

Mid-Term Evaluation Report For Zambia Family South Central (ZAMFAM SC) Project



April 2019

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"Re - booting development interventions"

Cover Photo: Pupils reading and sharing ideas based on the contents of the Youth Club Program Manual.

Photo: Courtesy of Promotion Team, DAPP Zambia

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LIST OF ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ART	Anti-retroviral
CAG	Community Action Group
CCV	Child Care Volunteer
CHW	Community Health Worker
Creative	Creative Associates International
CWAC	Community Welfare Assistance Committee
DAC	Development Assistance Committee
DAPP	Development Aid from People to People
DMS	Data Management System
DWAC	District Welfare Assistance Committee
ERG	Evaluation Reference Group
FGD	Focus Group Discussion
GRZ	Government of the Republic of Zambia
HIV	Human Immune-Deficiency Virus
KAHFI	Kabwe Adventist Family Health Institute
KII	Key Informant Interview
M&E	Monitoring and Evaluation
MCDSS	Ministry of Community Development and Social Services
MTE	Mid-Term Evaluation
NZP+	Network of Zambian People Living with HIV
OECD	Organisation for Economic Co-operation and Development
OVC	Orphans and Vulnerable Children
PCSC	Parent Community School Committees
PLWHA	People Living with HIV and AIDS
SILC	Savings and Internal Lending Communities
USAID	United States Agency for International Development
WASHE	Water Sanitation and Health Education
YWCA	Young Women Christian Association
ZAMFAM SC	Zambia Family South - Central Project

BASIC PROJECT INFORMATION

Table 1: Basic project information

Project Title	USAID – DAPP ZAMFAM – South Central Project
Project Number	Cooperative Agreement No. AID - 611 - A - 16 - 00002:
Project Goal	To improve the care and resilience of vulnerable populations in the Central and Southern Provinces of Zambia, specifically targeting OVC and PLWHA by supporting, protecting, and strengthening the capacity of children, families, and communities
Total Project Cost	US\$ 24,411,023.00
Finance Agency	United States Agency for International Development (USAID)
Implementing Agency	Development Aid from People to People (DAPP)
Implementing Partners	Creative Associates International, Inc., Network of Zambian People Living with HIV and AIDS (NZP+), Kabwe Adventist Family Health Institute (KAFHI) and Young Women Christian Association (YWCA)
Project Location	The project is operating in 10 districts of Zambia; 6 districts in Southern Province namely, Choma, Livingstone, Mazabuka, Monze, Namwala and Sinazongwe and 4 districts in Central Province namely Chibombo, Kabwe, Kapiri Mposhi and Mumbwa
Expected Results	i. Resilience of households to care for children and adolescents living with, affected by and/or vulnerable to HIV measurably increased. ii. Child wellbeing status measurably improved due to provision and accessing of quality care and support services. iii. Capacity of government and community structures to care for and support children and adolescents living with, affected by and/or vulnerable to HIV measurably increased. iv. Shared learning and evidence - base to improve programming, inform policy and program investment strengthened.
Start Date	20 November 2015
End Date	19 November 2020
Final MTE Report Date	12 April 2019

Source: Adapted from DAPP ZA MFAM SC Annual Report 2017 - 2018

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In undertaking the Mid - Term Evaluation (MTE) of Development Aids from People to People (DAPP) Zambia Family South - Central (ZAMFAM SC) project, PathMark Rural Development Consult received appreciable support and co-operation from a number of organizations and individuals. Therefore, we wish to take this opportunity to convey our profound gratitude to them.

Our special gratitude is being extended to Ms. Elise Soerensen, DAPP Zambia Managing Director; Dr. Vincent Munene, DAPP ZAMFAM SC Chief of Party and all Evaluation Reference Group (ERG) members for giving us an opportunity to carry - out the MTE assignment. In addition, we acknowledge both guidance and support received from the ERG members throughout the assignment period.

Furthermore, we convey our appreciation to other DAPP Zambia staff, especially the district coordinators, project leaders and community mobilizers in the sampled six project districts of Livingstone, Mazabuka, Kabwe, Kapiri Mposhi, Kabwe, Mumbwa and Chibombo. These staff mobilised targeted respondents for our evaluation meetings, especially caregivers, orphans and vulnerable children, members of Community Action Groups and other key stakeholders in their respective geographical districts.

In addition, we extend our gratitude to Dr. Nkomba Kayeyi and Lyson Phiri of the Population Council for the information and experiences shared on the use of caregiver/children household questionnaires, processing and analysing gathered field data.

We also thank the Ministries of Community Development and Social Services as well as Health Headquarters in Lusaka for granting us permission to work with their field staff in the sampled project districts. In the same vein, we appreciate the co-operation we received from school heads/ teachers of the schools interviewed. In addition, we extend our gratitude to Mr. Sitwala Mungunda, USAID representative, who accorded us time for an in-depth interview.

Finally, we convey our appreciation to all the traditional and civic leaders as well as other people who spared some time from their schedules to be interviewed.

Views and opinions expressed in this report do not represent those of DAPP Zambia or USAID Zambia office or the people interviewed. These are wholly attributed to the Evaluation team.

EXECUTIVE SUMMARY

Introduction

Zambia Family South – Central (ZAMFAM SC) is a five – year (2015 – 2020) integrated community project with overall goal of improving care and resilience of vulnerable populations, specifically targeting Orphan and Vulnerable Children (OVC) and People Living with HIV and AIDS (PLWHA). ZAMFAM SC Project is being implemented in 10 districts of Zambia by Development Aid from People to People (DAPP) in partnership with Creative Associates International, Kabwe Adventist Family Health Institute (KAFHI), Network of Zambian People Living with HIV and AIDS (NZP+) and Young Women Christian Association (YWCA). The project provides support and services to 72,219 households and 130,000 OVC each year. ZAMFAM SC receives financial and technical support from the United States Agency for International Development (USAID).

Evaluation Purpose and Methodology

As ZAMFAM SC Project reached half - way mark of its implementation period, DAPP commissioned a Mid – Term Evaluation (MTE) in accordance with the signed Cooperative Agreement. The MTE purpose was to assess progress made so far towards achieving ZAMFAM SC Project objectives, outcomes and drawing - out lessons on how the project performance can be improved during its remaining implementation period. PathMark Rural Development Consult was engaged to undertake the MTE assignment and employed mixed - methods approach gleaning both quantitative and qualitative data to inform the evaluation. The MTE was anchored on assessment of the four project result areas, namely, resilience of households to care for orphans and vulnerable children, child wellbeing status, capacity of government and community structures to care and support children as well as shared learning and evidence – base to improve programming. In addition, the MTE addressed the following assessment criteria with related evaluation questions:

Relevance: To what extent were operations and objectives of the ZAMFAM SC Project consistent with beneficiaries’ needs, GRZ and donors’ policies?

Effectiveness: What best practices can be documented with regard to service delivery and implementation?

Efficiency: To what extent have project resources been efficiently utilized?

Exit & Sustainability: What supportive mechanisms have been put in place for the household?

Co-ordination, Gender & Environment. What have been environmental concerns? To what extent has project implementation mainstreamed gender issues?

The Evaluation team utilised a Non-Experimental Design Study of 72,219 ZAMFAM beneficiary OVC households (represented by actual sample of 665 caregivers, 341 children (0 – 9 years) and 139 children (10 – 17 years) in project communities of 6 selected districts. These districts are Livingstone and Mazabuka in Southern Province; Mumbwa, Chibombo, Kabwe and Kapiri Mposhi in Central Province. The survey districts were purposively- sampled on account of being in the project since its inception. Survey respondents were selected from DAPP ZAMFAM beneficiary lists which had been used during the benchmark survey but updated in the course of

project implementation. Using Sampling Proportional to Size technique, a total of 784 caregivers/households were sampled for data collection.

For consistency and compatibility of benchmark values with MTE findings, the Evaluation team used same caregivers/children questionnaires which had been used during the benchmark survey. Being a mixed – methods approach, data collection tools such as Focus Group Discussion (FGD) targeting Community Action Groups and Youth Clubs as well as Key Informants Interviews (KII) were utilised to enhance the depth and breadth of data collected. This approach also facilitated triangulation and cross - checking of the gathered data. Field data collection exercise in the sampled 6 project districts was divided into two phases. Phase one covered Livingstone and Mazabuka districts and was carried - out from 15 – 21 December 2018. Phase two involving Kapiri, Kabwe, Chibombo and Mumbwa districts ran from 14 – 25 January 2019. As field data collection exercise was conducted during the rainy season, most targeted respondents could hardly be available for evaluation meetings because they were pre - occupied with farming activities. Moreover, due to impassable roads triggered by rains, a few sampled project areas and households also became inaccessible. Alternatively, the Evaluation team replaced inaccessible respondents with accessible ones as long as they had similar characteristics.

Key Evaluation Findings

Using Android smartphones loaded with caregiver/children questionnaires, the Evaluation team administered these questionnaires to 665 caregivers/households out - of the sampled 784 respondents, representing 85% achievement. This result was due to inaccessibility of some sampled project areas and households caused by the rains. The Evaluation team also conducted 19 FGDs against 12 planned ones, representing 158% achievement and 65 KIIs against planned 24 ones, representing 271% achievement. More data was collected using FGDs and KIIs to augment caregiver/household data.

At benchmark stage, 91.4% of households/caregivers interviewed were females and 8.6% were males. At MTE stage, 86.4% of households/caregivers interviewed were females and 13.6% were males. These results were statistically significant at $z = 3.848$, $p = <.001$. The results were also supported by information from FGDs where participants indicated that more males were taking up caregiving responsibilities.

The mean years of schooling increased from 5.9 at benchmark stage to 7.9 at MTE and was statistically significant at $z = 17.002$, $p < .001$. In addition, the percentage of caregivers who could not read a sentence, significantly dropped from 33.4 % at benchmark stage to 16.0% at MTE stage ($z = -9.851$, $p < .001$). ZAMFAM SC puts emphasis on education of project population for both children and adults. This was noticed during the direct observations made by the Evaluation team at the project beneficiary schools especially those that had received reading and teaching materials. In addition, weekly trainings conducted by project leaders and community mobilisers for Community Action Group members inspired beneficiaries to take education more seriously.

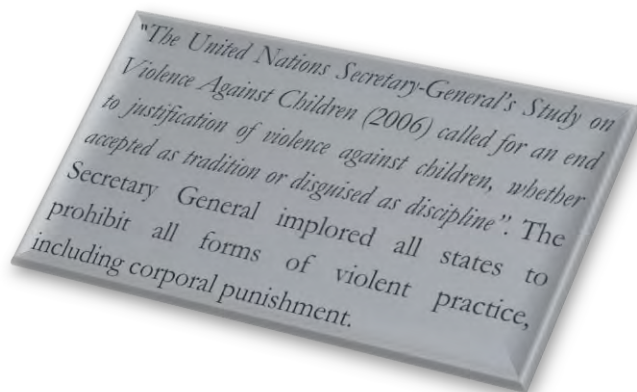
At benchmark stage, undernourishment was at 3.7%. At MTE, undernourishment was at 13.4%. The differences in percentages of undernourishment at benchmark stage and the MTE were

significant, $z = -48.733$, $p < .001$. According to the 2013 – 14 ZDHS, 40% of children Under 5 were stunted, 6% were wasted and 15% were underweight. The MUAC tape measurement taken during both benchmark and MTE surveys speak more to underweight. The undernourishment value of 13.4% recorded during MTE is in closer sync with ZDHS's underweight of 15%. On the basis of the ZDHS and MTE result values comparison, it is evident that there is a reduction in undernourishment among the children under 5 in the sampled project districts.

The Wealth Mean (count type of 19 items) at benchmark stage was 4.9% and 4.2% at MTE. The drop was significant at $z = -495.376$, $p < .001$. The drop-in wealth mean count was minimal and the difference could be attributed to the context in which the benchmark was conducted compare to the MTE. For example, the BM includes items like boats which are necessary in water bodies while the MTE covered areas where there were no water bodies.

At benchmark stage, 52.8% caregivers knew HIV status of their children. At MTE stage, the percentage increased to 98.6%. These results were significantly different at $z = 51.198$, $p < .001$. During FGDs, most of the participants had indicated that there was a lot of sensitisation activities about issues surrounding HIV and AIDS in particular VCT promoted under ZAMFAM project. These activities had raised their level of awareness about HIV and AIDS and they were keen on knowing HIV status of their children. The positive result on Caregivers knew HIV status of their children resonates with both the Ministry of Health National Health Strategy as well as National HIV and AIDS Strategy Framework 2017 – 2021. These strategic documents were formulated on UNAIDS 95 – 95 – 95 Fast-track Targets on epidemic elimination. The Caregiver knew HIV status indicator is a first step on the fast track indicators.

The percentage of caregivers agreeing to claim that harsh punishment is appropriate discipline to be given to a child was at 38.5% during benchmark stage. The percentage dropped to 32.4% at MTE time. The drop was not statistically significant at $z = -0.939$, $p = 0.348$. This means that there is still an appreciable number of respondents who believed that harsh punishment was appropriate way to discipline the child.



The survey found notable best practices for service delivery and implementation as harnessing comparative advantage of partner organisations in projects' activities implementation. Creative Associates, KAFHI, YWCA and NZP+ bring to the partnerships their expertise in critical areas of project management. In addition, working with and through existing government and community structures which will continue functioning even after the project ends. The new approach of "TRIOS" in caring and supporting children on ART. This approach provides a back-up person to encourage the person on treatment not to default.

In all 6 project districts visited by the Evaluation team, the members found functional ZAMFAM SC Project structure of District Coordinator, project leaders and community mobilizers. In each

district, there are 8 - 10 project leaders. Each project leader is supported by three (3) community mobilizers in the operational area. Each community mobiliser manages about 250 households and 500 OVCs. Each District Coordinator and project leader had been given some form of transport - motorbike and community mobilisers had also been given bicycles for transport. Mobile phones had been given to all full-time project staff in each district visited. Motorbikes, bicycles and mobile phones had improved the project staff mobility and communication.

Notwithstanding the challenges experienced in administering the school block grants, particularly procurement of school desks, ZAMFAM SC is performing well on essential indicators such as Improvement in Child Status, Caregiver knows child's HIV status and increasing number of men taking up caregiving roles. DAPP ZAMFAM SC Project is leveraging the comparative advantage of its sub-grantees; NZP+, YWCA, Creative Associates and KAFHI in activities implementation. In addition, the project has innovated "TRIOs approach" in caring and supporting children on Anti-retroviral (ART).

Key Recommendations

Based on what DAPP ZAMFAM SC Project has hitherto achieved, it is most likely that it will achieve most project targets. Some of the key recommendations being advanced are as follows:

- i. Innovative and consistent caregiver/household economic strengthening interventions should be implemented to tackle the endemic household undernutrition on sustainable basis
- ii. Procurement of project materials, especially school desks, should be carried out in good time so as not to disrupt school attendance by targeted beneficiary pupils.
- iii. More efforts should be directed at facilitating establishment and strengthening savings and internal lending communities in project areas.
- iv. Community Action Group Training Manual, currently produced in English Language, be translated in at least two local languages to make the contents more user – friendly to trainers
- v. ZAMFAM has provided a huge market to equipment suppliers (motorbikes – Honda Zambia; bicycles – Buffalo & Zambike, mobile phones and airtime – MTN). As a normal business practice, these companies can be approached for project support/donations under their respective social investment strategy
- vi. Crucial Surveys, like Mid - Term Evaluation, should be conducted during dry season when accessibility to all sampled project areas, communities and households is feasible
- vii. Closer consultations to be made with Ministry of Fisheries and Livestock for technical advice and guidance on procurement of "pass – on" livestock (goats and chickens) and livestock movement ban.
- viii. More conscientization efforts to be made among project population to change endemic belief that harsh punishment is appropriate discipline to be given to the child.

1 INTRODUCTION

The Zambia Family South - Central (ZAMFAM SC) is a five – year (2015 – 2020) integrated community project with main goal of improving care and resilience of vulnerable populations, specifically targeting Orphan and Vulnerable Children (OVC) and People Living with HIV and AIDS (PLWHA). ZAMFAM SC is being implemented by Development Aid from People to People (DAPP) in partnership with Creative Associates International, Kabwe Adventist Family Health Institute (KAFHI), Network of Zambian People Living with HIV and AIDS (NZP+) and Young Women Christian Association (YWCA) to strengthen comprehensive, integrated service delivery and support to children and adolescents living with, affected by, and /or vulnerable to HIV and their households.

The project is being implemented in ten (10) districts of Zambia; six in Southern Province (viz Choma, Livingstone, Mazabuka, Monze, Namwala and Sinazongwe) and four in Central Province (viz Chibombo, Kabwe, Kapiri Mposhi and Mumbwa). ZAMFAM SC is operationalized through collaboration with government ministries of Health, Community Development and Social Services, General Education, Agriculture, Fisheries and Livestock providing services and support to 72,219 households and 130,000 OVC each year. The project receives financial and technical support from the United States Agency for International Development (USAID).

As ZAMFAM SC Project reached half - way mark of its implementation period, DAPP commissioned a Mid – Term Evaluation (MTE) in accordance with the signed Cooperative Agreement to assess progress made so far towards achieving its objectives. In this regard, PathMark Rural Development Consult was engaged to conduct the evaluation assignment.

The Mid- Term Evaluation Report is organised into eight chapters. Chapter one provides introduction and chapter two presents ZAMFAM SC Theory of Change and implementation logic. Chapter three gives the Mid – Term Evaluation Rationale, Stakeholders and users' of findings and chapter four outlines the MTE purpose, objectives and scope. Chapter five shows the Evaluation questions and chapter six carries the Evaluation design, methods and limitations. Chapter seven provides the Findings and Conclusions and chapter eight presents recommendations.

2 THEORY OF CHANGE AND IMPLEMENTATION LOGIC MODEL

The overall goal of ZAMFAM SC Project is to improve the care and resilience of OVC in the Central and Southern Provinces of Zambia, by supporting, protecting and strengthening capacity of children, families and communities. The project is underpinned by the following objectives:

- Increasing resilience of households to care for children and adolescents living with, affected by and/or vulnerable to HIV
- Improving child wellbeing status due to provision and accessing of quality care and support services
- Increasing capacity of government and community structures to care for and support children and adolescents living with, affected by and/or vulnerable to HIV; and
- Strengthening shared learning and evidence - base to improve programming and inform policy and program investment.

ZAMFAM SC Project is premised on the hypothesis that accessing social services and economic support contributes to HIV and AIDS epidemic control and mitigation for OVCs and their households. It is assumed that positive change, as articulated in the foregoing project objectives, will be achieved through operationalising the following strategies:

- **Improving health and livelihood which should start with each individual:** Sensitising all individuals including adults, adolescents and children that they themselves have the main responsibility for their own health and future
- **Strengthening families to improve care and support for OVC:** Families have the social mandate and actual daily connections with OVC. These are primary organs responsible for welfare of OVC
- **Organisation and strengthening of community groups:** Successful activities will be achieved through organising participating households into Community Action Groups (Village/Community Action Groups, Saving and Lending, Youth Clubs etc) in which they can provide mutual support. These act as structures through which to reach individuals with information and support services.
- **Strengthening of government structures to care for OVC:** The project working with government structures at district and community levels i.e. District Welfare Assistance Committees (DWAC), district health office and follow up systems to provide HIV and other quality services for OVC wellbeing.

- **Strengthen shared - learning and evidence to improve programming and inform policy as well as programme investment, sharing lessons – learnt, discussing successes and constraints with the community through community review meetings:** These will improve community planning while sharing best practices, lessons learnt with civil society to improve planning and implementation at project level.

3 MID – TERM EVALUATION RATIONALE, STAKEHOLDERS AND USERS' OF FINDINGS

3.1 Rationale

The MTE was commissioned based on the following reasons:

- i. DAPP ZAMFAM SC Project conducted a baseline study before start of the project which provided a situational analysis. This informed establishment of the project indicator baseline information and verification of targets provided in the project agreement. This MTE will allow DAPP ZAMFAM SC to follow - up on the progress of project indicators measured against the baseline values
- ii. Project improvement, using MTE results as feedback to DAPP ZAMFAM SC Project, to make the project function more effectively and efficiently
- iii. Project accountability and transparency; so that stakeholders and funder alike, are aware of the project progress
- iv. Provide strategic and concrete evidence on the relevance, results, processes and utilization of resources by the project.

3.2 Stakeholders

A number of stakeholders, both inside and outside DAPP ZAMFAM SC Project, have keen interests in the evaluation findings. Predominantly, these stakeholders are individuals, groups and organisations who may affect, or perceive to be affected by decision, action or outcome of the project. DAPP ZAMFAM SC Project main stakeholders are the project staff, government ministries, beneficiaries (OVCs, care givers, youth), implementing partners, USAID, Ethical Boards etc.

In conducting the evaluation, PathMark Rural Development Consult and internal Evaluation Reference Group (ERG) made every effort to ensure that respondents represented all key stakeholders. In addition, they ensured that all ethical review procedures and protocols were strictly followed.

3.3 Users' of MTE Findings

The expected users of the MTE findings are primarily; the DAPP ZAMFAM SC Project team, DAPP Partnership Office, Government, USAID and implementing partners.

4 EVALUATION PURPOSE, OBJECTIVES AND SCOPE

4.1 Purpose

It was to assess progress made so far towards achieving project objectives, outcomes and drawing - out lessons on how ZAMFAM SC Project can be improved during the rest of its implementation period for a more positive impact.

4.2 Specific Objectives

In particular, the MTE aimed to:

- i. Assess relevance of ZAMFAM SC Project objectives and its approach.
- ii. Assess effectiveness and efficiency in implementation of ZAMFAM SC Project at province, district, and sub-district levels
- iii. Assess results achieved in ZAMFAM SC Project and extent to which sustainability considerations have been built-in
- iv. Compare baseline data with the current evaluation data. Then provide insights into progress against the project targets
- v. Assess extent to which issues of gender equality, social inclusion and equity as well as environment have been taken into consideration
- vi. Assess extent of co -ordination with partners and other actors in the area of OVC HIV and AIDS with a view to strengthening partnerships; and
- vii. Identify lessons and good practice from ZAMFAM SC implementation, opportunities to improve current planning, project implementation and feed into the project improvement plan for the remaining two years of the project life.

4.3 Scope

The evaluation covers ZAMFAM SC Project interventions during the period November, 2015 – September 2018. The evaluation is forward-looking and provide lessons and plausible recommendations to improve on the future performance of ZAMFAM SC Project for the remaining implementation period. The geographical scope includes six sampled ZAMFAM SC operational districts, namely Mumbwa, Kapiri Mposhi, Kabwe and Chibombo; Mazabuka and Livingstone in Central and Southern Provinces respectively.

5 EVALUATION QUESTIONS

Under the guidance of the ERG, PathMark Rural Development Consult team employed five-evaluation thematic area criteria focusing mainly on the project process and outcome performance. The thematic areas and their respective key evaluation questions are tabulated in Table 2 below:

Table 2: Five Evaluation Thematic Area Criteria

Thematic Area	Evaluation Questions
Relevance	- To what extent were the operations and objectives of the ZAMFAM SC Project consistent with beneficiaries' needs, GRZ and donors' policies? - Were approaches and strategies used relevant to achieve the intended changes in the baseline values?
Effectiveness	- What best practices can be documented with regard to service delivery and implementation? - What is the level of knowledge and awareness of OVC around HIV/AIDS? - What is the change in Knowledge, Practice and Attitude on HIV and AIDS among adolescents and youth? - How have rates of graduation of OVC due to decreased vulnerability changed over the course of implementation
Efficiency	To what extent have the resources of the project been efficiently utilized?
Exit & Sustainability	- What will household likely continue doing beyond the life of the project? - What supportive mechanism have been put in place for the household?
Cross-cutting Issues	
Coordination, Gender & Environment.	- What has been the environmental concerns and what has been the mitigations this far? - To what extent has the project implementation mainstreamed gender issues?

Source: Adapted from Revised MTE ToRs

6 EVALUATION DESIGN, METHODS AND LIMITATIONS

For consistency and compatibility of MTE findings with Baseline values, the PathMark Rural Development Consult team predominantly utilized the caregiver/household questionnaires which had been used during the benchmark survey. As a way of deepening and widening scope of the evaluation, the Evaluation team used a mixed – methods approach to glean both quantitative and qualitative data. In this regard, the team used a wide array of data collection tools, which among others, included the following:

6.1 Document and System Review

The Evaluation team undertook a desk interrogation of critical ZAMFAM SC Project documents such as the following:

- i. Signed USAID Co-operative Agreement which provides key guidelines on utilization, management of project grant and project implementation
- ii. Benchmark Assessment of Orphan and Vulnerable Children in Areas of the ZAMFAM SC Project Report. This Report compiled by the Population Council succinctly explains how the baseline was undertaken. It also presents baseline values on nine (9) PEPFAR OVC's Outcome Indicators, the anchor of ZAMFAM SC M & E system
- iii. ZAMFAM SC Project Activity Monitoring and Evaluation Plan (AMEP). This plan provides project monitoring and evaluation system. It also articulates the project theory of change and its logical framework.
- iv. ZAMFAM SC Annual Operation Plans 2015 – 2016; 2017 – 2018 and 2018 – 2019. These plans give details on the planned activities in line with the project objectives and result areas for the project operational year under consideration
- v. ZAMFAM SC Annual Progress Reports 2015 – 2016; 2016 – 2017 and 2017 – 2018. Aside from Annual Reports, some Quarterly Reports were availed. The quarterly reports' activities implementation status has been collated into Annual Reports. These reports provide key information required for evaluation assignment.
- vi. Ministry of Health's National Health Strategic and Adolescent Health Strategic Plans 2017 – 2021; National HIV and AIDS Strategic Framework 2017 – 2021. These plans postulate the government strategic direction on health, HIV and AIDS for driving towards attainment of UNAIDS 90 – 90 – 90 Fast Track Targets on Elimination of HIV and AIDS. Ministry of General Education 2013 School Curriculum which has embraced comprehensive sexuality education in school learning. It resonates well with

ZAMFAM SC Project's school – targeted HIV and AIDS as well as sexual reproductive health awareness interventions.

- vii. Internet Search on prominent global websites with information and education on HIV and AIDS such as www.avert.org. This provides latest information for selected countries (including Zambia). The website has availed information on Zambia's Progress towards UNAIDS 90 - 90- 90 Targets, which by end of December 2018, was not available either at National AIDS Council or Ministry of Health institutions.

6.2 Inception Report

The first evaluation assignment meeting between PathMark Rural Development Consult and DAPP Zambia ERG to discuss the ZAMFAM SC MTE exercise was convened on 11 Oct. 2018 in Kabwe. During this meeting, the PathMark Rural Development Consult team presented a proposed MTE design and plan. Subsequently, the team prepared a first draft Inception Report and submitted it to DAPP ERG. The Evaluation team and ERG discussed the proposed evaluation design, sampling methodology, work plan and time frame.

On 22 October, 2018, an assignment contract involving PathMark Rural Development Consult and DAPP Zambia was signed. The MTE work plan and time frame were based on the timing that field visit to six selected project districts would be undertaken during the month of November, 2018, just at the start of the rainy season. During this time, most sampled project areas and villages were accessible and targeted respondents were not yet fully immersed in seasonal crop farming activities.

