# Multisectoral Responses to HIV/AIDS

## A Compendium of Promising Practices from Africa


**USAID-PVO Steering Committee**
**on Multisectoral Approaches to HIV/AIDS**



THE Mitchell GROUP, INC.

USAID

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Academy for Educational Development

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# Acknowledgments

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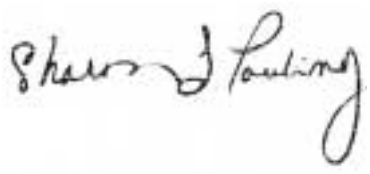
# Foreword

HIV/AIDS is a crisis that expands beyond the health sector and will soon touch everyone in Africa. It is a development problem that defies easy answers and routine solutions. Therefore, creativity, synergy, and collaboration from all sectors of society are required to find solutions to mitigate and prevent the expansion of the epidemic.

Many organizations working in Africa, particularly those not involved in health, have been feeling the effects of HIV/AIDS on their programs and asked USAID for some guidance in how to address these complicated issues. In Washington, D.C., USAID's Bureau for Africa formed the USAID/PVO Steering Committee on Multisectoral Approaches to HIV/AIDS to explore these issues, learn what was already happening, and catalyze action. A conference was held in October 2002 to examine the enormous challenges of HIV/AIDS confronting PVOs and nongovernmental organizations (NGOs) working in Africa. It stressed the multisectoral nature of HIV/AIDS, shared promising practices that organizations have adopted, and identified ways for PVOs and NGOs to collaborate with others and take steps toward overcoming the challenges facing them.

This document brings together the promising practices identified by the PVO community. Our definition of "promising" is purposefully broad to include the many ideas and experiences of different organizations that seem likely to combat HIV/AIDS successfully. Several of these practices are new and as such, do not yet have hard evidence to show that they work. However, rather than wait for documented success, the committee decided to share all the practices available to spur ideas and action.

This compendium is aimed at any person or program that is interested in mitigating the spread of HIV/AIDS, though the emphasis is on those in Africa seeking new ways to act. We hope that the ideas shared in these pages will resonate and stimulate you to adapt them to meet your needs and your situations. And we look forward to hearing about any innovations that do emerge as a result of this compendium.



Sharon Pauling
Senior PVO/NGO Civil Society Advisor
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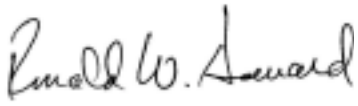

Ronald W. Howard
Executive Vice President
OIC International

# Introduction

HIV/AIDS is among the greatest challenges to sustainable economic, social, and civil society development today; it is a global crisis that undermines all aspects and all sectors of entire societies. An effective response demands committed, urgent, and sustained action by alliances of individuals, organizations and governments. Furthermore, an epidemic as complex and as destructive as HIV/AIDS requires innovative and multisectoral responses beyond standard public health measures. The implementation of multisectoral HIV/AIDS programs warrants total national commitment and reduction in stigma associated with the disease. Thus all governmental and nongovernmental agencies and private organizations engaged in development efforts need to have necessary information to respond to HIV/AIDS as a major development issue. Private voluntary organizations (PVOs) are key players in development efforts.

In January 2000, as the new administration was settling in, 40 leaders of private voluntary organizations met with USAID, Bureau for Africa officials and identified the onslaught of HIV/AIDS as a priority continuing challenge facing sub-Saharan Africa. HIV/AIDS was identified as a key challenge requiring interventions in multiple sectors and by multiple actors in the development assistance community. In response, a PVO/USAID Steering Committee on Multisectoral Approaches to HIV/AIDS was formed and met regularly to discuss these issues and catalyze action. This compendium of promising practices was proposed as a way for the PVOs to share multisectoral HIV/AIDS promising practices and innovations.

This promising practice compendium, a direct outcome from this conference, features 22 practices submitted by 13 organizations working in Africa. To ease the submission process and the comparability of practices, organizations followed a format adapted from other promising practice compendia and limited their entries to five pages. A background piece introduces the practice.

This is a collection of *promising* practices. Most practices in this compendium are very young practices. Therefore, they do not have measurable results without which they cannot be termed best practices.

This compendium can also be found several places online, including http://sara.aed.org/pvo-aids, www.advanceafrica.org, www.interaction.org, and www.synergyaids.org. We want this to be a living document and welcome new submissions and updates to ones included here and will post them in the online version. Items should be submitted to sara@aed.org.

# *I. Agriculture / Food Security / Nutrition*

# Engaging Stakeholders to Improve the Nutritional Status of People Living with HIV/AIDS in Uganda

*Academy for Educational Development*
*FANTA Project*

### Background

Uganda is often cited as a success story in fighting HIV/AIDS, and the country has achieved a substantial decline in HIV/AIDS prevalence over the last decade, especially among younger population groups. However, the nutritional status of people living with HIV/AIDS (PLWHA) in Uganda continues to be of concern. Effective nutritional care and support can help manage symptoms, maintain health and nutritional status, and may slow the progression of the disease. Constraints to nutritional care in Uganda include slow integration of nutrition into HIV/AIDS disease management, lack of national-level or country-specific guidance about nutrition and HIV/AIDS, lack of contextually adapted educational materials about nutrition and HIV/AIDS, and lack of training in nutrition and HIV/AIDS for home care providers and health workers.

Following participation in a workshop supported by USAID/REDSO/ESA, the Uganda National AIDS Control Program (NACP) decided to help fill these gaps by developing national guidelines to serve as the reference document for HIV/AIDS nutritional care and support at district, community, and household levels. The NACP is involving a wide range of multisectoral stakeholders in developing these guidelines. The process has generated enthusiasm and support from stakeholders and donors to strengthen nutritional care and support for PLWHA. The development of national guidelines is supported technically and financially by USAID/Kampala, USAID/REDSO/ESA, the FANTA project, and the Regional Centre for Quality of Health Care (RCQHC). Other donors have already expressed interest in funding activities and materials to apply the guidelines. Major challenges the activity must address include maintaining momentum throughout the process, engaging district and community partners to take the lead in applying the guidelines, and properly monitoring progress.

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| **Description of Practice** | The NACP is leading an inclusive multisectoral process to develop and apply national guidelines for providing nutritional care and support to PLWHA. |
| **Level of Intervention** | • National<br>• District<br>• Community |
| **Prospective Users of the Practice** | • Various line ministries (e.g., health, agriculture, education)<br>• Different sectors (government, nongovernmental organizations [NGOs], private sector, and PLWHA networks)<br>• Numerous intervention levels (policy makers, programmers, trainers, counselors, caregivers, and PLWHA) |
| **Problem Addressed** | • Lack of national guidance on the dietary needs of PLWHA<br>• Lack of integration of nutritional care and support into existing programs |

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| ***Problem Addressed (continued)*** | These problems have led to very slow integration of nutritional care and support of PLWHA, inadequate knowledge and skills in nutrition and HIV/AIDS for front line workers delivering home-based care and counseling services, and insufficient culturally competent nutrition education materials aimed at AIDS service organizations, caregivers, and PLWHA. |
| ***Purpose of Intervention*** | To provide policy makers, programs, caregivers, and PLWHA with sound guidance to improve the nutritional status of those infected by HIV/AIDS. |
| ***Context*** | Situation analysis revealed:<br>• Slow integration of nutrition into HIV/AIDS disease management.<br>• Lack of national guidelines for HIV/AIDS nutrition recommendations, programming, and development of education materials.<br>• Limited existence of HIV/AIDS nutrition education resources.<br>• Lack of contextually appropriate nutrition education materials.<br>• Lack of nutrition training for home care providers.<br>• Lack of specialized nutrition training for counselors.<br>• Cultural, economic, and linguistic factors constrain adoption of recommended practices and limit access to information.<br>• Lack of monitoring and evaluation systems to measure the effectiveness of HIV/AIDS nutrition education. |
| ***Process*** | • Conducted situation analysis by compiling and reviewing existing material and interviewing several program managers and coordinators (no specific tool was used).<br>• Built capacity of a multisectoral team to develop nutrition and HIV/AIDS guidelines through a regional workshop (supported by USAID/REDSO and FANTA).<br>• Built capacity of trainers in medical, health, and nutrition schools to integrate nutrition and HIV/AIDS into their training activities.<br>• Developed a country workplan for developing and applying national guidelines through multisectoral collaboration.<br>• Organized a multisectoral task force on national guidelines to advocate for, draft, and facilitate application of national guidelines.<br>• Mobilized resources.<br>• Advocated on the importance of good nutrition to stakeholders and donors so nutrition could be integrated into existing programs. (This is an ongoing activity. The expected outcomes are to get nutrition care and support recognized as an important component of care and support programs and to impart providers with skills and knowledge required to deliver proper nutrition and care services and increase recognition of nutrition as an important component of care and support programs.)<br>• Involved the main stakeholders in reviewing the national guidelines and developing and implementing an application strategy. |

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| ***Steps in Implementation*** | • Following the above process, a technical team, in collaboration with multisectoral stakeholders, drafted, reviewed, and finalized the guidelines. Inputs used to draft the guidelines included international guides and resources on HIV/AIDS and nutrition and Uganda-specific information on food habits and on HIV/AIDS interventions.<br>• National guidelines were disseminated to a range of ministries, organizations, networks, programs, private companies, resource centers, and others with access to PLWHA.<br>• National guidelines will be applied at the national, district, and community levels through integration into programs and services with training, IEC, advocacy, etc.<br>• Implementation will be carried out at the national level and will involve the main stakeholders. This will allow implementing partners to adjust their ongoing programs accordingly. |
| ***Duration*** | The process began in January 2002, and final national guidelines will be completed by May 2003. Following that, applying the guidelines will begin at the district and community levels. |
| ***Resources Required*** | The entire process in Uganda cost approximately $50,000 over a 17-month period. These costs included developing and disseminating national guidelines and producing and disseminating a booklet of key messages on nutrition and HIV as well as some additional related activities. Costs will vary from country to country depending on the process, products other than guidelines that are developed, and the level of technical assistance required.<br><br>In Uganda, the initiative is funded by:<br>• USAID/Kampala with FANTA/AED for the national guidelines development<br>• USAID/REDSO with FANTA/AED for capacity building and technical assistance<br>• Uganda National AIDS Control Program<br>• Expressed interest from other donors in funding the application process |
| ***Indicators for Monitoring*** | The country team will design a monitoring and evaluation plan with indicators and targets in the coming months. |
| ***Positive Impact*** | The project is not yet completed so the following are expected impacts based on experience to date:<br>• Technically sound and relevant national guidelines on HIV/AIDS nutritional care and support will enable improved nutritional care and support of PLWHA in Uganda, which leads to a better quality of life and improved health.<br>• Working with National AIDS Control Program and involving key national stakeholders in adapting these guidelines for the Ugandan context will ensure ownership and implementation at all levels. |

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| ***Positive Impact (continued)*** | • Nutritional care and support of PLWHA is now being included in Uganda programs and services.<br>• Coordination and dialogue among stakeholders from different sectors will improve. The process in Uganda has brought together stakeholders from different sectors and built consensus that nutritional care and support is important and should be integrated into existing programs and that national guidelines are necessary and should be used by all sectors. It is implied that this coordination may carry over to other activities.<br>• The main stakeholders (NACP and government ministries), NGOs, and donors have all expressed keen interest in applying national guidelines for nutritional care and support. |
| ***Challenges and Pitfalls*** | • Broadening the concept of care and support to include nutrition remains a challenge.<br>• Maintaining momentum throughout the process is difficult, especially while maintaining involvement and ownership by the variety of stakeholders.<br>• Engaging the district and community partners in taking the lead to apply the process (facilitating, coordinating, funding, monitoring, and evaluating) will take a lot of work.<br>• Top-down process from policy makers and programs managers to implementing partners takes a long time to result in improved nutritional practices at the household level.<br>• Indicators do not exist to measure the impact of improved nutritional care and support.<br>• Monitoring plan must be designed and implemented. |
| ***Critical Issues and Lessons Learned*** | • Ongoing sensitization of the stakeholders to the benefits of good nutrition for PLWHA is required.<br>• Capacity building at different levels is required.<br>• Linking the initiative with other programs aimed at improving food access and availability is critical.<br>• Although stakeholders are currently focused on developing the guidelines rather than applying them, it is expected that once all the stakeholders begin using these same guidelines, the quality and impact will increase because they are technically sound, relevant, and accepted by all sectors.<br>• Involving the main stakeholders from the start resulted in improved multisectoral collaboration and dialogue and may contribute to more sustainable programs.<br>• This is an example of how the Uganda National AIDS Control Program, recognizing the benefits of good nutrition for PLWHA in developed countries (after a field visit), has mobilized and involved all the sectors to develop and apply national guidelines. However, this strategy should address capacity building, behavior change communication, advocacy, and improved service delivery in all sectors at all levels to result in better nutrition for PLWHA. |

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| ***Critical Issues and Lessons Learned (continued)*** | The national AIDS control program as well as the stakeholders must find ways to engage and motivate districts and communities to apply the national guidelines to their reality. |
| ***Source of Practice and Dialogue*** | • Uganda National AIDS Control Program, MOH, Kampala<br><br>• Regional Centre for Quality of Health Care (RCQHC) Makerere University, Kampala, Uganda<br><br>• FANTA/AED, Washington, DC<br>Eleonore Seumo (eseumo@aed.org)<br><br>A handbook will be published by RCQHC and FANTA on the process of developing and applying national guidelines. |

# HIV/AIDS Awareness Component of Supplemental Survey to 1999/2000 Postharvest Survey in Zambia

*Zambia Food Security Research Project (FSRP), Michigan State University*
*Zambia Integrated Health Program (ZIHP)*

## Background

The postharvest survey (PHS) is commissioned on an annual basis by the Zambia Ministry of Agriculture, Food, and Fisheries and forms the basis for agricultural statistics. Traditionally, the Central Statistical Office's Agriculture Division is contracted to execute the survey. This practice describes the 1999/2000 supplemental survey that revisited households to collect information not normally covered in the PHS. The supplemental survey included an HIV/AIDS awareness component that was developed by the Zambia Food Security Research project of Michigan State University in collaboration with the Zambia Integrated Health Program (ZIHP) partners.

One of the greatest threats to Zambia's future development is the HIV/AIDS pandemic. Approximately 20 percent of adults in Zambia are infected with HIV, and an estimated 1.2 to 2 million Zambians were living with HIV/AIDS in 2002. HIV/AIDS prevalence is higher in urban than in rural areas, although rural prevalence is rising. Therefore, rural HIV extension efforts are important. In a sparsely populated country the size of Zambia, the physical presence of extension staff should be utilized to the extent possible, complementing mass media extension messages. National household surveys have been identified as important vehicles for such a physical presence. At the same time, it was recognized that national surveys involve large numbers of professional staff away from home for extended periods and are at risk due to practices involving multiple sexual partners. As the Food Security Research Project focuses on rural development and building research capacity among Zambia Ministry of Agriculture and Central Statistical Office staff, adding an HIV/AIDS awareness component to the supplemental survey was an appropriate suggestion to which ZIHP responded positively. Because this was a "piggyback" activity, the additional costs were limited to performing workplace training sessions and printing sufficient leaflets and were covered by the various ZIHP partners.

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| ***Description of Practice*** | An HIV/AIDS awareness component was added to the Supplemental Survey to the 1999/2000 Postharvest Survey for both survey field staff and respondents. |
| ***Level of Intervention*** | • Individual (enumerator)<br>• Household and community (respondent) |
| ***Prospective Users of the Practice*** | • National and regional government offices<br>• Other research organizations that conduct household surveys |
| ***Problem Addressed*** | • Survey field staff travel away from their families for periods of time and may have multiple sexual partners and need knowledge of HIV/AIDS prevention.<br>• Rural HIV incidence is lower than in urban areas, but is increasing. HIV/AIDS information needs in rural areas are not always being met. This is an opportunity to focus some of the outreach to rural households using dissemination methods other than radio. |

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| ***Purpose of Intervention*** | • To increase HIV/AIDS awareness among survey staff and rural populations that are often hard to reach.<br>• To outline the importance of testing and options for HIV-positive people. |
| ***Context*** | • A supplemental survey was designed to revisit the 7700 households with valid records from the PHS to gather more information.<br>• As a matter of policy, the supplemental survey included an HIV/AIDS awareness component that was developed for this purpose. |
| ***Process*** | • The Zambia Integrated Health Program held a "workplace" training of the survey field staff in seven locations based on three pamphlets being distributed.<br>• The surveyors were instructed to leave pamphlets with the survey respondents in the households surveyed and to suggest that they contact their local health worker or teacher to go through the pamphlets with them.<br>• Pamphlets on HIV/AIDS were distributed to each household during the supplemental survey. |
| ***Steps in Implementation*** | • Several organizations collaborated to develop an HIV/AIDS awareness program that could be used in collaboration with the postharvest supplemental survey.<br>• Survey field staff underwent a "workplace" HIV/AIDS training course for their own benefit.<br>• Survey field staff were trained to discuss the pamphlets developed for the survey households.<br>• Survey staff went to community as "informed enumerators" and not as health workers.<br>• Pamphlets were distributed to survey respondents, and enumerators answered questions where possible and referred household members to health workers as necessary. |
| ***Duration*** | Process started with the 1999/2000 supplemental survey to the PHS, and continuation is planned for future PHSs. |
| ***Resources Required*** | • Trainers for the survey field staff workplace training courses; and<br>• Pamphlets for distribution. |
| ***Indicators for Monitoring*** | A monitoring component now exists for the PHS Supplemental Survey. This would be applicable if and when the practice is more widely adopted by the Central Statistical Office in collaboration with organizations such as ZIHP. |

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| ***Positive Impact*** | • Workplace sessions for field staff were well received, stimulated discussion, and created a very open and frank atmosphere, particularly around sensitive topics.<br>• Survey respondents often asked the enumerators questions and wanted more than one copy of the pamphlets.<br>• By the time the interview was nearly done and the HIV/AIDS component was discussed, neighbors of the responding households had joined the interview, significantly increasing the number of households exposed to the session.<br>• People from outside the sampled households were interested and requested pamphlets. |
| ***Challenges and Pitfalls*** | • The pamphlets were only available in English.<br>• Demand for pamphlets exceeded supply (due to the point mentioned above).<br>• Demand for information sometimes exceeded the qualifications of the enumerators, suggesting the need for more direct involvement of health providers. |
| ***Critical Issues and Lessons Learned*** | • The supplemental survey is a very cost effective way to reach a widely disbursed group of rural households with basic HIV/AIDS information.<br>• Greater coordination is needed with health providers to handle more complex questions and to promote continuing awareness.<br>• Before pamphlets are translated into local languages, the information should be evaluated for effectiveness. |
| ***Source of Practice and Dialogue*** | • J.J. Nijhoff<br>Food Security Research Project<br>Michigan State University<br>fsrp1@msu.edu<br><br>• George Gardner<br>USAID<br>ggardner@afr-sd.org |

# HIV/AIDS and Food Security in Swaziland—Increasing Household Incomes through Vegetable Gardening

*World Vision*

### Background

Swaziland, one of the few middle-income countries in sub-Saharan Africa, is devastated by the HIV/AIDS epidemic. As in neighboring countries, the rate of HIV infection in Swaziland is high. In 1999, it was estimated that 33.4 percent of adults aged 15-49 years were infected with HIV. In 2001, as many as 12,000 people of a population of 1,077,122 died of AIDS. By 2016, this population will be 42 percent lower than was projected prior to the HIV/AIDS pandemic.

