Evaluation Report

Name of the Programme:
Lusaka Outreach Programmes of SOS Children's Village of Zambia Trust (Family Strengthening Programme and Medical Centre)

Country:
Zambia

Implementing Agency of the Evaluation:
National Institute of Public Administration (NIPA)

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Date:
December 2007

The Cover Photo

The cover photo shows the venue for the focus group discussions with beneficiaries from Kabanana catchment area. It portrays the participatory theme of the evaluation methodology as it was undertaken with children, the youth, women and men in the four targeted communities of Chazanga, Chipata, Kabanana, and Mandevu.

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First edition December 2007:

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Table of Contents

Acknowledgement

The evaluation team was greatly humbled and appreciated the support and trust that the SOS Childrens' Village Trust National Office gave during the evaluation process. The depth and magnitude of the evaluation was a monumental one, but the profound cooperation of all the staff in general, and specifically the Family Strengthening Programme and the Medical Centre staff made the process much easier.

The team is also highly indebted to the beneficiaries in the four communities of Chazanga, Chipata, Kabanana, and Mandevu for their time and patience during the long hours of field visitations. Their information indeed made this evaluation report possible.

Lastly but not the least, thank you to the National Institute of Public Administration (NIPA) management for supporting the evaluation process.

Acronyms

ART	Antiretrol Viral Treatment
VCT	Voluntary Counselling and Testing
BCC	Behaviour Change Communication
CSO	Central Statistical Office
COVCCs	Community Orphan and Vulnerable Children Committees
CIDRZ	Center for Disease Research in Zambia
MP	Member of Parliament
FSP	Family Strengthening Programme
FDP	Family Development Plan
IGA	Income Generating Activity
NHC	Neighbourhood Health Committee
MACO	Ministry of Agriculture and Cooperatives
MCDSS	Ministry of Community Development and Social Services
MCDYS	Ministry of Child Development, Youth and Sports
MOE	Ministry of Education
RAPIDS	Reaching HIV/AIDS Affected People with Integrated Development and Support
SP	Support Programme
HBC	Home Based Care
JICA	Japan International Cooperation Agency
UN	United Nations
UNDP	United Nations Development Programme
UNICEF	United Nations International Childrens'Educational Fund .
UNAIDS	United Nations AIDS
WHO	World Health Organisation
HBC	Home Based Care
NGOs	Non Governmental Organisations
CBOs	Community Based Organisations
OVC	Orphans and Vulnerable Children
CCF	Christian Children Fund
PTA	Parents and Teachers Association
FGD	Focussed Group Discussion
PRA	Participatory Rural Appraisal
RPA	Rapid Participatory Approach
PAM	Programme For The Malnutrition
LCMS	Living Conditions Monitoring Survey
DHS	Demographic health Survey
VTC	Vocational Training Centre
CS	Community Schools

EXECUTIVE SUMMARY

Introduction

This evaluation was an attempt to measure the impact the Family Strengthening Programme and Medical Centre had made with a view to draw lessons learnt and recommend a way forward. The specific objectives of the evaluation were: (1) To assess the impact the programmes made in the lives of the participating children within the target group, their families as well as in the community; (2) To establish the relevance, effectiveness, efficiency, sustainability and how participatory the programme interventions were; and, (3) To identify the lessons learnt from the programmes that could be taken to further develop the programmes.

This therefore meant that the evaluation required a programme and project document review, brainstorming and participatory consultative sessions, and meeting informants in the communities. These were undertaken. This called for professionalism and openness on the part of both the evaluation team and the client. Consequently, there was active participation of all key stakeholders in the evaluation process.

Methodology

The evaluation used a qualitative management and operational research study methodology that engaged a rapid participatory assessment and consultative approach whose output was expected to inform current and future practice. The rapid participatory assessment technique applied focus group discussions (FGD), social and service mapping, timeline, wealth ranking, individual in-depth interviews, and questionnaire interviews to collect the data. There were equally consultative meetings, stakeholder meetings, and desk reviews.

The study sites for the evaluation were four compounds; namely Mandevu, Chazanga, Kabanana, and Chipata. These were selected for the evaluation because the 103 targeted beneficiary households were in these areas at project inception in 2002.

Study Findings

The study findings showed that targeting beneficiaries was well defined and conformed to nationally conceived criteria that identified the vulnerable as such. The FSP had followed this up with an assessment of recruitment that rigorously identified beneficiaries with community involvement. On the health part, it was observed that generally the Medical Centre dealt with primary health care, HIV and AIDS and TB awareness, prevention and treatment programmes, child immunizations, nutritional programmes for the mulnourished children and AIDS terminally ill, health education, and home based care. All the beneficiaries in the communities who were on the FSP accessed the medical services at subsidized costs.

The evaluation results indicated that the FSP education support component had integrated and re-integrated children in the supported households. It was also worth noting that the gender balance was being addressed in the support school, for instance, re-integration of pregnant girls and enhanced enrolment of girl children. Similarly, it was observed that in the first 103 households, three (3) children out of the five (5) that completed their grade twelve (12) were in the university studying degree programmes. It was also revealed that the education school support was working closely with other partners to secure scholarships for tertiary education. Other than those children under the FSP supported households, there were some children that had benefited from FSP through the school support programme to community and government schools.

Child rights issues and para-legal training were part of the broad interventions delivered to the beneficiaries of which 271 households were targeted. From these households, 120 children (62 girls and 58 boys) were trained. The number of adults that were under the training included 176 women and 4 men. The trainings took workshop approaches.

Furthermore, the beneficiairies were empowered and benefited in the following areas; (i) Title deeds sensitisation campaign and subsequent gazetting of the Chazanga and Kabanana townships as legal settlement areas, (ii) Training for life skills transformation workshops, (iii) Community Home Based Care, (iv) Sport (training and formation of under 14, 17 and 20 clubs registered with Football Association of Zambia), (v) HIV and AIDS awareness campaigns, (vi) ART, (vii) Paralegal training, (viii) School support programme to government and community schools, (ix) Establishment of community

resource centres, and (x) 2005 rice relief programme on behalf of the government response to the famine.

Lessons Learnt

The operational lessons learnt were as follows;

a. It would be much easier to evaluate a programme with a clear documented SOS organisational policy guideline than one with none.

b. There was need to increase budgetary allocation on economic support if signifcant impact was to be made.

c. There was need for increasing budgetary allocation on long term capacity building activities (care giver focussed and educational scholarships) than short term interventions (medical schemes, household improvement and food parcels).

d. There are households that may require more than 5 years of interventions to exit from the programme and therefore needed individualised interventions in order for them to be self sustaining.

e. There was need for general food assistance during the pre-harvest season because there are households which were unable to be food secure throughout the pre-harvest famine period.

f. A balanced staff – beneficiary ratio enhances close programme implementation monitoring through frequent home visitations (i.e. unlike the 4 social workers to 2014 beneficiaries or 1 to 503 ratio).

g. Some interventions such as IGAs, food security, and paralegal required specialised skills and experience if they were to make significant impact on the households.

h. Clear objective output, outcome and impact indicators enhances tracking progress of household empowerment interventions.

i. Community capacity building in preparation for community involvement and project ownership requires more investment i.e. leadership and project management training, awareness raising projects, and adequate budgetory provisions.

j. For every project intervention to be effective and impact making, it needs to go hand in hand with beneficiary motivation and confidence building and mentoring in order to facilitate their meaningful participation in the wider society.

k. Medical Centre preventive interventions are more cost effective than curative interventions.

l. Services offered by Medical Centre would reach more beneficiaries in the far flang catchment areas like Kabanana if offered through outreach programmes such as mobile clinics.

Recommendations

Based on the evaluation findings, the evaluation team recommends the following;

a. There is need for a permanent position at National Office to offer technical support and quality control monitoring to both the Medical Centre and FSP.

b. The National Office should assist the Medical Centre to develop a comprehensive monitoring and evaluation system.

c. There is need to increase the field officer staffing levels within the FSP and futher train them in driving to ease mobility.

d. There is need to either employ specialist staff in IGA, food Security, and Para-legal or build capacity among the existing field officers.

e. The procurement office should be transfered to be under the National Office though functioning at location level and further increase its staff compliment to include two procurement officers and a stores person.

f. There is need to diversify and recapitalise the household IGAs in accordance with household sizes.

g. There is need for continuously close monitoring and mentoring of household IGAs.

h. There is need to enhance the initiated practice and use of organic fertiliser as against chemical fertiliser.

i. Food assistance should be considered for some households in the pre-harvest famine period.

j. There was need for enhanced motivational and confidence building, support and mentoring to households and youths.

k. There is need to re-evaluate the budgetory allocation to care-givers and community capacity building interventions.

l. The households that are in the 36% category of worst case scenario need vulnerability re-evaluation and individualised interventions.

m. There was need to re-evaluate the budgetory allocation to property household improvement to enable more households to be reached.

n. There was need to have an SOS organisational policy guidelines on the Medical Centre.

Chapter One

1. INTRODUCTION

1.1 Orphans and Vulnerable Children (OVC) Situation Analysis

Sub-Saharan Africa remains the global epicentre of the AIDS pandemic with 24,5 million adults and children living with HIV and in general no clear signs of declining HIV prevalence but two countries - Kenya and Zimbabwe (UNAIDS/WHO, 2006)

The impact of HIV/AIDS is most profoundly reflected in the lives of children, whose very survival and development are at stake. Globally, 2.3 million children are living with HIV. Currently, children under 15 account for one in six AIDS-related deaths worldwide and one in seven new HIV infections – the vast majority through mother-to-child-transmission of the virus. Over 15 million children have lost one or both parents to AIDS. Most of the children orphaned by AIDS live in developing countries, the vast majority of them in Sub-Saharan Africa. As the infection spreads, the number of children who have lost parents to AIDS is beginning to grow in other regions as well, including Asia, Latin America and the Caribbean and Eastern Europe. Although the impact of HIV/AIDS to date has already been catastrophic, the worst is yet to come (UNAIDS/WHO, 2006; UNICEF, 2005).

Zambia is not an exception from the duo scourge of poverty and HIV/AIDS that had led to increased cases of orphans and vulnerable children (OVC). With a total national population of 10.3 million people, 45.2% of the population is below 15 years of age. It was estimated that in the year 2004, over 917, 718 people in Zambia were living with HIV and that about 93670 deaths were as a result of AIDS per year *(CSO;HIV/AIDS epidemiological projections 1985-2010; January 2005).* In general death lags behind HIV infection by about 10 years, so even in a country where HIV prevalence has declined, orphan numbers remain high. Even with unprecedented global attention on the AIDS pandemic, the orphan crisis will persist for years.

Though Zambia's economy is gaining feet due to increased investment and production in the mining sector coupled with debt cancellation, the number of people trapped in poverty has remained high. For instance, the 2000-2003 Living conditions monitoring Survey (LCMS) from the Central Statistical Office (CSO), states that approximately 67% of Zambian households are

poor (unable to afford basic food and non-food items). Attempting to grasp more fully the depth of poverty in Zambia, the Ministry of Community Development and Social Services (MCDSS) undertook a number of small surveys in 2003 that studied primarily household food consumption and ability of households to work. From this survey, 400, 000 households in Zambia were found to be moderately poor while 600, 000 households were critically poor. These MCDSS estimates help separate the approximately 2,000,000 Zambian households into the following 5 categories:

1. Moderately poor and viable- 300, 000 households;
2. Critically poor and viable- 400, 000 households;
3. Moderately poor and incapacitated- 100, 000 households;
4. Critically poor and incapacitated – 200, 000 households (10% destitute households);
5. Non poor (viable or incapacitated)- 1, 000, 000 households.

The 200, 000 destitute households in Zambia are likely the ones most affected by HIV/AIDS related deaths, with women, children and elderly caring for numerous orphans.

1.2 SOS Children's Village Zambia Trust

SOS Children's Village of Zambia Trust is part of the worldwide independent, non governmental and social development organisation that has been active in the area of children's needs, concerns and rights since 1949. Its activities focus on neglected and abandoned children and orphans, as well as other disadvantaged families. In 1996 it registered its presence in Zambia as a family based child care organisation for children who had lost the care of their own family and is based on the SOS family child care model. In 2002 the Lusaka Outreach programmes under the names Social Centre and Medical Centre were developed and began operations on a pilot basis. The social centre has since been transformed as the Family Strengthening Programme (FSP), a community based child care intervention aimed at the prevention of child abandonment. This is in seeking to work toward the vision of a world where "*every child belongs to a family, and grows with love, respect and*

security."[1] On the other hand, the medical centre is a primary health care programme / facility offering services to both the SOS village and the surrounding communities of Chazanga, Mandevu, Chipata, and Kabanana.

1.3 Objectives of the Evaluation

In cognisance of the two programmes having been operational for at least three years, this evaluation was an attempt to measure the impact these two programmes had made with a view to draw lessons learnt and recommend a way forward. The specific objectives of the evaluation were:

1. To assess the impact the programmes made in the lives of the participating children within the target group, their families as well as in the community.
2. To establish the relevance, effectiveness, efficiency, sustainability and how participatory the programme interventions were.
3. To identify the lessons learnt from the programmes that could be taken to further develop the programmes.

1.4 Overall Evaluation Process

In order to meaningfully review and evaluate the performance of the Family Strengthening Programme (FSP) and the Medical Centre, there was need for an understanding and appreciation of the past and current programmatic practices that gave the frame conditions such as the strategic plan, institutional arrangements, social and economic conditions, human dynamics, programme indicators, and the overall international and local policy dimensions affecting the programmes.

On the other hand, the exercise involved a close scrutiny of the programme structure and management arrangements in order to establish the reporting mechanisms within SOS, the Government, Donors and Communities. The main aim from this was to determine and gain information on how things were working and provide guidance for the future.

