Vision Statement: "A nation free from the threat of HIV and AIDS"

Mission Statement: "To contribute to the prevention of the further spread of HIV/AIDS in Zambia and to the provision of an integrated care and support response to the infected and affected"

Contact: Executive Director
The Family Health Trust (FHT); Head Office
Plot No. 5232, Makishi Road, Fairview
Private Bag E243, Lusaka, Zambia
Tel: +260 211 223589; Fax: +260 211 222834
E-mail: fht@zamnet.zm

FAMILY HEALTH TRUST (FHT)

Marking twenty years of service (1987 - 2007)

Our Shared Hope and Commitment...

Celebrating 20 years of the FHT's Contributions to Positive Change of People's Lives in Zambia

Our Shared Hope and Commitment...

DOCUMENTATING THE FAMILY HEALTH TRUST (FHT) - FROM ITS ESTABLISHMENT IN 1987, THROUGH ITS TWENTY YEARS OF EXISTENCE UP TO 2007. THE FHT WISHES TO SHARE ITS EXPERIENCES AND LESSONS WITH OTHER STAKEHOLDERS, WITH THE HOPE OF CONTRIBUTING TO EFFORTS OF IMPROVING THE NATIONAL RESPONSE TO HIV AND AIDS.

Published by the Family Health Trust
Private Bag E243
Lusaka, Zambia
Tel: +260 21 1 223585; Fax: +260 21 1 222834
E-mail: fht@zamnet.zm

Authored for the FHT by Ignatius M Kayawe

ABREVIATIONS AND ACRONYMS

AAC	AIDS Action Club (s)
AAP	AIDS Action Programme
AASU	Administration and Accounting Support Unit
AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Treatment
ARV	Antiretroviral drug
ASO	AIDS Service Organisation
CBO	Community Based Organisation
CHEP	Copperbelt Health Education Project
CINDI	Children In Distress
CRS	Catholic Relief Services
DK	David Kaunda
FHT	Family Health Trust
FLM	Family Life Movement
GFATM	Global Fund for HIV/AIDS, Tuberculosis and Malaria
GIK	Gift In Kind
HBC	Home Based Care
HIV	Human Immuno-deficiency Virus
IGA	Income Generating Activity
Kara Counselling	Kara Counselling and Training Trust
KCTT	Kara Counselling and Training Trust
M&E	Monitoring and Evaluation
MOE	Ministry of Education
MOH	Ministry of Health
NGO	Non Governmental Organisation
NORAD	Norwegian Agency for International Development
OVC	Orphaned and Vulnerable Child/Children
PLWHA	People Living With HIV/AIDS
SANASO	Southern African Network of AIDS Service Organisations
SAPEP	Simalelo AIDS Prevention and Education Programme

SAT	Southern African AIDS Trust
SLA	Savings and Loan Association
SW	Sex Worker
SWW	School Without Walls
UN	United Nations
UNAIDS	United Nations programme on HIV and AIDS
UTH	University Teaching Hospital
VCT	Voluntary Counselling and Testing
ZARAN	Zambia HIV/AIDS Research and Advocacy Network
ZNAN	Zambia National AIDS Network

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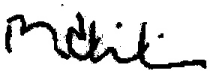
FOREWORD

It is with great pleasure and privilege that I provide a foreword to this booklet about the Family Health Trust (FHT).

The FHT is a unique organisation that has made unique contributions to the national AIDS response in Zambia. Its founders and promoters foresaw the looming calamity of HIV and AIDS much earlier than most of us did. They did not just see that threat; they also acknowledged it. They went even further by establishing the FHT, in order to provide and facilitate interventions to that looming calamity. This, they did with honour and dignity in the most altruistic sense. On behalf of government, I wish to thank these men for their selfless work: Professor Alan Haworth, Dr. Rodger Chongwe, Dr. Guy Scott and Mr. Andrew Sardanis.

I find a lot of lessons in the story of the FHT, which came from the process of establishing the organisation: developing its governance, organisational and programming systems, and expanding its roles countrywide. This booklet is written in simple and easy language to facilitate understanding. I encourage anyone who is involved with NGO/CBO work responding, to HIV and AIDS to read it.

The Family Health Trust is an organisation worthy of the support, collaboration and partnership of any well-meaning cooperating partner. I therefore appeal for increased support to this great organisation, so that through the Family Health Trust, more of the needy in our society can be helped to live healthy and productive lives.



Brig. Gen. Dr. Brian Chituwo (rtd), MP
Minister of Health

ACKNOWLEDGEMENTS

The Board of Trustees, Management and Staff of the Family Health Trust (FHT) wish to profoundly thank our various stakeholders for their involvement and contributions in the production of this booklet and accompanying video/DVD. We thank, especially our clients, for talking about their personal lives and experiences in relation to services rendered to them by the FHT. We further wish to thank the people and organisations that were interviewed, or contributed, one way or another to the production of this publication.

This booklet and accompanying video entitled, "*Our Hope, Our Commitment*", on the occasion marking 20 years of the FHT's existence could not have been achieved without the financial support from our cooperating partners through the Zambia National AIDS Network (ZNAN). We are very grateful to them and ZNAN for this support.

Appreciation also goes to Mr. Ignatius M Kayawe, the consultant who led the process and task of making these publications a reality; as well as to Mr. Charles Mafa, cameraman and producer on behalf of Catholic Media Services, for their painstaking efforts.

We cannot over-stress our profound gratitude to our resource providers, cooperating partners and other stakeholders who have supported us over the years:

- The Government of Zambia, especially the MOH and MOE
- Royal Norwegian Embassy/Norwegian Agency for International Development (NORAD)
- The Canadian High Commission
- Southern African AIDS Trust (SAT)
- Christian AID

- HIVOS
- Catholic Relief Services (CRS)/RAPIDS
- Children International
- Zambia National AIDS Network
- United Nations joint programme for HIV and AIDS (UNAIDS)
- Changes II
- Regional Psychosocial Support Initiative (REPSSI)
- United Nations Children's Fund (UNICEF)
- Royal Netherlands Embassy
- Southern African AIDS Dissemination Services (SAfAIDS)
- Word Granny
- International Labour Organisation (ILO)/IPEC
- Community Response to HIV and AIDS (CRAIDS)

Once again, on behalf of the Family Health Trust Board, management and staff, we thank each and every person and institution for their role and support in seeing the Trust this far, in its duty of serving the community.

Prof Alan Haworth
Chairperson: The FHT Board of Trustees.

EXECUTIVE SUMMARY

The Family Health Trust was established and registered as a Non Governmental Organisation (NGO), in 1987. It was one of the earliest (if not the earliest) AIDS Service Organisations (ASO) in the country - established just few years after the first case of HIV/AIDS was diagnosed, in Zambia. Since then, the FHT has made appreciable progress and considerable contributions to health care service provision and response to HIV and AIDS in Zambia. Additionally, Trust has facilitated formation and development of a number of other ASOs in Zambia. These organisations, which at one time were 'babies' of the FHT have considerably contributed to success of the national HIV and AIDS response. One good example of such organisations is the Zambia National AIDS Network (ZNAN) which was supported and nested by the FHT for a number of years. We feel that the contribution of these organisations is therefore reflective of the FHT's good development support work.

***FHT's Vision and Mission Statements**:*

The organisation has the following Vision and Mission Statements:

Vision Statement: *"A nation free from the threat of HIV and AIDS"*

*M*ission Statement: *"To contribute to the prevention of the further spread of HIV/AIDS in Zambia and to the provision of an integrated care and support response to the infected and affected"*

In order to work towards the above vision and mission, the FHT has over the years set itself goals and objectives, and carried out activities that have assisted the community control further spread of HIV and enhance their quality of life. Operationally, FHT carries out its activities as an umbrella organisation of three (3)

programmess:

- **AIDS Action Programme (AAP) - formerly known as Anti AIDS Project:** An education for prevention project whose goal is to promote safer lifestyles among children and young people in order to contribute to the prevention of further spread of HIV and AIDS. The project targets youth and children, both in and out of school.

- **Home Based Care (HBC) Programme:** The goal of this programme is to facilitate provision of physical and psychological care to HIV/AIDS patients in their homes, in partnership with the community for improved quality care. This programme offers holistic clinical care, social support, counselling and nutritional support, among other aspects, to the infected and affected.