PathMark Rural Development Consult team employed a Non-Experimental Design Study of 72,219 (represented by a sample of 665 households, 341 children age 0-9 years and 139 children aged 10-17 years old) ZAMFAM beneficiary OVC households in project target communities of selected 6 districts in Central and Southern Provinces, namely Livingstone and Mazabuka; Mumbwa, Chibombo, Kabwe and Kapiri Mposhi respectively. The survey districts were purposively- sampled on account of being under the project since its inception. This implied that new project districts were left out. The MTE was conducted after three years of ZAMFAM SC implementation and had the following components as indicated in Table 3:

Table 3: Summary of components of the Mid-Term Evaluation

Study areas	Central, Southern provinces: DAPP implementation areas
Study population	ZAMFAM beneficiaries, specifically: Primary caregivers (aged 18+ years old) OVC aged 0–9 years (through caregiver interview) OVC aged 10–17 years
Minimum sample size	Targeted 784 Total OVC Hhouseholds in two provinces, Targeted 784 Primary Ccaregivers & OVC aged 0–17 years
Method & location of survey	Interviewer-administered survey questionnaire conducted either at Ccaregivers/OVC’s home or central place
Study instruments	Caregiver Qquestionnaire OVC Qquestionnaires: 0–9 years; administered to Caregiver 10–17 years; administered directly to the child Undernourishment measured by obtaining the mid-upper arm circumference (MUAC) for children 6–59 months
Timing	Field data collection was split into two phases. Phase 1 (Livingstone & Mazabuka 15 - 21 Dec. 2018 & Phase 2 (Kapiri, Kabwe, Chibombo & Mumbwa 14 - 25 Jan. 2019

Source: Adopted and modified from Mbizvo *et al.* (2018)

6.3 Sampling Design

PathMark Rural Development Consult used DAPP Lists of Household beneficiaries as the sampling frame. The aim of sampling was to represent OVC households in the two provinces, each ZAMFAM operating area and matching as best as possible, the varying urban and rural distribution in the two provinces. The idea was to ensure that both urban and rural project areas were represented in the study. Households that live in mixed urban /urban project areas were assigned as urban in the survey.

When a number of project areas needed for sampling was determined, a two-stage sampling procedure, stratified by urban and rural, was implemented. Project areas were selected proportional to size of the OVC beneficiary population. A fixed number of households per project area was sampled. “Sampling Proportional to Size” allowed for households in project areas with greater numbers of eligible OVC population to have a higher selection probability. A fixed sampling size per project area allowed for a sample to be self-weighting at the analysis stage within each province (Groves *et al.* 2009 as cited in Mbizvo *et al.*, 2018 p. 11).

Once project areas were selected, OVC eligible households enrolled in the ZAMFAM project were randomly stratified/ordered and recruited for the mid-term survey. If a household was located or refused to participate, it was noted as a non-response and replaced by a subsequent household on the randomly stratified/ordered list.

The minimum sample size for MTE was 784 OVC households for all 6 sampled project districts. It was anticipated that this target number would be 1% higher than 776 households sampled at benchmark survey stage. The sample size of 784 was yielded from factoring a 3.5% margin of error in the sample size calculation formula by Puszczka *et al.* (2013) as adopted from (Conchran, 1963)

See Appendix 1. The minimum sample size of caregiver and OVC participants needed for MTE was determined by setting a minimum acceptable confidence interval of ± 5 percent for key study indicators for caregiver and 0–17 age group; marginally higher confidence intervals of ± 8 percent and ± 7 percent accepted for the 0 to <5 and 5 to 17 age groups, respectively. The estimated sample sizes accounted for impact of the clustered sampling approach on the confidence intervals. A total of 665 caregivers/households out of the targeted 784 caregivers was interviewed during the field survey, representing 85% coverage. The margin of error for the 665-sample size was 0.038.

6.3.1 Focus Group Discussions

It was designed that two (2) Focus Group Discussions (FGDs) involving 10 participants, representing both females and males, would be conducted per district. Community Action Groups and School Clubs (Youth and Kids) as well as out – of – school clubs were targeted as key respondents.

At the end of field data collection in all 6 sampled project districts, 19 FGDs were held out of the planned 12 FGDs, representing 158 % coverage.

6.3.2 Key Informant Interviews

Further, it was planned that the following key respondents, purposively – sampled, be interviewed based on their level of involvement and interest in the project. These were as follows:

DAPP Zambia

Managing Director, Director of Programmes, Chief of Party, Deputies Chief of Party M&E specialist, Finance Director, Community Mobilisation specialist, District Coordinators, Project Leaders, Community mobilizers

Sub grantees

Creative International (management team – small meeting), KAFHI, and NZP+ (management team).

Government ministries

Participating health centre, schools, community development/social welfare

Other Key Informants

USAID Zambia, Population Council

The planned number of KIIs was 24 respondents from the aforementioned stakeholder organisations. The Evaluation team worked tirelessly and reached out to 65 respondents, representing 271% coverage.

6.3.3 Direct Observations

As field data collection was conducted during the rainy season, some initially sampled project areas and residential areas/villages became inaccessible due to impassable roads. Moreover, rains during

field visit period, made it difficult for the Evaluation team to reach some project areas. Worse still, schools had closed, pupils and teachers were on vacation and difficult to access.

Hence, direct observations were confined to the few beneficiaries whose homesteads were visited by the Evaluation team. Direct observations focussed on checking homesteads' sanitary and hygiene conditions (toilet, bath shelter, disk rack, rubbish pit), chickens /goats' pen /shelter and demonstration gardens. In addition, observations were made at beneficiary schools that were visited.

6.3.4 Field Data Collection

a) Orientation of Research Assistants to Field Data Collection

The PathMark Rural Development Consult team comprised thirteen (13) members. These were team leader (Reuben M. Chongo), ICT specialist/ field data collection supervisor (Phillip Chikasa) both hold Master's degree in agricultural and rural development and environment management respectively, OVC specialist (Maurice M. Sepiso) holds Master's degree in public health and 10 research assistants comprising 5 UNZA School of Medicine graduates (Patricia Ngoma, Nanyangwe Chikasa, Joy Lubasi, Kent Mutale and Samuel Chitupa); Master's Degree in Business Administration holder (Mutinta B. Moonga), Bachelors in Business Administration holder (Mukate Mukate), Bachelors Arts Degree in Environmental Geography holder (Joackim Kapapa) and Computer Software and Hardware assistant engineer (Chanda Mwape).

For three full days (12 – 14 December, 2018) all 10 research assistants were trained in use of the field data collection instruments, especially the Mobile to Web - based Tool Kit (MWB) loaded with questionnaires for caregiver and OVC, the latter classified children aged 0 – 9 years and children aged 10 – 17 years. The orientation training covered both theoretical and practical aspects of MWB, participants sampling, interviewing techniques and ethics as well as use of Measure field data collection manual for research assistants and supervisors.

On the second day of the training, the research assistants visited selected project operational areas in Chibombo District to pre- test data collection tools and practise field data collection techniques. Coincidentally, ZAMFAM SC field staff were distributing “pass – on” chickens to Community Action Groups in the project areas. The project staff were “overwhelmed with the chicken distribution exercise” but managed to organise sampled project areas and households for the pre-testing exercise. Moreover, the rainy season had started and scattered showers fell during the pre-testing day. As a result of the field challenges endured during the Chibombo pre- testing field visit, the Evaluation team and host district project staff agreed that instead of conducting house – to house interviews, sampled care givers/OVCs and CAG members should gather at an accessible homestead or central place where Evaluation team members could administer questionnaires to them. Then, the team leader and field supervisor selected 6 respondents with accessible homesteads

and visited their homesteads to check and verify erected project facilities (e.g. sanitary and hygiene, chickens/goats, demonstration plots).

6.3.5 Open Data Kit Software

Data was collected from sampled caregivers and children using Open Data Kit software (ODK) through an electronic survey interview conducted by research assistants on android/smart phone. There were no major challenges faced in the use of ODK because of the field pre- testing which had been conducted in Chibombo. During this exercise, research assistants were oriented to ODK and interviewing styles as well as techniques. In addition, the contingent measure of acquiring back-up smart phones and power banks worked very well.

The Evaluation team strictly followed PEPFAR's OVC survey guidelines i.e. no more than one OVC aged 0 - 9 or aged 10–17 was eligible for survey participation. If there were more than two children within these age groups in a household, then only one per age group was randomly selected. This process is summarized in Table 4.

Table 4: Survey interviews conducted in OVC households

Children in household	Interviews to be conducted	
Child 0–9	(x1) Caregiver	—Information about household & caregiver
No child 10–17	(x1) Caregiver	—Information about selected child 0–9
No child 0–9	(x1) Caregiver	—Information about household & caregiver
Child 10–17	(x1) Child	—Information about selected child 10–17
Child 0–9	(x1) Caregiver	—Information about household & caregiver
Child 10–17	(x1) Caregiver	—Information about select child 0–9
	(x1) Child	—Information about select child 10–17

Source: Adopted and modified from Mbizvo *et al.* (2018)

6.3.6 Study Instruments and Indicators

Data collected for the MTE was based on adopted and modified study instruments and indicators developed by Mbizvo *et al.* (2018) at the time of conducting the benchmark survey (Table 5). Data was collected on OVC, caregiver and household economic status.

Table 5: PEPFAR MER Essential Indicators

No	Indicator
NC.1	Percent of children whose primary caregiver knows the child's HIV status
CW.1	Percent of children <5 years of age who are undernourished as measured by MUAC
CW.4	Percent of children too sick to participate in daily activities
CW.9	Percent of children who have a birth certificate, observed or self-reported
CW.11	Percent of children aged 5–17 years regularly attending school
CW.12	Percent of children aged 5–17 years who progressed in school during the last year
CW.13	Percent of children <5 years of age who recently engaged in stimulating activities with any household member over 15 years of age
CW.14	Percent of caregivers who agree that harsh physical punishment is an appropriate means of discipline or control in the home or school
HW.2	Percent of households able to access money to pay for unexpected household expenses

Source: Mbizvo *et al.* (2018)

6.3.7 DAPP ZAMFAM SC Data Collection Summary

After successfully conducting both Phases of field data collection to the 6 sampled districts and conducting KIIs in Lusaka, the Evaluation team interviewed the following respondents (Table 6):

Table 6: Summary of MTE Respondents

District	Category	Target	Achieved	Percent
Chibombo	Household Questionnaires	111	114	103%
	FGDs	2	3	150%
	KIIs	6	15	250%
Kabwe	Household Questionnaires	118	116	98%
	FGDs	2	3	150%
	KIIs	6	15	250%
Kapiri	Household Questionnaires	157	100	64%
	FGDs	2	3	150%
	KIIs	6	12	200%
Mumbwa	Household Questionnaires	95	103	108%
	FGDs	2	3	150%
	KIIs	6	12	200%
Livingstone	Household Questionnaires	146	117	80%
	FGDs	2	4	200%
	KIIs	6	22	367%
Mazabuka	Household Questionnaires	156	115	74%

	FGDs	2	3	150%
	KIIs	6	16	267%
Overall	Household Questionnaires	784	665	85%
	FGDs	12	19	158%
	KIIs	24	65	271%

Source: MTE Field Survey, 2019

As seen from Table 6, more FGDs and KIIs were interviewed than planned, so as to compensate for shortfall on caregiver respondents' shortfall.

6.3.8 Data Processing and Analysis

Collected questionnaire data saved on the cloud - server was downloaded on a PC as a comma-separated value (CSV) file and converted into an Excel format. Raw data was cleaned to remove any inconsistencies. Data was then filtered to pick variables that were in line with the evaluation objectives. This data was further organised in an appropriate way for inputting into SPSS version 23 for respective/required data analysis. Analysed data was produced in tabular SPSS Statistics Viewer output file format form. Required information was picked and used as needed.

Data collected through the ODK was processed and analysed, generating MTE findings (values) which were compared with the benchmark values. Z - test was used to calculate statistical significance difference between the means.

Qualitative data gleaned through KIIs, FGDs and direct observations was collated on common themes in line with the evaluation questions. See Appendix 10 for a Summary Report. Processed qualitative data was triangulated and cross- checked with processed caregivers/OVC data. This process assisted in validating and confirming MTE findings which were compared with benchmark values.

For easy and convenient conducting of comparative analysis between benchmark values and MTE findings, both surveys' results are shown in some of the tables and appendices. Benchmark values are shown in amber colour and MTE findings in green colour.

6.3.9 Ethical Review

a) Obtaining MTE Ethical Approvals

In keeping up with the existing medical research ethical procedures and requirements in Zambia, PathMark Rural Development Consult submitted two separate applications to the Ministries of Community Development and Social Services and Health headquarters in Lusaka for MTE administrative consideration and approval. After about a fortnight, two separate approval letters were written and handed – over to PathMark Rural Development Consult team for survey use.

Subsequently, PathMark Rural Development Consult, prepared prescribed MTE application and submitted it to ERES Converge Institutional Review Board (private body in Zambia that approves medical researches) for ethical review. Subsequently, ERES reviewed and approved the application.

6.4 Adjustments to the approved Scope of Work/Protocol

The initial field visit plan was to visit 6 sampled project districts during October/November 2018, just before start of the rainy season. However, MTE assignment funds were made available in the first week of December, 2018. Inevitably, field data collection exercise was split into two phases. Phase one, covering Livingstone and Mazabuka districts, was conducted from 17 – 21 December 2018. Thereafter, DAPP Zambia closed for Christmas break until 14 January 2019. Phase two, targeting Kabwe, Kapiri, Chibombo and Mumbwa districts was conducted from 15 - 25 January 2019.

As the field data collection was undertaken during the rainy season, the season triggered serious operational challenges. Some of these challenges are enumerated in Table 7 below:

Table 7: Some of the challenges and mitigation measures put in place during field work

Challenges	Mitigation measures
Some roads to sampled project areas and communities became impassable due to waterlogging, even for 4WD vehicles.	Substituting sampled project areas, villages and households which were not accessible with accessible ones. Efforts were made to ensure that replacements had same characteristics with inaccessible ones. In addition, the team managed to interview all available respondents.
As it was raining during field visit to Kapiri Mposhi and Kabwe districts, door – to – door interviews could not be conducted.	In order to meet the district sample targets, the Evaluation team had to work late in the evening to ensure that all available respondents were interviewed. The Evaluation team purchased rain protective clothing (rain coats, umbrellas, plastic file carriers etc) for use during field visit
Most project beneficiaries especially care givers, children care volunteers, community health workers earn their living through seasonal crop farming. Hence, most of these targeted key respondents were not available for MTE meeting because they had gone out to work their crop fields	Exercised expediency in mobilising sampled project populations (project areas and villages) through project leaders, community mobilisers and CAG Co ordinators. PathMark assisted “some district contact persons” with mobile phone talk time to call selected respondents.
Schools had closed for end - of year holiday. Some teachers and pupils (especially children aged 10 – 17 years) could hardly be met as they had gone away for holiday. In fact, this situation resulted into the Evaluation team interviewing more children (aged 0 – 9 years) than children (aged 10 – 17 years)	Requested DAPP field office staff to inform and mobilise targeted project communities before Evaluation team visit.
Besides Livingstone, where DAPP district staff had informed and mobilized the project participants and other stakeholders beforehand, other project districts (Mazabuka, Kabwe and Kapiri) mobilized project	Maximising on FGDs and KII gathering more data to compliment caregiver - household gathered data. Hence, more respondents than planned were interviewed through FGDs and

participants when the Evaluation team had arrived in the district. This delayed commencement of intra – district field data collection.	KII and data gathered used to compliment, cross – check and triangulate caregiver data.
There was immense duplication of interviews per household (Care giver, children aged 0 – 9 years and children aged 10 – 17 years). The questionnaire, especially for care giver, contained culturally -sensitive questions which consumed a lot of time to explain to the respondents. In fact, the entire household, if interviewed with all three questionnaires, took about 90 minutes to complete.	The research assistants’ orientation exercise was thorough and effective. It focussed on use of Mobile to Web – based Toolkit highlighting both the theoretical and practical components. In addition, contingent plan effected (purchase of smart phones and power banks) worked very well
Long inter – household distances with some households lying about 3km apart. These long distances resulted in loss of time by the Evaluation team to reach targeted respondents.	Where possible and convenient, requested local project staff to assemble target respondents at a central place for interviews. Then, the team leader and assistant, visited a few accessible homesteads to check and verify their erected project facilities.

6.5 Procedures employed to achieve high data quality

In order to enhance data quality, besides the measures effected as enumerated under section 6.6, the following steps were taken:

- i. Engagement of highly qualified and experienced research assistants (trained up to University Degree level). Five of the research assistants were University of Zambia School of Medicine graduates.
- ii. The research assistants were taken through a rigorous 3-day orientation programme which covered classroom training and pre- testing of data collection tools and ODK in project areas of Chibombo district.
- iii. A Mobile-to-Web based Data Collection Tool kit was developed for quantitative data collection using smart phones. This eliminated errors which occur at entering/re-entering data in computers when traditional paper-based questionnaires are used.
- iv. To ensure non - loss of collected data, power banks were acquired for use in the field in an event that batteries of some smart phones got drained during data collection.
- v. Collected data was cleaned before subjecting it to analysis using SPSS version 23
- vi. Triangulation, cross – checking and interrogation of data gathered through different collection tools (questionnaire, FGD and KIIs)
- vii. During field data collection exercise in all sampled 6 project districts, the Evaluation team used to convene daily evening review meetings. These meetings helped to exchange field experiences and resolving challenges. In addition, daily check of gathered data was conducted by the field supervisor.

6.6 Limitations of design and analytic methods

Caregiver/OVC questionnaires used were adopted from the Benchmark report. Some respondents were finding problems in answering questions due to their sensitive nature e.g. *“In the last 12 months, has this household experienced death of any household member?”* If indeed a person died recently, it invoked sad memories of their deceased loved ones. Inevitably, the research assistants had to spend more time with respondents to try and convince them answer such sensitive questions.

During ODK programming, some questions were not validated. This in some instances resulted in research assistants missing out on collecting some data. Hence, the Evaluation team had to rely on other data collection tools – FGDs, KIIs and direct observations to provide the missing data.

As the field data collection exercise was conducted at the peak of the rainy season, some sampled project areas and households could not be reached due to impassable roads. However, inaccessible respondents were replaced with those who could be reached and had similar characteristics.

7 FINDINGS AND DISCUSSIONS

7.1 Sample Characteristics

As shown in Table 8 below; in all 6 sampled project districts, 27 operational areas were visited. A total of 665 caregivers/ households, taking care of 341 children aged 0- 9 years and 139 children aged 10 – 17 years were interviewed. In addition, 19 FGDs involving 10 participants each and 65 KIIs were conducted.

Table 8: Sample characteristics

Element	Sample size
Districts	6
Operational Areas	27
Households	665
Children (0-9 years)	341
Children (10-17 years)	139
FGDs	19
Participants per FGD	10
KII	65

Source: MTE Field Survey, 2019

7.2 ZAMFAM Result Areas

7.2.1 Expected Result 1

Resilience of households to care for children and adolescents living with, affected by and/or vulnerable to HIV measurably increased.

Result 1 was addressed using data gathered from “caregiver and household demographic characteristics”, “PEFPAR MER Essential Indicators, by age group, residence, and sex” and “PEFPAR MER Core Indicators, by age group, residence and sex”.

a) Caregiver and household demographic characteristics

Caregivers by gender: At benchmark stage, 91.4% of the households/caregivers interviewed were females and 8.6% were males. At MTE stage, 86.4% of the sampled households/caregivers interviewed were females and 13.6% were males. These results were statistically significant at $z = 3.848$, $p = <.001$ (Figure 1 and Appendix 4). The results were also supported by data from FGDs where participants indicated that more males were taking up caregiving responsibilities. Furthermore, the Evaluation team observed that there was a considerable number of male participants in FGDs who also participated actively in the discussions. In between these two

surveys, the number of male caregivers had increased by 5% and this may be attributed to ZAMFAM SC gender promotion activities. Appendix 4 provides more data on caregivers by gender.

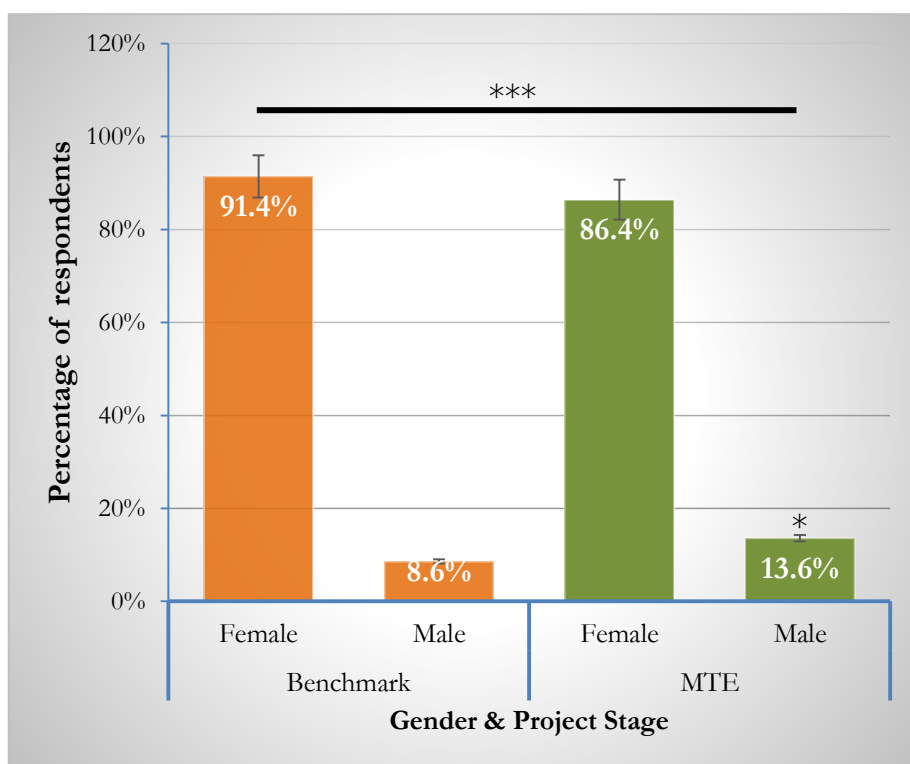


Figure 1: Percentage of OVC caregiving by gender

Source: MTE Field Survey 2019 and Mbizvo, *et al.* 2018

Mean age of caregivers: At benchmark stage, the mean age of caregivers was 43 years. At MTE stage, the mean age rose to 44 years. Differences in the mean age were statistically significant at $z = -4.191$, $p = <.001$ (Figure 2 and Appendix 4). It means that older caregivers were getting more involved in OVC caregiving compared to previous years when there were many young people taking care of the OVC. These results were supported by what caregivers reported during the MTE FGDs.

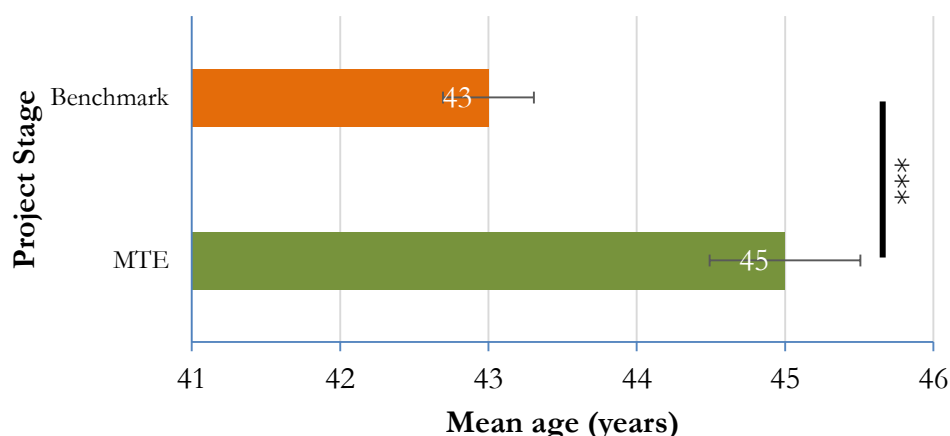


Figure 2: Mean age of OVC caregivers

Source: MTE Field Survey 2019 and Mbizvo, *et al.* 2018

Education of caregivers: The mean years of schooling increased from 5.9 at benchmark stage to 7.9 at MTE and were statistically significant at $z = 17.002$, $p < .001$ (Table 8 and Appendix 4). In addition, the percentage of caregivers who could not read a sentence, significantly dropped from 33.4 % at benchmark stage to 16.0% at MTE stage ($z = -9.851$, $p < .001$).

ZAMFAM SC puts emphasis on education of project population for both children and adults. This was confirmed from direct observations made by the Evaluation team when members found that teaching materials had been distributed to schools and CAGs. Furthermore, collaborating data obtained from both FGDs and KIIs presented the same picture. (i.e. ZAMFAM SC Project was placing great emphasis on education for both young and elderly people).

Table 9: Information about caregivers and households

Variable	Benchmark (%)	MTE (%)	Statistics
Education			
• Years of schooling	5.9	7.9	$z = 17.002$, $p < .001$
• Can't read sentence	33.4	14.0	$z = -9.851$, $p < .001$
Wealth mean (count type of 19 items)	4.9	4.2	$z = -495.376$, $p < .001$
Livestock ownership	47.7	50.7	$z = -2372.325$, $p < .001$

Source: MTE Field Survey 2019 and Mbizvo, *et al.* 2018

Wealth mean (Count of 19 items): At benchmark stage, the wealth mean was 4.9% and it dropped to 4.2% at MT stage. The drop was significant at $z = -495.376$, $p < .001$ (Table 8 and

Appendix 4). The drop-in wealth mean count was minimal and the difference could be attributed to the context in which the benchmark was conducted compared to the MTE. For example, the BM includes items like boats which are necessary in water bodies while the MTE covered areas where there were no water bodies.

Own livestock: At benchmark stage, 47.7% owned livestock and increased to 50.7% at MTE. This was significant at $z = -2372.325$, $p < .001$ (Table 8 and Appendix 4). The project had been



providing goats and chickens through “pass – on” arrangement (Figure 3). This practice resulted in a steady increase of livestock numbers at household level. Pass-ons were conducted together with training of the recipients in general animal husbandry. During FGDs and KIIs, the participants reported that livestock numbers were going up and that ZAMFAM SC Project was supporting households on best practices in rearing of goats and chickens.

Figure 3: Caregivers receiving goats as pass - on gifts

Photo: Courtesy of David Mwale 2019, District Coordinator, Chibombo District, Kabwe

b) PEPFAR MER Essential Indicators, by age group, residence, and sex

NC.1 Caregiver knows child’s HIV status

At benchmark stage, 52.8% of caregivers knew about HIV status of the OVCs who were under their care. At MTE stage, the percentage increased to 98.6%. These results were significantly different at $z = 51.198$, $p < .001$ (Tables 9, 10 and Appendix 6).

During FGDs, most of the participants had indicated that there were a lot of sensitisation activities about issues surrounding HIV and AIDS, in particular VCT promoted under ZAMFAM project. These activities had raised participants’ level of awareness about HIV and AIDS and they were keen on knowing HIV status of their children. The positive result on Caregiver knows HIV status of children resonates with both the Ministry of Health National Health Strategy as well as National HIV and AIDS Strategy Framework 2017 – 2021 goals. These strategic documents were formulated on UNAIDS 90 – 90 – 90 Fast Track Targets on epidemic elimination. The Caregiver knows the child HIV status which is the first indicator on the fast-track targets continuum.

Table 10: PEFPAR MER Essential Indicators for OVCs and household level

Indicator	BM (%)	MTE (%)	Statistics	Projection to 2020 (%)
NC.1 Caregiver knows child's HIV status	52.8	98.6	$z = 51.198, p < .001$	68.8
HW.2 Household able to access money to pay for unexpected household expenses	50.9	58.5	$z = 2.269, p = 0.023$	11.8
CW.14 Caregiver agrees harsh punishment is appropriate discipline for the child	38.5	32.4	$z = -0.939, p = 0.348$	-12.6

Source: MTE Field Survey 2019 and Mbizvo, *et al.* 2018

HW.2 Household able to access money to pay for unexpected households.