In Swaziland, as in other developing countries, addressing the needs of HIV/AIDS patients is a challenge. Interventions must be designed in a way that do not unduly compromise energy levels of AIDS patients. This challenge severely limits options for addressing needs of AIDS patients in poor communities.

For the past three years, communities in the Nkalashane and Lubombo, Swaziland area development programs (ADPs) have embarked on vegetable gardening as an income-generating activity to increase incomes of households affected by HIV/AIDS. Emphasis is on vegetable gardening because vegetables provide families with sources of much needed vitamins, thereby improving nutrition for HIV/AIDS patients and other household members. In addition, demand for vegetables in and around the communities is high, and the project has established linkages to restaurants to ensure that farmers receive competitive prices for their produce.

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| **Description of Practice** | Community members establish vegetable gardens to provide an additional source of nutrition in the family diet and source of income. |
| **Level of Intervention** | The project initially targeted two communities in Nkalashane and Lubombo ADPs, with the prospect to expand to up to 20 other needy communities. |
| **Prospective Users of the Practice** | Unemployed community members |
| **Problem Addressed** | • Households affected by HIV/AIDS in Nkalashane and Lubombo have limited access to improved diets, which are necessary to prolong lives of infected individuals.<br>• Limited opportunities exist among rural communities to increase incomes to support education of orphans and other vulnerable children.<br>• Communities lack an irrigation infrastructure. The dams constructed as part of this project are designed to maximize water retention capacity to meet the water need of off-season vegetables. |

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| ***Purpose of Intervention*** | The project provides improved nutrition for beneficiaries to prevent opportunistic infections and to prolong lives of people infected with HIV. It also aims to increase household incomes to facilitate investment in orphan education. |
| ***Context*** | Many people living with HIV/AIDS (PLWHA) in Nkalashane and Lubombo ADPs are caught in a vicious cycle of poverty and disease that limits opportunities to increase incomes. The result is food insecurity for many poor families, which is worsened by the fact that many families have become responsible for orphans of deceased relatives. At the end of 2001, 35,000 children had lost either one or both parents. As a consequence, many families are unable to pay school fees for their children and/or orphans, restricting the potential of a future generation to support itself. |
| ***Process*** | Community members in Nkalashane and Lubombo ADPs initiated the project. Saddled by orphan care, poverty, and helplessness, the communities requested support from World Vision (WV) to improve their livelihood.<br><br>WV conducted a rapid food and livelihood security assessment to ascertain the level of need and appropriate interventions to address them.[1] The analysis of collected information determined that vegetable gardening was a key intervention to address food insecurity and financial needs of households. Vegetables were particularly attractive not only as sources of vitamins, but also for their high cash value and short growing cycle. Demand for vegetables in and around the communities is also high.<br><br>The project was designed in collaboration with key community members and included three components:<br>1. Constructing dams to stock water to irrigate gardens.<br>2. Training farmers to produce vegetables for the market.<br>3. Developing the market.<br><br>Informed by market analysis of produce in the communities, WV designed the marketing component of the project so that produce from the gardens would be sold either directly to restaurants or through market channels developed by the Usuthu Farm, a WV/ Anglican Church for-profit vegetable farm. This was purposely done to eliminate middle men and women in market transactions, thereby increasing the farmers shares of proceeds from end users.<br><br>In conjunction with the community, WV developed work plans and submitted the proposal for funding to the U.S. Department of Agriculture. |

[1] Nankam, Claude. *Rapid Food and Livelihood Security Assessment: A Pocket Guide for Identifying Vulnerabilities and Nutritional Insecurity* (World Vision Inc. 2002).

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| ***Steps in Implementation*** | Implementation began with community sensitization and awareness creation, which facilitated registration of targeted households. In a community, each gardening scheme has 35 members, drawn from households affected by HIV/AIDS.<br><br>Registration was followed by allocation of plots. The average plot size per household is 10 meters by 10 meters. WV provided technical assistance in selecting sites for dams and also established demonstration plots to show project beneficiaries techniques in vegetable gardening.<br><br>WV organized discussion sessions with farmers to examine the nutritional and market values of the vegetables. Other factors, such as resistance to pests and diseases and tolerance to water stress, were also discussed with participants before final decisions on niche vegetable crops were made. Selected vegetables include cabbages, carrots, fennels, leeks, lettuce, spinach, and tomatoes. Leeks and fennels are mostly grown for export through the Usuthu Farm. |
| ***Duration*** | In 1999, the program started in one community, Shoka, and was later scaled up to other communities. In all, eighteen garden schemes operate in the two ADPs. The project is ongoing, and many of the schemes are now self-sustaining. |
| ***Resources Required*** | Required resources include regular agricultural inputs, such as tools, seeds, fertilizers, pumps, and fences. WV provided loans to beneficiaries to procure the seeds. In addition to supplying tools, WV provided technical expertise in irrigation design and vegetable gardening. |
| ***Indicators for Monitoring*** | The indicators listed below have been established to monitor and assess impact of the project.<br><br>*Impact indicators:*<br>• Percentage of needy school-age children in school<br>• Percentage of households eating at least two meals in a day<br><br>*Monitoring indicators:*<br>• Types of crops cultivated in a region<br>• Average yield of crops per plot<br>• Volume of crops sold<br>• Number of food groups consumed by households<br>• Total school fees paid per year<br>• Frequency of consuming vegetables in households |

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| ***Positive Impact*** | Without established indicators at the design stage of the program, it was difficult to conduct a baseline survey to determine benchmarks for specific indicators of interest. Therefore, the impacts discussed below should be considered in light of that constraint.<br><br>An informal evaluation of the project suggests the following impacts:<br><br>• *Diversification of diets*<br>Scheme members have reported that they eat vegetables at least three times a week, compared with none, or less prior to participating in the project. Additionally, community members have also diversified their diets by eating different types of vegetables.<br><br>• *Adoption of technology*<br>Technology adopted by scheme members has spilled over to non-scheme members. Many non-scheme members have established plots and are growing vegetables.<br><br>• *School attendance*<br>Many families have reported that they are able to send their children to school or are able to keep them in school. |
| ***Critical Issues and Lessons Learned*** | Many of the lessons discussed below appear to be generic lessons associated with designing and implementing community-driven programs. However, the fact that they surfaced in this project attests to their importance in program design.<br><br>• Government officials should be engaged in the project design and planning stages to ensure ownership and continuation of low-cost technical assistance.<br><br>• WV would prefer to undertake and focus on gravity-fed irrigation systems rather than diesel-operated pumps. In the context of Nkalashane and Lubombo ADPs, the likelihood of sustaining gravity-fed irrigation systems is high. Operating and maintaining pumps is costly, and replacing them might prove impossible because scheme members pay only $1/month to maintain the pumps. Should diesel pumps become necessary in future garden schemes, a detailed cost/benefit analysis would be necessary to determine the long-term viability of the scheme. Such analysis would also need to compare costs and benefits from using simple drip irrigation as well as gravity-fed systems.<br><br>• WV believes that organic manure should be promoted for gardening schemes instead of artificial fertilizers. Local organic substitutes to artificial fertilizer would increase the long-term viability of these schemes and would increase demand and create a market for manure. It would also facilitate integration of livestock into the garden schemes to increase income for other families. |

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| ***Critical Issues and Lessons Learned (continued)*** | • People living with HIV/AIDS (PLWHA) are sensitive to discussions of the disease. They often feel embarrassed and tend to be defensive and angry. Project staff learned to be mindful of discussing HIV in their presence. During community discussions, the virus is not mentioned by name. Rather, references are made to the sudden increase in deaths and the growing number of orphans and vulnerable children. Thus HIV/AIDS-positive individuals feel comfortable among scheme members.<br><br>• PLWHA tend to be feeble and are unable to tend their gardens as well as those without the virus. Despite the less intensive nature of the gardening scheme, the delicate health of PLWHA clearly suggests the need to shift from traditional labor-intensive farming systems to those that require low management, yet have high output. Scheme members help frail colleagues by collectively weeding and watering their plots and harvesting their produce for sale.<br><br>• The relative success of the project is largely dependent on the motivation of community members. The community has a sense of ownership not only because they initiated the project, but, more importantly, because they helped plan and design the processes. Many people in the community, especially HIV/AIDS-infected individuals, are also enthused about eating vegetables because they have become aware of the nutritional benefits. As a result, many have improved their diets through eating vegetables with the hope of gaining those benefits in case they are already infected with the virus. |
| ***Source of Practice and Dialogue*** | Claude Nankam<br>World Vision<br>cnankam@worldvision.org |

# LEAD Low-Cost Drip Irrigation for Household Plots

*Development Alternatives, Inc.*

### Background

Linkages for the Economic Advancement of the Disadvantaged (LEAD) is a five-year USAID-funded project implemented by Development Alternatives, Inc. (DAI). LEAD is designed to increase access to economic opportunity for Zimbabwe's disadvantaged groups and to help mitigate the economic impacts of HIV/AIDS. In response to the worsening humanitarian crisis, LEAD has expanded its efforts in the area of food security through the promotion of drought-resistant edible cash crops and household nutrition gardens.

As a pilot test, LEAD has introduced 560 low-cost household drip irrigation kits and 100 low-cost water pumps to households affected by HIV/AIDS. An evaluation of the pilot program carried out in February 2003 found that kit users experienced higher yields and better quality crops compared to a control group using traditional means of vegetable growing and saved labor and conserved water in drought-prone areas. The evaluation concluded that proper training and careful targeting of beneficiaries were two essential ingredients for success.

The evaluation found that 49 percent of the participating families were caring for orphans. The findings also highlighted that extra income earned from the sales of vegetables was used to keep kids in school and buy medicine needed to treat opportunistic infections. Experience from the pilot phase shows that sufficient vegetables can be grown using low-cost drip irrigation techniques to satisfy the vegetable needs of a family of five and generate sufficient income to purchase the equivalent of one year's supply of maize for the household.

Based on initial positive results, LEAD has designed a major program with support from USAID's Office of Foreign Disaster Assistance (OFDA) to reach an additional 20,000 households in 2003. In the expanded program, which focuses exclusively on the drip irrigation kits, LEAD is working with dozens of local and international field-based nongovernmental organizations (NGOs) who will utilize the kits in their humanitarian and development programs. LEAD is sourcing kits from local, regional, and international suppliers to provide the best value for beneficiaries and stimulate commercialization.

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| **Description of Practice** | Local and international NGOs promote household nutrition gardens using low-cost drip irrigation systems in response to micronutrient needs of people living with HIV/AIDS (PLWHA) and the deepening food crisis in Zimbabwe. |
| **Level of Intervention** | The 2002 pilot phase reached 500 HIV/AIDS-affected families. Plans are now being implemented with support of OFDA to reach 20,000 households in 2003/4. The potential for program expansion is huge, especially as commercialization takes off. |
| **Prospective Users of the Practice** | The drip irrigation kit is aimed at both food-insecure and HIV/AIDS-affected households, including orphan-headed, elderly-headed, or households with PLWHA. However, any farmer who wishes to farm small plots of land more intensively will find the kit helpful. |

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| ***Problem Addressed*** | The combination of HIV/AIDS and drought has made irrigating small plots an increasing burden for the weak, sick, elderly, or underage. More efficient use of water through a drip system can significantly reduce the quantity of water required, along with the required time and energy for drawing and transporting water. The kit provides a means of producing more nutritious food and generating needed income for medicine and school-related expenses. |
| ***Purpose of Intervention*** | To provide more efficient means to intensify the production of vegetables in household gardens and increase income for HIV/AIDS-affected households and the food insecure. |
| ***Context*** | According to recent estimates, 38 percent of the country's population ages 15 to 49 is HIV-positive. In the last decade, life expectancy has plummeted from 61 to 38 years, and AIDS has orphaned more than 800,000 children age 14 or younger. In addition, rural land grabbing has been extensively reported in the press, leaving AIDS-affected families with smaller plots available for agricultural production. The difficult economic and political situations have placed 8 million people, nearly 2/3 of Zimbabwe's population, in the category of food insecure. |
| ***Process*** | LEAD works with and through NGOs already able to distribute the irrigation kits rapidly to vulnerable households at the community level. Grants are provided to NGOs to cover their management, training, and reporting costs. Hardware is being procured through an open-bidding process. Training and support is being carried out by LEAD directly in support of its NGO network. |
| ***Steps in Implementation*** | • Identifying NGO partners<br>• Training NGO partners<br>• Distributing and installing kits by NGOs<br>• Monitoring and evaluating the kits<br>• Mass producing technology through commercial channels<br>• Building capacity of users, distributors, and producers |
| ***Duration*** | • Drip kit pilot effort began in August 2002 with 560 kits.<br>• Pilot was evaluated in February 2003.<br>• OFDA expansion began in 2003. |
| ***Resources Required*** | • Drip kits and pumps<br>• Network of partner NGOs and AIDS service organizations |
| ***Indicators for Monitoring*** | • Acceptability and understanding of proper use<br>• Technical reliability and performance<br>• Benefits for users<br>• Impact of use at household level |

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| ***Positive Impact*** | • Better nutrition<br>• Labor saving<br>• Water saving<br>• Higher yields<br>• Better quality crops<br>• Income earning potential<br>• Food security |
| ***Challenges and Pitfalls*** | A clear understanding of design irrigation technology is the main barrier to its effective use. This underscores the importance of training and field monitoring for successful implementation.<br><br>LEAD has not encountered barriers due to stigma, in part because non-PLWHA houses have not explicitly been excluded, though they may be reached in larger numbers in later phases. Because the program is relevant to all households coping with drought in Zimbabwe, the entire community is interested in participating. |
| ***Critical Issues and Lessons Learned*** | The importance of training and support for users in the field has been mentioned. One proxy for good use of the system is whether a family reports water savings or not. If they are not saving water, they are using the kit incorrectly. In the pilot phase, about one-half of those receiving the kits used them properly. Training is being emphasized in the OFDA-supported scale up. |
| ***Source of Practice and Dialogue*** | • Linkages for the Economic Advancement of the Disadvantaged<br>1 Downie Avenue<br>Harare, Zimbabwe<br>Tel: (263) 4 797 210<br>Fax: (263) 4 733 517<br><br>• Joan Parker<br>Development Alternatives, Inc.<br>joan_parker@dai.com |

# *II. Capacity / Human Resources Development*

# Addressing the Challenges of HIV/AIDS through Human Capacity Development

*Management Sciences for Health*

## Background

*The Health Sector Human Resource Crisis in Africa: An Issues Paper,* published by USAID, Bureau for Africa, Office of Sustainable Development, lays out the dimensions of the human resources (HR) crisis in Africa and how it has been worsened by HIV/AIDS. Historically, the number of trained health workers has been inadequate, but now severe shortages exist in almost all cadres. When deaths are compared with the capacity to train replacement staff, the training schools can barely replenish 60-70 percent. In addition, out-migration has adversely affected the labor supply in many African health sectors because health workers, generally the most skilled, move to more affluent countries. The health staff who remain are poorly paid, poorly equipped and ill-motivated in the face of an increased demand for health services.

USAID has established the human capacity development (HCD) technical working group to develop a framework for HCD. In collaboration with UNAIDS, the World Bank, and other donors, USAID is also seeking to promote an understanding of this framework and to increase donor support for countries to undertake national HCD planning. HCD is a new approach to an old question—how can governments ensure that adequate human capacity exists to meet the health needs of the people? This was referred to as "manpower planning" in the past and encompassed statistical forecasting and either increasing or decreasing the numbers of students entering preservice training institutions to address imbalances.

With the advent of HIV/AIDS, forecasting is no longer feasible. In many countries there are not enough preservice training institution applicants, faculty, or equipment/supplies to make up for any imbalance. Much more rigorous measures that include retaining as many staff as possible and reaching out to and recruiting community caregivers and nontraditional healers as part of the "service delivery" sphere must be put into practice. In some cases, steps must be taken to stem the tide of health staff migrating to other countries. In all cases, health facilities must transform their human resource management practice to be more fully supportive and respectful of the staff they have. Civil service law and labor unions must review their policy and practice to support the retention of skilled workers. HCD will involve leadership, collaboration, and partnerships with a wide range of stakeholders as well as long-range commitments to pursuing solutions.