- **Children In Distress Programme (CINDI):** The goal of this project is to improve the quality of life of children in distress, in partnership with the community, to enable them to realize their potential. Recognizing the burden of orphan-hood and child vulnerability in general, this project helps to build capacity in families and communities to absorb the extra burden of care for orphans and vulnerable children.

The above projects are supported by an institutionalised monitoring and evaluation system under the Monitoring and Evaluation Unit. The organisation also has a strong Administration and Accounting Support Unit (AASU) to ensure necessary organisational support in the areas of finance, accounting, human resources; as well as providing guardianship for and enforcement of the organisation's policies, procedures and guidelines.

During these 20 years of its programming and continued institutional development, the FHT faced and overcame a lot of

challenges. The organisation weathered turbulent times, gained a lot of valuable experience including taking, sometimes difficult, strategic decisions and actions. The FHT developed strong institutional systems, including policies, values and practices; and acquired a culture of continuous learning. All of this has helped sustain the organisation and its programmes. In a country where a number of secular local NGOs have come and gone, not many NGOs can show an equivalent track record of perseverance, effectiveness and success. It has therefore become an organisation that other ASOs have looked up to for mentoring and capacity development support. Similarly, capacity development agencies have regularly counted on the FHT to provide mentoring support to, and lessons and lessons sharing with, other ASOs. For example, the Southern African AIDS Trust (SAT) has on a number of occasions called upon the FHT to provide mentoring and related support to SAT's partner organisations. Although the FHT has produced theme specific documentation of its work, there has been an expressed need, by other ASOs and capacity development agencies, that the FHT produces documentation about itself (i.e. about how the organisation evolved and developed) in order to share lessons with others.

Why document the FHT's experience?

The role of ASOs, NGOs and CBOs, in responding to HIV and AIDS in Zambia, is very significant. It is acknowledged that NGOs and CBOs took a key role in addressing the problem of HIV and AIDS in the country especially during the early stages of the epidemic. Even in later years when government has taken on the major role, the work of ASOs, particularly at community level, NGOs and CBOs still play a critical role in the success (or lack of it) of the national response. Huge amounts of financial and other resources have been allocated and disbursed to HIV and AIDS work. A lot of exciting results have been realised. Notwithstanding, concern has also been expressed at the

disproportionate ratio of disbursed resources versus performance (and ultimately expected impact versus realised impact). It has been noted that achieved results are far less than expected in relation to disbursed resources. Many NGOs and CBOs fail to sustain their programmes and fall by the wayside a situation that may imply resource wastage. Factors such as real motives and motivations for founding and running an NGO/CBO, its ethos, values, governance systems, personnel, how it plans and manages its institutional and programme development, have very strong bearing on its effectiveness and success. In FHT we believe through feedback from our stakeholders that we have exhibited a track record of good practice that has borne good results, outcome and contributed to desired impact. Most if not all of these good results came about through deliberate planning and efforts. We therefore feel privileged to be able to share our experiences with other organisations. Through this booklet and accompanying video/DVD entitled, "*Our Shared Hope and Commitment*", we hope:

- *To document the FHT's 'life story' for the purpose of not just enhancing preservation of an institutional memory but also providing lessons for sharing with other AIDS Support Organisations.* The publication reflects on the founding, development and growth of the organisation. During that period, we experienced difficult and challenging moments. That information might be useful to other organisations, especially up-coming ones.

- *To promote Effective interventions and approaches:* Over the 20 years of our existence, we have tried a number of approaches and interventions. For considerable part of the time, national policies, guidelines and procedures were not available to guide us. This was because we started our work right at the beginning of the HIV/AIDS epidemic, and everybody was still trying to learn and understand the epidemic. Through practical, evidence-based approaches and interventions that involved key stakeholders like government, communities and beneficiaries, themselves, we found our work bearing positive results and outcomes in the communities we serve. We therefore feel duty-bound to share our work with others.

- *To share what we consider as "Good Practice" from our experience:* Over the last 20 years, we have consistently tried and implemented quality, relevant, life-saving and effective interventions, in a participatory and accountable manner. While attainment of perfection is utopian, this effort has benefited our intended beneficiary communities. Based on performance, accountability and trust, we have been able to maintain long term relationships with our key stakeholders. Here too, we feel duty-bound to share this experience.

We hope this booklet lives up to its intended purpose, and that you find something useful from it. Enjoy your reading.

John N. Munsanje
Executive Director - FHT

SECTION 1

Pupils of St. Joseph's Girls High School (Chivuna, Monze) watching an AIDS Action Club performance in 2005.
Girls between the ages of 15 to 25 years are especially vulnerable to HIV

1. INTRODUCTION

What is Family Health Trust (FHT) and what does it do?

The Family Health Trust is a not-for-profit Non-Governmental Organisation that provides a comprehensive response to HIV and AIDS in Zambia. Comprehensive response means a holistic combination of interventions that include prevention, care, support and impact mitigation. It does this through its Home Based Care (HBC) programme, AIDS Action Programme (AAP) and Children in Distress (CINDI) programme. The HBC programme also facilitates treatment through provision of nutritional, psychological and social support to PLWHA who are on Anti Retroviral Treatment (ART).

FHT envisions an AIDS free society; as noted from its mission statement which is to contribute to the prevention and control of further spread of HIV and AIDS, and provision of care and support response to those infected and affected.

The Family Health Trust was established in 1987 for the purpose of responding to HIV and AIDS in the country. At that time, the HIV and AIDS epidemic was still in its very early stages, only 3 years after the first HIV case was diagnosed in Zambia. The FHT is evidently the first AIDS Support Organisation in the country. The organisation was registered 1 year earlier than Copperbelt Health Education Project (CHEP) and 2 years earlier than Kara Counselling and Training Trust (KCTT). CHEP and KCTT (popularly known as Kara Counselling) are two of the oldest and most established local AIDS Support Organisations (ASO) in the country.

Twenty years on, the Trust has scaled up its work to many parts of Zambia and became a house-hold name within the health service and even beyond. It directly runs programmes in 4 provinces of

Zambia – Central, Eastern, Lusaka and Southern – covering 18 selected districts. Indirectly, through franchise of its Children in Distress (CINDI) programme, and the AIDS Action Programme (AAP) approaches, the FHT has managed to cover the Copperbelt province as well. The FHT's monitoring statistics indicate that the organisation was supporting more than 5,900 people on its HBC programme covering 9 districts namely Chibombo, Chongwe, Kabwe, Kafue, Kapirimposhi, Luangwa, Lusaka, Mumbwa and Mkushi, at close of quarter ending September 2007. The CINDI project was directly supporting a total of more than 5,600 orphaned and vulnerable children in over 1,500 households in the districts of Chipata, Katete, Petauke, Nyimba, Lusaka, Mkushi, Kalomo and Monze by the end of the same reporting period. Through its AIDS Action Clubs based in primary, secondary and tertiary institutions of leaning, formerly known as Anti AIDS Clubs, the Trust provides HIV and AIDS prevention messages and strategies that reach hundreds of thousands of youth countrywide, every year. Detailed narration on each of these programmes is provided in the respective parts of this booklet.

…The FHT provides HIV and AIDS prevention messages and strategies that reach hundreds of thousands of youth countrywide, every year.

One does not have to look far or for long before finding people in the community who fondly speak of the FHT as the organisation that has helped them prolong and improve the quality of their lives in the face of HIV and AIDS.

Mrs Dorothy Mukuka Bwalya, widow, mother of six and member of FHT HBC Group – Chunga asserts, "I am very grateful for what our parent organisation, FHT has done for me and my family. When I discovered that I was HIV positive in 1997, I was devastated. But the FHT Lusaka Home Based Care took very good care of me till I became well again. It took about 2 years for me to come round, and throughout that period, FHT was always there for me. When I got well, I decided to join the programme as a care giver. Through FHT I acquired counselling skills and income generation skills like making door mats, sewing and tailoring among others. Now my friends and I have teamed up together and formed Steadfast Support Group, as part of the Chunga HBC. We provide care to 144 clients as of now, and we run a community school for OVC here in Chunga."

It is not difficult either to find evidence of how the FHT's work has contributed to the national response to HIV and AIDS. FHT has initiated, nested and mentored a number of organisations that are themselves major implementers in the response to HIV and AIDS in the country today.