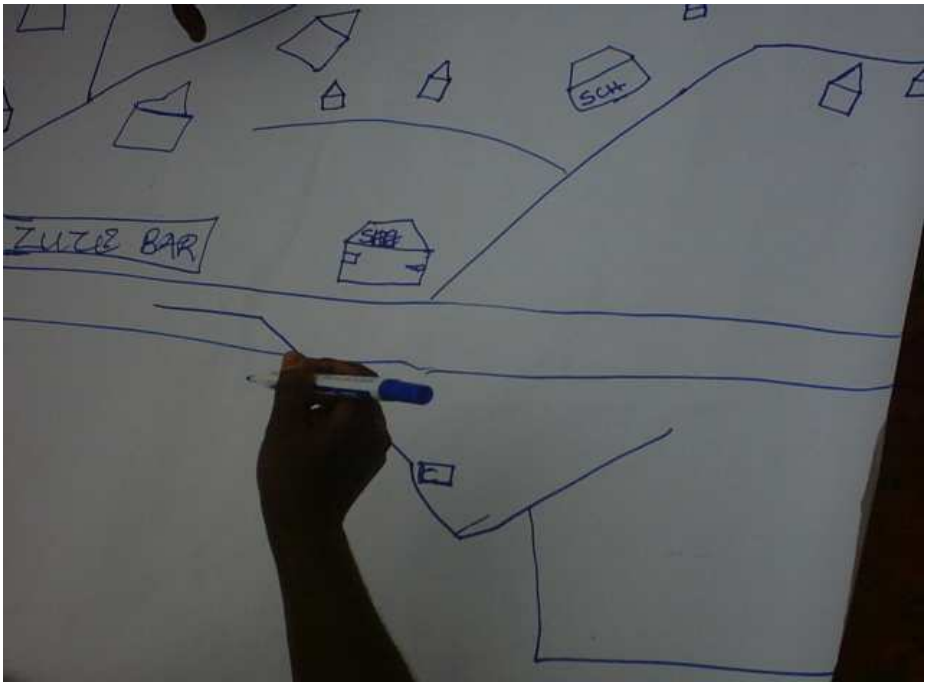
[1] SOS Mission Statement

This therefore meant that the assignment required a programme and project document review, brainstorming and participatory consultative sessions, and meeting selected informants in the communities. This called for professionalism and openness on the part of both the consulting team and the client. Active participation of all key stakeholders was important to the success of this assignment.

1.5 Methodology

1.5.1 Data Collection Techniques

The evaluation used a qualitative management and operational research study methodology that engaged a rapid participatory assessment and consultative approach whose output was expected to inform current and future practice. The rapid participatory assessment technique applied focus group discussions (FGD), social and service mapping, timeline, wealth ranking, individual in-depth interviews, and questionnaire interviews to collect the data. There were equally consultative meetings, stakeholder meetings, and desk reviews.



Beneficiaries drawing a social and service map in Kabanana

1.5.2 Study Sites

The study sites for this evaluation were four compounds, namely Mandevu, Chazanga, Kabanana, and Chipata. These were selected for the evaluation because the 103 targeted

beneficiary households at project inception in 2002 were all in these areas. This therefore meant that the respondents could only be drawn from the 103 households. Community meetings were held in all the four sites where FGDs and other rapid participatory assessment tools were used. Participation in these meetings

Table 1

Townships	Number of supported Households	Number of Individuals in the Household	Supported Primary School Children	Supported Secondary School Children	Supported Trades Training Students
Chazanga	23	156	88	6	14
Mandevu	30	211	63	4	24
Kabanana	26	161	63	1	3
Chipata	24	174	71	4	9
Other	-	-	13	2	-
Total	**103**	**702**	**298**	**17**	**50**

Source: *SOS Children's Village of Zambia, Social Centre Progress Report June 2003*

1.5.3 Sources of Information

Information was collected from a wide segment of informants in the study sites and at SOS Children Village. These included National Director, Deputy National Director, SOS staff, community committees, beneficiary community members (men and women, children both boys and girls), gatekeepers, community mobilisers, and institutional partners.

1.5.4 Arrangements for Field Data Collection

The field data collection was intensive as it required sufficient time with informants. All field visits by the evaluation team to the informants were arranged at least 24 hours in advance courtesy of the SOS FSP Coordinator and Community mobilisers.

1.5.5 Description of the Study Sites

The study sites or targeted compounds were situated in the surrounding areas of SOS Children's Village Zambia Trust. Mandevu lies on the South while Chazanga borders SOS Children's Village on the Northern part. Kabanana is situated North – East of the Village and

Chipata is on the Eastern side. These compounds are similar in nature and share a number of characteristic features such as very high density shanty compounds populated by largely very poor families.

Due to high levels of poverty, most families are unable to provide for their basic needs and thus children were normally forced to both leave school and start petty trading or simply beg on the streets. Furthermore since the families were more concerned with meeting the basic needs, their children's educational needs and family medical care became secondary and were perceived as luxuries.

The devastating impact of death due to HIV and AIDS and other related infections, which usually targets family bread winners, had left many families either headed by children or an elderly relative usually a grandmother. The entire area has a population of 90,000 or more people but only serviced by two government clinics, which are understaffed and under supplied with medicines. The absence of a functioning social/medical support programme by the government has led to many vulnerable people having no access to medical care.

Table 2 below gives the characteristics of the populations in the study sites.

Table 2

COMPOUND	*POPULATION*	*# OF H/HOLDS*	*# OF H/HOLDS WITH ORPHANS*	*# OF ORPHANS*	*# OF WIDOWS*	*# OF GRANNY HEADED H/HOLDS*	*# OF CHILD HEADED H/HOLDS*	*# OF AUNT/UNCLE HEADED H/HOLDS*
MANDEVU	33,169	6,189	358	720	187	80	29	62
CHIPATA	35,385	6,453	729	1,097	419	141	68	101
KABANANA	9,448	1,554	438	692	230	109	29	70
CHAZANGA	11,242	2,104	579	1,596	304	138	48	89
TOTAL	***89,244***	***16,300***	***2, 104***	***4,106***	***1,140***	***468***	***174***	***322***

Source: *SOS Children's Village of Zambia, Social Centre Survey 2002*

1.5.6 Limitations and Constraints of the Evaluation

The evaluation findings were evidence based and addressed all areas of concern which the evaluation team collected and observed. However, the conclusions drawn could have been hampered by limitations and constraints encountered during the data collection exercise. Key

among the limitations was that the evaluation exercise was undertaken during the month of December when the rains were heavy thereby working to the detriment of the data collection. Movements were limited and proper planning of the timings became a game of chance.

Apart from the fact that the time allocated for the whole exercise was very short, some valuable information was received at the time of report writing and this implied information could not be triangulated with the caregivers and children as the FDGs with these groups had already been undertaken.

Male caregivers were visibly absent from the caregiver FDGs as only two of them attended, one in the Chipata FDG and the other in the Kabanana FDG. The information therefore could be gender biased. Another limitation was that SOS staff went on the festive break thereby disturbing their well deserved rest as the evaluation team had to call on them in the consolidation of data and collaboration of certain facts. Since the evaluation was designed to establish the impact of the programmes on the beneficiaries from the year 2002 to 2007, the beneficiaries appeared not to have certain information on the finger tips and thus relied more on guess work or memory. Furthermore, it was very difficult to exclusively isolate the 103 households in making generalisations as beneficiary numbers had risen to 271 households.

1.6 Evaluation Team

Given the complexity of the assignment, the National Institute of Public Administration (NIPA) brought together a team of experts to execute this evaluation. The team comprised the following:

i) **Nixon Chisonga** – Principal Consultant and Team Leader;
ii) **Patson Kaluba –** Social Worker and Team Advisor
iii) **Justine Chilufya Chileshe** - Finance Consultant and Team Member;
iv) **Dr. Nhandu Venerandah Lwiindi** – Medical Consultant and Team Member;
v) **Benny Sidono** – Programme Evaluation Consultant and Team Member; and,
vi) **Carolyn Chibinga** – Research Consultant and Team Member.

In the execution of this assignment, the evaluation team committed themselves to the following ethics/principles:

i) Impartiality and Independence;

ii) Consultation;

iii) Objectivity;

iv) Professionalism;

v) Confidentiality; and,

vi) Fairness.

Chapter Two

2 PROGRAMME DESCRIPTION

2.1 Programme Scope

2.1.1 Location

The SOS Children's Village of Zambia Trust is situated 6km from Lusaka central business district on the Great North Road. In order to enhance the total development of a Child, SOS Children's Village at its location, runs various projects like the Kindergarten, Primary and Secondary Schools, Vocational and Skill Training Centre, Medical Centre and Family Strengthening Programme. The Lusaka outreach programmes are implemented in the communities of Chazanga, Chaisa, Chipata, Garden, Kabanana and Mandevu. This evaluation was aimed at the Medical Centre and the Family Strengthening Programme interventions in the four communities of Chazanga, Chipata, Kabanana and Mandevu.

2.1.2 History and Current Status

The family strengthening programme is a relatively recent initiative to the SOS work and was developed in 2002 as a social centre implemented as a community intervention aimed at children at risk of losing the care of their families. At inception in 2002 operating as a social centre, it began with 34 children under the guidance of one social worker. After a vulnerability assessment survey of 2002, the recruitment of more beneficiaries made the list grow to 103 households by early 2003. As the enlisted beneficiaries grew with time so was the need to re-think the structural capacity of the social centre. More social workers were therefore recruited in 2003 and the trend continued bringing the number to six (6) as at 2007. The beneficiaries also grew from the 103 households in 2003 to 278 households in 2007.

2.1.3 Duration

A review of programme and project documents does not show a clear timeframe of the existence of the FSP and the medical centre as most of them are 2007 policy frameworks. However, it became clear through interviews that the FSP was a pilot programme that has existed since 2002.

2.1.4 Beneficiaries/Participants

The primary beneficiaries or participants for the family strengthening programme are orphaned and vulnerable children looked after by either fellow children or very old grand parents in high density shanty compounds surrounding the SOS Children's Village premises in Lusaka. The population of surrounding shanty compounds is estimated at over 90,000 people.

2.1.5 Budget Summary

The budget information was that a total of 7.1 Billion ZMK (about 1.7 Billion US$) was expended for the operational costs of the FSP and Medical Centre since the commencement of the programmes in 2002 to 2006. However, this was within a total budget of ZMK 7.7 Billion. In Kwacha terms, the expenditure was within budget, but in Dollar terms due to exchange fluctuations, there had been an apparent under funding of US $75,446 as per SOS management accounts as at December 2006.

2.2 Programme Objectives and Activities

The objectives and activities of FSP and medical centre included:

2.2.1 Family Strengthening Programme

To main objective of the family strengthening programme, is to assist alleviate negative impact of poverty and mitigate conditions that lead to the situation of street children and orphans. The programme employs a two pronged strategy, namely;

- to assist deal with the short term impact and effects of poverty and disease,

- while also supporting initiatives that lead to long term mitigation of the negative consequences of these factors.

The focus of the support activities are to:

i. Carefully identify needy children and grand mother headed households in the high density shanty areas surrounding the SOS Village in Lusaka.
ii. Provide supplementary household budget support.
iii. Provide household development support for child education, economic activities and property improvement.
iv. Provide psycho-social counseling for traumatized children and HIV and AIDS affected and infected households.

2.2.2 Medical Centre

The main objective of this support is to provide clinical and laboratory treatment/services, to provide primary health care and an HIV and AIDS awareness and care programmes.

The areas to be covered under the primary health prevention and education programme are to:

i. The activities based on the above objectives were HIV and AIDS and sexually transmitted diseases (STDs) awareness education and counseling.
ii. Child Health and growth monitoring including under five Clinic immunization.
iii. Nutrition and health – Theory and practical.
iv. Hygiene and Sanitation – personal, public, environmental issues.
v. Reproductive health education for Youths especially family planning, among others.
vi. Prevention of communicable diseases – Theory as well as Practical.
vii. Specifically for HIV and AIDS affected families, in addition to the general awareness creation, there is support aimed at supplementary feeding and counseling through the family strengthening programme.

2.3 Programme Planning, Monitoring and Evaluation

2.3.1 Applied Planning

The planning of the Family Strengthening Programme takes into consideration the resources at its disposal including the building facilities for office use and staff houses as well as storage containers. The other aspect is transport, specifically looking at the appropriate mode due to the nature and scope of operation and catchment area. Motorbikes, bicycles and small trucks/vans are often planned for. Office equipment is another resource area planned for and included one computer each for the Coordinators and for every two field workers, among other office requirements.

2.3.2 Monitoring and Evaluation Processes for Programme Implementation

The monitoring is done at two levels – the formal and informal. Formal monitoring includes monthly, quarterly, and annual reports. Quarterly meetings are held at National level where as there are monthly at project level to capture field visit reports from field workers and community reports.

The informal monitoring only serve to bring out valuable information which might remain imbedded in formal discussions. In addition, the community had the responsibility to monitor the programme.

On the Evaluation, the key Principles followed are;

i. Local people are active participants –not just sources of information
ii. Stakeholders evaluate while outsiders facilitate.
iii. Focus on building stakeholder capacity for analysis and problem –solving.
iv. Process aimed at building commitment to implementing any recommended corrective actions.

2.4 Management Structure of the Programme

The Family Strengthening programme and Medical Centre are managed within the National Office of the SOS Children's Village Zambia Trust. The management structure of the programmes is made up of the National Director, the Deputy National Director, and facility heads that include the FSP Coordinator, Medical Coordinator, Education Coordinator, and Kindergarten Coordinator.

2.5 Programme Human Resource Staffing Patterns and its Implementation Partners

The FSP and Medical Centre have a staff compliment of nine (9) and twelve (12) respectively, as at December 2007. The staff were on permanent and pensionable employment except for the driver, who is on one year renewable contract. Where implementation partners second staff to the two programmes, they work and follow the programme hierarchy and general framework while following the implementation partner guidelines.

2.6 Guiding Philosophy Influential to Programme Development

SOS pioneered a family based child care for children who had lost the care of their biological families. Over time though there was a realisation that many more children in the communities were at risk of losing the care of their biological families due to several reasons, among them was the HIV and AIDS scourge. In this sense the FSP was conceived to be a community and child welfare programme. The understanding was that children were vulnerable and voiceless. Therefore, the first line of intervention was thought to be the strengthening of families as a way of preventing child abandonment. Families could only be strengthened by equally taking care of their health – this brought in the medical centre.