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| **Description of Practice** | HCD is developing the will, skills, capabilities, and systems to enable people to respond effectively to HIV/AIDS. HCD is supported by USAID, UNAIDS, and the World Bank Institute. |
| **Level of Intervention** | Three spheres of action or intervention are:<br>• Community<br>• Service providers<br>• Policy/resource allocation |

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| ***Prospective Users of the Practice*** | Managers concerned about strengthening human capacity for the future. |
| ***Problem Addressed*** | • Staff shortages due to increasing attrition of health staff as a result of death and illness.<br>• Staff shortages due to the out-migration of health staff for opportunities in other countries or sectors. |
| ***Purpose of Intervention*** | To develop a national plan to mitigate the impact of HIV/AIDS on human capacity in the health sector. |
| ***Context*** | National HCD planning in the health sector requires input from a wide range of stakeholders: policy makers (i.e., civil service boards, ministries of health, finance, etc.), labor unions, education/preservice training institutions, service providers, and community representatives. |
| ***Process*** | • Identifying the problem.<br>• Capacity mapping—projecting staffing needs now and in the future as weighed against current staff, levels of attrition for all reasons, including government downsizing, and size of anticipated recruitment pools.<br>• Analyzing labor/civil service policy to identify barriers to human capacity development.<br>• Analyzing the status of decentralization and the extent to which it supports effective HCD at all levels.<br>• Assessing the human resource management systems (HRM) and the extent to which these can respond effectively to the impact of HIV/AIDS on human capacity, including the ability of HRM to:<br>— plan effectively for the human resources needed to support the HIV/AIDS program<br>— recruit and retain staff<br>— develop a training plan to adjust for HIV/AIDS skills and staff turnover<br>— promote a stigma-free workplace<br>— develop a benefits program adjusted to maximize retention<br>— increase staff morale and improve performance<br>— implement a workplace prevention program<br>• Assessing linkages among the service sector, the policy sector and the community to allow local input into services and to support scaling up effective HIV/AIDS programs.<br>• Assessing leadership issues at all levels for an effective response to HIV/AIDS and developing a program to strengthen leadership and management.<br>• Developing a sustainable process for multisectoral planning and program implementation. |

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| ***Steps in Implementation*** | • Establish national commitment and leadership.<br>• Create an open process to identify all required stakeholders.<br>• Ensure commitment from all stakeholders to participate.<br>• Assess HR data currently available.<br>• Hold a two-day dialogue to develop a planning process.<br>• Advocate with donors for support of planning and implementation.<br>• Implement the planning process.<br>• Agree to and put monitoring mechanisms in place. |
| ***Duration*** | Anticipated six months to one year for the planning process and ongoing work on implementation. |
| ***Resources Required*** | • Skilled leadership<br>• Facilitators<br>• Budget for travel and meetings |
| ***Indicators for Monitoring*** | Stakeholders and donors keep to the agreements and timeframes. |
| ***Positive Impact*** | Mitigation of the impact of AIDS on human capacity. |
| ***Challenges and Pitfalls*** | HCD planning is a complex process. It requires long-term commitments and the ability to see the long-range goal as well as the ability to form effective partnerships. |
| ***Critical Issues and Lessons Learned*** | None identified for HCD. Lessons are available from other national strategic planning activities. |
| ***Source of Practice and Dialogue*** | Management Sciences for Health HCD Framework; meeting notes from HCD meetings in Barcelona and London.<br><br>Mary O'Neil<br>Management Sciences for Health<br>moneil@msh.org |

# Building Capacity of Community-Based Initiatives to Increase and Improve Adolescent Reproductive Health Awareness and Education

*Africare*

## Background

With youth constituting 33 percent of the continent's total population, Africa has the world's youngest population. Moreover, sub-Saharan Africa is home to 70 percent of young people living with HIV/AIDS (PLWHA) and 90 percent of the AIDS orphans in the world. Vulnerability to HIV/AIDS is compounded by gender and age, making young people, particularly young women, more likely to contract the virus than others. The age distribution of HIV infection in Africa is skewed towards younger females, with infection rates among teenage girls five times higher than teenage boys in some countries.

Since 1999, Africare has implemented adolescent reproductive health initiatives (ARHI) in Malawi, South Africa, Zambia, and Zimbabwe. A key strategy of ARHI has been to identify and link existing community development groups and initiatives to technical, financial, and health information services. Thus the project has attempted to unleash the enormous potential of community-based initiatives (CBIs) to arrest the spread of HIV and to help cope with the socioeconomic consequences of the disease. CBIs, as distinguished from community-based organizations (CBOs), are loosely formed entities that do not receive any financial or technical assistance from government or external sources.

Participating CBIs are all undergoing institutional change processes, with each at different stages of transformation. They are strengthening their capacity to support themselves and contributing to improve the health of their communities. These CBIs reached 2 million youth in rural, low-resource areas where HIV prevalence is high, yet access to information is slim, especially for youth.

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| **Description of Practice** | Africare provided training in organizational development, HIV/AIDS prevention and care, sexual and reproductive health, income-generating activities (IGAs), and life skills to 144 CBIs in four southern African countries. |
| **Level of Intervention** | Community |
| **Prospective Users of the Practice** | • Communities<br>• Local, district, national, and regional authorities<br>• CBIs<br>• NGOs |
| **Problem Addressed** | • Lack of financial and technical support for struggling community-based initiatives.<br>• Low levels of HIV/AIDS, sexual, and reproductive health (RH) awareness and education. |

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| ***Purpose of Intervention*** | • To improve HIV/AIDS awareness and sexual and reproductive health among individuals 10-24 years old in Malawi, South Africa, Zambia, and Zimbabwe.<br>• To support community-based initiatives to be more self-sustaining.<br>• To develop and use innovative information, education, and communication (IEC) approaches. |
| ***Context*** | • HIV/AIDS disproportionately affects the younger population, putting the survival and long-term expectancy of the whole world at risk.<br>• The four project countries have urgent RH problems, including high prevalence of HIV (20% and higher), STIs, and unwanted pregnancies, particularly among adolescents.<br>• Sex and RH are still very much taboo topics. As a result, youth access information through their peers that is often incorrect. The project trains peer educators in participating CBIs to disseminate correct information that will help youth to make informed decisions. |
| ***Process*** | • Identified a minimum of 30 CBIs in each of the four participating countries.<br>• Trained and provided technical assistance to all CBIs in HIV/AIDS prevention and care, sexual and reproductive health, organizational development and management, and IGAs.<br>• Established revolving loan fund for IGAs.<br>• Shared and exchanged best practices. |
| ***Steps in Implementation*** | The practice was implemented in collaboration with local NGO partners, such as Planned Parenthood Association, and local government agencies. Africare provided technical and financial coordination in four phases:<br><br>*Phase One:* Identified RH initiatives and conducted needs assessment.<br>*Phase Two:* Documented and synthesized best practices and lessons learned.<br>*Phase Three:* Disseminated best practices.<br>*Phase Four:* Replicated successful programming.<br><br>Over 2½ years the following inputs were provided to the CBIs:<br>1. Training:<br>• Sensitization and awareness<br>• HIV/AIDS prevention and care, including counseling<br>• Life skills<br>• Project/business management<br>• Vocational skills training for income generation activities (agricultural, sewing, baking)<br>• Special skills/services (theatre for community action and provision of youth friendly services) |

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| ***Steps in Implementation (continued)*** | 2. IEC materials<br>3. Direct financial support<br>4. Mass media IEC activities:<br>• Musical performances<br>• Behavior change communication campaigns<br>• Radio shows<br>• Support/supply of print material |
| ***Duration*** | A proposal submitted to the Bill & Melinda Gates Foundation in February 1999 was funded, and program activities began in May 1999 and ended January 2002. Funding for smaller-scale activities has been secured for two additional years. The ideal timeframe for this kind of activity is 3-5 years. |
| ***Resources Required*** | • Technical expertise and facilitation skills in various areas—HIV/AIDS prevention and care, life skills, counseling, peer education, community theatre, leadership development, strategic planning, business management, project planning, and IGAs, such agriculture, sand casting, baking, and pottery.<br>• Each country program required a project coordinator at the national and community levels, community mobilizers, and NGOs with similar project goals and interventions at the district/community level to provide additional assistance and guidance.<br>• Financial resources needed depend on level of activities and number of CBIs targeted, support from local resources, and donor capabilities. High costs will come from group exchange trips, salaries, and transportation. |
| ***Indicators for Monitoring*** | In all four countries, a baseline survey was conducted using both qualitative and quantitative research methods. In addition to documenting the knowledge, attitudes, and practices at the onset of the intervention, the baseline identified issues and needs of the target audience. The baseline study also revealed prevailing community norms, existing skills, and health-seeking behaviors. Findings from the baseline were shared widely with government, communities, participants, and other stakeholders. Project indicators were as follows:<br>1. Percentage of CBIs that received RH information and support<br>2. Percentage of CBIs that found the information relevant and useful<br>3. Number of adolescents who received RH information<br>4. Number of IEC materials with RH messages<br>5. Number of adolescents attending “youth friendly corner”<br>6. Number of requests CBIs receive for additional RH information<br>7. Identified and documented best practices for each CBI<br>8. Number of CBIs/NGOs that received document on best practices<br>9. Number of CBIs/NGOs that have adopted best practices<br>10. Number of CBIs participating in appropriate training courses<br>11. Number of persons trained |

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| ***Indicators for Monitoring (continued)*** | 12. Percentage of trainees demonstrating newly acquired planning and management skills<br>13. Level of increase in total number of beneficiaries<br>14. Increased geographical coverage<br>15. Sustainability<br>16. Number of participating CBIs that diversified sources of funding<br>17. Number of participating CBIs that increased personnel/ volunteers<br>18. Number of participating CBIs that increased program activities |
| ***Positive Impact*** | The evaluation at the end of three years indicated that the program has increased 144 CBIs' focus and accountability, expanded the knowledge base of all stakeholders on HIV/AIDS, created new attitudes among participants, strengthened staff capacity, and activated mechanisms to facilitate the involvement of the larger youth community in CBI affairs. These CBIs are all undergoing institutional change processes, with each at different stages of transformation.<br><br>The relationship between Africare and these CBIs represents a real partnership between donor and recipient. The approach was unique, working hand-in-hand with the CBIs to develop customized "home grown" solutions to address their needs as they arise.<br><br>The program reached over 2 million youth in the four countries, creating youth forums at the district level with government representatives. One Zambian youth was selected to serve on the national youth committee. This same young man is currently the Youth Representative at Zambia's Country Coordinating Mechanism for the Global Fund to Fight AIDS, Tuberculosis, and Malaria.<br><br>A culture of openness and transparency on HIV/AIDS/STIs is beginning to emerge among all stakeholders interviewed who exhibited a general willingness to acknowledge problems and find solutions.<br><br>The Phase II (2002 – 2004) evaluation will focus on behavior change among the CBIs' beneficiaries at the community level. |
| ***Challenges and Pitfalls*** | • Lack of basic education among some CBI members sometimes limited the training impact and follow-up to ensure learned skills were used.<br>• In general, the program indicators were designed to monitor the capacity building process. No benchmarks exist against which to measure achievements in terms of impact on adolescent RH.<br>• Program supervision mechanisms were weak, as evidenced the large periods of inactivity in Malawi and South Africa prior to the staff turnover, which led to a delay in program implementation. |

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| ***Critical Issues and Lessons Learned*** | The project design was comprehensive, involving CBIs, stakeholders, and their respective communities and targeting IEC approaches to both individual decision making and community norms of sexual behavior. Other key factors contributing to its success included:<br>• Bottom-up, participatory approach that ensured a sense of ownership and commitment.<br>• The presence of an outside facilitator to troubleshoot and assist in analyzing and resolving issues.<br>• Availability of funds to undertake new interventions once identified.<br>• Network of partners to support implementation and offer complementary forms of support, such as government ministries, NGOs, NACP, etc.<br>• Increased awareness by the community of the positive role of youth and the potential benefits of improved support and appreciation of their contributions to reduce and prevent the spread of HIV/AIDS. |
| ***Source of Practice and Dialogue*** | Jennifer Mboyane<br>HIV/AIDS Communication Specialist<br>Africare House<br>440 R Street, NW<br>Washington, DC 20001<br>Tel: (202) 462-3614<br>Fax: (202) 387-1034<br>jmboyane@africare.org |

# Human Resource Management Assessment for HIV/AIDS Environments

*Management Sciences for Health*

## Background

The Human Resource Management (HRM) Assessment Tool for HIV/AIDS Environments is a self-evaluation tool that helps institutions assess the status of their HRM systems and develop improvement strategies. The assessment and action planning require just one day of commitment from a group of 12-16 senior managers. An effective HRM system can increase the human capacity of the institution to meet its goal, minimize the impact of HIV/AIDS on the health work force, increase staff morale, improve performance, and increase the organization's ability to manage change.

The original HRM Assessment Tool and the new version adapted for HIV/AIDS environments have been used in both the public and private sector in Albania, Bolivia, El Salvador, Ghana, Honduras, Kenya, Nicaragua, Papua New Guinea, Paraguay, Uganda, and Zambia.

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| **Description of Practice** | Assess and strengthen HRM systems to assist in the retention and productivity of health staff. |
| **Level of Intervention** | Service provision in either public or private sector. |
| **Prospective Users of the Practice** | • Ministries of health<br>• Nongovernmental (NGOs) and private voluntary organizations (PVOs) who want to strengthen their HRM system |
| **Problem Addressed** | The practice addresses the attrition and low morale of health staff as a result of HIV/AIDS. |
| **Purpose of Intervention** | Strengthen HRMs. |
| **Context** | The HRM Assessment Tool for HIV/AIDS environments provides an opportunity for managers in public- and private-sector organizations to assess their HRM capacity and take steps to strengthen it, designing strategies to develop human capacity in light of HIV/AIDS. |
| **Process** | • Make decision to address HRM issues.<br>• Gain the support of leadership.<br>• Identify a group of 12-16 managers from different levels.<br>• Do the assessment (1/2 day).<br>• Prioritize the results.<br>• Develop an action plan (1/2 day).<br>• Implement the action plan. |
| **Steps in Implementation** | Depends on the elements in the action plan. |

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| ***Duration*** | Technical assistance can last from one week to several years. Management Sciences for Health has worked with organizations that have seen strong improvements in the systems, morale, and productivity of health staff in one year's time. |
| ***Resources Required*** | The primary cost is for technical assistance. There are few material or equipment costs. |
| ***Indicators for Monitoring*** | *Systems indicators:*<br>• Adequate, experienced HR staff in organization.<br>• Organizational structure in place.<br>• Personnel policy manual in place, understood, and practiced.<br>• Data system for tracking employees developed and used.<br>• Performance management system in place and used.<br>• Training plan developed.<br><br>*Performance indicators:*<br>• Reduced absenteeism rates.<br>• Lower staff turnover rate.<br>• Reduced staff grievances.<br>• Fewer vacancies left unfilled over one month.<br>• Staff paid on time.<br>• More internal promotions.<br><br>*Climate indicators:*<br>• Employees feel that:<br>— they are being treated fairly<br>— they understand what they are expected to do<br>— they get adequate feedback on their performance<br>— their work is meaningful and valued by organization<br>— they have opportunities for career development |
| ***Positive Impact*** | • Strengthened HRM system that is responsive to the impact of HIV/AIDS on the health staff.<br>• Increased retention and productivity of health staff.<br>• Capacity to change as environment changes. |
| ***Challenges and Pitfalls*** | The practice requires sustained leadership and the time to make changes. |
| ***Critical Issues and Lessons Learned*** | • Successful change requires leadership and time.<br>• A strong and resilient health staff, linked to the community and to the policy makers, is essential in fighting HIV/AIDS. |
| ***Source of Practice and Dialogue*** | Mary O'Neil<br>Management Sciences for Health<br>moneil@msh.org |

# *III. Care and Support*

# *Male Volunteers Providing Home-Based Care, Support, and Education to People Affected by HIV/AIDS in Zimbabwe*

*Africare*

### *Background*

With initial funding from Ireland AID and Kodak, the Mutasa Male Empowerment project encourages men to provide HIV/AIDS education and basic nursing care to ailing community members. One of the greatest challenges posed by the HIV/AIDS epidemic is caring for people living with HIV/AIDS (PLWHA). The initial focus in the fight against HIV/AIDS has been prevention, but as the epidemic matures, attention is shifting to care and support of those with HIV infection. With no cure in sight, and the available antiretroviral medication beyond the reach of most Zimbabweans, new approaches to caring for the terminally ill had to be adopted. Home-based care programs utilizing the already existing community nursing and hospice structures became the national strategy.

The Mutasa district health office in Manicaland is running a rural-based home care program. While the home-based care program is playing a vital role in mitigating the medical and social impact of HIV, the program has targeted women as voluntary caregivers and AIDS educators. However, surveys show that men exert great influence on a couple's sexual life. Traditionally in Zimbabwean culture, men make the decisions, and women are often powerless and unable to question issues pertaining to their own health and sexuality.

To highlight the contributions men can make in containing the spread of HIV, this home-based care project has focused on the influence and power of men to prevent new infections and provide care and support for people infected and affected by HIV. The male empowerment project and its programs help men to identify new roles regarding the ownership of HIV/AIDS within the community, acquire new ways of approaching and attaining goals through income generation, and increase the support network available to those affected by HIV/AIDS. The long term goal of the male empowerment initiative is to reduce the transmission of HIV/AIDS by altering personal, social, and cultural views surrounding HIV/AIDS care and support for healthy and socially and economically viable communities.

