Telling our Stories:
Lessons from Gender and HIV Programming in Zimbabwe
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This journal was compiled by Juliet Mkaronda and Obrian F. Nyamucherera with review by Ngoni Chibukire, Sara Page-Mtongwiza and Lois Chingandu and edited by Vivienne Kernohan.

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### Acronyms

<table>
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<tr>
<th>Acronym</th>
<th>Definition</th>
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<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<td>ASO</td>
<td>AIDS Service Organisation</td>
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<td>CBOs</td>
<td>Community Based Organisations</td>
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<td>CSOs</td>
<td>Civil Society Organisations</td>
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<td>DV</td>
<td>Domestic Violence</td>
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<tr>
<td>DfID</td>
<td>Department for International Development</td>
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<td>GCN</td>
<td>Girl Child Network</td>
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<td>EC</td>
<td>Engendering Change</td>
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<td>GBV</td>
<td>Gender Based Violence</td>
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<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>HBC</td>
<td>Home-Based Care</td>
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<td>MAC</td>
<td>Matabeleland AIDS Council</td>
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<td>MDGs</td>
<td>Millennium Development Goals</td>
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<tr>
<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
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<tr>
<td>MPoA</td>
<td>Maputo Plan of Action</td>
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<tr>
<td>NAP for OVC</td>
<td>National Plan of Action for Orphans and Vulnerable Children</td>
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<tr>
<td>NGOs</td>
<td>Non Governmental Organisations</td>
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<tr>
<td>OI</td>
<td>Opportunistic Infection</td>
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<td>SADC</td>
<td>Southern African Development Community</td>
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<td>SAfAIDS</td>
<td>Southern Africa HIV and AIDS Information Dissemination Service</td>
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<td>SIDA</td>
<td>Swedish International Development Cooperation Agency</td>
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<td>SRHR</td>
<td>Sexual and Reproductive Health and Rights</td>
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<td>STAR</td>
<td>Societies Tackling AIDS through Rights</td>
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<tr>
<td>UBH</td>
<td>United Bulawayo Hospitals</td>
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<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<tr>
<td>VCT</td>
<td>Volunteer Counselling and Testing</td>
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<td>WASN</td>
<td>Women and AIDS Support Network</td>
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<tr>
<td>YPW C</td>
<td>Young People We Care</td>
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<tr>
<td>ZNASP</td>
<td>Zimbabwe National HIV and AIDS Strategic Plan of Action</td>
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Executive summary

This journal is the outcome of a Southern Africa HIV and AIDS Information Dissemination Service (SAfAIDS) project that was supported by Oxfam Canada and highlights good practices and case studies on gender and HIV programming in Zimbabwe. A key part of the project focused on the documentation of good practices which SAfAIDS has pioneered to scale-up interventions based on what is known to work; and encourage the replication of successful interventions in the region. In the face of the high levels of gender-based violence (GBV) and HIV in Zimbabwe, greater documentation of good practices can improve programming in gender and HIV and will lead to better outcomes in the lived experiences of those affected by gender inequality, as well as those infected and affected by HIV.

Here, we profile aspects of the work of four Oxfam Canada partners that conduct gender and HIV programming in Zimbabwe and that display elements of good practice. The partners are: Matabeleland AIDS Council (MAC), Musasa, SAfAIDS and Women and AIDS Support Network (WASN). Within these pages you will find exciting examples of innovative good practice programming in gender and HIV, helping communities and beneficiaries to improve their lives.

MAC’s programme in home-based care reminds us that the reality of AIDS-related illness and its multiple impacts on families and children is still with us; but so is hope, for the integration of youth volunteers is empowering young people who might otherwise have no jobs and no purpose in their lives. Instead they are fulfilling a valuable role in their communities.

Much of Southern African society remains deeply patriarchal, and the work in liberating young women to achieve their sexual and reproductive health rights by Girl Child Network (GCN) documented here by SAfAIDS is inspiring; this programme can and will change the future of families and communities. Musasa’s project to empower and provide psychosocial support to survivors of gender-based violence is critical; the Farai Tendai story presented as a case study is telling and tragic, but also hopeful.

Life remains hard in Zimbabwe’s rural areas - the ‘dollarisation’ of the economy has eaten away the little margins that many people survived on, hence the importance of projects such as WASN’s Societies Tackling AIDS through Rights (STAR), building the capacity of women and girls to respond to the issues that affect them in ways that increase their ability to survive in this harsh climate. Again the case studies presented clearly demonstrate the value of these simple and cost-effective interventions.

The aim of publishing these aspects of good practice is three-fold; to highlight the value of documentation; to encourage the documentation, sharing, and hopefully replication of good practices in the region; as well as to encourage programmes to objectively assess their projects using the good practice criteria in order to identify weaknesses and address them. Together, we believe good practice documentation will strengthen organisational responses to the twin challenges of gender and HIV.

The overall goal of the SAfAIDS project was to strengthen the institutional capacity of organisations addressing issues of women’s rights, gender equality and HIV and AIDS in Southern Africa in order to effectively promote women’s rights, address GBV and advance gender equality, through enhanced documentation and communication skills. Fourteen staff members from four participating organisations took part in a three-stage training programme from January to June 2010 — facilitated by experienced SAfAIDS staff — to learn about various types of documentation and communication tools and techniques. Documentation of projects and their positive impacts on individuals and communities in Zimbabwe has been identified as a major gap in much of the good work being done in the country that goes unrecognised and unrecorded.

The personal learning experiences of the participants were also recognised to be an important part of the process and these can be found in a complementary booklet, called Personal Journeys of Growth: Building capacity, building confidence in gender and HIV programming. Capacity building in documentation can be life-changing.

The methodology used for the documentation of the projects referred to as ‘good practices’ in this publication is based on the Southern African Development Community (SADC) Framework for Best Practice. This is a practical tool developed to identify and facilitate sharing of good practices among member States. The methodology has been modified and developed by SAfAIDS to cater for a wide range of programme interventions.

The good practices and case studies presented in this journal represent the practical application of the skills and evaluation criteria that participants were taught during the three training workshops, on programmes already being carried out by their organisations. Having been trained as good practice documentalists, participants were able to
identify aspects of their own work which either were, or had the potential to be, good practices. As part of the training, the participants documented a good practice of their own organisation. Thus, whilst it is acknowledged that the programmes profiled herein might not necessarily score as good practices when analysed more objectively by independent and experienced documentalists, they nonetheless show the value of applying the good practice methodology while also demonstrating some important advances being made in the field of gender and HIV programming in Zimbabwe.
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Introduction and Background to the Project

The full extent of the problem of GBV in Southern Africa is difficult to measure, as the majority of countries in the region do not have surveillance mechanisms for GBV. Available statistics, therefore, do not reflect the true magnitude or scope of the situation. However, studies and surveys done to-date do point to very high levels of violence. These levels of violence can be attributed to a number of factors, including: gender power imbalances, gender based stigma and discrimination, socio-economic inequalities, poverty and cultural practices. When a high level of GBV is combined with high HIV prevalence in a country, the dual impact on women and girls is especially devastating. In their definition of GBV, the United Nations Population Fund (UNFPA) states that, “Violence against women takes many forms: sexual assault, child marriage, incest, wife beating, prostitution, female genital mutilation, dowry-related violence, trafficking, sexual violence during wars, femicide, sexual harassment, ‘honour’ killings, forced sterilisation, date rape, pornography and bride kidnapping. Violence against women may also take many forms of psychological abuse, intimidation and harassment. All are unacceptable violations of human rights. Together they form a huge obstacle to gender equality and genuine human progress.”

While it is universally accepted that GBV is high but underreported in Southern Africa, it is also acknowledged that there are very few platforms for women to tell their stories. Many organisations involved in combating GBV lack the necessary skills to document women’s experiences so that they can be shared with other women. As a result, many of the stories that could serve to inspire, or to teach other women to recognise when they are in abusive relationships, remain untold. Based on SAfAIDS’ extensive experience of working with CBOs in Southern Africa, it has been observed that CBOs rarely document the innovative work that they are doing in the area of HIV and gender. Any work documented tends to be done either by a local consultant or an international organisation, reinforcing the notion that documentation is a sphere for experts only. The disadvantage of this approach is that many fledgling or low resource organisations are unable to afford the high costs involved in contracting a consultant to undertake documentation. This leads to massive and recurrent loss of organisational memory when key individuals resign from the organisation. In addition, key lessons that are important for promoting learning and sharing are lost in the process.

In the past five years, SAfAIDS has developed a training programme that equips programme officers, managers and directors with communication and documentation skills. This includes general office documentation as well as the documentation of good practices. The training is hands-on and allows participants to collect data, analyse it and produce reports, proposals and case studies with support from the trainers. Positive feedback has been received from participants both during and after the training, by organisations that have subsequently managed to document their own programmes.

Recognising the significance of this gap, and based on priorities identified by partner organisations in Zimbabwe, Oxfam Canada requested that SAfAIDS train some of their partners in a graduated capacity building process, that would ensure that organisations value and incorporate various documentation tools and techniques into their day-to-day planning and work schedules.

This journal is the final output of the capacity building programme, in which staff from MAC, Musasa, SAfAIDS and WASN learned about various aspects of documentation, and were provided with onsite mentoring and e-learning support from experienced SAfAIDS staff. As part of the second training, participants were introduced to the methodology for good practice documentation and were then given small grants to document the projects, programmes and case studies that form this journal. However, since SAfAIDS is not an implementing organisation, it was agreed that the SAfAIDS participants would document the work of one of their partner organisations in order to fulfil the requirements of the training programme.

A Word about ‘Good’ versus ‘Best’ Practice

W hilst ‘best practice’ has been widely used as the terminology to describe an exemplary programme, there are concerns that the term ‘best’ is exclusive and implies a rigid system that cannot be improved upon. In Zimbabwe, the term ‘good practice’ is preferred and is most commonly used. The ‘best practice’ criteria nevertheless remain relevant and it should be noted that the terms ‘good practice’ and ‘best practice’ are used with a common meaning. A good practice is not reserved only for ‘truths’ or ‘gold standards.’ It can be anything that works, in full or in part, and can be useful in providing lessons learnt. Therefore a good practice need not necessarily meet all the
criteria listed above. Good practices, however, should ideally have a ‘rights-based approach,’ meaning that they hold accountable the governments and duty bearers who are responsible for ensuring that the rights of all people are equally respected, protected and fulfilled.

**Methodology**

SAfAIDS has pioneered the application of the SADC Best Practice Framework in various programme areas. It involves the use of the following data collection tools:

- Interview guide for key informants (see Appendix A)
- Interview guide for programme implementers (see Appendix A)
- Focus group discussion guide for primary and secondary beneficiaries (see Appendix A)
- Scoring was then undertaken using the SAfAIDS good practice score card (see Appendix B).

The seven areas of focus used during the assessment exercise are as follows:

**Effectiveness**

This is a project’s overall success in producing its desired outcomes and reaching its overall goal.

**Ethical Soundness**

An ethical practice is one that follows, or does not break, principles of social and professional conduct. Important principles in Gender and HIV and AIDS work include compassion, solidarity, confidentiality, consent, responsibility and tolerance. Practices should support equity and distributive justice.

**Cost Effectiveness**

Cost effectiveness is related to efficiency. It measures whether the services are provided in a non-wasteful and cost saving manner. Efficiency measures the capacity of the programme to produce desired results with minimum expenditure of energy, time and resources. It also includes innovative utilisation of available resources to realise, in a timely manner, the goals and objectives of the programme at hand.

