lack of long term career development opportunities was potentially a de-motivating factor as most workers in Zambia placed high priority on career development as a means to promotion and higher incomes. Consideration should be made to sponsor staff on a cost sharing basis and that such staff could then be bonded at DCA for at least two years to recoup on the investment and also as a staff retention strategy. An improved staff incentive system (not only salaries) and provision of more career development opportunities could help resolve some of these challenges. DCA recognized these challenges and consistently supported capacity building and training of its programme staff through Continuous Professional Development (CPD) courses and attendance at local, regional and international workshops. Courses attended included HIV Management,
Advocacy, Organizational Assessment and Organizational Development (OA/OD), Gender, RBA, and M&E training. Members of staff that underwent CPD were able to apply new knowledge and skills to their work and shared this with partner staff. DCA was cognizant of emerging issues in HIV/AIDS such as the changing nature of AIDS epidemiology, MSM, male circumcision, Post ART and paediatric HIV management that required re-training of its staff and partners. Since the programme focuses on RBA and HRG there also need to strengthen technical capacities of staff in these focal areas.

3.3 Programme Monitoring and Evaluation and Reporting
As a first step in assessing achievements and results in programme monitoring and evaluation (PME), we reviewed DCA’s global M&E objectives which for clarity’s sake are repeated hereunder as: i) to provide an overview of how well a programme is on track to achieve its’ project/programme’s objectives; ii) to keep track on programme progresses, outcomes, challenges and lessons learnt; support a timely adjustments of plans, operations and organization; iii) to provide the basis for programme platform members to take joint action on common challenges and advocacy initiatives; iv) to identify programme relevant capacity needs of partners; v) to provide the basis for accountability through sharing progress results with the stakeholders involved (partners, projects, beneficiaries, DCA HQ, the Danish public and back donors); and vi) to provide information that allows the programme to be reviewed and evaluated.92

DCA uses the LFA and requires that partners’ use the same LFA approach although partner projects’ LFA’s do not necessarily have to match the programme’s LFA. However, DCA insists that all partner projects should be linked to the country programme through the LFA logic, with partner projects representing the activities of the country programme. PME is done at different levels including: i) at the global level (DCA H/Q), where the vision, mission and main working approaches as well as policies and guidelines are developed; ii) at regional (country) level where the global programme’s monitoring guidelines are translated into concrete actions and outputs and reports of DCA thematic areas (e.g. PT1, PT3 and PT4) and iii) at partner level where work is further divided into projects implemented by partners or occasionally by DCA itself. At each level a cycle of planning, monitoring and evaluation and reporting processes is developed and linked to DCA’s financial, administrative, human resources and management information systems.

All DCA partners followed and used agreed progress and performance indicators. These were initially formulated at the programme design phase and on the basis of the total outcomes as expected from the partner projects. Programme indicators were the link between the partner projects and the country HIV programme since the project immediate objectives and the projects own outcome indicators are attached to the country HIV programme outcome indicators.93 Partners’ performance indicators were also defined at input; output, outcomes and impact levels, and were discussed and shared among the partners. Allowing flexibility, DCA encouraged its partners to develop appropriate data collection tools and monitoring methodologies such as Most Significant Change (MSC), Story Telling, and Participatory Assessment, which were appropriate for use at community levels and which would enrich DCA’s LFA framework, especially for the purpose of bringing in additional data on outcomes and change.94

Programme monitoring at partner level was of sufficient depth and scope that it provided adequate data to feed into the programme (regional) level requirements. Data and information was first collected at partner level, analysed, summarized and sent to the regional (country) level for further analysis and consolidation. Monitoring of project activities at community level was done by CPT’s, PLWHA Support.

92 DCA, Programme Monitoring Document, 2009
93 Ibid, 2009
94 DCA, 2009
Groups, and a network of community volunteers while data collection and analysis was done by partners’ field staff (AFOs, Field staff and Administrators/Medical Officers in Charge of CHIs) and volunteers using pre-defined forms and tools. Information on cross-cutting issues such as HRG and advocacy work, general capacity building, governance, fund raising or operational issues was collected at both programme and project levels, summarized at separate levels and mainly analysed at the programme level. DCA country programme staff conducted monitoring and support visits to partners at least once or twice per year e.g. in 2007 DCA staff (RR, Programme Officer and PTA) monitored sites of the LCCB programme.

At country (regional) level efficient documentation systems including archives of concept papers, overviews, policy briefs, plans, reports, manuals and programme guidelines enabled easy access to information by all partners. Project and Programme Manual (PPM) and procedures for planning and implementation were readily available while DCA Programme Officers and partners were properly oriented in the use of the PPM. The documentation systems enabled DCA and partners to prepare publications and annual reports, facilitate media links and public relations and served as a repository for advocacy work. At partner level documentation of the HIV programme activities varied as it was not mandatory for partners to adopt DCA’s documentation procedures. Documentation systems of some partners were not well developed or at least were in the early stages of development. The main challenge was integration of information from various partners into the country documentation systems to ensure preservation of DCA’s institutional memory.

In terms of reporting the partners supplied DCA with regular narrative and financial reports on project progress throughout the period of cooperation. The most important instruments included the Annual Progress report, the Audit Report and the six month Progress Report covering the period January-June. There were no major deviations from the original plans or requirements, and where these occurred DCA was consulted and approved the changes in writing. Partners collected, stored, prepared and submitted reports using their own specific and different formats. Additional feedback was obtained through scheduled meetings, workshops, Indabas and partner platforms at which lessons of experience and challenges were shared by all partners.

The main reports generated at country (regional) level included Quarterly, Bi-Annual and Annual Reports, MTRs and Evaluation Reports. Other programme documents used for reporting purposes included the Programme LFA Matrix, Programme Overview, Programme Progress Chart, Project Monitoring Planning and Visits, Programme Reviews and the Programme Annual Report. Feedback into the documentation system was also provided through the partners’ bi-annual project reports, programme platforms minutes, workshop reports, Regional Office follow up notes and DCA HQ follow up notes. The reports were widely used by the DCA Regional Office’s programme staff, partners and their management (e.g. in production of Annual Reports), partner platform members, projects and target groups for improving project interventions. Reports from the country (regional) office were also widely used by DCA HQ based programme staff, the CCs, PDU, GPU etc, the DCA HQ Management and Board, back donors and sister organizations.

DCA promoted and facilitated organizational learning by ensuring sound programme monitoring, efficient data collection, documentation, and follow up. At country level, the main structures used to promote organizational learning (sharing and exchange of lessons of experience including best practice), were the DCA Regional Office’s Programme Management Committee, Programme (Partner) Platforms, Programme Review workshops, and during project facilitation in communities and capacity building events. The partner platform enabled partners to critically reflect and provide constructive feedback and collaborative analysis of issues while regular formal and informal meetings helped to improve organizational learning. DCA acted as mentor and supported its partners in organizational learning processes. Specifically, data from programme processes was used to promote and “institutionalize”
learning leading to improvements in individuals and partner organizations’ knowhow of HIV/AIDS programming. Organisational learning also helped DCA and partners improve on programme content (focus) and organisational strategy (approaches and methodologies) and to re-align strategic direction during the implementation period.

Programme monitoring improved the ability of DCA and partners to promote accountability. DCA upheld and prioritized the principle of participation which enabled partner involvement in influencing the design of the programme and decision making at all stages of implementation and finalization of programme activities which promoted downwards accountability.\textsuperscript{95} Emphasis was placed on the development and use of proper communication mechanisms in projects in order for rights-holders and their communities to influence projects and address their concerns during implementation with emphasis on the rights of most vulnerable and marginalised groups. DCA also promoted up-wards accountability to DCA HQ, the Danish public, back donors, GRZ and other supporters by ensuring that high quality updated reports (and documentation) were available at the right time and in the relevant document handling systems. Through monitoring activities, DCA generated enough evidence to facilitate advocacy work, basic project and programme management, supervision and control, resource allocation, public relations, marketing and funding raising activities (e.g. TV Collections). Information from programme monitoring activities was not only used to review the programme’s policies, strategies, tools and procedures but also to feed the Danish public debate and advocacy initiatives at national and international level and to provide valuable inputs to the ongoing dialogue with DCA back donors such as Danida and the EU.\textsuperscript{96}

\textit{Challenges in Programme Monitoring and Reporting}  
At the country level the main challenge encountered was the use of different reporting formats by partners which resulted in DCA programme staff spending lot of time on data analysis, harmonizing and consolidating different reports. Different report formats also affected the systematic capture; sharing and follow up of lessons learnt and sharing and comparison of lessons among partners. DCA recognized these shortcomings and encouraged partners to use a common reporting template although this was not a DCA HQ requirement. Harmonizing the reporting requirements of different back donors such as Danida and EU with non-negotiate guidelines and differing information requirements as a basic condition for funding, was also challenge to both DCA and partners.

At partner level, the main challenges (for some but not all partners) were poorly defined M&E objectives, low quality of and reliance on proxy indicators which was evident in the absence of a comprehensive baseline study\textsuperscript{97} e.g. some CHAZ clients reported unwanted pregnancies as indicating increasing risky behavior among girls. In addition information requirements were not clearly defined and targets and milestones not clearly indicated (e.g. the means of identifying unexpected events and outcomes were not included and hence reliance on proxy indicators). Data analysis focused more on output indicators (quantities/numbers) than on outcomes and impact indicators. Some partners had not developed appropriate monitoring guidelines, tools and instruments and protocols including those on data analysis and usage to help them gather, analyze and report data. Information sources and methods and users were also not clearly defined and clarified (in terms of who was expected to provide what information, methods used and frequency and what sort of analysis was made of the information/data collected). Some partners were not clear on who was expected to use their information, what media was used to communicate information and feedback to providers of information (e.g. insufficient field visits

\textsuperscript{95} DCA, 2009  
\textsuperscript{96} Ibid, 2009  
\textsuperscript{97} For the DCA programme no baseline study was conducted prior to implementation although a comprehensive situation analysis was conducted at the formulation stage. Subsequently performance and progress indicators were designed and agreed upon with partners, who incorporated them in their project formulation phases.
to beneficiaries and absence of a transparency policy). The timing and sequencing of M&E activities and linkages between M&E activities and project activities were also unclear in some cases.

Partners, like GGAZ and CCZ, were in the process of developing and strengthening their organizational M&E frameworks with the support of DCA. Partners, however, faced the challenge of inadequate M&E skills and reporting capacity to effectively implement the new systems. Others like CHAZ, who had already developed their own M&E procedures and practices and reporting systems, indicated that they preferred to continue using their own systems. Reliance on community volunteers to capture M&E information often resulted in poor data quality since their record keeping was not up to date and they tended to spend more time on HBC and sensitization activities than on M&E. Some partners like GGAZ, did not have sufficient capacity (focal persons) at community level to monitor, collect and store data which made the work of the Project Coordinator difficult. Some partners like CHAZ and CCZ had to deal with reports from scores of CHIs and FBOs who maintained their own M&E systems. Partners did also not have sufficient knowledge of other DCA partners’ PME systems and reporting practices.

Programme/Project Evaluations and Reviews
It is standard DCA policy to conduct periodic programme/project evaluations and reviews for the purpose of assessing level of achievements of objectives and level of impact and for bringing essential learning to new possible phases. Such exercises are facilitated by the Regional Office and are conducted on the basis of programme monitoring results which are readily available at the Regional Office. Mid Term Evaluations were conducted for all partners in consultation with the CC and PTA while partners and their projects beneficiaries took part in the evaluation, briefings and follow up. DCA commissioned a number of external evaluations for its PT4 sub grants and the results have been used to improve program design and implementation. However evaluations of specific PT4 projects have made little reference to other PT4 partners’ interventions and how these are linked or the synergy that is being achieved by all partners. The value adding aspect has been that evaluations have helped DCA to identify factors that facilitated or hampered achievement of results and DCA’s contribution to broader development objectives (e.g. MDGs). Recommendations from evaluations have also been used by partners to improve programming and to review policies, strategies and budgeting process.

3.4 DCA Country Office Allocation of Resources

3.4.1 Sources and Allocation of Programme Funding
The HIV programme funding in Zambia was mainly sourced from the DCA mainstream funding envelope (about 50-100m DKr), which are mostly used for administration and operational purposes; from Danida (about 115m DKr) through the Danida Framework Agreement (DFA), which are disbursed on the basis of 3 to 4 year rolling plans and allows for greater flexibility of usage and application and thirdly from Global Funding, which included funding from the EU and other back donors. This type of funding is project specific and comes with specific terms and conditions of usage, monitoring and evaluation. Through its partners like CHAZ, funding was sourced from the United Nations Global Fund for TB, Malaria and HIV/AIDS (GFTMHA) while the Irish and Royal Netherlands Embassies (RNE) provided additional financial support to CHAZ.

