Sida Evaluation 03/04

Sida Support to the Pact Home Based Care Programme in Zimbabwe

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List of Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ASO	AIDS Service Organization
DAAC	District AIDS Action Committee
FCA	Foreign Currency Account
FGD	Focus Group Discussion
GOZ	Government of Zimbabwe
HBC	Home Based Care
HIV	Human Immune Virus
HQ	Head Quarters
IGAs	Income Generating Activities
MOH&CW	Ministry of Health and Child Welfare
MOU	Memorandum of Understanding
NGO	Non Governmental Organization
OPD	Out Patient Department
OVC	Orphans and Vulnerable Children
PMTCT	Prevention Of Mother to Child Transmission
PLWHA	People Living with HIV and AIDS
PVO	Private Voluntary Organization
RDC	Rural District Council
TOT	Training of Trainers
USAID	United States Agency for International Development
USD	United States Dollars
VCT	Voluntary Counseling and Testing
ZRP	Zimbabwe Republic Police
ZWD	Zimbabwe Dollars

Executive Summary

Pact has operated in Zimbabwe since 1997. In its first four years of operation, Pact's focus was on strengthening the organisational capacity of partner NGOs working in the area of HIV/AIDS. Currently, Pact is implementing two types of programmes in Zimbabwe. One of the programmes focuses on enhancing community response to the HIV/AIDS crisis while the other focuses on enhancing advocacy, research, and analysis and information dissemination. In October 2001 Pact and the Swedish Embassy entered into a one-year agreement to implement a home based care programme in partnership with 14 local non-governmental organisations (NGOs).

The strategy adopted by Pact was to strengthen the capacity of local NGOs so that they can in turn effectively mobilise communities towards HBC activities. This strategy enables partner NGOs to build the capacity of local communities so that affected households can adopt better coping mechanisms.

The goal of the HBC programme was to build the capacity of NGOs so that they could better mobilise and facilitate community responses through the implementation of a comprehensive and quality home based care programme. The role of Pact in the partnership included, mentoring and coaching; provision of grants for scaling-up; facilitation of exchange and sharing of information among NGO partners; suggesting innovative ideas to partner NGOs for possible implementation; and provision of home based care kits.

Data for the evaluation was collected from six NGO partner organisations, namely, Gwaci, Chiundura, UDACIZA, Rujeko, Seke Rural and St. Theresa. The methods used for data collection are review of relevant programme documents; in-depth individual interviews with Pact and NGO staff and stakeholders; and focus group discussions (FGDs) with volunteer caregivers, supervisors and members of support groups for people living with HIV/AIDS and the general public.

Pact has trained partner organisations in administrative and financial issues. The organisations have gained skills in these areas. However Pact has not done much to strengthen the organisational and governance aspects of its partner organisations. It is crucial that Pact build the capacity of the organisations in relation to governance. This could be done through training and mentoring.

The management practices adopted by Pact seem to have been too centralised and has not been empowering to the organisations. Pact's communication and interaction with partners could be improved in the interest of mutual partnerships. The organisations seem to be more accountable to Pact than to the constituencies they represent. It appears staff is employed by Pact and not their organisations. In future it is crucial that Pact considers decentralising power to its partner organisations to enable them to work as autonomous bodies.

The designing for the HBC was good in that the partners were involved in self-reflection. The designing also included pertinent HBC programming however the issues such as the importance of GIPA, lobby, advocacy, human rights, gender and governance were not included. The design did not appear to have included an exit strategy of Pact from the partner organisations. It is recommended that the programme include lobby, advocacy, human rights, gender, good governance, community participation and empowerment as integral components of the programme.

Pact has sector skills in the area of home based care. Its volunteer management is good. It may however need to consider developing its staff relating to service delivery in the area of monitoring and evaluation, governance, gender and advocacy. It may also consider outsourcing provision of these services.

The evaluation showed that the HBC programme was implemented according to the plans detailed in the project document submitted by Pact to Sida. The programme also largely met the objectives as they are articulated in the same document. For example, the programme has trained 2,173 volunteer care-givers, 235 supervisors and cumulatively has attended to 14,988 patients.

There is limited community ownership of the HBC programme in most the NGO partners visited during the evaluation. This is largely due to lack of involvement of community members in the planning of HBC programme activities. If the programme needs to be sustainable in the long-run, Pact and its NGO partners may want to make deliberate efforts to involve community members in the next planning phases of the programme. Such involvement will build a sense of community ownership of the programme and will no doubt contribute to the long-term sustainability of the HBC programme.

The model that was adopted by Pact to implement the HBC programme in partnership with local NGOs has great potential to enhance programme coverage and impact. The model is also well structured and simple and can be easily replicated.

The partnership between Pact and NGOs was perceived by some NGO partners to be loop-sided in favour of Pact. This is a situation that can easily be addressed through continuous dialogue and development of a Memorandum of Understanding (MoU) between Pact and each NGO partner.

The capacity building approaches used by Pact are well appreciated in terms of both content and style of delivery by both NGO partner staff and volunteers. This is largely attributed to the use of carefully designed training manuals.

The quality of care provided by the HBC programme was rated highly by programme beneficiaries, volunteers, NGO partner staff and community members.

All the NGO partners have forged strong linkages with other organisations and individuals in both the public and private sectors. These linkages have benefited the HBC programme through sharing of resources (facilitation in workshops by staff of other NGOs, provision of office space by the RDCs, provision of care to HBC patients by trained professionals etc).

The monitoring and evaluation system of the HBC programme only collects data on output and process indicators. There are no indicators of quality of care and impact in the HBC programme.

According to most of the respondents, the HBC programme is not likely to continue without donor funding. This is largely due to the fact that some of the programmes are still in their infancy, thus, do not have enough resources at their disposal. Thus, the HBC partners still need to be further nurtured by being assisted in putting the requisite administrative and financial resources and management systems in place.

Volunteer motivation remains a challenge in the HBC programme irrespective of the efforts that Pact has done in providing uniforms for volunteers and additionally, bicycles for supervisors.

The evaluation has shown that Sida funds are being utilised as per the initial budget between Sida and Pact. Furthermore, although there is room for improvement, there seems to be enough controls in the accounting and financial systems at Pact to safeguard any resources put in the organisation.

1 Introduction

Sida has been providing support to HIV/AIDS related issues through the health sector programme, but since 1998 a multi-sectoral approach has been adopted in recognition of the importance of multi-sectoral participation as well as the broad impact of the disease in many sectors. To operationalise this, a Strategic Planning Fund was formed through the bilateral agreement with the Government of Zimbabwe (GoZ), to support projects and programmes not only in HIV and AIDS prevention but also in other areas such as home based care, orphan care, gender and civic education. Since 2002, the Swedish Government decided that development co-operation with the GoZ will focus on support to civic society within the areas of human rights, democracy, HIV and AIDS. The Pact home based care programme falls under the priority category of the Swedish Embassy's areas of focus.

The Swedish Embassy entered into a one-year agreement on home based care with Pact in October 2001. The agreement covered funding for 10 organisations in Zimbabwe, however, Pact support to the organisations has gone beyond this figure and Pact has to date signed agreements with 14 organisations. The agreement between the Swedish Embassy and Pact was extended at no cost from October 2002 to December 2002. The current agreement on home based care has organically grown, as a natural development of the needs in present day Zimbabwe. It now includes an orphan programme component in six cases as well as a pilot project on the church and community AIDS prevention and care around St Theresa Mission Hospital.

Pact was founded in 1971, as a membership organisation of private volunteer organisations (PVO) and NGOs. Pact revised its by-laws in 1992 and established itself as an independent international non-profit corporation. The United Nations Agency for International Development (USAID) has been providing financial support to Pact as a vehicle to fund PVOs since Pact's inception. Currently Pact manages 15 USAID programmes in Asia, Africa and Latin America. Pact also has a network of offices in 22 countries around the world. Sida has arrangements with Pact in both Asia and Africa.

Pact has worked in Zimbabwe since 1997. In Zimbabwe Pact is implementing four types of programmes. Two of the programmes are concentrating on enhancing community response to the HIV/AIDS crisis and the other two are concentrating on enhancing advocacy, research, analysis and information management. In Zimbabwe Pact has been registered as a trust. This evaluation sought to establish the extent to which Pact has achieved objectives as set in Sida and Pact programme document regarding the home based care programme. It assesses whether the organisation has administrative structures in place for financial and programmatic follow up and whether the programme is being implemented in a cost-effective way. It assesses the performance of the organisations in terms of capacity to deliver quality home based care programmes.

For this evaluation, GERUDE put up a strong team of professionals with strong strengths in the area of HIV and AIDS, organisational development and finance management. The evaluation team was composed of **Shinga Mupindu** who was the team leader and **Ityai Muvandi, Paschal Changunda** and **Caroline Maphoshere**. As the evaluation required some extensive field visits to the partner organisations, GERUDE provided three trained research assistants to assist in data collection.

2 Context of HIV/AIDS in Zimbabwe

In Zimbabwe, the first case of HIV was diagnosed in 1985. Since then, the numbers of HIV/AIDS cases have grown exponentially to crisis proportions with a prevalence rate of 35% among the adult population (CDC Surveillance, 2000). Usually 10% of the HIV positive population have AIDS and are in need of care. The majority of AIDS patients need hospital beds and/or home based care. Statistics show that more than 2000 deaths occur every week in Zimbabwe and between 60–70% of these deaths is due to AIDS-related factors. Most AIDS-related deaths are due to illnesses like Tuberculosis, meningitis, pneumonia and diarrhoea. The population sub-group with the greatest share of AIDS-related mortality is that of reproductive age, thus, the majority of the dependants who are left are mostly young widows and school-age going orphans. Currently, Zimbabwe is estimated to have more than a million orphans (UNAIDS, 2000).

The age structure of the population of Zimbabwe has been distorted by high mortality largely due to HIV/AIDS-related factors. The population pyramid has thus, been transformed from the traditionally broad-based one to the current demographic chimney which is a reflection of a preponderance of deaths among the young.

HIV/AIDS should not be treated purely as a health problem, but should be seen as a developmental issue whose effects are felt across all sectors. Most of the developmental gains in the country have been reversed or wiped away by the epidemic. The infant mortality rate has been doubled while the under five-mortality rate has trebled the levels prevailing in the 1940s (UNAIDS, 2000). AIDS increases poverty at household, community and national levels. Family expenditures increase while savings are wiped away. Due to poverty, children are withdrawn from school (especially girls) and they are called upon to help look after sick family members.