"…We are happy to note that FHT worked closely with government right from the organisation's inception. FHT contributed significantly in the establishment of the National AIDS Council; in the formulation of national guidelines, especially on care, among other areas. As former Minister of Education, I am very aware of, and appreciate, the contribution that the FHT has made in terms of facilitating prevention. I am talking about the AIDS Action Clubs that FHT introduced and supports in our schools all over the country…". – Hon. Brig. Gen. Dr. Brian Chituwo (rtd) - Minister of Health.

At international level, FHT is a regular contributor to many fora of learning and sharing of good practices. The organisation has developed and produced high class material and human resource that is providing a significant contribution to the global HIV and AIDS response.

"I owe all my learning and experience, in as far as HIV and AIDS

work, to FHT. I am a Social Worker by profession, but before I joined FHT, I had no HIV and AIDS experience. So, I am what I am today in this field because of FHT, and I am very grateful…" – says FHT first Executive Director - Mrs. Elizabeth N Mataka: Executive Director Zambia National AIDS Network (ZNAN); Deputy Chairperson, Global Fund for HIV/AIDS, Tuberculosis and Malaria (GFATM); UN Secretary General's Special Envoy on HIV and AIDS in Africa.

But how did FHT, an organisation with such a record of achievements, meaning and, logically, life ahead of it, come to be? Who were the people behind formation of this great organisation? What motivated its initiators and what were their intentions then? What challenges has FHT experienced along the way, how did it handle such challenges? What lessons can be reflected upon and learned from the FHT story?

This booklet aims at addressing such questions and providing further information. We hope you will find the reading interesting, and the contents helpful.

FHT HOME BASED CARE TEAM
POSING FOR A PICTURE IN NKOLONGA, MKUSHI

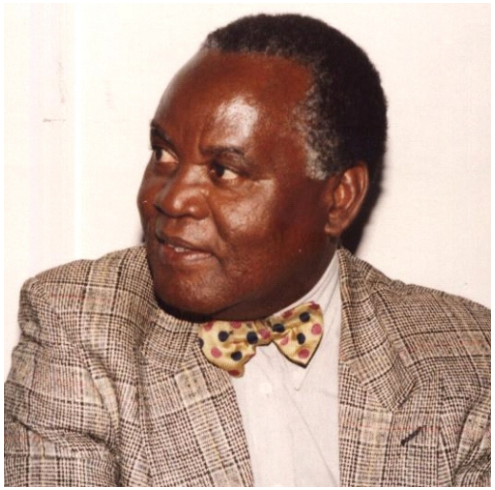
2. THE BIRTH OF FAMILY HEALTH TRUST

A traditional old adage says, "*Ideas transform an ant-hill into a mountain"*. True to this saying, Family Health Trust (FHT) was born out of concern and ideas of a group of friends. The ideas of these friends resulted into formation of a small Lusaka-based project in 1987, which eventually grew into the big organisation it is today.

Conception of FHT

Located along Great East Road, about 15 kilometres from the central business area of the city of Lusaka was a farm known as Walk-Over Estate, producing fresh vegetables and strawberries for the local and export markets. One of the shareholders of Walk-Over Estate was Dr. Guy Scott, then working for Oxford University in the United Kingdom. One of Dr Scott's staff back home in Zambia had AIDS and later died. One afternoon, in 1987 or slightly before that year, Dr. Guy Scott, on vacation from Oxford University, had invited friends over for lunch at the farm. The friends included Dr. Roger Chongwe, and Professor Alan Haworth. Others at the 'Walk-Over Estate lunch' that day included Mrs. Sardanis, Mrs. Chongwe and Dr Barbara Wood (then an intern at UTH), each of whom later played a key role in the establishment of the FHT. That afternoon, the concern about the cancer-like illness, AIDS, that was seemingly gripping society with ferocity in Zambia, became the dominant subject of the social conversation. Even at that stage of the AIDS epidemic, almost each one of the people gathered at Walk-Over Estate that afternoon knew of someone who was dying or had died of "the disease"! Dr. Chongwe recalled, "We realized that not much was known about HIV then, but its devastating results were all very clear for anyone to see. And from the estimations and statistical projections that Dr. Guy Scott and Professor Alan Haworth shared with us of how the problem would become if nothing was

done about it, everybody was convinced that we needed to do something about it immediately. But what, and how"?



DR. RODGER CHONGWE

PROF. ALAN HAWORTH

Unfortunately, not much seemed to be done about the new problem then. Why? "Because HIV/AIDS at that time was "taboo"; nobody was to talk about it! The Government then preferred to keep quiet about HIV/AIDS in Zambia, fearing that bringing the problem to the fore would scare away tourists, among other perceived possibilities. The Ministry of Health then wanted to have tight control over HIV/AIDS", remembered Professor Haworth.

"The hope of government at that time was that the "new disease" would eventually disappear. But this was not to be! "…Even as we committed ourselves to doing something about the problem, we too never thought HIV/AIDS was to become so awful and to such an extent as it is now! I thought it was to be a small task. The reality became pronounced as time went by. In 1987 a friend of mine, a Zambian artists died of AIDS. The need to address this problem became very urgent in my mind. Clearly, the decision taken by the group of friends at Walk-Over Estate, to do

something about the problem was a very noble one", reflects Mr. Andrew Sardanis.

That afternoon at Walk-Over Estate, the social conversation ended in a decision by the group Dr. Guy Scott, Dr. Rodger Chongwe and Professor Alan Haworth - to start a project that would help families and communities in Zambia to address the problem of HIV and AIDS. So, the idea to establish the Family Health Trust was conceived, from a social conversation, that very afternoon.

Mr. Andrew Sardanis, a businessman running an Africa-wide corporation at that time, was also very concerned about HIV and AIDS. He had just lost a close friend, a celebrated Zambian artist, to AIDS. Mr. Sardanis therefore joined the initiative and became the fourth member of the founding team of the FHT.

Inception of FHT

A small committee AIDS Surveillance Committee - was set up at the University Teaching Hospital (UTH), to look into developments relating to HIV/AIDS. This was a major help.

"The choice of the name '*Family Health Trust*' for the new organisation was very fitting because HIV affects not only individuals, but families," notes Professor Haworth.

Soon a Steering Committee for the proposed project, agreed upon at the Walk-Over Estate lunch discussion, was set up. There was an immediate challenge - the committee had no money. Mr Andrew Sardanis and Dr. Rodger Chongwe donated K39,000 and K9,000 respectively, towards setting-up costs. That was substantial amount of money in 1987 since the Zambian Kwacha had a lot of value then.

The legal task of registering the newly conceived organisation was an easy one, given that the 'founding fathers' had a lawyer among them Dr Rodger Chongwe. Nevertheless, the task still had challenges. The initial major challenge relating to registration of the organisation was the noted silence on HIV and AIDS by government. It was understood that government preferred to handle the problem of HIV and AIDS quietly, and therefore would not grant permission to register an organisation that would take the lid off this problem and unnecessarily alarm the nation, as it was perceived. To get round this challenge, the founders decided not to mention HIV and AIDS anywhere in the constitution, which was drafted by Dr Chongwe. “Since it was a taboo to talk about HIV and AIDS those days, we decided not to use 'HIV/AIDS' but the term, '*chronic and cancer related illnesses*' in the charter. However, in the Articles and Memorandum of Association, we outlined the symptoms, without mentioning, HIV and AIDS.

Much as Dr. Chongwe, the legal mind for the founding team, was available, he did not have much flexibility to do logistical ground work. So it was decided that another lawyer be gotten on board. So, Ms. Kay Turner, who later became Professor of Law in New Zealand, joined the team and worked on the legal tasks with Dr. Chongwe. Kay Turner did a lot of foot-work. The Family Health Trust was eventually registered as a company limited by guarantee (not-for-profit charitable organisation) on August 6, 1987, under the Companies Act. We chose not to register under the Societies Act, due to limited freedom under this act.

“We knew that donors would be willing to help Zambia in the fight against HIV and AIDS, but there was no channel through which they could work. So, establishing and registering the Trust created a vehicle through which donors could work. …The challenges were many. For instance, most people at that time doubted the reality of HIV/AIDS. So, the Family Health Trust had to figure out how to deal with this doubt and that was a big challenge”, recalls Dr. Scott.