**Relevance**

Relevance is about how closely the practice is focused on the Gender and HIV and AIDS response in the context of the society/ environment in which it is implemented. It includes factors such as cultural traditions, religious beliefs, the political system and economic organisations – in so far as they affect vulnerability, risk behaviour or the successful implementation of a response. This also includes the extent to which the intervention is accepted by communities and implementers, the cultural and social spaces of the area where an intervention has been launched. It is closely related to ethical soundness.

**Replicability**

Sustainability is the programme’s or project’s ability to continue, and to do so effectively, over the medium to long-term, especially without total reliance on external resources.

**Innovativeness**

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

**Sustainability**

Sustainability is the programme’s or project’s ability to continue, and to do so effectively, over the medium to long-term, especially without total reliance on external resources.
The methodology for the good practice documentation includes use of a score card adapted by SAfAIDS from the SADC Framework. The basic methodology involves the assessment of a project in the seven key areas: effectiveness, ethical soundness, cost effectiveness, relevance, replicability, innovativeness and sustainability. Each area is then given an overall score and this is transferred onto the score card. How well a project scores in these criteria determines whether or not it can be classified as a ‘good practice.’ However it should be noted that even a single element of a project may be classified as a good practice worthy of replication.

Standard good practice documentation would include an initial, rigorous selection process, as well as peer review after documentation. The studies in this publication were conducted in part as a training exercise for workshop participants, therefore, represent aspects of good practice as perceived by the newly trained good practice documentalists. The studies presented here should be reviewed in this light.

Good practices should ideally have a “rights-based approach”. One of the central features of a rights-based approach is that it comes with responsibilities. This also means that governments and office bearers are responsible for ensuring that the rights of all people are equally respected, protected and fulfilled.

The good practice documentation exercise was carried out using the following data collection tools:

- Interview guide for key informants
- Interview guide for programme implementers
- Focus group discussion guide for primary and secondary beneficiaries
- Scoring was undertaken using the adapted SAfAIDS good practice score card. Following a detailed review process, the project is assessed in each of the criteria listed above and allocated a score. The score card is then used to total up the marks the project is awarded and this overall score reveals whether or not it can be classified as a good practice. This method also highlights areas where the project is weak, which allows improvements to be made in such areas.

**The Documentation Process**

Each organisation that participated in the SAfAIDS capacity building programme was asked to identify potential areas of good practice in their organisation and to document them using SAfAIDS’ Best Practice methodology. While participants were taught the full Best Practice methodology, the budget available for the practice documentation was limited. Thus, participants used their own judgment as to how many interviews and focus group discussions they were able to conduct in the time available to carry out the documentation of their own organisation’s project.

Having visited the projects and gathered material through carrying out document reviews, key informant interviews and focus group discussions, each team then went through the final assessment process to determine the results of their analysis. This involved a detailed review process that required discussion and agreement on the project’s performance in each criterion, to agree its score for each of the seven criteria listed above. The agreed scores were then entered onto the score card and the scores the project was awarded were totalled to give an overall score. This revealed whether or not the project could be classified as a good practice. The participants were then required to write up the report and demonstrate why the project they had selected qualified to be described as a good practice.

The training process also encouraged participants to explore the value of case studies to show project impact and enable experience sharing. Case studies are a form of qualitative, descriptive research and this method of collecting and presenting detailed information about a particular participant or group was also taught as part of the documentation and communication skills training. A case study looks intensely at an individual or small participant pool, drawing conclusions only about that participant or group and only in that specific context. Case studies personalise a documentation and demonstrate the actual benefits a project has brought to its beneficiaries in a more accessible way than is possible in objective documentation of a project.

The very different styles of the reports in this journal are a result of the individual style of each group as they made use of the skills developed during the training. Thus, where a group opted to use design elements from Ms Word to enliven their report, for example, these have been left in as a further demonstration of the capacities gained in the training.
Introduction

Matabeleland AIDS Council (MAC), through this good practice report, hopes to contribute meaningfully to the regional and national information sharing platforms on HIV interventions. MAC is also aware that documenting good practices is in line with SADC regional strategies as contained in the Maseru Declaration, which stipulates that: “within the SADC region there have been successes and Best Practices in changing behaviour, reducing new infections and mitigating the impact of HIV and AIDS, and these successes need to be rapidly scaled up and emulated across the SADC region.”

The good practice highlighted in this report is based on what has worked for MAC as an organisation in HIV programming but, more importantly, the stories are credited to the hard work, commitment and responsiveness of the community volunteers and general communities of Matabeleland who are involved in the programme interventions. This report has been developed by MAC, partially in fulfilment of the capacity building training programme supported by Oxfam Canada, and also as a contribution to regional and global efforts to increase the knowledge base of what works in HIV interventions. This report presents a good practice model of integrating a youth initiative, called ‘Young People We Care,’ (YPWC) with a Home-Based Care (HBC) programme. It is hoped that the innovative model, which has worked well in Bulawayo, can be effectively adapted and replicated. Ultimately, this report seeks to strengthen, add value and improve the effectiveness and efficiency of HIV care and support interventions.

Project Background

MAC has over 15 years of experience in implementing the HBC programme - primarily with support from the Department of International Development (DfID) and ActionAid.

MAC works with 160 HBC community volunteers in Bulawayo and 400 HBC Community volunteers in Matabeleland South Province, in Insiza and Matobo districts.
HBC community volunteers have the responsibility of providing support to the families in the community, through provision of education on HIV and AIDS, assisting in referrals and helping with the care of the terminally ill at home. As of 2010, as part of the HBC programme, MAC works with 160 HBC community volunteers in Bulawayo and 400 HBC volunteers in Matabeleland South Province, in Insiza and Matobo districts.

MAC also has over five years of experience implementing psychosocial care and support activities through the YPWC programme, funded by UNICEF. The YPWC project was started in 2004 under the auspices of a country-wide UNICEF project. The YPWC project is being implemented by a variety of community-based organisations across the country. The project aims to empower young people to make a meaningful difference in their communities around issues of HIV and AIDS.

The YPWC project was started in 2004, under the auspices of a country-wide UNICEF project. The YPWC project is being implemented by a variety of community-based organisations across the country. The project aims to empower young people to make a meaningful difference in their communities around issues of HIV and AIDS. MAC’s implementation of the YPWC project covers urban and peri-urban sites in Bulawayo, such as St Peters, Methodist villages, Robert Sinyoka and Hope Fountain.

At the inception of the project, MAC worked with three YPWC clubs – one urban and two peri-urban. Today there are ten YPWC clubs – six urban and four peri-urban – under the programme.

Traditionally, MAC has implemented their HBC and YPWC programmes as separate entities.

**Vision**

Vibrant membership based organisation accountable for sustained empowerment of communities coping with the impact of HIV and AIDS.

**Mission**

MAC’s mission is to capacitate and empower individuals and organizations in the Matabeleland Region through the provision of engendered, client-centred services in the form of prevention, mitigation, care and support, and livelihood skills training, to initiate and manage sustainable responses to the impact of HIV and AIDS.

**Background of the Integrated Programme**

Over the last two years, programme implementers at MAC realised the benefits of integrating the two seemingly separate projects of HBC and YPWC. This was partly born out of the experiences in Hope Fountain – a peril-urban community about 30km away from the nearest health centre and heavily dependent on village health workers for their health care.

While implementing the HBC project, other significant gaps were identified, alongside the absence of health care facilities; whilst HBC volunteers were paying close attention to the infected person in the household – in most cases an adult – little or no consideration was given to any children in the household. As a result, children living with a terminally ill parent or adult were given no assistance to cope with their situation, which impacted negatively on their overall development. Reflection on the overlaps between the two programmes resulted in the decision to consider integrating the two, and the need to re-strategise eventually brought about the merging of the HBC and YPWC programmes. The integration process built on and harmonised common activities covered by the two projects.

The first table below summarises the common programme components of HBC and YPWC, while the second table indicates the unique components in each programme that became part of the integrated programme.
### Components shared between HBC & YPWC Activities

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<tr>
<td>Support to families and households</td>
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<tr>
<td>Referrals</td>
</tr>
<tr>
<td>Psycho-social care and support</td>
</tr>
<tr>
<td>Health and hygiene promotion</td>
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<td>Community education and awareness on HIV issues</td>
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Table 1: Shared components of MAC’s HBC and YPWC programmes

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<tr>
<td>HBC</td>
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<tr>
<td>YPWC</td>
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<td>YPWC</td>
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Table 2: Unique components now integrated into both programmes

Once the decision to integrate the two programmes was made, a model representing the integrated programme was developed, shown below, and it is this model that MAC opted to highlight for their good practice documentation exercise.

**The integration of YPWC into the HBC model**

When HBC volunteers conduct home visits to chronically ill clients, they now do so jointly with YPWC volunteers. While the HBC volunteers attend to the ill client(s) in the household, YPWC volunteers attend to the children, assessing their coping mechanisms, helping them with chores and school work, and sometimes just playing with them. Through this model, the entire household is targeted with psychosocial care and support. Since 2008, MAC has noted the positive impact of this integrated approach, which include improved psychosocial support for young
people in households where this is chronic illness, as well as the empowerment of those young people who volunteer. As an organisation, MAC is advocating for the need to design response interventions that are not standalone, but integrated with other relevant approaches and strategies.

The integrated model has been used successfully in the five districts in which it has been implemented: Umguza, Nkulumane, Emakhandeni, Matobo and Insiza, and MAC hopes to reach out to other AIDS service organisations implementing HBC and YPWC programmes with this approach. The model may also be used by organisations implementing only one intervention and not necessarily both. For instance, an organisation doing HBC may simply train young care givers to initiate some of the activities done by young people in the YPWC programme. The integrated model may also be achieved through strategic partnerships, such that an organisation doing YPWC activities may link up with an organisation implementing HBC activities in the same ward.

The programme officers at MAC, after assessing the outcomes and achievements of merging the two projects over the years, deemed it a good practice worth duplicating in other areas. However, they had not documented the project using the regionally recognised Framework for Best Practice. The capacity building initiative on documentation of good practices by SAfAIDS, with support from Oxfam Canada, has availed an opportunity to assess the Hope Fountain integrated project in this manner.

Description of the Hope Fountain Integrated Project

Hope Fountain is a peri-urban community about 30km away from the nearest health centre and heavily dependent on village health workers and CBOs for their health care. The project’s aim is to improve the quality of life of its beneficiaries. The integrated project specifically targets young people (boys and girls) aged between 10 and 24 in the community. Young people within the community are mobilised and they then identify and select their peers to be volunteers.

The volunteers visit households where there is chronic or acute illness - often, but not always, HIV-related - and provide an expanded form of home based care assistance that concentrates on the younger family members, alongside an adult home based care volunteer. This results in improved psychosocial support for young people in households where this is chronic illness, as well as the empowerment of those young people who volunteer. The youth volunteers are mentored by the adult, experienced HBC volunteers and will hopefully, one day become HBC volunteers themselves. It also ensures simultaneous psychosocial support to chronically ill clients and to vulnerable children in a household, which also relieves the burden of anxiety about the welfare of the children on the sick household member.

Good Practice Documentation Methodology

Planning the documentation process

The process was initiated by brainstorming by the MAC Programme Officers on programmes thought to be worth putting to the test of good practice documentation. Having identified the integrated YPWC and HBC programme model, the team agreed to use the Hope Fountain project for the documentation of the programme.

Allocation of roles and responsibilities

The documentation team trained by SAfAIDS co-opted four other staff members at MAC to facilitate the documentation process and share skills internally. The entire documentation team was made up of six people: three males and three females. To facilitate systematic and effective good practice documentation, each team member was assigned specific roles and responsibilities, including photography, note taking and interviewing.