Although the current HIV/AIDS situation is alarming, the full impact of the epidemic has yet to be felt. The high prevalence has an in-built momentum that implies high transmission for years to come. Mortality rates will continue to increase in the coming years, thus, swelling the number of orphans. Thus, the only realistic solution to caring for the AIDS patients is to increase the coverage of home based care programmes.

2.1 National HIV/AIDS Policy in Zimbabwe

As a response to the HIV/AIDS problem, the Government of Zimbabwe (GoZ) formed the National AIDS Co-ordination Programme (NACP) within the Ministry of Health and Child Welfare in the mid-1980s. Some of the activities that have been implemented to address the HIV/AIDS problem include interventions targeted at youth in and out of school, women, the workplace, people living with HIV/AIDS, control of sexually transmitted infections, counselling and care. Voluntary Counselling and Testing for HIV (VCT) has been recently introduced with a view to complementing other behaviour change interventions. The GoZ has recognised the magnitude of the HIV/AIDS pandemic and the need to co-ordinate multi-sectoral efforts by establishing the National AIDS Council (NAC) and creating a Fund by introducing the AIDS Levy.

The GoZ took three years to develop a "National Policy on HIV/AIDS for the Republic of Zimbabwe" which was published in 1999. The National HIV/AIDS Policy was developed as a guide to both individual and collective efforts in addressing the HIV/AIDS pandemic. The process used in developing the policy was both consultative and participatory, a recognition that HIV/AIDS is a national problem. The national HIV/AIDS policy addresses and provides guidelines in eight (8) broad areas.

These are:

- Management of the national response to HIV/AIDS;
- General Human Rights;
- Public Health;
- Care for people living with HIV/AIDS;
- Human Rights;
- Gender;
- Information and education about HIV/AIDS and sexually transmitted infections (STIs); and
- HIV/AIDS/STI Research (For more detail on these guidelines see the "National HIV/AIDS Policy Document").

These areas of focus show that care of people living with HIV/AIDS is an important area that needs deliberate interventions. However, given the constraints that clinics and hospitals are currently experiencing, that is, limited beds, funding and shortages of staff, institutionalisation of HIV/AIDS is not a reality. This realisation has resulted in a number of organisational efforts to facilitate the development and implementation of home based care initiatives. Taking a lead role in this direction are the so-called *'AIDS Service Organisations (ASOs)*'. The term ASO has a connotation that these organisations are directly involved in caring for the HIV/AIDS patients. In reality, this is what has actually been happening. It is only lately that there is a shift in approach by the ASOs from direct implementation to community facilitation. However, the approaches adopted by these ASOs are fragmentary and there is therefore need for standardisation.

3 The Terms of Reference and Purpose of the Evaluation

The evaluation sought to establish the extent to which Pact had achieved the programme objectives as set in the programme document, whether the organisation has sufficient administrative structure in place for financial and programmatic follow up, assessment of cost effectiveness, assessment of the progress achieved to date by the Pact partner organisations, the partner organisations' ability to deliver quality home based care programmes and identification of any challenges in the organisations. The evaluation assessed whether Pact had implemented the project in accordance to the programme proposal, utilised funds provided accordingly and if the implemented activities have achieved the desired results.

In particular the evaluation assessed the following:

- Programme Performance: Performance was assessed at two levels, that is, the level of Pact and NGO partner levels. Performance was assessed regarding the home based care programme in terms of the extend to which Pact had been effective in achieving the set objectives and whether it had implemented the programme in accordance with the programme proposals and work plans; the extent to which the programme achieved its objectives (Purpose) or produced the desired outcome. The team assessed factors that contributed to the failure or success to achieve project objectives. The second level of assessment made was on the performance of the partner organisations.
- Assessment in relation to the Partner Organisations: The evaluation focused on the partner organisation's progress in relation to programme implementation; programme approach and strategies; extent to which set objectives were achieved, strengths and challenges encountered by the programme; impact of the input from Pact; quality of service delivery, quality measurement indicators for home based care that are in place and how they are used; planning, extent to which communities have participated in the project in terms of problem identification and analysis, planning, project strategic focus, mapping interventions, implementation, monitoring and evaluation mechanisms that have been put in place to track project progress and how effective these have been; assessment of whether the home based care component within the organisation is sustainable and viable, identification of sustainability and viability measures that have been put in place to ensure that the home based care programme continues beyond the life of the project.
- Impact: Assessment of the major outputs of the Pact home based care programme and its effectiveness in achieving the set objectives. The extent to which the programme activities addressed the needs of the organisations working on home based care programmes. Assessment of positive and negative planned and unplanned changes in Pact and the organisations as a result of the Sida supported intervention.
- Quality of service: Evaluation of the extent to which quality of Pact service delivery to the partner organisations has been achieved.
- Relevance: The evaluation team assessed relevance of the programme approach in relation to the organisations providing services on home based care.
- Organisational, Institutional and Financial issues: The team reviewed the organisational and financial issues of Pact. In particular the following were assessed:
    - Organisational capacity for carrying out the project. This covered assessment of Pact's human resources in relation to strategic planning, programme implementation and management, programming, monitoring and internal evaluation capacity, leadership and Pact governance issues.

- Financial Issues: Assessment of financial systems that exist within the organisation to monitor the financial operations of the organisation. Assessment of whether the funds were used as specified in the project document. Assessment of whether financial, human and material resources allocated to the project were used efficiently and optimally. Whether optimum outputs were obtained from this project. Assessment of the adequacy of the internal accounting and control systems. Financial management and reporting skills of the organisation.

- Provide recommendations for future direction and way forward for the programme, Pact, other stakeholders and the Swedish Embassy.

4 Methodology

In order to answer the evaluation questions, qualitative information was collected from a variety of sources. Thus, the evaluation involved a number of data collection methods that include desk review; individual interviews with Pact staff members, selected NGO staff members, community leaders and representatives of stakeholder organisations; focus group discussion (FGDs) with project beneficiaries and community members; and observations of volunteer caregivers interacting with People Living with HIV and AIDS (PLWHAs). Each of the data collection methods is discussed in detail below.

Review of Documents

Relevant programme documents were reviewed during the evaluation. Some of the documents reviewed include project proposal submitted by Pact to the Embassy of Sweden which formed the basis for funding; work plans; programme narrative and financial reports from partner NGOs to Pact; Pact quarterly reports; audit reports; personnel procedures manuals; and accounting manuals.

A review of documents assisted in providing the background information to the programme; the objectives of the programme; and the implementation process conceived at the design stage. Key programme indicators for the HBC programme were found from the proposal. Progress reports revealed the extent to which programme objectives have been achieved.

Individual In-depth Interviews

Individual in-depth interviews were conducted with Pact staff members; community leaders; representatives from stakeholder organisations; and staff members from the six sampled NGOs. The following sections detail the type of information that was collected from each of the respondent categories:

Pact Staff: – Interviews with Pact staff solicited information on the objectives of the HBC programme; programme achievements and impact; implementation bottlenecks; existence and functionality of organisational functional system (management and supervision; financial management and resources; monitoring and evaluation, etc).

Community Leaders: – Community leaders were asked about their perceptions on the relevance, appropriateness and sustainability of the HBC programme. Issues related to community involvement at all phases of the project cycle, that is, design, strategy selection, monitoring and evaluation are also assessed. Ideas were also sought on how best to make the HBC programme more effective.

Representatives from Stakeholder Organisations: – *Information collected from this category of respondents pertains to their perceptions of the relevance, success, implementation bottlenecks, impact and sustainability of the HBC programme. The role of stakeholders in the programme is also assessed. The linkages between the HBC programme and other programmes in the area of HIV and AIDS were also explored*

Staff Members from Sampled NGOs: – *The information collected includes the perceptions of staff members on the goals of the programme, its relevance, appropriateness, effectiveness, impact and sustainability. The effectiveness of both technical and financial support provided by Pact to partner NGOs was also assessed. The existence and level of functionality of linkages between the sampled NGOs and other organisations involved in HIV and AIDS are also explored.*

Focus Group Discussions (FGDs)

FGDs were conducted with members of support groups for people living with HIV and AIDS; and community members (men and women). The information collected during the FGDs included perceptions of the HBC programme in terms of relevance; appropriateness; effectiveness; efficiency; and sustainability. The role of community members at all the stages of the project cycle, that is, design, strategy selection, implementation, monitoring and evaluation was also assessed. Participants to FGDs were asked to suggest what they think should be done differently in order to enhance the effectiveness and impact of the HBC programme.

Observations

The evaluation team will observe volunteer caregivers as they interact with PLWHA. Such observations are important in two respects. First, they help in establishing the process of caring for the PLWHAs. Second, this will assist the evaluation team to make some judgements about the quality of care that the programme is providing to PLWHAs.

Sampling

Although PACT has signed agreements with 14 NGOs in the implementation of the home based care (HBC) programme, it was not possible to visit all these organisations during the evaluation largely due to time constraints. Six organisations implementing the HBC programme in partnership with Pact were selected for the evaluation. The sampling was intended to have a broader geographical coverage as well as having a sample that include high, medium and poor performing NGO partners.

Data Collection

Data collection was conducted by the four consultants with assistance from three experienced research assistants. Literature pertaining to the sampled organisations was reviewed during fieldwork. The evaluators split into two teams. Each of the team collected data from three organisations. Each evaluation team spent about two days per NGO.

The fieldwork for this evaluation was not very smooth. There was shortage of petrol and this affected the planned schedules for the evaluation. Despite this problem, all the six sampled HBC partners were visited.

The fourth consultant was focusing on financial management issues and spent most of his time at Pact. However, he visited two NGOs that were sampled and are within Harare in order to verify some of the issues discussed at Pact.

5 Pact NGO Partners Visited During the Evaluation

As already alluded to, data to answer the evaluation questions were collected from six non-governmental organisations (NGOs) that are implementing home based care programmes in partnership with Pact. The six NGOs are Chiundura Community Home Based Care, Gwaci Home Based Care, Rujeko, Seke Rural Community Home Based Care, St. Theresa and UDACIZA. This section briefly discusses each NGO in terms of when it started, its governance structure, what it is involved in and the organisations that it networks with. This type of discussion puts the evaluation findings into perspective.