The Danida Framework Agreement (DFA) funds comprise over two thirds of total planned and disbursed funding to the programme. DFA and DCA earmarked funds have consistently been available during the period under review from 2005 to 2009 while global and other funds covered a limited period of time only. The total consolidated budget for the period 2005-2011 is estimated at DKK 58, 463, 98 CHAZ Bi Annual Report, 2007
798,00. Of this amount 67% is secured DFA funding 13% was EU project funds (2005-2006) and 8% was from TV Collections (2007-2009). DCA earmarked and un-earmarked funding contributed 9.0% and 1% respectively while Parish funds (2007-2009) made up 2.0%. The total amount of funding available to partners from different funding sources is shown in the Table 2 below.

<table>
<thead>
<tr>
<th>DCA Source</th>
<th>Amount</th>
<th>Percentage of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>DANIDA Frame</td>
<td>39,205,029</td>
<td>67%</td>
</tr>
<tr>
<td>DCA Unmarked</td>
<td>383,415</td>
<td>1%</td>
</tr>
<tr>
<td>DCA Earmarked</td>
<td>5,113,335</td>
<td>9%</td>
</tr>
<tr>
<td>Parish</td>
<td>1,195,645</td>
<td>2%</td>
</tr>
<tr>
<td>TV Collections</td>
<td>4,857,352</td>
<td>8%</td>
</tr>
<tr>
<td>EU</td>
<td>7,509,023</td>
<td>13%</td>
</tr>
<tr>
<td>Unsecured Advocacy fund</td>
<td>200,000</td>
<td>0%</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>58,463,798</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

Table 3-1: DCA Source of Programme Funding and Allocations (2005-2009)

Source: DCA Program Budget, 2009

3.4.2 Programme Costs, Implementation Support and Monitoring

DCA's total program costs are modest in comparison to amounts of funding allocated to partners. Clearly DCA has been able to exercise prudence in application of financial resources with modest amounts allocated for capacity building and partner workshops (644,386 DKr and 138,634 DKr respectively); and administrative fees and contingencies (340, 130 DKr and 381, 500 DKr respectively). Implementation support received about 3,4m DKr up to 2009 and a further 971,000 DKr is allocated up to 2011. The main sources of funding for programme costs and implementation support have been DFA and DCA unmarked funds. A shortfall of 20,000 DKr in implementation support was recorded in 2008 ostensibly arising out of unsecured funding of the same amount. Monitoring visits have been allocated 92, 974 DKr up to 2009 with a further allocation of 48,000 DKr up to 2011. The allocation for monitoring was initially high when the project started, possibly due to requirements of the FCCT and LCCB projects, but reduced by half from 2006 and has remained consistent since then.

Overall DCA has an efficient fund administration and disbursement system that enabled efficient implementation and achievement of agreed targets. Although the system is centralized and in some cases procedurally cumbersome, efforts were made to improve disbursements through promotion of use of the intranet for records management and the Enterprise Resource Planning (ERP) system for financial management. Devolution of fund administration is further anticipated with the implementation of the Decentralization Policy. DCA allocated sufficient funds for monitoring visits (about 92, 974 DKr up to 2009 with a further allocation of 48,000 DKr up to 2011). The allocation for monitoring was initially high when the DCA programme started, possibly due to monitoring requirements of the FCCT and LCCB projects, but reduced by half from 2006 and remained consistent from then on.

DCA has maintained a sound financial monitoring system and has used this effectively to assess how well the programme has performed in relation to the planned budget. The introduction of the ERP system and better management information systems, DCA created efficient monitoring processes to track progress not only in finances but also in other crucial aspects of their work. Funding allocations, flows and usage by partners are closely monitored by the country representatives and programme staff using the readily accessible global DCA intranet and ERP system.
3.4.3 Disbursements to Partners
The disbursement system has worked well both at programme and partner levels. Funding requests originate from partners on the basis of approved Annual Work Plans after which funds are disbursed on the basis of an agreed transfer plan. All project requests above 500,000 Dkr have to be authenticated by the PTA before final approval by DCA Headquarters in Denmark. Funding allocations, flows and usage by partners are closely monitored by the country representatives and programme staff using the readily accessible global DCA intranet system. DCA and partners usually work on annual funding cycles with 3 year commitments. At the end of each funding cycle (usually by 31st December) partners are required to expend all Danida project funds while they are allowed to roll over into the next cycle other unused DCA earmarked funds. Interest and/or exchange gains accumulated from deposited DANIDA/DCA funds are returned to DCA annually, if not considered part of the following year’s transfers which are consequently reduced. The partner must reimburse all unspent DANIDA/DCA funds by the end of the project period or if the project is discontinued. DCA program and project budgets are reviewed in consultation with partners at least once per year or as need arise. This may happen when more funds are available and the partner justifiably submits a request for additional funding to implement activities. When changes to the budget are proposed, addendums have to be prepared to support the requests.

CHAZ has been the major recipient of DCA funding accounting for over half of the total funding disbursed (or nearly 37,5m Dkr) during the period under review (2005-2009). By proportion GGAZ has been the second largest recipient of DCA funds mainly from the DFA and DCA earmarked funds from implementation of the AIDS Project in Zambia (GGAP). KCTT has been the third major recipient of DCA funding mainly for implementing the Kara Umoyo Training centre project (2005-2011), Day Care Centres and Hospices (2006-2009) and the Kwasha Mukwenu Access to Care (2005-2008) which was supported through DCA earmarked funding. The Circles of Hope project (2005-2010) implemented by CCZ has been the fourth largest recipient.

3.4.4 Joint Financing Arrangement (JFA)
In 2007, DCA entered into a Joint Financial Arrangement (JFA) with the Embassy of the Kingdom of Netherlands (EKN) and Irish Embassy to support HIV/AIDS activities implemented by CHAZ. All CHAZ AIDS programme activities were integrated into the JFA and focused on: HBC, OVC support, ART, CT, and IGAs. DCA’s funding contribution to the JFA was mainly from DFA sources (about 14mDKr) and DCA earmarked funds (about 1.35m Dkr). As a funding mechanism the JFA has enabled CHAZ to leverage additional resources to scale up the AIDS response. In terms of financial reporting CHAZ only has to provide one common report while monitoring is conducted jointly with other JFA funding partners. The JFA also provides an opportunity for CHAZ to leverage additional funding from other back donors who appreciate and prefer the basket funding approach. CHAZ has to contend with the different approaches, development paradigms, and institutional frameworks of JFA donors. It will be important, at some stage in the future, for DCA to undertake an exercise/study to determine the efficacy of the JFA mechanism and impact of its contribution to this basket fund.
### Table 3-2: Allocations to Partners and Source of Funding (2005-2009)

<table>
<thead>
<tr>
<th>Partner/Project</th>
<th>Project Duration</th>
<th>Allocation (DKr)</th>
<th>Source of Funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. CHAZ FCCT</td>
<td>2005-2007</td>
<td>6,122,306.00</td>
<td>Danida Framework Agreement</td>
</tr>
<tr>
<td>2. CHAZ LCCB</td>
<td>2005-2007</td>
<td>12,362,504.00</td>
<td>DFA (about 50%), Dan LCCB, EU, DCA earmarked</td>
</tr>
<tr>
<td>3. CHAZ JFA</td>
<td>2007-2011</td>
<td>18,557,855.00</td>
<td>DFA (about 14mDKr), DCA earmarked (about 1.0m DKr), TV Collections</td>
</tr>
<tr>
<td>4. CHAZ Clinics</td>
<td>2008</td>
<td>212,400.00</td>
<td>DCA earmarked</td>
</tr>
<tr>
<td>5. CHAZ Advocacy</td>
<td>2009</td>
<td>200,000.00</td>
<td>TV Collections</td>
</tr>
<tr>
<td>6. CHAZ St. Edmunds OVC Support</td>
<td>2006</td>
<td>20,000.00</td>
<td>DCA earmarked</td>
</tr>
<tr>
<td>7. GGAZ</td>
<td>2005-2011</td>
<td>6,478,703.00</td>
<td>DFA (about 5mDKr), Parish, DCA earmarked</td>
</tr>
<tr>
<td>8. Access to Care Kwasha Mukwenu</td>
<td>2005-2008</td>
<td>334,229.00</td>
<td>DCA earmarked; TV Collect</td>
</tr>
<tr>
<td>9. Kara Umoyo</td>
<td>2005-2011</td>
<td>4,228,783.00</td>
<td>DFA (about 3.4m DKr), DCA earmarked</td>
</tr>
<tr>
<td>10. Kara Day Care Centres</td>
<td>2006-2009</td>
<td>871,398.00</td>
<td>DCA earmarked</td>
</tr>
<tr>
<td>11. CCZ Circles of Hope</td>
<td>2005-2010</td>
<td>1,471,824.00</td>
<td>DCA unmarked; Parish, DCA earmarked</td>
</tr>
<tr>
<td>12. New Partner - JCTR</td>
<td>2006</td>
<td>26,500.00</td>
<td>DCA unmarked</td>
</tr>
<tr>
<td>13. New Advocacy Partner</td>
<td>2010-2011</td>
<td>400,000.00</td>
<td>DCA own funds</td>
</tr>
</tbody>
</table>

Source: DCA Program Budget, 2009

### 3.4.5 Cost Effectiveness Analysis

In line with its decentralisation policy, DCA allows its partners flexibility in utilizing project resources in ways they deem to be most efficient and effective to achieve the desired results. However, DCA is also concerned that resources are used and managed in the most cost-effective way, that is, it is concerned with how project money is spent, where resources are channeled and what results are achieved. In this regard DCA encouraged its partners to apply the most efficient (least cost) methods of meeting their projects’ objectives and achieving a certain level of efficiency in implementation and optimizing the use of their budget allocations. Effective organizational development support has also contributed to increased resource mobilization capacities, transparent and accountable partners who are able to use DCA resources in a most efficient and cost effective way. This in turn has given DCA the confidence to guarantee funding from back donors to the partners.

DCA has put in place improved financial management and monitoring measures that ensure financial prudence in partners. These include putting in place appropriate cost saving measures to minimize administrative overhead costs including: cost sharing of facilities (office space) and staff (drivers and cleaners), pooling of motor vehicles and joint outsourcing of IT support with Christian Aid and Norwegian Church Aid (NCA). There are mark ups on how much partners can spend on administrative and operational costs as well as workshops. Another cost saving measure is the sharing of responsibilities for monitoring of partner projects although partners are given more responsibility for project monitoring. DCA has also put in place clear procedures and regulations for asset management, procurement and contract management, which are simplified and shared with partners. However, DCA procedures are not mandatory upon the partners who may adapt them to suit their organizational environments. The challenge lies at the partner level where DCA Manuals are used in conjunction with partners’ organizational manuals, operational procedures and financial regulations.
3.4.6 Challenges related to funding and disbursements

DCA partners have faced a number of challenges related to funding and disbursements. These included under-spending resulting in funds returning to the donors. It was observed that in 2008 about 135,433DKr in Danida funds were unspent (11,609 DKr by GGAZ and 123,824 DKr by Kara Umoyo). Late submission of financial reports, approval of new projects (by DCA) and misunderstanding on reporting formats affected timely disbursements. The overall effect was increased workload of and pressure on partners towards the end of the year. Funding deficits were reported especially in the areas of IGA support, HBC Kits, prevention especially PMTCT services and training in HRG. This was mainly due to increasing demand for partner services in the target areas and not necessarily due to insufficient DCA support. DCA funding policy did not support capital investments such as construction of buildings although DCA through various projects bought equipment (computers, printers etc), motor vehicles and provided funds for operations of community counseling centres.

Within the programme framework DCA did not support infrastructure development. It was, however, observed that insufficient capital investments in VCT facilities and Life Skills Education and Drop-in centres for young people affected partners’ service delivery in rural areas. It was also observed that despite the support received from DCA’s Global Funding Unit (GFU), some partners still lacked adequate technical capacity in preparation of winning grant proposals. Some partners like CHAZ had already established Grants and Resource Mobilisation Units which enhanced their capacity to mobilize resources. There was need for other partners to set up similar Units with support of the GFU. In future DCA could also consider decentralizing the GFU functions to country (regional) offices.

