

Promising Practices II

HIV and AIDS Integrated Programming



SEAN SPRAGUE/CRS



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Promising Practices II

HIV and AIDS Integrated Programming

March 2008



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ACRONYMS

AB	Abstinence and Be Faithful
ABY	Abstinence and Be Faithful Youth
AHEAD	Action for Health and Development
AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Care
ART	Antiretroviral Therapy
ARV	Antiretroviral
CAFOD	Catholic Agency for Overseas Development
CBHC	Community Based Home Care
CBHCT	Community Based Home Care Team
CHAZ	Churches Health Association of Zambia
CI	Chronically Ill
CoC	Continuum of Care
CPN+	Cambodia People Living with HIV & AIDS Network
CP	Country Program
CR	Country Representative
CRS	Catholic Relief Services
CSN	Catholic Secretariat of Nigeria
CT	Counseling and Testing
DAP	Development Assistance Program
DFID	UK Department for International Development
DIP	Detailed Implementation Plan
DRC	Democratic Republic of Congo
FBO	Faith Based Organization
FFS	Farmer Field Schools
FFP	Food for Peace
FFW	Food for Work
GIDC	Gujurat Industrial Development Corporation
GIK	Gifts in Kind
GIPA	Greater Involvement of People with AIDS
HBC	Home-based Care
HBCS	Home-based Care and Support
HEP	High Energy Protein
HIV	Human Immunodeficiency Virus
IDP	Internally Displaced Person
IDU	Injecting Drug User
IFMS	Integrated Farming and Marketing Systems
IGA	Income-Generating Activities
IHD	Integral Human Development
IR	Intermediate Result
ITN	Insecticide Treated Mosquito Nets
J&P	Justice and Peace
LPTF	Local Partner Treatment Facility
M&E	Monitoring and Evaluation
MMM	Medical Missionaries of Mary
MOVE	Mountain Orphan and Vulnerable Children Empowerment
MSM	Men who have Sex with Men

MTCT	Mother to Child Transmission
NCHADS	National Center for HIV/AIDS Dermatology and STDs-Cambodia
NGO	Non-Governmental Organization
OD	Operational District
OI	Opportunistic Infection
OVC	Orphans and Vulnerable Children
PACA	Parish Action Committee on AIDS
PCAZ	Palliative Care Association of Zambia
PEPFAR	President's Emergency Plan for AIDS Relief
PIH	Partners in Health
PLHIV	People Living with HIV
PLHWA	People Living with HIV and AIDS
PLVP	Protecting Vulnerable Livelihoods Program
PMTCT	Prevention of Mother to Child Transmission
PP	Point Person
PPN+	Provincial People Living with HIV & AIDS Network
pPTCT	Prevention of Parent to Child Transmission
PTCT	Parent to Child Transmission
PRA	Participatory Rural Appraisal
PSI	Population Services International
PSS	Psychosocial Support
RADE	Rural Association for the Development of the Economy
RAPIDS	Reaching HIV and AIDS Affected People with Integrated Support
RFCA	Raskob Foundation for Catholic Activities
RUTF	Ready to Use Therapeutic Food
SGBV	Sexual and Gender Based Violence
SARO	Southern African Regional Office
SHG	Self-help Groups
SO	Strategic Objective
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
SW	Sex Worker
TB	Tuberculosis
TSA	The Salvation Army
UN	United Nations
USAID	United States Agency for International Development
VCCT	Voluntary Confidential Counseling and Testing
VCT	Voluntary Counseling and Testing
WatSan	Water and Sanitation
WHO	World Health Organization
WPP	Workplace Program
WVI	World Vision International

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INTRODUCTION

The Situation of HIV and AIDS Globally

UNAIDS estimates that 65 million people have been infected with HIV to date. In 2007, there were approximately 33.2 million people living with HIV (PLHIV) around the world. Sub-Saharan Africa is the most heavily affected region in the world, with nearly 63% of current global infections being located in this geographic area. Approximately 2.5 million children under the age of 15 are now living with HIV. Nearly 90% of children living with HIV are in sub-Saharan Africa.¹

UNAIDS 2007 Global Estimates			
Region	Adults and Children Living with HIV	Adults and Children Newly Infected with HIV	Adult and Child Deaths due to AIDS
Sub-Saharan Africa	22.5 million (20.9 million-24.3 million)	1.7 million (1.4 million-2.4 million)	1.6 million (1.5 million-2 million)
Middle East and North Africa	380,000 (270,000-500,000)	35,000 (16,000-65,000)	25,000 (20,000-34,000)
South and Southeast Asia	4.0 million (3.3 million-5.1 million)	340,000 (180,000-740,000)	270,000 (230,000-380,000)
East Asia	800,000 (620,000-960,000)	92,000 (21,000-220,000)	32,000 (28,000-49,000)
Oceania	75,000 (53,000-120,000)	14,000 (11,000-26,000)	1,200 (<500-2,700)
Latin America	1.6 million (1.4 million-1.9 million)	100,000 (47,000-220,000)	58,000 (49,000-91,000)
Caribbean	230,000 (210,000-270,000)	17,000 (15,000-23,000)	11,000 (9,800-18,000)
Eastern Europe and Central Asia	1.6 million (1.2 million-2.1 million)	150,000 (70,000-290,000)	55,000 (42,000-88,000)
Western and Central Europe	760,000 (600,000-1.1 million)	31,000 (19,000-86,000)	12,000 (<15,000)
North America	1.3 million (480,000-1.9 million)	46,000 (38,000-68,000)	21,000 (18,000-31,000)
Total	33.2 million (30.6 million-36.1 million)	2.5 million (1.8 million-4.1 million)	2.1 million (1.9 million-2.4 million)

With so many people already infected, the pressure is immense to stem future infections from occurring. However, more than 2.5 million people were newly infected with HIV in 2007 alone. Broken down, that means that more than 6,800 people are still newly infected with HIV daily. Of these 2.5 million, 420,000 new infections occurred in children, meaning that 1,150 children were infected with HIV on a daily basis in 2007.²

¹ UNAIDS. (2007). AIDS epidemic update: December 2007. Geneva.

² *Ibid.*

Globally, women and men are infected on a relatively equal rate. However, these figures vary greatly according to region. In sub-Saharan Africa, nearly 61% of infected adults in 2007 were women. In the Caribbean, 43% of infected adults were female. In many regions, female infection rates continue to increase. In Latin America, Asia and Eastern Europe, the proportion of infected women is growing as HIV infection spills over to female partners of men who have been infected through injecting drug use or via sex with other men.³

The number of PLHIV is astounding, creating a tremendous need for affordable, reliable and adequate healthcare. However, globally, only 12% of people who want to be tested for HIV are able to do so. Those who are tested and are HIV positive will eventually need access to life-saving antiretroviral therapy (ART). Currently, less than 30% of people in need of treatment globally are receiving it. However, the treatment situation is improving. The number of people receiving ART in low- and middle-income countries has tripled since the end of 2001.

In addition to the immense numbers of PLHIV, there are also millions of affected families and children. PEPFAR reports estimate that by 2010, the number of children orphaned by AIDS globally may exceed 20 million, and the number of other children made vulnerable because of HIV and AIDS may be more than double that number.⁴ To date, UNAIDS estimates that more than 15 million children under the age of 17 have lost one or both parents to an AIDS-related illness. In sub-Saharan Africa alone, more than 12 million children have been orphaned as a result of AIDS.⁵ Orphans and vulnerable children (OVC) are more vulnerable to malnutrition, illness, abuse, sexual exploitation and ultimately HIV infection.

The CRS Response

HIV and AIDS continue to be areas of programmatic focus for Catholic Relief Services (CRS). CRS has more than 250 HIV-focused projects in 52 countries. In 2007, the agency directly reached 4 million people affected by HIV. Last year, the agency's HIV projects were valued at more than 120 million USD.

CRS projects raise awareness about the virus, promote abstinence and behavior change, support orphans and other vulnerable children, offer home-based care and provide antiretroviral therapy and other related services. To ensure the care is comprehensive, many of the projects also link to programs focused on agriculture, microfinance, education, health, and water and sanitation. CRS recognizes that an appropriate response to HIV must include an integrated response that addresses the different aspects of impact at the community, household and individual levels.

The priority HIV program areas for CRS include: treatment, holistic care and support to PLHIV, and support to orphans and vulnerable children. CRS assists in providing ART to more than 84,000 PLHIV, more than 6,200 of which are children. With local partners, CRS is also providing care and support to more than 150,000 PLHIV who are not yet in need of the ART.

An Integrated Response

CRS believes that development occurs within an integrated framework, which parallels the lives of the people we serve. As such, CRS often uses the Integral Human Development (IHD) framework as a tool to understand the multiple levels of human development and related issues. The IHD, which is derived from

³ *Ibid.*

⁴ The Power of Partnerships: The U.S. President's Emergency Plan for AIDS Relief. 2008 Annual Report to Congress

⁵ UNAIDS. (2006). "Report on the Global AIDS Epidemic."

Catholic Social Teaching (CST)⁶, provides a framework to assist people to be able 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.⁷ A key purpose of the IHD framework is to help CRS and partners become more effective in assisting the people we serve to improve their livelihood outcomes with the primary livelihood outcome sought being Integral Human Development, meaning that people are able to meet their basic needs and improve their well-being in an atmosphere of social justice and human dignity.⁸

A holistic understanding of peoples' constraints and opportunities for progressing toward IHD can be understood through a thorough analysis of their livelihood strategies, and the surrounding context in which they live.⁹ This analysis can be based on three fundamental components:¹⁰

1. **Assets:** resources people use to generate livelihoods. Assets are divided into six categories under the IHD Framework: (1) human and spiritual; (2) social; (3) political; (4) financial; (5) physical; and, (6) natural.
2. **Structures and Systems:** the “rules of the game” that govern access to various assets, how different assets can be used to generate livelihoods, and the types of assistance that people may access from external sources. They also have a significant impact on issues of social justice and human dignity. Typically structures and systems include local culture and customs, legal regulatory frameworks (and the application of laws), and the institutions and organization (governmental and non-governmental) that affect and govern peoples' lives.
3. **The Vulnerability Context:** reflects the sources of risk that impact peoples' lives. They are usually classified as shocks (sudden events such as an earthquake or the outbreak of war), cycles (regular but not necessarily predictable events such as droughts or heavy rains that may lead to flooding) and trends (such as economic decline or growth, or global warming).

People then use strategies to respond to the structures, systems, vulnerabilities and asset situations. Strategies primarily are based on many different assets, which are the resources available to work with and build on. The systems and structures are the institutions, rules and social norms of the surrounding context, which affect how they can use certain assets, and in some cases, who has access to specific assets. Strategies also consider risks that threaten lives and livelihoods. These are listed as shocks, cycles and trends in the IHD framework.¹¹

The IHD graphic below depicts these basic concepts: livelihood strategies are developed based on available assets, which are used within the local context (systems and structures). The major sources of risk to lives and livelihoods also must be considered when strategies are developed.¹²

The use of the IHD framework helps to provide a holistic understanding of the specific impacts of HIV, as well as local constraints and opportunities for mitigating these effects. Furthermore, the IHD framework leads us to examine the increased risk and vulnerability imposed on individuals, households and communities affected by HIV and AIDS; the impacts on individual and household assets; and the structures and systems that affect, and are affected by, the disease.

6 Catholic Social Teaching is the body of social principles and moral teaching from the Catholic Church that addresses social situations, with a particular concern for the poor and the causes of poverty and marginalization. Catholic Social Teaching calls on people everywhere, and of every faith, to work toward the elimination of poverty, to speak out against injustices, and to actively shape a more peaceful and just world.

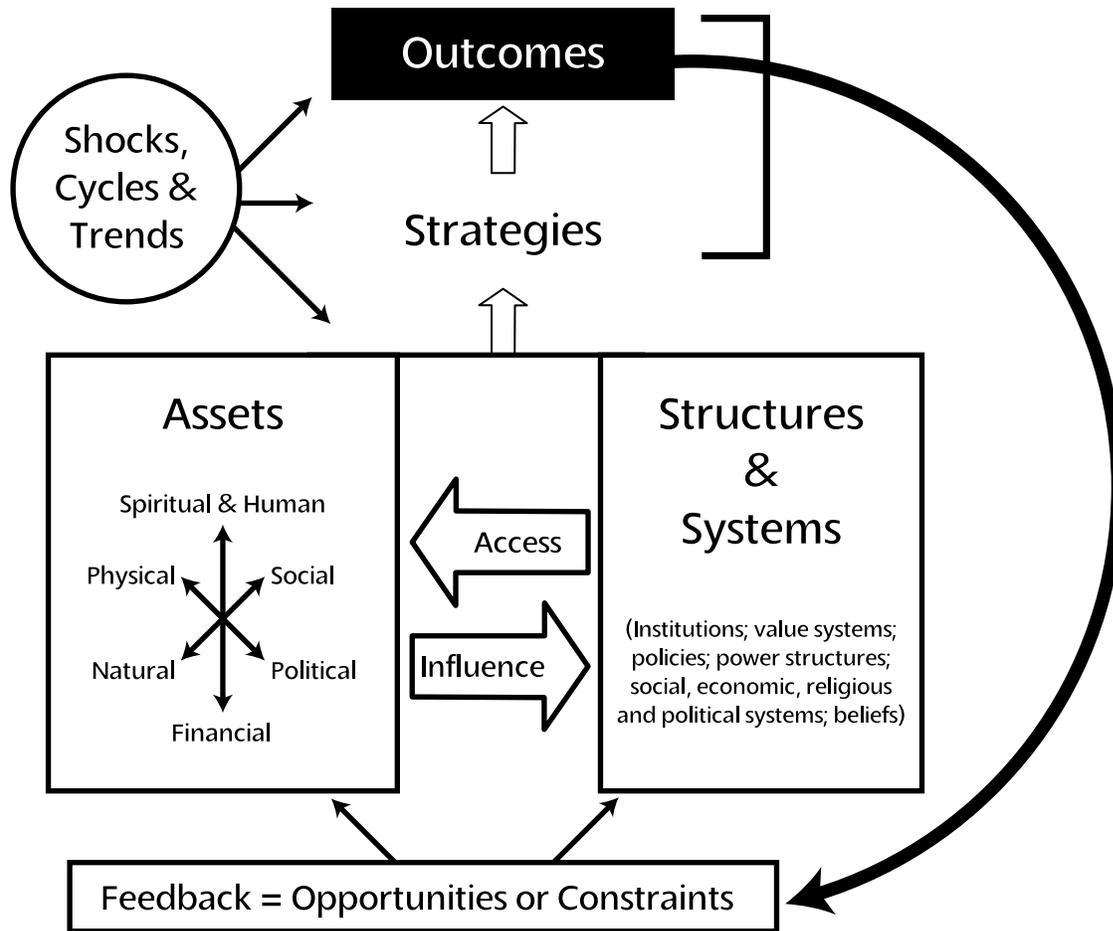
7 Burpee, G., Heinrich, G., & Zemanek, R. (2006). The CRS Integral Human Development Framework: A Brief Overview. Catholic Relief Services
8 *Ibid.*

9 *Ibid.*
10 Heinrich, G., Penders, C., Senefeld, S., & Burpee, G. (2008) Agriculture and Environment Interventions in Support of HIV and AIDS Programming: A look at why and how. Catholic Relief Services.

11 Burpee, G., Heinrich, G., & Zemanek, R. (2006). The CRS Integral Human Development Framework: A Brief Overview. Catholic Relief Services.

12 *Ibid.*

Figure 1: CRS' Integral Human Development Framework.



This framework can clearly be applied to HIV programming, as HIV and AIDS affects all the levels outlined in the IHD framework. However, it is important to note that each of these levels also influence HIV programming and, at times, the nature of HIV's progression in general. For example, malnutrition of a person living with HIV may speed disease progression. Malnutrition would be a result of other components within the IHD Framework (e.g. cycle if there were a seasonal drought, resulting in fewer household food inputs or a reduced level of financial assets to buy foods, as a result of decreased labor due to illness).

The impacts of HIV are felt at multiple levels within the community, household and individual. HIV and AIDS currently are no longer viewed as solely medical issues, as the ramifications extend well beyond the traditional medical model of disease. Normally, people utilize their assets to cope with shocks, cycles and trends. However, in the case of HIV, these assets are slowly broken down, making later coping even more difficult. The following examples demonstrate how HIV can affect the various asset levels mentioned above.

Examples of the Impact of HIV on Assets¹³

LEVEL	IMPACT
Human Capital	<ul style="list-style-type: none"> • At the individual level, compromised health status and accelerated morbidity and mortality. • Life expectancy in southern Africa has fallen by more than 10 years since the HIV epidemic began. Countries such as Botswana, South Africa, Swaziland, Zambia and Zimbabwe have all seen decreases in life expectancy as a result of HIV.^{14 15} • At the macro level, HIV and AIDS increase the number of people seeking health services and the number of needed health care workers. The supply of health workers is also under pressure, as more health workers are themselves at risk for infection. • Botswana lost close to 17% of its health care workforce due to AIDS between 1999 and 2005.¹⁶
Physical Assets	<ul style="list-style-type: none"> • Physical assets may be sold to pay for medical expenses or to compensate for reduced labor and income within the household. • In Kenya and Uganda, HIV-affected households have reported having to sell off their physical assets and even close small business in order to pay for HIV-related medical expenses.¹⁷
Natural Resources	<ul style="list-style-type: none"> • Reduced agricultural production due to decreased labor • A study in Zimbabwe found that agricultural output declined by nearly 50% in HIV-affected households.¹⁸ • Natural resources not used due to illness or financial constraints (e.g. anti-erosion practices are not maintained, land is not left fallow; crops are not rotated, etc.)
Financial Assets	<ul style="list-style-type: none"> • Reduced financial assets used to pay for medical expenses • Studies of low-income South African and Zambian AIDS-affected households found monthly income decreased by 66%–80% as a result of coping with AIDS-related illness.¹⁹
Social Capital	<ul style="list-style-type: none"> • Social ties may be cut or reduced due to suspicion that an individual may be HIV positive • Children may drop out of school to care for sick family member • One study in India found that children living in households with an ill family member were more likely than children in households without HIV to drop out of school in order to take a job or care for younger siblings and other household work.²⁰
Political Capital	<ul style="list-style-type: none"> • Political capital reduced due to suspicion that an individual may be HIV positive. • PLHIV may be excluded from decision-making groups such as women's groups/ men's groups, community development committees, etc.

13 The tables in this introduction were adapted from: Bishop, C., Senefeld, S., Greenaway, K., Kruse-Levy, N., Weinbauer, K., & Perrin, P. (2006). Nutrition and Food Security for People Living with HIV and AIDS. Catholic Relief Services: Baltimore.

14 UN. (2007). World Population Prospects: The 2006 Revision.

15 UN. (2002). HIV/AIDS and Fertility in Sub-Saharan Africa: A Review of the Research Literature. www.un.org/esa/population/publications/fertilitysection/HIVAIDSPaperFertSect.pdf

16 UNAIDS. (2006). "Report on the Global AIDS Epidemic."

17 Donahue, J., Kamau, K., & Osinde, S. (2001). HIV/AIDS - Responding To A Silent Economic Crisis Among Microfinance Clients In Kenya and Uganda. Micro-Save: Kenya. www.microfinancegateway.org/files/3661_ST_HIVAIDS_Crisis.pdf.

18 UN. (2004). The Impact of AIDS.

19 See: Steinberg M. Johnson S. Schierhout S. Ndegwa D. (2002). Hitting home: how households cope with the impact of the HIV/AIDS epidemic. Cape Town, Henry J Kaiser Foundation & Health Systems Trust. October and Barnett T. Whiteside A (2002). AIDS in the 21st century: disease and globalization. New York, Macmillan.

20 As reported in "The Multisectoral Impact of the HIV/AIDS Epidemic-A Primer." (2007). Produced by the Henry J. Kaiser Family Foundation. Original study by Pradhan, BK et al. (2006). Socioeconomic Impact of HIV/AIDS in India. Report submitted to NACO, UNDO, NCAER.

Structures and Systems refer to the “rules of the game” that govern access to various assets, how different assets can be used to generate livelihoods, and the types of assistance that people may access from external sources. Structures and systems can have a large impact on social justice and human dignity, as they often include local culture and customs, application of laws, and the institutions themselves that affect people’s lives. There are numerous examples of this that relate to HIV and AIDS including:

- Local customary practices may increase the risk of HIV infection, especially in areas where gender inequity is an issue. For example, widow cleansing is common in many areas in Africa, as are numerous other risky sexual practices.²¹
- In many cases, laws do not exist to protect the rights of those affected by HIV and AIDS. In those cases where laws do exist, their application is often haphazard and does not truly provide the protection for which it was designed.

Vulnerabilities refer to an individual’s inability to resist external stressors called shocks (sudden events), cycles (events that occur on a somewhat regular cycle, although not always predictable), and trends (events that are worsening over time). Some vulnerabilities are general and apply to the entire population in an area, such as natural disasters or seasonal famine. However, others are specific to PLHIV, such as resistance to medicine over time. PLHIV are often more vulnerable to stressors as their individual and household coping mechanisms are often already stretched to their limits prior to these additional shocks, cycles and trends. The following are examples of vulnerabilities faced by PLHIV.

- **Shocks:** One example would be the death of a spouse or other family member within the household. One study in Zambia demonstrated that on average, within 1 to 3 years after the death of their husbands, widow-headed households controlled 35 percent less land than what they had prior to their husband’s death²², indicating that they were made vulnerable to land loss by the death of their spouse.
- **Cycles:** An example of a cyclical vulnerability for households affected by HIV would be a seasonal famine. De Waal and Whiteside (2003) hypothesize that HIV and AIDS have created a new category of highly vulnerable households, meaning those affected by HIV. They propose that the burden of care has reduced the viability of farming livelihoods, and that the sensitivity of rural communities to external shocks has thus increased, while their resilience has decreased. This positions these households and regions (namely southern Africa) at a precipice for severe famine and decreased possibilities for recovering. This is called the new variant famine.²³
- **Trends:** The increasing numbers of OVC would be an example of a trend in vulnerability. PEPFAR now estimates that the number of children orphaned as a result of AIDS could reach 20 million by the year 2010.²⁴

Strategies are those methods or series of activities that people use to respond to the structures, systems, vulnerabilities and asset situations. PLHIV and affected families often employ various strategies to respond to and mitigate their current situation, which is impacted by HIV. There are seven common strategies that people employ to respond to their situations. Oftentimes, people employ multiple strategies to respond to the multiple impacts they are feeling within different aspects in their lives. Some examples of how this applies specifically to HIV and AIDS include:

21 Muula, A.S. & Mfutso-Bengo, J.M. (2004). Important but neglected ethical and cultural considerations in the fight against HIV/AIDS in Malawi. *Nursing Ethics* 11 (5), 479-488.

22 Chapoto, A., Jayne, T.S., & Mason, N. (2007). Security of Widows’ Access to Land in the Era of HIV/AIDS: Panel Survey Evidence from Zambia. www.uni-kiel.de/ifw/konfer/pegnet07/chapoto_jayne_mason.pdf

23 De Waal, A. & Whiteside, A. (2003). New variant famine: AIDS and food crisis in southern Africa. *Lancet*, 362: 1234–37.

24 The Power of Partnerships: The U.S. President’s Emergency Plan for AIDS Relief. 2008 Annual Report to Congress.

- **Coping/Survival Strategies** are employed to assist people in getting through difficult periods. The coping strategies used by HIV and AIDS-affected households often differ from non-affected households. A study in six southern African countries by Caldwell found that households with chronically ill (CI) members utilized coping strategies that had a negative impact on diet²⁵ to a significantly higher degree than did households without CI members.²⁶
- **Risk Reduction Strategies** reduce vulnerability to shocks, cycles and trends. For PLHIV, one example would be the use of prophylaxis to reduce opportunistic infections.
- **Empowerment Strategies** increase the influence of people and communities to advocate and claim rights and services. Many PLHIV join advocacy groups to influence decision-makers to increase the services available for PLHIV. In South Africa, the Treatment Action Campaign (TAC) was formed in 1998 to advocate for increased treatment access. Many now credit TAC for their role in advancing the implementation of mother-to-child transmission prevention and treatment programs.²⁷
- **Asset Recovery** focuses on rebuilding assets lost in a disaster. For PLHIV, this may include joining income-generating groups for PLHIV or other skills-building groups. Seed and livestock fairs have been used in select situations as an option for rebuilding lost assets.
- **Asset Diversification** increases resilience by diversifying the types of assets to depend on in crisis, thus reducing vulnerability to the loss of one or a few asset types. For households affected by HIV, strategies may include select household members migrating in search of work or diversifying small business holdings. Many affected households begin small gardens and diversifying their existing crops. Several programs are increasingly linking HIV-affected households with agro-enterprise interventions.
- **Asset Maximization** increases the quantity and quality of assets to increase the capacity of households to leave poverty and reduce vulnerability. One of the most efficacious strategies for maximizing assets is the introduction of antiretroviral therapy for those who need it. Access to high-quality treatment and adherence to this treatment makes a tremendous difference in the lives of PLHIV, as they are able to return to work and pre-illness levels of health and work, thus reducing their vulnerabilities.
- **Asset Protection** moves to protect assets. People can best protect their human assets by preventing HIV infection. Once a person is infected with HIV, asset protection can be assisted by access to treatment. In addition, many programs are now providing access to savings and internal lending communities (SILC).

Due to these multiple levels of effects, CRS believes that the more effective responses to HIV and AIDS should holistically examine the needs of our clients and what holistic solutions are available to them. Every situation should respond to the local context and consider a holistic approach as defined by that context, no matter where the program is being implemented. By addressing HIV in a holistic, integrated manner, CRS believes that programs are more likely to achieve a more sustainable, efficacious program.

25 The Coping Strategies were: Limit portion size at mealtimes; Reduce number of meals eaten per day; Skip entire days without eating; Borrow food or rely on help from friends or relatives; Rely on less expensive or less preferred foods; Purchase/borrow food on credit; Gather unusual types or amounts of wild food/hunt; Harvest immature crops (e.g. green maize); Send household members to eat elsewhere; Send household members to beg; Reduce adult consumption so children can eat; and Rely on casual labor for food.

26 Caldwell, R. (2005). Food Aid and Chronic Illness: Insights from the Community and Household Surveillance Surveys. Presentation at the International Conference on HIV/AIDS and Food and Nutrition Security, International Food Policy Research Institute, Durban, South Africa.

27 For information on TAC, please visit their website at: www.tac.org.za/index.html.

Learning from What We Do

CRS is committed to becoming a dynamic learning organization. With so many HIV projects spread out around the world, it becomes essential for the country programs and local partners to have an opportunity to learn from one another's experiences. As such, in 2006, CRS published its first book of Promising Practices for Integrated HIV Programming. This book highlighted more than 20 case studies of promising work in HIV and AIDS programming. Originally, the editors planned to have the book document only best practices, but the criteria for determining whether a practice met all the criteria for a "best practice" meant that many promising interventions would be left out. Thus, the editors decided to amend the book and allow "promising" practices, meaning those that had shown initial success and produced initial lessons learned in the field, but may not have undergone stringent evaluations to date.

The editors also originally solicited promising practices that were integrated in a multi-sectoral fashion, but when they first began collecting the promising practices in 2005, they noticed that a program did not have to be multi-sectoral in order to be integrated. In some cases, the following chapters are multi-sectoral; in other cases, the project has integrated one traditional aspect of HIV programming with another. In either case, integration for this book is defined as being representative of addressing the problems in a holistic manner whether that occurred through multi-sectoral programming or not.

When programming services to people affected and infected with HIV and AIDS, it has become increasingly apparent that the issues that affect their livelihoods are complex and can vary greatly depending on the context. HIV is well documented as a disease that needs interventions from a multitude of sectors (i.e. agriculture, education, rights based initiatives) and through various players (i.e. national and local government, private health centers, community leaders, etc.). This is made more complex by the need to find funding that supports the needs of those affected by HIV and AIDS and simultaneously support the predetermined goals of the donors. The amount of response that is needed is often overwhelming and there has been a demand from CRS program managers on how to best address these issues.

CRS recognizes these programs cannot be 'cookie cutter' and that programs that have the most impact are ones that are specialized to fit the needs of those in each of the communities. In order to facilitate sharing of lessons learned among CRS Country Offices and contribute to documentation of promising practices in this area of programming, this manual has compiled a sample of programs from around the world.

The objectives of this publication are to:

- Document some of the creative solutions or 'promising practices' used by CRS programs to address those affected and living with HIV and AIDS.
- Emphasize the importance of critical thinking from program managers as they plan, assess, monitor and evaluate programs in these complex settings to ensure maximum program impact.
- Stress that integration into existing services and based on actual needs of the beneficiaries is essential.
- Create a forum for learning from one another's programs, successes, and lessons learned.

The first edition of Promising Practices in 2006 was well received by country programs and partner staff. Therefore, a second edition of Promising Practices was planned for 2008. This second version contains 24 case studies of promising HIV and AIDS practices from around the world. Each case study is organized in much the same way, including sections on how the project works, what the successes have been, and what lessons learned have emerged. At the end of each case study is the contact information for the relevant programs. Please contact the local programs directly for any additional information.

A Way Forward

Recent estimates by UNAIDS suggests that HIV prevalence is lower than previously estimated. While this is positive news, it is more important than ever that programs continue to engage in effective HIV programming to ensure that the rates stabilize and decline. In addition, all HIV programmers need to continue to strive to implement the highest quality programs possible. Sharing initial success stories and lessons learned through established mechanisms such as Promising Practices enables HIV programmers globally to learn from one another and build on one another's successes and innovations.

Part I: Care and Support



CRS CAMBODIA STAFF

CAMBODIA

Mobilizing Community Support: Community-Based Home Care Teams

Introduction to Project

The Community-Based Home Care (CBHC) project is one component of the integrated response to HIV and AIDS offered by Catholic Relief Services (CRS) Cambodia and its local partner Action for Health and Development (AHEAD) in the province of Battambang and municipality of Pailin, Cambodia. The CBHC project seeks to ensure access for people with HIV (PLHIV) and their families to high quality physical and psychosocial care in a community that is free from discrimination. The project also works to prevent HIV and reduce its impact on individuals, households and communities. As part of its integrated programming, CRS AHEAD improves services by collaborating with and building the capacity of government health officials at the provincial, Operational District (OD), health center and community levels. The CRS AHEAD project is part of a larger program called Supporting the Development of the Cambodian Response to and AIDS, which is presently implemented by CRS and eight partners in six provinces in Cambodia and funded by USAID, CRS and CAFOD.

The CBHC project traces its origins back to 1995 when CRS began work to raise awareness about HIV. In 2001, CRS expanded to HIV and AIDS care and support interventions, and in 2002, CRS instituted a pilot community-based home care project at the Khnach Romeas health center in Battambang. The pilot project targeted PLHIV, their families, orphans and vulnerable children (OVC), and people with other chronic illnesses.

AHEAD began as a CRS primary health care program that started in Battambang in 1994. As part of CRS' strategy to build the capacity of local organizations, CRS has helped AHEAD to develop into a local NGO with the goals of fostering more independence of national staff and improving the cost effectiveness and sustainability of its HIV programming. AHEAD's localization process was finalized in 2007.

Country	Cambodia
Type of Project	Home-based care
Intervention Aspects	HIV prevention, care and support, HIV impact mitigation, PSS, health system strengthening
Number of Beneficiaries	250 PLHIV, including 114 on ART 326 OVC 1049 people with chronic illness
Beneficiary Type	PLHIV and their families, OVC, people with chronic illness
Source of Funding	USAID, CRS
Duration of Project	2002-2008
Promising Practice Highlighted	Volunteer-driven and community-based home care

Problem Statement and Context

A post-conflict country, Cambodia is among the poorest countries in the world. Three decades of war and civil conflict ended in 1998, but the legacy of these years of turmoil remains. The poverty rate ranges from 35 to 40%, while income inequality is increasing, particularly in rural areas. About one-third of Cambodia's households are headed by women, and these households tend to be significantly poorer than those headed by men, in keeping with lower literacy rates among women. Another consequence of poverty which affects HIV prevalence is out-migration, especially in border areas, of people leaving poverty stricken areas for areas with more economic opportunity. Another challenge for Cambodia is improving its education system: Cambodia suffers from high dropout rates, particularly in secondary school, and especially among girls. However, Cambodia is rebuilding in many ways. The economy is recovering as the government strengthens the education and health systems, along with other infrastructure.

The face of HIV in Cambodia is changing quickly. Prevention efforts have greatly improved as a result of a multi-pronged approach led by the government, international, local organizations and civil society. The most significant change is the advent of antiretroviral therapy (ART), which became available in Cambodia in 2002. The number of Cambodian PLHIV receiving ART grows every year. Cambodian



officials plan to scale up access to ART in the coming years, from 20,131 adults and children at the end of 2006¹ to 46,141 adults and children by 2012.

Cambodia's estimated HIV prevalence, at 1.6%,² is the highest in the Asia-Pacific region, although the country has seen great success in reducing HIV prevalence in the past several years. The high rate of poverty contributes to the prevalence of HIV because the poor are much more likely to engage in high risk behavior, and to have less access to health information and services. Poverty also drives migration patterns, which are often linked to higher rates of HIV.

In Battambang and Pailin, HIV has an even greater impact. These areas are transit points for workers crossing the border to Thailand and magnets for those seeking cheaper health care than can be found across the border. Due to extended conflicts with members of the Khmer Rouge until 1996, Battambang housed many members of the military, a group with a higher HIV prevalence. The impact of HIV is also more profound in Pailin and Sampov Loun ODs (former Khmer Rouge areas), because they are border areas and for many years had no access to government health services.

Even though access to ART continues to increase, universal coverage still is not available. ART only recently became available in some areas served by the project. For example ART was only initiated in

1 National Center for HIV/AIDS, Dermatology and STDs (NCHADS) 2006. 2006 Annual Comprehensive Report. Retrieved from World Wide Web July 20, 2007: www.nchads.org/reports.php

2 UNAIDS (2006). Cambodia Epidemiological Fact Sheets. Retrieved July 20, 2007, from the world wide web: www.who.int/globalatlas/predefinedReports/EFS2006/EFS_PDFs/EFS2006_KH.pdf

Thmor Kol at the end of 2006. The National Centre for HIV/AIDS Dermatology and STDs (NCHADS) planned to establish ART in Pailin and Sampov Loun OD in 2007. Often PLHIV must wait until they are very ill – and have exhausted their assets after prolonged periods without income – to receive this life-saving treatment. Serious health challenges remain. Those who receive ART need assessment for eligibility, education and treatment for opportunistic infections (OIs), and follow-up care at the referral hospital and health centers. PLHIV who are not on ART need diagnosis, treatment and care for OIs, as well as support to attend Mondol Mith Chouy Mith (Friend Helping Friends) (MMM) activities, which is one entry point for obtaining ART. Poor PLHIV need support for basic needs and help in gaining access to care and treatment.

