

Promising Practices III

HIV and AIDS Integrated Programming



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2011



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ACRONYMS

AHEAD	Action for Health and Development
AIDS	Acquired Immunodeficiency Syndrome
AMHR	Applied Mental Health Research Group
ANC	Antenatal Care
ART	Antiretroviral Therapy
ARV	Antiretroviral
BG/RE	Block Grant/Resource Exchange
CAFOD	Catholic Agency for Overseas Development
CBO	Community-based Organization
CCN	Community Care Networks
CHEW	Community Health Extension Workers
CLHIV	Children Living with HIV
CSN	Catholic Secretariat of Nigeria
CV	Community Volunteers
DACA	Diocesan Action Committees on AIDS
DOLISA	Department of Labor, Invalids and Social Affairs
DOTS	Directly Observed Therapy-Short course
EARO	East Africa Regional Office
FSW	Female Sex Workers
FY	Fiscal Year
GBV	Gender-based Violence
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HBC	Home-based care
HCT	HIV Counseling and Testing
HIV	Human Immunodeficiency Virus
HSS	Health Systems Strengthening
IDU	Injecting Drug Users
IGA	Income Generating Activity
IHD	Integral Human Development
IHV	Institute of Human Virology
IMCI	Integrated Management of Childhood Illnesses
IYDSA	Institute for Youth Development/South Africa
JDPC	Justice Development and Peace Commission
JFFS	Junior Farmer Field School
LPTF	Local Partner Treatment Facilities
LSC	Life Skills Centers
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MCP	Multiple and Concurrent Partners
MOH	Ministry of Health
MTCT	Mother to Child Transmission
NAP	National Action Plan
NGO	Non-Governmental Organization
OI	Opportunistic Infection
OVC	Orphans and Vulnerable Children

OWT	OVC Wellbeing Tool
PACA	Parish Action Committees on AIDS
PAV	Parish AIDS Volunteers
PDS	Patient Data System
PEPFAR	President's Emergency Plan For AIDS Relief
PHD	Provincial Health Department
PLC	Positive Living Centers
PLHIV	People Living with HIV
PMTCT	Prevention of Mother-to-Child Transmission
PPTCT	Prevention of Parent-to-Child Transmission
PTSD	Post-Traumatic Stress Disorder
SACA	State Action Committee on AIDS
SACBC	South African Catholic Bishops Conference
SARAR	Self-esteem, Associative strength, Resourcefulness, Action planning, Responsibility
SCA	Site Capacity Assessment
SIGA	SILC Group Associations
7D	Seven Diocese (Nigeria)
SILC	Savings and Internal Lending Communities
SL	Sierra Leone
SO	Strategic Objective
STI	Sexually Transmitted Infection
STRIVE	Support To Replicable Innovative Village Level Efforts
SUN	Scaling Up Nigeria's Faith-based Response to HIV/AIDS
TB	Tuberculosis
TBA	Traditional Birth Attendant
TF-CBT	Trauma-Focused Cognitive Behavioral Therapy
TFH	The Faithful House
TFHCT	The Faithful House Coordination Team
UN	United Nations
USAID	United States Agency for International Development
USD	United States Dollars
VCT	Voluntary Counseling and Testing
VCCT	Voluntary Counseling and Confidential Testing
WHO	World Health Organization
WSA	We Stop AIDS

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INTRODUCTION

Global Overview

UNAIDS estimates that there are 33.3 million people living with HIV and 2.5 million children living with HIV.¹ Sub-Saharan Africa is the most heavily affected region in the world, bearing 68 percent of the global burden.² While the prevalence of HIV in Africa remains high, incidence and the number of HIV-related deaths have declined due to progress in prevention and treatment programs. In Asia the epidemic has stabilized—no country in the region currently meets the definition of a generalized epidemic—yet incidence among groups with risky behaviors remains high. Eastern Europe and Central Asia also have concentrated epidemics, but the region is at-risk for having a generalized epidemic as HIV prevalence has tripled in this region in the past decade.³

The dramatic expansion of treatment has had a positive impact on survival. Since they peaked in 2004, AIDS-related deaths have dropped 19 percent among adults (2.1 million to 1.8 million) and children (320,000 to 260,000). Prevention of mother-to-child transmission (PMTCT) has improved—there has been a 24 percent decrease in the number of children born with HIV—yet it is not good enough: 370,000 children were infected in 2009.⁴ While antiretroviral therapy (ART) is reaching into the farthest corners of the world, for every two people started on ART, five people are newly infected.⁵ In 2010, the World Health Organization revised treatment guidelines to recommend earlier initiation of ART, resulting in an increase in the treatment need.⁶

While incidence is declining and treatment is improving, there are millions of affected children. An estimated 17.5 million children under the age of 17 have lost one or both parents due to AIDS-related illnesses.⁷ Children who are caring for sick parents have lower rates of school attendance,⁸ and orphans who have lost both parents are 12 percent less likely to attend school.⁹ Children orphaned due to AIDS are also more likely than other orphaned children to experience post-traumatic stress disorder, depression and anxiety.¹⁰ Orphans and vulnerable children are also more vulnerable to malnutrition, illness, abuse and to HIV infection. Because of the long lag time between infection and illness, even if there were no new infections, the number of affected children would still increase.¹¹

Progress is being made in treatment roll-out, prevention interventions, and systems of care and support. Where once the landscape was dark with fear and the unknown, the global forecast for HIV now includes patches of light and hope; the work of CRS and its partners are part of the hope.

1 UNAIDS. (2010). Global Report: December 2010. Geneva.

2 From the WHO website: http://www.who.int/topics/millennium_development_goals/diseases/en/index.html. Accessed on Feb 16, 2011.

3 UNAIDS. (2010). Global Report: December 2010. Geneva.

4 Ibid.

5 From the UNAIDS website: http://www.unaids.ru/en/HIV_data/. Accessed on Feb 16, 2011.

6 World Health Organization. (2010). Antiretroviral Therapy for HIV Infection in Adults and Adolescents: Recommendations for a Public Health Approach. Geneva.

7 PL109-95 Secretariat. (2009). Third Annual Report to Congress on Highly Vulnerable Children. Washington, DC.

8 UNICEF. (2007). Enhanced protection for children affected by AIDS.

9 (2008). Report on the global AIDS Epidemic.

10 Cluver, L, Gardner, F & Operario, D. (2008). Poverty and psychological health among AIDS-orphaned children in Cape Town, South Africa. *AIDS Care*, 21(6): 732-741.

11 Foster, G., Levine, C., & Williamson, J. (2006). *A Generation at Risk: The Global Impact of HIV/AIDS on Orphans and Vulnerable Children*. Cambridge University Press.

The CRS Response

HIV continues to be an area of programmatic focus for CRS. CRS has more than 280 HIV-focused projects in 62 countries. In 2009, the agency directly reached 8 million people and indirectly reached 20 million people affected by HIV. The agency's HIV projects were valued at more than 192 million U.S. dollars (USD). CRS projects offer a holistic range of care and support for people living with HIV (PLHIV) as well as wrap-around services for affected families. To ensure that care is comprehensive, many projects link with programs focused on agriculture, microfinance, education, health, and water and sanitation.

CRS' integrated response addresses the impact of HIV at the levels of the individual, the household and the community. CRS is guided by the Integral Human Development (IHD) framework as a tool to understand the multiple levels of human developmental and related issues. The IHD, which is derived from Catholic Social Teaching, provides a framework to assist people to lead full and productive lives, meeting their basic physical needs in a sustainable manner, while living with dignity in a just and peaceful social environment.¹² The IHD framework ensures that CRS is not just meeting the medical needs presented by HIV, but is addressing the multiple levels of impact on the individual, family and community.

CRS has identified four priority areas for health and HIV programs: treatment, home-based care, orphans and vulnerable children, and health systems strengthening.

Treatment

Since 2004, CRS has been the prime grantee of a PEPFAR-funded (President's Emergency Plan for AIDS Relief) consortium of five organizations providing care and antiretroviral treatment in ten countries. Through the AIDSRelief consortium, CRS provided ART to almost 200,000 PLHIV, including more than 14,000 children. With more than 240 local partner treatment facilities under this grant, CRS is providing care and support to more than 500,000 PLHIV who are not yet in need of treatment. In addition to AIDSRelief, this document highlights the other programs where CRS is supporting treatment in hard-to-reach areas, such as Pakistan, and through outreach to special populations such as children living with HIV.

Home-based Care

While impressive gains have been made in the scale-up of ART, with 37 percent coverage in sub-Saharan Africa,¹³ there are still large numbers of people who do not have access or fail to respond to treatment. Home-based care (HBC) is a method of service delivery provided by formal and informal caregivers in a home setting. CRS supports HBC and palliative care projects in more than 25 countries. Through these projects, caregivers are trained to provide physical care, assistance with daily activities, emotional support, spiritual guidance or counseling, assessment and referral, nutritional counseling, and advocacy for a critically ill patient and his or her family.

Orphans and Vulnerable Children

In programs for orphans and vulnerable children (OVC), CRS applies an ecological framework of child development, which stresses the importance of strengthening not only the child, but also the systems

¹² Burpee, G., Heinrich, G., & Zamanek, R. (2006). *The CRS Integral Development Framework: A Brief Overview*. Baltimore: CRS.

¹³ UNAIDS. (2010). *Global Report: December 2010*. Geneva.

and structures that influence child development.¹⁴ Programmatically, this theoretical framework translates into building OVC programs that are child-centered, family-focused, community-based, and government-supported, recognizing that children are part of this larger social structure which contributes to each child's ultimate wellbeing. Catholic Relief Services currently supports more than 650,000 OVC with direct intervention in more than 25 countries. CRS demonstrates leadership and expertise within seven intervention areas: Psychosocial Support, Economic Strengthening, Child Protection, Health Care, Education, Food and Nutrition, Shelter and Care.

Health Systems Strengthening

CRS realizes that as interventions are rapidly scaled up to address global health issues, health system constraints are a major impediment to increasing coverage. Health System Strengthening (HSS) approaches and strategies, which can be aligned with national priorities and harmonized into practice, are essential to achieve national and international health goals. CRS strives to contribute to strengthening of equitable and comprehensive health systems to reach the most marginalized communities. Practically, HSS translates into actions in strengthening community and national governance, facilities, human resources, commodities and service systems, and financing.

Why Promising Practices III?

Progress in the response to HIV is largely due to critical reflection and quality evaluation of what is working. Programs that have the most impact are those that are specialized to fit the needs of each community. In order to facilitate sharing of lessons learned among CRS country offices and contribute to documentation in the HIV field, this compilation includes promising practices from programs around the world.

Recent UNAIDS estimates suggest that HIV prevalence is lower than previously estimated. While this is positive news, it is more important than ever that programs engage in effective HIV programming to ensure that the rates continue to decline. In addition, as resources tighten, HIV programs must demonstrate effectiveness and strive to implement the highest quality of programs. Sharing success stories enables HIV programmers globally to learn from one another and build upon one another's successes and innovations.

This is CRS' third version of promising HIV and AIDS practices. Each of the 17 case studies is organized according to context, project implementation, identification of successes and lessons learned, and contact information. Please contact local programs directly for additional information.

14 Bronfenbrenner, U. (1977). Toward an experimental ecology of human development. *American Psychologist*, 32, 513-531. Also see Bronfenbrenner, U. (1988). Interacting systems in human development. In N. Bolger, A. Caspi, G. Downey, & M. Moorehouse (Eds.), *Persons in context: Developmental processes* (pp. 25-49). New York: Cambridge University.

**Part I:
Care and
Support for
People Living
with HIV**



PHOTO BY KAREN KASMAUSKI FOR CRS

NIGERIA

Increasing Access to Facility-based Services via a Community Model

Introduction to the Project

The Seven Dioceses (7D) Project was initiated in September 2003 with the aim of mitigating the impact of HIV and AIDS in selected states in Nigeria. The project has been implemented in collaboration with the Catholic Secretariat of Nigeria in 11 out of the 36 states. The states are mainly in the North Central zone of the country, where HIV prevalence is highest, and also in the South West zone, which has a high population. The project is funded by the President's Emergency Plan for AIDS Relief (PEPFAR) through the United States Agency for International Development (USAID).

CRS Nigeria's local implementing partner, the Catholic Secretariat of Nigeria (CSN) works at the national level, while the dioceses implement the program through the Diocesan Action Committees on AIDS (DACAs). The DACAs carry out the bulk of the activities within the States and are the primary conduits through which resources are channeled. The DACAs are also responsible for mobilizing Parish Action Committees on AIDS (PACAs) in each parish, which constitute a core

element in the church’s response to HIV. PACA members are drawn from local parishioners and are responsible for the identification of the community’s needs and the implementation and coordination of community-based activities.

The 7D project has facilitated an effective response to the AIDS epidemic by bridging the existing gaps, such as limited government capacity, persistent political and social turmoil, and silence and denial caused by stigma associated with HIV.

NIGERIA	
Type of Project	Home-based care (HBC)
Integration Aspects	Integrated with the SUN orphans and vulnerable children (OVC) project
Number of Beneficiaries	Currently serving 36,580 individuals (16,000 adults and 20,580 children)
Beneficiary Type	Adults living with HIV and OVC
Source of Funding	USAID
Duration of Project	September 2003 – March 2011
Promising Practice Highlighted	Community-based prevention of mother-to-child-transmission (PMTCT) model of service delivery using community care networks made up of community resource persons such as traditional birth attendants (TBAs), community health extension workers (CHEWS) and volunteers

Problem Statement and Context

With HIV prevalence of 4.6 percent,¹ Nigeria has the second highest number of infected people in absolute terms in Africa (around 2.9 million), posing an enormous strain on the country’s already inadequate health care resources. Moreover, sub-populations display worrying trends; for example, some states, such as Benue, have prevalence as high as 10.8 percent.

Additionally, the epidemic has a disproportionate impact on women and girls in their reproductive years, with 4.9 percent of pregnant women aged 25-29 infected with HIV, followed by 4.7 percent of women aged 20-24.² More alarmingly, 3.6 percent of women aged 15-19 are infected, suggesting early sexual debut that could be attributed to various aspects of community socio-cultural observances.³ Young women have a much higher prevalence as compared to young men.

The number of children contracting HIV is on the increase, with mother-to-child transmission (MTCT) being one of the main routes of transmission. Over 90 percent of pediatric infection worldwide occurs through MTCT at a rate of almost 2,000 new pediatric infections daily⁴ (about 75,000 babies were born

1 Federal Ministry of Health. (2008). National HIV Sero-prevalence sentinel survey.

2 Federal Ministry of Health. (June 2008). Progress Towards Universal Access to HIV Prevention, Treatment, Care and Support.

3 National Agency for the Control of AIDS (2005-2009) National HIV/AIDS Response Review.

4 UNAIDS. (2009). UNAIDS Progress report.

positive in Nigeria in 2005). Prevention of MTCT (PMTCT) intervention is considered an emergency effort. The variations in the epidemic pattern suggest that prevention, treatment and palliative care interventions must target states and localities where infection rates are highest and must ensure that particularly vulnerable groups, such as youth and pregnant women, are prioritized for services.

Unfortunately, measures to respond to the epidemic in Nigeria have been inadequate, due to limited government capacity and other inhibiting factors, including persistent political and social turmoil as well as silence and denial caused by the stigma associated with HIV. Nigeria's health sector is also severely deprived of the financial, material and human resources needed to confront the pandemic. In a World Health Organization assessment of the overall health performance of 191 member states, Nigeria ranked a dismal 187th. Thus, there is a need to develop the capacities of community members, faith-based organizations and civil society to partner with government at the state and local level to more effectively respond to the disease. Such a partnership will assist beneficiaries with receiving a full package of essential services and reduce pressure on over-burdened and under-funded local and state health services.

High rates of HIV infection among pregnant women demonstrate the considerable risk of MTCT. Out of an estimated 200,000 HIV-positive pregnant women nationally, only 11 percent are receiving antiretroviral therapy (ART) to reduce MTCT, which contributes up to 30 percent of the global gap in PMTCT coverage. Yet, the Federal Government of Nigeria estimated that 1.25 million women who require PMTCT services would not be covered by programs in 2010. Therefore, scaling up community-based PMTCT and linking communities to comprehensive PMTCT in antenatal care (ANC) facilities is essential to addressing this gap. PMTCT services need to be accessible, ensure continuity of care for HIV-positive women, and provide treatment and early infant diagnosis for HIV-positive mothers and their children. Addressing the PMTCT gap requires a broad-based multidisciplinary effort that includes strengthening both public and private health systems and community-based support networks.

For the past decade, the North Central zone has consistently had the highest prevalence rate in the country, and all but one of the states in this zone are regarded as "HIV hotspots"- states where HIV prevalence rates are much higher than the national average. This zone has numerous high-risk factors that serve to perpetuate the HIV epidemic, including low levels of education, poor awareness of HIV risk factors, and high numbers of most-at-risk populations, such as military personnel, migrant workers, and commercial sex workers. Other high-risk factors include socio-cultural traditions such as wife inheritance and polygamy.

Purpose of the Project

The goal of the 7D project is to improve the quality of life of people living with HIV (PLHIV) in eleven archdioceses of eight selected states in Nigeria.

STRATEGIC OBJECTIVES	To increase the use of quality HIV prevention services and interventions through (a) improved access to PMTCT services; and (b) improved access to abstinence and be faithful prevention services
	To improve access to and increase use of quality HIV care and support services and interventions
	To strengthen public, private and community enabling environments through (a) strengthening enabling environments for PLHIV in target communities; and (b) building capacity of Catholic parishes

The following six guiding principles inform and direct the project strategy and activities:

1. Focus on capacity-building activities within the Catholic Church and target communities.
2. Streamline activities to accelerate service delivery to PLHIV.
3. Promote the opportunities afforded by the Catholic Church.
4. Take advantage of the cadres of mobilized parish AIDS volunteers (PAV).
5. Emphasize effective monitoring and evaluating (M&E) and communication systems.
6. Promote the leadership of the Catholic Church in Nigeria in HIV programs.

Steps in Implementation

The 7D project provides at all sites a minimum package of PMTCT services that includes basic ANC services: counseling and testing services within ANC centers; labor/delivery; antiretroviral (ARV) prophylaxis for mothers and HIV-exposed infants; mother support groups; postpartum care services; and follow-up of HIV-exposed infants, including infant feeding counseling.

The package of PMTCT services currently being provided to beneficiaries is integrated into maternal and child health services provided by the facilities. In addition, the Church implements Safe Passages (safe motherhood) programs at all of its health facilities, and PMTCT sites link clients from the catchment areas served by these facilities to the Church health facilities for maternal and child health services. This ensures that women have greater access to high-quality antenatal, labor, delivery and postpartum care, including counseling and support for infant feeding; and use existing services more frequently and earlier in pregnancy. An effort is also made to ensure that mothers who cannot return to CRS PMTCT facilities for maternal and child health services are linked to other United States Government Implementing Partners, facilities or Government of Nigeria facilities.

The 7D PMTCT component maintains linkages with the care and support component of the project to ensure that PMTCT clients and their families receive a comprehensive package of services. The mother support groups initiated in the sites are linked to the diocesan PLHIV support groups to ensure that the mothers receive home-based care (HBC) from parish AIDS volunteers. The project uses traditional birth attendants (TBA) and community health extension workers (CHEWs) to enhance community outreach and encourage uptake of PMTCT services, particularly among women in rural communities with limited access to ANC. From May 2007, CRS Nigeria supported 13 primary health care centers in high prevalence and under-served communities in seven states to provide a minimum package of PMTCT services in line with national guidelines. A total of 169 community resource persons comprised of 130 TBAs and 39 volunteers were recruited and trained to

PHOTO BY KAREN KASMAUSKI FOR CRS



Healthy mother and baby who benefited from PMTCT services.

create awareness, mobilize pregnant women for ANC and HIV counseling and testing, and provide follow up for HIV-positive pregnant women and their families in the target communities through a community care network model. The 7D project ensures availability of functional CD4 count machines at all the sites in order to address the loss to follow up of pregnant women who access PMTCT services in CRS sites. This increases the numbers of pregnant women provided with ARV prophylaxis in CRS PMTCT sites.

CRS Nigeria and its partners work together to improve the quality of basic care and support services provided to PLHIV by providing continuous capacity-building of service providers on HBC and psychosocial support, ensuring targeted beneficiaries have access to a continuum of quality HBC services. Volunteers and CHEWs are trained on basic care including treatment of minor ailments as well as psychosocial support which includes grief counseling and emotional support. Training also includes skills for identifying persons requiring referrals and documenting referrals. PLHIV and their family members enrolled in the 7D program receive routine HBC visits by PAVs trained to provide basic medical care, psychosocial and spiritual support, and to give medical referrals for more serious issues. Additional psychosocial and adherence support are often provided by mother support groups.

The basic care and support component of the 7D project also supports targeted counseling and testing services to family members of HIV-positive individuals enrolled in the project. PAVs encourage HIV counseling and testing during home visits and the project conducts mobile testing in conjunction with community awareness campaigns.

PHOTO BY SILVAS IDEMA FOR CRS



HBC volunteer caring for a client during a home-based care visit.

All PLHIV enrolled in the program receive a basic care kit, comprised of a mosquito net, bucket, and Water Guard. The 7D project has negotiated block grants with health facilities to improve access to medical care for PLHIV and OVC. PAVs refer clients to participating health facilities.

Integration

While the 7D caters to the needs of adult PLHIV, the Scaling Up Nigeria's Faith-Based Response to HIV/AIDS (SUN) program addresses the needs of their vulnerable children. CRS Nigeria works to support the family as a whole. With this in mind, purposeful links have been made to connect these two programs, working with families to include the families' children within the HBC activities, as appropriate in the 7D project. This linkage is ensured by having the same PAVs visiting PLHIV also serving vulnerable children and making referrals where necessary.

CRS Nigeria is the lead agency in a five-member consortium called AIDSRelief, which provides ART to PLHIV and HIV-positive children through partnerships with faith-based organizations and community-based organizations in Nigeria. The 7D project benefits from this consortium in states where both projects are co-located and children from families supported by the project who require ART are linked to treatment facilities. Beneficiaries under care and support are assured treatment services and others not on treatment who require advanced medical care are equally offered accesses to these services in AIDSRelief facilities. In a number of states where the 7D project is located, the State Action Committees on AIDS (SACA) collaborate with the DACAs to effectively support a broad range of beneficiaries requiring treatment and care.

Positive Outcomes and Impacts

The 7D project started with the aim of mitigating HIV impact in selected states in Nigeria through a robust network of Catholic health structures. Since its inception in 2004, the 7D project has supported over 16,000 PLHIV who have received services at home or in health facilities supported by the project or by AIDSRelief. These services have improved the quality of life of PLHIV who would have been unable to get immediate medical care without support from these mutually reinforcing projects.

Through the support group network, PLHIV have strengthened the enabling environment that is supporting an effective response to the AIDS epidemic in Nigeria. This is exemplified by PLHIV ability to transform support groups into community-based organizations that are used as platforms to advocate for the rights of PLHIV and to mobilize government and civil society resources to support HIV interventions in communities.

PMTCT facilities have been strengthened and are now delivering an improved package of child survival interventions besides providing the required PMTCT services to HIV-positive pregnant women and their babies, families and communities. The majority of HIV-exposed babies born to HIV-positive mothers who receive ARV prophylaxis in 7D supported facilities are testing HIV-negative. The available data from the project in fiscal year 2010 indicates that 95 percent of the HIV-exposed babies who accessed early infant diagnosis tested negative. Through the HBC activities, infants born to HIV-positive mothers continue to receive services at home and are followed up to ensure that they access diagnostic services on time.

The project has built capacity at DACA and PACA levels; some PACAs have been transformed into registered community-based organizations and are already receiving small grants from individuals and organizations supporting the AIDS response in Nigeria.

Lessons Learned

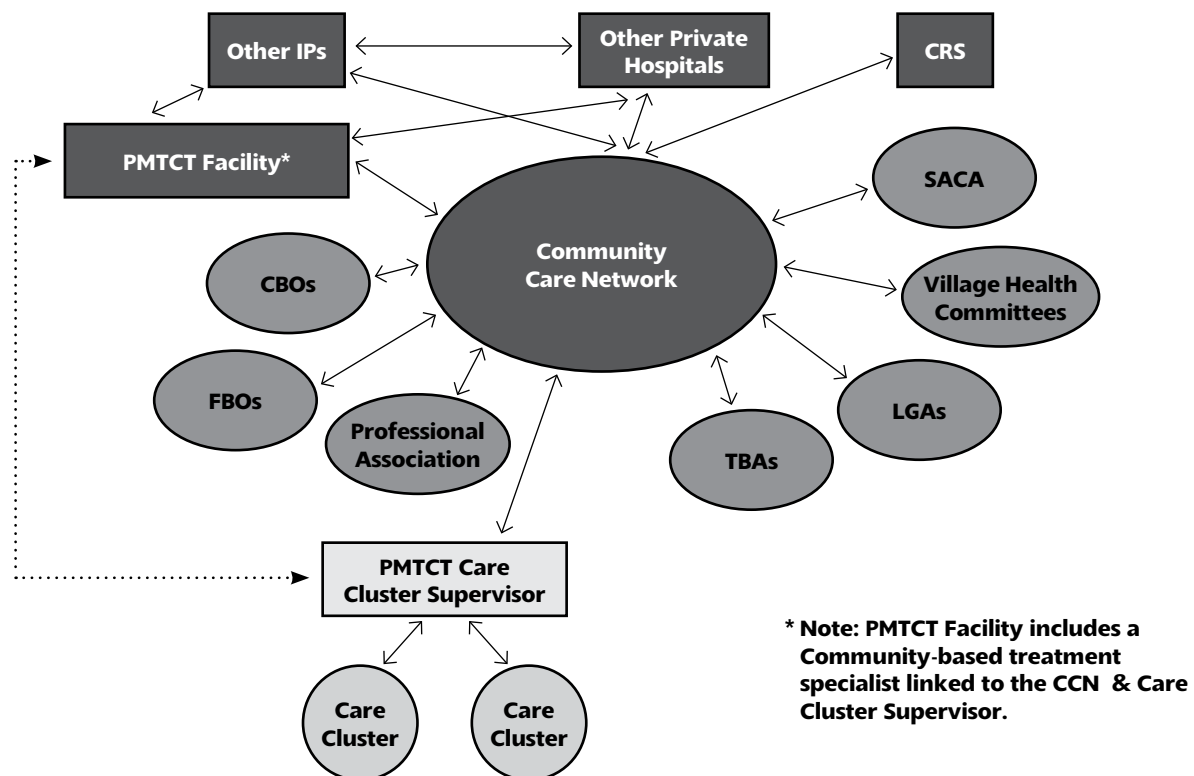
- Strengthening the logistics and supply chain system improves the efficiency and effectiveness of service provision by ensuring uninterrupted supply of rapid test kits, basic care kits, other commodities and informational materials required for timely provision of HIV services at community level. Availability of supplies for testing and materials for creating awareness is key to improving uptake of services in health facilities.
- Motivating volunteers by recognition, incentives, and training in key service delivery areas improves the quality of services provided to beneficiaries and increases the success of home-based service delivery models.
- Support groups for PLHIV help reinforce the psychosocial support provided during home visits. All PLHIV enrolled in the project are encouraged to participate in a support group. These groups provide both motivation and support through peer group discussions and are a means for PLHIV to receive accurate information regarding issues such as nutrition, basic health care, and HIV prevention.
- Public-private partnerships play a vital role in improving uptake of HIV counseling and testing services and other components of PMTCT.
- The success of block grants for health facilities is contingent upon transparent identification of beneficiaries and streamlined recordkeeping.
- Verification of beneficiaries and mapping of institutions providing services in the project coverage areas helps in justifying resources and improves the monitoring of services provided to beneficiaries.

Promising Practices

The community awareness and mobilization component of the PMTCT program is structured to increase awareness about and promote increased uptake of available health services for pregnant women. The PMTCT program collaborates with communities around 13 comprehensive PMTCT facilities to form community care networks (CCNs) to mobilize broad-based community support for PMTCT, strengthen referral linkages between the target health facility and the local community, and enhance capacities for community-based care of HIV-positive pregnant women and their families (see Figure 1: Community Care Network).

Leveraging 7D's community care model, the DACAs in the targeted areas provide technical assistance and institutional support to the CCNs. The DACA supports the CCN to mobilize a broad base of community stakeholders, including community-based organizations, other PEPFAR Implementing Partners (IPs), State and Local Action Committees on AIDS (SACA/LACAs), professional organizations, youth groups, support groups, TBA associations, public and private health providers, and other faith-based organizations to collaborate to promote increased uptake of PMTCT services and enhanced care for HIV-positive pregnant women.. To ensure sustainability and increased local management capacity, local government structures are integrated into the CCN through the participation of local government area authorities and primary health care management.

Figure 1: Community Care Network



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PHOTO BY ADIL SHERAZ/CRS

PAKISTAN

Taking the Lead in Treatment, Care and Support for PLHIV in Low Prevalence Settings

Introduction to Project

Catholic Relief Services (CRS), in collaboration with two local partners, has been involved with HIV treatment, care and support in Pakistan for a decade. The two partners, New Light AIDS Control Society and AWARD, work together with CRS in two provinces, Punjab and Khyber Pakhtoon Khwa. Utilizing CRS private funds from March 2005 to September 2010, the project served 450 people living with HIV (PLHIV). This project was intended to meet the health care and psychosocial needs of PLHIV by improving access to clinical care services, providing educational support to infected and affected children, and offering a skill development training program for both male and female PLHIV to help them achieve economic self-sufficiency. CRS also facilitated the establishment and functioning of support groups which provided opportunities for PLHIV to come together socially in informal settings, share experiences, and create self-help networks. The project was unique, as CRS was the only organization

in Pakistan providing home-based care (HBC) services. With financing from the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) Round 9, CRS will expand its programming model to reach more than 4,000 PLHIV over two years.

PAKISTAN	
Type of Project	Home-based care
Integration Aspects	Livelihood, educational support, care and support
Number of Beneficiaries	450 PLHIV from 2005-2010 (CRS Private Funds); 4,000 PLHIV from 2011-2012 (GFATM)
Beneficiary Type	OVC, PLHIV
Source of Funding	CRS Private Funds and Global Fund to Fight AIDS, Tuberculosis and Malaria Round Nine
Duration of Project	March 2005 to September 2010 (Private funds) and January 2011 to December 2012 (GFATM)
Promising Practice Highlighted	<ul style="list-style-type: none"> (a) Bridge the antiretroviral therapy (ART) gap in a low-prevalence country (b) Provide the necessary social support (c) Promote economic strengthening through vocational training (d) Distribute home-based care kits and train PLHIV and caregivers on their use

Problem Statement and Context

The first HIV case in Pakistan was identified in 1987. Since then, the National AIDS Control Program has recorded an increasing number of cases, and currently an estimated 98,000 people are living with HIV and AIDS in the country. Similar to other countries in Asia, Pakistan's epidemic is concentrated among groups with risky behaviors. HIV prevalence in Pakistan in the general population is less than 1 percent; however, prevalence is 30 percent in some high-risk groups like injecting drug users. Socio-cultural factors, particularly stigma, discrimination, and lack of effective interventions for high-risk groups make Pakistan a high-risk country.¹

In the absence of decisive action, Pakistan risks the development of a serious HIV epidemic. The fight against HIV has strong commitment from the highest levels of government, but the response has been slow. Progress continues to be impeded by reluctance to address some of the important drivers of the epidemic and limited national capacity to do so. Most public and private sector interventions have focused on prevention of HIV among high-risk and vulnerable populations. There are few initiatives for care and support of PLHIV. The available health services do not adequately meet the diagnostic, treatment, care and support needs of PLHIV, and existing interventions in-country fail to engage communities meaningfully. There is limited capacity to provide the necessary services for children living with and affected by HIV, and treatment as a key prevention strategy has not been implemented. Currently, CRS is

¹ National AIDS Control Program 2003 project progress report.

the only agency providing comprehensive care and support services for PLHIV.

Most of the known PLHIV in Pakistan are migrant workers (mostly belonging to Punjab, Khyber Pakhtoon Khwa and Baluchistan provinces) deported from Middle Eastern countries² because of their positive status. Loss of income, the indignity of being deported and the profound shock of HIV diagnosis is further magnified as PLHIV returning home face enormous challenges in maintaining any dignity in their lives because of the extreme stigma attached to the disease. PLHIV have limited access to counseling, diagnostic and treatment services. Many PLHIV live in isolation, not disclosing their status to family, community members, or health care providers (whose low awareness and poor attitude further alienates PLHIV). As a result, many PLHIV do not access available services and may waste their life’s savings on questionable, non-proven “cures” from untrained vendors. Some returnees even get married in the belief that fidelity will result in a cure for HIV. This decision poses a great risk of HIV transmission to their new spouse.

Purpose of the Project

When this project began in 2005, HIV care and support services were not provided by the government or non-governmental sector in Pakistan. Considering this gap, CRS Pakistan initiated care and support programming in the country with the goal of improving the quality of life for PLHIV. The project had two main goals: (1) PLHIV have improved health status, and (2) HIV- affected families have reduced socio-economic burden. Four strategic objectives work toward those goals.