3.4.7 Balance of Resources Spent on HIV/AIDS

To assess the balance of DCA resources spent on HIV/AIDS activities compared with resources available to the health sector as a whole we made a qualitative review of general trends in HIV/AIDS funding and the role played by CHAZ, the principal recipient of DCA programme funding. It is well documented that DCA has spent well over 30mDKr in support of the HIV/AIDS response in Zambia. Nearly half of these funds have been channelled through CHAZ to target populations. Since CHAZ provides nearly 50% of formal health services in rural areas and 30% in the entire country through its network of 133 affiliated Church Health Institutions (CHIs) and other FBOs. CHAZ supports 31 hospitals, 75 rural health centres and 27 Community Based programs including 10 Catholic Dioceses. CHAZ has worked with close to 400 FBOs and has mentored and provided lessons to other organizations in the area of HIV/AIDS program implementation, resource mobilization and in working with the government and the Global Fund. In view of CHAZ’s influence we drew the conclusion that DCA had made a significant contribution to the Zambian health sector as whole. However, in the absence of empirical evidence it was difficult to determine how much what this contribution amounted to in real terms.

Globally donors were shifting emphasis away from HIV/AIDS support to health systems strengthening (HSS) and to tackling other health issues such as child and maternal health, SRH, and fatal diseases like malaria and diarrhea. This trend, which also was reflected in Global Funds, had implications for DCA and partners since in future there could potentially be lesser resources committed to HIV/AIDS programmes. CHAZ, CCZ and other FBOs that depended on Global Fund grants and sub-grants could be affected by this shift in priorities of donors. There was need for DCA and partners to start looking ahead and to re-align their funding strategies particularly with regard to Global Fund and PEPFAR funds.

101 CHAZ Annual Report, 2008
102 Medicine Sans Frontiere, 2009
3.5 Relevance and Quality of Programme Design

The section presents the findings and conclusions on the relevance and quality of the program design and in particular focuses on whether the strategic approach as presented in the program LFA matrix is still valid and what adjustments, if any, are needed. It is not the intention of the evaluators to repeat the problem and context analysis here as this is already extensively discussed in Section 2.0 above of this report. Rather the intention is to draw conclusions from previous background analysis and to use this information to ascertain the relevance and validity of the strategic approach. Some of the analysis will be repeated for the sake of clarity.

3.5.1 Comment on DCA’s Logical Framework Approach

The PT4 (HIV) program (2005-2009) was developed taking into account the global DCA HIV strategic approach, formative assessments and recommendations of previous program and project evaluations. The formative assessments were participatory while potential partners and rights holders were consulted in the program design phase, which engendered a sense of program ownership during implementation. DCA follows a logical Framework Approach (LFA), and uses this technique as planning and monitoring management tool. Log frame analysis is mandatory for all DCA program and partners’ projects (DCA, 2009). DCA Zambia works through well established partners (also known as PT4 partners), whose project immediate objectives are linked to the program’s LFA logic.

A few observations concerning, but not necessarily affecting the relevance and validity of program’s intervention logic are that: the key result Areas (or program outputs) are not explicitly presented in the program’s LFM although these can be subsumed from the array of indicators outlined in the LFM and immediate objectives of partner project’s LFMs; ii) Baseline indicators are not clearly presented in the LFM although it is clear from the PT4 Program for Zambia that significant formative assessments and contextual and problem analysis were made prior to program design. As a result, the program LFM does not clearly state the actual quantities targeted by interventions, to make them, in LFM parlance, “objectively verifiable” indicators (OVIs). It was found that none of DCA’s partners in Zambia have conducted impact studies or baseline studies (the EU LCCB project implemented by CHAZ had a baseline study, but it was not supported by DCA). Thus it is difficult to measure any direct impact of some of the programs like behavioural change and peer education.103

3.5.2 Connectedness of the HIV/AIDS Programme to other Program Types

The connectedness and synergy achieved between and among the HIV programme and other Programme Types at country (regional) level was also evaluated. It was found that the HIV programme was not well connected to the other PTs, notably the Civil and Political Space and Food Security programmes, at country level. There was a general tendency towards a compartmentalized approach to programming (that is, staff working in some kind of “boxes”) with no clear terms for coordination and integration. It was also observed that in spite of the minimal linkages, HIV/AIDS was still dealt with as a cross-cutting issue and that there were a number of areas of common and shared interest among the PTs notably in advocacy, human rights and gender which required greater coordination across all PTs. The latter were also already exchanging expertise and sharing information whenever need arose.

Overall there was sufficient potential to create strong linkages and synergy among the PTs especially in the area of food security and HIV/AIDS (PT3/PT4) as well as in good governance and HIV/AIDS (PT1/PT4). The Civic and Political Programme (PT1) targets gender inequalities at community and national level as well as promotion of human rights and so provides much scope for collaboration with the HIV/AIDS programme. Similarly there is need to strengthen the linkage with the Food Security Programme (PT3) since food insecurity is experienced by many households in both rural and urban areas.

103 Danida/NCG, 2006
Food insecurity contributes to family members engaging in risk-taking behaviour in order to survive. The relationship among the PTs at country level should be symbiotic to ensure a coordinated response to HIV/AIDS. There was clear need for greater cohesion and integration in programme strategies through identification of crosscutting needs such as capacity building relating to HIV/AIDS and human rights. There was, however, need for a more institutionalized and systematic approach to staff exchange and information sharing across the PTs.

### 3.6 Validity of DCA’s Strategic Approach

#### 3.6.1 Changes in HIV/AIDS epidemiology and Characteristics

DCA and its partners have made significant gain in the fight against HIV/AIDS in the target communities and have contributed to the nationwide multi-sectoral response to the epidemic (all which are well documented and discussed above. The disease related factors, problems and contextual conditions that initially guided the development of the program strategy have not changed much in the country but instead have taken on new dimensions, some positive while others with further implications for the DCA response. The current issues presented in the strategic approach: primary prevention; Home based care; support for PLWHA and orphans and vulnerable children and capacity building of partners still remain valid in the Zambia context where the initial conditions still prevail and in some cases even escalating while the HIV/AIDS pandemic is assuming a new face.

Although not backed by empirical data, interviews with beneficiaries revealed that in the target communities more people were accessing VCT and ART and hence there was a reduction in the number of PLWHA in need of care and support. However, other issues were emerging such as drug resistance, Opportunistic Infections (IOs) and nutritional and livelihood support for PLWHA and increasing numbers of paediatric HIV cases due to low levels of PMTCT. Although VCT had been scaled up, it was reported that only 13.4% of Zambians knew their HIV status and recent reports indicate that new infections are on the rise. Similarly despite a reduction in morbidity rates of parents, the overall picture is one of increasing numbers of OVCs in Zambia. Previous structural barriers and harmful practices were being removed through concerted project interventions and people were more aware of their rights; were able to exercise these rights and were willing to accept change.

Further the number of children being born with HIV was increasing and soon these would become teenagers and eventually adults, who would join the ranks of PLWHA. MSM has its moral and legal implications which present particular challenges for implementers and social activists, in a country where MSM is illegal. The changing scenario and context of HIV/AIDS epidemiology calls for re-adjustment and re-alignment of future programme strategy to adequately address emerging issues such as drug resistance, male circumcision as a prevention strategy, paediatric HIV and Men having Sex with Men (MSM), which is emerging as one the key drivers of HIV/AIDS in Zambia. There was need for partners to focus more on advocacy work and engagement with GRZ and other stakeholders around the new dimensions of the epidemic.

#### 3.6.2 Trends in HIV/AIDS donor funding and Support

Global health experts contend that HIV/AIDS funding has sparked massive increases in international aid for health that have benefited a range of other health issues and systems. Globally funding for HIV/AIDS rose from 5.5 percent of health aid in 1998 to nearly half of it in 2007 while total funding for

---

104 ZSBS, 2006
105 UNGASS, 2007
106 MSM is an emerging phenomenon in Zambia and the law does not allow indicating the challenges that lie ahead for people engaged in MSM

46
health nearly tripled between 1998 and 2007. In Zambia HIV/AIDS funding has contributed to increased donor funding especially since the mid 1990s when the government started conducting surveillance surveys, putting in place strategic plans and rolled out the HIV/AIDS response, particularly ART. As Global Fund Principal Recipient CHAZ was able to leverage and mobilize large amounts of resources for a nationwide roll-out of HIV/AIDS prevention, treatment and care and support interventions.

The current trend is that several HIV/AIDS donor organizations have begun shifting their efforts to strengthening health systems, based on the realization that weak health systems are frustrating their AIDS-related goals. It is also held that money spent on combating HIV/AIDS in the last decade has been at the expense of other fatal diseases and little strengthening of weak national health systems. For example the US President's Emergency Plan for AIDS Relief (PEPFAR), the main contributor to ART interventions in Zambia, intends to widen its focus to include maternal and child health and tropical diseases. After leading the charge for universal access, the UK Department for International Development (DfID) has started redirecting funds to other health issues, while The Netherlands is considering a reduction of 30 percent in its HIV/AIDS spending.

The global economic crisis has further worsened the situation with the GFTM considering cancelling its 2010 call for funding proposals. Already the total amount of Global Fund HIV grants recommended for funding in 2009 was 35 percent lower than in 2008. It was announced that PEPFAR intended to widen its focus to include maternal and child health and tropical diseases. Donors will thus generally need to "align their actions with the priorities and approaches of partner governments and other national stakeholders" to achieve a broader focus on health-related issues. The bottom line though is that HIV/AIDS has received a disproportionate share of donor funding and so the focus should be on how best that money could be spent to improve access to HIV treatment, prevention and care and to strengthen health systems. DCA partners like CHAZ who have a significant proportion of their funding drawn from the Global Funds have to be cognizant of these developments and trends and start taking appropriate measures and strategies including re-aligning their programme strategies before rolling out HIV/AIDS interventions. Diversification of sources of funding and preparation of viable sustainability and exit plans are suggested.

### 3.6.3 Assumptions for Future HIV/AIDS programming

A number of assumptions and risks concerning implementation were made at PT4 programme design phase that are part of the programme LFA. Regarding the first key assumption, it is the view of the evaluation team that there has been continuation and increase in political will and commitment of GRZ and stakeholders to fight the HIV/AIDS epidemic. Since 2005 a number of policies, strategic, guidelines and other operational planning instruments have been developed by GRZ, NGOs and other stakeholders. Many activities have also been successfully carried out at community level indicating receptiveness of the target groups. Although the flow of financial resources to HIV/AIDS from GRZ and donors has been steady since 2005, recently poor governance and particularly financial mismanagement, has lead to loss of donor confidence and reduced support to the health sector which has dire implications for HIV/AIDS interventions as a whole.

---

108 PlusNews IRIN, 2009
109 PlusNews/IRIN, 2009
110 US President's Emergency Plan for AIDS Relief, 2009
111 Ruth Levine and Nandini Oomman, 2009
112 Fraud cases involving misuse of donor funds have been unravelled notably the MoH scam involving ZMK27 Billion
One of the major risks anticipated at program design phase was the unfolding and future political situation in Zambia. The evaluation team notes that the political situation has remained fairly stable in spite of two highly contested elections in 2006 and 2008 (Presidential By election). However, it’s the continued economic decline in Zambia that poses a major obstacle to the fight against HIV/AIDS as this has the potential to reverse some of the gains made by DCA and its partners. The economic burden of fighting HIV/AIDS often falls on poor communities who have little means to adequately respond to the pandemic. It is inevitable that the strategic approach be re-aligned to address the changing economic and governance scenarios to mitigate the impact on poor people, for example, by increasing budgetary allocations to partners to help mitigate the impact of inflationary trends, losses through fluctuations in exchange rates and filling the gap left by donors who have withdrawn funding to the health sector, particularly to HIV/AIDS activities.

External risks that could potentially affect the programme strategic approach include: i) economic development related to huge mining investments in certain areas of Zambia such as the North Western and Luapula provinces which have the potential to increase the HIV/AIDS epidemic in these traditionally low prevalence areas; ii) slow response by state and non state actors, and institutions to changing international and regional trends and innovations in the fight against HIV/AIDS; iii) fairly inept and static national policy, legislation and national and locally constituted committees and their reactive nature of responses and weaknesses in coordination of the HIV/AIDS multi-sectoral response to the epidemic iv) slow pace of legislative and constitutional reforms which could significantly delay policy reforms and restructuring in GRZ, particularly to address issues of human rights and gender equality; v) inadequate district structures for a multi-sectoral response to HIV/AIDS and how to operationalise decentralised structures is a challenge.
4. Lessons to be learned

The main value of any evaluation is to learn lessons that can be applied to future programmes and projects. This section outlines the key lessons drawn from implementing the HIV programme in Zambia in terms of the policy, programmatic, organizational (e.g. for DCA) and operational lessons as well as the general development lessons drawn from the evaluation in relation to sectoral, country or regional strategies.