None of the founders had any idea about how long the HIV and AIDS problem was going to last. They only hoped a lasting solution was to be found soon, so that many people did not have to continue suffering the way some already were.

But what exactly did the founders have in mind when they established the Trust? For how long did they think the new organisation would remain relevant and necessary? What challenges did the work of the FHT encounter at the very start and how were these challenges handled? The next chapter sheds light to these questions.

3. DEVELOPMENT AND GROWTH OF FAMILY HEALTH TRUST

So the Family Health Trust was registered at last, but had no office accommodation, no transport, and no staff only volunteers, most of whom were professionals with full-time jobs or businesses. The founders were however determined to work with what they had. Mr. Andrew Sardanis offered a temporary office to FHT at Horizon House. Mrs. Chongwe and Mrs. Fern both of whom were running Zintu Craft Centre at the then Ridgeway Hotel, provided a vehicle to Ms. Kay Turner to coordinate activities of the FHT. Meetings of the organisation used to take place at Mrs and Dr. Chongwe's house.

Home Based Care (HBC) starts in Lusaka - 1987

Mainly due to logistical challenges, the FHT struggled to design and implement appropriate programmes and activities for their interventions. One other significant challenge was the lack of policies, guidelines, or procedures relating to HIV and AIDS at that time. However, through its wide pool and network of volunteering professionals, the FHT took up the challenge and saw itself as a factor in working with government to bridge the gaps. Things were eventually falling into place. Ms. Virginia O'Dell, an American close colleague of Professor Anne Bailey who was working for the University Teaching Hospital (UTH) at that time, was carrying out research into the impact of AIDS on families. Ms Virginia O'Dell soon realised that something needed to be done. She therefore started a Home Based Care (HBC) Programme at the UTH in Lusaka. The programme was mainly a referral and follow-up service for chronic patients who were discharged from the hospital, but still needing care and support. The health care delivery system had already started showing signs of buckling under the burden caused by HIV and AIDS. It was at this time also that Professor Haworth had started working closely with Prof bailey in establishing counselling for these patients.

The establishment of the Family Health Trust was therefore seen as a good opportunity to have patients followed up and cared for in their homes, thereby reducing the burden on UTH. Consequently, through the facilitation of Professor Bailey, an arrangement was made between UTH and FHT in which the latter was given a room in the “G” block of UTH and allowed to operate within the hospital fee of charge. Here we see the first collaborative relationship between a government institution and FHT. A win-win relationship in which a government institution outsourced service delivery to an NGO and the NGO provided a service within the premises of a government institution without having to pay rent. The Lusaka FHT Home Based Care was therefore born in 1987.

First Grants and Support Come FHT's way

The founders of the FHT shall not forget the first donations that came their way in 1988. These came from the Royal Norwegian Embassy and the Canadian High Commission.

The FHT received its first donation a small grant and an Amstrad desk-top computer from the Ambassador's Grant of the *Canadian High Commission*. Small though it may have been, the grant and computer donation was very strategic to the FHT. The same year, more blessing followed. *NORAD* through *Royal Norwegian Embassy* signed a grant agreement with the Trust to provide funding for 3 years, renewable!

The FHT Teams up with Dr. Kristina M. Baker on Anti AIDS Clubs (AAC) in Schools - 1987

Dr. Kristina Baker, then a newly qualified medical doctor, intern at UTH and newly married to a school teacher of David Kaunda Secondary School (fondly known as DK) was asked by her husband to give talks on HIV/AIDS to students at DK. This was out of realization of the amount of exposure to HIV and AIDS young people were experiencing, following a simple survey conducted at DK. Appreciating the gravity of the problem and realizing the need to act, students at David Kaunda found it necessary to start a club through which they could meet regularly, be addressed by Dr. Baker and learn about HI and AIDS. The club was called Anti AIDS Club (AAC).

Soon, other schools asked to have the service extended to them and Dr. Baker found herself running a programme from her back-garden! Through the Anti AIDS Clubs, messages and information about HIV and AIDS, promoting abstinence and behavioural change strategies were disseminated among school going children and youth through regular newsletters. As the project grew larger and larger, and with help from Professor Haworth, Dr Baker decided to ask the Family Health Trust to take up the running of the programme. The Trust gladly agreed. So in 1987, the Anti AIDS Project was adopted by the FHT.

Kara Counselling and Training Trust is born and teams up with FHT

The year 1987 was full of initiatives and activities as far as HIV and AIDS work was concerned. Having just returned from sabbatical leave and post graduate studies, a Catholic Jesuit priest, Reverend Fr. Michael Thomas Kelly (not the professor from UNZA) was concerned about the threat of HIV and AIDS in Zambia. Moved by wastage and loss of friends as well as people

he knew to HIV related deaths, Fr. Kelly, encouraged by Fr. Dick Cremins, decided to establish an organisation that was to offer counselling and psychosocial support to people infected and affected by HIV. But he had difficulty in gaining MOH support then. Working through an existing organisation, for the time being, seemed to be the most feasible strategy of ensuring that counselling and psychosocial support was made available to those in need of the service soon. Fr. M.T. Kelly considered the Family Life Movement (FLM) a Catholic organisation, but because FLM was not particularly focused on HIV and AIDS, the priest decided to team up with FHT in 1988. As a trained psychotherapist, Fr. Kelly had already started working closely with Professor Haworth at Chainama, by then. So he approached Professor Haworth regarding the FHT. The trustees agreed that Fr. Kelly's project operate under the aegis of the FHT.

A very resourceful and effective worker, Fr. Kelly managed to find a building called Kara House on Chachacha Road in Lusaka which would serve as a base for the programme he was developing. The FHT had now found the location of its own office offered by Fr. M.T. Kelly. In 1989, Fr. Kelly managed to have an independent organisation, Kara Counselling and Training Trust, popularly known as Kara Counselling, registered as an independent company limited by guarantee (a charitable not-for-profit organisation), under the Companies Act. Hence, the first institution offering counselling service in Zambia came to be.

The work of the FHT and Kara Counselling was boosted by government support since the Ministry of Health established the Counselling Services Unit, and Professor Haworth was appointed as its first Director in 1989. As their programmes were scaling up, soon space was not sufficient to accommodate both organisations at Kara House. The Family Health Trust moved out from Kara House to its own rented premises on Broads Road off Great East Road in Rhodes Park. Later, the Trust managed to find its own property its current head office on Makishi Road in Fair View area of Lusaka, in 1991.

CINDI (Children In Distress) Project is Established - 1989

While the HBC programme was doing good work, the FHT soon realized the anguish and distress that HIV and AIDS was bringing upon children. It must be appreciated that in the early stages of the epidemic, there were few children living with HIV. However from a survey conducted in Matero east in 1989 by teachers who were FHT volunteers, it was established that children underwent a lot of distress as a result of HIV and AIDS. The survey established that even before their parents or guardians died of AIDS, children started grieving and anguishing - watching their parents and guardians suffer due to AIDS. The Trust decided to act on this evidence, taking into consideration the need of children who were non-orphans but vulnerable due to various reasons, as well. A project called Children In Distress (CINDI) was therefore established in Lusaka in 1989 the youngest of all the three major programmes of the FHT.

FHT Appoints Its First Executive Director

One of the major steps and turning points in the history of FHT was the appointing of its first chief executive, who was going to marshal further work and development of Family Health Trust.

With Dr. Kristina Baker and Ms Kay Turner leaving Zambia and therefore not available, the Family Health Trust Board, headed by its first Chairperson, Dr. Rodger Chongwe, saw it necessary to recruit a full time person to run the FHT. It was clear from their interactions with potential donors that a full-time chief executive would enhance the likelihood of FHT getting funds from donors. It was therefore decided that the job be advertised, and so it was.

Among the applicants, came a social worker. A lady who had worked for government of Zambia, as a civil servant for some years. She had later left the civil service to run her own restaurant

business in a building belonging to the Central Statistical Office, near the UTH. She was Mrs. Elizabeth N Mataka. Concerned that she had had no NGO and HIV/AIDS work experience before, one of the interviewers asked if she would manage in this prospective job! “I am a Social Worker, I can learn”, was the response from the interviewee who, eighteen years later, became Vice Chairperson of the Global Fund and UN Secretary General's Special Envoy on HIV/AIDS in Africa. So Mrs. Mataka took up the appointment in 1988.

