SADC HIV and AIDS Best Practice Series

Mboole Rural Development Initiative (MRDI) in Zambia

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Contents

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List of Acronyms

AIDS	-	Acquired Immune Deficiency Syndrome
ART	-	Antiretroviral Therapy
ARVs	-	Antiretroviral Drugs
CRAIDS	-	Community Response to HIV and AIDS
CSO	-	Central Statistics Office
DACA	-	District HIV and AIDS Coordination Advisor
DATF	-	District HIV and AIDS Taskforce
DHMT	-	District Health Management Team
HBC	-	Home-Based Care
HBO		Home-Based Care Organisations
HIV	-	Human Immunodeficiency Virus
OVC	-	Orphans and Vulnerable Children
MRDI	-	Mboole Rural Development Initiative
PLHIV	-	People Living With HIV
SADC	-	Southern Africa Development Community
SAfAIDS	-	Southern African HIV and AIDS Information Dissemination Service
VCT	-	Voluntary Counselling and Testing
NZP+	-	Network of People Living with HIV/AIDS
ZDHS	-	Zambia Demographic Health Survey

1. In Context

The Member States of SADC have been responding to the HIV epidemic for more than two decades. The combined experiences of the member states is over 200 years, yet these rich experiences have not been fully harvested or systematically documented to guide the Member States and the region at large, in the design and implementation of HIV and AIDS interventions. One of the most useful avenues for strengthening the response is through Member States sharing Best Practices on HIV and AIDS between and within themselves. This will guide and maximise efficiency and effectiveness in responses to the various facets of the epidemic.

SADC is fully committed to the challenge of controlling the epidemic and the Maseru Declaration on Combating HIV and AIDS recognises *" – that within the SADC Region there have been successes and Best Practices in changing behaviour, reducing new infection and mitigating the impact of the HIV and AIDS pandemic, and that these successes need to be rapidly scaled up and emulated across the SADC Region"*. Both the SADC Strategic Plan and Business Plan on HIV and AIDS advocate the sharing of Best Practices between and within Member States.

To provide a systematic working definition for a SADC HIV and AIDS Best Practice, and standardising documentation methodology, the SADC Framework for Developing and Sharing Best Practice on HIV and AIDS was designed. In line with this aim, SADC in 2007, commissioned the documentation of Best Practices in four Member States: Mauritius, South Africa, Zambia and Zimbabwe, where Best Practices had been identified through a comprehensive selection process involving Governments and National Co-ordinating bodies.

The documentation of these Best Practices will stimulate and encourage the exchange of ideas, and increase collaboration and co-ordination among the multiple actors and institutions responding to the epidemic across the region. It is against this backdrop that the Mboole Rural Development Initiative (MRDI) has been documented as a Best Practice.

2. Supporting the SADC HIV and AIDS Best Practice Framework

2.1 Documenting HIV and AIDS Best Practices

For HIV and AIDS organisations, Best Practice documents are important for sharing knowledge, experiences and lessons learnt, both internally and externally.

"Don't reinvent the wheel, but learn in order to improve it, and adapt it to your terrain to make it work better." While this metaphor is clearly too simple, it certainly captures the essentials of what Best Practice is all about." - Aidsnet

"Best Practice" documents are unique documents that describe and evaluate - against specific criteria - detailed elements of a programme, project or activity which have contributed towards successful interventions in the response towards HIV.

Best Practices can be viewed as a continuous process of learning, feedback, reflection and analysis of what works (and what does not work), and the reasons why. The purposes of documenting a Best Practice include:

- avoiding duplication of effort (within the same target area) by sharing information and lessons learned
- promoting knowledge exchange and learning to improve and adapt effective strategies of intervention, within specific environments

" A Best Practice on HIV and AIDS is a body of knowledge about an aspect of HIV prevention, treatment or care that is based on practical experiences and lessons learnt in a maturing field that can be replicated to improve the quality of an intervention that has as its objective the mitigation of one aspect of the HIV epidemic"

- SADC Framework for Developing and Sharing Best Practices on HIV and AIDS

2.2 In Harmony with the SADC Framework for HIV and AIDS Best Practices

The SADC Framework definition describes a Best Practice on HIV and AIDS as one that has four essential components: body of knowledge; practical experiences and lessons learned; replication; and mitigation.

The SADC Best Practice Business plan envisages the development of a database of Best Practices, and towards this end, a series of Best Practices among Member States is being identified and documented to meet the seven Best Practices Criteria stipulated by SADC.

Thus the overall purpose of this document is to share how, and to what extent, the Mboole Rural Development Initiative meets the seven SADC criteria of Best Practices, and whether it can be replicated by the multitude of actors and institutions responding to the epidemic across the region. Ultimately, the SADC Best Practices should catalyse increased collaborations and co-ordination – within and among Member States - towards a sustained and effective response to HIV and AIDS, in keeping with the Maseru Declaration.

2.3 SADC Best Practice Criteria and Definition

The SADC Framework for HIV and AIDS Best Practices, defines the primary purposes of a Best Practice as a practical instrument that facilitates sharing within and between Member States in order to assist local authorities to scale-up interventions based on what is known to work – through documenting, understanding and appreciating good experiences; facilitating learning of what works and what does not; sharing experiences; and assisting replication of small and successful interventions on a larger scale. The criteria are explained in detail below:

1. Effectiveness

A best practice must have clear objectives guided by identified community needs obtained through a baseline study and it must have evidence that it is achieving these objectives. The community participates from project inception to implementation, monitoring and evaluation of the project.

2. Ethical Soundness

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

3. Cost Effectiveness

Cost of delivery for a cost effective programme is proportionate to available resources, that is "the capacity to produce desired results with a minimum expenditure of energy, time or resources.[1]" The intervention should have in place cost saving and reduction systems. The programme should provide a standard package of HIV prevention, treatment or care at a reasonable cost. This should result in an improvement in the quality of life of an increased number of community members. Efficiency measures the capacity of the programme to produce desired results with the minimum expenditure of energy, time and resources.

4. Relevance

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

5. Replicability

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

6. Innovativeness

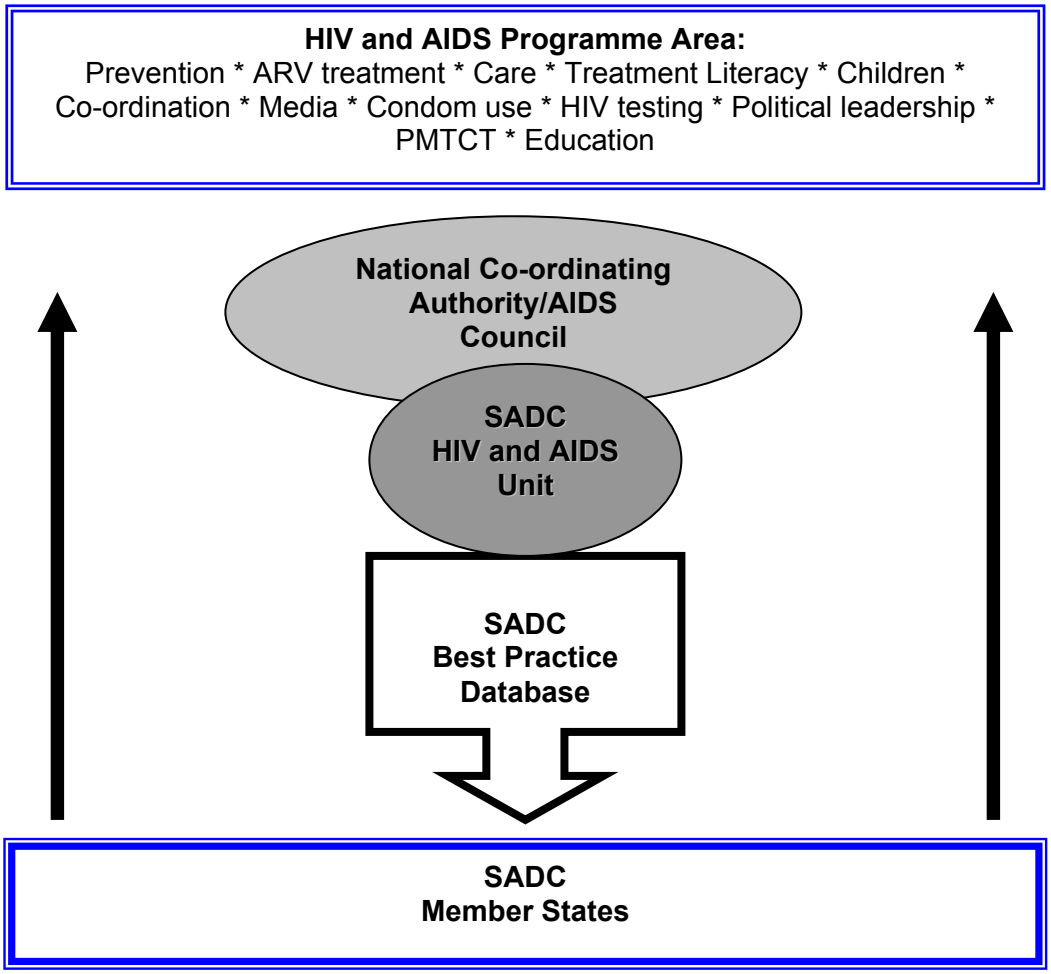
A Best Practice may demonstrate a unique and more cost effective way of implementing a programme.