Purpose of the Project

The CBHC project seeks to ensure access for PLHIV and their families to high quality physical and psychosocial care in a community that is free from discrimination. The project also works to prevent HIV and reduce its impact on individuals, households and their communities. The CBHC project is one component of a larger HIV and AIDS health program aimed at building the capacity of the OD, referral hospital and health center staff, as well as communities, to deliver quality, effective and sustainable health services.

The key element of the CBHC project is the core of community volunteers serving on the CBHC teams (CBHCTs). The project is unique in its use of community volunteers as a key access point for PLHIV and their families. As part of an integrated approach tailored to the needs of its clients, the project provides individualized services and an “open door” to the broader health care system. CBHCT members provide basic home care and psychosocial support to clients, teach PLHIV and their families principles of self-care, encourage families to provide care and support, and help clients to connect with health centers and referral hospitals. Clients rely on these teams for support and information, and health centers rely on them for outreach to existing and potential clients. CBHCTs also play a key role in reducing stigma and discrimination in communities and families.

Steps in Implementation

CRS staff spoke with health centers about the HIV and AIDS situation in their communities. Health center staff were encouraged to assign a specific staff member to work with the HIV and AIDS activities, including the CBHCTs, who were made up of community volunteers.

The program chose to employ community volunteers instead of NGO workers, which is a common approach used in home care in Cambodia, for a number of reasons. The experiences of program staff working with health center staff and community structures on other initiatives suggested that health center staff already had many tasks to do and would not be able to spend a lot of time on routine home care activities. Program staff wanted to find a more cost-effective model that did not draw health workers away from other important duties or create long-term expectations by paying incentives to health center staff. They wanted the home care teams to be part of the community served, readily available to assist individuals and families in their villages. Program staff believed that community volunteers, as members of the same communities, would be accepted by PLHIV, would understand the daily lives of PLHIV and could provide many of the routine services needed. While based in the community, it was clear from the beginning that CBHCTs needed to be closely linked to health centers and CRS staff for training, monitoring, support and supervision.



In the early stages of implementation, the program sought to build trust among its clients and to build community support. When the program began looking for volunteers in each village, staff considered PLHIV or their families, along with others who showed willingness to care for their neighbors. The program sought volunteers with compassion, interest, commitment, respect for clients and availability in the village. CRS engaged local authorities and representatives from various community structures such as village health volunteers, village health committees, health center management committees and traditional birth attendants in their search. Ultimately the local authorities, community representatives, health center staff and communities identified five candidates for interviews, and based on the results of the interviews, selected two CBHCT members in each village.

New CBHCT members receive a comprehensive eight-day training course covering a range of topics related to prevention, care, support and referral for people with chronic diseases and/or HIV. The course includes information on ways to educate family members of clients. Health center staff are responsible for providing periodic updates and refresher training for the volunteers.

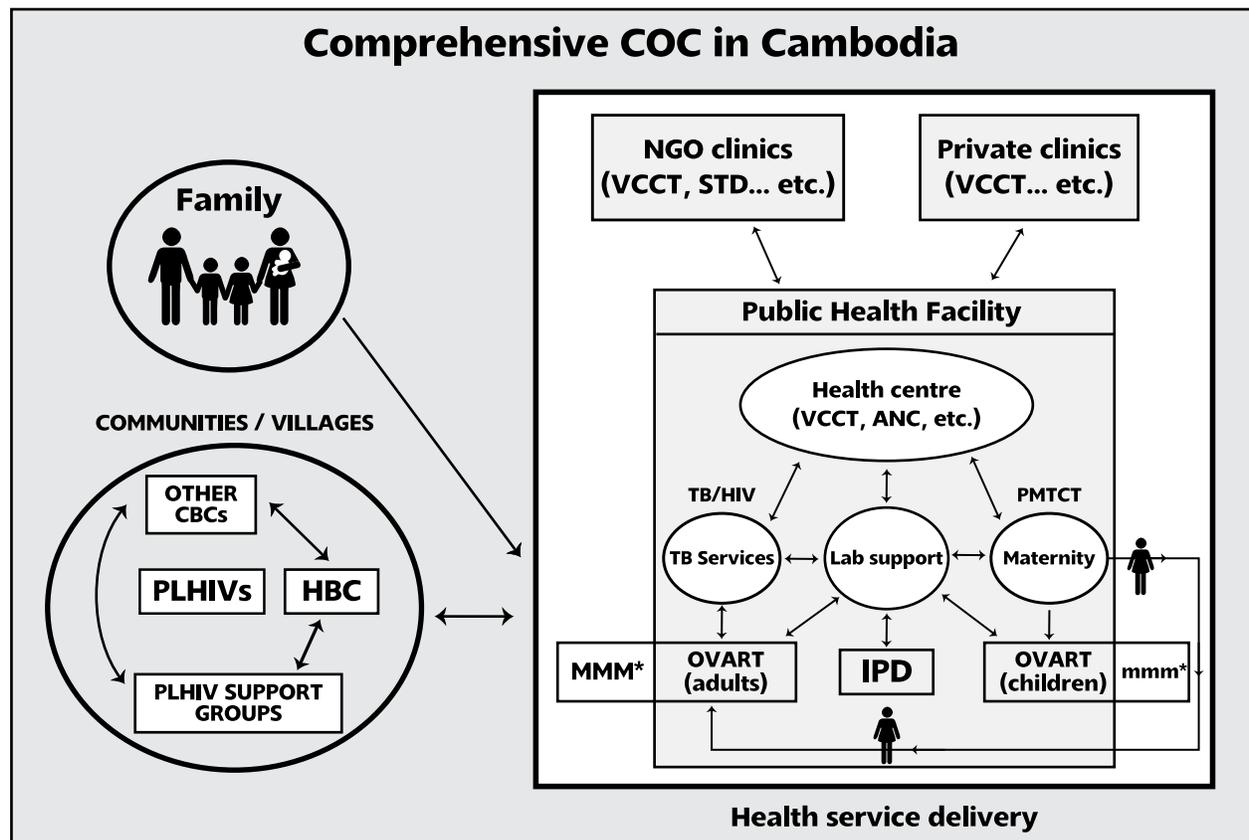
PLHIV self-support groups were also formed to allow participants to share their experience, learn more about how to care for themselves, how to advocate for their own needs, and gain valuable insight about living their lives fully. CBHCT members have played an important role in encouraging PLHIV to join the self-support groups; they are also involved in facilitating group activities in conjunction with health center and CRS AHEAD staff. Self-support groups are organized around health centers and as of early 2007 all home care clients were participating in group activities at their local health centers.

Integration

The CBHC project is one part of a comprehensive approach designed to provide and strengthen a Continuum of Care (CoC) services to PLHIV. In this system PLHIV visit referral hospitals for care and treatment of OIs; assessment for, education about and treatment with antiretrovirals (ARV); and referrals to other services like prevention of parent-to-child transmission or TB screening. Health centers in turn provide counseling, referrals, simple OI prophylaxis and treatment, TB treatment, and basic follow-up of clients on ART. Clients also rely on the CBHCTs for home visits, linkages to basic need support provided through the CRS AHEAD program (food, household materials, transportation, etc.), and referrals to health and other available services, such as self-support groups.

In addition to the CBHC component, CRS AHEAD supports the CoC by collaborating with government health officials at the provincial and OD levels to plan and implement CoC activities, building the capacity of OD, referral hospital, health center and key community members with training and technical assistance to provide CoC services.

Figure 1: The Continuum of Care Model in Cambodia³



CBHCTs build relationships based on trust and recognition from community and local authorities, which enables them to provide counseling and education to PLHIV and their families. CBHCTs focus

³ World Health Organization (2006), The Continuum of Care for People Living with HIV. AIDS in Cambodia: Linkages and Strengthening in the Public Health System.

on each client as an individual and tailor their services accordingly. For example, when clients begin receiving ART, the CBHCT educates them about possible side effects, monitors their compliance in taking their drugs and reminds them when it is time for follow up and refilling prescriptions. As clients regain their health, the volunteers talk about nutrition, home gardens, and livelihood options, such as raising chickens, making handicrafts or selling items at the market. If clients are dying, the CBHCTs assist families in coordinating the funeral ceremonies. The CBHCTs also help ensure ongoing care for OVC by making referrals to health centers when children are in need of health care, investigating the needs of OVC, and reporting and discussing them with health center staff and CRS AHEAD for support.

Positive Outcomes and Impacts

- Clients receive better health care due to the encouragement and support of the CBHCTs.
- As CBHCTs build trusting relationships with their clients, they also provide powerful psychosocial support. PLHIV have less fear and better health status overall as a result of counseling and access to self-help support groups.
- PLHIV often improve hygiene and their living conditions as they start taking better care of their health.
- As clients' spirits and mental health improve, they are more likely to reconnect with their family, which in turn improves quality of life.
- CBHCT volunteers report growing understanding about HIV prevention as they raise awareness through community outreach and individual counseling. One result is that when neighbors see the CBHCTs visit clients, "people have confidence to get tested," said one CBHCT volunteer from the Khnach Romeas Health Center area.
- Another result is greater numbers of individuals and organizations getting involved in raising awareness. In the service area of the Bovel II Health Center, a village chief integrates awareness activities into commune council meetings. School officials have added it to the school curriculum in Khnach Romeas commune.
- Beyond their relationships with PLHIV, CBHCTs have strong bonds within their communities which help them connect their clients to other people. The CBHCTs report that PLHIV have visits from neighbors, who often bring them food.
- As the volunteers in the CBHCTs gain the respect and confidence of people in their communities, they become more empowered themselves. Their status increases and more people come to them to ask for help, which increases their confidence.
- The CBHCT model costs less than using professional staff to visit clients, so it may be more sustainable due to its low cost. Even though they do not receive a salary, CBHCT members report a strong commitment to continuing their work in the future.
- Health center staff agree that the CBHCTs have strengthened their ties to villages in their areas and increased referrals for counseling and testing and other services.

Lessons Learned

- The CBHCTs respond to the varied needs of their clients with personal contact and individualized care programs. The project has learned to train CBHCTs to build trust and to be flexible, so they can ensure that clients get what they need from referral hospitals, health care centers, PLHIV and the teams themselves.
- To stay abreast of all possible options for assisting clients, CRS AHEAD maintains partnerships with different entities at all levels. The agency has strong partnerships with government agencies focusing

on health and development from the national level to the village level, community groups, and NGOs. CRS AHEAD also maintains ties to village health volunteers and traditional birth attendants. At Khnach Romeas the CBHCT attended a Human Rights Day in the village to talk about basic human rights, advocacy to the local authorities, problem solving, reporting if the problems were not solved, the Cambodian HIV and AIDS Law, and services for OVC.

- Volunteers on the CBHCTs have proven their commitment to their work again and again. CRS AHEAD has learned that these volunteers genuinely want to help PLHIV. Although the volunteers face challenges in balancing their own need to spend time earning income with meeting the needs of their clients, their ongoing presence in their communities often makes up for times when they are not available to see clients. CRS AHEAD and health centers respond to the CBHCT members' need for improving their skills and knowledge by building capacity through regular meetings and training sessions. The project also provides incentives such as recognition awards and simple materials, such as T-shirts and bags.
- CBHCTs continually expand their efforts to combat stigma and discrimination. The program also reinforces the need to respect the privacy of those who wish to pursue medical treatment elsewhere, and health centers with such clients do not refer them to home care teams or disclose their names. At the same time, CBHCTs continue to demonstrate their own acceptance of PLHIV while raising awareness about HIV transmission and the value of PLHIV through community outreach efforts.
- CRS AHEAD addresses the varying needs of self-support group leaders by building their capacity to facilitate meetings. The organization links self-support group leaders with organizations that work with PLHIV for additional capacity building, such as MMM group, Provincial People Living with HIV & AIDS Network (PPN+) in the province and Cambodia People Living with HIV & AIDS Network (CPN+) in other provinces. Strong ties with these organizations, as well as others, also assist CBHC volunteers in organizing special community events.
- Stronger health centers enable CBHCTs to provide better service.

Promising Practices

- CBHCT volunteers are accepted as representatives of their communities by clients and the larger community as well. As neighbors to their clients, they can build trust and gain credibility. They also provide powerful examples for other neighbors, which helps them combat stigma and build a strong web of community support for PLHIV.
- The CBHCTs' tailored approach enables them to see their clients as human beings with unique needs and interests. Home visits enable them to see clients in their daily surroundings and gain a greater appreciation of their hopes and dreams and fears. This approach also enables CBHCTs to be flexible when their clients' needs change, as they gain understanding and knowledge about their health and can benefit from a wide range of services.
- CBHCTs serve as gateways and as guides to a comprehensive range of services. Clients gain access to health centers and other health services, PLHIV self-support groups and community leaders involved in outreach and education.
- Through a powerful combination of outreach and support, CBHCTs ensure that clients get the help they need from health centers. CBHC volunteers help clients understand how health centers can help them and allay their fears. Sometimes they accompany clients to health centers. In turn, health centers have an opportunity to serve more PLHIV and to boost their capacity. This strong linkage improves clients' health status and also the health centers' ability to serve them.

- Peer support provided by PLHIV self-support groups is invaluable. Members of these groups value the opportunity to speak frankly about their experience and to gain wisdom and support from others. They also benefit from concrete information about ART adherence and opportunities to earn income. These groups provide safe havens where PLHIV can find understanding and support.

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Case Study: Ms. Sok Sopheap

After facing and overcoming discrimination at work and at home, Ms. Sok Sopheap has emerged as a leader in her PLHIV self-support group and a role model for others. Sopheap, age 37, is a teacher in Bovel District. She teaches children in grade 1 and grade 4. She has four children from ages seven to 16, all of whom are in school.

In 2002, Sopheap's husband had been working in Thailand when he got very sick. She and her husband traveled to Battambang for HIV testing. They decided not to seek testing closer to home because they did not want other people to know about their tests. They were diagnosed with HIV; her husband later died.

Sopheap told school officials about her HIV status six months later. Staff from CRS AHEAD also spoke to the school director on her behalf. The staff explained the facts about HIV transmission and prevention, and outlined the legal provisions prohibiting discrimination against PLHIV in Cambodia. Sopheap has kept her job teaching school since her diagnosis, even though she initially faced discrimination from her neighbors and her family when she was diagnosed. The mother of one of Sopheap's students would not allow Sopheap to teach her child. Sopheap was also separated from her family for awhile. Sopheap says this discrimination has ended because people in her community understand about transmission and prevention of HIV through TV, community education and events on World AIDS Day. She has reconciled with her family, she feels welcome at work, and she is no longer shunned by school parents, friends, or relatives.



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Sopheap faced a major health problem in 2005 when she contracted TB. She spent one week in a hospital, and missed four months of work. Her weight dropped to 37 kilograms. She began receiving ART in 2005 and is now much healthier. Her weight is up to 53 kilograms. She is able to work a second job in the school to earn extra money to support her family.

The CBHCT helped Sopheap with counseling, emotional support and information on ART. She is always happy to see them and says it is like “seeing my parents.” She also credits the CBHCT with increasing knowledge in her community, and in turn increasing understanding and support. She said that village chiefs, commune council members and monks often discuss HIV and AIDS in her community.

Through her work with the PLHIV self-support group, Sopheap has been trained in facilitation and communication. She believes strongly in raising awareness about HIV because she believes that she, herself, waited too long to get treatment.

These days her focus is on the future: she wants her children to get a good education at a higher level. She is pleased that her community is “99% free of discrimination.” Her message to the community is that “PLHIV can work, and they have a right to survive, but they need community support.”



CRS CAMBODIA STAFF

CAMBODIA

Bridges of Hope

Introduction to Project

Bridges of Hope (Bridges) is a key component of the comprehensive Seedling of Hope program (SoH), which seeks to improve the quality of life of people living with HIV (PLHIV). The program began in 1996. SoH ensures access to a continuum of care and support services; strengthens the capacity of targeted government and non-governmental organization (NGO) staff to deliver services to PLHIV and improves awareness and acceptance of HIV, AIDS and PLHIV. SoH provides an integrated range of services tailored to the needs of its clients, who include the poorest of the poor and other marginalized populations, such as ethnic Vietnamese. The program offers social support that few agencies are able to provide to PLHIV and also refers clients to health services for antiretroviral therapy (ART) and treatment for opportunistic infections (OI). The SoH program is funded by United States Agency for International Development (USAID), Catholic Relief Services (CRS), Catholic Agency for Overseas Development (CAFOD), Caritas Australia and Maryknoll. Bridges combines an individualized approach with a comprehensive package of services to assist PLHIV to reintegrate into society. With its unique combination of home visits, group counseling and tailored assistance to create plans for earning income

in the future, Bridges has helped PLHIV enter the workforce and rebuild their lives within their families and communities. As clients gain independence, they move off assistance from SoH, which allows the program to focus on clients not yet receiving ART. Thus the program promotes independence for clients while ensuring its own sustainability.

Bridges has a positive track record of helping PLHIV on ART re-enter society. The program continues to grow exponentially, along with the ART caseload in Cambodia. The Bridges caseload includes clients from SoH, as well as clients who come to the program on their own after hearing about it from their friends. By early 2007, 233 clients had gained independence from the program, with approximately 12 clients “bridging” each month.

Country	Cambodia
Type of Project	Reintegration of PLHIV into society
Integration Aspects	Microfinance, OVC, PSS, HBC
Number of Beneficiaries	233 since 2004
Beneficiary Type	PLHIV in Phnom Penh and Kandal
Source of Funding	CRS, USAID, CAFOD, Caritas, Maryknoll
Duration of Project	2004-present
Promising Practice Highlighted	Bridges of Hope focuses on independence and individualized exit strategies to help clients live their lives fully. It also ensures sustainability of the larger Seedling of Hope program.

Problem Statement and Context

HIV and AIDS are among the main health threats in Cambodia. Despite great success in reducing the prevalence of HIV in Cambodia in the past several years, it is still among the highest in the Asia-Pacific region at an estimated rate of 0.9%.¹ The high rate of poverty contributes to the prevalence of HIV because the poor are more likely to engage in behavior that increases risk for HIV transmission and to have less access to health information and services. In turn, HIV and AIDS further impoverish those who are forced to sell their assets to pay for health care. Cambodian social norms also contribute to the epidemic, allowing men to have multiple sexual partners, thus creating the demand for the sex industry, and discouraging wives from challenging their husbands about these practices. A multi-pronged approach led by government, international organizations and civil society has greatly improved prevention efforts, particularly among sex workers and their clients. At the same time, the epidemic is maturing in Cambodia, so the need for care and support continues to evolve.

The advent of ART in Cambodia in 2002 has changed the face of the disease. The number of Cambodian PLHIV receiving ART grows every year. Cambodian officials plan to scale up access to ART in the coming years. However, demand for ART currently outstrips the supply. Often PLHIV

¹ UNAIDS (2006). Cambodia Epidemiological Fact Sheets. Retrieved July 20, 2007, from the world wide web: www.who.int/globalatlas/predefinedReports/EFS2006/EFS_PDFs/EFS2006_KH.pdf

must wait until they are very ill—and have exhausted their assets after prolonged periods without income—to receive this life-saving treatment. This means that Cambodia has a growing population of people who are slowly recovering their health and facing serious challenges with societal reintegration at the same time.

As a post-conflict country, Cambodia has high rates of food insecurity and poverty. Three decades of war and civil conflict ended in 1998, but the legacy of these years of turmoil continues. Few of those living in rural areas have sustainable livelihoods, causing much migration within Cambodia and beyond its borders. The education system needs significant improvement. Cambodia suffers from high dropout rates, particularly in secondary school and among girls. Another legacy of the Khmer Rouge regime and the decades of strife is frayed social bonds, which continue to foster mistrust in Cambodian society. However, Cambodia is rebuilding in many ways. The economy is recovering as the government strengthens the education and health systems, along with other infrastructure.

Bridges of Hope springs from Maryknoll's Seedling of Hope program, which provides integrated and holistic care and support services to improve the lives of PLHIV. SoH provides both direct health services and referrals to other agencies. The program also raises awareness about HIV and AIDS to reduce risky behavior, stigma and discrimination. Finally, the program focuses on children of PLHIV by providing care and support services as well as education assistance.

In 2004, SoH staff realized that as clients began working again, they were able to provide for many of their own basic needs, instead of receiving assistance from SoH. The program conducted a feasibility study focusing on the needs of these clients, as well as possible ways to help them.

Informed by the feasibility study, Bridges began in 2004, helping SoH clients who regained their health to rebuild their lives. The program was charting new territory, with no existing models to follow. Their clients were facing a new reality. "Before they received ART, many were prepared to die," explained founder Father Jim Noonan. In these early days of ART in Cambodia, "when they began treatment, they understood it would make them stronger, and they wanted this. But they didn't realize it would bring them back to a stage in their lives when they could take responsibility."

Many among the first group of Bridges clients were afraid as they realized their former way of life was ending. Many were dependent on housing and food aid from SoH. Some clients even said they wanted to stop ART so their assistance would continue.

Along with this psychological and emotional transition, clients faced serious obstacles to earning a living. Many had not worked in a long time, and some had never worked outside the home. Others had low levels of education or were illiterate. Many had sold their business and household assets to pay for treatment. Some could not return to their earlier work, such as construction or manual labor, because of their health status. Many had suffered the loss of loved ones, or rejection by their families or their neighbors. Others were far from home, after moving to the city for work or medical treatment.

Through a combination of home visits, group counseling and help with preparations to earn income, many clients gained confidence and knowledge, and ultimately became self-sufficient. Through intensive support and field visits by the staff, many clients were reconciled with their families. The tailored approach offered by Bridges laid the groundwork for successful transitions for these first clients, who in turn inspired confidence in the clients who followed.



CRS CAMBODIA STAFF

Purpose of Project

Bridges assists PLHIV to reintegrate socially and economically into society when they have started ART and regained their health. Although the program does not provide ART directly, it helps each client build an individualized “bridge” to the future by addressing health, social, economic and psychosocial aspects of living a productive life with HIV. Bridges also focuses on families, which contributes to long-term sustainability of the intervention. The program uses a case management approach to tailor its support to each client’s health status, skills and family situation, ultimately crafting an exit strategy.

Strategic Objective: *Impoverished PLHIV and their families have improved health and quality of life.*

- IR 1.1: Families and communities demonstrate acceptance towards PLHIV.
- IR 1.2: PLHIV and their families access quality continuum of care services.
- IR 1.3: SoH and targeted government and non-government organizations staff demonstrate improved capacity to deliver HIV and AIDS services.

Steps in Implementation

Bridges staff visit clients at home during the entire length of their participation in the program. They see how each client lives, observing hygiene, sanitation and nutrition practices that are important for PLHIV.



In 2004, SoH staff realized that as clients began working again, they were able to provide for many of their own basic needs, instead of receiving assistance from SoH. The program conducted a feasibility study focusing on the needs of these clients, as well as possible ways to help them.

After extensive home visits and group counseling sessions, Bridges staff evaluate the readiness of clients for a “life of work.” The program considers clients’ health, energy level, living conditions, and support system, among other factors. Clients attend a workshop on making a plan for the future.

Bridges awards small grants to clients who want to reclaim the occupations they had prior to falling ill or who wish to develop new enterprises. Grants support a range of livelihood options including small vending, market selling, food/juice preparation and sales, motorcycle repair, public phone booths, shoe and key repair, agriculture, animal raising, weaving, motor-taxi, among others. Bridges works with other NGOs and employers in the private sector to identify vocational training and education opportunities for clients.

The Bridges job placement coordinator talks with clients about their knowledge and past work experience, as well as their wishes for the future. Then the job placement coordinator matches clients with apprenticeships and job opportunities nearby. Former Bridges clients now hold jobs in construction and work as gardeners, caregivers, guards, cleaners, household help, peer counselors, factory workers, and drivers.



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Integration

At the core of Bridges' unique approach is its commitment to crafting an individualized plan for each client to rebuild his or her life. The program provides a comprehensive package of health, social, economic and psychosocial services to help each client live a full life with HIV. But Bridges staff are trained to think beyond these services and to be flexible so that they can help each client meet their needs. Due to this client-centered approach, the length of participation of each client varies. The average length of participation is eight months, but in some cases services have extended up to two years.

This intensive focus on the clients continues during the first three months of the clients' new venture into employment or small business. Bridges continues to provide money for food and housing support, if needed, during this period. Bridges staff make home visits to help clients address problems, and provide a safe space for clients to discuss fears, stress or any mistakes they have made so they can move on emotionally.

Many Cambodians live in households with large extended families who share resources and can provide aid in times of trouble. But many PLHIV are afraid to tell their families about their HIV status, and some are even estranged from their families.

Bridges staff work to reunite clients and their families, even in cases of extreme family dysfunction, such as where parents have trafficked their children. In practice, staff assist clients in disclosing their HIV status to

loved ones and help educate families about HIV and AIDS. This often leads to reconciliation with families and inner healing. Stronger family ties make it easier to include family members in future business plans, which in turn increases the likelihood of success. Family reunification also helps to ensure a support system for PLHIV after they leave Bridges, gives a sense of normality, and lays the groundwork for community acceptance.

Positive Outcomes and Impacts

Economic Independence

- A total of 233 clients have been reintegrated into society since the program began in 2004.
- The vast majority of former clients are productive and economically active, and 57.4% of those surveyed² were the largest income earners in their households.
- A full 96% reported that they had enough income for food, and 80% had enough money for health care.
- Nearly 71% had electricity and more than half had television sets and mobile telephones. A significant number had started saving money (20.6%) or purchased livestock (18.4%).
- The vast majority (90%) of clients' children attend school.

Physical Health

- In keeping with their general productivity, clients had reported some degree of satisfaction with the health care they received (87.5%), relatively good nutrition and a diverse diet.
- Among the surveyed population, physical health scores were significantly higher than mental health scores.

Family Role

- In the survey of former clients, 93% said they were satisfied with the role they play in their families, and were satisfied to some degree with the support they received from their families.
- Most of those surveyed (76.5%) had disclosed their health status to their spouse or partner, and three-quarters had disclosed their status to their siblings. A total of 65% had disclosed their status to their parents. Those who disclosed their status had a significantly higher mental health quality of life score than others.

Community Role

- Most clients said they were accepted by their communities, though 7.4% said they were not accepted at all.

Lessons Learned

Focusing on Individuals

- People need to be treated as individuals. The success of a transition depends on the health and personality of the client. The Bridges staff respond to shifting challenges by continually tailoring services for each client, and by discussing each case as a group to ensure full consideration of all possible options.
- Bridges is flexible about the length of service, and clients often remain in the program during their first weeks or months of employment to ensure support during this critical period. The program refers former clients who cannot afford education fees for their children to other NGO programs, including Maryknoll Little Folks.

² The survey of 150 people who completed the program was conducted in October and November, 2006. Catholic Relief Services, Bridges of Hope Socioeconomic Reintegration Project (Phnom Penh: 2007).

- In response to special concerns raised by clients, such as enterprise development, domestic violence, disabilities, or legal matters, Bridges refers clients to staff with specialized training or experience in these areas. The program also responds to clients' emerging interests and concerns on practical matters related to reentering society by continually reviewing and modifying informational workshops for clients.

Providing Economic Opportunities

- Clients need more opportunities for wage employment because many choose microenterprises, and these efforts often fail. In order to be competitive in the job market, clients need more education and vocational training. Bridges hired a job placement coordinator and is stepping up its efforts to find vocational training opportunities.
- Because this area is beyond the scope of Maryknoll's services, the program has built partnerships with a small network of NGOs and employers to provide jobs and training for clients. Most Bridges clients seek non-traditional jobs that do not require long-term vocational training, so the program focuses on opportunities for on-the-job training.
- Bridges encourages clients to include an active role for family members in their reintegration plans. Family members can provide critical support for businesses. And in some cases small business start up grants are made to a parent or sibling if they are open to supporting a PLHIV who is unable to work. The program helps PLHIV lay the groundwork for these arrangements by assisting clients in disclosing their health status to family members and offering family counseling.

Supporting Clients to Stay Healthy

- Along with referral to agencies providing ART and opportunistic infection (OI) services, Bridges provides basic health education to clients during home visits, group counseling and informational workshops.
- Bridges responds to clients' needs for psychosocial support in several ways. When the program asked former clients what was most useful about the program, the most common answer was group counseling, cited by 83.8%.

Combating Stigma and Discrimination

- Bridges staff serve as positive role models when they spend time with clients, eat with them and have contact with them as with any other person. This shows families, neighbors and others how to treat PLHIV with dignity and acceptance. As a result, many clients report that their families and neighbors accept them.
- The program serves as a role model for employers by hiring PLHIV.
- Bridges helps clients address stigma and discrimination from loved ones by assisting them in disclosing their health status and by providing family counseling.

Supporting Staff and Building Capacity

- Staff members meet regularly not only to discuss clients but also to support each other.
- Specialized staff can make a big difference. As the program has grown, it has added staff members with experience and education in counseling, in order to improve counseling services. A counselor with Vietnamese language skills and cultural experience in this community has effectively helped clients in this group face their special circumstances, and counselors with expertise in other areas (such as domestic violence, disabilities, legal issues) have provided a higher level of insight for clients.



Promising Practices

Bridges' unique approach is itself a promising practice. Its focus on independence and individualized exit strategies to help clients live their lives fully – and ensure sustainability of the larger SoH program – is unique in a country with a wide range of HIV programming. Although one of the program's strengths is its range of services taken as a whole, several components of Bridges are also promising in themselves.

Client-centered Approach: Focusing on each client as a unique human being helps the program tailor its assistance to help clients succeed in rebuilding their lives. This approach extends to all areas of programming, from the length of services, to actively seeking training and employment opportunities for clients. This ensures that clients begin their transition with the tools they need to rebuild their lives.

Comprehensive Range of Integrated Assistance: To help clients succeed during a challenging transition, the program provides a range of services to help them regain and maintain their physical and emotional health, and to prepare them to earn income and lead full lives in their families and communities. Bridges helps clients gain access to health services, vocational training, and jobs, all while providing psychosocial support and practical workshops on topics facing people in transition.

Supporting Microenterprises: Bridges goes beyond counseling and training to provide small start-up grants for micro-businesses. These grants provide critical support to clients who have no other sources of

capital. A total of 77% of former clients said these grants were helpful to them. After clients benefit from the range of services offered by Bridges, these grants help them move forward to reintegrate into society.

Holistic Focus on Families: Assisting with family reconciliation is critical to a successful transition for many clients. In addition, family participation in business ventures increases their chance of success. In a country with a strong emphasis on families, clients value this type of assistance: 66% of former clients cited spouse and family counseling as being helpful to them.

Involvement of PLHIV: The Bridges staff includes PLHIV. This helps build trust with clients and provides real insight into their needs. Hiring PLHIV gives Bridges credibility when seeking opportunities for clients and helps build a culture of hope about the future for clients.

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Living Fully: Prat Dany

Ms. Prat Dany's life demonstrates the great potential of people living fully with HIV, as well as the complications in their lives. Dany was one of the pioneer clients of Bridges. When she joined Bridges she was physically healthy but not yet on ART. Her husband was on treatment already, and because couples are required to go through Bridges together, she participated.

From the beginning, Dany displayed business acumen but her fear of the future was very strong. Despite participating in the group counseling sessions, this fear persisted, as Dany's life was full of challenges. Though on ART for some time, her husband had not fully recovered his health. They had no living children as their two children had died. They also had no relatives or family support. They were renting a small house in a community that was not aware of the couple's HIV status.

Prat Dany and her husband were very enterprising. They opened a small grocery in their rented home and took stocks on a consignment basis. The bridge plan provided start-up capital so they could purchase inventory with cash and therefore earn a higher profit. A few months later, their grocery was able to expand and Prat Dany ventured into another business by operating a telephone booth. A year later she took culinary classes and began baking and selling local delicacies from their home. She was able to buy a motorcycle with her profits, and jewelry, which is a way that Khmer people keep their money in savings.

As the sole income earner in her household, she works selling household items from her home from 3 a.m. to 8 p.m. every day, working even longer hours on holidays. She also cares for her husband,

previously a motorcycle taxi driver, who is unable to work. Although her business is doing well, one negative effect is that it is more difficult for Dany to remember to take her ART. Sometimes she forgets to take it on holidays, for example, because she is so busy with work. From time to time she has also taken her medicine late. Another consequence is that the business offers some neighbors an opportunity to discriminate against her and her husband, by refusing to buy goods from her.

Prat Dany continues to see Bridges staff today. She's now on ART and for the most part healthy. Her husband tends the store when she comes to the office, where she has helped in the past as a resource for group counseling or external speaking engagements. Dany still worries about her future but her fear has reduced tremendously. Since they have no family, sometimes she worries that she may get sick and become unable to support her husband. But despite these worries Prat Dany has hope, optimism and a great deal of motivation.



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CAMBODIA

Developing the Cambodian Response to HIV and AIDS: HIV and AIDS Livelihoods Project Svay Rieng and Prey Veng

Introduction to Project

The goal of Catholic Relief Services (CRS) Cambodia's HIV and AIDS programs is to reduce HIV and AIDS-related morbidity and mortality so that individuals are able to live longer and positively contribute to the development of Cambodian society. The HIV and AIDS Livelihoods Project strives to help improve the livelihoods of HIV affected families in Svay Rieng and Prey Veng provinces. The HIV and AIDS Livelihoods Project builds on more than ten years of effort and achievements by CRS and its partners in agriculture, livelihoods, community development, and HIV in other provinces of Cambodia. CRS provides technical, financial and administrative support to four implementing partners, implements in 88 villages or target areas and is responsible for overall performance. The HIV and AIDS Livelihoods Project has received funds from USAID and CRS private funds since the beginning of the project in October 2005 and will continue with these donors through September 2008.

COUNTRY	CAMBODIA
Type of Project	HIV and AIDS care and support, including prevention, integrated with rural livelihoods
Integration Aspects	Agriculture (aquaculture, rice, vegetable, animal husbandry, small rural business) and HIV and AIDS; beginning to integrate gender and peace building on a small scale
Number of Beneficiaries	109 PLHIV, (79 women) 1336 OVC, (612 girls) 397 (211 women) PLHIV and household members 477 HIV-affected and other vulnerable households 195 Farmer groups
Beneficiary Type	PLHIV, OVC, HIV-affected households, vulnerable households, community groups
Source of Funding	USAID; CRS private funds
Duration of Project	October 2005 – September 2008
Promising Practice Highlighted	Integrating HIV-affected households into farmer groups and reintegrating PLHIV into rural socioeconomic activity

Problem Statement and Context

CRS began agricultural activities in Svay Rieng and Prey Veng provinces in 1996. Since its inception, the scope of the agriculture program has steadily increased due to the growing need of the provinces. The agriculture program focuses on improving the food security of poor, small-scale farmers and their families through intensifying rice production and diversifying homestead farming activities; increasing small rural business and market linkages are also key components. CRS implements the project in cooperation with four community development-focused local NGOs: Santi Sena, Por Tom Elderly Association, Chet Thor, and Rural Association for the Development of the Economy. CRS' local partners raised concerns about the impact of HIV in target communities, and in response CRS completed assessments and identified major needs. The gaps included lack of care and support initiatives focused on livelihoods and income; food insecurity and lack of adequate shelter, nutrition, transport and basic needs for children; few community-driven or sustainable approaches for supporting vulnerable households; prevalence of stigma and discrimination; and insufficient prevention efforts focused on abstinence and be faithful (AB) intervention strategies. Based on these gaps and the capacities of our current partners, CRS developed the HIV and AIDS Livelihoods Project.