MRS. ELIZABETH N MATAKA
FIRST E.D. OF THE TRUST

With an Executive Director in place, the Board of Trustees of the FHT provided enough guidance and support to the management team through the Executive Director, but limited themselves to their role of ensuring that systems including policies and governance of the organisations were in place and implemented. They provided sufficient latitude to the executive director and her management team to do the day-to-day functions and move the organisation forward. Mrs. Mataka recalls that the Trust worked with a large number of professionals from the Ministry of Health Springbok House such as Dr. Ben Chirwa who was then Health

Education Specialist and later became head of the HIV/AIDS Unit.

At that time, systems for working in the HIV and AIDS field were not developed, so the FHT had the challenge of developing its organisational systems as well as being part of the teams that were working on national systems. Donors also did not have experience in providing support to NGO working in the AIDS field. So winning donor confidence was a critical challenge. Tribute is paid to NORAD for being the first donor agency to provide long term grant to the FHT. The trust is very grateful for the support from NORAD as well as that which later came from other organisations.

The FHT sees the period from 1988 through 1990s as the phase of organisational and programmatic development. During this period, the Trust:

- Prepared appropriate target-group specific prevention materials. Youth have always been considered as the strategic target group. Care, support and mitigation interventions were also developed and implemented, amidst continual learning.

- Was flexible to make changes where necessary. In some cases renegotiations had to be entered into with donors to ensure that necessary adjustments were allowed in order to meet the evolving needs responding to the dynamic HIV and AIDS epidemic. Tribute is paid to the Board of Trustees and resource providers for allowing that flexibility.

- Developed its organisational systems, including for financial and administration functions. For the first 10 years the organisation relied on out-sourced Finance and Accounting services. The organisation set up its own Administration, Accounting and Support Unit in 1997 when it recruited its own accountant, who later also took up the headship of administration and human resources functions.

- Developed programming systems that included those for monitoring and evaluation. The systems have been undergoing continuous improvement, as the Trust acquired increased resources, including knowledge and skills.

- Developed and worked within the framework of three-year strategic plans which were regularly reviewed.

The period of 2000 – 2007 has been a period of scaling-up and consolidation. Coverage and quality of services were being scaled up; while consolidating and strengthening systems (developed during the first 10 years) that supported the organisation's work. For example, the Accounting and Administration Support Unit was strengthened through additional staff, up-skilling and multi-skilling of personnel as well as ensuring adequacy and documentation of policies and procedures. One example of multi–skilling of personnel was that of the accountant, Mr. Harrison Chibale who was supported to acquire training in human resource management. This was a strategic move. Mr. Chibale has been able to combine headship of the accounting, administration and human resource functions. This development has enabled the organisation to save on cost relating to maintaining another management position to head administration and human resource functions.

MR. CHIBALE

During this period, the Family Health Trust made strides to reach more districts with support from existing and in-coming resource providers. The following section provides more information on the level of

organisational and programming progress of the Trust towards the end of 2007.

The Zambia National AIDS Network (ZNAN) is Born and is Nested by the Trust

Through the initiative of a number of ASOs, and leadership of Mrs Mataka, the Trust's Executive Director, a network that would support, coordinate and promote work of member ASOs in Zambia was conceived and established in 1994. The Zambia National AIDS Network (ZNAN) was also registered as a member of Southern African Network of AIDS Service Organisations (SANASO). Since the newly registered ZNAN had inadequate organisational capacity and funding, the FHT took up the task of housing it and providing necessary organisational support, until 2003 when ZNAN was able to stand on its own.

SECTION 2

IN-SCHOOL YOUTH PEER EDUCATION: PART OF THE CROWD OF HANAMAILA BASIC SCHOOL PUPILS WATCHING PEER EDUCATION PERFORMANCE AT THEIR SCHOOL, CHISEKESI, OCTOBER 2005

4. THE FHT 20 YEARS ON: INTERVENTIONS, APPROACHES,ACHIEVEMENTS AND CHALLENGES

Twenty years from inception the vision, mission and values of the FHT remain basically unchanged, as HIV and AIDS still persist. The organisation has intensified and scaled up its work. It now works in 18 selected districts, spread in 4 provinces of Zambia. These districts are Lusaka, Kafue, Luangwa and Chongwe in Lusaka province; Monze, Choma, Kalomo, Gwembe and Mazabuka in Southern province; Nyimba, Petauke, Katete and Chipata in Eastern province; and Chibombo, Mumbwa, Kabwe, Kapirimposhi and Mkushi in Central Province.

The FHT employs a total of 45 full-time staff, supported by a large pool of community volunteers carrying out activities in the communities. The organisation's mission is delivered through 3 major programmes.

4.1 *Home Based Care Programme (HBC)*

With the goal of facilitating provision of physical and psychological care to HIV/AIDS patients in their homes, in partnership with the community for improved quality care, this programme offers holistic clinical care, social support, counselling and nutritional support, among other aspects, to the infected and affected. The FHT carries out its Home based care within the framework of the national Public Health.

In the first 15 years of the Trust's existence, Home Based Care was only provided in Lusaka. This programme was later extended to 7 other districts Kafue, Chongwe, Luangwa, Chibombo, Mumbwa, Kabwe, Kapirimposhi and Mkushi. In each of these districts, the catchment area is divided into zones. Each zone has a team of community volunteers through whom various activities and projects are implemented, such as:

- Food Supplementation to needy patients, especially those on ART: The Trust receives food stuffs from various resource providers. These foodstuffs are distributed on regular basis from the warehouse to clients in the various districts and communities.

- Voluntary Counselling and Testing (VCT): The service was integrated into the HBC programme in 2003. This move has improved the comprehensiveness of the programme, making it more of a one-stop-shop for clients.

- Clinical care, physical and social support: Community care givers are trained in basic care giving skills, including ART support. The care givers also carry out activities such as cleaning patients and simply being there for them in order to facilitate the needed social reinforcement.

- PLWHA Support Groups; IGAs and Distribution of Insecticide Treated Mosquito-Nets (ITN): the programme supports PLWHA to run IGAs, such as knitting, gardening, trading, among others, as a means of livelihood support as well as therapy. This mentoring and capacity development is in addition to training of HBC service providers that the trust carries out on an on-going basis.

During the period between December 2006 and September 2007, the Trust trained 600 community ART monitors. By the end of September 2007, the HBC programme had 5,379 clients on its registers, an average of 672 clients per district. The programme also mentored 22 community groups through which service delivery is facilitated to the community. Besides helping prolong and improve the quality of life of clients, one of the outcomes of the HBC programme has been reduction of HIV related stigma

and increased access to VCT and ART. The example below is one of the many indications of this development.

"Now, people know that we HBC care givers can help them here in the compounds; they even come to our homes or call us to go and see them so that we help them get VCT or ART. Before this programme, everyone was hiding and did not want to come in the open that they had HIV; but now things have changed, they are better". …said Mrs Hilda Mwabila, Chunga HBC member.

The programme does have challenges. Some of these challenges include inadequate transport and not having offices and even staff in most of the locations where the programme operates. Various partners in those locations, such as Katondwe Mission hospital in Luangwa district, the DHMTs and local churches (based on mutual trust born out of mutual commitment and performance) have provided coordination on behalf of the FHT. The collaboration approach has enabled the Trust to scale-up its national HIV response at limited overhead costs.

A HOME BASED CARE-GIVER ATTENDING TO A CLIENT IN LUSAKA

HANDING OVER A 25Kg BAG OF MEALIE-MEAL
TO A CHILD-HEADED HOUSEHOLD IN LUSAKA

4.2 *AIDS Action Programme (AAP)*

AAP is an education for prevention programme whose goal is to promote safer lifestyles among children and young people in order to contribute to the prevention of further spread of HIV and AIDS.

The programme targets children and youth, both in and out of school primary, secondary and tertiary institutions - countrywide. More than 2,600 schools and learning institutions are supported by this programme.