The percentage of households that indicated they were able to access money to pay for unexpected household expenses was 50.9% at benchmark stage. It increased to 58.5% at MTE stage. Percentage mean differences were significant, $z = 2.269, p = 0.023$ (Tables 9, 10 and Appendix 6).

During FGDs and KIIs, it was revealed that disposable income at household level had increased as beneficiary households were able to access money to pay for unexpected expenses. It was explained that project interventions such as savings internal lending committees, entrepreneurship training spurred increase in household income. FGDs participants mentioned that they participated in gardening, through which they grew vegetables (rape, cabbage, onion, impwa etc). The produce was retained for household consumption and the surplus sold to realise cash income. In addition, the participants reported that they had received “pass-ons” (legume crops, goats and chicken in rural areas) and cash (loan) in urban areas. In Mazabuka, some beneficiary households showed the Evaluation team the small groceries they had invested in their cash loans.

CW.14 Caregiver agrees harsh punishment is appropriate discipline for the child.

At benchmark stage, the percentage of caregivers agreeing to harsh punishment is appropriate discipline for the child was 38.5%. The percentage dropped to 32.4% at MTE stage. The drop was not statistically significant at $z = -0.939, p = 0.348$ (Tables 9, 10 and Appendix 6). This means that there was still an appreciable number of respondents who believed that harsh punishment was appropriate way to discipline the child.

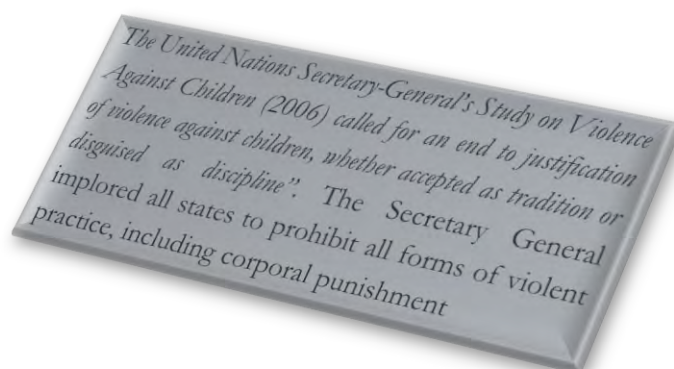


Table 11: PEFPAR MER Essential Indicators, by age group, residence, and sex FY18

		0-4 n = 417		5-9 n = 943		10-14 n =1,129		15-17 n= 422		Total n = 2911		Total rural n = 1,123		Total urban n = 1,788		Total female n = 1,435		Total male n = 1,476	
		%	CI	%	CI	%	CI	%	CI	%	CI	%	CI	%	CI	%	CI	%	CI
OVC																			
NC.1 Caregiver knows child's HIV status (n=2,791)																			
No		38.4	33.3–43.8	43.5	39.0–48.1	52.9	48.5–57.3	48.3	42.3–54.3	47.2	43.6–50.9	52.8	47.6–58.0	44.0	39.1–49.0	48.5	44.5–52.5	46.0	41.9–50.2
Yes		61.6	56.2–66.7	56.5	51.9–61.0	47.1	42.7–51.5	51.7	45.7–57.7	52.8	49.1–56.4	47.2	42.0–52.4	56.0	51.0–60.9	51.5	47.5–55.5	54.0	49.8–58.1
No (n = 418)		1.0	0.0–2.1	0	---	1.9	0.6–3.2	0	---	1.6	0.8–2.4	1.6	-0.2–3.5	0.5	-0.5–1.6	1.7	0.4–3.1	1.7	0.4–3.1
Yes (n = 418)		99.0	97.9–100	100	---	98.1	96.8–99.4	100	---	98.6	97.6–99.2	98.4	96.5–100.2	99.5	98.4–100.5	98.3	96.9–99.6	98.3	96.9–99.6
CW.1 Undernourished (n = 2,791)																			
No		96.3	93.8–97.8	—	—	—	—	—	—	96.3	93.8–97.8	96.8	91.9–98.8	95.9	92.6–97.7	96.7	93.3–98.4	95.9	92.1–98.0
Yes		3.7	2.2–6.2	—	—	—	—	—	—	3.7	2.2–6.2	3.2	1.2–8.1	4.1	2.3–7.4	3.3	1.6–6.7	4.1	2.0–7.9
No (n = 82)		88.6	79.1–94.1	---	---	---	---	---	---	86.6	79.1–94.1	83.3	64.3–102.4	94.4	82.7–106.2	88.9	72.8–105	94.4	82.7–106.2
Yes (n = 82)		13.4	5.9–20.9	---	---	---	---	---	---	13.4	5.9–20.9	16.7	-2.4–35.7	5.6	-6.2–17.3	11.1	-5.0–27.2	5.6	-6.2–17.3
CW.4 Too sick to participate in daily activities (n = 2,791)																			
No		56.6	51.2–61.9	67.0	63.6–70.3	63.1	60.1–66.1	63.6	58.2–68.6	63.5	61.3–65.7	63.4	60.9–65.8	63.6	60.3–66.7	63.6	61.2–65.9	63.5	60.5–66.3
Yes		43.4	38.1–48.8	33.0	29.7–36.4	36.9	33.9–39.9	36.4	31.4–41.8	36.5	34.3–38.7	36.6	34.2–39.1	36.4	33.3–39.7	36.4	34.1–38.8	36.5	33.7–39.5
No (n = 470)		79.5	71.9–87.1	75.9	67.8–83.9	100	---	100	---	87.0	84.0–90.1	100	---	100	---	100	---	100	---
Yes (n = 470)		20.5	12.9–28.1	24.1	16.1–32.2	0	---	0	---	13.0	9.9–16.0	0	---	0	---	0	---	0	---
CW.9 Has a birth certificate (n = 2,791)																			
No		76.2	70.4–81.3	88.8	85.8–91.2	94.8	93.1–96.1	96.1	93.7–97.6	90.5	88.5–92.1	87.3	83.4–90.4	92.2	89.9–94.0	91.6	89.6–93.2	89.4	86.8–91.5
Yes		23.8	18.7–29.6	11.2	8.8–14.2	5.2	3.9–6.9	3.9	2.4–6.3	9.5	7.9–11.5	12.7	9.6–16.6	7.8	6.0–10.1	8.4	6.8–10.4	10.6	8.5–13.2
No (n = 33)		72.7	56.7–88.8	66.7	49.7–83.6	78.8	64.1–93.5	78.8	64.1–95.5	72.7	56.7–88.8	69.7	53.1–86.2	75.8	60.3–91.2	75.8	60.3–91.2	72.7	56.7–88.8
Yes (n = 33)		27.3	11.2–43.3	33.3	16.4–50.3	21.2	6.5–35.9	21.2	6.5–35.9	22.2	18.4–26.0	30.3	13.8–46.9	24.2	8.8–39.7	24.2	8.8–39.7	27.3	11.2–43.3
CW.11 Regularly attends school (n = 2,791)																			
No		—	—	69.3	65.4–72.8	59.2	55.3–63.0	58.5	52.2–64.5	62.8	59.8–65.8	64.3	60.6–67.9	62.1	57.9–66.1	62.9	59.7–66.1	62.8	59.0–66.4
Yes		—	—	30.7	27.2–34.6	40.8	37.0–44.7	41.5	35.5–47.8	37.2	34.2–40.2	35.7	32.1–39.4	37.9	33.9–42.1	37.1	33.9–40.3	37.2	33.6–41.0

No (n = 152)	---	---	17.8	11.6-23.9	21.3	12.1-30.4	24.1	7.6-40.7	19.5	14.7-24.4	29.6	11.2-48.0	25.9	8.3-43.6	33.3	14.3-52.3	22.2	5.5-39.0
Yes (n = 152)	---	---	82.2	76.1-88.4	78.8	69.6-87.9	75.9	59.3-92.4	80.5	75.6-85.3	70.4	52.0-88.8	74.1	56.4-91.7	66.7	47.7-85.7	77.8	61.0-94.5
CW.12 Progressed in school during the last year (n=1,854)																		
No	—	—	46.8	41.3-52.5	10.0	8.3-12.0	18.8	15.0-23.2	21.1	19.1-23.3	23.1	20.0-26.5	20.0	17.5-22.9	21.0	18.4-23.8	21.2	18.2-24.7
Yes	—	—	53.2	47.5-58.7	90.0	88.0-91.7	81.2	76.8-85.0	78.9	76.7-80.9	76.9	73.5-80.0	80.0	77.1-82.5	79.0	76.2-81.6	78.8	75.3-81.8
No (n = 160)	---	---	35.0	22.6-47.4	30.3	13.8-46.9	5.0	-5.5-15.5	0.6	-0.5-1.9	3.0	-1.2-7.2	50.0	36.2-63.8	3.6	-0.5-7.7	14.9	6.6-23.2
Yes (n = 160)	---	---	65.0	52.6-77.4	69.7	53.1-86.2	95.0	84.5-105.5	81.5	98.1-100.6	97.0	92.8-101.2	50.0	36.2-63.8	96.4	92.3-100.5	85.1	76.8-93.4
CW.13 Children <5 years of age who recently engaged in stimulating activities with any household member over 15 years of age (n=328) *																		
No	6.8	4.3-10.6	—	—	—	—	—	—	6.8	4.3-10.6	8.1	4.5-14.0	5.7	2.8-11.5	7.4	4.2-12.9	6.2	3.5-10.8
Yes	93.2	89.4-95.7	—	—	—	—	—	—	93.2	89.4-95.7	91.9	86.0-95.5	94.3	88.5-97.2	92.6	87.1-95.8	93.8	89.2-96.5
No (n = 8)	31.3	5.0-57.5	---	---	---	---	---	---	31.3	5.0-57.5	35.7	7.0-64.5			38.9	-24.4-102.1	26.7	-18.7-72.0
Yes (n = 8)	68.7	42.5-95.0	---	---	---	---	---	---	68.7	42.5-95.0	64.3	35.5-93.0			61.1	-2.1-124.4	73.3	28.0-118.7
Household level indicators																		
HW.2 Household able to access money to pay for unexpected household expenses (n=1,098)																		
No	—	—	—	—	—	—	—	—	49.5	45.3-53.7	38.9	32.1-46.1	54.9	49.6-60.0	—	—	—	—
Yes	—	—	—	—	—	—	—	—	50.5	46.3-54.7	61.1	53.9-67.9	45.1	40.0-50.4	—	—	—	—
No (n = 20)	---	---	---	---	---	---	---	---	60.0	36.5-83.5	60.0	36.5-83.5	45.0	21.1-68.9	---	---	---	---
Yes (n = 20)	---	---	---	---	---	---	---	---	58.5	35.5-63.5	40.0	16.5-63.5	55.0	31.1-78.9	---	---	---	---
CW.14 Caregiver agrees harsh punishment is appropriate discipline (n=1,098)																		
No	—	—	—	—	—	—	—	—	61.5	58.9-64.1	56.4	51.9-60.9	64.4	61.3-67.5	—	—	—	—
Yes	—	—	—	—	—	—	—	—	38.5	35.9-41.1	43.6	39.1-48.1	35.6	32.5-38.7	—	—	—	—
No (n = 319)	---	---	---	---	---	---	---	---	69.9	64.8-75.0	69.6	64.5-74.7	67.4	62.2-72.6	---	---	---	---
Yes (n = 319)	---	---	---	---	---	---	---	---	32.4	25.0-35.2	30.4	25.3-35.5	32.6	27.4-37.8	---	---	---	---

*Stimulating activities = Read books to a child, tell stories to a child, sing songs to a child, take child outside home, play with the child and name things/count/draw things with a child

Source: MTE Field Survey 2019 and Mbizvo, *et al.* 2018

c) PEPFAR MER Core Indicators, by age group, residence and sex

HW.1 Caregiver has basic support in 4 domains

At benchmark stage, 46.9% of caregivers indicated that they had basic support in the 4 domains. At MTE stage, the percentage of caregivers who indicated that they had basic support in the 4 domains increased to 76.2%. The difference in mean percentage were significant at $z = -2157.958$, $p < .001$ (Tables 11, 12 and Appendix 7). Findings were supported by information obtained from FGDs and KIIs where participants indicated that ZAMFAM SC had activities put in place to support caregivers in the 4 basic domains. Generally, ZAMFAM SC Project had a number of activities addressing issues relating to basic support to caregivers in the 4 domains.

Table 12: PEPFAR MER Core Indicators

Indicator	BM (%)	MTE (%)	Statistics	Projection to 2020 (%)
HW.1 Caregiver has basic support in 4 domains*	46.9	76.2	$z = -2157.958$, $p < .001$	49.5
HW.2 Household able to access money to pay for food related expenses	42.9	92.3	$z = 35.044$, $p < .001$	91.3
HW.2 Household able to access money to pay for school-related expenses	33.8	46.7	$z = 7.227$, $p < .001$	30.3
HW.3 Household food insecure (ever no food in past 4 weeks)	74.0	65.6	$z = 6.881$, $p < .001$	-9.0

*Domains of child development = Physical, social-emotional, cognitive, communicative-language and adaptive

Source: MTE Field Survey 2019 and Mbizvo, *et al.* 2018

HW.2 Household able to access money to pay for food - related expenses

The percentage of households/caregivers that were able to access money to pay for food - related expenses at benchmark stage was 42.9%. The percentage increased to 92.3% at MTE. The increase was significantly different at $z = 35.044$, $p < .001$ (Tables 11, 12 and Appendix 7). Households had been accessing money from their small businesses and other monetary related benefits such as money from SILC groups after sharing the profits. These money sources came out prominently during FGDs.

HW.2 Household able to access money to pay for school-related expenses

Money to pay for school-related expenses was accessed by 33.8% of households at benchmark stage. The percentage significantly rose to 46.7% at MTE with $z = 7.227$, $p < .001$ (Tables 11, 12 and Appendix 7). During FGDs, caregivers said that chickens from the pass-ons were acting as banks where they were “locking their money” only to be accessed when need arose (like paying their children’s school requirements) through sale of chickens. Such initiatives of keeping money in liquid assets like chickens were brought out and discussed during ZAMFAM SC group trainings.

Table 13: PEFPAR MER Core Indicators, by age group, residence and sex FY18

		0-4 n = 417		5-9 n = 943		10-14 n =1,129		15-17 n = 422		Total n = 2911		Total rural n = 1,123		Total urban n = 1,788		Total female n = 1,435		Total male n = 1,476	
		%	CI	%	CI	%	CI	%	CI	%	CI	%	CI	%	CI	%	CI	%	CI
OVC																			
CW.2 Diarrhoea in past 2 weeks																			
No		66.6	61.6–71.2	—	—	—	—	—	—	66.6	61.6–71.2	67.1	60.1–73.4	66.2	59.1–72.6	66.7	60.1–72.7	66.5	58.7–73.5
Yes		33.4	28.8–38.4	—	—	—	—	—	—	33.4	28.8–38.4	32.9	26.6–39.9	33.8	27.4–40.9	33.3	27.3–39.9	33.5	26.5–41.3
No (n = 48)		77.1	64.8-89.4	---	---	---	---	---	---	85.3	81.5-89.1	83.3	72.4-94.3	75.0	62.3-87.7	81.3	69.8-92.7	77.1	64.8-89.4
Yes (n = 48)		22.9	10.6-35.2	---	---	---	---	---	---	14.7	10.9-18.5	16.7	5.7-27.6	25.0	12.3-37.7	18.8	7.3-30.2	22.9	10.6-35.2
CW.3 Fever in past 2 weeks																			
No		56.8	50.9–62.5	—	—	—	—	—	—	56.8	50.9–62.5	53.9	44.5–63.1	59.2	51.9–66.2	59.0	51.6–66.1	54.6	46.9–62.0
Yes		43.2	37.5–49.1	—	—	—	—	—	—	43.2	37.5–49.1	46.1	36.9–55.5	40.8	33.8–48.1	41.0	33.9–48.4	45.4	38.0–53.1
No (n = 48)		64.6	50.5-78.6	---	---	---	---	---	---	76.8	68.8-84.7	77.1	64.8-89.4	68.8	55.1-82.4	70.8	57.5-84.2	77.1	64.8-89.4
Yes (n = 48)		35.4	21.4-49.5	---	---	---	---	---	---	23.2	15.3-31.2	22.9	10.6-35.2	31.3	17.6-44.9	29.2	15.8-42.5	22.9	10.6-35.2
CW.5 Day without eating in last 4 weeks (Age 2 – 17, n = 2,819)																			
No		76.5	70.5–81.6	68.7	64.5–72.5	75.4	71.8–78.7	74.4	69.9–78.5	73.1	70.3–75.8	77.2	72.7–81.1	70.9	67.2–74.4	75.4	72.0–78.5	70.9	67.7–74.0
Yes		23.5	18.4–29.5	31.3	27.5–35.5	24.6	21.3–28.2	25.6	21.5–30.1	26.9	24.2–29.7	22.8	18.9–27.3	29.1	25.6–32.8	24.6	21.5–28.0	29.1	26.0–32.3
No (n = 14)		92.9	77.4-108.3	71.4	44.4-98.5	85.7	64.7-106.7	78.6	54.-103.2	83.0	79.4-86.7	64.3	35.6-93.0	71.4	44.4-98.5	57.1	27.5-86.8	92.9	77.4-108.3
Yes (n = 14)		7.1	-8.3-22.6	28.6	1.5-55.6	14.3	-6.7-35.3	21.4	-3.2-46.0	17.0	13.3-20.6	35.7	7.0-64.4	28.6	1.5-55.6	42.9	13.2-72.5	7.1	-8.3-22.6
CW.6 Fully immunized (Age 1 – 4, n = 390)																			
No		47.0	42.3–51.7	—	—	—	—	—	—	47.0	42.3–51.7	43.4	36.9–50.0	49.8	43.5–56.1	48.5	41.2–55.9	45.4	38.5–52.5
Yes		53.0	48.3–57.7	—	—	—	—	—	—	53.0	48.3–57.7	56.6	50.0–63.1	50.2	43.9–56.5	51.5	44.1–58.8	54.6	47.5–61.5
No (n = 105)		0	---	---	---	---	---	---	---	0	---	0	---	0	---	0	---	0	---
Yes (n = 105)		100	---	---	---	---	---	---	---	100	---	100	---	100	---	100	---	100	---
CW.7 Has basic shelter																			
No		—	—	—	—	—	—	—	—	12.5	10.9–14.3	14.8	12.1–18.0	11.2	9.2–13.5	—	—	—	—
Yes		—	—	—	—	—	—	—	—	87.5	85.7–89.1	85.2	82.0–87.9	88.8	86.5–90.8	—	—	—	—
No (n = 321)		---	---	---	---	---	---	---	---	19.4	16.4-22.4	20.2	15.8-24.7	18.1	13.8-22.3	---	---	---	---
Yes (n = 321)		---	---	---	---	---	---	---	---	80.6	77.6-83.6	79.8	75.3-84.2	81.9	77.7-86.2	---	---	---	---
CW.8 Child has basic support in 4 domains*																			
No		—	—	—	—	56.1	52.4–59.8	64.1	59.7–68.2	58.3	55.1–61.5	58.9	52.7–64.8	58.1	54.4–61.7	60.3	56.2–64.1	56.5	51.9–60.9
Yes		—	—	—	—	43.9	40.2–47.6	35.9	31.8–40.3	41.7	38.5–44.9	41.1	35.2–47.3	41.9	38.3–45.6	39.7	35.9–43.8	43.5	39.1–48.1
No (n = 83)		---	---	---	---	0	---	0	---	0	---	0	---	0	---	0	---	0	---
Yes (n = 83)		---	---	---	---	100	---	100	---	100	---	100	---	100	---	100	---	100	---
CW.10 Currently enrolled in school																			

No	—	—	34.4	30.3–38.9	11.4	9.2–14.1	24.6	21.0–28.7	22.3	19.8–25.1	21.8	18.0–26.0	22.6	19.4–26.2	21.3	18.5–24.4	23.3	20.1–26.9
Yes	—	—	65.6	61.1–69.7	88.6	85.9–90.8	75.4	71.3–79.0	77.7	74.9–80.2	78.2	74.0–82.0	77.4	73.8–80.6	78.7	75.6–81.5	76.7	73.1–79.9
No (n = 151)	---	---	6.0	2.1-9.8	0	---	0	---	3.4	1.2-5.7	2.8	-0.4-5.9	3.9	0.8-7.0	1.1	-1.1-3.2	5.4	0.7-10.2
Yes (n = 151)	---	---	94.0	90.2-97.9	100	---	100	---	96.6	94.3-98.8	97.2	94.1-100.4	96.1	93.0-99.2	98.9	96.8-101.1	94.6	89.8-99.3
Household level indicators																		
HW.1 Caregiver has basic support in 4 domains*																		
No	—	—	—	—	—	—	—	—	53.1	50.2–56.0	53.8	49.3–58.1	52.7	48.9–56.5	—	—	—	—
Yes	—	—	—	—	—	—	—	—	46.9	44.0–49.8	46.2	41.9–50.7	47.3	43.5–51.1	—	—	—	—
No (n = 311)	---	---	---	---	---	---	---	---	23.8	19.0-28.6	15.4	11.4-19.5	23.5	18.7-28.2	---	---	---	---
Yes (n = 311)	---	---	---	---	---	---	---	---	76.2	71.4-81.0	84.6	80.5-88.6	76.5	71.8-81.3	---	---	---	---
HW.2 Household able to access money to pay for food related expenses (n = 1,812)																		
No	—	—	—	—	—	—	—	—	57.1	52.2–61.8	47.6	39.7–55.6	62.1	55.8–68.0	—	—	—	—
Yes	—	—	—	—	—	—	—	—	42.9	38.2–47.8	52.4	44.4–60.3	37.9	32.0–44.2	—	—	—	—
No (n = 323)	---	---	---	---	---	---	---	---	7.7	4.8-10.7	6.2	3.5-8.8	5.0	2.6-7.3	---	---	---	---
Yes (n = 323)	---	---	---	---	---	---	---	---	92.3	89.3-95.2	93.8	91.2-96.5	95.0	92.7-97.4	---	---	---	---
HW.2 Household able to access money to pay for school-related expenses (n=1,412)																		
No	—	—	—	—	—	—	—	—	66.2	61.8–70.3	58.9	51.6–65.7	70.8	65.2–75.8	—	—	—	—
Yes	—	—	—	—	—	—	—	—	33.8	29.7–38.2	41.1	34.3–48.4	29.2	24.2–34.8	—	—	—	—
No (n = 199)	---	---	---	---	---	---	---	---	53.3	46.3-60.3	47.2	40.2-54.2	53.8	46.8-60.8	---	---	---	---
Yes (n = 199)	---	---	---	---	---	---	---	---	46.7	39.7-53.7	52.8	45.8-59.8	46.2	39.2-53.2	---	---	---	---
HW.3 Household food insecure (ever no food in past 4 weeks)																		
No	—	—	—	—	—	—	—	—	26.0	22.7–29.6	35.5	29.1–42.5	20.6	17.1–24.6	—	—	—	—
Yes	—	—	—	—	—	—	—	—	74.0	70.4–77.3	64.5	57.5–70.9	79.4	75.4–82.9	—	—	—	—
No (n = 320)	---	---	---	---	---	---	---	---	34.4	29.1-39.6	49.7	44.2-55.2	35.0	29.7-40.3	---	---	---	---
Yes (n = 320)	---	---	---	---	---	---	---	---	65.6	60.4-70.9	50.3	44.8-55.8	65.0	59.7-70.3	---	---	---	---

*Domains of child development = Physical, social-emotional, cognitive, communicative-language and adaptive

Source: MTE Field Survey 2019 and Mbizvo, *et al.* 2018

HW.3 Household food insecure (ever no food in past 4 weeks)

At benchmark stage, 74.0% of households agreed that they ever had no food in past 4 weeks. At MTE, a positive development was noted where the percentage of households who were food insecure dropped to 65.6%. The drop was significant at $z = 6.881$, $p < .001$ (Tables 11, 12 and Appendix 7). During FGDs and direct observation by Evaluation team, it was noted that most households visited had become active in the back-yard gardens teeming with a variety of crops



growing. Households with small back yards or no back yards (especially in urban areas) were growing their vegetables in disused contains. Other households had poultry which they got as “pass-on” gifts (Figure 4). Deliberations from FGDs reviewed that knowledge on food security was passed-on to the caregivers by ZAMFAM SC Project staff during training sessions.

Figure 4: Poultry from pass-on

Photos: © Phillip Chikasa, PathMark Rural Development Consult, Lusaka

7.2.2 Expected Result 2

Child wellbeing status measurably improved due to provision and accessing of quality care and support services

a) PEPFAR MER Essential Indicators, by age group, residence, and sex

CW.1 Undernourished: A MUAC tape was used (Figure 5) to capture data on undernourishment for children aged 0-5 years. All the children that measured less than 125mm, as specified in PEPFAR guidelines, were undernourished.



At benchmark stage, undernourishment was at 3.7%. At MTE, undernourishment was at 13.4%. The differences in percentages of undernourishment at benchmark stage and the MTE were significant, $z = -48.733$, $p < .001$ (Tables 13,10 and Appendix 6).

Figure 5: MUAC tape put to practice in undernourishment data capture

Photo: Courtesy of DAPP Promotion Team, Zambia

According to the 2013 – 14 ZDHS, 40% of children Under 5 were stunted, 6% were wasted and 15% were underweight. The MUAC tape measurement taken during both benchmark and MTE surveys speak more to underweight. The undernourishment value of 13.4% recorded during MTE is in closer sync with ZDHS's underweight of 15%. On the basis of the ZDHS and MTE result values comparison, it is evident that there is a reduction in undernourishment among the children under 5 in the sampled project districts. ZAMFAM with its child wellbeing activities (especially nutrition – related activities) has contributed to the recorded reduction in undernourishment among the children in the project areas.

Table 14: PEPFAR MER Essential Indicators

Indicator	BM (%)	MTE (%)	Statistics	Projection to 2020 (%)
CW.1 Undernourished	3.7	13.4	$z = -48.733, p < .001$	207.9
CW.9 Has a birth certificate	9.5	22.2	$z = -5.536, p < .001$	106.0
CW.11 Regularly attends school	37.2	80.5	$z = -12.012, p < .001$	92.3
CW.12 Progressed in school during the last year	78.9	81.5	$z = -2797.017, < .001$	2.6
CW.13 Children <5 years of age who recently engaged in stimulating activities with any household member over 15 years of age*	93.2	60.0	$z = -419.001, p < .001$	-28.3

* = Read books to a child, tell stories to a child, sing songs to a child, take child outside home, play with the child and name things/count/draw things with a child

Source: MTE Field Survey 2019 and Mbizvo, *et al.* 2018

CW.9 Has a birth certificate: At benchmark stage, the percentage of children with birth certificates was 9.5%, it rose to 22.2% at MTE. There were significant differences in percentages at BM and MTE $z = -5.536, p < .001$ (Tables 13,10 and Appendix 6). This positive change (increase in obtaining birth certificate) may be attributed to ZAMFAM awareness activities on the importance of obtaining birth certificates).

In Zambia, issuance of a birth certificate is a legal requirement for children. PEPFAR also considers birth certificate a critical indicator of the rights of the child and confirming their right to access public services from the government such as health and education.

CW.11 Regularly attends school: The percentage of pupils regularly attending school was 37.2% at benchmark stage. The percentage rose to 80.5% at MTE and results were significantly different at $z = -12.012, p = < .001$ (Tables 13,10 and Appendix 6). Interventions being advanced by ZAMFAM to ensuring that pupils were attending classes on regular basis were yielding positive results. This information was supported by submissions from caregivers during FGDs and augmented by evidence gathered from school authorities during KIIs.