Methodology

Once the documentation team had been established and roles and responsibilities allocated, the team arranged meetings with the various stakeholders (key informants) and implementers (HBC and YPWC volunteers) and then visited the project sites to carry out the evaluation. Tools used included an interview guide for key informants, an interview guide for project/programme implementers and a focus group discussion guide for communities/beneficiaries (see Appendices A and B).
The methodology involved the triangulation of methods, tools and techniques. The data collection tools employed included the SAfAIDS good practice tools including the score card. The tools were reviewed and adapted to suit the programme to be documented. While the team attempted to change some of the questions into local vernacular, this exercise proved very difficult as there was no equivalent or synonymous term in the local Ndebele language. Therefore, instead, the English versions were simplified before use. Once all the data collection tools were completed, the team sat together to agree on final scores for each of the good practice criteria. Scoring as a team and reaching a consensus was a learning point, as each person gave a reason for their weighting. It tested team building skills and it was interesting to see how much time it took to reach a consensus.

**Score Card**

Some team members found the score card challenging to use as it required the application of complicated formulas not used in day-to-day programming. The initial reaction was that it was intimidating, particularly regarding the translation of data from the field onto the score card. However with guidance from experts in mathematics among the team, it became easier.

**Interaction with communities**

Data collection with beneficiaries proved to be easy, as focus group discussions were established in a conducive and youth friendly environment. It was pleasing to see both young people (YPWC volunteers) and adults (HBC volunteers) freely share their experiences. It was noted that community volunteers are experts in their own right and are very knowledgeable.

**Achievements of the Hope Fountain Integrated Project as Scored in the Good Practice Documentation**

1. Increased awareness of HIV and open communication on the subject, leading to reduction of stigma
2. Simultaneous psychosocial support to chronically ill clients as well as to vulnerable children in a household
3. Empowerment of young people to respond positively and responsibly to the impact of HIV and AIDS. Young people are now generally more responsible and their potential to care for the infected and affected has been unlocked
4. Community mobilisation and a proactive response to mitigating the impacts of HIV, community collaboration and a spirit of respecting one another have been fostered.

**Evaluation Findings of the Hope Fountain Integrated Project**

**Effectiveness**

The project is highly effective and feeds into various national strategies, such as the Zimbabwe National HIV and AIDS Strategic Plan of Action (ZNASP) and the National Plan of Action for Orphans and other Vulnerable Children (NAP for OVC). The project’s aim is to improve the quality of life of its beneficiaries and the lives of a significant number of children and chronically ill people have been improved.

- The project fosters community participation; and youth empowerment
- It embraces an integrated approach;
- It has well articulated goals, targets and implementation plans;
- Monitoring and evaluation (M&E) needs to be strengthened at community level. Community involvement could be scaled up in terms of project evaluation.

**Ethical Soundness**

The integrated project is ethically sound with regard to respecting the interests of vulnerable groups such as young people, women, children living with HIV, orphans and vulnerable children.

- It protects the human rights of its target beneficiaries in keeping with the confidentiality principle;
- Both projects, HBC and YPW C, are run in a transparent manner.
**Cost Effectiveness**

The integrated approach is cost effective:

- Distribution of project resources is both equitable and cost effective
- Services are delivered in a timely manner due to “task shifting” of basic health care from distant district hospitals to local communities. Several of the villages now have personnel who administer HBC, palliative care and psychosocial care and support to community members.
- The project has made a difference in the community as more young people are playing a role in caring for the ill within their communities. This is also an empowering experience for the youth, who are often unskilled and unemployed.
- The project has realised improved quality of life for both those suffering from chronic illnesses and their families, with minimum resources. Psychosocial support for children living in households with a chronically ill person has been assured by the incorporation of visits from the youth volunteers. Youth volunteers who observe children having particular problems are able to raise the alarm within the community structures, or to ensure the child is referred to someone who can help.

**Relevance**

The project is very relevant and is empowering communities and is both socially and culturally acceptable.

- Local leadership appreciates the integrated programme, as indicated by the support that they give both the young people and the community volunteers in the work that they do. They often applaud the young people for their active involvement in the community. The councillor for Hope Fountain has expressed his gratitude to the community volunteers for the sterling work they are doing;
- The project has achieved buy-in from local religious leaders, as evidenced by the religious leader who had been praying for a chronically ill patient without referring her for medical attention who eventually came to seek the services of the volunteers at the Hope Fountain integrated project, “Sokukubi ngale buyani mahBC” (Please come to my aid this person is chronically ill).
- The community is involved at all stages of project implementation, as reported by a community member during the evaluation;

“MAC involves the community at all stages, unlike other organisations who tell people that they want to carry out the project in their fashion.”

**Replicability**

The successful integration and increased impact of the integrated programme shows that the model is replicable, as evidenced by the successes MAC has witnessed as HBC and YPW C volunteers work together in their communities and co-ordinate their activities.

Most rural communities have an untapped reserve of unemployed youth who can be empowered to play a valuable role in their communities.

**Innovativeness**

The integrated model scored high in this area showing that it is both unique and innovative:

- It is unique, as it covers a broad spectrum of those needing assistance, giving psychosocial care and support to both infected and affected members of the household at the same time.
- The involvement of young people in HBC services is new. It was previously unheard of, and would not be possible without their working together with older HBC volunteers, who have the experience and exposure to deal with more difficult cases.
- It is economically sound, as available resources are shared between the young people and the HBC volunteers.
A case study of Maria, a mentally disturbed elderly woman, living with a teenage boy and two granddaughters

Maria was severely burned by hot water over all her limbs. HBC volunteers came in to offer medical assistance as well as helping with household chores. YPWC volunteers came in to assist with fetching water and firewood. During that time, YPWC volunteers, whilst playing with the children, identified symptoms of sexual abuse and reported this to the village health worker. The village health worker engaged Child Line, who took up the matter and the children were assisted.

Sustainability

- The project can be said to be sustainable as the community volunteers have been capacitated on issues around care and support, and are confident that they can carry on providing a service in their community even in the absence of donor funds.
- The community’s willingness to participate in project activities encourages the community volunteers to carry on and assures them of a support base if the need arises.
- Skills transfer from HBC volunteer to YPWC volunteer takes place as a natural outcome of their visiting a home together and will ensure project continuity.
- The project has the potential to be self sustainable since the decision to integrate the two programmes arose out of a community initiative and the recognition that many young people lacked a purpose in their lives.
- The project includes an income generating component which could serve as a source of income to motivate the volunteers.

Lessons Learnt

- Young people are able to care for the infected and affected and find the experience to be empowering. However, they face particular challenges in the Hope Fountain area as there are only 17 young people there and these are too few to cover the width and breadth of the community. More YPWC volunteers need to be trained.
- The integrated project is not well known by stakeholders, or by everyone in the community. Therefore there is need to develop social marketing tools and strategies to make the project more visible.
- Integrating the HBC and YPWC projects is cost effective and allows for greater achievement of goals with limited resources. The provision of simultaneous psychosocial support to chronically ill clients as well as to vulnerable children in a household improves the wellbeing and quality of life of all household members.
- Successful projects may not be recognised unless they are properly documented.

Conclusion

In view of the above analysis, this project has been identified as a good practice, with an overall score above 75% and is worth documenting as such.

In general, the project has had a positive impact in the communities. It has motivated the community to collaborate and collectively respond to the impact of HIV. Through the integration of the two projects, young people have become more responsible and responsive to community needs and have been given a purpose in life. On the whole, the project has contributed to the national health care system, as well as to the implementation of the national plan of action for OVC and the ZNASP, and to achieving millennium development goal six, which focuses on health and HIV and AIDS.

The combining of youth and home-based care volunteers to provide psychosocial and other support to the chronically ill employed by MAC in this project constitutes a good practice that can be replicated in other districts.

Note that the information was obtained from the Hope Fountain, however the integrated model is being used by all MAC’s partner CBOs and YPWC clubs.
Background of the Organisation

Musasa is a non-governmental, non-profit making organisation established in 1988 by two women as a result of their growing concern over the high levels of violence against women within the home, and the lack of support for these women. Since its inception, Musasa has sought to enable targeted groups in society to change their beliefs, attitudes, behaviours, laws and policies in order to curb gender violence. This is done in part through the collection and dissemination of information on domestic violence and other pertinent gender issues, in an effort to change attitudes and influence policies and programmes that affect women.

Vision

To have a society in which an increasing number of women live free of gender-based violence and are able to fully participate in development.

Mission

To work towards ending gender-based violence, with particular focus on women targeting groups in society to change retrogressive beliefs, attitudes, behaviours, laws and policies in order to end gender based violence.

History of Project

Musasa’s foundation as an organisation lies in the empowerment of women, which led to the formation of the ‘Survivors’ Clubs’ project, through funding from SIDA. The goal of the project is to empower women who have overcome Domestic Violence (DV) and for them to realise the shift from being victims of DV to being survivors. Community-based counsellors are trained in basic counselling skills by Musasa and attend educational talks to increase their knowledge on issues of GBV with a special emphasis on domestic violence. The women are capacitated with knowledge on income generating skills as well as on different topical issues, such as reproductive health matters and legal concerns, among others. Musasa facilitates the formation of peer support groups, which create a platform to enable women to support each other and interact with other women with similar emotional and psychological violence and their children.

Currently, two survivors’ clubs are running, called Siyancedana and Good Hope. The members named the groups themselves, and in so doing took ownership of them. The women that make up the bulk of the group membership are ex-clients of Musasa from Entumbane and Nketa – high density suburbs in Bulawayo – where Musasa’s trained community-based counsellors operate; along with others drawn from Ngozi mine, a squatter camp of people displaced through Operation Clean Up (Murambatsvina).

The survivors’ club meets every fortnight and Musasa attends every other meeting, in order to monitor growth and produce a progress report for evaluation, as well as to provide information to the members on selected topics, as requested. These sessions are educational talks, with an expert engaged to disseminate information to the group. In the initial stages of the project, the counsellor from Musasa facilitated the meetings but, over time, the club members have taken over this role themselves.

Club members have also been provided with training on income generating projects, such as peanut butter-making. This assists the women to gain confidence and gives them the possibility to have a measure of economic independence.
It could also help the groups to become self-sustaining, as the women can pool the income generated by the group to cover other costs.

Musasa deems the project a good practice worth replicating in other areas that the organisation works in. Adopting the set criteria, the project met the seven key elements of a good practice, with a score of 73%, making it a project worth documenting but requiring small adjustments, according to the score card.

**Good Practice Evaluation**

**Methodology**

Separate focus group discussion were held with members of the two survivors club, that is, Siyancedana and Good Hope, stakeholders and the programme officer as the implementer. The score cards were filled in by the good Practice team that was made up of Counsellors, the Programme Officer and student interns.

**Effectiveness**

The impact of the project on the women is a clear indication of its effectiveness. Because of the environment that is created, which is gives the women a sense of freedom and enables them to express themselves freely, a paradigm shift is realised, where the women moved from being timid and unable to communicate, to being confident and able to articulate issues convincingly. Group membership is voluntary. Survivors are introduced to the clubs during the counselling relationship and can then opt to join the group or not. The groups were primarily established for those clients who showed signs of being emotionally and/or psychologically affected by the abuse they experienced. The project involves group counselling in the initial stages of group formation, progressing to becoming a mature and vibrant group, determined by the capabilities of group members. This creates a sense of ownership and members are given the opportunity to plan and direct the proceedings of their meetings. The women are enthusiastic about the success of the project and document and share diaries of events in their lives.

“Musasa has helped us grow and discover our potential. The success of the group is in our hands. We plan our meetings and invite Musasa once a month to our meetings.”

- Chairlady of Good Hope survivors

Community halls are used for the talks and invitations are open to other women from the community. As a result other women from the communities are encouraged to seek help from Musasa.

“Every time the group has the community dialogues, it creates more clients that need the services of Musasa. Some women find out about Musasa during these talks and seek assistance. The groups have become watchdogs on domestic violence issues in communities.”