7. Sustainability

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

[1] International Federation of the Red Cross and Red Crescent Societies. Best Practice Document, 2006.

Figure 1: Framework for SADC HIV and AIDS Best Practices



This Best Practice document marks a step towards operationalising the above Framework and:

- Validates the Mboole Rural Development Initiative as an HIV and AIDS Best Practice in the area of providing a sustainable and replicable community-based initiative in OVC support as part of the national HIV and AIDS response
- Adds to the body of knowledge on community support strategies for OVC that have worked, and key elements thereof
- Stimulates replication of programmes that utilise local resources, are sustained by the communities they serve, and also promote HIV risk reduction

3. Methodology

The methodology applied for this documentation was based on the SADC Framework for HIV and AIDS Best Practices. The design sought to determine and confirm the four essentials for the identified Best Practice, by assessing its:

- Contribution to the *body of knowledge* in the area of providing a sustainable and community-based response to the support of OVC within the national HIV and AIDS response
- Ability to offer *practical experience and lessons learned* from its implementation in Mboole
- Extent of *replicability* in countries in the region and elsewhere and
- Contribution to *mitigation* of the impact of HIV and AIDS and subsequently the spread of HIV, and impact mitigation of AIDS in Zambia

In accordance with the SADC Framework, for this programme to be classified as an HIV and AIDS Best Practice, it needed to demonstrate the following criteria:

- Effectiveness: by showing achievement of clearly outlined objectives
- Ethical Soundness: by illustrating the upholding of human rights and meeting universally accepted ethical standards
- Cost effectiveness: by showing that it is efficient and does not waste resources
- Relevance: by taking cognisance of the specific context within which it is being implemented, taking into account cultural, religious and other norms
- Replicability: by displaying characteristics that make it easy to copy
- Innovativeness: by showing a new way of implementing a programme that is more effective and saves resources
- Sustainability: by displaying the ability to continue to deliver benefits

The following data collection methods were employed, using a triangulation approach:

- Focus group discussions (7 FGDs were held at project site and 1 with policy makers),
- Key informant interviews (with policy makers, program implementers, DACA, donor representatives, NAC staff, community leaders)
- Observations (project site and beneficiaries environment)
- Review of existing literature on the project (national and project related documents)

See Annex 1 for more details on the methods of adapt collection, data collection instruments, the target groups, sample size and method of data analysis. Instruments used during data collection were standard instruments have been matched with the UNAIDS and other international Best Practice criteria, to ensure validation of the Best Practice within, and beyond SADC.

Figure 2: Village Chief Singani, one of the Key informants

4. Background

4. 1 The HIV and AIDS Situation in Zambia and Mboole

Zambia, with a population of about 10.6 million people is one of the countries worst hit by the HIV epidemic. The Zambia Demographic Health Survey (ZDHS 2002), estimates that about 16% of the population is infected with the virus. The social and economic impact of the epidemic, has been to increase poverty and leave families disintegrated. Breadwinners have been lost and only grandparents remain to take care of the orphans left behind.

Choma, like other rural districts, has not been spared by the epidemic. According to the ZDHS of 2002, the district's HIV prevalence rate was projected at 18.7% for 2005, and this is the third highest in the province. It is estimated that there are currently about 3,850 people in Choma, within the 15–49 age group, who are HIV positive. Among these, 2,550 are in urban locations while about 1,300 are in rural areas. Cumulatively, the district has experienced 25,190 AIDS deaths from the year 1985 to 2005. HIV-related deaths in the district have worsened the problem of orphans. In the year 2005, the district was reported to have a total of 22,202 orphans of which 17,308 had been orphaned by the AIDS-related deaths of parents or guardians.

4.1.1 Mboole

The Mboole Rural Development Initiative is named after the community where it began. The project is located in the Southern province of Zambia in Choma district, in the village of Mboole. Choma is a rural district situated along the line of rail, 289km south of Lusaka. Choma is centrally located in the province and shares boundaries with five other districts.

Figure 3: Map of Zambia

The total population of the district, according to the latest population census (Central Statistics Office - CSO, 2000) stood at 208,989. About 80% of the district's population is rural and only 20% urban.

Mboole is a typical rural area with over 18,000 inhabitants; characterised by high levels of unemployment and poverty, aggravated by the high HIV prevalence rate and resulting in serious socio-economic problems. The main source of income is subsistence farming. The MRDI currently reaches out to 17 villages and approximately 5,400 people. As with many of Zambia's rural areas, the majority of the inhabitants are women. There are limited health facilities and schools that are available to residents, with only one basic government school, two community schools and one health facility (13kms from the main community setting) serving all 17 villages of the project site. The district is predominated by youths and a significant number of OVC, being cared for by aged grandparents.

The impact of HIV and AIDS is greatly felt in this area and the relationship between poverty and HIV and AIDS is apparent. High levels of poverty directly and indirectly promote behaviours that create vulnerability to HIV infection and transmission. In turn, the impacts of the epidemic fuel poverty, generating a complex interrelationship, especially where the majority of the poor are youth and women.

It is against this background that the Mboole Rural Development Initiative was conceived. In the project chairman's (manager) words, the initiative was started *"like a joke"* by three family members (youths), who were later joined by nine other youths. These 12 youths continue to constitute the core team of MRDI. The project's objectives have gradually been formalised as the socio-economic needs of the community they serve become increasingly evident over the years, driven by the dual impacts of HIV and poverty

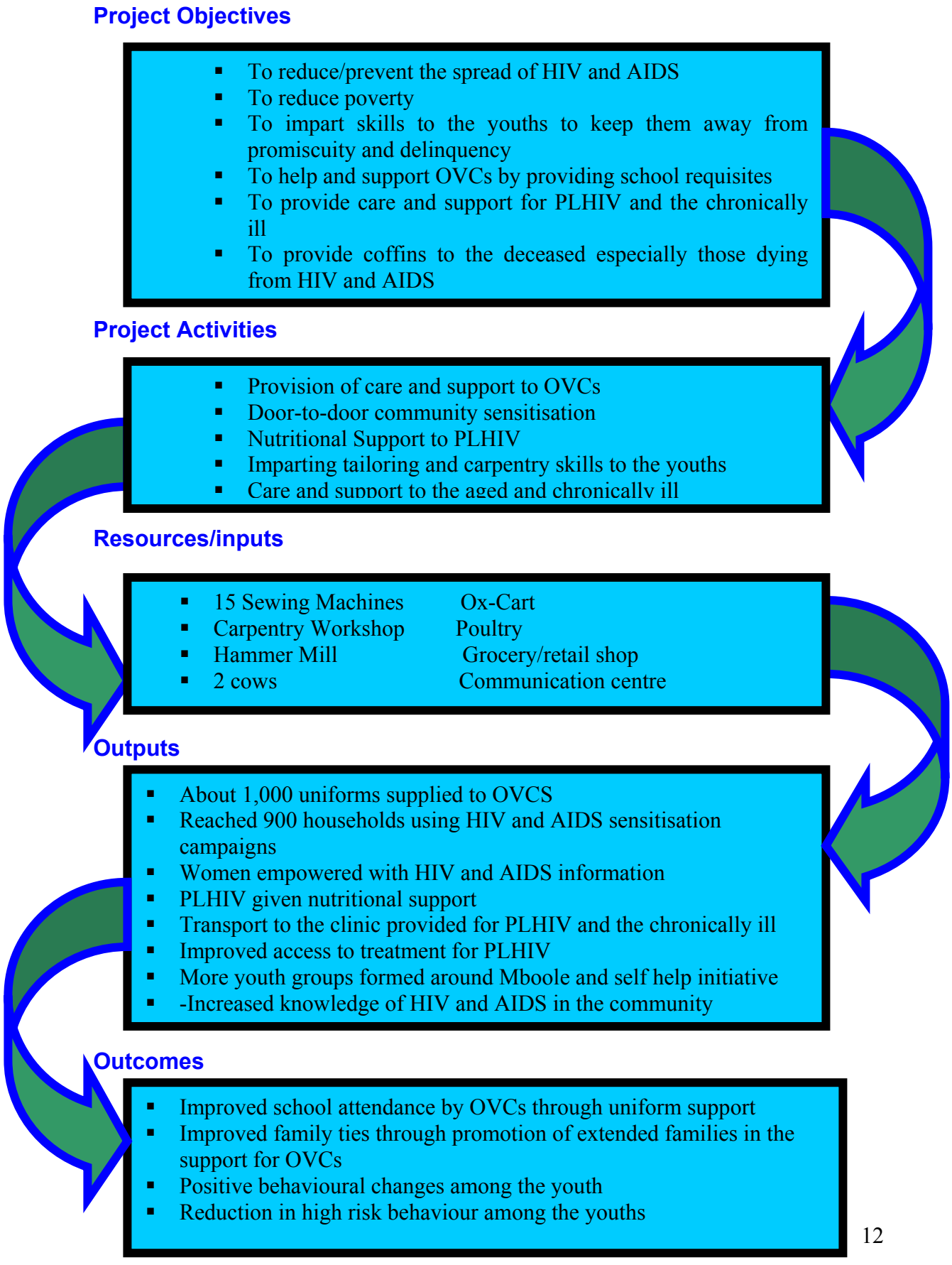
4.2 MRDI Overview

Figure 4: Some members of the MRDI core team

Mboole Rural Development Initiative is a rural project, now spearheaded by 53 youths (35 female and 18 male). The core team (executive) consists of twelve youths, of whom seven are female. Their average age is 25, with the youngest aged 21 and the oldest 30. The highest level of education attained by team members is senior high school, while the rest have completed either primary or junior high school. However, team members have pursued skills building and capacity building activities that enable them to contribute effectively to the objectives of the project.