4.1 Policy and Programmatic lessons learnt

Contained within the international and national consensus on the principles that should govern the HIV/AIDS response, is the recognition that problems must be identified and resolved according to a local context and solutions developed which take into account the local context and particularities. In terms of policy the DCA HIV programme has made significant contribution to the national HIV/AIDS policy and strategies by supporting project interventions implemented by partners at the grassroots level, particularly in rural areas where government interventions are inadequate or entirely missing. Thus through the programme, DCA and partners have been pivotal in influencing HIV/AIDS policy development and change in Zambia. The changing context of the HIV/AIDS epidemic, however, calls for a review of national policies and strategies and corresponding response.

Prevention has been a central feature of all DCA interventions and should be strengthened in future more so in light of growing evidence of new HIV infections and the fact that many Zambians, especially those living in rural areas, have not tested for HIV. Granted access to ART has brought hope to many previously sick people and positive gains through reduction in morbidity and improvement in the quality of life of PLWHA. However, there is a danger that people might become complacent and forget about prevention altogether. Further it was found that some aspects of prevention strategies were not strong enough to make any meaningful change in lives of young people. Since so much was achieved in the areas of sensitization and awareness creation the focus should be on partners establishing more centres for Counselling and Testing and Psycho social support. Prevention targeting young people should be scaled up and access to VCT services and facilities particularly in rural areas be increased.

HRG concepts are still new to most DCA partners and the process of internalization of these concepts is slow in most communities. At grassroots level especially in rural areas uptake of HRG is still low partly due to high illiteracy levels. Clearly claim making on various rights e.g. the right to prevention and care and support still require strengthening especially for rights holders, who do not know which rights to claim partly due to inadequate sensitizations on human rights. However it should be noted that sustained efforts are ensuring that RBA issues are adequately addressed by the target groups.

While DCA’s global advocacy work has been strong and effective, the partners’ advocacy work has not been as strong. DCA has prioritized advocacy work in partner cooperation and uses its global experience and expertise to strengthen advocacy work at country (regional) level by supporting the partners to develop advocacy strategies. More advocacy work is required particularly engagement with GRZ to further support the majority poor, especially those in rural areas. Opportunities should be seized and well-targeted interventions implemented if advocacy activities shall bear fruit. For example partners should continue to strengthen their relationship with traditional institutions to increase its advocacy work and contribute more to public policy advocacy.

In terms of HBC, it is evident from the programme context analysis that the situation for PLWHA has changed significantly since 2005. This is particularly so with the GRZ’s roll out of ART and other related interventions. Many previously terminally ill people are now up and about and living relatively normal lives. The Post ART situation is presenting a number of challenges such as drug resistance and
people passing on new and resistant strains of HIV. The main issues to be considered in future by the partners include adherence support, dealing with drug resistance and access to nutritional, livelihood and psychosocial support.

Considerable DCA resources have been spent on supporting OVCs and other vulnerable children in communities with positive impact since the lives of many children have been improved. Recent statistics, however, indicate an increasing number of OVCs in Zambia (estimated at 1.3 million in 2008). All stakeholders are confronted with the enormous and daunting task of taking care of and supporting OVCs. Many scholarship beneficiaries who complete primary or secondary education are unable to proceed for further education due to lack of support. The existing OVC referral system to other NGOs and particularly to government run institutions is weak and needs strengthening. There are no viable GRZ adoption programme or bursary schemes for OVCs. Partners should also develop comprehensive plans for further training of OVCs and other graduates by mobilizing additional resources to expand their facilities and by developing strong small business enterprises at community level.

IGAs are an integral part of HIV/AIDS activities and will remain so for some time to come. They essentially play a key role in supplementing the support from DCA and partners to the target groups. Parents or guardians who are taking care of OVCs and sick people should be particularly supported with IGAs. Where they have been successfully implemented, IGAs have been important in mitigating the impact of HIV/AIDS by empowering poor communities with small businesses. The main challenge is sustainability as many communities do not have business management skills, business plans or have not conducted market research to determine viability of businesses. Further IGAs are not well supported by the local financial market while structural barriers such as access to micro-finance remain. There is need to improve access to micro-finance and to develop viable IGA models to support local communities on a sustainable basis.

4.2 Organisational and Operational Lessons Learnt

In terms of organizational lessons, the HIV programme has been well administered and implemented on the back of strong leadership, governance and management. However, the main issue, at country level, has been high staff turn-over of programme officers. This requires DCA to conduct a self assessment to ascertain the real and potential causes of and to resolve this situation. In future consideration should be made to improve career development opportunities and to provide other incentives. The emerging issues, such as HRG and advocacy and the new dimensions of the HIV/AIDS pandemic (changing epidemiology, MSM, circumcision, Post ART HIV management etc), require specialized knowledge and skills and properly qualified manpower which are lacking at all levels.

The partner platform has been an effective mechanism for coordination and sharing of experiences among partners. However, it has not been effectively used for other purposes such as advocating and lobbying government and its agencies like NAC to improve service delivery especially in rural areas. Due to lack of clear terms of reference, however, the full utility of the partner platform has not been achieved by partners. The private sector has not been fully harnessed to take advantage of the sector’s expertise, management skills and financial resources.

Some partners still lack basic skills in Grant and Report Writing, Communication, Participatory M&E, Documentation, IGA management, Counselling, Psycho-social Support and general project cycle management skills. Further capacity building is required in advocacy, human rights and gender and financial management for partners. The quality of reports from some partners has been poor resulting in DCA demanding revisions and resultant delays in disbursement. The absence of a standard reporting format had the effect of reducing efficiency of programme staff due to time required to consolidate partner reports in different formats. At partner level documentation and knowledge management have
not yet been fully prioritized and as such knowledge resources generated by some partners are not properly documented, shared and utilized.

The Danida Framework Agreement funds comprise over half of the total planned and disbursed funding, and together with DCA earmarked funds have consistently been available during the period from 2005 to 2009. The rest of the funding was global funds and covered a limited periods of time during the implementation period (2005-2007). Although the fund administration system is centralized and in some cases procedurally cumbersome, it has worked well for both DCA and partners. The shifting emphasis by donors from HIV/AIDS to other health issues presents a challenge for all partners since the basket of funding will slowly be dwindling. It is in this context that DCA and partner should re-align their funding strategies and options.

In light of the changing environment and context of the epidemic DCA partners should diversify their sources of funding and even prepare strong sustainability and exit plans. The technical capacity of partners to prepare winning grant proposals is weak and so there is need for the GFU to play an increasing role in training partners in grant writing and resource mobilization. One viable option is for all partners to establish strong Grants and Resource Mobilisation Units to ensure that in future there are no funding gaps or deficits that could affect sustainability and consolidation of gains made through the DCA programme.

The JFA mechanism has proven a good mechanism for supporting partners like CHAZ with well established systems, leadership and who have demonstrated good governance. Monitoring is done jointly with other donors and joint progress reports are prepared and shared among all donors. The main issues has been the difficulty of attributing success or failure to any specific funder and the fact that the JFA’s effectiveness and benefits have yet to be known since this mechanism was only initiated in 2007. In practice it has also been a challenge for the partner to harmonize the different approaches, development paradigms and institutional requirements JFA funders although with time the barriers are slowly been overcome by both donors and the partner.

Overall the programme strategy has worked well and most of the programmes objectives have been met at all levels. However, in future, the strategic approach should be re-aligned to focus more on advocacy work and engagement with GRZ and other local stakeholders, especially on emerging issues and new dimensions of HIV/AIDS. Some partner projects have been perceived as temporary “come and go” mobile interventions and so the need for more permanent and practical projects. Overall HIV/AIDS issues should be looked at holistically and so future programming by partners should integrate other aspects of community needs and development as water and sanitation, community strengthening and additional capacity building in Sexual Reproductive Health, nutrition and Human Rights.
5. Recommendations

The recommendations outlined in this section are based on the main finding and conclusions of the evaluation. For clarity they are discussed in terms of overall recommendations, for the programme as whole, specific and other recommendations for the short- and long term.

5.1 Overall Recommendations

It is evident from the findings and conclusions that the HIV/AIDS epidemic in Zambia still requires a holistic and multi-sectoral approach that enables the expansion of access to prevention, care and treatment. DCA and partners should therefore build upon their previous successes in prevention, care and support as well as in the cross-cutting issues of human rights and gender mainstreaming. The transition should be to move from the current programme strategy to promoting sustainable community driven HIV/AIDS interventions by partners themselves. This could be achieved by strengthening the community response and structures (CPT’s, PLWHA Support Groups, HBC care givers, other Volunteers etc) established with the help of DCA over the past five years.

The AIDS epidemic represents a shared burden at all levels and so the next cycle of programming presents an opportunity for DCA to promote shared responsibility with current partners, GRZ, sister organizations and donors. DCA should seize this opportunity by supporting partners in taking leadership of the local responses to the epidemic in addition to supporting an expanded collective action and increased collaboration with other organizations. In future programming at all levels should address HIV/AIDS within a broader context of health and development issues to ensure an effective response to overall health needs (e.g. food security, water and sanitation etc) of people especially those in rural areas. It is recommended that the HIV programme be integrated with the Civil and Political Space (PT1) and Food Security (PT3) programmes to enable DCA and partners expand their local capacity to address a broader array of health demands and to respond to new and emerging challenges and issues presented by the HIV/AIDS.

5.2 Specific Recommendations

The following specific recommendations are made based on the findings and conclusions of the evaluation. It is important to refer to the relevant sections of this report (particularly Section 3) which outlines in detail the findings and conclusions on specific programme areas. These recommendations are logically presented as follows:

Prevention, knowledge building and behaviour change

In the Zambian context, prevention remains the most paramount challenge of the HIV epidemic, and so should be the major priority for partner interventions in the next five years. With more than 82,000 new HIV infections per year reported and on the basis of the findings of this evaluation, it is recommended that DCA partners scale up prevention efforts by increasing PMTCT services particularly testing for pregnant women, provision of antiretroviral drug (ARV) prophylaxis and treatment of women found to be HIV-infected. Partners’ strategies should also ensure that the number of at-risk babies born HIV-free from HIV-positive mothers is increased from the current levels. Partners should contribute to national efforts to ensure that Zambia reaches a desirable threshold for early infant diagnosis and testing of older children of HIV-positive mothers, with increased referrals and linkages to care and treatment.

Successful prevention programmes will require a combination of evidence-based, mutually reinforcing biomedical, behavioral, and structural interventions. Future partner prevention strategies should emphasize on the following: tracking and reassessing the epidemiology of the epidemic, in order to devise a prevention response based on best available and most recent data; emphasizing prevention strategies that have been proven effective and targeting interventions to most vulnerable and at-risk
populations with high incidence rates; and increasing emphasis on supporting and evaluating innovative and promising prevention methods. Partners should also focus on other areas such as increasing peer education, life skills education and empowerment, and strengthening strategies relating to BCC particularly information dissemination using the media and communication tools. DCA partners should invest in new diagnostic labs, Counselling and Psycho social support (PSS) centres in rural and peri-urban areas to strengthen VCT and PMTCT. This should include purchase of appropriate equipment and management support of these centres.

**Care and Support and Treatment**

It is also evident from the finding that the HIV/AIDS epidemic has transformed from a fatal disease to a manageable one. There are more than 100,000 PLWHA on treatment, care and support and more than 1.2 million OVCs nationally but the ability of most families and communities to provide supportive services, such as food, nutrition, education, livelihood and vocational training, to orphans and vulnerable children is inadequate. It is recommended that the Integrated Home Based Care and Support strategy be re-aligned to focus more on adherence support to prevent drug resistance and livelihoods mainly nutritional support and management of OIs. Specifically there will be need to increase training and education of care givers and PLWHA on management of OIs, nutrition, drug resistance and strengthening of the referral system to quickly identify sick people and refer them to GRZ ART centres. There will also need to implement follow-up (tracking) programs for sick people and to integrate community health workers within the continuum of care and support.