Though a steady decline in HIV prevalence has been documented (currently estimated at 1.6%), Cambodia still has many challenges to address regarding HIV and AIDS. In Svay Rieng and Prey Veng, there is an increasing need for treatment, care and support services for people living with HIV (PLHIV) and orphans and vulnerable children (OVC) focused on livelihoods and sustainable systems. While access to antiretroviral therapy (ART) is slowly improving, services are still difficult for many to access due to cost, distance to referral hospitals, stigma and discrimination. Services to meet the basic needs of OVC are only now beginning to get attention in project provinces and are still inadequate.



Forty to forty-five percent of the Cambodian population lives below the poverty line of 0.46-0.63 USD per day. In project areas, health-related expenses are the main cause of impoverishment of families who use their scant savings, sell land and other possessions, and borrow money to pay for poor quality health care. Large numbers of rural poor from the provinces migrate to Phnom Penh, border areas and other provinces in search of employment opportunities. Many young women migrate to work in garment factories and men of all ages migrate to look for work in construction, as motorcycle taxi drivers or through military/police service. Poverty, exploitation and separation from families and partners all remove migrants from the socio-cultural norms that guide behavior in stable communities. Migrants are more vulnerable to HIV and other sexually transmitted infections (STIs) than local sedentary populations; consequently, when they return to their families in rural communities, HIV and other STIs often follow. Those infected experience frequent illnesses and have reduced productive and economic capacity. Household income declines, while at the same time healthcare expenses increase. In an attempt to cope, families sell land, other assets and remove children from school. As household income declines, household nutritional status declines and children experience increased rates of malnutrition and morbidity, especially if HIV infected. Many PLHIV in the project areas are in need of assistance to reintegrate into rural livelihoods, to have support from community members and household members, and to develop alternative sources of income. Often, it is the women who are widowed and left with the burden of providing economic support for the family. It has been found that OVC living with extended families maybe more vulnerable to abuse, sexual and non-sexual exploitation and have fewer opportunities for education and employment. These children often migrate and may engage in risky behavior, thus having a greater risk of becoming infected with HIV, if not already infected. Poverty drives the sale and trafficking of young children into the sex industry or unsafe manual/physical labor, both within and outside of the country. Thus, integrating rural livelihood opportunities and prevention, care and support programming is essential in HIV prevention in the project target areas.



Purpose of the Project

Strategic Objective 1: *That households affected by HIV will have improved livelihoods, through integration with the agriculture project, the project uses the collective strength that staff and partners have in community development and agriculture-based livelihoods to target the most poor and marginalized, including HIV-affected households and OVC.*

- IR 1.1: Improve access of vulnerable households to livelihood improvement activities;
- IR 1.2: Strengthen capacity of communities and families to protect and care for OVC through training and support for grassroots initiatives;
- IR 1.3: Communities are mobilized to provide sustainable support to vulnerable households.

Steps in Implementation

Steps in the first year of implementation included significant technical support and institutional capacity-building to four local NGO partners by holding participatory agriculture, HIV and AIDS planning workshops, jointly developing detailed implementation plans with Agriculture and HIV staff, carrying out a baseline assessment and community audit, and developing implementation guidelines to clarify the process and goals of project activities. Partners and CRS began field implementation by organizing community mobilization meetings, introducing the project, identifying needs and providing AB HIV prevention, anti-stigma and discrimination awareness sessions and identifying key community members,



including village health volunteers, village leaders, farmer group leaders and PLHIV. The project ensured coordination at the community level with existing agriculture groups as well as other community-based structures and officials. Partners and CRS, starting in October/November 2006, used the agriculture project model of core farmer groups and integrated household farming techniques to help HIV-affected households participate in needed social and technical support activities. HIV-affected households were integrated into existing groups and were provided with household technical assistance by the project and local model farmers. Needs identification, and in some cases, rural small business training followed, including small grants—all modeled and implemented with the guidance of the Agriculture staff. Additionally, the project focuses on community mobilization activities to build and strengthen village-based support networks for OVC, including identification of community volunteers to care, support and monitor the situation of OVC in a community, and provide household level awareness, counseling, and linkages to livelihoods activities, as well as basic needs support. Guidelines for these approaches have been developed and implemented. Small grants are beginning to be provided to community initiatives to address HIV and AIDS and will continue to increase as CRS and partners implement additional programs.

Integration

The project was integrated with CRS and its implementing partners, four local Cambodian NGOs. The needs were first identified and determined by CRS and partners by implementing a rural development, HIV and AIDS Participatory Rural Appraisal (PRA). Once HIV staff joined, the agriculture team was willing and



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open to working to develop integrated strategies and needs assessments. The four local partners had some basic HIV and AIDS and health education skills, as well as many years of experience in rural agriculture-based livelihoods, reaching the poorest and most vulnerable in the community and using participatory community action. All teams realized that health issues, specifically HIV, were affecting people in their communities, often the most migratory and marginalized people, often lacking sustainable on-farm livelihoods. Through intensive meetings, planning and analysis workshops, CRS and partners strategized how to integrate HIV and agriculture at the community level. The HIV project worked through the existing farmer group model, in the same target areas (a subset of the full agriculture target areas).

Positive Outcomes and Impacts

Awareness of HIV and anti-stigma messages among farmer groups and group leaders, with support from partners, lead the groups to welcome HIV-affected households into their groups for support.

- HIV-affected members were provided with revolving funds and loans from the group to help get them get started in composting, vegetable production and chicken and pig raising (the group makes their own decisions on how to allocate the funds).
- Farmer group members often helped monitor and provide follow up at the household level for new members, for example, to build fences and link to water for home gardens.

- HIV-affected households now experience increased support, participate in group meetings and receive increased social capital, an increase in social status, acceptance and integration, enabling them to rebuild their livelihoods. Once marginalized, they now receive information regarding other sources of support: credit, small loans, and linkages with model farmers.
- Agriculture teams are aware of and can assist in identifying HIV-affected or other marginalized groups in their communities to participate in agriculture activities. There is increased awareness among agriculture staff of key concepts in HIV prevention, care, support and anti-stigma.
- HIV staff have increased awareness and skills in livelihoods and on-farm socioeconomic support to benefit entire households.

Lessons Learned

Integrating a new HIV project with a long-standing agriculture project:

- Ensure management and staff awareness and buy-in of the plans to integrate; designate staff to participate in planning and provide opportunities for all existing project staff to provide input on the new project, the earlier the better.
- Work together to prepare integrated objectives, targets, activities and indicators. Develop work plans together: include a responsibility column for all activities to indicate which sectors/staff will implement integrated activities.
- Use a participatory approach early on with staff and partners to design what and how the integration process will look like.
- Prepare clear guidelines for implementing integration activities, step by step, and have a full section on the roles of existing project staff and the roles of new staff. Identify areas for coordination. Revised job descriptions should be developed, if possible, to reflect new focus on integration, emphasizing staff expertise and skills.
- Begin with HIV awareness and community mobilization activities with existing community groups (e.g. farmer groups) to ensure the involvement of PLHIV and farmers.
- PLHIV on ART and those who are in good health and/or their family members can and should participate in on-farm livelihoods activities in rural areas. Through livelihoods programming, technical assistance in agriculture can be linked with adherence counseling, future planning for the family, small business and credit, loans and small grants, as well as referral support and basic health care education. Community-based volunteers, farmers and agriculture technical staff can support this process.
- Livelihood support groups, such as farmer groups, provided with education on HIV and AIDS, are willing and able to help HIV-affected households reintegrate and participate in the community.

OVC Specific

- OVC can benefit from rural livelihoods activities through linking their caregivers to farmer groups, as well as bringing OVC and school or community children together to work on a school or community garden.
- The project found it useful to integrate HIV prevention, anti-stigma, nutrition and hygiene awareness and learning games with simple composting and dry season vegetable training.
- Children plan the session trainings, work and monitoring, as well as how to use the output of the sessions. In this project, the children chose to use the output for themselves, the most vulnerable classmates, or their teachers.

- In some cases, children sell the outputs and use the money to help vulnerable children in their school and community and to buy seeds for the next year.
- Household follow up with the caregivers and OVC ensures a sustainable link to learning and improvement of household livelihoods.

Promising Practices

The integrated farmer group model provided HIV and AIDS education and awareness and helped groups understand that vulnerable and marginalized households need community and group support. Many groups welcomed HIV-affected households to join their groups. This will lead to ensuring rural agriculture-based livelihoods, minimizing migration and providing opportunities for communities to become aware and take action to mitigate the impacts of HIV and AIDS.

- Joint sector planning: the process was more holistic and fulfilled several needs of beneficiaries, rather than just focusing on health or livelihoods issues; all families reported health, basic needs, livelihoods, medical support as important.
- Share and develop human resources: it is difficult to identify staff with HIV, livelihoods, agriculture and food security backgrounds, thus multiple staff from the two projects, with their collective skills, provide a holistic response to the community in training, awareness and reaching beneficiaries. Using the existing project systems and guidelines as a base was efficient. Likewise for finance and support staff, it was easy and effective to cost share.
- School/Community garden model: ensuring OVC attend school and fully participate is important. Thus encouraging students to think about and learn livelihoods skills, linked with HIV prevention, anti-stigma, hygiene and nutrition addresses many of the holistic needs of the individual. Additionally, household follow-up with OVC and caregivers participating in livelihoods projects can strengthen the impact of the program.

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RADE Partner Prey Veng, CRS Svay Rieng

Family Receives Community Support and Acceptance in Rural Livelihoods

Pheanh Rong, 29, lives in AngKhang village in Prey Veng Province, on the border with Svay Rieng Province. Rong is married and has one young son. Rong and his wife found out they were HIV positive two years ago, after receiving counseling and testing at Svay Rieng Referral Hospital. Both now receive opportunistic infection prophylaxis and treatment and have stayed fairly strong over the past few years; they are not yet taking ARVs. They have good days and bad days, but are working hard to support their family with the assistance of CRS' partner in Prey Veng, RADE.

Rural Association for the Development of the Economy (RADE) is a local Cambodian NGO that has been working in AngKhang since 1996 when RADE started their work as an NGO. RADE has been a CRS partner since 2004 with the Integrated Farming and Marketing Systems (IFMS) Project and with the HIV and AIDS Livelihoods Project since 2006. RADE works with communities to mobilize very poor and vulnerable farmers to support each other in local farmer groups and to battle the problems of poor soil, floods and food insecurity in Prey Veng. These local groups act as social support, receive training in agriculture techniques as well as loan and credit support from a revolving fund set up by the members for the families involved. The group is organized for farmers to support each other in agriculture and rural livelihoods activities, such as animal husbandry, dry and wet season vegetable and rice production, fish farming and small rural business.

Pheanh Rong always grew rice to help support his family; however, due to poor soil, floods and lack of information and resources on improved agriculture techniques, he often did not gain enough income to adequately support his family. Additionally, he and his wife would make small snacks to sell during festivals to increase their income to buy vegetables. Rong would leave his village to find work in Phnom Penh to supplement the family income.

After Rong discovered he was HIV positive, only his very close relatives visited his family. Neighbors and other farmers no longer contacted him; he wasn't involved in any social support groups or committees in the community. He had to spend a lot of money to travel to the referral hospital to receive care. In 2006, RADE began implementing HIV prevention and anti-stigma and discrimination awareness with community farmer groups, as well as mobilizing communities to understand, help and care for vulnerable households facing challenges like HIV, TB and extreme poverty. Rong and his family were invited to join the farmer group in his village to help him regain his livelihood and receive social and economic support from his community. Now, Rong explains that since joining the farmer group, "I have many people come



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to visit my family and help care for us and now we all [in the group] understand clearly about preventing HIV and how HIV is transmitted; I have also learned about animal raising and seed (vegetable and rice) production, as well as other support; we are now growing vegetables from seeds supported by the group revolving fund for eating.” Rong and his wife received support and technical assistance from the farmer group leader and other members, including vital encouragement and support.

RADE has worked with Rong to provide livelihood skills training, input support, HIV prevention and care, anti-stigma and discrimination awareness, as well as providing transport support to attend monthly medical check ups. RADE has helped the family continue to send their son to school by providing a uniform, school bag, soap (including hygiene practice) for the 2006/2007 school year-he is thriving and attending primary school. Rong and his wife hope to ‘find a good future for our child’ and to receive ARVs in the near future to live a long life.

ERITREA

HIV and AIDS Home-Based Care and Support

Introduction to Project

CRS has been involved in Home-Based Care and Support (HBCS) project since 2003 in partnership with Eparchy of Asmara Catholic Church. The diocese of Asmara receives funds from multiple sources including the Eritrea government through its HIV and AIDS, Malaria, Sexually Transmitted Infections, and Tuberculosis (HAMSET) Project, local churches' private funds, and compassionate citizens. This project is intended to meet the medical, nutritional, and psychosocial needs of people living with HIV (PLHIV) by improving access to health care and home-based care (HBC) providers, providing food rations, and livelihood security, using microfinance or in-kind grants for income-generating activities (IGAs). This project's coordination and integration with multisectoral projects is unique. Also, it has established a number of group support centers for PLHIV and their caretakers, providing activities such as a monthly coffee ceremony, which is a forum for open discussion to share ideas, experiences, to learn from each other, give testimonies, disclose their HIV status, obtain spiritual and moral support, receive updated information and to socialize.

COUNTRY	ERITREA
Type of Project	Home-based Care and Support
Integration Aspects	Nutrition, PSS, care and support and IGA
Number of Beneficiaries	490
Beneficiary Type	PLHIV and those affected by HIV
Source of Funding	CRS, UNFPA through Eritrean Ministry of Health
Duration of Project	October 2003-September 2008
Promising Practice Highlighted	Holistic approach to sustain the lives of PLHIV and their families. Establishment of group support centers for PLHIV.

Problem Statement and Context

The HIV prevalence in Eritrea is less than 3%. Given poverty, the mobilization and demobilization of troops, lack of awareness, commercial sex activity in urban areas, and the large population of UN Peacekeepers, it is likely that HIV prevalence is likely to increase. This expected increase contributes to the current and future challenges of preventing HIV. In addition, HIV-related stigma and discrimination decreases willingness to

openly disclose HIV status or voluntarily seek counseling and testing (CT). These factors combine to create strains to meet the medical, nutritional and psychosocial support needs of PLHIV.

Since 2001, the Government of Eritrea, His Excellency President Isaias Afewerki, and development partners have acknowledged HIV as a serious health and development problem and have thus been committed at the highest level to mitigating the impact of HIV. An illustration of this commitment was the development of a multi-year strategic plan. Led by the Ministry of Health, the plan includes comprehensive policies and guidelines to prevent and control HIV. The plan emphasizes a multicultural and decentralized approach that includes community-based, faith-based, and HAMSET project responses in conjunction with bilateral donors and United Nations Agencies. In February 2006, the government and its partners began distributing antiretrovirals (ARVs) free of charge. Functioning CT centers and the establishment of a national association of PLHIV have created an environment conducive for socialization, psychosocial and economic support, and advocacy for PLHIV. The involvement of faith-based organizations (FBOs) in HIV prevention has played a great role in encouraging testing before marriage and when necessary, facilitating the necessary care (spiritual, social, economic and medical) for PLHIV.

Purpose of the Project

Strategic Objective 1: *To address increased nutritional requirements for PLHIV.*

- I.R. 1.1: PLHIV have increased access to improved nutrition.

Strategic Objective 2: *To reduce the psychosocial stress of PLHIV by providing home-based health care and support.*

- I.R. 2.1: Quality of life for PLHIV through HBC, psychological, and material support is improved.

Strategic Objective 3: *To promote awareness and understanding of HIV prevention methods.*

- I.R. 3.1: Capacity of project staff to improve knowledge, attitudes, and practices regarding HIV prevention is strengthened.

Strategic Objective 4: *To promote awareness of HIV and AIDS stigma and discrimination.*

- I.R. 4.1: Capacity of FBO to address stigma and discrimination is strengthened.

Strategic Objective 5: *To integrate HIV and AIDS topics in all CRS program.*

Steps in Implementation

- Mobilize and train HBC providers. Care and support provided by volunteers includes: providing emotional and spiritual support, basic care and palliative treatment, and referral to welfare support;
- Train family members how to care for the chronically ill;
- Train individual households on nutritional intake requirements;
- Distribute general and supplementary feeding rations;
- Organize awareness groups or peer educators; train these groups in behavioral communication skills;
- Provide interest free loans (microfinance) and in-kind support to PLHIV;
- Establish group support centers, committees and regular get-togethers for PLHIV and their caretakers through a coffee ceremony. Traditionally when coffee is prepared, families, relatives or friends gather, chat and have fun for hours. Having a monthly coffee ceremony provides a time when PLHIV and caretakers

can disclose their status, share ideas, learn from one another, and openly discuss success stories, and possible solutions to the challenges they face in their day-to-day activities. Other refreshments like tea, milk, popcorn, and bread are also served, and people can have whatever they order.

Integration

The CRS Eparchy of Asmara HIV and AIDS HBC and support project integrates activities with the general food distribution project, microfinance, health clinics, HAMSET project and connects PLHIV with the church. In addition, it creates links with individuals who would need and seek assistance. The integration of HIV with the HAMSET Project has helped PLHIV receive optimal health education, understanding, and treatment for these particular diseases.

Positive Outcomes and Impacts

- Most PLHIV in this project enjoy better health, adopt healthier lifestyles, have lower opportunistic infection incidence, and experience slower progression to AIDS.
- The majority of PLHIV became stronger and got involved in IGA. Since initiation, nearly 75% have re-paid their loans.
- Created a compassionate environment where a large number of PLHIV and caretakers could share ideas, learn from one another, and openly discuss success stories and possible solutions to the challenges faced in day-to-day activities through a monthly coffee ceremony. Often, confidential discussions take place between PLHIV and their caretakers. Additionally, group support centers, comprised of PLHIV and caretakers are established.
- As a result of material support, 300 orphaned children continued their education.
- PLHIV have adequate access to health care, including ART, educational and psychosocial services.
- 98% of registered PLHIV had prolonged survival and are in better health. 61% are on ARV treatment.
- Numerous networks for PLHIV have been established including social, psychosocial, and economic support networks.

Lessons Learned

- PLHIV do not participate when the project lacks economical and material support or is consolidated with other projects like microfinance and general food distribution projects and medical service providers.
- The coffee ceremony conducted by group support centers has wide acceptance by PLHIV. The coffee ceremony is an effective means of conveying messages and creates a welcoming environment to share experiences, life-skills development, promote openness and disclosure, renew strength, and enhance socialization.
- Religion and spirituality have a significant effect on individual health. Religion and spirituality assist individuals in coping with illness, live with a positive state of mind and provide emotional support. The spiritual support and beliefs influence the inclination to provide care for others.

Promising Practices

- CRS addresses the impact of HIV by embarking on a strategy to mainstream HIV education into all elements of policies, procedures, and programs. The first step is to increase staff HIV awareness and skills. Increasing staff awareness and education helped to reduce HIV stigma, allowing staff the

opportunity to openly reflect on ways to better support PLHIV. CRS, in partnership with Eparchy of Asmara, trained volunteer HBC providers. These volunteer care facilitators support PLHIV households by providing first aid for OI management, disseminating key health and nutrition messages, and providing psychosocial, emotional, and spiritual support.

- Establish group support centers, committees and regular get-togethers for PLHIV and their caretakers through a coffee ceremony. Traditionally when coffee is prepared, families, relatives or friends gather, chat and have fun for hours. Having an arranged, monthly coffee ceremony serves as a time when PLHIV and caretakers disclose their status, share ideas, learn from one another, openly discuss success stories and problem solve challenges faced daily. Refreshments like tea, milk, popcorn, and bread are served. The ceremony may have presentations on self-disclosure, updated HIV information, prayers and spiritual lessons led by a bishop. This practice has helped PLHIV normalize HIV as any other disease, interact with other PLHIV, and carry on community activities with courage and dignity. Furthermore, it has helped caretakers to become more courageous and equipped them with the skills and strategies to reduce HIV stigma. This interactive, engaging practice has gained acceptance by participants and recognition by the Ministry of Health. The Ministry of Health has indicated it intends to share the coffee ceremony idea with other FBOs for replication.
- The integration of a FBO helped engage PLHIV. PLHIV engagement led to procedures and interventions to provide better support to PLHIV.
- CRS and partners distributed general food rations and supplementary food to meet increased food and nutritional needs of HBC clients.
- PLHIV and their households are encouraged to get involved in IGAs which help resolve some economic problems. Previously, the majority said “HIV is not a disease but joblessness is.” By engaging PLHIV in business, the project relieved emotional stress and anxiety related to economic status, while allowing PLHIV to be open about their health status.
- The integration of HIV with education on malaria, sexually transmitted infections, and TB has helped PLHIV to be familiar with the diseases, detect them early, take necessary precautions, and develop health-seeking behavior.
- Previously, HBC and counseling services were between PLHIV and her/his caretaker alone, in a confined and secretive way. Since last year, the project has now formed group support centers composed of many volunteer HBC providers, caretakers and PLHIV. On average, in each group there are 10 caretakers and 65 PLHIV.

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Case Study: Mrs. Hiwet

Mrs. “Hiwet” is a 52 year old widow living with HIV and the mother of nine. Her eldest child is 22 years old and the youngest is nine. Her husband passed away when her youngest child was less than a year old. He had been a merchant with an honorable position and attractive income, enabling the family to live a high standard of living. When the father’s health began to deteriorate, the family suffered financial stress and debt. After a long and terrible illness, he died.

When her husband was sick, Hiwet frequently heard rumors that her husband was suffering from AIDS, but she disregarded all the gossip. She trusted her husband and was confident that he had never had sexual relations with anyone but her.

During his illness, a woman visited frequently. Suspicious, Hiwet began asking her husband who the woman was. He told her the woman was a broker selling his old stocks. She accepted this. Following the death of Hiwet’s husband, the woman continued to show up and give Hiwet sincere, valuable advice on life. Hiwet soon learned the woman was an HIV counselor. Hiwet was shocked, despite the gossip during her husband’s illness. She was formally informed of her husband’s cause of death. After a rigorous counseling process, the counselor convinced Hiwet to get tested. Unfortunately, Hiwet was HIV positive. She felt despair and hopelessness, especially for the future of her orphaned children. The counselor understood and assisted Hiwet to overcome her stress and grief. She helped Hiwet regain confidence to lead a positive life and to raise her children normally. She connected Hiwet with the national association of PLHIV where she could get food and other assistance, but Hiwet was not happy with their management. Later, the counselor connected Hiwet with the CRS-supported HBC project. This connection changed her life. They assigned her a HBC caretaker who visits Hiwet at least twice a month. The caretakers provide emotional, physical, and spiritual support. In addition, the church organized a monthly coffee ceremony whereby PLHIV and their caretakers gather, share ideas and experiences, care and learn. They learn that there are people like them. Hiwet found this practice useful, especially for newcomers.

After attending a self-disclosure lesson, Hiwet announced her HIV status to her sexually mature children. Initially, they felt as if she was dead, mourning for almost a week. Soon after, they began to be more concerned about her health. Eventually they reassured their mother by saying, “we will be in trouble only if you are away from us, but as long as you are alive and taking your medicines properly, we will not worry.”

Hiwet understands that the assistance of the church is not limited to counseling services. She gets school material support for her children, connects with the clinical management service providers for ARV and opportunistic infection treatment. Considering her debts and the future of her orphaned children, Hiwet is the beneficiary of interest-free microfinance assistance. Hiwet inherited a small shop, but she had no capital to start up the business. After she got a loan from the church, she opened up the shop with her eldest children. After a short period, she was able to repay her loan. With the constant income, she then repaid of all of her debt.

Hiwet thanks the organizations, church, counselors, and compassionate citizens who have changed her life, enabling her to sustain the life of her children. Hiwet concluded, “With the current steady increase in prices on all commodities, house rent, and the shortage of supplies in the city, it is difficult to stand alone

without external assistance, until the market stabilizes.” Hiwet adds with pride, “I am covering all the expenses of my rental house bills, school fees, and earning some amount for my living. All my children are continuing their education without any problem.”



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INDIA

Samudra Home and Community-Based Care and Support Programme

Introduction to Project

Samudra is an HIV project in five port towns of Gujarat State. This project is implemented with an overall goal of improving the quality of life for labor migrants in the port towns of Gujarat, Bhavnagar, Jamnagar, Veraval and Gandhidham. These towns are the most industrialized regions of the state. Samudra focuses on the slum and village areas of the towns. In Gujarat state, Samudra is unique. Samudra is one of the few care and support projects in the state. In the first year of implementation, the project established a strong referral system and received sponsorships for 50 orphans and vulnerable children (OVC).

COUNTRY	INDIA
Type of Project	Home and community-based care and support project
Integration Aspects	The program emphasizes developing seven integrating community structures and facilitating linkages with the existing services to address the issue of HIV prevention as well as care and support HBC, micro-finance.
Number of Beneficiaries	837
Beneficiary Type	Truckers, sex workers (SW), migrants, industrial workers and OVC
Source of Funding	CRS funds and local resources including individual donors, government industrial sector support
Duration of Project	June 2006 – May 2007
Promising Practice Highlighted	Strong referral system, sponsorships for OVC, sponsorships and subsidies for nutritional and medicinal supplements.

Problem Statement and Context

The Samudra HIV project operates in five port towns of Gujarat State: Gujarat, Bhavnagar, Jamnagar, Veraval and Gandhidham (see map below).



Gujarat has an HIV prevalence of <1%¹, but is potentially vulnerable to increased infection due to natural and man-made factors including rapid industrialization, large migrant population, long stretches of national highways, and long coastlines. The industrial boom and economic opportunity at port towns has attracted a large number of people from across the country, mostly between the ages of 15-45 years. More than 70% of the labor force in the ports and its industries are migrants from outside of Gujarat state. A combination of factors such as separation from family, isolation, poor living conditions, anonymity of towns, and disposable income make the migrants prone to behavior that puts them at risk and susceptibility to HIV infection. Additionally, more than 100,000 trucks traverse the highways daily; the risk-taking behavior of truck drivers increases the risk of transmitting HIV from one place to another.



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HIV awareness among migrants is low. Consequently, very few get tested. Even when tested, they are reluctant to reveal their HIV status for fear of stigma and discrimination. This increases the vulnerability of their sexual partners. Families of people living with HIV (PLHIV) become vulnerable as limited health-seeking behavior and lack of awareness results in the transmission of the virus to spouses and children. Additionally, illnesses decrease income as productive capacities decrease while health care expenses increase. In the absence of HIV education and experience in handling such a sensitive issue, communities fail to provide support and increase stigma and discrimination.

Samudra cares for 837 PLHIV and OVC. Samudra is committed to the Greater Involvement of People Living with HIV and AIDS (GIPA) and employs PLHIV as outreach workers and peer educators.

Purpose of the Project

Strategic Objective 1: *Communities in five port towns of Gujarat protect themselves from STIs and HIV.*

- I.R.1.1: Communities (truckers, industrial workers, SW, families) in five port towns avoid high-risk behaviors.
- I.R.1.2: Communities demonstrate health-seeking behavior.

Strategic Objective 2: *PLHIV and their families experience improved quality of life in terms of increased social acceptability, care and other support services in five port towns.*

- I.R. 2.1: The communities provide care and support to PLHIV and their families.
- I.R. 2.2: PLHIV and families access and follow up with referral services.
- I.R. 2.3: Health service providers provide treatment to people with STIs and PLHIV.

¹ According to NACO.

Strategic Objective 3: *Communities and PLHIV in five port towns have well developed mechanisms to access existing services.*

- I.R. 3.1: PLHIV in target area experience decreased stigma and discrimination.
- I.R. 3.2: PLHIV receive improved home and community-based care and support.
- I.R. 3.3: PLHIV and their family access credit for income generation programs.

Steps in Implementation

- Program orientation to church partners of five port towns who implement the project.
- Recruitment and staff training.
- The launch of Samudra at all locations involved representatives from all stakeholder communities.
- Selection and training of peer educators and volunteers.
- Build rapport with the communities and other stakeholders, including target groups.
- Social and resource mapping of the intervention zones.
- HIV awareness campaigns.
- Conduct trainings on issues related to HIV and AIDS, behavior change communication, counseling, and HBC.
- Form self-help groups, including positive members.
- Provide medical and nutritional support.
- Develop referral system for medical treatment and also in the initial stage income-generating activities.
- Utilize local medicine, nutritional support and other local resources.

Integration

The program emphasizes developing community structures and facilitating linkages with the existing services to address HIV prevention, care and support, and psychosocial support (PSS). A key component of the project is to dovetail government and community efforts to complement and strengthen existing service delivery for PLHIV to ensure access to high quality services. The impact during the first year of the project has been demonstrated in the form of enhanced self esteem of PLHIV, sensitized government and medical functionaries, increased health-seeking behavior, and sponsorship for PLHIV educational, nutritional and medicinal needs.



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Positive Outcomes and Impacts

- Through home visits and awareness generation programs, the project has addressed the issues of stigma and discrimination with approximately 5–25% of the population in the intervention zones.
- One of the great achievements for Veraval centre was obtaining access to Gujrat Industrial Development Corporation's (GIDC) migrant workers. Most of the migrants working in the fish packing and processing industries stay in hostels within the GIDC campus. Despite long working hours with short

breaks, these workers are only permitted to go off the premises once or twice a week. The rest of the time they work and stay inside the GIDC compound. Access to this population has been critical.

- In the port town of Gandhidham, the project has increased the number of PLHIV in the network from 250 to 525.
- PLHIV report increased awareness and education among about the disease.
- PLHIV regain self-esteem and self-confidence which can be witnessed during their interactions with the community.
- The project works with men who have sex with men and eunuchs (castrated or transgendered men) in HIV education. These populations, particularly eunuchs, are highly stigmatized. This program is one of the few working with these populations.

Lessons Learned

- The credit institute is not ready to provide loans to PLHIV, as repayment becomes a question due to the uncertainty of PLHIV capacity to work. Therefore, there is a need to develop a local resource network which would lend to PLHIV.
- Entrance into a closed population, such as eunuchs, is a slow process. Work with eunuchs began with the invitation from several eunuchs to initiate HIV education programs in their areas.
- Building relationships with populations at risk is important.
- When working with new populations, in this case eunuchs, it is critical to first learn about the population and acquire necessary skills to adequately engage in activities.

Promising Practices

- The project supports PLHIV, those affected by HIV, and OVC through local resource mobilization. The project has succeeded in getting sponsorships for 50 OVC for educational, medicinal and nutritional needs. This is done during Advocacy meetings and some events organized by the project, like AIDS Day.
- In the short span of 12 months, the project has developed referral systems within their intervention districts. All partners work very closely with the Gujarat's State AIDS Control Society local unit; it has also been able to develop local level linkages with the other stakeholders in the zones. This has helped the partners to mobilize resources.

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Case Study: Bhuri

“Why do you need property, you are going to die...!”

Bhuri is 27 years old and HIV positive. From Gandhidham, Bhuri married at the age of 20. “My husband was HIV positive but used to talk about his various affairs with other women quite proudly. He used to torture me by burning me with cigarettes; still I was with him and nursed him till his death. My in-laws held me responsible for his death and threw me out of the house.”

Thrown out of the family and with no one to take care for her, Bhuri returned to her father’s house. Life was difficult to bear because of stigma and discrimination. One day, Bhuri came across an outreach worker of the Samudra project. He counseled and encouraged her to look at life positively. The Samudra project was looking for PLHIV to work as peer educators, and Bhuri soon began working with Samudra. While working with Samudra, the project provided legal aid training, which encouraged her to pursue her rights of property from her in-laws. When Bhuri approached a lawyer to take legal action, he said “Why do you need property? You are going to die...!” Bhuri was again discouraged, but the Samudra project intervened and helped her to file a case in court to access her husband’s property. Today, Bhuri is waiting on the outcome of the court case while she continues to work as a peer educator for the Samudra project.



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INDIA

SAATHI Care and Support

Introduction to Project

In 2000, SAATHI (*friend*) initiated work on raising HIV awareness in three districts: Ujjain, Shahjapur and Rajgarh. The awareness program directed the future vision of care and support programming for people living with HIV (PLHIV). Gradually, the care and support program expanded to include nutritional support, community awareness programs, opportunistic infection (OI) treatment, and counseling and testing. In addition, SAATHI started a school education program to supplement the educational needs of children living with HIV, including tuition and other school fees. Through the care and support program, PLHIV have gained confidence and lead a healthy, dignified life. Additionally, some PLHIV supported by the project are working to reduce stigma and discrimination through community sensitization activities.

COUNTRY	INDIA
Type of Project	Home-based care and support program
Integration Aspects	Income-generating activities (IGA), microfinance, psychosocial support (PSS), stigma and discrimination reduction
Number of Beneficiaries	350
Beneficiary Type	PLHIV and their families
Source of Funding	CRS and Kinder Mission
Duration of Project	2007 – 2010
Promising Practice Highlighted	Specialized programs to reach truck drivers, the establishment of services for OVC and PLHIV

Problem Statement and Context

Ujjain district has the second highest HIV prevalence in Madhya Pradesh State. Economic migration into the area from nearby districts is high. Additionally, since the district lies in the major railway and transport junction, laborers, truckers and migrants routinely travel from rural areas located in the interior of Ujjain to cities.

Ujjain city is a religious place and holy city for large numbers of pilgrims and a hub for migrant employment. Street children, who are particularly vulnerable to sexual abuse, are very common in Ujjain. Ujjain is also a major center for higher education. In India, university-aged students are often at higher risk for HIV infection due to increased unsafe practices, behaviors and experimentation. Madhya Pradesh State AIDS Control Society (MPSACS) estimated more than 700 PLHIV in the city or about 1%.

The dire condition of PLHIV encouraged SAATHI to intervene and extend care and support to people affected by the disease. PLHIV in this area experience poor health status and high socio-economic burden. PLHIV also face social stigma and discrimination at the household and community level. Many PLHIV are unaware of their status. Given these conditions, SAAATHI initiated the care and support program with a vision to provide home-based care to PLHIV, build the capacity of PLHIV and the community to prevent HIV transmission, and increase access to treatment services.