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| ***Description of Practice*** | Male volunteers care for HIV/AIDS-affected people through home-based visits by offering compassion, basic food and medical support, and HIV/AIDS education. The goal of project activities is to reduce transmission rates of HIV/AIDS within the community. |
| ***Level of Intervention*** | Community |
| ***Prospective Users of the Practice*** | • Communities<br>• Government ministries<br>• Local authorities<br>• Public and private health sector<br>• NGOs and churches |

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| ***Problem Addressed*** | • Failure to mobilize male involvement in HIV/AIDS management and prevention efforts;<br>• Insufficient resources to provide adequate care for PLWHA in the community; and<br>• High HIV/AIDS transmission rate in the community. |
| ***Purpose of Intervention*** | To help reduce HIV/AIDS/STI transmission and increase the provision of care and support for the HIV-affected through male volunteer services. |
| ***Context*** | • HIV/AIDS is now the greatest threat to life in Zimbabwe (HIV prevalence is 30% for adults). In Mutasa district, baseline survey results indicated that an orphan exists in one of every two households, and HIV/AIDS is the leading cause of death among young parents.<br>• Cultural traditions contribute to the male role in the spreading HIV/AIDS (e.g., promiscuity, polygamy, wife inheritance) and failing to help care for and support HIV-positive community members (role orientation).<br>• Families in the target area are unable to absorb the financial burden of caring for PLWHA, leading to a high incidence of poverty and premature deaths.<br>• Existing community-based structures and response mechanisms need to be linked formally to maximize sparse local resources and maintain demographically reflective HIV care and prevention programs. |
| ***Process*** | • Recognized that public health services are overwhelmed in target community due to HIV/AIDS, even as transmission rates are increasing.<br>• Identified need for increased home-based care activities for HIV/AIDS patients.<br>• Identified lack of male participation in existing or past HIV/AIDS prevention and support initiatives in target area.<br>• Assessed participant interest in working on HIV/AIDS in target area.<br>• Conducted baseline survey to provide a comprehensive needs assessment of the target population for sustainable/viable project design and to provide a benchmark for project evaluation.<br>• Refined project concept and developed full proposal.<br>• Received $23,000 from Ireland AID for Mutasa Male Empowerment project. |
| ***Steps in Implementation*** | Under the guidance of the project officer who provides training and support, volunteer male caregivers implement project activities. These include:<br>• Weekly home visits to identified clients in the community.<br>• Developing and disseminating HIV/AIDS information, education, and communication (IEC) materials to surrounding community. |

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| ***Steps in Implementation (continued)*** | • Forming support groups to provide psychosocial support to volunteers and their families affected by HIV/AIDS and to facilitate income-generating activities (IGAs).<br>• Establishing IGAs that include basketry, oil pressing, peanut butter making, market gardening, poultry and pig rearing, cattle fattening, and savings schemes. |
| ***Duration*** | The project started in 2000 and secured funding in 2001. Implementation began in 2002, and the project is currently operating on a two-year budget. |
| ***Resources Required*** | *Skills required:*<br>The Africare field officer teaches required skills to caregivers at workshop sessions. Participants must be genuinely motivated to assist and work closely with people affected by HIV/AIDS.<br><br>*Infrastructure and materials required:*<br>• Bicycles for transport to home-based clients<br>• Home care kits for volunteer caregivers<br>• Initial inputs for IGAs<br>• Funding for IEC material development<br><br>*Financial resources required:*<br>• $23,000 (two-year implementation plan)<br><br>*Participants must be trained in:*<br>• Business management skills<br>• Home-based care<br><br>*Human resources required:*<br>• One field officer to monitor initial stages<br>• Caregivers (number depends on assessed needs for home-based care) |
| ***Indicators for Monitoring*** | • Number of volunteer male caregivers<br>• Visits per month to home-based care clients<br>• Number of home-based care kits distributed<br>• Weekly and monthly reports by caregivers and field officer<br>• Establishment of home-based care registers<br>• Number of male volunteers trained in HIV/AIDS prevention, counseling, and home-based care<br>• Type and amount of IEC materials developed and distributed<br>• Number of support groups established<br>• Income raised through IGAs<br>• Provision of bereavement services<br>• Increase in services and community involvement when referenced against baseline survey findings |

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| ***Positive Impact*** | • Improved linkages between and maximization of local resources for viable and sustained community involvement.<br>• Increased health care and psychosocial support of those affected by AIDS in the community.<br>• Reduced stigma in the community due to outreach activities.<br>• Income of HIV/AIDS-affected families supplemented through income generated from small enterprises.<br>• Increase in "men living positively" in the community through support and education endeavors. |
| ***Challenges and Pitfalls*** | Need to secure funding to provide caregivers with transport (bicycles), particularly in rural projects lacking public transport facilities. Inability to do so will decrease the number of home visits and eventually lead to volunteer attrition. |
| ***Critical Issues and Lessons Learned*** | • Support from respected community members to encourage men's participation in HIV/AIDS activities is critical for success.<br>• Increasing access to improved HIV care and support, including prevention and treatment of opportunistic infections for men, is paramount.<br>• Home-based care clients can improve their economic and nutrition status by engaging in IGAs offered through self-help groups.<br>• Providing a forum for HIV-positive people to meet and share ideas and experiences through support groups is essential.<br>• Need to utilize a multisectoral approach to improve the continuum of care between hospital, clinic, and home and to improve issues surrounding stigma.<br>• An external monitoring body (community-based organization or NGO) is required during initial stages of implementation for seed funding, training, and resource networking and support.<br>• The project centers on the sustainability of new behaviors learned by participating men (care-giving activities, safe sexual practices, and community mobilization and involvement).<br>• Similar projects have wide-ranging application throughout Africa (particularly southern Africa). |
| ***Source of Practice and Dialogue*** | Mrs. C. Chipere<br>HIV/AIDS Program Coordinator<br>Africare Zimbabwe<br>africare@mweb.co.zw |

# *IV. Children*

# Community-Based Childcare in Traditional Authority—Nthondo, Malawi

*World Vision*

### Background

Caring for needy extended family members, especially children, has been practiced for years in Africa. In recent years, however, the death toll of adults in the small, rural community of Nthondo, Malawi has escalated to a level that individual families can no longer take in and care for additional children. The community saw that several children were left without the traditional care and support from an adult. In other instances, orphaned children were left with aged grandparents, foster families, or a single parent. In the late 1990s, several child-headed households emerged. In these instances, the older siblings, often less than 15 years old, were forced to drop out of school to look after their younger siblings. Girls were particularly affected, because the girl child is often expected to stop attending school to look after her younger siblings.

This disturbing trend of increased school dropouts concerned some community members who believed that orphans, losing their education, would become terribly disadvantaged and have no chance to escape the vicious cycle of illiteracy and poverty. When the community of Nthondo realized that family members could not care for affected children because of economic hardship, the community devised a plan to intervene. Following a series of meetings and focus group discussions with key stakeholders—elders, faith and community-based groups, families, and individuals—the community of Nthondo decided to establish several community-based childcare centers.

The childcare centers are located all across the village for families highly impacted by the death of parents or guardians. The centers provide day care to preschool orphaned and vulnerable children, while older children continue with their education. The centers are open from 7:00am to 4:00pm so older siblings can drop off and pick up the younger ones on the way to and from school.

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| **Description of Practice** | World Vision assisted the Nthondo community members to pull together their resources and donate their time and effort to establish and run 10 childcare centers. Childcare centers are either established in existing school or administrative buildings or are constructed by local volunteers and artisans.<br><br>Local leaders have also donated portions of their farmland to establish community gardens. School volunteers, in collaboration with the local leaders, mobilize people in the surrounding villages to work on the community gardens. Produce from the gardens is used to feed the children in the centers. Leftover produce is sold at the local market to generate income to offset the cost of running the centers. |
| **Level of Intervention** | Community |

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| ***Prospective Users of the Practice*** | Each community develops its own set of criteria for deciding which children to admit into the center. All children are between 2-6 years old, and most are orphaned or vulnerable to extreme poverty, as defined by the community. However, to avoid stigmatization against the children in the centers, some children who are neither orphaned nor vulnerable have been included. Applications for admission into the day care centers are considered regardless of the cause of the parent's death, though it is assumed that most of the parental deaths in the community are attributable to AIDS. |
| ***Problem Addressed*** | Attrition in school, particularly of girls who were staying home to care for younger siblings. |
| ***Purpose of Intervention*** | To provide both a safe and supportive environment for preschool orphans and increased access to food and nutrition. |
| ***Context*** | In response to the increasing number of school dropouts and children taking care of themselves, the community of Nthondo decided to establish several community-based childcare centers. |
| ***Process*** | Within the last year, the Nthondo community has established ten childcare centers. Each center is staffed by 10 volunteer teachers and has a volunteer parent committee who receive basic training from the district government in early childhood development and resource mobilization.<br><br>The district social welfare office plans, monitors, and supervises center activities. Childcare center volunteers prepare and distribute a free lunches, snacks, and refreshments; provide spiritual and psycho-social care and nurturing; and organize recreational activities.<br><br>Educational materials, school supplies, toys, and cooking utensils are often donated by the community or supporting nongovernmental organizations (NGOs), including World Vision. However, some of the centers purchase their own educational materials and school supplies. |
| ***Steps in Implementation*** | • Community members pull together their resources and donate their time and effort to establish and run the centers.<br>• Community members screen applications received on behalf of the children and decide which children to enroll at the childcare centers. |
| ***Duration*** | The community-based childcare centers have been in operation for almost one year. |

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| ***Resources Required*** | • School furnishings and supplies<br>• Building supplies<br>• Farmland<br>• Animals<br>• Educational materials<br>• Toys<br>• Farm inputs |
| ***Indicators for Monitoring*** | • Number of childcare centers established<br>• Number of children enrolled at each center by age and gender<br>• Number of volunteers trained and assigned to each center<br>• Number of years volunteers remain with a center |
| ***Positive Impact*** | • The children attending the childcare center receive care and attention from the caregivers during the hours their family members need to be either at school or at work. They receive the nutrition, protection, and mental, social, and physical stimulation necessary for healthy development.<br>• Older siblings do not have to drop out of school to care for their younger siblings, and guardians and foster parents continue to work regular hours.<br>• The caregivers are empowered because they are helping to alleviate the impact of AIDS on their communities and are engaged in meaningful work. Volunteers are recognized as selfless individuals contributing valuable services to the community.<br>• The government appreciates the efforts of the community in coming together to implement this project. It encourages other NGOs to assist the government in providing childcare and educational training of all children.<br>• Currently, an almost equal number of boys (335) and girls (326) are attending ten community-based day care centers in Nthondo. |
| ***Challenges and Pitfalls*** | • Sometimes children do not attend the center when their siblings are not able to bring them, and most centers do not have the resources to track and provide transportation to those children who need assistance in getting to school.<br>• Currently, the centers do not have a first aid kit for treating minor medical ailments such as cuts, bruises, and headaches, but they have links to existing healthcare facilities within the community.<br>• The demand for childcare services increases each year. Enrollment has increased from the initial average of 30 per center to 60 within 10 months. The centers need to address how to secure continued funding, especially as the need for the services increases and the demand continues over a prolonged period.<br>• Incentives, such as peer recognition, awards, continuous training, and/or stipends, are needed to ensure increased volunteer retention.<br>• It is important to link between the childcare centers to existing services such as healthcare facilities and education and food security programs for additional support. |

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| ***Critical Issues and Lessons Learned*** | • Communities can come to together to work on projects that they identify as important;<br>• Communities are encouraged to embark and fund projects when the benefit is for children's education; and<br>• Communities are likely to maintain projects when all key stake-holders are involved in designing, implementing, and evaluating the project, even when funding is not guaranteed. |
| ***Source of Practice and Dialogue*** | Ann Claxton<br>World Vision<br>aclaxton@worldvision.org |

# Community Creates Skills Center to Empower Orphans and Vulnerable Children in Nthondo, Malawi

*World Vision*

### Background

World Vision has helped to establish the Kayoyo Skills Center for orphans and vulnerable children (OVC). The center was started by the Community Orphan Care Committee in Nthondo, Malawi with support from the District AIDS Coordinating Committee (DACC) and the faith community to provide skills and income-generating activities (IGAs). The skills provided include life skills, tailoring, and carpentry. The center also has recreation facilities and an HIV/AIDS resource center. Thirty-two OVC are now benefiting from the project.

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| **Description of Practice** | OVC are taught income-generating activities (IGAs) and life skills at a community-supported center. |
| **Level of Intervention** | Community |
| **Prospective Users of the Practice** | • OVC<br>• Church groups<br>• District AIDS Coordinating Committees<br>• Nongovernmental organizations (NGOs) and other institutions involved in orphan care |
| **Problem Addressed** | • Out-of-school OVC lack income-generating skills<br>• Inadequate knowledge on HIV/AIDS<br>• Lack of recreation facilities for the youth<br>• Low socioeconomic income<br>• Lack of parental guidance |
| **Purpose of Intervention** | • To impart skills to OVC that support their psychosocial recovery.<br>• To generate income to support OVC to support education, clothing and food needs for the OVC and their families.<br>• To provide a resource center for HIV/AIDS. |
| **Context** | • The area of the project is remote and rural. The HIV prevalence is about 11 percent and is growing.<br>• The area has little access to programs that support OVC.<br>• A baseline survey of OVC found that this group had limited knowledge of HIV/AIDS, problems with drugs and alcohol abuse, limited skills to generate income to support their needs and those of their families, and spent time doing nothing. |

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| ***Process*** | • An assessment was conducted with the community and OVC to identify problems.<br>• The community discussed how to tackle these problems and through these discussions identified tailoring and carpentry as skills that were needed and could be taught. |
| ***Steps in Implementation*** | • The community identified the problem.<br>• Discussions were held with the community on how to tackle the problem, and the skills center project was identified as a viable project that would address the two issues—income generation and vocational skills acquisition.<br>• A training program was held on how to get and manage resources for the project.<br>• Local tailors and carpenters were identified to act as mentors for the OVC.<br>• A grant of $5750 was provided to purchase the equipment for the center and all materials for the project.<br>• The equipment is kept and managed by the orphan care committee.<br>• The garments and carpentry produced are sold to the public. Special orders to make school uniforms, women's garments, and school benches have been received.<br>• The money collected after the sales is used to reinvest in the project to buy more material so that it can benefit more orphans. |
| ***Duration*** | The process started in 2001, and the project received funding through a grant. The project is continuing and receives technical support as needed. |
| ***Resources Required*** | Technical support and expansion of the project to benefit more OVC. |
| ***Indicators for Monitoring*** | • Increase in number of OVC benefiting from the project.<br>• Increase in demand for their products.<br>• Proper management of materials and machines (no theft). |
| ***Positive Impact*** | • The participants have expressed their happiness in earning a living.<br>• The project has gained recognition.<br>• The community feels pride in ownership of the project. |
| ***Challenges and Pitfalls*** | • Fear of flooding the market because this is a rural area.<br>• Fear of burglary.<br>• Fluctuation of the local currency.<br>• Distance to the center prevented some orphans from easily accessing it, therefore, the community has recommended that the program decentralize to four communities centers. |

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| ***Critical Issues and Lessons Learned*** | • Community involvement in identifying the problem and solution is very critical.<br>• Involving the local structures and linking the community to all the relevant services for sustainability is necessary.<br>• World Vision/Malawi only facilitated the process.<br>• Lack of skills and income is one challenge that OVC in Malawi and other African countries are facing. OVC need vocational skills and IGAs to become independent. IGAs on their own can be very challenging, but if coupled with other skills, the effect is multiplied.<br>• As players in the fight against HIV, empowering communities to deal with their problems is a priority. |
| ***Source of Practice and Dialogue*** | • Nthondo Orphan and Vulnerable Children project<br>Nthondo Area Development Program, Ntchisi District Malawi<br><br>• Ann Claxton<br>World Vision<br>aclaxton@worldvision.org |

# *Integrated Support to Vulnerable Children while Strengthening Productive Capacities of Families and Communities to Cope*

*World Vision*

### *Background*

At the start of the program in 1990, HIV/AIDS had already emerged as a national crisis in Uganda. With seroprevalence rates of 15-25 percent in most urban centers, Uganda stood out as the most affected country in the world. AIDS cases were reported to be present in 33 out of 34 of Uganda's districts, but the most affected districts were Rakai, Masaka, and Gulu. All three had experienced a prolonged period of warfare during the campaign to rid the country of dictator Idi Amin.

There was still much stigma associated with AIDS that contributed to difficulties in identifying and assisting people living with HIV/AIDS (PLWHA) and their children. A rough estimate by UNICEF in 1989 indicated that there were between 500,000 to 700,000 orphans in the country, a level never known before in Uganda.

The Uganda Ministry of Labor and Social Affairs had the principle responsibility for the welfare of orphans, but government capacity was very limited and needed rehabilitation itself. With a loan from the World Bank Program to Alleviate Poverty and Social Costs of Adjustment (PAPSCA), the Ugandan government adopted a strategy to provide resources directly to local communities, utilizing established nongovernmental organizations (NGOs) as principle implementers. World Vision received funding for the program in Rakai and Masaka districts.

This is an example of an integrated, multisectoral program to respond to and mitigate the impacts of HIV/AIDS. It is a very effective way to respond to the HIV/AIDS pandemic because the effects and causes of the spread of HIV/AIDS are cross-sectional and multidimensional. Integrated approaches broaden the support base for the project and ensure that families and individuals benefit at different levels. The success of the Rakai orphans was mainly due to the community participation and partnership, key components to the project's effectiveness and sustainability.