Regarding OVC support it is recommended that DCA partners continue supporting OVCs especially those in Day Care centres, Hospices and Scholarship beneficiaries for some time to come. There is need for DCA partners to strengthen their advocacy work to promote rights of OVCs, support for the most vulnerable children and promote a strong and effective referral system to GRZ and other organizations for OVCs. It is proposed in that in future partners consider introducing new OVC initiatives such as the Memory Book and succession planning to respectively enable OVCs trace their and secure their future. The partners should also invest in Life Skills Education/Drop-in centres infrastructure for OVCs and other youths. With regard to mitigating the socio-economic impact of HIV/AIDS through IGAs, it is recommended that DCA and partners develop a viable micro-finance model for IGAs that could be applied effectively and sustainably to all areas of Zambia and to provide resources for strengthening capacity of CBOs in business planning and management.

**RBA, Gender and Advocacy Work**

The evidence points to the fact that RBA and gender issues have not been fully understood or internalized by most individuals and communities. This implies the need for more concerted efforts in this area. Key to future programming is the need to expand DCA’s and partners’ commitment to cross-cutting integration of RBA and gender equity in programmes and policies. The new focus should be on addressing and reducing gender-based violence and strengthening advocacy work by identifying local organizations with a strong track record in advocacy and human rights issues and engaging with these in new partnerships. There will also need to advocate for continued change in policies to address the larger structural conditions, such as gender-based violence, stigma, or low male involvement, which contribute to the spread of the epidemic.

**Cross Cutting Capacity Building Issues**

Although DCA performed very well in this area, the evaluation pointed to the need for further training and capacity building in Psycho-social Support, VCT, general HIV management and Peer Education, Project Management, Proposal and Grant writing Skills, Human Rights, M&E and Small Business Management, Resource Mobilization and fundraising. Since DCA invested so much in capacity building the partners will have to assume responsibility for future capacity building initiatives. It is further recommended that the number of partner exchange visits and study tours including visits abroad
required be increased to strengthen networking and exchange of information among partners. To ensure sustainability, it is recommended that DCA partners continue their support for training and retention of community health care workers to strengthen local health systems.

**Partner Cooperation and Coordination**

The impact of the HIV/AIDS pandemic remains huge in Zambia and so it is important that DCA continues supporting and working with different partners and stakeholders to achieve the desired sector wide impact. It will be necessary therefore to review and strengthen the existing cooperation agreements and to make the necessary adjustments to align with the future programme direction of integration of the HIV programme in other DCA Programme Types. It is recommended that DCA continue working with the same partner organizations (CHAZ, CCZ, Kara and GGAZ) as well as other stakeholder’s but should that DCA should consider bringing in other partners to focus on advocacy and HRG issues. This will require identification of new partners with strong track record in advocacy and human rights issues. There will also be need to forge stronger linkages with political space actors in light of increased movements towards decentralization in Zambia.

DCA succeeded in enhancing greater coordination and for joint advocacy on free education for OVC, gender and human rights. However, it was also found that the partner platform mechanism was not very effectively used to promote greater interaction, dialogue, coordination and exchange of information and lessons among partners. Another challenge was lack of ownership (of the platform) and participation by some partners. On the sustainability of the partner platform, it was not clear whether the partners would be willing to continue participating once DCA phased out the HIV programme. It is therefore recommended that in future the partner platform mechanism be reviewed and terms of reference, roles and responsibilities of platform members be clearly defined and a clear exit strategy be put in place.

The evaluation noted the challenges faced in the coordination and connectedness of DCA’s Programme Types (HIV/AIDS, Civil and Political Space and Food Security. For example it was found that the interaction between Programme Officers was less than desired. It is recommended that in future DCA at country level promotes greater interaction among the Program Type Officers to discuss and clarify administrative and operational issues related to their respective programmes. DCA should also promote greater programmatic interaction and integration to create the desired synergy in the country response. One area of interaction could be in the cross-cutting issues of food security, human rights, gender and women empowerment. DCA’s working relationship with ACT and Aprodev partners is sound and strong. However, it is recommended that there be greater coordination and planning of joint activities to maximize use of available resources such as transport and shared staff.

**Program Management Capacity and Competencies**

The main challenge has been the High staff turnover of the HIV Programme Officers and to some extent similar staff at partner level. The other challenge has been insufficient technical expertise in the area of HIV/AIDS to effectively run the programme. It is therefore recommended that for future programming the position of HIV Programme Officer be stabilized and strengthened through improved working conditions and recruitment of a Programme Assistant to deal with M&E, documentation and networking issues. This measure is required to lessen the pressure on HIV Programme Officer due to increased workload. It is further recommended that technical capacity of Programme Officers in HIV/AIDS, RBA and HRG be further strengthened.

On the operational side there is need to strengthen logistics by acquiring 1or 2 new all terrain MVs at country level while at partner level motor bikes and bicycles are required to improve mobility and service delivery. DCA partners should consider providing incentives for hard working community volunteers, CPTs and AIDS Team members and in case of CHAZ even re-introduce honorarium for deserving CHI staff and volunteers to boost their morale. Some of the partners, such as GGAZ, require
addional capacity in form of part time Site Coordinators to ensure effective implementation and monitoring of project activities and networking with other organizations. However, we recommend that such partners look beyond DCA to source funding from other donors recruit additional staff.

**Programme Monitoring and Evaluation and Reporting**

DCA’s regional and partner M&E policies and procedures, systems design, and structures have facilitated the implementation process and ensured the intended results were achieved. In light of the observations during in the evaluation, DCA and partners’ M&E systems should be reconciled and streamlined with various information demands of back donors and other stakeholders such as NAC. It is also recommended that in future programming M&E systems procedures and tools should be developed in such a way as to promote mutual learning while maintaining the flexibility of allowing partners to use their own systems.

It was also found that monitoring focused more on outputs rather than outcomes or evidence based and qualitative indicators. It is recommended that partners be provided with additional technical capacity to be able to prepare and submit quality and desired reports. It is further recommended that DCA should encourage proper and consistent documentation of all its activities not only to ensure preservation of institutional memory but to effectively measure the quality of results and services. Since no baseline studies or impact studies were conducted prior to implementation of the HIV programme, it is recommended that prior to implementation of future programmes, partners should conduct baseline studies for each of the programme’s strategic components. Further it is recommended that thematic research and KABP studies related to human rights and HIV/AIDS be commissioned to measure impact and for future advocacy work.

**Country Office allocation of Resources**

Generally there have been no major challenges regarding Country Office allocation of resources although there were sentiments that some DCA partners received disproportionately higher funding levels than others. We also found that the effectiveness of the JFA mechanism had not yet been assessed. In light of inadequate capacity of some DCA partners to prepare grant winning proposals it is recommended that technical capacity be provided through the Global Fund Unit for partners to develop appropriate grant writing skills or to establish Grants and Resource Mobilization Units.

**Validity of the DCA strategic approach**

Although the current DCA strategic approach is still valid it is recommended that the programme strategy be re-aligned to focus more on strong advocacy on PMTCT and male circumcision as a prevention strategies, Post ART drug resistance, children infected with HIV and HRG. DCA should in future strengthen its advocacy work and strive to engage more directly with the government and its agencies in these areas of interventions. This will require that DCA identifies new partners with strong track records in specific or thematic areas such as human rights and advocacy. There will also be need for more programmatic interaction and integration of the HIV programme (PT4) with the Civil and Political Space (PT1) and Food Security (PT3) programmes and actors to achieve synergy in some of these areas.
ANNEXURE
Annex 1: Terms of Reference

2009 DCA HIV/AIDS END OF PROGRAM EVALUATION (FINAL VERSION)

1. Introduction

1.1. Country Context

The HIV/AIDS epidemic continues to impact the various sectors of the Zambian economy and the well being of the Zambian people. The national HIV prevalence rate among adults aged 15-49 years has slightly declined from 15.6 per cent in 2002 to 14.3% in 2007, with a high proportion of HIV positive individuals in the 35-39 age groups, and twice as high in the urban than rural areas at 10% and 20% respectively (2007 DHS). About 1 million people are living with the HIV virus and over 200,000 require anti-retroviral therapy. The 2007 UNGASS report projected the number of orphans at 1,320,026 in 2008.

Knowledge of HIV/AIDS is still high in Zambia, reported at 99% in the 2007 DHS preliminary report, although lower among women and men who have never had sex, and those with less education. Although information about the existence of counselling and testing facilities is constantly high, this has not been accompanied by a corresponding increase in the number of people testing for HIV. Only 13.4% knew their HIV status in 2006 (ZSBS, 2006). Care and support programs have been strengthened and expanded over the years, to include orphan support, home based care, nutritional support, support for care givers, and palliative care including, pain management and prophylactic treatment for opportunistic infections (OIs).

Zambia has exhibited some changes in social norms relating to sexual behaviour, such as postponement of the age at first sex from 16.5 to 18.5 years among young people aged 15-24 between 2003 and 2005. However, multiple and concurrent partnerships still pose as a major challenge for HIV prevention activities, with 17% of women and 38% men reporting they had sex in the previous 12 months with someone who was not their spouse (ZDHS 2007).

To mitigate this impact, the Government of the Republic of Zambia (GRZ) has developed and implemented various policy and guideline documents, to guide implementation of HIV/AIDS related programs in the country. These documents include, the Ministry of Health (MOH) 2006-2010 National Health Strategic Plan, the National AIDS Council (NAC) 2006-2010 HIV/AIDS Strategic Framework, the 2005 HIV/AIDS/STI/TB policy, PMTCT, CT, ART guidelines, PMTCT scale up plan, laboratory Standard Operating Procedures (SOPs), and various national training manuals. The NAC 2009-2011 draft HIV Prevention Strategy is also in its finalization stage. In addition, the GRZ has also put in place Monitoring and Evaluation (M&E) systems for data collection and monitoring of national HIV/AIDS activities. GRZ with the help of collaborating partners has developed and implemented national ARV drugs and HIV Test kit quantification, procurement and distribution systems. The development of national laboratory and OI drug systems is underway.

Both the MOH and NAC emphasize equity of access to cost effective and quality health care services by all Zambian, that are as close to the family as possible. This vision is achieved through good Leadership, Accountability, Partnership and Sustainability.

1.2. The Current DCA Programme

1.2.1. Overall objective of the programme

The overall program objective is to contribute to increased claiming and upholding of the “Right to prevention, care, treatment, and knowledge for HIV/AIDS affected persons, especially the consequences for women, children and orphans as well as the negative impact HIV/AIDS has on the cultural and socio-economic situation of the target population, alleviated”

1.2.2. Specific Objectives and Indicators

The specific objectives and indicators for the current program include:

a. Risk-taking behaviour (sexual and non-sexual) for women, children and youth in rural and peri-urban areas, reduced.

Indicators:
i. Targeted communities are knowledgeable about the modes of HIV transmission and can identify ways infection can be prevented.

ii. Increased number of people exercising their right to voluntary counselling and testing services

iii. Increased number of girls and adolescence women claim their sexual and reproductive rights.

iv. Increased number of community members sensitized on gender inequalities by churches and local NGOs.

v. Access to counselling, care and treatment support, and socio-economic assistance for PLWHA, orphans and vulnerable children, increased and promoted.

Indicators:

i. Number of PLWHA accessing support from home-based care and community support groups.

ii. Number of orphans and vulnerable children supported and empowered with life skills and knowledge.

iii. Number of referrals to governmental service deliverers enhanced, particularly of OVC.

iv. Number of PLWHA claim right to ART.

v. Number of vulnerable women economically strengthened through income generating activities.

c. Churches and local NGOs’ role in the fight against HIV/AIDS and their ability to target key barriers in particular stigmatization, strengthened.

Indicators:

- Number of PLWHA actively involved in DCA supported HIV/AIDS activities.
- Number of support groups established by churches and local NGOs.
- Increase in quantity and quality of church HIV/AIDS activities.
- Increased advocacy by churches on HIV/AIDS and human rights issues such as churches publicly opposing condemnation of PLWHA.

d. DCA has been instrumental in facilitating increased capacity of partner organizations, in particular on rights based approach (RBA) and advocacy.

Indicators:

- Church leaders and partners apply skills obtained on RBA, gender and advocacy to activities, monitoring and evaluation.
- HIV/AIDS Partner Platform established and functional with increased advocacy and networking activities.