Chiundura Community Home Based Care Programme

The Chiundura HBC is women's empowerment programme that is currently being implemented by the Women's Action Group (WAG) in partnership with Pact. This programme started in May 2002 and is implemented in four wards in Chiundura district of Gweru rural.

Structurally, there is a Programme Officer based at WAG Head Office in Harare who has the overall responsibility for the programme. At the community level, the day-to-day activities of the programme are the responsibility of a Programme Co-ordinator who was elected with the participation of the local leadership. Reporting to the Project Co-ordinator are HBC supervisors whose responsibility is to supervise volunteer caregivers. Volunteer caregivers work closely with the primary caregivers that are family members of the terminally ill patients. The organisation has no local committee to oversee the activities of the programme.

The programme is involved in HBC activities for the terminally ill irrespective of the form of illness. This programme is community based and the local leadership and all community members are fully involved in project implementation activities. For example, the community participated in the selection of the Project Co-ordinator, supervisors and volunteer caregivers.

The programme has to date trained 45 volunteer caregivers and 5 supervisors. Among these volunteers, there are three men. Cumulatively the Chiundura HBC has served 214 patients. The organisation works closely with the Rural District Council (RDC) which has provided it with office space. The Ministry of Health and Child Welfare (MOH&CW) is an important partner of the NGO and the two organisations are involved in cross referrals of patients either for testing or for home based care after being discharged from the hospital. The Ministry of Gender is involved in the training of volunteer caregivers in general business skills as a way of preparing them for the implementation of income generating activities.

Gwaci Home Based Care Programme

Although Gwaci started in 1997, it got its initial funding from Pact in February 2002. Organisationally, Gwaci has a management committee that has the responsibility of providing policy directions and financial oversight to the organisation. The management committee is made up of seven members (3 men and 4 women). The composition of the management committee is fully representative as it has members of the community and people living with HIV and AIDS (PLWHAs). There is a Director who is responsible for resource mobilisation, facilitating participatory planning with community members and stakeholders, supervision of program staff and writing program reports. The Director is part-time and is available during school holidays, weekends and whenever there are important occasions, which call for his presence.

Gwaci has a community office in Matshetshe area and they have been allocated a bigger piece of land by the local leadership for them to build larger offices. The local community is actively involved in the project, especially activity implementation; for example, they were involved in the selection of volunteer caregivers.

There are two full-time staff members, that is the HBC Program Officer and a BookKeeper. Reporting to the Programme Officer are nine supervisors. These supervisors are responsible for ensuring that the 82 volunteer caregivers that have been trained for the HBC programme do their work according to the plans.

The NGO has strong linkages with the Ministry of Health and Child Welfare, Forestry Commission, World Vision and MS Zimbabwe. The organisation is also working closely with a local Medical Doctor who visits patients in their homes on a regular basis.

Rujeko Home Based Care Programme

The HBC programme for Rujeko evolved from other HIV/AIDS activities that the NGO was implementing. It is situated in the hospital premises of Birchenough Bridge Rural Hospital in Buhera South, Manicaland Province. The programme started as an extension of hospital activities, implemented by the Community Health Sister.

In addition to HBC activities, the NGO provides the following activities to the community:

- counselling + pre and post HIV test counselling
- collect blood specimens for VCT
- peer education activities for prevention programmes

Rujeko has a newly appointed advisory board, which has not formerly met since it was formed this year. The board membership includes community leaders, local chief, councillor, Head of a local high school, PLWA representative, HBC care givers representative, Hospital matron, peer NGO staff member and the director.

On a day-to-day basis, the organisation is run by a Director whose primary role is to oversee the HBC programme activities. Professionally, the director is a Registered Nurse. Reporting to the director are two field officers whose primary responsibility is to ensure that activities are implemented according to plans. Supervisors report to the field officers and they in turn monitor and supervise the activities of the volunteer caregivers. There is also an office orderly and driver as part of the staff.

To date, the NGO has trained 302 caregivers, attended to more than 1946 patients, and distributed 150 HBC kits.

St. Theresa Home Based Care Programme

St. Theresa is a hospital in Mvuma District (Chirumhanzu) and is very actively involved in a number of HIV/AIDS programmes that include Home Based Care, Prevention of Mother to Child Transmission (PMTCT), Orphan and Vulnerable Children (OVC) and Support to people living with HIV/AIDS.

The HBC programme started as an extension of hospital activities when hospital nurses were making domiciliary visits to discharged patients. As the impact of HIV/AIDS continued to manifest in the community, there was need to expand and formalise the HBC activities. Through the hospital board, money was found from overseas sources supporting the (order of Nuns) Roman Catholic Church. Through the church parishes, HBC volunteers were recruited for training in care giving.

St. Theresa applied for inclusion into the Pact Sida HBC programme and were successfully selected. The HBC programme is manned by Project Co-ordinator who is a Registered Nurse on the hospital establishment. Reporting to the Project Co-ordinator is the Project Assistant Co-ordinator, who was recruited to strengthen the HBC programme. Pact is responsible for paying the salary of the Assistant Project Co-ordinator. There is also a Project Finance Officer whose responsibility is the financial management of the programme. Thus, there are three core programme staff who run the HBC activities with support caregivers and supervisors.

From a governance point of view, there is a hospital board which comprises of the hospital Doctor, Matron, Deputy Matron who is also the Sister-In-Charge, Project Co-ordinator and two nursing sister from the Outpatient Department and maternity Ward. This board meets quarterly. All the members of the board are actively involved in the day to day running of the HBC programme. For example, the deputy matron and the OPD nurse were actively involved in the training workshops for caregivers. The matron periodically appraises the Project Co-ordinator. Thus, the programme is run like any other hospital department, hence enjoys technical support from the hospital administrator and other members of staff at the hospital.

To date St. Theresa has trained over 132 volunteer caregivers, 9 supervisors and cumulatively has served 2,932 patients and distributed over 200 HBC kits.

The HBC programme has an Advisory Board that meets half yearly. The Advisory board members include a local Member of Parliament, ZRP member in charge, local teacher representative and a councillor.

Seke Rural Community Home Based Care Programme

Seke Rural HBC started in 2001 as a brainchild of the current Director and her husband. From a governance point of view, the organisation has a Management Board that is responsible for giving policy guidelines and providing financial oversight. The composition of the management committee is quiet representative as it has community members and PLWHAs represented. The Chairperson of the Management Committee is also the Chairperson of the Rural District Council (RDC). On a day-to-day basis, a Director runs the organisation with assistance from three other members of staff, namely, the HBC Project Officer, Administration and Finance Officer and a Secretary. On a day-to-day basis, there are HBC programme supervisors who make sure that the volunteer caregivers are visiting patients on a regular basis.

The Seke Rural HBC has twenty supervisors (16 women and 4 men). The programme has trained 249 secondary caregivers. It should be noted that the terms *secondary caregivers* and *volunteer caregivers* are used interchangeably in this report.

The NGO networks with the Ministry of Health, especially Kunaka Hospital where the NGO is housed, Department of Social Welfare, the Police and the RDC. The RDC has provided offices that are currently being used by the organisation.

Over and above the HBC program, Seke Rural HBC has a youth component, which is responsible for HIV prevention among its peers. The organisation has also trained commercial sex workers in income generating projects.

UDACIZA Home Based Care Programme

UDACIZA is a young organisation, which was formed in 1993. The organisation is composed of representatives of apostolic churches in Zimbabwe. Most apostolic churches are "Spiritual churches" which believe in absolute faith healing and hence did not allow their members to seek for medical treatment whatever the ailment the person had. In outbreaks such as cholera, malaria, typhoid, HIV/AIDS and when a person had fractures there has been severe suffering and loss of life as members would not take medication. The sectors' children were not allowed by the principles of the churches to be immunised. Ministry of Health and Child Welfare (MOH&CW) has especially encountered a big challenge because of these beliefs.

The MOH&CW has especially had some dialogue with representatives of the sector. It is against this background that UDACIZA was formed. Representatives of the apostolic sector who realised that their sector needs to be an integral part of the development process within the country formed UDACIZA. UDACIZA was founded in Chitungwiza and has now decentralised throughout the country. It has a board, which is governed by a constitution. According to the board members of UDACIZA the overall vision for UDACIZA is ***"CHANGE"*** and in particular change regarding the area of having polygamous marriages, women empowerment, seeking for medical treatment, economic and social development especially with a focus towards the youth, reduction of child abuse and early marriages. In each of the districts of the country there is an UDACIZA committee.

UDACIZA is structured in such a way that it has a board, which has office bearers. The office bearers include a chairperson, secretary, treasurer, co-ordinator, and committee members. These are drawn from the heads of the denominations with representation from the different provinces. The denominations represented in the board include Johhanne Masowe, Zviratidzo ZvaJehovha, Johane Masowe Chishanu, Gospel church, Faith Apostle, Zion, Zion St Agness and Zvapupu.

This organisation is a special organisation considering its history. It serves a special Niche sector, which cannot be served by any other organisation that is not part of the sector. PACT had dialogue with UDACIZA and collaboration started in the area of home based care. The acceptance of UDACIZA to work with PACT was in itself a break though. The home based care programme is piloted in the Epworth area.

The Home based care programme is headed by an UDACIZA director who is a director and chairperson of UDACIZA and has been working in the home based care programme on voluntary basis. However, from October 2002 the director started receiving a salary from the project. The person with the overall home based care responsibility is the project co-ordinator. The project also has a bookkeeper that is responsible for doing the books of the organisation. The project trained secondary caregivers and from the trained secondary care givers supervisors were selected.

The program trained 85 secondary caregivers that provide home based care to the target group. Ten supervisors have been trained by the programme while cumulatively, 1,229 patients have been attended to. The HBC secondary caregivers were drawn from various UDACIZA denominations.

UDACIZA does not provide HBC services to members of its organisation only but it provides services to all the community members irrespective of their denominations. The secondary caregivers are well supplied with home based care kits.

6 Findings

6.1 Organisational Development Issues

The organisational development issues in this section are discussed in relation to the structure, planning and designing, human resource issues which include; skills, capacity, secondary care giver management in relation to recruitment, training and motivation, management practices which include; decision-making, resource management and governance issues

6.1.1 Structure

Pact is an international organisation, which currently manages 15 USAID programs in Asia, Africa and Latin America. Pact also has a network of offices in 22 countries around the world. Sida has made arrangements with Pact in both Asia and Africa.