STRATEGIC OBJECTIVES	Improve PLHIV access to comprehensive HIV health care services.
	Train family members so that they get effectively involved in home-based care.
	Develop the capacity of PLHIV, especially HIV-positive widows, through skill development, enabling PLHIV to start generating income.
	Support HIV-infected and -affected children to continue their education.

Steps in Implementation

CRS was at the forefront of HIV treatment, care and support in Pakistan. In collaboration with local partners, CRS was the first organization to bring antiretroviral drugs (ARVs) to Pakistan in 2005. CRS procured and donated the first equipment to monitor CD4 counts and viral loads to the Pakistan Institute of Medical Sciences, Islamabad, and to Shaukat Khanum Hospital in Lahore. Between 2005 and 2008, these tests were provided without charge to PLHIV who received care at the two hospitals. CRS’ contribution filled a major treatment gap and it placed CRS in a key position to successfully advocate to the Ministry of Health to secure ARVs for the entire country. CRS Pakistan developed the capacity of its local partners on care and support through formal trainings and regular technical support. CRS and its partners have developed a close working relationship with the Ministry of Health, the National/Provincial AIDS Control Program, local government and private sector hospitals. Most PLHIV are unable to afford the cost of transportation, laboratory services, ancillary investigative procedures, opportunistic infection treatment, and hospitalization costs. The project covered these costs to ensure that the PLHIV were able to access the necessary care and treatment. Additionally, provision of skills development training, especially for women, enabled them to work from home and provide economic support for themselves and their families.

² National AIDS Control Program 2003 project progress report.

Integration

The project was unique in nature for Pakistan because of its integrated approach to address the multiple needs of PLHIV. Partners provided care and support services to PLHIV and actively linked PLHIV to the Ministry of Health treatment and prevention of parent-to-child transmission (PPTCT) program. This helped PLHIV to access free ARVs, counseling and PPTCT services. Partner organizations managed to get food support for extremely poor PLHIV through local philanthropists. Food support helped PLHIV to reach their nutritional requirements and improve their health status. Home visits by the project doctor contributed to raising HIV awareness within affected families and communities, and therefore helped in reducing stigma and discrimination. Educational support offered for children living with and affected by the virus reduced the financial burden on families and allowed the children to continue their education. Men and women received vocational training to develop skills that improve their ability to find productive employment and help PLHIV meet household expenses and gain more confidence in their own abilities.

Positive Outcomes and Impacts

Over the five-year period, this project has created a number of positive outcomes. Foremost has been the introduction of free nationwide ARVs in Pakistan, with the Ministry of Health taking over this responsibility in 2007. Care and support services have reached 450 PLHIV in Punjab and Khyber Pakhtoon Khwa provinces. Ninety children living with and affected by HIV have been able to continue their education. Skill development training has empowered many PLHIV, including widows of PLHIV. When they complete the program, they are able to initiate income generating activities. The majority of PLHIV clients participating in the project enjoy better health and reduced opportunistic infections. They experience reduced stigma within their family and community and report that they are not stigmatized when receiving medical services. Building on the experience and relationships developed as a result of the CRS private fund investment, the programming model will be expanded to cover over 4,000 PLHIV in the next five years with GFATM Round 9 resources.

Lessons Learned

- PLHIV monthly meetings have wide acceptance by PLHIV and their families. PLHIV meetings play a vital role in encouraging PLHIV to share their experiences and challenges in a supportive environment. These meetings also help PLHIV to promote openness and disclosure, to develop life skills, and to enhance social networking.
- Regular follow-up of PLHIV is necessary to ensure better treatment outcomes. Home visits to PLHIV complement scheduled check-ups and provide necessary medical and counseling care. Additional training on HIV and home care management increases PLHIV knowledge and reduces misconceptions regarding their illness.
- Local microfinance institutes including microfinance banks are not ready to provide loans to PLHIV due to uncertainty concerning PLHIV's capacity to work. Therefore, there is need to explore and identify local resource networks that can provide loans to PLHIV. For economic empowerment, another solution is to provide skill development training to PLHIV, a large percentage of whom are in need of a sustainable income source.
- Very few HIV-positive children in Pakistan know their status, though care and support services including pediatric ARVs available to those that do. There is lack of expertise on pediatric counseling related to HIV. Pediatric counseling is challenging, and trained counselors are needed to provide regular counseling of children infected with HIV.

PHOTO BY ADIL SHERAZ/CRS



Educational support has allowed children in HIV-affected households to continue with school.

Promising Practices

Bridge the ART gap in a low-prevalence country

CRS was instrumental in introducing ARVs to Pakistan in 2005. Until that time no ARVs were available in the country. Continuous collaboration and coordination with the Ministry of Health and the National AIDS Control Program allowed CRS to bridge the initial gaps in HIV treatment and care. Advocacy efforts by CRS and its partners supported the meaningful involvement of PLHIV, who highlighted the challenges they face in accessing treatment and contributed to generating the necessary momentum for inclusion in the policy agenda. The project has succeeded in cultivating the Government of Pakistan's support and helped the government recognize its responsibility to provide free ARVs to PLHIV in Pakistan.

Provide the necessary social support

In a low-prevalence country like Pakistan, cultural attitudes contribute to the social exclusion of PLHIV, leading to isolation, marginalization and the resulting psychosocial consequences. Establishing PLHIV support groups and providing an opportunity for interaction through monthly PLHIV meetings helps PLHIV and caretakers disclose their status, share ideas, get together with each other socially, discuss their issues and problems, and seek support in a safe and non-judgmental environment. All meeting members were provided with lunch, which creates an opportunity for PLHIV members to develop social networks. Monthly meetings also aid in reducing stigma and empowering PLHIV.

Promote economic strengthening through vocational training

PLHIV were provided vocational training in skills such as sewing, hand embroidery, beautician work, and electrician work. These trainings were attended by 30 widows whose husbands died due to HIV. These widows were also HIV-positive and were the main bread winners for their families. The trainings have helped widows to learn skills they could use to work from home and support their household. Some of these trainings, like sewing and handmade embroidery, are now facilitated by HIV-positive women who completed the training, leading to further empowerment of these women.

Distribute home-based care kits and train PLHIV and caregivers on their use

This activity has helped PLHIV to treat minor opportunistic infections (OI) at home, leading to improved health status. The kit includes basic OI medicines and first-aid items. PLHIV and caregivers were trained in HBC by outreach workers and a care and support manager. Major topics covered in the training were ARV adherence, how to treat basic OIs at home, basic hygiene at home, and use of local food items for better health. The outreach workers conducted monthly home visits to each PLHIV, however, when necessary, more frequent visits were made by the outreach worker, care and support manager and project doctor. The outreach workers followed-up on ARV adherence, health and hygiene issues and skills development trainings, while also supporting family counseling and offering psychosocial support.

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CASE STUDY

Razia

Razia is a 45-year-old widow living with HIV and the mother of two children. Her elder child is 15 years old, and the younger one is twelve. Her husband, Aslam, used to work in Abu Dhabi as a landlord's assistant collecting rent and providing maintenance in rented homes. When he returned home to Pakistan in 2004 for vacation, he started suffering from continuous high fever. Treatment from private practitioners failed to provide any relief and his health continued to deteriorate. Finally he was taken to a government hospital. The doctor advised him to go through a series of tests including tests for HIV. He was found to be HIV-positive. The doctor advised Razia and her children to also have an HIV test. Razia tested positive; however, her children were negative.

Aslam was referred to CRS' partner, New Light AIDS Control Society. Anti-retroviral therapy (ART) was immediately initiated as his health was deteriorating rapidly. Aslam and his family also received psychosocial and medical support by New Light. Sadly, Aslam died within two months after starting ART. It was a shocking moment for Razia and her children to lose their beloved husband and father.

Aslam's death left the family in very dire circumstances, as Aslam was the only wage-earner for the family.

Disclosing her status in the family was not challenging as the family knew Aslam's sero-status. They accepted Razia whole-heartedly and provided her with all the necessary social support. Aslam had left the house to Razia, however, she had very little cash to run her house. She started selling her valuables, but then realized that this money would only help out in the short term and they would soon need another source of income. She opened a small grocery shop near her home, which helped to meet her family expenses. Unfortunately, Razia became severely ill in 2008 and had to close her shop. She then expressed interest in the New Light skill development training. Razia was trained in hand-made embroidery. This training has helped her to improve her economic status without putting stress on her physical health. Now she receives regular orders from local clients in her village for whom she prepares hand-made embroidery to provide for herself and family. Her 12-year-old son is in grade 5 and is continuing his studies with support of CRS. Razia is happy that her child is provided with educational support. Razia regularly attends PLHIV meetings organized by New Light and socially supports other PLHIV. She is a true "Ambassador of Hope" and constantly encourages other PLHIV to learn new skills and start their own income generating projects.

Razia recognizes and thanks the New Light team and CRS who have provided her care and support as well as skill training so that she can live a healthy and productive life.

"New Light and CRS are doing a wonderful job by providing care, support and treatment services to PLHIV in Pakistan," Razia says. "It's through the true efforts of New Light who trained me for handmade embroidery that I am able to pay household bills and earn some amount for my living. New Light and CRS support also helps my child to continue his education," she adds with pride.



PHOTO BY ADIL SHERAZ/CRS

Razia creates beautiful embroidery which enables her to support her family.



PHOTO BY LOVENESS MLAMBO/CRS

Zimbabwe

“Orphanages Without Walls”: Strengthening Comprehensive Care, Support and Treatment for Children Living with HIV Project

Introduction to Project

The Children Living with HIV project tackled many core challenges facing children living with HIV (CLHIV) in Zimbabwe, including a fragmented continuum of care, limited access to treatment for orphans and vulnerable children (OVC), and lack of child participation. The project was implemented in high density areas of Bulawayo and Harare from August 2006 to January 2010 using a community and family centered approach which emphasized capacity building of communities and families to care and support OVC and CLHIV. As a result, communities have continued to care for CLHIV in the provision of comprehensive care, support and treatment even after the funding period.

ZIMBABWE	
Type of Project	HIV treatment, care and support
Integration Aspects	Income generation, food assistance, education assistance and mainstreaming services for prevention of mother-to-child transmission.
Number of Beneficiaries	2000
Beneficiary Type	OVC
Source of Funding	The Royal Netherland Embassy and CRS Private funds
Duration of Project	August 2006 to January 2010
Promising Practice Highlighted	“Orphanages without walls” ensuring that children living with HIV are supported and cared for within the extended family system and in their communities.

Problem Statement and Context

Children living with HIV have the same needs for care and support as other vulnerable children. In addition to their range of general needs, HIV infection makes the need for adequate nutrition, psychosocial support, education, medical care, and support more complex and varied. This project was developed to address some of the gaps identified by the Situational Analysis for Children living with HIV and AIDS carried out by Catholic Relief Services (CRS) Zimbabwe, the Elizabeth Glaser Pediatric AIDS Foundation, and the Ministry of Health and Child Welfare in 2006.

According to the Ministry of Health and Child Welfare, Zimbabwe National HIV Estimates 2009, nearly 1.2 million Zimbabweans (14.3 percent of the population) are living with HIV. As Zimbabwe deals with one of the highest HIV epidemic rates in the world, it is also dealing with the rising number of AIDS orphans, most of whom are not only affected but also living with HIV.

In Zimbabwe, more than 72,000 children under 15 years—approximately 44 percent of CLHIV—need antiretroviral therapy (ART). But a disproportionately low number, only around 1,700 children or 2 percent of CLHIV needing treatment, are enrolled in ART programs. CLHIV’s limited access to ART is of significant concern, particularly for older adolescents who are heading households.¹

Due to their compromised immune systems, CLHIV get sick more often than other children. They face a public health care system which is short of both human resources and medications. When free medical facilities are available, transport and associated costs pose another problem. Moreover, food is often inadequate or not available, which creates a serious issue for children on ART who need to take their medication with food. The complex situation of malnutrition and low immunity also puts CLHIV at greater risk of suffering from opportunistic infections. This situation requires greater involvement by all players to improve both the access to and quality of the care, treatment and support of CLHIV.

¹ NAC. (2006). End of year report.

Purpose of the Project

While prevention of HIV infection in children remains a priority, the importance of ensuring provision of appropriate services for thousands of children already infected, as well as their caregivers, cannot be overstated.

STRATEGIC OBJECTIVES	Strengthen the continuum of care, support, and treatment for CLHIV and other vulnerable children.
	Increase access to care, support and treatment for CLHIV, with a focus on the most vulnerable children.
	Children and adolescents are empowered to play an active role in their own treatment and care.

Steps in Implementation

CRS Zimbabwe partnered with five local organizations that operated in Harare and Bulawayo, covering mostly high density suburbs. These are:

- *Child Protection Society*: Mufakose, Kambuzuma and Highfield (high density suburbs of Harare)
- *Mavambo Trust*: Bbobho area, Tafara and Mabvuku (high density suburbs of Harare)
- *Sibambane*: North End, Tegelar, Kingsdale, Makokoba, Mzilikazi, Ngubuyenja (High density suburbs of Bulawayo)
- *Sibambane – MMPZ*: Stationed at Mpilo Hospital’s Opportunistic Infection (OI) Clinic in Bulawayo- serves children ages five and older coming to this clinic for OI treatment and ARVs.
- *The Centre*: Hatcliffe Extension and Hatcliffe High density suburbs in Harare

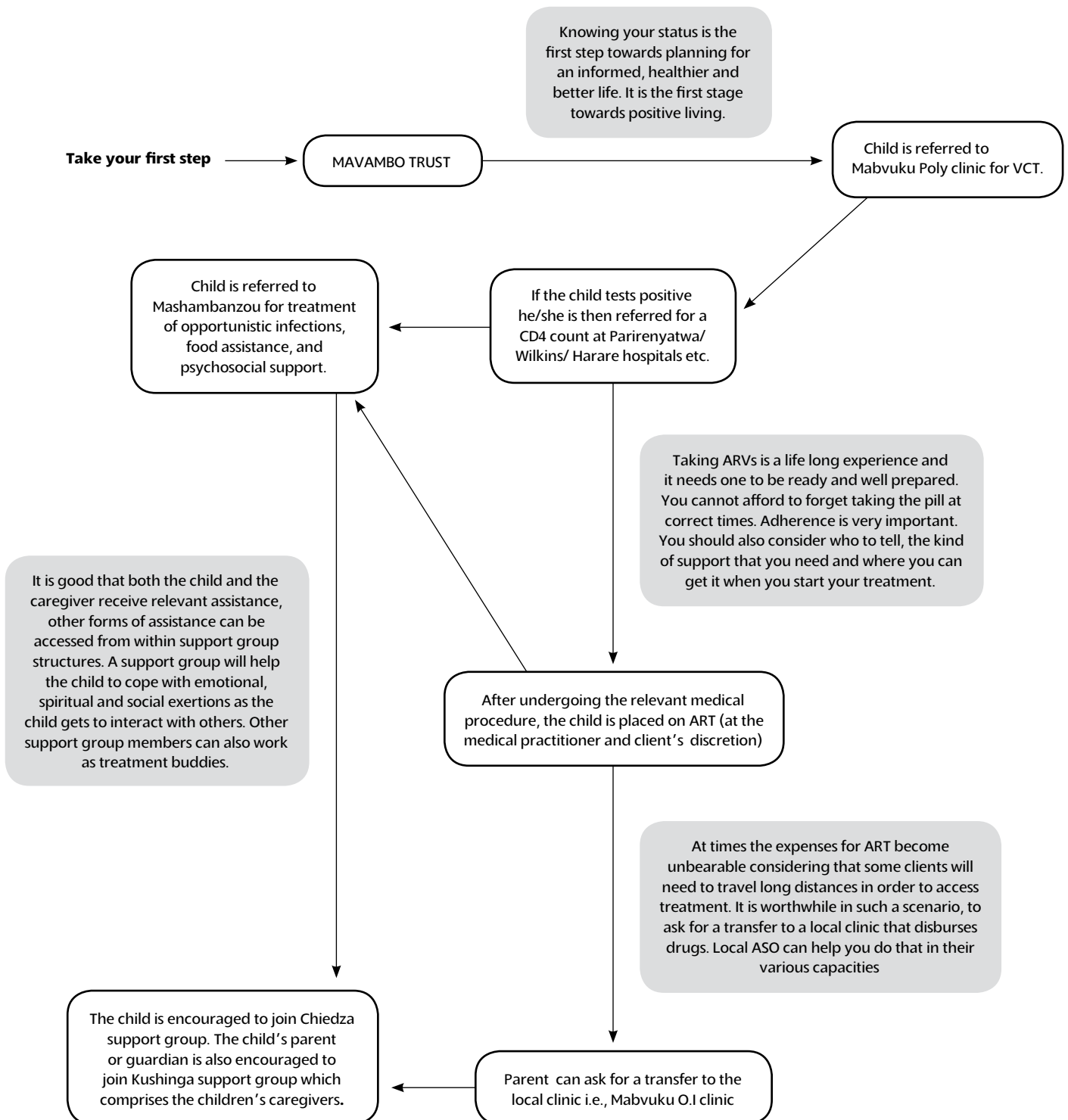
To strengthen the continuum of care, support and treatment for CLHIV and other vulnerable children, CRS Zimbabwe and partners built networks with other organizations, leading to 34 referral partners being able to provide access to a comprehensive continuum of care, treatment and support to children living with HIV. Most referrals that were conducted were for children who needed treatment for OIs.

To ensure access to treatment, CRS introduced a medical block grant system through which CRS disbursed funds to project partners. The project partners entered into agreements with hospitals and clinics, where the health centers treated children from two partners for OIs for an agreed upon period of time, without payment of cash up front. At the end of each month, the partners then reconciled the figures and settled the bill using the money from the medical block grant. Children who did not have money for transport were also given bus fares to collect their ART. In total 387 children were treated under this mechanism.

Another innovative strategy used was the development of maps of service providers which were distributed to caregivers. The maps informed caregivers and beneficiaries on where to access essential services for CLHIV within their communities. See Figure 1 for an example of a treatment roadmap. In some instances, communities drew up their own informal maps of treatment sites.

Figure 1: An example of a road map

MAVAMBO TRUST ROADMAP FOR ANTIRETROVIRAL THERAPY



The project emphasized the importance of appropriate care, support and treatment of CLHIV. To ensure that partners and community members are on the same page on support group issues, CRS developed “Guidelines for Establishing and Operating Successful Support Groups for People Living with HIV.” The guidelines targeted PLHIV who belonged to support groups or wanted to form support groups, as well as non-governmental organizations and health facilities that initiate and assist support groups.²



Chipo's Heroes is a treatment literacy tool for children.

CRS also produced a child-friendly toolkit on pediatric ART entitled “Chipo’s Heroes”, to educate children and their caregivers on ART and how ART can be accessed in Zimbabwe.³ The toolkit also assisted CLHIV to play an active role in their treatment and care. The toolkit is comprised of a comic book, information cards, posters, and guidance on how to lead dramas based on the characters in the comic book. Child-friendly treatment literature and tools focusing on ART adherence provided over 300 children with simple strategies for adherence and empowered them with information they needed to better understand their HIV status. Through theater and memory work, the children managed to express their feelings, needs and emotions regarding their status. This in turn enabled caregivers to identify the kind of support that the children needed, whether it was counseling, psychosocial support or basic needs.

Integration

Income Generating Activities

To strengthen the economic status of households caring for CLHIV, partners sourced funding and started pilot projects focusing on income generating activities. Caregivers were put in groups and embarked on poultry, bakery and lotion-making projects. The proceeds from these activities have been used to take children for health check-ups and purchase food to improve nutritional status and adherence.

Education Assistance

Chronic illness often leads to financial strains on the family. A lot of money is used for medical needs and in most cases leaves families without resources. CLHIV who were unable to pay their school fees were linked to CRS’s Program of Support that pays schools fees for OVC.

Food Assistance

CLHIV, require good nutrition, as an inadequate diet may result in poor adherence. Through partners’ networking, children benefited from the food programs run by other organizations. The food package included mealie-meal, beans, bulgur and cooking oil.

² Fanelli, C. and A. Moyo. (2008). CRS Zimbabwe. Guidelines for Establishing and Operating Successful Support Groups for People Living with HIV.

³ CRS Zimbabwe . (2007). CHIPO’s Heroes-How ARVs help Chipo stay strong.

Prevention of mother-to-child transmission (PMTCT) mainstreaming

All five implementing partners were trained on PMTCT. Community volunteers were also trained and helped to identify HIV-exposed children and provided appropriate help and referrals. They also disseminated correct information to pregnant women, who then knew to take appropriate action to prevent transmission of HIV to their unborn babies.

Positive Outcomes and Impacts

Formation of support groups

Fifteen support groups for CLHIV and caregivers were formed, creating child advocates and treatment buddies. In these support groups, mothers and guardians of HIV-positive children came together to improve care and reduce discrimination through open communication. These support groups have also taken extra steps to strengthen their household's economies. They have been contributing money and saving together through Savings and Internal Lending Communities, and 33 women comprising two groups have initiated income generating activities. After these groups had been formed, project partners assisted with training on candle making, baking buns, poultry rearing and financial management. The proceeds from these economic activities have contributed towards members' transportation and medical costs.

Use of psychosocial support (PSS) as a tool for positive living

The hero's book approach leads children through a series of autobiographical storytelling and art exercises to find solutions to personal and social challenges. These books are solution-focused and can be used generally in schools or as a focused intervention for more severely affected children. The hero book allows children who can draw or write to express their feelings. Used in support groups, it is able to offer support to larger numbers of children in resource scarce settings. The CLHIV put together their hero books, and project officers read through the books to follow up on counseling issues.

Creation of child advocates

The project groomed 284 child advocates who spearheaded the formation of CLHIV exclusive support groups, where children shared information on adherence and how they were coping with treatment. Through a youth initiative, "Young People We Care," children are raising awareness about the situation of CLHIV through drama, poetry and music. Young People We Care has become a leading child-advocate group for CLHIV.

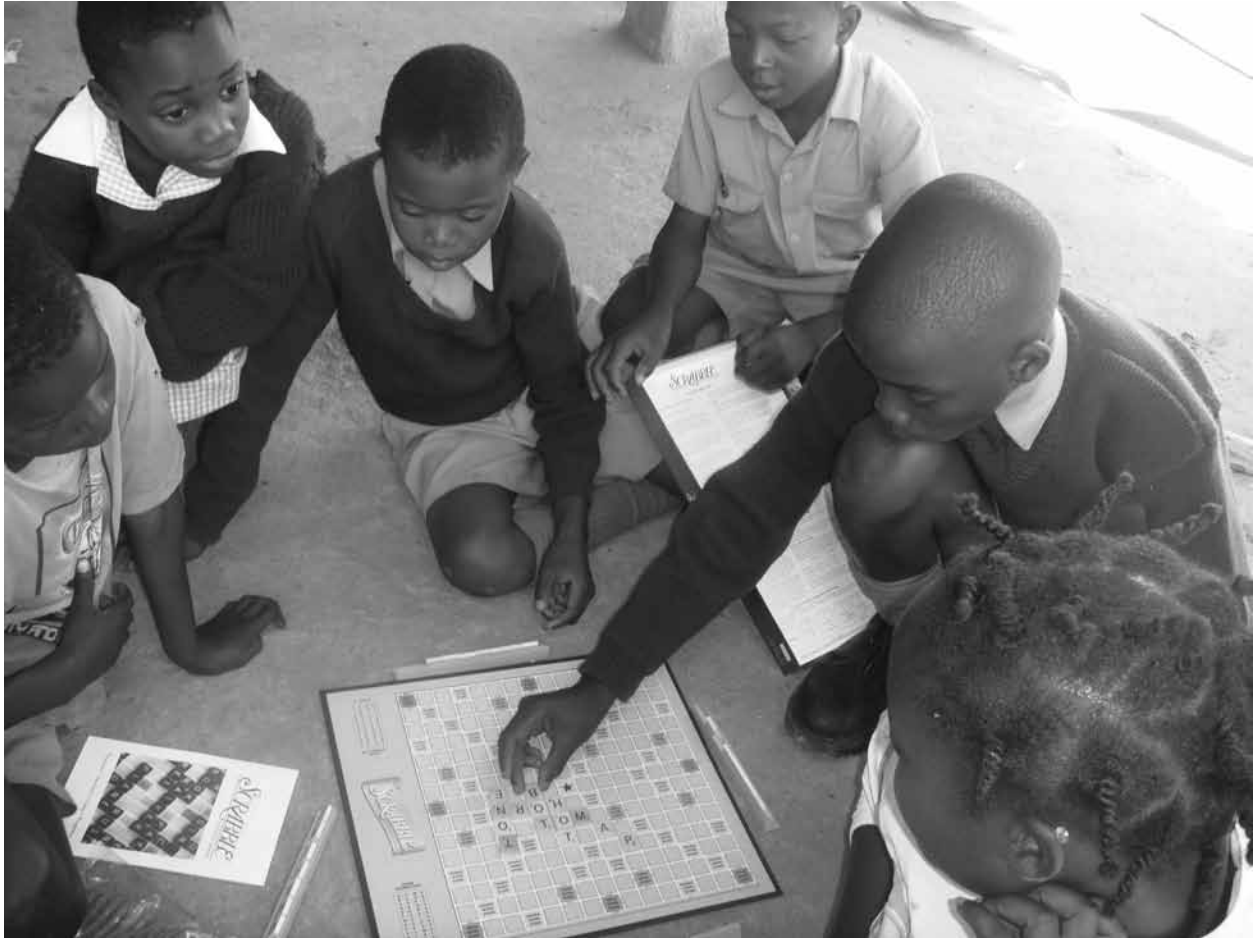
Increased access to care, support and treatment of CLHIV

A total of 2,234 home-based care (HBC) and community volunteers were trained on different topics that included home nursing, herbal therapy, life skills, pediatric care and basic counseling. The trained volunteers and caregivers were equipped with skills that enabled them to follow-up on HIV-exposed children and refer them to health centers. As a result of these efforts, 235 HIV-exposed children were identified and enrolled in ART programs.

Lessons Learned

- There is a wealth of knowledge on children and HIV within the scientific community. However, very little literature is available and suitable for use at the community level. It is important to tailor such information and empower communities to better understand, support and manage CLHIV.

PHOTO BY LOVENESS MILANBO/CRS



CLHIV project partner MMPZ uses games as PSS tools to reach out to children living with HIV. As they play and through interacting with others, children open up and the facilitators can identify some of the psychological issues that are affecting them.

- Psychosocial support is more effective if implemented at the family level. To ensure success, it is vital to equip primary caregivers with these skills.
- Support groups enhance children’s confidence, happiness, friendship and sense of belonging. They enable other children to appreciate and further understand the situation of CLHIV. The CLHIV in turn realize and appreciate that they are not alone in their situation.
- Most parents and caregivers are willing to discuss HIV issues with their children, but they lack the skills to do it.

Promising Practices

The project places emphasis on the concept of “orphanages without walls”, which ensures that orphans are cared for within the extended family system and in their communities. Formation and training of support groups, promotion of treatment literacy and treatment maps have empowered primary caregivers and family members of CLHIV to provide better care to the children. Empowering parents, caregivers and volunteers has ensured sustainability of the project. Support group meetings are continuing without any support from CRS and its partners.

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VOICES

Debbie DeVoe, CRS' regional information officer for Eastern and Southern Africa, sat down with members of the *Kubatana* ("Unity") Support Group in Mufakose township outside of Harare in Zimbabwe. The group was formed in early 2009 with the support of CRS' local partner, the Child Protection Society, and with funding from the Royal Netherlands Embassy. The women meet weekly to talk about their problems and share solutions. They also receive training every few months on topics such as good nutrition and the importance of taking HIV medication as directed (antiretroviral adherence). By coming together, these mothers and guardians are helping their children live with HIV while breaking down barriers across their community.

DeVoe: What do you like about being in a support group?

Nyarai Pinduka: The problems that I face with my children are different from the problems others may have. When we come to the support group, we can share our problems and discuss how we can care for our children. I've learned a lot about issues related to caring for children living with HIV, including nutrition.

Beauty Kidado: I learned about [antiretroviral] adherence and the importance of giving medication to children at specific times. I also learned that certain medications may cause side effects, like numbness.

DeVoe: I'm surprised to learn that most of you are so open about your children's HIV status and your own status. Do you or your children face any stigma or discrimination?

Monica Mashingaidze: When my family learned of my status, they didn't want to touch anything I had touched, eat food I had prepared or wash any of my clothes. Even when I'm sick, I still have to do my own laundry. I lost my husband last year in October, so I don't have anyone to help me. Sometimes I get help from the church, but sometimes if I'm hospitalized, I don't have anyone to pay the bills.

Stella Kandeya: My child is the one facing stigma. Other children noticed she had a skin rash, warts on her face and was missing class. Now they won't play with her. Initially she was sad about it, but after counseling and therapy she's okay with it.

Matope: In my family, no one discriminates against my child. They share utensils, and they all love and care for the child. They'll even take her to the hospital if I'm not there.



Kubatana Support Group in Mufakose, Harare come together to improve care and support one another.

DeVoe: Why do you think most of you don't face discrimination?

Matope: Because we've been trained, we share [our knowledge] with this community.

Kidado: Other community members are reluctant to disclose their status. We try to encourage them.

Mashingaidze: Other people have come up to me and said they are scared. They ask how I disclosed my status.

DeVoe: Do you think that because you're open about your and your children's status that other people lose their fear of HIV?

All answering in unison: Yes!

Part II:

Health Systems

Strengthening



PHOTO COURTESY OF PAUL JEFFREY/ECUMENICAL ADVOCACY ALLIANCE

SOUTH AFRICA

Transitioning AIDSRelief South Africa to Local Leadership

Introduction to Project

In 2004, Catholic Relief Services (CRS) South Africa was one of ten CRS country programs included in the AIDSRelief consortium, a five-year program funded through a grant from the U.S. President's Emergency Plan for AIDS Relief (PEPFAR). AIDSRelief was managed globally by CRS headquarters, in collaboration with the Human Resources and Services Administration of the U.S. Department of Health and Human Services. In country, the U.S. Centers for Disease Control and Prevention provided program oversight.

The purpose of AIDSRelief was to support the rapid scale up of HIV care and treatment services through select faith-based organizations. In South Africa, CRS supported the South African government's rollout of antiretroviral therapy (ART) by making it available in needy communities where services consisted primarily of small, community-based programs providing home-based palliative services.

AIDSRelief was implemented through two umbrella organizations¹: the AIDS Office of the Southern African Catholic Bishops Conference (SACBC), with 20 treatment sites, and the Institute for Youth Development/South Africa (IYDSA), a faith-based organization based in the Eastern Cape Province of South Africa, with five sites—one based in a church and most others connected with rural government clinics. Sites under the SACBC umbrella included two hospitals, four primary care clinics, and six hospices. Nine of the 20 programs offered clinical outreach services in a variety of community settings, often with the most basic infrastructure. Some services were delivered from converted freight containers, from a caregiver’s simple shack, or even from the back of the nurse’s car. Eighteen sites provided home-based care services. The AIDSRelief sites were located in seven of the nine provinces of South Africa. The focus of the AIDSRelief program was to build local capacity of the existing church service organizations to sustain high quality HIV care and treatment for people living with HIV (PLHIV).

SOUTH AFRICA	
Type of Project	HIV Care, Antiretroviral Drug Treatment, and Health System Strengthening
Number of Beneficiaries	73,293
Beneficiary Type	PLHIV
Source of Funding	PEPFAR
Duration of Project	2004-2009
Promising Practice Highlighted	Strengthening capacity of local partners

Problem Statement and Context

South Africa has an estimated population of 5,600,000 PLHIV, the largest in the world.² Prior to PEPFAR, only a limited number of government facilities offered HIV treatment. Despite the fact that South Africa has one of the largest treatment programs in the world, in 2004, less than 10 percent of those who needed treatment were able to access it.³

Prior to AIDSRelief, most church service organizations lacked not only access to antiretroviral medications but also the trained staff and laboratory facilities to provide high quality HIV treatment. They instead focused their efforts on providing home-based palliative care services for people living in resource-limited communities. In 2004, when antiretroviral treatment became available through PEPFAR funds, it became possible to save lives as well as provide care. The challenge was to strengthen the capacity of SACBC and IYDSA and expand existing home-based care programs into competent medical treatment sites that contributed to the South African government’s treatment program. In addition, CRS South Africa recognized that funding for international organizations would be of limited duration and that the partners would eventually need to manage the treatment programs and associated funding independently, requiring improved systems, structures, and procedures.

1 An umbrella organization is an association of organizations that work together informally to coordinate activities and pool resources.

2 UNAIDS. (2010). Towards Universal Access Report 2010; WHO. (2010). Global TB Control Report.

3 UNAIDS. (2010). South Africa Country Fact Sheet: Accessed on Feb 15, 2011 at <http://cfs.unaids.org/>.

Purpose of Project

The goal of the AIDSRelief project is to assure that people living with HIV have access to ART and high quality medical care.