1.2.3. Current Interventions

The DCA Zambia 2005-2009 HIV/AIDS program strategy is multi-pronged and responds to the need for comprehensive HIV/AIDS programming. The strategy supports the following:

- Primary prevention (awareness raising, increasing knowledge, and promoting behaviour change);

- Human rights, advocacy and gender issues (dealing with stigma and discrimination, human rights and gender mainstreaming through education campaigns and advocacy at different levels);

- Home based care (strengthening home based care services and facilities, and establishing community systems for provision of quality home based care services to people living with HIV/AIDS);

- Support for orphans and vulnerable children (addressing immediate and long term needs of children through general support that covers basic necessities, school requirements and income generating activities for households with orphans); and,

- Capacity building of partners (rights based approach, gender mainstreaming and advocacy)

1.2.4. Implementing Partners

DanChurchAid is currently implementing HIV/AIDS activities through 4 partners; Churches Health Association of Zambia (CHAZ), Kara Counselling and Training Trust (KCTT), the Council of Churches in Zambia (CCZ), and the Girl Guides Association of Zambia (GGAZ). These agreements have been extended up to 2010. DCA has also supported other activities within this current program which have since come to an end. These include; Kwasha Mukwenu OVC support project and the CHAZ ART support program.
Church Health Association of Zambia

The Churches Health Association of Zambia (CHAZ) is an umbrella organization of church health institutions (CHIs) in Zambia. It complements government efforts in the delivery of quality health care by bringing into the health sector: human, material and financial resources, innovation, and care. CHAZ’s member institutions are mostly situated in rural areas where government services are few or sometimes non-existent. CHAZ is also one of the principal recipients for the global funds in Zambia. The funding supports Faith Based Organizations (FBOs), including Church Health Institutions (CHIs).

The partnership between DCA and CHAZ started in 1993, providing support for HIV/AIDS education; capacity building for health institutions and communities to provide care and support services including home based care, STI treatment, and counselling and testing; orphan support; and prevention activities. In 2005 the DCA/Danida funded Care and Prevention project entered a third phase, with emphasis on scaling up existing initiatives to more CHI’s. In 2006, DCA entered into a Joint Financial Arrangement (JFA) with other partners: Embassy of the Kingdom of Netherlands (EKN) and the Irish Embassy, to support HIV/AIDS activities implemented by CHAZ. Activities implemented under this arrangement include; HBC, OVC support, ART, CT, and income generation.

Kara Counselling and Training Trust

Kara Counselling and Training Trust (KCTT) is a charitable organization established in 1989, to provide voluntary counselling and testing (VCT), counselling training, peer education, HBC, and hospice services through a network of VCT centres, training centres, HBC groups, community based organizations (CBOs). The Umoyo Training Centre started as a pilot project in November 1996, to support girl orphans and vulnerable children, and supports about 80 girls at the centre per year. Main activities in this program include; skills and entrepreneurship training, provision of scholarships for follow on empowerment of the girls, HIV education and provision of health care services. KCTT also runs three day care centres for HIV/AIDS children who are mostly orphans. The day care centre activities include provision of medical check-ups, ART, food supplementation, education and psychosocial support. The objective of this program is to improve children’s mental, physical and psychosocial wellbeing including, placing children back into school. A mid-term review was conducted in 2006 with a long list of recommendations to Kara. Some of these were taken into the new proposal presented to DCA in 2008. Others still have to be monitored for inclusion as the new project phase is implemented.

Council of Churches in Zambia (CCZ)

CCZ is an ecumenical umbrella organization of the Christian Churches in Zambia that seeks to promote cooperation and fellowship between Christian people and organizations, since its inception in 1914. The DCA has supported CCZ’s HIV/AIDS activities since 2002. In particular, supporting the Makeni HIV/AIDS Resource and Training Centre, various training for church leaders in psychosocial counselling, HBC, and HIV/AIDS advocacy, and formation of support groups for PLWHA within the churches, through the Circles of Hope project which has an income generating component. An evaluation of the CCZ ‘Circles of Hope’ program is taking place in April-May 2009. The findings will be important for the next phase of the program and for DCA’s possible future engagement with CCZ on HIV/AIDS.

Girl Guides Association of Zambia- GGAZ

The Girl Guide association of Zambia (GGAZ) is a voluntary non-profit making and non-partisan organization for girls and young women, established in 1924. The principal objective of the organization is to provide non-formal educational program and teach life skills, confidence building and responsible citizenship. DCA started working with GGAZ in 2000 in cooperation with the Green Girl Guides in Denmark. The current project which runs up to 2010 supports peer education, OVC scholarships, HBC and human rights activities. A mid-term evaluation was conducted in 2008, and the key findings were that although the program was relevant to the Zambian context and situation, the design was not focused and projects did not overlap; partners were recognizing and beginning to use rights based approach in program implementation; there was good mutual trust between DCA and its partners including satisfaction with the capacity building DCA was providing; there was need for a stronger focus on advocacy and to develop guidelines for caring for caretakers/volunteers; need for greater ownership of the program platforms by partners; need for proper documentation of the effectiveness of behavioural change interventions; M&E needed to be improved; and partners were directly or indirectly contributing to increased access to VCT, decreased stigmatization and increased disclosure of HIV status.
2. Evaluation Purpose and Objectives

2.1. Purpose
The purpose of the end of program evaluation is to assess the design, implementation, results, relevance, efficiency, effectiveness, impact and sustainability of the 2005-2009 HIV/AIDS program, and determine whether DCA should initiate a new phase of its HIV/AIDS program in Zambia for 2010-2013 and what changes should be made to the program.

2.2. Specific Objectives

Specific objectives include:

1. To assess the relevance, appropriateness and effectiveness of the current HIV/AIDS program design and implementation in order to:
   - Measure the extent to which the program has achieved its goals, objectives and output and outcome indicators;
   - Has the program enabled the partner’s and DCA’s advocacy work with other relevant actors, e.g. facilitation of networks?
   - Ascertain to what extent the program strategy has the right balance in interventions and partner types to meet the intended program objectives? In particular, has the program got a good and realistic balance between advocacy, empowerment and service-delivery components?
   - Measure the impact the program has made to reduce risk taking sexual behaviour among young people and other target groups, increase access to services, and economic empowerment of targeted groups and communities;
   - Assess partner capacity to reach intended program objectives and appropriateness of the level of capacity building provided by DCA;
   - Examine the level of partners ownership of the program management process (design, planning, implementation and monitoring and evaluation) including their level of involvement in information sharing platforms, documentation of results and best practices, and the level of participation in joint activities, such as advocacy initiatives and capacity development;
   - Assess the extent to which the benefits achieved are likely to continue after DCA ends its partnership;
   - Assess to what extent RBA and Gender is reflected and operationalized in projects and project implementation, and what the main constraints are? To what extent is the program successfully targeting and involving the moral duty bearers i.e. faith based leaders?
   - Assess the quality of advocacy, empowerment and service-delivery efforts;
   - Assess the end of program achievements in relation to the indicators set, challenges experienced during the implementation process, and the overall impact the program has made;
   - Assess which funds have been available for the program and how they have spent as well as an assessment of what funding has not been available and what consequences that has had for the implementation of the program;
   - Assess the balance of resources spent on HIV/AIDS activities compared with resources available for the health sector as a whole;
   - Assess the relevance and effectiveness of the program strategies in addressing the needs of the most affected and discriminated groups across projects;
   - Assess significant changes in the context, including government policies and practices and which consequences they may have for the program in future;
   - Assess whether the strategic approach as presented in the program LFA matrix still is valid and/or what adjustments are needed?
   - Assess the connectedness of the program with DCA’s other program and the synergy achieved.
   - Assess how DCA’s PT4 program fits in with and relates to HIV/AIDS activities carried out by other NGOs, including ACT/Aprodev partners in Zambia.
2. Determine the quality and effectiveness of the DCA and partner program monitoring and evaluation process:
   - Assess the ability of DCA and implementing partners to systematically capture, share and follow up lessons learnt and good practices; and,
   - Assess challenges related to monitoring that are faced by implementing partners and DCA and how these are being addressed.
   - Does the DCA RO maintain an effective program monitoring system that allows for learning and follow up on challenges? Does the monitoring system set up for the program allow the PO to follow the progress of the program in a systematic way?
   - How has program staff made use of the DCA Project and Program Manual (PPM) procedures for planning and implementation?

3. Examine DCA’s program management and reporting capacity, including assessing whether the DCA country office allocation of resources to the PT4 program is sufficient.

3. Tasks

Using a participatory and consultative process, the overall methodology shall include the following:

1. Form an evaluation team comprising 2 external consultants and 3 DCA staff members.
2. Develop an evaluation plan and budget including, tools for data collection, and review and finalize the data collection and reporting tools.
3. Hold consultations with In-country and Headquarters DCA staff, implementing partners and relevant stakeholders if need be.
4. Conduct a desk review and analysis of DCA and implementing partner documents including project proposals, work plans, budgets and reports.
5. Conduct field visits to make observations, hold meetings and focus group discussions with beneficiaries, and conduct interviews with beneficiaries and implementing staff and volunteers.
6. Conduct focus group discussions with beneficiaries on impact of the program.
7. Analyze data, prepare a draft report, and debrief with DCA. Data should come from a variety of sources to ensure its accuracy, and also to ensure that all affected people/stakeholders are considered. Data should be triangulated (i.e. cross-checking of quantitative and qualitative data and different types of data sources i.e. interview, observation, and document analysis).
8. Hold a debrief meeting with partners, and where possible with other relevant stakeholders to present and discuss the findings and prepare final report.

Self assessments
It is a good idea for the RO to prepare the evaluation by conducting self assessments (carried out by DCA staff or partners) to make up for any gaps in data availability. This assessment should primarily be done by discussing the program at a PT4 platform meeting.

Background documentation
The evaluation team will spend a lot of time carrying out interviews, and should not be spending time collecting documents that could already have been collected by the ROs. This should be forwarded to the team beforehand in soft copy to give them a chance to prepare before the evaluation mission begins. This includes, but is not limited to:

- the program policy
- the program document
- an overview of the projects under the program, and a balance of expenditure per project (planned vs. actual expenditure)
- an overview of the cross cutting activities carried out and planned vs. actual expenditure on that budget line
- any baselines and assessments carried out
- the program reports
- program and project reviews and evaluations
- reports from monitoring visits
any documentation from the platform meetings

Regarding Data collection and requirements

Part of the method is figuring out what data to collect and how to collect it. Data collection typically includes:

- document reviews (internal to DCA and from external sources)
- consultations with DCA staff in country and in Copenhagen (e.g. via phone or Skype)
- Field mission to perform key informant interviews with e.g. rights-holders, partners, local authorities, sister agencies, etc. Data collection tools include structured/semi structured interviews, surveys, individual or group interviews, focus group discussions, site observations, etc. For more information on how to apply these methodologies see the online resources referenced below.

Furthermore, the evaluation will be made based on the generic DCA Guidelines for program evaluation, although additional tools for interview and group discussions could be developed by the team.

4. Expected Deliverables

a. Evaluation reports to DCA. The report should follow the standard reporting format (attached).
b. Short-term plan with key follow-up actions, which must cover the key questions in the TOR.
c. Recommendations for future project direction, support, and funding.
d. Make recommendations on the focus of the new programme.
Annex 2: Description of Methodology

A participatory evaluation method and approach was followed, which enabled the participation and involvement of a broad range of stakeholders and beneficiaries. The overall approach ensured collective learning and provided flexibility in data and information collection. The methodology was mainly qualitative than quantitative as there was less time to conduct an empirical study.

**Sample Selection and Size** - The sample population was defined as “all DCA implementing partners and beneficiary communities”. A simple selective random sampling technique was applied to select a representative sample of projects to include in the evaluation. The final choice of sample projects was determined by geographic location (mainly proximity to each other) and diversity of representation in order to maximize on available time and resources for the final evaluation. The Southern Province was selected because it had a good representative sample of all the partners’ projects in addition to accessibility factor and continuity of partners’ projects. A total of five (5) PT4 partner projects including GGAP in Livingstone, Kara Choma (VCT centre, Day Care and Hospice), CHAZ HIV/AIDS Care and Prevention Project in Chikankata (Mazabuka), Kara Umoyo Training Centre, CCZ PLWHA Support groups and Graduate Guardian Councils) were visited and interviews held with 170 beneficiaries. In addition more than 50 community members including CPT members, traditional leaders and youth drama groups attended the meeting at Malala in Chikankata. Respondents included young school going girls, Kara graduates, Volunteers, PLWHA, OVCs, School teachers, Villagers, Health Workers and Care Givers. The Table below illustrates the actual number of beneficiaries interviewed for each PT4 partner.