In Zimbabwe Pact is headed by a director who is responsible for the overall strategic processes and co-ordination. A team of technical program and administrative staff supports the director. Reporting to the director is a program manager who is responsible for the management of the OVC and HBC programs. A team of two program officers, one for the HBC and the other for the OVC supports the program manager. The entire program is supported by a team of finance and administration staff.

Given the origin and the international nature of Pact Zimbabwe it has no local Zimbabwe governing structure or advisory board. The office reports directly to its US headquarters. There are advantages and disadvantages to this kind of arrangement. By not having a local advisory board, local based bureaucracy is reduced. The advantage of having a local advisory board is that the organisation may be able to get locally based technical advice and inputs.

To implement the Sida Funded Home Based care program, Pact selected partners with whom to work. The strategy to work through partners was good considering that it would not be cost effective and not practical for PACT to work directly with the communities. Working through partners is also in line with the way of working of Pact and in line with the national HIV and AIDS strategy, which advocates for local ownership of programs.

6.1.2 Planning and Designing

At inception of the Pact/Sida HBC programme, Pact organised and facilitated a workshop for potential partners. The selection process afforded every potential partner an opportunity to compete. The process was not only transparent but also empowering to the partners, as they were given the opportunity to present their proposals. At the same workshop, selected partners were helped to develop HBC plans and budgets in a highly participatory manner. However, involvement of community members did not happen. At this stage although Pact trained the partners in community facilitation skills, the project design does not seem to have clear mechanisms for partners to include ways in which community members are involved in the planning and evaluation stages of the programme. There seems to be the traditional tendency to mainly involve community members during the implementation stage as volunteer caregivers.

At NGO partner level, most of the community leaders were informed of the programme activities. There were no deliberate efforts to involve them in the planning of the programme activities. It was good that they were informed of the programme to ensure their support during implementation i.e. help with mobilising community members. Usually when there is community input at these initial stages, community ownership of programmes is enhanced. Both Community leaders and the members

continued to view the HBC programme, as "Programme yaana sister" Programme yeveRujeko programmes for the NGO not theirs even after Pact's intervention of attempting to strengthen community involvement. Statements like *"yes we do help them in their programmes by calling people for meetings"*, show that the community leaders do not think that it are their programme.

Only 2 of the visited 6 partners have formed local community committees. The committees monitor HBC activities at community level. This enhances community ownership of the HBC program and ensures more active participation as well as sustainability.

Lately in HIV/AIDS responses, there has been a shift from the mindset of just service provision to inclusion of lobbying and advocacy activities. It is commendable that Pact has as one of the expected programs results, improved access to quality and comprehensive care services by HBC patients. However, the strategies used to achieve the improved access to care do not include advocacy activities. In the programme, improved access to care seems to be limited to increasing the number of caregivers and provision of kits only. This is very good but it is not enough. Inclusion of advocacy activities that would ensure local policy changes would be helpful. Examples of local advocacy would include activities that advocate for free treatment of HBC patients at local health institutions, advocating for special and preferential treatment of HBC patients during relief food distribution, etc.

Although the draft HBC manual developed by Pact for use by the partner NGOs points out some human rights issues, plans seem to be silent on how human rights would be respected and realised during programme implementation.

Plans and the strategy seem to be silent on how gender issues that come out of HBC implementation would be addressed i.e. deliberate efforts to involve more men and youths in the care of terminally ill people in a given community.

When Pact started working with the organisations it appears there was limited planning relating to its exit strategy. There was no exit strategy developed at the design stage of the Sida /Pact HBC program. If there was an exit strategy, then it could be ease to detail minimum conditions that needs to be realised before the weaning takes place.

6.1.3 Human Resources

The Pact staff does not seem to have adequate skills in strategic planning. This shortcoming was also admitted by some of the staff members. This shortcoming has also been manifested at partner organisation level where strategic planning and reporting on strategic issues is rather weak. An analysis of the activities that have been carried out so far at PACT and partner level also reflects a rather limited strategic focus.

Some basic forms have been designed for use by partner organisations. Some organisations do not have the forms and use exercise books. The programming does not include indicators of a qualitative nature. The details regarding monitoring and evaluation is elaborated under the programmatic section. However in essence it is our opinion that Pact has limited skills in monitoring and evaluation.

There is a lot of sectoral expertise in Pact to implement and monitor the HBC programme. Two of the program staff have a health background and this is a very appropriate and relevant background for HBC activities. This health background has been complimented by additional professional training in adult education and communication. The additional training is relevant especially for training and implementing HBC program activities. NGO partners do recognise, acknowledge and benefit from this expertise. It is commendable that Pact realised its limitation of inadequate staff capacity and outsources expertise for some of the activities like facilitation skills training as well as training in management of income generating projects.

Pact staff members have job descriptions and there is clarity of roles and responsibilities, which were explained to NGO partner staff during the introduction workshop. However, Pact does not seem to have staff with lobbying and advocacy skills, as well as gender and human rights implementation expertise.

At partner level, the majority of the partner NGOs has a lot of the human resource component elements in the nascent stage of organisational development. Mostly, the new Pact partners like Gwaci, UDACIZA, Chiundura and Seke have some or all of the following challenges: no clear staff recruitment policies and procedures, no written job descriptions for staff, no staff performance appraisal systems. Staff capacity is noted to be low- inadequate and at times not well skilled to render quality services to the HBC program. However, there were efforts to enhance staff capacity through training workshops; on the job training e.g. for facilitation skills, provision of procedure manuals – HBC manual and periodic support supervisory visits to partner NGOs.

Unfortunately, the current staff level at Pact is inadequate to provide the needed support visits to NGO partners on a more regular basis. The visits were reported to be either infrequent or too brief. While some partners would have benefited from longer duration support visits during which certain aspects of HBC skills would have been demonstrated, others were in need of updated HIV/AIDS information. There seemed to be no link between visits i.e. there was no follow up of issues raised during previous visits. Use of checklists for support supervisory visits ensures standardised information noted at each visit.

All the interviewed NGO partners pointed out some improvement in HBC volunteer management i.e. better recruitment of volunteers, improved training, better supervision and more motivated volunteer caregivers. The programme required that, partners liase with community leaders to identify more caregivers for training. Use and provision of the manual improved the training procedure itself. Volunteer motivation was raised by provision of incentives like uniforms and bicycles for supervisors. Introduction of HBC volunteer supervisors enhanced not only the supervision of the volunteers but raised the status of the caregivers through improved leadership skills of these community members.

6.1.4 Management Practices

Most administrative decisions on HBC issues are made at Pact. This is a rather centralised approach in dealing with partners and the approach seems to be dis-empowering to partner organisations. Too much seems to be done for the organisations without their involvement. Very strict communication procedures were outlined at the introduction workshop. Some partners felt that the relationship was not of a partnership nature at all since they had very little room for flexibility and innovation. They felt that at times Pact staff made them feel like they had never managed programs before. Pact did not seem to acknowledge existence of other management or administrative systems present in partner NGOs. While it is appreciated that some of the organisations that Pact is dealing with are still quite young and may not have the capacity to draw job descriptions, it maybe important that Pact facilitate a participatory process of development of systems and job descriptions so that they are owned by the partner organisations and that the partner organisation's capacity is built in the process.

In some of the partner NGOs, there are no stock control systems to use for monitoring the HBC kit contents, which are replenished periodically. The non-existence of such a management tool leaves the system open for abuse.

Although caregivers collect some data, the type and quality of data collected does not seem to be helpful in the measurement of intended program outcomes. The caregivers and staff have not yet started using the data for planning at NGO level. The data are collected mainly for the purpose of reporting to Pact.

6.1.5 Governance

As part of the selection process, Pact gathered a lot of organisational capacity information, scoring and categorising of partner NGOs. It appears however that the information was not adequately used to tailor make support to NGOs' organisational needs. This was more used for improving issues related to service delivery, however, effecting meaningful program impact does not only require strengthening of the service delivery component but addressing some of the major organisational development issues as well.

Pact did not include in the program design, strengthening of organisational development components like governance where stakeholder participation issues would have been addressed e.g. guidelines in board composition as well as facilitating board training sessions. This would have enhanced the realisation of the goal on improving community participation in program activities. Partner NGOs also needed a lot of help in formulating their vision, mission and goal statements in participatory ways that actively involve community members.

The roles and responsibilities of the NGOs and Pact do not appear in practice to be clear. Pact seems to be doing most of the deciding. It appears there is more accountability of the organisations to Pact than to the communities and organisations they are working with. The selection process of the partners was clear with a clear criterion, however on the selection criteria, there was no mention of willingness of the organisation to include PLWHAs in their staffing and governance processes.

6.2 Programmatic Issues

Programmatic issues are discussed under a number of sub-sections. The first part discusses the elements of the intervention package that is detailed in the proposal submitted to Sida by Pact. This is followed by a discussion of the goals, objectives and expected results. Programme implementation will be discussed in order to objectively assess whether activities were implemented according to plans. Finally, programme elements will be discussed, that is community involvement and participation; partnerships; capacity building; quality of care; linkages; monitoring and evaluation; sustainability; programme achievements; and programme challenges.

6.2.1 Pact's Strategy

The strategy adopted by Pact is to strengthen the capacity of local non-governmental organisations so that they can effectively mobilise communities towards HBC activities in order to enhance social cohesion that facilitates the adoption of collective responsibility towards the terminally ill. This strategy enables the NGOs to build the capacity of local communities so that the affected households can adopt better coping mechanisms. This approach was to ensure that HBC should not be synonymous with *'home dumping'*, but is all about provision of quality care services within the homes of the patients.

To this end, Pact entered into partnership with 14 NGOs with a view to enhancing the quality of services offered in home based care programmes. It should be noted that initially, Pact had planned to partner with 10 NGOs. Thus, Pact clearly defined a minimum package of quality home based care that involved the provision of home based care kits. The strategy involved encouraging the communities to rely on the use of community assets in caring for the terminally ill instead of waiting for external resources, which are usually difficult to come by.

6.2.2 Pact's Home Based Care Intervention Package, Goals, Objectives and Expected Results

The HBC model that Pact is implementing through partnership with NGOs had clearly defined roles for Pact. These are:

Mentoring and coaching: – The assumption was that the NGOs would require technical support in order for them to effectively facilitate community processes and projects aimed at enhancing the quality of services provided by the home based care programme.