The founder of the SOS Children's villages put it rather that "A global welfare network like SOS Children's Villages can only remain alive and dynamic if a continuous effort is made to respond to changing conditions in the society involved and to accept new challenges in the interest of the welfare of the children. With this ongoing process of adaptation to the various social realities of the world, the work of SOS Children's Villages will continue to lead to targeted developments in the facilities and services offered."[2]

[2] Statement by Hermann Gmeiner, Founder of SOS Children's Villages

Other instruments that would have been influential to programme development include international human rights protocols as championed by the United Nations. The UN Convention on the Rights of the Child in its preamble states that "The family, as the natural environment for the growth and well-being of children should be afforded the necessary protection and assistance so it can fully assume its responsibility within the community." This overall framework is what FSP and consequently the medical centre had followed working within a vision were "*every child belongs to a family, and grows with love, respect and security*."[3]

[3] UN Convention on the Rights of the Child, Preamble

Chapter Three

3 EVALUATION RESULTS

3.1 Targeting

3.1.1 Target group

Targeting is always a critical exercise. An organization may have a very good programme but if it fails to reach the correct target, its efforts would be displaced and its intentions defeated. The poor are not a homogenous group and are defined as people who do not have adequate access to basic human needs, particularly food, water, health, clothing, shelter and education. Therefore, for organisations dealing with the poor and vulnerable households;

> … the target groups are those who are unable to access adequate livelihoods without external support and who are incapable of withstanding shocks. They have no assets, have limited productive capacity due to their circumstances, normally suffer from socio-political exclusion, that is, do not have any credibility, voice or platform in their communities partly due to low self-confidence, and are dependent on public and/or private transfer of resources.[4]

This is generally the same definition that the Zambian Government uses in its Public Welfare Assistance Scheme (PWAS); a definition that was arrived at through a national consultation with the communities, a process that is highly regarded as necessary for improving targeting (UNICEF 2004:12,26; Save the Children UK et al 2005:36,37). The PWAS Identification Matrix (MCDSS, 2003) outline three (3) categories (also known as qualifiers) that must be taken into consideration in assessing and qualifying vulnerable people for social welfare assistance. These qualifiers describe social, economic and other characteristics of the person or household.

Generally, these characteristics were in line with what the FDGs with children of the FSP beneficiaries outlined as characteristics that describe a poor person.

[4] Oxfam GB (2006)

Box 1 below gives the definitions (as outlined by the children) of who a poor and a rich person is. It should be noted that this definations are mostly from their own experiences.

Box 1: Descriptions of What Characterizes Poverty and Wealth as Espoused by Children Participating in the Focus Group Discussions

	Poverty Definition	Wealth Definition
Chazanga	• they beg from their neighbours (kumpempa ba neighbour), • sleep on empty stomachs (bagona na njala), • sponsored at school (by well wishers), • piece work, • street kids, • eat once a day (kudwa kamozi), and • can not manage to provide for the family (sakwanisa kudwesa banja).	• those who have big houses in wall fences (manyumba akulu mugate), security guards, vehicles (mamotoka), • They are liked by people (bantu bamu konda bambili), • more money (ndilama zambili), • fat, • have many shops (mashop), • things are not difficult (vintu sivivuta), • has bars (mabar), • their houses have running water and many taps of water (mapompi yamanzi), • their children are driven to school (bana kusikulu baba peleka na mamotoka), • their children do not do house work (siba gwila nchita).
Chipata	• the lack of wealth, being not wealth – an implication of poor	• Some pointed out that it meant the wellbeing of a person, • while others said it was managing to take care of people. • There was yet another view that suggested wealth was anything that an individual owned,.
Kabanana	• Lack of basic needs • Lack of education • No shelter • Torn clothes (vovala va mama gamba) • Thin looking (aoneka ku yunda) • Plans finish • No human rights • One meal a day • Begger • Street kids • No support from family	• Manage everything (akwanisa vonse) • Provide basic needs to the family • No problems (alibe ma problem) • Has houses (ali na manyumba) • Own public companies • Running big businesses • Work in government where pay is good • Has many vehicles (bali na mamotoka yambili)
Mandevu	• as ovutika or osauka. • They sleep on the floor (magona pansi), • They do not have blankets (balibe mablangent), • no floor in their homes (mulibe floor munyumba), • no food (balibe vokudya), have no houses (balibe banyumba, bachita lent), are without shoes (balibe mansapato), do not go to school (sibaenda kusukulu), no food, and bergers (bapempa pempa).	• Chinondo, kulemela, or rich. • a person with money (ndilama), • vehicles (mamotoka), • houses (manyumba), • fridges (mafridge), • TVs (maTV), • beds (mabed), • sofas (mamipando), • matrices, blankets (mablangent), • shops (mashop), • clothes (vovala), clocks and watches (mankolonko), radios (vilimba), cell phones and land phones, DVDs and CDs.

Source: Field Data

The FSP programme did attempt to take care of the above mentioned characteristics at the inception of the programme as indicated in the Household Vulnerability Assessment and

Nomination of Households Support Facility document (2002). The FSP targeted clients are thus households headed as follows:-

- Households headed by the aged/grand parents;
- Households headed by children (siblings);
- Households headed by the *Terminally ill;*
- Households headed by widows;
- Households headed by persons unable to work.

It should be however noted that in HIV and AIDS programming, issues of stigmatisation are cardinal. The categorisation of the chronically ill as *"the terminally ill"* is being defeatist. It carries a connotation of resignation to one state. This is the same attitude that gets portrayed in the children when they are repeatedly called Orphans and Vulnerable Children (GRZ, 1999:12, 13). One of the key informants interviewed at Breza Engineering[5] did testify to this fact in that some of the youths carried this stigmatisation to an extent that they wanted incompetence to be tolerated just because of their background of poverty and economic difficulties. The interviewee explained that it is important that the FSP should inculcate self-esteem in the orphans and children from the vulnerable households so that they could consider themselves as valuable persons who could "fly" and accomplish things just like any other children.

3.1.2 Vulnerability Factor

The examples and definitions of groups of poor given in the data from Children FDG (Box 1) imply a certain vulnerability that the FSP beneficiaries suffer from. However it is not true that all poor people are vulnerable. As a DFID (undated:1) definition puts it "Vulnerability is not the same as poverty, although poor people are necessarily vulnerable, but not all vulnerable people are poor". The SOS Family Strengthening Programmes Manual (2007:9) indicates the method which the programme beneficiares are identified and targeted as:

[5] This is one of the organizations that SOS FSP collaborates with on youth employment and field attachment for its Vocational Centre graduates.

Our programmes are targeted at those children who are most at risk of losing the care of their biological family. This means identifying a clear target group and then focusing on those children who are living in the most vulnerable circumstances".

Further SOS FSP (2007:9), acknowledges that;

Factors increasing the risk of family breakdown and separation of children from the family vary according to different community settings." As a result "Specific issues that increase vulnerability of children and their families shall vary from community to community. For example, according to social status; gender; age; ethnicity; health status; location or type of home etc. Therefore, vulnerability criteria are developed in consultation with community members, including children from our target group as well as their care-givers.

The household vulnerability assessment conducted as part of the evaluation indicate that high levels of vulnerability for the households on the FSP still exists (Box 2). The findings from the vulnerability assessment show the relevance of the interventions the FSP is providing. This outlook and approach agrees with the MCDSS approach that is not only community-generated, but also allows communities to include what they deem describes the poor. SOS FSP (then known as Social Centre)'s involvement of the Community Orphan and Vulnerable Children Committees (COVCCs), schools and other community based organizations (CBOs) to spearhead the identification of potential beneficiaries (SOS 2002:2) agrees with this principle. The report does indicate that the verification process was done by the then Social Centre Social Worker. This too is cardinal in ensuring that the vulnerability criteria are adhered to.

Box 2: Summary of Household Vulnerability Assessment Observations

1. INCOME GENERATING ACTIVITIES

In the majority of the households visited, businesses have either closed down or are petty vegetables, tomatoes, onion and charcoal selling. Others earn a living through Piecework and stone crushing. They lack money to either start or expand their businesses. The cause of this include among others; unemployment, ignorance on where to get loans, high interest rates and harsh conditions applied when one fails to repay a loan.

2. INFREQUENT MEALS

Very few households manage to buy a 25 kg bag of mealie meal. Most households buy "**Pamelas**'' (2.5 kg packed mealie meal). Some children from these households feed from the Community Home Based Care centers where they are provided with breakfast and lunch and only come home to sleep. As for those not under this programme, they go without the two meals of the day and only have supper, sometimes they spend the whole day without any meal. Their meals often comprise nshima with okra and /or vegetables.

3. INADEQUATE KITCHEN UTENSILS

Poor quality and inadequate kitchen utensils such as pots, plates and washing basins characterize most of these households. Some families have even devised washing basins by cutting open the cooking oil containers.

4. BEDDINGS

Some households have few torn blankets shared among the family members. In no vulnerable household visited was there a situation where each person did not share a blanket with another person. Those who do not have any blanket use **"Chidakanya"** which is patchwork of different pieces of clothes sewed together. Most households have no beds and if they are there, they have no mattresses.

5. LACK OF CLOTHES

Few dirty and rugged clothes with many having no jerseys and shoes.

6. SCHOOL DROP OUTS

More than three quarters of the households visited have school dropouts from different grades. The coping strategy for some households has been to take the children to neighboring community open school. It was also observed that there was lack of awareness on the new deal Government policy of allowing primary school pupils to go to school without paying fees and non compulsory buying of uniforms. Some parents not sending children to school claimed of having no money for school fees and uniforms.

7. POOR HOUSES

Most houses have weak structures characterized by cracks, mad walls and floors, absence of windows, few rooms in comparison to the number of occupants, drum made roofs. They are mostly owned except a few rented.

8. LACK OF PROPER SANITATION

Most households have no toilets, bathrooms or pit-latrines. The cause for this, range from irresponsible landlords, lack of resources and land to build toilets. Consequently, these people use neighbours toilets or near bushes. The materials used for constructing the latrines are sacks, plastics and scraps of metals, unroofed and mad floors. The height is very low depriving users their privacy.

9. SICKNESS

Most households have sick persons suffering from different diseases, but malaria and T.B cases are more prominent.

10. POVERTY

Poverty in these households is exacerbated by theft, unemployment, loss of productive breadwinner, retrenchments, prolonged sickness and drunkenness.

11. OVC PROBLEM MANAGEMENT

Efforts to address or reduce the negative impact of OVC related problems have been made. However, it was observed that most of the efforts made are initiated by outsiders e.g. donors and NGO's. Residents need to be proactive and start to take responsibility of their own problems.

12. COPING STRATEGIES

The coping strategies employed by the orphaned households are clearly short term measures and do not interdict the problems in the long run. Most of the copings strategies are not employed at community level. There is therefore, a need for the community members to strategize on long-term community development activities
in order to eliminate the problems they are faced with.

(13) HEALTH PRACTICES

There are currently a lot more unhygienic health practices in the households than are hygienic ones. Obviously, household members need to be educated on the dangers of such unhygienic health practices in order to avoid disease outbreaks. Therefore, there is need to embark on an extensive health and hygiene education through training of local Community health and hygiene promoters and COVCC.

14 COMMUNAL SANITARY FACILITIES

There is need to consider construction of communal sanitary facilities in places where there is no adequate space for individual latrines.

Source: Field Data

3.2 Children's Access to Essential Services

3.2.1 Health support

The FSP provides medical support to the beneficiaries on the programme. The Medical center also provides services to members of the community from the surrounding areas of Chazanga, Chipata, Kabanana and Mandevu compounds of Lusaka. However the medical center is not the only medical facility in the catchment area as there are two other facilities.

The major threats to health in Zambia are Malaria, Child Health and Nutrition, Reproductive health, HIV and AIDS and STIs, Tuberculosis, and water and Sanitation (ITGFHW, 2002). Of these health threats, Malaria is the leading cause of hospital attendance in Zambian medical centers (CSO, 2005). The report indicate that forty percent of all persons that reported illness in Zambia had either Malaria or fever. The SOS baseline survey(2002) revealed that the communities had poor sanitation and most people in the households were suffering from a number of diseases hence justifying the relevance of establishing of the Medical center. The disease pattern reported by the care givers and the children from the Focus Discussion Groups was the same as the national, with malaria is still topping the list.

Data from the SOS medical centre registers lists the most common illness that beneficiaries report for treatment in order of frequency as :

1. Malaria
2. Respiratory tract infections
3. Diarrhoea diseases
4. Skin infections
5. Surgical cases

Source: Field Data

From the above disease burden, it shows that the frequency of diseases is still the same as illustrated in the national trends and as reported by the community. However where as the disease burden is still the same, the project had mitigated in that individuals who are on the FSP recieve medical support now which they could not afford before the intervention was introduced. The arrangement is that FSP meets all the medical costs incured at the health center on behalf of its beneficiaries. Considering the data from the Medical center, the following statistics were provided;

Number of beneficiaries identified needing support 20,000
Number of children under FSP attending medical centre for treatment per year – 600
Total number of new attendance-5000
Percentage of attendance attributed to the target group = 12%

Source: Field Data

The medical center offers the following servces;

- Primary health care
- HIV/AIDS and TB awareness, prevention and treatment programmes
- Child immunizations
- Nutrition programmes for the malnourished children and the AIDS terminally ill.
- Health education
- Home based care

Source: Field Data

The findings from FDG revealed that the above services were adequatly provided for by the Medical center and the clients expressed satistifaction on the services provided.

HIV and AIDS Programme

The HIV and AIDS programme was limited to raising awareness, health education and Voluntary Counseling and Testing for the period 2002 to 2007. The table below shows tha HIV and AIDS and ART activities at the centre. All the clients that needed treatment after VCT were referred to other Medical facilities for further management. The ART Programme was only introduced in Novermber 2007 and is done in partnership with Center for Disease Research in Zambia (CIDRZ)[6] .The partner provides all the logistics and laboratory services for CD4 count. There is an HIV and AIDS and Nutrition coordinator who is one of the registered nurses at the center. All the clinical officers and the nurses are trained in ART management and psychosocial counseling.

[6] CIDRZ is a non Governmental Organization

ART Register Details

YEAR	Counseling	Testing	Receiving results	Awaiting treatment	On treatment
2002	-	-	-	-	-
2003	-	-	-	-	-
2004	3	3	3	-	-
2005	506	506	506	217 289(NEG)	All those who needed treatment were referred to ART centre

Source: Field Data

3.2.2 Educational Support

Access to formal basic education as well as informal education is still a major challenge for larger percentage of children from vulnerable households in the Zambian society. The SOS Family Strengthening Programme activities were first implemented in four communities that had 16,300 households where there were 4106 orphans (SOS, 2002). Of these households SOS supported 103 families mainly Child-headed, Grandparent or Maternal parent headed households giving an indication that majority of the children on the FSP were actually paternal orphans. Using demographic and health surveys (DHS), Case et al. (2003) investigated the impact of orphan hood on primary school enrolments in 10 Sub – Saharan countries between 1992 and 2000. They found that orphans are significantly less likely to be enrolled in school than non-orphans of the same age, while the effect is greatest for double orphans. Bearing this in mind information from key informants shows relevance of the educational support program in that it mainly targets to support orphaned children by providing for their school requirements in different ways.

The FSP Educational Policy and Guidelines (2007) indicates that a number of educational support service are offered by the FSP. The policy provides for the provision of school

requisites by the FSP except for items such as books, pens pencils and rubbers that are only purchased in exceptional cases. Information from the Focused Group Discussions (FGD) for guardians conducted in all the four locations indicate that the FSP educational support component was meeting all the school requirements for the orphans on the programme during the first year of support. However, the FGD further indicated that from the second year of support to date, the educational support is limited to provision of shoes, school uniforms, and payment of school fees for children in partner schools where fees are applicable.