- Entumbane Community based counsellor

The dialogues have also become fora to discuss other topical issues like the constitution making process, guardianship, types of marriage and the implications of these issues.
In the early stages, the Good Hope women were withdrawn and were reluctant to share their diaries; comments were short and unelaborated – their contributions had to be solicited. However, after several meetings where they were left on their own, the group bonded and the women’s feelings of intimidation gradually subsided. They came up with a structure that includes a chairperson, a treasurer and a secretary. Subsequently, the programme started to grow and it is clear that it will be sustainable.

- Musasa counsellor

When the groups started sharing, they would each write a problem or issue that they needed the group’s help to address, on a piece of paper. Then they swapped papers so that each person held a piece of paper with an issue from another member, which they then read aloud for the group to comment on. Now they are free to own their issues and discuss them openly, telling the group what kind of help they need.

**Ethical Soundness**

As counselling is about the client’s agenda, the clients made an informed decision to be part of the groups. Issues of confidentiality and its limits within the group are discussed. Members are encouraged to discuss their membership with their families, so as to avoid the recurrence of DV as a result of their acting without informing their significant others. Consent is sought from the group for report writing, including the use of direct quotations and digital documentation. Basic protocols were also adhered to when setting up the groups, by informing local leadership in the areas of operation about the objectives of the initiative. The project has, therefore, been implemented based on sound ethics.

Musasa has become a partner where we wit and discuss issues and come up with solutions together.”

- Domestic violence

**Cost Effectiveness**

To reduce the cost of running the educational talks, the local Councillors were approached and they agreed to assist by allowing use of the community halls at no cost, provided requests to utilise them were made in good time. The survivors’ group chairpersons manage the bookings, assisted by the local community-based counsellor. Some of the group meetings are held in the Musasa office boardroom when other venues are unavailable.

The establishment and training of community-based counsellors by Musasa has reduced office travelling expenses as they attend group meetings within their areas. Budgeting skills have been imparted to the groups and they plan in line with the availability of funds. If meals are to be provided at the community meetings, these are prepared by the groups themselves, reducing the cost of catering.
Figure 2: Women from the clubs during the peanut butter-making income generating project.

Relevance

The positive responses to the project by both the women and their communities are an indicator of its relevance and show that it is filling a gap. The project has proven to be empowering to targeted women and communities. Women in the communities who are experiencing DV, but are not yet ready to be open about it, have benefited immensely from the information disseminated and are gradually being convinced of the need to take a stand against DV in their homes. They are also encouraged to pass on the information to other young women who might find themselves in the same trap.

The local councillors confirmed a reduction in domestic violence cases in their areas due to the project. One of them had this to say:

The councillors have shared the impact of the project at other platforms, such as churches, burial societies and other groups have expressed their interest in having similar projects running within their areas. The need for scale up is evident.

Replicability

The project has been shared with other organisations and the sentiments are that it is unique in addressing the issues of DV and the empowerment of women who have survived DV. These organisations have supported Musasa with expertise on specific issues whenever requested. Musasa intends to replicate the project in the rural areas where they have other programmes and activities running. Surveys in these areas have shown that women are more prone to abuse and have nowhere to express their emotions and deal with them - an important part of the healing and coping process. The idea has been shared with other organisations in Africa and interest in adapting the project has been expressed. Proper documentation of the project is necessary to allow replicability.

Innovativeness

The groups are encouraged to use whatever means they can to ensure that all the women in the community who need support know about, and are incorporated into, the survivors clubs. Thus the members have sought out the help of women community leaders who have gone through violence themselves. With this experience, members of the clubs are able to talk with new GBV clients and show them that violence can happen to women whatever their social status, and they need to act to protect themselves and their children. The women are also given the opportunity to be creative in their meetings by using drama, poetry and songs to disseminate information. This has led to growth and created interest in joining the groups among other women. The advice shared by the members has proven beneficial and the input of co-members is taken seriously by the member who is being assisted.
One of the group members, named Julia, was having problems with her husband, who felt challenged by her assertiveness. The husband then brought his girlfriend to the matrimonial home and told Julia to go back to her parents with the children. Instead of working on the problem, Julia was very angry and lost focus on what she needed to do. At the group meeting, she presented her case and her colleagues analysed it with her. The counsellor was also present at the meeting observing the proceedings. After a lot of debate and suggestions, Julia told her group that she had decided to go home and tell the husband to move out because their marriage did not permit him to have another wife. She would inform him that she would remain in the house with the children, who were of school-going age, apply for maintenance for their upkeep and get a protection order, so that the husband and his girlfriend could not continue to harass her and the children. A round of applause from the group, commending her for the strong stance, gave her encouragement.

At the next meeting, Julia reported how shocked her husband had been when she told him what she wanted. He insisted that someone else must have told her to do that and wanted to know who it was. Julia said, “wayifunga kuti ndakapusa” (“so you thought I was stupid”). The husband moved out and a maintenance and protection order has been applied for. At the time of writing, Julia awaits her court hearing date.

**Sustainability**

There is room for improvement in this element, in terms of raising awareness on dangers of GBV with the male members of the communities. The buy-in of the councillors will help ensure the sustainability of the programme.

The volunteer community-based counsellors contribute positively to the success of the project once a club has become independent, though ongoing and refresher training of the counsellors is necessary to ensure continued benefit to the target groups.

Resulting from the training in income generating projects, groups can become self-sustaining, as members can create a pool of funds from their projects to serve as an income resource base for activities.

This is evidence that the process is sustainable, because the communities themselves request for new support groups to be established.

"Some women have visited the office after being told about the procedure of being a member of a support group, and after one or two sessions they enquire about joining a support group"

- Musasa Counsellor

**Case Study: Farai Tendai**

“My name is Farai Tendai. I was born in March 1972; I have four children, all girls. I got married in 1993. I had a good life with my husband until my third daughter was born. I was staying in the rural areas and he was working in Bulawayo, as a bus driver. He used to visit me when possible and I also visited him. We built our rural home and got a stand in Cowdray Park high density suburb in Bulawayo. Our second daughter was raped when she was two and half years old, in 2003. We reported the case to the police, not knowing who the perpetrator was. I was very worried about this issue and the rural police were also baffled and had no solution to the issue.”
In 2007, I decided to move from the rural area to join my husband in town. I discovered that our third daughter had also been raped and I told my husband. He got very aggressive and started telling relatives that I was a bad wife and that he did not love me anymore. All the relatives, on both sides of the family, turned against me.

I decided to take our third daughter to the rural area and told my father-in-law the story, leaving my two daughters, who were going to school, with the landlord. When I came back I discovered that my first-born daughter had been raped. I went to Entumbane police station and the police came and took my husband to the charge office. He was beaten severely and when he came back he packed all his clothes and went to stay with his girlfriend, for whom he had been renting a room in another suburb. My children and I suffered. We were thrown out of our lodgings because he told the landlord that I was an evil woman and a witch. I moved from one lodging to another. I decided it was better for me to look for a job as a housemaid and put my daughters under my sister’s care. I don’t know why my husband chose to rape his daughters.

Then I heard about Musasa; that they help women solve their domestic problems. In 2009, I approached the organisation and they accepted me whole heartedly. We formed a group with other women and named it Good Hope. Musasa would meet with us every month, and gave us food and transport money and strengthened us. In February 2010, I told my group about my problems and the abuse that my children were subjected to staying with my sister and Musasa helped take my children to a home. Presently, I am working as a housemaid and my children are continuing with their education at the home. I am very grateful for what Musasa did to help me. My employer is very understanding and gives me time off to visit Musasa for my group meetings. When I have problems she encourages me to go to my group. Musasa empowered us by teaching us to make peanut butter in a hygienic way, so that we can support ourselves. They also encouraged us to help others in similar situations. Right now I am a happy and healthy person who is able to help others with similar problems to those I suffered – this is all due to the help that I got from Musasa.

**Project Challenges**

Changing men’s perceptions about the factors that contribute to GBV has faced resistance, both from the men and from culturally sensitive members in the communities, such as chiefs and leaders of particular religious groupings. They have perceived the project as a rebellion of the women against their husbands. However, these challenges have been lessened by some men who have been encouraged to attend the community meetings and have shared the information with their counterparts.

The key informants who participated in the good practice documentation exercise, who included local traditional leadership and councillors, mentioned that even though the project has had some positive impacts, there is still need for more information to be disseminated through awareness campaigns and drama, and especially to reach men at their meeting places, such as beer gardens and bars.

It took longer than expected to gain the buy-in of local leadership but, with time and continued information dissemination, they are now convinced of the community benefits of the project.

It is vital that implementers be observant, especially after income generating training, as there is a risk that members become too busy to attend meetings. Thus there is a risk that they will drop out and the groups will fold.
Lessons Learnt

Critical learning points have been brought to the fore by the survivors’ groups project and these will be valuable for future planning and the inception of more groups. Lessons learnt include:

- Engagement of, and support from, local leadership is key to the success of any project that is implemented at community level;
- Strong networking partners are vital in the provision of expertise for the project. For example, for Musasa, it is important to have good networking partners, as regards to providing safe shelter for clients; with the courts; the police and lawyers, amongst others. These networking partners have improved service provision in many ways;
- Keeping the organisation’s good reputation is vital in order to get buy-in from targeted organisations and experts.

Conclusion

Tangible success has been demonstrated by this project; it has also witnessed life changing experiences both within the group and in their communities. It has brought about hope and empowerment for the women. Realising the depth of the impact motivates Musasa to solicit more funds for the continued replication of the project.
History of the project

In Zimbabwe, there is rampant sexual abuse of children, especially young girls, at times by their own fathers. Because they lack information, some of the girls are not even aware that they are being abused, or that they should report their cases and seek help. Forced marriage and child marriage, which violate the human rights of women and girls, are still widely practiced in sub-Saharan Africa, while trafficking of women and girls for forced labour and sex is widespread and often affects girl children.

Less than one third of Africans have access to reproductive health information or services. In most African countries, there is no deliberate effort to ensure that information on reproductive health is given to girls and boys early in life. Rapid population growth often outstrips economic growth, and the growth of basic social services, such as education and health, contributes to a vicious cycle of poverty and ill health.

Recognising that one million maternal and newborn deaths are recorded annually, while an African woman has a one in six chance of dying while giving birth, southern African governments have agreed to implement a Maputo Plan of Action (MPoA) as part of the Continental Framework for Sexual and Reproductive Health and Rights (SRHR).

In this context, SAfAIDS, with support from the Ford Foundation, is implementing a two-year project in Southern Africa to scale up access to SRHR. In Zimbabwe, SAfAIDS partners with three civil society organisations to undertake this work: the Community Working Group on Health (CWGH), Girl Child Network (GCN) and Women’s Action Group (WAG). Each group focuses on a different segment of the population, but their work is complementary, allowing SAfAIDS’ programmes to reach girls, women and marginalised populations such as orphans and widows. The work of GCN on SRHR is the focus of this report.

GCN envisions a society where girls are empowered and enjoy their rights with support from whole communities, so as to walk in the fullness of their potential, in line with the Millennium Development Goals (MDGs). Its mission is to build the knowledge and confidence of girls so that they articulate their individual and collective rights and strategically position themselves to take charge of their own empowerment. By teaching girls about their sexual rights, they are able to stand up and defend their rights; support and promote themselves and their peers to be in school; and advocate for a violence-free school environment so they are able to get maximum benefits from their education.

Although primarily focused on girls in school, GCN programs aim to mobilise whole communities to eradicate the patriarchal structures that dominate the home, school, and community, to promote and protect the rights of the girl child and to ensure girls at risk and those most vulnerable to abuse are rescued and empowered to speak out. In addition to its community- and school-based programs, GCN provides safe shelter and referrals to legal and medical aid for girls who have survived abuse.