All the youths managing the project are doing so as dedicated volunteers.

Figure 5: MRDI Activities and Successes resultant from Project objectives



5. The Mboole Rural Development Initiative(MRDI)

5.1 Programme Start Up

The project was initiated by three family members in March 2003, as a small tailoring workshop to generate income for themselves and their families. However, due to the high poverty levels prevailing in the community, tailored products were generally unaffordable by community members, even for such essentials as school uniforms. The group then resolved to either subsidise the products or give them to the very needy at either no cost, or allowing payment in kind. The demand for the group' s tailoring service increased substantially as a result and local support for the group was evidenced by the donation of two sewing machines by the Chief Headman and another community member.

At this stage the group decided to formalise their business and turn it into a socio-economic project that would serve the needs of the Mboole community. With assistance from a UN volunteer, the project conceptualisation was formalised in 2004, when it began to receive seed funding from the Community Response to HIV & AIDS (CRAIDS). CRAIDS is an initiative under the District HIV/AIDS Taskforce (DATF), which is funded by the Zambia National AIDS Council (NAC).

The MRDI embraces the spirit of volunteerism and was primarily inspired by the high unemployment levels among community members, especially among the youth; high poverty levels; an increasing number of people suffering from chronic illness (in particular, those living with HIV) and an increased number of orphans and vulnerable children (OVC), who were dropping out of school due to lack of support for school fees, uniforms and nutrition.

The youths who initiated the project, consulted widely within the community and the development sector, as well as with the local traditional and political leadership to gain a clear picture of the immediate and most important needs of the community. With guidance from the DACA, several consultative meetings were held with the chief, village headmen, headmasters, teachers, religious leaders and community members. The most urgent needs were identified and subsequently project objectives and activities were shaped. This process ensured community involvement and ownership from the project's inception. Community mobilisation is at its very centre. *"There would be no community project unless it is owned by this community, and they do feel close to it"* said a project implementer.

The project's staff regularly consult with the community about their needs which are determined by the current socio-economic situation experienced in the area. In addition, the MRDI's implementing youth also conduct outreach projects from time-to-time, to sensitise community members and groups on critical issues around HIV and AIDS. They conduct these activities at no cost, on a purely humanitarian basis, as a form of work and a useful way of spending their time.

MRDI's objectives as derived from the needs of the community are to:

- Reduce/prevent the spread of HIV and AIDS
- Reduce poverty
- Impart skills to the youths to keep them away from promiscuity and delinquent and risky behaviours
- Help and support OVC by providing them with necessary school materials
- Provide care and support for people living with HIV (PLHIV) and the chronically ill
- Provide coffins for the deceased, especially those who die from HIV and AIDS related illnesses

Although in its initial stage, the project was reaching out to only one village (Mboole), it has now spread to an additional 16 villages. To date, it has reached about 900 households. The following are key project activities that bear witness to the Best Practice project the MRDI has evolved into:

Provision of care and support to OVC

Provision of care and support to children orphaned by AIDS and other vulnerable children, is central to the project's mission. Orphans (as understood by project implementers), are defined as children under the age of 18 who have lost one or both parents. Vulnerable children, on the other hand, are understood to be those affected by HIV through the illness of their parents or principle caregivers. OVC are identified by the traditional leadership, headmasters and teachers who also liaise with MRDI staff on the needs of OVC, and are then registered with the project. School uniforms are provided at the beginning of each term. Once registered, OVC are provided with all their school requirements; uniforms, books, and shoes. Children who have lost both parents do not pay anything, while those who have lost one parent and other vulnerable children receive the items at a subsidised cost. The guardians of these children are able to purchase uniforms from the MRDI at half the normal price. So far, more than 1, 000 uniforms have been provided under the initiative.

Figure 6 : Some of the OVC supported by the project

Figure 7: OVC in School uniforms from MRDI

Besides school requirements, OVC are also offered emotional support by project staff. HIV and AIDS talks are frequently given to OVC, and they are involved in sports and games to keep them productively engaged and away from risky behaviours. MRDI also uses games and sport as a way of providing counselling and other psychological services to children.

Care and Support to the Aged and Chronically Sick

Care and support is also extended to the chronically ill (PLHIV) and to the aged. MRDI youth provide identified households with ploughing services during the planting season and with physical labour at harvest period. The MRDI also avails transport in the form of bicycles, and ox-carts to transport chronically ill individuals to the health facility. This has significantly improved quality of life for the aged and the chronically ill, where access and affordability (to farming, nutrition and health care) can be grossly reduced due to poverty.

Transferring Tailoring and Carpentry Skills to the Youth

The needs of the youths are also addressed by the project. With unemployment close to 90% (CSO, 2002), unemployed youths are at greater risk of indulging in high risk behaviour, making them susceptible to contracting HIV. Currently, the project has a small carpentry workshop and a tailoring workshop, used to train community youth in basic carpentry and tailoring skills. This has enabled many youths to become self-reliant and to make a meaningful contribution to their community. Parents and elders in the community have witnessed the positive impact of this MRDI activity and strongly encourage their youths to participate in the MRDI's skills building activities. The tailoring workshop produces school uniforms, and designs and tailors various other garments that are sold to the community at a low cost. In the carpentry workshop, home furniture, such as stools and tables, is produced and sold to the community. The project cares not only for the quality of life but also for the quality of death, by providing free coffins for deceased community members, especially those who have died from AIDS-related illness and where household incomes are often severely reduced.

Figure 8: Away from the risks of social ills, youths are happily involved in tailoring

Figure 9: Having acquired carpentry skills, youths are engaged meaningfully

Nutritional Support

One of the key challenges in the provision of ART is nutrition. Although ARVs are provided free in Zambia, the issue of nutrition remains a challenge and is viewed as the patient's responsibility. This adversely affects many people on treatment who are unable to cater for their increased nutritional needs. The worst affected are those living in rural areas. To cater for this need, the MRDI has incorporated the provision of nutritional support to ART clients within the project area. To ensure this, the project has acquired a piece of land for food production for PLHIV. By the end of 2006, 42 x 90 kg bags of maize and 3 x 50 kg bags of beans had been provided as nutritional support to people living with HIV and AIDS.

Door-To-Door Community Sensitisation

Project staff reached out to the communities through door-to-door visits which are used as HIV and AIDS sensitisation campaigns, aimed at educating community members on the facts around HIV and AIDS. They also discuss gender equality and traditions as they relate to HIV and AIDS. Over 900 households in 16 villages have been reached with HIV and AIDS information through the MRDI driven sensitisation campaigns. The entire community is now involved in developing strategies to reduce the spread of HIV and increase support and care for those already infected and affected. Sensitisation campaigns are also carried out for school-going children. Consequently more activity-focused youth groups have been formed around Mboole.

5.2 Elements of Best Practice

A detailed reflection of the MRDI reveals its fulfilment of various criteria needed for a Best Practice. Using the SADC Best Practice criteria, the analysis of MRDI was as follows.

1) Effectiveness

Since its inception, the MRDI has defined clear, specific and measurable objectives that are being met through the various project activities. These objectives are in line with the Zambian HIV and AIDS national strategic framework, (2006-2010). Both the national policy and the District HIV and AIDS strategic plan 2006–2010 identify the need for community-based projects to recognise OVC and other marginalised groups as partners in the response to the epidemic. MRDI is a unique initiative that complements government efforts in responding to HIV.

There is clear evidence that the community owns the project and there is an outstanding depth of community participation that gives the project health and a tangible vibrancy. There has been and continues to be, wide and systematic consultation between project implementers and community members, as the project evolves and expands. Project objectives are shaped arounf\d community needs identified by frequent consultation with traditional leaders and key community group representatives.