The beneficiaries indicated that they were aware of SOS policy that encouraged them to fend for the children's other school requirements such as books, pencils and ball pens though due to the extent of vulnerability they still preferred that FSP provided all the school requirements. The informants however indicated the programme still meets all school requirements for child headed households on the programme.

Table 3

SCHOOL	MALE	FEMALE	TOTAL NO PUPILS
Hg kindergarten	8	12	20
Hg basic	155	170	325
Hg high school	54	24	78
Government (grz) schools	329	313	642
Ndola school for the blind	1	0	1
Hg VTC - 2007	53	51	104
UNIVERSITY OF ZAMBIA (Bayport Zambia support)	1	1	2
Copperbelt University (100% GRZ Bursary)	1	0	1
TOTAL on EDUCATION SUPPORT	602	571	**1173**

Source: FSP November 2007 Report

Limited literature was available from SOS to explain the factors that affect school attendance by the enrolled children under the FSP though information from FDGS that ensued after the

participatory service mapping in the four beneficiary communities indicated that guardians were vigilant in ensuring that the children attended school once enlisted on FSP. Table 3 above shows the total number of beneficiaries on FSP school support.

The informants indicated that there were no reasons for the children under the FSP support not to attend school because often SOS sponsored all the children belonging to a sponsored household. There were no reasons that could be directly attributed to the FSP intervention for sponsored children not attending school. Only in exceptional cases were there children not attending school because of either being deviant or were cases of where they had just been adopted by the family and SOS was in the process of admitting them on the FSP Educational Support programme. However an impact evaluation of World Bank support to Basic education in Ghana (2004) indicates a number of factors that were significant determinants of whether or not a child attends and stays in school and salient to this evaluation are the child characteristics; where children with more siblings are less likely to attend school, especially those of lower birth order. This finding fits with the common observation that older children in Aging Grandparent and Child headed households often work to pay for the education of their younger sibling, being themselves deprived of education.

The main reasons could be due to the emphasis on the household type of caring for orphans and vulnerable children that the FSP bases its activities on (SOS, 2007). This approach is the dominant form of caring arrangement for orphaned children throughout Africa, and for most stakeholders it remains the most desired model of care for these children (The World Bank, 2004). The approach is in line with the traditional practices where orphans are integrated within their close relatives hence providing a more sustainable safety net.

The evaluation results indicate that the FSP education support component has integrated and re-integrated children in the supported households. It was also worth noting that the gender balance was being addressed in the support school children, for instance re-integration of pregnant girls and enhance enrolment of girl children. Similarly, it was observed that in the first 103 households, three (3) children out of the five (5) that completed their grade twelve (12) were in the university studying degree programmes. It was also revealed that the

education school support was working closely with other partners to secure scholarships for tertiary education. Other than those children under the FSP supported households, there were some children that had benefited from FSP through the school support programme to community and government schools.

On the other side, the FSP had made tremendous strides in the youth vocational training. For the households that were ready to exit from the programme (13%) they had children who had gone through the FSP vocational supported skills training and were working. This equally contributed to household income. It was also noted that these youths were either employed or self employed. In a country with limited employment opportunities, vocational training with a bias towards self entrepreneurship is likely to address issues of youth unemployment. Thus, it can be noted that the vocational skills training support is relevant to household empowerment.

One of the youths (Michael Banda) who went through the FSP supported vocational skills training working at Breza Engineering Company

3.2.3 Promotion of Child Rights/Parenting Skills

Child rights and parenting skills and their promotion inevitably requires an understanding that is context specific and universally acceptable. This is because children have been the subject of abuse whether in the home which would be expected to provide a safe haven for them or

indeed outside the home. Whereas rights to respect for human dignity, physical integrity, and equal protection under the law are upheld for everyone, the Universal Declaration of Human Rights and the Convention on the Rights of the Child (CRC) re-emphasises the fact that children are equally holders of human rights. Thus, children are neither the property of their parents nor are they helpless objects of charity. They have rights, just like other human beings and their rights are not an option or a favour. The idea then is one that establishes young people as partners in upholding human rights in all spheres of society.

Out of all societal ills committed against children, the home had been the major setback. In a UN Secretary General's report (2005) on "*Ending Legalised Violence against the Children"*, it pointed out that states must protect children from all forms of physical or mental violence while in the care of parents or others. The simple reason for this was that while children had rights, it would appear they did not know their rights. Silke-Andrea Mallmann, (2003) adds that this has made children more vulnerable to abuse and exploitation. Therefore, it becomes very important for children, caregivers, community leaders and others to know about children's rights.

The children's rights as espoused in international conventions and as domesticated in national laws and policies (Zambia included) cover the civil, economic, social and political rights of children that recognise the importance of tradition and cultural values for the protection and harmonious development of the child. These rights could be grouped into four categories as;

1. Survival rights which include adequate living standards and essential health care. The rights focus on the child's rights to live, grow and enjoy good mental and physical health.
2 Developmental rights which include the rights to education, play and cultural activities. "A child's life must not only be saved, it must be worth living."
3 Protection rights which safeguard children against harm and address the needs of children in especially difficult circumstances – for example those children who are abused, neglected or exploited – as well as children with special needs, children without families and children with disabilities.

4 Participation rights which relate to self-determination, such as the right of children to be heard on matters affecting their own lives, and the right to play an active role in society.

In order to promote such ideals to children, parents, guardians, caregivers, and other community actors, there was need to secure this capacity within the institutional framework or in a network of institutions. From interviews with the SOS Regional Advisor and the FSP Coordinator, it was clear that the SOS FSP and Health Centre did not have (child) Human Rights experts in their ranks. Instead the institution had a good network with other organisations that assisted in child rights education and paralegal training.

However, according to statistics of SOS Zambia FSP support package database (undated), child rights promotion was silent among the listed interventions although there was paralegal and psychosocial training. Assuming that child rights issues were part of this broad intervention, 271 households were targeted. From these households, 120 children (62 girls and 58 boys) were trained. The number of adults that were under the training included 176 women and 4 men. The training took a workshop approach. The focus group discussion with the children in Chipata and Kabanana acknowledged the SOS arranged workshops to train them on rights issues but were quick to point out that not all of them participated. In fact, out of the 17 children in the FGD in Chipata compound, only four (4) participated in the workshop. In Kabanana the comparison was more acute as only two (2) out of the 22 children in the FGD had participated in the workshop. That notwithstanding, there was an appreciation of rights in the groups as examples were cited that included the right to life, right to freedom, shelter, child abuse, and an understanding of rape.

Parental skills training is another level of intervention that was listed in the SOS Zambia FSP support package database were 176 and 4 women and men respective household caregivers were trained in parental skills.

While the workshop approaches to promotion of child rights and parenting skills was well suited to provide appropriate activities to the children and caregivers, it may be inadequate to

address the different needs of the segments that comprised the children and adults. Guedes (2004) points out that the promotion of child rights/parenting skills and other abuses could be highlighted by the unique contribution that Behaviour Change Communication (BCC), community mobilisation, and specific programs aimed at the youths may play. These approaches have their own challenges but add variety in addressing promotional aspects to child rights and parenting skills. It was interesting to note from the FGD that those children that had not participated in the SOS arranged workshops had knowledge of the child rights based on contacts from other community mobilisers in the area. Therefore, the interventions needed to be holistic and not exclusive to one. A good example of progress due to the intervention provided by SOS was noted when one Chipata compound youth explained in an FGD as follows,

"I used to watch pornographic movies with my sisters and aunties in the sitting room in the night. After the SOS invited me to a workshop, I learnt a lot, no on can cheat me now. I found out that pornographic movies are not good and I stopped. Even at home, no one watches pornography".

BCC, according to Guedes (2004), like community mobilization, has an important role in challenging prevailing beliefs and norms that contribute to the acceptability and perpetuation of rights abuse. On the individual level, BCC can impart information and influence individuals' awareness, attitudes, and potentially behaviours. At the community level, BCC influences the individual external environment, the public and policy initiatives, and could create the necessary conditions for change at both individual and group levels.

3.2.4 Sports

For all the communities that the evaluation team visited, there were active community child sports programmes facilitated by the Norwagian football federation which offered training in club management, coaching, and refereeing. The evaluation team established that the organisation and training of these community sports had greatly contributed to performance of these clubs in the footbal association of Zambia league. At the time of the evaluation, the season had closed with the FSP main team leading the league chart for both the under 17 and under 20.

3.3 Families' Capacity to Protect and Care for their Children

3.3.1 Living Conditions

Living conditions for households and communities in Zambia face the risk of suffering from covariate and idiosyncratic shocks. Even if all households can be affected by the shocks not all the households have the same probability of recovering from the consequences of suffering from them. Poor households that lack the necessary physical and human capital will be less likely to recover from it. Therefore certain groups in society are more vulnerable to shocks that threaten their livelihood or even their survival (Marini, 2005). Some groups are so vulnerable that they live in chronic state of impoverishment where their livelihood remains in a constant state of risk. This is more so considering the large proportion of poor people {The Zambian situation, where 68% (LCMSIV, 2005:115) of the people live in poverty (53% of theme in extreme poverty), is no exception.} and the low level of human capital and outcomes. Understanding risks and insecurity are an important component of getting an understanding the living conditions for populations in peri-urban areas in Zambia (World Bank, 2003). In fact, among the broad mass of "poor" people, certain groups can be considered particularly vulnerable to shocks due to their lack of human, physical and social capital with which to confront the shocks.

The findings from the FGD show that majority of the households have not moved away from the state of abject vulnerability that they were in when the project was initiated. Discussions with children in the FGD and comparing with what the adults group indicated in terms of wealth ranking were similar.

Table 4

Community area	Household Property/Assets
Chipata	Buckets, chairs, display, spoons, mats, plates, plots, blankets, radio, TV, folks, and mattresses.
Chazanga	Pots (mapoto), sofa (mipando), plates (mambale), blazer (mbaula), tables, cups, beds, blankets, buckets, mattresses, and mpansa.
Mandevu	Chairs, display, spoons, mats, plates, plots, blankets, radio, TV sofa (mipando), plates (mambale), blazer (mbaula), tables, cups, beds, and blankets.
Kabanana	Sofa (mipando), plates (mambale), blazer (mbaula), tables, cups, beds, and blankets.

Source: Field data

The table indicates a summary of what was considered as major property for the households in the four areas. The items listed as assets are obviously not as valuable as one would expect. This data seem to agree with the rankings that were done by the FSP in terms of Best, Average, and worst case scenario because only 9 Households were ranked as best case scenario out of the 72 households. For average cases there were only 37 households leaving out a balance of 26 from the list or 57 households as still striving. This indicates that the households are still far from being self sustaining considering that they are still hoping that the programme reintroduces the food parcels that were originally part of the support when the programme was initiated.

The baseline information at the start of the programme indicates a picture showing that the living conditions of the beneficiaries needed to be addressed by the programme. The findings revealed the programme attempted to improve the living conditions through the Home improvement scheme which has worked well except it is not meeting the huge existing

demand.[7] This is because data from the FGD show that there still a number of individuals who are on the waiting list to be assisted in improving their houses.

One of the houses in Kabanana that received home improvement support in terms of roofing iron sheets

Apart from house improvement, the project has attempted to provide economic support through Income Generating Activities (IGA).

3.3.2 Economic Support

Reviewing available literature (RESAL, 2000:4; GRZ, 1999;) shows that for IGAs among the ultra poor to be successful, a number of ingredients are required. An assessment of these ingredients was conducted on the IGAs provided by FSP, and Table 5 below provides summary findings.

[7]Under the house development scheme FSP provides Roofing sheets, timber and labour to maintain and improve houses for beneficiaries with occupancy licences.

Table 5

INGREDIENT FOR SUCCESS	ASSESSMENT OF SOS FSP BENEFICAIES
1. Skills and Knowledge of the IGAs in the person setting it up;	All the beneficiaries were offered the skills for running IGAs. However there was need to segement the clients into different categoies and specifically target those who can viably be trained and operate such businesses and those who can not. For instance, the aged, especially those in households with no grown up children to assist, are not well placed to run such an IGA.
2. Projects requiring relatively low starting-up capital, from own savings rather than from a loan. However, the higher the starting capital, the higher the success rate;	Though low-capital base businesses were adopted, these have not been from own savings but are dependent on SOS FSP loans.
3. The business should require Low technical skills in setting it up e.g. poultry rearing projects requires low technical skills;	Most IGAs supported by FSP required low techinical skills to set up.
4. Quality training should be provided by the NGO implementing the programme;	The FSP provided training for beneficiaries at the time of disbursing the loan facility. The programme conducts yearly trainings to build capacity.
5. Support should be provided to the beneficiary after the IGA starts;	Community mobilisers and social workers provide supervision after the IGA starts though faced with staffing constraints which impacted on the frequency of the supervision.
6. Beneficiaries must engage in IGAs providing immediate returns and later shifting to others with longer term perspective;	While a few have managed to “diversify”, a lot more of them have not.
7. IGAs must be capitalised frequently after starter capital	FSP recapitalises the IGAs once every year excerpt for 2006 when the project was constrained with the budget.
8. Acknowledgement by both NGOs and the beneficiaries that IGAs are ”businesses” and must be run as such;	While some of the beneficiaries do acknowledge that the business needed to run as businesses, others thought the loans were mare assistance to them.
9. The NGO providing the assistance must have some business acumen, not just social work skills;	None of the SOS FSP staff have business skills. What they have is the same type of training that the beneficiaries received.
10. Incorporation of strict accounting practices and audits.	From the curricula, it is evident that they were trained in some accounting principles. However most of the beneficiaries were constrained by their inability to read and write. Those that were able to read and write were able to implement the basic accounting practice.

Source: Field Data

Beneficiaries participating in drawing a service timeline

3.3.3 Family Development Planning

The FSP has at its core the family development plan which is a means for every household to be self reliant. Accordingly, the SOS FSP has stipulated why there was a need for the FDP and what it meant. An undated SOS Lusaka family strengthening programme family development planning document states as follows:

"There was a need for:

1. Consistent, systematic approach to working with beneficiary families;
2. Tool for monitoring services provided and progress made;
3. Clear withdrawal plan.

What is Family Development Planning (FDP)?