GCN covers nine out of the ten provinces, incorporating 40 out of the 58 districts, in Zimbabwe. The districts have a combined population of more than 6.9 million out of the total national population of about 13 million people. At least 80 per cent of GCN’s work is in the rural areas; 10 per cent is in the high density suburbs and the other 10 per cent is shared between farming, mining and low density areas.

The establishment of Girls Empowerment Villages is an innovative and key strategy of the programme.
These are strategically positioned villages found across Zimbabwe which serve as information dissemination, and service provision and relief centres for abused girls, through mitigation and case management. The goal is to foster a sense of hope for abused girls who, through their rehabilitation, are transformed from being victims into being survivors and leaders, whilst also educating girls so that develop their full potential in an otherwise very patriarchal and male dominated society.

SAfAIDS has chosen to document GCN’s Rusape project as a good practice. Rusape is a small town in Manicaland district towards the eastern border with Mozambique. Children attending school in the town come from the urban and peri-urban areas, as well as from surrounding farms. Four schools in Rusape - Vengere High School One and Two, St James High School and Tsanzaguru High School - received GCN training in concert with government efforts to raise girls’ awareness of their sexual and reproductive health rights in order to reduce their vulnerability and exposure to HIV. Trainees were also taught to lobby parliamentarians about the needs of the girl children.

GCN Empowerment Program in Rusape

Girls Empowerment Clubs

Established in schools and communities, girls empowerment clubs are platforms that allow and encourage girls to speak about the challenges and wrongdoings they face and to exercise their rights so that they realise their full potential and to address the challenges or wrongdoings they experience. Without the Clubs, the girls would have no other forum in which to learn about their rights or express their needs.

In Rusape, the two schools that were documented - Vengere and St James - have vibrant girls empowerment clubs co-ordinated by a senior teacher (who volunteers their time to mentor the girls) and an elected leadership structure made up of the girls themselves. The girls meet once a week in the clubs to discuss issues on growth and development (issues around adolescence), sex and sexuality, girl's rights, HIV and other risks that the girls might face, as well as health and general well-being. They also invite presenters to share with them on topical issues. The clubs then send reports to GCN every month. They are also invited for trainings by GCN whenever there are new issues and funding for such trainings.

During the clubs, the girls indicated that prostitution among school girls was rampant in Rusape, due to poverty. Most girls are indirectly forced into marriage, as parents encourage their daughters to have relationships with men who can afford to give them gifts, or even pay their school fees. The girls agreed that learning about sexual and reproductive health rights in schools would help prevent most girls from ending up in difficult situations. The girls welcomed information on the dangers of early sexual relations, child abuse and of entering into early and forced marriages. The need for affordable sanitary wear was also raised, as lack of sanitary wear leads to girls missing school, for fear of public exposure of their periods and the ensuing embarrassment. Girls may miss up to five days of school a month as a result, which has a negative effect on their schoolwork. Girls also sometimes use unhealthy and potentially dangerous substitutes, such as maize cobs (chiguri), which expose them to infection.

Most girls felt there was a need to bring politicians into the meetings, as their involvement would help Rusape become a leader in respecting SRHR. The participants felt that they were being ignored by their elected representatives and thus were more vulnerable to abuse.

Advocacy, Lobby and Law Implementation

Most of the problems faced by girls are the result of the absence of a girl-friendly society with policies, laws and socio-economic structures that promote and protect girls' and women's rights. This programme supports the development of such a society and aims to eradicate, or at least minimise, the obstacles that hinder the development and empowerment of girls and women. The involvement of local leadership, including political leaders in the Rusape meeting and trainings, allows for dialogue between the girls and the leaders, while the revival of the traditional, respectful view of girls as vaZvare (princesses) is an innovation that will ensure sustainability, since it is linked to the area's culture. The issue of sanitary wear has been taken up by the local parliamentarian who promised to table it in Parliament, so that import duties on sanitary wear are scrapped to make it more affordable.
Information, Documentation and Dissemination

The girls in Rusape write and publish their own stories in the GCN’s ‘In Touch Magazine.’ This is in recognition that lack of information keeps girls vulnerable and prevents communities from implementing their own strategies to combat abuse. GCN has developed a culture of documentation and information dissemination from the girls to stakeholders and vice versa.

Girls at Risk Support Programme

Realising that there are some girls who miss out on GCN’s empowerment training and end up in risky situations, GCN has devised this programme to capacitate communities to respond to the plight of girls during difficult situations. It institutes the Survivor Protection and Support Strategy which seeks to urgently address the concerns and predicament of girls at risk, particularly of girls who have been sexually abused. Members of the public who include parents, other support organisations and service providers, work with the GCN clubs to provide support where required. The Police Victim Friendly Unit comes into the schools and gives information on child abuse and what a child/young person can do without fear of victimisation, when abused. This programme is co-ordinated by the GCN clubs in the four schools. In Rusape, the nearest Girls Empowerment Village is situated at Chisora, 20km out of Rusape town. The Village is near an existing community and is secured by a 24 hour guard, to ensure the protection of the children in need of care who are housed in the village as a temporary measure, until social workers and judicial officers have processed their cases. A matron and care givers look after the children in need of care at the shelter.

In order to achieve the goal of documenting the GCN project as a good practice, the SAfAIDS documentation team travelled to Rusape and conducted interviews with headmasters, club co-ordinators and programme implementers, as well as with the girls and their parents.

Scoring was done using the SAfAIDS good practice score card (see Appendix B).

Good Practice Evaluation Findings On The GCN Girls Empowerment Project In Rusape

On completion of the evaluation of the Girl’s Empowerment Project, SAfAIDS made the following assessment.

Effectiveness

The goals of the GCN Rusape Girl Empowerment project are clearly articulated and understood by the girls, their headmasters and teachers as well as by the project implementers.

Due to sensitisation meetings, GCN has realised a new breed of empowered girls who are able to assert their sexual and reproductive health rights, which are frequently ignored. The girls are empowered to speak out about abuse and make decisions about their lives without undue pressure from either society or their families.

Ethical soundness

The project promotes and protects the rights of girls and operates within the boundaries of good ethical practice. All beneficiaries are treated with dignity and respect. The project has strong integrity and sound governance, ensuring transparency and accountability. Teachers, who are also the club co-ordinators, are trained guidance and counselling teachers and operate under the supervision of a senior teacher in guidance and counselling. The teachers, therefore, value confidentiality and privacy. Parental or guardian’s approval for a girl’s participation in the club is also obtained.

Cost effectiveness

The Girl Empowerment project operates through a cascading model whereby a pool of peer educators is trained. They then educate other girls within the school and in the community. This reduces the cost of the additional trainings required to cover all the girls who want to be trained. The momentum of the project is sustained by the enthusiasm and efforts of the girls and their co-ordinators. The schools also have a handover and takeover system in place, in cases where a co-ordinator transfers or retires.
Relevance

There is a high prevalence of child abuse in Zimbabwe, according to the Girl Child Network, with one girl being abused during every 24 hour period. Abuse of girls is significantly higher than of boys. The Rusape project, for that reason, highly relevant as it aims to equip girls with knowledge on their sexual and reproductive rights. The beneficiaries perceive the project as being relevant and timely. The project is supported by the leadership of the schools and parents. Some parents fear that their children will have their minds polluted and that the training will encourage disobedience, but in general, the programme has been accepted in the community.

The project is in line with the Maputo Plan of Action as well as the National HIV and AIDS Strategic Plan and has clear and well defined objectives and targets. There are also clear strategies in place for evaluating the impact of the project. The strategies include a well developed Girl Child Club Co-ordinator Scheme Book and lists of participating girls. Both school communities have taken ownership of the project, enhancing its impact and sustainability. Each school visited has a teacher dedicated to the implementation and co-ordination of the project.

The project fits in well with the Zimbabwe Republic Police Victim Friendly Unit’s campaigns against child abuse, which are held on a regular basis. It also fits in well with the Ministry of Education’s HIV and AIDS curriculum taught in the schools and sets an example for similar programmes in other schools. Most schools in Zimbabwe have HIV and AIDS clubs and HIV is part of the school curriculum, which provide a good foundation for implementing the strategy, either as an extra-curricular activity, or as a timetabled class.

Replicability

The project can be easily replicated in total or in part as it makes use of existing resources. The project is adaptable in different contexts as it takes into account the various age groups and education levels, according to the child’s evolving capacity. It can be taught in the three main languages, using teachers already available, and the pupils themselves are peer educators for their schoolmates. Each of the Rusape GCN club co-ordinators has a scheme book that they use to plan and document club activities, which can give guidance to those wanting to replicate the project.

Innovativeness

The project is unique since training takes place at a specially established child-friendly village in a rural setting, where the children are away from the distractions of urban lifestyles and protected from potential abusers, since care-givers and a guard are present at all times. The village is situated in the mountains on the outskirts of the main residential area of the community, offering privacy and tranquillity for the residents, who are survivors of abuse. The project has made a significant contribution to the knowledge base in children’s sexual and reproductive health and rights.

It uses a child friendly participatory approach and some of the trainers are also survivors of child abuse with first-hand knowledge of the issues. They provide living testimonies and act as examples for the children. The involvement of local political and traditional leadership in a forum where the girls are able to address them directly is also unique and empowering for the girls, who would not ordinarily be able to speak to men in positions of authority. At the same time the project has revived a traditional system of respect for girl children and linked it with the programme, which is very unusual. Training methods are diverse and flexible and include discussion, question and answer sessions, testimonies, games, role playing, indirect drama, song, dance and other forms of ‘edutainment.’

Sustainability

The project is run by women and girls from schools in Rusape and has the support of teachers, the Police Victim Friendly Unit and the community. It has been embraced by the schools, as evidenced by teachers being allocated to co-ordinate the club activities. The clubs include girls in grades three right up to form six, to ensure continuity.

Trained girls are able to share their knowledge with other girls in their clubs, at the schools and in the Rusape community, which has led to more girls being equipped with sexual reproductive health and rights information for life skills and self preservation. Only low-cost inputs are required, such as funds for refresher courses for staff and exchange visits for the staff and girls but, on the whole, the programme is self sustaining. This is one of its strongest points. The project has also been embraced by the community who form the monitoring committee and since it has been merged into Rusape community tradition, who respect the girl children as vaZvare, with a designated meeting place, the project can be sustained without external support.
Case Study: Fadzayi’s story

Fadzayi Matsikai is the 18-year old President of the Girl Child Empowerment Club running at Vengere High School. This young lady has risen to become head girl of her school due to the high confidence levels she has built in the past few years, since becoming a member of the club.

For her, joining the club was the best thing that she could have done. “I have achieved things I only used to dream of. My life has changed, both at school and at home, and it is all because I have been empowered,” she said. Having grown up watching her parents’ marriage crumble before her eyes and seeing her father beat her mother as and whenever he felt like it, Fadzayi was not always the most confident of children.

When her parents divorced some ten years ago, she found herself staying with her mother in Harare. “I was so relieved that my mother was empowered enough to walk out of that marriage. I am very thankful that she was able to look after my brother and me until the day she died. When I was told I had to go and live with my father in Rusape, I was filled with dread but, because there was nothing I could do, I found myself in Rusape,” she told the team.

At first, joining the Girl Child Network Empowerment Club was just a means of avoiding her father. As far as Fadzayi was concerned, the more clubs she joined, the longer she could stay at school. “It meant I would only go home to eat and sleep and that was what I wanted because my father and I did not get along. I had this bitterness in me and felt like a prisoner in my own home with my own father,” she said. All that began to change however. As she learnt about the rights that children had - to love, to a home and to an education, among other things, Fadzayi’s confidence began to grow. She started to value and love herself more.