STRATEGIC OBJECTIVES	Existing ART service providers are able to rapidly scale up delivery of quality ART.
	The number of health care facilities providing quality ART is increased and the capacity of smaller sites with limited or no experience with provision of antiretroviral drugs is increased to allow initiation of ART.
	Community-level services providing quality ART to low-income HIV infected persons are expanded.
	Health care treatment networks are created and strengthened to support capacity building within their countries and communities.

In South Africa, AIDSRelief was implemented in a way that strengthened the capacity of the umbrella organizations to manage and assume leadership for the program, while delivering quality clinical services to those in need.

Steps in Implementation

Preparation for transition to local leadership began even before the first day of the AIDSRelief program. CRS’ relationship with the SACBC goes back to the year 2000 when CRS’ office first opened in South Africa. By 2004, when PEPFAR funds became available, SACBC and CRS had established a collaborative, mutually respectful, and trusting relationship. CRS’ relationship with IYDSA began in 2004 at the start of AIDSRelief and grew over the course of the program. Critical to a successful transition was the mindset among all staff that program leadership should transition to the umbrella organizations as soon as was feasible.

CRS worked side-by-side as a team with the SACBC and IYDSA - meeting regularly, participating in trainings together, and working in the field together. For example, the financial management capacity of SACBC project managers and finance staff was strengthened by working directly with their CRS counterparts. The CRS monitoring and evaluation (M&E) team facilitated trainings and supported M&E at the treatment sites. Partners participated in all CRS meetings with donors and technical experts. Together CRS and the umbrella organizations identified local clinical experts by approaching leaders in the Southern African HIV Clinicians Society, known internationally for their academic credentials, their published research, and their excellence in clinical practice. Through this network of local experts, AIDSRelief had access to excellent clinical faculty and mentors and established linkages with local educational institutions. The President of the Southern African HIV Clinicians Society agreed to serve as the Medical Advisor for the program and continues in that role to this day. Staff and consultants from the Centers for Disease Control, the National Department of Health, international accounting firms, as well as other PEPFAR-supported training organizations, provided additional support.

CRS and the local experts provided intensive training and support in the areas of clinical management, financial compliance, and M&E. Through consultations, joint activities and exchange visits between treatment sites, the partners assisted each other. An example is the effective and user-friendly Patient Data System (PDS) developed by IYDSA and later shared with and adopted by the SACBC.

Patient Data System (PDS)

The PDS is a user-friendly electronic tool for managing the care and treatment of PLHIV and for generating the patient statistics and other reports required by the donor and the local health authorities. The PDS is a web-based application that can be accessed via a server through a network or as a stand alone application on a laptop. The system was designed to work in areas where technology and communication structures are limited and costly.

The PDS includes patient demographic data, as well as clinical information essential to patient care and treatment. The PDS also keeps track of the patient's expected day of return to the clinic. This enables the clinic to produce lists of expected patients, assisting with workload planning. If a patient misses an appointment date, the system will reflect the days missed, alerting the clinic staff to the need for active follow up.

The PDS is now being further developed into a pharmacy ordering tool. This will enable the treatment sites to order drugs based on patient numbers and prescriptions, thus ensuring accurate data and effective stock control.

Finally, the PDS makes it possible to accurately monitor and evaluate treatment quality and outcomes for large numbers of patients and to identify needs for additional program support and staff training.

Over the five years of the grant, as partner capacity grew, CRS staff gradually disengaged from providing hands-on implementation, to only providing assistance upon request. This gave the umbrella organizations the opportunity to demonstrate their ability to serve as prime recipients of grant funds.

Positive Outcomes and Impacts

By September 2009, towards the end of the five-year AIDSRelief grant, a cumulative total of 73,293 people had received HIV care and 35,038 were enrolled in ART. Throughout the project hundreds of health workers were trained, including 296 in 2008-2009 alone. During the final years of the grant, SACBC, IYDSA, and St. Mary's Hospital, the largest treatment site (see success story below for more information), independently applied for, obtained, and successfully managed small U.S. government grants to support complementary activities, such as care for orphans and vulnerable children. Over time, they all developed the capacity and the confidence to work with the donors and assumed leadership of this large and complex treatment grant. Then in 2010, all three organizations successfully applied for and won a second five-year grant. Through a sub-agreement, CRS provides technical support in the areas of clinical coordination and training, M&E, and certain aspects of financial management to the two umbrella organizations. CRS provides technical assistance to St. Mary's Catholic Hospital upon request.

In addition to the successful transition of the umbrella organizations from sub-recipient to primary recipient, the AIDSRelief treatment program needed to ensure that patients would be able to access life-long treatment. To ensure sustainability, the program adopted four strategies to align itself with the South African Department of Health's treatment program. These approaches were (1) accreditation of the local

PHOTO BY DEBBIE DEVOE/CNS



At the Phelandaba outreach center, a patient receives counseling and antiretroviral medications.

partner sites as South African government antiretroviral treatment rollout sites, which allowed these institutions to provide heavily subsidized services; (2) transfer stable AIDRelief patients to Department of Health facilities as their absorptive capacity increased; (3) transfer the AIDSRelief treatment site to another program funded by a different donor; or (4) obtain antiretroviral medications from the South African government for local partner sites accredited as down-site referral clinics.

Lessons Learned

The involvement of international organizations in development programs is, by nature, temporary. Effective and sustainable programs require local leadership and may depend on government support as well. The lessons learned in transitioning a large and technically complex HIV care and treatment program to local partners were:

Respect local capacity and begin early

Transition to local leadership begins even before the beginning of the project. It begins with an understanding that the participation of the international organization is only temporary; with an acknowledgement that the local partner is the one who knows what will work best in the local context and that the local partner is the one best suited to implement activities in their own country. All program planning should take into account the final goal of transitioning to local leadership, and all activities should be planned from the project start with that goal in mind.

Learn together

Local partners should attend training courses with staff from the international organization. If the donor conducts a training, partners should attend with the staff of the international organization, as opposed to having the international staff attend and then pass on the information learned to the local partner. When the local partner is given the opportunity to participate directly in training on donor regulations, for example, they will learn the requirements first-hand and will not perceive them as arbitrary requirements imposed by the international partner. Learning the regulations together is a collegial sharing experience, far more acceptable than the teacher-student dynamic created when the international partner is the one to deliver the information.

Approach donors jointly

Local partners should be included in all meetings with donors or consultants. This allows local partners to get to know the donors directly, to understand the donor perspective, and to gain experience in working with them. It also gives the donor the opportunity to know the local partners and to see their capacity. When concerns about the local partner arise, continue to meet the donor together with the partner and share ownership of the situation; that is, speak to the donor about “our ” concern, about the challenges “we” face. This approach will strengthen the relationship with the partner and earn the respect of the donor.

Utilize local resources

The linkages established with local resource people and institutions will provide continued long-term, cost-effective support for the local partners after the external funding has come to an end. However, in countries where local experts are oversubscribed and institutions stretched to the limit, external experts may be the best option.

Work with the host government

In most countries, health services are the responsibility of government. External donor funding for PLHIV will not continue forever. If life-long treatment is to be sustained, the local government must be on board. Challenges may arise when a government resists working with local and/or international organizations and when the local implementing partner does not want to invest the time and energy in establishing a relationship with officials who are not supportive of their work. Relationship-building activities can help overcome these barriers—activities such as inviting government officials to project workshops, sharing educational resources, and looking for ways to be helpful. In all cases, international and local organizations should refrain from criticizing government health services. In all instances, all partners should convey the message that their work is in support of government efforts to provide treatment.

Reinforce local ownership

Local partners should be the face of the program. For example, when there are presentations to be given, the local partner should be the speaker, if possible. When local partners are inexperienced, joint presentations (preparation and delivery) will help the partner gain these skills and will reinforce the collaborative nature of the partnership.

Build an effective team

Team-building should be a priority, with joint implementation of activities, and shared and joint decision-making. Mutual respect and a consultative relationship should characterize all interactions.

Work side by side

Joint implementation of activities, with local and international partners working side by side, contributes to team-building and builds the capacity of both. The challenge lies in the fact that the international organization, as the grant holder, is ultimately responsible for the deliverables of the project as well as for timely submission of reports to the donors. Joint activities remain the responsibility of the international partner, no matter which organization is implementing them. If the work is divided and the local partner does not do their part or does not deliver on time, it is the international partner who will be held accountable. In a relationship of equals, partners help one another. In a good relationship, the local partner will appreciate being asked to help the international partner, once they understand the need.

Disengage gradually

As the time for transition to local leadership draws near, the staff of the international organization should gradually disengage from day-to-day implementation, while continuing to accompany the local partner and provide support when requested. For example, the role of chairperson should first alternate between the two organizations and then gradually be assumed by the local partner. The international partner should gradually withdraw from representational activities. The outcome should be a transition that is so natural that it is hardly commented upon.

Promising Practices

The AIDSRelief transition experience in South Africa had a number of promising practices. CRS' partnership with the umbrella organizations was approached as a relationship between equal decision-makers. While not always easy, this dynamic set the groundwork for an effective transition that was planned from the start of AIDSRelief and had the full support of the U.S. government's PEPFAR team, at the country level as well as in Washington, D.C., and was approved by the Office of the Global AIDS Coordinator. At the beginning, CRS and local experts provided intensive hands-on support for the umbrella organizations and the community-based treatment sites, which improved patient care, but also strengthened their financial and management systems. In addition, every effort was made to send staff from the treatment sites to government- accredited training courses and conferences. This enabled the umbrella organizations to assume an increasing amount of responsibility for the program, including functions associated with representation.

Also critical to this program's success was the alignment it sought with the South African government's ambitious strategic plan. This plan intends to extend HIV treatment services to 80 percent of all South Africans that need antiretroviral treatment by 2011. The capacity strengthening provided through AIDSRelief played an integral role in expanding services and reaching underserved areas. Dialogue with the government allowed for the creation of four different approaches toward sustaining patient access to quality care and treatment.

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PHOTO BY DEBBIE DEVOLF/CRS

Like St. Mary's, this ART center at St. Gabriel's has updated lab equipment through its partnership with AIDSRelief.

CASE STUDY

"Graduating" St. Mary's Catholic Hospital

St. Mary's Catholic Hospital, the largest AIDSRelief treatment facility in South Africa, was originally part of the network coordinated by the SACBC, specifically, the SACBC AIDS Office. Founded in the late 1880s, St. Mary's has long provided services for patients in the surrounding communities—public and private. Under the AIDSRelief South Africa program, the hospital provided antiretroviral drug treatment to over 4,000 patients.

During the years of its partnership with AIDSRelief, St. Mary's qualified as a government-accredited antiretroviral therapy rollout site, giving it access to HIV drugs and laboratory support from the South African government.

Through its partnership with AIDSRelief, the pharmacy has been renovated; the hospital building has undergone needed repairs; a M&E unit has been established; four mobile treatment units have been equipped; the Patient Data System has been installed; and over 200 health workers have been trained. AIDSRelief assisted St. Mary's by providing the needed resources, by sponsoring training, and by seconding AIDSRelief and SACBC staff to St. Mary's for extended periods of time.

By 2009, after working together for five years, St. Mary's Hospital had achieved the capacity to function independently of AIDSRelief and outside of the larger SACBC network. Today St. Mary's Hospital receives funds directly and operates independently, fulfilling its mission of providing quality health care to the communities it has served for so many years. CRS continues to provide technical support on an informal basis when needed.



PHOTO BY AHEAD STAFF FOR CRS

CAMBODIA

Towards Universal Coverage in Cambodia: Expanding HIV and Tuberculosis Control to Battambang Prison

Introduction to Project

Although Cambodia is drawing close to reaching universal access for people living with HIV (PLHIV), the prison population has been neglected. International charters stipulate that prisoners have the right to attain the same standards of care as everyone else, yet little work has been done in rural Cambodia to link prison health services with national HIV and tuberculosis (TB) programs.

An HIV pilot project was introduced by Catholic Relief Services (CRS) and its partner, Action for Health and Development (AHEAD) at Battambang prison. Links were drawn between the Provincial Health Department (PHD), referral hospital, and the prison. Three strategies were deployed: (1) Promotion of voluntary counseling and confidential Testing (VCCT) through education and referral to the hospital; (2) Provision of proper care, treatment, and support to PLHIV prisoners; and (3) Ensuring good

coordination and capacity-building among prison and PHD staff. To date 1,324 prisoners have been provided with VCCT, and 23 new HIV cases identified, 424 TB suspects were tested and 34 TB cases confirmed. The prison project funded by CRS private funds was implemented from October 1, 2008 through September 30, 2010.

CAMBODIA	
Type of Project	Cross-sectoral and Health Systems Strengthening
Integration Aspects	Integration with health and prison department and TB/HIV
Number of Beneficiaries	1,115 prisoners per year, 3 prison health post staff, 40 prisoner peer educators
Beneficiary Type	General prison population and prisoners with TB and/or HIV
Source of Funding	CRS Private Funds
Duration of Project	2 years (October 1, 2008 – September 30, 2010)
Promising Practice Highlighted	Multi-tiered approach to building support and bringing health services to clients in the prison

Problem Statement and Context

Prisons and other overcrowded settings act as crucibles of communicable diseases. Prisons tend to concentrate and contribute to the spread of infectious diseases like TB and HIV due to factors inherent in the system. Needs usually remain unmet due to (a) lack of awareness of and/or disregard for the rights of prisoners to attain minimum standards of health; (b) inadequate resource allocations; and (c) failure to appreciate the public health threat posed by the concentrated congregation of prisoners under sub-optimal environmental conditions. Additionally, there is a definite need to respect international laws, covenants and charters that stipulate the provision of equitable health services to all with the goal of upholding the rights and dignity of every human, irrespective of status.

In October 2008, CRS entered into partnership with AHEAD, a local health NGO based in Battambang, to pilot expanding HIV and TB services to the provincial prison. The primary findings of the service gap analysis carried out by CRS and AHEAD were (a) poor coordination of services between the prison and the health department; (b) poor reporting and recording of routine health information; (c) overcrowding and poor hygienic practices; (d) incomplete observation for Directly Observed Therapy-Short Course (DOTS); (e) absence of VCCT services within prisons; (f) absence of health promotion activities; (g) lack of appropriate nutritional support for clients on treatment; and (h) presence of other co-morbid conditions.

Cambodia is ranked 21st on the list of 22 high-burden TB countries in the world. An estimated 64 percent of Cambodians are infected with TB, and a substantial number of cases remain undetected.¹ There were almost 71,000 new TB cases in Cambodia in 2006, with an estimated prevalence of 665 cases per 100,000 people. The National TB Control Program began DOTS implementation in 1994 and by 2004, DOTS

¹ From USAID website, accessed on 8 Feb 2011: http://www.usaid.gov/our_work/global_health/id/tuberculosis/countries/asia/cambodia_profile.html

coverage reached 100 percent, cure rates were above 80 percent, and case detection rates were quickly approaching the 75 percent target.²

Cambodia is one of the few countries in the world which has achieved Millennium Development Goal 6 – to halt and begin to reverse the spread of HIV by 2015. HIV prevalence has fallen to an estimated 0.9 percent among the adult population in 2009, down from a high of 2 percent in 1998. At the same time, intensive work is underway to reach ambitious, yet attainable, Universal Access targets for HIV prevention, treatment, care and support. But these gains in TB and HIV have yet to be realized in prisons, where a higher prevalence could reverse advances already made.

Since 2008, a growing momentum fueled by the National Center for HIV/AIDS, Dermatology & STIs, the principal government body responsible for the HIV response, and complemented by United Nation (U.N.) agencies and civil society, has undertaken tangible steps to improve health standards in prisons. These efforts have come to fruition with the drafting and adoption of (1) a Standard Operating Procedure for implementing each HIV and TB program in prisons in Cambodia; (2) a nationwide assessment of TB in prisons by National Center for TB & Leprosy Control; and (3) civil society and U.N. agencies' assessments conducted in 2007 – 2008 by CRS, the U.N. Office on Drug & Crime, and the TB Control Assistance Program. These initiatives have provided the necessary impetus for starting up several pilot projects across the country including CRS' Battambang Prison Project.

Purpose of the Project

The pilot project was designed by CRS and AHEAD with the aim of improving access to TB and HIV services in Battambang prison. The Four strategic objectives provided the road map to achieve the project's goal of providing prisoners access to the necessary TB and HIV diagnostic, treatment, care, follow-up, and preventative services.

STRATEGIC OBJECTIVES	Promote VCCT and TB screening through health education and establish formal referral mechanisms.
	Foster treatment and care services for PLHIV and TB prisoners to meet their clinical and social needs.
	Improve coordination among the related departments/stakeholders and NGOs working with the prison.
	Build the capacity of the health post staff through formal training, supportive supervision, and ongoing technical assistance.

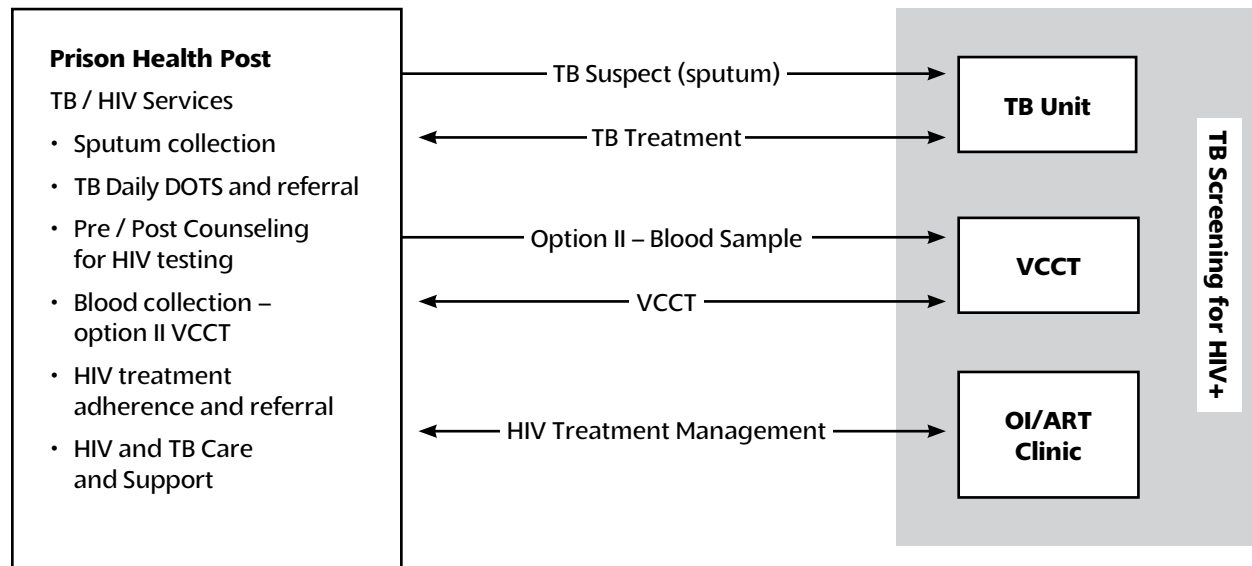
Steps in Implementation

Stakeholder buy-in was crucial to the success of this novel intervention and was achieved through a series of coordination meetings that defined the roles and responsibilities of the key players which included the General Department of Prison, Provincial and District Health Department personnel. The process was further facilitated by stakeholders' sense of urgency as well the availability of capable service delivery partners.

² Ministry of Health. (2007). National Tuberculosis Program TB Report.

Referral pathways were established, defining critical processes to be followed for sputum collection, counseling, testing for HIV, collection and administration of medicines, as well cross-screening for TB and HIV. The referral pathways strongly emphasized screening for co-infection using provider-initiated testing and counseling for the integration of TB and HIV services (see Figure 1) because prisons often exhibit higher than normal number of co-infection cases. Furthermore, TB is the primary opportunistic infection in PLHIV and one of the leading causes of mortality in prison conditions.

Figure 1. Referral Pathways for TB and HIV for Battambang Prison



Through continuous capacity-building, routine supportive supervision, technical assistance, and provision of the necessary supplies, the project created a cadre of personnel able to deliver quality TB services. DOTS was prescribed by the referral hospital physician, using fixed dose combinations, and was observed and recorded by the prison health staff. Infection control using WHO/UNAIDS guidelines, including provision and use of essential supplies (e.g. masks, gloves, cleaning supplies, bleach, disinfectant, sharps container, etc). Creating awareness among the prison authorities regarding the transmission dynamics of TB led to designation of a room for isolation of sputum-positive cases.

HIV service delivery strategies were developed through a collaborative process, drawing inputs from the Battambang Provincial AIDS Office, the antiretroviral treatment clinic, counseling staff at the referral hospital, the prison authorities, and the health staff. Emphasis was placed on establishing systems and procedures which would be feasible in the prison setting, where the capacity of health post staff is limited and security is a major concern. Awareness creation, pre- and post-test counseling, blood sampling of consenting clients, provision of test results, and appropriate referrals constituted the principal elements of the services provided.

The Strategic Information System was introduced with national TB and HIV registers and forms, complemented by on-the-job training on how to input the information, ensuring that prison data was fed into the national information grid. The project stocked the health post with essential medicines to supplement the few supplies the health post receives from other service providers alleviate morbidity due to other health conditions.

Trained inmates who functioned as peer educators conducted health education to create awareness, dispel myths and misconceptions, increase case findings, encourage testing and decrease stigma. Behavior change communication materials were specifically designed for prisons. Peer educators also facilitated the formation and functioning of self-help groups.

Integration

The Battambang Prison Project is the vanguard of health care provision in closed settings in Cambodia. It has paved the way for coordination between different arms of the national government—bringing the prison health posts under support of and in line with the Ministry of Health systems.

It has created strong linkages

between service providers which are expected to become stronger. Word has spread, and other prisons have shown an interest in providing similar services. Within the prison, the program has fostered a climate of dialogue and participation that allows for better interaction between inmates and staff. Capacity building for prison health staff created a cadre of dedicated professionals who can provide primary health care, in addition to TB/HIV interventions. Training and constant mentoring improved staff ability to recognize and manage general illnesses, lessening the need for referrals. Commitment to quality has been the hallmark of this program, as evidenced by the approval of post-test counseling within prisons, following quality assessments by the Provincial AIDS Office. It has also resulted in overall strengthening of the health information systems, with routine information being fed into the national morbidity and mortality data. All these outcomes are in keeping with the CRS health system strengthening objectives of improved service provision, quality assurance in health care, sustainability and complementing the national efforts.

Positive Outcomes

The project was successful at expanding TB and HIV services to Battambang Prison. The prison health post is now adhering to standard operating procedures and treatment protocols as well as using Ministry of Health forms, with data feeding into the national health information system. Communication and coordination has greatly increased between the prison and health departments with a functional referral mechanism in place. Many services are now provided in the prison health post, thereby reducing the number of visits to the hospital and hospitalizations. VCCT testing revealed an HIV prevalence among those being tested much higher (1.74 percent) than the national prevalence (0.9 percent).



PHOTO BY AHEAD STAFF FOR CRS

Prisoner having his blood drawn by prison health post staff for HIV screening after receiving pre-screening counseling. The blood will be sent to the lab at the provincial referral hospital for testing.

Outcomes as of June, 2010 CRS/AHEAD project review

AVERAGE # PRISONERS	VCCT		HIV (DISCOVERED IN TESTING IN PRISON)		PLHIV (NEW AND ALREADY KNOWN POSITIVES)		TB SUSPECTS IDENTIFIED	NO. TB DIAGNOSED		
	m	f	m	f	m	f		S+	S-	EP
1,114	1,324		23		49		424	34		
	1,275	49	18 m	5 f	44 m	5 f		S+	S-	EP
	1.74% HIV prevalence among those tested							17	14	3

m = male, f = female, S+ = sputum smear positive, S- = sputum smear negative, EP= extra pulmonary TB

Outcomes of CRS/AHEAD project review

Prison health staff trained on Option 2 (Drawing blood sample on site and sending to health facility for testing)	5
Prison health staff trained on pre/post testing counseling for VCCT	3
Prison health staff trained on TB control and sputum collection	3
Prison peer educators trained on TB and HIV control	40
Prisoners receiving health education on TB and HIV	2,628
Posters disseminated on HIV and TB prevention	44
Leaflets disseminated on HIV and TB prevention	2,000

Lessons Learned

- HIV prevalence is high among the prison population in rural Cambodia, indicating that prisoners are a high risk population that needs to be targeted in the National HIV Program.
- Though active screening of the entire prison population is required to reduce TB transmission, the limited human resource capacity and space constraints for isolation facilities precluded the use of such an intervention in the initial phase and only inmates with relevant symptoms were screened.
- Given the high toxicity of the drugs, low nutritional status of the prisoners, and the low availability and poor quality of food in the prison, nutritional support must be included with all TB and HIV services. However, when providing additional nutritional support to cope with treatment side effects, it is difficult to ensure confidentiality in the isolated social microcosm of a

PHOTO BY AHEAD STAFF FOR CRS



Prison health post nurse provides health education on TB and HIV to prisoners.

prison. Standard operating procedures therefore need to provide guidance to health post staff on how to attain some measure of confidentiality given the realities of working in a prison.

- Partner notification and family disclosure are particularly difficult to achieve with HIV-positive prisoners. Most prisoners are alienated from family and friends. Familial support is helpful to the mental state of the prisoner and for the provision of supplemental food and resources.

Promising Practices

Multi-tiered approach to building support

Following the identification of the unmet health needs in closed settings, CRS/AHEAD engaged in a strategic build-up of support for the proposed interventions. CRS assessment and reporting of prison health conditions, particularly in relation to HIV and TB, highlighted the need to implement programs to address these issues. CRS was able to coordinate with a broad range of stakeholders, effectively bridging two line ministries—the Ministry of Health and Ministry of Interior—by bringing together the following key players: Director of Battambang Prison, Provincial Health Department Director, Provincial AIDS Office Manager, Provincial TB Manager, Referral Hospital Director, Technical Opportunistic Infection Manager, VCCT Chief, Laboratory TB Manager, and the Chief of TB Ward.

Linkages and coordination were defined at every level of the system to ensure that the roles and responsibilities were clearly understood. The program design was aligned with the standard operating procedure for interventions in prisons. The project was discussed with the national TB and HIV programs

to ensure their concurrence and support. Professional relationships built on mutual trust, respect, transparency and a proven track record of effective, consistently high quality program management garnered further support for the project from the national TB and HIV responders. Though the project focused on TB and HIV particularly, cross-cutting approaches strengthened health systems by improving overall drug procurement, referral, and health information systems. This resulted in not only improved TB and HIV services but improved general primary health care as well; the health post personnel have been able to diagnose, treat, and report on many minor illnesses which previously required the inmates to be escorted to the health center.

Taking the service delivery to the client

Provision of a comprehensive service package within the prison walls has added new dimensions to the delivery of health services on both the supply and demand sides. Prior to the initiation of the CRS/AHEAD project, every suspected/confirmed case needed to be transported outside the prison walls which entailed deployment of extra human and material resources. It also raised security concerns every time a prisoner needed to be taken outside the confines of the facility. Bringing the services to the “doorstep” has obviated this need and significantly reduced the number of trips, allaying the security concerns of the prison authorities while significantly improving access to services.

Prison systems have social hierarchies with leaders and people of influence within the prison population. Peer-led education and training on TB and HIV, designed with due recognition of the social hierarchies, has afforded the opportunity to create awareness regarding service availability, benefits of testing, myths and misconceptions, symptom identification, and positive health-seeking behavior. It has also contributed to the reduction of stigma and promoted the understanding that these are chronic diseases, and that people living with these diseases need care and support. Increased uptake of testing/screening procedures and higher rates of case finding is possible because of the cadre of competent health care workers and availability of required resources. It has also boosted staff confidence and given them a sense of ownership of the project. Linkages with other service providers have ensured that the continuum of services is available to the client. Allotment of specific days/hours in the treatment clinics for inmate-clients has additionally provided the opportunity to streamline referrals/visits and make the operations more cost effective. Consistent DOTS implementation and nutritional support has ensured optimal adherence to the prescribed regimens contributing to higher cure rates. The program is in the beginning stages of developing appropriate referral systems to link prisoners to health care services upon release.

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PHOTO BY CRS STAFF

GLOBAL

AIDSRelief Site Capacity Assessment (SCA) Tool

Introduction to Project

AIDSRelief, a five-member consortium funded through the U.S. President's Emergency Plan for AIDS Relief (PEPFAR), has supported the rapid scale-up of HIV care and treatment programs for poor and underserved people in ten countries across Africa, the Caribbean, and Latin America. The consortium brings together a powerful set of international experts working hand in hand with local partners to build the skills and systems needed to support high-quality HIV care: Catholic Relief Services as prime grantee; the University of Maryland School of Medicine Institute of Human Virology as technical lead for clinical care and treatment; Futures Group International as lead agency for strategic information; IMA World Health and Catholic Medical Mission Board as implementing partners; and Children's AIDS Fund, a sixth organization that serves as a key sub-grantee operating sites in three countries. By building clinical capacity and regularly monitoring patient outcomes, AIDSRelief supports its partners in delivering high-quality, sustainable care.

Since the start of the grant in 2004, more than 610,000 patients have received care and treatment in over 240 Local Partner Treatment Facilities (LPTFs). More than 211,000 patients are currently receiving ART as of February 2011.

ETHIOPIA, GUYANA, HAITI, KENYA, NIGERIA, RWANDA, TANZANIA, UGANDA, ZIMBABWE (SOUTH AFRICA, PART OF THE AIDSRELIEF CONSORTIUM FROM 2004, TRANSITIONED TO LOCAL LEADERSHIP IN 2009)	
Type of Project	Treatment, Health Systems Strengthening (HSS)
Integration Aspects	HIV care and treatment program integrated across a wide variety of interventions including PMTCT, OVC, TB/HIV, HBC, palliative care, etc.
Number of Beneficiaries	211,000 people have received antiretroviral therapy and more than 600,000 people have received care and support services
Beneficiary Type	PLHIV, including adult and pediatric treatment patients
Source of Funding	PEPFAR
Duration of Project	March 1, 2004 – February 29, 2012
Promising Practice Highlighted	Site Capacity Assessment Tool

Problem Statement and Context

HIV care and treatment programs require well-managed health systems that can provide comprehensive care. A strong network depends not only on the strength of the local partners, but also on the strength of each health care facility, or site, in its care and treatment delivery model and in its linkages with the public health sector and the community. Therefore, AIDSRelief focuses on strengthening those essential capacity areas that are crucial for the sites to provide uninterrupted access to HIV care and treatment for the long term.

AIDSRelief is committed to transferring management of the antiretroviral therapy (ART) program to local partners by March 1, 2012. In moving toward transition, it became apparent that a specialized tool was needed to assess each health facility's overall capacity to deliver quality HIV care and treatment. To that end, CRS, Futures Group International and the University of Maryland School of Medicine Institute of Human Virology (IHV) modified the Clinical Site Capacity Assessment tool developed by IHV to serve as a tool for routine program monitoring and supporting the long-term sustainability of its local partner health facilities.

In 2010, AIDSRelief developed, pilot-tested and rolled out the Site Capacity Assessment tool (SCA) that provides AIDSRelief (and, after transition, the local partners) with a practical tool to assess the overall capacity of a site to deliver quality HIV care and treatment in a consistent and sustainable manner, for designing targeted technical assistance, and for ongoing monitoring of site performance.

Purpose of the Project

The SCA is designed to give AIDSRelief and eventually the local partner a useful tool to assess a health facility's overall capacity of program operations to deliver quality HIV care and treatment in a consistent and sustainable way. The SCA does not assess program outcomes; instead, it assesses the capacity of

program operations. This tool evaluates which facility is meeting the basic “pass level” of sustainability; i.e., the minimum capacity to provide quality HIV care and treatment services on a continuing basis. The results of the assessment enable AIDSRelief and the local partner to prioritize activities to strengthen capacity where needed.

What is the Site Capacity Assessment (SCA) Tool?

- The SCA assesses a health facility’s overall ability to deliver consistent and sustainable HIV care and treatment.
- The SCA does not assess program outcomes; rather, it assesses the capacity of program operations. The information is used to identify needs and prioritize activities to strengthen and improve capacity.
- The SCA also identifies areas of excellence that may be used to model best practices.
- The SCA is designed to promote learning. Once gaps are identified, AIDSRelief and its partners work with the health facility staff to consider the root causes of problems and develop strategies for improvement.
- The SCA is intended to be used on an annual basis.

Steps in Implementation

How is the SCA designed?

The SCA is organized by 12 program components and 7 cross-cutting functional areas as listed in Figure 1. Each component includes a set of indicators that represent the capacities critical for sustainability. Each indicator has sets of observable statements on a 5-point scale. Level 3 on the scale represents the minimum level required for sustainability. Level 1 represents no capacity, whereas level 5 represents a highly developed capacity and a potential best practice.

The use of observable statements enables the health facility staff to see what is needed to move to a higher level with respect to each indicator. The functional areas are consistent across all components, which allows for analysis of scores by program component and by functional area.