An ***approach*** to working with beneficiary families that builds **self-reliance** and engages them in their own development

A ***structured process*** that works with each family's individual needs and priorities, documents their progress towards achieving self-reliance in these areas, and recognizes their successes

A ***tool*** to coordinate programme service delivery with co-workers and community partners"

Based on this understanding, the FDP is a tool that seeks to instill responsibility in the beneficiaries so that they could be independent to make personal and household decisions that bordered on ensuring a sustainable future for themselves and the children. At the centre of the intervention are the caregivers and children making plans through SOS facilitation. This would appear to be a recent thinking to helping household vulnerability.

The family development plan, though differently framed, is like the Children Development Accounts (CDAs) of Uganda. According to a pilot study by Ssewamala (2005) the strategy involved working with orphaned children while they are still with their families or caregivers within the community and combined standard reactive care with an economic empowerment

component. What is similar in both situations is that they are aimed at creating and broadening asset-ownership opportunities for the orphaned children and their families. The principle behind these interventions inevitably rests on the understanding that reduced family breakdown could minimize school dropouts, and minimize the influx of orphaned children to the city streets by creating asset-ownership opportunities for the children and their families before they are pushed away from each other.

From the FGDs and interviews, it was clear that beneficiaries knew what was expected of them, what to expect from FSP, when, and the length of the support which are the major components of the Family Development Plan (FDP). However, it was noted that the FDP monitoring was constrained by the low staffing levels that is four (4) field officers against 2071 beneficiaries giving a staff beneficiary ratio of 1 to 518. Similarly the realisation of the FDP goals have been constrained by limited resources to enable recapitalisation of IGAs, food security, and other income generating ventures.

3.4 Community Empowerment

3.4.1 Community Based Structures

Development practitioners have been incorporating some form of participation into their efforts since the late 1950's (Rahnema, 1992). It was then, and remains, a response to the perception that top-down development doesn't work, and that development imposed on a community by people who are not from that community will not only be ineffective, but may also be destructive . Participation is inoculation against imposition. Participation is a kind of dialogue "during which the agenda is jointly set and local views and indigenous knowledge are deliberately sought and respected "(Gorman, 1995). People are viewed as partners and actors of their own development (Schneider and Libercier, 1995). Participation suggests equality between beneficiaries of development and those who fund and organize the process, and that decisions will not be made without the beneficiaries input. Community based structures are therefore a vehicle for participation.

Community based structures are being applied in a range of different contexts, both as part of an idealised model of decentralised government and also in the absence of effective

government. Cliffe et al (2003) argue that community based structures build foundations for systematic delivery of essential services and partly establishes the social contract between emerging institutions of governance and their constituencies. Proponents of community-based approaches argue that their inherent flexibility makes it possible to intervene in areas where the state is weak, but critics argue that in practice they often fail to build, or even undermine, state capacity.

There is broad agreement that community based interventions and structures have the potential to be more responsive to the needs and priorities of beneficiaries (allocative efficiency). There is also some evidence that community based projects are comparatively cost effective (productive efficiency) because of lower levels of bureaucracy and better knowledge of local cost (McLeod, 2003; Rawlings et al, 2004). While those projects which draw primarily on locally available skills, materials and financing are clearly likely to be more sustainable, some commentators have argued that this simply amounts to shifting the financial burden of service delivery to potential beneficiaries (Ribot, 1995; Joshi, 2002).

The evaluation findings established that the FSP project has community based structures. It was revealed that these community structures were registered with the registrar of societies thereby acquiring a legal identity and autonomy to function within their localities. The evaluation team established that in two of the catchment communities, there were community schools and resource centres run by the communities. Thus, this gives the potential for communities to continue running their affairs in the event of SOS FSP pull out.

3.5 Networking

3.5.1 Legal Support

The legal support to beneficiaries was mainly through paralegal training and as well as helping with occupancy licenses. This is well articulated in the FSP Policy Document on Property Development that emphasizes land ownership and property rights. This component involves the training of beneficiaries on the aspect of acquiring title deeds or occupancy licence as legal evidence of ownership of land and /or legal way of right of ownership of property. The understanding of this policy SOS framework is that empowering beneficiaries necessarily

meant assuring and securing the beneficiary lives through helping them understand the legal implications and owning property.

Acquiring title deeds in Chazanga and Kabanana would appear to be difficult because under the local authority provisions act, land that was designated as squatter area can not have title deeds. The argument was that it was not gazetted. However, in-depth interviews, focus group discussions and questionnaire responses indicated that despite their inability to have title deeds, a large number of beneficiaries owned houses either through the chief or occupancy licenses. The beneficiaries of Mandevu and Chipata were relatively secure because ownership could be through title deeds. In all beneficiary areas, those that could not own houses still had the opportunity to have shelter through renting.

The ownership of houses by the beneficiaries either through title or occupancy licences equally entailed FSP planning a home improvement programme as outlined in the policy;

> "This specifically involves the renovations of the roof of the house and to a lesser extent working on the walls. The toilet is also to be considered under this component. Under toilet improvement, as beneficiary contribution, the beneficiary shall build the toilet from deep down the pit and the structure above the ground. FSP shall provide the sunplast and roof the toilet and do all necessary work such as putting the door so as to make the toilet ready for use."

From the beneficiary assessment there was provision of iron sheets in renovations of the roofs in 2003, 2004 and 2005. After 2005, there was a stop in this programme that kept beneficiaries guessing.

3.5.2 Programme Partners

Partnerships among various stakeholders often signify cooperation. Various community organisations working in a particular sector usually find the need to cooperate in order to provide the services more efficiently. Most community organisations will cooperate because of the presumed assumption of providing a public good to the community they operate. A public good is non-excludable and non-rival (Samuelson, 1947). That is once it is provided, no-

one can be excluded from its benefits and one person's consumption does not decrease the amount of the good left to be consumed by everyone else. Organisations therefore cooperate by revealing their preferences for the good to ensure that the efficient service is provided (Gillinson, 2004). Partnering organisations should therefore be honest about how much they value the public good in the interest of society.

Findings from the stakeholder analysis conducted revealed that the programme was working with a number of partners in ensuring that the FSP and the interventions are a success. Among the partners are CIDRZ, ZANAN, Bwafwano, DHMT, Pharmaceutical companies, National milling, Local Schools, Department of social welfare, Department of youth and child welfare, Bata, Community orphans and vulnerable committees, Community Health Based Agents, Ward Development Committees, Local Churches, Local traditional Leaders, Local Leaders politicians, Volunteer Services Organisation (VSO), Bayport, Brazer Engineering, Ministry of Education – Bursaries ,National Legal Aid clinic for Women, Scope OVC etc. Table below is the completed stakeholder analysis explaining what each partner's interest is and what each contributes to the programme. However it is worth noting that most beneficiaries do not have an idea that there are other stakeholders involved in improving their lives.

3.6 Management/Administration Systems

3.6.1 SWOT Analysis

The management and administrative systems were assessed using the SWOT analysis. The results of the SWOT analysis performed on the Family Strengthening Program and the Medical Center are as presented below;

The exercise assessed the strengths and weaknesses from;

1. A financial performance and resources
2. Management team and employees
3. Quality of services provide by the organization

The opportunities and threats were assessed against the following;

1. Beneficiaries factors that may affect the sector
2. Competition and competitive forces in the sector
3. Government, economic and societal factors that may affect the sector in the next 2-3years.
4. Workforce and employment factors that may affect the sector in the next 2-3 years.

5. Supplier and raw materials (inputs) factors that may affect the sector in the next 2-3 years.

THE FAMILY STRENGTHING PROGRAMME (FSP)

The exercise reveals that the greatest strengths for the FSP were;

1. Stable funding
2. Skilled and committed staff
3. Holistic approach in service provision
4. Ability to network with other stakeholders

On the major weaknesses the exercise reveled that the FSP had the following weaknesses;

1. Perceived low salaries
2. Lack of continuity in the position field officer due to transfers and promotions
3. Delays in the procurement of inputs
4. Limited infrastructure (office Space)

The FSP is also faced with opportunities and threats from the external environment. The exercise reveals that the Program's major opportunities were;

1. Availability of skilled and qualified personnel
2. Innovation in the sector such as ability to networking
3. Technology changes
4. Availability of new sources of funding

The major threats that the Program faced were;

1. Brain drain
2. Changes in economic conditions.
3. Population growth
4. Changes in social values and norms

MEDICAL CENTRE

The exercise reveals that the greatest strengths for the Medical centre were;

1. Prompt service delivery
2. Availability of drugs and lab reagents
3. Team work and good work relationships
4. Community involvement in some programmes such as home based care
5. Stable funding
6. Skilled staff

On the major weaknesses the exercise reveled that the Medical center had the following weaknesses;

1. Low staff establishment
2. Non availability of SOS organizational policy guidelines
3. Inadequate infrastructure
4. Dependency on donor funding

The Medical centre is also faced with opportunities and threats from the external environment. The exercise reveals that the centre's major opportunities were;

1. Expansion of the OVC care to other towns and provinces.
2. Expansion of already existing infrastructure due to increased demand for service
3. Availability of willing Partners for collaboration

The major threats that the Medical Center faced were;

1. Brain drain
2. Competitors in service delivery
3. Economic changes
4. Changes in government policies
5. Non availability of grant from government

3.6.2 Human Resources

The project had a staff compliment of 23 (9 for FSP and 14 for medical Centre) at the time of the evaluation. The table presents the details in terms of job titles:

Table 6

No	Title	Qualifications	Years on the Programme		
Family Strengthening Programme					
1	FSP Coordinator	BSW	4		
2	Field Social Worker	BSW	1.8		
3	Field Social Worker	BSW	1.8		
4	Field Social Worker	BSW	0.1		
5	Field Social Worker	BSW	0.1		
6	Accountant	Dip. Acc	2		
7	Procurement	Adv. Cert.	1.5		
8	Stores Officer	Dip. Stores	1.5		
9	Driver	PSV	0.7		
10	Cleaner	G. 9. Cert.	0.7		
Medical Centre					
1	Coordinator	MPH, MBChB, BSc	6		
2	Clinical Officer	Dip. Clinic Med, Dip. HR	4		
3	Clinical Officer	Dip. Clinic Med.	0.6		
4	Nurse	Dip. Nursing	5		
5	Nurse	Dip. Nursing	3		
6	Nurse	Dip. Nursing	3		
7	Nurse	Dip. Nursing	1		
8	Pharmacy Technologist	Dip. Pharmacy	1		
9	Lab. Technologist	Cert. Lab. Sc	3		
10	Accountant	Dip. Acc	2		
11	Clinic Clerk	Cert. Secretarial	3.5		
12	Driver	PSV	0.7		
13	Cleaner	G.7. Cert.	0.7		
14	Cleaner	G. 7. Cert	1.7		

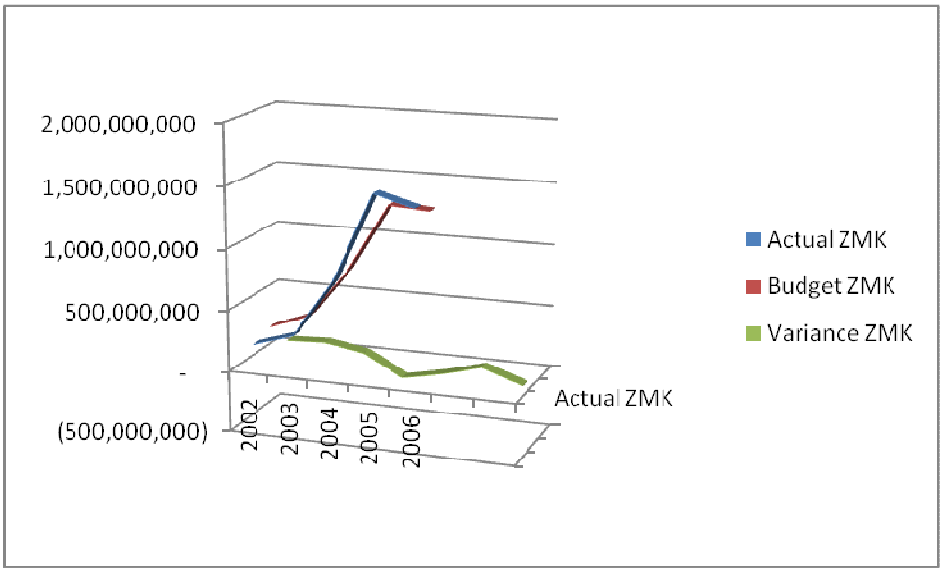
The FSP staff had suitable minimum qualifications for their roles, but it was noted that none of the field staff had specialised training and experience in the major interventions of IGAs, food security, and paralegal. Similarly, it was observed that the current staff establishment had four (4) field officers to serve the 271 households, representing a ratio of 1 to 68 (or 2014 beneficiaries to 4 field officers representing 1 to 504).

The Medical Center staff had minimunm required qualifications for thier roles. The nurse patient ratio at the Medical Center is 1 to 5000. Comparing this ratio, shows that there is need to increase the staff compliments for the clinical staff bearing in mind that there is also need for outreach programmes in the targeted communities.

3.6.3 Financial/Asset Management

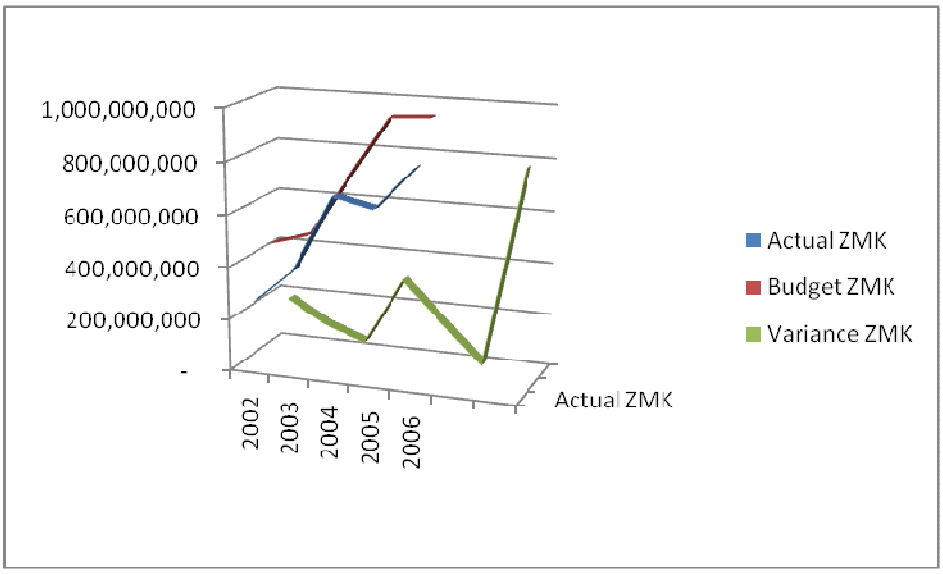
Based on interviews with the National Director and Deputy National Director, and follow up discussions with the Senior Accountant and the facility Accountant, the internal controls and the financial management systems appeared to be strong.