Figure 10: Village headmen as part of FGDs

> *"…..We are where we are because all community leaders and other members of the community positively support the project. They feel part of the project"*
>
> *Jonsen Habachimba; Chairman (Director)*

The project takes into cognizance gender dynamics and the team composition exhibits a good balance of males and females. Similarly, in services delivery issues, gender needs are prioritised and as a result, women within the community are well informed about HIV. It was clear that the MRDI has given women a voice in responding to the epidemic. Previously, it was considered taboo for a woman to speak out in public about HIV, but now, women participate fully in issues around HIV, at community level.

MRDI is undoubtedly effective in meeting its objectives. It has improved school attendance for orphans and vulnerable children by providing them with school requisites such as uniforms, school shoes, and books. Nutritional support to people living with HIV and AIDS is provided in a timely manner, enhancing the quality of life in households affected by the epidemic. Access to treatment for people living with HIV and AIDS has also improved, as transport is provided using a bicycle purchased from funds generated by the MRDI. Previously, patients had problems in accessing treatment as they had no money to pay for transport to take them to the clinic. Almost every member of the community has been reached by the project's volunteers and the entire community is now involved in strategies on how to reduce the spread of HIV and take care of the infected and affected.

2) Ethical Soundness

For an HIV and AIDS Initiative to succeed, it needs to adopt a human rights approach. This requires that the rights of people, their equality before the law and their freedom from discrimination, are respected and protected. It entails the project to be people-centred and culturally sensitive. The MRDI has taken cognizance of these requirements and has adopted all these elements, a key factor in its success.

The Mboole Initiative has gained the confidence of various vulnerable groups, including: people living with HIV and AIDS, orphans and other vulnerable children, and the aged. It has meaningfully involved these groups at all levels of the project's activities. PLHIV are consulted and their views taken note of. Issues of confidentiality and informed consent are adhered to by all the project's staff. PLHIV themselves attest to feeling respected by the project's staff and to being not in any way discriminated against in the accessing of the project's services. This is a clear indication of ethical soundness, and of the meaningful involvement of people infected with or affected by HIV and AIDS (MIPA).

3) Cost Effective

The MRDI also illustrates cost effectiveness. Before 2006, the MRDI's only means of survival was local funding. The project has thrived and survived on voluntary work by members and other community members, as well as small financial incentives from the income-generating activities mentioned earlier. Despite limited financial resources, the project has continued to have a major impact on the community.

Project staff are locals and thus have a feel for the community's needs. Project personnel are all dedicated volunteers who give their time to serve the needs of their community without pay. The degree of volunteerism among the staff is notable and essential to the progress of the project. Although project implementers do not have higher formal educational attainment, they have received short term training through the DACA in the areas of: project management, HIV and AIDS, volunteerism, community mobilisation and self help initiatives.

MRDI has evident support for its work from the community it serves. This is demonstrated in the range of contributions it receives – both in cash and in kind, from community members. For example, three sewing machines were donated to the project by community members. Community members have also been physically involved in project activities such as brick moulding for the expansion of the project's buildings, thus demonstrating a deep sense of project ownership.

MRDI has effectively used income generating activities to raise money locally to scale up project activities. In 2006 MRDI was awarded US$20,000 for being an outstanding project in the area of OVC. In the same year, it received a boost of a US$12,000 donation from the World Bank, through the Community Response to HIV /AIDS (CRAIDS) project. This money

is being used to extend the project to more beneficiaries. To ensure financial discipline, the project has two accounts with the bank; one for discretional funds and the other for non-discretional funds.

The project has also had multiplier effects in that, while its core business is to look into issues affecting OVC, project staff also from time-to-time assemble community members and offer them VCT information. The project not only refers people for VCT but physically transports those who are interested, to and from the VCT centres. The project has also acted as a link between the Ministry of Agriculture and the community as through MRDI, the Ministry of agriculture identifies the agricultural needs of the community and responds to these needs through project staff. For instance, some women's groups in the community have been trained in agricultural management by the Ministry of Agriculture, using MRDI staff.

4) Relevance

The initiative has received overwhelming support and acceptance from both political leadership (NAC, District commissioner, area councillor), and traditional leadership (Chief and Village Headmen). The project has also been accepted by religious leaders, although a degree of disagreement is unavoidable. For instance, the stance of the Roman Catholic Church on condoms poses a challenge to the project, which promotes condoms as a prevention measure. However, overall, the project operates well within the traditional and cultural norms of the community.

The relevance of this initiative cannot be over-emphasised, since MRDI attempts to address the critical problem of HIV facing Zambia as a whole and rural communities in particular. With some 16% of Zamiba's population infected with HIV, Zambia has experienced both the social and economic impact of the epidemic which has left families disintegrated and devastated. Breadwinners have been lost and grandparents have been left to take care of the orphans left behind. Most of these grandparents are too old to care for young children and generally do not have the means to do so. The children end up not going to school as there is no one to pay for their school requisites. Some end up on the streets, where they turn to theft and prostitution for survival. It is estimated that 70% of these orphans are due to AIDS.

> *"…..When my mother died, I dropped out of school because I did not have a uniform and books…thanks to MRDI, I'm now back at school "*
>
> *says an 11 year old girl*

The initiative has thus addressed the needs of the affected; OVC, youths, women and the aged, as well as PLHIV. All these groups are vulnerable and the initiative has helped send many children back to school. It has also improved their quality of life by providing nutritional support and transport to the local health centre, as well as agricultural support for the sick and the aged.

5) Replicability

MRDI uses simple but effective processes that can easily be copied or replicated in similar contexts and even at a broader level. The project has used the traditional leadership as an entry point into the community and utilised local and available resources in a meaningful manner, so that its impact has been greatly felt. Contrary to the widely held misconception that HIV initiatives need a lot of resources, MRDI sets a unique example that you can make use of what is within your means and still make a significant impact.

The social and economic conditions prevailing in Mboole are typical of many rural situations in Zambia and in the whole southern African region. Many other SADC countries are facing the same challenges. This intervention, if replicated, would help them address some of their challenges. Moreover, the resources needed to start such an initiative are within reach of many such communities. To initiate the project, commitment from local leaders, youth and other members of the community is essential. Once this is assured, communities can pool their resources and start income generating activities such as those undertaken by the MRDI, or other economic ventures best suited to their area. The community can then identify those to benefit from the project. The initiative need not be limited to care and support, but can be focused on any other thematic area including prevention, reduction of stigma and discrimination, or mitigation. By documenting this initiative and working through the local leadership, other communities can be encouraged to start similar initiatives.

Village headmen and youths from villages outside the project area have visited MRDI to get ideas on how to go about replicating this successful initiative in their own settings. Women's groups have also replicated the project on a smaller scale and are now running income generating activities to help alleviate poverty among women.

6) Innovativeness

MRDI is one of the few initiatives, that has succeeded in using minimal resources to score greater outcomes and as such, the project's operation is unique. The initiative has been properly managed by the youths who have a passion for community work. They are both spirited and visionary and this has gained them the confidence and respect of diverse community members. Unreserved confidence and support for the project is expressed from the level of the district commissioner to traditional and religious leaders. For the community members, *" MRDI is the best that has ever happened in the community."*

> *"It is amazing how these youths dedicate their lives to serving the needs of the community. We always pray for them that they should live longer. At first we thought they were just like these come-and-go organisations, but we were wrong. Today I can even tell men to be using condoms because I have learnt this from these youths".*
>
> - an elderly woman showering praises on MRDI

The programme has also introduced female condoms as part of their HIV prevention activities.

A unique facet of MRDI is the level of community participation in project activities. MRDI's innovation is exhibited through the use of local resources. For instance, the wood used for furniture production is locally sourced, but because of the danger of deforestation, MRDI has adopted a policy of planting trees as they use them, and timber reserves have been established to conserve wood supplies for the future. Another innovative aspect is that while some uniforms are sold at low cost to raise income for the project, others are provided at no cost to OVC who are unable to pay for them.

The degree of volunteerism is another unique aspect of MRDI. The youths running the project spend eight hours a day helping PLHIV, the aged and OVC. At present, the initiative does not have adequate transport to take project staff on community sensitisation trips in distant villages, but this does not deter the youth from walking long distances to ensure that HIV and AIDS information is made available to everyone within their reach. They also use these door-to-door campaigns to identify the varying needs within the community. All these valuable activities are conducted without payment.

7) Sustainability
Prior to 2006, MRDI has been sustained through small financial incentives from its income generating activities (IGAs). From inception, it has been locally funded through its IGAs and the good will of community members, which shows that the initiative is sustainable.

There is a deep sense of community involvement in the project simply because community members have constantly been interacting with it from its conceptualisation to its implementation. The initiative has the full backing of the community and there is no doubt that the project can continue in the absence of the external donors. However, to scale up MRDI's efforts, more funds need to be sourced both internally and externally.

Community members were part of the team that designed the HIV and AIDS prevention and OVC support project proposal submitted to CRAIDS. This proposal took into account locally identified needs, since community members added their concerns on HIV and AIDS for inclusion in the project proposal.