Figure 1: SCA Components and Functional Areas

COMPONENTS	FUNCTIONAL AREAS
<ul style="list-style-type: none"> • Adult HIV Care • Community-based Treatment Services • Finance and Compliance • Fundraising and Advocacy • Health Care Management • Laboratory • Maternal Child HIV Care • Nursing • Pharmacy Management • Quality Improvement Program • Strategic Information • Youth HIV Services 	<ul style="list-style-type: none"> • Physical Infrastructure and Equipment • Human Resources • Planning and Budgeting • Practices /Activities • Management, Supervision, and Communication • Commodities and Supplies • Record Keeping and Reporting

Use of the SCA

The SCA is intended to be used on an annual basis by the AIDSRelief or local partner program manager responsible for health facilities. In addition, health facility staff may also use the SCA for self-assessment on an ad hoc basis. For some health facilities, particularly those undergoing significant change, administration of the SCA every six months would be helpful to track the impact of change, and to identify gaps and areas that need capacity strengthening

This tool is designed to promote learning. Once gaps are identified, AIDSRelief and local partner experts work with the health facility staff to implement more in-depth assessments. Conversations and additional assessments enable staff to consider the root causes of problems and develop strategies for improvement. Staff can also identify areas of excellence so that good work can be acknowledged and reinforced. As a result, this exercise engages health facility staff in a dynamic conversation and leads to a planning exercise to address challenging areas and build on strengths. With information from this tool, AIDSRelief and local partners can also identify health facilities that are performing well in specific components to promote exchange visits between high-performance health facilities and those that are facing challenges.

The information from the assessment enables AIDSRelief and local partners to prioritize activities to strengthen capacity where a need is identified. This tool will tell which health facility is meeting the basic “pass level” of sustainability, which is the minimum level of capacity to provide quality HIV care and treatment services on a continuing basis with overall technical and management support from AIDSRelief and the local partner.

Preparation

It is necessary for the program manager responsible for administering the SCA to have successfully completed the training module so that he/she has an in-depth understanding of the purpose of the tool and the technical content of each component, including the use of documentation and the methodology for administering the tool, in order to accurately score each indicator.

Program managers qualified to administer the SCA should not administer the SCA at those sites that they routinely manage in order to avoid bias in scoring.

Scoring

Each indicator is assessed on a 5-point scale. Level 3 on the scale represents the minimum level required for sustainability. Level 1 represents no capacity, whereas level 5 represents a highly developed capacity and a potential best practice. Once the assessment is complete, an average score is calculated for each component and across each functional area. For example, if the scores for Pharmacy Physical Infrastructure are 1, 3, 4, 2, 2, 5, and 1, then the total average score is 2.6 and the site is not sustainable in that area.

For simplicity, the final scores are grouped in a color scheme indicating their level of sustainability.

Figure 2: Scoring

1.0-1.9	2.0-2.9	3.0-4.5	4.6-5.0
Red Flag Significant support needed	Yellow Flag Targeted Assistance Needed Approaching Sustainability	Green Flag Sustainable	Blue Flag Exceeds Expectations Consider for training purposes

However, there are some areas which are considered critical to delivering high quality HIV care. A site must receive a minimum score in these components; if the score is insufficient, these components can cause the site to be considered a red flag even if the total averages fall in the green – blue continuum. The critical components are:

- Adult HIV Care
- Nursing
- Community-Based Treatment Support
- Laboratory
- Pharmacy
- Finance and Compliance

Positive Outcomes and Impacts

In January 2010 (Year 7 of the grant), AIDSRelief staff and local partner staff from eight of the nine country programs were trained to administer the SCA. From February through April, the SCA was administered at a sample of 59 sites (24 percent of all AIDSRelief sites). The results of this initial rollout phase, as shown in the tables below, indicates that 32 (54 percent) of the sites were scored sustainable and 27 (46 percent) scored approaching sustainability. Rollout is continuing so that all sites in all nine

countries are assessed during Year 7 and then again in Year 8. Results from the SCA assessment are used to develop capacity-strengthening action plans that will target technical assistance to specific capacity areas and bring sites to a sustainable level.

Rollout feedback indicated that sites were very pleased with the SCA and see it as a tool that they can use to strengthen the capacity of their programs.

Table 3: Overall SCA Results for 59 Sites Assessed in 8 Countries

CATEGORY	NUMBER OF SITES	PERCENTAGE OF SITES
High Performer	0	0
Sustainable	32	54%
Approaching Sustainability	27	46%
Not Sustainable	0	0

How to obtain the tool

The SCA is available for download on the CRS website at <http://crsprogramquality.org/scatool/>.

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SCA Dashboard

The dashboard is a visualization tool to aid all levels of users in decision making. Global level users (program headquarters, country managers, health facility managers) can compare aggregated results between countries and within a country. They can identify and address overarching problems. Country managers can compare selected facility segments and regions. They can view component and facility score trends over time. Health facility managers can query site-level indicators and look at the individual pieces that are required to meet a specific score. They can create action plans for improvement where additional focus is needed.

The dashboard aggregates data at the global, country and facility levels, by component and functional areas. Maps, charts and tables are automatically generated and are color coded to match the sustainability ranges so that it is easy to analyze the results at different levels of detail. All of the data is uploaded to the SCA database, and managers are able to see all of the data at one time.

After aggregating data, the SCA includes an Action Plan feature to help program and clinic managers enumerate, plan and coordinate the activities needed for improvement in various component areas. Each component has many indicators and within each indicator up to eight criteria for any particular score level. Cutting and pasting this information into another spreadsheet is time consuming and tedious. The Action Plan feature allows facility staff to focus on the planning activities themselves rather than preparing the management tool.

The SCA Action Plan feature creates a customized, component-by-component work plan at the indicator and criteria level. Based on a facility's assessment scores, assessment indicators are suggested within each component for inclusion in the action plan. Once users have gone through the selection process, the system creates an Excel Action Plan Workbook using a pre-defined template.

The Action Plan Workbook is based on the components prioritized in the SCA Dashboard. Each row in a spreadsheet displays one criterion per indicator. Cells are provided for entering the activity that addresses the criterion not yet met, resources and leadership needed to perform the activity, as well as target date and status. A summary sheet is provided to view the overall number of activities per component and their progress towards completion.

**Part III:
Orphans
and Vulnerable
Children**



PHOTO BY KAREN KASMAUSKI FOR CRS

MALAWI

Support to Orphans and Other Vulnerable Children Project

Introduction to Project

Lusubilo Community Orphan Care is a community-based organization founded by Rosarian Sister Beatrice Chipeta in 1997. Since its inception, Lusubilo, meaning “hope” in the local language, has distinguished itself with a profound vision to improve the lives of vulnerable children and their families in Karonga district, Malawi. Catholic Relief Services (CRS) began supporting Lusubilo in 2005 with the assistance of a generous private donor from Mexico. In the last few years, Lusubilo has attracted additional attention and resources, including United States government funding, UNICEF resources and other private foundation support. Lusubilo’s programming grew out of extreme food insecurity in Malawi during the 1990s and beyond. In the years since, Lusubilo has maintained a strong food assistance programming base while growing its agriculture and nutrition programming for better integration. The program currently reaches some 9,000 vulnerable children in four catchment areas, approximately 260 of whom are extremely vulnerable infants receiving replacement infant

formula in a highly targeted program.¹ Lusubilo complies with Government of Malawi Infant and Young Child Feeding Guidelines and CRS Milk Policy.

MALAWI	
Type of Project	Orphans and vulnerable children (OVC)
Integration Aspects	Food security
Number of Beneficiaries	9,760
Beneficiary Type	OVC
Source of Funding	Private funds
Duration of Project	November 2005 – September 30, 2013 (Donor provided 3 year cost extension)
Promising Practice Highlighted	Infant replacement and complementary feeding in an HIV-affected, resource poor setting

Problem Statement and Context

Malawi is a chronically food-insecure country, with most households experiencing food shortages in the months before the harvest season. Contributing factors to limited food security include high levels of population density, poor land productivity, high rates of post-harvest loss, and a high prevalence of HIV (the current HIV prevalence for adults aged 15-49 is estimated at 12 percent²). Most of the Malawi population is estimated to be Vitamin A deficient, and the nutritional status of most children is poor: nearly 50 percent of children under the age of five are chronically malnourished and over 20 percent are underweight. Vitamin A supplementation reaches only 65 percent of children (aged 6 – 59 months).³ The high HIV prevalence has also resulted in an enormous population of orphans, estimated at 560,000 orphans due to AIDS, with a total of 1.1 million orphans due to all causes.⁴ The increasing number of orphans and the added burden of caring for the chronically ill have overwhelmed traditional Malawian support networks in Karonga as in other districts. Over the past several years, district social welfare authorities have also observed an increase in child abandonment, or “dumping.” Severe malnutrition is estimated at 1.7 percent in Karonga while moderate malnutrition is at 2.5 percent. Malnutrition not only results from a lack of essential nutrients and calories to meet growth needs, but also poor health that limits the body’s ability to absorb vital nutrients from consumed food. Diarrheal diseases resulting from poor hygienic practices, repeated bouts of malaria, and acute respiratory infections further contribute to malnutrition. A rapid nutritional assessment report⁵ in December 2004 showed that 27 percent of children in Karonga suffer from malaria and 26 percent from diarrhea, two common illnesses which negatively impact a child’s nutritional status. In addition, Karonga has been affected by both droughts and flooding in the past several years, resulting in decreased food availability.

1 Prior to initiating any programming involving artificial infant formula or milk, country programs must ensure they are compliant with CRS’ Policy on the Procurement, Distribution and Use of Milk Products and Infant Feeding Equipment in Field Programs.

2 UNAIDS Fact Sheets on HIV and AIDS 2008 cites HIV prevalence as 11.9%. In support of the National Response, this document uses 12.0%. as cited in OPC, MoH and NAC documents.

3 National Statistical Office (NSO) [Malawi], and ORC Macro. (2005). NSO and ORC Macro. (2004). Malawi Demographic and Health Survey.

4 UNICEF, UNAIDS and WHO. (2009). Children and AIDS Fact sheet: Malawi.

5 Malawi Red Cross. (2004). Nutritional Assessment in Karonga and Salima Districts, November-December 2004.

Perhaps what distinguishes Lusubilo from other partners is its strong network of grassroots community partners. In the early 1990's, Sister Beatrice Chipeta (Rosarian Sisters) recalls walking the rural areas of Karonga and witnessing the devastation wrought by food insecurity, high HIV prevalence and high rates of orphanhood. People were desperate for assistance, and Sister Beatrice began a long process of working with communities to organize themselves. To this day, communities linked with Lusubilo play an active role in designing and delivering services for their members. To reinforce key relationships with communities and the district officials, Lusubilo holds meetings with Village Orphan Care Committees and community-based organizations. In these meetings, communities review the project and identify challenges and possible solutions. Project staff hold monthly and quarterly meetings to improve project planning, reflection and sharing. Lusubilo works closely with the Ministry of Gender, Children and Community Development, the Ministry of Agriculture and the Ministry of Health to strengthen the referral system. The referral system truly works in both directions. For example, Lusubilo will refer a malnourished child failing to gain weight after four months of supplementary feeding to the Ministry of Health for further evaluation. Conversely, when Ministry district officials or the police find abandoned infants, they frequently place them in the Lusubilo Children's Village for round-the-clock attention and appropriate replacement feeding from professional caregivers.

Purpose of the Project

Lusubilo now has several CRS-supported projects, but the main program aims to improve food security of targeted households with interventions under two strategic objectives.

STRATEGIC OBJECTIVES	Improve nutritional status of OVC and orphan-headed households.
	Strengthen the capacities of communities to better respond to the food security and nutritional needs of OVC and orphan-headed households.

While the program includes four age-specific feeding interventions, the promising practice highlighted here is the successful provision of infant formula to highly targeted beneficiaries under 24 months of age. In keeping with Government of Malawi Infant and Young Child Feeding Guidelines and CRS Milk Policy, Lusubilo only provides infant formula to infants under two conditions: first, the biological mother has died; or second, the District Hospital has declared the mother medically contraindicated to breastfeed. Positive HIV status alone is not grounds for inclusion in the program unless the mother has been declared medically contraindicated to breastfeed by the district health authorities. Lusubilo does not promote usage of infant formula by any child who does not meet the criteria.

Steps in Implementation

For implementation, caregivers of enrolled infants collect infant formula twice per month. Each child gets 800g of milk per two weeks for the first six months, sufficient to cover the child's caloric needs during this period. During distribution sessions, a Karonga District Hospital Nutrition Officer and Health Surveillance Assistant visit Lusubilo and work with Lusubilo staff to conduct health and nutritional lessons, including HIV message dissemination, demonstrate proper water treatment and infant formula preparation techniques (the formula preparation techniques include the right ratio of water to milk powder according to the age of the child, and the use of safe warm water for reconstitution), conduct growth monitoring and promotion, and check immunization status. In keeping with the Government of Malawi policies and guidelines, Lusubilo trains caregivers to feed

their babies using a cup and a spoon rather than a bottle, and this is monitored during home visits. The field team makes home visits to the beneficiaries to check issues of hygiene and adherence to proper milk preparation and feeding practices. Lusubilo has trained its staff in commodity management who ensure that milk is in good condition by looking at expiration dates and who monitor supplies to ensure there is enough milk for distribution all year round. Any infants showing health problems or failing to gain weight are identified and referred to the Karonga district hospital.

Upon reaching six months of age, Lusubilo also provides likuni phala (a locally produced, fortified corn soy blend), a highly nutritious complementary food. During this period, caregivers are taught to prepare a balanced diet for the child rich in six food groups, as per the Malawi Nutrition guidelines, using locally available foods which complement the formula and the corn soy blend. During the first month of introducing complementary feeding, the caregivers are taught to prepare thin porridge, which is easily digestible at this age. Infants remain in the program and continue to receive infant formula and likuni phala until they reach age two or are graduated from the program by the district health authorities.

Positive Outcomes and Impacts

In 2009, 266 orphans and vulnerable infants under two years of age benefited from Lusubilo's infant feeding program. In the case of these orphaned and highly vulnerable babies, Lusubilo's help is literally a life-saving intervention: infant formula is prohibitively expensive in Malawi, and most rural families cannot purchase the minimum required quantity to ensure good growth. Thanks to Lusubilo's close follow up and ongoing hygiene and nutrition demonstrations, incidents of diarrheal disease among targeted infants, a critical concern with formula preparation in resource-poor environments, have been minimal. In the past, the struggle to feed such infants has often led to the use of inappropriate alternatives (cow's milk or a porridge-based diet) or abandonment. The reliable provision of nutritious formula has helped caregivers to keep these infants in their extended families.

Lessons Learned

Partners may shy away from replacement feeding due to the high cost involved and high risk of mortality if inappropriately used. Lusubilo has found that with ongoing beneficiary training, strong collaboration with district health professionals and constant follow up, orphaned infants can receive the nutritional support they so desperately require. In addition to direct interaction with beneficiaries, it is also essential to have strong procurement systems, adequate warehousing capacity, appropriate distribution channels, and rigorous monitoring activities.

Lusubilo recognizes that an overreliance on food distribution is unsustainable. Therefore, Lusubilo makes a deliberate effort to integrate agricultural production, irrigation, livestock production and other activities to improve the food security of local communities.

Promising Practices

- For areas with high rates of maternal or adult mortality among women of reproductive age, infant replacement feeding may be an important strategy for programs providing nutritional support. Consult closely with the Ministry of Health and/or Ministry of Social Welfare to determine if this is an appropriate strategy.
- The unit cost of infant formula per child is significant—often over \$1,000 per child per year when

all of the associated costs are calculated. Programs should ensure adequate resources for at least two years before undertaking replacement feeding.

- Changing infant formula brands can also cause some children mild discomfort, so be sure to choose a reputable formula brand that is manufactured or imported in the required quantities.
- Occasionally there are manufacturing problems with infant formula, as was the case with the melamine tainting in China in 2008. Be sure to choose a brand that has rigorous quality control, including batch numbers and expiration dates imprinted on every canister to facilitate testing as needed.
- Distribution sessions should include growth monitoring and promotion as well as practical sessions on nutrition, hygiene, and proper infant formula preparation. Involve district/local health authorities in the enrollment, monitoring and discharging of children.
- For verification of maternal death, it is also advisable to engage the traditional leader in the area.
- Consider what complementary foods will be available to caregivers when the infant reaches six months of age. Incorporate complementary feeding education into distribution sessions, as reliance on infant formula past the age of six months will cause serious malnutrition.

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CASE STUDY

Godwin and Beatrice

Godwin and Beatrice are twins from Gweleweta village in Traditional Authority Kilupula. These twins have been receiving support from Lusubilo since 2006. The twins were born on the 10th of August in 2006 and since their mother's death their grandmother (Victoria Nyaunthali, 53 years old) has been taking care of them.

Devastated by her daughter's death, Victoria vowed to care for the twins. The babies were never breastfed by their mother, as she was gravely ill. The grandmother was referred to Lusubilo for nutritional assistance where she was received warmly and counseled. Lusubilo staff gave Victoria infant formula for Godwin and Beatrice and trained Victoria to prepare the formula safely.



PHOTO BY CRS MALAWI STAFF

Beatrice and Godwin are twins who are healthy and thriving because of Lusubilo.

Victoria lives in Kaporo Village, about 50 kilometers from Lusubilo's office, with her husband, five of her own children and the twins. Victoria traveled to Lusubilo every week to collect infant formula. She traveled by bus, which cost her about \$3.60 per trip. While this was quite expensive for a rural family, she was determined to see the twins grow up strong and healthy. Beatrice and Godwin's father is also committed to their care and helped the grandmother with transport money whenever he could.

When Lusubilo staff noticed that there were many infants registered for support from Kaporo, they decided to open a distribution center in the area as a way of relieving the guardians from traveling such a long distance to Lusubilo. The distribution center is still in operation, and there are currently about 32 babies being supported. Victoria was very happy to be able to receive the formula closer to home. When the twins reached six months, she also started receiving likuni phala as a complementary food. In addition to the food, Beatrice and Godwin also benefit from the instruction and health care advice given by Lusubilo staff. Lusubilo's integrated approach has helped ensure that the twins received all immunizations at the right time.

Beatrice and Godwin graduated from the Lusubilo project weighing 12 and 12.5 kilograms respectively, healthy weights for their age and height. Lusubilo project staff continue to check on the twins and encourage the grandmother to continue such great care. Victoria appreciates Lusubilo's support. She said, "I am very thankful to Lusubilo for all the assistance not only for the material and spiritual support but for the education on food preparation, health and hygiene." She admits that raising these children was not easy for her as they were very young and it had been a long time since she had her own children. At first she had no hope that they would survive to this day. She says, "Lusubilo gave me the courage and strength."



PHOTO BY KAREN KASMAUSKI FOR CRS

NIGERIA

Strengthening Local Capacity to Provide Care and Support for Orphans and Vulnerable Children

Introduction to the Project

Catholic Relief Services (CRS) Nigeria through the Catholic Secretariat of Nigeria (CSN) and eleven arch/diocesan partners implements the *Scaling Up of Nigeria's Faith-Based Response to HIV/AIDS (SUN)* project. With funds from the President's Emergency Plan for AIDS Relief through USAID, the project is implemented across eight states in Nigeria. Through the broad community outreach of the Catholic Church of Nigeria, the SUN project provides a comprehensive package of services including psychosocial support, protection, education, health care, food and nutrition support, and economic strengthening to orphans and vulnerable children (OVC), parents and other caregivers in the target areas. The project also focuses on building the capacity of Church partners and communities to respond to the OVC crisis. The project has reached over 25,000 beneficiaries since 2008 using the unique model of block grant mechanisms to provide education and health services to vulnerable

children and their caregivers. The project is focused in the high prevalence and underserved states in the North Central and South Zones of Nigeria.

NIGERIA	
Type of Project	OVC Care and Support
Integration Aspects	Closely linked with another CRS HIV project entitled The Seven Dioceses Community-Based Care and Support Program for PLHIV
Number of Beneficiaries	25,000 OVC
Beneficiary Type	OVC (children aged 0-17 years) and their caregivers
Source of Funding	USAID, CRS private funds, Diocesan and Community contributions
Duration of Project	March 2006 to March 2011
Promising Practice Highlighted	<ol style="list-style-type: none"> 1. Block grants to improve access to education and health care services. 2. Market assessments used to plan the crops grown in community farms.

Problem Statement and Context

Nigeria is among the countries with more OVC than any other nation. The *2008 Situation Assessment and Analysis on OVC in Nigeria* revealed that 17.5 million (24.5 percent) of Nigerian children were OVC.¹ Among the estimated 7.3 million orphans in Nigeria², approximately 1.2 million children lost one or more parents due to AIDS.³ Traditionally, extended families serve as safety nets for these vulnerable children; however, with the high numbers of vulnerable children, many extended families have overstretched their capacity to care for more OVC. Grandparents now care for orphaned grandchildren and older siblings take care of younger ones. According to the OVC National Plan of Action (2006)⁴, when immediate families do not or cannot support children living with or affected by HIV, communities and the non-governmental organization sector have tried to fill in the gaps. Currently these responses have been limited in size and scope with gaps in the quality and consistency of care provided. Without a large scale-up of targeted quality interventions, many vulnerable children in Nigeria face a bleak future of poor/inadequate education, poor health, few marketable skills, and increased risk for acquiring HIV.

Purpose of the Project

The goal of the SUN project has been to improve the quality of life for orphans and children made vulnerable by HIV and AIDS.

1 Federal Ministry of Women Affairs and Social Development (2008). Situation Assessment and Analysis on OVC in Nigeria.

2 Federal Ministry of Women Affairs and Social Development. (Sept 2009). Monitoring and Evaluation Plan for The Orphans and Vulnerable Children (OVC) Response in Nigeria.

3 Unite for Children, Unite against AIDS. (2008). Children and AIDS: Third Stocktaking Report.

4 Federal Ministry of Women Affairs and Social Development. (2006-2010). Orphans and Vulnerable Children National Plan of Action.

STRATEGIC OBJECTIVES	Partner capacity to respond to HIV and AIDS in their communities is increased.
	Community capacity to provide quality comprehensive and compassionate care for OVC is increased.
	Livelihoods for OVC and OVC households are strengthened through increased life skills and access to education.

Steps in Implementation

To achieve the objectives, the SUN project provides a comprehensive package of services including protection, psychosocial support, education, health care, economic strengthening for OVC, parents and other caregivers, as well as food and nutrition support services. The following section provides an overview of the project's service delivery model and monitoring approach as well as a short summary of each service delivery area.

Service Delivery and Project Monitoring

The Diocesan Action Committee for AIDS (DACA) is responsible for coordinating service delivery in the SUN project at the Diocesan level. The DACA collaborates with Justice, Development and Peace Commissions (JDPCs) and at community level with Parish Action Committee on AIDS (PACA) and volunteers to ensure a holistic package of services is available in each community. PACA supervises the trained parish AIDS volunteers (PAVs) who are responsible for day-to-day program implementation at the community-level. PACA acts as the coordinating body for the PAVs to conduct monitoring & evaluation, advocacy and community mobilization activities.

Protecting Children

The Justice, Development and Peace Commissions (JDPCs) are well established and respected church structures that operate at the diocesan level. They have traditionally been involved in a variety of child protection activities such as the protection of inheritance rights and the resolution of disputes. Project services provided include the development of enhanced community justice systems, promotion and provision of birth registrations, promotion of succession planning, prevention of child abuse, and advocacy for a supportive community environment for PLHIV, OVC, and caregivers.

Addressing Psychosocial Needs

Psychosocial support can help to reduce stress and increase resilience among OVC and their caregivers. At inception, 58 support groups were formed; by September 2010, the project had over 167 support groups providing psychosocial support to OVC and their caregivers. Support groups for vulnerable children are sub-grouped (ages 0-5 years, 6-12 years and 13-17 years) within each cluster of proximate parishes. The support group meetings are held monthly at designated centers within the parish. During support group meetings, peer group discussions under the guidance of PAVs allow participants to learn from each other as well as provide mutual support and motivation. Support groups help to ensure that OVC and caregivers receive accurate information on key issues such as nutrition, basic health care and HIV prevention. Beneficiaries requiring bereavement and spiritual counseling are referred by PAVs to parish priests. PAVs also provide psychosocial support to children during home visits, including counseling on life skills or careers and identifying and referring cases of abuse.

PHOTO BY SILVUS IDEMA FOR CRS



A mother shows son's newly-laminated birth certificate to a registration officer from the National Population Commission.

Improving access to health care through home visits

Cost, distance, stigma, and other factors may reduce the ability of OVC and their caregivers to seek health care. To address this problem, the project provides basic care and support through routine home-based care visits at least once a month. During home visits, trained PAVs provide basic medical care and make referrals where necessary. To prevent common illnesses such as malaria and diarrhea, OVC enrolled in the SUN project receive yearly basic care kits, comprised of mosquito nets, buckets and Water Guard (a sodium hypochlorite solution added to water to make it potable). Replenishment of Water Guard is done monthly during home visits or at support group meetings. Linkages with the community-based care and support component of the Seven Dioceses project allow children to receive priority access to HIV counseling and testing services in their homes. PAVs provide sensitization about home-based testing services during the home visits and HIV prevention awareness campaigns in communities.

Improving access to education and health care through block grants

The SUN project uses a block grant approach to improve OVC access to education and health care services. Under this approach, PACA, PAVs and caregivers identify centrally located schools and medical facilities of good quality, and the local Diocesan team in coordination with CRS Nigeria, establishes an agreement with the selected institutions. Based on the agreement, the schools and medical facilities use grant funds to make capital improvements such as purchasing teaching/learning aids or equipment for a school science laboratory, library, and health center laboratory, etc. In exchange for the grant, the respective institutions waive education or health care service fees for a pre-determined number of OVC

PHOTO BY SILIAS IDEMA FOR CRS



Samuel and his caregiver, Uncle Emm, make shoes to sustain their livelihood.

or caregivers over a set period of time. To ensure that children are receiving quality education, DACA staff and PAVs routinely monitor school attendance and performance and meet regularly with teachers identified in each school where an institutional relationship has been established. PAVs initiate referrals to health facilities during home visits and at support group meetings and verify whether such referrals are completed using tracking forms. PAVs also monitor satisfaction with services provided to beneficiaries at health facilities, based on oral feedback discussions.

Economic Strengthening for OVC Households

The income generating activity (IGA) structure is anchored on a three-pronged approach, namely the small grant scheme to individuals and groups, the Savings and Internal Lending Communities initiative, and skill acquisition (via direct vocation skill acquisition or through USAID Markets Collaboration on an entrepreneurial skills acquisition program).

Beneficiaries (OVC and caregivers), PACA and DACA coordinate the small grant scheme for individuals. The beneficiaries express their interests via their respective support group cells, who screen and submit names of qualified members to the PACA. PACA accesses funds directly from DACA based on support group submissions. Each support group unit with support from PACA is responsible for the establishment of a sustainable mechanism for repayment and re-disbursements of remitted fund to other beneficiaries. The group small grant scheme is similar, and these group economic strengthening activities involve investment in agricultural processing equipment such as a cereal grinder, community farms, canopy rentals, etc.

In 2009, the SUN project launched a CRS-developed savings-led microfinance approach called Savings and Internal Lending Communities (SILC). The premise of the SILC methodology is to help members of poor households manage their own small resources by teaching them basic financial management skills, along with providing a safe place for saving. The accumulation of savings and the ability to access flexible credit also allows members to invest in productive activities, such as agro-enterprise. In addition to SILC services, OVC caregivers receive microenterprise development and entrepreneurial skills trainings supported by USAID MARKETS, a USAID-funded project designed to increase agribusiness competitiveness and food security.

In some cases, OVC are enrolled in vocational training institutions to acquire skills such as tailoring, aquaculture/fish farming, carpentry, etc. On completion of training, the beneficiaries are provided with start-up capital and tools. PAVs conduct quarterly monitoring visits to OVC in vocational training and to those who have set up their own businesses.

Improving Food and Nutrition Security and Building Local Capacity to Sustain Interventions

In the first year, the SUN project provided supplemental locally purchased food rations for enrolled OVC and caregivers. This was complemented by a number of more sustainable interventions such as the promotion of small-scale home gardening and community farms and gardens. These strategies were chosen to improve household food security and adequate nutrition and to reduce dependency on supplementary food rations. Other benefits of these food security strategies include ability of the caregivers to sell produce to pay for services such as education and health care.

Integration

Integration between the SUN and CRS Seven Diocese home-based care projects is an important aspect of the SUN Project's service delivery model. This collaboration ensures that affected children and HIV-positive beneficiaries residing in the same geographic areas receive the services offered by both projects as appropriate. Areas of working together include use of the same volunteers, staff and other resources of the project. At the CRS country program level, inter-sectoral integration between the OVC/HIV team and the agriculture unit was essential to create linkages to the USAID Markets project which provided technical assistance in agro-enterprise and microenterprise development as well as entrepreneurial skills for SUN beneficiaries. CRS Nigeria and the diocese worked closely with local and international organizations with capacity for agricultural development to perform market assessments, such as Cocoa Research Institute of Nigeria, International Institute for Tropical Agriculture, etc.

CRS Nigeria is the lead agency in a five-member consortium project called AIDSRelief, which provides antiretroviral therapy (ART) to PLHIV and HIV-positive children through partnerships with faith-based organizations and community-service organizations. The SUN project benefits from this consortium in states where both projects are co-located and children from families supported by the project who require ART are linked to treatment facilities. Beneficiaries are assured of available treatment services, and others not on treatment who require advanced medical care are equally offered access to these services in AIDSRelief facilities.

Positive Outcomes and Impacts

Through the implementation of the seven core service delivery areas⁵ commonly used in OVC programming, the SUN project has ensured access to basic needs and improved the quality of life of not

⁵ Food and nutrition, shelter and care, health, education, protection, psychosocial support and economic strengthening.

only 25,000 OVC, but also their caregivers and communities. A total of 11 DACA, 160 PACA, and over 3,000 PAVs were trained in care and support for OVC, palliative care, home-based care, referrals, family life and health education, and monitoring and evaluation. With support from this project the JDPCs were able to issue 9,801 birth certificates and supported 55 Community Justice Committees. Regular psychosocial support has helped to improve the self confidence and emotional wellbeing of OVC and their caregivers. Block grants to 60 schools and 37 health facilities have supported the establishment of sustainable structures that will serve the educational and health needs of the vulnerable children and the communities in which they live. Currently about 10,150 OVC are accessing education support in block grant schools and other schools, where quality of service has been improved by provision of teaching aids, training of teachers on OVC care and support, and infrastructural development such as provision of libraries, laboratory equipment and school desks. At present, 132 OVC are in vocational training, and approximately a quarter of this number have set-up their own businesses.

A total of 58 SILC groups with 1,214 members have been formed since 2009. SILC groups, combined with skills training, have helped to support successful income generating activities. Some of the most successful models were replicated and scaled-up. Through SILC involvement, some OVC caregivers were gradually able to meet the basic needs of the children in their care.

Finally, and perhaps most important, the project has strengthened the community structures to enable them to deliver services to OVC. Community members have gained a sense of ownership of projects initiated at the community level. The community farming initiative allowed approximately 1,600 OVC and 500 PLHIV to receive food support in the last year.

Lessons Learned

- Improving access to food security through supporting communal farms benefits not only OVC, but also members of the community and caregivers. This increases a sense of ownership of the project.
- Volunteer support can be more effective when coordinating structures are strengthened at the parish level and when volunteers are trained in areas where the project is focusing its priorities.
- Empowering archdioceses to take the lead in the implementation of various projects enables development of capacity at lower levels, thus enabling them to sustain critical interventions.

Promising Practices

Two highlights of the interventions described above are (1) the block grant approach, and (2) the diocesan farms.

Block grants are administered as part of an institutional relationship between service facilities and CRS, through its local partners, in order to provide high quality, sustainable services to OVC and their caregivers. Block grants⁶ involve an award of direct financial or material investment to an identified service facility to improve quality of services and/or to address a capacity gap. For example, a targeted school may lack an equipped science laboratory and would use the block grant funds to procure the necessary materials. In return, a specified numbers of OVC would be guaranteed a comprehensive scholarship, exempting them from fees/ service charges for a period of 1-3 years or more, depending on the agreement. Similar terms and conditions apply to medical facilities where OVC are able to access health care services through institutional relationships. A key element in this collaboration is the involvement of different levels of community partnership

⁶ Additional information on block grants may be found in “CRS Nigeria: SUN/OVC and 7D Guidelines for Block Grant Administration with Health and Education service facilities.”

that enhances the prospects of sustainability. Moreover, this strategy ensures vulnerable children have uninterrupted access to long term pre-paid health and education services, along with improving the overall quality of services provided to the target community.