Trend analysis for the FSP



Funding trend analysis conducted revealed that the FSP is above the Budget by ZMK 116,165,726.00. The graph above shows the trends analysis. The FSP had 2071 beneficiaries against the budgeted 1500. This explains the over expendture incured.

Trend analysis for the medical center



The Medical Centre was within Budget by ZMK 776,900,301.00. Medical center did not meet its target of attending to 20,000 beneficiaries and could be the reason why they under spent.

3.7 Evaluation Criteria

	Main Question	Sub Question	Method	Comments by Evaluation Team
3.7.1 Relevance	Does the FSP and Medical Centre meet the target needs?	Are the beneficiaries getting the required services	Focused Group Discussions/questionnaire/Site visit	The interventions; school support, paralegal training and health care, among others, provided by the FSP and the medical centre were well received by the beneficiaries. According to beneficiary FDGs and discussions with staff, Interventions like food support have been reduced only to serve critical homes where there are the terminally ill people, child-headed, and aged. House Development Schemes where roofing of houses using iron sheets continued to be done on a yearly basis. This support was provided only to critical houses and the selection process of the critical houses was community driven.
		Do the beneficiaries need medical support?	Focused Group Discussions/questionnaire/Site visit	All the beneficiaries thought the medical support they were receiving was timely and critical to their lives. In fact the beneficiaries expressed a lot of satisfaction with regard to the delivery of medical services by the medical staff.
		Do the children need educational support?	Focused Group Discussions/questionnaire/Site visit	The major talking point with the children was on education and the support they received from SOS. Educational support, it was pointed out, was very important to the children that they were looking forward to finishing school. After that they would then be in position to support others as well.
		Do the beneficiaries require economic support?	Focused Group Discussions/questionnaire	There was a general understanding from the beneficiaries that economic support was a necessity to the beneficiaries, and that they had appreciated the support they had so far been accorded.
	Is the project approach relevant	Was Mandevu, Kabanana, Chipata, and Chazanga as a chosen project area suitable?	Focused Group Discussions/questionnaire/literature review/interviews/Site visit	Based on the premise that these are shanty and highly impoverished areas, SOS might have found them to be suitable. However, there are more shanty compounds in Lusaka that are even in more dire conditions than these four which could have been well suited to be project areas. Furthermore, only 103 (271 now) households were beneficiaries begging the question of how many more eligible beneficiaries are not actually on the programme given there were over 16000 households in the project area.
	Is the MCDSS and MYSCD still interested in the project.	Is the project goal in line with government policy goal?	Interviews and literature review	It was clear from policy review of literature that the MCDSS and MYSCD were active partners in the project as they collaborated well with SOS in child welfare services and sporting activities, as well as the Ministry of Education in the school programmes
3.7.2 Effectiveness	Are the essential implementation mechanism for the FSP and Medical	Are the FSP and the Medical centre manuals and programmes	Interviews and literature review	The period of programme evaluation was from 2002 to 2007. However, the review of literature and interviews with staff revealed that the FSP organisational manual was only released in January 2007 whereas the SOS organisation does not have any

	Centre established	compiled?		organisational policy guidelines for the Medical Centre programmes. This means the two programmes have operated without essential implementation manuals necessary for programme management.
		Are these manuals followed in implementation of FSP and Medical centre programmes?	Interviews and literature review	Without manuals and policy guidelines to follow, the programmes were highly constrained on this score. Nevertheless, it was noteworthy that though these programmes were implemented on a pilot basis, they had clear cut objectives and output indicators but without outcome indicators.
		Was enough capacity built in the households and community?	Interviews, Focused Group Discussions/questionnaire/Site visit	A lot of collaboration with different organisations had been undertaken in sensitisation and training workshops to build skills capacity to beneficiaries. The trainings were followed by starter capital for IGAs and food security inputs although there was no further recapitalisation of these IGAs following revelations by both the FSP staff and beneficiaries that the IGA and food security inputs were given once a year. Consequently, without adequate capital base for IGAs and food security, the impacts of these interventions remain limited and unsustainable.
		Are there model households in the FSP?	Interviews/questionnaires/ Site visit	According to the findings, 13% of the beneficiaries are categorised as best case models, while another 51% as upcoming models with further interventions.
	Has the FSP been successful?	Concerning education?	Focused Group Discussions/questionnaire	All the beneficiaries appreciated the education support FSP provided to them for the Kindergarten, primary, basic, high school and vocational training (refer to statistics of beneficiaries accessing this support provided in the previous chapter).
		Concerning psychosocial counselling?	Interviews, Focused Group Discussions/questionnaire	There was no symptomatic evidence of community psychosocial problems based on field visits. However, the programme staff indicated that FSP undertook psychosocial counselling that was need driven and their role was to build capacities in the beneficiary communities.
		Concerning Family development plan?	Interviews, Focused Group Discussions/questionnaires	From the FGDs and interviews, it was clear that beneficiaries knew what was expected of them, what to expect from FSP, when, and the length of the support. However, it was noted that the FDP monitoring was constrained by the low staffing levels that is four (4) field officers against 2071 beneficiaries giving a staff beneficiary ratio of 1 to 518. Similarly the realisation of the FDP goals have been constrained by limited resources to enable recapitalisation of IGAs, food security, and other income generating ventures.
		Concerning IGAs?	Interviews, focus group discussions, questionnaires	The IGAs were a welcome intervention as they brought a sense of self responsibility, independence, and self confidence in the households. It was noted however that the success of the IGAs varied tremendously across the households to vulnerability situation, previous experience in running IGAs, and the capital base regardless IGA training. It was noted that the 13% households that come out as best case scenario had viable IGAs,

				while the 36% households of the worst case scenario accounted for the larger portion of the unviable IGAs. It was noted that the success of IGAs was dependant on the following factors: • Diversified IGAs e.g. one family running a restaurant, shop, tailoring, renting out houses, etc. • Follow up recapitalisation after the starter capital. • Professional entrepreneurial mentoring than relying on the general skilled field officer without relevant experience and knowledge in IGA management. • Continuous monitoring of the household IGAs by the field officers.
		Concerning shelter?	Interviews, focus group discussions, questionnaires	The FSP provided roofing materials like iron sheets and home improvements to selected households at different times from 2003 to 2006. This intervention was good but there were more beneficiaries than the resources available. Thus, those beneficiary households that had not yet benefited raised perceptions of favouritism in the provision of this intervention. However, SOS staff indicated that the selection process started from the community, to community mobiliser, and to social workers based on expert recommendation.
		Concerning food support?	Interviews, focus group discussions, questionnaires	Giving food parcels had been the major intervention in the initial year which was later replaced by faming inputs for those with land and IGA starter capital for those without land. However, food assistance was maintained and only limited to critical households such as child headed homes and those on home based care. Further, it was noted that for households in Kabanana, their harvest did last throughout the year which left them with nothing to eat in the pre-harvest famine season (December to February).
		Concerning legal issues and child rights?	Interviews, focus group discussions, questionnaires	FSP had no legal expertise within its ranks which made it difficult to address legal issues as a programme. However, FSP had networked with other organisations to build capacity in their social workers and selected community members through training workshops. More is required to address beneficiaries' knowledge on child rights.
		How effective are the current Monitoring activities for FSP?	Interviews/literature review	The review of literature revealed that FSP had well conceptualised and tabulated monitoring systems. The monitoring system entails that social workers visit beneficiaries on a weekly basis to keep track of program activities. However the physical weekly visits are hampered by the low field officer staff levels. The review of literature further indicate that the monitoring activities are done on a continuous basis and reports done weekly, monthly, quarterly and annually.
	Has the Medical Centre been successful?	Concerning medical services?	Interviews, focus group discussions, questionnaires	The medical service provision at the centre appeared to be satisfactory to the beneficiaries. Generally, the intervention addressed the beneficiary needs.

		Home based care	Interviews, focus group discussions, questionnaires /Site visit	Most of the beneficiaries expressed reservations on the effectiveness of home based care as they were not visited when there was an ailing patient in the house. It was noted that only transport would be provided to transport the chronically ill to the Medical Centre or any other referral centre.
		How effective are the current monitoring activities for the Medical centre?	Interviews, literature review	It was noted that the Medical Centre had internal monitoring for the drugs, personnel, and clients' progress as it used tally sheets and generated reports monthly and annually. However, these have not been documented in formal monitoring guideline policy.
3.7.3 Efficiency	Has the project been cost efficient	How much funds were spent for the project operation?	Interviews, literature review	A total of 7.1 Billion ZMK (about 1.7 Million US$) had been expended for the operational costs of the FSP and Medical centre since the commencement of the project in 2002 to 2006.
		Were funds allocated appropriately?	Interviews, literature review	Within the total budget of ZMK 7.7 Billion, ZMK 7.1 Billion was used for funding the FSP and Medical Centre projects in Lusaka. In Kwacha terms, the expenditure was within budget, but in Dollar terms due to exchange fluctuations there had been an apparent under funding of US $75,446 as per SOS management accounts as at December 2006.
		Were there inputs the project could have done without?	Interviews, literature review	Most of the inputs under all interventions were necessary though the beneficiary perceptions of quality and under measurement could be addressed. For example, some items provided for IGAs such as Kapenta and Beans where perceived to be of poor quality and expensive, and in most cases where under weight resulting in some beneficiaries incurring unnecessary losses.
		Is the budget for the Project adequate?	Interviews, literature review	After the review of the management accounts for 2002 to 2006, the budget of ZMK 7,725,608,000 was adequate for the actual expenditure of ZMK 7,064,873,425.
	Are Project Activities timely?	Are programme activities executed as and when required?	Interviews, literature review	The beneficiaries noted that supplies of services and certain activities were not executed in time particularly in 2006.
	Were resources allocated for the project adequate?	Has the project got enough resources that it utilized (i.e. number of experts and Vehicles)	Interviews, literature review	There were 23 members of staff in the FPS and Medical Centre as at June 2007 according to the management accounts. The staff who participated in the SWOT analysis stated that the staff compliment was inadequate given the reduced visitations to the community. A total of three (3) vehicles where allocated to the FSP and Medical centre.

3.7.4 Impact	What changes have occurred among institutions and target beneficiaries	Are the target beneficiaries still vulnerable?	Site visits, FGDs Interviews	According to the findings, 13% of the beneficiaries are categorised as best case scenario, 51% as good, and 36% as worst case scenario. This data indicated that out of the initial targeted 103 households, 13% of these were ready to exit some programme interventions except education while another 51% households needed further economic interventions to be finally ready to exit from the programme. The remaining 36% households required a re-assessment of their vulnerability factors so that appropriate individual household interventions can be underpinned. It is clear that these 36% households had not responded to the interventions. The evaluation team established that the composition of these households were child headed, very old grandparent headed, and the terminally ill (bedridden cases).
		Have relationships among beneficiaries changed by the Project?	Site visits, FGDs Interviews	Most beneficiaries indicated that they have continued to enjoy reasonable relationship and cooperate among themselves.
		How have people outside the targeted beneficiaries benefited?	Site visits, FGDs Interviews	Though a survey was not carried out with people outside project, project beneficiaries believed that outside people benefited through the services from the project such as the Medical Centre, IGAs, supplementing government effort in education. Specifically the services provided included; i) Title deeds sensitisation campaign and subsequent gazetting of the Chazanga and Kabanana townships as legal settlement areas, ii) Training for transformation trainings iii) Community Home Based Care iv) Sport (training and formation of clubs registered with Football Association of Zambia v) HIV and AIDS awareness campaigns vi) ART vii) Paralegal training viii) School support programme to government and community schools ix) Establishment of community resource centres x) 2005 rice relief programme on behalf of the government response to the famine xi) 2004 to 2005 FSP run a radio programme in conjunction with ZNBC on the "*Voice of the child"*
		Are there new problems that have come as a result of the project?	Site visits, FGDs Interviews	According to the majority of beneficiaries there are no new problems that have come as a result of the project. However, some interviewees pointed out a number of problems as a result of the project that had happened sporadically. However some older beneficiaries experienced burglaries where their donated items such as blankets and food would end up being stolen by thieves.

		Any social conflict or misconduct in the project?	Site visits, FGDs Interviews	There were no recorded cases of social conflict among project beneficiaries.
		What skills have been acquired by beneficiaries?	Site visits, FGDs Interviews	The beneficiaries interviewed indicated that a number of skills have been imparted to both the children and the care givers. These included; • children's rights, • survival skills such as tie and dye for care givers, • farming, • organic faming • mushroom growing, • sausage making, • paralegal, • psychosocial counselling, • Vocational Youths Skills training • Training for transformation
	Has poverty reduced in target beneficiaries households?	How many meals do beneficiary households have per day?	Site visits, FGDs Interviews	Above 60% of the beneficiaries indicated that they have three meals per day, with the frequency and nutritional values improving during the harvest periods and immediate post harvest period. During the pre-harvest famine season (December to February) the frequency of meals reduces to Two or less per day.
		Have the individuals/ households income (life standards) increased?	Site visits, FGDs Interviews	The beneficiaries reported that their life standards had improved especially when the programme started. This is attributed to the scope of the interventions at inception. For 64% of the 103 households, the standard of living had greatly improved and 13% are ready to exit from the programme.
		Has the project positively or negatively affected the Beneficiaries?	Site visits, FGDs Interviews	All interviewed groups acknowledged that the project had positively affected their livelihoods. The reasons being that the beneficiaries never had the opportunity to take their siblings to school, being vulnerable themselves. The IGAs start up capital, food security inputs, food parcels, access and utilisation of services at the health centre meant that most beneficiaries were now able to live healthy lives. Another positive impact were the skills that the beneficiaries got from the training in survival skills.
	Will the model for SOS FSP be extended to other area?	Is there any clear strategy for expansion?	Site visits FGDs Interviews	The project has a clear strategy for expansion to other areas as evidenced by; • Extension of the catchment area (Chaisa and Garden townships) • Establishment of the FSP satellite project (Zani Muone, independence, Lilanda and Ngwerere townships). • Establishment of the school support programme to community and government schools • Increment of beneficiaries over the past years.