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| ***Description of Practice*** | World Vision collaborates with communities and government to ensure orphans and vulnerable children (OVC) have age-appropriate education and families are strengthened to provide adequate care. |
| ***Level of Intervention*** | • Family<br>• Community |
| ***Prospective Users of the Practice*** | • Families<br>• Communities<br>• NGOs<br>• Civil society<br>• Government |

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| ***Problem Addressed*** | • There is a high orphan population, and extended and foster families taking in orphans were not able to cope well.<br>• School enrollment was dropping in some areas, due, in most cases, to the cost of education and reduced income of foster, single, and child-headed households.<br>• With lower enrollment, schools lacked the income to meet costs of necessary building improvements and therefore raised fees, causing more drop out. |
| ***Purpose of Intervention*** | • Ensure OVC receive age-appropriate education.<br>• Increase productive capacities of foster parents to raise income for OVC needs.<br>• Enable older orphans to attain self-reliance skills.<br>• Support communities to address the psychosocial needs of children and their foster families. |
| ***Context*** | • Communities in Masaka and Rakai districts were aware of the enormity of the AIDS crisis.<br>• The highest numbers of orphaned children in the country (13%) were in these districts (25,000 registered at the time).<br>• Local leaders at the government and traditional levels perceived children as the prime investment for their future community and appealed to the government for OVC support.<br>• Raising children in institutions was, and is still, not popular in Uganda because children are traditionally taken in by extended family.<br>• Communities formed community care associations whose main objective was to support orphans.<br>• Many school-age children were not in school (Masaka: 33.8% and Rakai: 36.4%). |
| ***Process*** | • A needs assessment was conducted within the target area that involved face-to-face interviews with local government and community, focus group discussions with fathers, mothers, youth, and teachers, and a structured questionnaire.<br>• Analysis of the results generated the information regarding the impact of HIV/AIDS, response to it by the communities, and the overall condition of households in the wake of the HIV/AIDS crisis.<br>• Communities described vulnerability in a way that would reduce stigma and build community support.<br>• In 1990, a baseline survey of households with orphans within the program area quantified the well-being of orphans and confirmed any strain on the extended family.<br>• Communities discussed results of the baseline.<br>• Formal partnership of World Vision with government was formed, and funding was provided to implement activities.<br>• Communities defined vulnerable children, targeted age groups, and identified target families through focus groups.<br>• Communities determined the activities World Vision would assist in and those the community would tackle. |

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| ***Steps in Implementation*** | World Vision collaborated with already established structures. These partners included government departments at local and district levels, orphan care committees selected by the communities, women's associations that provided care and support for orphans, farmers groups, parents and teachers associations in schools, and churches.<br><br>*Activities:*<br>• Paid school fees and contributed to cost of scholastic materials.<br>• Supported community efforts to construct and/or rehabilitate primary schools.<br>• Provided agricultural inputs including seeds, animals, and short-term loans to foster families to increase food for children.<br>• Trained foster farmer families in modern farming methods.<br>• Attached vocational training to existing primary schools.<br>• Supported and encouraged local artisans to apprentice older out-of-school youth in marketable skills.<br>• Trained counseling and development workers at village level in home-based care for PLWHA and psychosocial support to OVC.<br>• Provided HIV/AIDS information to households, especially children.<br>• Supported community efforts to renovate and expand health facilities. |
| ***Duration*** | Under the initial PAPSCA grant, the program operated from 1990 to 1995. In 1999, the program was evaluated and continued, with World Vision funding only, to consolidate and expand the impacts made. The program was reorganized into smaller area development programs for greater community management and integration of additional development. The program is designed to phase out in 2007. |
| ***Resources Required*** | Total costs over the initial 5-year PAPSCA period were $1,869,080 for Masaka and $1,540,060 for Rakai.<br><br>These amounts include costs for the following:<br>• Construction materials<br>• Establishing training centers<br>• Training/education<br>• Agricultural credit<br>• Tools and agricultural implements<br>• Vehicle purchases and maintenance<br>• Salaries and administration costs<br>• Equipment for staff<br>• Community labor contribution |

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| ***Indicators for Monitoring*** | • Number of orphans attending school<br>• Number of schools constructed and repaired<br>• Number of older youth attaining vocational skills training<br>• Number of families receiving agricultural inputs<br>• Number of groups and members trained in modern farming skills<br>• Number of community health resource persons trained<br>• Health facilities renovated/constructed and equipped<br>• HIV/AIDS awareness campaigns conducted |
| ***Positive Impact*** | • Approximately 13,000 AIDS and war orphans received assistance to attend school in 1992. By 1995, this number reached over 30,000.<br>• Enrollment increased from 61 percent to 84 percent in Kakuuto county.<br>• By 1998, over 3,000 youths were trained in tailoring, carpentry, building, and bicycle repairs using local artisans and technical institutions.<br>• Improvement in school buildings helped to retain staff and reduce teacher turnover.<br>• Number of pupils passing the primary learning examination increased from 36.65 percent in 1992 to 60 percent in 1996 with more of the passes being in grades 1 and 2.<br>• Sense of common purpose, collaboration, ownership, and responsibility by community members for the ongoing maintenance of school buildings, attendance of pupils, and quality of instruction.<br>• Restored hope, personal growth, and development of children and foster parents.<br>• Reduced stigma associated with AIDS.<br>• Increased community discussion and response (e.g., participation in project activities, caring for orphans, volunteering as home-based care providers).<br>• Helped reduce district and national HIV/AIDS prevalence rates;<br>• Contributed to a low incidence of cholera in the area.<br>• Increased food and income in foster families for children and adults. |
| ***Challenges and Pitfalls*** | • How to provide assistance to children in a family setting that would also contribute to family and community recovery.<br>• Physical plant could not keep up with demand, especially since universal primary education (UPE) was enacted.<br>• Assessing what should go into the education assistance package since the launch of the UPE.<br>• How to overcome the overwhelming psychosocial impact of the pandemic which caused a sense of helplessness, denial, and malaise. |

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| ***Critical Issues and Lessons Learned*** | • Children's education is fundamental to psychosocial well-being as it returns a sense of normality to children and communities traumatized by so much disease and death.<br>• Education support keeps siblings together in foster families, helping them recover from the loss of loved ones.<br>• Children are heavily impacted by the HIV/AIDS pandemic. However, children have high levels of resilience and can cope with difficult situations if their needs are addressed. Long-term focus to respond to HIV/AIDS should be placed on children.<br>• Proactive care and involvement with infected parents before they become too ill to plan or provide for their families is important.<br>• Registering orphans at the funeral of their parents is an efficient way to ensure no child is left behind.<br>• Providing support for school fees helps to stabilize the price of school for all and prevents school fees from spiraling upward. By keeping attendance up of those who otherwise would be forced to drop out, schools do not need to raise the fees for other children.<br>• Small loans are feasible even in a situation of heavy HIV/AIDS devastation and are effective in improving household incomes to meet the basic needs of vulnerable children. Solidarity group methodology is very effective and successful.<br>• The presence of an NGO actor/facilitator in an HIV/AIDS devastated community is fundamental to maintaining community morale and a positive outlook towards the future.<br>• Skills training for older children is effective at ensuring self-reliance and personal development of older children.<br>• Apprenticeships are often an existing, low-cost, and effective form of skills training. |
| ***Source of Practice and Dialogue*** | • Rakai Birungi Byokka Orphans Project, Rakai District, Uganda<br>World Vision/Uganda<br><br>• Ann Claxton<br>World Vision<br>aclaxton@worldvision.org |

# Speak for the Child—Kenya

*Academy for Educational Development*
*Ready to Learn Center*

## Background

Today more than 13 million children have lost either one or both parents to AIDS. The vast majority of these children live in sub-Saharan Africa, and one-third of them are under age five. However, the majority of orphan care and support programs target school-age children. The Academy for Educational Development's (AED) Ready to Learn Center received support from USAID's Displaced Children and Orphans Fund and USAID/Kenya to explore how families and communities are caring for young orphans and vulnerable children (OVC) and to develop community-based models to improve their physical, cognitive, and psychosocial care and development. In March 2001, a model program called Speak for the Child was piloted in the South Kabras community of Kenya's Western Province. (South Kabras comprises five communities or "sublocations" with an estimated population of 32,000.) The principal objective of the Speak for the Child project is to develop, test, and disseminate effective models, tools, and strategies to improve the care and development of young OVC. Through a participatory process with field staff, the models, tools, and strategies developed over the past two years have been revised and refined to increase their simplicity, reliability, and replicability. USAID/Kenya has provided funding through 2003 to increase coverage in South Kabras, to provide training to interested nongovernmental (NGOs) and community-based (CBOs) organizations throughout Kenya and to conduct national-level advocacy.

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| **Description of Practice** | Home-visiting community mentors help caregivers solve problems for OVC under 5 and facilitate access to preschool and health services. |
| **Level of Intervention** | Household<br>Community |
| **Prospective Users of the Practice** | • Communities<br>• NGOs<br>• CBOs<br>• Churches |
| **Problem Addressed** | • Poor health, nutrition, and psychosocial care for OVC under 5<br>• Caregiver isolation<br>• Lack of access to local services |
| **Purpose of Intervention** | • To improve the health, nutrition, and psychosocial caring situation for OVCs under 5.<br>• To support access to relevant community services. |
| **Context** | South Kabras, Kakamega District, Western Province<br>Kenya has the following characteristics:<br>• High HIV/AIDS prevalence area (around 16% adult seroprevalence)<br>• Lack of programs for children under 5 years of age<br>• High prevalence of orphans and abandoned children<br>• Rural area with community commitment |

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| ***Process*** | • Identified the problem (no programs for OVC under 5 in most AIDS-affected communities).<br>• Identified a community in Kenya with need, NGO presence, and some community activism;.<br>• Discussed joint activities with local NGOs.<br>• Conducted community mobilization participatory learning and action (PLA) exercises.<br>• Conducted needs assessments at community and household levels.<br>• Developed home-visiting mentor and community service link plan.<br>• Recruited and trained mentors.<br>• Monitored mentor work and caregivers' needs and practices regarding child health, nutrition, stimulation, and care. |
| ***Steps in Implementation*** | • Conducted PLA activities with community, focused on situation of young children.<br>• Formed committees (Speak for the Child subcommittees formed for each sublocation).<br>• Recruited and trained volunteers for sublocation surveys to target households with most vulnerable children under 5 (two project-supported volunteers per village in each sublocation).<br>• Made initial household visits to assess needs (community nurse).<br>• Recruited and trained community mentors (community nurse).<br>• Visited homes to identify and solve problems (ongoing; one mentor per five households).<br>• Enrolled children in local preschools.<br>• Assisted in completing immunizations.<br>• Held monthly mentor meetings to add training, collect monitoring records, and solve problems (community nurse with about five mentors in each sublocation). |
| ***Duration*** | Process started in October 2000 with funding from Displaced Children and Orphans Fund (DCOF). Activities are ongoing in four of five sublocations. When DCOF funding ends in March 2003, USAID/Kenya will fund an extension year. |
| ***Resources Required*** | *Skills:*<br>• PLA or community mobilization expertise<br>• Community nurse for needs assessment<br>• Mentor support<br><br>*Training:*<br>• Volunteer survey training<br>• Mentor training<br><br>*Human resources:*<br>• 1 community mentor per 5 households<br>• 2 survey volunteers for each village<br>• 1 full-time community nurse |

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| ***Indicators for Monitoring*** | • Immunization status<br>• Preschool attendance<br>• Feeding frequency and diversity<br>• Changes in planting<br>• Getting medical treatment<br>• Hygiene—washing children, cooking utensils, and pots<br>• Psychosocial:<br>— Verbal interaction, telling stories, singing, reading to the child<br>— Teaching children tasks or skills<br>— Not beating children<br>— Encouraging children to play and socialize<br>— Caregivers' interactions with extended family and neighbors<br>— Child more active/less shy<br>— Decreased fears and night terrors<br>— Decrease in amount of time child left alone |
| ***Positive Impact*** | • Improved feeding, health seeking, and caring practices for young children.<br>• Improved food security for OVC households.<br>• Completed immunizations for OVC.<br>• OVC enrolled in preschools.<br>• Decreased caregiver isolation and depression.<br>• Local leaders have praised the program for its impact and transparency.<br>• During their monthly meetings, mentors report that they practice their training and are quite confident in their skills and abilities.<br><br>Caregivers indicated that while the children are at preschool they are able to clean their compound, farm/plant, fetch water and firewood, wash utensils and clothes, prepare lunch, and perform other casual work. The majority also reported that their children now sing, count, tell stories, greet and sit with visitors, play well with other children, wash themselves, and better perform small household chores. |
| ***Challenges and Pitfalls*** | Creating sustainability of program within community. |
| ***Critical Issues and Lessons Learned*** | • Involve critical actors in the community.<br>• Get community involved in targeting children.<br>• Develop clear rationale for targeting children under 5 years old.<br>• Use a listening and problem-solving approach, not lecturing or "delivering messages."<br>• Get NGOs involved from the beginning.<br>• Ensure activities are transparent to community. |
| ***Source of Practice and Dialogue*** | Academy for Educational Development<br>Diane Lusk (dlusk@aed.org) or<br>Sarah Dastur (sdastur@aed.org) |

# *V. Conflict and Humanitarian Relief*

# Churches and Home Care—Meeting the Needs of the Whole Person in Postconflict Rwanda

*World Relief*

## Background

Rwanda is a country with the densest population of sub-Saharan Africa—a country where 65 percent of people live below the poverty line, where war has killed up to one million people and destroyed the health infrastructure, and where 11 percent of the adult population is estimated to be HIV-positive. The Rwandan government spends $12.68 per capita on health, with only 10 percent of its national health budget going to HIV/AIDS treatment. With a huge demand and limited services, the access to care and drugs in Rwanda has been defined by the ability to pay and access to a financial support system to sustain that access.[1] This combination of factors has created a demand for home care training for caregivers of people living with HIV/AIDS (PLWHA).

Churches' strength of numbers, longevity, and mandate to care for the suffering make them ideal vehicles to bring care to the home of those with AIDS. In 2000, World Relief (WR) began mobilizing church networks, assisting them in forming volunteer ministry teams, and then training them in home care practices. The original funding was used to train churches in home care and to develop a manual that uses simple pictures and words to explain the importance of touch and the practical matters of caring for someone who is dying.

The HIV/AIDS crisis is an opportunity for faith communities to answer the needs that traditional government services are not able to meet by caring for the physical, spiritual, and emotional needs of the whole person. The skills gained through the training and the volunteer networks created are sustainable beyond the original funding. And as the volunteers have become familiar with the problems of families affected by AIDS, they have generated creative ideas to provide additional physical support and care for those families.

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| ***Description of Practice*** | Training for churches in home care and counseling to provide physical and spiritual support to the families and persons affected by HIV/AIDS. The program works with a total of 58 Christian denominations in the regions of Kigali, Kigali-Ngali, Ruhengeri, and Cyangugu. These denominations include the Anglican, Catholic, and other evangelical churches. |
| ***Level of Intervention*** | Community |
| ***Prospective Users of the Practice*** | • Churches<br>• Community organizations |
| ***Problem Addressed*** | • Stigma towards PLWHA<br>• Inadequate health care facilities<br>• No disposable income for treatment<br>• Children providing health care to dying parents without proper knowledge of how to care for them |

[1] *Utilization and Expenditures on Outpatient Health Care by HIV Positive Individuals in Rwanda.* A.K. Nandakumar, Pia Schneider, Manjiri Bhawalkar, Damascene Butera; Abt Associates presentation at APHA, November 2001.

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| ***Purpose of Intervention*** | To create community volunteer networks trained in home health care that can provide holistic care to families affected by HIV/AIDS. |
| ***Context*** | • The average per capita income is $260 per year, and there is significant disparity between urban and rural areas.<br>• The majority of the population (65%) lives below the poverty line.<br>• An overburdened health system means most people are being cared for at home.<br>• In many cases, PLWHA can receive better care at home than in overcrowded hospitals, if family members have basic care skills and access to local community health services.<br>• Caring for family members with AIDS at home is often less disruptive to healthy family members than visiting PLWHA in hospitals or clinics.<br>• Churches can provide committed and compassionate leadership and a potential volunteer base.<br>• The infrastructure of the church is far reaching and stable. |
| ***Process*** | • Gather local church leaders to raise awareness and form strategy.<br>• Train church leaders and other members in conducting needs assessments.<br>• Conduct a needs assessment to identify families affected by AIDS in the community.<br>• Pastors present the problem to the congregation and identify volunteers.<br>• Have donor-sponsored writing and/or adapting of home care manual or other training materials (e.g., counseling manual).<br>• Organize church volunteers into small groups of 7-10.<br>• Train volunteers in home care methods.<br>• Train PLWHA caregivers and distribute materials.<br>• Have volunteers meet regularly in small groups for encouragement, lateral learning, and support. |
| ***Steps in Implementation*** | • National level church leaders consulted to form statement of commitment and strategy (Nov. 1999).<br>• Knowledge, attitudes, and practices survey conducted (Oct. 2000).<br>• Home care manual produced (Nov. 2000).<br>• Church networks developed (Aug. 2000-Spring 2001).<br>• Training courses conducted in small groups (ongoing).<br>• Home care volunteer groups and PLWHA support groups meet regularly (ongoing).<br>• WR regional coordinators support implementation (ongoing). |
| ***Duration*** | • Process started in July 2000.<br>• Home care manual completed in December 2000.<br>• Volunteer groups trained in Spring 2001.<br>• Support of volunteer groups is ongoing. |

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| ***Resources Required*** | • Full-time coordinator/trainer<br>• Church leaders and volunteers (can be scaled up according to interest and willingness)<br>• Training for trainers and volunteers in basic home care of PLWHA<br>• Home care manuals<br>• Identification tools for volunteers (e.g., a tote bag for volunteers to carry on home visits, which also provides an incentive)<br>• Funds for home care materials and training (Budget must include enough for initial and follow-up training and, as a minimum, should allow for one manual per small group ministry. Following initial writing and production costs, manuals are reproduced for a little more than $1 a piece.)<br>• Estimated cost of $20,000 for training and production of materials<br>• Possible future support to churches for care (rent, food, school fees, and treatment) |
| ***Indicators for Monitoring*** | • Number of volunteers involved in home-based care<br>• Number of community volunteers trained<br>• Number of churches committed to supporting volunteer groups<br>• Number of churches having a home care program |
| ***Positive Impact*** | • De-stigmatization and acceptance of PLWHA in churches and communities<br>• Better conditions for PLWHA<br>• Child caregivers (i.e., future orphans) identified in households<br>• Holistic needs—spiritual and physical—of patients met |
| ***Challenges and Pitfalls*** | • Expectations for material help (such as food, school fees, etc.) increases among those receiving home care.<br>• Exhaustion/burnout for volunteers. |
| ***Critical Issues and Lessons Learned*** | • Home care has led to de-stigmatization of HIV/AIDS in the community. This has resulted in support groups for PLWHA, an unforeseen and exciting consequence of the home care groups.<br>• Home care has also been integrated well with community banking programs. Community banks provide a forum for training and creating support groups.<br>• As volunteers become familiar with families affected by AIDS, they become aware of the material needs. The result is an increase in demand on churches to provide for physical assistance, such as food and financial assistance.<br>• Home care requires that volunteers be trained in the professional medical services that are available. Volunteers are then encouraged, where possible, to create working relationships with the medical services to provide referrals. |
| ***Source of Practice and Dialogue*** | • Mobilizing for Life Program<br>World Relief Rwanda<br><br>• Emmanuel Ngoga<br>World Relief<br>engoga@wr.org |

# HIV/AIDS Prevention among Refugees and Internally Displaced Persons in Sierra Leone

*World Vision*

## Background

Much of Africa's vulnerability to HIV/AIDS may be attributed to conflict, poverty, and cultural and behavioral practices. At least 30 countries in Africa are involved in one type of conflict or another, resulting in large number of refugees and internally displaced persons (IDPs). Numerous challenges in conflict and transitional environments increase the vulnerability of refugees and IDPs to HIV infection, not least of which are the breakdown of primary and preventative health systems, the exposure of women and girls to sexual violence and exploitation, and the presence and movement of governmental, intergovernmental, and rebel military forces.