“I started trying out subjects I used to think were for boys alone, such as sciences, and found myself doing well. I tried my hand at public speaking which I never used to be confident doing. I even found myself approaching my father and talking about how I felt. Can you imagine that today we are good friends? It was not easy; initially he did not like the fact that I was in the empowerment club or that I would do science experiments at home, at times playing around with electrical cables, but now he encourages me.”

Fadzayi also found herself with two homes. Her father agreed to let her stay with his sister and her family from time-to-time, something which Fadzayi loves. “I am comfortable there. It is my other home and I love the fact that my father cared enough about my feelings to allow it.” She became more aware of the abuse of women that was going on in her community and was more confident about challenging accepted norms, because of the empowerment she gained through the empowerment club. “There was a tenant at home who was always beating his wife. While we always used to tell him that what he was doing was unacceptable, it took several empowerment sessions to be able to tell him that what he was doing was a crime and that if it did not stop, he would be reported to the relevant authorities. Amazingly it stopped!”

Figure 3. The girls at a G PN club meeting
At school, Fadzayi was able to tell her friends who were being pushed into sex by their boyfriends before they were ready, that they had the right to say no. “I tell other girls that our virginity is our pride and that, as girls, we can achieve our dreams. I am empowered to know that not even the sky is the limit, and I have passed this on to all the girls I meet. I do public speaking now and have even presented a paper to teach boys about the importance of respecting females. The boys now understand,” she said. Most of all, Fadzayi herself now understands that she matters as a person, just as much as any boy. She also knows that the things that went wrong in her past do not have to influence her future. “I am aiming for the stars. I want to go to University. I want to become a lawyer or a food scientist and I will become one. A woman can do anything she wants if she sets her mind to it. A woman has rights. A woman does not have to put up with what she is not comfortable with, such as someone putting their hands on her body. A woman is protected by the law,” says Fadzayi with enthusiasm.

The Fadzayi of today is very different from the girl she used to be, after three years in which she has gained innumerable life skills through the GCN empowerment programme at her school. Currently undertaking her sixth year of high school, this young lady has emerged from being a scared and timid child into a confident, bubbly young woman who can stand up for herself and for her peers.

**Lessons Learned from the GCN project**

Some of the key issues raised by the young girls and women under the GCN Rusape trainings were as follows;

- The girls stated that Rusape is a small town which lacks entertainment facilities. As a result most youths engage in sexual activities and promiscuity, as “an idle mind is the workshop of the devil”. They felt that politicians cared only for their own interests and not those of the youths. Since sex was their only source of entertainment they ended up in difficulties as they indulge in sex without being aware of the dangers and consequences.

- The girls felt that those that are not so intelligent are ignored by their parents who feel they have no obligation to invest in them and this results in them getting married prematurely.

- They also raised concern over the number of girls who were engaging in backstreet abortions and that efforts needed to be made to reduce such cases.

- The girls echoed the need to involve boys and parents in such meetings as without this, the girls would be unable to assert their rights since the boys, and sometimes the parents, are ignorant of their existence.

- They also aired their concern over the price of sanitary ware. Most of the parents thought sanitary ware was a luxury resulting in girls losing their self esteem, especially during menstruation.

- The girls also alluded to the fact that they lack focus in their lives and have no role models to inspire them to be better people; they see nothing ahead save for being sex workers, who appear to be leading a better life, although the serious consequences of this life style were recognised.

This information from the girls has been taken up by GCN for continuous programming in their project in Rusape and in other parts of the country. SAFAIDS has also benefited from this information and is using it in programme for the youth.

In addition, the process of documenting a project as a good practice also highlights weaknesses in project design and implementation that may prevent the project from being classified as a good practice, or that hinder its full achievement of its goals. The findings of the documentation team in this respect, are indicated below.

The project should also target boys and parents to ensure that they understand issues about girls’ sexual reproductive health and rights, as they are an integral part of a community and interactions and interdependencies exist with boys, men and women. Boys sometimes abuse girls without understanding that their actions constitute abuse. The children’s parents, who are secondary beneficiaries of the project, have little understanding of the project goals and objectives.

- There is need for partnership arrangements to continue between civil society organisations (CSOs) and Government in the implementation of SRHR programmes even where external funding is not available.

- Improvements in the Ministry of Education Sport and Culture curriculum should be made to include SRHR and combine it with HIV awareness. The subject should be made examinable by 2011.

- The GCN clubs should be made compulsory for all girls rather than being voluntary, in light of the absence of aunts and uncles to provide young girls and women with sexual health information as they grow up. The programme appeared very relevant to the schools documented and can be further assessed for the rest of the country.

- Parents should be involved in the planning and monitoring of the SRHR programmes and should also have
awareness sessions so that they appreciate the value of the programme, as well as to bring them up to date with current trends so they are on the same wavelength as their children.

- The GCN club co-ordinators should undergo annual refresher courses on the club concepts and for networking and cross learning. This also helps with new co-ordinators who have not been trained at the initial stage.
- Provision of sanitary ware for girls at subsided rates should be urgently taken up by government, civil society and the private sector, to enable school girls to fully participate in school activities. This would also benefit other women.

Conclusions
SAfAIDS found that, on the whole, GCN trainings were well received by the intended beneficiaries. As a result, girls were more informed of their rights and more confident of their capabilities. Their parents were also supportive of the trainings and said they would welcome similar initiatives so that girl children could realise their rights and be afforded the same dignity and respect as boys.

Specifically the project has achieved the following:
- Establishment and development of girls’ empowerment clubs
- Individual, household and social transformation, mainly involving girls
- Improved media sensitivity to issues of child abuse, particularly sexual abuse in the local newspapers
- Improvement of girls’ access to information, resources and referrals
- Increased access to justice for survivors of rape and abuse
- Successful advocacy and lobbying for laws and policies that meet the special needs of girl children.
- Establishment of excellent relations with donors and key stakeholders, based on mutual trust, respect and confidence
- Increased community acceptability and involvement to penetrate the patriarchal system that characterises Zimbabwean communities
- Improvement in girls’ access to education through their reinstatement and retention in school.

In Zimbabwe, HIV still poses a challenge with regards to attaining universal access to health care, despite the decline in prevalence. Universal access to health implies that every citizen should have access to sexual and reproductive health, at all levels, including girls in schools.

In terms of the current law, abortion is illegal in Zimbabwe and is only allowed in cases of rape, incest or in instances where the pregnancy poses danger to the life of the mother. In other countries, such as South Africa, abortion is a choice and is provided on demand. Feedback from the project suggests that the girls want abortion to be available on demand in Zimbabwe.
Adolescent girls and boys and other youths lack recreational options in and out of school, leading to antisocial behaviour. Providing recreational facilities keeps young people occupied and thus they are less exposed to risky behaviours.

Community involvement is a critical factor in the success of girls sexual reproductive health rights programmes and an outreach programme to get in touch with out-of-school girls and boys should be developed.

Some girls do not recognise abusive behaviour and do not know how to deal with abusers. Parents indicated it would be more beneficial if boys were also included in the trainings so that they could also understand and support women and girl’s rights. Educating and empowering girls alone, without taking into account that in the societies in which they live males often play a dominant role, may dilute the benefits of the programme.

The GCN project, which is being implemented in Rusape as part of a national programme, has been well received in the schools and given a place for operation. It is viewed with high esteem by the teachers and pupils and is understood to be very valuable. There are recommendations from children and parents in the community for it to be available to all girls as it provides useful life skills and career guidance. There is need to market the project to ensure both continued support and enable other communities to replicate it.

Because of the project’s visible outputs in the form of empowered girls, there has been a request from both girls and boys in schools to include boys in the clubs. In order for girls’ empowerment to make the best impact, it is important that boys also be made aware of the ways in which they contribute to the lack of empowerment of their female counterparts. There is also need to work with parents in communities for the empowerment project to be fully effective. Basic needs of beneficiaries should be taken into account and referral channels put in place so that those requiring further support can be reached.

Having scored over 75%, the GCN project as implemented in Rusape is seen as a good practice that can be replicated in all the schools in the country.
Women and AIDS Support Network (WASN) was founded in 1989 to respond to the challenges facing women and girls in the fields of HIV/AIDS and sexual and reproductive health rights. Their core strategies include research; advocacy; information dissemination; networking; development of effective gender-specific models and capacity building.

Societies Tackling AIDS through Rights (STAR) is an innovative participatory approach that engages communities in tackling issues around HIV and AIDS. The methodology used resembles that of ‘Stepping Stones and Reflect’. The ultimate goal of STAR is empowering communities in the face of HIV and AIDS. The approach is comprehensive and follows an integrated approach to HIV and AIDS, sexual, reproductive health and rights policies and programmes. It facilitates community involvement in prevention, access to qualitative care, treatment and support.

STAR focuses on relationships and communication skills, with the intention of reducing HIV transmission, improving sexual and reproductive health (SRH), eradicating violence against women and girls, as well as fostering women’s rights. This approach enhances adult learning by enabling people to plan their development activities based on their needs and considering their local reality.

The STAR approach further aims to strengthen the literacy and communication skills of vulnerable women and girls by building negotiation skills, opening up dialogue and participating in decision-making within the household and community. It also increases the ability of both the poor and those living with HIV to advocate for their priorities, particularly around HIV and AIDS, for example by demanding increased access to testing and affordable treatment.

WASN’s main objective in the STAR project is to build the capacity of women and girls to address issues affecting them in the areas of HIV prevention, treatment, care and support as well as other social determinants of health, such as nutrition and housing.

“The objective is to develop an integrated approach to individual and community empowerment in the face of HIV, with a particular emphasis on gender equity. Women and girls are not only the most vulnerable to infection, they are the least able to voice their concerns and make decisions affecting their lives in both the household and public spheres.”

- STAR Focal Person - WASN

Chitungwiza and Lupane: Societies Tackling AIDS through Rights (STAR) Circles

Chitungwiza is a peri-urban town situated 27km east of Harare Metropolitan, whilst Lupane is a growth point in Matabeleland North, 180km from Bulawayo. Chitungwiza and Lupane each have three STAR circles spread across the provinces, comprising of women living with HIV, widows, young people and other women and girls who are affected by HIV and AIDS.
The groups periodically converge to share information on topical HIV-related issues, design advocacy strategies and engage in livelihood projects such as buying and selling clothing and transactions made through maize or cash and chicken rearing.

The circles are led by women facilitators who, with support from WASN, have undergone training in facilitation and the use of participatory methodologies to lead sessions on HIV and AIDS and advocacy. The STAR project builds the capacities of communities to engage in educational awareness programmes and advocacy to address issues that affect their lives at community level. Part of the strategy involves fostering linkages between STAR activities and other community-based organisations for the purposes of advocacy or awareness.

**Elements of a Good Practice**

The WASN team assessed the STAR project and confirmed that with an overall score of 75%, it was a good practice worth documentation.

**Effectiveness**

One of the major advocacy issues identified by a Chitungwiza circle was lack of access to treatment and health-related services. Most women and girls were failing to access adequate health care as they could not afford to pay hospital user fees. Some of the women were taking their antiretroviral therapy (ART) inconsistently due to failure to raise the hospital consultation fee. The circle participants mobilised themselves and went to the Chitungwiza hospital authorities in 2008 to advocate for the eradication of hospital user fees for women living with HIV.

Through their advocacy at the community level, the women were exempted from paying consultation fees at the hospital. In addition, the circle was allocated stands by Chitungwiza Town Council to build their residential houses. This was following the murambatsvina (clean up) exercise in the country which led to the destruction of ‘illegal’ structures.

One of the community facilitators, Mrs. Loveness Dzvimbo, said: “Before the STAR project I was shy to stand in front of people and share ideas. Now the project has trained me to speak out. I know my rights and can speak to issues that concern my rights without fear.”