3.7.5 Sustainability	Will the beneficiary households continue meeting their needs without the support of FSP and Medical Centre?	Will the households have enough resources to continue with the project interventions?	Site visits, FGDs Interviews	The findings indicate that 13% of the beneficiaries were in a position to meet their needs being ready to exit the programme, while 51% of the beneficiaries have the potential to continue meeting their needs without the support of FSP and the Medical Centre given additional economic recapitalisation support.
3.7.6. Participation	The presence of stakeholder needs in FSP and Medical Center projects activities and their active participation.	Does the Project Supply information so that stakeholders make enlightened decisions?	Site visits, FGDs Interviews	The project attempts to provide information to stakeholders through the weekly community meetings where progress on project activities was shared.
		Do the project employees undermine the efforts of the beneficiaries?	Site visits, FGDs Interviews	There was no evidence to suggest to that effect.

Chapter Four

4.0 LESSONS LEARNT, CONCLUSIONS AND RECOMMENDATIONS

4.1 Operational Lessons Learnt

a. It is much easier to evaluate a programme with a clear documented SOS organisational policy guideline than one with none.

b. There was need to increase budgetary allocation on economic support if signifcant impact was to be made.

c. Need for increasing budgetary allocation on long term capacity building activities (care giver focussed and educational scholarships) than short term interventions (medical schemes, household improvement and food parcels).

d. There are households that may require more than 5 years of interventions to exit from the programme and therefore need individualised interventions in order for them to be self sustaining.

e. There is need for general food assistance during the pre-harvest season because there are households which were unable to be food secure throughout the pre-harvest famine period.

f. A balanced staff – beneficiary ratio enhances close programme implementation monitoring through frequent home visitations.

g. Some interventions such as IGAs, food security, and paralegal require specialised skills and experience if they are to make significant impact on the households.

h. Clear objective output, outcome and impact indicators enhances tracking progress of household empowerment interventions.

i. Community capacity building in preparation for community involvement and project ownership requires more investment i.e. leadership and project management training, awareness raising projects, and adequate budgetory provisions.

j. For every project intervention to be effective and impact making, it needs to go hand in hand with beneficiary motivation and confidence building and mentoring in order to facilitate their meaningful participation in the wider society.

k. Medical Centre preventive interventions are more cost effective than curative interventions.

l. Services offered by Medical Centre would reach more beneficiaries in the far flang catchment areas like Kabanana if offered through outreach programmes such as mobile clinics.

4.2 Conclusions

The findings of the evaluation shows that the two programmes, FSP and the Medical Centre, have existed since 2002. At this inception period, they functioned with a skeleton staff and very few beneficiaries from the communities. However, after the recruitment assessment undertaken in 2002, there has been a stead increase in beneficiary households from the initial 34 children to the 271 households as at December 2007. This though was against an expanding but inadequate staff compliment to cater for growing beneficiary needs.

The findings showed that the targeting for beneficiaries was well established and objective, with the beneficiaries accessing health and educational support, as well as the para-legal services through a network of partners. There were also capacity building interventions on housing, economic support like the IGAs and food security. The two programmes were relevanat to the beneficiary needs.

4.3 Recommendations

a. There is need for a permanent position at National Office to offer technical support and quality control monitoring to both the Medical Centre and FSP.

b. The National Office should assist the Medical Centre to develop a comprehensive monitoring and evaluation system.
c. There is need to increase the field officer staffing levels within the FSP and futher train them in driving to ease mobility.
d. There is need to either employ specialist staff in IGA, food Security, and Para-legal or build capacity among the existing field officers.
e. The procurement office should be transfered to be under the National Office though functioning at location level and further increase its staff compliment to include two procurement officers and a stores person.
f. There is need to diversify and recapitalise the household IGAs in accordance with household sizes.
g. There is need for continuously close monitoring and mentoring of household IGAs.
h. There is need to enhance the initiated practice and use of organic fertiliser as against chemical fertiliser.
i. Food assistance should be considered for some households in the pre-harvest famine period.
j. There was need for enhanced motivational and confidence building, support and mentoring to households and youths.
k. There is need to re-evaluate the budgetory allocation to care-givers and community capacity building interventions.
l. The households that are in the 36% category of worst case scenario need vulnerability re-evaluation and individualised interventions.
m. There was need to re-evaluate the budgetory allocation to property household improvement to enable more households to be reached.
n. There was need to have an SOS organisational policy guidelines on the Medical Centre.

REFERENCES

Central Statistics Office (2005), Living Conditions Monitoring Survey Report 2004, CSO Lusaka Zambia

DFID – Zambia (2004), Vulnerability, Food Security and Social Protection in Zambia: Working Notes on Vulnerability, Lusaka?

Guedes, A., (May 2004), Addressing Gender Based-Violence from the Reproductive Health/HIV Sector: A Literature Review and Analysis.

Government of the Republic of Zambia (GRZ)(1999), Orphans and Vulnerable Children: A Situation Analysis, USAID/UNICEF/SIDA/Study Fund Project

Ministry of Community Development and Social Services (MCDSS) (2003) Understanding the New Public Welfare Assistance Scheme (PWAS), GTZ/MCDSS

Mwiinga Robby, Drost Nancy and Glyde Sarah (2005), Civil Society Social Protection Position Paper, DFID funded Consultancy

Oxfam GB (2006), Cash Transfer Programming in Emergencies (edited by Pantaleo Creti and Susanne Jaspars), Oxfam GB, Oxford

RESAL Bangladesh (2000), Report on the RESAL Seminar "Prospects and Limitations of Income Generating Activities as Instrument for Food Security of the Poor" held in Dhaka on 27 and 28 March 2000, GOPA Consultants

Save the Children UK, HelpAge International and Institute of Development Studies (2005), Making Cash Transfers Count: Lessons from Cash Transfer Schemes in East and Southern Africa for Supporting the Most Vulnerable Children and Households, UK

Silke-Andrea Mallmann, (2003), Building Resilience in Children Affected by HIV/AIDS , Maskew Miller Longman, Cape Town

Ssewamala, F. M. (2005), Children Development Accounts in Africa: A Pilot Study, CSD Working Paper No. 05-05, Centre for Social Development, Columbia University

SOS Children's Village of Zambia Trust (2002), Household Vulnerability Assessment and Nomination of Households for Household Support Facility, Social Centre Report, Lusaka

SOS Children's Village of Zambia Trust (undated) IGA Training Workshop Report, Lusaka

UNICEF (2004), Addressing the Needs of Children Orphaned and made Vulnerable by HIV/AIDS: The Experiences of UNICEF in Tanzania, Rwanda and Swaziland, UNICEF

UN Report, Ending Legalised Violence against Children: Report for East & Southern Africa Regional Consultation – the UN Secretary General's Study on Violence against Children, Johannesburg, South Africa, 2005

Appendices

Stakeholders and their interests/stake

No.	Stakeholders	Interest/importance	Collaboration	Obstacles	Advantages
1.					
2.					
3.					
4.					
5.					
etc					

SWOT Analysis Exercise

The information you provide will help your organisation craft strategies that leverage the company's strengths and minimize the impact of external threats to future growth.

Be honest and thoughtful in your responses.

A. STRENGTHS and WEAKNESSES

Every organization has certain strengths and weaknesses that will influence its long-term performance and competitive position. Strengths and weaknesses are internal capabilities and resources that are likely to lead respectively to higher or lower levels of performance. Your organisation's greatest strengths are the core competencies upon which it should build its competitive advantage.

1. Please rate your organisation's FINANCIAL PERFORMANCE and RESOURCES.

To what extent is each a strength or weakness?

	Major Weakness	**Minor Weakness**	**Neither**	**Minor Strength**	**Major Strength**	**NA**
Access to capital (Three year period)				*		
Cash management					*	
Inventory level and turns (Availability of Systems)						
Degree of capacity utilization						
Asset management						
Liquidity						
Other (record other in box below)						

Other:

3. Please rate your company's MANAGEMENT TEAM and EMPLOYEES capabilities.

To what extent is each a strength or weakness?

	Major Weakness	**Minor Weakness**	**Neither**	**Minor Strength**	**Major Strength**	**NA**
Management communication						
Responsiveness to change						
Ability to attract and retain the best people						
Use of technology to improve profitability						
Management teams leadership						
Employees capabilities and skills						
Company culture and values						
Compensation and benefits						
Strategic planning process						
Other (record other in box below)						

Others:

4. Please rate the quality of your organisation's PRODUCTS and SERVICES.

To what extent is each a strength or weakness?

	Major Weakness	**Minor Weakness**	**Neither**	**Minor Strength**	**Major Strength**	**NA**
Quality of services						
Service differentiation						
Customer service						
Breadth of service line						
Depth of service line						
New service development						
R&D capabilities/resources						
Customer satisfaction and loyalty						
Other (record other in box below)						

Other:

5. What are the major STRENGTHS of your organisation? Be specific and record them in order of importance.

a. Our greatest strength is

b. Our second greatest strength is

c. Our third greatest strength is...

d. Our fourth greatest strength is

6. What are the major WEAKNESSES of your organisation? Be specific and record them in order of importance.

a. Our greatest weakness is...

b. Our second greatest weakness is...

c. Our third greatest weakness is...

d. Our fourth greatest weakness is...

B. OPPORTUNITIES and THREATS

In setting a long term direction, every organization is confronted with a number of opportunities and threats that will influence its future success. Opportunities and threats are external environmental factors that are likely to lead respectively to higher or lower levels of performance. Your strategy should be to pursue its best opportunities while minimizing its greatest threats.

7**. Please rate these CUSTOMER and MARKET factors that may affect your industry**

To what extent does each represent an opportunity or a threat to your organisation?

	Major Threat	**Minor Threat**	**Neither**	**Minor Opportunity**	**Major Opportunity**	**NA**
Community growth rate						
Changing customer(Children) needs and preferences						
Customers sensitivity						
Access to new communities for our products/services						
Technology change						
Size of our communities						
Degree of product differentiation						
Other						

Other:

8. Please rate the COMPETITION and the COMPETITIVE FORCES in your industry.

To what extent does each represent an opportunity or a threat to your organisation?

	Major Threat	Minor Threat	Neither	Minor Opportunity	Major Opportunity	NA
New competitors (organisation) entering our market						
Competitors' (Other organisations) pricing policies/practices						
Competitors' (other Organisation) product/service quality						
Competitors' (Other Organisations) strategies						
Innovation in the industry						
Competitors product/service offering						
Capacity utilization in the industry						
Cyclicality/seasonality in the industry						
Industry profitability						
Intensity of competition						
Size of competitors						
Merger/acquisition activity in industry						
Other (record in box below)						

Other:

9. Please rate these GOVERNMENT, ECONOMIC and SOCIETAL factors that may affect your industry over the next 2-3 years.

To what extent does each represent an opportunity or a threat to your organisation?

	Major Threat	Minor Threat	Neither	Minor Opportunity	Major Opportunity	NA
Changes in government						

regulations						
Changes in economic conditions						
Tax policies						
Changes in social values and norms						
Changes in demographic of population						
Other (record in box below)						

Other:

10. Please rate these WORKFORCE and EMPLOYMENT factors that may affect your industry in the next 2-3 years.

To what extent does each represent an opportunity or a threat to your organisation?

	Major Threat	**Minor Threat**	**Neither**	**Minor Opportunity**	**Major Opportunity**	**NA**
Availability of qualified and skilled employees						
Values, beliefs and expectations of workers						
Wage and salary costs						
Costs of benefits and other employee programs						
Other (record in box below)						

Other:

11. Please rate these SUPPLIER and RAW MATERIAL factors that may affect your industry in the next 2-3 years.

To what extent does each represent an opportunity or a threat to your organisation?

	Major Threat	**Minor Threat**	**Neither**	**Minor Opportunity**	**Major Opportunity**	**NA**
Price of raw materials						
Access to raw materials						
Forward and backward integration						
Quality of raw materials						

Suppliers capabilities and resources						
Other (record in box below)						

Other:

12. What are the major OPPORTUNITIES that your organisation should pursue in the next 2-3 years?

a. Our greatest opportunity is...

b. Our second greatest opportunity is...

c. Our third greatest opportunity is...

d. Our fourth greatest opportunity is...

13. What are the major THREATS to your organisation over the next 2-3 years?

a. Our greatest threat is...

b. Our second greatest threat is...

c. Our third greatest threat is...

d. Our fourth greatest threat is...

Guideline for Community Meetings

For the men, women, youth and children

1. General meeting to explain;

   a) Purpose of the evaluation

   b) The role of beneficiaries

   c) Expectations

2 Mapping for the area showing location of households

3 Time line

a) When the intervention was started

b) Frequency of getting assistance

c) Burden and vulnerability according to calendar year (what do the families do to mitigate the situation?)

d) Improvement in their lives.

4 Wealth Ranking

4 Service Mapping (for FSP and Medical Centre)

5 Drawings representing what constitute the composition of families.

6 Targeting

7 Success stories (factors) or case studies

8 Failure stories (factors) or case studies

INDIVIDUAL HOUSEHOLD QUESTIONNAIRE

Compound:……..……. Respondent No.:……..……

Respondent Category: 01 - Best Case ☐ **02 – Average Case** ☐ **03 – Worst Case** ☐

Q1. How were you identified to be on the Family Strengthening Programme (FSP)?

01 Due to Household head being Old Aged ☐

02 Due to Household head being Terminally ill ☐

03 Due to Household head being Child-headed ☐

04 Other (Relative-headed) ☐

05 Other specify:…….

……

Q2. In which year did you join the SOS FSP? ***Please tick ONE as applicable.***

01. 2001 ☐ 02. 2002 ☐

03. 2003 ☐ 04. After 2003 ☐

Q3. Have you remained with all the children you had at the commencement of the programme?

01. Yes ☐ 02. No ☐

Q4. If "NO" to Q3, what happened to them?

01. SOS Village has taken them on ☐

02. A relative got them ☐

03. They died ☐

04. They became Street Kids ☐

05. They just left home and I do not know where they are ☐

06. Other specify:

……

……

……

Q5. Have you taken on additional children while you had already been on the programme?

01. Yes ☐ 02. No ☐

Q6. If "YES" to Q5, what happened to them? What are the reasons why you took them on?

01. Another daughter/Son passed away ☐
02. A relative passed away **AND I DECIDED TO TAKE THEM ON (not because** They had nowhere to go ☐
03. A relative passed away **AND CHILDREN HAD NO WHERE TO GO** ☐
04. A male dependent I have impregnated someone and the child was brought here ☐
05. A female dependent I have was impregnated by someone and I continue to care for both mother and child **SO THE MOTHER CAN CONTINUE SCHOOL** ☐
06. A female dependent I was impregnated by someone and I care for both the mother **(NOT SCHOOL-GOING)** and the child ☐
07. Other specify:

……

……

……

Q7. What were your **PRIORITY NEEDS <u>WHEN YOU FIRST JOINED THE SOS FSP</u>**? ***Tick the applicable ones***.