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Purpose of the Project

The purpose of the project is for *the community affected by HIV and AIDS to have increased resilience and for PLHIV to live a quality life with dignity in Ujjain district.*

Strategic Objective 1: *PLHIV have improved health status with major focus on improving access to health care services for treatment of OIs and ARVs, care through home-based activities, and maintaining good nutritional status through providing nutritional education and supplements.*

- I.R. 1.1: PLHIV utilize quality comprehensive HIV health care services without stigma and discrimination.
- I.R. 1.2: PLHIV receive quality HBC and support without stigma and discrimination.

Strategic Objective 2: *HIV-affected families have reduced socio-economic burden through increased savings and introduction to viable livelihood opportunities.*

- I.R. 2.1: PLHIV have improved livelihood options.
- I.R. 2.2: Children of PLHIV attend school regularly.

Steps in Implementation

SAATHI initiated the program with the specific objective of increasing awareness of HIV as the stepping stone for building the strength of the community and PLHIV. Project staff planned and implemented project activities with a long-term vision of providing care and support to PLHIV. They developed strong linkages with the community as well as PLHIV.

The care and support program for PLHIV brought about positive changes, both physically and psychologically. These positive attitudes were created by expanding knowledge about HIV through education for PLHIV and community members. The project facilitated the creation of various support groups, many of whom participated in trainings in basic HIV education, prevention, home-based care and support. PLHIV were trained on nutrition and health basics to improve their health status.

Integration

The care and support program, initiated through the support of CRS Madhya Pradesh, uses a holistic approach while considering program sustainability. Though the program started with the goal of increasing HIV awareness, it was soon realized that education activities could be expanded to include other services, such as care and support for PLHIV. The program now covers a wide range of support services for PLHIV including financial, social, psychological and nutritional assistance. Home visits accompanied by counseling as well as community mobilization events to expand HIV awareness have led to greater acceptance of PLHIV and reduced stigma, as well as improved incomes through income-



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generating activities. Self-help groups, created with support from microfinance projects, have begun community mobilization activities to raise awareness about HIV transmission and the need to support PLHIV and their families, both of which have led to the reduction of stigma and discrimination.

Support groups increase the likelihood of sustainability and create a network in which PLHIV can support one another. Additionally, the support groups work as resource to advocate for rights for PLHIV and mobilize resources.



Networking and collaboration with other government and non-government organizations have increased support for the program. This program's beneficiaries included children, young adults, women, truckers and sex workers.

Positive Outcomes and Impacts

- 125 HIV infected and affected families, 100 children affected by HIV, and 19 children living with HIV are supported. The 100 affected children are provided with education support, and the 19 infected children are supported through the Clinton Foundation with support for ART, nutrition, and travel expenses. Additionally, clinics and hospitals admit PLHIV for routine care and treatment as needed.
- The formation and registration of Ujjain Positive People's Network. The network will be involved in increasing awareness of HIV at the district level to reduce stigma. The network will advocate for various HIV related issues, including food and support programs for PLHIV.
- PLHIV have started income-generating activities. Several PLHIV have opened shops.
- PLHIV are appointed as implementers of the project, contributing positively toward extending support to PLHIV and creating awareness of HIV.

Lessons Learned

- It is relatively easier to bring about attitudinal change towards PLHIV in rural areas than urban, as HIV stigma is very deep-rooted in urban areas.
- It is necessary to support the entire family through nutritional rations and education costs as part of an overall care and support program.
- Regular check ups and continuous monitoring for PLHIV are necessary to ensure proper treatment.
- Economic sustainability is an important aspect of psychosocial support and therefore is essential to improve the social conditions of PLHIV.

Promising Practices

- SAATHI has built strong collaboration with the truckers' association in Madhipur block in Ujjain district, the largest truck building industry. With a total number of 600 trucks, the Nagauri

association of truck owners is operational in and outside the state. Both the truckers and the greater community felt the need to design an intervention to address the issues of education and behavior change as it specifically relates to behavior that puts truck drivers at risk for HIV infection.

- SAATHI initiated HBC and support for children affected by and living with HIV.

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INDIA

UNNILE NAAN Theni Project

Introduction to Project

The *Unnile Naan* (I am in you) Comprehensive Home and Community-based Care and Support project for people living with HIV (PLHIV) started in October 2004. The Madurai Multipurpose Social Service Society (MMSSS), the official diocesan social work organization, is the nodal agency for the implementation of the project. MMSSS collaborated with four local non-governmental organizations (NGOs) in this project, all of which are working on various health issues in the Theni district: Ambelal Heinrich Memorial Trust, Maitri Society, Varushanadu Social Service Society, and Jeevan Jyothi Hospice. These NGOs have a history of implementing community-based interventions. The program currently reaches 12,000 PLHIV across 281 villages in seven blocks of the Theni district.

COUNTRY	INDIA
Type of Project	HCBC
Integration Aspects	PSS, vocational training, HIV/TB, microfinance, IGA, LSE
Number of Beneficiaries	3,000
Beneficiary Type	Direct Beneficiaries: PLHIV, children living with HIV, OVC
Source of Funding	CRS, Chennai Tamil Nadu and Clinton Foundation
Duration of Project	October 2004-September 2006
Promising Practice Highlighted	Reduce stigma and discrimination within communities; contribute to increased feelings of a safety and supportive environment for PLHIV.

Problem Statement and Context

The Madurai Multipurpose Social Service Society has successfully been working in community development in Theni, Virudhunagar, Dindigal and Madurai districts since 1968, giving particular emphasis to health issues. In Theni district, MMSSS has worked since 1986 on community health education, with special emphasis, since 1989, on working with Dalit communities.¹ While working to enhance the integral growth and development of the Dalits, MMSSS became aware of the rapid spread of HIV and discovered women and children were the most negatively impacted.

Dalit communities have strong beliefs in witchcraft and superstitious events, routinely seeking care and treatment from “healers.” It is not uncommon that Dalit communities spend more money and resources on healers rather than medical treatment and care. Additionally, economic migrants, sexual exploitation of women, and drug use have increased vulnerability to HIV transmission. The 2002-2003 Behavioral Sentinel Surveillance Survey conducted by the AIDS Prevention and Control Project-Voluntary Health Services and the National AIDS Control revealed an HIV prevalence of 10% in Theni district among sex workers, migrants, factory/industrial workers, men who have sex with men (MSM), truck drivers and injecting drug users (IDUs). This high infection rate calls for an urgent and immediate action to address transmission risk.



¹ Dalit communities are treated as untouchable in the caste system. They are deprived of equal status and have poor living conditions.



Theni district is located in the south-western part of Tamil Nadu state, bordering the state of Kerala. The district has agriculturally fertile land with two flowing rivers, attracting laborers to migrate to the district for work. The town of Cumbum has become a major commercial hub. A combination of factors such as separation from family due to migration, internal mobility, poor living conditions, tourism, consumerism, traditional customs, anonymity of the town and availability of disposable income make the migrants prone to engage in behavior that puts them at risk for HIV infection.

Purpose of the Project

Strategic Objective 1: *Increased acceptance and improved quality of life among 3000 PLHIV by 50% within the communities of 304 villages in 7 blocks of Theni district.*

- I.R. 1.1: Communities in Theni accept PLHIV into community-based organizations.
- I.R. 1.2: Communities provide support services to meet the needs of PLHIV.
- I.R. 1.3: Communities ensure sustainable ownership of the program.
- I.R. 1.4: PLHIV access services and facilities to address opportunistic infections (OI) and sexually transmitted infection (STI) testing and treatment.
- I.R. 1.5: PLHIV receive psychosocial and economic support.
- I.R. 1.6: PLHIV receive improved home-based care (HBC) and support.

Strategic Objective 2: *Improve quality of life by 75% among 150 children living with HIV and 1000 affected children in 7 blocks of Theni district.*

- I.R. 2.1: Children living with and affected by HIV and AIDS and orphans and vulnerable children (OVC) access treatment for OI and other available health care and support systems (mental and physical health).
- I.R. 2.2: Children living with and affected by HIV and AIDS and OVC receive nutritional support.
- I.R. 2.3: Communities increase acceptance for children living with and affected by HIV and AIDS.
- I.R. 2.4: Children living with and affected by HIV and AIDS receive life skills education.

Strategic Objective 3: *Increase protection of PLHIV, children living with HIV, OVC and vulnerable women through 1170 CBOs by 25% in 7 blocks of Theni district.*

- I.R. 3.1: PLHIV, children living with HIV, OVC and vulnerable women experience increased safety, security and protection, and decreased victimization due to violence and crime.
- I.R. 3.2: PLHIV and other vulnerable women experience developed self-confidence and skills.
- I.R. 3.3: PLHIV and their families access networking and linkages to microcredit facilities.

Steps in Implementation

Staff and community capacity is enhanced by trainings provided for staff, self-help groups (SHG), caregivers, and health care providers, as well as by cultural events to raise awareness about HIV. The trainings create an environment in which an effective intervention and the involvement of staff and stakeholders converge through referrals, as well as linkages with government and nongovernmental credit institutions. In addition, they provide direct support such as nutrition, medicine, and counseling. At these trainings, community stakeholders helped to identify PLHIV. SHG members are women from the community who live below the poverty line. SHG members meet weekly and acted as caregivers, lay counselors, and peer educators; their inclusion is particularly laudable in that PLHIV also served in these roles. The provision of nutrition and clinical support to treat OI helped PLHIV to have better health outcomes. The district-level stakeholders meeting held twice a year played an advocacy role to focus the efforts at the district level to better care for PLHIV. Linkages with PLHIV networks have strengthened PLHIV cohesiveness and have begun to increase the human rights perspective in their approaches.

Integration

When the program began, it mainly provided HBC and support with few provisions of nutrition, medicine and counseling. After proper training and increased programs, community involvement increased, as did the perception of HIV as not just a medical issue but a socio-economic issue. This perception increased the strength and depth of integration with other programs and sectors. For example, credit linkages increased the



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income of PLHIV, and the SHG increased the acceptance of PLHIV through peer education, HBC and psychosocial support (PSS).

Formerly, SHG excluded PLHIV due to stigma and discrimination. After HIV education and support, SHG admitted and actively engaged PLHIV. Special focus on vulnerable populations was emphasized. While CRS supported care and support for PLHIV, the Clinton Foundation extended its support to children living with HIV. There are increased efforts to care for OVC. There is a separate initiative taken to address the co-infection of HIV and TB. Partnerships at the grass-roots level with other NGOs, government, faith groups, and other key stakeholders have strengthened the program by enhancing program impact on direct and indirect beneficiaries.



Positive Outcomes and Impacts

- Out of 1900 PLHIV identified and enrolled in the 3 year project period, 70% accessed services at the project clinic.
- Out of 1900 PLHIV identified and enrolled in the 3 year project period, 90% accessed drugs for the treatment of OI.
- At least 10,000 people used the community resource center.
- 873 infected and affected families are in SHG.
- 353 PLHIV participate in SHG.
- At least 30,000 infected and affected people report reduced stigma and discrimination after mass behavior change and communication programs and awareness campaigns.
- 103 runaway and out-of-school youth were moved from street life to safe locations in orphanages.
- 362,500 INR in loans distributed through the income-generating program.
- 155 income-generating program beneficiaries. PLHIV involved in incoming generating program have improved economic status.
- Increased HIV care and support awareness among staff, peer educators and lay counselors.
- PLHIV and children living with HIV experience increased safety and secured living environment. Children living with and affected by HIV have supportive environment and experience decreased stigma and discrimination.
- Increased community involvement in PSS and care for PLHIV. PLHIV and families have more supportive social environment. Caregivers deliver good quality HBC and support.
- Increased community and PLHIV awareness of health status; increased approaches to the health institution for treatment.
- Increased staff ability to provide counseling, regular follow up and referrals for PLHIV.
- PLHIV, mothers and caregivers have increased knowledge, access to services and facilities, and demonstrate improved health-seeking behavior.
- Children developed self confidence and skills; demonstrably increased knowledge about child rights.

- Communities and PLHIV have demonstrably increased knowledge of issues related to the safety, security and protection of women and children.
- PLHIV and vulnerable women have received behavior change intervention.



Lessons Learned

- HIV education, training and awareness programs increase staff and community knowledge and decrease misconceptions.
- Identification of and association with community resources increase community confidence to access and utilize those resources.
- Community events are particularly effective in increasing testing behavior among populations who engage in activities that put them at risk for HIV. Behavior change communication motivates the community to change negative attitudes towards PLHIV, decrease HIV-related stigma and increase awareness of risk of HIV transmission.
- Identification and training of caregivers to provide PSS and counseling helped PLHIV in the community.
- Regular PLHIV home visits helped to provide necessary medical and counseling care.
- Livelihood is one of the prime necessities of PLHIV and their families. This project developed innovative efforts to help establish income-generating activities for PLHIV through SHG.
- Reduction of HIV-related stigma and discrimination increased involvement of PLHIV in SHG and other community organizations.
- SHG members contribute to the project as lay counselors, caregivers and peer educators.

Promising Practices

- Involvement of community stakeholders as advocates for the support of PLHIV.
- Incorporate PLHIV into existing income-generating activities.
- Engage existing groups in HIV education to increase community acceptance of PLHIV.
- Involvement of community stakeholders in stigma and discrimination reduction.

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DAVID SNYDER/CRS

UGANDA

Virika Hospital AIDS Clinic AIDSRelief Program

Introduction to Project

Virika Hospital AIDS Clinic opened its doors in 1990 and provided one of the Catholic Church's first responses to the HIV epidemic in Uganda. The clinic initially started with basic care and support to patients including psychosocial support (PSS), pain management, and management of opportunistic infections. Presently, the clinic offers a range of services including counseling and testing (CT), treatment of opportunistic infections (OI), prevention of mother to child transmission (PMTCT), palliative care, provision of antiretrovirals (ARVs), community sensitization, and home-based care (HBC). Services are provided to both adults and children.

Virika Hospital's mission is the fundamental motivating force that drives the AIDS clinic in all of its activities. It emphasizes the promotion of life to the fullest and healing, based on the mission of Jesus Christ. Therefore, Virika AIDS Clinic pursues both the good of sick people and the common good of the community. Because of the diversity of problems that people living with HIV (PLHIV) present, Virika Hospital AIDS Clinic has responded through a holistic approach in its organization and provision of

services. In this perspective, the Virika Hospital considers the promotion of health and the prevention of diseases as an integral part of its mission.

COUNTRY	UGANDA
Type of Project	Care and Support
Integration Aspects	HBC, CT
Number of Beneficiaries	314
Beneficiary Type	PLHIV, Children and Adults
Source of Funding	PEPFAR
Duration of Project	February 2004-January 2009
Promising Practice Highlighted	Creation of unique identifier shared by female patients and their children for ease of identification, follow up and treatment

Problem Statement and Context

Virika Hospital AIDS Clinic provides HIV and AIDS comprehensive care services to both adults and children. Despite the clinic's ability and staff capacity to provide quality pediatric HIV care and treatment, there were very few children, only 5% of all patients, in care prior to 2004. Moreover, out of the children eligible to start antiretroviral therapy (ART), 45% could not start due to various social problems, including resource limitations, food insecurity, lack of follow up at the community level, and poor family in HIV care. In general, it was difficult to monitor children in the PMTCT program; many mothers believed there was no need for continued infant assessment and monitoring after delivery. Further still, community volunteers were unable to trace many children since they were unable to locate their homesteads or identify their family members, because often the children were being cared for by relatives and family friends who may have been outside of the community or who were unknown to the community members. These factors resulted in few children on ART, lack of follow up, poor adherence, and high infant morbidity and mortality.

Virika initiated the concept of a "family number" to address the low numbers of children on ART. The "family number" is a unique identifier given to a female clinic patient. This identifier is shared by the patient's children. The patient and her children share the same number for ease of follow up in case of PMTCT services and HIV exposed children.

Purpose of the Project

Objectives of the family number strategy:

- To develop a unique identifier that links female patients and her children for ease of identification of children.
- To increase the number of children accessing AIDS Clinic services.
- To increase the number of children accessing ART.
- To increase follow up of children by community volunteers.

Steps in Implementation

Every client receives a unique identifier (serial number and family number):

- Male clients have individual family numbers
- Female clients share family numbers with their children but with different serial numbers (xxxx/year/family number); where the first part is the serial number.

The unique identifiers enable clinic staff to distinguish each child from the other and from one family to another, hence enabling even distribution of resources, i.e. medications and donated materials such as clothes, shoes etc. And even carrying out home visits, there might be children with similar names who would be differentiated by unique identifiers. Both names and numbers are used by clinic staff and the community volunteers during home visits to identify children. Once family numbers are assigned an identifier, it is a confirmation that the recipient is eligible for all the services offered at the clinic.

To increase and facilitate the follow up of children, the community volunteers are given the names of the children with their respective family numbers in their areas of operation. Each family number is tagged to an adult who is assumed to be known in that particular community making it easier to trace children who may not be known of the villages.

With the family number, the community volunteer looks for a particular home where, with the help of the unique identifiers, they will be able to recognize the different children in the home.

Positive Outcomes and Impacts

- In the two years since implementation of the unique identifier program, children under care at the clinic increased more than 24 fold, from 13 in 2005 to 314 in March 2007.
- In March 2007, 59% of eligible children were on ART.
- 96% of children on ART are visited monthly at home by community volunteers.
- The program allows staff to identify potential problems affecting children's welfare, adherence and design strategies to address them at both family and project level.
- The program allows the clinic to reach a number of HIV exposed children, get them counseled and tested with eventual enrollment into care using a family number approach.
- Easier identification of children has led to better follow up and has enhanced adherence on long term treatment.
- More children are now accessing comprehensive HIV care at the clinic. This increase is a direct result of the clinic's program to offer free services to those children brought in for testing, found to be positive. Only HIV positive patients are enrolled into care.
- No child will receive care without a family number. The process of enrollment involves assigning the family number, encouraging the parents/caregivers to bring children for testing, and articulating the benefits of family testing and having a family number.
- Better HIV sensitization of family members.
- Better program retention rates.
- Strengthened PMTCT program due to more children being brought in for prophylaxis and follow up.
- More children are being brought to the clinic for HIV testing services, HIV education. These children receive information on how to support themselves and their parents on long term treatment. Parents are encouraged to disclose their HIV status to their children.

Lessons Learned

- It is easy to link children born of positive mothers with family numbers used while providing care, including Cotrimoxazole prophylaxis, ART, on-going counseling and psychological support.
- Family involvement in HIV care is critical for better adherence, follow-up, and identification and eventual recruitment of HIV exposed children into care.
- Give the clinic staff the opportunity to meet the caregivers from the home environment, discuss more about HIV-related issues, address the family's psychosocial needs and educate on the measures necessary to reduce HIV infection in the family.
- Provide adherence support and encouragement. This is mainly done by the community volunteers who regularly visit the children.

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DAVID SNYDER/CRS

ZAMBIA

Reaching HIV and AIDS Affected People with Integrated Support (RAPIDS)

Introduction to Program

The RAPIDS consortium has a long history of working in Zambia. World Vision (WV), Catholic Relief Services (CRS), The Salvation Army (TSA) and Expanded Church Response (ECR) are faith-based organizations with well-defined packages of care and support of orphans and vulnerable children (OVC) and people living with HIV (PLHIV). This large network of churches and community groups has enabled the program to extend coverage on a national scale. Africare brings expertise in increasing livelihood options for youth and managing small grants and micro-finance activities. Africare works closely with Population Council's Horizons Project in Zambia in providing monitoring and evaluation (M&E) related responsibilities, i.e. conducting impact assessments, operations research, etc. for the RAPIDS Program. CARE international with its years of work in rural parts of Zambia is the sixth Consortium Member and is involved both in HBC and OVC programming. The RAPIDS program features a multisectoral approach to HIV and AIDS-related problems, implementing a

sustainable community-led response to HIV and AIDS. This approach enables us to work with ever-greater numbers of organizations, institutions and partners in a coordinated manner to achieve the multiplying effects needed to respond on a scale equal to the magnitude of the need.

The RAPIDS program provides home-based care and support using both short and long term strategies. The program employs a unique household approach, which is the hallmark of the RAPIDS consortium service delivery. Although the Zambian government has championed a coordinated, multisectoral national response to HIV and AIDS, the efforts and resources do not match the results. This is because the programs are on a small scale, isolated and disconnected exacerbated by the resource and capacity challenges that remain real obstacles. Recognizing the gaps in the health care system in providing long term care to people with AIDS-related illnesses and the concerns of institutionalizing orphans, RAPIDS has developed a framework that places the household as the focal point for problem identification and response. Well-defined packages of care and support have been developed for each strategic objective which serves as the basis for the minimum package of services provided. RAPIDS has completed its third year of operation and has demonstrated significant progress in program objectives and targets.

COUNTRY	ZAMBIA
Type of Project	HBC, OVC, Youth Programming and Food Security
Integration Aspects	Nutrition and Counseling and Testing
Number of Beneficiaries	69,837 direct as of 31 September 2007
Beneficiary Type	Direct: PLHIV, people with TB, other AIDS-related complications, chronic illnesses and OVC Indirect: Community volunteer caregivers, families
Source of Funding	USAID - PEPFAR
Duration of Project	August 2004-September 2009
Promising Practice Highlighted	Promotion of a household approach for an integrated development and support approach to programming that defines its services within this more dynamic construct, one that addresses not only effect, but also the root cause.

Problem Statement and Context

The RAPIDS program response complements the Zambian government's response to the epidemic, evolving since the mid-1980s from a public health approach to the current multisectoral approach with support for community-led initiatives. RAPIDS has contributed to elements of both lines of intervention, though a systematic scale-up of successful community-based palliative care models of HBC and support to OVC, as well as interventions targeting economic stability and life skills for vulnerable youth, including prevention and abstinence messages for young people. Linkages with other on-going programs are contributing to further prevention, counseling and testing (CT), clinical care, and antiretroviral therapy (ART).

In Zambia, HIV is robbing a generation of its childhood and parental guidance, placing an unbearable strain on those caring for PLHIV and OVC, reducing economic productivity and prematurely ending the lives of thousands of productive Zambians. The situation for OVC is already critical; the number of orphans is estimated at 1.1 million and growing. There are an estimated 900,000 to 1.2 million adults living with HIV in a total population of 10 million. Zambia's Central Statistics Office estimates that the total number of orphans will increase 16% by 2010 and 70% of all the orphans under age 15 will lose their parents to AIDS. Children orphaned by AIDS are among the most vulnerable because of stigma, poverty, and an accelerating loss of social support from their families and communities. Confronted with a high rate of unemployment and low number of jobs, Zambian youth face an uncertain future. Some 50% of Zambia's population is under 16 years of age. Given this situation, and the rate of illness among adults, youth are increasingly responsible for all aspects of a household's livelihood security, from raising siblings to agricultural production to earning off-farm income.

Purpose of the Project

The goal of the RAPIDS program is to improve the quality of life of Zambians affected by HIV through a systematic scale up of successful household-focused models of HBC, palliative care, and support to OVC. Further interventions include targeting youth with livelihood opportunities and life skills, which also include abstinence, prevention and testing initiatives.

Program interventions are divided between the four strategic objectives, reaching the three main target groups with a household focus that delivers distinct packages of services according to the specific needs of the household, seeking to assist households to recover from the impacts of HIV and regain their livelihoods.

Strategic Objective 1: *Improve the quality of life and resilience of OVC and their households.*

- I.R. 1.1: Improve enabling environments at national, provincial, district and local levels for the benefit and well being of OVC.
- I.R. 1.2: Mobilize and strengthen community-led responses to protect and care for OVC and their families.
- I.R. 1.3: Strengthen capacity and resilience of OVC and household members to care for themselves through increased livelihood options.
- I.R. 1.4: Establish referral systems for counseling and testing and referrals for treatment and follow-up of HIV positive OVC.

Strategic Objective 2: *Improve the health, quality of life and resilience for PLHIV and their households.*

- I.R. 2.1: Mobilize and equip community-led home-based care for the chronically ill.
- I.R. 2.2: Strengthen capacity and resilience of PLHIV and household members to care for themselves through increased livelihood options.
- I.R. 2.3: Establish referral systems for treatment and follow-up.

Strategic Objective 3: *Improve livelihoods and healthy norms for youth, abstinence, behavioral change and CT.*

- I.R. 3.1: Increase access of youth to livelihood opportunities.
- I.R. 3.2: Increase integration of youth livelihood and HIV prevention programs.
- I.R. 3.3: Increase number of young people who know their HIV status.

Strategic Objective 4: *Increase capacity of households and communities to cope with HIV and AIDS, including small grants to local organizations, multi-agency coordination and advocacy, and assisting the government with planning and policy formulation in support of OVC and PLHIV.*

- I.R. 4.1: Strengthen capacity of local organizations to provide care and support to OVC and PLHIV.
- I.R. 4.2: Strengthen multi-agency networks and alliances for coordination and advocacy.
- I.R. 4.3: Strengthen government planning, policy and support systems for OVC, PLHIV and youth.

At the same time, the following are pertinent to, and integrated as, crosscutting themes:

- **Gender Equity:** The need to address issues of gender equity and the empowerment of women and girls among all target groups.
- **Stigma Reduction:** The pressing call for efforts to transform prevailing attitudes of stigma and discrimination directed towards PLHIV and their families, in order to create a positive and transparent environment in which HIV and AIDS-related services can be more freely and openly accessed by those who need them.
- **Food and Nutrition:** Assuring nutrition of household members is essential to reducing household vulnerability and enabling the household to fully regain its livelihoods. Attending to the nutritional needs of OVC and PLHIV is a core element of the overall package of services provided to households severely affected by HIV and food insecurity.

Steps in implementation

RAPIDS' strategic framework reflects the HIV and AIDS priorities of both the government of Zambia and the local USAID mission as outlined in 2004 - 2010 USAID's Country Strategic Plan. As a result RAPIDS' program M&E system has been set up to measure progress towards achievement of program objectives, prioritizing the measurement of PEPFAR mandatory and USAID core indicators. Additional indicators are included to provide greater detail with regard to program outputs as well as measuring the quality of service provision. The Program Performance Monitoring Plan with its strategic objectives and intermediate results with their corresponding activities lead to a breakdown of a yearly and six year Detailed Implementation Plan (DIP). During the first year of the program, RAPIDS developed a minimum package of care and support that is being used as a basis for service delivery for all clients. The minimum package consists of:

- Psychosocial support, education and vocation support, shelter rehabilitation, provision of food and nutrition care, child protection, and provision of paralegal services and health care for OVC;
- Basic nursing care, symptomatic pain relief, nutrition and adherence support, provision of working tools for health workers and volunteers, psychosocial support for clients, their families and volunteer caregivers, paralegal care, targeted trainings for all levels of caregivers, referral for continuum of care for PLHIV;
- Behavioral change, life skills and livelihood activities for youth.

Guided by community needs, RAPIDS has added a malaria control program through provision of Insecticide Treated Mosquito Nets (ITNs) and a Goods In Kind (GIK) program where material resources are sourced through World Vision (WV). GIK received and distributed so far includes bicycles and 'tools for work' for volunteer caregivers and basic nursing kits for nurses, volunteer caregivers and clients. RAPIDS mobilizes community committees as the primary mechanism for providing care and support. Greater involvement of PLHIV is also promoted at all levels of program implementation. These approaches have formed the basis for broader community capacity

development maximizing the various contributions made across interventions. Under the leadership of the Population Council's Horizons project, a baseline survey was conducted at the start of the project. An impact assessment survey has recently been completed and another will be conducted during the final year of the program.

Integration

Past experience has shown that a lack of focus leads to dissipated and ineffective efforts. Consequently, the RAPIDS program use of a multisectoral and household approach has resulted in greater coordination and efficacy in order to target the most vulnerable. Ultimately, it has resulted in increased cost-effectiveness and prioritization, reducing vertical programming and enhancing inter and intra-sectoral links. Additionally, RAPIDS has successfully built other program interventions onto existing, successful ones. For example, through utilization of multi-disciplinary skilled volunteer caregivers, services related to OVC, youth, livelihoods, CT, malaria control, and ART have been integrated with HBC to promote greater efficiency. Significant steps have also been undertaken where AIDSRelief¹ service points conduct fortnight ART community outreach services in selected HBC sites. This has increased access to the service contributing to the government initiative in which 3,000,000 people were to be on ARVs by 2005. In the short term, RAPIDS has increased the resilience of vulnerable HIV affected households by providing food support by drawing on C-SAFE and SUCCESS experience. In the long term, RAPIDS will promote innovative and appropriate agricultural strategies through linkages with CRS agricultural and livelihood programs so that, as the project reaches its planned closure in 2010, partners in target areas will be better positioned to address and care for HIV affected households in general and will have frameworks and care models to support them.

Positive Outcomes and Impacts

RAPIDS is in its third year of implementation, and program impact thus far will only be determined after the completion of the mid term evaluation which is underway. However, notable positive outcomes include:

- 98% (28,206) coverage for HBC clients and 95% (34,834) for OVC in 17 districts of Zambia for year ending March 2006.
- The RAPIDS strategic objective of improving the quality of life of PLHIV has been fulfilled by putting in place policies and guidelines that support palliative and HBC.
- Client access to and use of ART have increased due to the linkages established with both government and mission hospitals.
- Quality of care has further improved through the provision of government standardized HBC basic nursing kits to approximately 4,000 caregivers.
- Targeted food distribution to TB and ART food insecure households has improved quality of life and drug compliance of these clients.
- Establishment and strengthening of the paralegal committees has heightened awareness of human rights and justice issues.
- Educational support and school retention rates for OVC have increased. Impact of the educational support will be determined by the mid-term evaluation.

¹ AIDSRelief is a 5-member consortium providing anti-retroviral therapy (ART), HIV care and wraparound services to underserved populations in 9 countries in Africa, Latin America and the Caribbean, through the support of PEPFAR. The consortium is led by Catholic Relief Services (CRS) and also includes the University of Maryland School of Medicine Institute of Human Virology, Constella Futures, Catholic Medical Mission Board and Interchurch Medical Assistance.

Lessons Learned

- *The need to focus program interventions at the household level:* The household approach has not only improved service delivery but also a more efficient dynamic construct.
- *Community-Led Response:* Community committees have taken on increasing responsibility for caring for their members. This is increasingly being recognized as the key long-term sustainability strategy in the response to HIV in Zambia.
- *Multisectoral Interventions:* Since HIV is not a stand alone health issue, the use of a multisectoral approach has heightened positive outcomes observed so far. RAPIDS has a member of staff to Ministry of Youth Sport and Child Development to assist policy development. At community level, a number of support groups focusing on agricultural, livelihoods and micro enterprise, child protection, drug adherence, social welfare, etc. have been established.
- *Inter- and Intra- Linkages:* Through the complementary and multiplying effects of many programs working towards similar objectives, the collective response can meet the magnitude of the HIV challenge. This has been shown by the increase in ART uptake for HBC clients since RAPIDS established linkages with AIDSRelief in selected sites.
- *Private Partnership:* RAPIDS operates in both peri-urban and rural areas of Zambia where the geographical terrain poses a huge challenge for volunteer caregivers to reach as many clients as possible. Through collaboration with United States-based private sector, RAPIDS partners have received 23,000 bicycles to ease the transport burden. Medical supplies have also been provided through GIK program.

Promising Practices

- Promotion of a household approach for an integrated development and support approach to programming that defines its services within this more dynamic construct, one that addresses not only effect, but also root causes.
- Communities and PLHIV will continue to take the lead role of the primary care and support providers.
- Encourage PLHIV, especially women and, where appropriate, girls to play major roles in decision-making and leadership in program implementation to reduce gender disparity in the context of HIV.
- In collaboration with other CRS projects, institutionalize the integrated implementation approach for maximum health impact and synergy.

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CRS ZAMBIA STAFF

ZAMBIA

SUCCESS Return to Life: A holistic approach to care

Introduction to Project

The Scaling Up Community Care to Enhance Social Safety-nets (SUCCESS) Project scaled up the provision of quality palliative care and support to people living with HIV (PLHIV) through the provision of services such as home-based care (HBC), community-based counseling and testing (CT), prevention of mother to child transmission (PMTCT), targeted nutritional interventions, referral to antiretroviral therapy (ART) for adults and children, and adherence support. SUCCESS-Return to Life (RTL) commenced in July 2006, as a follow-up project to SUCCESS. The project name SUCCESS RTL reflects the return of PLHIV to productive lives after diagnosis, care, and treatment by programs such as SUCCESS. The overall objective of the program is improved care and support for PLHIV by offering a unique holistic approach to prevention, care, and treatment that takes into account evolving and complex needs during the course of the disease.

COUNTRY	ZAMBIA
Type of Project	Palliative Care, through HBC and hospices
Integration Aspects	PMTCT, ART, CT, HBC, TB, OVC, MCH
Number of Beneficiaries	33,365
Beneficiary Type	PLHIV and their families
Source of Funding	USAID/PEPFAR, CRS cost share
Duration of Project	July 2006 - September 2008
Promising Practice Highlighted	Using a holistic palliative care model and a multi-disciplinary approach, clients are returning to life and productive living.

Problem Statement and Context

The SUCCESS RTL program is implemented through a unique network of palliative care implementing partners including Catholic Diocese HBC programs, Hospices of Zambia, and the Palliative Care Association of Zambia (PCAZ). Together they help to meet both project and Zambian national goals and objectives, as well as contribute to alleviating the burden of HIV care. The project works in predominately rural areas, although most of the hospices are in urban or peri-urban locations. The core of the project is quality palliative care that is offered in both homes and hospices.



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Zambia is one of the Sub-Saharan African countries most affected by the HIV pandemic. Estimates put HIV prevalence at about 16 percent among those 15-49 years old, with about 1 million Zambians infected and 7.7% of young people 15-24 years old infected. The burden of HIV continues to pose a major challenge to Zambia’s health care system, as well as overall national development.

Purpose of the Project

The purpose of the project is to improve the lives of PLHIV through increased care and support offered through an integrated holistic approach to care.

This goal is being accomplished through two interlocking strategic objectives and inspired by the overarching theme, RTL. The supporting interventions are designed to improve the quality of life as per the WHO definition of palliative care¹ as well as to extend it.

¹ Palliative care is “An approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual” (WHO 2002).



Strategic Objective 1: *Increase quality of comprehensive palliative care delivery by CRS partner HBC and Hospice programs.*

- I.R. 1.1: Existing services within HBC programs and/or hospices are strengthened.
- I.R. 1.2: Involvement of youth and family members, including men, in providing care for PLHIV is increased.
- I.R. 1.3: Service linkages with other provider organizations and programs are increased.