Sierra Leone, situated on the coast of West Africa, is recovering from one of the bloodiest wars on the continent and ranks as the poorest country in the world.[1] Average life expectancy has fallen to 37 years, principally as a result of war. Statistics from World Vision clinics indicate that sexually transmitted infections (STIs) among pregnant women are 42 percent, and UNAIDS estimates the HIV prevalence rate is 7 percent. Results of HIV testing among national army recruits showed 1000 out of 1500 testing positive for HIV. In recent years, Sierra Leone has had UN peace keeping troops and Economic Community of West African States (ECOWAS) troops from Nigeria in the country—groups with high potential of transmitting STIs and HIV/AIDS.

Kono district is in northeastern Sierra Leone, where infrastructure is virtually nonexistent. The district has no paved roads, running water, sewage, or garbage collection/disposal system. During the war, major settlements were razed to the ground, homes and grain stores looted, and an excess of 80 percent of the population displaced. The entire health structure was completely destroyed. World Vision (WV) began the Kono Emergency Primary Health Care project in collaboration with the Sierra Leone Ministry of Health (MOH) through the Kono District Health Management Team in 2000. The project serves as a catalyst to integrate public health services with effective leadership and training, community participation and child-centered services, and other business tools, such as quality assurance and data collection.

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| **Description of Practice** | Integrating HIV/AIDS prevention interventions into primary healthcare programs for refugees and IDPs. |
| **Level of Intervention** | • Community<br>• Refugee/IDP camps |
| **Prospective Users of the Practice** | • National government<br>• District authorities<br>• Communities<br>• Private voluntary organizations (PVOs)<br>• Nongovernmental organizations (NGOs) |

[1] *State of the World's Children* (UNICEF 1998).

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| ***Problem Addressed*** | • Refugees and IDPs are vulnerable to HIV/AIDS in a conflict and transitional context.<br>• The population lacks basic health and disease prevention strategies or services.<br>• Knowledge of STIs and HIV/AIDS is practically nonexistent.<br>• HIV/AIDS testing is only available in the capital city. |
| ***Purpose of Intervention*** | To provide effective HIV/AIDS prevention activities, care, and support to at-risk populations of refugees and IDPs. |
| ***Context*** | • The district was heavily populated with refugees and IDPs.<br>• The Government of Sierra Leone asked WV to provide primary health care (PHC) in war-torn communities.<br>• No health care facility or programs were in place, and no attention was given to HIV/AIDS issues, because all was concentrated on emergency humanitarian needs.<br>• The project fostered partnerships between the MOH, the district health management team (DHMT), community leaders and members, and local NGOs for effective HIV/AIDS prevention intervention. The partnerships were supported by a set of common core values strengthened by the use of quality assurance methods, participatory learning and action, performance indicators, and active commitment to transformational leadership principles. |
| ***Process*** | • Community volunteers mobilized to build PHC clinics by providing food for work.<br>• Orientation meeting was held with the DHMT. All health plans and decisions, including the integration of HIV/AIDS in primary health care, were discussed.<br>• A community health infrastructure was established to complement MOH infrastructure.<br>• Chiefdom development committees (CDC) were established in each community with the primary health clinic to determine community needs and appropriate use of funds.<br>• CDCs appointed community health promoters (CHPs).<br>• WV/Sierra Leone conducted “training of trainers” workshops for supervisory health staff, community and youth leaders, DHMTs, and all MOH clinic staff.<br>• Schools were targeted to deliver health education through peer education and competitions.<br>• Monthly health talks were delivered in the clinics on personal hygiene, clinic attendance, immunization, and HIV/AIDS.<br>• HIV/AIDS information gathered on the causes and prevention of the disease was used in discussions to motivate government and civil society to address the problem by pointing out the risks of complacency.<br>• District health team and community volunteers all share responsibilities and provide a range of support for patients. |

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| ***Steps in Implementation*** | • Identify target population.<br>• Engage national government in discussions with health team and community leadership.<br>• Determine strategic framework.<br>• Develop/gather assessment tools and resources.<br>• Mobilize and train supervisory, health management, and community teams.<br>• Diffuse information at clinics, community levels, and through institutions.<br>• Provide incentives for community health team and peer educators in the form of training, improved materials, logistical assistance, and team building.<br>• Monitor health staff and community team performance.<br>• Document results and progress reports of activities.<br>• Identify performance gaps and critical needs.<br>• Provide resources and technical assistance for continuity.<br>• Develop follow-up plan for care and support. |
| ***Duration*** | Project process started in late 2000 and continues to grow as more clinics are established. There are approximately 50 clinics involved, 30 in Kono District and 20 in Bonthe District. The clinics serve approximately 380,000 people. |
| ***Resources Required*** | Approximately $200,000 for two years. Funds are needed for:<br>• IEC materials<br>• Improving laboratory services for STIs and HIV/AIDS testing<br>• Training health care personnel from the primary to the tertiary level in all aspects of HIV/AIDS<br>• Developing specialized health care clinics, particularly for STI and HIV/AIDS testing<br>• Incentives for community health team and clinical staff who are usually not paid salaries on time by the government<br>• Tool kits for community health team that include materials for teaching about STIs and HIV/AIDS<br>• Staff and administrative costs |
| ***Indicators for Monitoring*** | • Number of patients assessed<br>• Number of training workshops and types of training<br>• Number of clinical staff, community health volunteers (CHVs), and CHPs trained<br>• Number of chiefdom development committee meetings and reports of meetings<br>• Number of schools involved in HIV/AIDS education program<br>• Number of youth participants in HIV/AIDS education<br>• Number of HIV/AIDS counselors<br>• Monthly individual HIV/AIDS status statistics and referrals<br>• Number and percentage of people demonstrating accurate knowledge of method of HIV transmission and ways of HIV/AIDS prevention |

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| ***Indicators for Monitoring (continued)*** | • Number and percentage of people reporting behavior change in lifestyles, particularly relating to condom use<br>• Number of weekly visits made by CHVs to those who tested positive for HIV<br>• Retention of volunteers for project sustainability |
| ***Positive Impact*** | • Created a platform for HIV/AIDS prevention at national, district, and community levels.<br>• Launched discussions with MOH and partners for designing an application to the Global Fund for AIDS, Tuberculosis, and Malaria.<br>• Forty percent increase over baseline in STI and HIV/AIDS awareness among those attending clinics and community programs.<br>• Forty percent increase over baseline in STI and HIV awareness among mothers of childbearing age as measured by information retention interviews.<br>• Forty-five percent increase in knowledge of the value of abstinence and behavior change as measured by exit interviews.<br>• Fifteen percent increase in early treatment-seeking behavior for STIs as measured by increased clinic attendance for treatment.<br>• Twenty-five percent increase in counseling and testing interest, based on numbers of people requesting information about and desiring voluntary counseling and testing.<br>• Patients who knew their HIV status were responsive to behavior change and positive lifestyles, based on client exit interviews. |
| ***Challenges and Pitfalls*** | • Improving and sustaining volunteer participation due to economic hardship and transport difficulties.<br>• Overburdened staff due to high demand for emergency health, including clients from IDPs and refugees returning to Sierra Leone.<br>• Establishing benchmarks to measure adequacy of performance in a chaotic environment and with a government that does not have the resources to assist the population in matters of health.<br>• Coordinating and building mutually beneficial relations with other health providers given lack of resources, difficulties of communication, and unclear health policies.<br>• Inadequate pharmaceuticals and medical supplies due to limited resources and increasing influx of refugees and IDPs.<br>• Ongoing frustration and mental health challenges of refugees/IDPs.<br>• Inadequate infrastructure to strengthen care and support. |
| ***Critical Issues and Lessons Learned*** | • A successful implementation of the HIV/AIDS prevention in post-conflict environment should operate within the context of PHC.<br>• PHC services create access for effective HIV/AIDS education, especially for women of childbearing age.<br>• Prevention, care, and treatment of HIV/AIDS are strongly linked, as patient care provides an entry point for effective prevention.<br>• Many clinics were missing two critical elements: the ability to test patients for HIV/AIDS, which now can only take place in the capital city, and antiretroviral drugs. |

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| ***Critical Issues and Lessons Learned (continued)*** | • Collaborating with national government agencies and empowering the community by building a community health infrastructure enhances effective intervention and builds community ownership of program framework.<br>• Even with increased resources, community health workers confront cultural and traditional practices that conflict with Western approaches to treating HIV/AIDS. The civil war exacerbated power-based sexual behavior and broke down traditional practices that prevented the spread of STIs. |
| ***Source of Practice and Dialogue*** | • Ann Claxton<br>World Vision<br>aclaxton@worldvision.org<br><br>• Heinke Bonnlander<br>World Vision International<br>Heinke_Bonnlander@wvi.org |

# *VI. Democracy and Governance*

# *Engaging Legislators and Communities in Linking Increased Awareness about HIV/AIDS Prevention with Democratization*

*Pathfinder International*
*National Democratic Institute*

## *Background*

The government of Nigeria has only recently made the transition to democracy, and it continues to struggle with weak public administration, corruption, and poor social services. The HIV/AIDS epidemic continues to take its toll in Nigeria, exacerbating these difficulties. At the end of 2001, approximately 3.5 million Nigerians were infected with the virus. The government is now worried about sharply increasing HIV prevalence rates, but has few policies to address HIV/AIDS and implements those that do exist erratically.

Pathfinder International and the National Democratic Institute (NDI) have collaborated to develop programs that educate Nigerian policymakers and citizens about HIV/AIDS prevention and other reproductive health issues and increase linkages between legislators and their communities. These programs are implemented at the grassroots and government levels, but are primarily focused on national legislators and their constituents (communities). Through linkages with other USAID partners working at the state level, well-documented initiatives will hopefully be replicated with state assemblies.

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| ***Description of Practice*** | Legislators are supported to raise community awareness of HIV/AIDS, propose longer-term legislation or policy reforms, and increase resource allocation for HIV/AIDS-related information, care, and support at all levels. |
| ***Level of Intervention*** | Community/state assemblies |
| ***Prospective Users of the Practice*** | • Legislators and policy makers at all levels<br>• Community leaders<br>• Health care providers |
| ***Problem Addressed*** | • HIV/AIDS prevalence rate at "explosion point" (5.8%) in Nigeria and rising.<br>• Limited information about HIV/AIDS.<br>• No national focus on HIV/AIDS.<br>• Legislators' desire to respond more effectively to perceived community crises and felt needs.<br>• Significant gaps in policy information, resources available in light of needs. |
| ***Purpose of Intervention*** | • Raise awareness about HIV/AIDS prevention, care, and support.<br>• Provide more effective legislative, policy, and programmatic responses to the HIV/AIDS crisis.<br>• Foster participatory problem identification and problem solving at the community level, with corresponding increases in responsiveness and accountability from legislators. |

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| ***Context*** | • The national climate in Nigeria is characterized by denial and ignorance of HIV/AIDS.<br>• The government is now worried about sharply increasing HIV prevalence rates, but has few policies to address HIV/AIDS and implements those that do exist erratically.<br>• Lawmakers are confronted by evidence of the epidemic's impact on constituencies and their own lack of information on or strategies to address HIV/AIDS prevention, care, and support.<br>• Lawmakers asked NDI for technical assistance (TA) to raise constituents' and colleagues' awareness of HIV/AIDS so that effective legislation, policies, and programs could be implemented nationally. |
| ***Process*** | • NDI engaged in more intensive constituency outreach programs as part of its national assembly (NA) capacity-building program.<br>• During NDI constituency outreach visits, several constituents identified HIV/AIDS and reproductive health issues as vital or "felt needs."<br>• Several NA members asked NDI for TA to raise awareness about HIV/AIDS.<br>• NDI identified a local partner with HIV/AIDS expertise and established plans of action to increase HIV/AIDS awareness funneled through or linked with democratization or participatory processes. |
| ***Steps in Implementation*** | • Plan with partners to develop "generic" community-level activities, select target communities, schedule visits, and prepare appropriate materials in local languages.<br>• Sensitize legislators and their constituency staff.<br>• Tailor activities so they reflect community or traditional structures, levels of need, languages, norms, and infrastructure.<br>• Monitor levels of participation and assist constituency staff to conduct follow-up monitoring or establish feedback mechanisms so effects of information sharing and events are known.<br>• Assist legislators to translate observations and feedback into legislative, policy, and program initiatives. |
| ***Duration*** | Ongoing |
| ***Resources Required*** | *Funding for:*<br>• Community-level events, including sensitization seminars or meetings<br>• Travel for monitoring and supervision<br>• Materials preparation and dissemination<br>• Public hearings or fact-finding missions<br>• Dedicated staff (i.e., 50-100% time) for implementing agencies and local partners<br>• Consultants and facilitators as needed<br>• Publicity (such as Posters of National Concern) |

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| ***Resources Required (continued)*** | *Expertise in:*<br>• Reproductive health (especially HIV/AIDS)<br>• Training techniques and adult learning<br>• Legislative drafting and committee strengthening<br>• Participatory processes and advocacy<br>• Program implementation, monitoring, and coordination |
| ***Indicators for Monitoring*** | • Number/type of activities conducted at the constituency level<br>• Number/gender/age of participants in activities<br>• Number/type of activities initiated at the community level<br>• Number/type of materials distributed<br>• Number/type of new pieces of legislation, policies, or programs introduced in target areas<br>• Number of community residents, legislators indicating awareness of HIV/AIDS prevention, and behavior modification strategies |
| ***Positive Impact*** | • Interest in publicizing HIV/AIDS issues (e.g., public hearing scheduled by NA caucus on HIV/AIDS, creating and distributing a Poster of National Concern signed by legislators and luminaries).<br>• Increased demand by legislators and community residents for activities emphasizing HIV/AIDS in local communities.<br>• Review of national initiatives focused on HIV/AIDS spearheaded by NA, but with request for TA from NDI and local partner.<br>• Increased number of traditional rulers or leaders seeking more information about HIV/AIDS. |
| ***Challenges and Pitfalls*** | • Some leaders and areas still deny that HIV/AIDS is a problem.<br>• Lack of resources devoted to HIV/AIDS by Nigerian government.<br>• Many persons believe that HIV/AIDS is the domain of health care professionals or extremely educated persons, and affected individuals, families, communities have little or no role.<br>• Slow and uneven NA functioning.<br>• Competing priorities such as food security, education, unemployment, economic development, crime, and instability. |
| ***Critical Issues and Lessons Learned*** | • A successful multisectoral initiative requires intensive commitment from intended beneficiaries, even if they have not worked together effectively in the past.<br>• Sponsors of the initiative have to serve as interlocutors and facilitators of broadly participatory processes so that "ownership" of activities and outcomes is established and reinforced.<br>• Resistance to discussing sexual issues is often deep-seated and usually overcome only by linking them with other critical issues like community development and progress. Similarly, communities will only focus on democratization if it is linked with a felt need or manifest problem like HIV/AIDS or another health issue.<br>• In conservative or highly traditional areas, HIV/AIDS should be linked to family health initiatives to reduce stigma surrounding the disease. |

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| ***Source of Practice and Dialogue*** | • Mr. Mike Egboh, Country Director, Pathfinder International/ Nigeria (Megboh@pathfind.org)<br>• Mrs. Bisi Tugbobo, Deputy Country Director, PI/N (Btugbob@pathfind.org)<br>• Ms. Fran Farmer, Senior Technical Advisor, NDI (Ffarmerndi@aol.com)<br>• Mr. Wayne Propst, Country Director, NDI (Wpropstndi@aol.com)<br>• Ms. Shelagh O'Rourke, Senior Advisor for HIV/AIDS, USAID/ Nigeria (sorourke@usaid.gov) |

# *VII. Economic Development / Microfinance*

# Future Search—Building Organizational Capacity and Local Leadership in Zimbabwe

*Pact*

### Background

During its organizational capacity-building program in Zimbabwe in the late 1990s, Pact realizedthat local organizations did not adequately engage in strategic planning and positioning of services. Because of a growing feeling of helplessness and despair among organizations, local leaders and advocates for progressive reforms and innovative problem solving had lost sight of long-term or strategic considerations. Pact sought an approach to strategic planning and management that went beyond business and service-delivery matters and inspired an interest in broader concerns.