<table>
<thead>
<tr>
<th>District</th>
<th>Project Partners</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>GGAZ</td>
<td>KARA</td>
</tr>
<tr>
<td>Livingstone</td>
<td>76</td>
<td>15</td>
</tr>
<tr>
<td>Choma</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mazabuka</td>
<td></td>
<td>39</td>
</tr>
<tr>
<td>Lusaka</td>
<td>2</td>
<td>20</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>78</strong></td>
<td><strong>30</strong></td>
</tr>
</tbody>
</table>

Source: Core Evaluation Team, September 2009

The sampling method presented a probability of bias since partners could ‘easily’ select the “best performing” projects that could reflect well on their performance. This bias was removed by a method of triangulation in which information from three (3) or more data streams (or sources) was compared for accuracy and reliability and verified against other data sets.

**Data Collection and Limitations** - Data was collected during a three-week period using various tools and instruments including documentary review, and during fieldwork, In-Depth (Key Informant) interviews, Direct Observations, Focus Groups and Participatory Rapid Appraisal (PRA) methods. Transect Walks and Social Mapping was conducted with Care Givers, PLWHAs and OVCs to map and discuss the effects of HIV/AIDS in communities. Structured and semi-structured questionnaires, Checklists, phone/Skype interviews and e-mail were applied were appropriate. DCA Guidelines for program evaluation were followed in the design of the methodology and tools for data collection. Overall the data collection phase was well organized and few constraints were encountered as reports were made available and project officers were available to assist the Evaluators. Most notable, however, was the tight schedule which resulted in some respondents (mainly pupils) not been found at one school visited. Some key informants mainly Support group and Graduate Guardian Council members could for some reasons not attend the meeting and so only a few were interviewed. Few logistical problems were encountered during data collection.

**Data Analysis** - Data analysis started early with the documentary review while a significant amount of project data analysis was done during fieldwork. The Evaluation team held daily meetings to compare notes and discuss the findings and challenges encountered. These feedback meetings helped in clarifying emerging issues and drawing lessons and conclusions as the fieldwork progressed. A detailed means-ends analysis was used to identify the relationships between program inputs and outputs and to discuss the program’s effectiveness, efficiency, impact and sustainability.

63
Annex 3: Bibliography


5. Churches Health Association of Zambia: JFA 2008 Annual Report


7. CCZ. 2009 Emergency and Development. First Quarter Report


9. CCZ Strategic Plan 2007-2009


11. Danish Ministry of Foreign Affairs/DANIDA: Annex 3: General administrative provisions applicable for grants obtained by DCA from state appropriations/DANIDA.

12. Danida/NCG Report, 2006, Thematic Review of Danish Church Aid with special focus on Organizational Decentralization and HIV/AIDS.


17. DCA Programme Policy: Rights Based Commitment, Copenhagen, 2006


19. DCA Partnership Policy, 2006


23. IRIN website 2009


27. Kara. Consolidated Bi Annual Report- Ambuya, Gerald Healey and Sables Drop in centres


34. PlusNews IRIN, 2009


41. Zambia Sexual Behavior Survey1999


## Annex 4: List of people interviewed and institutions visited

<table>
<thead>
<tr>
<th>Date</th>
<th>Name</th>
<th>Organization</th>
<th>Phone/Cell No; E-mail address</th>
</tr>
</thead>
<tbody>
<tr>
<td>23.09.09</td>
<td>Lars Jorgensen</td>
<td>Country Representative</td>
<td><a href="mailto:LJ@DCA.DK">LJ@DCA.DK</a></td>
</tr>
<tr>
<td>02.10.09</td>
<td>Martin Rosenkilde Pedersen</td>
<td>Programme Type Adviser</td>
<td><a href="mailto:MR@DCA.DK">MR@DCA.DK</a></td>
</tr>
<tr>
<td>16.09.09</td>
<td>Uffe Gjerding</td>
<td>Regional Representative DCA</td>
<td><a href="mailto:CRZAMBI@DCA.DK">CRZAMBI@DCA.DK</a></td>
</tr>
<tr>
<td>15.09.09</td>
<td>Gertrude Musonda</td>
<td>Programme Officer-HIV/AIDS DCA</td>
<td><a href="mailto:Glen.zambia@dca.dk">Glen.zambia@dca.dk</a></td>
</tr>
<tr>
<td>15.09.09</td>
<td>Buumba M Kaunga</td>
<td>Finance and Administrative Controller DCA</td>
<td><a href="mailto:Bmk_zambia@dca.dk">Bmk_zambia@dca.dk</a></td>
</tr>
<tr>
<td>15.09.09</td>
<td>Costin Mwale</td>
<td>Finance and Programme Assistant DCA</td>
<td><a href="mailto:gg.zambia@dca.dk">gg.zambia@dca.dk</a></td>
</tr>
<tr>
<td>27.10.09</td>
<td>Monica Mutua</td>
<td>Program Officer Christian Aid</td>
<td><a href="mailto:mutua@christian-aid.org">mutua@christian-aid.org</a></td>
</tr>
<tr>
<td>27.10.09</td>
<td>Sylvia Thornicroft</td>
<td>Finance and Administrative Manager, NCA</td>
<td><a href="mailto:Sylvia.thornicroft@nca.no">Sylvia.thornicroft@nca.no</a></td>
</tr>
<tr>
<td>15.09.09</td>
<td>Munalula Akakulubeha</td>
<td>HIV/AIDS Program Officer - Council of Churches in Zambia (CCZ)</td>
<td>0977-818497</td>
</tr>
<tr>
<td>15.09.09</td>
<td>Angela Konayuma</td>
<td>Circles of Hope Coordinator - Council of Churches in Zambia (CCZ)</td>
<td>0977548275</td>
</tr>
<tr>
<td>15.09.09</td>
<td>Emelia Mweemba</td>
<td>Kara Counselling and Training Trust (KCTT)</td>
<td><a href="mailto:hopekara@zamnet.zm">hopekara@zamnet.zm</a></td>
</tr>
<tr>
<td>15.09.09</td>
<td>Richard Yona</td>
<td>Kara Umooyo</td>
<td>0977-467128</td>
</tr>
<tr>
<td>30.09.09</td>
<td>Nambula Kachwi</td>
<td>Executive Director - GGAZ</td>
<td>0211255529</td>
</tr>
<tr>
<td>15.09.09</td>
<td>Royter Choongo Phiri</td>
<td>Project Officer- GGAP HIV/AIDS GGAZ</td>
<td>0977-893059</td>
</tr>
<tr>
<td>21.09.09</td>
<td>Yoram Siame</td>
<td>Senior Programme Officer-HIV/AIDS-CHAZ</td>
<td>0966-404071</td>
</tr>
<tr>
<td>24.09.09</td>
<td>Dr. Dhally Menda</td>
<td>Health Programmes Manager-CHAZ</td>
<td>0211-232850/0211-223297</td>
</tr>
<tr>
<td>28.09.09</td>
<td>Alan Zulu</td>
<td>ART Programme Coordinator-CHAZ</td>
<td><a href="mailto:ysiame@yahoo.com">ysiame@yahoo.com</a></td>
</tr>
<tr>
<td>22.09.09</td>
<td>Malambo Hangawa</td>
<td>DEBS Livingstone</td>
<td><a href="mailto:yorum.siame@chaz.coz.zm">yorum.siame@chaz.coz.zm</a></td>
</tr>
<tr>
<td>22.09.09</td>
<td>Alice Sichila</td>
<td>Education Standards Officer</td>
<td></td>
</tr>
<tr>
<td>22.09.09</td>
<td>Alex Kalusa</td>
<td>Headmaster Namujala Basic School</td>
<td>0979-889122</td>
</tr>
<tr>
<td>22.09.09</td>
<td>Ann Mukelabai</td>
<td>Chief Commissioner-GGAZ</td>
<td>0977-755371</td>
</tr>
<tr>
<td>22.09.09</td>
<td>Selina Mwiya</td>
<td>Leader/Volunteer</td>
<td>0977-749863</td>
</tr>
<tr>
<td>22.09.09</td>
<td>Maggie Hambamba</td>
<td>Leader/Volunteer</td>
<td>0977-815550</td>
</tr>
<tr>
<td>22.09.09</td>
<td>Marjorie Kalusa</td>
<td>Leader/Volunteer</td>
<td>0977-882040</td>
</tr>
<tr>
<td>22.09.09</td>
<td>Mildred Mbagweta</td>
<td>Leader/Volunteer</td>
<td>0979-062401</td>
</tr>
<tr>
<td>22.09.09</td>
<td>Michelo Mbewe</td>
<td>Leader/Volunteer</td>
<td>0976-681475</td>
</tr>
<tr>
<td>22.09.09</td>
<td>Rose Likokoto</td>
<td>Leader/Volunteer</td>
<td>0977-393529</td>
</tr>
<tr>
<td>22.09.09</td>
<td>Koma Mukanga</td>
<td>Leader/Volunteer</td>
<td>0955-711818</td>
</tr>
<tr>
<td>22.09.09</td>
<td>Isabel Habwacha</td>
<td>Leader/Volunteer</td>
<td>0977-653382</td>
</tr>
<tr>
<td>22.09.09</td>
<td>Christine M. Banda</td>
<td>Guardian</td>
<td>0955-794717</td>
</tr>
<tr>
<td>22.09.09</td>
<td>Mable Habasembe</td>
<td>Guardian</td>
<td>0977-602908</td>
</tr>
<tr>
<td>22.09.09</td>
<td>Christine Mwiya</td>
<td>Guardian</td>
<td>0978-170963</td>
</tr>
<tr>
<td>22.09.09</td>
<td>Green Shakatuka</td>
<td>Guardian</td>
<td></td>
</tr>
<tr>
<td>22.09.09</td>
<td>Christopher N Mahita</td>
<td>Guardian</td>
<td>0979-494335</td>
</tr>
<tr>
<td>22.09.09</td>
<td>Mody M Muyambango</td>
<td>Guardian</td>
<td>0979-275643</td>
</tr>
<tr>
<td>22.09.09</td>
<td>Written Sibande</td>
<td>Orphan</td>
<td>0977-598796</td>
</tr>
<tr>
<td>22.09.09</td>
<td>Sitembiso Sibande</td>
<td>Orphan</td>
<td></td>
</tr>
<tr>
<td>23.09.09</td>
<td>Vincent Chilufya</td>
<td>Programme Manager KaraChoma</td>
<td>0968-416666</td>
</tr>
<tr>
<td>23.09.09</td>
<td>Michael Mwila Sindao</td>
<td>Branch Accountant - KaraChoma</td>
<td>0977-784608</td>
</tr>
<tr>
<td>23.09.09</td>
<td>Laswell Muchimha Siawala</td>
<td>VCT Project Assistant- KaraChoma</td>
<td>0977-412115</td>
</tr>
</tbody>
</table>