Strategic Objective 2: *Demonstrate progress toward sustainability of palliative care programs.*

- I.R. 2.1: Partners demonstrate an increased capacity to implement and manage sustainable and effective palliative care programs.
- I.R. 2.2: PLHIV have increased and more meaningful integration in all aspects of programming.
- I.R. 2.3: A volunteer force of committed caregivers is created and supported.

Steps in Implementation

The project is implemented through CRS partners' Catholic Diocesan HBC programs and Hospices in various locations of Zambia. Staff and community volunteers are trained in palliative care and pain management so that quality holistic palliative care is offered to PLHIV, HBC clients, and hospice patients. This holistic approach looks at the whole person and takes care of their physical, social, psychological

and spiritual needs. Applying the network model, SUCCESS RTL integrates palliative care activities with ongoing activities in the same geographic areas. Referral systems are set up to encourage wider access to and use of health services that include PMTCT, tuberculosis care and treatment, ART, orphans and vulnerable children (OVC), maternal and child health (MCH), and livelihood services both from private and government structures (mission and private hospitals, hospices and clinics).

Integration

The key aspect of this project is the holistic approach supported by a multi-disciplinary team. Some partners do not have all necessary team members to provide the full range of services needed for a holistic approach. It is therefore necessary for them to partner with other providers so that the full range of services can be provided to PLHIV, meeting their physical, social, psychological and spiritual needs, including ART adherence support. In particular, there are strong links with AIDSRelief² sites for the provision of ART.



Positive Outcomes and Impacts

SUCCESS RTL is making a difference to PLHIV in Zambia. By offering quality care, as well as the opportunity to access a wider range of HIV services, HBC clients and hospice patients are returning to productive lives. This has a positive impact on communities as people can once again work and fend for themselves, lessening the burden on the community. Likewise as people ‘return to life’, they are able to care for their children and therefore lessen the burden of increasing numbers of OVC in need of care and support from their communities.

A welcomed impact of RTL in communities has been the reduction of HIV stigma and discrimination. This has been attributed to the fact that as people have returned to life, other people in the community observe them and relate this to recovering from HIV and AIDS-related illnesses. Fears of the disease are being allayed, and people are more willing to get tested for HIV, disclose their status, and go for treatment.

Lessons Learned

- Networking with other health services in same geographic areas is important for integration and referral systems, in particular with government structures.

² AIDSRelief is a 5-member consortium providing anti-retroviral therapy (ART), HIV care and wraparound services to underserved populations in 9 countries in Africa, Latin America and the Caribbean, through the support of PEPFAR. The consortium is led by Catholic Relief Services (CRS) and also includes the University of Maryland School of Medicine Institute of Human Virology, Constella Futures, Catholic Medical Mission Board and Interchurch Medical Assistance.

- Quality care that deals with the whole person through a holistic care model helps PLHIV return to life and productivity.
- PLHIV who have ‘returned to life’ are the best advocates in reducing stigma and discrimination.
- Mobile clinics in some partner programs have helped to increase access to counseling and testing and thus access to care and treatment.



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Promising Practices

- Integration of services leads to better quality of care for PLHIV.
- Using a holistic palliative care model and a multi-disciplinary approach, clients are returning to life and productive living, making a positive difference on the impact of HIV to communities. This holistic model can take place in any setting: rural or urban, HBC or facility setting.

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Case Study: St. Luke’s Mission Hospice at Mpanshya, Zambia

St Luke’s Mission Hospital and hospice is located in remote Mpanshya, Chongwe District, 200 km east of Lusaka, Zambia. Mpanshya has a catchment area with a total population of 190,000. It has developed into a centre for holistic integrated health care that provides seamless integration of CT, PMTCT, ART and palliative care service delivery through its in-patient hospice and community home-based care.

The area is quite hilly with little access or infrastructure, and many villages are located in the hills. It is not connected to the national electricity grid and relies heavily on alternative energy sources. Fifty percent (50%) of the population live in abject poverty³ and engage in subsistence farming. Despite geographic and

³ Chongwe District statistics



CRS ZAMBIA STAFF

economic challenges, an integrated health delivery approach has been established. This approach builds on the central location of the mission hospital and hospice within Chongwe District, from which there is a network of 7 government Rural Health Centers and mobile clinics to four outstations run by the hospice. The members of this network have worked together to establish a multi-referral and care system which meets the complex and evolving needs of PLHIV. The care and referral system strategically takes advantage of community resources, such as community halls, churches, school rooms where services can be offered.

The hospice works closely with the local parish HBC programs whose caregivers have been trained by CRS on basic nursing care, ART adherence support and palliative care. Some volunteers have also been trained in counseling so that they can participate in CT.

Community peer education through the HBC program promotes prevention through the training of youth and male caregivers. They are trained in basic palliative care so they can offer the holistic integrated care to clients in their communities

The hospice CT program offers counseling for couples, children, sexually transmitted infections and those on pre-ART. Those in need are referred to ART within the hospital. In the span of 4 years, the number of people counseled has jumped from 31 to over 709 per annum; a 22-fold increase. Integration with the PMTCT program takes place with referral for ART when indicated; 47 women and 9 children have commenced ART.

The government of the Republic of Zambia began free antiretroviral medication in 2004. Scale-up took place in 2006; ART is currently being scaled up to reach another 100 people. The development of the hospice's ART Mobile Clinic has allowed the program to expand rapidly. Weekly the program serves one of four locations to provide follow-up to existing clients and assess new clients to begin ART. The Mobile Clinic has greatly helped barriers to HIV testing as people are more willing to go to their local community facility rather than travel the long distances to the hospital. In this era of ART, the hospice has had to change from end-of-life care to a more holistic model that caters for PLHIV needs as they begin to have a better quality of life and in many cases return to productive life. This has meant new challenges for the hospice, with more psychosocial support being required.

Positive Living Groups (PLG), integrate their services with clinical services in 5 outstations, giving information on available HIV services. A nutrition center at the hospice provides important education on positive living and nutrition rehabilitation for PLHIV and children living with HIV. Ready to Use Therapeutic Food, High Energy Protein Supplement (HEPS) and general food supplements are provided along with cooking demonstrations. This service has been extended to the community during the mobile clinic to outstations, where locally trained PLHIV give the nutrition education sessions and cooking demonstrations.

Pastoral care is a major component of the services offered to both in-patients at the hospice and those on the HBC program. The program cares for 200 OVC from the ages of 1-18, referring them when necessary for CT and ART.

The linking of community HBC, CT, PMTCT, and ART as well as with PLGs has helped in achieving this integrated holistic palliative care approach.

Part II: Treatment



DAVID SNYDER/CRS

ZAMBIA

AIDSRelief Zambia

Introduction

AIDSRelief¹ Zambia is a five-year program to support hospitals in scaling up of antiretroviral therapy (ART) in Zambia and is funded through the US Government's President's Emergency Plan for AIDS Relief (PEPFAR) funding. The overall goal of the program is to assure that people living with HIV (PLHIV) have access to ART and high quality medical care. AIDSRelief Zambia has targeted more than 21,000 patients to receive ART free of charge from March 2004 through February 2009. The provision of ART is part of a package of services that AIDSRelief Zambia supports including: community mobilization, links to home-based care (HBC), counseling and testing (CT), prevention of mother to child transmission (PMTCT) and capacity building.

¹ AIDSRelief is a 5-member consortium providing anti-retroviral therapy (ART), HIV care and wraparound services to underserved populations in 9 countries in Africa, Latin America and the Caribbean, through the support of PEPFAR. The consortium is led by Catholic Relief Services (CRS) and also includes the University of Maryland Institute of Human Virology, Constella Futures, Catholic Medical Mission Board and Interchurch Medical Assistance.

COUNTRY	ZAMBIA
Type of Project	ART, pediatric palliative care, HBC
Integration Aspects	Nutrition, adherence, CT, PMTCT, HBC
Number of Beneficiaries	12,841 patients on ART and 29,661 in care
Beneficiary Type	PLHIV and children living with HIV
Source of Funding	PEPFAR
Duration of Project	March 2004 – September 2009
Promising Practice Highlighted	<ul style="list-style-type: none"> • Involvement of local government (especially relevant ministries) in the needs assessment and program implementation stages. • Thorough pre-assessments and site activation procedures help in the rapid scale up of the ART program. • Ongoing provision of technical services ensures a faster learning curve and provides encouragement as well as disaggregated patient data. • Development of both paper and computer-based records systems ensures access to patient history to facilitate better clinical and treatment decision-making.

Problem Statement and Context

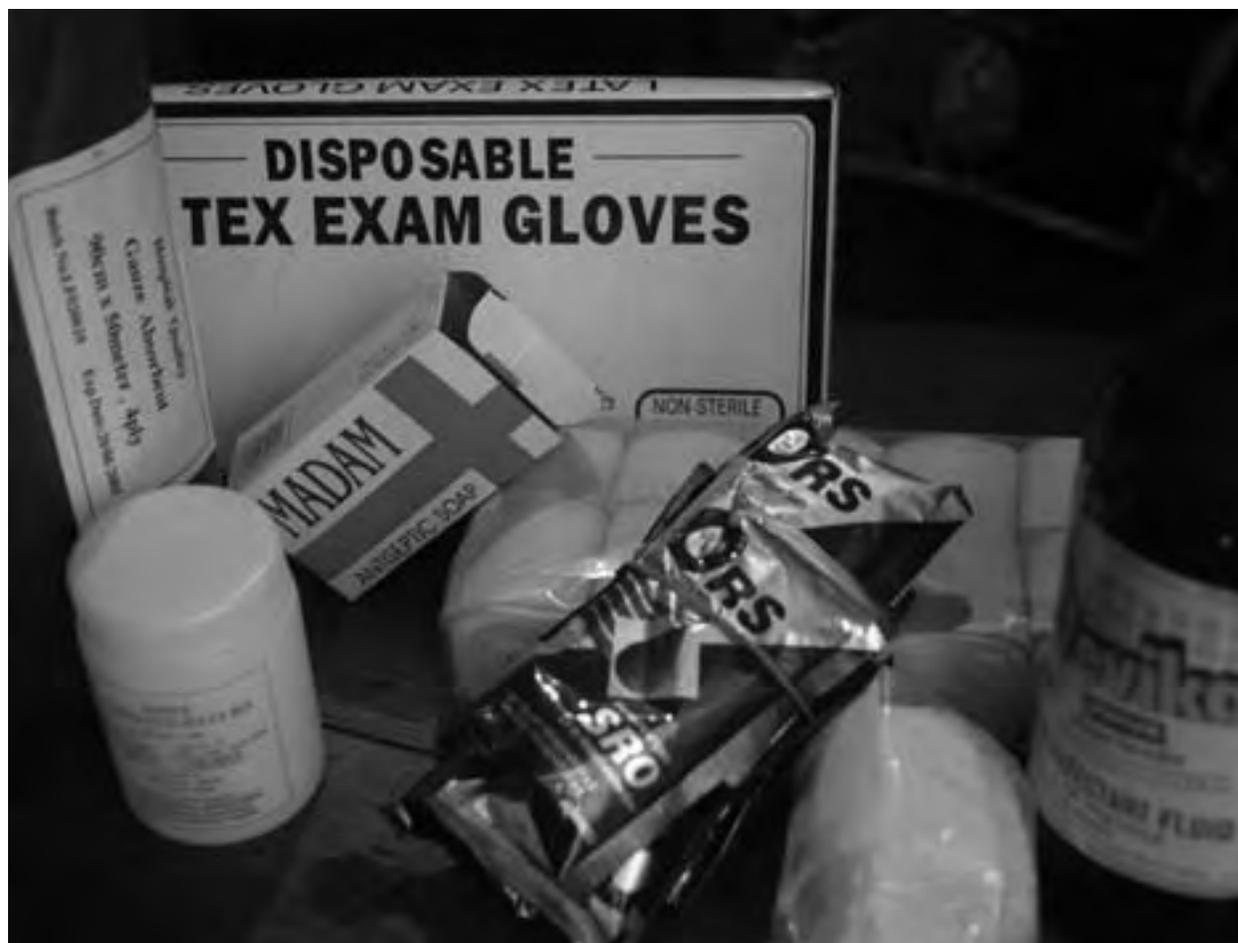
UNAIDS estimates there are 1.1 million people living with HIV in Zambia. UNAIDS estimates HIV prevalence among adults aged 15 – 49 at 17%.² Though the access to ART has increased in Zambia, in some areas access continues to remain limited. In part because of this, Zambia continues to lose productive members of society to AIDS. The AIDSRelief Zambia project is implemented to support the Government of Zambia's Scale up Plan for ART and to provide capacity building to the hospitals and health facilities to manage ART services.

AIDSRelief Zambia works with the Churches Health Association of Zambia (CHAZ), a national ecumenical body to ensure the sustainability of the program. Efforts have been made to house AIDSRelief staff at CHAZ and to have joint involvement at site level. The objective of having staff at CHAZ is to transfer appropriate technical and management skills to ensure a smooth transition from AIDSRelief to CHAZ managed sites. AIDSRelief efforts are conducted in accordance with national plans, protocols, guidelines and policies of the countries in which it operates. AIDSRelief also collaborates with other public and private sector programs where appropriate. In addition to these guiding principles, AIDSRelief promotes and supports a holistic package of services to ensure a continuum of care for every client.

Purpose of the Project

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

² UNAIDS (2006). UNAIDS Country Profile. Retrieved July 19, 2007 from the world wide web: www.unaids.org/en/Regions_Countries/Countries/zambia.asp



The first two strategic objectives target *existing ART service providers to rapidly scale up delivery of quality ART and to build capacity of smaller sites with limited or no experience with provision of ARVs to initiate ART services.*

Strategic Objective 3: *Community level services providing quality ART to low income HIV infected persons are expanded.*

Strategic Objective 4: *Health care treatment networks are created and strengthened to support capacity building within their countries and communities.*

Crosscutting IR: *Community mobilization promotes an increased awareness of accessible and affordable programs and reduces stigma.*

Steps in Implementation

The major steps in the implementation of the AIDSRelief Zambia project include the following: initial meetings with the Zambian Central Board of Health and CHAZ to identify potential Local Partner Treatment Facilities (LPTF), pre-assessments of potential sites to determine ART readiness or current levels of ART-related services, site activations that involved assessment tools to identify potential gaps and challenges, as well as orientation and guidance to LPTF on budgeting and developing work plans. Implementation also included signing of sub-recipient agreements, technical training that incorporated

national ART guidelines as well as the latest treatment options available in developed countries, and the development of both paper- and computer-based medical records systems that allow for aggregated and disaggregated analysis of patient data, as well as frequent provision of quarterly technical assistance and monitoring visits.

Integration

CRS Zambia receives PEPFAR funding for several program areas and is making every attempt to create synergy between the programs, as well as identify areas of collaboration with other organizations. Internally, CRS has established programming meetings for the HBC, OVC, and food security and livelihoods programs to discuss opportunities for synergistic interaction and to identify potential areas of improved integration. In addition AIDSRelief has teamed up with the SUCCESS³ HBC program to provide Ready to Use Therapeutic Food (RUTF) to three AIDSRelief partners. Other areas of linkages include adherence training and pediatric palliative care with CRS RAPIDS⁴ program and other international organizations based in Zambia.

Positive Outcomes and Impacts

The project has a number of positive impacts. The initial positive impact is a result of the intensive site activation process. Positive outcomes and impacts include:

- Partner hospitals were fully involved in the development of work plans that identify ways to address gaps and overcome challenges in order to rapidly scale up or in some cases establish ART services.
- The site activation process allows both the hospital and the consortium members to continuously monitor progress and to focus technical assistance on specific need-based areas.
- The site activation process helps identify and form the basis of all the initial technical trainings that are provided and guide the actual provision of on-site clinical mentoring and other technical assistance for further “on the job training.”
- Patients’ response to treatment has been encouraging. Targeted evaluation shows a high level of sustained viral suppression. Quality Assurance/Quality Improvement (QA/QI) helps LPTF staff engage in continuous improvement of service delivery.
- Preliminary Life Table Analysis shows a cumulative retention rate over 85% since the beginning of the program.

Lessons Learned

- The relationship of local partners in the development and implementation of the sustainability plan needs to be strong or sustainability of the project cannot be ensured.
- Lack of funding flexibility within both AIDSRelief and PEPFAR requires the integration of other projects such as HBC and food security to strengthen the project.
- LPTFs need assistance in creating linkages between existing HIV related services, such as CT and PMTCT, to the new ART services. This ensures a continuum of care for the clients and good information sharing within the facility.

3 The Scaling Up Community Care to Enhance Social Safety-nets (SUCCESS) Project scaled up the provision of quality palliative care and support to PLHIV through the provision of services such as home based care (HBC), community-based counseling and testing, prevention of mother to child transmission targeted nutritional interventions, referral to ART for adults and children, and adherence support.

4 The Reaching HIV and AIDS Affected People with Integrated Support (RAPIDS) program provides home-based care and support using both short and long term strategies. The program employs a unique household approach, which is the hallmark of the RAPIDS consortium service delivery.



- Patients initiating ART need both group counseling as well as ongoing individual counseling to identify potential barriers to treatment adherence.
- Provision of nutritional support that includes High Energy Protein Supplements (HEPS) and/or Ready to use Therapeutic Food (RUTF) supplements has a positive impact on patient treatment adherence.
- Drug management supply chain systems need to be well developed and frequently reviewed to ensure a consistent supply of ARVs.
- Along with treating mothers in the PMTCT plus program, it is important to treat other family members who may be infected, including children and partners. AIDSRelief Zambia calls this a “family approach” to treatment.
- Site mentoring and coaching from highly qualified HIV and AIDS physicians has a tremendous impact in increasing LPTF clinicians’ capacity and confidence.
- Involvement of traditional leaders and headmen in stigma reduction and adherence result in a high level of adherence to treatment in sites where this model is introduced.

Promising Practices

- Involvement of local government, especially relevant ministries, in the stages of needs assessment and program implementation.
- Thorough pre-assessments and site activation procedures help in the rapid scale up of the ART program.

- Ongoing provision of technical assistance through mentoring ensures a faster learning curve and provides encouragement; this hands on training leads to increased experience and capacity of clinical staff.
- The development of both paper- and computer-based record systems ensures access to aggregated data for analysis. Additionally, these systems allow for evidence-based care and treatment at clinical level treatment.

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CRS NIGERIA STAFF

NIGERIA

Scaling Up the Nigeria Faith-Based Response to HIV and AIDS: SUN OVC Project

Introduction to Project

The USAID/Nigeria-supported Scaling Up the Nigeria Faith-Based Response to HIV and AIDS (SUN) Project is a partnership with the Catholic Secretariat of Nigeria (CSN) and 10 Catholic Archdioceses in eight states spread across the North-Central and South-South geo-political zones of Nigeria. The Catholic Church in Nigeria has an extensive network of established structures such as schools, Parish Action Committees on AIDS (PACAs), Catholic health facilities, Catholic Youth Organizations, Catholic Women's Organizations, Orphanages, Catholic Men's Associations, as well as the Diocesan Education Office, HIV and AIDS Office and Justice, Development and Peace Commission. The SUN project capitalizes on the vast reach of the Catholic Church as well as Catholic healthcare and

education infrastructures to mainstream orphan and vulnerable children (OVC) care activities into already existing structures. It builds the capacity of the Church to mobilize, coordinate and monitor networks of community-based OVC care activities. In addition, this project helps Church partners develop effective referral systems, linking OVC children to financial assistance, health care, legal aid and housing.

This three-year initiative is designed to improve the quality of life of orphans and children made vulnerable by HIV and AIDS in Nigeria. The project is completely integrated into the current community-based care and support project and capitalizes on the unique opportunities afforded by the Catholic church to increase and strengthen the care provided to OVC or people living with HIV (PLHIV), who are the traditional beneficiaries of the community-based care and support project as well as the economic strengthening component of the Nigeria program.

COUNTRY	NIGERIA
Type of Project	OVC and their caregivers integration into community-based care and support
Integration Aspects	Service integration including education, livelihoods, life skills, healthcare Integration with local partners and services
Number of Beneficiaries	6000 OVC and their caregivers
Beneficiary Type	OVC
Source of Funding	USAID
Duration of Project	March 2006 – 2011
Promising Practice Highlighted	Beneficiaries choose services that meet their needs, strengthen community traditional justice system to redress protection of rights.

Problem Statement and Context

Traditionally, the extended family structure in Nigeria has provided an effective safety net for orphans in the past, but as the number of OVC increase, the extended family structure is becoming overburdened. Vulnerable children include those who must care for sick relatives, those discriminated against because of a relative’s HIV status, and children from a family with stretched resources due to caring for orphans. In many cases, grandparents care for their orphaned grandchildren, and sometimes older siblings care for younger siblings.

OVC and their caregivers often have increased psychosocial and economic needs such as food, education, health care and social support.

Nigeria has the largest population in Africa, about 150 million people, as well as a vast geographical area. It is a country with diverse cultural identities and a highly literate population. Moreover, it is

an emerging democracy with enormous resources. The main project activities target the “Middle Belt Region” of Nigeria, Edo State and Kaduna State. The average HIV prevalence for the six states located in the “Middle Belt” region is estimated at 7%, higher than the national average.¹ The “Middle Belt” region is considered a high-risk area for HIV transmission because of lateral migration and mining industries. Edo State, with an estimated HIV prevalence of 4.3%, is considered a high-risk area since it is a bordering state to an area of the country with high infection rates and where trafficking in women is pronounced. The President’s Emergency Plan for AIDS Relief (PEPFAR) estimates there are nearly 1 million children orphaned due to AIDS.²

Purpose of the Project

The SUN project goal is to *strengthen the Church’s capacity to provide quality comprehensive and compassionate care for OVC and their caregivers.*

Strategic Objective 1: *Improve capacity of communities, families, and orphans to respond effectively to the needs of OVC.*

- IR 1.1: Provide improved OVC access to education.
- IR 1.2: Provide improved OVC access to health care services.
- IR 1.3: Develop life skills training for decision making amongst youth, especially for OVC, to reduce HIV transmission.
- IR 1.4: Strengthen the economic capacity of caregivers through income generating activities.

Strategic Objective 2: *Strengthen capacity of CRS church partners to respond to HIV and AIDS in their communities.*

- IR 2.1: Provide management and technical training to senior church staff.
- IR 2.2: Provide ongoing financial support and oversight to the church in the management of sub-grants.
- IR 2.3: Provide access to training and a network of experts schooled in project design and implementation, monitoring, evaluation, and data analysis.
- IR 2.4: Train twenty community health workers in ten dioceses to provide care and support activities for OVC and their caregivers.

Steps in Implementation

The project is designed in a two-phase approach. During the first year, CRS Nigeria worked with five partners (CSN and four diocesan partners currently involved in OVC care and support activities) to implement OVC activities while building the capacity of the remaining five partners to be included in year two.

Core steps to implementation include an introductory/start-up workshop for collaborating partners. This allows partners to review the implementation process and take ownership of expected outcomes. Another step is OVC pre-implementation assessment, providing the baseline for identification and registration of OVC households. The pre-assessment also helps to determine priority needs.

¹ 2003 HIV Sentinel Survey

² United States President’s Emergency Plan for AIDS Relief. 2006. The United States President’s Emergency Plan for AIDS Relief Country Profile: Nigeria. Retrieved July 18, 2007 from the world wide web: www.pepfar.gov/press/75924.htm.

Integration

The SUN project builds on current community-based care and support projects, while capitalizing on the unique opportunities afforded by the Catholic Church to increase and strengthen OVC care. CSN coordinates Catholic Church activities within Nigeria. The HIV and AIDS unit within CSN provides leadership and guidance for the Church's response to HIV and AIDS. Forty-nine dioceses across Nigeria receive support from the CSN primarily in the form of information dissemination and trainings, and the project is embedded within the existing communication channel between CSN and the dioceses. In addition, through the PMTCT amendment, CRS has provided administrative, financial, and technical support to CSN for the development of an HIV and AIDS unit in the Abuja CSN office for a better coordination of activities.

Positive Outcomes and Impacts

- Well-integrated in the care and support project.
- Provide support to children of PLHIV.
- Help reduce stigma.
- Encourage open discussion about HIV status.
- Prospect for sustenance of services provided to OVC.
- Ensure participation of all critical stakeholders especially the Government of Nigeria agencies.
- Develop OVC's skills in peer education.
- Promote succession planning and protection of child rights.
- Households are identified as point of intervention.
- More OVC are registered and retained in school.
- Economic strengthening activities have created alternative means of livelihood for OVC and caregivers.

Lessons Learned

- In OVC rights protection, emphasizing community justice system is far more beneficial to OVC and caregivers than the formal legal process of seeking and redress of protection of rights.
- Ensuring that the household is the intervention point, as opposed to orphanage and child and OVC care institutions, increases self-esteem of beneficiaries, reduces stigma and promotes community ownership.

Promising Practices

- Economic strengthening activities to enhance current support provided to OVC.
- Peer education skills training for OVC.
- Community participation and capacity building.
- Service delivery at the household level.
- Involvement of community volunteers belonging to the Catholic Church network.
- Involvement of OVC in the choice of activities that address their needs.

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DAVID SNYDER/CRS

UGANDA

Comboni Samaritan of Gulu (Community Resilience and Dialogue program and AIDSRelief program)

Introduction to Project

Comboni Samaritan of Gulu is a faith-based organization (FBO) founded in 1992. In 2003, Comboni sought and received funding from international donor organizations for projects dealing with home-based care (HBC); prevention of mother to child transmission (PMTCT); antiretroviral (ARV) adherence; abstinence-based youth (ABY); and orphans and vulnerable children (OVC). Comboni receives funding

from CRS and the President’s Emergency Plan for AIDS Relief through the AIDSRelief project. Comboni uses a holistic approach to support their beneficiaries, integrating services to address their various needs. Realizing that it may not be possible to meet all the demands of beneficiaries, Comboni focuses on supporting people living with HIV (PLHIV) by meeting basic needs.

COUNTRY	UGANDA
Type of Project	Integrated ART, OVC Program
Integration Aspects	Microfinance, OVC, PSS, capacity building technical assistance, ABY, HBC, PMTCT, ART
Number of Beneficiaries	5,500 registered PLHIV, 1,450 on ART
Beneficiary Type	PLHIV
Source of Funding	CRS, USAID, AIDSRelief
Duration of Project	PMT 2005- Sept 2007, ART 2004 – Sept 2009
Promising Practice Highlighted	Holistic, multi-faceted to HIV prevention, care, and treatment.

Problem Statement and Context

Comboni began as its founders became aware of the increasing prevalence of HIV. Early on, Comboni, recognizing the dynamic nature of HIV infection, adopted a holistic, multi-faceted approach to HIV prevention, care, and treatment. This approach was based on the institutional values of respect for human dignity, and sexuality, honesty, love, care, respect, trust, and dedication.

Northern Uganda is a post-conflict area with high insecurity and large groups living in internally displaced person (IDP) camps. In 2007, the people in the IDP camps were asked to resettle and return to their homes. The strength of Comboni is the organization’s motivation and connections with Lacor Hospital, one of the best known and prestigious private not for profit hospitals of the Uganda Catholic Medical Bureau based in Gulu. Lacor Hospital is famous for handling difficult situations including war, AIDS, and Ebola. Lacor lost several staff, including 2 high caliber doctors, due to work-acquired HIV and Ebola. Comboni’s holistic, multi-faceted approach is unique. Comboni staff not only get technical trainings but also spiritual trainings and trainings on the ways to treat patients as Good Samaritans would. This increases individual initiation to view the patient issues holistically including family, income, children, etc.



CRS UGANDA STAFF

1 AIDSRelief is a 5-member consortium providing anti-retroviral therapy (ART), HIV care and wraparound services to underserved populations in 9 countries in Africa, Latin America and the Caribbean, through the support of PEPFAR. The consortium is led by Catholic Relief Services (CRS) and also includes the University of Maryland School of Medicine Institute of Human Virology, Constella Futures, Catholic Medical Mission Board and Interchurch Medical Assistance.

Purpose of the Project

The project aimed to combine the similar work being done under CRS Comboni and AIDSRelief to accomplish similar objectives within the Gulu District. The purpose of the project was to improve the health and wellbeing of PLHIV by ensuring access and adherence to ART. In addition, the project aimed to increase general services to PLHIV, while ultimately strengthening local partner capacity within Comboni.



CRS UGANDA STAFF

The CRS project goal is *to improve the health and well-being of 400 PLHIV and strengthen their capacity to become self-reliant in the Gulu District.*

Strategic Objective 1: *To improve access to medical care and treatment to 400 PLHIV in Gulu District.*

Strategic Objective 2: *To provide HBC services to 400 PLHIV in Gulu district.*

Strategic Objective 3: *To enable 100 PLHIV to acquire knowledge and better access to a balance diet during a six months period.*

The ART Project Goal is *to improve adherence to antiretroviral therapy (ART) in Gulu District.*

Strategic Objective 1: *To prolong the life of 1,500 clients through training of caregivers and the provision of Care and Treatment with ARVs.*

Strategic Objective 2: *Equip HIV clients, caregivers, community leaders, counselors and staff with skills and knowledge of implementing adherence plan through capacity building.*

Strategic Objective 3: *To develop a positive attitude in the community toward ARV and clients undergoing the treatment through community sensitization.*

Strategic Objective 4: *To ensure that the 1500 clients on treatment stick to adherence plan through daily monitoring of clients.*

Integration

Comboni has been successful in addressing unique challenges into its programming. Comboni utilizes its HBC program to assist in the identification and enrollment of possible recipients of ART through AIDSRelief project. To prevent in-utero transmission, Comboni identifies pregnant women in order to be enrolled into PMTCT program. If eligible they will be put on treatment. As patients on ART improve, Comboni trains them in vegetable gardening, revolving funds and other projects to improve the likelihood of individual success and longevity.

Given the political instability of the region, Comboni has provided services to people in the IDP camps. Comboni has provided outreaches and services to youth, OVC, and PLHIV in IDP camps.

Lessons Learned

- A small community-based organization (CBO) potentially could become a great implementer if capacity is built, meaning the organization has created policies, been trained and is competent in financial management, has the technical capacity to implement strong programs (for example, it

can provide training and guide caregivers associated with the project), etc.

- For a CBO to be accountable there is need of stewardship and this comes from the spiritual education that the Comboni Samaritans are given and by whom guides them.
- The work of a CBO is not just implementing a project but about the humanity and solidarity that can be transmitted. This can be done only if staff are continually reminded of the roots of their work
- The growth of a CBO should be gradual in order to be sustainable and to not lose the heart of the original mission of the organization.
- Once a CBO reaches the level of Comboni, it can advocate by showing its documented results, which contributes to sustainability.



Positive Outcomes and Impacts

- Expand program service area from a local municipality to two administrative districts, Gulu and Amuru.
- Monitor beneficiary ART adherence through visits by 180 community volunteers.
- Develop the memory genealogical tree project, which collects family history information, providing training to encourage PLHIV to document their family history for posterity.
- Make hard copies of files, each with photos to give to children whose parents died when they were still young as part of the memory work, a project to provide orphans with documents as memories of their parents.
- Assist in making wills through the advice of lawyers. (Currently, when a man dies, his family can take away everything from the widow and children; wills can protect the family after death.)
- Provide data management for beneficiaries through a software program used by the AIDSRelief consortium.
- Provide skills training, career guidance, talent identification, sponsorship, PSS and counseling to 1,500 OVC.
- Provide university sponsorship to 28 OVC.
- Provide youth development programming including: promote human growth, provide spiritual guidance in moral values, develop decision making skills and trust in God.
- Integrate microfinance theories, demonstrated by the establishment of “Wawoto Kacel;” Cooperative Society Ltd, a cooperative saving society in which HIV beneficiaries develop creativity and self-reliance skills by practicing crafts such as basket weaving, tailoring, card making, bead weaving, cowry shells and broidery. Comboni solicits locations to market the products. The cooperative has linkages with other cooperatives or benefactors in Italy that would sell the products. They entered now into the network of EQUO-SOLIDALE and can export worldwide.
- Organize annual drama and sports competition events, themed “Kick HIV out of Gulu” guided by the motto “Choose, Treasure, and Celebrate Life.”

- Provide free treatment to 255 mothers under PMTCT. A recent evaluation revealed 95% of infants born in Lacor Hospital to be HIV negative.
- Provide free medical treatment and support services to 1450 ARV beneficiaries, including transportation, meals, medication, fees, burial arrangements, and housing repairs.
- A recent study demonstrated an average 87% viral suppression in patients followed up for adherence.²

Promising Practices

- A policy on staff rotation throughout various departments (including M&E, financial management, proposal writing and data management) to enhance skill development while minimizing inability to address beneficiary needs. This holistic approach emphasizes multi-tasking and helps meet organizational goals.
- Institution of an open door policy so that beneficiaries can freely contact anyone in the organization.
- Extensive training on the goals, objectives and moral imperatives for staff will increase dedication and program accountability. The moral imperatives stress caring for others and positive stewardship.

Contact		
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Beneficiary Story

Margaret, 42 years old, is a mother of 2 children in secondary school.

“In mid 1987, my husband started having frequent sicknesses with chest pains and a constant cough. The sickness increased and the doctors told the family members that my husband had “slim” (HIV). It was not easy for us as most of the family relatives left and never came back again to see us in the hospital until he met his death 1992.

I started having a lot of body pains and frequent malaria in 1998. My mother and brother asked me to go to Lacor hospital and test my blood for the “slim” disease. It took me another five months just to decide and go for the test. A friend came to my house the following day and asked me about the public gossip going out in the neighborhood about that I had HIV. Then she encouraged me to be strong in such situations, but also told me about World Vision helping people with the disease. She asked me to go there and test my blood so that if I have it I could be helped.

² AIDSRelief Quality Assurance Study.

I didn't know that my neighbor was also HIV positive until 2000, when she came to my house and asked me what people were saying about me. She told me about Comboni Samaritan where she gets assistance. She said she was ready to take me to their office so long as I was ready to go and meet the staff. The following week I asked her to take me to the Comboni Samaritan office. They welcomed us and talked to me as a friend and a sister. They filled out my forms, took my photograph to be attached to my file and wrote the names of all my biological children and those I stay with in the same house.

The staff of Comboni Samaritan started visiting me at home at least thrice a week and would even invite me for seminars on HIV or spirituality events. They are always by my side when I need them. They paid for my medical bills at Lacor hospital whenever I went there for medical treatment.

After gaining strength I worked as a volunteer, but became ill. I went for another CD4 count test in 2005; it was only 220. I was told to be put on drugs, but I was afraid at first because people used to say that these drugs kill. I saw that I was getting weaker and went for the pretreatment classes. I asked my mother to come but she refused so I called my sister who became my treatment companion (caretaker). The first two weeks of taking the drugs weren't easy as the side effects made me sicker, but I later gained strength and found that I was even more powerful in doing my normal work at home.