"The future of the project remains bright", observed community members who have pledged to continue supporting the Initiative. Future plans for the project include:

- Expanding the initiative to surrounding areas,
- Expansion of the three income generating activities to:
    - create employment for youths, increase the number of OVC receiving support from the initiative, and
    - support the already registered OVC with other school requisites.

5.3 Key Programme Successes

MRDI has scored a number of successes, some of which have been mentioned, however some unique successes of the initiative worth highlighting are indicated below.

World Recognition
MRDI has become known and recognised nationally, regionally and worldwide as a community HIV and AIDS initiative that works. MRDI was selected by the UNDP as the Zambian entry for the Red Ribbon Award at the 2006 Toronto AIDS Conference. This is a new global Community AIDS Award that celebrates community action in fighting the HIV and AIDS epidemic. Nominations were made at country level and the MRDI was submitted. Nearly 600 communities from around the world went through a rigorous review process; a committee of 50 international HIV and AIDS experts identified the top 25 candidates. In Toronto, the MRDI was awarded the prize in the "Support to orphans and vulnerable children" category. It received USD20,000 for scaling up project activities. This money is currently being used to scale up project activities to other villages in Choma district.

In 2007, the MRDI project site was selected to host the national World AIDS Day event, which drew a number of distinguished figures including government ministers and other policy makers who were visiting the area for the first time.

Life Changing

Without over-emphasising, MRDI is simply offering life-changing services to PLHIV, the youth, women and OVC. This was evident from the touching success stories that community members willingly shared with the documenting team. Some of the captured stories are shared here:

"One day I was very sick and I could have died. I did not have the means to reach the clinic, as it is very far. I was fetched to the clinic on a bicycle by MRDI volunteers. One was holding me as the other one pushed.. .Each time I need to go for treatment, MRDI come to my aid".

\- a PLHIV

"I stay with my grandmother since the death of my parents. I once stopped school because I felt ashamed to attend classes without school uniforms and books while my friends had. My grandmother is too old and poor to afford my school requirements. My teacher took me to Jonsen (MRDI Chairman) and they gave me a uniform and books. Am very happy to go back to school, my performance has improved".

\- an OVC

"Life has really changed because of MRDI, sometime back, some people who died, especially from HIV and AIDS would just be wrapped in a sack and buried. This is because, due to poverty, they could not afford a coffin. Now this is not possible because MRDI provides them for free to those who can not afford"

– a Village Headman

Women's Empowerment

Gender is a critical aspect of the fight against the HIV epidemic. Traditionally, women are taught never to deny their husbands sex, regardless of the number of extra-marital partners he may have or his unwillingness to use a condom. The MRDI has been exemplary in creating awareness on HIV and AIDS and related human rights issues. It has helped address the gender inequalities that fuel the spread of HIV and AIDS by sensitising community members, especially women, about their right to say no to sex if they do not want to engage in it. With the continued education on the dangers of HIV and AIDS and women's rights, women in the community have become knowledgeable about their rights and are bold enough to hold on to them securely. The initiative has introduced female condoms as part of their community sensitisation programme. Male community members, including the Chief of Singane, attested to this change in gender dynamics following the MRDI interventions.

"It was not easy for us women to speak about sex and AIDS to our husbands. This is because we did not have the necessary information. Now we have received the information from MRDI and we openly discuss these issues with our husbands"

- female community member

Figure 11. Women's views relating to HIV and AIDS are heard and respected

5.4 Challenges

Burnout
While the MRDI has been a remarkably successful initiative, it nonetheless faces the challenge of burnout on the part of its core members, whose remarkable dedication needs more than social rewards if it is to be sustainable. While these passionate young people clearly get a great deal of personal satisfaction from their work, they also need to satisfy their families' broader needs.

Capacity Building
MRDI staff need to be assisted if they are to establish and maintain monitoring and evaluation systems to cater for the increasing scope of the project. Furthermore, accounting, or at least basic book keeping skills are likely to be needed, once additional funding is obtained, as this will also increase the need for proper reporting to donors on the use of funds.

5.5 Lessons Learnt

A number of Key lessons have been learned from the MRDI.

Using Traditional Leadership as Entry Point To Community Participation
MRDI would not have had such success, had its implementers not recognised, respected and incorporated the role of traditional leaders in community mobilisation. Traditional leaders possess significant authority over the communities they head and once tapped, they greatly support effective community mobilisation. This is particularly relevant in rural settings, where the belief and trust in traditional leadership remains strong. First, the area Chief and village headmen were briefed about the intended project activities. They subsequently organised community meetings at which they sold the idea to the entire community. As a result, the communities accepted the initiative and were eager to be part of it. This is a critical and key strategy used effectively by MRDI.

Community participation is key to Project Sustainability

The point well learnt from MRDI is that for any HIV and AIDS Home/Community Based Care project/Initiative to succeed, it requires full and meaningful participation from community members. Since its inception in 2003, the MRDI has been locally sustained by small income generating activities and donations either financial or in kind, from community members. This has only been possible because the community has been fully involved in the project. Regular feedback is obtained the community through consultative meetings with community representatives, and improvements and adjustments to activities are regularly made to activities, based on this feedback. Vulnerable groups and women are equally represented during the consultative process, and their needs are taken into account by the project.

Figure 12: From right: Jonsen (MRDI founder youth), C.Moonga (DACA/UN HIV and AIDS volunteer), R. Eghtessadi (SAfAIDS), Chief Singani, C. Chomba (SAfAIDS) and Mr Maxwell Muteteka (NAC Treatment and Care Specialist)

The Urgent response to HIV and AIDS - not waiting for money to take action

A quick review of MRDI reveals a unique approach in handling HIV and AIDS-related activities. The initiative succeeded in its activities up to 2006, not because of handsome donations, but because of the commitment and passion of the project staff combined with the good will of the community. The initiative has kept costs low by using local expertise and other necessary resources to ensure that the project's core activities are successful. It was only in 2006 that the initiative received external funding from the World Bank and UNDP. The initiative had done its work of imparting positive HIV and AIDS behaviour modes to the community with limited resources up until 2006. This however, does not imply that such financial resources are not necessary.

6. The Way Forward

This report has validated the MRDI as a Best Practice which needs minor improvements, according to the SADC criteria for evaluating Best Practices. After data collation and completion of the score card, the initiative scored 71%, meaning that it is a Best Practice requiring only minor adjustments. The areas needing minor improvements are:

Establishment of a Monitoring, Evaluation, Reporting and Documentation System (MERD)

There is evidence of good work being done at MRDI and having a clear system of documenting and reporting project activities is obviously critical. A clear system to indicate the direction of the Initiative including all data collection protocols, the frequency of reporting and how impact will be measured, needs to be established. Having such as system in place will not only provide a clear direction of project progression but is fundamental to assuring future funding, especially as the project's activities are scaled up to reach more beneficiaries.

MRDI has a sound working relationship with the District HIV/AIDS Task Force (DATF) and the DHMT. These have clear MER systems based on the national guidelines, which the MRDI can borrow.

Programme Assessment

The MRDI has been running since 2003, and various successes have been observed. It would do well to conduct an evaluation of the project at this point. This could be regarded as a mid-term evaluation. Proper documentation of the findings of the evaluation would do justice to the project and form a basis for future funding, as it would show the positive impact the project has had and will continue to have on the people.

Expanded Resource Base

The demand for the services provided by the initiative is increasing daily as it is scaled up to include other villages. This will certainly need more financial and human resources. There is a need for project staff to cast their net wider than local income generating activities. This can be done by proposal writing and the establishment of a strategic committee to ensure the initiative is well marketed to all stakeholders. As one of a few rural community strategies that work, the initiative has great potential to attract additional funding, if more proactive resource mobilisation strategies are adopted. This will also ensure project sustainability.

More Training for Project Staff

The area of HIV and AIDS is a dynamic one and anyone working in this area needs to be in constant touch with its dynamism. Although project staff have received some vital training relating to volunteerism, HIV and AIDS, and Community mobilisation, it is prudent for MRDI staff to constantly be up-to-date with current developments in their area of operation. This will ensure efficiency in delivery of services to the clients. They need frequent additional training, especially in areas relating to OVC and HIV and AIDS.