CW.12 Progressed in school during the last year:

At benchmark stage, percentage total/overall progression in school during the last year was 78.9%. At MTE, the percentage significantly increased ($z = -2797.017, < .001$) to 81.5% (Tables 13,10 and Appendix 6). The increase is linked to interventions put in place by ZAMFAM SC Project which were encouraging pupils to be in school such as increased support by Caregivers, implementing the go - back to school campaign and provision of teaching materials to schools. The increase was also supported by information obtained from both FGDs and KIIs which was praising ZAMFAM SC Project about the good works done by the project through its project staff. The good works included provision of desks, books and teaching charts to schools, conducting awareness sessions with youth and kids' clubs on a range of topics as guided by the DAPP ZAMFAM SC Youth Club Program Manual.

CW.13 Children <5 years of age who recently engaged in stimulating activities with any household member over 15 years of age:



Children less than 5 years of age, who recently engaged in stimulating activities (*stimulating activities refer to reading books to a child, telling stories to a child, singing songs to a child, taking child outside home, Playing with the child and naming/counting/drawing things with a child*) with any household member over 15 years of age stood at 93.2% at benchmark stage. The percentage dropped to 60% at MTE time. Results were statistically significant at $z = -419.001, p < .001$ (Tables 13,10 and Appendix 6). The reason for the drop could be due to the period the MTE was conducted. Most of the older household members were engaged in farming activities at the time. This left younger children to be stimulated by fellow children below the age of 15 years in some cases (Figure 6).

Figure 6: Young children being stimulated by older ones

Photo: Courtesy of David Mwale 2019, District Coordinator, Chibombo District, Kabwe

b) PEPFAR MER Core Indicators, by age group, residence and sex

CW.2 Diarrhoea in past 2 weeks: The percentage of diarrhoeal cases was 33.4% at benchmark stage. The percentage dropped to 14.7% at MTE. The results were statistically significant at $z = -6.296, p = < .001$ (Tables 14, 12 and Appendix 7). Reduction in the number of diarrhoeal cases was attributed to WASH activities implemented by the ZAMFAM SC Project and partner staff. During FGDs, caregivers said that they had been taught about proper disposal of kitchen and other household solid wastes, use of toilets when defecating and the importance of having a toilet.

Washing hands using tip tap with either soap or ash after using the toilet. Washing hands before and after eating. Importance of having a dish drying rack. Keeping homesteads clean and general personal body hygiene. According to the FGDs participants, teachings from the ZAMFAM SC Project on WASH greatly contributed to the reduction of diarrhoea cases. Staff from health centres, although they did not provide statistics due to ethical issues, confirmed that there was a steady decline in diarrhoea and diarrhoeal - related cases treated at their health centres.

Table 15: PEFPAR MER Core Indicators

Indicator	BM (%)	MTE (%)	Statistics	Projection to 2020 (%)
CW.2 Diarrhoea in past 2 weeks	33.4	14.7	$z = -6.296, p = < .001$	-44.4
CW.3 Fever in past 2 weeks	43.2	23.2	$z = -3.848, p = < .001$	-36.7
CW.5 Day without eating in last 4 weeks	26.9	17.0	$z = -4.558, p = < .001$	-29.2
CW.6 Fully immunized (Age 1 – 4)	53.0	100	$z = -7353840.488, p = < .001$	70.3
CW.7 Has basic shelter	87.5	80.6	$z = -5620.487, p = < .001$	-6.3
CW.8 Child has basic support in 4 domains*	41.7	100	$z = -181995.253, p = < .001$	110.9
CW.10 Currently enrolled in school	77.7	96.6	$z = 13.445, p = < .001$	19.3

*Domains of child development = Physical, social-emotional, cognitive, communicative-language and adaptive

Source: MTE Field Survey 2019 and Mbizvo, *et al.* 2018

CW.3 Fever in past 2 weeks: At benchmark stage, 43.2% had fever in the past 2 weeks. At MTE, the percentage of children significantly dropped to 23.2% ($z = -3.848, p = < .001$). (Tables 14, 12 and Appendix 7). Results were supported by information gathered during FGDs where participants indicated that most of the OVCs were sleeping under mosquito nets, hence reducing incidences of malaria cases, one of the diseases causing fever in human beings. Awareness creation and teachings about the importance of sleeping under a mosquito net being promoted by ZAMFAM SC Project staff in collaboration with CHWs and health centre staff. Furthermore, confirmation on reduced incidences of fever was made by staff at health centres during KIIs. Here again, statistics on fever cases could not be availed to the Evaluation team by health centre staff due to medical confidentiality of patients' information.

CW.5 Day without eating in last 4 weeks: At benchmark stage, 26.9% of the respondents had agreed that OVCs had spent a day without eating in the last 4 weeks. At MTE, 17.0% of the respondents said that OVCs had spent a day without eating in the last 4 weeks. The drop from 26.9% at benchmark stage to 17.0% at MTE was statistically significant at $z = -4.558, p = < .001$ (Tables 14, 12 and Appendix 7). The positive development was as a result of interventions put in

place by the ZAMFAM SC Project aimed at alleviating hunger in the project areas. Information from FGDs showed that incidences of OVCs going hungry for days had been minimised as households were at least having something to eat in one way or another. Backyard gardens, poultry rearing and small businesses were assisting in household's food provisions. However, as reported under CW 1. Undernourishment for under 5 children was rife in some households, especially during the lean period (November – March) when food was scarce.

CW.6 Fully immunized (Age 1 – 4): At benchmark stage, the percentage of OVCs fully immunised was 53.0%. At MTE, the percentage significantly increased to 100% at $z = -7353840.488$, $p < .001$ (Tables 14, 12 and Appendix 7). Campaigns by ZAMFAM SC Project staff on the importance of immunising children was yielding fruits. This quantitative data was supported by information gathered from FGDs where participants indicated that there was a lot of emphasis placed on immunising children. Consequently, several children, although their statistics were unavailable, had been immunised. Again here, immunization figures could not be provided by health facility staff.

CW.7 Has basic shelter: Percentage of OVCs with basic shelter was 87.5% at benchmark stage. The percentage significantly ($z = -5620.487$, $p < .001$) dropped to 80.6% at MTE (Tables 14, 12 and Appendix 7). This reduction was due to some shelters being affected by rain water, with a few becoming inhabitable/abandoned. However, from what was coming out of FGDs, some households had been selling their pieces of land on which their shelter/houses were located and moved to other areas.

CW.8 Child has basic support in 4 domains: At benchmark stage, 41.7% of the children had basic support in 4 domains. The percentage rose to 100% at MTE and was significantly different at $z = -181995.253$, $p < .001$ (Tables 14, 12 and Appendix 7). The increase was attributed to ZAMFAM SC Project activities which had incorporated children's welfare into the activities. Results were supported from information gathered during FGDs (with caregivers) and KIIs (with ZAMFAM SC staff, school teachers and health care providers at health centres) where respondents reported that children were being supported in the 4 basic domains.

CW.10 Currently enrolled in school: The percentage of pupils enrolled in schools at benchmark stage was 77.7%. At MTE, it was 96.6%. The increase in percentage was statistically significant at $z = 13.445$, $p < .001$ (Tables 14, 12 and Appendix 7). The increase was attributed to ZAMFAM SC Project efforts in seeing to it that every child was educated. (Campaign, youth and kids' clubs). The ministry of education is promoting education for all campaign through which all children who are eligible to be in school are encouraged to get into school. All the teachers interviewed from the 9 schools interviewed reported that due to the government policy of education policy has bolstered school enrolment, with class size in some schools reaching 80 pupils per class.

7.3 Key Findings in relation to Evaluation Criteria

Result Area 3: Capacity of government and community structures to care for and support children and adolescents living with, affected by and/or vulnerable to HIV measurably increased.

The Evaluation team visited 27 operational areas and conducted FGDs with CAG, Youth and Kids Clubs. The team also conducted KIIs with school/heads/teachers, government ministries (health, community development and social services, education) officials, parents, traditional and civic leaders. In these interviews, the respondents reported that ZAMFAM project staff (project leaders, community mobilizers, CAG Coordinators) work with community structures (CAG, traditional (especially chiefs and village headpersons) and civic authorities (ward development committees), parents and teachers associations in carrying - out project activities. The Evaluation team found that there were also other community structures such as V- WASHE committees, community welfare and assistance committees (CWACs), neighbourhood health committees and community support groups. According to the KIIs and FGDs, community structures were trained by project staff in governance and leadership.

According to Peter Banda, a community mobiliser in Nangoma/Mumba scheme in Nakasaka ward under Chief Mumba in Mumbwa District, works with CAGs to build capacity of community- based structures in caring for and supporting children and adolescents living with, affected by /or vulnerable to HIV. Households who are keeping vulnerable children are the members of the community structures. Each week, Mr. Banda conducts meeting with CAG members and during the fourth week meeting, the group draws up action plan and which is then implemented by the group. Every month, the community mobiliser with involvement of the CAG Coordinator conducts planning meeting with the action group. The community mobiliser conducts training sessions with CAG using the Community Action Group Manual produced by ZAMFAM SC annually.

According to data gathered during the FGDs and KIIs, each group prepares an action plan in the fourth week of a month after undergoing training based on Community Action Group training manual. It was a good training guide written in English Language but contained some technical jargons which were difficult to understand and interpret in the local language.

The FGDs and KII confirmed that project leaders and community mobilisers drew up their workplan which they shared with District Coordinator. Each month, the District Coordinator convened a planning and review meeting. This meeting was meant for project leaders so share their plans and review the previous activities implemented. At community level, community dialogue drawing participants from all key stakeholders – traditional and civic leadership, schools, health centers, churches etc. convened to share information and ideas about ZAMFAM project and related development matters.

In addition, the District Coordinators on quarterly basis convened stakeholders meeting which was attended by the sub- grantees to share their plans and reports for the previous quarters. In face to face interviews with KAFHI, NZP+ and YWCA representatives, they all confirmed that they participated in the quarterly stakeholders during which time they share their plans and reports for the previous period.

On quarterly basis, each of the two ZAMFAM Deputy Chief of Party (Central and Southern provinces) also convened stakeholder meetings to share information on implementation of the project activities.

At national level, DAPP ZAMFAM SC is a member of the National Technical Working Group on OVCs. This Group meets every quarter to share information and experiences amongst participating organisations.

In collaboration with five health centres visited by the team, the project frontline staff (CHWs) conducted HIV screening and testing of OVC. Those found positive were enrolled onto the project and linked to health facility for ART. ZAMFAM SC engaged CHWs and gave them a monthly incentive of K200.00. These in-community staff visited ART clients regularly to ensure that they took medicine as prescribed. The CHWs were supplied with tools for work including bicycles, rain coats, T – shirts and hard- cover book for recording results and activities.

The project staff work with government (e.g. District Welfare Assistance Committees, District medical office, health centres) and community structures (e.g. Community Action Groups, Community Welfare Assistance Committees, Neighbourhood health committees, parents and teachers' associations, traditional leadership, elected civic leadership etc) to provide care and support to the OVC and people living with HIV and AIDS. These structures were trained in governance and leadership, recording and monitoring the impact of the project care system for OVC.

Result Area 4: Shared learning and evidence - base to improve programming, inform policy and program investment strengthened.

According to the KIIs and Direct Observations conducted by the Evaluation team, the project staff documented best practices and lessons learnt and these were shared with the government, implementing and co-operating partners through district, provincial and national working groups. Every quarter, at the district and provincial levels, the project staff conducted stakeholder meetings to share and disseminate project related information. They also utilised other platforms – meetings organised by other organisations e.g. agricultural ward and district shows -to showcase the project activities and experiences.

In addition, the KIIs held with ZAMFAM SC staff, revealed that DAPP Zambia was a member of the national OVC steering committee whose meetings were held every quarter to share and discuss related - subject matters. ZAMFAM SC Project also produced and aired interactive community radio programmes on local radio stations such as KNC Radio in Kabwe and Mosi O Tunya Radio in Livingstone. The feedback to the radio programmes was that the programmes were educative and provided relevant information about health issues which were affecting most people in the community.

The KIIs and FGDs further reviewed that through training teachers in project schools, there was an exchange of information and experiences between the project staff and teachers. The teachers shared information on their experiences with all school pupils, including those who were not direct

beneficiaries. The exchange and learning also extended to parents through the parents and teachers associations during the trainings conducted by the project leaders and community mobilizers.

It was further learnt that the cross learning was also taking place during the training with traditional and civic leaders as duty-bearers. These gatekeepers were instrumental in explaining to the local community members the importance of participating in the project activities. They explained the importance and benefits of

“I have encouraged my subjects to get involved in ZAMFAM project and about 90% of them are benefitting from project activities. I have also made an appeal to men to join the project and this call has increased men’s participation in the project” remarked Senior Village Headman Chimoto.

the project to their right holders. Mr. Bornwell Shambwalu is senior village head man Chimoto serving 146 households in Mumbwa District. According to the village headman about 90% of his subjects were project beneficiaries. They participated in ZAMFAM project activities such as gardening, savings and internal lending schemes.

According to KIIs conducted with project staff, community dialogues were held every quarter in each project area. Community dialogues were platform attended by government officials (agriculture, health, education, community development) community- based organisations operating in the area, traditional and civic leaders, local community members, church leaders etc. Project information was disseminated during the dialogue meetings and other development related matters discussed during the same fora.

7.3.1 Relevance

During the field visit conducted by the Evaluation team in the 27 project operational areas in 6 sampled project districts using the data collection instruments of questionnaires, FGDs, KIIs and direct observation gathered critical project data. The data provided insight on key project activities which had been carried out during the three-year project implementation and are outlined below:

- i. Community Action Groups in their respective operational areas meeting and implementing project activities such as monthly meetings, weekly training sessions, developing action plans in the fourth week and subsequently carrying - out planned activities
- ii. Some Community Action Group members (at least 8 members in each) received and planted vegetable seeds (cabbage, onion, rape, tomatoes etc) and legumes seeds (cowpeas, pigeon peas and soybeans). For legumes, recipients harvested and passed - on the seeds to other group members. The surplus harvest was consumed within the household and sold to raise income for the household. The “pass – on” was also done through goats and chickens. In Chibombo, Mumbwa, Kabwe and Kapiri Mposhi project areas, it was reported that several chickens had died within few days of being distributed. The team established from the Department of Veterinary that there was an outbreak of new castle disease in these project districts which had decimated chickens in the areas. In Mazabuka, Livingstone, Kabwe and Kapiri urban project areas, the team saw small businesses (e.g. selling second-hand clothes, broiler chicken rearing) financed by pass-on grants given to group members

- iii. Establishing and strengthening Savings and Internal Lending Communities (SILC). In all 27 operational areas visited by the team members, they were told by the beneficiary group members that they had set up savings and lending groups of 10 members each. These members were saving cash amounts (ranging from ZMW 2.00 to 50.00) and giving small loans to their members (ranging from ZMW 200 to ZMW500 each member) which they paid back with small interest (ranging from 5 – 10%). The loanees were using the borrowed money to finance their small businesses, pay school fees for their children etc.
- iv. 6 out of 9 schools, representing 67%, visited by the team, reported that had received desks, exercise books and teaching charts from ZAMFAM SC. The desks had greatly alleviated the desk shortage at their schools. In addition, school fees had been waived for selected orphans and vulnerable children which enabled the beneficiary pupils attend school consistently without being bothered about school fees payment. Interviewed school teachers, even if they could give actual figures, reported that waiving school fees for targeted OVC pupils was helpful and kept beneficiary pupils in school
- v. The team established that all interviewed Community Action Group members were being trained in OVC care, support, protection and child assessment, using the Child Status Index Tool. These Community Action Groups were platforms for provision of support and services to OVC which bolstered their wellbeing. The extended services were predominantly related to education, health, water, sanitation, hygiene and issuance of birth certificates
- vi. In collaboration with five health centres visited by the team, the project frontline staff (CHWs) conducted HIV screening and testing of OVC. Those found positive are enrolled onto the project and linked to health facility for ART. ZAMFAM SC engages CHWs and gives them a monthly incentive of ZMW200. These in-community staff visits ART clients regularly to ensure that they take medicine as prescribed. The CHWs are supplied with tools for work including bicycles, rain coats, T – shirts and hard- cover book for recording results and activities
- vii. The project staff work with government (e.g. District Welfare Assistance Committees, District medical office, health centres) and community structures (e.g. Community Action Groups, Community Welfare Assistance Committees, Neighbourhood health committees, parents and teachers' associations, traditional leadership, elected civic leadership etc) to provide care and support to the OVC and people living with HIV and AIDS. These structures are trained in governance and leadership, recording and monitoring the impact of the project care system for OVC.
- viii. The project staff document best practices and lessons learnt and these are shared with the government, implementing and co-operating partners through district, provincial and national working groups. Every quarter, at the district and provincial levels, the project staff conduct stakeholder meetings to share and disseminate project related information. They also exploit other platforms – meetings organised by other organisations – e.g. agricultural ward and district shows -to showcase the project activities and experiences.
- ix. DAPP ZAMFAM SC is a member of the national OVC steering committee which meets every quarter to share and discuss related - subject matters. The project also produces and

airs interactive community radio programmes on local radio stations such as KNC Radio in Kabwe and Mosi-O-Tunya Radio in Livingstone.

DAPP Zambia

The organisation works with those in need in a collective process that supports them to effect changes, improve their lives and solve their problems. DAPP believes that poverty and other social vices can be overcome through co-ordinated, community - wide approaches which combine education and literacy, health and hygiene, improved livelihoods and sustainable agriculture. The organisation works with long term sustainable programmes that address needs of families and communities by empowering people to take action to improve their circumstance in a collective and collaborative way.

Under ZAMFAM, DAPP is working with care givers, local communities and other stakeholders (ministries of health, community development, agriculture, education etc) to provide care and support to OVC. The care givers use their own resources and are organized in Community Action Groups provide parenting skills and menu of essential services to OVC.

Zambian Government

The government of Zambia, through the ministry of health has developed and rolled out National Health Strategy Plan and National HIV and AIDS Strategic Framework 2017 – 2021. These frameworks aim at reposition prevention of new HIV infections as the main focus of the national multi- sectoral HIV and AIDS response. In addition, the ministry of general education revised its school curriculum in 2013 which included integration of comprehensive sexuality education in all public schools. The ministry of community development and social services has a mandate to provide basic social protection services and programmes offering social assistance and promotional services (livelihood and empowerment) to the poor and vulnerable people in society.

USAID Zambia Office

It supports Zambia in strengthening its public health system at the national, provincial, and community levels. USAID in collaboration with the Ministry of Health, work towards supporting prevention and treatment of diseases such as HIV/AIDS, malaria, and tuberculosis, increasing the overall quality of health care, changing attitudes and behavior on maternal and child health, nutrition, family planning, gender-based violence. USAID through the United States President's Emergency Plan for AIDS Relief (PEPFAR) supports scaling - up integrated prevention, care, and treatment programs and lessen the impact of HIV/AIDS. As part of its strategy of disease prevention, management, and mitigation, USAID supports services to over 400,000 children. The agency supports parenting programs, life-skills training for adolescents and young women, access to education through school block grants, access to HIV treatment and household economic strengthening. The agency also helps build capacity of HIV/AIDS-affected communities to access effective, quality HIV/AIDS prevention services, including counseling and testing, voluntary male circumcision, and the prevention of mother-to-child transmission of HIV. It actively works with communities and leaders to create a unified and strengthened response to HIV/AIDS.

On the basis of the foregoing Evaluation team field survey findings, DAPP Zambia's operational strategic framework, the Zambian government strategic direction on HIV and AIDS prevention, care and support, the USAID policy on strengthening the Zambia's health public health system and controlling HIV/AIDS, it is plausible that ZAMFAM strategies and objectives resonate well with these key stakeholder's policies and strategies.

Implementing approaches and strategies

The Evaluation team succeeded in conducting in – depth interview with key staff of the implementing partners involved in carrying - out project activities. These partners are as follows:

- i. Creative Associates who spearheaded building capacities in the areas of financial management, strategic plan development and implementation, proposal writing and human resource management. Through participatory process, Creative Associates facilitated identification of capacity needs, development of capacity building plan and providing technical support during the plan implementation
- ii. Young Women Christian Association (YWCA) took a lead on training DAPP and partner organisations on psychosocial counselling and gender- based violence management
- iii. Network of People Living with HIV (NZP+) with its specialization in forming support groups for people living with HIV which provides counselling, support and encouraging members to adhere to treatment programme. It also encourages people living with HIV to take HIV test to establish their status.
- iv. Kabwe Adventist Family Health Institute (KAFHI) implementing the project in all four result areas namely increasing household resilience, improving child wellbeing status, increasing capacity of government and community structures and strengthening shared learning and evidence – base.

DAPP ZAMFAM SC, through partnership with the four implementing partners, is leveraging competences and expertise of these organisations in implementing the project. These organisations have been operating in their fields of specialization for a considerable time and acquired expertise in those areas.

ZAMFAM SC is working with and through government and community structures. The project is working in schools and targeting young people as the primary beneficiaries, teachers and parents as secondary beneficiaries. In the project areas visited by the Evaluation team, the project has established linkages with the health centres: CHW working as volunteers availing health services to targeted OVCs. In addition, CWAC members, work as volunteers and participate in assessing and identifying children to be enrolled onto the project. As mentioned earlier on, the project is reaching out to parents through parents' teachers association. Parents participate in making decisions on the school block grant.

The Evaluation team established and found that the existing project approaches and strategies as outlined in the preceding sections are appropriate and effective in achieving the intended positive changes in the project targeted OVCs.

7.3.2 Effectiveness

Table 16: Updated Key Indicator Table

No	Indicator	LOP Targets	Year 1 Results	Year 2 Targets Jan 2015- Dec 2016	Year 2 Results Oct 2016 - Sept 2017	Year 3 Targets Oct 2017 – Sept 2018	Year 3 Results Oct 2017 - Sept 2018	Percent of LOP Targets (%)
1	Number of active beneficiaries served by PEPFAR OVC programs for children and families affected by HIV/AIDS OVC_SERV	125,000	129,913	125,000	130,549	130,000	127,239	97.8
1.1	Number of OVC received parenting/ caregiver services	125,000	0	100,000	127,445	125,000	117,283	93.8
1.2	Number of OVC received social protection services	100,000	0	16,000 ¹	100,805	100,000	118,860	118.8
1.3	Number of OVC received education services	17,000	0	18,000	18,543	17,000	10,861	63.8
1.4	Number of OVC received economic strengthening services	100,000	0	100,000	118,321	100,000	101,633	101.6
1.4.1	Number of target families who received pass-on gifts	26,000	0	18,000	48,548	23,500	12,267	52
2	Number of OVC beneficiaries who know their HIV status and have self-disclosed HIV status to OVC implementing partners. OVC_HIVSTAT	60,000	57,166	60,000	67,776	124,000	109,949	90
3	Number of OVC who completed a standardized HIV prevention intervention	30,000	0	30,000	12,133	30,000	32,456	108.2

¹ When settings goals in the AMEP we did not count on services provided through the kids and youth clubs, which is a reason for this goal being low compared to achieved

No	Indicator	LOP Targets	Year 1 Results	Year 2 Targets Jan 2015- Dec 2016	Year 2 Results Oct 2016 - Sept 2017	Year 3 Targets Oct 2017 – Sept 2018	Year 3 Results Oct 2017 - Sept 2018	Percent of LOP Targets (%)
4	Number of active Community Action Groups	2,500	1,703	2,500	2,463	2,500	2,836	113.4
5	Number of families who are members of Community Action Groups	40,000	42,575	40,000	72,219	60,000	72,000	120
6	Number of youth and kids' clubs (ANTI AIDS and ZAMFAM School clubs and Out of School Clubs)	800	0	800	646	950	894	94
7	Number of children who are members of Youth Clubs and Kids Clubs	16,000	0	16,000	9,989	16,000	13,684	85.5
8	Number of CWACs strengthened	500	0	500	412	500	516	103.2
9	Number of local leaders trained to support OVC programs	2,400	0	2,400	3,448	3,000	3,480	116.0
10	Number of school block grants provided	460	1	160	210	420	195	46.4
11	Number of Children graduated	0	0	0	2,014	5000	32,513	361
12	Number of Children transitioned	0	0	0	80	2000		
13	Number of Children left without graduation/ transitioning	0	0	0	1,555	2000		

Source: DAPP ZAMFAM SC Annual Report 2017 - 2018

The Report noted that Indicator 1.5 was low due to a gap in Data capturing on this indicator. In mitigation, the reporting formats for the Community Health Workers (CHWs) and Project Leaders and Community Mobilizers to ensure the data is captured.

As seen under Table 16: Updated Key Indicators, ZAMFAM SC had performed exceptionally well on the following main and subsidiary indicators:

1.0, 1.1, 1.2, 1.3, 1.4, 1.4.1, 1.5; 2, 3, 4, 5, 6, 7, 8 and 9. The impressive performance on the foregoing indicators may be attributed to best practices adopted regarding service delivery and implementation as elucidated under Section 7.3.2.1

Conversely, the project has not performed well on indicators 1.3, 1.5 and 10. This project dismal performance may be explained as outlined below:

Indicator 1.3: Number of OVCs received education strengthening services was low – standing at 63.8%. This indicator is directly linked to Indicator 10.0 Number of Block grants provided – 46.4%. This situation is due to the challenges encountered in the procurement of school materials. As mentioned under section., 6 out of 9 visited schools, had not received school block grant. Therefore, would - be school fees - waiver beneficiaries were not able to attend school regularly due to outstanding school fees.