S/N	Services	Tick the Priority Needs THEN
1	Education (Pre-School)	
2	Education (Primary)	
3	Education (Basic)	
4	Education (High School)	
5	Vocational Training	
6	Referral for Employment	
7	Medical	
8	Psychosocial Counselling (PSS)	
9	Home Based Care (HBC)	
10	Family Development Plan (FDP)	
11	Grocery Business – Using Loan	
12	Other Business (beans, rice, mealie-meal) – Using Loan	
13	Agricultural Input Loan e.g. Fertilizer and Seeds	
14	Shelter	
15	Food Handouts	

Q8. What are your **PRIORITY NEEDS <u>NOW</u>**? ***Tick the applicable ones***.

S/N	Services	Tick the Priority Needs NOW
1	Education (Pre-School)	
2	Education (Primary)	
3	Education (Basic)	
4	Education (High School)	
5	Vocational Training	
6	Referral for Employment	
7	Medical	
8	Psychosocial Counselling (PSS)	
9	Home Based Care (HBC)	
10	Family Development Plan (FDP)	
11	Grocery Business – Using Loan	
12	Other Business (beans, rice, mealie-meal) – Using Loan	
13	Agricultural Input Loan e.g. Fertilizer and Seeds	
14	Shelter	
15	Food Handouts	

Q9. Which of these Services were **YOU INVOLVED IN DESIGNING AND PLANNING?** ***Tick the applicable ones***.

S/N	Services	Tick
1	Education (Pre-School)	
2	Education (Primary)	
3	Education (Basic)	
4	Education (High School)	
5	Vocational Training	
6	Referral for Employment	
7	Medical	
8	Psychosocial Counselling (PSS)	
9	Home Based Care (HBC)	
10	Family Development Plan (FDP)	
11	Grocery Business – Using Loan	
12	Other Business (beans, rice, mealie-meal) – Using Loan	
13	Agricultural Input Loan e.g. Fertilizer and Seeds	
14	Shelter	
15	Food Handouts	

Q10. Are you ALWAYS told what assistance you qualify for?

01 Yes Always ☐

02 Many Times ☐

03 Sometimes ☐

04 Rarely ☐

05 Never ☐

06 Other, specify ……

Q11. Are you ALWAYS told what AMOUNTS of assistance you qualify for?

01 Yes Always ☐

02 Many Times ☐

03 Sometimes ☐

04 Rarely ☐

05 Never ☐

06 Other, specify ……

Q12. Are you ALWAYS **GIVEN** the AMOUNTS of assistance you qualify for?

01 Yes Always ☐

02 Many Times ☐

03 Sometimes ☐

04 Rarely ☐

05 Never ☐

06 Other, specify ……

Q13. When you **DO NOT** get the AMOUNTS of assistance you qualify for, are you ever given an explanation?

01 Yes Always ☐

02 Many Times ☐

03 Sometimes ☐

04 Rarely ☐

05 Never ☐

06 Other, specify ……

Q14. When you do get assistance, is it **ALWAYS TIMELY?**

01 Yes ☐ 02 No ☐

Q15. Which assistance is NEVER timely? Please explain who you say so.

S/N	Services	Tick	Explanation i.e. why do you say so?
1			

	Education (Pre-School)		
2	Education (Primary)		
3	Education (Basic)		
4	Education (High School)		
5	Vocational Training		
6	Referral for Employment		
7	Medical		
8	Psychosocial Counselling		
9	Home Based Care (HBC)		
10	Family Development Plan		
11	Grocery Business – Using Loan		
12	Other Business (beans, rice, mealie-meal) – Using Loan		
13	Agricultural Input Loan		
14	Shelter		
15	Food Handouts		

Q16. What did you use to do to meet your food requirements before SOS adopted our family for assistance? ***TICK ALL THE RELEVANT ANSWERS***

01 We would sleep hungry ☐

02 We would ask for handouts from NEIGHBORS ☐

03 We would ask for handouts from RELATIVES ☐

04 We were on another NGO programme assistance ☐

05 We used to get credit ☐

06 Other, specify ……

……

Q17. What do you do NOW when food runs out? ***TICK ALL THE RELEVANT ANSWERS***

01 We would sleep hungry ☐

02 We would ask for handouts from NEIGHBORS ☐

03 We would ask for handouts from RELATIVES ☐

04 We ALWAYS go back to SOS to ask for help ☐

05 We SOMETIMES go back to SOS to ask for help ☐

06 We get credit ☐

07 Other, specify ……

……

Q18-26.Please give the details of all the people you stay with.

s/n	Name of Person	Sex	Year of Birth	If Orphan, State whether Maternal (M), Paternal (P) or Double (D)	Relationship to Household Head	Marital Status	Occupation	How did children come into Household	
								Reason	Year

Q27. Please give the EDUCATION ASSISTANCE details of all the people you stay with that is, the kind of assistance you receive from SOS and its frequency.

S/N	Name of Child	Type of Assistance										
		School Fees	Shoes	Uniform	Socks	School Bag	Books	Pens	Pencils	Sports wear	Other specify:	Other specify:

Q28-33 Details about the **HEALTH** of Household members

s/n	Name of the sick member	What is the most serious disease that ... is/was suffering from? ***See Code Sheet***	For how long has/had ..... been sick? **(record the period in months)**	Has …….. been unable to perform his/her usual work as a result of this illness? **01 - Yes during the illness** **02 - Yes during/after the illness** **03 - No**	For how long has ……. been unable to perform normal duties? ***Record duration in months***	What help is SOS currently providing with regards to health and how often

Q34. What do you do when a member of your family members is sick

01 We always go to the SOS medical centre ☐

02 We sometimes seek help from our nearest clinic (other than SOS) ☐

03 We always go to the nearest clinic ☐

04 We do nothing ☐

05 Other, specify

……

…… ..

Q35. If you do not use the SOS clinic, why

01 It is very far ☐

02 The staff there shout at us for going frequently ☐

03 The staff at the nearby clinic are very friendly ☐

04 SOS has no food supplement programme for the HBC client ☐

05 Other, specify

……

……..

Q36. Do you have any Home Based Care patient?

01 Yes ☐ 02 No ☐

Q37. Where do you get your HBC medical assistance

01 SOS ☐

02 Bwafano ☐

03 Catholic ☐

04 Other, specify

……

……..

Q38. If you do not use the SOS clinic for HBC, why

01 It is very far ☐

02 The staff there shout at us for going frequently ☐

03 The staff at the nearby clinic are very friendly ☐

04 SOS has no food supplement programme for the HBC client ☐

05 Other, specify

……

……

Q39. Have you ever received an education on HIV/AIDS and sexually transmitted diseases?

01 Yes ☐ 02 No ☐

Q40. Who pays for you medical fees?

05 SOS ☐

06 Bwafano ☐

07 Catholic ☐

08 Other, specify

……

……

Q41. Are you able to get adequate help at the SOS clinic

07 Yes Always ☐

08 Many Times ☐

09 Sometimes ☐

10 Rarely ☐

11 Never ☐

12 Other, specify

……

Q42. Do you have children who fail to go to School due to frequent illness?

01 Yes ☐ 02 No ☐

Q43. How do you travel to the SOS clinic when you have a sick family member

01 We walk ☐

02 We use our bicycle ☐

03 We hire a bicycle ☐

04 We use our wheelbarrow ☐

05 We hire a wheelbarrow ☐

06 We hire a taxi ☐

07 We call a relative with a car ☐

08 Neighbors help us using their bicycle ☐

09 Neighbors help us using their wheelbarrow ☐

10 Neighbors help us using their car ☐

11 We call SOS and the send a vehicle to pick the patient ☐

12 Other, specify

……

……

Q44-45 What is your judgment of the services being provided?

S/N	Services You Receive	Q44. Rate 01 – Working Excellently 02 – Working Very Well 03 – Working Well 04 – Working Badly 05 – Working Very Badly 06 – Total Failure	Q45. Reason i.e. why do you say so?
1	Education (Pre-School)		
2	Education (Primary)		
3	Education (Basic)		
4			

	Education (High School)		
5	Vocational Training		
6	Referral for Employment		
7	Medical		
8	Psychosocial Counselling		
9	Home Based Care (HBC)		
10	Family Development Plan		
11	Grocery Business – Using Loan		
12	Other Business (beans, rice, mealie-meal) – Using Loan		
13	Agricultural Input Loan		
14	Shelter		
15	Food Handouts		

Q46. Which **ONE** would you say have been the **BEST** services that SOS has offered? ***Tick the applicable ONE***.

Code	Services	Tick the best and give the reason
01	Education (Pre-School)	
02	Education (Primary)	
03	Education (Basic)	

04	Education (High School)	
05	Vocational Training	
06	Referral for Employment	
07	Medical	
08	Psychosocial Counselling (PSS)	
09	Home Based Care (HBC)	
10	Family Development Plan (FDP)	
11	Grocery Business – Using Loan	
12	Other Business (beans, rice, mealie-meal) – Using Loan	
13	Agricultural Input Loan e.g. Fertilizer and Seeds	
14	Shelter	
15	Food Handouts	

Q47. Which **ONE** would you say have been the **WORST** services that SOS has offered? ***Tick the applicable ONE***.

Code	Services	Tick the worst and give the reason
01	Education (Pre-School)	
02	Education (Primary)	
03	Education (Basic)	

04	Education (High School)	
05	Vocational Training	
06	Referral for Employment	
07	Medical	
08	Psychosocial Counselling (PSS)	
09	Home Based Care (HBC)	
10	Family Development Plan (FDP)	
11	Grocery Business – Using Loan	
12	Other Business (beans, rice, mealie-meal) – Using Loan	
13	Agricultural Input Loan e.g. Fertilizer and Seeds	
14	Shelter	
15	Food Handouts	

Q48. Which ones would you recommend for them to continue? ***Tick the applicable ones***.

S/N	**Services**	Tick	**Explanation i.e. why do you say so?**
1	Education (Pre-School)		
2	Education (Primary)		
3	Education (Basic)		

4	Education (High School)		
5	Vocational Training		
6	Referral for Employment		
7	Medical		
8	Psychosocial Counselling		
9	Home Based Care (HBC)		
10	Family Development Plan		
11	Grocery Business – Using Loan		
12	Other Business (beans, rice, mealie-meal) – Using Loan		
13	Agricultural Input Loan		
14	Shelter		
15	Food Handouts		

Q49. Which ones would you recommend for them to discontinue? ***Tick the applicable ones***.

S/N	**Services**	Tick	**Explanation i.e. why do you say so?**
1	Education (Pre-School)		
2	Education (Primary)		

3	Education (Basic)		
4	Education (High School)		
5	Vocational Training		
6	Referral for Employment		
7	Medical		
8	Psychosocial Counselling		
9	Home Based Care (HBC)		
10	Family Development Plan		
11	Grocery Business – Using Loan		
12	Other Business (beans, rice, mealie-meal) – Using Loan		
13	Agricultural Input Loan		
14	Shelter		
15	Food Handouts		

Q50. Which Services **HAVE BEEN DISCONTINUED** which you wish should not have been discontinued. **TICK AGAINST** Programme that has been discontinued

S/N	**Services**	Tick	**Explanation i.e. why do you say so?**

1	Education (Pre-School)		
2	Education (Primary)		
3	Education (Basic)		
4	Education (High School)		
5	Vocational Training		
6	Referral for Employment		
7	Medical		
8	Psychosocial Counselling		
9	Home Based Care (HBC)		
10	Family Development Plan		
11	Grocery Business – Using Loan		
12	Other Business (beans, rice, mealie-meal) – Using Loan		
13	Agricultural Input Loan		
14	Shelter		
15	Food Handouts		

Q51. How do you **RECOMMEND** that the services could be **improved**?

S/N	Services	Explanation i.e. why do you say so?
1	Education (Pre-School)	
2	Education (Primary)	
3	Education (Basic)	
4	Education (High School)	
5	Vocational Training	
6	Referral for Employment	
7	Medical	
8	Psychosocial Counselling	
9	Home Based Care (HBC)	
10	Family Development Plan	
11	Grocery Business – Using Loan	
12	Other Business (beans, rice, mealie-meal) – Using Loan	
13	Agricultural Input Loan	
14	Shelter	
15	Food Handouts	

Q52. Do any of your household members receive assistance from elsewhere?

01. Yes ☐ 02. No ☐

Q53-55. If "Yes" to Q52, please state the organization helping, type of assistance given and frequency?

S/N	Name of Organization	Help provided	
		Item	Frequency

Q56. Have you received any life skills training from SOS?

01. Yes ☐ 02. No ☐

Q57. If "YES", What kind of training was it?

……
…….

……
…….

……
…….

Q58. Who owns the house you stay in?

Q59. If it is Your own, do you have legal title deed to it?

01. Yes ☐ 02. No ☐

Q60. Do you KNOW what will happen to the children when you pass away?

01. Yes ☐ 02. No ☐

Q61. If "YES" to question Q34 what would happen to them? ***TICK AS MANY AS ARE APPLICABLE***

01. SOS will get them ☐
02. One of the elderly children in the household will continue looking after them **JUST HERE** ☐
03. The elderly children in the household will continue looking after them **ELSEWHERE** ☐
04. Relatives will get them ☐
05. Other specify:

……
……
……
…….

Q62. What would love to happen to them?

01. SOS should taken them in ☐
02. Relatives should take them ☐
03. They should be given up for foster care else where ☐
04. They should be given up for adoption else where ☐
05. Other specify:

a. ……
….

b. ……
.

c. ……
….

Q63. Have you discussed this with the SOS FSP workers?

01. Yes ☐ 02. No ☐

Q64. If "YES" to Q63, has it been agreed to?

02. Yes ☐ 02. No ☐

Q65. If "YES" to Q64, what has it been agreed to?

……
……

……
……

……
……

……
……

Q66. What has been your greatest challenge? **PLEASE TICK THE RELEVANT ONES.**

01. Food for children ☐
02. Food for the whole household ☐
03. School for all the children ☐
04. School for the Orphans ☐
05. Employment for the Vocational Centre Graduates ☐
06. Employment for the non- Vocational Centre Graduates ☐
07. Health for the Children ☐
08. Health for myself ☐
09. Health for the adults in the Household ☐
10. Business not being viable ☐
11. Lacking a sustainable business venture ☐
12. Children truancy from School ☐
13. Children truancy from Home ☐
14. Rebellion from Children ☐
15. Other specify:

    a. ……
    ….

    b. ……
    .

c. ……
….

Q67. What is your opinion of your community mobiliser?

……
……

……
……

……
……

……
……

……
……

Q68. What other things do you wish to say as we conclude?

……
……

……
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……
……

THANK YOU FOR YOUR TIME