Prior to the block grant initiative, health and education services were provided to project beneficiaries on pay-as-you-go or voucher basis. This strategy was reviewed as a result of fundamental deficiencies that revolved around bureaucratic challenges, poor quality services and low prospects for sustainability. Block grants not only guarantee free services for needy beneficiaries, they also enable the institution to make a capital investment thereby improving service quality overall. This benefits not only vulnerable children but the entire community. The block grant approach has a number of advantages over the traditional fee-for-service model. Services are pre-paid by partners to service facilities; this guarantees continuum of care and prevents interruptions in the provision of educational/medical services when fees and other obligations are not paid on-time. The block grant model reduces stigmatization of beneficiaries, as it focuses on holistic system strengthening rather than providing individualized benefits to specific project beneficiaries. In the long run, block grants are cost-effective and improve quality of service.

Diocesan-owned community farms provide access to food and cash resources, replacing the need for supplementary food rations. Some vulnerable children do not have parents and others have parents who are incapacitated by illness and unable to teach them the rudiments of farming, which is the way of life for most rural dwellers. The farm serves as a training opportunity for them and bridges the gap of inter-generational transfer of knowledge on farming. The SUN Project supports the creation of diocesan and community farms using the following approach.

- Land access is secured by the Bishop in coordination with the Diocesan Health and/or JDPC coordinator (largely Catholic priests and nuns) who in turn supports PACA and/or DACA to advocate to community leaders for land and drought-resistant seeds. In certain cases, it is appropriate for the local partner organization to purchase the land outright due to the fact that the tree crops will not mature for several years and it is necessary to ensure the profits are used to benefit beneficiaries and not privatized by the original landowner. Initiating the farm early on in the project is also important due to the high cost of the initial capital investment.
- At the same time, a market assessment is conducted to identify cash crops with market potential, such as palm oil, cashews, etc. Market assessments were conducted by DACA, PACA and in some cases with assistance of consultants and other local private organizations. Market assessments were conducted in five Dioceses using a combination of methods including decision tree, maps of current market supply chain and market survey of current prices of produce and cash crops.
- Once the land and seeds are acquired for project use, PAVs, OVC aged 15 and older, their caregivers, and PLHIV from the Seven Dioceses Project are encouraged to cultivate seeds in the community farms and gardens. In exchange for free labor, they benefit from a share in the harvest. Rations of the harvest are distributed to all OVC in need (25 percent of the harvest), 20 percent of the harvest is kept aside as seeds for the next planting season and the rest is sold.

In some cases, the diocese hired a farm manager to oversee planting and ensure proper farming techniques were followed. The project allocated a budget for farm management to cover casual labor during peak periods in the agricultural cycle.

- At harvest, the crops are distributed by DACA and PACA to beneficiary households, and the remainder is processed and sold on the local market. The case study at the end of this chapter describes in detail the approach taken to develop a community farm and garden in Ayingba village in Idah Diocese, Kogi State.

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CASE STUDY

Improving food security and OVC program sustainability in Idah Diocese, Kogi State, Nigeria

The vision of a community farm project for Idah Diocese in Kogi State was conceived by the Diocesan Action Committee for AIDS (DACA) in 2007. The idea was formed by CRS and community leaders in response to a need to sustain food support for OVC households enrolled in the CRS Nigeria SUN project.

Development of a Community Farm

The Parish Action Committee for AIDS (PACA) in Ayingba, a village in Kogi State, advocated for land from community leaders for the purpose of creating a community farm dedicated to the needs of vulnerable groups in the community such as OVC and PLHIV. A feasibility study commissioned after the land was acquired by DACA indicated that the annual average market demand for certain cash and food crops exceeded supply, suggesting opportunities for the cultivation and marketing of certain crops. To ensure that the investments would be directed towards the project goal, the DACA, with support from the community leader, purchased land in phases using diocesan private funds. The farm measures about 16 acres and is located 10 kilometers from Anyigba along Abejukolo road in Okabo.



PHOTO BY CRS NIGERIA STAFF

Bean crops are grown in a community garden to support OVC.

The traditional ruler acted as guarantor for the land, and the Cocoa Research Institute of Nigeria provided technical support for constructing the nursery, marking the land, planting, and doing early growth monitoring for the cash crops. The farm includes stands of 1,100 cashew trees and 300 palm oil trees. Seasonal intercropping of cassava, yam, melon, maize and beans provides food for food insecure OVC and PLHIV households.

A full-time farm manager was recruited by DACA, and community members, including OVC ages 15 and up, contribute labor in exchange for food. During peak periods, DACA hires additional community members, including vulnerable youth ages 15 and up during non-school hours, to provide labor. A DACA focal person provides farm oversight and manages accounts and records. The initial costs of acquiring and preparing the land totalled Nigerian Naira (N)

820,000 (US\$6,560) and the breakdown of costs is below:

- Land acquisition (first parcel) = N580,000 (US\$4,640)
- Land certification at Local Government Area = N82,000 (US\$656)
- First cashew seedlings (at N65 each x 500) = N32,500 (US\$260)
- Land clearing = N105,000 (US\$840)
- Marking and setting-out (N30 x 500) = N15,000 (US\$120)
- Planting (at N5 per stand) = N2,500 (US\$20)

In 2007, DACA acquired an additional six acres that was planted with 700 cashew seedlings in 2008. Also in 2008, DACA received a grant from CRS to support expansion and security of the farm. This added an additional five acres used to plant 300 additional palm oil trees in 2009 and 1,000 yam seedlings in 2010. Over time yields have increased. For example, cassava production increased by 35 percent between 2009 and 2010. In 2009, DACA processed 250 kg of garri (also known as tapioca) from the cultivated cassava and distributed it to PLHIV and OVC.

Beneficiaries

- Ayingba support group members, PLHIV, OVC and PAVs were able to access paid job opportunities as casual laborers in cultivation and processing.
- Since inception approximately 350 OVC and 400 PLHIV received food supplements from the harvest including beans, melon, garri, palm oil, and maize.
- The SUN project will benefit from long term funding resulting from commodity sales. Profits may be used to provide long-term access to education and health services for OVC.

Production capacity and other opportunities

Estimated production from the 1,100 tree cashew stand is about 200 tonnes per year and estimated production for palm oil in two years is over 2,000 litres. The net monetary benefit from all these proceeds is estimated at US\$22,000 over the two year period. Estimated annual expenses to support the production are about N800,000 (US\$6,400). Breakdown is as stated below:

- Salaries and wages
 - Farm manager – N104,000 (US\$183)
 - Casual labour – N480,000 (US\$3,840)
- Seedlings (depending on what is being intercropped) – N120,000 (US\$960)
- Security (Local Village Network) - N24,000 (US\$192)
- Fire control – N50,000 (US\$400)
- Oil-processing – N80,000 (US\$640)

KSU cashew processing plant, a private company that purchases the raw cashew nuts, will provide an assured market for raw cashew materials from the farm. While the project has yet to turn a profit from this venture, it is anticipated that once the trees mature, the diocese will have a sustained source of revenue to support OVC service provision.



PHOTO BY DAVID SNYDER FOR CRS

TANZANIA

Data Collection for the OVC Wellbeing Tool using Mobile Technology

Introduction to Project

Catholic Relief Services (CRS) implemented a PEPFAR-funded (President's Emergency Plan for AIDS Relief) project to increase the capacity of communities, families and others to support orphans and vulnerable children (OVC) from 2004 to 2010. The project coordinated multiple partners in five regions to provide seven core services (education, primary health care, psychosocial support, shelter, child protection, food security, and economic strengthening) to 37,749 people.

In May 2009, the project piloted the use of mobile technology to collect four data forms used by community volunteers. The pilot was followed up with operations research in June 2010 to evaluate the effectiveness of the mobile technology and to produce recommendations for its effective implementation. This research is significant because while mobile technology has been widely used to capture information on health indicators, its application in collecting social indicators relevant to OVC has been unexplored. The investment in improving the new process could be widely applied to the field of programs for vulnerable children.

TANZANIA	
Type of Project	OVC
Integration Aspects	OVC integration with agro-enterprise and microfinance
Number of Beneficiaries	37,749 OVC beneficiaries; 39 stakeholder beneficiaries from participation in pilot project
Beneficiary Type	OVC and Community Volunteers
Source of Funding	Private funds (pilot research)
Duration of Project	OVC project from 2004-2010; Mobile technology pilot from 2009-2010
Promising Practice Highlighted	The benefits and cautions to community volunteers using mobile technology for data collection on OVC wellbeing

Problem Statement and Context

CRS staff noticed some challenges in collecting data for monitoring and evaluation (M&E). Traditionally done using pen and paper, long time delays between data collection and reporting negatively impacted decision-making. Often data was incomplete and inaccurate, sometimes due to multiple data entry clerks. Community volunteers, who are responsible for supporting OVC, often had little supervision as they made medical referrals and analyzed other data. CRS staff also noted problems with maintaining a database that was virus-free.

Most of these M&E challenges are related to the nature of the working environment; the geographical scope is very large, and infrastructure systems such as transport facilities and communication are poor.

Purpose of the Project

The goal of this operations research was to learn what support CRS partners require to use mobile technology for data collection. While technological support requirements are understood, less is known about the human resource requirements, such as training, competencies and skills sets, guidelines, etc, that are required by CRS partners and community volunteers to use mobile technology.

STRATEGIC OBJECTIVES	Identify the organizational technical support and structures that will most enhance effective usage of the technology.
	Identify the profile of the user who will most efficiently use mobile technology.
	Identify the support requirements for mobile phone users.
	Develop guidance for the administration and management of the telephones.

Steps in Implementation

Phase 1- Design: In Phase 1 of the pilot project, prototypes of four data forms were programmed and downloaded onto six mobile phones. These forms included the OVC Wellbeing Tool (OWT), follow-up form, exit form, and referral form. Six community volunteers participated in 13 trainings facilitated by the contracting agency, D-Tree. As this group received the most extensive training with the mobile applications, these volunteers were designated as “lead volunteers,” and additionally tasked with helping their colleagues once the project was expanded into Phase 3.

Phase 2- Refinement: In Phase 2 of the project, the phone prototypes were field tested, both CRS and partner staff were trained by D-Tree, and the pilot was implemented and assessed. On the basis of this work, the team refined the prototype of the mobile application, then created and disseminated a training manual for its use.

Phase 3- Operations Research: In Phase 3, the six lead volunteers, 17 new volunteers, four supervisors, four government representatives, four Uhai/OVC staff, two CRS staff and three D-Tree facilitators participated in four continuous days of training on the use of phones for data collection. After completion of the OWT mobile application training, volunteers began to use the application in the field. Following the field test, volunteers practiced administering the OWT using paper and electronic versions.

Data Collection Methods and Analysis

- *Quantitative Pre- and Post-Tests* measured perceptions of mobile technology and mobile application training among 29 stakeholders. Summary measures were calculated using STATA.
- *OVC Activity Questionnaire* measured 23 volunteers’ knowledge, attitudes, and practices about using mobile technology as part of their OVC outreach activities following two weeks of using the mobile format of the OVC Wellbeing Tool (OWT). Summary measures were calculated.
- *Field observation* of four volunteers administering the OWT with three children each using both pen and paper and mobile methods. Key user practices were identified and recorded.
- *Focus Group Discussions* allowed project stakeholders to provide comments and suggestions about their experiences using mobile technology in the OVC project. Notes were recorded and analyzed for key themes.
- *A volunteer user workshop* provided an opportunity for feedback based on themes identified during the focus group discussions including (1) problems associated with mobile technology; (2) phone maintenance; (3) OVC referrals; (4) community record-keeping; and (5) opportunity costs associated with pen and paper and mobile formats.
- *OVC interview simulations* using the OWT were performed in front of 21 volunteers during the volunteer user workshop. Volunteers coded one interview using the paper format and one using the mobile format. The number and type of errors from the paper and mobile formats were calculated. Error types and rates between the pen and paper and mobile formats were compared.

Integration

While this operations research was designed specifically for understanding the use of mobile technology in M&E of OVC programs using community volunteers, the study methodology could be useful to any project doing M&E with community volunteers. All levels (the agency, the region and the Ministry of Health and Social Welfare of the Government of Tanzania) and all sectors are interested in using mobile technology for data collection. The resource-poor settings, the type of partners, and the community volunteers are a common denominator in many CRS programs, and little is known about what makes mobile technology successful in these settings. This research has been important so that the Tanzania OVC program will know

what support mechanisms, resources, and guidance are required for the success of mobile technology within their OVC program; in turn, this information can be extrapolated to similar programs within CRS.

Positive Outcomes and Impacts

Volunteer characteristics and perceptions

All volunteers felt comfortable sending text messages, with 90 percent of volunteers owning their own phones. Most volunteers (66 percent) reported that sending paper forms to the project office took longer than a week. All volunteers favored mobile data transfer over paper. The majority of volunteers felt switching from the paper format to the mobile format would be easy, but did anticipate problems such as network failure (83 percent) and difficulty recharging phone batteries (48 percent). Volunteers (62 percent) believed the mobile application would improve communication with OVC.

Record keeping and data quality

During the field observation, volunteers were noted copying information from the pen and paper and mobile formats to keep for themselves. Focus group discussions with stakeholders revealed that volunteers maintained a community record to share findings locally with Most Vulnerable Children Committees and government officials. The volunteers felt unable to abandon paper forms because the mobile data system did not provide them with feedback or a record. While errors of omission and multiple responses were eliminated using the mobile application, some errors remained among the forms successfully sent to the server. Paper forms also contained some errors.

Lessons Learned

- Mobile data collection for OVC programming was accepted widely by volunteers, possibly due to familiarity with mobile phones or reduced opportunity costs.
- Mobile technology can significantly speed data transmission from the community volunteer to the project office, which has implications for the ability of project managers to monitor and supervise volunteers more effectively. This, in turn, can improve program quality.
- Skip and repetition errors were eliminated using the mobile format of the OWT.
- Additional support to volunteers is needed to transmit data to the server, reduce user errors, and ensure data quality.

Promising Practices

This study highlighted a previously unrecognized benefit of the paper format—namely the ability to create a community record used by key project stakeholders. A dual format method that uses both a paper and mobile format is recommended. Future designs should consider an electronic feedback mechanism to increase efficiency, foster local ownership of data, and ensure OVC needs are met. More research is needed to assess reasons for user errors, inconsistencies between the pen and paper and mobile formats as well as to evaluate timeliness and appropriateness of referrals made by community volunteers.

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PHOTO BY KAREN KASMAUSKI FOR CRS

TANZANIA

Poverty Alleviation and HIV/AIDS Mitigation through Agro-enterprises in the Lake Zone of Tanzania

Introduction to Project

The Poverty Alleviation and HIV/AIDS Mitigation through Agro-enterprises project, funded by USAID, was implemented in Misungwi district, Mwanza region from February 2006 to February 2010. The project's goal was to increase the quality of life for people living with HIV (PLHIV) and households caring for orphans and vulnerable children (OVC) in the district through integrating Savings and Internal Lending Communities (SILC), agriculture, income generating activities (IGA), and HIV impact mitigation.

TANZANIA	
Type of Project	Cross-sectoral
Integration Aspects	SILC, agriculture, HIV prevention, nutrition, OVC
Number of Beneficiaries	Direct: 2,142 SILC members from 766 households Indirect: 1,679 OVC
Beneficiary Type	PLHIV and OVC
Source of Funding	USAID
Duration of Project	February 2006 to February 2010
Promising Practices Highlighted	<ul style="list-style-type: none"> • Use of an existing value-chain analysis to inform crop selection. • Cross-sectoral collaboration in project design, implementation, and monitoring. • SILC as an entry point to increase income and improve food and nutrition security for households affected by HIV. • Well-managed SILC Group Associations as a method of collective marketing of agricultural products to increase small holder farmer income.

Problem statement and Context

Nearly 58 percent of Tanzanians live on less than \$1 per day.¹ Most Tanzanians (more than 50 percent) depend on subsistence agriculture as their primary livelihood.² Yet, lack of information about crop values, limited access to agricultural financing, and poorly organized markets force many farmers to sell their products to intermediaries at lower prices. The situation is aggravated further by irregular rainfall and drought, which can decrease agricultural production levels and contribute to food insecurity.

HIV-affected households, especially those with children, are susceptible to poverty and food insecurity, including malnutrition. Households affected by HIV often experience a decrease in productive labour and an increase in health care costs and other associated opportunity costs. This combination likely decreases household agricultural production, which leads to a reduction in income and a reduced ability of households to meet their basic needs, including access to food of sufficient quantity and quality to maintain good health. This is of particular concern to PLHIV, who have increased nutritional requirements and less income with which to procure them.

In response to these challenges, CRS Tanzania mobilized a multi-sectoral team of agriculture/agro-enterprise, microfinance, and HIV program specialists. CRS worked with local implementing partners the Center for Ethical Agriculture (KIMKUMAKA) and the Tanzania Home Economics Association (TAHEA) to design a project to address the diverse challenges faced by smallholder farmers and HIV-affected

¹ United Nations Development Programme. 2007. Human Development Report 2207/2008. New York: Palgrave Macmillan.

² National Bureau of Statistics Ministry of State President's Office Planning and Privatisation. (2009). The Tanzania Household Budget Survey for Mainland Tanzania 2007. Accessed on February 14, 2010.

households in nine villages in Misungwi district of the Mwanza region where 71 percent of people rely on agriculture for their livelihood. The Mwanza region is the third poorest region in the country, with an HIV prevalence of five percent, which is among the highest in the country. The project used a cross-sectoral approach to support poverty alleviation by providing increased marketing and income generation opportunities for rural households, including households of PLHIV and OVC. The project increased access to financial services through the promotion of SILC and SILC Group Associations (SIGAs). SILC, Savings and Internal Lending Community, is CRS’ model for community-based, self-managed savings-led financial services. SIGAs are a second-level organization of SILC groups which focus on improving the availability of nutritious foods and providing nutrition education.

Purpose of the project

The goal of this project was to increase the quality of life for PLHIV and OVC households in Misungwi district, Mwanza region through three strategic objectives.

STRATEGIC OBJECTIVES	SILC activities are developed and supported to provide access to savings and credit, and to improve household income.
	SILC members, including OVC households, are involved in income generating activities.
	The nutritional status of SILC members and their families, including 400 OVC households, is improved; care for OVC is enhanced.

Specific project activities included:

- Developing and strengthening SILC activities to improve household income and create resources available to invest in income generating activities.
- Promoting and marketing high-value leguminous crops, including green grams, pigeon peas, and chickpeas.
- Diversifying crop production through the promotion of orange fleshed sweet potatoes and homestead gardens.
- Mitigating the impact of HIV on infected and affected individuals and their household by improving household income, food security, and nutritional status.
- Increasing HIV awareness and prevention.

Steps in implementation

Prior to project initiation, CRS and Technoserve conducted a value-chain analysis to identify crops with market potential. The findings suggested that chickpeas, pigeon peas, and green grams were adapted to the local agro-ecological conditions of the project’s target areas and that a good market existed for these to be sold locally. Once the project began, community resource persons were identified and trained on how to mobilize community members into SILC. The SILC groups were comprised of subsistence farmers, which included PLHIV and OVC caregivers. In addition to training on the SILC methodology, the SILC members were trained by KIMKUMAKA in agronomy, crop production and marketing and business skills. A select group of SILC members were trained in poultry rearing.³

³ Poultry rearing training included chicken coop construction, disease management, record keeping, and other important skills.

TAHEA trained SILC members on production, processing and utilization of Vitamin A-rich orange fleshed sweet potatoes. The project further promoted sack and kitchen gardens using bio-intensive agricultural techniques to increase household dietary diversity and provide additional income earning opportunities. Select SILC members were trained to provide HIV education and awareness to their SILC groups using the *We Stop AIDS* curriculum. Groups received general nutrition education and training in psychosocial support for those caring for OVC.

In addition to working with integrated SILC, i.e., those which had members who were HIV-positive, negative, and of unknown status, the project also worked with PLHIV support groups. During their meetings, these PLHIV support groups discussed the challenges they faced, received nutritional counseling from TAHEA, and prepared a nutritious group meal using the agricultural products they grew. Over time, some of the support groups started their own SILC groups. While the funds generated from these SILC groups were smaller than those generated by integrated SILC groups, they did provide access to funding to assist ill members in times of need. Participation in SILC also improved their support group meeting attendance.

To ensure that this project maintained program quality across the three sectors involved—microfinance, agriculture/agro-enterprise, and HIV/health—all three sector specialists conducted joint planning meetings, joint trainings, and joint monitoring visits. This allowed for exchange of ideas across sectors and increased the ability of the project to respond to the diverse needs of project participants.

Positive outcomes

Because of this project, vulnerable households benefited from improved food security and increased knowledge and skills related to financial management, agriculture, HIV awareness and prevention, and nutrition.

With the support of CRS and its partners, beneficiaries in Mwanza were trained on the SILC methodology. By the end of the project, the SILC members had increased their household income so as to be able to save between US\$0.50 to US\$2 per week. This led to an increase in their ability to meet their basic needs, including food, shelter, education for their children, and health care. The percentage of those consuming three meals a day increased from 26.7 percent at baseline to



PHOTO BY DAVID SIVITER FOR CRS

Doughnuts are produced and marketed from the flour of ground orange sweet potatoes grown in the project.

68.2 percent at the time of the final evaluation.⁴ Monitoring data suggested that among the 1,554 households who participated in the SILC groups, 766 (nearly 50 percent) were able to provide for the basic needs of their families without external support, including the needs of OVC. SILC group members also reported increased psychosocial support and improved knowledge about the HIV services in their communities, including testing facilities.

Project participants, who were SILC group members, experienced an increase in production of green grams, chickpeas, pigeon peas, and orange fleshed sweet potatoes. Food security was further enhanced by homestead gardens and poultry rearing. All 388 SILC group members who trained in poultry rearing were able to earn an income from selling eggs and increase their household egg and chicken consumption. Most of the poultry farmers were women and PLHIV. In fact, the suggestion that the project should provide poultry rearing training was made by a group of PLHIV because they felt it was less labor intensive than crop production and thus more manageable for them.

The project was successful in creating nine SIGAs, which helped to improve market knowledge among their members. Of the nine SIGAs, five were able to link directly with the Export Trading Company to negotiate better prices for their produce. Through SILC and SIGAs, members increased their personal assets, including livestock, land, farming equipment, and household items.⁵

Getting a Fair Price through SILC Group Associations

Organizing smallholder farmers into groups allows them to bring together their production and create sufficient product volume so that buyers are willing to buy from them directly rather than use intermediaries. This has the potential to increase farmer profit margins and income.

To facilitate product bulking and direct price negotiations with buyers, the project promoted the establishment of SILC Group Associations (SIGAs), which consisted of at least five SILC groups in a village who collectively marketed their products. Each of the nine target villages formed a SIGA.

Prior to the end of the Poverty Alleviation and HIV/AIDS Mitigation through Agro-enterprises project, 20 SIGA leaders received training in SIGA roles and responsibilities. This training was followed by a study tour to villages that had successfully engaged in collective marketing through another project, which was funded by the Ryan Family Foundation. Training on business and marketing was conducted for 80 SILC members.

By the end of the Poverty Alleviation and HIV/AIDS Mitigation through Agro-enterprises project, five of the nine SIGAs had started harvesting and had already negotiated at least one contract with the Export Trading Company to sell their harvest at a higher price than they would have gotten individually through a local intermediary.

To learn more about SIGAs please see “*How Savings-Led Microfinance has Improved Chickpea Marketing in the Lake Zone of Tanzania*,” available at <http://www.crsprogramquality.org/publications/2011/1/18/how-savings-led-microfinance-has-improved-chickpea-marketing.html>.

⁴ (March 2010). Poverty Alleviation Project Final Evaluation.

⁵ Ibid.

Lessons Learned

- The SILC model allowed for the development of sustainable community-centered approaches to addressing the complex problems of poverty and HIV.
- SILC membership increased household incomes, strengthened the local community's financial base, provided assets to diversify income strategies and financial assets, and helped members become more self-reliant.
- In addition to providing access to financial services in rural communities, SILC provided an entry point for the provision of additional services to beneficiaries, such as crop production, marketing, business skills, and poultry rearing, especially for PLHIV and caregivers of OVC.
- Integrated SILC groups made up of HIV-positive, HIV-negative, and people of unknown status not only diversifies the risk pool, but also contributes to the reduction of stigma and discrimination against PLHIV.
- SILC made up exclusively of PLHIV often generated less income than integrated groups; however, SILC seems to help improve support group cohesion and attendance, reduce stress associated with HIV status, and provide improved access to savings, loans, and a social fund.
- PLHIV support group meetings provided an important platform for offering HIV-specific nutrition education and counselling. The most effective education method used was the cooking of nutritious group meals using local ingredients.
- The combination of SILC, improved agricultural production techniques, linkages to markets, business skills, homestead gardens, poultry rearing, and nutrition education increased food security and helped participants achieve and maintain a healthy nutritional status, something particularly important for PLHIV.
- Sack gardens were an effective way to increase food access and availability for vulnerable households, especially those headed by the elderly or children.

Promising Practices

- Use of an existing value-chain analysis to inform crop selection increases the likelihood that the crops selected will have a high market potential.
- Regular collaboration among sectoral experts in microfinance, agriculture/agroenterprise, and HIV/health in the joint design, planning, implementation, and monitoring of the project results in a more holistic project design and allows vulnerable community members to access a range of high quality services, contributing to improvements in lives and livelihoods.
- Provision of business skills training is beneficial, especially for women. Business skills increase the likelihood of income generation by SILC members.
- Well-managed SIGAs have the potential to improve farmer competitiveness by bulking agricultural products and removing the intermediary from buyer-seller negotiations, thus increasing the price paid to farmers for their crops.⁶

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⁶ To learn more about SIGAs please see "How Savings-Led Microfinance has Improved Chickpea Marketing in the Lake Zone of Tanzania" available at <http://www.crsprogramquality.org/publications/2011/1/18/how-savings-led-microfinance-has-improved-chickpea-marketing.html>.

CASE STUDY

The Story of Tatu Izile

PHOTO BY GODFREY LUGOE FOR CRS



Tatu Izile at her sweet potato farm.

“This SILC project is a savior because a member can easily get a loan. Everybody in the village wants to become a SILC member.”
—Tatu Izile

Tatu Izile is a woman living with HIV who belongs to a SILC. She is 45 years old and is married with five children. Her main source of income is agriculture. She became a SILC member in 2004. Her Mwanzo Mgumu SILC in Bukumbi Village has helped her to live positively with HIV. Although Tatu is open about her status, she is not a member of the PLHIV group which was established in the village in December 2008. Tatu has not started taking antiretroviral therapy as she is still healthy and very energetic.

Tatu attended training on orange fleshed sweet potato production, processing, utilization, and permaculture, and was among those who went for a study tour to see how SIGAs operate.

She sells vines and managed to buy a goat and a bicycle and is able to pay school fees for her children. She has no problem fulfilling the basic needs of her household.

Tatu has recently received chickens for production. She said, for her and many other SILC members, this is an opportunity to increase household income and improve nutrition.

PHOTO BY GODFREY LUGOE FOR CRS



Tatu with her children and nephew.

PHOTO BY GODFREY LUGOE FOR CRS



Tatu Izile (far right) and some SILC members holding chickens distributed by KIMKUMAKA.



PHOTO BY TRUONG NGOC TIEN/CRS

VIETNAM

Network for Children Model in Thu Duc District, Ho Chi Minh City

Introduction to Project

The Catholic Relief Services (CRS) Vietnam Network for Children model works within and strengthens existing community and Vietnamese government resources to provide children and families with quality comprehensive services. CRS' main partner, the Department of Labor, Invalids and Social Affairs (DOLISA), is the government department responsible for district-level social services. DOLISA coordinates among existing local government agency providers over six core service areas—health, nutrition, education, psychosocial, legal and shelter—to ensure holistic support for children with multiple needs. DOLISA acts as the main implementing agency, reviews the individual cases and facilitates the direct service provision from each service provider. The CRS Network for Children model uses a case management approach in which local social affairs volunteers, called Ward Workers, interact directly with children and families in the home to assess their needs and connect them to available community-based services. This model is a two year program that has reached 275 children and is funded by a sub-grant from PACT's USAID-funded orphans and vulnerable children (OVC) program.

VIETNAM	
Type of Project	OVC
Integration Aspects	Integration within all government-provided child services, including health/nutrition, education, legal, psychosocial support etc.
Number of Beneficiaries	275 children
Beneficiary Type	OVC and their caregivers living with and affected by HIV
Source of Funding	PACT's USAID-funded OVC program (PACT subgrant AL031)
Duration of Project	March 1, 2008 – September 30, 2009
Promising Practice Highlighted	Setting up a Network Model of existing government services to ensure coordinated, holistic and sustainable care for OVC

Problem Statement and Context

In the past decade, Vietnam's economic growth has been blinding. Since recent economic reforms, the country has had the second highest economic growth rate in the world. Thus a new social peril has emerged—injecting drug use—which coincides precisely with the economic reforms and the resulting open trade and human mobility. In Vietnam, the HIV epidemic is fueled by drug injecting practices and sex, with key populations at higher risk: injecting drug users (IDUs), sex workers, and men who have sex with men. More than half (57 percent) of the people living with HIV (PLHIV) in Vietnam have injected drugs, and roughly 33 percent of drug users are living with HIV. (This varies between provinces and is as high as 83 percent in some border areas).¹

Adult HIV prevalence is 0.4 percent.² However, a rise in the number of children living with and affected by HIV is rising.³ With the expansion of HIV programming and coverage of antiretroviral therapy (ART) in urban areas of the country, parents are more able to care for their children and solutions outside of institutional care are becoming mandated among government and civil society organizations are beginning to mandate solutions outside of institutional care. In addition to ART and health care, families affected by HIV are often also in need of other types of support, including economic, legal, social or mental health services. In many cases when children are orphaned due to AIDS, extended family members want to send the children to orphanages, rather than keep them at home, due to high stigma and discrimination in the community. The CRS' Network for Children project is a significant step in this direction of supporting families to care for children affected or infected with HIV in their homes and communities.

In many ways Vietnam is extremely well positioned for providing comprehensive OVC treatment, care, and support. Functional health, education, and social services are operating with strong capacity to deliver and manage quality care. The government has also instituted a number of pro-poor / vulnerable

1 UN Office on Drugs and Crime. (2010). World Drug Report. Available at http://www.unodc.org/documents/wdr/WDR_2010/1.0_Transnational_drug_market_analysis_Introduction.pdf. Accessed on Feb 12, 2011.

2 From UNAIDS website: http://unaid.org.vn/sitee/index.php?option=com_content&task=blogcategory&id=13&Itemid=27. Accessed on Feb 12, 2011.

3 Boston University with Hanoi School of Public Health. (2009). *Research Situation Analysis on OVC: Vietnam Country Brief*. Available at http://www.vietnamsc-cope.org/index.php?option=com_content&view=article&id=96:orphan-and-vulnerable-children-of-hiv&catid=41:ovc&Itemid=135. Accessed on Feb 12, 2011.

population schemes to provide supplemental resources that vulnerable children can access. Impeding the system for OVC to utilize these benefits are two critical barriers: (1) low awareness/stigma and discrimination; and (2) poor coordination among service providers. The majority of those living with HIV in Vietnam are populations that engage in “high-risk behaviors.” These groups experience a high level of discrimination. PLHIV are considered “guilty by association” which prevents them from seeking out assistance. Many PLHIV and their affected children are not aware of their rights or the support that is available to them. In addition, people have to register and disclose their status in order to receive support; thus, people in need avoid available services. Along with the government schemes provided, a number of other medical and social services are also available from numerous organizations. Poor coordination has resulted in some children receiving double services with others being left completely out of the system.

Purpose of the Project

The Network for Children Project’s goal is to “improve the quality of life for children in Ho Chi Minh City living with and affected by HIV.” This goal is to be achieved through the implementation of three strategic objectives.