23.09.09  Evelyn Mbalaka Machilika  Social Worker- KaraChoma
23.09.09  Beatrice Ngoma  Coordinator- Gerard Martin Hospice
23.09.09  Bertha Milimo  Community Coordinator- Martin Day Care Centre
23.09.09  Clare Salula  Volunteer Teacher- Martin Day Care Centre
23.09.09  Sr. Virginia Millane  Volunteer -Hospice  virginiamullane@yahoo.co.uk
23.09.09  Jessely Shapwalinge  Orphan-Martin Day Care
23.09.09  Tandi Sokoti  Kara Graduate - Tusone GGCE
23.09.09  Mary Nakawala  Kara Graduate- Tusone GGCE
23.09.09  Agness Mwanza  Guardian - Tusone GGCE
23.09.09  Margret Mweenda  Guardian - Tusone GGCE
23.09.09  Aina M Lameki  Guardian - Tusone GGCE
23.09.09  Albert Wangosa  Guardian - Tusone GGCE
24.09.09  Gift Munkombwe  Project Officer-HIV/AIDS-Chikankata Mission Hospital 0977-7716882
24.09.09  Peter Mulintha  Community Interactor/IGA Coordinator-Chikankata
24.09.09  Stephen Hamanjanji  CPT Chairperson - Nanzele
24.09.09  Patricia Mainza  Kulijata IGA member- Nanzele
24.09.09  Petronella Chilala  Kulijata IGA member- Nanzele
24.09.09  Beatrice Chintibule  Kulijata IGA member- Nanzele
24.09.09  Caroline Singandu  Kulijata IGA member- Nanzele
24.09.09  Malita Kaili  Kulijata IGA member- Nanzele
24.09.09  Percy Hamoonga  Peer Educator Chikankata
24.09.09  Bruce Chibawe  Orphan Grade 4 –Nanzele
24.09.09  Nkombo Kalema  Orphan Grade 4- Nanzele
24.09.09  Lina Moonga  Orphan Grade 3- Nanzele
24.09.09  Charlotte Gress Soerensen  DCA Volunteer-Chikankata
24.09.09  Henrik Kampmann  DCA Volunteer
24.09.09  Claire Whybrow  DCA Volunteer
24.09.09  Mulongo Kampmann  AIDS Club member-Malala Basic School
24.09.09  Bernard Hayiba  CPT Chairperson Chikankata
24.09.09  Bernard Hayiba  CPT member Chikankata
24.09.09  Lister Hachanga  CPT member Chikankata
24.09.09  Nomai Mabeta  CPT member Chikankata
24.09.09  Getruide Ngandu  CPT member Chikankata
24.09.09  Loveness Milimo  CPT member Chikankata
24.09.09  Christine Muyaaya  CPT member Chikankata
24.09.09  Audrey Mwiinga  CPT member Chikankata
24.09.09  Toupher Ngoma  CPT member Chikankata
24.09.09  David Choongo  CPT member Chikankata
24.09.09  Glyne Mulonga  CPT member Chikankata
24.09.09  Jethro Choonga  Headmaster - Malala  0979-206267
24.09.09  Alfred Malila  Deputy Headmaster
24.09.09  Bernadette Nialuna  AIDS Club member- Malala
24.09.09  Rodrick Muyabila  AIDS Club member-Malala
24.09.09  Violet Hamayobe  Orphan
24.09.09  Nelia Chiaya  Orphan
24.09.09  Angela Hanguba  Orphan
24.09.09  Joseph Siwale  Orphan
24.09.09  Olivia Muponde  Orphan
24.09.09  Emily Jamhwa  Orphan
24.09.09  Richard Hangandu  CPT Secretary- Malala
24.09.09  Gilbert Lwindi  CPT V/Secretary
24.09.09  Nurse Nakalonga  Care Giver

67
<table>
<thead>
<tr>
<th>Date</th>
<th>Name</th>
<th>Position/Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>24.09.09</td>
<td>Joyce Mweemba</td>
<td>Major Care Giver</td>
</tr>
<tr>
<td>24.09.09</td>
<td>Infred Simuule</td>
<td>CPT Chairperson</td>
</tr>
<tr>
<td>24.09.09</td>
<td>Alfred Chiwala</td>
<td>CPT Support Group</td>
</tr>
<tr>
<td>24.09.09</td>
<td>Halled Hamayobe</td>
<td>Support Group member</td>
</tr>
<tr>
<td>24.09.09</td>
<td>Deverick Moomha</td>
<td>Youth</td>
</tr>
<tr>
<td>24.09.09</td>
<td>Frank N Shupeta</td>
<td>Youth</td>
</tr>
<tr>
<td>24.09.09</td>
<td>Christopher Banda</td>
<td>Participant Training in Male involvement in PMTCT Nadezwe</td>
</tr>
<tr>
<td>24.09.09</td>
<td>Anthony Watson</td>
<td>Business Development Manager Chikankata Mission Hospital</td>
</tr>
<tr>
<td>28.09.09</td>
<td>Chipo Mutewa</td>
<td>CoH Support Group member</td>
</tr>
<tr>
<td>28.09.09</td>
<td>Precious Madyabi</td>
<td>CoH Support Group member</td>
</tr>
<tr>
<td>28.09.09</td>
<td>Mc Donald Ntilima</td>
<td>Chairperson- CoH Support Group</td>
</tr>
<tr>
<td>28.09.09</td>
<td>Liya Sakala</td>
<td>CoH Support Group member</td>
</tr>
<tr>
<td>28.09.09</td>
<td>Anna Zulu</td>
<td>CoH Support Group member</td>
</tr>
<tr>
<td>28.09.09</td>
<td>Fatness Soko</td>
<td>CoH Support Group member</td>
</tr>
<tr>
<td>28.09.09</td>
<td>Anna Chilubano</td>
<td>CoH Support Group member</td>
</tr>
<tr>
<td>28.09.09</td>
<td>Regious Malambo</td>
<td>CoH Support Group member</td>
</tr>
<tr>
<td>30.09.09</td>
<td>Severino Cheulo</td>
<td>Kara Umoyo</td>
</tr>
<tr>
<td>30.09.09</td>
<td>Diana Bulanda</td>
<td>Kara Umoyo Training Coordinator</td>
</tr>
<tr>
<td>30.09.09</td>
<td>Lucky Kasonde</td>
<td>Kanyama Youth Training Centre- Instructor</td>
</tr>
<tr>
<td>30.09.09</td>
<td>Maiju Aho</td>
<td>Kanyama Youth Training Centre Finidza Volunteer</td>
</tr>
<tr>
<td>30.09.09</td>
<td>Andrew Tembo</td>
<td>Kanyama Youth Training Centre Information and Training Manager</td>
</tr>
<tr>
<td>30.09.09</td>
<td>Anastasia Banda</td>
<td>Kara Umoyo Graduate</td>
</tr>
</tbody>
</table>
Annex 5: Sample Interview Guides Used in Evaluation

INTERVIEW GUIDE FOR FOCUS GROUP DISCUSSIONS
(Project Coordinators and Resource Centre Staff)

Basic Project Data

<table>
<thead>
<tr>
<th>Project Title</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Project Start Date</td>
<td></td>
</tr>
<tr>
<td>Project End Date</td>
<td></td>
</tr>
<tr>
<td>Project Location</td>
<td></td>
</tr>
<tr>
<td>Date of Meeting</td>
<td></td>
</tr>
<tr>
<td>Focal Person and Contact Details</td>
<td></td>
</tr>
</tbody>
</table>

1. History of the project request
   a) How did it all start?
   b) What conditions existed at the time of the project idea?
   c) What were the key determinants in the project idea?
   d) Who came up with the idea?

2. How was the Project formulated?
   a) Who formulated the project idea?
   b) Where was it done and to what extent did the beneficiaries participate in the initial design of the project?
   c) For how long have beneficiaries participated on the programme?

3. What is the level and quality of communication and information flow between the beneficiaries, partners and DCA?

4. Are beneficiaries involved in key decision making processes from community level to top government to DCA?
   a) Who do you work with on this programme? Are you involved in Decision Making?
   b) Are your views taken into account to improve the project?

5. What Implementation Strategies have been put in place? How is the project implemented?
   a) Who is actually implementing the activities?
   b) What activities are being implemented?
   c) What are some of the challenges you have experienced implementing this project?

6. How do you make efficient use of project resources? Explain how you achieve this

7. What are some of the tangible (Physical) and intangible impacts of the project (including capacity building, behavioural change etc)
   a) What results have you achieved and how did you achieve them?
   b) What do you like about this programme?
   c) What do you dislike about this programme?
   d) What can be done to improve the programme? How can this be done?

8. Are Human Rights, Gender and equality mainstreamed in processes

9. What are the five most pressing problems facing your community today?

10. Do you perceive HIV and AIDS and Human Rights as pressing issues?

11. How do these aspects affect development in your community?

12. In your opinion, do you think a pro-active HIV and AIDS that incorporates Human Rights programme is important?

13. What would be the best way of implementing this programme? What channels and messages should be used for it to have greater impact? Through what channels do you receive most information regarding the programme?

14. Who should be responsible for implementation and funding of HIV and AIDS projects?
INTERVIEW GUIDE FOR KEY INFORMANTS
(Project Managers and Staff)

Basic Project Data

<table>
<thead>
<tr>
<th>Project Title:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Project Start Date:</td>
<td></td>
</tr>
<tr>
<td>Project End Date:</td>
<td></td>
</tr>
<tr>
<td>Project Location:</td>
<td></td>
</tr>
<tr>
<td>Date of Meeting:</td>
<td></td>
</tr>
<tr>
<td>Focal Person and Contact Details</td>
<td></td>
</tr>
</tbody>
</table>

1. What does the project want to change and how? What is the project setting, existing situation, contextual factors, priority problems and needs addressed?

2. Was the project a good idea and why? What did you set out to do? What is the project purpose, specific objectives, target groups, activities, expected outputs/outcomes and assumptions etc?

3. Were beneficiaries involved in key decision making processes including planning and project design?

4. What have been the project’s main achievements (results) to date and what is the quality of results obtained?

5. How was the project administered to achieve these results? i.e. were inputs (resources and time), training etc available on time?

6. Were resources used in the most cost-effective way to achieve the results? What key challenges did you face when implementing the project?

7. What has been the overall impact of the project or what difference or change has the project made to the problem situation? To what extent has the project contributed to its long-term goals? What have been the quantitative and qualitative outcomes of the project?

8. How did the project integrate an advocacy, Rights Based approach and Gender issues in its activities?

9. What unintended/unanticipated positive or negative consequences (impacts) have occurred as a result of the project?

10. How do you expect the beneficiaries/target groups to maintain the benefits in the short- and long term? Will there be continued positive impacts as a result of the project once it has been finished?

11. Have you in place an Exit Strategy? Can your interventions be replicated or scaled up? If so, in what way form? What adjustments can be made to the interventions so that we “make a difference”
INTERVIEW GUIDE FOR KEY INFORMANTS
(DCA and Other Programme Staff)

1. Given the ever changing policy, political, institutional or target group context, has the HIV programme strategy remained useful, relevant and appropriate to address the problem situation?
2. What adjustments, if any, have been made to the programme strategy and overall design as presented in the LFA matrix?
3. To what extent is the HIV programme linked (connected) to and coordinated with other DCA Programme areas and what synergy has been achieved?
4. Is there sufficient technical, administrative and logistical competence and capacity to implement the programme’s strategies? Which areas require improvement or adjustment for greater efficiency?
5. Is the programme’s resource envelope adequate to meet its strategic ambitions or are there “perceived” or “real” funding gaps/deficits that should be addressed?
6. Are PT4 partners allocated with sufficient resources and on time? What mechanisms exist to ensure cost-effective utilisation of resources at programme and partner levels?
7. Does the programme have adequate proposal development and resource mobilisation capacity? Is there need for improvement in this area?
8. How effective are the programme’s budgeting and financial management systems? How effectively are Manuals, Procedures and Guidelines used?
9. What are the characteristics of and how effective is the monitoring and evaluation (M&E) system, processes and tools used at programme and partner levels?
10. How effective is the reporting system at programme and partner levels? Does the system of feedback promote learning and follow up on implementation successes and challenges?
11. Is there a policy for partnership building and cooperation and is this clearly understood by all parties? What criteria are applied for choice of, selecting, follow up and phasing out of partners?
12. Does an advocacy policy (or strategy) exist and to what extent has it been implemented? What is the balance between advocacy, empowerment and service-delivery components?
13. How and to what extent has the programme mainstreamed advocacy, Rights Based Approach (RBA), Gender, and empowerment in implementation?
14. To what extent is DCA’s PT4 programme linked and related to other NGOs HIV/AIDS activities (notably ACT/Aprodev partners) in Zambia?
15. What ‘models’, ‘best practises and windows of opportunity can be identified and replicated across the PT4 partners?
16. What has been the overall impact of the HIV Programme i.e. to what extent has the programme achieved its long-term goals or strategy?
17. What specific impact has been achieved in each of the programme strategic objectives? Were inputs (resources and time) used in the most cost-effective way to achieve the outcomes?
18. Which area of the programme has shown lack of progress or particular success? What is the possible explanation for this situation?
19. What have been some of the unintended/unanticipated positive or negative consequences (impacts) as a result of programme implementation?
20. How likely will the programme’s benefits, results and services be maintained by beneficiaries/target population at the end of DCA support?
21. What evidence is there that the programme has enhanced ownership and has enabled institutional and management capacity, transfer of knowledge, capabilities and appropriateness technologies?
22. Were gender and social cultural factors adequately considered in programme implementation?
23. What is the potential for future scaling up (or scaling down) and what is the potential for replicating some of the programme activities elsewhere in Zambia?
24. Which strategic areas of the programme require to be refocused to achieve greater impact for target groups?
25. Does DCA have sufficient capacity and competence to handle any scaling up or replication of programme activities? If not, what capacity and competences would be required for future HIV programming?