The programme runs the following projects/activities:

- AIDS Action Clubs (AAC): Formerly called the Anti AIDS Clubs, are school-based or learning institution-based project in which pupils or students form and run a club within the institution through which HIV and AIDS issues, and information are gathered, studied and shared. The main aim is prevention. Through this initiative, young people are supported with strategies such as assertiveness, life-skills and knowledge necessary to promote healthy life styles. Through close partnership with the Ministry of Health, this programme has had wide coverage in schools during the 20 years since 1987. Several hundreds of thousands of children and youth are reached with prevention information and strategies countrywide, every year.

  This information has helped young people to try and prevent HIV infection, as noted from Chipo Munyama below (one of the many youth who benefit from the initiative.

  "*We learn a lot from the AIDS Action Programme. For example we learn that if one as HIV/AIDS, they can go for treatment and receive ARVs. For prevention one can use condoms. One may abstain from sex if they can with abstinence, there is 100% protection",* Chipo Munyama, teenage grade 12 school boy, 2007 Monze Basic School.

- Mobile Video Services: The use of mobile video services was initiated twenty years ago when one of the founders, Dr. Rodger Chongwe, donated a caravan to the Trust for purposes of taking HIV and AIDS education to the door-steps and market places of residents in the community. Twenty years on, the FHT still uses this strategy to provide free video and audio services on many aspects relating to HIV and AIDS, accompanied by questions and answer and plenary discussions. This has been a powerful and effective strategy.
- Peer Education Services: Young people who volunteer are trained as youth counsellors and educators. They later educate other youth peers - in various aspects of HIV and AIDS. This service is run in schools and out of schools in the communities.

- Youth Friendly Health Services: Working in collaboration with local health centres and clinics, the FHT runs sexual and reproductive as well as general health services especially for youth in dedicated rooms or space within those clinics and health centres. Youth counsellors and educators provide counselling, information and sometimes VCT to their peers.

- Drop-in Knowledge Network Centre: This facility is mainly found at the head office in Lusaka, but the Trust is making arrangements to have the facility available in all their centres in the districts. Secure rooms equipped with computers connected to internet are provided. Youth can access the internet to interact and learn at no cost to them. The Trust is aware of the risk of youth accessing inappropriate materials, and facilitating and supervising staff are always present.

- Information, Education and Communication (IEC) material production and distribution: The Trust has for many years been producing newsletters, leaflets, and books mainly targeted to youth, but also to the general public. The first publication was the *Anti AIDS Club newsletter* in 1987. A number of other publications followed. *"Dr. Kalulu"* is one famous publication that has been providing HIV and AIDS education in Zambian communities from the late 1980s throughout the twenty years of the Trust's existence. The publication is now available in 7 major Zambian languages Bemba,

Kaonde, Lozi, Lunda, Luvale, Nyanja and Tonga. The Trust also published 2 books *'Happy, Health and Safe*"; as well as *"Life and Living"* the former targeting young people in club activities and the latter targeting further guidance on sexual and reproductive health as youth reach sexual maturity.

Through the above services, the AAP has contributed considerably to the national AIDS response by widespread dissemination of information. With support from this programme a number of other organisations were established, mentored and weaned off. An example of such an organisation is Simalelo AIDS Prevention Project (SAPEP). SAPEP has its head office in Mazabuka. It is mainly offering prevention interventions, operating also in Monze; SAPEP has plans to scale up to other districts. Mr. Wilson Nyirenda, Executive Director of SAPEP, says his organisation owes much of its success to the FHT's mentoring and sharing of approaches.

OUT-OF-SCHOOL YOUTH PEER EDUCATORS PERFORMING IN THE COMMUNITY

4.3 Children In Distress Programme (CINDI)

The goal of this project is to improve the quality of life of children in distress and enable them to realize their potential, in partnership with the community. Recognizing the burden of orphan-hood and child vulnerability in general, this programme works to build capacity in families and communities to absorb the extra burden of care for orphans and vulnerable children. CINDI operates in all the 4 provinces in which the Trust has physical presence. Although the programme operates in both rural and urban areas, rural populations have been underserved by the national response to HIV and AIDS over the years; yet they bear the harshest brunt of the pandemic's impact. Some of the interventions like agricultural support are in rural areas where land is available have therefore been prioritized.

The programme has several components:

- Scholastic Support: Through this initiative, OVCs are supported with school requisites such as stationery, text books, as well as basics like uniforms, and shoes. Vulnerable children including orphans

- Livelihood Support to OVC Households: OVCs and their economically poor households are supplemented with support to meet their basic needs. Items like food stuffs, blankets and other items are provided. The Trust also helps beneficiaries with agricultural inputs such as seed and fertilizer so that beneficiaries can try and achieve food security.

LIVELIHOOD SUPPORT: OVC RECEIVING BLANKETS FROM CINDI DURING 2006 COLD SEASON PETAUKE,

LIVELIHOOD SUPPORT: PART OF MAIZE FIELD BELONGING TO AN OVC HOUSEHOLD SUPPORTED BY CINDI IN CHIKHUTU VILLAGE, KATETE (2003/2004 SEASON)

- Economic Empowerment: Other than just providing hand-outs, the programme encourages economic empowerment initiatives such as rearing of pigs, and goats, trading as well as other strategies relevant and appropriate for a particular community and/or grouping. Beneficiaries are provided with grants; but they are also encouraged to raise some capital from among themselves. An initiative called the **Savings and Loan Association (SLA)** has been introduced by CINDI into some communities. Members of a particular community group themselves into an association. The CINDI project supports them draft a set of rules and regulations guiding their association. Every so often, say weekly or monthly, each member puts an amount into the association's coffers. In time the money grows and members of the association are able to access soft loans to enable them finance their intended economic venture, and pay affordable interest upon repayment.

- Child Protection: Due to many factors including traditional practices, socio-economic disparities among people in the community, and simply unjust tendencies among some people, a number of orphaned children and those from extreme poverty circumstances find themselves working as domestic help actually slaves in many parts of the country. Others find themselves being victims of many forms of abuse including physical and sexual abuse. A number of children have missed opportunities for schooling as a result of this situation. It is the policy of CINDI to protect children from such abuse and forced labour child labour. It also withdraws those that are already in such circumstances. If such youth are too old to start schooling, CINDI facilitates skills training for them such as carpentry and other craft work.

YOUTH WITHDRAWN FROM CHILD LABOUR RECEIVING SKILLS TRAINING IN CARPENTRY AT CHIMASUKO CINDI CENTRE IN KATETE - 2002

For purposes of flexibility in re-integrating vulnerable youth into school, the FHT found it necessary to construct community schools. One such example is the **Nyembe Community School**, in chief Bangombe's area, Katete district. With financial support from Children

International, this school was built and commissioned in 2002. At an appropriate stage, children from this community school are re-integrated into the mainstream national educational system.

Lack of, or limited access to, healthcare services has a severe negative impact on children and women. This is especially the case in rural areas. For that reason, the Trust also found it necessary to supplement government efforts in facilitating access to health care delivery services. It decided to construct and run community clinics and health centres. One example of such clinics is the **Kafunka Clinic**, also in Katete. The clinic serves about 30 villages in a radius of about 20 km, with a total population of about 9,000 people. Kafunka clinic attends to about 60 patients per day, 50% of whom are children.

A COMMUNITY SCHOOL UNDER CONSTRUCTION AT NYEMBE VILLAGE IN CHIEF BANGOMBE'S AREA,

- Counselling and Social Support: Counselling and social support are provided to children and youth that have undergone the trauma of orphan-hood, and abuse. Guardians and relatives of such children may also receive support.

In addition to the head office, the CINDI Programme has two major offices: Chimasuko Centre in Katete, Eastern province and Kalomo in Southern province which also act as coordination points for CINDI programme. Although these centres were started exclusively to focus on child interventions, it was later found necessary to include other programmes. These centres are therefore a hive of community activities and serve as community development centres in their districts. For example, Chimasuko Centre coordinates activities for all other activities in the district, including Kafunka clinic and Nyembe community school.

The Trust also carries out complementary programmes like the Gift-In-Kind project.

4.4 The Gift-In-Kind Project (GIK):

This a nationwide textbook distribution project started in July 2001 with the support of Children International. Between 16 to 20 containers with approximately 16,000 text books per container, are shipped to the FHT by Children International every year. These books are suitable for a wide range of target groups in: day-care centres, primary, secondary and tertiary educational institutions. A notable gift was made of new medical and scientific text books, valued at US$750,000. They were donated to the MOH and Health Training Institutions. Distribution of these text books is through network members, schools, Ministry of Education, Community School Secretariat, Community leadership and district councils/local authorities.