STRATEGIC OBJECTIVES	<p>Increase technical support for service delivery to OVC and their families: The Network for Children project works with the Vietnamese Government, improving information sharing among OVC providers and building OVC and HIV topics into the university social work curriculum.</p>
	<p>Caretakers and/or OVC have increased access to needed services: This is achieved through coordination of key government service providers at district and commune levels, who can offer health, nutrition, legal aid, education, psychosocial support, and/or shelter services as well as provision of trainings and routine monitoring support for caregivers of OVC.</p>
	<p>Psychosocial support services are increased in quantity and quality: This objective focuses on filling the present gap where few services are offered.</p>

Steps in Implementation

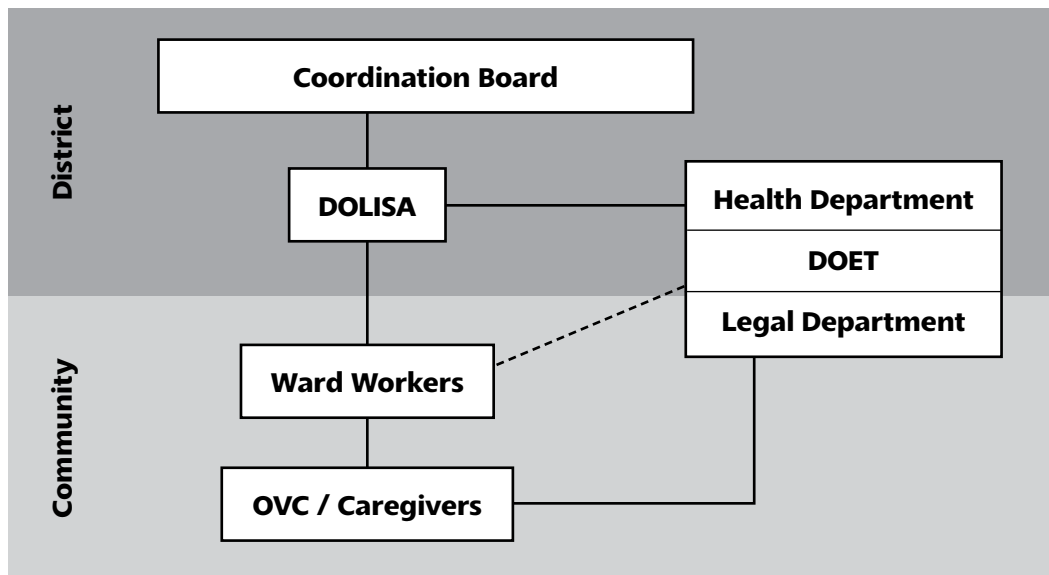
Commencing the Network Model was a challenging task. Ministerial staff assisted CRS with initiating a partnership with the district. Although some services in the six core areas were available in the district of Thu Duc in Ho Chi Minh City prior to the CRS project, the local government agencies had little experience working together in a cooperative network. Most local staff were also not familiar with concepts of service coordination or case management. A critical turning point in the project occurred at a joint meeting of all the providers facilitated by CRS in March 2009. The purpose of the CRS workshop was for the partners to look together at the actual needs from the point of view of an HIV-positive or affected child. Together they developed a menu of core interventions available to clients with each agency offering the support they could provide in the network (see Table 1). Roles and responsibilities were defined by the various partners including DOLISA and Ward Workers. The purpose of this meeting was to ultimately set up a Coordination Board headed by DOLISA.

Table 1. Partner-Defined Package of Interventions

HEALTH DEPARTMENT	DEPARTMENT OF EDUCATION AND TRAINING	LEGAL DEPARTMENT	DOLISA
<ul style="list-style-type: none"> • Health Check-Ups • Nutritional Support • ART/OI Support • Health insurance for children < 6 years 	<ul style="list-style-type: none"> • School Fees • Ensure enrollment • Prevent discrimination • Health insurance for children > 6 years 	<ul style="list-style-type: none"> • Birth registration • Child protection legal services 	<ul style="list-style-type: none"> • Psychosocial support • Enrollment in pro-poor government schemes for social benefits

CRS worked with DOLISA to set up the referral system between these key service providers, develop the monitoring system tools and software, and identify Ward Worker volunteers in the community. Following the initial training of the Ward Workers on the baseline needs assessment form, clients were formally enrolled into the program and the Network Model was put into effect. A needs assessment of 350 OVC was conducted in February-March 2009. DOLISA maintained the needs assessment forms which formed the basis for their service delivery plans. These forms were then shared with the other service providers so that they could establish their own plans.

Figure 1. Structure of the Network Model



The Network Model utilizes a two-pronged approach to implementation and coordination based in the district and the community (see Figure 1). Management and monitoring of the various services takes place at the district level, including any policy ramifications and special case considerations applying to individual children. The main channel for coordination is through the district-level Coordination Board who monitors activities and addresses special needs of unique cases. DOLISA, as the chief implementing agency, is the focal point linking the Coordination Board, the various service providers, and the particular OVC cases. The second prong is at the community level. The overall wellbeing of each child can be considered in their home environment, avoiding the necessity for institutional care. The child’s

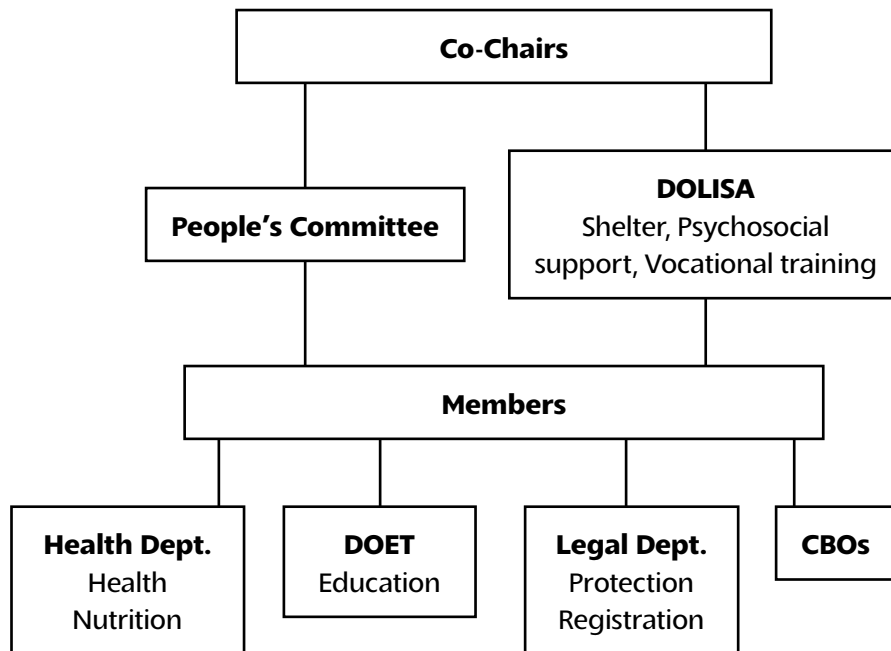
needs are assessed and responded to, utilizing a case worker approach by Ward Workers, supervised by DOLISA. The overall Network Model establishes functional systems for assessment, analysis, referral, and follow-up for enrolled children using simple assessment / monitoring tools (see Table 2).

Table 2: Steps in Implementation of the Network Model

STEP 1	Identify the “package” of services offered by each provider and their coordination role within the Network.
STEP 2	Enable DOLISA to strengthen the community-based system to support OVC using a case worker approach.
STEP 3	Build the referral network among the coordination board members at the district and commune levels.

Integration

Figure 1. Structure of Coordination Board



The success of the model is grounded in integration which is achieved on two fronts. At the district level, the Coordination Board functions as the formal management forum for the various government sector service providers in the district (see Figure 1). The Board meets quarterly. Meetings are organized by DOLISA and facilitated by the Vice Chair of the People’s Committee. The purpose of the meeting is for its members to discuss overall service outputs in the previous quarter, develop future plans and problem solve coordination issues for particular cases. Besides the members, Ward Workers and a representative from the Commune People’s Committee also attend to bring pertinent issues occurring in the

community directly to the attention of the Board and to seek solutions. It is envisioned that the meetings will eventually serve as a case review forum where detailed discussions can be held, including laying out clear plans on how to handle complicated cases.

Integration occurs on the frontlines in communities and households through the Ward Workers. The Ward Worker acts as the direct link between the client, DOLISA and the rest of the service providers. Each Ward Worker has 15 to 25 OVC clients and their families under their care. It is the Ward Workers’ responsibility to assess the full needs of the child based on the main pillars of the OVC framework: health, nutrition, education, psychosocial support, shelter, adult supervision, and socio-economic means. A service delivery plan is developed which outlines the basic needs by priority and the role of the network member in meeting them. When the service is provided the referred agency completes the referral form and returns it to DOLISA. The Ward Worker routinely visits the client and the referring agency to ensure clients are making use of the assistance being offered through the network. These home visits are also conducted to provide some emotional peer support to the caregivers and to routinely monitor the health, psychological wellbeing and living conditions. This cycle of assessment, analysis, network referral, and follow-up is repeated routinely—installing a system of ongoing review of the child’s needs with a plan of action.

Positive Outcomes and Impacts

CRS’ Network for Children Project provides a novel approach to OVC care in Vietnam and has yielded successful results. The aim of the project was for OVC to receive quality community-based care in one or more of the core service areas where they were assessed as having needs. Children receiving support in three or more core service areas are considered “primary direct support” beneficiaries, while those benefiting from one or two services are counted as “supplemental direct support.” Over the course of the project, the number of children receiving primary direct support increased from 17 to 150, showing that the Network Model provides a more efficient means for OVC to access multiple services, and also a mechanism for enrolling more children into the program. By September 2009, 275 children received direct services through the Thu Duc service provider network, exceeding the target of 250. One hundred fifty children received primary direct support, meeting the set target. An additional 158 children received services from sub-grantee Worldwide Orphans Foundation, plus a further 15 children were served by both CRS and Worldwide Orphans Foundation (see Table 3). Additional outcomes achieved within sectors include:

- All 15 children identified as severely malnourished improved their nutritional status.
- Forty-one percent of clients of school age (target OVC list) were enrolled in school, up from 21 percent at baseline.
- At baseline DOLISA served only 50 children but by the end of the project 275 were registered.

Table 3: OVC Supported by Networked Services in Thu Duc district, FY 2009

	NUTRITION	HEALTH	EDUCATION	PSYCHOSOCIAL	LEGAL
By June 2009	159	17	0	185	0
By Sept. 2009	275	40	150	275	2

Lessons Learned

The coordination strategy of the Network Model maximizes existing government services to more efficiently meet the needs of OVC. After a year of implementation, CRS and Thu Duc DOLISA's lessons learned are summarized below.

- The Network Model is a service network and systems strengthening approach. It requires time to bring together the stakeholders to define the coordination process and establish sustainable systems. As such, the first year focuses primarily on setting up the model, doing baseline child assessments, systems development, and capacity building. Subsequent years can focus more on the quality of case management and service delivery.
- It is very important to provide the Ward Workers with professional skills to work with OVC using a simplified case management approach. Ward workers are essentially volunteers, so initially their role is more realistically defined to be that of a coordinator of services to meet basic needs and simple peer support, with the long-term aim to build their capacity to be “case workers.”
- Training for Ward Workers and other service providers must be followed up by monitoring and technical support by implementing agencies and local partners. Capacity building is a long-term process that requires multiple interventions, not a single training course.
- Government agencies should also take care to select staff skilled in inter-personal communications and group facilitation, besides possessing technical knowledge.
- When setting up the Coordination Board, the roles and responsibilities of each of its members needs to be defined from the outset with clear communication lines and mechanisms established for exchange among network members.
- Coordination cannot be assumed even if the services exist. It sometimes takes an outside agency like CRS to facilitate the process, bring the actors together, define each agency's roles, and support the various agencies in implementation.
- Resources should be accessible to not only the lead service provider but also the other service providers participating in the model so that they can manage their own plans of action.

Promising Practices

The idea of the Network Model was born out of CRS' recognition of existing government services and the barriers to care experienced by vulnerable children and their caregivers. The basic principle — and the promising practice — of the Network Model is to encourage relevant government agencies to come together to meet the holistic needs of each individual child. In middle income countries, where the complete package of multi-sector child services are available, rather than creating a parallel vertical HIV package, existing services need to be coordinated and promoted. In light of USAID's new Global Health Initiative, the model also makes the essential shift from providing emergency services to vulnerable children to additionally building government and local systems for a sustainable approach to ensuring comprehensive OVC care.

The program also underwent a complete paradigm shift from public health focused HIV programming to working with the social side of the disease. The project focused more on social work interventions which cross-cut the various technical areas and allowed for a more multi-sector approach. This approach required shifting from traditional public health staff working on OVC programming to actual “social workers” not only on the CRS team but also among government partners. Several components such as adding OVC support to pre-service curriculums in the university, capacity building in psychosocial support, and placing university students within project areas to allow for them to develop practical experience working with vulnerable children, were built into the program and contribute to the long-term development of social work in Vietnam.

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CASE STUDY

Lan Starts to Smile

Lan* is a six-year-old girl born in Cambodia to a Vietnamese father and a Cambodian mother. When Lan's mother died of AIDS in 2005, Lan and her father, Nam,* were tested and discovered they are both HIV-positive. After receiving the news, they left Cambodia and returned to Nam's home in Ho Chi Minh City. They moved in with Lan's grandparents who have few resources and are very poor. In Vietnam, Nam was unable to find a steady job. Without money for health care, Lan's health was very poor. She constantly suffered from colds, fevers, and diarrhea.

In October 2008, Lan and her family started receiving services from CRS and DOLISA's Network for Children Program (funded by PACT and USAID). During the first visit, the Ward Worker discovered that there was little food in the house and Lan was suffering from severe malnutrition. Lan had no friends, was not attending school and spent hours playing alone. During the initial assessment, Lan was withdrawn; her father reported that she hardly ever smiled. Through the Network for Children Program, Lan and her family received a complete package of services from various government agencies. The assistance included monthly nutritional support (vitamins and food), transportation fees to and from the hospital, access to ART, education support (enrollment and supplies) and legal support (creation of a birth certificate). Nam participated in training courses on HIV, child development and nutrition so he could better care for his daughter.

As a result of the program, Lan now enjoys attending school and her health has improved. Lan gained 2 kilograms and is seldom sick. She said, smiling, *"I love to go to school. I love to play with my friends"*. Nam also remarks on the change in his daughter. *"I am really happy and moved to see happiness on my daughter's face. My daughter is now healthy and can go to school thanks to the strong support from DOLISA and CRS."*

*Names have been changed to maintain confidentiality



Lan's father uses hygiene skills he learned from DOLISA to care for his daughter.

PHOTO BY NGUYEN THI HOAI LINH/CRS



PHOTO BY DEBBIE DEVOE/CRS

ZAMBIA

Trauma-Focused Cognitive Behavioral Therapy Pilot Project

Introduction to Project

The Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) pilot project was born from the realization that basic mental health services, such as pediatric psychosocial counseling, help many children, but do not effectively meet the needs of children who have been through traumatic experiences. USAID-Zambia introduced the idea of piloting an evidence-based approach to identify and treat traumatized children and youth who were enrolled in palliative care, home-based care (HBC) and/or street youth services. Catholic Relief Services (CRS) Zambia partnered with the Applied Mental Health Research Group (AMHR) of the Johns Hopkins University Bloomberg School of Public Health to implement a pilot intervention between March 2009 and May 2010. Trained community caregivers assessed 343 Zambian children for trauma, identified 202 children with one or more signs of trauma, referred children to trained counselors in Trauma-Focused Cognitive Behavioral Therapy, and treated 65 children using the methodology. Children that completed treatment showed significant reduction in trauma symptoms. The project demonstrated that integrating advanced mental health services into existing community programs is feasible.

ZAMBIA	
Type of Project	Orphans and vulnerable children (OVC)
Integration Aspects	HIV (HBC, Palliative care) and mental health
Number of Beneficiaries	343
Beneficiary Type	OVC
Source of Funding	USAID
Duration of Project	March 2009 – May 2010
Promising Practice Highlighted	Advanced pediatric mental health services

Problem Statement and Context

With the advent of the President’s Emergency Plan for AIDS Relief (PEPFAR) in 2004, children’s access to psychosocial counseling greatly increased through U.S. government-funded home-based care, HIV treatment and OVC programs in Zambia. In the same year, a faculty member from the Applied Mental Health Research Group (AMHR), located at The Johns Hopkins Bloomberg School of Public Health, conducted a qualitative study to investigate mental health issues in Lusaka, Zambia. The AMHR group identified the need for increased mental health services, specifically for children and youth who had undergone trauma and grief. However, apart from one government inpatient mental health hospital and basic psychosocial support programs, few, if any, advanced mental health services existed in Zambia, especially for children. In addition, no PEPFAR program in Zambia had integrated advanced mental health services into an existing community program to support children who had undergone trauma and grief.

Zambia has an advanced HIV epidemic, with a prevalence of over 14.3 percent and more than 600,000 children orphaned by AIDS, and 1.1 million orphaned by all causes (UNAIDS 2008). HIV is concentrated in urban areas, with some of the highest prevalence in poor neighborhoods (or compounds). The combined impact of HIV and high rates of poverty places children living in compounds at high risk of experiencing traumatic events, such as physical and sexual child abuse and assault, exposure to domestic and community violence, serious accidents, natural and human disasters, violent crime, violent or sudden death of a loved one, and other experiences that create significant threat or fear. Significant mental health symptoms can result from experiencing such an event, witnessing it, or even having a close loved one experience the event.

A unique factor that preceded the pilot program was the research on mental health conducted by AMHR in Zambia. Equipped with the findings of the qualitative needs assessment in 2004, AMHR used the results to adapt, test and validate an assessment tool to identify youth with trauma histories and significant (i.e. severe) mental health symptoms. They also reviewed the treatment literature to identify intervention options that could be adapted to the Zambian context to treat these problems. Based on this review and consultation with local health professionals and mental health experts, an evidence-based¹ therapy called Trauma-Focused

¹ Evidence-based mental health treatments are defined as interventions that are (1) manualized; (2) have at least two randomized controlled trials conducted on them showing efficacy; and 3) have been tested by at least two different teams of researchers.

Cognitive Behavioral Therapy (TF-CBT) was selected. TF-CBT is a psychotherapy that helps children, youth and their families affected by traumatic events deal with the mental health consequences of the events.

Simultaneously with the instrument development and validation process, AMHR trained on TF-CBT and implemented a small feasibility study. This study sought to examine the feasibility of training local counselors in TF-CBT, the ability of counselors to deliver this treatment with adherence to the overall methodology, and the acceptability of this treatment from counselors and those receiving services. The findings from the research and the feasibility study served as the body of evidence for the CRS pilot program.

Purpose of the Project

The main goal of the TF-CBT pilot project was to examine the feasibility of integrating mental health services into existing service infrastructures. The pilot had the following four objectives.

STRATEGIC OBJECTIVES	Training community caregivers in evidenced-based mental health assessment.
	Training local counselors in TF-CBT.
	Training three advanced TF-CBT therapists in the supervision of TF-CBT.
	Rigorous monitoring and evaluation of all program activities.

Steps in Implementation

CRS Zambia selected eight local programs to implement the pilot. The programs, located in dense urban compounds in two major cities (Lusaka and Kabwe), had existing trained child counselors on staff, a network of community caregivers who could be trained in trauma assessment, and the ability to assess a large number of children during the pilot.

Forty-six community caregivers were trained by AMHR staff to use three validated mental health assessment tools: the Post Traumatic Stress Disorder Reaction Index (PTSD-RI), a shame measure, and the Child Behavior Checklist. By integrating use of the validated mental health assessment into their current job roles, caregivers assessed 343 children in three months, of which 202 (58.9 percent) met criteria for the TF-CBT treatment. Of the children who met criteria, 67 percent reported having experienced six or more traumas. In September 2009, the assessment activities were put on hold in order to maintain a manageable waiting list of children needing therapy.

Children who met criteria were referred to 18 child counselors trained in TF-CBT therapy. Training of these TF-CBT therapists, most of whom had secondary school education levels, involved a two-day online training followed by an eight-day-live training led by AMHR. The training modules built skills in the eight areas of TF-CBT treatment, namely: Psycho-education, Relaxation, Affective Modulation and Cognitive Processing, Trauma Narrative, Cognitive Reprocessing, and Enhancing Skills. CRS also contracted additional therapists (trained under the AMHR feasibility study) on a “fee for service” basis to help clear the waiting list.

Cases were assigned to therapists during weekly supervision groups. Led by a trained supervisor, these groups served as a way to problem-solve difficult cases while delivering ongoing training in TF-CBT skills. AMHR selected three therapists from the feasibility study to train as TF-CBT supervisors.

Supervision training included advanced role-plays to assure supervisor mastery of the TF-CBT skills, as well as training on how to run TF-CBT supervision groups and handle high risk cases.

Sixty-five children completed the full TF-CBT treatment by May 2010, with an average of 11 sessions completed; the overall number of completed sessions ranged from 8 to 23 sessions. Upon completion, a different therapist conducted post-assessment questionnaires with the child and a qualitative interview with both the child and guardian. Results from the pre/post analysis showed a significant difference in the average Post Traumatic Stress Disorder score post treatment ($p < 0.0001$) and in the shame score post treatment ($p < 0.0001$). Training on the Child Behavior Checklist was not completed by all assessors, so it was not included in the comparative analysis.

Integration

The intention of the pilot was not to establish a sustainable model, but rather to demonstrate that integration of the model was feasible. The pilot demonstrated that while the target group of the TF-CBT pilot project was orphans and vulnerable children, it could be successfully implemented in palliative care and street youth programs. The TF-CBT model could be equally adapted to other sectors, including HIV treatment, gender-based violence, or education initiatives.

The pilot transferred capacity for TF-CBT assessment, therapy and supervision to local institutions in order to build a foundation for continued expansion. Kara Counseling and Training Trust, a non-governmental organization recognized as a leader in counseling services, owned five of the eight sites that participated in the pilot. By the end of the pilot, Kara Counseling and Training Trust integrated TF-CBT into their programs, with several trained therapists, a cadre of volunteer community caregivers and outreach workers conducting assessments, and an employee at the national office trained as a TF-CBT supervisor.

Positive Outcomes and Impacts

Results from the pilot project demonstrated that it is feasible to integrate evidence-based mental health assessment tools and therapy within existing service infrastructures. Community caregivers, who were volunteers, conducted assessments with children in households, community centers and day care settings, and referred children meeting criteria. Counselors with basic pediatric psychosocial training were able to learn and apply new skills in TF-CBT as part of their existing counseling roles. Advanced therapists independently led supervisory groups by the end of the pilot program.

The treatment was effective in significantly reducing trauma and shame symptoms in this sample population. The average PTSD score in the total sample after treatment was 27.6, which was significantly lower than the average pre-treatment score of 49.6 ($p < 0.0001$). The average score in the shame scale for the total sample post-treatment was 2.2 ($SD = 5.4$), which was significantly lower than the pre-treatment average score of 8.3 ($p < 0.0001$). Males and females had a similar reduction, with no significant differences in the post-treatment average score. It should be noted that while the project uncovered a significant amount of trauma experiences and symptoms in children within the partner catchment areas, the sample is not representative of the Zambian population, and a nationwide survey is needed to determine the size and public health importance of trauma.

The pilot program raised awareness of an underestimated need for advanced mental health services for specific sub-groups of youth in Zambia. Children who reported sexual violence had higher PTSD

PHOTO BY DEBBIE DEVORE/CNS



scores than those that did not report sexual violence ($p=0.0007$). The PTSD scale score showed a significant trend, increasing from non-orphans, to single orphans, to double orphans ($p=0.020$). Street youth had higher average PTSD scale scores than non-street youth ($p<0.0001$). HIV-positive children had higher shame scores than HIV-negative children ($p=0.031$). At the end of the pilot, the Ministry of Health Mental Health Unit formed a working group to continue to examine mental health needs of children in Zambia.

Lessons Learned

Local organizations with higher levels of management support and interest enabled counselors to dedicate time to focus on implementing TF-CBT as part of their jobs. This resulted in higher numbers of quality assessments, more therapists completing cases within an appropriate time span, better attendance of supervision, and greater overall skill acquisition. Conversely, instability of the funding base of some local organizations, combined with inadequate human resource management, resulted in poorer outcomes (non-renewal of therapist contracts, under-staffing leading to limited time for TF-CBT sessions, diminished motivation, lower levels of caregiver coordination, etc.).

Supervisors and counselors' access to the children and families referred to the TF-CBT treatment relied heavily on the community caregivers. In addition to completing assessments, the caregivers linked all children that met criteria for treatment to the assigned counselor for their initial session and followed up with children and families to ensure continuation of the treatment. Lack of incentives, low motivation, lack of a phone or talk time and sickness and death of the assessors were issues identified in the pilot project that prevented successful case referral. As a direct result of

these issues, 36 children meeting criteria for therapy never received treatment, and seven cases did not complete the TF-CBT treatment. Future projects should carefully weigh the advantages and disadvantages of using volunteers in such a way.

Promising Practices

As mentioned above, Zambia was uniquely positioned to implement this pilot program because of the earlier research and feasibility study undertaken by AMHR, which identified TF-CBT as a model to address the needs in the Zambian context. CRS programs in other countries wishing to implement a similar initiative are advised to consult local research institutions or mental health bodies to see if similar groundwork exists. Once a methodology is identified, scale-up should be methodical with rigorous monitoring. Technical assistance will be required for supervision of therapists, assistance with management of high-risk cases, and ensuring fidelity to the model. In Zambia, an AMHR consultant filled this role for one year while building local expertise, but this amount of time was insufficient to transfer all areas of capacity. For example, the consultant successfully trained supervisors, but did not have time to equip them with skills to run assessment and TF-CBT trainings. Finally, even with positive results generated through rigorous analysis of the Zambia pilot program, AMHR recommends that a further impact assessment be conducted before further scaling up the model.

During implementation, CRS Zambia was contacted by other organizations looking to refer traumatized children to the pilot program. In future implementation, CRS recommends that an independent center is identified which is able to oversee the implementation of assessments, triage cases, assign cases to TF-CBT therapists, run supervision groups, and manage ongoing monitoring and evaluation of mental health services. In this way, the mental health initiative could support services by multiple local organizations and government.

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PHOTO BY CRS STAFF

Loveness Kamwendo shares a laugh with a group of children in Chawama compound, Lusaka.

CASE STUDY

Palliative care services address trauma in Zambian children

Loveness Kamwendo has volunteered her time for 11 years supporting household-based treatment for patients with tuberculosis and HIV in urban Lusaka, Zambia. Earlier this year, Loveness was trained by CRS with 45 other volunteer caregivers to assess mental health of children and to identify signs of trauma using evidence-based tools.

Loveness reports that, *“I never heard or knew anything about trauma. Now I am aware and I am able to help families. Even my family members recognize this skill and call me when they suspect anyone to have trauma symptoms.”*

According to Loveness, there was a noticeable impact of the TF-CBT pilot in the community. *“TF-CBT has made us have close relationship with children in the community. People in the community are now calling on me to talk to their children and the children are becoming free.”*

“Through this project I have seen children that were sexually abused and could not talk but are now speaking out, playing with other children and laughing after their sessions with the counselor. These children have learned how to deal with their problems and move on after the trauma. There is one child who even wants to go back to school now after quitting due to trauma.”



PHOTO BY LAMECK MAHOHOMA/CRS

ZIMBABWE

Support To Replicable Innovative Village Level Efforts (STRIVE)

Introduction to Project

In 2005, Zimbabwe launched a National Action Plan for Orphans and Other Vulnerable Children (NAP for OVC) which acts as the strategic guide for the care and support of orphans and vulnerable children (OVC). The mitigation program for OVC receives significant funding from the Programme of Support, a pooled donor funding mechanism which was set up to finance the implementation of the NAP for OVC. The NAP supports education, health care, birth registration and access to HIV prevention, treatment, and care and support services for vulnerable children. Through this arrangement, Catholic Relief Services (CRS) Zimbabwe and its partners are implementing the STRIVE (Support to Replicable Innovative Village Level Efforts)/OVC project, whose goal is to improve and reinforce care and support for OVC in Zimbabwe. This project was in operation from January 2008 to December 31, 2010.

ZIMBABWE	
Type of Project	OVC
Integration Aspects	Agriculture, gender, microfinance, HIV, education, and psychosocial support (PSS)
Number of Beneficiaries	17,000 per year
Beneficiary Type	OVC
Source of Funding	Funded by the Nation Action Plan for OVC through UNICEF. NAP for OVC is supported by international development funds from the nations of Great Britain, New Zealand, Sweden, Germany, Netherlands, Australia, and the European Commission
Duration of Project	January 2008-December 2010
Promising Practice Highlighted	Integrated response to multi-faceted effects of HIV and AIDS to ensure greater support to OVC

Problem Statement and Context

Sub-Saharan Africa, and specifically Zimbabwe, Swaziland, Lesotho and Botswana, remain the epicenter of the HIV epidemic. The number of children orphaned or made vulnerable by the impact of HIV and AIDS in Zimbabwe remains high. As a result, many extended families are overwhelmed and no longer able to adequately provide care and support to these highly vulnerable children. The goal of the STRIVE/OVC project is to ensure that care and support of OVC are improved and reinforced, through employing a multi-faceted approach that addresses the core needs of OVC in Zimbabwe.

UNICEF estimates that there are 1.7 million OVC in Zimbabwe, with approximately 1.3 million children having lost a parent; most have been orphaned by AIDS. A study by CRS Zimbabwe (2006) in conjunction with the Ministry of Health and Child Welfare and the Elizabeth Glaser Pediatric Foundation found 165,000 children (3 percent) to be living with HIV. With rising unemployment levels and diminishing government support to vulnerable populations, more OVC are fending for themselves. UNICEF estimates that there are over 50,000 children living on their own in child-headed households.¹ Another associated problem for OVC is coping with ill parents who are living with HIV. There is an increasing identification of child-carers who have little or no access to information on how to prevent HIV infection. They are often forced to leave school to provide care or are exhausted once they reach school. Additionally, it is the female children who in most cases end up taking on the burden house work. To escape from poverty and household responsibility, these girls are often vulnerable to being lured or forced into early marriage or prostitution.

¹ UNICEF. (Dec 2009). Progress Report for Children Affected by HIV/AIDS.

Purpose of the Project

The purpose of the STRIVE/OVC project is to improve care and support for OVC. The definition of an orphan and vulnerable child, as defined by the NAP, is any person below 18 years of age whose parents (one or both) have died (i.e. an orphan) or a child with unfulfilled rights (e.g. denied access to education, health, identity, food etc.). Primary beneficiaries of the project include: children living with and affected by HIV, children heading households, children living with disabilities, and adolescent parents. Indirect beneficiaries include other children who also benefit from community or school interventions such as psychosocial support and block grants to schools.

STRATEGIC OBJECTIVES	To increase access to formal education of 17,000 OVC with a special focus on girls aged between 6 and 18 years.
	To increase income generating opportunities for 3,000 OVC aged between 12 years to 18 years.
	To increase psychosocial support activities for 17,000 OVC aged between 6 to 18 years.
	To increase food and nutritional support for 3,000 OVC aged between 6 to 18 years.

Steps in Implementation

In order to provide integrated and holistic services to vulnerable children, CRS STRIVE/OVC partners carried out a combination of activities from four broad, results-oriented intervention areas: (1) education assistance, (2) economic strengthening, (3) psychosocial support, and (4) food security. Selection of services for individuals and communities was based on a prioritization of needs identified in the communities. All the activities were carried out using a child rights and gender lens as promoted in the Convention on the Rights of the Child.

CRS Zimbabwe and partners implemented innovative approaches and initiatives that also proved to be replicable in other parts of the country. These included:

1. Increasing access to education through Block Grants/Resource Exchanges

Education assistance forms an integral part of STRIVE/OVC programming. This intervention aims at increasing access to formal education, focusing on children’s attendance and retention at primary school level. To ensure that OVC are enrolled and attend primary school, CRS and partners implemented an innovative Block Grant (BG)/Resource Exchange (RE) model, where schools received from the project grants and/or resources (such as furniture or stationery) for enrolling a specified number of OVC without requiring tuition payment.

The partners started by conducting a needs assessment, administering questionnaires and collecting information that they later used to select the schools that would qualify for a BG or RE. After agreeing with each school which approach (i.e. either BG or RE) was appropriate for their schools, the partners then engaged the Education Assistance Committee formed by the school officials and the communities in identifying beneficiaries based on an agreed selection criteria. After all issues were discussed and agreed upon between the school and the implementing partner, they signed an agreement or Memorandum of

Understanding, which spelled out the amounts, number of beneficiaries, conditions for the BG/RE and the roles of each partner involved.

2. Economic strengthening through Savings and Internal Lending Communities

CRS and partners noted that as HIV takes its toll on communities, more children drop out of school to care for chronically ill relatives. Moreover, after the passing on of the parents, the eldest child, especially the girl child, is often left with the responsibility to care for the siblings.

Thus, among the interventions offered to OVC are Savings and Internal Lending Communities (SILC). SILC provide a safe alternative for accessing financial resources, teach young people basic skills in financial management, and help young people appreciate the importance of saving for emergencies and investments. Engaging vulnerable youth in positive economic strengthening activities has been critical in helping them develop the life skills and coping strategies required to meet their basic needs.

Implementation started with the diocese/partner staff holding introductory meetings with community structures such as local leadership, home-based care (HBC) givers, volunteer groups, school development committees, village and ward development committees, women's groups, burial societies, cattle herding family groups, church and Sunday school groups, youth groups and sports teams. The structures then held introductory meetings with community members. OVC and youth self-selected into groups and began saving. SILC builds up members' financial assets; increases human assets by building skills in numeracy, book-keeping, and policies and procedures related to SILC governance; develops social assets through the election of a committee and the drafting of a constitution; practices solidarity by supporting the poorest members of the community; and multiplies physical assets by allowing members to invest their loans in productive income generating activities. As the OVC and youth conducted their activities, partner field officers also held follow up meetings and discussions with the groups. Topics discussed included health education messages designed to reduce the youths' risk of contracting HIV, and general psychosocial support (PSS).

3. Increasing Psychosocial Support for OVC

A structured PSS package was provided to OVC and their communities to help them to cope with stress associated with parental loss, gender-based violence, family separation, peer pressure and chronic illness in the home. Under the guidance of a facilitator, physical activities (such as sport and games), drawings and role plays were used to illustrate the learning points in a simpler way. Partners also mainstreamed HIV, health, hygiene, nutrition, gender and protection during PSS sessions.