**Ethical Soundness**

The STAR project respects the principles of openness and confidentiality, as well as informed consent for those who want to disclose their HIV status. STAR upholds and protects vulnerable groups, including widows, HIV positive women and girls.
Cost Effectiveness

STAR is cost-effective and can run with minimal financial input. Funding STAR allows analysis of a full spectrum of critical development issues in the community—whether social, economic, political or cultural—in each case exploring the impact of, and connections to, HIV and AIDS. Often women and girls in the community do not realise the resources that surround them that can be exploited by them to better their lives. The idea is for women and girls and the community at large to be able to advocate for their particular needs in their communities. It is about being able to initiate activities that are run in the community, thereby ensuring ownership and sustainability.

Relevance

The involvement of the whole community in the project led to the successful implementation of the STAR project, as those who were genuinely interested joined. The testimonies from the members of the STAR circles attest to the relevance of the project.

Some comments from the women are listed below:

“Well we did not have anything, but we are now empowered to buy things for the home.”

“Through the project, we have managed to send orphans to school as well as take care of them.”

“My niece is on HIV treatment. I am taking care of the child very well as a result of the educational sessions we receive in the STAR circle.”

There is a strong sense of ownership amongst the involved communities. Although the project primarily targets women and girls, men and boys also attend the star circles, indicating that the project is relevant to the broader community.

Replicability

STAR is a multi-country project that aims at promoting the use of participatory approaches in addressing HIV and other development related issues. The STAR programme has been successful in countries such as Uganda, so its replicability has been proven.

Innovativeness

The most striking and innovative aspect of the STAR project is that it targets marginalised and vulnerable groups such as women and girls. The thrust is to build the capacity of groups to influence processes, policies, decisions, priorities and actions within their own localities. Groups identify their own solutions and actions rather than an outsider spearheading the process. In this way, community advocates are formed, resulting in the redress of various problems in the context of HIV.

In addition, circles identify their own issues and design action plans to address these issues. These have to do with HIV and AIDS prevention and treatment, as well as livelihoods initiatives. Communities individualise all the processes and activities, ensuring meaningful ownership and sustainability.

The formation of STAR circles results in the identification and mentoring of community advocates, who represent women’s rights issues in their locality.

Sustainability

The STAR project has demonstrated women’s ability to bring about positive changes within their own lives and those of their communities. The project requires minimal funding and thus is ideal for resource constrained settings. The focus is on community mobilisation as members and facilitators take up the initiative to address issues affecting them in their locality. The concept of community-based facilitators leading the process also ensures the sustainability and community ownership of the project.
Case Studies: Gladys

Although I was already a member of the STAR group, I did not have the courage to go and get an HIV test. Then it happened that I became pregnant. Because I had information that I learnt from STAR, I went to hospital for my first check-up and that is where I volunteered for an HIV test.

The tests were done and besides being pregnant, I also tested HIV-positive. I received counselling at the hospital and discussed the choices that I would need to make, such as whether I wanted to breastfeed my baby. I was also helped by members of my STAR circle, who have always been there for me. I decided not to breastfeed my child. I told my partner about the choice I made and, amazingly, he supported me. Even my in-laws supported me, especially my mother-in-law, with whom I am in the same circle. After giving birth to my twins, I followed all the instructions that I was given at the hospital and now my children are one year old and very healthy.

Besides being equipped with information and knowledge about health issues, the STAR project has taught me how to take care of myself and live positively. My life is not different from that of any other person. I have managed to sustain myself through projects such as chicken rearing and selling goods that we buy from Bulawayo and neighbouring countries. The only challenge is that now it is difficult to use the emergency travel documents that we were using before to cross to South Africa, where things are reasonably cheap, to buy for resale here in Lupane. If we could get passports, our lives would be easier.

Our circle has become innovative as we now pool our resources together and participate in the buying and selling of goods for income generation. This has allowed us to maintain our families’ incomes at a time when the economic situation in Zimbabwe was extremely difficult. We are like a family and are always there for each other in times of need.

Christine Ndlovu: A light from the STAR

Christine Ndlovu, 42, says if it were not for the STAR project, she wouldn’t be the business person she is today. A proud butchery owner, Christine is a force to be reckoned with in her rural home of Gwaai, 75 km from Lupane centre.

Christine has been equipped with information on how to stand up for what she believes in. She has been able to take care of her family in her own right and does not feel that she is just a widow living with HIV. People respect her for who she is and she has continued to be part of the STAR project to help those who are joining.

After she joined the STAR project in 2007, she and her friends in the Lupane centre STAR circle started a project involving rearing chickens for resale. It was not easy at first, but because of the skills they were taught by WASN and
the inspiration they gave each other, they persevered until they had their first sale. They did not give up and they went on to buy another lot of chicks to rear. Out of the proceeds that they shared as a group, Christine bought two cattle. As the project grew to greater heights, she decided to start a business of her own. She identified a butchery that was no longer functional in her rural home and asked the owner if she could rent it. At first it was difficult to run the butchery, especially as a woman in the rural area, but, as people gained confidence in Christine, her butchery project became more successful.

Figure 7: Christine N dolovu from Lupane.

Development Issues arising from STAR Chitungwiza and STAR Lupane

Reconnaissance missions by WASN have resulted in the realisation that the difficulty in establishing effective HIV and AIDS programmes comes from the lack of openness in many communities regarding issues such as sexuality, male-female relationships, illness and death - all of which are taboo subjects deeply rooted in tradition and culture. WASN feels that understanding what motivates people’s behaviours, knowing how to address these motivations appropriately and taking into consideration people’s cultures when developing programmes that address HIV are essential elements in changing behaviours and attitudes towards HIV and AIDS.

Challenges

Since the project relies on community organisation, the challenge is keeping circles motivated in the context of various social, cultural and economic challenges. Refresher courses for community facilitators are necessary so that they keep abreast of new developments and information around HIV- and AIDS-related issues.

Lessons learnt

- The involvement of the whole community in the project led to the successful implementation of the STAR project as those who are genuinely interested joined
- Active participation by local leadership is of paramount importance if information is to rapidly cascade to communities. Cultural and religious gatekeepers can then discard negative cultural practices
- The circle meetings provide a one-stop shop to obtain information on prevention of parent to child transmission (PPTCT), opportunistic infections, antiretroviral therapy and other related services. Other community members have seen the benefit of joining the circles for purposes of obtaining information that is vital for their survival. Other community based organisations, both regional and international, have visited the project areas and acknowledged the work STAR members are doing in the community.
Conclusion

The beneficiaries highlighted the fact that the STAR project had to continue so that others could see the benefits of a women’s project. Non-members will be motivated to join similar projects once success is apparent. There is a lot of potential for growth, education and advocacy within the STAR circles. Capacity building through refresher courses for members will enhance their skills at the community level and result in increased impact in terms of their organised advocacy activities.

The STAR project approach has facilitated women’s participation in economic and development activities in the rural areas. This was after the realisation that many women face violence and the attendant risk of HIV infection because they lack economic independence. In this context, the STAR approach aimed at building the capacity of women to have access and control over resources. WASN envisages that this will result in reduced HIV infections among women and girls, as well as reducing gender-based violence.

Overall Conclusions from the Good Practices Identified During this Project

A major lesson learned through this process, is that much good work is being done in Zimbabwe in Gender and HIV programming but because it is undocumented, it also goes unrecognised. Good practice documentation allows organisations to highlight their successes and share them with other partners so that they can be replicated. This reduces wasted effort on the part of other organisations in ‘reinventing the wheel’ when successful, tried and tested interventions already exist.

It is clear that the beneficiaries of the projects whose elements of best practice are documented here are making significant gains through these programmes. It is hoped that by reading these success stories, other organisations will be inspired and empowered to implement similar programmes in their own programme areas. Ultimately, the beneficiaries will be all those affected by gender inequality and HIV in Zimbabwe.

Whether or not the projects documented here would score as overall good practices when placed under a rigorous and objective good practice evaluation process, nonetheless, each of the projects documented here includes elements of good practice from which other organisations can learn.
Appendix A: SAfAIDS Good Practice Assessment Tools

1. Interview Guide for Key Informants

**Tool 1: Interview Guide for Key Informants**

**EFFECTIVENESS**

1. What is the purpose or aim of the project/programme?
2. How does the project/programme goal or aim relate or fit into the national HIV and AIDS strategic plan (ZNASP) and CEDAW and other gender commitments?
3. What are the strategies to achieve the goal? (Probe for implementation plans, services rendered and defined target groups – geographic and demographic catchments)
4. How are the project/programme services accessed by beneficiaries? (Probe for clarity on community outreach plan or disbursement / distribution plan)
5. What systems are in place to ensure effective implementation? (Probe financial, programming, procurement, human resource allocation, equipment, staff development, skills transfer and project sustainability)
6. How does the project/programme approach integrate into other programmes i.e. inclusion of other services, multitasking? (Probe to see if programme is vertical or not and assess multiplier effect - does one stone kill many birds?)
7. How were project/programme priorities determined? (Probe for information on needs assessments, community and other stakeholders involvement, is project addressing urgent needs of community?)
8. How is the community involved in the project/programme? (Participation in planning, monitoring, implementation and evaluation - probe for information on mechanisms put in place to solicit for feedback from community groups - probe for other ways that community contributes to the project, assess project acceptability - social, political, cultural and religious)
9. How does the project/programme take into cognisance gender dynamics at community level? (Probe for composition of structures, participation and beneficiaries)
10. How is the project/programme monitored? (Ask for monitoring tools, if any, and frequency of this, 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, people living with HIV are taken care of)
14. What policies are in place to ensure that the project/programme upholds and respects human rights? (Probe for policy or consideration of confidentiality, informed consent and safety issues)
15. What policies are in place to ensure continuity of services? (Probe for systematic weaning or phase out strategies, skills transfer)
16. What policies are in place to ensure equitable distribution of services? (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. is project allowing for both internal and external programme and financial audits? frequency of audits?)
COST EFFECTIVENESS
18. How are project/programme resources distributed? (Admin versus programme costs)
19. 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)
20. To what extent are available resources adequate to support delivery of project/programme services? (Probe for adequacy of human and financial resources, equipment and supplies)
21. What are the cost saving and cost reduction measures of the project/programme? (Use of low cost, improvised substitute, engaging volunteers for some of the services, does it have an increased financial burden on beneficiaries)
22. To what extent does cost sharing take place in the project/programme? (User fees, payment of some of the services like training, transport)
23. What is included in the minimum package of the service/s provided by the project/programme? (Compare with the standard package policy for the country, procedure guides)
24. How timely is the delivery of services?

RELEVANCE
25. 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, support offered by traditional systems)
26. Are all the services provided necessary? If not, which are unnecessary?

REPLICABILITY
27. What are some of the success stories that can be shared?
28. What are some of the project/programme challenges?
29. What are some of the lessons learnt? And how have these learning points 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).