I was among those also identified for Agricultural production training in 2005. After the training we were provided with seeds, tools, pesticides and insecticides. We had constant field monitoring by staff until harvest time. I was able to sell part of my harvest. It was really good as I was able to use part of the money to buy other things of my own, like cloth, scholastic materials for my children, and also feeding them a balanced diet. I really thank Comboni Samaritan so much because they were able to pay school fees for one of my sons under the education department.

When my sister, who is my caretaker, was pregnant she was tested and also found to be HIV positive. She couldn't accept that she was positive and even wanted to poison herself, but I only asked her one question: 'How long have I lived with the virus?' At least she was aware and this virus does not kill in one day; let alone she may deliver a baby who can be HIV negative given that she was also advised on what services are available when a pregnant woman is found positive.

I encouraged her and even stated that I was ready to help her in anyway so that she gets the service necessary. So she went to Comboni Samaritan and was registered in the program where she was given items like flask, saucepans, cups, spoons, jugs and Nan (infant formula). She received nevirapine tablet before delivery, would attend their mothers' monthly meetings and would be visited by the staff (home visits and follow ups). When her baby was tested at five months and found HIV negative both she and her husband were just too happy even though they are both positive. They say there's a need to be happy as their child is negative. All their appreciation goes to the staff of Comboni Samaritan and Lacor hospital for doing all their best to have their baby be negative.



RICK D'ELIA/CRS

UGANDA

Increasing HIV and AIDS Services in Rural Communities through Satellite Health Posts

Introduction to Project

Villa Maria is a faith-based organization that provides integrated home-based care (HBC) and antiretroviral therapy (ART). Attached to a hospital founded by the Catholic Church, Villa Maria started providing HIV and AIDS services in 1989 with support from CRS private funds. In July 2005 Villa Maria began providing free antiretroviral (ARV) from AIDSRelief.¹ The HBC project has an overarching goal of “reducing the resultant suffering among the HIV affected and infected population in the project area through mitigation of HIV and AIDS effects and reduction of HIV spread.” The project has successfully

¹ AIDSRelief is a 5-member consortium funded by PEPFAR providing HIV care, treatment and support to underserved populations in 9 countries in Africa, Latin America and the Caribbean. The consortium is led by Catholic Relief Services (CRS) and also includes the University of Maryland School of Medicine Institute of Human Virology, Constella Futures, Catholic Medical Mission Board and IMA World Health.

used collaboration and linkages with lower level satellite health units closer to clients' homes to attain high levels of adherence to opportunistic infection (OI) medication and ARV, and to collect blood samples for analysis. Villa Maria has achieved 93% adherence to ARV.

Services are offered through a partnership between the government and private not-for-profit health units in the catchment area. The program collaborates with 8 satellite health units to deliver a comprehensive package of services to geographically dispersed clients within 6 sub-counties.

COUNTRY	UGANDA
Type of Project	HBC, ART
Integration Aspects	CT, HIV/TB, OVC project, Basic Care Preventive package (LLITNs, safe water)
Number of Beneficiaries	3332 HIV clients, 927 on ART, 1605 OVC, 420 community leaders
Beneficiary Type	PLHIV, OVC, caregivers, individuals at risk for HIV, satellite health workers trained, and community.
Source of Funding	CRS private funds, AIDSRelief, Population Services International (PSI), Better Way Foundation
Duration of Project	July 2004-June 2007; for ART July 2005-February 2009.
Promising Practice Highlighted	Collaborating with satellite health units at ARV distributing centers to enhance adherence

Problem Statement and Context

The Villa Maria program catchment area has a weakened socio-economic support structure for families due to the HIV pandemic, making the indigent HIV infected and affected population vulnerable to its adverse effects, depriving them of the ability to attain a good quality of life and healthy living.

Villa Maria is located in Masaka district, the epicenter of the early HIV eruption, and serves a rural population characterized by high levels of poverty, low literacy levels, high HIV prevalence (9-13%), poor road infrastructure, poor government service delivery riddled with corruption, and ill-equipped health institutions.

Purpose of the Project

To achieve the overall goal, the project has the following strategic objectives:

Strategic Objective 1: *To provide medical care and counseling and testing services to 4,500 PLHIV and their families by June 2007.*

- I.R. 1.1: Individuals utilize services from the program.
- I.R. 1.2: Individuals make informed decisions about their lives.

Strategic Objective 2: *To provide educational support to 1,100 children orphaned by AIDS by June 2007.*

- I.R. 2.1: 250 OVC acquire marketable skills.
- I.R. 2.2: Improve psychosocial health of OVC.
- I.R. 2.3: Supported OVC have completed primary education.
- I.R. 2.4: Community members actively participate in OVC welfare.

Strategic Objective 3: *To increase community capacity to manage, provide care, and give support to PLHIV and families affected by HIV by 2007.*

- I.R. 3.1: Increase participation of community members in AIDS care and support activities.
- I.R. 3.2: Family and community members exhibit improved coping methods of dealing with PLHIV.

Strategic Objective 4: *To improve effectiveness and efficiency of Villa Maria AIDS program in implementing the HIV and AIDS program.*

- I.R. 4.1: Efficient management information systems (MIS) in place.
- I.R. 4.2: Improve tracking of pharmaceutical supplies at centre and satellite health units.
- I.R. 4.3: Staff improve skills in ART, PMTCT, and all components of HIV and AIDS care.

Steps in Implementation

Counseling and testing (CT) is carried out regularly at the facility level and outreach sites. Clients who test positive for HIV are registered and linked to satellite health units for OI management. A few communities have post-test clubs to support those who have undergone an HIV test.

The satellite health units provide clients with:

- ARVs and medical supplies for OI treatment.
- Referrals to the main clinic for inpatient care and complicated tests like chest X-rays and lumbar punctures. The program offsets 50-80% of inpatient hospital charges depending on critical analysis of the patient's ability to pay.
- Community health workers visit clients, report back to the satellite health unit of very sick clients, and accompany the medical team to the affected families.
- Visits to bedridden clients by the hospital-based mobile medical teams that circulate to all satellite health units regularly on a bi-weekly basis.
- Collection and transport of blood samples for targeted evaluation through viral load monitoring.
- Ongoing counseling, health education, hygiene, infection control, safe water, and malaria prevention are offered to clients and families.
- In addition, community health workers help to select and supervise orphans and vulnerable children (OVC) and oversee the distribution and supervision of safe water vessels and mosquito nets.
- The hospital supplies ARVs for stabilized patients to the satellite health units. It also provides initial adherence counseling and training for community health workers and "peer and expert patients" for ongoing adherence counseling and monitoring.

Integration

The Villa Maria program offers a wide range of health services including HIV prevention education, medical treatment, counseling and testing (CT), community mobilization and sensitization to HIV,

psychosocial support for clients, malaria prevention, and support to OVC through education, life skills, and positive parenting training for parents and guardians.

Medical care is funded by CRS, orphan support comes from Better Way Foundation, and PSI Uganda supports clean water activities and malaria control. These initiatives are interlinked to create impact in the lives of affected persons.

Positive Outcomes and Impacts

- 3332 PLHIV are in care, 2348 actively access OI treatment, and nearly 1000² receive ART.
- Increased access to ART-related services from within the communities: laboratory, counseling, adherence, OI treatment, and patient education.
- Accessing medical care for OIs and ART is cheaper for clients: average distance traveled has been reduced from 65km to 6km.
- Adherence for ART and OI prophylaxis was boosted from 83% to 97-100%.
- The focal clinic (Villa Maria Hospital main clinic) has doubled efforts to monitor field activities.
- Loss to follow up has reduced from 36.4% to 0.7%. Operating a satellite model of ART care delivery has led to better client retention and positive treatment outcomes.
- Improved adherence has led to tremendous improvement in client health, stimulating demand for CT, and reducing stigma.
- Clients on treatment now actively participate in program activities with vigor.
- The clients on ART have become productive and sound, thus improving integration in other multidimensional interventions.
- Because of positive visible impact of the packaged interventions, community attitudes towards HIV infected and affected have improved. Those who earlier refused to seek help are now openly accessing services offered by the program.

Lessons Learned

- Collaboration with satellite health units enhances timely treatment for clients, builds staff capacity, promotes referrals and linkages, and increases community trust in health units, especially government-run health units.
- A positive results-oriented ART program with visible outcomes can contribute to stigma reduction and increase demand for CT in communities with prevalent fear, stigma and discrimination.
- Peer and expert clients are strong communicators. They can influence behavior and are better believed than non-infected volunteers.
- Involvement of community health workers, PLHIV, OVC, and community leaders, coupled with partnership of local service providers within the locality, enhances transparency, maximizes synergies and ownership of the project.
- Signing agreements with artisan trainers, guardians, and orphans and involving community volunteers in monitoring orphans enhances regular attendance of the trainees and reduces school dropouts.
- Empowerment of OVC with practical vocational and apprenticeship skills improves livelihood and reduces vulnerability.

² As of September 30, 2007.

Promising Practices

- Creating collaborative functional relationships with existing health institutions reduces the distance clients move and thus ensures timely access to medical care, limits loss to follow up, and positively influences adherence.
- Use of client cards and registers that can track a patient for four years with coded services accessed optimizes monitoring and evaluation and can reduce client double dipping.
- Access to CT can be increased through outreach. The drawing of blood samples at satellite health units, transporting, and analyzing them in laboratories is feasible and cheaper than asking poor clients to travel miles for the same investigations.
- Using community health workers, peer educators, children and expert clients in reminding others to take their medications and monitoring them has a positive impact on adherence. Regular support supervision and capacity building for lower level satellite health unit staff reinforces quality of services for clients and enhances intra-institutional referrals.
- Integration of interventions maximizes clients' benefits and satisfaction.

Apprenticeships and vocational training for OVC are cost effective and make trainees self-reliant in a shorter period of time, especially if start-up tools are provided at the end of training.

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Beneficiary Story: Ssenyonga

Ssenyonga A., a 16-year-old orphan, lost his parents in 1997 to an AIDS-like illness. He was devastated by the loss. Following his parent's death, an aunt who lives in a trading center within the Villa Maria catchment area raised him. He irregularly attended a nearby government primary school, due to frequent illness and skin infection. He was a laughingstock and bullied at school by peers. In 2003, he attended Villa Maria hospital for treatment for illness; he was counseled and tested for HIV. Ssenyonga was HIV positive.

Encouraged by the staff of Villa Maria program, he accessed free medical care for opportunistic infections from the Butenga Health unit, one of



CRS UGANDA STAFF

the satellites collaborating with Villa Maria. As his condition continued to deteriorate, he was referred to Uganda Cares, a government unit 25km away for ARVs. Support for transport costs was borne by the Villa Maria program for seven months until Villa Maria started offering ARVs in July 2005.

As his condition improved on ART, Ssenyonga was enrolled in apprenticeship training at a local tailor near his home to train with other OVC trainees. Within one and a half years, he graduated. He was given a sewing machine by Villa Maria. He now earns between 30-60 USD per month³, a good income for a young Ugandan, which has improved his livelihood. He actively participates in community mobilization to CT, especially his peers, and adherence to ARVs. He is a strong advocate of PMTCT, encouraging pregnant mothers to take an HIV test to protect their unborn babies.

After realizing there are more orphans in a similar situation, Ssenyonga volunteered to impart the tailoring skills he learned to another identified by Villa Maria who, like him, is also HIV positive and on ART.

³ Human Development Report 2006 : Beyond scarcity: Power, poverty and the global water crisis. Estimates Ugandan GDP per capita at 1457USD. As accessed July 19, 2007 from hdr.undp.org/statistics/data/cty/cty_f_UGA.html.

Part III: Food Security and Livelihoods



DAVID SNYDER/CRS

ETHIOPIA

Productive Safety Net Program

Introduction to Project

CRS and the Ethiopian Catholic Church Social and Development Coordinating Office of Harar (ECC-SDCOH) have worked together since 1987. In 2005, they began the implementation of the Productive Safety Net Program (PSNP), a USAID Food for Peace (FFP) funded program designed to support the Government of Ethiopia's five year plan to reduce chronic food insecurity. The PSNP builds on previous Development Assistant Programs' (DAPs) overarching goal of enhanced food security of vulnerable populations. For the purposes of this publication, the activities of ECC-SDCOH are highlighted, but it should be noted that ECC-SDCOH is one of two partners working with CRS within the PSNP. ECC-SDCOH targets individuals engaged in public works programs and other strategic interventions designed to improve financial, physical, natural, human, social, and political assets and reduce vulnerability, especially to recurrent droughts. Food for work is provided to those who can work, while labor-constrained households identified by the community, such as those headed by the chronically ill, children or the elderly receive a safety net ration. Targeted communities are located in geographically contiguous communities within the same watershed

area, thereby increasing the impact of soil and water conservation activities. These activities in turn feed the water systems that are later installed within the communities. Critical project interventions include soil and water conservation, water and irrigation system construction, hygiene and sanitation interventions, agro-enterprise, seed and livelihood fairs. Though not a PSNP priority, ECC-SDCOH has developed creative ways to integrate HIV programming into its ongoing activities.

COUNTRY	ETHIOPIA
Type of Project	Food Security and Livelihoods
Integration Aspects	HIV and AIDS awareness and stigma reduction with food preservation, nutrition education, agro-enterprise, natural resource management, water, sanitation, hygiene and training of traditional birth attendants.
Number of Beneficiaries	144,004
Beneficiary Type	Rural chronically food insecure and vulnerable populations; vulnerable populations are those who depleted their assets due to recurrent drought and have low resilience to shock
Source of Funding	USAID/Food for Peace, CRS
Duration of Project	CRS portion 2005-2007 Government of Ethiopia 2005-2009
Promising Practices Highlighted	Building community assets, improving livelihoods, increasing opportunities to raise HIV awareness and stigma reduction using multiple channels of communication and interventions, which may decrease vulnerability to HIV and increase the ability of communities to mitigate the impacts of HIV. Increasing impact by directing multiple donor resources toward the same geographic areas to provide multiple complementary interventions.

Problem Statement and Context

Ethiopia is one of the poorest countries in the world. Eighty-percent of the population relies on agriculture for its livelihood, and a high proportion of Ethiopia's 81 million inhabitants experience chronic food insecurity. After a series of emergency food requests, donors, including USAID/FFP, came together to fund the Government of Ethiopia's (GFDRE) Productive Safety Net Program (PSNP) designed to reduce chronic food insecurity and improve livelihoods of Ethiopia's rural population in certain *woredas*, or districts. In addition Ethiopia has not escaped the ravages of the HIV pandemic. Nationally, an estimated 3.5% of the population between the ages of 15-49 is infected with HIV. While there are some signs that the Ethiopian epidemic is stabilizing, the difference in prevalence between the urban (10.5%) and rural areas (1.9%)¹ is of concern. This is especially troubling due to the background levels of chronic food insecurity and malnutrition that increase vulnerability to HIV infection and may hasten progression to AIDS and death. Only 57% of men and 35% of women know that limiting sex to one uninfected partner and the use of condoms can reduce the risk of getting HIV.² Stigma towards people living with HIV (PLHIV) is high,

1 Central Statistical Agency [Ethiopia] and ORC Macro. Ethiopia Demographic and Health Survey 2005. Addis Ababa, Ethiopia and Calverton, Maryland, USA: Central Statistical Agency and ORC Macro, 2006.

2 Ibid.



which serves as a deterrent for counseling, testing and accessing care and treatment services. To date, the majority of the HIV programs have focused on urban areas where prevalence is higher. ECC-SDCOH has recognized this gap and sought to build HIV awareness-raising and stigma reduction activities into the PSNP, essentially providing wraparound services by utilizing a variety of funding streams.

The ECC-SDCOH operating areas consist of four *woredas*, namely Keresa, Meta, Gorogutu, and Dire Dawa Zuria. The project area is mountainous and covers three agro-ecological zones – “*Dega*” (lowland), “*Woyenadega*” (midland), and “*Kolla*” (lowland). Many of the targeted communities live along a key trade and transportation route that runs from Dire Dawa to the port in Djibouti. The road and railways link high prevalence urban areas (8.5%) with the relatively low prevalence rural areas (0.9%)³ and has been identified as the “high risk corridor.” However, given the location of the project area, high levels of food insecurity, low knowledge levels about HIV and high levels of stigma towards PLHIV, ECC-SDCOH felt it imperative to identify ways to raise awareness, reduce risk of transmission, enhance community structures and livelihoods to enhance community resilience to the impact of HIV. This was accomplished even though the project’s strategic objectives and intermediate results did not specifically mention HIV.

Purpose of the Project

The project’s goal is to decrease the number of persistently poor requiring food or cash assistance to meet basic needs.

Strategic Objective 1: *Increased Government of Ethiopia (GFDRE) capacity at the regional, woreda and kebele⁴ levels to implement the PSNP in the four targeted woredas.*

- I.R. 1.1 : Increase GFDRE institutional capacity to implement PSNP activities.
- I.R. 1.2 : Increase GFDRE technical capacity to identify and support innovative solutions to chronic food insecurity.

³ Ibid.

Strategic Objective 2: *Strengthened and diversified livelihoods of 18,895 chronically food insecure households in the four targeted woredas.*

- I.R. 2.1 : Increase household financial assets through expanded agro-enterprise options.
- I.R. 2.2 : Increase household physical assets through seed and livelihood fairs.
- I.R. 2.3 : Rehabilitate communal natural assets through intensive natural resource management.
- I.R. 2.4: Strengthen physical and human assets through expanded application of multiple uses of water and sanitation approaches.

Steps in Implementation

The PSNP sponsored public works program has allowed communities to undertake a series of infrastructures projects including erosion control, reforestation, and water system construction. Ongoing community sensitization and organization around hygiene and sanitation has led to large scale community investment in basic latrines, mainly arborloos. Agro-enterprise interventions have allowed farmers to grow high value crops including nutritious vegetables.

Brief Description of the Arborloo:

The Arborloo is a very shallow pit that is designed to be, eventually, a home for a fruit tree. Designed by Peter Morgan of Zimbabwe especially for African conditions, the toilet is the simplest of all eco-toilets. The health and agricultural benefits are clear to the community, and the Arborloo is considered affordable and easy to replicate: it is easily constructed using locally available materials, the slab is light and easy to move (even for women), and does not need a deep pit, which is helpful in rocky conditions.

A pit about 80 cm deep and 60 cm in circumference is dug and dry leaves are added to the bottom. A simple concrete slab is placed over the opening. After each use, a cup of a soil/wood ash mixture is added to encourage soil composting (which kills fecal pathogens), to reduce smell and to discourage insect breeding. A very simple superstructure can be added for privacy. This toilet is used by a household for one year and then the slab is removed, the pit is topped up with good topsoil, and a fruit tree seedling or other crop plant is planted in the former pit. As the roots grow downward into the pit, the seedling takes up rich nutrients which result in a very healthy fruit tree that produces in abundance. It is very friendly and applicable for pastoral/ agro-pastoral communities.

In addition, since Arborloo toilets are shallow, there is less likelihood of ground water contamination or collapse during the rainy season. Because the pit contents are full of carbonaceous material (feces, ash and leaves), they act as a sponge. To date, there has been no report of Arborloo pits flooding and spilling their contents in the rainy seasons because the carbonaceous material absorbs water. Traditional pit latrines flood because the excreta material is hard and compact at the bottom and overly liquid near the top, creating ideal conditions for filling and then flooding with dangerous excreta. Thus the Arborloo is a safer toilet option for the protection of ground and surface water sources.

Complementary resources from other donors have been used by ECC-SDCOH in the same watersheds to improve dietary diversity by teaching communities to preserve harvested produce through drying and canning as well as the importance of good nutrition. Traditional birth attendants have been trained to link with health centers, increase HIV awareness, advocate for the reduction of harmful traditional practices that can increase HIV vulnerability, and use inexpensive simple delivery kits that eliminate the



reuse of materials and protect clients and trained traditional birth attendants during delivery. Additional activities that complement PSNP interventions include:

- Collaboration with local AIDS Clubs to raise awareness of HIV during large gathering such as public works days, seed fairs, and livelihood fairs primarily through the use of dramas.
- The use of “We Stop AIDS”, a SARAR-based methodology used with community groups and associations in the target areas. “We Stop AIDS” is based on adult learning principals and uses pictures and dialogue to help community members increase their understanding of HIV and AIDS, reduce stigma, and identify concrete actions they can take to address HIV in their communities.
- Promotion of improved wood burning stoves that conserve fuel, reduce burns, and decrease smoke inhalation.

Integration

ECC-SDCOH’s programming approach is holistic and multisectoral. By taking an integrated human development or livelihoods approach, communities are active participants in enhancing their lives through multiple interventions – this in turn can both reduce vulnerability to HIV and put communities in a better position to mitigate its impact. Sound natural resource management serves as a basis for improved soil quality and increased water quantity. Water systems have been installed increasing access to water for multiple purposes, including irrigation and drinking. Crop diversity has allowed

for the development of agro-enterprise. Nutrition education and food preservation techniques, such as blanching, drying and canning, have allowed families to utilize the unsold portion of their produce to increase dietary diversity.

Positive Outcomes and Impacts

The PSNP serves as a foundation not only for HIV awareness and stigma reduction, but interventions that improve the well-being of all community members, including those living with HIV. A mid-term evaluation of the PSNP was recently conducted, but the HIV component was not part of this evaluation and has thus far not been formally evaluated. Despite this, a number of very positive trends have been identified:

- Increased awareness of HIV and decreased stigma towards people affected and infected by HIV.
- Increased financial assets as a result of successful agro-enterprise interventions.
- Increased natural assets as a result of erosion control and conservation activities.
- Increased social assets through the formation of water management committees and agro-enterprise groups.
- Increased human assets through improved nutrition, increased access water, and reduction in harmful traditional practices.
- In Dodota *woreda*, they have worked to reduce the workload of women through the use of more efficient stoves, thus decreasing the amount of time spent collecting firewood (also decreasing risk of rape); stoves also reduce smoke inhalation and burns.





Lessons Learned

- The Integral Human Development (IHD) Conceptual Framework or a livelihoods approach can serve as a framework to build a holistic program, reduce vulnerability and enhance resilience.
- IHD requires collaborative work between multiple sectors – in this case a watershed- based approach was used as a basis to develop human, natural, social, and financial assets.
- Long-term relationship and ongoing dialogue with local government officials and communities engenders trust and willingness to try new things based on past positive experiences.
- Donor interests may not permit a stand-alone HIV strategic objective or intermediate result, which means that implementers must seek creative ways to integrate HIV activities into ongoing funded activities to reduce missed opportunities for increasing HIV awareness and reducing stigma.
- Implementing complementary activities unfunded by the principal donors in the same geographic area can, over time, produce a holistic program.
- Allocating sufficient resources for formal evaluation and documentation is needed to share promising practices and develop best practices in a timely manner.

Promising Practices

Building community assets, improving livelihoods and reducing missed opportunities for HIV awareness-raising and stigma reduction in rural areas of Ethiopia using multiple channels of communication.

- Increasing impact by directing multiple donor resources toward the same geographic areas to provide multiple complementary interventions.

- Reducing missed opportunities by integrating HIV awareness and stigma reduction into ongoing programs.
- The use of “We Stop AIDS” methodology.
- Targeting communities engaged in agro-enterprise with nutrition education and food preservation techniques such as blanching, drying, and production and canning of tomato paste. Processed foods may add value and produce another stream of income. This could be adapted to urban areas engaged in urban agriculture and associations of PLHIV.
- Watershed approach including erosion control structures, reforestation, and conservation can increase the availability of water for multiple uses. The installation of water systems with concomitant sanitation and hygiene interventions.

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SR. ANN DUGGAN/CRS

ZIMBABWE

Protecting Vulnerable Livelihoods Program: Integrating Interventions to Meet the Holistic Needs of HIV-affected Communities

Introduction to Project

Since 2004, CRS Zimbabwe's Protecting Vulnerable Livelihoods Program (PVLP) has worked to reduce the proportion of Zimbabweans who suffer from hunger and extreme poverty. In close partnership with four community-based organizations, PVLP supplies basic agricultural inputs, promotes innovative and appropriate agricultural strategies, strengthens community and household safety nets, improves access to community-managed water and sanitation, and mitigates the negative impact of HIV. PVLP is unique because it incorporates both relief programming (e.g., provision of agricultural inputs) with sustainable development interventions that address the root causes of vulnerability, such as gender inequalities and the high prevalence of HIV. This dual focus has led PVLP to create a "graduated package" of integrated

interventions that meet community needs. A “graduated package” means that households receive support from between one and six PVLP interventions, depending on whether they meet the community definition of “poor” and their level of vulnerability (presence of chronically ill, etc). For example, a poor household with a chronically ill member might take part in PVLP’s home-based care (HBC) program, acquire seeds and fertilizer, obtain small livestock, be provided with nearby sanitation facilities and receive training in conservation farming. The project is funded by the UK Department for International Development (DFID) through its Protracted Relief Program.

COUNTRY	ZIMBABWE
Type of Project	Agriculture/Livelihoods Security
Integration Aspects	Water, sanitation, relief and food security
Number of Beneficiaries	354,150
Beneficiary Type	OVC, PLHIV and their caregivers
Source of Funding	Department for International Development (DFID)
Duration of Project	Phase 1 September 2004 - July 2006 Phase 1 Extension August 2006 - July 2007 Phase 1 Transition August 2007 - March 2008
Promising Practice Highlighted	Graduated package of integrated interventions

Problem Statement and Context

The PVLP responds to increasing levels of food insecurity in Zimbabwe by helping community members preserve and acquire productive assets that will secure livelihoods and, ultimately, reduce poverty and vulnerability. PVLP responds to the need of community members to develop positive coping strategies that will carry their households and communities through illness, food insecurity, natural disasters and other difficult times. CRS Zimbabwe implemented this project to help communities deal with shocks – such as drought, inflation, and increasing numbers of orphans and vulnerable children (OVC) – in a community-driven, community-empowered way.

Zimbabwe is in a state of political, economic and humanitarian crisis, a situation compounded by an HIV prevalence of 15.6%.¹ The country has the world’s highest number of orphans per capita,² and the fastest shrinking economy outside of a war zone.³ Its inflation rate is also the world’s highest, 14,840%, according to October 2007 government figures.⁴ The cost of food and other basic necessities is increasingly out of reach for the average Zimbabwean. There are shortages of food staples, fertilizer, and spare parts, among other items, due to a lack of foreign currency to pay for imports and the impact of government-imposed price controls. More than two out of three Zimbabweans are not formally employed. On the humanitarian front, food insecurity across the country is increasing because of a severe shortage of

1 “ZIMBABWE: HIV rate falls again.” November 2, 2007. IRIN.

2 “UN: Zim has world’s highest orphan rate.” November 19, 2006. *Agence France-Presse*.

3 Raath, Jan. “A willful descent into poverty.” May 11, 2007. *The Times*.

4 Nyakazeya, Paul. “Zimbabwe’s inflation surges to 14,840%.” November 19, 2007. *Zimbabwe Independent*.

supplies in most markets, very high market prices and the continued erosion of people's purchasing power. In March 2007, the Zimbabwean government officially declared 2006-2007 a drought year, heightening food security concerns. In addition to food insecurity, another growing humanitarian challenge in Zimbabwe is water and sanitation. A diarrhea outbreak claimed the lives of 29 children and five adults over a two-week period in mid-2007, and, as of November 2007, 300-400 new cases of diarrhea were being reported each week in Bulawayo, the country's second-largest city.⁵

Purpose of the Project

The expected outputs of PVLP are:

- Improved access to inputs, adoption of improved agricultural technologies and livestock
- Self-help groups formed and trained in internal savings and lending and enterprise development
- Community-managed water supply projects in place, with communities trained in participatory health and hygiene
- Improved access to sanitation for the most vulnerable households
- Effective community HBC program for people living with HIV (PLHIV) established and operating in program areas
- Operational community-based monitoring, evaluation and impact assessment system in place.

Steps in Implementation

PVLP has its roots in a 2002-2003 emergency agriculture program designed to respond to a regional drought. As a result, the emergency program's initial focus was to ensure access to seeds and fertilizer for drought-affected communities. Its success was measured by the number of households reached. Following this drought year, the program began to take a more long-term relief-to-development view by working through four community-based partners to protect the livelihoods of vulnerable people who farm, for both subsistence and livelihood, and to improve communities' food security. PVLP initiated a system of seed and livestock fairs during which vulnerable households receive vouchers to "buy" the seeds and small livestock of their choice as a strategy to stabilize assets. Other interventions included conservation farming, establishment of Farmer Field Schools as local centers of agricultural learning and seed production, and provision of drip irrigation kits and seeds for community nutrition gardens.



SR ANN DUGGAN/ICRS

⁵ "ZIMBABWE: Thirsty Bulawayo struggles with diarrhea." November 7, 2007. *IRIN*.

During this move from relief towards development, called “protracted relief” by DFID, the impact of HIV on communities and the needs of PLHIV have taken center stage. PVLP trains community members in conservation farming because it requires comparatively less labor than traditional farming techniques, making it more feasible for PLHIV. Guided by community needs, in 2006 PVLP added two interventions: HBC and water and sanitation (WATSAN). In some ways, adding these new non-agriculture interventions took PVLP out of its “comfort zone.” The program adapted by drawing upon the HBC and WATSAN expertise within CRS and ensuring that partners and communities received appropriate training support. Overall, the evolution of the PVLP has been very community-driven, relying heavily on participatory rural appraisal techniques to understand community’s needs, develop targeting criteria, select beneficiaries, and monitor and evaluate program progress and impact. Currently, targeting is done using a combination of vulnerability indicators and wealth-ranking.

Integration

PVLP takes a two-pronged approach to HIV integration. First, it ensures that a variety of interventions cater to the various ways people can be affected by HIV. For example, Junior Farmer Field Schools (JFFS) target OVC who may not be able to receive agricultural knowledge from a parent, as would traditionally occur. In addition to learning about cropping, soil conservation and small livestock, JFFS participants also receive information on HIV prevention. Water and sanitation activities, such as the installation of water pumps and training in the Participatory Health and Hygiene approach help reduce water-borne diseases in the community – diseases which may have a particularly negative effect on PLHIV. These pumps are located close to villages so caregivers of PLHIV do not have to go far to collect water for washing, cooking and drinking. Additionally, livestock fairs create a means for widows and other vulnerable female headed households to acquire important household assets that will benefit their household for many years to come.

Second, PVLP has created a package of interventions for PLHIV in need of HBC. Each beneficiary participates in a minimum of one intervention, and, depending on need, in a “graduated package” of service. This means that beneficiaries participate in different types and a different number of interventions based on their type and level of need, as determined by poverty and vulnerability. The greater the level of poverty and vulnerability, the more interventions the households participate in. The package is graduated – if a household’s situation improves, they might participate in fewer interventions than before, and vice versa. All PVLP interventions are community-driven, relying on participatory rural appraisal techniques to understand community’s needs, develop targeting criteria, select beneficiaries and ensure sustainability.

Positive Outcomes and Impacts

This project has had a positive impact on individual community members, their households, and communities as a whole. PVLP highlights include:

- More than 4,000 vulnerable households have been trained in conservation farming. Conservation farming has proven to be one of the PVLP’s most popular interventions because the technique has enabled crops to resist the dry spell that occurred across the country in 2006-2007.
- More than 4,000 vulnerable households have received small livestock through livestock fairs. Subsequently, communities have devised an innovation called “Pass on the Gift,” in which beneficiaries “pass on” some of their livestock to another household in need after their livestock give birth.

- More than 10,000 vulnerable households have received the seed of their choice through seed vouchers and fairs. Although the drought negatively affected crops in some areas, many households have been able to provide nutritious food for household members and sell some crops for profit.
- More than 200 self-help groups have been formed, with the most mature groups receiving enterprise development training critical to members' long-term livelihoods security.
- 100 water pumps and 10 sand abstraction systems have been installed, providing 26,500 households with a clean, accessible water source.
- 2,000 PLHIV are being supported through a comprehensive community HBC program that meets their physical, emotional, spiritual, and social needs.

Lessons Learned

- *Targeted criteria should combine vulnerability indicators and wealth-ranking, and community meetings on targeting should be small.* PVLP only used vulnerability indicators to target and identify beneficiaries, until it learned that this process often overlooked the people that community members considered to be most poor. Now communities are asked to create their own definition of poverty. This definition, combined with vulnerability indicators, is used to divide beneficiaries into four groups: poor and chronically ill, poor and unable, poor and able, and not so poor. PVLP initially used ward-level meetings to make targeting and selection decisions, but found that the size of these groups was not conducive to broad participation. Small, village-level meetings, which use Participatory Rural Appraisal (PRA) tools such as village mapping, have proven to be much more effective in encouraging broad and meaningful community participation in targeting and selection.
- *Giving beneficiaries access to multiple, integrated interventions is a more effective way to change lives.* In 2004, the idea was to reach every beneficiary with the one intervention most appropriate for his or her household. Beneficiaries who accessed more than one intervention were considered to be “double-dipping.” It was learned that interventions assist beneficiaries much more effectively when strategically integrated to provide holistic support. Creating the environment for this integration was a primary focus of PVLP in 2006-2007. Now there is a “graduated package” of interventions which beneficiaries access according to the magnitude of their need, as determined by targeted criteria.
- *Community cohesion is critical to project success.* It is important to ensure that the whole community participates and benefits from the project in some way. PVLP discovered that some community members felt they were often consulted about program interventions and targeting, but never ultimately benefited from program interventions due to their “not so poor” status. In order to build community cohesion while expanding the impact of its work, PVLP took a number of steps. First, it opened its trainings to all community members, both beneficiaries and non-beneficiaries. PVLP engaged experienced and successful farmers in the community to serve as lead farmers for its FFS, conservation farming program, and community nutrition gardens. Third, it pursued interventions such as water provision that benefit the whole community, regardless of poverty and vulnerability status. Finally, rather than promote household nutrition gardens, PVLP began supporting community nutrition gardens, which gave community members greater opportunity to learn from each other and to participate in group trainings.

Promising Practices

- Create a “graduated package” of integrated interventions that beneficiaries can access according to their community-defined level of vulnerability and need.
- Organize “Field Days” as platforms for community members to share their use of innovative and

appropriate technologies, like drip irrigation and conservation farming, with other communities. Such events are effective in spreading agricultural knowledge, dispelling myths about “new” technologies, mobilizing community action, and inspiring pride and community ownership of PVLP interventions.

- Select “lead farmers” to serve as catalysts for the adoption of ‘new’ technologies rather than a partner staff member or agricultural extension officer, as people often learn better from their peers.
- Engage communities in discussing the need to integrate HIV, AIDS and gender needs during the project design stage.
- Support FFS members’ efforts to develop social protection and safety schemes to assist vulnerable households in the community with a seed multiplication program.
- Take advantage of the social interaction created by FFS to encourage collective discussion about social problems such as HIV, child protection and stock thefts.
- Encourage communities to consider the “pass on the gift” approach to small livestock, in which benefiting community members share their small livestock with poor and vulnerable community members once their livestock have bred. This promotes a spirit of giving and increases the impact and sustainability of the small livestock program.