Training: – In addition to the technical support mentioned above, the NGO staff, both paid and unpaid (volunteers) were perceived to require specific capacity building in order for them to devolve their roles more effectively. The plan was to conduct these capacity-building activities through workshops at the NGO site. The rationale was to equip NGO staff with training of trainers (ToT) skills and skills in community mobilisation and facilitation. Volunteer caregivers were to receive skills in home based care.

Peer information exchange: – Pact has been involved in facilitating the provision of home based care programmes for the past four years. Thus, the idea was to create a forum where NGOs involved in HBC programmes would come together and share experiences and better practices and learn from each other.

Provision of Grants: – this was a recognition that NGOs would require funding in order to scale-up their activities, thus, enabling the programme to reach the under-served while at the same time improving the quality of the services provided to patients.

Expertise: – In this case, Pact would act as a *'think-tank'*, sharing innovative ideas with NGO partners so that they could in turn implement these in order to enhance the quality of services provided by the HBC programme.

Provision of HBC Kits: – Pact would assemble and distribute home based care kits to partner NGOs. The major purpose of the HBC kits would be to enhance infection control through the use of protective gloves and aprons. The kit would also contain disinfectants to be used to clean and wash the patients' clothes.

These are the six elements that were at the heart of the intervention package developed by Pact. The impact due to the implementation of this intervention package will be discussed later in the evaluation report.

6.2.3 Goals of the HBC Programme

The HBC programme had the following three goals:

1. To build the capacity of NGOs to mobilise and facilitate community responses to home based care
2. To strengthen the capacity of the communities to provide comprehensive and quality home based care services
3. To increase access to quality home base care services for patients in need through scaling up the programme

More specifically, the objectives of the HBC programme were:

1. To equip NGO staff with community mobilisation and facilitation skills
2. To increase community participation and ownership of home based care programmes
3. To equip community members with comprehensive home based care skills through robust skills training processes
4. To equip the carers with home based care kits that will facilitate the provision of quality home based care services
5. To increase the number of skilled volunteer carers by 30 percent in each programme
6. To support NGOs through grants to reach under-served areas

6.2.4 Expected Results

At the design stage, Pact, Sida and the NGO partners had some results that they hoped to achieve through the implementation of the programme. These expected results are detailed below.

- 10 NGOs are supporting and facilitating communities to design, plan, implement and evaluate own home based care programmes
- Enhanced sustainable community level responses to home based care
- Strengthened capacity of organisations to mobilise communities in home based care
- Greater numbers of skilled volunteer carers
- Greater number of patients able to access quality and comprehensive home based care services
- Improved information flow and sharing of experiences between participating partners in the home based care programme
- Greater number of patients able to access basic needs to improve their quality of life

6.2.5 Programme Implementation

An analysis of programme documents and responses from various categories of respondents and participants to FGDs shows that Pact facilitated HBC programme was implemented according to plans detailed in the project proposal submitted to the Swedish Embassy. Training manuals were developed; training was conducted for volunteer caregivers in home based care skills and NGO staff were trained in community mobilisation and facilitation skills; there was a lessons learned workshop that allowed NGOs involved in home based care activities to share their experiences and learn from each other; home based care kits were assembled and distributed (over 8,000 HBC kits were distributed).

Community Involvement and Participation

All the programmes are community based and heavily involve community members in programme implementation activities. However, community members and other stakeholders were not involved in planning for the programme activities. Community members are involved in the identification and selection of volunteer caregivers. Community members and leaders are also involved in informing volunteer caregivers about the people in their villages who need HBC services. Although the programme staff members mobilise community members, community members are marginally contributing resources to the HBC programme and they do not perceive the HBC programme as theirs. Probably this is due to poverty prevailing in the country at the time the AIDS Service Organisations (ASOs) entered into partnership with Pact. It is the evaluators' opinion that community members do not own the programme because they were not involved in the planning phase of the programme. It should however, be noted that community involvement has led to community ownership of the HBC programme, which in the long run has the potential to lead to programme sustainability.

Rural District Councils (RDCs) are there to represent the interests of local community members. Thus, viewed from that broader perspective, RDCs have contributed to the HBC programme in various ways. For example, in Seke Rural and Chiundura, they have provided office space to the programmes. In Gwaci, a local businessman has provided office space while the local leadership has provided space for building more permanent offices for the programme.

Partnerships

It is the evaluators' point of view that if Pact had opted to be directly involved in service delivery, it would not have achieved the coverage and impact that it has managed through working in partnerships with NGOs. However, at the same time, one of the key development challenges is to form strong functional partnerships.

While all the Pact partners appreciate the quality of care introduced in the HBC programme through the partnership with Pact, they believe that the partnership between Pact and their organisations is rather loop-sided. Some partners feel that Pact programme staff view them as rather desperate people who need assistance and are thus on the receiving. This type of situation does not create healthy partnerships that entail mutual respect among partners. These negative perceptions can be addressed through continued dialogue and perhaps by developing a Memorandum of Understanding (MoU) with each partner. The MoU should clearly articulate the roles, responsibilities, expectations and deliverables for each partner.

Capacity Building

Pact is not only working with NGO partners to provide quality of care to home base care patients, but one of its goals is to strengthen the capacity of the NGOs so that they are better able to provide the services even after donor support. Pact has done this through training NGO partner staff members and volunteers.

NGO partner staff has been trained in community facilitation skills through Pact's facilitation. The skills acquired through this training could be a success factor for the effective community mobilisation and involvement noted in the HBC programme. The NGO partners are thus, better placed to network with other organisations in the development sector.

Volunteer caregivers have been trained through Pact's facilitation in home based care skills and psychosocial support. The training addressed issues related to basic nursing skills, referrals, bereavement counselling, basic counselling, aromatheraphy and hygiene. This training for volunteer caregivers is based on a HBC manual that was developed by Pact, thus, making sure that volunteer caregivers receive standardised training. The volunteers interviewed during the evaluation reported that the training was very good and provided sound preparation for their work. However, some of the volunteer caregivers reported that the training needed a longer time, as the issues covered are too many to be covered in one week.

Supervisors in the HBC programme also received training facilitated by Pact. The training covered issues related to management, supervision, leadership and report writing. The supervisors also reported that the training they received was good as a way of preparing them for their supervisory role.

However, given that Pact has been involved in conducting organisational capacity for their NGO partners in the "organisational capacity strengthening" programme, they have not conducted organisational capacity assessment and subsequent development for the new HBC partners. Most of the committee members of the partners have not been trained in their roles and responsibilities.

Quality of Care provided by the HBC programme

Pact has no doubt assisted partner NGOs to deliver high quality home care services. Home based care patients, volunteer caregivers and the community at large reported a great appreciation of the services that the different HBC programmes are offering to terminally ill patients.

The quality of care offered has been enhanced mainly by the introduction of HBC kits. HBC kits contain vaseline, basic medication for pain relief and gloves among other things. Gloves have contributed in important ways to enhancing infection control both on the part of patients and volunteer caregivers.

The second factor attributed to the good quality of care provided is the intensive training that the volunteer caregivers undergo. The training manual that is being used during training of volunteers was developed by Pact and is very comprehensive. The ASOs that are in partnership with Pact reported

that Pact first conducted a training of trainers' (ToT) course and it is these people who underwent the ToT who are now involved in training volunteer caregivers in home care.

In all the six programs visited, the quality of care provided is also enhanced by the motivation provided to supervisors and secondary caregivers. Volunteer caregivers are provided with uniforms (one pair each), hats and tennis shoes. Supervisors are also provided with the same uniform items and bicycles. The uniforms and bicycles serve two purposes. First, they motivate volunteers and supervisors who feel honoured and respected within their communities. Second, they are important for identification purposes.

Although stigma is still there in most of the communities where the HBC programme is implemented, it is on the decline. This has been due to the fact that the HBC programme currently being evaluated is not only attending to HIV/AIDS patients, but to all terminally ill patients irrespective of their illnesses. The community members have accepted the HBC programme and greatly appreciate the services that the programme is rendering. Programme acceptance has allowed volunteer caregivers to operate freely, thus, spending the time they feel is necessary with the patients.

In one of the NGOs, that is Seke Rural, Island Hospice has trained one nurse at each rural health centre in the programme's catchment area in palliative care. This has allowed patients to receive services from qualified health professionals. These trained nurses work closely with HBC volunteers and volunteers submit their service statistics to the local clinics on a monthly basis. When nurses in charge of the local clinics in the HBC programme's catchment area hold their monthly meetings at the district hospital where the NGO is housed, they discuss with the NGO director and project officer about the problems being encountered during the implementation of the HBC programme.

Linkages

All Pact's NGO partners have forged strong linkages with government departments, other NGOs and even the private sector. All of the NGO partners have links with the Ministry of Health and Child Welfare and local clinics in the programme's catchment area. In Gwaci and Seke Rural, there is a Medical Doctor and Nurse who voluntarily provide their services to HBC patients respectively. These service providers accompany volunteers during their visits to patients in their homes.

Linkages with the Rural District Councils (RDCs) are not common across NGO partners. In some areas, the HBC programme is closely linked with RDCs while in others, there are no strong links. In cases where the linkages are strong, the NGOs have been allocated offices by the RDC where they do not pay for water and electricity.

Programme Achievements and Impact

The home-based care program being implemented by Pact through partnership with NGOs has made some differences to the program beneficiaries and other program participants. The key achievements of the program are discussed below.

The HBC programme largely achieved the results that were expected at the design of the programme. Instead of having 10 NGOs that support and facilitate communities to design, plan, implement and evaluate their own home based care programmes, Pact ended up being in partnership with 14 NGOs.

Community level response to need for home based care services are no doubt evident in all the catchment areas of the six NGO partners visited. However, because most of the HBC programmes are still in their infancy, it is not clear whether they are sustainable if there is no donor funding.

The NGO partners have effectively mobilised communities, thus, creating strong cohesion (social capital) within these communities in support of home based care programmes. This is evidenced by

participation of community members in sensitisation workshops and their involvement in the implementation of programme activities.

Table 1 below shows the number of volunteer caregivers and supervisors who have been trained in the home based care programme from inception to the end of September 2002.