References

1. CSO (2002) Zambia Demographic Health Survey, 2002. Lusaka: CSO

2. CSO (2000) Census of Housing. Lusaka: CSO

3. NAC (2006) National HIV and AIDS Strategic Framework. Lusaka: NAC

4. NAC (2006) Choma District HIV and AIDS Strategic Framework. Lusaka: NAC

5. NAC (2007) Mboole Rural Development Initiative: Proposal Submitted to SADC. NAC: Lusaka

6. MRDI (2006) HIV/AIDS Prevention and OVC Support Project proposal submitted to CRAIDS

Annexes

Annex I: Methodology: Data collection and analysis tools

Data Collection

Data was collected from various categories of people drawn from all the villages reached by the project. This was done through focus group discussions (FGDs), face to face interviews, observations, photographs and review of the existing literature regarding the project. Seven FGDs were held at the project sites; two with OVCs, one with village headmen, one with the youths, one with women, one with PLHIV/Chronically ill and one with the project implementers. Interviews were also done with the Village Chief, Senior headman, School Headmaster, Teachers, the Area Councillor, the District AIDS Co-ordinator(DACA), the UN Volunteer, the District Commissioner, the Project Director and NAC staff

Data Collection Tools

Three data collection instruments were used; FGD guides for Beneficiaries, Interview Guides for Implementers, and Interview Guides for Key Informants. Copies of these are below. For ethical reasons, consent from all persons whose pictures are used in this document, was obtained. For ethical reasons, the Choma District Commissioner gave written consent for all concerned while verbal consent was also sought on site from all participants.

Data Analysis and Interpretation

Data collected was transcribed and analysed through triangulation and an appreciative mode of enquiry. Collected data was entered into the scorecard data for analysis and information was presented in graph form assessing the project against the SADC criteria for a Best Practice (effectiveness, ethical soundness, cost effectiveness, relevance, replicability, innovativeness and sustainability).

Validation of Mboole Rural Development Initiative as a Best Practice was based on the following guide:

The seven SADC Best Practice criteria were each further broken down into a number of key elements that best constituted the specific criteria. For example, the criteria of effectiveness was first broken down into the three main elements namely: project design/structure; community involvement; and monitoring and evaluation. These elements were further broken down to a number of variables. The variables were then scored at the time of assessment using a 0-4 scale as follows:

4	Excellent
3	Very good
2	Good
1	Just satisfactory
0	Need urgent attention
n/a	not applicable to the project

The scores for all the variables per criteria were added up and converted into percentages. The total possible score is 100%. Validation of a Best Practice is based on following interpretation of the scores:

Total Score (%)	Interpretation
80 or better	Truly a Best Practice
65 - 79	A Best Practice that needs minor improvements in certain areas
50 - 64	A good practice because of specific areas – it may not be a total package. It can be documented but it needs major improvements for it to qualify as a Best Practice
Below 50	Not yet a Best Practice but has potential to become one

To ensure validation within and beyond SADC, these standards have been matched with the UNAIDS and other international Best Practice criteria. Data was collated and then applied to the score card in order to obtain an overall Best Practice score.

Documentation Methodology Framework

Method	Tool	Target/Data Source	Number	Sampling Method	Method of analysis
Literature review	Checklist of key documents for review	• www search engines, on IDU and HIV interventions • Project and national data sources	At least 15 relevant documents were reviewed	Purposive selection	Scoring on checklist and Score Card
Focus Group Discussions (FGDs)	FGD guide	• Project beneficiaries- IDUs, client family members • Project implementers	7 FGDs were held	Random selection, as per specific country	Scoring by themes
Interview – Project Implementers	Interview guide	Project implementers and leadership	5 interviews were conducted	Purposive selection	Score Card
Interviews – Key Informants	Interview guide	• National – NAS, AIDS Unit, MOH&QL • Community level – NGOs	8 interviews were held	Purposive selection	Themes and scoring
Observation	Digital camera	• Project and NGO sites • Beneficiaries and implementers	Several per target group	As appropriate	-

Annex II: Data Collection Tools

SAfAIDS

SADC Project - Documentation of HIV and AIDS Best Practices among member states

Interview Guide: Key Informants

EFFECTIVENESS

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

ETHICAL SOUNDNESS

13. How does the project/programme ensure inclusion of vulnerable groups? (probe for value statement on how interests of young people, women, CSWs, LGBTI, people living with disabilities and PLHIV are taken care of)

14. What policies are in place to ensure that the project/programme upholds and respects human rights? (probe for policy or consideration of confidentiality, informed consent and safety issues)

15. What policies are in place to ensure continuity of services? (probe for systematic weaning or phase out strategies, skills transfer)

16. What policies are in place to ensure equitable distribution of services? (Do those with greatest need access the service?)

17. How is the project/programme audited and who does the auditing? (*probe for transparency i.e. project allowing for both internal and external programme and financial audits, frequency of audits)*

REPLICABILITY

18. What do you think is the most unique aspect of this project/programme?

19. Ask for any other additional information deemed relevant but not covered in the questions

20. What are some of the success stories that can be shared?

21. What are some of the challenges of the project/programme?

22. What are some of the lessons learnt? And how have these learning points been used to strengthen the project/programme?

23. What plans are in place to scale up the project/programme? (to reach more beneficiaries or to have more impact on currently reached beneficiaries)

SUSTAINABILITY

24. How is the vision of the project/programme aligned with current trends? (national and regional trends, epidemic, economic, developmental - political correctness- MDGs, Universal access etc)

25. What is the funding pattern of donors? (basket funding, % of funding from local sources and donors,)

INNOVATIVENESS

26. How does the strategy of the project/programme ensure financial sustainability? (probe for information on fundraising strategies, user fee, community initiatives)

27. What do you see as the future of the project/programme?

THANK YOU FOR YOUR TIME, SUPPORT AND PATIENCE

SAfAIDS

SADC Documentation of HIV and AIDS Best Practices among member states

Focus Group Discussion Guide (FGD): Communities/Beneficiaries

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

Effectiveness

1. What is the purpose or aim of the project ? (*goal, objectives*)

2. How were you involved in the establishment of the project /programme? *(conceptualisation, consultations, needs assessment, prioritization of needs, relevance of needs, usefulness, timeliness of project/programme, planning)*

3. What do you think are the benefits of this project/programme for you as women / men / young people and your communities?

4. How do you view this project/programme? *(is this YOURS, ownershipwith you, imposed, or donor driven, or neutrally accepted because you don't have a choice)*

5. How do the services/activities of the project/programme cater for the needs of different age-groups, sexes, and social classes within your community?

6. How does the project/programme take into cognisance gender dynamics in your community? (*probe for composition of structures, participation and beneficiaries – girls, boys, women & men and benefits)*

7. How has access to the services/activities of the project/programme been influenced by the economic or political trends in your community?

8. How are the project/programme implementers working with you to determine project/programme needs in order to meet your needs?

9. How are you participating in the implementation of the project/programme and in checking that the project/programme is progressing well (*monitoring and evaluation processes*)?

10. How do you share your feedback or feelings about the services/activities you are receiving, with the project/programme implementers? How often?

12. How does your community contribute towards the services/activities that this project/programme offers? *(cash, kind, other support, eg advice and networking)*

13. Describe the process that takes place when community members want to access the services /activities provided by the project/programme. *(probe should be specific to the BP you are documenting , this will measure how implementers are 'doing things' eg are human rights being adhered to etc.)*

14. What factors hinder your community members from accessing the services, or engaging in the activities that this project/programme is offering?

15. What would you like to be done in this project/programme, for it to be of greater benefit to your community?

Cost Effectiveness

16 Are services provided in a timely manner?

17 Is there an increase in the number of people in this community whose lives have been changed as a result of benefiting from the programme?

18. Is there a positive life story that you can share with us?

19. Is the service provided, cost effective? How can it be improved?

20. Do you find that the project has adequate personnel providing the service? (*numbers and skills.)*

Relevance

21. What are the views of your traditional and religious leaders on this project/programme? *(project was introduced to traditional systems, consensus sought, part of consultative process, commitment and support offered by traditional systems)*

22. Are all the services provided, necessary? Which ones are not?

Ethical Soundness

23. Are your rights and those of others respected in this programme? Explain.

24. In your opinion, is there a fair distribution of services between men and women, rich and poor, married and unmarried, adults and children ?

25. Is there transparency in the operations of this organisation?

26. Do you feel that the organisation and its staff are accountable to beneficiaries

27. Are people treated with respect, and are their opinions listened to by programme staff?

Innovation

28. In your opinion, is this programme creative and innovative, different from other projects?

29. Can you share with us a story that demonstrated this innovation?

Sustainability

30. Do you think this programme should continue in the absence of donor support? Why? *(has there been skills transfer in the community, is community contributing to the programme in cash or kind?)*

31. Is the programme well known in the community?

32. What are some of the challenges you faced in this programme and how have yourselves and the NGOs addressed these challenges?

THANK YOU FOR YOUR TIME, SUPPORT AND PATIENCE

SAfAIDS

SADC Project - Documentation of HIV and AIDS Best Practices among member states

Interview Guide: Project/programme Implementers

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

EFFECTIVENESS

1. What is the purpose or aim of the project/programme?

2. How does the goal (aim) of the project/programme relate to, or fit into, the National HIV and AIDS strategic plan?

3. What are the strategies for achieving the goal? (Probe for implementation plans, services rendered and defined target groups – geographic and demographic catchments)

4. How do beneficiaries access the services of the project/programme? (Probe for clarity on community outreach plan or disbursement / distribution plan)

5. What systems are in place to ensure effective implementation? (Probe financial, programmeming, procurement, human resource allocation, equipment, staff development, skills transfer and project sustainability)

6. How does the approach of the project/programme integrate with other programmess i.e. inclusion of other services, multitasking? (To see whether programme is vertical, assess multiplier effect – 'does one stone kill many birds?')