Indicator 1.4: Number of families who received “pass-ons” is low due to procurement challenges which delayed distribution targeted beneficiary families. This had a knock - on effect on the pass-on.

a) Best Practices regarding service delivery and implementation

DAPP ZAMFAM SC has demonstrated vibrancy in some practices which have been adopted. Some of these are outlined below:

- a. Leveraging comparative advantage of partner organisations in implementing projects activities. Creative Associates and KAFHI, YWCA, NZP+ which bring to the partnerships their expertise in relevant areas of project management
- b. Working with and through existing government as well as community structures. These will continue functioning even after the project end.
- c. Primary care givers/households, using their own resources and “given a booster by the project” to propel them in their livelihood activities - as the main means of their economic empowerment. The pass - ons given to Community Action Group members – legume seeds, goats, chickens, whose products and off springs they give out to other group members. In addition, pass-ons are providing food and income security to group members through own consumption and sale of surplus produce.
- d. Block grants given to selected schools and in return school fees of targeted school pupils being waived. This non- cash transaction ameliorates accountability challenges encountered by most project when they give out cash for pupils’ sponsorship
- e. The involvement of key stakeholders in the project i.e. traditional leaders, church leadership, schools, health centres, private sector players and government ministries. After serious challenges experienced with centralized procurement of project materials, the project management adopted local procurement system which is empowering local

suppliers. This is in line with the government policy of empowering local entrepreneurs by giving them a share of materials supply business

- f. Integration of Savings and Internal Lending in Communities which give opportunities to households to save and borrow money on more flexible terms. The loan is invested in some business or procuring capital item for the households
- g. New approach of “TRIOS” in caring and supporting children on ART. This approach provides a back - person to encourage the person on treatment does not default.
- h. According to ZAMFAM SC Project Annual Report FY18, the project increased number of children on ART from 7,562 to 13,063 during the period under review. The report further states that 95% of the children living with HIV are on ART. As the project is ending in the next two years, DAPP Zambia has started negotiations with the Ministry of Community Development and Social Services to take over supporting the children on ART.

b) Level of Knowledge and Awareness of OVC around HIV/AIDS

This is demonstrated in a number of ways and some of them are shown here below in Figure 7:

As shown in Table 10. which presents PEPFAR MER Essential Indicators shows that the Indicator Care giver knows child’s HIV status, was as follows:

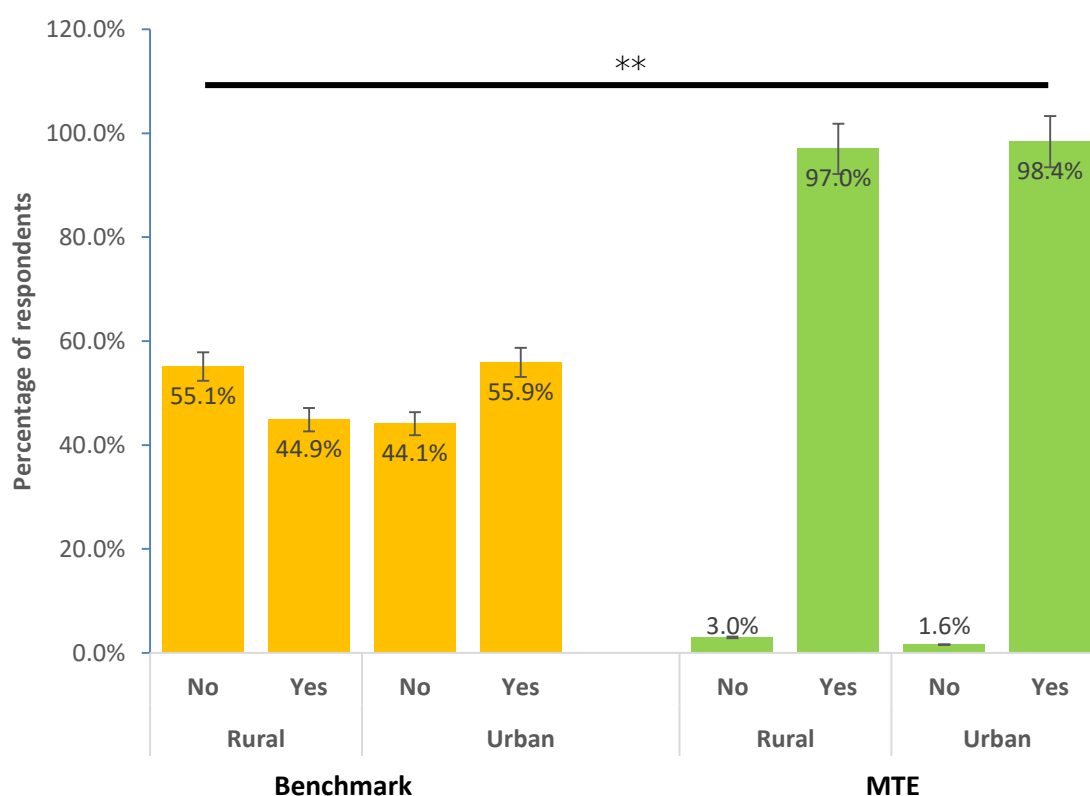


Figure 7: Knowledge and Awareness of OVC and HIV/AIDS

Source: MTE Field Survey 2019 and Mbizvo, *et al.* 2018

From Figure 6 above, the percentage of Caregivers who know Child's HIV status in both rural and urban areas has sharply increased from 44.9% in rural areas, 55.9% in urban areas to 97.0% and 98.4% respectively. Conversely, the percentage of Care givers who do not know Child's HIV status has reduced from 55.1% in rural areas to 3% and 44.1% in urban areas to 1.6%. The foregoing situation is attributed to increased level of knowledge and awareness of OVC around HIV/AIDS by the project caregivers. The table also confirms a well-known phenomenon that people in urban areas are more aware about OVC around HIV/AIDS than those in rural areas.

c) Knowledge, Practice and Attitude Among Adolescents and Youth on HIV/AIDS

The baseline survey does not provide either indicators or values on which to measure Knowledge, Practice and Attitude (KPA) among adolescents and youth. Consequently, the MTE KPA findings enumerated in Figure 8, will be used as benchmark values for future evaluations.

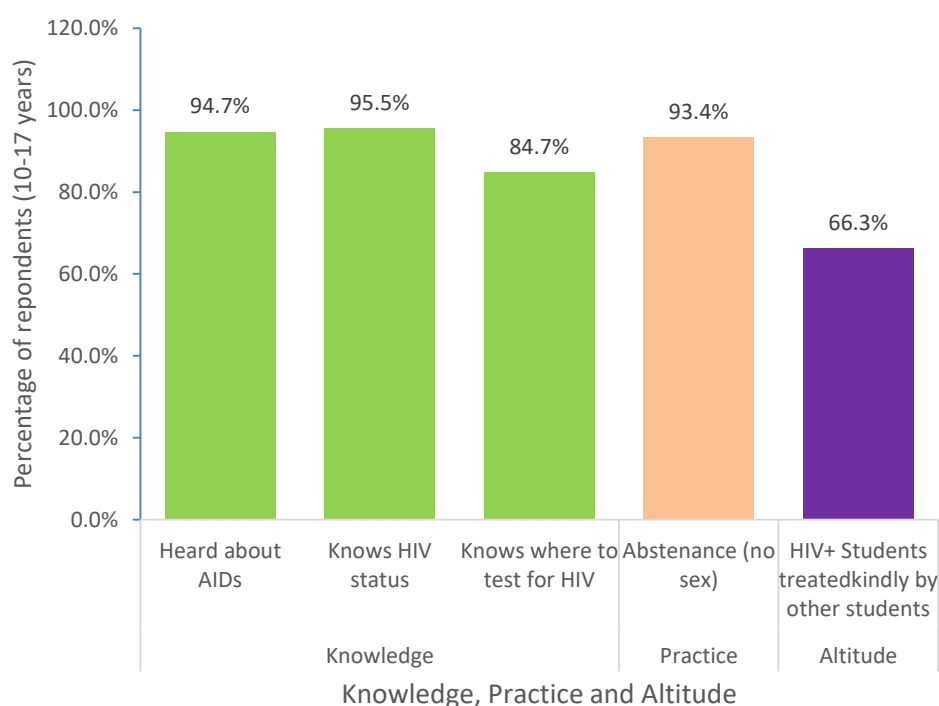


Figure 8: Knowledge, Practice and Attitude among adolescents and youth about HIV/AIDS
Source: MTE Field Survey 2019

More insight about KPA with regard to HIV/AIDS among children aged 10-17 years is provided in Table 17. Further details about the same can be obtained in Appendix 4.

Table 17: Knowledge, Practice and Attitude among adolescents and youth about HIV.AIDs

Category	Variable	% response	
		No	Yes
Knowledge			
	Child has heard of illness called AIDS	5.3	94.7
	Child knows HIV status	66.3	33.7
	Child knows where people can test for HIV	15.3	84.7
Practice			
	Child had sex in past one year	93.4	6.6
Altitude			
	HIV + Students treated unkindly by other students	66.3	33.7

Source: MTE Field Survey 2019

Almost 94% of children aged 10 to 17 years had no sex in past one year

Analysis of PEPFAR MER Essential Indicators for OVC Programmes by DAPP MTE Provinces, Age Group and Residence FY18

d) OVC graduation process

ZAMFAM primary target group are orphans and vulnerable children in two age groups (0 – 9 years) and children (10 – 17 years). The project is designed that when a child reaches 17 years of age, he/she can manage without consistent project support and moves out of the project mainstream support. The graduation takes a form of being referred to in or out of school club and the “graduate” can be monitored through CCV and NHW volunteers.

Peter Banda is a Community Mobilizer in Nangoma /Mumba Scheme in Nakasaka ward under Chieftainship Mumba in Mumbwa District. In an interview with Peter, he outlined a Case Management Process that ZAMFAM SC is following. He outlined the process as follows:

- i. Child identification which is conducted at the community by a committee comprising representatives from CWACs, local traditional and civic leadership, CVs, CHW and local churches. Using OVC guidelines developed by the Ministry of Community Development and Social Services, the committee identifies OVCs in their catchment areas.
- ii. Enrolment of selected children. This involves the OVC registered with DAPP ZAMFAM project by completing the prescribed child registration form
- iii. After formal registration of the child, using a Child Index Assessment tool, pressing needs of the child are identified and prioritised
- iv. Subsequently, a Child Development Plan is developed and locked in a book in readiness for implementation
- v. With the support of Community Action Group and the host caregiver/household, implementation of the child development plan commences.

- vi. As the child development plan is being implemented, it is closely monitored by the community mobiliser and project leader using developed assessment indicators and targets. After six months of implementation, an assessment of the child using Child Index Assessment is conducted.
- vii. Follow up is undertaken: no child is enrolled to the Project before assessment and after 12 months of a child participating in the Project, a second assessment is done.

In all 27 operational areas visited by the Evaluation team, they did not meet a child who had graduated. According to most CCVs interviewed, some children are due for scheduled graduation in the first quarter of 2019.

The team learnt that those who are being reported under graduated population are largely those whose caregivers/parents have migrated to non- ZAMFAM areas.

7.3.3 Efficiency

In ZAMFAM SC Project Monitoring and Evaluation Plan, there are no dedicated indicators to measure the project efficiency. However, project efficiency has been measured in terms of the following factors:

- i. In November 2015 when ZAMFAM SC Project implementation commenced, the Zambian Kwacha traded with US Dollar at 1 US \$ = ZMW 10.33. In November 2016, the Kwacha appreciated and traded at 1 US\$ = ZMW 9.82. In November 2017, the exchange rate rose marginally to 1US\$ = ZMW 9.97 and in November 2018, it rose to 1US\$ = ZMW 11.88. The volatility of the Kwacha against the US \$ led to periodic exchange gain and loss of the kwacha (Table 18).

Table 18: Currency exchange rates from 2015 to 2018

Period	Exchange rate	
	US\$	ZMW
November 2015	1	10.33
November, 2016	1	9.82
November 2017	1	9.97
November 2018	1	11.88

As the USAID Zambia office disburses to DAPP Zambia the project grant in Zambian Kwacha, it means the office manages the Kwacha exchange gain and losses.

a) Extent to which project resources have been efficiently utilised

The Extent to which project resources have been efficiently utilised is indicated in Table 19.

Table 19: DAPP ZAMFAM South Central Financial Report**AWARD NUMBER: AID-A-611-A-16-00002****START DATE: 20.11.2015 END DATE: 19.11.2020 (all amounts are in US\$)**

Budget Line	Budget	Obligated Amount to Date	Expenditures through Sept 2018	Difference against lifetime budget	Difference against current obligation	% Against obligation	Projected expenditure to Nov 2020
Personnel	5,236,078	2,661,929.75	2,421,167.01	2,814,910.99	240,762.75	91.0%	1,505,049.76
Fringe Benefits	2,673,290	1,384,627.27	1,301,763.99	1,371,526.01	82,863.28	94.0%	809,204.64
Travel	1,429,450	865,559.64	739,900.32	689,549.68	125,659.32	85.5%	459,938.04
Equipment	280,000	447,683.69	240,848.00	39,152.00	206,835.69	53.8%	149,716.32
Supplies	1,192,845	1,944,701.20	1,598,390.43	(405,545.43)	346,310.77	82.2%	993,594.05
Contractual	5,525,625	4,200,744.23	2,560,227.82	2,965,397.18	1,640,516.41	60.9%	1,591,492.97
Other Direct Costs (ODC)	3,839,880	3,603,725.89	2,629,124.17	1,210,755.83	974,601.72	73.0%	1,634,320.43
Training	2,495,721	2,022,116.37	1,517,742.51	977,978.49	504,373.86	75.1%	943,461.56
Indirect Costs	1,738,134	1,310,152.97	1,014,316.84	723,817.16	295,836.12	77.4%	630,521.28
TOTAL COSTS	24,411,023	18,441,241.00	14,023,481.08	10,387,541.92	4,417,759.91	76.0%	8,717,299.05

Source: DAPPZAMFAM SC FY 18 Financial Report

Overall view on Total Projections: **22,740,780.13** Total expenditure to Nov 2020 based on current expenditure rate
- 4,299,539.13 Over expenditure based on what is currently obligated

OBLIGATION ANALYSIS

Current Obligation	\$18,441,241.00
Expenditures through Sept 2018	\$14,023,481.08
Remaining Amount Obligated	\$4,417,759.91
Historical Burn Rate	\$465,649

As shown in the Financial Report, the least burning budget item is Equipment which stands at 53.8% of the obligated amount. The second lowest burning budget item is Contractual which stands at 60.9% of the obligated amount.

The personnel salaries and fringe benefits are burning close to the full amounts and should be kept under strict scrutiny to avoid overburning

As shown in Table 19: DAPP ZAMFAM South Central Financial Report as at 30 September 2018, the project had an obligated amount of US\$18.4 million and out of which US\$ 14 million had been spent, representing 76% expenditure. In comparison with the project performance as captured under Table 16: Updated Key Indicators, it is indicative of a situation that project funds were to some extent prudently used in implementing project activities. It is highly possible that the unspent obligated funds as well as unobligated, if the whole project amount will be drawn down, will be adequate to cover all planned project activities and expenditure.

In all 6 project districts visited by the Evaluation team, they worked with the District Coordinator, project leaders and community mobilizers. In each district, there are 8 - 10 project leaders, who each one of them is supported by three (3) community mobilizers in the operational area. Each community mobiliser manages about 500 households and 1,000 OVCs. Each District Coordinator and project leader has been given a motorbike and community mobilisers bicycles for transport. These modes of transport and mobile phone given to each project staff have improved their mobility and communication.

ZAMFAM SC Project planning is conducted periodically at all levels. According to the Key Informant from the Project staff who took part in the in-depth interviews, all Community Action Groups and Community Mobilisers/Project leaders, undertake weekly trainings and in the fourth session develop work plans for their respective structures. The Project leaders and District Coordinators also develop monthly and quarterly work plans which are linked to the work plans formulated at community level. In the quarterly planning meetings, implementing partners also take part and share their work plans which are in tandem with the ZAMFAM project work plan. The quarterly plans for all project districts are collated as the project work plans. At national level, district plans are collated and annual work plans for the whole project formulated and shared with implementing partners and the funding partner – USAID.

The planning system as explained in the preceding paragraphs is comprehensive and periodically undertaken at all levels of the project. It accords an opportunity for the community members, project staff and implementing partners to take part in reviewing the current/ending plan and provide informed- input into the upcoming plan. The planning meetings are participatory and provide space to adjust strategies and activities to make them appropriate to the prevailing project environment. The “Action and Reflection” meetings have enabled the project management to make adjustment to project activities. For example, at the start of the project, project materials such as desks, were centrally procured but this posed challenges in procuring and delivering the materials to the intended project users. Through action and reflection process, the project management learnt that central procurement was not effective and decided to adopt decentralised procurement through which required project materials are procured in districts.

ZAMFAM SC Data Management System (DMS) is elaborate and cascades down to the community level as presented in Table 20: ZAMAFAM SC M & E framework. At the community level, data is collected on services provided by CHWs, Community Action Groups and other community structures under the guidance of community mobilisers who pass-on the collected data to project leaders and verifies through field visit. After verification, data forms are passed on to the District Coordinator who reviews and verifies them and subsequently passes approved data forms to Data

clerks for reviewing and entering into the computer data base. Hard copies are kept in a safe place. Data entered into the data software is received and checked by the monitoring and evaluation officers who check and verify it.

According to the data clerks interviewed, when they receive data forms from the field, they check data for errors, completeness and omissions. Periodically, they also go in the field to check how data forms are completed by the Community Action Groups, CHWS, CCVs and Schools with guidance from the community mobilisers. These field trips give them an opportunity to understand project activities as they are implemented in the field and checking how data forms are completed. They also take advantage of the field to explain to the field staff how the forms should be completed, common errors observed in completion of the data forms and explain how the errors can be minimised or avoided.

The project data base is supposed to be connected to the national data management system so that project data is accessible to the government and other stakeholders entitled to access it for their official use. However, the national data management system has not been operationalised. The ZAMFAM SC data management system is exceptionally good and worth the investment which had been made into it. Hence, it should be properly maintained and kept for both current and future use.

7.3.4 Exit and Sustainability

a) Activities households are likely to continue conducting beyond project life

- i. Savings and Internal Lending Communities (SILC): All the 190 interviewed FGDs participants confirmed that they had been trained in saving and lending money.
- ii. Basic entrepreneurial activities such as trading in basic commodities like rice, beans, fish making flitters, African colony (chikunga) etc.
- iii. Pass-ons (goats, chickens and legume seeds) and have been training in basic animal husbandry and crop production
- iv. Have been empowered with information on HIV/AIDs (causes, prevention, care, support and treatment)
- v. Parenting skills have been imparted in care givers
- vi. Environmental protection: Unsafe disposal of waste, smart agriculture
- vii. Have been trained and empowered with knowledge on water sanitation and hygiene. Which include having clean and usable pit latrines, access to clean and safe water, practice of hand washing after use of toilet and hand washing before and after eating.
- viii. Governance and leadership: Learnt how to govern and lead groups/people in communities.

b) Supportive mechanisms put in place for household

- i. Community structures like VAGs and SILC which are platforms to provide support and services to households.
- ii. In schools, PTAs have been trained to work with parents/households in providing good education to their children
- iii. Through Community health workers and children care volunteers, in taking care of children, counselling, testing and treatment
- iv. Selected schools have been given block grants through which desks and learning materials are given to schools, which result in waving of school fees for some pupils.
- v. Traditional and civic leaders have been trained and are aware about the project's activities. They appreciate the project and support implementation activities.
- vi. Households have been trained in the construction housing for livestock
- vii. Structures such as CWAC and neighbourhood health communities have been strengthened in providing support and services to households.
- viii. Strengthen unity and corporation within communities

7.3.5 Cross – cutting Issues

a) Coordination

At Community Action Group level, each group prepares an action plan in the fourth week of a month after undergoing training based on Community Action Group Programme Manual.

On monthly basis, project leaders and community mobilisers draw up their work plan which they share with District Coordinator. Each month, the District Coordinator convenes a planning and review meeting. This meeting is meant for project leaders so share their plans and review the previous activities implementation. At community level, community dialogue drawing participants from all key stakeholders – traditional and civic leadership, schools, health centres, churches etc are convened to share information and ideas about ZAMFAM project and related development matters.

On quarterly basis, the district Coordinators convene stakeholders meeting which is attended by the sub- grantees to share their plans and reports for the previous quarters. In face to face interviews with KAFHI, NZP+ and YWCA representatives, they all confirmed that they participate in the quarterly stakeholders during which time they share their plans and reports for the previous period.

On quarterly basis, each of the two ZAMFAM Deputy Chief of Party (Central and Southern provinces) also convene stakeholder meetings to share information on implementation of the project activities.

At national level, DAPP ZAMFAM SC is a member of the National Technical Working Group on OVCs. This Group meets every quarter to share information and experiences amongst participating organisations.

As shown in the foregoing explanation, DAPP ZAMFAM has platforms at the community, district, province and national levels for coordination, sharing key information and experiences with stakeholders.

b) Gender Inclusion

At benchmark stage, there were less men involved in giving care to OVCs. In fact, there were 12.2% and 8.6% for rural and urban areas respectively. At MTE level, percentages had increased to 17.0% and 12.1% for rural and urban areas respectively (See Figure 1 and Appendix 4).

Furthermore, the percentage of total females regularly attending school increased from 37.1% to 66.7%. At benchmark stage, the percentage of total females and total males regularly attending school was 37.1% and 37.2% respectively. At MTE level, the percentage increased to 66.7% and 77.8% for females and males respectively (See Figure 1 and Appendix 4).

c) Age Inclusion

At benchmark stage, there was pressure on responsibilities of care giving for OVCs which was more on people as young as 18 years old. It stood at 7.2% and reduced to 4.4% for the same age group (See Figure 1 and Appendix 4). This positive situation frees young people from caregiving responsibilities and thereby they focus more on other things such as education. Comparatively, old people were made to understand and appreciate the importance of taking care of their relatives' orphaned children as evidenced in the age range of 45-50 years old where there was a percentage increase from 9.8% to 15.6% (See Figure 1 and Appendix 4).

d) Environmental - related issues

From the FGDs, it clearly emerged that caregivers, youth and kids' clubs were receiving a lot of training on agricultural activities which included climate smart agriculture to mitigate effects of global warming. Most of the teachings came from the Youth Club Program Manual, training programme guidelines produced by DAPP ZAMFAM for use among youth, those in and out of school.

Besides smart agriculture training, the youth were also receiving lessons on solid waste management, water and sanitation as well as hygiene. In these trainings, greater emphasis was placed on preserving the environment.

It was clear from the FGDs, that Community Action Groups, during their weekly meetings were also trained on smart agriculture, solid waste management, water, sanitation and hygiene. FGDs are trained by community mobilisers with support from project area leaders. Community Action Groups were also trained from the Community Action Group manual. These guidelines are produced annually and contain key areas on human development.

7.3.6 Monitoring and Evaluation Plan

DAPP ZAMFAM SC Project has a robust monitoring and evaluation system referred to as Activity Monitoring and Evaluation Plan (AMEP). It provides guidance on monitoring and evaluating project activities. It provides mechanisms for checking whether the project activities are on course or not. The document is also used as standardized reference for indicator definitions and reporting. It was envisaged that AMEP would provide a reporting system that feed into the Zambian national data sources and data collection tools, data analysis, dissemination and use.

AMEP contains both PEPFAR MER Essential Indicators for OVC programmes and DAPP ZAMFAM Key Output Indicators which makes it possible for the project to capture both its process and outcome performance. The M & E system with key roles and responsibilities at all project levels can be presented as shown below:

Table 20: ZAMFAM SC M & E Framework

Key Position	Core Responsibilities
Chief of Party	Provide guidance on all ZAMFAM SC M & E activities
M & E Specialist	Ensure reports are checked and approved before being distributed Coordinate and oversee implementation and manage ZAMFAM SC M & E system Provide technical assistance to community- based organisations during project implementation
Assistant M & E Officer	Work in collaboration with M & E Specialist in implementing AMEP Train CBOs and sub partners in use of M & E tools
Data Clerks & Data Assistants	Transcribe data from community registers and ensure that data captured on hard copy forms corresponds with what is on source documents (registers or data forms)
District Coordinators	Review reports and other data before delivering to data clerks for entering into data base Take part in quarterly data quality control visits in project areas and conduct progress monitoring visits
Project Leaders	Receive and verify data through regular field visits Facilitate quarterly performance community review and palling meetings
Community mobilisers	Collect data from community volunteers and community structures responsible to provide services such as CHWs, schools and Community Action Groups
Community health workers and Village Action Groups	Collect data from the field on services provided by CHWs, Village Community Action Groups and other community structures

Source: Adapted ZAMFAM SC AMEP Document

During in- depth interviews with data clerks in the field, they reported that on quarterly basis, they send out data capturing forms to project leaders/community mobilizers for completion. These are as follows:

Child Registration Form, Child Status Index, Community Health Worker Service Report, Community Action Group Child Service Report, Pass-on Gift Report, School OVC Service Report etc

When the foregoing data capturing forms are completed by field staff, they are returned to the District Coordinator who checks them before passing them onto data clerks for entering into data base. The main challenge being experienced as regards submission of completed data from was largely delayed submission of completed and some forms contain errors. In collaboration with district Coordinators, data clerks tackle the challenges.

The Evaluation team also interviewed project leaders who reported that on monthly basis, they receive log books from Community Action Groups which provide details on activities carried out. In collaboration with community mobilisers, they receive and check data capturing forms before submitting them to the district office. On quarterly basis, they prepare activities reports which they submit to the district office. These reports are checked against submitted quarterly plans.

The Evaluation team observed that all ZAMFAM SC Annual Reports (2015/2016, 2016/2017 and 2017/2018) covered activities implementation status and analysis of Output Indicators. The reports do not cover PEPFAR MTE Essential Indicator which are Outcome focussed. These show changes that have occurred in the primary target group (caregivers and OVCs.) lives. As the project is in its two year, it is advisable that an Outcome Assessment be undertaken to bring out more information and lessons – learnt.

7.4 Unexpected findings

ZAMFAM SC Project performance has stagnated /retarded on two PEPFAR MTE Essential Indicators and its own Output Indicators as outlined below:

Own livestock: At benchmark stage, 47.7% owned livestock, it increased to 50.7% at MTE. This suggested that the “pass-on” arrangement, involving goats was making an addition to beneficiary livestock herd.

Challenges in procurement of school block grant materials (desks & teaching materials)

6 out of 9 visited project schools, had received school block grant. 3 schools that had not received the grant experienced irregular school attendance and low number of pupils who progressed in school last year. The procurement challenge had also a knock - on effect on Number of families who received pass-on gifts (52% as per Annual Report FY18) and Number of school block grants provided (46.4%)

The Evaluation team visited a total of 56 homesteads for caregivers/CCVs to check on existence and condition of project facilities. For sanitary and hygiene facilities, only 4 out of 56 homesteads had functional pit latrines with tip tap, disk rack and rubbish pit. The rest had pit latrines without tip tap, disk rack and rubbish pit. Tip tap is least popular amongst all visited homesteads and yet it is a convenient facility for handwashing in homes.

7.5 Lessons Learnt

7.5.1 Private - public partnerships

ZAMFAM SC Project is a large – multi annual integrated project with overall budget of US\$24 million, employing more than 368 fulltime staff and working with more than four implementing partners. The project has produced a big market to a number of private companies supplying various project commodities and services. These companies are MTN supplied mobile phones and project staff using the phones continually buying airtime from the company; Honda Zambia supplied more than 37 motorbikes; local supplier of buffalo and Zambike bicycles, supplier of

school desks and yellow Chitenge materials and t- shirts given to CHWs and CCVs as well as commercial banks providing banking services. If DAPP Zambia approaches these private companies' suppliers, it is most likely that it can secure support, either cash or in kind, towards financing project activities.

7.5.2 Timing Mid – Term Evaluation

A mid- term evaluation is an assignment which requires extensive travel to all sampled project areas and households. During the dry season, it is possible to access all sampled project sites because access roads are passable and most targeted beneficiaries are available in their homesteads. The benchmark survey carried – out by the Population Council, was conducted during May/ June period, in the dry season and crop harvest season. As it was in the dry season with most sampled project areas and households being accessible, the research team managed to reach to most targeted respondents. Conversely, the MTE survey was undertaken during (Nov/Dec/Jan) period at the peak of the rainy season. The rains rendered some access roads impassable thereby making some sampled project areas and households inaccessible. Moreover, some project households were busy with crop farming activities and not available for evaluation meetings when the Evaluation team visited their areas. A critical project assignment, like MTE, which requires extensive visit to all sampled project areas, should be undertaken during the dry season when access roads are passable and targeted households free from farming activities.

8 CONCLUSION

The Mid – Term Evaluation has revealed that DAPP ZAMFAM SC Family Activity Project has made tremendous progress on PEPFAR MER Essential Outcome Indicators, especially Caregiver knows child's HIV status, too sick to participate in daily activities, Has a birth certificate, Regularly attends school, progressed in school during the last year and Children ≤ 5 years of age who recently engaged in stimulating activities with any household member. In addition, the project has made progress on Key Output Indicators, particularly Number of active beneficiaries served by PEPFAR programmes, Number of OVC received parenting caregiver services, Number of OVC received economic strengthening, Number of active Community Action Groups, Number of local leaders trained to support OVC programmes.

The achievement attained on the foregoing Outcome and Key Output Indicators are attributed effective strategies and approaches employed in the implementation of the project activities, These, among other practices, include leveraging comparative advantage of partner organisations in implementing projects activities. Creative Associates and KAFHI, YWCA, NZP+ which bring to the partnerships their expertise in relevant areas of project management, working with and through existing government as well as community structures. These will continue functioning even after the project end, primary care givers/households, using their own resources and “given a booster by the project” to propel them in their livelihood activities - as the main means of their economic empowerment. The pass - on given to Community Action Group members – legume seeds, goats,

chickens, whose products and off springs they give out to other group members and involvement of key stakeholders in the project i.e. traditional leaders, church leadership, schools, health centres, private sector players and government ministries.