Table 1: Program Performance of the Six Pact NGO Partners as 30 September, 2002

NGO	No. of Caregivers Trained	No. of Supervisors Trained	Cumulative No. of Patients Served
Gwaci	82	9	943
Chiundura	45	5	214
Rujeko	302	30	1946
Seke Rural	249	10*	1422
UDACIZA	85	7	1229
ST. Theresa	138	0	2932
Total	**909**	**61**	**8686**

* This figure is different from the one that was provided during fieldwork. During fieldwork, the number of supervisors was reported to be 20.

In all, the HBC program has trained a total of 2,173 volunteer caregivers and 235 supervisors. Cumulatively, the program has served 14,988 patients. Table 1 shows the number of secondary caregivers and supervisors trained and the cumulative number of patients served by each of the six NGOs visited during the evaluation. Service statistics from the HBC programme clearly demonstrate that there has been substantial increase in the number of patients attended at all the NGO partners.

In July 2002 Pact convened a "lessons learned" workshop in which the Sida, ZimAids and NetAid HBC partners participated. The goal of this workshop was create an opportunity for the NGOs to share experiences and learn from each other. An evaluation of the workshop showed that participants had greatly benefited from this workshop.

The achievement mentioned by all the HBC partners visited is that of improved quality of care provided by the programme and received by patients. The quality is mainly attributed to the quality training received by both supervisors and secondary caregivers. The other factor contributing to the high quality is the provision of HBC kits by Pact for use by volunteers. Use of HBC kits has elevated the social status of volunteers within their communities. In all, Pact has assembled and distributed over 8,000 HBC kits.

Some of Pact partners are church based and had the tendency of associating HIV with a curse from God for some wrongdoing. UDACIZA for example did not allow its members to go to hospital. However, due to the HBC programme, HBC patients easily go to hospitals for treatment. In St. Theresa, church leaders are now speaking openly about HIV and AIDS.

In the early stages of the HBC programme, there was a lot of stigma associated with terminally ill patients, especially HIV/AIDS patients. However, due to community sensitisation, mobilisation and involvement in all the phases of the programme, stigma has been reduced. Actually, instead of hiding patients, community members are informing volunteers about people who need home based care services in their villages.

Pact, by conducting a course in community facilitation to staff of its partner NGOs has enhanced further the capacity of NGOs to facilitate the implementation of local initiatives. The skills acquired during this course has also built the capacity of NGOs to network with other organisations either directly involved in the HIV and AIDS sector or those who are interested in supporting efforts to mitigate the impact of the epidemic.

The HBC model used by Pact is well structured and thus, very easy to replicate. Thus, even very small community based organisations can easily implement the model.

Pact has developed an HBC manual, which was launched by the Ministry of Health and Child Welfare (MOH&CW). The existence of a manual standardises the training received by volunteers.

There are HBC programmes, which have strong relationships with the National AIDS Council structures, especially the District AIDS Action Committees (DAAC). The DAACs have provided training to secondary caregivers in some of the communities served by the HBC programmes. NGOs who enjoy strong linkages with the DAAC have the chance to continue with programme activities even without donor support.

The HBC programme has managed to reduce stigma associated with HIV/AIDS by attending to patients with all illnesses in the home based care programmes.

Monitoring and Evaluation

The supervisory structure of all the HBC programs visited during the evaluation is standard. The majority of supervisors have bicycles to enable them to effectively cover their catchment areas. Sometimes the supervisors make spot checks on the secondary caregivers in order to assess whether volunteer caregivers are visiting patients as planned. During these spot checks, supervisors interact with patients and direct caregivers asking them about the secondary caregivers' visits and the quality of care that the patients are receiving from the program.

Once every month, each supervisor meets with secondary caregivers to get reports, share experiences and discuss progress and problems that the caregivers may have encountered during the previous month. Supervisors and secondary caregivers suggest possible solutions to the problems that will have been raised.

Pact has designed some monitoring tools that are used by its HBC partners. One of the tools is a ''History Record" for each patient in the HBC. This form collects information on the name of the patient, age, sex, religion, marital status, number of children, age of youngest child, address, type of illness, treatment received and problems that the patient is facing. The status of the patient, that is, whether the patient is bed-ridden, housebound or mobile is also captured by the monitoring system. The information that is collected is used to chart the trends especially in terms of numbers and to plan the requirements of the program, for example, the number of HBC kits that are needed and those that need to be replenished. It should however, be noted that there are a number of partner NGOs which do not have these forms and write their statistics in a note book.

Each supervisor compiles a monthly report that is based on the reports submitted by secondary caregivers. The supervisor's reports are discussed with project officers responsible for the HBC program. The project officers then discuss the program performance with the Directors of the various organisations before submitting their statistics to PACT.

At Pact level, all the data from the fourteen HBC partners are used to compile quarterly reports. The quarterly reports highlight successes and challenges associated with the program in general. Discussions with Pact 's HBC partner seem to suggest that although verbal feedback is sometimes provided to

partners, there is need to give structured written-feedback which would go a long way in assisting NGOs to improve their programs.

Pact program staff make quarterly visits to partners. In some cases, volunteer caregivers reported that during these visits, Pact staff visits communities seeing patients and talking to community members in order to get their perceptions about the HBC program. In other cases, volunteers were reporting that they are hardly visited by Pact staff. There may be a need on the part of Pact to develop a standard checklist to be used during field visits to partners.

The major challenge associated with the issue of quality of care is that there are limited quality of care and impact indicators that are being used by the programme. The two indicators that are being used are the number of HBC kits distributed and the number of volunteer caregivers trained. There is however need for more detailed qualitative indicators for the programme.

Sustainability

Community involvement and participation is critical to the success of local initiatives including HBC programmes because it enhances programme ownership and ultimately sustainability. Community members discussed with in a number of the programmes visited indicated that if donor funding stops, the HBC program is likely to stop. This is mainly attributed to the fact that most of the programmes are still in their infancy, thus, do not have sound resource bases.

Other partner staff members believe that HBC programme activities will continue although quality will be compromised. They believe that the quality training that volunteers have received will see the programme activities continue. Respondents belief that the programmes cannot afford to replenish the HBC kits. This will clearly happen as even now in some cases when delays are made in replenishing HBC kits, volunteer have problems in exercising infection prevention.

There are some HBC partners who have effectively networked with the National AIDS Council structures especially the District AIDS Action Committees (DAACs) and the DAACs have already trained some volunteer caregivers. Some of the DAACs are have planned to provide HBC kits to the programmes. Thus, effective networking can go a long way in contributing to the sustainability of HBC programmes that are currently facilitated by PACT.

Pact has provided money to volunteer caregivers through its NGO partners to start income generating activities. However, some of the income generating projects (IGPs) have not been very successful. This could be due to the type and quality of training and follow-up provided to the volunteers as a way of preparing them for the IGPs. In some organisations, the partner NGOs requested the Ministry of Gender to train the volunteer caregivers in general business skills. There may be need to have clear partnerships between the Ministry of Gender so that they can also provide technical support to the IGP activities.

Program Challenges

The major challenge that the HBC program is facing is unavailability of drugs especially those for opportunistic infections and pain control. However, the HBC kits that are availed through PACT have some medications for pain relief. Given that some of the medicines which the HBC patients have to take should be administered after eating, there is need to provide HBC patients with food. PACT has agreed to provide food packages to patients that are very desperate. Although provision of food packages in HBC programs is not sustained, the poverty that has affected Zimbabwe makes provision of food a priority.

In all the HBC programs visited, volunteer motivation is a big challenge. Admittedly, PACT has put in place certain things that contribute to motivation of volunteers. These include provision of uniforms

for supervisors and secondary caregivers and provision of bicycles to the supervisors. PACT has also provided some money to groups of volunteers to start income generating activities. The Ministry of Gender has assisted in some of the projects to train volunteers in general business skills as a way of preparing them for implementation of successful income generating activities. PACT may want to consider linking its HBC partners with micro-finance development institutions, which can also train volunteers in proper selection, planning and management of income generating projects.

The third challenge is that of program sustainability. Most of the programs are still in their infancy, thus, they have limited resources to continue without donor funding. Although there is deliberate effort on the part of Pact and its partners to involve community members in all phases of the project, community members are so poor that they cannot meaningfully contribute to the sustainability of the program.

Pact has fourteen HBC partners who are scattered all over the country. At the same time, Pact has only three program persons. This makes it difficult to effectively provide technical support to all partners. Having partners scattered all over the country makes the program less cost-effective and attenuates its potential impact.

6.3 Financial Management Issues

We have reviewed the financial records and systems of internal control at PACT. In doing this, we have tried to address the following areas:

1) Assessment of financial systems that exist within the organisation to monitor its operations;
2) Assessment of whether the funds were used as specified in the project document;
3) Assessment of the adequacy of the internal accounting and control systems and the organisation's compliance thereof; and
4) Financial management and reporting skills of the organisation.

Background on Financial Issues

PACT receives donor funding from USAID and Sida. USAID is the main donor. The organisation's head office is in the USA and it is to this office that PACT Zimbabwe reports.

PACT Zimbabwe follows USAID regulations for accounting and dealing with sub-grants and has got a procedures manual for this purpose. Separate Bank Accounts exist for Sida funds (USD and ZWD). All Funds pass through the Head Office. Funds are transferred into the Sida FCA in United States Dollars. These are then converted into Zimbabwe dollars by seeking the best rate on the market. It is the Finance Manager's responsibility to source for the best rate and the Director's to sign the letter authorising transfer. It was good to note that the conversion of foreign currency is dealt with at the highest level because this is an important area at this time in Zimbabwe.

Reports are submitted every month to HQ and these include:

- ZWD general Ledger
- USD general Ledger
- ZWD Bank reconciliation
- USD Bank reconciliation
- Weighted Average report
- Summary of Expenditure report and
- Cash valuation report

PACT is computerised and uses a system called QuickBooks for its accounting. Most of the partner NGOs use manual systems. However, most of them have had Computers purchased for them and some use excel for their reports. PACT has about 14 partner NGOs receiving Sida funding and a separate ledger is maintained for each Partner. Any amount given to the Partner NGO is treated as an advance and is recorded as such in the NGOs ledger. The NGO is then required to submit a liquidation report, which, details how the grant has been utilised. This is then reviewed and only after this are the NGOs expenses recognised and their account gets credited.

Findings

Below are evaluation findings on the financial management aspects of the HBC programme.