7. How were the priorities of the project/programme determined? (Probe for information on needs assessments, community and other stakeholder involvement, project addressing urgent needs of community?)

8. How is the community involved in the project/programme? (Participation in planning, monitoring, implementation and evaluation – probe for information on mechanisms put in place to solicit feedback from community groups – probe for other ways in which community contributes to the project, assess project acceptability – social, political, cultural and religious)

9. How does the project/programme take into cognisance gender dynamics at community level? (Probe for composition of structures, participation and beneficiaries)

10. How is the project/programme monitored? (Ask for monitoring tools, if any, and frequency e.g. coverage, reporting forms, tally sheets, monitoring committees, quality assurance mechanisms or quality bench marks)

11. How is the project/programme evaluated? (Measurement of impact – probe for knowledge of main indicators and baseline information, frequency of conducting evaluations)

12. How is monitoring and evaluation data used? (frequency of use for project review, timeous dissemination to relevant stake holders?)

13. Who are the implementers of the project/programme? (Probe for information on sectoral expertise amongst staff, volunteers, out-sourcing as necessary, adequacy of staff, roles and responsibility)

ETHICAL SOUNDNESS

14. How does the project/programme ensure inclusion of vulnerable groups? (Probe for value statement on how interests of young people, women, CSWs, LGBTI, people living with disabilities and PLHIV are taken care of)

15. How are human rights upheld or respected during establishment and implementation of the project/programme? (Probe for policy, consideration of confidentiality, informed consent and safety issues)

16. How are continuity of services, support or care ensured after end of current funding cycle? (Probe for systematic weaning or phase-out strategies, skills transfer mechanisms)

17. How is equitable distribution of services ensured? (Those with greatest need access the service?)

18. How is the project/programme audited and who does the auditing? (Probe for transparency i.e. project allowing for both internal and external financial audits, frequency of audits)

COST EFFECTIVENESS

19. How are the resources of the project/programme distributed? (Admin versus programme costs)

20. How is the service-cost measured within this project/programme? (Probe for methods of tracking inputs/outputs in relation to outcomes so as to enable calculation of cost per client)

21. To what extent are available resources adequate for supporting service delivery to the project/programme? (Probe for adequacy of human and financial resources, equipment and supplies)

22. What are the cost saving and cost reduction measures of the project/programme? (use of low cost, improvised substitutes, engaging volunteers for some of the services, does it have an increased financial burden on beneficiaries)

23. To what extent does cost sharing take place in the project/programme? (user fees, payment of some of the services like training, transport)

24. What is included in the minimum care package of the service/s provided by the project/programme? (compare with the standard care package policy for the country, procedure guides)

25. How timely is the delivery of services?

REPLICABILITY

26. How are the activities and processes of the project/programme documented? (get copies of reports, case studies collected, documentaries, manuals, books etc)

27. What are some of the success stories that can be shared on the positive impact or influence of the project's services on beneficiaries?

28. What are some of the challenges of the project/programme?

29. What are some of the lessons learnt from this project/programme, and how have they been used to strengthen the project/programme?

30. What plans are in place to scale-up the project/programme? (to reach more beneficiaries or to have more impact on currently reached beneficiaries, quality & quantity)

SUSTAINABILITY

31. How is the vision of the project/programme aligned with current trends? (national and regional trends, epidemic, economic, developmental - political correctness- MDGs, Universal access etc)

32. How is the project/programme marketed to stakeholders? (assess for active education and awareness building amongst stakeholders, language and medium used, are you getting the expected responses?)

33. How does the strategy of the project/programme ensure financial sustainability? (probe for information on fundraising strategies, user fee, community initiatives)

34. What do you see as the future of the project/programme?

INNOVATIVENESS

35. What do you think is the most unique aspect of this project?

36. Ask for any other additional information deemed relevant but not covered in the questions above.

37. Share with us a success story that demonstrates the success of your programme.

T H A N K Y O U FOR YOUR TIME, SUPPORT AND PATIENCE

SADC Secretariat Commissioned Secretariat Project - Documentation of HIV and AIDS Best Practices among member states

Key Assessment Tool – Score Card

** This Score card is measured from a total of 100*

Variable	Data Source	n/a	0	1	2	3	4
1. EFFECTIVENESS (15.5/25 points = 62%)							
Project/programme Design/Structure (7/10 marks)							
Goal/s is/are clearly articulated and well understood by beneficiaries and implementers.(1)	Lit. review						X
Project/programme is in line with the National HIV and AIDS strategic plan (0.5)	Lit. review / Interviews						X
Strategies are in place and clearly articulate how the goal can be achieved supported by clear implementation plan. (1)	Lit. review/ Interviews				X		
Clear strategies are in place to evaluate impact of the project (0)	Lit. review/ Interviews		X				
Project/programme has clear results as defined by implementers, beneficiaries and stakeholders and in line with original objectives. (1)	Lit. review/ Interviews						X
Project's/programme's services/activities are clearly defined. (1)	Lit. review						X
Project/programme has clear systems in place (financial, community outreach, distribution/disbursement, equipment). (0.5)	Lit. review/ Interviews			X			
Baseline/assessment/ground work was undertaken prior to project's/programme's commencement. (0.5)	Lit. review						X
Project/programme has clearly defined targets. (1/2)	Lit. review						X
Project's/programme's objectives are SMART. (0)	Lit. review				X		
Project/programme embraces an integrated approach (vs vertical). (1/2)	Lit. review/ Interviews						X
There is sectoral expertise to manage and implement the project/programme. (0.5)	Interviews				X		
1.2 Community Involvement (8/10 marks)							
Project/Programme priorities are based on actual needs of the community – evidence of needs assessment done. (1)	Lit. review/ Interviews/ FGDs						X
Community knows and understands the objectives of the project/programme. (1)	Interviews/ FGDs						X
Community participated in the initiating/conceptualisation of the project/programme, setting priorities. (1)	Lit. review/ Interviews/ FGDs						X
Community participates in the project/programme planning, monitoring and evaluation. (0)	Lit. review/ Interviews/ FGDs			X			
Community participates in the project/programme implementation as volunteers or paid staff. (0.5)	Lit. review/ Interviews/ FGDs						X

There is a sense of ownership of the project/programme, among communities. Community feels the project and its outcomes belong to them. (1)	Lit. review/ Interviews/ FGDs/ Observation						X
Community contributes in cash or in kind towards project/programme activities. (1)	Lit. review/ Interviews/ FGDs						X
There is gender sensitivity in community participation. (both men and women are involved equally). (0.5)	Interviews / FGDs Observation					X	
Community is satisfied with the project's/programme's services. (both men and women) (2)	Interviews / FGDs/ Observation						X
1.3 Monitoring and Evaluation (M&E) (0.5/5marks)							
Systematic methods of tracking inputs and outputs are in place. (0)	Lit. review/ Interviews		X				
Key stakeholders, including the community, participated in the development of the project/programme indicators. (0)	Lit. review/ Interviews/ FGDs		X				
Project's/programme's activities are periodically monitored and evaluated including coverage. (0)	Lit. review/ Interviews		X				
Quality assurance/quality benchmarks are in place and followed. (0)	Lit. review/ Interviews		X				
Participatory monitoring and evaluation methods are being used that include the community. (0.5)	Lit. review/ Interviews/ FGDs				X		
M & E (impact, assessments, outputs) data are analysed periodically. (0)	Lit. review/ Interviews			X			
Results of impact evaluations are used to make meaningful adjustments to the project/program. (0)	Interviews			X			

Variable	Data Source	n/a	0	1	2	3	4
2. ETHICAL SOUNDNESS (10/10 points = 100%)							
Confidentiality, as a principle, is upheld in interactions with project's/programme's service beneficiaries. (1)	Lit. review/ Interviews/ FGDs						X
The interests of vulnerable groups (LGBTI, people living with disabilities, CSWs), are respected and protected. (1)	Interviews/ FGDs						X
Project/ programme does not directly or indirectly violate human rights. (1)	Interviews/ FGDs						X
Project/programme has a Value Statement for protection of interests of various vulnerable groups. (1)	Lit. review/ Interviews/ FGDs						X
Project/programme always embraces the concept of informed consent when dealing with human beings as participants. (1)	Lit. review/ Interviews/ FGDs						X
There is evidence of equitable distribution of project/programme resources (finances, geographic distribution, sex). (1)	Lit. review/ Interviews/ FGDs						X
The autonomy of clients is protected and respected during project/programme roll-out. (1)	Lit. review/ Interviews/ Observations						X
There is an ethical standard ("do no harm" principle) embedded in the project/programme/ policies. (1)	Lit. review						X