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Part IV:

OVC



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CAMEROON

Enhancing Community-Based Coping Mechanisms for Orphans and Vulnerable Children in the Kumbo Diocese

Introduction to Project

In 2003, CRS Cameroon and its implementing partner, the Diocesan Family Life Office of Kumbo Diocese, were awarded 129,721 USD over five years from the Raskob Foundation for Catholic Activities (RFCA) and 86,493 USD from CRS to reduce the impact of the HIV pandemic on orphans and vulnerable children (OVC) in Kumbo Diocese, Northwest Province, Cameroon through a multi-faceted community-based approach. The strategy builds on existing structures within the society and within the Diocese. The project targets OVC and their guardians; OVC living with parents/guardians with insufficient means of support; single mothers and widows; and single fathers living with HIV.

The Kumbo OVC project, as the project is commonly called, is unique in its provision of integrated services to different vulnerable groups. Most importantly, the project taps into existing human and institutional resources in various departments of the robust Diocesan structure to provide care and support services for OVC.

COUNTRY	CAMEROON
Type of Project	OVC, Home-based Care
Integration Aspects	Integrated with microfinance and gender
Number of Beneficiaries	Direct beneficiaries 2680; indirect 23,750
Beneficiary Type	OVC, PLHIV
Source of Funding	Raskob Foundation for Catholic Activities, CRS
Duration of Project	2003 – 2008
Promising Practice Highlighted	The integration of project activities into other sectors of the Diocese has enabled a comprehensive HIV response as well as the integration of HIV into “non-core” HIV projects.

Problem Statement and Context

The Northwest Province of Cameroon has the highest HIV prevalence (8.7%¹) of the country, far above the national prevalence of 5.7%. Today, AIDS is perceived to be the leading cause of death among adults in the country. Increasing rates of HIV infection and AIDS-related deaths have increased the number of children affected by HIV.

Traditionally, following the death of both parents, grandparents or other family members take in orphans, placing enormous strain on already meager resources (both financial and emotional). Within Kumbo, the average family has seven to eight children and an annual family income of 100,000 CFA (142 USD). Guardian families often experience both economic and emotional stress when taking in OVC. The situation for grandparents can be even more challenging as they typically have less money, energy and productive capacity than younger adults and may even rely on their children for support.² In many cases, the physical health and nutrition of OVC may



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1 McIntyre, J. and Gray, G. (2002). What can we do to reduce mother to child transmission of HIV? *British Medical Journal*. 324, 220. in Taha TE, Miotti P, Liomba G, Dallabetta G, Chipangwi J. HIV, maternal death and child survival in Africa. *AIDS* 1996, 10:111-2.
 2 Social capital refers to the social cohesion, common identification with the forms of governance, cultural expression and social behavior that makes societies more cohesive and more than a sum of individuals – in short, to the social order that promotes a conducive environment for development and solidarity. (Source: Baas, S. February 1998. Participatory institutional development. SD Dimensions, Sustainable Development Department, Food and Agriculture Organization.

decline. Guardian families may not have the resources to send the OVC to school, which ultimately reduces their future economic opportunities and increases their vulnerability to HIV infection. Ultimately, children with poor health, less education and increased vulnerability to HIV may have long-term consequences for society as a whole.

Widows, who may have become estranged from their husband's family (a traditional form of support), or single mothers, who do not receive support from the father of their children, are more likely to resort to behaviors that increase risk of HIV infection, such as prostitution or transactional sex, simply to meet basic food and health care needs for themselves and their children. Once a mother becomes infected with HIV, the effects on the children can be devastating. "Studies in Africa have shown a threefold to fourfold increased risk of death in children whose mothers have died."³



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For socio-cultural reasons, single mothers in the Northwest Province of Cameroon tend to be ostracized and have less social capital than widows. Single mothers may not have access to the same support mechanisms as widows. The children of single mothers sometimes face physical and mental abuse as they are perceived to use resources to which traditionally they would not be entitled, such as shelter in the maternal family compound, money spent on their care, and even food, particularly given the growing Western influence and increased focus on the nuclear family.

Additionally, baseline survey observations revealed that OVC are more likely to be absent from school than are other children of the same age and gender. In addition, OVC are less likely to be well nourished, less likely to receive proper medical care, and have a lower performance in school than other children of the same age.

Purpose of the Project

The goal of the project is to reduce the impact of the HIV pandemic on orphans and vulnerable children in Kumbo Diocese.

Strategic Objective 1: *Improved health and well being of OVC within the Kumbo Diocese.*

- I.R. 1.1: The Diocese of Kumbo and associated communities effectively respond to the health and psychosocial needs of OVC.

Strategic Objective 2: *Enhanced future economic prospects for OVC.*

- I.R. 2.1: Improved access to educational/vocational training opportunities for OVC in Kumbo Diocese.
- I.R. 2.2. Target groups (single mothers, widows, PLHIV and business partners) met regularly and received business training and support.

³ James McIntyre and Glenda Gray. (2002) What can we do to reduce mother to child transmission of HIV? BMJ. 324(7331): pg 218-221.

Steps in Implementation

The project is being implemented through the following strategies:

SO1: *Improved health and well being of OVC within the Kumbo Diocese.*

The diocese made use of Parish Family Life Commissions to identify OVC who are in turn matched with community-based counselors. Children are usually not moved from their homes unless close relations cannot be found. Counselors provide psychosocial support (PSS) to children and their families as well as assist families to develop plans for the future of the children once their parents have passed away. Plans may include referrals to other services, inheritance issues, as well as other services. The counselors are able to provide referrals to other services such as the Diocesan Justice and Peace commission in cases where the inheritance of the child is in jeopardy. Children in need of medical care are referred to health clinics, and care is assured through a health insurance scheme put in place for the children.



SO2: *Enhanced future economic prospects for OVC.*

The project pays for school fees for 608 children in primary schools. The Diocese identified older OVC who have completed primary school and placed them with vocational training schools and local skilled tradespeople in fields such as construction, motor maintenance, tailoring/dress-making, electronic repairs, agriculture and livestock, and embroidery/craft programs. These trades can be learned in relatively short period of time and are economically viable within the rural milieu of the Diocese. In addition, following completion of vocational training, OVC are provided with training in basic business skills and a starter kit including the tools of their chosen vocation.

Women are vulnerable to HIV infection due to physical, socio-economic, and cultural factors. Within Cameroonian society, women are poorer and have fewer economic opportunities than men. Frequently they are less educated and do not have access to credit to start a business.⁴ Cultural norms such as the inability to negotiate sex within marriage, wife inheritance, and general acceptance of male promiscuity during his wife's pregnancy and breastfeeding, increase women's vulnerability to HIV infection. In addition to these challenges, single mothers and widows are expected to cover the cost of basic needs for themselves and their families.

In response to these challenges, the diocese has facilitated the organization of widows and single mothers' self-help groups in each parish. The project targets 22 single mother and 22 widow self-help groups (SHG) with business development training, the formation of *Njangis* and seed money for business start up. *Njangis*,

⁴ MINCOF. Juin 2000. *Annuaire Statistique sur la situation de la Femme au Cameroun*. Yaounde, MINCOF.

originally established as an indigenous form of savings in rural areas where banks were either non-existent or inefficient, have since evolved into a structure able to provide loans. Seed money is provided to each group. Each *njangi* has its own operating procedures and collateral is based on trust and relationships.

The goal of the business development training course and seed money for income-generating activities (IGA) is to empower single mothers and widows, who are members of the *njangis*, to meet the needs of their families and reduce their vulnerability to HIV infection. Each *njangi* has its own operating procedures determined by the group. Collateral is based on trust and personal relationships. Seed money is provided to these groups to run small group businesses. The group initiates savings and operating procedures and provides start up money for other small businesses. Proceeds are used to set up a rotating credit scheme, from which the members can acquire capital for businesses and increase income. Members are expected to save on monthly basis. The savings are pooled and given as loans to qualifying members. The slogan of all the *njangis* is: Save regularly, Borrow wisely, and Pay promptly. Interest from the group business is used to create individual loans for small businesses. An interest rate of 2.5% is charged on all small business loans which must be repaid in 30 days. Each *njangi* develops a “Sinking Fund” for members who may experience sickness or a death in the family. This “Sinking Fund” is a trouble fund for unexpected expenses like medical tests and drugs. A donation of 1,000 FCFA to the *njangi* “Sinking Fund” is required by all members. Through this program, mothers have been able to earn income which in turn has benefited their children.

Forty-two PLHIV and 42 business partners are also assisted through business training, strengthening, and IGA start-up grants. This intervention is expected to help families deal with the negative economic impacts of HIV infection.

Integration

Though the main thrust of the project is care and support for children and vulnerable women, prevention activities have recently been included. These are mainly awareness-raising activities for community leaders and youth in the Diocese.

The Kumbo OVC project is integrated into core activities of other units of the Diocese. For example, the Agriculture Department provides training and monitoring for children receiving assistance for livelihoods-related activities, the Health Coordination Unit provides health care for OVC ,and



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the Diocesan Justice and Peace Commission is actively addressing problems related to property grabbing and inheritance rights of beneficiaries.⁵

Positive Outcomes and Impacts

Over 186 counselors have been trained in PSS for OVC and coping skill development for guardians.

A mid-term evaluation showed a remarkable improvement in the health and nutritional status of the OVC based on a 24 hour recall of the number of meals eaten. Ninety two percent (92%) of males and 98% of female OVC could recall having had at least 2 meals within the last 24 hours compared with 73% of males and 81% of females at baseline. In addition, the payment of school fees, reduction in housework and the less frequent need for farm work and market selling during school hours have contributed to narrowing the gap of absenteeism between OVC and non-OVC. Single parent and widow SHGs, reported an 80% increase in their ability to deal with financial crises from baseline.

The Diocese has made use of skills acquired within the course of the project to develop other HIV projects and to access additional funding. In 2006, the government of Cameroon, in recognition of the positive impact of the project on beneficiaries, awarded grants to CRS Cameroon to scale up the project to six other divisions in the country.



Lessons Learned

- Providing support, especially assistance to strengthen economic capacity, to women's groups fosters peer mentoring, including how to manage savings and loan schemes and basic business management, increases the effectiveness and impact of women's groups.
- In addition to the economic support, women's groups enhance and increase social connectedness and provide a forum for sharing of experiences.
- A comprehensive approach to addressing health care, poverty, psychosocial support, education, and advocacy of OVC in the Diocese is the project's greatest strength. Anecdotal data suggests that the impact and effectiveness of such programs in Cameroon is greater than programs that address only one area.
- Increased awareness of the plight of OVC has increased support services. Additionally, counselors and community members increasingly take in more children into their households.

Promising Practices

The Kumbo OVC project has a number of promising practices to highlight. First, the integrated nature of the project recognizes that OVC and their caregivers have a variety of needs that can only be met through multisectoral collaboration, which builds on the expertise of the various diocesan offices and

⁵ In Cameroon, property grabbing is still a common problem faced by many OVC and widows, as the deceased husband/father's family takes the property after his death, leaving the children and widow with little in the way of assets.

the communities. For example, the Family Life Office provides psychosocial support, microfinance/microenterprise development support, the Diocesan Commission of Justice and Peace addresses protection issues, all children in the Kumbo OVC program attend Catholic school; teachers in the Education Department monitor OVC attending their schools. The Agriculture Department provides training and monitoring for children receiving assistance for livelihoods-related activities. Furthermore, the integration of project activities into most of the departments of the Diocese has enabled a comprehensive HIV response. This has led to greater awareness of the impact of HIV and the gradual mainstreaming of HIV responses into “non-core” HIV projects in the Diocese which in turn fosters program sustainability.



The quality of services provided through the project has improved through capacity building initiatives, supportive supervision and increased community awareness, involvement and ownership of the project. For example, before the project began, volunteer counselors from the Diocese provided rudimentary care to OVC. Through training, the project has strengthened their ability to provide psychosocial support, referrals and basic care services. All of these activities were built on existing structures contributing to sustainability.

To keep track of the variety of activities, a unique multi-layer monitoring system was developed to ensure delivery of quality services. Project monitoring is carried out at five different levels: parishes monitor volunteer counselors, deaneries monitor parishes, divisions (geographical divisions) monitor deaneries, divisions report to diocese who report overall monitoring to CRS headquarters. It has proven invaluable to implement monitoring and accountability structures at all levels to ensure accurate reporting at every level of the project. However, there have also been challenges in this approach. As the deanery and divisional supervisors have higher academic qualifications than the volunteer counselors at the parish level, expectation and capacity to perform monitoring may vary. To compensate for education and experience differences, staff at the diocesan level cross-check information received from parishes levels for accuracy. In addition, there is a system for feedback through regular meetings.

Finally, one of the most successful and exciting activities of the project has been the vocational training program which targets child-headed households. Through this program, targeted children, who are often responsible for ensuring the well-being of their siblings, receive vocational training in areas such as carpentry, sewing, hairdressing, and mechanics. Upon graduation, community members contribute money, at times up to 70%, for the purchase of starter vocational tool kits. This degree of community involvement encourages community ownership and commitment to the project. The successful graduates of the program have then offered to provide training for new trainees. This not has been very successful and efficient for OVC learning hairdressing.

The most promising practice for project sustainability is using vocational training graduates and livelihood activities as trainers for new candidates. The project currently pays people to train the

children. Recently, vocational training graduates have agreed to provide training at reduced rates and in some cases free of charge to other project beneficiaries. As a result money has been saved and there are prospects for more children to be trained at reduced cost.

A Beneficiary Story

A Happy Vocational Training Graduate

Immaculate Leinyuy is one of five OVC who graduated from vocational training in 2006. The head of a household of four, Immaculate was trained as a tailor. The community raised 60 USD, which was matched by 140 USD provided by CRS Cameroon. The money was used to purchase a sewing machine and basic materials to set up a tailoring shop. Within four months, Immaculate earned over 190 USD, more than half of the amount spent on her entire training including setting up the shop. Immaculate uses her income to pay school fees and purchase books for her four siblings. She is now saving for a second sewing machine, which she plans to buy within the year because of her success and increase in business. With one apprentice already, she expressed willingness to serve as a trainer for two more from the Diocese. When asked about her willingness to serve as a trainer Immaculate replied, “I want (to help) children who are orphans like me because I know the hardship they are going through. I will be very happy to train them because this training will keep them away from bad things and will eventually provide them with an income which they can use to take care of themselves.”

When asked what would have happened if the Diocese did not intervene to assist her, Immaculate looks away and ponders for a minute. Choked by emotion with tears in her eyes she responds, “I do not know. Really, I do not know what would have happened to my junior ones and me. I thank God for all this.”

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CRS DRC STAFF

DEMOCRATIC REPUBLIC OF CONGO (DRC)

AIDS Mitigation Initiative to Enhance Care and Support (AMITIÉ)

Introduction to Project

AIDS Mitigation Initiative to Enhance Care and Support (AMITIÉ) is a four year project begun in October 2005. AMITIÉ is a consortium consisting of Catholic Relief Services (CRS), World Vision International (WVI) and Eglise de Christ au Congo (ECC). Working closely with local partners such as Fondation Femmes Plus, Avenir Meilleur pour les Orphelins-Congo, and Bureau Diocésain des Œuvres Médicales/Comité Diocésin de lutte contre le sida, the AMITIÉ project builds upon the existing interfaces between community and government structures and people infected and affected by HIV and strengthens local networks to provide a client-focused holistic approach to care and support of people living with HIV

(PLHIV) and orphans and vulnerable children (OVC). AMITIÉ carries out activities in three project sites in the DRC: Bukavu, Lubumbashi and Matadi. Through integration of OVC and home-based care (HBC) programs into HIV care and support, AMITIÉ aims to reduce transmission and mitigate the impact of HIV in Bukavu, Lubumbashi and Matadi. The AMITIÉ strategy is a community-led, cross-sectoral approach that leads to an integrated system. Beyond the HIV, the activities of AMITIÉ cover a few key sectors in the lives of the beneficiaries: health, nutrition, education, and livelihood training and skills building. Rather than create separate spaces for PLHIV, the project activities target the beneficiaries in the very heart of their communities of origin and residence. AMITIÉ builds upon existing interfaces between community, government structures and people infected and affected by HIV. The underlying principle of the AMITIÉ strategy is a client-focused holistic approach in its care and support of each person living with HIV and OVC.

COUNTRY		DEMOCRATIC REPUBLIC OF CONGO (DRC)
Type of Project	Care and support interventions to include OVC and HBC programs	
Integration Aspects	OVC education and vocational training, microfinance, income-generating activities (IGA), nutritional assistance, psychosocial support (PSS), and legal assistance	
Number of Beneficiaries	6,275 OVC and 3,221 PLHIV as of September 30, 2007	
Beneficiary Type	OVC and PLHIV	
Source of Funding	USAID, cost share CRS, and GIK from World Vision US	
Duration of Project	October 2005 - September 2009	
Promising Practice Highlighted	Including OVC, PLHIV and community leaders in awareness campaigns, beneficiary recruitment and all care and support interventions has been a cornerstone for the success to date.	

Problem Statement and Context

For over two decades, DRC governments have invested only small portions of the gross national product (GNP) on health services. Traditionally, Catholic and Protestant churches and other non-government entities have provided almost 50% of basic health services. The last conflict in DRC exacerbated already deteriorating conditions, leaving some areas with a severely limited health infrastructure. Costs of health services create additional barriers to health care access, while inefficient referral systems aggravate the problem. For PLHIV and OVC growing up in the context of HIV and AIDS, there is very little support.

According to the National Programme for the Fight against AIDS (Programme National de Lutte contre le Sida - PNLs), the HIV prevalence for adults 15 to 49 years is 5.1%, which translates into over 3 million people infected with HIV. While years of isolation during the Mobutu regime and close to 10 years of conflict have contributed to keeping infection rates low, the advent of peace and freedom of movement in and out of DRC augurs a faster, broader spread of the epidemic. The sheer size of its

population, now estimated at 60 million, makes even the smallest increase in HIV prevalence translate into significant HIV incidence or absolute numbers of people infected. When seen from the perspective of its geographic position, DRC could be the vehicle of rapid spread to the less affected countries of West Africa.

Purpose of the Project

The AMITIÉ program goal is to reduce transmission and mitigate the impact of HIV and AIDS in Bukavu, Lubumbashi and Matadi:

Strategic Objective 1: *Improved quality of life for OVC.*

- I.R. 1.1: Improved capacity of communities, community-based (CBO) and faith-based organizations (FBO) to provide care and support for OVC.
- I.R. 1.2: Improved resilience of OVC and their households.
- I.R. 1.3: Improved environment at national, provincial, district and local levels that enables the support and protection of the wellbeing of OVC.

Strategic Objective 2: *Improved quality of life for PLHIV.*

- I.R. 2.1: Strengthen capacity of CBOs and FBOs to provide quality HBC.
- I.R. 2.2: Strengthen health services to support and link with HBC.
- I.R. 2.3: Improve the resilience of PLHIV and their households.

Steps in Implementation

Several key steps have led to strong start up and early success of the project. Strong community involvement in project planning with consensus among all the consortium member organizations on the project goal, objectives, and implementation plan, culminated in the signature of all related agreements by the consortium member organizations. Early and ongoing dialogue with local community members and a community needs assessment were also key. Careful recruitment and training of staff for the three project sites and standardization of tools preceded identification and enrollment of the first project beneficiaries. The project organized a strategy for continuous home visits, the delivery of key services, care and support to OVC and PLHIV, organization of continuous support group meetings and continuous monitoring visits.

Integration

The AMITIÉ strategy is a community-led, multisectoral approach that leads to a holistic system of care. The strategy contributes to the overall improvement of the quality of life for beneficiaries, including health, nutrition, education, and socio-economic aspects. The strategy builds upon the interface between community and government structures and people infected and affected by HIV. Four guiding principles are foundational to the program:

- A sustainable, community-led response to support for PLHIV and OVC is more likely to be context-appropriate and successful;
- Multisectoral interventions serve OVC and PLHIV better than a healthcare-only approach;
- Successful OVC and PLHIV interventions ensure child and PLHIV involvement and gender equity;
- All screening, counseling, and medical care and support must be held to high standards of quality and incorporate a holistic focus on the client.

The AMITIÉ package of services includes assistance for education and vocational trainings to OVC, microfinance and IGA, nutritional assistance, psychosocial support, legal assistance, and access to primary medical care.

Positive Outcomes and Impacts

As of September 30, 2007

- 3,208 OVC have been assisted for education (including 334 for vocational training);
- 1,788 families (721 OVC and 1,067 PLHIV) have been provided with items for their IGA;
- 3,765 cases were referred for healthcare;
- 10,007 nutritional kits were provided to malnourished OVC and PLHIV.

Lessons Learned

- AMITIÉ utilized lessons from partners and projects to standardize tools and implement a holistic approach.
- Cultural customs may conflict with legal issues. Culturally, it has long been disputed whether “correction” (or discipline) administered by a parent to a child who has misbehaved constitutes a case of violence/abuse. Some caregivers/parents feel that it is their right to correct (i.e. beat) their children without the interference of an external party (i.e. the AMITIÉ project).
- A sustainable, community-led response to support PLHIV and OVC is more likely to be context appropriate and successful.
- Multisectoral interventions serve OVC and PLHIV better than a healthcare only approach.
- Successful OVC and PLHIV interventions ensure child and PLHIV involvement and gender equity.
- All screening, counseling, medical care and support must be held to high standards of quality and incorporate a holistic focus on the client.

Promising Practices

- Including OVC, PLHIV and local community leaders (from the community coalitions of care) in the awareness campaigns, the recruitment process, and all care and support interventions has been a key for the success to date.
- In a context where so many small projects have taken it upon themselves to act and speak on behalf of the local populations without having any real contact with them, many communities no longer had any trust in these kinds of interventions.
- Training home visitor volunteers to identify potential abuse of minors during home visits and engaging community in an ongoing dialogue has resulted in the community having a better understanding of child rights and working towards culturally appropriate and acceptable child discipline.
- Recruiting beneficiaries and volunteers without discrimination and bias with respect to gender equity ensures more successful OVC and PLHIV involvement and program success.
- Involving OVC and PLHIV, along with other members of the community, has allowed the project to legitimize the project activities and to motivate volunteers to be of service to their peers.

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CRS LESOTHO STAFF

LESOTHO

Mountain Orphan and Vulnerable Children Empowerment (MOVE) Project

Introduction to Project

Beginning in December 2006, Catholic Relief Services (CRS) and the Lesotho Catholic Bishops Conference (LCBC) entered into an innovative collaboration with the Clinton Foundation, Partners in Health (PIH), and Mission Aviation Fellowship (MAF) with the goal of bringing a complete continuum of HIV and AIDS care and support to communities in the mountains of Lesotho. CRS and LCBC target 6,000 OVC and 3,000 OVC household members to address OVC care and support, community-based food and nutrition security interventions, HIV prevention, and child protection. The Clinton Foundation is responsible for procuring antiretrovirals (ARVs), HIV test kits, and food rations for ARV clients' households, ARV clients, and prevention of mother to child transmission (PMTCT) clients. PIH is responsible for implementing antiretroviral therapy (ART), HIV testing and counseling services, PMTCT, and training community health workers. MAF provides the essential logistical support, transporting both staff and supplies to project sites that are not accessible by road.

COUNTRY	LESOTHO
Type of Project	OVC
Integration Aspects	Integrated with agriculture (food security), health, education, HIV and AIDS, child rights and child protection
Number of Beneficiaries	6,000 OVC and 3,000 OVC household members
Beneficiary Type	OVC and OVC households
Source of Funding	International Donors (Irish Aid) Local Government and private funds
Duration of Project	2006-2009 (1 year funding but 3 year planned project)
Promising Practice Highlighted	Complete continuum for care, prevention, impact mitigation, treatment and support to rural communities through strategic partnerships using the IHD framework

Problem Statement and Context

Lesotho now has the third highest HIV prevalence in the world, with approximately 23% of the population between 15-49 years of age infected with the disease.¹ According to 2005 UNAIDS data, Lesotho also has one of the highest proportions of orphans and vulnerable children (OVC) – an estimated 180,000 children in Lesotho orphaned, 100,000 of whom have lost parents due to AIDS. In early 2006, CRS and the Lesotho Catholic Bishops Conference Commission for Justice and Peace (J&P) conducted an OVC rapid needs assessment in two mountain districts of the country. This assessment confirmed OVC had limited education and training opportunities as well as inadequate care and support. Underlying causes of threats to the basic rights of OVC included a strained economic and social situation, lack of access to education, poor quality of education, limited psychosocial care and support services, child abuse, lack of community participation, an increasing number of OVC, poverty, stigma and discrimination, food insecurity, and deteriorating social cohesion. These underlying causes became even more concerning when it was discovered that already an average of 35% of the students in schools were single and double orphans.

While much work is being done to address the HIV crisis in Lesotho, the harsh terrain and high mountain areas of Eastern Lesotho make access to many communities very difficult. A vast 59% of the country is mountain territory where approximately 20% of Lesotho's population lives. Within this mountain region, adequate roads, means of transportation, and communication are extremely limited. As a result, very few organizations have established programs and activities in these areas.

Purpose of the Project

For the CRS portion of the project, the goal is: *Orphans and vulnerable children in Lesotho's mountain region grow up in communities where their basic rights are met.*

¹ UNAIDS. *The Status of the Lesotho National Response to the United Nations General Assembly Special assembly, 2005*; p.5.



Strategic Objective 1: *Education and training opportunities for OVC, especially girls, are improved.*

- I.R. 1.1: OVC have access to education and training opportunities.
- I.R. 1.2: The quality of education and training opportunities for OVC is improved.

Strategic Objective 2: *The capacity of targeted communities to mitigate the socio-economic impact of HIV and AIDS is improved.*

- I.R. 2.1: The productive capacity of households with OVC is improved.
- I.R. 2.2: Community-based organizations (CBOs) provide regular care and support to OVC.
- I.R. 2.3: Social cohesion² is strengthened in target communities.

Crosscutting Intermediate Results: *HIV Prevention and Child Protection*

- Crosscutting I.R. 1: OVC demonstrate a decrease in behaviors that put them at risk of HIV infection.
- Crosscutting I.R. 2: OVC are protected and empowered to protect themselves from abuse and exploitation.

² "Social Cohesion" is here defined as the solidarity and willingness of communities to work cooperatively to address OVC and other HIV and AIDS-related issues.

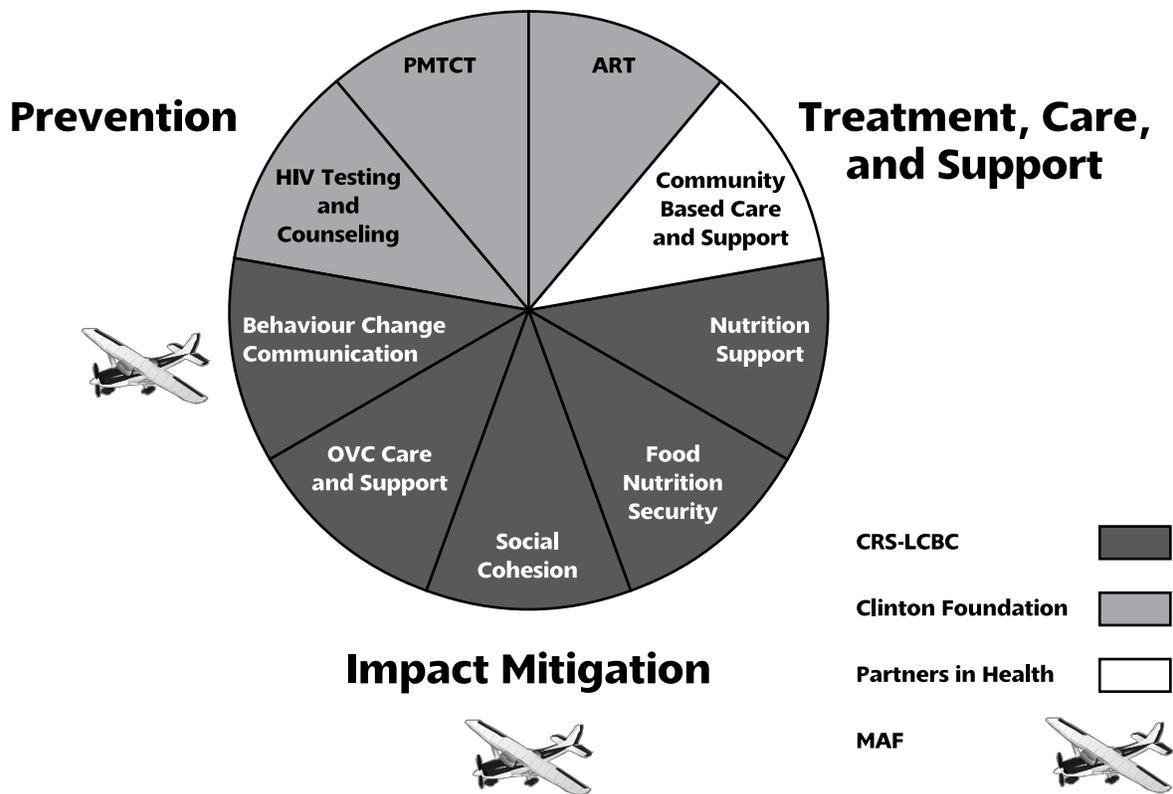
Steps in Implementation

Implementation of the Mountain Orphan and Vulnerable Children Empowerment (MOVE) Project is in partnership with the Lesotho Catholic Bishops Conference Commission for Justice and Peace (J&P) and Caritas Lesotho. J&P implemented the school-based interventions, confronted issues dealing with child protection, collaboration with CBOs, and social cohesion issues. J&P’s technical expertise is in civil society and advocacy, with experience in OVC programming in the mountain regions. Caritas works with households with OVC on food and nutrition security interventions, community agriculture projects and income-generating activity (IGA) development. Caritas’ expertise is in food security, particularly with low-input agriculture technologies such as keyhole gardens. As it is unrealistic that one organization can address all the issues around HIV and AIDS, especially in the rural mountain areas of the country, CRS’ implementing partners’ diverse expertise allowed for the successful implementation of the project’s multisectoral approach to OVC programming in the mountain regions.

Integration

Partnership for Change in the Lesotho Mountains

No single organization has the scope, technical expertise, or human and financial resources necessary to address all of the HIV and AIDS-related issues facing mountain communities in Lesotho. The following diagram illustrates the collaborative efforts underway to assist people in the 53 communities surrounding the Bobete Health Clinic area.



Positive Outcomes and Impacts

Although the project is in the initial stages, the work done in Bobete serves as a model integrated, holistic project with promising practices programming for HIV, AIDS, and OVC in Lesotho. The project is in direct line with the Government of Lesotho's National Strategic Plan (2006-2011) and works directly with multiple Lesotho Government Ministries, both on a national and local level, providing technical training and material resources to understaffed local government structures. In addition, the area targeted has seen very little, if any, support from outside organizations due to its remote location and the difficulty of accessing the area, especially during the winter months. The health clinic located at the center of the project has seen an enormous increase in patients since the PIH doctors started working. CRS agriculture plots and trainings at the clinic serve as demonstration models for community members to improve agricultural practices.

Lessons Learned

- The importance of ensuring the safety and comfort of the field staff can not be underestimated, especially in very remote areas with harsh climates. It was very important to supply staff with heaters, boots, winter clothing, a refrigerator, and back packs.
- It is necessary to provide staff with added time away from the project to visit families and have respite from the difficulties of the area. Without these measures, problems of morale and motivation were developing.

Promising Practices

- The SARO office developed a child protection curriculum that is extremely well done, providing field staff with a great deal of information and thought on child protection issues. The manual should be a major part of any OVC or child-related programming.

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Part V: Prevention



CRS GUATEMALA STAFF

GUATEMALA

***Proyecto VIDA* HIV Prevention**

Introduction to Project

Since October 2004, *Proyecto VIDA* (Project Life) has been implemented in the southwest area of Guatemala, one of the HIV response target areas. The overall goal of the project is to contribute to the reduction of the spread of HIV by educating and raising the awareness of Catholic Church health organizations in Guatemala. *Proyecto VIDA* is unique because it targets priests, sisters and lay people from health pastorates. The project is designed so that priests, sisters and lay people can duplicate what they learn in their communities and parishes to help reduce stigma and discrimination against people living with HIV (PLHIV) and their families. *Proyecto VIDA* is funded by CRS private funds.

COUNTRY	GUATEMALA
Type of Project	Prevention, stigma reduction, care and support
Integration Aspects	HIV education, outreach, PLHIV, PSS
Number of Beneficiaries	600 PLHIV and their families
Beneficiary Type	PLHIV
Source of Funding	CRS private funds
Duration of Project	October 2005-September 2007
Promising Practice Highlighted	<ul style="list-style-type: none"> • Building the capacity of Catholic Church organizations is crucial to coordinate efforts of priests, sisters and lay people to provide effective accompaniment in solidarity with target population. • Home visits have proved to be an effective tool to encourage adequate care by the family, to increase ART adherence and promote an environment free of stigma and discrimination in the community.

Problem Statement and Context

HIV was first detected in Guatemala in 1984. Today, the HIV pandemic is classified at a concentrated level, primarily affecting men that have sex with men (MSM) and female sex workers. However, the number of housewives becoming infected with HIV is increasing. The Catholic Church response to the pandemic relies on the CRS partner, Proyecto VIDA. Proyecto VIDA is an institution founded and coordinated by Maryknoll sisters, with ten years of expertise in working in HIV and AIDS issues including food security, home-based care (HBC), life skills and education and counseling and testing (CT). The project has two main components: 1) educating PLHIV on proper HBC and 2) promoting an adequate response by the Catholic Church which includes educating, training, and raising the awareness of priests, sisters and lay people of diocesan health pastorates on the HIV epidemic. Through home and hospital visits, Proyecto VIDA educates PLHIV and their families on HIV, stigma and discrimination to elicit a positive response from the affected families and surrounding communities towards those living with HIV. The education of health pastorates helps promote Church openness and commitment to PLHIV, their families and affected communities.

The Guatemalan context presents a great need of integrated care for PLHIV and their families. Before 2004, the majority of PLHIV received treatment through *Medecins Sans Frontiers*. In 2004 when the Global Fund awarded support to national organizations for antiretroviral therapy (ART) and care universal treatment, it was thought that all PLHIV were going to receive treatment, but the reality was different. Today not everyone who needs ART has access to it. There has been little response from the faith-based organizations to the HIV epidemic. CRS and partner Proyecto VIDA saw the need to educate and raise awareness of HIV and AIDS among priests, sisters and lay people from the Catholic Church to promote an adequate Catholic response to the epidemic.