Although generally there is a file with financial information and reports for every month, there are instances where some important documents were not on file. For instance, bank statements for April, August and September where not on file and had to be looked for. The vouchers for the month of September were also not yet properly filed. PACT has got a computerised general ledger and backups are done frequently. In fact, the system actually prompts one to backup one's data now and again and this is good. The backups are stored on site.

The purchasing procedures require that three quotations be obtained whenever a purchase for goods above ZWD $20 000 is being made. However, there is no evidence on file that this procedure has always been adhered to. Some purchases were made (especially HBC kits) and yet there is no comparative schedule on file to indicate that competitive bidding has been done. A substantial amount of money has been incurred on the purchase of HBC kits. Unfortunately, there was no system in place for the control of the stocks. To add on, stock controls at one of the partner NGOs visited do not seem adequate. The Finance Officer just records stocks received in the movable assets register and then record them when issued out. A review of this book showed some issues to the co-ordinator that were not signed for. The Finance Officer does not keep a record of where the kits are eventually distributed.

There is an expense voucher system at PACT. This adequately allows for segregation of duties as the Accounts Officer initiates the transactions, the Finance Manager authorises them and the Director approves. This system seems to be working well except for a few vouchers that were not signed as approved. The cheque signing arrangements at PACT is that only one person can sign for amounts up to 1Million ZWD. For amounts above that, two signatures are needed and there are only two authorised Cheque signatories. The Finance manager is not a bank signatory.

PACT has got a fixed assets register which has the asset description, location, donor, purchase date and amount, serial number where applicable, tag number and description of condition. No depreciation is calculated, as HQ does not require this. However, our evaluation shows that over 2Million ZWD has been spent on the purchase of computers for NGOs and yet these are not in the Fixed Assets Register.

There was an instance where an amount not relating to Sida was taken out of the Sida account only to be reimbursed later (some Z$2 184 000 in August 2002). There was also an instance where some foreign currency where erroneously liquidated into the USAID account, and a transfer had to be done to the Sida account. Our review also shows that some charges that are supposed to be done to Sida for common expenses, for example, rentals and the Director's expenses were not being done. Salaries for three people are paid from the Sida account. These are the Programme Officer, the Finance Officer and the Driver.

Whereas the local October Cash at Bank was $1 062 771,46 the USD one was 2 978 in debit. The April 2002 ZWD balances were also negative. This is most likely to be a result of just overdrawing. However, it was refreshing to note that both NGO Finance Officers interviewed were aware that they

should maintain a minimum balance of 20 000 ZWD otherwise they risk failing to run programmes continually and will also incur interest charges.

There seems to be a clear policy at PACT on local travel, but the same cannot be said of foreign travel. This is probably because not much foreign travel is done and whenever this is envisaged, it becomes part of the main budget or agreement.

It was good to note that PACT monitors the partner NGOs but demanding that they submit reports (Liquidation) every month or when another cash request is about to be made. However, there seems to be no clear-cut dates when reports should be submitted. A review of the liquidation forms shows that some are being done well whereas some expense reports are not being done so well (e.g. Silveira) and are difficult to follow.

A separate schedule showing the utilisation of Sida funds from December 2001 to October 2002 is attached. Up to the end of October 2002, about 190 000 United States Dollars had been disbursed by Sida through HQ. This was converted on the market over the month and some 114M ZWD was raised. Some USD 22 000 was used to purchase a vehicle and some 4 800 for paying fuel.

7 Key Conclusions

Pact being an international organisation does not have a local advisory committee or a technical reference group. This reduces local bureaucracy but also reduces the possibility of getting systematic locally based inputs in the programme.

At design stage Pact made an assessment of its potential partner organisations using a set criteria. The assessment categorised the organisational development levels of the different organisation's subsystems. This development was quite good. However, Pact did not seem to have used the categorisations for programming or organisational support purposes. Yet all its technical support to individual partner NGOs seemed to have received similar support irrespective of their difference in organisational maturity.

Most of the different organisations that Pact is working with have got governing boards. This is supposed at least to ensure that there is community representation in the programs. However the boards are rather weak and there is limited clear definition of the roles of the board, staff and office bearers. One organisation even had a director who was its board chairperson. This is not proper but in the absence of organisational advise from Pact this has been nurtured and in the long run will be difficult to address. Pact did not seem to have used their previous experience in organisational capacity building to strengthen the organisations especially in the governing structure.

It is positive that Pact has developed administrative and financial procedures for the partner organisations, most of which are rather weak and would not have managed to develop such systems. Pact did not seem to have acknowledged that there are other organisations that were already using other systems, which could have been further developed for use in the project. Partner organisations are working with other organisations and if all organisations would bring in their own packages and require the partner organisations to follow them by the book, it would be very demanding and difficult for the partners to cope.

The roles and responsibilities between Pact and its partner organisations do not appear to be quite clear. This has resulted in confusion regarding accountability. It appears organisations are more accountable to Pact than to the constituency they are supposed to be accountable to. Within the organisations there are some staff e.g. co-ordinators and bookkeepers that are labelled as Pact staff. This is rather unfortunate as it is against the principle of building up autonomous bodies. There appears to be a centralist approach in Pact regarding its dealing with partner organisations which is rather disempowering to the organisations.

The majority of the organisations were not quite happy with the communication, interaction and attitude of some Pact staff to them. They seem to feel that there is limited *"partnershipping"* in the real sense of being equal partners because of the interaction process. It was felt that the way of interaction was sometimes patronising and demeaning to organisations and individuals. They had the feeling that there was limited mutual respect in the interaction process.

Having health backgrounds, the staff members at Pact have sector skills in the area of HIV and AIDS which have been positively used in programme implementation and planning. They acknowledge some of their limitations and achieve efficiency through subcontracting some tasks where they feel they have limited capacity such as in supporting income generating projects and provision of training. It appears however that there is limited capacity in Pact relating to strategic planning, gender, lobby and advocacy, monitoring and evaluation and for the HBC program it appears these have not been outsource.

Pact should be commented for its volunteer management in terms of provision of incentives to the secondary caregivers and their supervisors. They have been given uniforms, shoes, training on HBC and on leadership skills, home based care kits and some have been given some money to help them start income generating projects. The status of the secondary caregivers in their communities has been improved. However burnout strategies for the volunteers do not seem to have been clearly worked out.

Most of the challenges that are encountered in the program today seem to be originating from the seemingly limited project design and programming which did not seem comprehensive enough in terms of covering some of the pertinent issues such as inclusion of gender, lobby and advocacy and empowering approaches towards partner organisations.

The evaluation showed that the HBC programme was implemented according to the plans detailed in the project document submitted by Pact to Sida. The programme also largely met the objectives as they are articulated in the same document. For example, the programme has trained 2,173 volunteer caregivers, 235 supervisors, cumulatively it has attended to 14, 988 patients and has assembled and distributed over 8,000 HBC kits.

The model that was adopted by Pact to implement the HBC programme in partnership with local NGOs has great potential to enhance programme coverage and impact. The model is also well structured and simple, thus, can be easily replicated.

The partnership between Pact and NGO was perceived by some NGO partners to be loop-sided in favour of Pact. Partners believe that some Pact staff assumes a more privileged position in the partnership and partners are just desperate people who require assistance. Thus, there does not seem to be mutual respect within the partnership.

The capacity building approach used by Pact was well appreciated in terms of both content and style of delivery by both NGO partner staff and volunteers. This is largely attributed to the use of carefully designed training manuals.

The quality of care provided by the HBC programme was rated highly by programme beneficiaries, volunteers, NGO partner staff and community members. The success factors for the high quality of home care are:

- Quality training offered to volunteers and NGO partner staff;
- Provision of HBC kits, which enhance infection control to both patients and volunteer caregivers;
- Motivation of volunteers by providing them with uniforms and bicycles for supervisors; and
- Community support to the HBC programme

All the NGO partners have forged strong linkages with other organisations and individuals in both the public and private sectors. These linkages have benefited the HBC programme through sharing of resources (facilitation in workshops by staff of other NGOs, provision of office space by the RDCs, provision of care to HBC patients by trained professionals etc).

The monitoring and evaluation system of the HBC programme only collects data on output and process indicators. There are no indicators of quality of care and impact in the programme. It should however, be noted that during the training of volunteer caregivers, volunteer caregivers are taught how to make patient assessments. The instructions for patient assessment could be used as data collection tools, so that the volunteers would be able to write detailed reports which show the types of problems that they have managed to deal with effectively and problems that they are encountering more frequently.

Volunteer caregivers do not record the time that they spend with patients and/or explaining issues to direct caregivers. Recording of time would go a long way in assessing the cost-effectiveness of the HBC programme and also in identifying the issues that are normally dealt with in the HBC programme.

Volunteers were observed to be simply recording the number of visits that they make to patients without recording the content of the visit and detailing the actual actions performed during each visit.

If donor support stops now, the chances of sustaining the HBC programme activities are very low. Most of the HBC programmes are still in their infancy, thus, they have limited resources to continue without donor funding.

Volunteer motivation remains a challenge in the HBC programme irrespective of the efforts that Pact has done in providing uniforms for volunteers and additionally, bicycles for supervisors.

Pact is keen to enhance the sustainability of the HBC programme. This is evidence by the provision of money to volunteer caregivers so that they can start their own income generating activities (IGAs). The logic of this approach is to motivate volunteer caregivers so that they remain in the programme given that they do not receive any monetary allowance for their contributions. However, most of the projects that have been started in the HBC programme have not been very successful.

The money given to volunteer caregivers for projects was intended to motivate the volunteers. However, it is not clear how the proceeds from the IGAs will contribute to the welfare of poor patients.

There seems to be controls in the financial and accounting systems at PACT enough to safeguard resources put into the organisation. Finance should monitor to ensure that the documented systems are adhered to at all times. The submission of reports together with supporting documents by partner NGOs ensures that they remain accountable and reduces the risk of abuse of resources.

Sida funds disbursed so far have been used in accordance with the existing budget document.

The authorisation of expense vouchers before a cheque is written out is a good control measure for disbursements. Giving cheque-signing responsibilities to more than a single person can enhance these controls.

Foreign currency is a big issue in the country at the moment in terms of the scarcity of the commodity as well as the legality of trading on the parallel market. As such, it is best to have foreign currency issues dealt with at the highest possible level, and this is the case at PACT.