There is a minimum service provision package (clearly defined, access irrespective of colour, creed, sex, religion, political affiliation). (1)	Lit. review/ Interviews						X
The project/programme is transparent (allows for external and internal programmatic and financial audits). (1)	Lit. review/ Interviews						X
3. COST EFFECTIVENESS (8.5/12 points = 70.8%)							
Distribution of project/programme resources is cost effective (administration versus programming) and is proportionate to available resources. (1)	Lit. review/ Interviews						X
There is evidence of increased number of community members whose quality of lives have been improved by the project's/programme 's resources and services. (1)	Lit. review/ Interviews						X
There is evidence to enable calculation of 'cost per client' measure. (cost known) (1)	Lit. review/ Interviews					X	
A standard package is provided at a reasonable cost. (cost known) (2)	Lit. review/ Interviews						X
Services are delivered in a timely manner. (1)	Interviews/ FGDs						X
There are adequate human resources for project's/programme's activities (skills and numbers). (0.5)	Interviews				X		
The strategy used by the project/programme has resulted in a multiplier effect (cost - benefit). (1)	Lit. review/ Interviews/ FGDs						X
The project/programme has introduced cost saving / reduction systems. (1)	Interviews/ FGDs						X
4. RELEVANCE (11/11)							
The project/ programme is socially and culturally acceptable. (1)	Interviews / FGDs						X
The project/programme takes cognisance of specific contexts (literacy, messaging, lifestyle, economic, political, approach, environmental factors, risk groups and areas). (1)	Interviews / FGDs						X
Project/ programme does not conflict with the religious norms of the community and has support from political and traditional leadership. (1)	Interviews / FGDs						X
Beneficiaries perceive the project/programme as relevant and timely in addressing their most urgent needs. (2)	Interviews / FGDs						X
Project/ programme is in line with demographic, social, political, and economic trends. (1)	Interviews / FGDs						X
Gender dynamics are addressed by the project/programme. (2)	Interviews / FGDs						X
The project is appreciated by vulnerable groups. (1)	Interviews / FGDs						X
The project/programme is perceived as valuable and credible by the community. (2)	Interviews / FGDs						X
5. REPLICABILITY (6/10 points = 60%)							
Project/programme can be replicated in similar contexts. (1)	Lit. review / Interviews					X	
Project/programme sets an example for other similar programmes. (1)	Interviews						X
Project/ programme is adaptable in different contexts and at any level using local resources. (1)	Interviews / Observations					X	
Project is replicable in part or in totality (1)	Lit. reviews/ Interviews						X

Project/programme exhibits evidence of proper documentation in terms of goals, processes, evaluation, cost and resources. (0)	Interviews / Observations			X			
Project can be scaled-up to reach more beneficiaries. (1)	Interviews / Observations					X	
Project can be scaled-up to improve quality of service (1)	Interviews / Observations						X
6. INNOVATIVENESS (6.5/8 points = 81.3%)							
Project/programme is unique (different methodology from other organisations). (1)	Lit. review/ Interviews/ FGDs/Obs						X
Project/programme has a new way of reaching beneficiaries. (1)	Interviews/ FGDs						X
Variable	**Data Source**	**n/a**	**0**	**1**	**2**	**3**	**4**
Utilisation of available resources is done in a creative manner. (0.5)	Interviews/ FGDs/ Observations				X		
Strategy of implementation, used by programme implementers, is innovative. (1)	Interviews					X	
Project/programme concept is new to the community (as perceived by the community). (1)	Interviews/ FGDs					X	
Project/programme is contributing to the base of knowledge. (0.5)	Lit. review/ Interviews				X		
Project's/programme's approach and systems are scientifically/economically sound and safe. (0.5)	Lit. review				X		
7. SUSTAINABILITY (17/20 points = 85%)							
7.1 Programme sustainability (8/10marks)							
Project/ programme is supported by beneficiaries, community ownership, contributions in cash and kind. (2)	Lit. review/ FGDs/ Interviews						X
Community expresses confidence that programme will continue without donor support. (2)	FGDs					X	
Skills transfer takes place in relation to the project/programme. (1)	Lit. review/ Interviews				X		
Project's/programme's vision is in line with the development patterns of HIV and AIDS and national trends (social, economic and cultural. (1)	Lit. review/ Interviews/ FGDs						X
Project's/programme's vision is in line with national trends (social, economic and cultural) (1)	Lit. review/ Interviews						X
Planning and implementation takes into account the issue of sustainability. (sustainability plan) (1)	Lit. review/ Interviews					X	
7.2 Financial sustainability (6/7marks)							
Project/programme implementers are aware of potential donors (local and international). (0.5)	Interviews				X		
There exists a positive attitude and wiliness to achieve sustainability. (1)	Interviews/ Observations						X
Project/programme has the ability to access diversified resources to contribute to its	Interviews				X		

services/activities. (fundraising plan in place) (1)							
Cost sharing mechanisms are built into service delivery where appropriate. (2)	Lit. review/ Interviews					**X**	
Variable	**Data Source**	**n/a**	**0**	**1**	**2**	**3**	**4**
A percentage of financial support comes from the community, organisation has had stable funding over time. (1.5)	Lit. review					**X**	
7.3 Marketing and Awareness Building (3/3 marks)							
Project/programme is actively marketed to stakeholders and funders. (1)	Lit. review/ Interviews				**X**		
Project/programme actively educates and builds awareness amongst stakeholders about its own services/ activities. (1)	Lit. review/ Interviews				**X**		
Appropriate language is being used in information, education and implementation programmes. (1)	Lit. review/ FGDs				**X**		
TOTAL	**74.5%**						

KEY:

5	Excellent
4	Very good
3	Good
2	Just satisfactory
1	Need urgent attention
n/a	not applicable to the project

- Total score above 80% is truly a Best Practice
- Total score from 65% – 79% is a Best Practice that needs minor improvements in certain areas
- Total score from 50% - 64% is a good practice because of specific areas – it may not be a total package. It can be documented but it needs major improvements for it to qualify as a Best Practice
- Total score below 40% - 50% is not yet a Best Practice but has potential to become a Best Practice
- Any score below 40% is not a Best Practice and should not be documented

Annex III: Peer Review Team: terms of reference (TORs) and composition

SAfAIDS

SADC Secretariat Commissioned Project - Documentation of HIV and AIDS Best Practices among member states

TERMS OF REFERENCE FOR PEER REVIEWERS

1. Backdrop

A critical stage in this documentation process is the in-country Peer Review mechanism. Southern Africa HIV and AIDS Information Dissemination Service (SAfAIDS), a regional Information Dissemination service, with extensive experience and expertise in HIV and AIDS information documentation, dissemination and communication, has been commissioned, under the ***Regional Support for an Expanded Multi-sectoral Response to HIV/AIDS in the SADC Region Project,*** to document the four selected HIV and AIDS Best Practices This activity is being conducted in close collaboration with the National AIDS Commission's (or similar bodies) in each focus country

2. Documentation Process Overview

SAfAIDS, in collaboration with country NACs or other coordinating body, shall:

- Conduct a country stakeholders meeting to introduce the project
- Offer capacity building support to country stakeholders, through a two-day basic training workshop on HIV and AIDS Best Practice Documentation and Communication, thus creating a pool of in-country Best Practice documenters
- Document the country Best Practice and collate data collected and analysed into a Best Practice Report
- Share the country Best Practice Report with the country Peer Review Team, selected during the stakeholders meeting, for review
- Finalise the country Best Practice Report, incorporating feedback from the country Peer Review Team, and share the final product with SADC

3. Peer Review Teams – Structure and Composition

3.1 A Peer Review Teams shall be established in each country. The Team shall comprise representatives of in-country:

- National AIDS Commissions (or similar body)
- Ministries of Health, or other relevant Government bodies
- People Living with HIV (PLHIV)
- Civil Society (NGOs) working in the area of HIV and AIDS, and with specific focus on the area related to the country Best Practice
- HIV and AIDS researchers or community-based intervention experts

3.2 Each Peer Review Team shall comprise no more than 5 peer reviewers

4. Peer Reviewer - Terms of Reference

4.1 Each member shall participate in the following activities, to be hosted by the country NAC, in collaboration with SAfAIDS:

- Stakeholders meeting
- HIV and AIDS Best Practice Documentation Training

4.2 Each member shall receive a draft Best Practice Report, for review, from SAfAIDS, and this shall be their primary working document

4.3 The Team shall design their Peer Review Strategy

4.4 The Team shall utilize the Best Practice Score Card, provided to them by SAfAIDS, during the review process

4.5 Review comments from each member shall be collated into a Review Report, to be shared with SAfAIDS at the end of the review process, in Microsoft Word and on a CD-ROM

5. Peer Review - Time Frame

The review process shall take no longer than 3 days, following receipt of the draft country Best Practice Report from SAfAIDS.

for and on behalf of SAfAIDS	**for and on behalf of NAC Country …….**	**Peer Reviewer Country…….**
Date……	**Date…….**	**Date …….**