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| **Description of Practice** | Future Search is a participatory workshop that enables communities to envision the future through positive and motivating problem analysis. Participants engage in a proactive visioning exercise that leads to a shared or common understanding of the challenges of HIV/AIDS and collaborative ways of addressing them. |
| **Level of Intervention** | Community |
| **Prospective Users of the Practice** | Key beneficiaries are organizations and individuals at the community level that address practical issues of prevention, treatment, care, and support as well as ancillary issues of resource allocation and policy reform. The process works best when it engages a broad range of stakeholders including community leaders and representatives from local government, religious organizations, women's groups, etc. |
| **Problem Addressed** | Organizations in Zimbabwe felt the day-to-day challenges were debilitating, and they were unable to work toward big-picture, macro, or policy issues. Organizations were unable to do long-term planning and goal-setting and could not find support for scaling-up interventions, replicating model approaches, networking or alliance-building, and advocating for important reforms at the municipal and national levels. |
| **Purpose of Intervention** | • To assist organizations to better coordinate services and activities within their immediate service area and across communities, based on identification of explicit longer-term goals.<br>• To assist organizations to generate a better, more nuanced understanding of the challenges faced by people affected by HIV/AIDS and the ways in which they can target limited resources productively for enhanced impact. |

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| ***Context*** | Pact first used Future Search in Zimbabwe in 1998 when the country climate exhibited the following characteristics:<br>• Public and public-private coordinating bodies addressing HIV/AIDS were ineffective in channeling resources to the geographic areas and segments of the population with greatest needs.<br>• A sustained economic downturn limited the support available from the government and the private sector.<br>• Organizations suffered from heightened demands on their services without adequate means of meeting these demands.<br>• Many organizations tended to focus only on direct service provision, which both limited coverage and minimized impact.<br>• Many community initiatives existed in relative isolation and were hardly known outside their immediate area of operation. |
| ***Process*** | Pact developed an approach to assist organizations conduct long-term planning. Future Search is a facilitated workshop lasting no more than three days that encourages a fair amount of scenario-building and visioning of possible solutions to large-scale issues.<br><br>A few weeks prior to the workshop, Pact maps needs, aptitudes, and activities of local organizations and conducts outreach to ensure adequate participation, buy in, and leadership among participating organizations. |
| ***Steps in Implementation*** | Future Search is a three-day process that emphasizes changes in organizational outlook:<br>• Day one concentrates on recent experience and the past. The focus is on creating global and local timelines, noting milestones, underscoring important historical developments through the discovery/identification of patterns, and telling stories that reveal important lessons about past efforts.<br>• Day two (AM) revolves around appreciating the present. This is done by describing ongoing trends/concerns, acknowledging the strengths and weaknesses of current activities, and discussing the intended and unexpected implications of actions.<br>• Day two (PM) centers on the future. Frank discussions are held about future aspirations and various scenarios are developed—some are ideal, and some are more grounded in reality.<br>• Day three motivates action by confirming common themes, grounds for action, and potential projects/activities. This involves developing short- and long-term action agendas, and, most importantly, assuming responsibility for implementing these agendas through commitments made in public.<br>• For maximum effect, Future Search can be accompanied by Vision on Wheels, a detailed action planning workshop that allows organizations to generate precise operational plans that capitalize on and activate the vision and goals enumerated during Future Search. |

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| ***Duration*** | Preparation takes several weeks to map organizational needs, attitudes, and activities and to conduct outreach to ensure adequate participation and ownership in the process. The actual workshop lasts no more than three days. |
| ***Resources Required*** | Future Search does not require extensive resources. The cost of holding such an event includes:<br>• Conference room rental for three days<br>• Lodging and food for participants for three days<br>• Workshop materials<br>• Facilitator expenses<br><br>It has been effectively conducted in schools, churches, and community halls—any venue that is accessible for all participants. |
| ***Indicators for Monitoring*** | • Number of networks and coalitions that emerge as a result of the workshop<br>• Proportion of participating organizations that develop concrete strategic and operational plans based on workshop results<br>• Number of participating organizations that garner more donor support due to the presence of concrete, forward-thinking, strategic, and operational plans<br>• Number of participating organizations that begin to address higher-level policy issues or engage in advocacy |
| ***Positive Impact*** | Participants left the workshop with a shared vision and sense of purpose. They discussed establishing networks to deal more effectively with the issues they faced and to share information and methodologies. In strategizing together, they determined how to better effect change together and separately. In a short period of time, Future Search generated enormous enthusiasm, information, and analysis. Participants were pleased with the quality and amount of work accomplished. |
| ***Challenges and Pitfalls*** | Future Search is best used for overall visioning and problem analysis rather than as a method for generating detailed work plans. While follow-up action planning can occur during the Vision on Wheels workshops, Future Search does not concentrate on detailing all the steps needed to reach articulated goals. It is therefore best used as the foundation for strategic capacity building and for community mobilization, particularly with respect to generating a broad mandate for action. |
| ***Critical Issues and Lessons Learned*** | Shifting operational focus from the present to the future is not always easy. Owing to the extremely difficult external or operating environment of organizations in Zimbabwe, for instance, it was difficult to get participants to shift away from the past or present (and daily concerns) and concentrate on the generation of possible scenarios for the future. Considerable time was spent encouraging participants to change their mind sets and present various paradigms for future work. |

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| ***Source of Practice and Dialogue*** | • Phyllis Craun-Selka<br>Senior Associate<br>Pact Tanzania<br>phyllis@pacttz.org<br><br>• Elizabeth Kummer<br>Senior Program Officer<br>Pact DC<br>ekummer@pacthq.org<br><br>• Jillian Reilly<br>Former Country Representative<br>Pact Zimbabwe<br>reilly@hotmail.com<br><br>Future Search is a methodology for people seeking sustainable action on common ground. For a complete training on how to run a Future Search workshop, the following book will be of interest:<br><br>Wisebord, Marvin and Sandra Janoff. *Future Search: An Action Guide to Finding Common Ground in Organizations and Communities.* San Francisco: Berrett-Koehler Publishers, Inc. 2000 |

# Integrating HIV/AIDS and Microfinance—Crafting a Curriculum for HIV/AIDS Prevention, Care, and Behavior Change through Group-Based Lending

*Freedom from Hunger*
*World Relief*

### Background

For more than 10 years, Freedom from Hunger and World Relief have worked independently, but in a parallel way, to develop a strategy that offers clients a combination of microfinance and health education services. Based on the principles of scaling up and sustainability, group-based lending provides an effective, far-reaching delivery channel for HIV/AIDS prevention and awareness messages.

These two organizations collaborated to create a stronger product by drawing from the best ideas and resources from the partnership, reduce costs by avoiding duplication of efforts, and improve overall efficiency of the development process and effectiveness of the product.

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| **Description of Practice** | The practice is designed to provide HIV/AIDS education to microfinance groups during repayment meetings. |
| **Level of Intervention** | Community |
| **Prospective Users of the Practice** | The curriculum is designed for community microcredit groups using a credit with education methodology (where health and business education are offered along with credit) but can be used by any group that meets regularly (rural or urban). |
| **Problem Addressed** | • Need for comprehensive AIDS education for the illiterate poor<br>• Need for empowerment (especially of women)<br>• Need for forward planning regarding resources in HIV/AIDS-affected households<br>• The stigmatization of people living with HIV/AIDS (PLWHA) |
| **Purpose of Intervention** | • To promote changes in personal behavior to prevent the spread of HIV/AIDS.<br>• To encourage gender equality.<br>• To break down stigma associated with HIV/AIDS.<br>• To promote awareness of and confidence in locally available AIDS-related services.<br>• To strengthen community coping strategies. |
| **Context** | The African continent is facing an AIDS epidemic that threatens all countries. Access to credit and savings, awareness education, and empowering women are important elements in mitigating and preventing the spread of HIV. |

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| ***Process*** | Freedom from Hunger and World Relief worked together to develop a superior practice. The activities of the combined team include design, development, field testing, revisions, publication, and distribution of the documents and implementation of the program as a whole.<br><br>The training manual and adult education primer help ensure that dynamic facilitation methods are used. An adaptation guide is included to help tailor the "generic" education sessions to the local context. The materials use simple language so that they can be understood and translated more easily into local languages. |
| ***Steps in Implementation*** | • Signed partnership agreement (January 2001).<br>• Held first design team meeting (March 2001).<br>• Developed first draft (April-August 2001).<br>• Identified donor (April 2001).<br>• Held second design team meeting (September 2001).<br>• Produced second and third draft (October 2001-January 2002).<br>• Field tested in Asia and African contexts (February-May 2002).<br>• Revised curriculum (June-August 2002).<br>• Published curriculum (September-October 2002).<br>• Held regional and in-country training of trainers (September 2002).<br>• Implemented curriculum globally (Present and ongoing). |
| ***Duration*** | • Development started in March 2001.<br>• Implementation of the final product started in September 2002 and is ongoing. |
| ***Resources Required*** | • Technical expertise in adult non-formal education, HIV/AIDS, community development, and international community health to develop the curriculum<br>• Training in facilitation and adult education for field facilitators to deliver the learning sessions |
| ***Indicators for Monitoring*** | • Number of microfinance institutions or other groups offering this training<br>• Number of facilitators trained<br>• Number of community members receiving training |
| ***Positive Impact*** | Increased awareness of HIV/AIDS in the community through:<br>• Peer education<br>• Prevention of infections<br>• Reduction of stigmatization<br>• Empowerment of women<br>• Improved communication in families<br>• Increased use of available local services |

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| ***Challenges and Pitfalls*** | • Managing a collaborative relationship whether within or outside one's organization requires understanding, patience, and increased communication.<br>• The extra costs in time were outweighed by a better and more effective product as the best ideas and resources were used from a combined team. |
| ***Critical Issues and Lessons Learned*** | • Partnering to develop a common product requires sharing similar core values, standards of excellence, and willingness to suspend the way one normally operates.<br>• In terms of implementing the product, providing HIV/AIDS awareness and behavior change messages through established groups provides large-scale and effective delivery and draws on the strength of the group to facilitate preventative behavior change. |
| ***Source of Practice and Dialogue*** | • Laura van Vuuren<br>World Relief<br>laurav@wr.org<br>7 East Baltimore Street<br>Baltimore, MD 21202 USA<br>Tel: (443)-451-1949<br><br>• Freedom from Hunger<br>programs@freefromhunger.org<br>1644 DaVinci Court<br>Davis, CA 95616 USA<br>Tel : (530) 758-6200<br>www.ffhtechnical.org<br><br>Materials are available for purchase from either organization. |

# LEAD Legal Services Voucher Program

*Development Alternatives, Inc.*

## Background

Development Alternatives Inc.'s (DAI) USAID-funded Linkages for the Economic Advancement of the Disadvantaged (LEAD) program launched the Legal Services Voucher program to mitigate the economic impacts of HIV/AIDS on poor households through asset protection.

Zimbabwe is faced with the second highest HIV infection rate in the world. With the declining economic situation in Zimbabwe, compounded by the stigma of AIDS deaths, protecting the limited assets of poorer families has become critical. Previous donor-funded projects, such as the United Kingdom Department for International Development's Wills & Inheritance Programme, provided public information and education on the subject. However, these projects failed to connect the legal community directly to those needing services. LEAD created a pilot voucher program to provide defined legal products—wills, guardianship claims, and estate maintenance claims—to address this issue.

The program was developed with the cooperation and support of the USAID/Zimbabwe mission. In the pilot phase, the program will operate in and around four major city centers in Zimbabwe—Harare, Bulawayo, Gweru, and Mutare. At the end of the pilot phase, the program will be reviewed, and, if funding is secured, it will aim to expand to the entire country.

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| **Description of Practice** | DAI partners with local AIDS service organizations (ASOs), HIV/AIDS-focused nongovernmental organizations (NGOs), and local law firms to protect the assets of targeted low- and lower-income HIV/AIDS-affected households by providing vouchers for legal services (wills, guardianship and maintenance claims). |
| **Level of Intervention** | Community level; now in pilot test phase (September 2002-August 2003) in 11 sites and accessible to 12,000 people living with HIV/AIDS (PLWHA) |
| **Prospective Users of the Practice** | Low-income, HIV/AIDS-affected individuals |
| **Problem Addressed** | With more than half of its population facing starvation and with the world's second highest HIV incidence rate, Zimbabwe is in the midst of concurrent economic, social, and health crises. These related and compounding crises adversely affect all Zimbabweans, particularly the poor and specifically women.<br><br>Zimbabwe has strong ties to its cultural past, and despite the presence of a strong constitutional legal system, "tribal" laws are often the rule of the land, especially in rural communities. These beliefs include that women are "property" of the household. In addition to the stigma associated with an HIV/AIDS-related death, widows and their children are often cast out of their home while other family members take their assets. |

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| ***Purpose of Intervention*** | To use a business development approach (vouchers) to provide both affordable legal services to HIV/AIDS-affected households and create competition among Zimbabwean law firms on price, product, and outreach in the defined product areas. Market competition in these areas will reduce the perceived cost barriers between other economic segments of the population and law firms. |
| ***Context*** | Zimbabwe has one of the highest HIV prevalence rates in the world, now estimated at 38 percent. A negative impact of AIDS deaths has been the spouses' and children's inability to stay on the family's land after the death of an adult, which reduces their ability to retain their livelihood, particularly in rural areas. Other legal issues are also emerging as critical barriers, such as guardianship, transfers of property, and maintenance.<br><br>Typically when the husband dies of AIDS, his family takes possession of all of the husband's property and pushes the wife, and in many cases the children, out of the house with nothing. This is a very common occurrence in Zimbabwe due to a patriarchal family structure and the stigma that HIV/AIDS is connected with witchcraft.<br><br>This program aims to find a mechanism that provides large-scale access to legal services to respond to these issues, based on the voucher methodology from the "business development services" field. |
| ***Process*** | The LEAD program selects ASOs and AIDS-focused NGOs to educate their members on the voucher program and to issue vouchers to those who qualify. Currently the project partners with 11 organizations, but within another year, the plan is to have 14 partner organizations issuing vouchers.<br><br>Once they have received the voucher, clients contact participating law firms and select the firm they wish to visit based on location, price, or quality of the service. The law firm provides services to the client. Once the product has been delivered to the client, the law firm submits the voucher to LEAD for payment.<br><br>LEAD also enters client data (product, co-pay, and customer service rating of the firm) into the program's database. This information is transmitted to all distribution points to assist all new clients in making informed decisions on which law firm they want to use. This reinforces competition among law firms within the marketplace. |
| ***Steps in Implementation*** | • Conduct market assessment (supply, demand, and products).<br>• Design program and select partners (ASOs and NGOs).<br>• Open sign-up for interested suppliers (law firms).<br>• Train partners (program implementation) and law firms (HIV/AIDS sensitivity).<br>• Launch and market the program and conduct outreach.<br>• Manage project and data.<br>• End program. |

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| ***Duration*** | Two-year pilot with a critical review at the end of the first year:<br>• Project assessment and design started in December 2001.<br>• Distribution of vouchers started in August 2002.<br>• Project will be reviewed in August 2003. |
| ***Resources Required*** | • Network of partner NGOs and ASOs<br>• Interested law firms<br>• Database networked with partners<br>• Voucher funding<br><br>Total funding for the project design and implementation for the two years is $200,000. |
| ***Indicators for Monitoring*** | • Outreach<br>• Innovative competition among the participating law firms<br>• Usage of the end product (i.e., the will is used and honored) |
| ***Positive Impact*** | Though in its pilot stage, this product has generated interest in both the donor and NGO communities. LEAD is currently designing a study on how the program has impacted the households served. The study intends to look at the assets protected and how they were protected (e.g., Was the will followed?) as well as social impacts on the family—children protected or better cared for, due to a guardianship. More detailed parameters are under development. |
| ***Challenges and Pitfalls*** | • Developing defined products.<br>• Difficult to reinforce business development principles.<br>• Risk that this will become a subsidy program.<br>• Preventing voucher fraud. |
| ***Critical Issues and Lessons Learned*** | This is the first time that a business development tool (vouchers) has been used to address a social need of those adversely affected by AIDS, so it is still too soon to determine lessons learned. However, in this model, an exit strategy is needed. If the market has developed and is serving the target group, the goals have been achieved. If this has not happened, the vouchers run the risk of becoming a subsidy. |
| ***Source of Practice and Dialogue*** | DAI has used a similar voucher method to develop sustainable markets for training services for small businesses in the Ukraine and has reviewed similar programs implemented by Gama Consulting (Uruguay) across Latin America.<br><br>• LEAD<br>1 Downie Avenue<br>Harare, Zimbabwe<br>Tel: (263) 4 797 210<br>Fax: (263) 4 733 517<br><br>• Lendell Foan<br>DAI<br>lendell_foan@dai.com |

# Mitigating the Economic Impact of HIV/AIDS on Small Business—A Zambian Multisectoral Approach

*International Executive Service Corps*

## Background

Mitigating the economic impact of HIV/AIDS is an area that is only beginning to be addressed. Health and family issues have received the greatest attention, but the horizon of what is needed to combat the pandemic must be broadened. As more is known about the impact of the pandemic, International Executive Service Corps (IESC) has learned that sometimes a small amount of attention to business matters prior to a health crisis may save a family from economic disaster. While business survival is not strictly an HIV/AIDS health issue, more planning in this area might help to minimize the number of economically disadvantaged widows and orphans and create more economic stability for micro and small businesses as well as their employees and families.

IESC's comprehensive micro, small, and medium enterprises (MSMEs) intervention process is designed to create lasting impact in the business' ability to manage crises caused by HIV/AIDS, understand legal rights and opportunities, and access health-related resources for employers, employees, and their families.