4. Increasing food and nutrition support to OVC

A healthy diet is key to child development and is critical to improving individuals' health status. The STRIVE/OVC project worked to ensure increased food intake and food diversity for OVC. This was achieved through (a) promoting community and household nutrition gardens; (b) providing seed and fencing materials for the gardens; and (c) promoting drought tolerant, low maintenance, and nutritionally valuable crop varieties. CRS Zimbabwe used Junior Farmer Field Schools (JFFS) to impart nutrition techniques, agriculture and animal husbandry concepts. JFFS used an approach of twinning OVC and adults who shared their experience and indigenous knowledge on such topics as soil types and favorable crops. JFFS was designed to empower specifically OVC aged between 12-18 years. JFFS focused mainly on transferring agriculture skills and techniques to children through practice and experimentation. Besides agriculture, the curriculum also had a significant

PHOTO BY MARK ADAMS FOR CRS



RUDO is one of three STRIVE partners supporting SILC activities with children to strengthen economic capacity for OVC.

life component skills (self-awareness, assertiveness, and HIV prevention). The knowledge and skills acquired by the young girls and boys helped them develop positive values regarding gender equality and human rights.

Integration

STRIVE offered an integrated package to OVC that consisted of education assistance, food and nutrition, and PSS and economic strengthening. Integrating interventions led to improved outcomes through a better package of services, greater participation and increased coordination across sectors (education, health, food security and livelihoods).

Positive Outcomes

- Block Grant/Resource Exchange approach guaranteed education assistance to a larger number of children at a lower cost than direct fee payment. BG/RE benefited the entire school community through the purchase of materials and enhancement of infrastructure, while a targeted group of OVC received education. In total, CRS and partners reached 15,409 OVC, (9,245 girls) and helped them attend primary school. These OVC were supported through block grants, direct school fees payment and through school-related assistance such as stationery and uniforms.
- Education assistance has since been moved to the government, who are now assisting these OVC through the Basic Education Assistance Module.

- Through SILC, 2,640 OVC participated in positive economic strengthening activities, developed life skills and coping strategies that they have used to meet their basic needs. Most of the projects carried out by children and youth involved buying and selling. They sold items such as sweets, snacks, pens and exercise books, during school breaks, weekends and at church services. These OVC are using their profits to purchase small livestock, pay school fees, and buy food. Others use their income to pay for medical bills for their parents and relatives who may be ill.
- OVC and caregivers received inputs to set up nutrition gardens in their communities. Through twinning OVC and adults through Junior Farmer Field Schools, experienced farmers had the opportunity to share their valuable farming knowledge with OVC. These OVC now have improved access to vegetables and fruits grown from their gardens. As a social protection measure, the surplus from these gardens has been sold and proceeds used to pay for health care and sometimes school fees for the children.
- One STRIVE/OVC partner, Lower Guruve Development Association, implemented the “Pass on Project” with great success. The approach involved distributing small livestock (goats and rabbits) to OVC. When the animals give birth, the first female offspring is distributed to other OVC, leaving only the mother with the original recipient. Ultimately, the OVC will own the second generation of offspring, while every first generation is passed on. Since these goats are kept in a communal set-up there is always cross-breeding which allows the goats to reproduce and increase the flock. A total of 160 vulnerable children have so far received small livestock through the Pass on Project. Those who receive goats are trained in basic animal husbandry and are linked with Department of Agricultural extension services and veterinary services for further assistance and technical support.
- Community knowledge on preventing sexual exploitation and abuse of children has increased. The project trained more than 800 community volunteers and teachers on the rights of OVC and basic child counseling skills. Most of these teachers were guidance and counseling contact teachers. Teachers and volunteers identify children in distress, provide counseling, and refer children to relevant authorities for further assistance.
- Linkages created for child protection with the police, Department of Social Services (under the Ministry of Labour and Social Services) and the Ministry of Health and Child Welfare (government ministries responsible for child welfare) increased community participation on issues affecting OVC.

Lessons Learned

- Youth are more receptive to participatory learning such as Junior Farmer Field Schools, which are exciting vehicles for sharing farming and livestock husbandry knowledge. OVC enjoy the hands-on, practical experience in a home environment. They get personal satisfaction when they see their work result in high quality yields from their plots and when their small livestock multiply.
- Interventions that economically empower the household are much better than those that are child-focused (e.g., school fees). This proves that household-centered interventions are more effective in addressing the needs of vulnerable children in a sustainable way than individual-centered approaches.
- Provision of small livestock has both nutritional and economic benefits to OVC; however, it is important to hand over livestock to caregivers or communities on behalf of OVC in order for them to oversee caring of these animals.
- An integrated response to the multi-faceted effects of HIV has resulted in a positive impact on OVC. In line with CRS’ Integral Human Development framework, all interventions work together to

provide a comprehensive and integrated response to support the complex needs of the child. These different components are meeting immediate and long-term needs in a single project.

Promising Practices

- Using community-based structures which included chiefs, village heads, community volunteers, and child protection committees allowed for greater reach and enhanced impact on OVC. These structures played pivotal roles in identifying vulnerable children that needed assistance. They also provided linkages between OVC (through implementing partners) and referral structures in situations where the support of external agencies such as the police or social welfare was required.
- The Block Grant/Resource Exchange strategy of providing education assistance reduced stigma and discrimination of OVC. Compared with direct school fee payments where supported OVC are known and face high chances of being stigmatized, this strategy benefits the whole school, while still allowing beneficiaries to access the much needed education.
- Youth-exclusive SILC builds up members' financial, human, physical and social assets. Given its success to date, CRS will continue to expand SILC services to youth with a continued focus on tailoring those services to different youth audiences.

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Part IV:

PREVENTION



PHOTO BY STEPHEN CUNLIFFE FOR CRS

INDIA

Project LIFE AID: Reshaping Lives through Positive Prevention

Introduction to Project

Since October 2008, Catholic Relief Services (CRS) India has been implementing Project LIFE AID to address the increasing need of people living with HIV (PLHIV) for quality treatment, care, and support in the three high HIV prevalence states of Manipur, Nagaland and Mizoram in the country's North East region. The project targets 6,800 PLHIV and 7,950 family care providers using a community approach centered around Positive Living Centers (PLC). LIFE AID also builds the capacity of 1,440 religious and community leaders and reaches out to more than 19,440 general community members. The three-year CRS privately funded project has an operating budget of \$1.2 million (USD). The LIFE AID Positive Living Centers operate within the community as a one-stop-shop for health care, follow-up, peer support and referral services for people living with and affected by HIV. Training and counseling for PLHIV and their family care providers is an integral part of the services provided through these PLCs, and positive prevention is one of the major components of the project's training and counseling. LIFE AID relies on integrated approaches to promote positive prevention and reduce risky behavior at the individual level,

foster stigma reduction at the family and societal levels, and build capacity for more effective service delivery, thus improving and expanding quality treatment, care and support for PLHIV.

INDIA	
Type of Project	Cross-sectoral
Integration Aspects	Integrated with livelihoods (pilot), gender
Number of Beneficiaries	TOTAL: 35,630 6,800 PLHIV 7,950 family care providers 1,440 religious/community leaders 19,440 community members
Beneficiary Type	PLHIV, family caregivers, religious & community leaders, general community
Source of Funding	CRS Private Funds
Duration of Project	October 2008 to September 2011
Promising Practice Highlighted	LIFE AID's Positive Prevention component

Problem Statement and Context

PLHIV in northeast India suffer from discrimination and poor health conditions. The potential for PLHIV in northeast India to attain their full human dignity is threatened by the impact of HIV on their human, social, financial and physical assets. Stigma towards PLHIV is a persistent problem equally at the societal level and within the family unit. This stigma makes PLHIV fearful to disclose their HIV status to anyone, including their spouse or partner. Women, many of whom are widowed at a young age, are particularly vulnerable to discrimination based on their HIV status. Frequently, they are forced into sex work to ensure a livelihood for themselves and their children. Limited access to quality care, treatment and support services further aggravates the condition of this marginalized community in one of the most geographically rugged regions in India.

Northeast India is one of the most disadvantaged regions with one of the highest unemployment rates in the country, 12 percent compared to 7.7 percent nationally. The northeast has long suffered from frequent political and social unrest due to multiple separatist movements engaged in armed conflict against both the Indian Army and other separatist groups. The conflict has deeply impacted the civilian population, and many of them have been displaced. Others are victims of human rights violations. This region borders Bhutan, Bangladesh, Myanmar and China. Its close proximity to the so-called 'Golden Triangle' for illicit drugs has significantly contributed to a widespread injecting drug epidemic in the region. As a result, India's highest HIV prevalence is found in the northeast region.

Manipur and Nagaland continue to top India's states in terms of HIV prevalence and are the only states where more than 1 percent of the adult population is living with the virus. The epidemiological profile in northeast India indicates that more than 50 percent of HIV infections is attributed to needle and syringe

sharing in the course of drug injection. As reported by UNAIDS, 17.9 percent of drug users in Manipur are HIV-positive, compared with 7.2 percent nationally. HIV prevalence is also disproportionately high among sex workers in the region. HIV prevalence among female sex workers is 13.1 percent in Manipur, 8.9 percent in Nagaland and 7.2 percent in Mizoram, compared to the national prevalence among female sex workers of 5.1 percent. In addition, the northeast has the highest prevalence of HIV among women attending antenatal services, indicating that the epidemic is crossing from high risk groups to the general population through sexual partners. This situation is further exacerbated by those with multiple partners, particularly in states like Nagaland where sexual transmission is estimated to account for 45 percent of HIV transmission. If the epidemic is to be stopped, a stronger response is needed to mobilize resources for HIV in the northeast and to further the coordination and extension of treatment, care and support to the many rural and underserved areas of the region.¹

Purpose of the Project

The goal of Project LIFE AID is that PLHIV in northeast India live with dignity. Following the midterm evaluation, the project's results framework was revised to include four strategic objectives.

STRATEGIC OBJECTIVES	PLHIV have improved health status. Activities focus on improving access to quality treatment and care, including home-based care, and increasing the knowledge of PLHIV to manage their needs.
	PLHIV have improved social environment. Activities focus on connecting families and communities with PLHIV through support groups and stigma reduction.
	PLHIV in LIFE AID project sites in Manipur have improved economic conditions by September 2011. Activities focus on strengthening PLHIV's livelihoods through market-based training, skill development, and organizing joint liability groups to share economic risks and promote production and sales.
	PLHIV prevent further transmission of HIV. Activities focus on positive prevention including a wide variety of counseling services and education on voluntary counseling and testing, disclosure, positive living and the importance of treatment as prevention, as well as prevention of mother-to-child transmission (PMTCT).

Steps in Implementation

LIFE AID's emphasis on Positive Prevention is key to bridging the gap between individual, family and community-level care and support. LIFE AID created a series of resource documents for the project, including a *Guide to Effective Communication and Counseling*, which provides direction on both pre-marital and marital counseling, facilitating couple's discussion of fidelity, joint decision-making for HIV prevention, care and treatment—including choices about PMTCT interventions. These resources are used to support a diversified approach to Positive Prevention that encompasses group training at the PLC, individual and couples counseling, and outreach visits to promote behavior change and help reduce HIV transmission. Key steps in making the Positive Prevention component operational are summarized below:

1. Develop/adapt context-specific training manuals, guidelines and client references for effective communication and counseling, positive prevention and PMTCT, based on evidence-based practices.

¹ UNAIDS. (2007) AIDS Epidemic Update. WHO.

2. Ensure a gender-balanced project team with both male and female trainers, counselors and outreach workers, promoting the involvement of PLHIV in all of these roles.
3. Train project staff and ensure hard copies of manuals, guidelines and client references are readily available in locations where positive prevention activities are implemented.
4. Provide a variety of options for training and counseling sessions: male or female only; mixed groups; individual or couples counseling led by male and/or female counselors.
5. Promote cross-referral and follow-up between community outreach, training and counseling services for Positive Prevention and with government treatment, care and support services.

Integration

Through case management, the PLC operates as the focal point of service delivery for the LIFE AID project, providing health care, psychosocial support and capacity-building services to PLHIV and family caregivers. In an effort to complement the National AIDS Control Program, CRS has developed strong working relationships with the State AIDS Control Societies, serving on the State AIDS Steering Committee in all three states where LIFE AID works. To better address the full continuum of care and support, the project is also providing regular referral and follow-up for PLC clients to access antiretroviral therapy (ART) at in-state health facilities. Pregnant HIV-positive women register in the government's PMTCT program. The Positive Prevention component of LIFE AID utilizes an integrated behavioral change approach. Individuals and couples from the PLC receive free government-supported HIV counseling and testing services. Another major LIFE AID strategy is building capacity of the church in responding to the epidemic at various levels through advocacy, networking and community-based program implementation.



Thangjam Opendro Singh and his wife, Th. Bibi Devi, are one of many sero-discordant couples benefiting from the "Positive Prevention" aspect of CRS's Project LIFE AID in the northeast of India.

Positive Outcomes and Impacts

Many of LIFE AID's most encouraging outcomes and impacts are related to Positive Prevention, including the promotion of treatment as prevention. Participants in Positive Prevention activities also report reductions in stigma as reflected in the comments of one PLHIV in Nagaland during the midterm evaluation in April 2010.

- As of March 2010, 100 percent of registered sero-discordant couples (335 couples) in Manipur, Nagaland and Mizoram remained sero-discordant. This is LIFE AID's most significant impact to date and reflects the diligent work of PLC staff in positive prevention messaging, promoting treatment as prevention, and providing psychosocial support to these couples.
- Out of a total 1,784 PLC clients who are on ART, 99 percent (1,769) are still on first line treatment regime. As of March 2010, 72 percent of registered PLHIV on ART showed an increased CD4 count from their baseline measure.

- The midterm evaluation shows encouraging outcomes related to PLHIV adoption of positive behaviors. Nearly 85 percent of male and female PLHIV in the project report disclosing their status to someone they trust. Almost two-thirds of PLHIV report that their spouse has been tested for HIV. Qualitative data further indicate that PLHIV feel more responsible for themselves and their families and have realized the need to take proper care of themselves as a result of the project's emphasis on positive prevention.
- LIFE AID uses a peer-led approach, employing PLHIV as community mobilizers. Peer outreach and counseling encourage existing and new clients to seek services at the PLC. Six hundred out of 639 registered clients surveyed at midterm credit their referral to the PLC to the peer community mobilizers who, being from a similar background, make PLHIV feel more comfortable and can directly relate to their problems.
- As a strategy to reduce HIV-related stigma in the community, some of LIFE AID's implementing partners have trained PLHIV as "Positive Speakers" who share their life experiences in public gatherings. Particularly in Mizoram this has become a regular practice; Positive Speakers share every Sunday as a way of increasing HIV awareness among people attending church services. Attitudes towards PLHIV improved, and stigma and discrimination were reduced, as a result of LIFE AID's "Positive Speakers" program.

"The LIFE AID project has given a boost to my confidence level . . . I feel that I am a different person with stronger determination and motivation to help the infected and affected people of my community."
— a project beneficiary

Lessons Learned

- Couples' counseling for PLHIV helps to build confidence between a husband and wife in terms of disclosure, mutual support for treatment adherence, regular health monitoring and sharing of household responsibilities.
- Individually-focused health, nutrition and hygiene messaging helps to promote overall improvement of a client's condition.
- Treatment-focused messaging helps to address misconceptions around the initiation of ART; it also strengthens the confidence of registered clients to share information about ART with their peers who are not yet accessing treatment services.
- Inclusion of family members in LIFE AID trainings and follow-up activities helps to increase their level of understanding, promote disclosure, and reduce stigma at the family level.
- Linking with other service providers (e.g., ART, PMTCT, counseling and testing services, sexually transmitted infection clinics, drug treatment centers, etc.) helps to provide a comprehensive package of services to the registered clients.
- Application of standardized training modules across the project area allows for uniform information dissemination in the three states where LIFE AID works and helps registered clients have a common understanding of the importance of positive prevention, treatment adherence, safeguarding from re-infection, and substance abuse problems.

- Church organizations working directly with the network of PLHIV send a strong message to the larger community in terms of reducing stigma and discrimination towards the infected and affected community.

Promising Practices

- LIFE AID is successfully using male and female counselors to lead couples training and couples counseling to promote better communication and psychosocial support, partner disclosure, shared confidentiality and positive prevention. In places like northeast India where stigma is high and gender issues play strongly into family and social dynamics, this practice fosters communication between couples in a non-threatening environment enabling them to take joint responsibility for stopping the spread of HIV within the family unit.
- LIFE AID promotes treatment as prevention by educating and counseling PLHIV, their partners and family caregivers about the importance of early testing, treatment and ART adherence. Low viral loads associated with the timely initiation of and adherence to ART reduces the risk of HIV transmission. Particularly in areas where HIV is largely confined to high risk groups, where there is a high proportion of sero-discordant couples or where the adult prevalence is relatively low, treatment as prevention is a very promising means of helping of halt the spread of HIV.

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CASE STUDY

Successful conception among sero-discordant couples

Dr. H. Diamond Sharma is an HIV and AIDS Clinical Consultant and Researcher with CRS' partner, Catholic Medical Hospital, in Imphal in the state of Manipur in northeast India. He is actively engaged in the treatment and clinical management of HIV and related opportunistic infections, provision of ART, and management of HIV-Hepatitis C co-infection. Dr. Diamond has also successfully worked with three sero-discordant couples to conceive using the concept of lower HIV transmission when positive partners are adhering to treatment. This is particularly relevant in Manipur where studies¹ have shown that the female spouse is sero-negative in a significant proportion of HIV sero-discordant couples.

Sexual transmission of HIV is very low (< 0.2 percent).² For only a single sexual contact, the transmission could be negligible. Putting this concept into practice, Dr. Diamond has used the

1 UCLA – ICMR collaborative study on sexual transmission pattern among Intravenous Drug Users.

2 Romero JD, et al. (2010). *BMJ*; 340: c2205.

following four-step process to help sero-discordant couples conceive:

- A series of couples counseling sessions is conducted where Dr. Diamond reviews the basic concepts of HIV transmission, the need for HIV testing, the different options sero-discordant couples have for conception, the risks of conception for sero-discordant couples, and the possible outcomes.
- The eligibility criteria of the couple is initially assessed and then monitored throughout the period of conception, pregnancy and delivery.

The male spouse should be:

- Successfully adhering to ART with an undetectable viral load;
- Free from co-infection or associated infections such as STI, Hepatitis B or C;
- Healthy and free from alcohol or substance abuse.

The female spouse should be:

- HIV sero-negative, healthy and of optimal child-bearing age;
- Free from STI or any other genitourinary infections;
- Having a regular menstrual cycle.
- Consultation is made with a gynecologist who assesses menstration, ovulation, and other relevant gynecological issues of both spouses. Dr. Diamond and the gynecologist then consult, and written consent is obtained from both partners before proceeding to Step 4.
- Upon confirmed timing of ovulation, sexual contact takes place. If conception does not occur, Steps 2 and 3 are repeated and another attempt at conception is made during the woman's next ovulation. If conception is successful, standard prenatal care and institutional delivery follows with the gynecologist while clinical check-ups and counseling continue with Dr. Diamond. Couples' counseling on the safety of mother and child as a part of continued HIV prevention for the sero-discordant couple is one of the key sessions Dr. Diamond conducts following conception. The woman is retested for HIV three months after conception and again at the time of delivery. The baby is tested for HIV at 18 months of age.

The procedure described above was used successfully by Dr. Diamond with three sero-discordant couples in Manipur. All three women remained sero-negative and safely delivered



Doctor H. Diamond Sharma is an HIV and AIDS clinical consultant and researcher at the Catholic Medical Centre in Imphal in Manipur State, India.

STEVE CUNLIFE FOR CRS

babies who were sero-negative at 18 months of age.

Dr. Diamond does not actively recruit sero-discordant couples for conception, but works with couples on an individual basis as he meets them through his clinical practice. At writing, two more sero-discordant couples have approached Dr. Diamond for help with conception. He is counseling them and reviewing their clinical cases using the four-step process described above.

The concept of conception when the male partner is successfully adhering to ART with an undetectable viral load needs further study before it is widely promoted to sero-discordant couples seeking to conceive; however, it has promise as a conception alternative for couples in resource-constrained settings where the female partner is sero-negative. It is also a promising example of HIV treatment as prevention.



Kangabam Nishikanta and Anandi Devi, a sero-discordant couple who regularly attend PMTCT counseling sessions at the local MNP+ PLC, successfully gave birth to a healthy HIV negative daughter, Henthosana.



PHOTO BY MAYLING SIMPSON HEBERT/CRS

EAST AFRICAN REGIONAL OFFICE

SARAR Methodology for Community Action Planning

Introduction to Project

SARAR methodology is a participatory methodology that aims to create community discussion that leads to problem solving and planning for solutions. SARAR stands for Self-esteem, Associative strength, Resourcefulness, Action planning, and Responsibility. The methodology has been used to create a series of curricula that are in use by Catholic Relief Services (CRS) health and HIV projects throughout the East Africa region. The curricula created using this methodology are unique because they are designed to maximize community participation, encouraging participation and planning by illiterate and marginalized populations. The goal of SARAR methodology is to create a normative shift in behaviors by leading a community group through the process of solving local problems.

EAST AFRICA REGIONAL OFFICE	
Type of Project	Cross-sectoral
Integration Aspects	OVC, Health
Number of Beneficiaries	76,600 people were trained in <i>We Stop AIDS</i> and <i>In Charge!</i> in Ethiopia, Uganda and Rwanda from 2006-2009. The curricula have also been used in Tanzania, Zambia and Kenya.
Beneficiary Type	OVC, Community
Source of Funding	Private
Duration of Project	2004 to the present
Promising Practice Highlighted	Participatory methodology for social change

Problem Statement and Context

Behavior change is difficult to achieve and extremely difficult to sustain. Non-governmental organizations and government agencies often try to achieve behavior change through health educators or mass media by giving messages. However, behavior changes that are defined and promoted by community groups may be more sustainable. Thus the health changes required become community-led and community-owned. There is no real “handover” at the end of the project. The handover occurs at the beginning of the project when the planning module is implemented with a community planning group. While many curricula and approaches are used to teach people about HIV and healthy living, there are few that allow the community to discover the causes and arrive at solutions for themselves.



PHOTO BY DONOOTHY BREWSTER/LEIC/CMS

Ethiopian girls discussing HIV during *In Charge!* workshop.

The series of curricula using the SARAR methodology were developed in Ethiopia in 2004. Ethiopia is marked by low literacy rates, especially among women, and by a high degree of silence about HIV. Although the curricula were designed for Ethiopia, the training manuals give guidance about adaption of the curricula for local cultural context. The HIV prevention curricula, *We Stop AIDS* and *In Charge!* have been used in Ethiopia, Uganda, Rwanda, Tanzania, Zambia and Kenya.

Three of the SARAR curricula are used by malaria control and maternal and child health programs and three are primarily used in HIV prevention projects. Orphans and vulnerable children (OVC)

projects have also used the HIV module *We Stop AIDS* with OVC caregivers and *In Charge!* with OVC support groups.

Implementation

Five SARAR-based modules are described below:

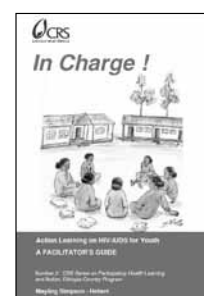
We Stop AIDS: Participatory AIDS Prevention and Support (WSA)

This module is designed to be used with community groups that wish to be active in HIV prevention. The activities stimulate learning about HIV and AIDS through discussions, dramas and role plays, followed by planning. *We Stop AIDS* is most appropriate for adults. It has eight learning activities followed by a planning activity and takes about 9 to 10 hours to complete. It is recommended that the curricula be completed in two half-days.



In Charge!: Action Learning Around HIV and AIDS for Youth

This module is a shortened version of *We Stop AIDS* for use in schools and among youth groups. It helps youth learn about HIV and AIDS, stigma and discrimination, and how to avoid infection, both biologically and socially. It has five activities and takes about four to five hours to complete. It is best administered in one day.



We Control Malaria: Participatory Learning and Action Planning

This module is designed to be used with a community planning committee to control malaria in their community. It has eight activities that involve learning about malaria transmission, addressing misconceptions on transmission, and planning for prevention. It takes about six to eight hours to complete all activities; community groups tend to prefer finishing the module in two days.

We Have Healthy Newborns: Participatory Learning and Action Planning

This module is designed to be used with a community planning committee and can complement activities in IMCI (Integrated Management of Childhood Illness) which is an approach for training community health workers in common newborn and infant illnesses, and facilitating them to reach out to parents. The difference between this module and IMCI is that *We Have Healthy Newborns* is designed, like all SARAR-based modules, to include people who are illiterate in discussions and planning. Another difference is that IMCI is largely focused on managing illnesses, but *We Have Healthy Newborns* also focuses on early marriage, harmful traditional practices, nutrition and general infant care. It is not a training course but there is a learning component that precedes the planning. There are eight activities; it takes about eight hours to complete the module.

We Have Healthy Children: Participatory Learning and Action Planning

This module is designed to be used with a community planning committee and can complement activities in IMCI, just as in *We Have Healthy Newborns*. It focuses on child care from infancy to age 18. It has seven activities on recognizing health problems in children, seeking health care for children, nutrition, and harmful traditional practices. It takes about seven hours to complete.

Positive Outcomes and Impacts

CRS carried out three studies in 2006 and 2007 to assess the impact of the participatory learning module *We Stop AIDS* on subsequent behavior of participants in Ethiopia and Uganda. A total of 521 participants were interviewed in the three studies.

The results of the three studies provide evidence that the learning objectives of *We Stop AIDS* were achieved among a large proportion of participants.

Table 1: Evidence of change among *We Stop AIDS* (WSA) participants from three studies

LEARNING OBJECTIVE	EVIDENCE OF CHANGE
Breaking the silence around HIV and AIDS	<ul style="list-style-type: none"> • Study 1: WSA participants were more likely to have talked with family and friends about HIV than non-participants, 49% to 31% (stat. significant at 0.05). • Study 2: 76% of WSA participants talked to someone else about HIV; out of 96 people interviewed, 6,114 secondary contacts reached. • Study 3: 44% of WSA participants reported talking to others about HIV and AIDS prevention.
Increased knowledge about HIV and AIDS	<ul style="list-style-type: none"> • Study 1: WSA participants reported having better knowledge than non-participants.
Personalized understanding of the epidemic and one's own risk	<ul style="list-style-type: none"> • Study 1: 62% of WSA participants in Site 1 and 82% of participants in Site 2 reported a change in themselves. Most common changes reported were better knowledge of transmission and prevention, the harmfulness of sharing sharp objects, stopping stigma and discrimination, and the importance of being faithful to one partner. • Study 2: 17% of WSA participants were tested for HIV as a result of participation. 43% advised others to get tested. • Study 3: 10% of WSA participants in Uganda were tested for HIV; 7% advised others to get tested. 18% decided to remain faithful to one partner; 15% decided to abstain from sex until marriage.
Reduction in stigma and discrimination against those living with and affected by HIV and AIDS	<ul style="list-style-type: none"> • Study 2: 45% of WSA participants reported changing their minds on stigma and no longer stigmatized or discriminated against PLHIV. 39% started helping PLHIV. • Study 3: in Uganda: 15% of WSA participants reported a change in attitude; they no longer discriminating against PLHIV, wanting to help them instead.
Challenging and changing harmful practices that could spread HIV	<ul style="list-style-type: none"> • Study 2: 21% of WSA participants reported changing their minds about female circumcision and now oppose it. They talked to others and averted 29 female circumcisions.
Personal or group action and behavior change	<p>Personal action plans:</p> <ul style="list-style-type: none"> • Study 2: Every respondent (100%) had taken at least one new action in their lives to protect themselves or help others. • Study 3: Ethiopia – 98% of respondents had taken at least one new action. • Study 3: Uganda – 98% of respondents had taken at least one new action. <p>Group action plans:</p> <ul style="list-style-type: none"> • Study 2: Of 11 WSA groups interviewed, 10 had made group action plans and 7 were implementing them. • Study 3: Ethiopia – 10 of 10 WSA groups made and implemented action plans. • Study 3: Uganda – 12 of 12 WSA groups made and implemented action plans.

Similar results were found for the effectiveness of *In Charge!* in changing attitudes and behaviors among youth.

In 2008, CRS tested the impact of the curriculum in five Tanzanian schools with 172 participants. The schools were selected because of the high proportion of OVC in attendance. The mean age of students in the analysis was 14.4; gender distribution was 46 percent male and 54 percent female. The religious distribution of the entire population participating in the five schools was as follows: 27 percent Catholic, 39 percent Protestant, 24 percent Muslim, and 10 percent other religions.

As the table below shows, risk was personalized, and participants demonstrated confidence to respond to risky situations.

Table 2: Changes in attitudes and self-efficacy as a result of *In Charge!* curriculum

		BEFORE	AFTER
RISK PERSONALIZED	Believes alcohol consumption is a risk factor	60%	72%
	Caring for PLHIV is a risk factor for infection	32%	19%
SELF-EFFICACY IMPROVED	Feels no control over life	12%	3%
	Feels greater control over life	43%	51%
	Able to resist bad influences	46%	57%
	Rarely able to resist bad influences	72%	80%
	Can stand for what s/he believes	18%	9%
	Rarely able to stand for what s/he believes	27%	20%

Lessons Learned

Who is the community planning group?

Composition of the community planning group naturally varies from site to site, but usually it is made up of formal and informal community leaders who have an interest in or responsibility for community development and a few representatives from households. Normally a community planning committee is 15 to 40 people. An ideal size is about 24 people; about half should be women. Even in very traditional societies where women's participation in speaking out and decision-making is discouraged, SARAR methods have been shown time and again to break through this barrier to successfully engage women.

For *In Charge!* it is best to use the modules with the head teacher, other teachers, parents, or the Parent-Teacher Association, before rolling them out in a school. In this way there are no surprises, and teachers can become trained as facilitators, which could lead to sustainability of the methodology in the schools.

Who are the SARAR facilitators?

SARAR facilitators should be paid project staff and not community volunteers. Being a good SARAR facilitator is a skill. It takes at least six days of training and practice to become a facilitator, and even at that, some people end up being much better facilitators than others. The best SARAR facilitators have completed high school and some additional higher education. It is also best if the facilitator has an adequate knowledge of the subject area before receiving training in the specific module. Each module provides some background on the health topic concerned.

SARAR facilitators work best in pairs. They meet with the community planning group at times specified as convenient by the group, until all activities are completed. In the course of completing the activities, the community planning group will make their final preliminary decisions for the project. However, these decisions can be changed as the project unfolds. The facilitators stay with the community group to support and assist the implementation of the community plan, but the facilitators do not implement it themselves. If the community planning group tries to turn over the plan to the facilitators, we can say that the process has failed in that community, and the likely reason for failure is that the facilitators did not “hand over the stick” to the community early enough or often enough, leaving the impression that the community plan was owned by someone else.

Promising Practices

One of the strengths of *We Stop AIDS* is that it is a cross-cultural methodology based on universal adult learning principles. There are no predetermined messages; rather, the activities stimulate discussions around what is relevant to that particular community and culture. This is reflected in the different action plans of Ethiopian and Ugandan groups. In Ethiopia, 90 percent of groups focused on spreading information in their communities and 70 percent worked on reducing harmful traditional practices such as sharing of sharp objects for traditional healing purposes (ritual scarification, bleeding, baby tooth extractions) and banning female genital mutilation. Half the groups promoted voluntary counseling and testing in the community. In Uganda, the age groups were younger than in Ethiopia, and this is reflected in their action plans. Half formed music, dance and drama groups to spread HIV messages, a third formed youth clubs to support each other in positive behavior change, and a third started income generating activities. In both countries some groups decided to support people living with HIV and vulnerable children.

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VOICES

From a focus group discussion in Ethiopia:

“After *We Stop AIDS* I have more knowledge about ways of transmission, stigma and discrimination and the link between harmful traditional practices and acquiring HIV. I have discussed the lessons I have learned from *We Stop AIDS* with my neighbors during coffee ceremonies. I have stopped discriminating against people living with HIV and AIDS, as I now eat and drink with them. I now believe I should not circumcise my daughters or extract the milk teeth of my children. I boil sharp objects before using them. I have decided together with my neighbors to get tested for HIV in the near future. My husband and I will get the test together.”

From an interview with a teacher in Uganda:

“Prior to *In Charge!*, the students were not attending all classes during school hours. A lot of students were going to bars and unnecessary places. The school is situated in a slum area, where there are many commercial sex workers. There is also a problem with students dropping out of school. However, after attending *In Charge!*, they changed radically. Now, almost no student goes out of school before the end of the school day and dropouts have decreased. The parents have given us great credit for the results.” “There were very hot discussions around the issues. Later, I noticed a change in the way the girls dressed; they became much more conservative.” “All students wanted to participate and some cried when they were not allowed to. Before *In Charge!* boys and girls were engaging in sex. However, after *In Charge!* they have shown significant improvements like attending classes regularly and avoiding bad groups. They are actively participating in school HIV and AIDS prevention education, which the school started after seeing the impact of *In Charge!* on the students.”