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

SUSTAINABILITY
33. How is the project/programme vision aligned to current trends? (National and regional trends, epidemic, economic, developmental - political correctness- MDGs, Universal access etc)
34. What is the funding pattern of donors? (Basket funding, % of funding from local sources and donors)
35. How does the project/programme strategy ensure financial sustainability? (Probe for information on fundraising strategies, user fee, community initiatives)
36. What do you see as the future of the project/programme?
Tool 2: Focus Group Discussion Guide (FGD) for 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/programme? (Goal, objectives)
2. How were you involved in the establishment of the project/programme? (Conceptualisation, consultations, needs assessment, prioritisation of needs, relevance to needs, usefulness, timeliness of project/programme, planning)
3. What do you think are the benefits of this project/programme for you as women / men / people living with HIV / young people and your communities?
4. How do you view this project/programme? (Is this YOURS, ownership, or imposed, or donor driven, or neutrally accepted because you don’t have a choice?)
5. How do project/programme services/activities cater for the needs of different age-groups, sexes, and social classes within your community?
6. How does the project/programme take into cognisance gender dynamics in your community? (Probe for composition of structures, participation and beneficiaries – girls, boys, women and men, benefits)
7. How has access to project/programme services/activities been influenced by the economic or political trends in your community?
8. How are project/programme implementers working with you to determine project/programme needs to meet your needs?
9. How are you participating in the project/programme implementation and checking that the project/programme is progressing well? (Monitoring and evaluation processes)
10. How do you share your feedback or feelings about the services/activities you are receiving, with project/programme implementers? How often?
11. How does your community contribute towards the services/activities that this project/programme offers? (Cash, kind, other support, e.g. advice and networking)
12. Describe the process that takes place for community members to access the services/activities provided by the project/programme? (Probing should be specific to the good practice you are documenting, this will measure how implementers are ‘doing things’ e.g. are human rights being adhered to etc)
13. What factors hinder women and young people and people living with HIV from accessing the services, or engaging in the activities that this project/programme is offering?
14. What would you like to be done in this project/programme, to be of greater benefit to your community?
15. Is the gendered nature of community care needs being recognised so that the intervention incorporates the needs of women?
16. Is the stigma of HIV being addressed at the level of the community?
17. Is the intervention of choice (wherever possible) home-based community-supported care?
18. Is there effective support of families and communities in their response to HIV (Such as income generating activities, nutrition, drug adherence, etc)
19. Is there broad engagement with other community services and networking?

**ETHICAL SOUNDNESS**

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

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

**RELEVANCE**

30. 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, support offered by traditional systems)
31. Are all the services provided necessary? If not, which are unnecessary?

**REPLICABILITY**

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

**INNOVATIVENESS**

36. In your opinion, is this project/programme creative and innovative, different from other projects?
37. Can you share with us a story that demonstrated this innovation?

**SUSTAINABILITY**

38. In the absence of donor support, do you think this project/programme should continue? Why? (Are there skills in the community? Is community contributing to the programme cash or kind?)
39. Is the project/programme well known to the community?
40. What are some of the challenges faced by yourselves in this project/programme and how have these challenges been addressed by yourself and the NGO?
Tool 3: Interview Guide for 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 project/programme goal (or aim) relate to, or fit into, the National HIV and AIDS strategic plan (ZNASP) and CEDAW and other international commitments on gender?
3. What are the strategies to achieve the goal? (Probe for implementation plans, services rendered and defined target groups – geographic and demographic catchments)
4. How are project/programme services accessed by beneficiaries? (Probe for clarity on community outreach plan or disbursement / distribution plan)
5. What systems are in place to ensure effective implementation? (Probe financial, programming, procurement, human resource allocation, equipment, staff development, skills transfer and project sustainability)
6. How does the approach of the project/programme approach integrate with other programmes i.e. inclusion of other services, multitasking? (To see whether programme is vertical, assess multiplier effect: ‘does one stone kill many birds?’)
7. How were project/programme priorities determined? (Probe for information on needs assessments, community and other stakeholders involvement, project addressing urgent needs of community)
8. How is the community involved in the project/programme? (Participation in planning, monitoring, implementation and evaluation - probe for information on mechanisms put in place to solicit for feedback from community groups - probe for other ways that community contributes to the project, assess project acceptability - social, political, cultural and religious)
9. How does the project/programme take into cognisance gender dynamics at community level? (Probe)
10. How is the project/programme monitored? (Ask for monitoring tools, if any, and frequency e.g. coverage, reporting forms, tally sheets, monitoring committees, quality assurance mechanisms or quality bench marks)
11. How is the project/programme evaluated? (Measurement of impact - probe for knowledge of main indicators and baseline information, frequency of conducting evaluations)
12. How is monitoring and evaluation data used? (Frequency of use for project review, timely dissemination to relevant stakeholders)
13. Who are the implementers of the project/programme? (Probe for information on sectoral expertise amongst staff, volunteers, out-sourcing as necessary, adequacy of staff, roles and responsibility)
14. Is the gendered nature of community care needs being recognised so that the intervention incorporates the needs of women?
15. Is the stigma of HIV being addressed at the level of the community?
16. Is the intervention of choice (wherever possible) home-based community-supported care?
17. Is there effective support of families and communities in their response to HIV and gender issues? (Such as income generating activities, nutrition, drug adherence, etc)
18. Is there broad engagement with other community services and networking?

**ETHICAL SOUNDNESS**

19. How does the project/programme ensure inclusion of vulnerable groups? (Probe for value statement on how interests of young people, women, people living with disabilities and people living with HIV)
20. 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)
21. How is continuity of services, support or care ensured after end of current funding cycle? (Probe for
systematic weaning or phase-out strategies, skills transfer mechanisms)

22. How is equitable distribution of services ensured? (Are those with greatest need accessing the service?)
23. How is the project/programme audited and who does the auditing? (Probe for transparency i.e. is the project allowing for both internal and external programme and financial audits, frequency of audits?)

**COST EFFECTIVENESS**

24. How are project/programme resources distributed? (Admin versus programme costs)
25. 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)
26. To what extent are available resources adequate to support delivery of project/programme services? (Probe for adequacy of human and financial resources, equipment and supplies)
27. What are the cost saving and cost reduction measures of the project/programme? (Use of low cost, improvised substitute, engaging volunteers for some of the services, does it have an increased financial burden on beneficiaries)
28. To what extent does cost sharing take place in the project/programme? (User fees, payment of some of the services like training, transport)
29. What is included in the minimum package of the service/s provided by the project/programme? (Compare with the standard package policy for the country, procedure guides)
30. How timely is the delivery of services?

**RELEVANCE**

Note: Relevance includes the acceptability of an intervention to the community in which it operates. Thus, as a criterion, questions on relevance are asked of beneficiaries and key informants, rather than of the implementors, who are unlikely to have an objective view on this.

**REPLICABILITY**

31. How are project/programme activities and processes documented? (Get copies of reports, case studies collected, documentaries, manuals, books etc)
32. What are some of the success stories that can be shared to depict positive impact or influence of the project/ programme services on beneficiaries?
33. What are some of the project/programme challenges?
34. What are some of the lessons learnt from this project/ programme, and how have these been used to strengthen the project/ programme?
35. 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 and quantity)

**INNOVATIVENESS**

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

**SUSTAINABILITY**

39. How is the project/ programme vision aligned to current trends? (National and regional trends, epidemic, economic, developmental - political correctness- MDGs, Universal access etc)
40. 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)
41. How does the project/ programme strategy ensure financial sustainability? (Probe for information on fundraising strategies, user fee, community initiatives)
42. What do you see as the future of the project/programme?
Appendix B: SAfAIDS Score Card (Sample)

Documentation of Good Practices in Gender and HIV Programming

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

<table>
<thead>
<tr>
<th>Variable</th>
<th>Data Source</th>
<th>No</th>
<th>Almost</th>
<th>Yes – Definitely</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td>0 POINTS</td>
<td>3 POINTS</td>
<td>5 POINTS</td>
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<tr>
<td><strong>A. EFFECTIVENESS (5)</strong></td>
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<tr>
<td>1  Project/ programme/ practice complements the National Action Plan for HIV and AIDS and any International Commitments and Declarations on Gender that the country has signed up to</td>
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<td>2  Project/programme/ practice results correlate with original objectives OR practice is in line with project/ programme objectives</td>
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<td>3  There is a sense of gender balance and community ownership with regard to project/programme or practice</td>
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<td>4  Project/programme/ practice seems to have clear and effective M&amp;E procedures and impact evaluation systems in place, such that data is analysed regularly and results used to make meaningful adjustments to project/programme or practice</td>
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<td>5  Project/Programme/ practice has well articulated goal/s and target/s and clear implementation plan/s and strategies are in place to achieve the proposed objectives OR practice has a clear purpose and the reason for implementation of given practice in order to achieve programme/project goals is explicit</td>
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<td><strong>B. ETHICAL SOUNDNESS (2)</strong></td>
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Southern Africa
HIV and AIDS Information
Dissemination Service

Telling our Stories: Good Practice in Gender Programming in Zimbabwe

38
<table>
<thead>
<tr>
<th>Variable</th>
<th>Data Source</th>
<th>No</th>
<th>Almost</th>
<th>Yes – Definitely</th>
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<td>0 POINTS</td>
<td>3 POINTS</td>
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<tr>
<td>6 The practice or project/programme activities are ethically sound, e.g.</td>
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<td>with regard to: respecting confidentiality; respecting and protecting</td>
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<td>the interests of women and those affected by HIV; equitable distribution</td>
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<td>of resources</td>
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<td>7 The practice or project/programme seems to be transparent</td>
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<td><strong>C. COST EFFECTIVENESS (2)</strong></td>
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<tr>
<td>8 Project/programme/Practice is deemed cost effective with regard</td>
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<td>to cost of delivery of the project/programme services vs. available</td>
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<td>resources and degree of impact vs. input costs. O R: practice is deemed</td>
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<td>cost effective with regard to project/programme service delivery vs.</td>
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<tr>
<td>cost of implementation of practice</td>
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<td>9 Service delivery occurs in a timely manner. O R practice encourages</td>
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<td>timely delivery of project/programme services or does not hinder service</td>
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<td>delivery in any way</td>
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<td><strong>D. RELEVANCE (2)</strong></td>
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<tr>
<td>10 The project/programme or practice takes into account specific</td>
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<tr>
<td>contexts of target area/group</td>
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<td>11 Project/programme or practice activities are relevant to community</td>
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<td>needs and are socially and culturally acceptable</td>
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<td><strong>E. REPLICABILITY (3)</strong></td>
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<td>12 Project/programme can be replicated (in part or in totality) in</td>
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<td>similar contexts or adapted if necessary. O R practice can be</td>
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<td>replicated for use within similar projects/programmes or adapted if</td>
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<td>necessary</td>
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<td>13 Practice or project/programme exhibits evidence of proper</td>
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<td>documentation in terms of goals, processes, methods, evaluation, cost</td>
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<td>and resources</td>
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<td>14 Other groups and locations would benefit from the implementation of</td>
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<td>a similar project/programme or other projects/programmes would benefit</td>
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<td>from the implementation of a similar practice</td>
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<td><strong>F. INNOVATIVENESS (3)</strong></td>
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<td>15 Project/programme or practice is unique/new either in concept/</td>
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<td>implementation strategy/use of available resources/reaching</td>
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<td>beneficiaries or is new to the country/region or community</td>
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<td>16 Project/programme or practice is contributing to the base of knowledge</td>
<td>Concept Papers</td>
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<td>17 Project/programme or practice approach and systems are scientifically/</td>
<td>Concept Papers</td>
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<td>and economically sound</td>
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<td>G. SUSTAINABILITY (3)</td>
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<tr>
<td>18 Project/programme activities are sustainable (skills/knowledge transferred) and long-term plans are achievable and in line with national trends as well as development patterns of gender and HIV programming OR practice is sustainable and plans to continue practice are in line with national trends as well as development patterns of Gender and HIV interventions</td>
<td>Concept Papers</td>
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<tr>
<td>19 Project/programme or practice is financially sustainable</td>
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<tr>
<td>20 Marketing and awareness building is evident and project/programme or practice is actively and appropriately marketed to stakeholders and funders</td>
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<td>TOTAL number of questions (30)</td>
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<tr>
<td>SUBTOTALS</td>
<td>x0</td>
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<td>GRAND TOTAL (possible perfect score is 150)</td>
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<tr>
<td>PERCENTAGE SCORE</td>
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**Score Key:**

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