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| **Description of Practice** | Work with business associations, their members, and other micro, small, and medium enterprises (MSME) in the community to address the needs of business owners and employees. |
| **Level of Intervention** | Prevention for business owners, employees, and their families. |
| **Prospective Users of the Practice** | MSMEs and business associations in urban, peri-urban, and rural areas |
| **Problem Addressed** | Crisis caused by illness or death of business owner and/or employees. |
| **Purpose of Intervention** | To help MSMEs prepare for business crisis and utilize community resources for business and legal assistance and HIV/AIDS education. |
| **Context** | Small business is the economic backbone of most developing countries, yet these businesses face disaster at a time of health crisis. This practice helps small businesses prepare to manage the challenges caused by HIV/AIDS, thus protecting business income, client base, and assets in addition to employee income, family stability, and community health. The program has been field tested in Zambia in urban, peri-urban, and rural areas (Lusaka, Livingstone, Zambezi, and Petauke). |

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| ***Process*** | Targeted training for MSMEs in three specific, yet thoroughly integrated, areas:<br>• Business planning<br>• Basic HIV/AIDS information and/or HIV/AIDS in the workplace training<br>• Legal rights and opportunities<br><br>When relevant, partner with local service providers to implement the program. |
| ***Steps in Implementation*** | IESC MSME experts provide the core training and draw upon other resources in the community when needed and accessible to address legal issues and specific health issues. This may include HIV/AIDS in the workplace training, legal training, widows and orphans issues, etc.<br><br>The core training uses IESC's *MSME HIV/AIDS Business Planning Workbook* to help business owners identify their business assets, ensure support for business management in their absence, understand the importance of cross-training employees, and create a network to support their business in times of crisis or transition. Basic business skills and issues are addressed, including basic accounting, marketing, and finance. |
| ***Duration*** | Variable modalities exist. However, in most cases, training takes place over a period of two-weeks for up to 20 participants. |
| ***Resources Required*** | • MSME expert<br>• HIV/AIDS *MSME Business Planning Workbook*<br>• Training space<br>• Presentation materials |
| ***Indicators for Monitoring*** | • Number of MSMEs assisted that participate in the training, disaggregated by gender<br>• Number of MSMEs working one-on-one with experts, disaggregated by gender<br>• Number of MSMEs reporting sustained financial records<br>• Number of MSMEs with business crisis plans<br>• Number of employees of each MSMEs<br>• Number of MSMEs reporting new business practices<br>• Number of MSMEs reporting profits or losses after intervention<br>• Number of MSME owners with wills<br>• Number of MSMEs with HIV/AIDS policies |
| ***Positive Impact*** | • MSMEs have a business planning tool that did not exist before.<br>• Owners of MSMEs begin to include family members in business and training to ensure interim management or ownership of business after owner dies.<br>• Owners and employees have better understanding of community resources available to them.<br>• MSMEs are in a better position to withstand a health-related business crisis. |

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| ***Challenges and Pitfalls*** | • Negative impact of HIV/AIDS already greatly felt by MSMEs.<br>• Assets of MSME are often stripped while owner is ill.<br>• Local resources may not be available to provide ongoing business support, voluntary counseling and testing, medication, legal advice, condom distribution, etc. |
| ***Critical Issues and Lessons Learned*** | • Legal issues, such as wills and property ownership, are of great concern both in business and personal contexts.<br>• Few MSMEs have developed a survival/succession strategy.<br>• Women-owned businesses have special needs that must be addressed to protect assets and savings.<br>• In rural areas, basic HIV/AIDS education is often needed.<br>• Workplace programs are generally directed to medium and large enterprises, so small businesses are left without resources.<br>• Workplace programs usually only address health issues, not strategies for mitigating impact on business or family assets. |
| ***Source of Practice and Dialogue*** | Mary Katherine Cope<br>International Executive Service Corps<br>mkcope@iesc.co.za |

# *VIII. Education*

# Communities Supporting Health, HIV/AIDS, Nutrition, and Gender Education in Schools Project

*CARE International-Zambia*
*Creative Associates International*

## Background

In 2002, an estimated 1.2 to 2 million Zambians were living with HIV/AIDS. Despite this figure, Zambia serves as a model for developing countries trying to reduce HIV prevalence. HIV infections among young Zambians appear to be declining due to effective prevention and social change.

The Communities Supporting Health, HIV/AIDS, Nutrition, and Gender Education in Schools (CHANGES) project works to promote prevention and social change in the Southern and Eastern provinces of Zambia by providing communities, nongovernmental organizations (NGOs), and other nonprofit organizations the opportunity to obtain small-grant funds for innovative interventions. These interventions are designed to increase girls' and other vulnerable children's access to education, support school activities that will improve learning, health, and nutritional status, and integrate AIDS-awareness and prevention messages into ongoing school and community activities.

The project, run by CARE International in collaboration with Creative Associates International, is part of a larger program known as the Basic Education Sub-Sector Investment program.

CARE provides training in proposal writing to interested communities and organizations and will ensure capacity building as needed for good financial management of the grant funds.

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| **Description of Practice** | A school-based health, HIV/AIDS, nutrition, gender, and equity education program for formal rural schools |
| **Level of Intervention** | Schools and communities |
| **Prospective Users of the Practice** | • Marginalized communities<br>• Parents<br>• School children (ages 5-14)<br>• Teachers |
| **Problem Addressed** | • The health of school-aged children in rural and marginalized communities is not adequate.<br>• Children's diets contain low levels of nutrition especially key micronutrients.<br>• Lack of understanding and information about the HIV/AIDS pandemic sweeping through Zambia.<br>• Lack of parental awareness concerning the need to educate orphans, especially girls.<br>• Lack of coordination between health, education, and rural development ministries in dealing with health and HIV/AIDS issues. |

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| ***Purpose of Intervention*** | • To develop model interventions to provide large numbers of school children with basic health care and to raise community awareness about HIV/AIDS its causes and prevention<br>• To encourage rural communities to play a more proactive role in the detection, prevention, and care of HIV/AIDS |
| ***Context*** | The project was designed to involve baseline research, do pilot testing, and develop innovative approaches to:<br>• Increase girls' and other vulnerable children's access to education.<br>• Support school health and nutrition activities that will improve learning, health, and nutritional status.<br>• Integrate AIDS awareness and prevention messages into ongoing school and community activities. |
| ***Process*** | • Raise community awareness of health and HIV issues and mobilize these communities to develop targeted actions to address HIV/AIDS, girls' education, and better health and nutrition for school-going children at the primary level.<br>• Use theatre to involve communities in an open discussion about their health and education problems. Headmen, chiefs, and local district offices are brought together to develop participatory strategies to deal with their problems.<br>• Train a cadre of district-level personnel to work with villages and schools to address targeted issues.<br>• Train district- and community-level education and health personnel to work together to address the health and education issues cited.<br>• Assist villagers and school heads to write grant proposals for targeted school- and community- level projects to address HIV/AIDS, education, and school health and nutrition issues.<br>• Monitor and assess program implementation and impact on an ongoing basis. |
| ***Steps in Implementation*** | • Villages and schools in Southern and Eastern provinces implemented the program about nine months after project's start up.<br>• Program implementation in Southern Province is delayed due to unclear implementation plan and management problems.<br>• The disbursement of grants is being delayed by communities' inability to write grant proposals. |
| ***Duration*** | • The project, which started in 2001 and will run until 2004 is currently in phase 2.<br>• Phase 3 will scale up the intervention to the provincial level.<br>• Phase 4 will take the program to scale at the national level. |
| ***Resources Required*** | Small grants typically range from $1,000 to $50,000. This depends on community need and the type of proposal submitted. |

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| ***Indicators for Monitoring*** | • Number of beneficiaries or children reached<br>• Number of schools participating<br>• Number of technical personnel trained<br>• Number of children treated with which drug regime<br>• Number of children diagnosed as infected with helminths, malaria, bilharzia, and malnutrition |
| ***Positive Impact*** | • A strong demand from parents, community leaders, and partner ministries is being registered for the school health and nutrition component of the project.<br>• Communities are asking to speed up the grant process.<br>• Provincial and district staff of the ministries of health and education are requesting that both components of the project be extended beyond the initial pilot catchment areas in both provinces. |
| ***Challenges and Pitfalls*** | • Weak management on the part of participating Zambian government entities and poorly supported and paid staff are a major constraint.<br>• The project must become sustainable beyond the initial pilot phase once USAID financial support stops.<br>• The current famine in both provinces is confusing the situation.<br>• Project outcomes and targets seem less of a priority given the pending hunger crisis.<br>• Low levels of overall nutrition are adversely affecting HIV-positive adults and children. |
| ***Critical Issues and Lessons Learned*** | • Project or program design needs to fit national conditions and not those of a neighboring country. Some of the project's initial assumptions were based on a successful model developed in Malawi, a country that is very different culturally and geographically from Zambia.<br>• This approach has potential, but needs to be carefully planned and implemented with the full participation of all the partners. Pilot efforts should be well targeted and modest in their coverage, and only when the chosen methodology or approach is successful on a limited scale should an attempt be made to scale up.<br>• Weak management and leadership can adversely affect project implementation.<br>• More reliance can and should be placed on Zambian leadership and technical inputs.<br>• Public sector personnel need incentives to play an active role.<br>• Transport and communications issues need to be carefully addressed to replicate this program successfully in remote rural communities in other provinces.<br>• Radio and mass media should be used more effectively to promote and disseminate project messages and information.<br>• Clearer messages about HIV/AIDS need to be worked into the strategy for positive impact to be discernible. |
| ***Source of Practice and Dialogue*** | CARE International-Zambia and Creative Associates International<br>Frank Dall, FrankD@caii-dc.com |

# Fostering Collaboration between NGOs and Education Officials in Ghana

*World Education-Ghana*

## Background

Today, HIV/AIDS threatens to undermine decades of considerable progress in Ghana's education sector as the epidemic ravages the ranks of both teachers and students. In the face of this challenge, World Education's Strengthening HIV/AIDS Partnerships in Education (SHAPE) project strengthens the capacity of Ghanaian nongovernmental organizations (NGOs) to plan and implement more effectively innovative activities that prevent the spread of and mitigate the epidemic's impact on Ghanaian schools. Project activities, which include tailored training and small grant assistance for local partners, are carried out in close collaboration with the Ghana Ministry of Education (MOE) and other stakeholders. With SHAPE's support, participating Ghanaian organizations improve the effectiveness of their work, targeting students, teachers, and parents with interventions ranging from youth drama clubs and puppet shows to teacher support groups and peer education programs.

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| ***Description of Practice*** | NGOs and government education officials collaborate to develop and implement school-based HIV/AIDS activities. |
| ***Level of Intervention*** | Community |
| ***Prospective Users of the Practice*** | • Students<br>• Teachers<br>• Parents<br>• NGOs<br>• Government education officials |
| ***Problem Addressed*** | • Declining education quality due to increase of absenteeism by both school personnel and students infected or affected by HIV.<br>• Lack of coordination and collaboration between NGOs and education officials, including school health coordinators. |
| ***Purpose of Intervention*** | • To improve coordination and collaboration between NGOs and school health coordinators to increase school-based actions that will mitigate the impact of HIV/AIDS.<br>• To increase capacity within the education sector to address the challenges of the epidemic. |
| ***Context*** | • The HIV prevalence rate is increasing in Ghana.<br>• MOE has developed an HIV/AIDS strategic plan, but collaboration between NGOs and local education officials to implement the strategy is inconsistent or nonexistent.<br>• School health coordinators do not have the capacity to implement health programs. |

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| ***Process*** | • Coordinate exchange visit of education officials and NGO representatives to high prevalence country (Uganda).<br>• Convene key stakeholders from Ghana's education and HIV/AIDS sectors to introduce project.<br>• Conduct a joint organizational assessment of potential NGO partner organizations (provides baseline for subsequent capacity building activities).<br>• Select 5-10 partner organizations.<br>• Provide in-depth training to partner organizations in conducting research activities (monitoring and evaluation to improve programmatic activities).<br>• Assist partners to develop action plans to conduct school-based activities, based on findings of NGO research.<br>• Support implementation of action plans with financial and technical assistance.<br>• Conduct workshops for NGO partners on financial management, strategic planning, adolescent reproductive health, and non-formal education.<br>• Monitor impact and share best practices. |
| ***Steps in Implementation*** | Nine NGOs are currently implementing school-based action plans in collaboration with school health coordinators. |
| ***Duration*** | Process started in 2001 and is expected to continue until 2004. |
| ***Resources Required*** | • Skills in monitoring and evaluation.<br>• Training in needs assessment and design, strategic planning, and subgrant management of grants to NGO partners.<br>• Funds to conduct workshops and activities. |
| ***Indicators for Monitoring*** | • Research designed and conducted by NGOs and education officials.<br>• Action plans with input from school health coordinators. |
| ***Positive Impact*** | • Smoother design and implementation of baseline research and action plans.<br>• Continued collaboration between NGOs and education officials. |
| ***Challenges and Pitfalls*** | • No mandate to improve the capacity or fund government education initiatives.<br>• Ineffective bureaucratic structure at the regional level (interferes with local collaboration). |
| ***Critical Issues and Lessons Learned*** | • Education officials must be included from the beginning (both central and local level).<br>• Need to focus on opportunities for collaboration in specific activities (not theoretically). |
| ***Source of Practice and Dialogue*** | John Yanulis<br>World Education/Ghana<br>WorldEd@idngh.com |

# *Underprivileged Ethiopian Youth Receive Reproductive Health Education through Informal Vocational Training Programs*

*OIC International*

### *Background*

The unrelenting spread of the HIV/AIDS epidemic in Ethiopia greatly concerned the population. In response, the youth, a segment of the population hit hard, organized themselves into clubs to educate members and the general public about the disease and discuss ways to prevent its spread. Many governmental, private voluntary (PVOs), and nongovernmental (NGOs) organizations support clubs activities, but few have provided these youth club members with employable skills to keep them from reverting to risky sexual behavior resulting from unemployment, poverty, and hopelessness.

OIC International developed a program for youth that integrates reproductive health education with skills training. The program started with two and expanded to three training centers. OIC also introduced a computer-based tutorial for underprivileged youth who perform poorly in schools. Since February 2003, these youth centers have been delivering a complete service including reproductive health, HIV/AIDS counseling, skills training, and basic education.

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| ***Description of Practice*** | OIC International, in collaboration with its Ethiopia affiliate, established adolescent reproductive health (ARH) centers for underprivileged youth to obtain marketable vocational skills training while learning about HIV/AIDS prevention. These centers serve as a safe-haven for youth to spend free time away from situations of reproductive health risk. |
| ***Level of Intervention*** | Community |
| ***Prospective Users of the Practice*** | • Schools<br>• Local communities<br>• Training centers<br>• Clinics<br>• Youth clubs |
| ***Problem Addressed*** | • Low-income youth lack access to marketable skills training.<br>• At-risk youth lack access to reproductive health education.<br>• Community lacks knowledge of HIV/AIDS transmission. |
| ***Purpose of Intervention*** | To provide underprivileged youth with marketable skills for self-sustaining career development while preventing unhealthy reproductive health decisions through early education. |

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| ***Context*** | • A needs assessment found that service providers did not address the critical issue of unemployment among the youth while administering adolescent reproductive health education.<br>• Hopelessness due to unemployment encourages youth to engage in irresponsible and risky reproductive health behavior.<br>• Youth initiatives focused solely on HIV/AIDS among their peers were not viable without real-world skills and practical career development support. |
| ***Process*** | • Conducted assessment to identify needs and gaps through on-site visits of adolescent reproductive health service providers and youth clubs.<br>• Held discussions to explain needs assessment findings to funding agencies.<br>• Solicited "best practices" input from service providers, community leaders, youth clubs, and school and government officials.<br>• Prepared and submitted a proposal to funders.<br>• When funding was in place, various youth clubs formed an umbrella organization to help implement the project. |
| ***Steps in Implementation*** | • Briefed collaborating NGOs, youth clubs, and other stakeholders on the aims and strategies of the project.<br>• Secured training sites through government officials efforts.<br>• Recruited staff and procured training materials and classroom furniture.<br>• Conducted orientation of staff.<br>• Developed curricula and teaching materials.<br>• Selected the first batch of trainees to advise on the implementation of the project.<br>• Created umbrella youth organization committee with members from collaborating NGOs, representatives of women's association, and OIC Ethiopia team members. |
| ***Duration*** | • The project was approved in June 2001.<br>• Actual training started in January 2002.<br>• The project will be financed through June 2004. |
| ***Resources Required*** | The David and Lucille Packard Foundation and USAID currently sponsor these efforts.<br><br>*Skills:*<br>• One project coordinator with a degree in sociology and a diploma in nursing<br>• A person with a degree in economics or accounting to teach life skills and entrepreneurship<br>• Reproductive health nurses to teach ARH<br>• Computer instructors with diploma in computer applications<br>• Site managers with degree in sociology |

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| ***Resources Required (continued)*** | *Infrastructure/materials:*<br>• Computers with printers<br>• Television sets and video cassette recorders<br>• Satellite dishes<br>• Complete set of classroom furniture<br>• Appropriate building with adequate space for offices, audiovisual rooms, classrooms, and a library<br><br>*Financial resources for each ARH center:*<br>• Project coordinator at $280 per month<br>• Site manager at $150 per month<br>• Reproductive health nurse at $130 per month<br>• Entrepreneurship instructor at $150 per month<br>• Computer instructor at $150 per month<br>• Security guard at $30 per month<br>• Secretary/typist at $60 per month<br><br>*Training required:*<br>• Reproductive health nurses required a ten-day training in participatory methods of ARH.<br>• All staff required orientation in developing curriculum, preparing lesson plans, and locating resources. |
| ***Indicators for Monitoring*** | • Number of out-of-school youth that completed computer training<br>• Number of out-of-school youth that completed life skills and entrepreneurship training<br>• Number of youth that attended reproductive health classes<br>• Number of in-school youth that participated in sessions given by reproductive health nurses<br>• Number of stakeholders that attended annual workshops on ARH best practice<br>• Number of youth clubs and local NGOs that strengthened their ARH activities through grants from OICI/OICE |
| ***Positive Impact*** | • Participants in the program and their families and peers showed increased awareness on family planning methods and HIV/AIDS prevention.<br>• Participants demonstrated greater self-esteem and positive attitude.<br>• A number of trainees secured employment or started their own businesses as a result of skills acquired in the training program. |
| ***Challenges and Pitfalls*** | • Inability to secure adequate employment opportunities for trainees. Failure to find gainful employment creates disillusionment and frustration among some participants.<br>• Lack of credit facilities for trainees interested in starting their own businesses.<br>• Shortage of finances to buy operational equipment (i.e., vehicles to support youth club needs or help members participate in adolescent reproductive health education campaigns). |

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| ***Critical Issues and Lessons Learned*** | • Frustration due to joblessness is the most important cause of risky reproductive health behavior.<br>• Adequate information on marketable basic skills does not exist.<br>• It is necessary to train a limited number of beneficiaries in a wide range of disciplines rather than to train many beneficiaries in a few disciplines.<br>• To respond to growing business start-up initiatives, small-scale financing must be included in the training program. |
| ***Source of Practice and Dialogue*** | The project was developed by Dr. Makonnen Fantaw, Country Representative of OICI-Ethiopia Office with the assistance of Dr. Jeffrey Gray of OICI Headquarters in Philadelphia. Dr. Makonnen is currently directing the program.<br><br>• Dr. Makonnen Fantaw<br>OICI Country Representative<br>P.O. Box 13183<br>Addis Ababa, Ethiopia<br>Tel: 251-1-505160<br>Fax: 251-1-507847<br>Email: tabgiday@telecom.net.et<br><br>• Dr. Jeffrey Gray<br>Vice President for Food Security<br>OIC International<br>240 West Tupplehocken St.<br>Philadelphia, PA 19144<br>Tel: 215-842-0220<br>Email: jgray@oici.org |