PHOTO BY DOROTHY BREWSTER-LEE/CRS

GLOBAL

Family Strengthening: The Faithful House

Introduction to Project

Studies from Uganda and Kenya indicate that half of new HIV infections occur during marriage,¹ with multiple and concurrent partnerships being a driver of the epidemic.² Even though the largest share of new infections in many African countries occurs among older heterosexual couples, relatively few prevention programs have specifically focused on adults. Couple-centered approaches are one response which appears to be promising.

The Faithful House (TFH) Core Manual was developed in 2005 by Catholic Relief Services (CRS) in partnership with Maternal Life International and Maternal Life Uganda. The curriculum was implemented as one component of the President's Emergency Plan for AIDS Relief (PEPFAR) Track 1 Abstinence and Be Faithful program operated by CRS in Uganda, Ethiopia and Rwanda from 2005-2010. CRS is continuing to scale up the use of TFH through rollout in Cameroon, Kenya, Nigeria, Sudan, Malawi, Tanzania, Liberia, Gambia, Mozambique and Zambia.

¹ UNAIDS and World Health Organization. (2007-2009). AIDS Epidemic Update. Available at UNAIDS website: http://data.unaids.org/pub/Report/2009/JC1700_Epi_Update_2009_en.pdf. Accessed Feb 15, 2010.

² Mah TL, Halperin DT. Concurrent Sexual partnerships and the HIV epidemics in Africa: evidence to move forward. *AIDS Behavior*. 2010 Feb; 14 (1):11-6

GLOBAL	
Type of Project	Cross –Sectoral, Family Strengthening
Integration Aspects	Can be integrated in any program that could profit from family strengthening through enhanced couple communication; e.g., treatment, PMTCT, prevention of gender-based violence, etc.
Number of Beneficiaries	6,585 couples and church leaders
Beneficiary Type	Primarily couples attending church programs or health clinics for HIV-related interventions
Source of Funding	CRS private funds, Centers for Disease Control, UNAIDS, Church in Need, Catholic Agency for Overseas Development (CAFOD)
Duration of Project	2006 to the present
Promising Practice Highlighted	Couples’ skill-building methodology

Problem Statement and Context

As the HIV epidemic expands in sub-Saharan African countries, there is a tremendous need for culturally-aware, locally developed, evidence-based programs that address a significant driver of HIV transmission on the continent: multiple and concurrent partnerships (MCP). An extensive USAID multi-country study, which looked at variables associated with HIV prevalence in four African nations (Benin, Cameroon, Kenya, and Zambia), yielded results showing that the only factors significantly associated with lower HIV prevalence were lower lifetime number of partners (fidelity), older age of sexual debut, and male circumcision.³ Recent studies from Uganda and the 2007 Kenya Indicator Survey indicate that half of new HIV infections are occurring in married people.⁴ According to data from nationally-representative surveys conducted during 2004-2006 in Cameroon, Rwanda, Uganda, and Zimbabwe, “Having fewer lifetime sexual partners and being faithful to spousal partner(s) are strongly associated with reduced risk of HIV infection. Thus...HIV prevention programs should focus more on promoting partner reduction and partner faithfulness, especially for men.”⁵

TFH was initially designed as a faith-based curriculum for HIV prevention for use with couples within church programs but it has since been used in various operating environments. Within the church environment the program has been implemented as part of Family Life programs, small Christian communities and marriage preparation. Although religious programs continue to be the primary venue for TFH programming, the curriculum has now been extended to both general community settings and health clinics as part of the outreach to HIV sero-positive couples. The program can easily be adapted to fit into any program that can benefit from family strengthening as an integral component of human development.

³ Bessinger, Akwara and Halperin, *Sexual Behavior, HIV and Fertility Trends*, xii.

⁴ 2009 AIDS Epidemic Update. UNAIDS, World Health Organization, 2007. Available at http://data.unaids.org/pub/Report/2009/JC1700_Epi_Update_2009_en.pdf

⁵ Vinod Mishra et al., *The Role of Partner Reduction and Faithfulness in HIV Prevention in Sub-Saharan Africa: Evidence from Cameroon, Rwanda, Uganda and Zimbabwe*, DHS Working Paper 61, Macro International for USAID, January 2009, 10, <http://www.measuredhs.com/pubs/pdf/WP61/WP61.pdf>

Purpose of the Project

TFH is a faith-based, skills-building curriculum created collaboratively by CRS and Maternal Life International/Uganda. The goal of the program is to reduce the vulnerability of families to HIV transmission through family strengthening. This goal is built on the understanding that effective responses to the problem of multiple and concurrent partnerships must increase the capacity of couples to effectively communicate around issues which threaten the integrity of the family unit.

This approach is based on experiences over the past four years of TFH implementation which has demonstrated that an evidence-based intervention, which fosters couple-level skills building, and a supportive environment that facilitates dialogue and enhanced communication around such issues as intimacy, faith, integrity, cultural norms, gender roles and family management, can change attitudes and behaviors within the couple dyad.

This program has improved the quality, quantity and diversity of communication around relationship factors for couples. The improved communication skills enhance mutual fidelity and strengthen the family unit. Families have been able to put a plan in place for the management of family assets.

Steps in Implementation

When introducing TFH into a country or diocese, the project manager should first organize one or two TFH beneficiary workshops. This allows the CRS country program and other potential in-country stakeholders an opportunity to familiarize themselves with the curriculum. These workshops should include pre- and post- workshop assessments in order to assess the potential utility of the curriculum. This also allows the country organizers an opportunity to assess the curriculum against the challenges of the local social context and identify specific areas that may need greater emphasis when implemented in the locality.

Once the curriculum has been adapted to the local setting, national or diocesan, local TFH Coordinators are identified. TFH Coordinator(s) are individuals or couple whose work contributes to family strengthening. TFH Coordinators act as technical resources, support an in-country TFH Coordinating Team, and submit monthly reports on TFH activity in their dioceses or county. The Coordinator links the in-country TFH Trainer of Facilitators to localities which desire to implement TFH activities.

In order to assure sustainable expansion of TFH activities within a country, it is important to establish a local group of 5-10 stakeholders who act as a board of advisors in developing the direction, promotion strategy and opportunities for integration into local church and community institutions. Members of this TFH Coordination Team (TFHCT) commit to giving at least two hours of service/week toward the development and promotion of TFH activities in their church and/or community. Their primary responsibility is to establish and support the implementation of the strategic objectives of the TFH Coordination Team in their country or diocese. Depending on the level of engagement (hours worked/week), assessment of performance and financial resources which are available in the community, TFHCT may also provide TFH Coordinator(s) with a monthly stipend.

Five manuals support TFH implementation:

- *The Faithful House: Affirming Life, Avoiding Risk Core Manual Modules*: five modules with eight sessions each.
- *The Faithful House: Affirming Life, Avoiding Risk PMTCT Supplement*: training to be used when counseling discordant or sero-positive couples.
- *The Faithful House: Training of Facilitators Manual*: curriculum for training master couples in a religious setting as facilitators for Faithful House workshops.
- *The Faithful House: Training of Facilitators Manual*: curriculum for training master couples in a secular setting as facilitators for Faithful House workshops.
- *The Faithful House Couple Handbook*: a pictorial review of Faithful House training.



ILLUSTRATED BY KAREN RAY BROWER

Integration

Although TFH was developed as an HIV prevention curriculum to address the problem of multiple and concurrent partnerships in both church and clinic settings, it can be used in any setting that could benefit from family strengthening.

It is believed that as couples are better able to communicate around issues of sex, finance and parenting roles, they will establish more equitable relationships based on their mutual affection and respect, trust, enhanced sexual relationship, and faith. Building stronger families where parents are enjoying mutual fidelity and intimacy—and providing healthy role modeling for their sons and daughters—will be a cornerstone for other community development initiatives.

Positive Outcomes and Impacts

Evaluations of The Faithful House to date demonstrate the following:

- 99 percent of participant couples report a positive change in behavior in a key area of their couple relationship.
- 80 percent of couples report they have the skills to be faithful after attending TFH workshop.
- 94 percent report they are more free to discuss sexual issues.
- 42 percent report they respect each other more as partners.

Some country-specific results are as follows:

Nigeria: TFH was introduced in Nigeria in 2008; two years later, CRS Nigeria conducted a facilitator’s refresher training for TFH. The refresher training provided the CRS Nigeria team an opportunity to review regional best practices. One such practice was “The Cell Group Initiative.” A Faithful House Cell is a group of four to eight couples recruited with an objective of undergoing Faithful House mentoring over a period of three months, related to a set of Faithful House modules. Upon graduating, these couples are able to mentor other couples and serve as role models for these couples and their own children. Fifteen facilitator couples attended the refresher workshop. These couples subsequently conducted refresher trainings in each diocese, bringing the number of trained couples to ninety. The total number of active TFH Cells across the 11 dioceses was 50 by the end of June 2010. The Cells serve as venues for experience sharing, counseling and problem solving for married couples. In less than three months, 282 couples were participating in TFH Cell groups.

Cameroon: TFH workshops were incorporated into an on-going diocesan Family Life program. In a confidential survey, 49.5 percent of workshop participants admitted to having been unfaithful to their current partner. Additionally, roughly two-thirds of the participants reported experiencing barriers to faithfulness before attending the workshop (66 percent in Kumbo and 61 percent in Bamenda). Preliminary results from a current study have demonstrated impressive improvements in these couple's relationships. For example, when the participant was asked to rate on a scale of 1-10 (10 representing very high and 1 representing very low) the quality of communication between himself/herself and his/her partner, rates increased from 7.7 to 9.2 in Kumbo and from 7.6 to 9.6 in Bamenda. Participants were also asked questions about respect within the relationship. In the pre/post workshop results, in Kumbo, ratings increased from 7.3 to 9 and in Bamenda, ratings increased from 8.1 to 9.2. Dramatic increases were also noted in the ability of the spouses to communicate with each other and their children ages 13-18 around sexual issues. When asked the likelihood that the couple would go together for HIV testing in the next three months (on scale from 1 = definitely no, 10 = definitely yes), increases in average scores (from 5.6 to 8.35) were observed in both Kumbo and Bamenda. TFH curriculum encourages couples to put trust in each other by communicating openly their desires and struggles. In the pre-test, 81 percent and 77 percent of participants in Kumbo and Bamenda respectively reported that they considered their spouse their best friend. At the post-test, these percentages increased to 95 percent and 90 percent. A control study is currently being conducted to determine if these results are maintained over time.

Uganda: The CRS prevention of mother-to-child transmission (PMTCT) project started in 2007 in western Uganda, funded by UNICEF and CRS. The objective of the program is to increase the number of HIV-positive pregnant women receiving quality PMTCT services. Project partners include five district health offices, health facilities, village health teams and AIDSRelief. TFH core curriculum was adapted for the PMTCT venue; over the course of four years 3,700 couples were trained in 47 health facilities to reach out to other couples. TFH-PMTCT curriculum is being used to address key implementation challenges identified in the PMTCT project, such as HIV couples testing and counseling, disclosure of HIV status between couples, ART adherence (mother and baby), support for mothers to attend antenatal care and deliver babies at health facilities, and choosing feeding options for babies born to mothers who are HIV-positive. Review meetings for community volunteers are held every two months. In some diocesan-related programs in Uganda, TFH has been instituted as part of the mandatory premarital counseling requirement.

Lessons Learned

A primary challenge with the original five-day workshop was that many couples were unable to commit to such a lengthy retreat for the training. As a result, the workshop was shortened to 3 ½ days. However, in places where social and cultural gender roles are deeply entrenched, the full five days, which provide couples additional time for dialogue, may be required. Once the couple has redefined their marriage and expressed their intentions to adopt different behaviors, it is important that these couples are embraced by a support group/cell which helps them maintain these new behaviors, which may be counter to their local cultural norms.

It is helpful to have a compassionate and knowledgeable marriage counselor available as a referral source for exceptional couples who require more professional, psychological intervention as a result of disclosure made during the workshop.

The question will arise as to whether co-habiting couples should be allowed to participate in TFH beneficiary workshops. Although each implementing group must make this determination, we *strongly*

recommend that these couples be allowed to join the workshops. Another frequent request is for the workshop participation of one spouse. Although a limited number of program staff and community stakeholders are invited to participate, we discourage the participation of one spouse as a “beneficiary.” The success of the program heavily depends on the participation of both spouses. Lastly, criteria are given for the selection of facilitators. These criteria are based on the individual’s character and performance during and post workshop. In operational research, however, it was determined that an additional consideration which needs to be made in selecting facilitators is the long term plan for the program. TFH projects which desire a strong link to church programs will profit by utilizing church members such as catechists and securing the concurrence of church officials. These church-designated facilitators, however, may be less inclined to serve in the community. Similarly, programs that desire a strong impact within the general community may need to recruit facilitators from community organizations. Strict adherence to the standard TFH facilitator criteria should be maintained whether couples are selected from church or community groups.

The greatest obstacle to scaling up the program is the expense associated with hosting a three to five day workshop. Some groups have circumvented this by hosting one-day sessions over the course of three to five weeks. When implementing TFH beneficiary workshops in shorter sessions over a longer period, it is important to maintain the integrity of the group. Once the group of 10-12 couples is established the group membership should be closed. Bringing in new couples may disrupt the progress of the group whose members will have shared confidential stories. Also, new couples may not be as advanced in their interpersonal (couple) communication.

Promising Practices

Currently, the curriculum is being used by 27,000 beneficiaries in eleven countries in sub-Saharan Africa. Studies related to TFH workshops have demonstrated improvements in communication between partners in areas such as finance, spousal roles, power imbalances, sexual intimacy, parenting, and communication with children around sex-related issues.

Even though the largest share of new infections in many African countries occurs among older heterosexual couples, relatively few prevention programs have specifically focused on adults. Couples-centered approaches are one response which appears to be promising; however, additional research is necessary to build a stronger theoretical and methodological basis for couples-focused HIV prevention. As CRS continues to expand the use of TFH curriculum for HIV prevention, it will also seek to increase its application in other areas—such as peace building and post-war stabilization, gender-based violence, livelihood strengthening, antiretroviral therapy adherence, and support for vulnerable children—which can all benefit from family strengthening.

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VOICES

Sergent Bekele

Sergeant Bekele, traffic policeman, lives in Doyogena Woreda, which is within the project site of Sodo Hosanna Catholic Secretariat. He is one of the 35 Woreda police officers that took part in The Faithful House training offered by the Catholic Secretariat. Sergeant Bekele said: “We have participated in many workshops prepared by different organizations at different times. Our participation was to get per diem but not to change our life styles. This training is really different because it enabled us to look at ourselves, into the management of our marriage and family. Even if we are from different cultures or religions, no church has so far helped us to prepare ourselves for marriage or how to live within. This training played an important role to reform our marriage to understand the meaning of it. Really, I could say now we have an understanding of what true love and marriage are all about. Today is a very special day in my married life.”

Agnes and Waswa Vincent

Waswa agreed to marry Agnes, 28, largely because she wanted to take Holy Communion on Sunday. They were both middle-income health workers in their small community on the outskirts of Masaka, Uganda, and maintained separate, independent lifestyles. Waswa, 31, continued hanging out late with friends, going to clubs and drinking.

“Even after making my marriage vows, I still never thought that my wife had some important role to play in my life. I would never even tell her where I was going because I wanted her to get used to my way of life early enough, so I would leave the office and go meet my friends for booze and return after midnight,” says Waswa.

It wasn’t until the couple started participating in The Faithful House program in May 2006 that they saw a turnaround in their marriage. Since completing the program, Agnes and Waswa find themselves reflecting daily on conversations and commitments they made during the workshops.

“When we attended The Faithful House workshop together, the topic of communication was widely covered,” says Waswa. “I felt so embarrassed and thought I owed [Agnes] an apology. From that time, I changed my ways and now I inform her of all of my whereabouts because she is my wife.”



PHOTO BY CRS UGANDA STAFF

Agnes and Waswa Vincent holding their baby.

Justin and Mary Grace

In Gulu, reported as having the second-highest HIV prevalence rate in Uganda, The Faithful House workshops have also helped couples like Justin and Mary Grace.

Justin, 49, and his wife have three children of their own and take care of 14 more children whose families were lost to AIDS. The couple frequently holds hands and seems renewed in their faith and commitment. But Mary Grace confides that she used to harbor distrust when Justin would go on his many work-related trips.

Wed in 1983, the couple says they were raised with faith-based values. But when they took part in The Faithful House marriage workshops in the summer of 2007, they began strengthening their vows by improving communication at home. This, Mary Grace says, placed them on a path of forgiveness from the past.

“This workshop has indeed increased my [awareness] about HIV, but also my fear of leaving my children as orphans in the hands of my older mother since all of my brothers and sisters are already gone,” Justin says.

“With the growing love for my husband and children, I no longer suspect him of cheating on me even when he goes away from home for such a long period of work,” says Mary Grace. “I always stay focused, pray for him and look forward to his return.”



PHOTO BY CRS UGANDA STAFF

Justin and Mary Grace discuss their relationship after participating in The Faithful House.



PHOTO BY MICHAEL BAMIE SAM FOR CRS

SIERRA LEONE

Acquiring Skills, Improving Lives: Life Skills Center for Sierra Leonean Youth

Introduction to Project

Catholic Relief Services (CRS) Sierra Leone (SL), in conjunction with Caritas Bo, has been implementing HIV and AIDS prevention activities since February 2008, with funding from the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM) Round Six. The goal of the project, entitled “*Acquiring Skills, Improving Lives: Life Skills Center for Sierra Leonean Youth*” is to enable Sierra Leonean youth to make positive life decisions that protect themselves and each other from HIV infection. At its completion in December 2012, the project aims to have reached approximately 30,000 children (aged 12 to 18) in Bo, Makeni and Kenema through activities. CRS SL expects the project to also benefit the targeted youths’ family and friends, adding approximately 90,000 indirect project beneficiaries.

SIERRA LEONE	
Type of Project	Prevention
Integration Aspects	Youth education
Number of Beneficiaries	30,000 direct beneficiaries; approximately 90,000 indirect beneficiaries
Beneficiary Type	Youth, ages 12 to 18 (direct beneficiaries)
Source of Funding	Public donor: Global Fund to fight AIDS, Tuberculosis and Malaria Round Six
Duration of Project	February 2008 to December 2012
Promising Practice Highlighted	The program not only helps youth learn how to avoid HIV, but it also provides them with valuable life skills such as good decision making, literacy, and knowledge about women's and girls' rights. Youth-oriented, participatory, group approaches are effective methods for working with youth.

Problem Statement and Context

After more than a decade of civil war and societal disintegration, it is critical to ensure that Sierra Leonean youth have the necessary capacities and support to make positive choices in their lives. This project aims to equip youth with knowledge, skills, attitudes, and support needed to make good life choices, especially those that relate to their health and well-being. In the absence of this kind of intervention, youth are more prone to engage in high-risk behaviors, resulting in outcomes such as early and/or unplanned pregnancies, sexual harassment, violence, sexually-transmitted infections (STIs), and HIV.

In Sierra Leone, some children have been documented to begin sexual relations as early as age ten,¹ and the median age at first intercourse nationwide is 15 years.² Exchanging sex for goods, money or services is relatively common among young people, and these behaviors predispose the population to HIV infection and other STIs. Indeed, STIs have already been found to be the fifth most common cause of morbidity in Sierra Leone.³ Despite the severity of the situation, studies reveal that discussing sex and reproductive health-related issues is viewed as taboo by most parents and adolescents.⁴ Unsurprisingly, many Sierra Leonean adolescents feel that people living with HIV or AIDS should be discriminated against, stating that positive individuals must not be allowed to continue their schooling or work.

Purpose of the Project

The overarching goal of the intervention is to enable Sierra Leonean youth to make positive life decisions that protect themselves and their peers from HIV. The project employs a structural approach to reducing HIV by creating the conditions in which youth can adopt safer behaviors. The project has three major strategic objectives.

1 CARE International. (2004). Baseline Survey.

2 Sierra Leone and the National HIV/AIDS Secretariat. (2005). National Sero-prevalance survey.

3 WHO. (2002). Death and DAILY estimates by cause.

4 GoSL and UNICEF. (2002). Adolescents and HIV/AIDS in Sierra Leone Facts and Figures.

STRATEGIC OBJECTIVES	Establish youth-friendly Life Skills Centers
	Provide targeted youth with accurate knowledge about HIV
	Provide youth with skills necessary to avoid HIV

The first objective is to establish three functioning, youth-friendly Life Skills Centers (LSCs) in Bo, Makeni, and Kenema. These facilities provide a safe place for young people to obtain accurate information about HIV, acquire skills critical for preventing HIV and STIs via multimedia materials, including low-literacy materials, and computers equipped with internet access. LSCs provide a variety of services, some of which are accessible on a drop-in basis, such as internet access or talking with a life skills facilitator. Each LSC offers a variety of information on HIV and resources on prevention, stigma reduction, and life skills development. Finally, in addition to in-facility activities, LSCs provide an ideal venue for outreach activities, gaining access to highly vulnerable out-of-school youth through activities such as sports.

The second objective is to provide targeted youth with accurate knowledge about HIV and AIDS. In order for young people to remain free of HIV, they must have correct information about modes of transmission and prevention strategies. Many Sierra Leoneans, including youth, continue to believe that HIV does not exist, or that it may be transmitted by sharing food, or that it may be cured by a traditional healer. If young people are to effectively protect themselves from HIV, it is critical to correct misconceptions and provide realistic and feasible strategies to avoid infection. Abstinence before marriage and fidelity within marriage are issues discussed in the “Red Window of Hope” curriculum. Trust exercises with puppets and drawings are employed to educate youth on sensitive issues about sex education. In order for youths to stay healthy, and prepare for a brighter future, they learn to abstain from sexual activities and are provided with the skills to make positive choices in their teen lives. Parents of children who have benefited from life skills sessions have noted that abstinence tends to increase their children’s ability to finish school, as most teenage girls are taken out of school if they are found to be pregnant.

Lastly, the project aims to provide youth with the skills necessary to avoid HIV. This is achieved through life skills education programs designed to foster positive behavior and attitudes that will enable children to respond effectively to situations requiring life-changing decisions, especially those that affect their health and well-being. These programs target five core skills: (1) decision-making and problem-solving, (2) communication and inter-personal skills, (3) critical and creative thinking, (4) empathy and self-awareness, and (5) coping with stress and emotions. For children between 8 and 12 years of age, the manual used is called the “Windows of Hope”⁵, (modified to the Sierra Leone context). Children above the age of 12 are targeted with locally-adapted life skills manuals such as “Sissy Aminata”⁶, “Stepping Stones”⁷, and the “Journeys of Hope”⁸.

By targeting young people with HIV prevention education, the proposed intervention fits well within the government of Sierra Leone’s goal of “[developing] a comprehensive national response to HIV and AIDS encompassing adequate prevention, treatment, care and support for those affected in Sierra Leone.” Specifically, establishing LSCs works toward fulfilling objective three of the national strategy: “to provide

⁵ First published by the Ministry of Basic Education, Sport and Culture, Namibia HIV and AIDS Management Unit (HAMU); modified to its current content by Catholic Relief Services, Sierra Leone Program, 2009.

⁶ CARE Sierra Leone. (2006). *Sissy Aminata*.

⁷ Alice Welbourn. (2002). *Stepping Stones*.

⁸ Ministry of Education, Lifeskills Unit, Ghana. (2001). *The Journeys of Hope*.

knowledge and skills on STI/HIV/AIDS prevention to youths.”⁹ The proposed project is also in line with UNAIDS’ best practices, which recognize the provision of life skills as an effective methodology in equipping youth with the capacities needed to prevent HIV infection.

Life skills education has shown to be successful in post-conflict countries as it serves a dual purpose of addressing conflict resolution and overall health-seeking behaviors. Selecting multiple life skills curricula has proven to be an effective strategy in reaching out to both in- and out-of-school youths, especially those within different age groups. Conducting life skills sessions with manuals targeting similar age brackets enhances better understanding and open discussions among peer groups, and is thereby effective in changing youth behavior, attitude, knowledge and skills.

Steps in Implementation

The project commenced with the identification and rehabilitation of buildings that could be used as Life Skills Centers (LSCs). Sites were selected based on criteria such as: (a) accessibility to youth populations, (b) proximity to open areas such as football fields which are conducive for recreation and games, and (c) priority areas for the National AIDS Secretariat in the implementation of the Global Fund grant. These centers were furnished and management systems were established, including hiring and training LSC facilitators, setting-up a board of advisors and youth councils for each center, and developing an organizational vision and mission, rules, regulations and other guidelines for the use of the centers. CRS works with Caritas partners responsible for maintaining a well-functioning center.

On average, it takes four months from selecting a company to construct the LSC to having the center be fully operational. There are six key staffing positions dedicated to this project:

- One Project Officer who is in charge of the overall management of the project, contributing 50 percent of her time to the project.
- One Life Skills Center Coordinator who has overall responsibility for the day-to-day running of the center, including managing life skills facilitators and committees to develop monthly activity programs, ensuring the proper use and maintenance of all center property, and observing all center rules and regulations. This is a full-time position.
- Four full-time Life Skills Facilitators who are responsible for identifying, forming and training youth groups in life skills. In addition, these facilitators play an active role in the design, preparation, and realization of other activities, particularly those related to outreach. They also have administrative responsibilities related to the day-to-day management of the center.

The Life Skills Centers are open Monday through Saturday from 9 am – 9 pm. During this period, project staff are available to monitor activities and ensure youth safety and security.

The CRS Program Officer for Life Skills coordinates the Life Skills training for the facilitators over a three week period. This time frame allows enough time for trainees to practice sessions and feel comfortable and confident before facilitating sessions with children. At present, center staff conducts regular participatory discussion sessions and recreational activities with youth, either in the center or through in-school visits. Outreach activities (such as sports tournaments) are also carried out to reach children that are not enrolled in the education system and other more marginalized at-risk youth. Instruction is done in the local language, *Krio*, to foster an atmosphere that is conducive for casual sharing and to allow for participants’ better comprehension. Furthermore, since behavior change (including the practice

⁹ The National HIV/AIDS Secretariat. (2005-2010). National Strategic Plan.

PHOTO BY MICHAEL BANNE SAM FOR CRS



Life skills session held at the Life Skills Center.

of new life skills) can only be effectively achieved through an enabling environment, parents and other community members are also targeted through a variety of “event nights” and public outreach activities. During these events, youth participants demonstrate the new life skills they are learning in the center. The parents are also given an opportunity to ask questions they may have about the program and about their children. These activities serve as an important avenue for all project participants to have a voice in the direction that the LSC takes on.

Throughout the program, surveys and reviews are conducted to monitor the participants’ learning. These are important for assessing whether new knowledge has indeed been obtained, and whether attitudes, perceptions, and behavior have changed. There is continual monitoring of all phases of the implementation both by the project partner and CRS staff. A new cohort of participants is recruited every quarter.

Integration

A major strength of this project is that the methodology not only targets HIV, but also cuts across many other issues involving youth. The life skills education program teaches how to avoid contracting HIV and reduces stigma against HIV-infected individuals, but the curriculum also includes skills and knowledge that are necessary in all aspects of life, such as good decision-making, handling peer pressure, reproductive health, and human rights and responsibilities (especially those that pertain to gender). Educating both boys and girls on how to treat each other with respect is key—this is discussed in the “Yellow Window of Hope.” Additionally, both boys and girls are taught about honesty, integrity, self esteem, and being assertive. The lessons range from right and wrong to firmly

saying “no” and dealing with unwanted advances. Options are also suggested on what to do if faced with a particular situation.

Life skills facilitators have also observed that LSCs serve as “study centers” wherein kids and their peers can discuss lessons and do homework. As such, the LSCs contribute to improving literacy and encourage formal education. Furthermore, the LSCs, mainly through its outreach activities (e.g., sports tournaments), get the attention of out-of-school youth and provide them with productive educational activities.

Life skills sessions are also being conducted in schools. School community stakeholders (school administrators, teachers, parents and pupils) meet to convene on an agreed upon schedule for the life skills sessions in each school. Some sessions will be integrated in the school curriculum, while others are conducted immediately after formal school hours. The pattern of conducting sessions is not standardized for all schools and the schedule is open to change. A better understanding by participants of the project, especially students and parents/caregivers, will enhance effective participation and support for the project.

Positive Outcomes and Impacts

Since inception of the first CRS-sponsored LSC, project staff have observed that a major impact of the project is the increased knowledge of HIV and other STIs and their prevention. Anecdotal evidence suggests that the project has had an impact on the lives of the participants in terms of obtaining the know-how and motivation necessary to protect themselves and their partners from STIs by abstaining from sex. Teenage pregnancy is reported to have been decreased, and female youth are now more vocal and assertive in delaying sexual intercourse until marriage. An evaluation of the project will be conducted in 2012 to look at these observations and other potential impacts of these life skills sessions.

This project also seeks to address violence in schools and within communities. Project staff and community members have observed a reduction in aggressive behavior especially among boys who now understand what causes them to be angry and who have learned to manage their anger without hurting each other. Furthermore, stigma against infected individuals by youth has lessened—participants have articulated in program activities the need to care for and support community members affected by HIV.

LSC staff have noted that people living around the LSC are happy with the physical presence of the centers. They appreciate the centers as venues that provide children with opportunities for recreation. LSCs also provide: a continuous learning atmosphere where young people can get accurate information; an environment where they can go to if they need someone to talk to or ask for help from; where they can socialize and talk about their life aspirations with their peers; and where they can showcase their abilities and talents to the community through sports, theater, and other enjoyable activities.

Lessons Learned

Prior to receiving funds from the Global Fund to fight AIDS, Tuberculosis, and Malaria, CRS Sierra Leone was implementing a life skills project with CRS’ private funds. Preliminary project successes under the privately-implemented project were used to gain acceptability from the National AIDS Secretariat, acting as the principal recipient of funds under GFATM Round Six, to bring life skills activities to scale in other major cities in Sierra Leone.

The project also showed the importance of trusting young people, their capabilities, and their roles in addressing pertinent social issues. In order to recruit youth to participate in activities, registration is open and free to all youth. Additionally, a youth council (a youth-only committee) is formed during a general meeting of members from the community. The youth council works with the Life Skills Center staff to plan activities, discuss progress and challenges, and find ways to solve them.

The participants themselves have been key to this project's success. Their enthusiasm, energy, commitment, and engagement in project activities have allowed it to flourish and continue in many communities. Changing social norms can be important for promoting protective behaviors and decreasing HIV risk among youth. The life skills education program's success can be associated with discussing and digging deep into the participants' beliefs, mentalities, and attitudes about issues that are relevant to them as Sierra Leonean youth—e.g., gender roles, peer pressure, sexual activity, alcohol use—and offering viable alternative normative behaviors.

Unlike most school-based interventions wherein information is didactically taught by teachers in classrooms, the project uses a more effective participatory approach, engaging youth in collective critical thinking. Connected to this, LSC facilitators have also noted that combining educational learning based on a structured curriculum with drama, song, and dance is an effective method for maintaining attention and involvement of young people as the different curricula cater to different age groups and different contexts.

Administratively, the project has found that there is a need to engage schools differently in HIV prevention interventions among youth. Facilitators are recruited to conduct life skills sessions both at the center and at schools during outreach activities. Using trained facilitators to engage youth in schools is more effective than peer education alone. This gives the program a unique twist, as other organizations mostly implement an HIV prevention program using one strategy. With this dual approach, peer facilitators engage their friends at school in an informal setting to discuss issues affecting youth, then provide feedback and share the issues raised with the trained facilitator. Sessions around these issues are then thoroughly discussed and addressed. This approach is also effective due to the fact that the trained facilitators are able to clarify issues not being addressed by the peer facilitators during the life skills sessions.

Promising Practices

The life skills project improves HIV prevention among youth and promotes their development by providing the participants with:

1. A safe environment where they can get accurate information; where they can have fun and recreation; where they can develop relationships with peers and mentors;
2. Activities that are educational and engaging;
3. Dedicated staff who enable youth to think about their current beliefs, attitudes, behaviors regarding issues such as HIV and who effectively teach life skills that enable the participants to protect themselves and their peers;
4. A positive peer group who can encourage them in making health-seeking choices.

The key to getting the involvement of youth is to combine educational activities with fun, recreational activities such as sports competitions and theater. This can be done by providing them with designated “recreational centers/areas” such as the ones provided by this project. By working in conjunction with

teachers and providing trained life skills staff, HIV prevention messages can be integrated with school curriculum. Also, participatory group-approaches where the youth can discuss among themselves and where they can share their opinions are important for making them feel empowered.

Life skills projects not only offer knowledgeable lessons against issues such as HIV, but also provide youth with productive activities. Communities appreciate the engagement of youth in learning valuable skills. Community appreciation helps to build local ownership and contributes to the project's sustainability.

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