We are operating in a hyperinflationary economy and prices are changing every day with suppliers of uncontrolled commodities charging prizes as they wish. Competitive bidding can save any organisation from being prejudiced and this should be done whenever possible. In such times of economic hardships, it is also imperative to have enough controls on stock, as this is one area that can be easily abused. This is an area PACT should look at seriously.

8 Key Recommendations

Pact could consider having a locally based advisory committee in the area of HIV and AIDS. Such a board could consist of people with expertise in HIV& AIDS community based NGO management, participatory approaches, gender, monitoring and evaluation as well as have a representative of a non-governmental organisation to represent the interest of staff. Such a board could provide technical advice regarding the program such as the design and implementation processes.

Pact could consider having an empowering approach to organisations through working together with the partners and involving them in a process of decentralising some of the operations.

Consideration could be made to train and build the capacity of the organisations particularly those that are still in the nascent stage. Specific attention and focus could be made on building the capacity of the boards to know their roles and responsibilities as a board, the demarcation and operational parameters between the staff and the board as well as defining the responsibilities of the office bearers.

The roles and responsibilities between Pact and the partner organisations could be more streamlined especially in relation to human resources. For purposes of sustainability and ownership of the organisations by the partner organisations the employees need to report and be accountable to their boards and not to Pact. Pact should not be more visible and pronounced compared to the partner organisations. Administrative and finance systems development could be made with the involvement of the partner organisations as a way of building their capacity and also as a way of cultivating ownership of the systems within the organisation. Organisations need to be treated with respect and interaction processes need to have similar tone in order to build mutual harmonious functional partnerships.

Pact could consider outsourcing the tasks it does not have skills and capacity in. Such areas could include, monitoring and evaluation, gender, lobbying and advocacy for HBC, strategic planning and organisational development. The programmatic aspects cannot be separated from the organisational capacity issues, as they are inter-related and inter-dependant.

After realising that the partners were at different levels of development, a capacity development package would not have been homogenous, but could have taken into consideration the different developmental stages of the NGO partners.

Consideration could be made regarding development of burnout strategies for the secondary caregivers. Partner organisations could be given advice on best practices for addressing burnout and be assisted on how to implement the burnout strategies.

There is limited ownership of the HBC programme by community members and this is largely perceived to be due to the limited involvement of community members in the planning for the programme's activities. If the programme needs to be sustainable in the long-run Pact and its NGO partners should make deliberate efforts to involve community members in the next planning phases of the programme.

The partnership between Pact and NGO was perceived by some NGO partners to be loop-sided in favour of Pact. Pact and its NGO partners may want to consider dialoguing and developing a Memorandum of Understanding (MoU) between Pact and each NGO partner. The MoU should detail the roles, responsibilities, obligations, reporting systems and deliverables from both Pact and partner NGO.

The monitoring and evaluation system of the HBC programme only collects data on output and process indicators. There are no indicators of quality of care and impact in the programme. It should

however, be noted that during the training of volunteer caregivers, they are taught how to make patient assessments. The instructions for patient assessment need to be used as data collection tools, so that the volunteers would be able to write detailed reports which show the types of problems that they have managed to deal with effectively and problems that they are encountering more frequently.

Volunteer caregivers do not record the time that they spend with patients and/or explaining issues to direct caregivers. Recording of time would go a long way in assessing the cost-effectiveness of the HBC programme and also in identifying the issues that are normally dealt with in an HBC programme.

Volunteers were observed to be simply recording the number of visits that they make to patients without recording the content of the visit detailing the actual actions performed during each visit. It is important to categorise visits by actions taken and/or services provided. This can also go a long way in assessing the impact of the HBC programme. For example, during the early days of a home based care programme, the volunteer caregivers are expected to be performing most of the activities with the patient. However, as the programme matures, one would expect the direct caregivers to be more and more involved in aspects related to the patient's needs and the actions of the volunteer caregiver declining – a sign that the direct caregivers have been effectively trained.

If donor support stops now, the chances of sustaining the HBC programme activities are very low. Most of the HBC programmes are still in their infancy, thus, they have limited resources to continue without donor funding. Pact may want to continue nurturing these programmes by helping them to set up fully functional administrative, financial management and resources systems with a view to solidifying their resources base.

Volunteer motivation remains a challenge in the HBC programme irrespective of the efforts that Pact has done in providing uniforms for volunteers and additionally, bicycles for supervisors. There is need for Pact and its NGO partners to further explore ways and means of improving the motivations of volunteers as they are at the centre of service delivery in this programme.

The money given to volunteer caregivers for projects was intended to motivate the volunteers. However, it is not clear how the proceeds from the IGAs will contribute to the welfare of poor patients. Pact and its NGO partners may want to clearly define how the proceeds from the IGAs will benefit the HBC patients.

It is important that filing be done as soon as documents are received and all files need to be kept intact for the stipulated period. PACT can also consider having backup offsite in case a disaster occurs on its premises.

The purchasing procedures especially as regards obtaining quotations should be observed as strictly as possible. This will safeguard the organisation from losing money especially with the current state of the economy when prices are rising by the day. Comparative schedules should be put on file for future reference.

We understand that PACT is considering sub-contracting the production of HBC kits. However, we still recommend that some stock control procedures be put in place to take care of stocks that might be held from time to time. These should include a reconciliation of goods delivered to NGOs. Stock takes should be done frequently and count results compared to theoretical stocks. Likewise, partner NGOs should also maintain stock records. These should include lists of the recipients of the HBC kits or whatever goods. Any issues made should be signed for.

The expense voucher system is good as it ensures that management is aware and get to authorise all expenses being incurred by the organisation. The finance department should ensure that all authorisations are obtained through signing at all times.

It is important that all cheques be signed by at least two signatories regardless of the amounts involved. We also suggest that the Finance Manager be a cheque signatory as she is the custodian of the Organisation's financial resources. PACT should consider having three authorised signatories with an arrangement that two of them could sign at any one time. The organisation can further instruct the bank that for amounts above a Million, then the Director has to be one of the signatories. The increase in signatories will also ensure that there are no problems in the event of another signatory being unavailable. This should also be the case with the partner NGOs. If signatories are limited, this can lead to the pre-signing of cheques, which is very dangerous.

There is need to ensure that all assets purchased for the partner NGOs be made part of the Fixed Assets Register for control purposes, and that the NGOs keep Fixed Assets Registers.

Care should be taken to ensure that Sida funds do not get mixed with other funds since a separate bank account is maintained specifically for Sida. Furthermore, the finance department should ensure that expenses that should be shared are allocated accordingly. As part of financial management, finance should also ensure that accounts do not get overdrawn as this will only result in the organisation incurring interest charges.

There is need for Pact to have a well-documented policy on foreign travel.

PACT should also consider setting reporting dates for partner NGOs every month and insisting that these be met. PACT should also continue with the finance workshops to ensure continuous improvement in the quality of reporting.

Annex I

Terms of Reference for Evaluation of the Home-based Care Programme with Pact

1 Background

The Strategic Planning Fund through the bilateral agreement with Zimbabwe was created in 1998 to support projects/programmes in an effort to combat the spread of HIV/AIDS.

Since 2001 the Swedish Government has decided that development co-operation should focus on support to civic society within the areas of human rights and democracy and HIV/AIDS.

Pact was founded in 1971 as a membership organisation of private volunteer organisations (PVO) and NGOs. Pact revised its bylaws in 1992 and established itself as an independent international non-profit corporation. USAID has since the inception of Pact used the organisation as a vehicle to fund PVOs. Currently Pact manages 15 USAID programmes in Asia, Africa and Latin America. Pact also has a network of offices in 22 countries around the world. Sida has agreements with Pact both in Asia and Africa.

Pact has worked in Zimbabwe since 1997. In Zimbabwe they implement four programmes: two concentrated on enhancing community responses to the HIV/AIDS crisis and two concentrated on enhanced advocacy, research and analysis, and information management. Pact has also registered as a trust in Zimbabwe.

The Swedish Embassy entered into a one-year agreement on home-based care with Pact in October 2001, and agreed to fund through Pact 10 organisations around Zimbabwe. Actually, Pact has to date signed agreements with 14 organisations. The agreement between the Embassy and Pact was extended from October to December 2002 as a no cost extension. The agreement on home-based care includes now, as a natural development of the needs in present-day Zimbabwe, an orphans' component in six cases as well as a pilot project on church and community AIDS prevention and care around St. Theresa's Mission Hospital. It was felt that an evaluation of the achievements regarding the home-based care programme so far should be evaluated prior to a possible new agreement during 2003 onwards.

2 Purpose and scope of the evaluation

Pact

The evaluation should establish to what extent Pact has reached the objectives set as regards the home-based care programme, assess whether the organisation has a sufficient administrative structure in place for financial and programmatic follow-up, and establish if the programme is cost effective.

Partner organisations

As regards the partner organisations the evaluation shall assess, by sampling from the 14 organisations, the progress of the programme. The evaluation shall assess qualitatively if the organisations' ability to deliver quality home-based care has increased as a result of the programme, and identify if bottlenecks occur.

The findings from the evaluation are expected to assist and guide the Embassy on the way forward as regards the programme, as well as Pact itself and other interested stakeholders.

3 Evaluation methodology and time schedule

The evaluation will consist of:

- Desk review of the project proposal, workplan and budget submitted by Pact to the Swedish Embassy, project narrative and financial reports etc. and other relevant documentation
- Interviews with Pact staff
- Assess office, programmatic and documentation routines at Pact
- Visits to 5 selected organisations where programme has taken place and assess offices, programmatic and documentation routines

The proposed time schedule is 15 man-days.

4 Reporting

A draft evaluation report shall be presented to the Embassy latest two weeks after the completion of the task. The Embassy will comment on the draft report within two weeks of receiving the report. A final report shall be submitted latest one week after the Embassy's comments have been submitted to the consultant. The report shall be written in English and include an executive summary, and not exceed 30 pages excluding annexes. The final report shall be submitted in three copies as well as a copy on a diskette. The consultant is expected to present the final report during a joint meeting between the consultant, Pact and the Embassy.

Subject to decision by Sida, the report will be published and distributed as a publication within the Sida Evaluation Series. The mid-term review shall be written in Word 97 Office for Windows NT (or in a compatible format) and should be presented in such a way that enables publication without further editing.

5 Organisation and Co-ordination

The consultant will report directly to the responsible Programme Officer within the Embassy as regards the evaluation, in this case Johanna Palmberg.

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