However, DAPP ZAMFAM SC Project faces an uphill battle on changing the common belief that harsh punishment to children is appropriate punishment. This works against the internationally practice of protecting children against child abuse. Moreover, maintaining proper records on pass – ons to keep track of the intervention progress and effectiveness.

DAPP ZAMFAM SC contributed towards establishing community structures like CAGs and SILC and strengthening government structures which are platforms to providing support and services to households. In schools, PTAs have been trained to work with parents/households in providing good education to their children. In addition, Community health workers and children care volunteers are active in taking care of children, counselling, testing and treatment

It is highly possible that DAPP ZAMFAM can make more achievement and impact on target communities if positive changes hitherto achieved can be consolidated and expanded. At the same time, weak areas be addressed aggressively to optimise the project performance and impact. The project is on a positive trajectory towards the fulfilment of its goals.

9 RECOMMENDATIONS

DAPP ZAMFAM SC Family Activity project has demonstrated clear progress on both PEPFAR MER Essential Indicators and Key Output Indicators. The project should consolidate positive improvements achieved in its operationalization. In addition, ZAMFAM should consider adopting the proposed recommendations which are aimed at addressing weaknesses found in its planning and implementation approach.

- 9.1 Innovative and consistent caregiver/household economic strengthening interventions should be implemented to tackle the endemic household undernutrition on sustainable basis
- 9.2 Procurement of project materials, especially school desks, should be carried out in good time so as not to disrupt school attendance by targeted beneficiary pupils.
- 9.3 More efforts should be directed at facilitating establishment and strengthening savings and internal lending communities in project areas
- 9.4 Community Action Group Training Manual, currently produced in English Language, be translated in at least two local languages to make the contents more user – friendly to trainers
- 9.5 ZAMFAM has provided a huge market to equipment suppliers (motorbikes – Honda Zambia; bicycles – Buffalo & Zambike, mobile phones and airtime – MTN). As a normal business practice, these companies can be approached for project support/donations under their respective social investment strategy
- 9.6 Crucial Surveys, like Mid - Term Evaluation, should be conducted during dry season when accessibility to all sampled project areas, communities and households is feasible

- 9.7 Closer consultations to be made with Ministry of Fisheries and Livestock for technical advice and guidance on procurement of “pass – on” livestock (goats and chickens) and livestock movement ban
- 9.8 In the same vein, at least one Outcome Survey focusing on PEPFAR Essential Indicators, be carried out to provide more comprehensive and current information before the project end
- 9.9 Community Action Group Training Manual, currently produced in English Language, be translated in at least two local languages to make the contents more user – friendly to the trainers (especially some community mobilizers
- 9.10 More conscientization efforts to be made among project population to change endemic belief that harsh punishment is appropriate discipline to be given to the child.
- 9.11 Improving record keeping on “pass on” to keep track of the intervention progress and effectiveness.

10 REFERENCES

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11 APPENDICES

Appendix 1: Sample Size Determination

The required sample size will be calculated based on a formula by Puszcz et al. (2013) as adopted from (Conchran, 1963). In this MTE, the acceptable sampling error will be adjusted from 0.05 down to 0.035 to achieve the desired household sample size of 784. The formula consists of two equations as indicated below.

$$n_0 = \frac{Z^2 pq}{e^2}$$

Equation 1: Formula for calculating a sample for proportions

n_0 - The sample size

Z^2 - The abscissa of the normal curve that cuts off an area α at the tails or the critical value, 1.96

e - The acceptable sampling error or the desired level of precision i.e. 95% confidence level, 0.035

p - The estimated proportion of an attribute that is present in the population or maximum variability, assume $p = 0.5$

q - This is $1-p$, 0.5

In the event that the number of households falls below 10,000, an adjustment formula as shown below will be used.

Equation 2: Finite population correction for proportions

$$n = \frac{n_0}{1 + \frac{(n_0 - 1)}{N}}$$

Where:

n - Adjusted sample size

N - The population size.

For the 6 ZAMFAM districts,

n_0 is 784, N is 72,219 and thus inputting into the above formula yields a sample size of 784

Study Sample Size per district

In view of the high degree of variations in the sizes of households in the project districts, a multi-stage sampling technique will be employed (UNICEF, 2014). The following steps are to be followed:

1. Data on household numbers will be obtained from DAPP and presented in form of a table
2. Add up all the households per district to obtain the population of households for the 6 districts.
3. Subject the household numbers to Proposal Size Sampling to obtain the desired household sample sizes for the districts.
4. Get household data for each of the district projects
5. List projects (with corresponding household data) for each district in tabular form
6. Determination of the number of projects to be sampled for a particular district will be done by using the formula:

$\sqrt{(\text{number of wards for that particular district})}$ i.e. Square root of the number of projects.

7. Determination of the minimum and maximum numbers of households for each of the projects in a particular district.
8. Organise the projects into strata based on their household numbers (as population sizes) at an interval determined by using the formula: Total number of households in all the projects for a particular district divided by the desired project sample size obtained in stage 6.
9. Use Proportionate stratification method where the sample size of each stratum will be proportionate to the population size of the stratum. Strata sample sizes will be determined using the following equation:

$$n_h = (N_h / N) * n$$

Where n_h is the sample size for stratum h , N_h is the population size for stratum h , N is total population size, and n is total sample size (StatTrek, 2017)

10. Project sample size in each stratum will follow the 10% rule. Which according to Theme Horse (2017), states that sample sizes should be no more than 10% of the population. The resulting project sample size in the first to the fifth strata will be subjected to Probability proportional to size sampling technique to yield the selected projects. The corresponding household sample size for each stratum will be considered.
11. Villages that fall under the respective projects will be selected using Probability Proportional to Sample size as explained earlier in the selection of projects.

12. Systematic Randomised Sampling will be applied in the selection of households in the selected villages.

The interval will be obtained by using the following formula:

Total number of households / Target number of Household to be interviewed

Sample Size for Qualitative Data Collection

While the concept of “saturation” may be ideal or a guiding principle when it comes to the determination of the sample size in qualitative research, it is still hotly debated, and some say little understood (Mason, 2010). Since the approach will be based on Action research, as a rule of thumb, 20-30 people will typically be enough to reach saturation. This will equally suffice when the rule of thumb is based on data collection method, to interview approximately 20 people during In-depth interviews and approximately 5 people for Key Informants’ interviews. The sample size to be used in qualitative research methods will often be smaller than that used in quantitative research methods. This is because qualitative research methods will often be concerned with garnering an in-depth understanding of a phenomenon (Dworkin, 2012).

Appendix 2: Data Collection Garget

Android/Smart phone

Version of Android: Operating System (OS) Android 4.3.1 or better is required; Android 5.0+ is strongly recommended. – RAM Minimum 1.5GB – Memory 8GB of flash memory storage. At least 1GB of available space must be available for ODK's use. Enough space on phone will be required during the operation of the software. The ultimate requirements for space depend on the kind of survey (questionnaire) and the mode of use of the phone (number of assignments, simultaneously started assignments, rejections, etc. Better technical characteristics will improve responsiveness of the program.

All Android gargets should be ZICTA type approved for quality data collection. “These Type Approval Guidelines covering all types of Radio and Telecommunication Terminal Equipment (RTTE) are issued by the Zambia Information Communication Technology Authority (ZICTA) in line with Type Approval Policy as well as Statutory Instruments (SIs) 6 and 65 of 2011 under the ICT Act No.” <https://www.zicta.zm/Views/Articles/Type%20Approval%20Guidelines.htm>

Computer

Windows-based computer, OS Windows 7, Windows 8, or Windows 10; 4GB RAM, 120GB hard drive space (solid-state drive (SSD) drive is preferable); If the supervisor is working in the field, then connectivity from the field via 3G or 4G, (built-in, USB, or external wireless modem, or a similar device).

Appendix 3: DAPP ZAMFAM SC Field Data Collection Summary Report

Household Questionnaires					Focus Group Discussions				Key Informants Interviews			
Chibombo	Category	Target	Achieved	Percent	FGDs	Target	Achieved	Percent	KIIs	Target	Achieved	Percent
	Caregiver (Household)	111	114	103%		2	3	150%		6	15	250%
	Children 0 - 9 yrs		59									
	Children 10 - 17 yrs		10									
	Sub Total		183		Sub Total				Sub Total			
Kabwe	Category	Target	Achieved	Percent	FGDs	Target	Achieved	Percent	KIIs	Target	Achieved	Percent
	Caregiver (Household)	118	116	98%		2	3	150%		6	15	250%
	Children 0 - 9 yrs		49									
	Children 10 - 17 yrs		16									
	Sub Total		181		Sub Total				Sub Total			
Kapiri	Category	Target	Achieved	Percent	FGDs	Target	Achieved	Percent	KIIs	Target	Achieved	Percent
	Caregiver (Household)	157	100	64%		2	3	150%		6	12	200%
	Children 0 - 9 yrs		54									
	Children 10 - 17 yrs		12									
	Sub Total		166		Sub Total				Sub Total			
Mumbwa	Category	Target	Achieved	Percent	FGDs	Target	Achieved	Percent	KIIs	Target	Achieved	Percent
	Caregiver (Household)	95	103	108%		2	3	150%		6	12	200%
	Children 0 - 9 yrs		51									
	Children 10 - 17 yrs		15									
	Sub Total		169		Sub Total				Sub Total			
Livingstone	Category	Target	Achieved	Percent	FGDs	Target	Achieved	Percent	KIIs	Target	Achieved	Percent
	Caregiver (Household)	146	117	80%						6	22	367%
	Children 0 - 9 yrs		57			2	4	200%				
	Children 10 - 17 yrs		59									
	Sub Total		233		Sub Total				Sub Total			

Mazabuka	Category	Target	Achieved	Percent	FGDs	Target	Achieved	Percent	KIIs	Target	Achieved	Percent
	Caregiver (Household)	156	115	74%		2	3	150%		6	16	267%
	Children 0 - 9 yrs		71									
	Children 10 - 17 yrs		27									
	Sub Total		213		Sub Total				Sub Total			
Overall	Category	Target	Achieved	Percent	Overall	Target	Achieved	Percent	KIIs	Target	Achieved	Percent
	Caregiver (Household)	784	665	85%		12	19	158%		24	65	271%
	Children 0 - 9 yrs		341									
	Children 10 - 17 yrs		139									
	TOTAL		1,145		TOTAL	12	19	158%	TOTAL	24	65	271%

Source: MTE Field Survey, 2019

Appendix 4: Caregiver and household demographic characteristics for Central and Southern Provinces

Total n=665			Total				Central/Southern			
			Rural n=116		Urban n=113		Rural n=35		Urban n=64	
			%	CI	%	CI	%	CI	%	CI
Caregiver										
Sex										
Female	91.4	89.9-92.7	89.0	86.9-90.8	92.8	90.7-94.5	87.8	85.0-90.1	91.4	88.7-93.5
Male	8.6	7.3-10.1	11.0	9.2-13.1	7.2	5.5-9.3	12.2	9.9-15.0	8.6	6.5-11.3
Female (n=323)	86.4	82.6-90.1	83.0	78.9-87.1	87.9	84.4-91.5	83.0	78.9-87.1	87.9	84.4-91.5
Male (n=323)	13.6	9.9-17.4	17.0	12.9-21.1	12.1	8.5-15.6	17.0	12.9-21.1	12.1	8.5-15.6
Age										
Age (mean)	43.1	42.1-44.1	41.2	39.4-43.0	44.1	42.9-45.3	41.2	39.0-43.5	44.3	43.0-45.5
18-24	7.2	5.8-8.8	10.9	8.0-14.8	5.0	3.9-6.5	10.9	7.6-15.4	5.4	4.0-7.4
25-29	10.1	8.6-11.8	11.5	8.8-14.9	9.3	7.6-11.3	11.0	8.6-14.1	9.4	7.1-12.3
30-34	13.7	12.0-15.6	14.6	11.8-17.9	13.2	11.2-15.6	15.1	11.7-19.2	12.3	9.5-15.9
35-39	15.0	13.3-16.9	14.3	12.1-16.9	15.4	13.1-18.1	13.4	11.1-16.1	15.3	12.1-19.1
40-44	11.8	10.4-13.4	12.4	10.1-15.3	11.5	9.8-13.4	13.2	10.7-16.3	13.2	10.6-16.3
45-50	9.8	8.5-11.3	9.7	7.4-12.6	9.9	8.4-11.6	9.2	7.1-11.8	10.7	8.4-13.5
50+	32.4	29.4-35.4	26.6	22.0-31.7	35.7	32.0-39.5	27.2	21.0-34.3	33.7	29.0-38.7
Age (mean) n=315	44.1	42.7-45.7	45.4	44.0-46.8	45.6	44.1-47.1	45.4	44.0-46.8	45.6	44.1-47.1
18-24	4.4	2.2-6.7	2.5	0.8-4.3	2.9	1.0-4.7	2.5	0.8-4.3	2.9	1.0-4.7
25-29	7.6	4.7-10.6	6.7	3.9-9.4	6.7	3.9-9.4	6.7	3.9-9.4	6.7	3.9-9.4
30-34	11.4	7.9-15.0	9.2	6.0-12.4	10.8	7.3-14.2	9.2	6.0-12.4	10.8	7.3-14.2
35-39	12.7	9.0-16.4	15.2	11.2-19.2	14.9	11.0-18.9	15.2	11.2-19.2	14.9	11.0-18.9
40-44	13.0	9.3-16.8	13.7	9.8-17.5	14.0	10.1-17.8	13.7	9.8-17.5	14.0	10.1-17.8
45-50	15.6	11.5-19.6	16.5	12.4-20.6	15.2	11.2-19.2	16.5	12.4-20.6	15.2	11.2-19.2
50+	33.3	28.1-38.6	35.2	29.9-40.5	34.6	29.3-39.9	35.2	29.9-40.5	34.6	29.3-39.9
Current marital status										
Married/cohabiting	60.1	57.2-62.9	71.6	67.5-75.3	53.6	49.7-57.4	74.3	69.3-78.7	56.0	48.1-63.5
Never married	4.6	3.6-5.9	3.5	2.4-4.9	5.2	3.8-7.2	3.2	2.0-5.3	5.2	3.2-8.5
Divorced/separated	8.9	7.6-10.4	8.9	6.7-11.7	8.9	7.4-10.7	7.7	5.4-10.8	8.8	6.3-12.2
Widowed	26.4	24.1-28.9	16.1	13.6-19.0	32.3	28.9-35.8	14.8	11.8-18.4	30.0	24.7-35.8
Married/cohabiting (n = 665)	58.2	54.4-62.0	29.8	26.3-33.3	28.3	24.8-31.7	29.8	26.3-33.3	28.3	24.8-31.7

Never married (n = 665)	2.0	0.9-3.0	0.8	0.1-1.4	1.2	0.4-2.0	0.8	0.1-1.4	1.2	0.4-2.0
Divorced/separated (n = 665)	10.0	7.8-12.4	5.1	3.4-6.8	5.0	3.3-6.6	5.1	3.4-6.8	5.0	3.3-6.6
Widowed (n = 665)	29.6	26.1-33.1	12.9	10.4-15.5	16.7	13.9-19.5	12.9	10.4-15.5	16.7	13.9-19.5
Education										
Years of schooling completed (mean)	5.9	5.6-6.2	5.7	5.4-5.9	6.0	5.6-6.4	5.7	5.4-6.0	6.0	5.3-6.7
Highest level completed										
Never attended school	11.1	9.4-13.1	11.7	9.3-14.6	10.8	8.6-13.4	11.5	8.7-15.1	12.3	8.6-17.4
Some primary school	36.6	33.9-39.4	36.4	32.7-40.3	36.8	33.1-40.6	36.2	31.3-41.3	35.8	29.8-42.3
Completed primary school	24.8	23.2-26.5	26.8	23.6-30.2	23.6	21.9-25.5	28.4	24.3-32.7	20.5	17.3-24.2
Some secondary school	22.0	19.7-24.6	22.4	19.3-25.9	21.8	18.6-25.4	21.7	18.2-25.8	22.0	16.9-28.0
Completed secondary school	4.2	3.2-5.4	2.2	1.2-3.8	5.3	3.9-7.0	1.7	1.0-2.9	7.3	4.4-11.9
Higher than secondary school	1.3	0.8-2.0	0.5	0.2-1.3	1.7	1.0-2.9	0.5	0.2-1.5	2.1.0	1.0-4.2
Years of schooling completed (mean) n = 231	7.9	7.6-8.2	7.4	7.1-7.8	8.0	7.6-8.3	7.4	7.1-7.8	8.0	7.6-8.3
Highest level completed										
Never attended school (n = 323)	11.1	7.7-14.6	11.8	8.2-15.3	9.3	6.1-12.5	11.8	8.2-15.3	9.3	6.1-12.5
Some primary school (n = 233)	44.2	37.8-50.6	56.2	49.8-62.6	43.8	37.4-50.2	56.2	49.8-62.6	43.8	37.4-50.2
Completed primary school (n = 231)	77.1	77.6-82.5	72.7	66.9-78.5	77.1	71.9-82.5	72.7	66.9-78.5	77.1	71.9-82.5
Some secondary school (n = 233)	53.6	47.2-60.1	41.2	34.8-47.6	54.5	48.1-60.9	41.2	34.8-47.6	54.5	48.1-60.9
Completed secondary school (n = 231)	9.5	5.7-13.3	7.4	4.0-10.8	11.7	7.5-15.9	7.4	4.0-10.8	11.7	7.5-15.9
Higher than secondary school (n = 233)	2.1	0.3-4.0	2.6	0.5-4.6	1.7	0.0-3.4	2.6	0.5-4.6	1.7	0.0-3.4
Ability to read sentence in preferred language										
Cannot read at all	33.4	30.6-36.4	38.1	33.9-42.5	30.8	27.0-34.8	38.7	33.6-44.0	30.2	24.8-36.2
Read part	18.0	16.3-20.0	18.3	15.7-21.2	17.9	15.5-20.5	19.4	16.2-23.1	20.5	16.3-25.5
Read whole	48.5	45.4-51.6	43.6	40.3-46.9	51.4	46.9-55.8	41.9	38.1-45.9	49.3	44.1-54.4
Cannot read at all (n = 322)	14.0	10.2-17.8	16.5	12.4-20.5	15.8	11.8-19.8	16.5	12.4-20.5	15.8	11.8-19.8
Read part (n = 322)	26.1	21.3-30.9	33.2	28.1-38.4	27.0	22.1-31.9	33.2	28.1-38.4	27.0	22.1-31.9
Read whole (n = 322)	52.8	47.3-58.3	41.0	35.6-46.4	49.4	43.9-54.9	41.0	35.6-46.4	49.4	43.9-54.9

Household											
Floor											
Unfinished	41.3	37.2–45.5	71.7	66.3–76.6	24.0	18.7–30.2	77.9	71.9–83.0	39.1	26.6–53.2	
Finished	58.7	54.5–62.8	28.3	23.4–33.7	76.0	69.8–81.3	22.1	17.0–28.1	60.9	46.8–73.4	
Unfinished (n = 323)	0	---	0	---	0	---	0	---	0	---	
Finished	100	---	100	---	100	---	100	---	100	---	
Roof											
Unfinished	20.7	17.4–24.4	45.4	38.1–52.8	6.7	3.9–11.1	52.0	43.0–60.8	12.8	6.4–23.9	
Finished	79.3	75.6–82.6	54.6	47.2–61.9	93.3	88.9–96.1	48.0	39.2–57.0	87.2	76.1–93.6	
Unfinished (n = 318)	0.3	-0.3-0.9	0.3	-0.3-0.9	0.0	---	0.3	-0.3-0.9	0.0	---	
Finished	99.7	99.1-100.3	99.7	99.1-100.3	100	---	99.7	99.1-100.3	100	---	
Wall											
Unfinished	30.9	26.8–35.4	54.0	46.3–61.6	17.8	13.2–23.5	59.9	49.3–69.7	24.5	15.5–36.4	
Finished	69.1	64.6–73.2	46.0	38.4–53.7	82.2	76.5–86.8	40.1	30.3–50.7	75.5	63.6–84.5	
Unfinished (n = 319)	0.0	---	0.0	---	0.0	---	0.0	---	0.0	---	
Finished	100	---	100	---	100	---	100	---	100	---	
Wealth (count of 19 items: mean)	4.9	4.6–5.2	3.9	3.7–4.2	5.5	5.1–5.9	3.8	3.5–4.1	4.9	4.3–5.6	
Wealth (count of 19 items: mean) n = 323	4.2	2.7-5.7	2.2	0.6-3.8	13.8	10.1-17.7	2.2	0.6-3.8	13.8	10.1-17.7	
Own livestock											
No	52.5	48.1–56.8	19.2	13.9–26.0	71.4	65.2–76.9	15.8	10.8–22.5	56.9	42.4–70.3	
Yes	47.5	43.2–51.9	80.8	74.0–86.1	28.6	23.1–34.8	84.2	77.5–89.2	43.1	29.7–57.6	
No (n = 324)	56.8	51.4-62.2	30.9	25.8-35.9	66.7	61.5-71.8	30.9	25.8-35.9	66.7	61.5-71.8	
Yes (n = 324)	50.7	46.9-54.5	69.1	64.1-74.2	33.3	28.2-38.5	69.1	64.1-74.2	33.3	28.2-38.5	
Own agricultural land											
No	47.8	43.3–52.3	15.7	10.6–22.7	66.0	59.7–71.8	11.0	7.8–15.3	53.3	38.4–67.7	
Yes	52.2	47.7–56.7	84.3	77.3–89.4	34.0	28.2–40.3	89.0	84.7–92.2	46.7	32.3–61.6	
No (n = 297)	63.6	58.1-69.1	32.0	26.7-37.3	74.7	69.8-79.7	32.0	26.7-37.3	74.7	69.8-79.7	
Yes (n = 297)	36.4	30.9-41.9	68.0	62.7-73.3	25.3	20.3-30.2	68.0	62.7-73.3	25.3	20.3-30.2	

Source: MTE Field Survey 2019 and Mbizvo, *et al.* 2018

Appendix 5: Knowledge, Practice and Attitude Among Adolescents and Youth aged 10 to 17 years on HIV/AIDs

Total rural			Total urban		Total Female rural		Total Female urban		Total Male rural		Total Male urban		Total	
%	CI		%	CI	%	CI	%	CI	%	CI	%	CI	%	CI
OVC 10 to 17 years														
Child has heard of illness called AIDs														
No (n = 131)	7.5	-1.0-16	5.0	-2.1-12.1	13.0	-1.8-27.9	0	---	0	---	11.1	-5.0-27.2	5.3	1.4-9.2
Yes (n = 131)	92.5	84.0-101.0	95.0	87.9-102.1	87.0	72.1-101.8	100	---	100	---	88.9	72.8-105.	94.7	90.8-98.6
HIV+ Students treated unkindly by other students														
No (n = 98)	65.0	42.1-87.9	80.0	60.8-99.2	66.7	35.4-98.0	83.3	58.6-108	50.0	5.3-94.7	50.0	5.3-94.7	66.3	56.8-75.9
Yes (n = 98)	35.0	12.1-57.9	20.0	0.8-39.2	33.3	2.0-64.6	16.7	-8.1-41.4	50.0	5.3-94.7	50.0	5.3-94.7	33.7	24.1-43.2
Child knows HIV status														
No (n = 89)	7.1	-8.3-22.6	7.1	-8.3-22.6	0	---	0	---	14.3	-20.7-49.2	0	---	4.5	0.1-8.9
Yes (n = 89)	92.9	77.4-108.3	92.9	77.4-108.	100	---	100	---	85.7	50.8-120.	100	---	95.5	91.1-99.9
Child knows where people can test for HIV														
No (n = 124)	20.0	6.1-33.9	17.1	4.0-30.3	26.3	4.5-48.1	15.8	-2.3-33.8	12.5	-5.7-30.7	18.8	-2.7-40.2	15.3	8.9-21.8
Yes (n = 124)	80.0	66.1-93.9	82.9	69.7-96.0	73.7	51.9-95.5	84.2	66.2-102.	87.5	69.3-105.	81.3	59.8-102	84.7	78.2-91.1
Child had sex in past 1 year														
No (n = 122)	81.8	67.9-95.7	93.9	85.3-102	78.9	58.8-99.1	89.5	74.3-104	85.7	84.7-105	100	--	93.4	89.0-97.9
Yes (n = 122)	18.2	4.3-32.1	6.1	-2.5-14.7	21.1	0.9-41.2	10.5	4.7-25.7	14.3	-6.7-35.3	0	--	6.6	2.1-11.0

Appendix 6: PEPFAR MER Essential Indicators for OVC programs by DAPP provinces, age group and residence FY18

PEPFAR MER Essential Indicators for OVC programs by DAPP provinces, age group and residence FY18