4.5 Governance

In delivering the above programmes, the FHT has a strong governance system that ensures good institutional governance and checks and balances. The structure comprises a Board of Trustees, Executive Director, management committee as well as

departmental and functional units.

The Board of Trustees is the highest governance and policy making body of the organisation. It comprises men and women from different walks of life the Trust tries to ensure balance of women and men on its Board. By having people of various professions, such as medical and health experts, legal, accounting and financial professionals, educationists, social scientists and community representatives on the Board, the Trust ensures provision of organisational guidance that has wholesome cross-pollination of ideas and expertise. Membership of the Board is on self-perpetuating basis, but tenure of office and conduct of members are regulated and well stipulated in the constitution of the Trust. The Chairperson presides over the deliberations of the Board. Other office bearers include Treasurer, secretary and a number of other Trustees. The Board has provision for quarterly meetings in a year; but may meet to deliberate specific matters as need arise.

Except for Dr. Guy Scott and Mr. Andrew Sardanis, the other founding members of the Trust Professor Alan Haworth and Dr. Rodger Chongwe still serve as members of the Board, availing the needed institutional memory, besides a wealth of medical and legal expertise.

Below the Board of Trustees is the Executive Director who reports to the Board of Trustees through its Chairperson. The Executive Director of FHT is an Ex-Officio member and secretary of the Board, as well as holding overall day-to-day responsibilities of the organisation.

Management Committee: The management committee comprises the Executive Director, and 4 managers AAP Manager, AASU manager, HBC Manager and CINDI Manager. Each of these managers heads their departmental and functions units. The Management Committee is headed by the Executive

Director. The committee oversees all executive functions.

4.6 Administration and Accounting Support Unit (AASU)

This unit provides human resource, administrative, financial and accounting functions to the organisations. It is headed by the Finance and Administration Manager. The unit holds custodianship of the FHT's policies, procedures and controls. The Finance and Administration Manager advises the Executive Director and the management team, controls spending and ensures accountability in line with agreements between the Trust and resource providers. As already implied above, the Finance and Administration Manager reports to the Executive Director of the Trust.

The AASU coordinates annual audits for the organisation's accounts and finances; as well as specific project audits as per donor requirements. In some cases, the unit has opened up its offices and books for appropriate stakeholders. During the 20 years, the trust has never had any problems with its donors or auditors. This resulted in the same donors continuing to support the Trust and its work over long periods exceeding 10 years.

4.7 Monitoring and Evaluation Unit

Monitoring and Evaluation (M&E) are two distinct but very complementary functions that any organisation carrying out the kind of work that the FHT does, should have in place. Recognising the criticality of this function, the Trust decided to enhance it by having in place full-time staff.

Planning is a pre-requisite for ay M&E function; and the FHT work is based on regular strategic plans and accompanying implementation plans. From 2007, the Trust has decided to move

from 3 year strategic plans to 5 years strategic plans for several reasons. Firstly, the nature of the HIV and AIDS epidemic is well understood now, and more predictable than it was before, so a longer planning period like 5 years is reasonable. Secondly, 3 years was still rather too short a period in which impact could be made and measured. Thirdly, the national strategic framework in Zambia has moved to that period, and the FHT wishes to be in line.

The M&E function coordinates data collection, collation and analysis from and for all the programmes. It also provides feedback on a regular basis, so that each programme as well as the management committee are aware of whether activities are being done as per plan. Episodically, evaluations are done to ascertain the extent to which the Trust's work is contributing to impact, as well as how relevant and helpful it is to beneficiaries, among other areas. Evaluations are carried out at mid-term and at the end of the strategic plan period. Besides reporting on results, the M&E function now focuses on demonstrating evidence of Outcomes and how the Trust's work contributes to impact.

SECTION 3

MR. JOHN N MUNSANJE SECOND AND INCUMBENT EXECUTIVE DIRECTOR OF THE TRUST CHAIRING A PALLIATIVE CARE MEETING IN LUSAKA.

5. HIGHLIGHTS OF LESSONS LEARNED

Over the years, the Family Health Trust employed strategies, approaches and practices that enabled the organisation to succeed in many areas. Lessons can be drawn and shared from this experience. This section highlights and reflects on some of the factors that helped to make the Trust a success. For example, what motivated the FHT founders to persevere and succeed in registering and developing the organisation in spite of the reluctance to grant approval by the government? What factors contributed to the sustainability of the organisation through the 20 years? What makes the Trust's work relevant and meaningful?

A lot of lessons can be drawn from the Trust's story, looked at and shared from different perspectives. For the purpose of this publication a few lessons are highlight and discussed from 3 perspectives:

- Founding, development and growth of the organisation
- Effective Interventions and Approaches
- Good Practice

Lessons Relating to Founding, Development and Growth of the Organisation

Many initiatives die even before they are born. Some initiatives start to provide services in the community, get registered, but for various reasons and causes, they cease to be. Others never get registered as organisations; but a number who get registered only exist on paper; they have no physical presence and do not do any work that benefits the community and add value to the national response. The FHT, as we have seen from its story in the

earlier section of this publication, may provide something to share with others, in relation to its success.

From the Trust's experience it can be seen that:

- *Altruistic and Service-driven Motives Backed by Good Constitution are vital for success of establishing, developing, growing and sustaining a charitable organisation*.
  The Family Health Trust was initiated, started and developed by founding members who were, and still are, driven by the strong desire to serve, and save others from HIV, AIDS, poverty and their related multiple issues. It is this altruistic disposition that motivated the founders to persevere, and attracted other stakeholders to join hands into the cause of the Trust. That resulted in success.

  Altruism and commitment of members and founders should be backed by a written constitution that adequately stipulates the status, direction and protects the organisation, and society (including stakeholders). As the highest policy document of the organisation, the constitution should have clear provisions upon which all other policies can be based; including having in place clear roles and responsibilities of its Board, management and staff teams.

  A charitable organisation thrives on good-will and generosity of people, based on trust that support and donated resources will go towards intended overt purposes, benefiting the needy in society or addressing needs of the community in general. If the motive for establishing an NGO or CBO is founded in myopic and selfish purposes of its founders, support to develop, grow and sustain such organisation and its work may not be realised. In most cases, even support to start the initiative

may not be realised.

NGOs and CBOs that do well, like the FHT, are those that ensure presence of altruistic motives within them. In the case of the FHT, all the founders had well established professional careers or businesses. They did not have to establish the Trust; and they wanted nothing in return for their contribution in the trust. The Family Health Trust therefore may be considered exceptionally fortunate and unique in that it was founded by very eminent professionals and business people. What about CBOs (and even NGOs) established by needy people to address their own welfare and strategic needs? Self-help membership organisations established and run for the benefit of needy members can also ensure presence of altruism within them by getting selfless, well-resourced and socio-economically established persons (or simply people who do not intend to use the charity for their selfish purposes) to serve on the Boards of such organisations. That way, the likelihood of checks and balances, void of conflict of interests will be strengthened.

It is important for the various levels of the organisation to observe and stick to their roles and let others function to perform their parts in a manner that is complementary, thus ensuring that each level and function meet their obligations. This has always helped the FHT.

- *Focus on the Vision and Mission of the Organisation helps to stay the course and achieve success.*
  A vision of a charitable service organisation is the idealistic picture of a perfect scenario' usually of society, in future after having done all its work and achieved all it set itself to achieve. The mission is the purpose or reason for the existence of that organisation. The vision and mission require an organisation to outline its values, goals

and objectives as well as strategies for achieving them.

From the inception (as evidenced from its formation documents), the FHT defined these parameters. The most important process after this was to adhere, actually comply, and stay focused on the mission and core mandate of the organisation. Mrs Elizabeth Mataka, the first Executive Director of the Trust attributes the success in the development and sustainability of the FHT to this factor, "The mainstay of the FHT was to due to its focus on its core mandate the mission statement, values, goals and objectives; ensuring that strategies, activities and results were congruent with these. You cannot waiver and expect to be successful." It is this focus that ensured that the FHT remained on course, did not dissipate its energies in futility and remained in well-standing with stakeholders. Of course the vision, mission and core mandate of the trust were periodically reviewed alongside other parameters over the years, and adjustments made where necessary. Such adjustments were however minor because of the percipience and prudence exercised at the inception of the Trust.