Purpose of the Project

The purpose of the project is *to contribute to the reduction of HIV incidence by educating and raising the awareness of Catholic Church health organizations in Guatemala.*

Strategic Objective 1: *To strengthen the technical capacity of Catholic health organizations within the Health Commission of the Episcopal Conference of Guatemala to develop activities focused on prevention.*

- I.R. 1: A high percentage of priests, sisters and lay people of diocesan pastorates are trained in basic topics, including sexually transmitted infections (STIs), HIV and AIDS so that in the short-term they are able to provide an adequate response and spiritual guidance to PLHIV and their families.

Strategic Objective 2: *To support and accompany PLHIV to reduce stigma and discrimination.*

- I.R. 2: The majority of PLHIV are accepted by their families and communities, receiving the care and support necessary to improve their quality of life.

Steps in Implementation

- Strengthen the technical capacity of CRS partners.
- Strengthen the technical capacity of the organization of PLHIV, *Gente Unida* (United People), in the southwest region of Guatemala. Proyecto VIDA promoted the formation of this organization. Currently, Proyecto VIDA and Gente Unida work together to execute the project.
- Identify, together with CRS partner, the target areas for project activities.
- Coordinate efforts with the National Commission of Health Pastorates.
- Conduct training workshop in the following issues: HIV (modes of transmission and prevention methods), AIDS: (opportunistic infections, ART, nutrition, adherence, etc.), counseling, testing and treatment, and other themes.
- Design, publication and dissemination of educational materials according to local context.
- Promote the development and implementation of a work plan for each trained diocese.
- To provide support to PLHIV through home and hospital visits.

Integration

Throughout project implementation CRS has tried to coordinate directly with the National Commission of Health Pastorates to assure that all priests and sisters commit to become informed and to provide support to PLHIV and have the willingness and capacity to do so.

The project has coordinated with the local public health system (e.g. Hospital Regional de Coatepeque) to provide ART to PLHIV as well as necessary medical follow-up.

Positive Outcomes and Impacts

- An increased number of priests, sisters and lay people, members of health pastorates trained in HIV topics. CRS Guatemala is financing the project to increase the capacity and knowledge of priests and nuns in general, with a goal of 350 for FY 2007.
- An increased number of dioceses that provide an adequate spiritual guidance and promote prevention activities in their parishes.
- Increased ART treatment for PLHIV and increased adherence.

- Number of home and hospital visits to PLHIV to encourage adherence and to assist them in living positively.
- Number of communities visited with activities that promote the reduction of discrimination and stigma against PLHIV.

Lessons Learned

- It is crucial to inform, educate and raise the awareness of church organizations to be able to provide an adequate response to the needs of PLHIV.
- Home visits are necessary to increase adequate adherence and ensure PLHIV continue with medical follow-up in specialized clinics.
- Home visits are needed to promote an environment free of stigma and discrimination.

Promising Practices

- Capacity building of Catholic Church organizations is crucial to coordinate efforts of priests, sisters and lay people to provide effective accompaniment in solidarity with target population. Solidarity in this case refers to offering spiritual support to PLHIV and their families. It is necessary that priests and sisters have basic knowledge of HIV to provide this support. If not, they might contribute to stigmatization and discrimination against PLHIV unknowingly or unintentionally.
- Home visits have proven to be an effective tool to encourage adequate care by the family, to increase ART adherence and promote an environment free of stigma and discrimination in the community.

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CRS INDIA STAFF

INDIA

Vasai Region AIDS Control Society (VRACS)

Introduction to Project

Kripa Foundation is a nationwide, secular NGO, the largest in the field of chemical dependency financially supported by the Ministry of Social Justice & Empowerment. It is a recognized training resource of National Institute of Social Defence (NISD), Ministry of Social Justice & Empowerment, Government of India, and a Scientific and Industrial Research Organisation (SIRO) under the Ministry of Science and Technology. Since 1990, Kripa has included HIV and AIDS care as an integral component of its service provision. Vasai Region AIDS Control Society (VRACS), a project under the Kripa Foundation's AIDS initiative, is a comprehensive care initiative, is the premier example of this application. VRACS has a strong background in community empowerment earned through participation and presence of influential community members from education, political, business, enforcement, social services and faith based fields on the VRACS project advisory board. It provides

continuous surveillance, multiple targeted interventions, clinical therapeutic activities, care and support programs, multi-dimensional capacity building and research, in addition to social networking and public-private initiatives. The overall goal of the project is to establish, monitor and support a controlled zone for HIV and AIDS care, through a clinic-community model. CRS partners with VRACS on the care and support component.

COUNTRY	INDIA
Type of Project	Prevention and Care and support
Integration Aspects	OI, TB, HBC, STI, nutrition support, drug use
Number of Beneficiaries	1010
Beneficiary Type	PLHIV, Children living with HIV
Source of Funding	CRS, Maharashtra, AVERT Society for Prevention, Clinton Foundation
Duration of Project	Oct 2002-2007. It is renewed annually contingent upon the previous year's performance
Promising Practice Highlighted	Active and continuous surveillance, politically-linked advocacy, community empowerment through participatory care and support systems.

Problem Statement and Context

VRACS project covers a large geographic area with a population of over 6 million. Vasai is about 50 kilometers northwest of Mumbai. The geographic area includes semi-urban, industrial and rural sites, creating substantial challenges on effective surveillance. In recent years, proximity to the national highway has created a diverse, migrating population with active practices of drug use and commercial sex. In this context, there is a gap in appropriate service provision through government resources. In addition, indigent populations are seeing an increased burden of HIV, TB and sexually transmitted infection (STI). HIV stigma and discrimination is common. Government resources are not frequently accessed due to travel difficulty, resulting in under-representation of populations at risk such as those with low literacy and awareness levels, economically compromised, migrant and bridge populations, those infected and those in urgent need of care and support.



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The population in the VRACS project area has traditionally engaged in fishing and agrarian livelihoods. There has also been a history in the area of significant incidence of non-injecting drug use and STIs. In recent years, these traditional populations have interacted more frequently with new residents, industrial populations and migrants who have tended to engage in the high risk behaviors,

such as drug use, that increases risk for HIV infection. The number of people engaging in behaviors that increase risk of transmission steadily increased over the last decade, adding to the existing burdens of STIs and HIV in the region.

Purpose of the Project

The purpose of this project is *to improve the quality of life for PLHIV and their families.*

Objectives:

- To operate an integrated and comprehensive clinic-community program.
- To utilize a counseling system that maintains confidentiality during testing.
- To operate surveillance systems that monitors the changing trends in the HIV epidemic.
- To maintain a system of community empowerment and participation.
- To include operational research into every project it undertakes either on social or on the clinical front.
- To provide medical and psychosocial support (PSS) and care for PLHIV including a clinical care center for opportunistic infection (OI) management and nutritional counseling.
- To empower HIV infected and affected women and children for positive health.
- To incorporate Greater Involvement of PLHIV (GIPA) principles at advisory, therapeutic and advocacy levels.
- To map socio-demographic data in the newly identified areas in the VRACS zone.
- To conduct targeted interventions in identified areas of the VRACS zone with high STI prevalence.
- To strategize prevention measures specific to different target population in the VRACS zone.
- To maximize health care workers' capacities to cater to current target populations.

Steps in Implementation

The mid 2002 baseline assessment of the target population showed an overall 2.5% HIV prevalence. Examination of community lifestyles and practices indicated a variety of factors that put people at risk for HIV such as high risk sexual behavior and drug use. High levels of stigma and discrimination towards PLHIV were common. To address these issues, wide scale awareness activities were undertaken that were strengthened by the inclusion and participation of prominent community leaders in the advisory board. The local medical association was enlisted to provide support through clinical networks,



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including laboratory networks in the private sector. Project staff participated in the social marketing of the project concepts developed by project staff and stakeholders, achieved through multiple small and festival-related publicity and awareness activities. A technically qualified team provided comprehensive medical care, counseling, nutritional support, short term inpatient care and home-based care services. Important gatekeepers to the community such as political and enforcement agencies provided support and advocacy for community participation and ownership of the project, thus strongly directing a trend towards reduction of HIV-related stigma. The increasing affected populations necessitated suitable capacity building through regular training programs. Research on clinical and psychosocial issues is periodically published and information made available to the community at large.



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Integration

The Kripa Foundation through years of dedicated service has established mutual respect and support from the community. A VRACS, proposal to community elders to establish comprehensive services including HIV and AIDS care was welcomed and promised through community support and continuity. Before comprehensive services were available, care and support were provided to the existing affected populations through CRS-funded HBC interventions. With increased capacity within the project team, focus was widened to include medical and other care, targeted interventions and specific group support activities.

Over 65% of PLHIV suffer from tuberculosis (TB) in their lifetime. Accordingly, the VRACS medical officer was trained by the District Revised National Tuberculosis Control Programme (RNTCP) office and thereafter. VRACS is recognized as an RNTCP center for case identification and treatment by the TB Directly Observed Treatment-Short Course (DOTS) method.

STIs were assessed on a clinical symptom basis and directly treated on outpatient basis. Identification and treatment of STIs help to reduce overall morbidity as well as significantly reduce the incidence of new infections as a consequence of high risk sexual behavior. Prophylactic interventions delay the rate of immunological decline as well as reduce morbidity.

All the clients are provided nutritional supplements on every visit to the center, during admission for treatment and during home visits by the staff. The nutrition package, which includes protein, fruit, and locally grown grains, improves general health, increases weight and body mass index and prevents the early onset of OIs. Advocacy through the Elected Leaders Forum against AIDS (ELFA) and the Advisory Board, comprising prominent members of the community, made it possible to enhance the impact of the project activities by greater visibility and acceptance. Community peers having undergone capacity building training in HIV education and advocacy are integral to community-linked risk reduction activities, mass awareness and social stability.

Positive Outcomes and Impacts

- Mass awareness campaigns to reduce risk and stigma.
- Provision of counseling, medical follow-up and treatment services.
- Participation of community in continued project strategy and implementation of GIPA principles.
- Address TB and STI co-infections.
- Appropriate care and treatment of OI.
- Facilitation of networks and linkages between community, local government and hospitals.
- Provision of nutrition supplement resulting in delayed onset of OI and increased body weight of PLHIV.
- 270 patients on ART.
- 136,048 reached through targeted intervention.
- 17 training programs for health care providers/workers.

Lessons Learned

- Quality of care has a direct impact on patient's health status as measured by decreases in treatment seeking for infections, improved clinical nutritional status and weight gain.
- Effective community mobilization through the advisory board of VRACS has been a large part of the success of the project. The advisory board helped build bridges to the community, as authority figures and community leaders.
- Participatory social marketing is effective for primary prevention.
- VRACS has shown that HIV and AIDS can be effectively managed in limited resource environments with upgraded medical, nutritional and psychosocial technology.
- Provision of nutrition support is extremely beneficial in delaying the onset and management of OIs.
- HIV awareness-raising activities do not translate into behavior change; specialized behavioral interventions are required.

Promising Practices

- Including prominent community stakeholders in the advisory board.
- Maximizing advocacy initiatives by encouraging locally elected representatives to speak about the need for HIV testing, prevention and/or treatment.
- Networking with laboratories in the private sector for sustained surveillance and monitoring epidemic trends to include co-infections, eg. STI, TB, hepatitis B and hepatitis C, in comprehensive clinical care. This provides insight into referral systems and channeling for suitable treatment, documents positive outcomes of testing, provides a credible database that is forwarded to the State AIDS Control Society and complements the government public health effort.
- Providing appropriate and adequate nutrition supplement to PLHIV to delay the onset of OIs and increase body weight as based on case documentation.
- Capacity building of caregivers and community peers, care and support of PLHIV provided through home-based services.
- Addressing vulnerable populations through special group focus (e.g. women and adolescent support groups).

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Case Study: We Can Make a Difference

A 42-year-old widow lost her husband to AIDS. She came from a reputable family and owned a beauty parlor. When she learned of her husband's HIV status, she went to be tested and discovered she was also HIV-positive. Her 13-year old daughter, fortunately, was HIV-negative.

On her first visit to VRACS, she complained of fever, cough and cold, loss of appetite, and weight loss. Psychological evaluation revealed she was very depressed. She had lost all hope of surviving with the infection and had suicidal thoughts. One of her main concerns was her daughter, who was unaware of her status. She also feared HIV-related stigma and discrimination. Fortunately, her in-laws were very supportive. She was looked after and provided for by family members. Clinical and counseling interventions promoted support from family and community.

Family members reported that she had completely withdrawn herself from society. After clinical examination and tests, she was started on antiretroviral therapy (ART) and treated for an opportunistic infection. She attended her medical appointments regularly and strictly adhered to ART. On every visit she was provided with ongoing psychosocial and nutritional counseling. She began to improve with time and gained weight. A few months later, she returned with complaints of severe weakness, nausea, vomiting, loss of appetite and knee pain. Initially, when the doctor advised her to be admitted to a hospital, she was reluctant because she did not want to be a burden to her family members, but her family insisted.

During her stay in the facility, she reported that her husband appeared to her in a dream and called to her. Over a period of time, with a proper balance of counseling, medication and nutrition, she has improved rapidly—physically, mentally and emotionally.



CRS MADAGASCAR STAFF

MADAGASCAR

Let us Help Ourselves to Fight STI and HIV/AIDS

Introduction to Project

The “*Tolory Tanana ny voafonja*” (Give a Helping Hand to Prisoners) project is an 18-month project implemented by Aumonerie Catholique de Prisons (ACP)/Morondava in collaboration with the local department of justice, the governmental body responsible for correctional facilities in the area. Its goal is to contribute to improving the conditions of detention in the prison of Morondava. The project strategies consist of educating peer educators and strengthening their capacities to promote healthy behaviors and lower risks for sexually transmitted infections (STIs) and HIV among prisoners. Like all prisons in Madagascar, the Morondava prison is substantially overpopulated. At the end of 2004, the prison of Morondava had sheltered an average 580 prisoners in an infrastructure with a capacity for 200. Prison overcrowding has harmful consequences on the health and nutrition status of prisoners. Based on numbers collected by ACP/Morondava, 95% of the prisoners are affected by severe malnutrition due to the combination of lack of adequate food and inappropriate care, sanitation and hygiene.

COUNTRY	MADAGASCAR
Type of Project	Prison-based peer education project
Integration Aspects	Justice and civil society
Number of Beneficiaries	750
Beneficiary Type	Prisoners
Source of Funding	CRS private funds
Duration of Project	October 2006 – September 2007
Promising Practice Highlighted	Peer education in prison environment

Problem Statement and Context

One of the groups with the highest risk for HIV transmission in Madagascar is prisoners, and yet this target population is often overlooked in HIV interventions. The Morondava prison, located in the Southwestern part of Madagascar, was selected for this project because of the large numbers of tuberculosis (TB) deaths and unconfirmed high HIV prevalence. On average, there was one death due to TB every two weeks in 2004.¹

Moreover, prison sexual practices increase the risk of the spread of STIs and HIV. These practices consist of trading sex for food and/or money, particularly for prisoners who do not receive any help from their families. As such, CRS Madagascar supported its partner, ACP/Morondava, to institute HIV “Peer Educator” teams inside the Morondava prison, thus promoting prisoner participation in STI and HIV education and prevention. Even though there is a relatively low HIV prevalence in Madagascar, about 1%, there is well-founded concern that transmission rates may rapidly increase because Madagascar has one of the highest STI prevalence rates amongst developing nations. This situation combined with the promiscuity factors at the Morondava prison enhances the vulnerability of prisoners to contract STIs and HIV.

Purpose of the Project

The purpose of this project is *to prevent STI and HIV transmission in a sustainable manner, by effectively involving prisoners using the “peer educator” approach, promoting prisoners’ self-esteem and dignity, thus enhancing ownership of the system.*

Strategic Objective 1: *Increase prisoner and administrative staff knowledge of prisoners’ rights.*

- IR 1.1: The administrative staff of the penitentiary respect prisoners’ rights.

Strategic Objective 2: *Improve Morondava prisoners’ nutritional status.*

- IR 2.1: Prisoners eat improved and better quality food.

¹ CES/SANTE Morondava



Strategic Objective 3: *Reduce the vulnerability of prisoners to HIV.*

- IR 3.1 Morondava prisoners adopt responsible behaviors to prevent STIs and HIV.

Steps to Implementation

- Determination of the roles of the peer educators.
- Discussion with penitentiary agents of the prison about the process of recruiting peer educators and provide information on their roles.
- Determination of the selection criteria of the prisoners peer educators.
- Raise awareness among prisoners of peer educators' roles and provide information on the selection process.
- Selection of peers educators:
 - The selection is done by prison cell, so that there are educators in each prison cell.
 - The norm is one peer educator for every 25 cell mates.
 - Prisoners with sentences of more than 5 years are solicited to participate as educators for program sustainability.
 - Peer educators should possess communication skills, at a minimum.
- Peer educators undergo training/capacity-building on the fundamental rights of prisoners as well as STI and HIV prevention.
- The program team and peer educators develop an action plan (communication plan) to educate prisoners about prisoners' fundamental rights and STI and HIV prevention.

Integration

The goal of this educational program is to integrate three cross-cutting activities to address major issues: prisoner fundamental rights, enhancing self-esteem (justice, peace-building and solidarity), and preventing STIs and HIV. These activities are:

- **Training prisoners to become peer educators.** They are chosen by their peers and organized by cell. Their main responsibility is to sensitize and educate their cell mates about STI and HIV prevention.
- **Providing regular education on STI and HIV prevention:** Twenty (20) peer educators have been selected to receive the necessary training to perform adequately as peer educator. Their training will be based on curricula that CRS Madagascar and the partners will finalize after pre-testing. These peer educators are also responsible for providing cell mates with education. Currently, there are three cells including 300, 250, and 200 prisoners. Each cell will then have respectively 8, 7 and 5 Peer Educators each targeting 38 cell mates to reach the 750 prisoners. Depending on new incarcerations, this number is expected to fluctuate. The education process through discussions will take place at night once the cell doors are locked and before prisoners' lights are switched off.
- **Providing treatments to prisoners who have contracted STIs.** The project provides a doctor, a medical assistant and an educational trainer. The plan is to expand services to offer confidential HIV counseling and testing (CT). Discussions are taking place between the Ministry of Justice and the Catholic Chaplaincy to continue this initiative after CRS funding.

Positive Outcomes and Impacts

- The project has trained 20 prisoner peer educators in Morondava prison. This proximal approach allows involvement and contact with prisoners directly by those at the closest level to them.
- The local government prison agents and prisoners have worked to determine the selection criteria for the peer educators and define peer educator roles and responsibilities.
- The project has strengthened and increased the knowledge of peer educators about prisoner fundamental rights, particularly as regards to rights to aspire for healthy life including STI and HIV prevention.
- An action plan with the specific activities and expected results has been developed and shared with the prison hierarchy (local, regional, national).
- This project responds to the needs of prisoners by offering STI testing and treatment, as well as pre- and post-test counseling. In addition, this center offers confidential HIV counseling and testing.
- CRS Madagascar is piloting this initiative in close collaboration with the Ministry of Justice which is looking for strategies to roll it out nation-wide.

Lessons Learned

- More peer educators ensure the continuity of the program and mitigate the impact of dropout.
- Incentives help to motivate prison peer educator and increase likelihood of participation.

Promising Practices

- CRS is the first organization in Madagascar to promote the “peer educator” approach within a prison setting.
- Collaboration with the Ministry of Justice is key to ensuring success, buy-in, and sustainability; additionally it has promoted the possibility of nation-wide implementation.

- Involvement of prisoner and prison hierarchy (prison managers, regional chaplaincy, and Ministry of Justice) in the process has been key to the success of the project to date. A solid foundation of project ownership increases the project's success and potential for sustainability.
- With CRS and the Chaplainship support, the Ministry of Justice has become more engaged in preventing the spread of new HIV and STI infections within the prison.
- Promotion of a participatory and proximal approach increases the likelihood of success and replication in other prisons.

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Part VI: Workplace Policy

I PROMISE TO
TALK OPENLY
ABOUT MY HIV+
STATUS.

I Prom
PEOP

CRS SARO STAFF

SOUTHERN AFRICAN REGIONAL OFFICE (SARO)

CRS' HIV in the Workplace Program

Introduction to Project

Addressing the impact of the HIV epidemic in the workplace has been one of CRS' greatest challenges. CRS often forgot that the same issues of discrimination, stigma, and the need for care and support that exist in the communities where it works are present in the lives of CRS staff and their families. Addressing this gap, CRS was ahead of the times when it wrote an HIV/AIDS Workplace Policy in 2001. However, this policy needed an update to reflect the changes in the epidemic, the latest research on the cost-benefit of such programs, and advances in programming within the workplace. The new HIV workplace policy, approved in September of 2005, has an overall goal of improving the quality of life of CRS staff and their families.

The CRS HIV workplace program (WPP) is implemented in 35 countries where CRS works, reaching approximately 3,000 employees. All seven of the Southern Africa Regional Office (SARO) country programs (CPs) have implemented the program, reaching approximately 600 staff members and more than 3,500 staff member families. The focus of the WPP is threefold in nature: 1) provide ongoing education and information to all staff on HIV-related issues, 2) ensure that all staff and their families have access to HIV-related care, treatment and support, and 3) review related policies and procedures to ensure that they complement the HIV WPP. CRS' HIV WPP is unique in that it combines the faith-based components of its guiding principles with the vast knowledge and experience that CRS has gained implementing HIV programs in communities around the world. In addition, the WPP is backed by a comprehensive written policy that provides HIV care and treatment for CRS employees and their dependents both during and post employment.

COUNTRY	SOUTHERN AFRICA REGIONAL OFFICE (SARO)
Type of Project	HIV Workplace
Integration Aspects	Stigma reduction, Counseling and testing (CT)
Number of Beneficiaries	~596 SARO staff 3,576 Family Members/Indirect Beneficiaries
Beneficiary Type	CRS national and international staff
Source of Funding	CRS Private funds
Duration of Project	September 2005 - ongoing
Promising Practice Highlighted	A participatory workplace HIV program and promising practices as implemented on the country level.

Problem Statement and Context

As the HIV pandemic intensifies, the need for businesses and organizations to respond has become a necessity. CRS sees its response to HIV and AIDS in the workplace not only as a social responsibility but as an opportunity to support its employees and their families, as well as to prevent future HIV infections. The effects of HIV in the workplace can be categorized by the impact on the organization, such as rising health care costs, increased employee absenteeism, high employee turnover and organizational loss of skills and experience. The effects can also be categorized by the impact on the employee, such as physical and emotional stress associated with chronic illness, stigma and discrimination, fear of loss of employment or family, and lost work time and productivity.

The uniqueness of WPP is the flexibility and participatory nature of the program. The flexibility is reinforced in that each CP is mandated to develop a local HIV workplace policy that represents the needs of staff within the cultural and legal context of that particular country. In addition, CRS has outlined and implemented a participatory process that ensures ownership of staff and ongoing input of various levels of employees.



The Southern Africa Regional Office (SARO) was the only CRS region to have 100% CP participation during the first year of the roll out. As the region of the world with the highest HIV prevalence, CRS SARO had large numbers of employees and dependents affected by HIV. Additionally, the SARO region had the largest HIV program of all CRS regions. This large number of staff affected meant there was a high level of interest in the WPP. In addition, many SARO CPs had already begun to develop workplace policies for HIV independently (as early as 2004) by the time the global workplace policy was developed. Ultimately this led to early progress and many lessons learned. The program experience ensured that technical staff in CPs could support the education and information needs of employees working in those countries.

Purpose of the Project

The WPP goal is *to improve the quality of life for CRS employees and their families.*

Strategic objective 1: *To create a compassionate and just workplace environment.*

- I.R. 1.1: Stigma and discrimination in the workplace are reduced.
- I.R. 1.2: CRS has clear policies and procedures that provide a framework for managers and staff.
- I.R. 1.3: Staff information is kept confidential.

Strategic objective 2: *To ensure CRS staff and dependents have access to quality support care and treatment.*

- I.R. 2.1: Staff have consistent access to quality medical care.
- I.R. 2.2: Staff have consistent access to psychosocial support.

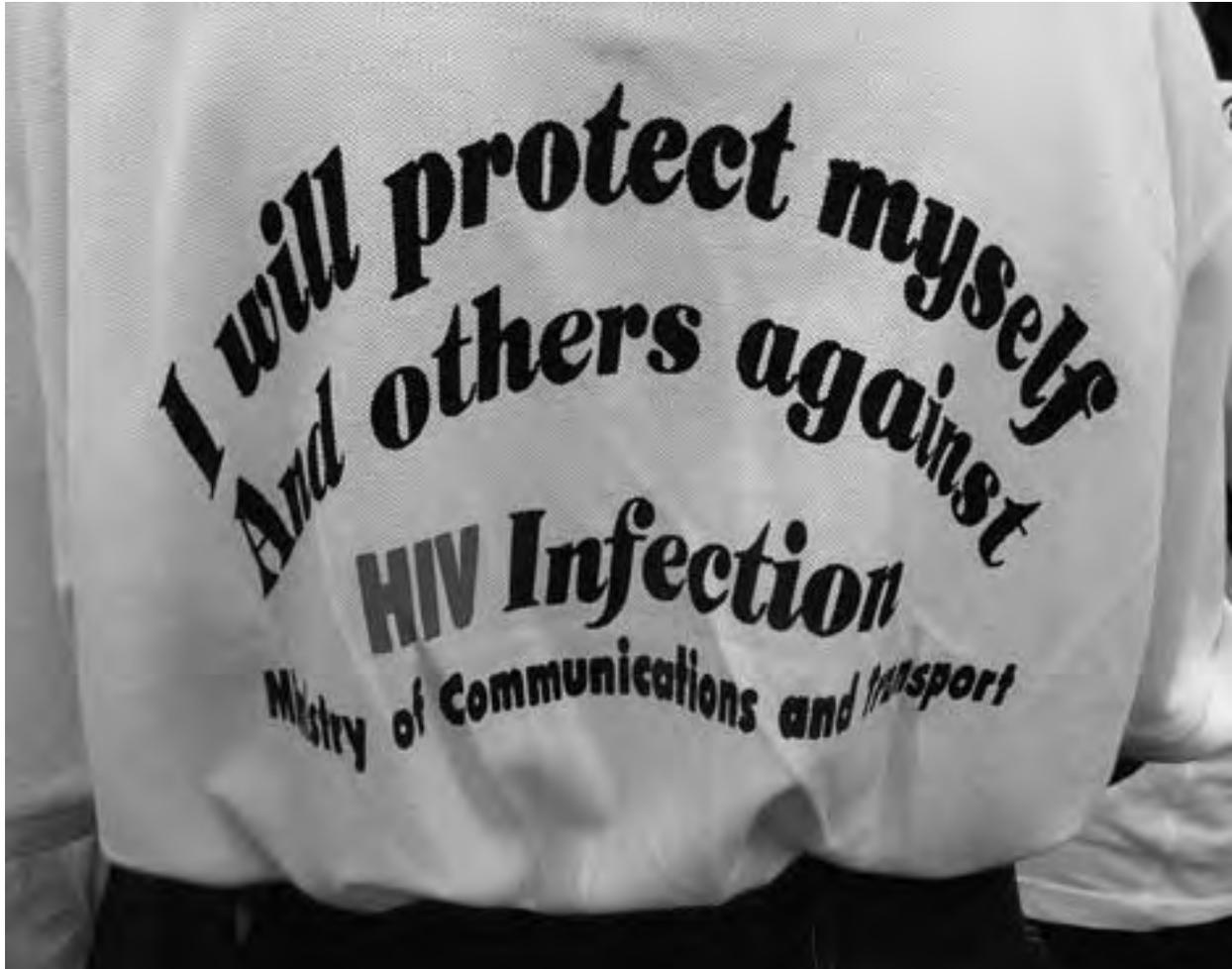


Steps in Implementation

In general most CRS CPs, including all those in SARO, that have begun to implement the HIV workplace program have followed a participatory process framework that utilizes the following activities:

- Sensitize staff
- Survey staff
- Form working groups and workplace committee
- Share results of survey with staff
- Working group begins draft of policy
- Circulate draft and revise
- Draft and implement final policy
- Follow-up and follow-through

After drafting a local HIV workplace policy, many SARO CPs began to focus on the immediate needs of their employees. Some felt training and information were the next important steps; others needed to establish a more diverse workplace committee representative of the various levels and types of employees, while other CPs focused on ensuring or improving access to HIV-related care and treatment for their employees and dependents. Some CPs did these steps as part of the policy development process, while others worked from a draft policy and updated the policy once different variables were addressed.



Positive Outcomes and Impacts

To date, 35 country programs globally have developed and implemented a comprehensive HIV workplace policy, adapted from the agency policy, through highly participatory processes. The seven SARO CPs report:

- Progressive input and participation of all levels of staff.
- Positive uptake of education messages, particularly on CT and accessing treatment.
- Positive change in workplace environment for CRS staff living with HIV.
- Increased office morale due to having a written HIV workplace policy.
- Increased knowledge of basic HIV information.
- Improved access to HIV-related care and treatment.

Lessons Learned

- Open, routine, on-site testing days may encourage staff to be tested.
- Integral, ongoing staff participation is essential for buy-in and success.
- HIV-related health services and treatment must be localized to the country.
- Explore all local options for care and treatment services and partner with the best fit.

- HIV workplace programs should reflect the realities of the local context of the disease.
- Widespread regional participation in World AIDS Day with commemorations relevant to each country's unique operating environment and which tend to reflect similar issues faced by communities they and their implementing partners serve.

Promising Practices

- On the macro or regional level, the hiring or designating of the WPP Point Person (PP) is key to focalizing the staff support and participation that is a hallmark of CRS' WPP. The PP's role is multi-faceted:
 1. To maintain and ensure the confidentiality of human resources;
 2. To lead the CP's Workplace Committee or Task Force;
 3. To manage the WPP's activities and finances; and
 4. To liaise with CP senior staff, regional and headquarters WPP coordinators.
- When the WPP Point Person is living with HIV (although this is not required in order to be a point person), modeling 'positive living' is an added bonus to the CP staff.
- In addition, the early and full support of the Country Representative also seems to have a very positive effect on the progress and implementation of the HIV workplace program in each CP. Early results from the HIV workplace program also show that the Point Person feels that the participatory process they followed led to the employees feeling more valued and feeling encouraged to voice their needs and issues.

On-site CT Days can invoke various outcomes, but **Lesotho's** first was particularly successful. More than two thirds of CP staff were tested, resulting in increased openness about "knowing their status." Factors contributing to this positive outcome may be:

- An early commitment by the CR to the importance of the program and a highly capable program manager to serve as the Point Person to develop Lesotho's WPP.
- Peer Supporters nominated by their staff colleagues and trained in their support role.
- Point Person hired and actively implementing the program in collaboration with the Workplace Committee.

Lesotho Point Person:

Mr. Mochekoane Mohlerepe, mmohlerepe@crslesotho.co.ls

- Staff participation is the hallmark of CRS' Workplace Program. A survey of **Angola's** staff revealed that 70% were interested in being involved in the development of their CP's Workplace Policy. Countries speaking languages other than English face extra challenges regarding global CRS programs, notably translation to national language. Angola initiated translation of reporting forms into Portuguese to better facilitate the integration of their PP, as well as reporting compliance.

Angola Point Persons:

Ms. Sandra Kakunda (for Portuguese), skakunda.crsangola@gmail.com

Ms. Leslie Santamaria (for English), lasantamaria@gmail.com

- Health coverage for HIV-related services and treatment must be localized to each CP, as each face a unique operating environment. In **Zimbabwe**, the WPP faces the challenges of increasing health care costs, an increasing unavailability of essential medications (including ART) and the world's sixth highest HIV prevalence. Providing comprehensive medical coverage to staff was an early program priority. The CP selected a well-respected healthcare provider that offered a chronic disease "add-

CRS SARO STAFF



on” which catered to HIV and AIDS treatment. Then, to encourage more people to sign up for this coverage, CRS increased the proportion of medical care costs covered, thus reducing employees’ contribution. The CP undertook a survey to gauge the level of satisfaction with this healthcare plan, as well as to understand why some staff members had not signed up for the plan. The results from this survey are currently being analyzed and will inform future changes in health coverage.

- Other practices that the Zimbabwe CP has found effective are:|
 - Encouraging peer educators to develop skits for staff events based on the concerns and questions that emerge from staff members. For example, skits to address staff concerns about seeking CT.
 - Offering quarterly staff training for every office and sub-office on topics identified as priorities within those offices. Trainings have addressed topics such as will-writing, the creation of memory boxes, and CT.

Zimbabwe Point Person:

Mrs. Nomthandazo Jones, njones@crszim.org.zw

- Care, support, and treatment facilities vary from country to country. **Malawi** is in the position to partner with top-notch medical providers for testing and diagnostics. While not replicable across the region due to variances in capacity, the CP explores all possible local options and selects the highest quality services. This process has instilled confidence in the staff members who use these services and has encouraged family members to participate in the WPP.

Malawi Point Person:

Mr. Wisdom Kanyamula, wkanyamula@crsmalawi.org

- Training plays an important role in CRS' HIV in the Workplace Program. **South Africa** is unusually well endowed with well established and high caliber academic and professional learning opportunities. The CP has enrolled three of its national staff in a distance learning care and counseling course that they may serve as support resources for staff.
 - **South Africa** facilitated the enrollment of 92 implementing partners in the same training course. This may be an important early step toward supporting partners to develop their own workplace policies and programs.

South Africa Point Person:

Mrs. Itai Munyaradzi, imunyaradzi@crsrsa.co.za

- Reflecting local realities is a cornerstone of CRS' HIV WPP. Most countries in the Southern Africa Region are home to the world's highest HIV prevalence and concomitant efforts toward all manner of mitigation. However, **Madagascar** faces an unusually low HIV prevalence but an extraordinarily high rate of sexually transmitted infections (STI). Because an STI increases the risk of HIV transmission, Madagascar focuses its HIV in the Workplace efforts through the entry point of STI prevention. Awareness and education on STI prevention gets tied to HIV risk and prevention.

Madagascar Point Person:

Ms. Nombana Razafinisoa, nrazafin@crs.mg

- World AIDS Day figures prominently in the activities of CPs across the Southern Africa Region. CRS CP offices plan and implement World AIDS Day commemorations relevant to their unique operating environments which tend to reflect similar issues faced by communities they and their implementing partners serve. Given that SARO is now based in Lusaka, the **Zambia** CP combined forces with SARO staff for co-leading the program as well as sharing relevant presentations. Zambia focuses on their staff for World AIDS Day, while focusing on family members through other events.

Zambia Point Person:

Ms. Carol Mumba, cmumba@crszam.org.zm

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