	0-4				5-9				10-14				15-17				Total			
	Rural n=64		Urban n=48		Rural n=116		Urban n=113		Rural n=35		Urban n=64		Rural n=7		Urban n=27		Rural n=222		Urban n=252	
	%	CI	%	CI	%	CI	%	CI	%	CI	%	CI	%	CI	%	CI	%	CI	%	CI
OVC																				
Caregiver knows child's HIV status (n=1,530)																				
No	40.7	32.3-49.6	46.9	36.6-57.4	53.6	1-61.0	36.0	26.5-46.8	62.3	53.7-70.3	48.2	38.8-57.6	57.1	43.9-69.4	49.0	33.4-64.8	55.1	48.2-61.8	44.1	35.3-53.2
Yes	59.3	50.4-67.7	53.1	42.6-63.4	46.4	39.0-53.9	64.0	53.2-73.5	37.7	29.7-46.3	51.8	42.4-61.2	42.9	30.6-56.1	51.0	35.2-66.6	44.9	38.2-51.8	55.9	46.8-64.7
No (n=211, 240)	2.4	0.3-4.4	1.2	-0.2-2.7	---	---	---	---	10	-4.4-24.5	4.5	-1.9-11	0	---	0	---	3	0.8-5.2	1.6	0.2-3.1
Yes (n=211, 240)	98.6	95.6-99.7	98.8	97.3-100.2	---	---	---	---	90.0	75.5-104.4	95.5	89.0-101.9	100	---	100	---	97.0	94.8-99.2	98.4	96.9-99.8
Undernourished																				
No	96.5	89.8-98.9	95.7	90.1-98.2	---	---	---	---	---	---	---	---	---	---	---	---	96.5	89.8-98.9	95.7	90.1-98.2
Yes	3.5	1.1-10.2	4.3	1.8-9.9	---	---	---	---	---	---	---	---	---	---	---	---	3.5	1.1-10.2	4.3	1.8-9.9
No (n=38, 44)	65.8	50.0-81.6	81.8	70.0-93.7	---	---	---	---	---	---	---	---	---	---	---	---	65.8	50.0-81.6	81.8	70.0-93.7
Yes (n=38, 44)	34.2	18.4-50.0	18.2	6.3-30.0	---	---	---	---	---	---	---	---	---	---	---	---	34.2	18.4-50.0	18.2	6.3-30.0
Too sick to participate in daily activities																				
No	50.0	42.6-57.4	56.3	41.1-70.3	67.1	61.9-71.9	69.7	63.6-75.3	67.3	62.4-71.8	63.6	56.4-70.3	59.0	50.0-67.4	72.1	60.1-81.6	63.4	60.4-66.3	65.9	60.9-70.6
Yes	50.0	42.6-57.4	43.8	29.7-58.9	32.9	28.1-38.1	30.3	24.7-36.4	32.7	28.2-37.6	36.4	29.7-43.6	41.0	32.6-50.0	27.9	18.4-39.9	36.6	33.7-39.6	34.1	29.4-39.1
No	85.9	77.2-94.7	70.8	57.5-84.2	83.6	76.8-90.5	83.2	76.2-90.2	100	---	100	---	100	---	100	---	87.4	83.0-91.8	86.9	82.7-91.1
Yes	14.1	5.3-22.8	29.2	15.8-42.5	16.4	9.5-23.2	16.8	9.8-23.8	0	---	0	---	0	---	0	---	12.6	8.2-17.0	13.1	8.9-17.3
Has a birth certificate																				
No	70.7	58.2-80.6	86.5	62.5-96.1	86.9	79.0-92.1	90.8	84.5-94.6	94.2	90.1-96.7	97.1	94.6-98.4	98.7	91.1-99.8	100	---	88.0	82.3-92.0	93.9	89.0-96.7
Yes	29.3	19.4-41.8	13.5	39.0-37.5	13.1	7.9-21.0	9.2	5.4-15.5	58.0	3.3-9.9	2.9	1.6-5.4	1.3	0.2-8.9	0.0	---	12.0	8.0-17.7	6.1	3.3-11.0
No	78.1	67.7-88.5	68.7	55.1-82.4	72.4	64.2-80.7	79.6	72.1-87.2	78.8	64.1-93.5	84.8	76.0-93.7	85.7	50.8-79.3	77.8	61.0-94.5	75.3	65.681.1	78.7	73.7-83.8
Yes	21.9	11.5-32.3	31.3	17.6-44.9	27.6	19.3-35.8	20.4	12.8-27.9	21.2	6.5-35.9	15.2	6.3-24.0	14.3	20.7-49.2	22.2	5.5-39.0	24.7	18.9-34.4	21.3	16.2-26.3
Regularly attends school																				
No	---	---	---	---	74.4	67.7-80.1	69.7	60.9-77.3	62.4	54.9-69.4	55.5	47.5-63.2	60.3	45.8-73.2	61.5	47.5-73.9	67.1	62.0-71.9	62.1	54.3-69.2
Yes	---	---	---	---	25.6	19.9-32.3	30.3	22.7-39.1	37.6	30.6-45.1	44.5	36.8-52.5	39.7	26.8-54.2	38.5	26.1-52.5	32.9	28.1-38.0	37.9	30.8-45.7
No (n=109,155)	---	---	---	---	86.1	78.3-93.9	77.3	67.6-87.0	62.5	41.6-83.4	84.2	74.4-94.0	66.7	12.5-79.1	78.3	60.0-96.5	79.8	72.2-87.5	80.0	73.6-86.4
Yes (n=109,155)	---	---	---	---	13.9	6.1-21.7	22.7	13.0-32.4	37.5	16.6-58.4	15.8	6.0-25.6	33.3	-20.9-87.5	21.7	3.5-40.0	20.2	12.5-27.8	20.0	13.6-26.4
Progressed in school during the last year (n=112)																				
No	---	---	---	---	55.6	44.9-65.8	42.5	35.0-50.5	9.9	7.2-13.4	86	6.7-11.0	16.9	10.3-26.6	17.4	8.8-31.6	22.9	20.0-26.1	19.8	16.3-23.8
Yes	---	---	---	---	44.4	34.2-55.1	57.5	49.5-65.0	90.1	86.6-92.8	91.4	89.0-93.3	83.1	73.5-89.7	82.6	68.4-91.2	77.1	73.9-80.0	80.2	76.2-83.7
No	---	---	---	---	10.5	2.3-18.7	22	11.1-32.9	23.8	3.9-43.7	24.3	9.8-38.8	16.7	-26.2-59.5	12.5	-5.7-30.7	14.3	6.6-21.9	21.4	13.7-29.1
Yes	---	---	---	---	89.5	81.3-97.7	78.0	67.1-88.9	76.2	56.3-96.1	75.7	61.2-90.2	83.3	40.5-126.2	87.5	69.3-105.7	85.7	78.1-93.4	78.6	70.9-86.3

Children <5 years of age who recently engaged in stimulating activities with any household member over 15 years of age (n= 328) *																
No	8.1	3.8-16.5	7.9	2.9-19.8	---	---	---	---	---	---	---	---	8.1	3.8-16.5	7.9	2.9-19.8
Yes	91.9	83.5-96.2	92.1	80.2-97.1	---	---	---	---	---	---	---	---	91.9	83.5-96.2	92.1	80.2-97.1
No	4.8	-0.6-10.2	0	---	---	---	---	---	---	---	---	---	4.8	-0.6-10.2	0	---
Yes	95.2	89.8-100.6	100	---	---	---	---	---	---	---	---	---	95.2	89.8-100.6	100	---
Household level indicators																
Household able to access money to pay for unexpected household expenses (n= 340)																
No	---	---	---	---	---	---	---	---	---	---	---	---	35.7	29.1-43.0	58.4	52.5-64.0
Yes	---	---	---	---	---	---	---	---	---	---	---	---	64.3	57.0-70.9	41.6	36.0-47.5
No	---	---	---	---	---	---	---	---	---	---	---	---	48.4	39.5-57.3	35.8	28.0-43.6
Yes	---	---	---	---	---	---	---	---	---	---	---	---	51.6	42.7-60.5	64.2	56.4-72.0
Caregiver agrees harsh punishment is appropriate discipline																
No	---	---	---	---	---	---	---	---	---	---	---	---	55.2	49.4-60.8	63.0	56.8-68.7
Yes	---	---	---	---	---	---	---	---	---	---	---	---	44.8	39.2-50.6	37.0	31.3-43.2
No	---	---	---	---	---	---	---	---	---	---	---	---	69.2	64.1-74.2	66.4	61.3-71.4
Yes	---	---	---	---	---	---	---	---	---	---	---	---	30.8	25.8-35.9	33.6	28.6-38.7

*Stimulating activities = Read books to a child, tell stories to a child, sing songs to a child, take child outside home, play with the child and name things/count/draw things with a child

Appendix 7: PEFPAR MER Core Indicators, by DAPP provinces, age group and residence

PEFPAR MER Core Indicators, by DAPP provinces, age group and residence

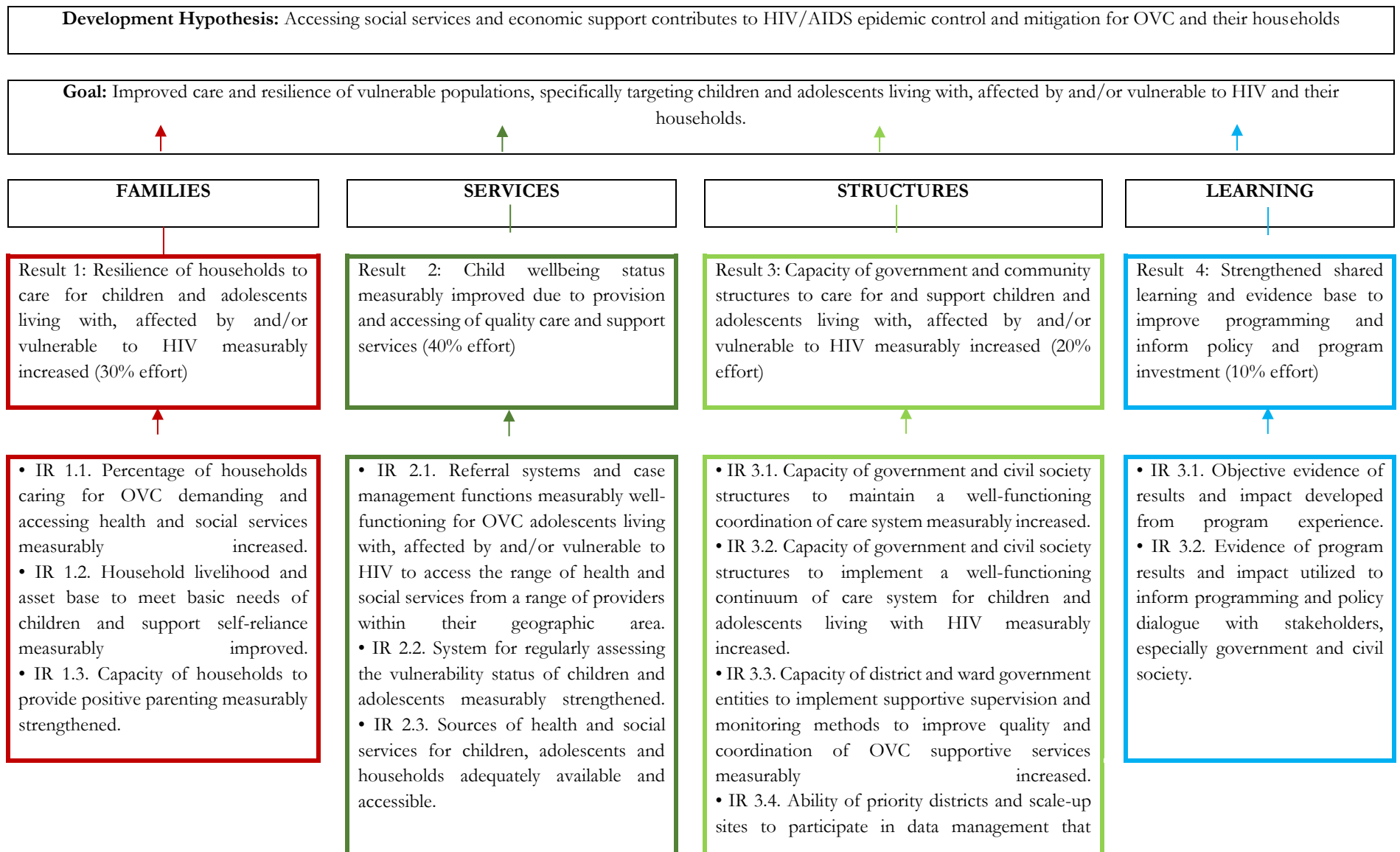
	0-4 n = 417		5-9 n = 943		10-14 n =1,129		15-17 n = 422		Total n = 2911		Total rural n = 1,123		Total urban n = 1,788		Total female n = 1,435		Total male n = 1,476	
	%	CI	%	CI	%	CI	%	CI	%	CI	%	CI	%	CI	%	CI	%	CI
OVC																		
CW.2 Diarrhoea in past 2 weeks																		
No	66.6	61.6–71.2	—	—	—	—	—	—	66.6	61.6–71.2	67.1	60.1–73.4	66.2	59.1–72.6	66.7	60.1–72.7	66.5	58.7–73.5
Yes	33.4	28.8–38.4	—	—	—	—	—	—	33.4	28.8–38.4	32.9	26.6–39.9	33.8	27.4–40.9	33.3	27.3–39.9	33.5	26.5–41.3
No (n = 48)	77.1	64.8-89.4	---	---	---	---	---	---	85.3	81.5-89.1	83.3	72.4-94.3	75.0	62.3-87.7	81.3	69.8-92.7	77.1	64.8-89.4
Yes (n = 48)	22.9	10.6-35.2	---	---	---	---	---	---	14.7	10.9-18.5	16.7	5.7-27.6	25.0	12.3-37.7	18.8	7.3-30.2	22.9	10.6-35.2
CW.3 Fever in past 2 weeks																		
No	56.8	50.9–62.5	—	—	—	—	—	—	56.8	50.9–62.5	53.9	44.5–63.1	59.2	51.9–66.2	59.0	51.6–66.1	54.6	46.9–62.0
Yes	43.2	37.5–49.1	—	—	—	—	—	—	43.2	37.5–49.1	46.1	36.9–55.5	40.8	33.8–48.1	41.0	33.9–48.4	45.4	38.0–53.1
No (n = 48)	64.6	50.5-78.6	---	---	---	---	---	---	76.8	68.8-84.7	77.1	64.8-89.4	68.8	55.1-82.4	70.8	57.5-84.2	77.1	64.8-89.4
Yes (n = 48)	35.4	21.4-49.5	---	---	---	---	---	---	23.2	15.3-31.2	22.9	10.6-35.2	31.3	17.6-44.9	29.2	15.8-42.5	22.9	10.6-35.2
CW.5 Day without eating in last 4 weeks (Age 2 – 17, n = 2,819)																		
No	76.5	70.5–81.6	68.7	64.5–72.5	75.4	71.8–78.7	74.4	69.9–78.5	73.1	70.3–75.8	77.2	72.7–81.1	70.9	67.2–74.4	75.4	72.0–78.5	70.9	67.7–74.0
Yes	23.5	18.4–29.5	31.3	27.5–35.5	24.6	21.3–28.2	25.6	21.5–30.1	26.9	24.2–29.7	22.8	18.9–27.3	29.1	25.6–32.8	24.6	21.5–28.0	29.1	26.0–32.3
No (n = 14)	92.9	77.4-108.3	71.4	44.4-98.5	85.7	64.7-106.7	78.6	54.-103.2	83.0	79.4-86.7	64.3	35.6-93.0	71.4	44.4-98.5	57.1	27.5-86.8	92.9	77.4-108.3
Yes (n = 14)	7.1	-8.3-22.6	28.6	1.5-55.6	14.3	-6.7-35.3	21.4	-3.2-46.0	17.0	13.3-20.6	35.7	7.0-64.4	28.6	1.5-55.6	42.9	13.2-72.5	7.1	-8.3-22.6
CW.6 Fully immunized (Age 1 – 4, n = 390)																		
No	47.0	42.3–51.7	—	—	—	—	—	—	47.0	42.3–51.7	43.4	36.9–50.0	49.8	43.5–56.1	48.5	41.2–55.9	45.4	38.5–52.5
Yes	53.0	48.3–57.7	—	—	—	—	—	—	53.0	48.3–57.7	56.6	50.0–63.1	50.2	43.9–56.5	51.5	44.1–58.8	54.6	47.5–61.5
No (n = 105)	0	---	---	---	---	---	---	---	0	---	0	---	0	---	0	---	0	---
Yes (n = 105)	100	---	---	---	---	---	---	---	100	---	100	---	100	---	100	---	100	---
CW.7 Has basic shelter																		
No	—	—	—	—	—	—	—	—	12.5	10.9–14.3	14.8	12.1–18.0	11.2	9.2–13.5	—	—	—	—
Yes	—	—	—	—	—	—	—	—	87.5	85.7–89.1	85.2	82.0–87.9	88.8	86.5–90.8	—	—	—	—
No (n = 321)	---	---	---	---	---	---	---	---	19.4	16.4-22.4	20.2	15.8-24.7	18.1	13.8-22.3	---	---	---	---
Yes (n = 321)	---	---	---	---	---	---	---	---	80.6	77.6-83.6	79.8	75.3-84.2	81.9	77.7-86.2	---	---	---	---
CW.8 Child has basic support in 4 domains*																		
No	—	—	—	—	56.1	52.4–59.8	64.1	59.7–68.2	58.3	55.1–61.5	58.9	52.7–64.8	58.1	54.4–61.7	60.3	56.2–64.1	56.5	51.9–60.9

Yes	—	—	—	—	43.9	40.2–47.6	35.9	31.8–40.3	41.7	38.5–44.9	41.1	35.2–47.3	41.9	38.3–45.6	39.7	35.9–43.8	43.5	39.1–48.1
No (n = 83)	---	---	---	---	0	---	0	---	0	---	0	---	0	---	0	---	0	---
Yes (n = 83)	---	---	---	---	100	---	100	---	100	---	100	---	100	---	100	---	100	---
CW.10 Currently enrolled in school																		
No	—	—	34.4	30.3–38.9	11.4	9.2–14.1	24.6	21.0–28.7	22.3	19.8–25.1	21.8	18.0–26.0	22.6	19.4–26.2	21.3	18.5–24.4	23.3	20.1–26.9
Yes	—	—	65.6	61.1–69.7	88.6	85.9–90.8	75.4	71.3–79.0	77.7	74.9–80.2	78.2	74.0–82.0	77.4	73.8–80.6	78.7	75.6–81.5	76.7	73.1–79.9
No (n = 151)	---	---	6.0	2.1-9.8	0	---	0	---	3.4	1.2-5.7	2.8	-0.4-5.9	3.9	0.8-7.0	1.1	-1.1-3.2	5.4	0.7-10.2
Yes (n = 151)	---	---	94.0	90.2-97.9	100	---	100	---	96.6	94.3-98.8	97.2	94.1-100.4	96.1	93.0-99.2	98.9	96.8-101.1	94.6	89.8-99.3
Household level indicators																		
HW.1 Caregiver has basic support in 4 domains*																		
No	—	—	—	—	—	—	—	—	53.1	50.2–56.0	53.8	49.3–58.1	52.7	48.9–56.5	—	—	—	—
Yes	—	—	—	—	—	—	—	—	46.9	44.0–49.8	46.2	41.9–50.7	47.3	43.5–51.1	—	—	—	—
No (n = 311)	---	---	---	---	---	---	---	---	23.8	19.0-28.6	15.4	11.4-19.5	23.5	18.7-28.2	---	---	---	---
Yes (n = 311)	---	---	---	---	---	---	---	---	76.2	71.4-81.0	84.6	80.5-88.6	76.5	71.8-81.3	---	---	---	---
HW.2 Household able to access money to pay for food related expenses (n = 1,812)																		
No	—	—	—	—	—	—	—	—	57.1	52.2–61.8	47.6	39.7–55.6	62.1	55.8–68.0	—	—	—	—
Yes	—	—	—	—	—	—	—	—	42.9	38.2–47.8	52.4	44.4–60.3	37.9	32.0–44.2	—	—	—	—
No (n = 323)	---	---	---	---	---	---	---	---	7.7	4.8-10.7	6.2	3.5-8.8	5.0	2.6-7.3	---	---	---	---
Yes (n = 323)	---	---	---	---	---	---	---	---	92.3	89.3-95.2	93.8	91.2-96.5	95.0	92.7-97.4	---	---	---	---
HW.2 Household able to access money to pay for school-related expenses (n=1,412)																		
No	—	—	—	—	—	—	—	—	66.2	61.8–70.3	58.9	51.6–65.7	70.8	65.2–75.8	—	—	—	—
Yes	—	—	—	—	—	—	—	—	33.8	29.7–38.2	41.1	34.3–48.4	29.2	24.2–34.8	—	—	—	—
No (n = 199)	---	---	---	---	---	---	---	---	53.3	46.3-60.3	47.2	40.2-54.2	53.8	46.8-60.8	---	---	---	---
Yes (n = 199)	---	---	---	---	---	---	---	---	46.7	39.7-53.7	52.8	45.8-59.8	46.2	39.2-53.2	---	---	---	---
HW.3 Household food insecure (ever no food in past 4 weeks)																		
No	—	—	—	—	—	—	—	—	26.0	22.7–29.6	35.5	29.1–42.5	20.6	17.1–24.6	—	—	—	—
Yes	—	—	—	—	—	—	—	—	74.0	70.4–77.3	64.5	57.5–70.9	79.4	75.4–82.9	—	—	—	—
No (n = 320)	---	---	---	---	---	---	---	---	34.4	29.1-39.6	49.7	44.2-55.2	35.0	29.7-40.3	---	---	---	---
Yes (n = 320)	---	---	---	---	---	---	---	---	65.6	60.4-70.9	50.3	44.8-55.8	65.0	59.7-70.3	---	---	---	---

*Domains of child development = Physical, social-emotional, cognitive, communicative-language and adaptive

Appendix 8: USAID Zambia OVC Results Framework

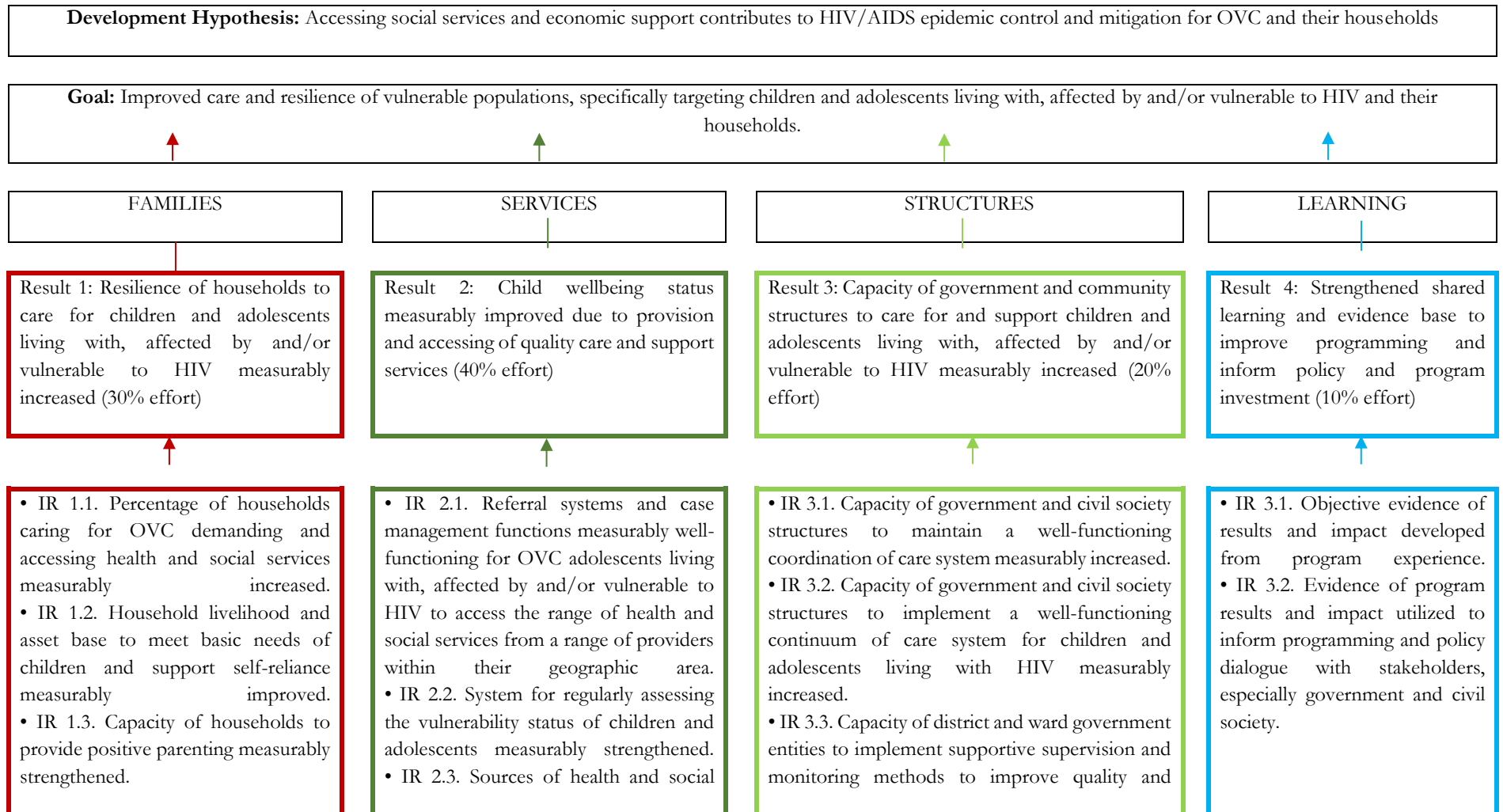
Chart 1: USAID Zambia OVC Results Framework



consolidates and provides community-level data to regional databases for reporting up into a national monitoring system measurably improved.

Appendix 9: USAID Zambia OVC Results Framework

Chart 2: USAID Zambia OVC Results Framework



services for children, adolescents and households adequately available and accessible.

coordination of OVC supportive services measurably increased.

- IR 3.4. Ability of priority districts and scale-up sites to participate in data management that consolidates and provides community-level data to regional databases for reporting up into a national monitoring system measurably improved.

Appendix 10: Summary Report on Key Informants and Focus Group Discussions

Key Informants Interviews were conducted with 65 Key Informants from key stakeholder organizations comprising DAPP, USAID, Creative Associates, NZP+, KAFHI, YWCA, Ministry of Health, Ministry of Community Development and Social Services and Population Council., In addition, FG Hs were convened with 19 Groups of 10 participants (190 participants). Tabulated below is a summary of FGDs and KIIs:

1. Relevance

Major activities of the project included the following

- Vegetables (cabbage, onion, rape, beans, pumpkins) growing as group, sales proceed used to support OVC
- Savings and Internal Lending Communities (SILC). In a group of 10 members, make cash savings and lend money to members at minimum interest.
- Provision of “pass – ons” to VAG members and pass-on to other members of the group who are in the line of receiving. The pass – ons include livestock (chicken and goats) and legume crops (cowpeas, pigeon peas and soya beans)
- Community Health Workers (CHWs) and Children Care Volunteers (CCVs) are trained by the medical staff in health centres in HIV counselling, testing, treatment, care and support. These volunteers conduct outreach visits to households with OVC infected/affected by HIV and AIDS
- Project leaders in conjunction with community mobilizers conducting training with VAG members in health, agriculture, HIV and AIDS, water, sanitation and hygiene. The trainings were conducted for VAG members, Youth and Kids Clubs using VAG training and Youth Training manuals respectively.
- School Block grant to selected schools (desks, books and teaching materials). Selected OVC pupils have had their school fees waived.

Responding to community needs

- Able to grow vegetables and legumes which are sold. Some are retained for household consumption and surplus sold for cash. Sales proceeds are used to meet household expenses and pay school fees for children
- Pass – ons (goats and chickens) given to VAG members (households) constituting liquid assets. Meat to be consumed in households and manure to be used in gardens
- SILC: Able to save and borrow on affordable terms (2 – 5 % interest) By laws in place to govern defaulters. Loans used to invest in small businesses and proceed used to pay school fees

2. Effectiveness

Individual service providers (CHW, CCVs) who are trained by medical experts and psychosocial counsellors in counselling and screening OVCs perform better (professionally, ethics, quality of service) because they had been prepared for service provision.

In fact, according to Zambian Health Act, no one is allowed to conduct counselling and HIV testing without undergoing training and being certified by relevant body

Uptake of social grants, health care and child protection services amongst OVCs and their households is high as long these services were readily available to them (OVCs & households). The barriers were manifested in terms of procuring school block grants (desks & teaching/learning materials). 6 out of 9 schools had received the school block grant. For health care, few facilities which are far away from some villages beset with medicine stock outs and few medical staff and inadequate HIV testing kits.

Trainings conducted by project leaders and community mobilisers who stay in the same project communities with targeted households and OVCs. Training manuals useful but could have been more helpful if translated into local languages

Support to communities in setting up SILC groups

Delays in disbursement of school block grant resulting in non- waiving of school fees which made some OVC pupils not attending school regularly

Pass-ons “goats and chickens beset with problems of chickens dying as soon as there were give out to recipient households+

3. Exit and Sustainability

Household Level

Care givers received training in parenting (looking after OVCs and supporting them) the skills which they are using in keeping OVCs

Skills acquired in gardening and entrepreneurship being used. Households will continue using them even after project end

Pass-ons (goats, chickens & legumes) assets of households. Source of food and income

Acquired WASHE knowledge and skills improved household sanitary and hygiene conditions

OVC pupils enrolled and retained in schools.