- *Learning from, and working with, others in a transparent and mutually beneficial manner, focusing on service to the community brings positive results:*
  From inception, the FHT was about team working, collaboration, broad-based and evidence-based input. Four people founded the Trust; many others contributed significantly, including starting up projects which they asked the Trust to adopt and take over. The Home Based Care AIDS Action Programmes were brought on Board by other people who collaborated with the Trust; and Kara Counselling and Training Trust introduced counselling into the interventions of the FHT. The Trust developed and maintained a strong partnership with government

throughout, as has been evidenced from the collaboration with UTH in providing HBC; as well as collaboration with the Ministry of Education on running AIDS Action Clubs in schools country-wide. Working with others and learning from each other heightens capacity in a holistic manner.

MRS PRISCA CHITOMFWA, AAP MANAGER DELIVERING A PRESENTATION AT ICASA IN 1999, LUSAKA

- *Maintaining good relationship with stakeholders, including resource providers, builds and enhances transparency as well as trust, and ultimately sustainability.*

  The FHT maintained consultative, collaborative, transparent performance-based accountable partnership relationships with its clients, beneficiary communities, government (through its agencies at various levels) other implementers and resource providers. For example it is not enough to go to communities, donors or government agency only when an NGO/CBO needs something from them. It is important to discern stakeholders' needs such as information (e.g. progress reports, additional or new

information) and share even if they have not asked for it. The important caution is to observe necessary communication protocols if so required. Programme and fiscal performance that is in line with agreed conditions, that add value to intended beneficiaries should be backed by regular and transparent communications with stakeholders.

MRS ELIZABETH N. MATAKA, EXECUTIVE DIRECTOR OF THE TRUST (1988 2003) WITH H.E. MR. JON LOMOY, THE AMBASSADOR OF THE ROYAL NORWEGIAN EMBASSY TO ZAMBIA IN 2000

Lessons Relating to Effective Interventions and Approaches

Interventions:

- *Comprehensive Interventions that provide prevention, care, support, treatment and impact mitigation apply more practically and holistically to the needs of beneficiaries, and promote increased access to services.*

  Initially, the FHT started with a single service HBC. Soon, it was realised that the service was not meeting many

other needs of its clients, for example in-depth psychosocial support that required counselling; needs of children of these clients and that of other vulnerable children. Prevention interventions through AIDS Action Programme as well as Interventions focusing on children were introduced. A person usually has several inter-connected needs. So the 'systemic and holistic' interventions became practical in addressing needs of clients. Centres which only offered one type of intervention soon included other interventions. For example, Chimasuko CINDI Project focusing on child intervention became a programme offering HBC, Community Economic Support initiatives, among others.

Single focus interventions work well in an environment of multiple ASOs working in the same catchment area. Interventions not offered by one organisation can be provided by other ASOs. Even then, experience has shown that people prefer a 'one-stop shop' where HIV and AIDS response is concerned. Intra-organisational referral is preferred to inter-organisational referral. However, issues of capacity in terms of skills, resources, other aspects that influence the quality of service provision is critical for any ASO in deciding to offer comprehensive interventions.

Vulnerability and rights-based targeted interventions: As understanding of how socio-economic vulnerability plays a part in the HIV and AIDS epidemic became clearer over the years, the Family Health Trust saw the need to provide target specific interventions in response to these vulnerabilities. The Trust's programmes therefore, rightly started to provide interventions that address issues of:

- Gender and Human rights, mainstreamed in all their work, a seen in child-protection (withdrawal of children from child-labour; prevention and following-up of child abuse, among others) implemented within the CINDI Programme.

- Promoted involvement of PLWHA and communities (through their representation (chiefs, local community leadership at various levels, etc)

- Access to services by people in the hard-to-reach categories such as SW, people in remote rural areas, those in extreme poverty or social bondage without freedom or self-esteem to go and access services.

Approaches:

The success of the Trust in terms of its contribution to scaling up the national response to HIV and AIDS has been due to its approaches of working with other organisations and stakeholders. Additionally, throughout, the 20 years of its existence, FHT's work has been evidence-based.

A VOLUNTEER DELIVERING MEALIE-MEAL TO A CLIENT

Briefly the following lessons could be noted:

- *Evidence-based approaches increase relevance, effectiveness, efficiency and sustainability of interventions, and ultimately increased likelihood of contributing to impact.*

  As noted in the earlier sections, all of the three main programmes of the Trust have come about in response to felt needs informed and verified by research and surveys. Evidence-based information facilitates correct application of interventions; avoids potential inefficiencies, ensures that culturally sensitive and appropriate people-focused approaches are adopted. All these increase likelihood of acceptability of interventions by the intended beneficiaries, as well as the likelihood of ownership by beneficiary communities (especially if their involvement has been adequate). These are key factors for sustainability.

- *Involvement of stakeholders promotes consensus, relationship building and increases relevance, effectiveness, efficiency and sustainability of interventions, and ultimately increased likelihood of contributing to impact:*
  It is of little help to design programmes without involving intended beneficiaries, or major stakeholders in whose jurisdiction the intended beneficiaries are. The major stakeholder at any level is the government at that level. The local leadership, including traditional leaders are key, as they are in position to understand their local issues and relevant interventions well.

CHIEF HANJALIKA (L) AND CHIEF MONZE AT A WORKSHOP ORGANIZED BY FHT IN MONZE

- *Strategic collaborations and partnerships facilitate scaling up and cascading of interventions:*
  Through working with the Ministry of Education, the Trust has been able to cascade the concept and practice of AIDS Action Clubs (formerly known as Anti AIDS Clubs) in all schools country-wide. Literature such as “Dr Kalulu” has been distributed through schools. This way, information about HIV and AIDS, assertive behaviour and positive attitudes necessary for prevention has been able to reach in-school youth throughout the country.

  Another way has been through franchising the CINDI Programme approach. While the FHT runs CINDI in 8 districts, the concept has been adopted by a number of groups in several other districts in a similar approach to that of the Trust.

- *Mentoring and nesting support of community groups as well as other organisations scale-up and cascade of*

national response:

The Family Health Trust has nested, mentored and supported a number of organisations. These organisations have now grown and become major AIDS Support Organisations in the country. Examples are SAPEP in Southern Province and the ZNAN at national level.

Lessons Relating to Good Practice

In the overall context, Good Practice refers to the holistic manner in which an organisation performs its services and runs its affairs. The Family Health Trust has been an exemplary organisation in this regard, as may be seen from this publication. However, this section wishes to highlight only two of such aspects.

- *Compliance with national and international policies, guidelines standards and other requirements increase appropriateness, client acceptability and donor support of interventions and programmes.*
  Over the years, the FHT did not only comply with such requirements, but also actively took part in developing and reviewing them to ensure increased quality and beneficiary satisfaction. Although there is no legal recourse for non compliance with policies and guidelines, it is unethical not to comply, and service providers are encouraged to do so, otherwise they stand the misfortune of having their services disallowed by authorities or lose donor support.

- *Accountable programmes and organisations that are transparent and allow stakeholder participation are successful, attract further support and become sustainable.*

One of the Trust's strength has been accountability. During its 20 years of existence, the organisation has always produced financial reports to its donors as per requirement. The FHT has always been audited by very reputable auditors every year. The organisation has never had any problems with its donors and auditors. As a result, the Trust has been supported by the same donors on long term periods exceeding ten years.

It is important that ASOs make their work as accountable as possible, as transparent to stakeholders including donors and beneficiary as possible. Creating impressions to deceive stakeholders only lasts a short time before the falsehood if exposed.

- *Good Monitoring and Evaluation systems (and practice) are essential to facilitate validation and justification of an ASOs work.*
  The FHT has always worked within a framework of strategic plans, with well outlined monitoring and evaluation systems. Planning is the back-born of M&E. A well designed and thought through M&E system will enable an ASO to track progress on an on-going basis, as well as measure outcomes and impact. Such measurement of performance enables the organisation and stakeholders to justify the investment being made to the organisation's work.