Support Groups, where they have been formed provide counselling and support to OVCs on ART

Community Level

Weekly meetings and trainings improved relationships and unity in project communities

Increased small business, distributed livestock and legumes, increased economic activities of project communities

Through community dialogues – identify community problems and solutions to address. The community platform can be used to lobby for development from relevant authorities (community voice)

OVC community structures

NHC and CWAC (CHW) are existing structures which will continue. CHWs are attached to local health facilities

Trained CCVs and CHWs will continue rendering services as they are linked to health facilities

Youth and Kids Clubs are part of school structures and will continue functioning after project end

Traditional and civic leaders and Parents Teachers Association have been sensitized on OVCs and project interventions to provide support and services to them

DAPP ZAFAM Project Challenges

- Delays in procurement of school block grant (desks, learning & teaching materials)
- Long distances to health facilities, in some areas, where communities have to walk long distances. Referral system not working well
- Support group not established in each project community: Some are far off

ZAMFAM SC embedded in local structures

- NHC, WASHE, CWACS, traditional and civic structures- strongly embedded in these structures
- Schools: Youth and Kids Clubs
- Community Support Group
- Community Action Groups/Saving Groups
-

4. Cross Cutting Issues

4.1 Gender

- Parenting responsibilities tilt more towards women. Gender sensitization (trainings) being made. More women caregivers than men (*Demographic statistics*)
- **VAG/Saving Groups, more women than men.** At project start, more women and men started joining them. Involvement of traditional and civic leaders and school teachers
- Apparently, more men involved in goats and women in small livestock

4.2 Environment

- WASH training considered environmental challenges (*diseases covered – bacterial & malaria*)
Caring services (use of mosquito net)
- SMART agriculture training and practice
- Youth & Kids Clubs: environmental protection

5. Lessons learnt and recommendations

- Projects targeting urban areas should be differentiated from rural areas
- Wellbeing can be improved if empowered with knowledge and information e.g. SILC, entrepreneurship can reduce dependency on government and donor
- Possible to reduce new infections based on ZAMFAM results – reduced indulgence in casual sex, usage of condoms
- Targeting youth and parents, effective in reducing casual sex
- School block grant enhances OVC pupils school attendance and progression in school
- Improved quality of housing among participating households
- Reduced cases of diarrhoea cases
- Malnutrition, especially during lean period, continues to be challenge. Benchmark and MTE were done at different agricultural seasons (benchmark – May & July) and MTE (Dec/Jan). at lull period.

Appendix 11: List of Key Informants

LIST OF KEY INFORMANTS

S/N	Full name	Sex	Position	Organisation	District	Phone No.
1	David Mwale	M	District Coordinator	DAPP	Chibombo	096 0282862
2	Shambulo Kalengu	M	M & E Specialist	DAPP	Kabwe	
3	Andrew Nkole	M	Project Leader	DAPP	Chibombo	0960282942
4	Idah K. Phiri	F	Senior School Teacher	Syanalumba Primary School	Livingstone	0977 620314
5	Hurryness T. Lilanda	F	Deputy School Head	Syanalumba Primary School	Livingstone	0977 670661
6	Festus Chisenga	F	Community Mobiliser	DAPP	Livingstone	096 8721 123
7	Miriam Sinamuwi	F	Community Mobiliser	DAPP	Livingstone	096 8721 123
8	George Manyika	M	Community Mobiliser	DAPP	Livingstone	0960282779
9	Kalembi Luyako	F	Environmental Health Technician	Libuyu Health Centre	Livingstone	0977934845
10	Emma Muchela	F	Deputy Sister – in-Charge	Libuyu Health Centre	Livingstone	0977653710
11	Kuliwa Makale	F	CWAC member	Ministry of Community Development	Livingstone	0978172305
12	Juliet Zulu	F	NHC member	Ministry of Health	Livingstone	0979152686
13	Roy Kanganja	M	NHC Zonal Chairperson	Ministry of Health	Livingstone	0972064303
14	Munalula Yuwanga	M	Community Mobiliser	DAPP	Livingstone	0960282999
15	Mercy Nawa	F	Community Mobiliser	DAPP	Livingstone	0960283024
16	Martin Balengu	M	Community Mobiliser	DAPP	Livingstone	0960283010
17	Lisa Shantungwa	F	Project Leader	DAPP	Livingstone	0960282966
18	Blending Mendes	F	Project Leader	DAPP	Livingstone	0960282973
19	Melvis Zulu	F	Community Mobiliser	DAPP	Livingstone	09602822995
20	Caroline Kauseni	F	DAC Advisor	District AIDS Task Force	Livingstone	097406779
21	Kalumba Melvin	M	Social Economic Planner	City Council	Livingstone	0977311927
22	Sekeleti Nanda	M	Environmental Planner	City Council	Livingstone	0966878842
23	Linda Chitanda	F	Volunteer	Youth Alive Zambia	Livingstone	0965862544
24	Austin Makembo	F	Community Mobilizer	DAPP	Mazabuka	0960282823
25	Able Chilundika	M	Project Leader	DAPP	Mazabuka	0960282927
26	Nchimunya Habwebe	M	Community Mobilizer	DAPP	Mazabuka	0969122093
27	Audrin Kasompola	M	Project Leader	DAPP	Mazabuka	0969182804
28	Joyce Mapulanga	M	Community Mobilizer	DAPP	Mazabuka	0960282801
29	Salome T. Simbule	F	Assistant Social Welfare Officer	Ministry of Community Development	Mazabuka	0973077766
30	Prudence Mulosa	F	Assistant Community Development Officer	Ministry of Community Development	Mazabuka	0979552403
31	Geoffrey Chisala	M	Senior Teacher /Clubs Coordinator	Mount Camel Primary School	Kapiri Mposhi	0972756162
32	Petronella Chibesa	F	Community Mobiliser	DAPP	Kapiri Mposhi	0960282752
33	Milton Simwinga	M	VAG Coordinator	DAPP	Kapiri Mposhi	0965445392
34	Ellen Mambo	F	VAG Coordinator	DAPP	Kapiri Mposhi	
35	Christopher Simfukwe	M	Deputy School Head	Mushimbili Community School	Kapiri Mposhi	0979548113
36						

37	Alick Mwelwa	M	Community Mobilizer	DAPP	Kapiri Mposhi	0960282816
38	Nalwamba Prisca	F	Sister in Charge	Mutaba Clinic	Kapiri Mposhi	0966242704
39	Loveness Kabwe	F	Nurse	Mutaba Clinic	Kapiri Mposhi	
40	Agness Matanda	F	Nurse	Mutaba Clinic	Kapiri Mposhi	
41	Janet M. Kachenga	F	Children Care Giver	DAPP	Kapiri Mposhi	0976312091
42	Audrey Kaumba	M	Community Mobiliser	DAPP	Kapiri Mposhi	0969183081
43	Reuben Kamalondo	M	Village Head man	Judan Village, Chief Chipepo	Kapiri Mposhi	09792213856
44	Milimo Munanyimbo	M	Data Entry Clerk	DAPP	Kapiri Mposhi	0960282764
45	Kunda Lubingu	F	Data Entry Clerk	DAPP	Kapiri Mposhi	
46	Bonaventure K. Siatumbu	M	Capacity Building Specialist/Team Leader	Creative Associates International	Kabwe	
47	Eunice Mwenya	F	Programs Manager	Kabwe Adventist Family Health Institute (KAFHI)	Kabwe	0974567771
48	Angela Mkandawire	F	Programs Officer	KAFHI	Kabwe	0977737434
49	Josephine K. Siame	F	Regional Coordinator	YWCA	Kabwe	0978564004
50	Eurny Ngoma	M	Programme Officer	YWCA	Kabwe	
51	Joseph Siwabamundi	M	Finance Director	DAPP	Kabwe	
52	Wilson Chipulu	M	Community Mobiliser	DAPP	Kabwe	0960282772
53	Solomon Mumisa	M	District Coordinator	NZP+	Kabwe	
54	Stellious Muyeye	M	Finance & Administrative Officer	NZP+	Kabwe	0976981091
55	Mick Mwanabunga	M	Youth Coordinator	NZP+	Kabwe	0971781705
56	Alice Lungu	F	Programme Assistant	NZP+	Kabwe	0979443137
57	Nkomba Kayeyi	M	ZAMFAM Unit Head	Population Council	Lusaka	
58	Justin D. Kalenga	M	Village Headman	Chiwaya Village, Chief Liteta	Chibombo	0968449422
59	George Mweene	M	CHW/Village Headman	Hamabwe Village, Chief Liteta	Chibombo	0967238319
60	Royce Bbenkele	F	Sister – in- Charge	Malombe Health Centre	Chibombo	0977379279
61	Mwitila Audrey	F	Teacher/Club Coordinator	Malombe Primary School	Chibombo	0962081847
62	Matthews Muzingwa	M	VAG Coordinator	DAPP	Chibombo	0965403246
63	Eunice Phiri	F	Community Mobilizer	DAPP/Chazanga	Chibombo	0978600746
64	Cynthia Shafuluma	F	Deputy School Head	Chinshanshi Community School	Chibombo	0973583312
65	Tickley Chilinga	M	School Head	Muleke Community School	Mumbwa	09792729916
66	Faustin Musanje	F	Deputy School Head	Muleke Community School	Mumbwa	0978930825
67	Bornwell Shambwalu	M	Senior Village Head	Chimoto Village, Chief Mumba	Mumbwa	0953765658
68	Phinia Mooya	M	School Head	Mumba Scheme Primary School	Mumbwa	0966468721
69	Killian Mweemba	M	Deputy School Head	Muleke Community School	Mumbwa	0961998376
70	Given Mwansa	F	Teacher/Clubs Coordinator	Muleke Community School	Mumbwa	0966805154
71	Patrick Hangumbulu	M	CHW/Counsellor	Maimwene Health Post	Mumbwa	0977386059
72	Charity Juma	F	Nurse	Maimwene Health Post	Mumbwa	097607368
73	Peter Banda	M	Community Mobilizer	DAPP	Mumbwa	0960282776

Appendix 12: List of Focus Group Discussion participants

LIST OF FOCUS GROUP DISCUSSION PARTICIPANTS

District	Planned FGD	Actual FGD	Number of Participants
Livingstone	2	4	40
Mazabuka	2	3	30
Kabwe	2	3	30
Kapiri Mposhi	2	3	30
Chibombo	2	3	30
Mumbwa	2	3	30
Total	12	19	190

Appendix 13: Terms of Reference



Terms of Reference (ToR)

***Mid-Term Evaluation of Development Aid from People to People (DAPP)
Zambia Family (ZAMFAM SC), a United States for AID International
Development (USAID) funded Project November 2016–March 2018***

ZAMFAM SC Project Monitoring and Evaluation Unit

8/5/2018

Version 2.0



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List of Acronyms

AIDS	Acquired Immune Deficiency Syndrome
DAPP	Development Aid from People to People
ERG	Evaluation Reference Group
ET	Evaluation team
EoI	Expression of Interest
HIV	Human Immune-deficiency Virus
HTS	HIV Testing Services
KAFHI	Kabwe Adventist Family Health Institute
KAP	Knowledge, Attitude and Practice
M&E	Monitoring and Evaluation
MTE	Mid-Term Evaluation
NGOs	Non-Governmental Organizations
NZP+	Network of Zambian People Living with HIV
OVC	Orphans and Vulnerable Children
PEPFAR	President's Emergency Plan for AIDS Relief
USAID	United States Agency for International Development
ToR	Terms of Reference
ZAMFAM SC	Zambia Family South Central Project
ZMK	Zambian Kwacha

1. Introduction

1.1 About DAPP

DAPP-Zambia is a local Non-Governmental Organization (NGO) whose goal is to reduce poverty by enabling marginal groups in communities to make sustainable improvements to their wellbeing through participatory development models. DAPP is registered as a Zambian welfare organization and has a track record of successful grass-roots development in Zambia.

1.2 About the project

USAID is supporting DAPP to implement the Zambia Family South-Central (ZAMFAM SC) project. ZAMFAM SC is a five-Year project (November 2015-November 2020) working collaboratively with Creative Associates International, Kabwe Adventist Family Health Institute (KAFHI) and the Network of Zambian People Living with HIV and AIDS (NZP+) to strengthen comprehensive, integrated, service delivery and support to children living with, affected by, or vulnerable to HIV and AIDS. The goal of the project is to improve the **care** and **resilience** of Orphans and Vulnerable Children (OVC) and their households in the two targeted provinces of Zambia: Southern and Central. ZAMFAM SC is providing child and family focused services, including community-based child welfare support and sustainable delivery of a full range of services needed for the families. The specific objectives which ZAMFAM SC is actively pursuing include:

- Increasing resilience of households to care for children and adolescents living with, affected by and/or vulnerable to HIV;
- Improving child wellbeing status due to provision and accessing of quality care and support services;
- Increasing capacity of government and community structures to care for and support children and adolescents living with, affected by and/or vulnerable to HIV; and
- Strengthening shared learning and evidence base to improve programming and inform policy and program investment.

ZAMFAM SC is implementing activities in ten districts namely: Chibombo, Kabwe, Kapiri, Mubwa in the central part of Zambia, and Livingstone, Mazabuka, Monze, Namwala, Sinazongwe in the southern part of Zambia. The project maintains services to **72,219** households and 125, 000 OVC each year.

As the ZAMFAM SC Project has now reached the half-way point, an MTE is being commissioned in accordance with a cooperative agreement as indicated in the Monitoring and Evaluation (M&E) Plan to assess the progress towards achieving the project objectives thus far.

2. Rationale, Evaluation users and Stakeholders

2.1 Rationale

The MTE is being commissioned for the following reasons:

- The ZAMFAM SC Project conducted a baseline study before the start of the project that provided a situational analysis. This allowed ZAMFAM SC to establish indicator baseline information and to verify the targets established in the project agreement. This MTE will allow ZAMFAM SC to follow up on the progress of the indicators established based on the results of the baseline study.
- Project improvement - using MTE results as feedback to ZAMFAM project to make the project function more effectively and efficiently.
- Project accountability and transparency – to allow stakeholders and funder to be aware of the progress of the project.
- Provide strategic and concrete evidence on the relevance, results, processes, and resource utilization for the project.

2.2 Evaluation Users

The expected users of this MTE will be, primarily, the ZAMFAM SC Project team, DAPP Partnership Office, Government of the Republic of Zambia (GRZ), USAID, and the partners that are involved in project implementation.

2.3 Stakeholders

A number of stakeholders both inside and outside of the ZAMFAM SC Project have interests in the results of the evaluation and some of these will be asked to play a role in the evaluation process. The Evaluation team (ET) will provide a deep stakeholder analysis as part of the Inception phase.

Accountability to affected populations is tied to DAPP's commitments to include beneficiaries as key stakeholders in DAPP's work. DAPP is committed to ensuring gender equality and women's empowerment in the evaluation process, with participation and consultation in the evaluation with women, men, boys and girls from different beneficiary groups.

3. Evaluation Purpose, Objectives and Scope

3.1 Purpose

The purpose of the MTE is to assess progress so far towards achieving project objectives and outcomes and draw out lessons for how ZAMFAM SC Project can be improved during the rest of its implementation for a more positive impact.

3.2 Specific objectives

In particular, the MTE will aim to:

- Assess the relevance of the strategies and the approach used in the implementation of ZAMFAM Project;
- Assess the effectiveness and efficiency in the implementation of ZAMFAM Project at province, district, and sub-district levels;
- Assess the results achieved in ZAMFAM Project and the extent to which sustainability considerations have been built-in;
- Compare baseline data with the current evaluation data and provide insights into progress against the targets of the project;
- Assess the extent to which issues of gender equality, social inclusion and equity, and environment have been taken into consideration;
- Assess the extent of coordination with partners and other actors in the area of OVC/HIV with a view to strengthen partnerships; and
- Identify lessons and good practices from the implementation of ZAMFAM SC, and opportunities to improve current planning, project implementation, and feed into the project improvement plan for the remaining two and half years.

3.3 Scope

The evaluation will cover ZAMFAM SC Project interventions during the period November, 2016- June, 2018. The evaluation will be forward-looking and will provide lessons and actionable recommendations to improve on the future performance of ZAMFAM SC Project for the remaining period.

The geographical scope will include all two provinces in the ZAMFAM project six districts of operation where the project interventions are being undertaken: Chibombo, Kabwe, Kapiri, Livingstone, Mazabuka and Mumbwa.

4. Evaluation Approach

4.1 Evaluation Criteria and Questions

- **Evaluation Criteria:** The evaluation will apply the international evaluation criteria of Relevance, Effectiveness, Efficiency, Impact and Sustainability.
- **Evaluation Questions:** Allied to the evaluation criteria, the evaluation will address the following key questions, which will be further developed by the Evaluation team during the inception phase. Collectively, the questions aim at highlighting the key lessons and performance of the ZAMFAM project, which could inform future strategic and operational decisions moving forward in the remaining two and half years implementation. Below is a table with relevant criteria and evaluation questions.

TABLE 1: CRITERIA AND EVALUATION QUESTIONS

Criteria	Evaluation Questions
Relevance	- To what extent were the operations and objectives of the ZAMFAM SC Project consistent with beneficiaries' needs, and GRZ and donors' policies? - Were approaches and strategies used relevant to achieve the intended changes in the baseline values?
Effectiveness	- What best practices can be documented with regard to service delivery and implementation? - What is the level of knowledge and awareness of OVC around HIV/AIDS? - What is the change in Knowledge, Practice and Attitude on HIV and AIDS among adolescents and youth? - How have rates of graduation of OVC due to decreased vulnerability changed over the course of implementation
Efficiency	To what extent have the resources of the project been efficiently utilized?
Exit and sustainability	- What will the household likely going to continue beyond the life of the project? - What supportive mechanism have been put in place for the household?
Cross-cutting Issues	
Coordination, Gender, and Environment.	- What has been the environmental concerns and what has been the mitigations this far? - To what extent has the project implementation mainstreamed gender issues?

5. Approach and methodology

The evaluation approach will be both process and outcome based.

The project implements a routine monitoring system based on a Log Frame developed at the beginning of the project and corresponding data collection plan to collect data against key output and outcome indicators. The evaluation methodology is expected to review this data and, as far as possible, allow comparability taking into account any issues around data collection for the first half of the project.

The consultant is expected to employ a variety of data collection and analysis techniques for both quantitative and qualitative data to ensure a comprehensive evaluation exercise. This will likely include, at a minimum:

- **Document and systems review:** Review of existing documentation, including; project reports, project log frame and monitoring and evaluation data.
- **Surveys:** Application of structured survey questionnaires with a representative, random sample of target population to quantitatively assess outcomes. This will be in greater in scope, breadth and depth compared to standard routine project monitoring.
- **Focus Group Discussions:** With target groups and other stakeholders to assess implementation experiences and effectiveness, document successes, challenges and lessons learned, and develop recommendations for improvement.

- **Key Informant Interviews:** Consultations with key project stakeholders, including field staff and partners. Guidance on appropriate stakeholders will be provided by ERG.

The consultant will be expected to:

- Review relevant project documents, including but not limited to: project reports, project log frame, household survey reports and data and baseline surveys.
- Collect and review relevant guideline document and relevant secondary data etc.
- With the guidance of ERG develop, test and apply survey questionnaires. A representative random sample of the target population should be interviewed to assess outcomes and establish prospect impact of the project interventions in line with log frame indicators. The project is putting a strong emphasis on the need to collect information's on outcome indicators.
- Design and conduct focus group discussions with relevant community members, both male and female, to assess implementation experiences and effectiveness, document successes, challenges and lessons learned, and develop recommendations for improvement.
- Carry out key informant interviews i.e. consultations with key project stakeholders, including field staff and partners. Guidance on appropriate stakeholders will be provided by ERG.
- Collate and analyses data.
- Present findings to ZAMFAM key stakeholders and staff and invite comments at a one-day workshop.
- Draft report and submit to ZAMFAM for comments.
- Incorporate comments and produce final report.

6. Expected Deliverables and Timeline

All written documentation is to be submitted in English using Microsoft Word in both soft and hard copy. The main body of all reports should be written in simple, non-technical language (i.e. plain English), with any technical material to be presented in annexes. All primary data collected and analysis conducted for the purpose of the evaluation will remain the property of ZAMFAM SC and must be submitted electronically and in a clear and comprehensible format in Excel.

The evaluation should begin no later than between the 20th August 2018, with the evaluator(s) expected to take a total of 40 days from the day of contracting to complete the assignment.

The consultant will provide the following deliverables to ZAMFAM SC within the timeframe stated:

1. **Inception Report:** within 5 working days of evaluation launch, a detailed report on the evaluator's proposed approach to the evaluation will be submitted for approval. This will provide preliminary findings/understandings based on document review, rationale and a detailed description of the methodology and tools, research questions, analytical methods, budget with a breakdown of costs and detailed work plan for the entire exercise. Any draft questionnaires or interview forms will also be submitted for review at this stage.

2. **Data collection:** testing questionnaires, refining data collection tools, and administer data collection within **7 working days** of the evaluation launch.
3. **Data analysis and reporting: Preliminary Report and Presentation:** within **30 working days** of evaluation launch, the consultant will present the preliminary findings for discussion at a stakeholders' workshop. This should include a draft set of recommendations and lessons learnt. At the end of the workshop, a report incorporating comments by stakeholders should be produced.
4. **Final Report:** within 50 days of evaluation launch, a detailed report of the overall findings of the MTE will be submitted to the Managing Director and Chief of Party for approval. The report structure is annexed to this ToR.
5. A Power point presentation outlining key findings and implications, and recommendation for future implementation to be presented at a Stakeholders' Workshop in November 2018.

7. Management and Implementation Responsibilities

The consultant will report directly to the Chief of Party and ERG Coordinator. However, s/he will also be expected to work closely with the field staff. Any proposed changes to the personnel listed in the application must be explained in the inception report and approved by ERG.

DAPP ZAMFAM project will provide:

- Relevant project documents;
- Guidance and technical support as required throughout the evaluation;
- Logistical arrangements for all field travel;
- Copies of all key background resources identified;
- ERG time up to a maximum of 3 person to assist with data collection;
- Introductory meetings with key government staff;
- Comments and feedback on, and approval of, all deliverables within agreed timeline

The consultant will be responsible for:

- Review documents and submit inception report;
- Developing the detailed evaluation methodology;
- Conducting all data collection;
- Analysis of data and reporting in a clear and accessible format;
- Regular progress reporting to the evaluation manager, including responding to any comments or technical inputs wherever reasonable;
- Production of deliverables within agreed timeline and in accordance with quality requirements of evaluation manager;
- Seeking comments and feedback from ERG regularly, through ERG Coordinator, in sufficient time to discuss and incorporate these into the final report.
- Production of the final evaluation report containing data against all indicators in the project log frame, evidence-based responses to the key evaluation questions, summary of lessons learnt and recommendations for future implementation.

Qualification and Desirable Competencies: Applications from individuals or teams are welcome and will be assessed on their ability to demonstrate the following qualifications and competencies:

Essential requirements:

- A minimum of 5 years' experience in carrying out impact evaluations, demonstrable academic and practical experience in qualitative and quantitative research methodology, evaluation design and implementation.
- Experiences in public health, preferably including HIV programs
- Experiences in community engagement and economic strengthening programs
- Good knowledge of gender issues
- Strong analytical and communication skills, evaluation experience and familiarity with Zambia OVC landscape
- Familiarity with the approaches, rules, regulations of the donors, particularly that of USAID/PEPFAR

8. Quality Assurance

The first level of quality assurance of all evaluation deliverables will be conducted by the **EET** prior to submitting the deliverables to the ERG.

The ERG recommends the evaluation quality assessment checklist (see below) is used as an element of the proposed quality assurance system for the draft and final versions of the thematic evaluation report. The main aim of the checklist is to ensure that the thematic evaluation complies with evaluation professional standards.

Evaluation quality assessment checklist:

Components	Explanation
1. Structure and Clarity of the Report	To ensure report is user-friendly, comprehensive, logically structured and drafted in accordance with international standards.
2. Executive Summary	To provide an overview of the evaluation, written as a stand-alone section including key elements of the evaluation, such as objectives, methodology and conclusions and recommendations.
3. Design and Methodology	To provide a clear explanation of the methods and tools used including the rationale for the methodological choice justified. To ensure constraints and limitations are made explicit (including limitations applying to interpretations and extrapolations; robustness of data sources, etc.)
4. Reliability of Data	To ensure sources of data are clearly stated for both primary and secondary data. To provide explanation on the credibility of primary (e.g. interviews and focus groups) and secondary (e.g. reports) data established and limitations made explicit.
5. Findings and Analysis	To ensure sound analysis and credible evidence-based findings. To ensure interpretations are based on carefully described assumptions; contextual factors are identified; cause and effect links between an intervention and its end results (including unintended results) are explained.
6. Validity of conclusions	To ensure conclusions are based on credible findings and convey evaluators' unbiased judgment of the intervention. Ensure

	conclusions are prioritized and clustered and include: summary; origin (which evaluation question(s) the conclusion is based on); detailed conclusion.
7. Usefulness and clarity of recommendations	To ensure recommendations flow logically from conclusions; are targeted, realistic and operationally-feasible; and are presented in priority order. Recommendations include: Summary; Priority level (very high/high/medium); Target (administrative unit(s) to which the recommendation is addressed); Origin (which conclusion(s) the recommendation is based on); Operational implications.

The second level quality assurance will be conducted by ZAMFAM internal ERG who will comment on the evaluation deliverables as well as the draft and final evaluation reports, notably to verify accuracy of facts presented and validity of interpretations of evidence.

The Managing Director of DAPP Office maintains an oversight and quality assurance role in terms of the final evaluation report.

9. Budget

For the purpose of this evaluation, the evaluators will be identified through a tender process, in which case the budget (with detailed breakdown) will be proposed by the applicant. The budget to be proposed should include all costs including local transportation, field work, and consultancy fees.

- **Payment Modalities**

The payment modalities will be as follow:

Professional Fees:

- 50% of total Professional Fees upon acceptance of the Draft Inception Report
- 50% upon production of acceptable final MTE report.

Interested evaluators or firms are requested to submit:

1. An Expression of Interest detailing their interpretation of the TOR, proposed methodology including sampling framework, work schedule and proposed budget for Two Hundred and Fifty Thousand Zambian Kwacha (**K250, 000**), **equivalent to 20,833 USD**.

2. A capability statement demonstrating how you meet the required qualifications and competencies;

3. Copies of all relevant Curriculum Vitae (CVs). Only CVs for the specific individuals that will form the proposed Evaluation team should be included;

4. A sample of an evaluation report for a similar project completed within the last 24 months (this will be treated as confidential and only used for the purposes of quality assurance);

5. Two references (including one from your last client/employer).

All documents must be submitted by email to the Chief of Party: munene.v@dappzambia.org copied to the Evaluation Reference Group Coordinator Andrew andrewtandeo@hotmail.com and to Info@dappzambia.org. by close of business Wednesday 22nd August, 2018.

APPENDICES

A. MTE report structure

A. MTE report structure

#	Components	Content
1	Cover and Title pages	- Title of evaluation - Date of release of report - Name of evaluators
2	Executive Summary	No more than 3 pages containing evaluation purpose, evaluation questions, brief description of the project, data collection methods, analytic methods, evaluation findings, limitations, conclusions and recommendations
3	Project Background	Brief description of the project including dates of project implementation, total cost, geographical location, and objectives, targeted beneficiaries and stakeholders
4	Evaluation purpose, objectives and scope	Evaluation purpose statement, specific objectives and scope of work
7	Evaluation questions	Evaluation criteria and questions the evaluation will answer
8	Evaluation Design, Methods, and Limitations	- Overall evaluation design - Type of evaluation (process, outcome, and prospect impact) - Sampling strategy - Data collection methods and rationale as aligned to evaluation questions - Sources of data analytic methods and rationale - Ethical considerations and assurances (e.g., non- research determination and/or approval with dates; application of informed consent, if appropriate; procedures to ensure human rights protection) - Deviations and adjustments (if any) from the approved Scope of Work/protocol

		• Procedures used to ensure that the data are of the highest achievable quality • Data analysis plan • Limitations of the design and analytic methods
9	Findings and Conclusions	• Key findings in relations to the evaluation questions • Key findings for the project improvement in relations to the evaluation questions • Unexpected findings • Lessons learnt • Conclusions • Graphical representation of results and quotes where relevant
10	Recommendations	• Actionable, feasible, and specific recommendations aligned to key findings
11	Dissemination	• Dissemination procedures/plan
12	References	• Reports or publications cited in the body of the report
13	Appendices	• Approved ToRs • Data collection instruments/tools • Informed Consent, where relevant • Abridged bios of the Evaluation team members including qualifications, experience, role on the team, and Ethical certifications (if applicable) • Conflict of interest statement • Evaluation costs • Project Results Framework or Logical Framework