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PREVENTION  
ADVOCACY  
CARE

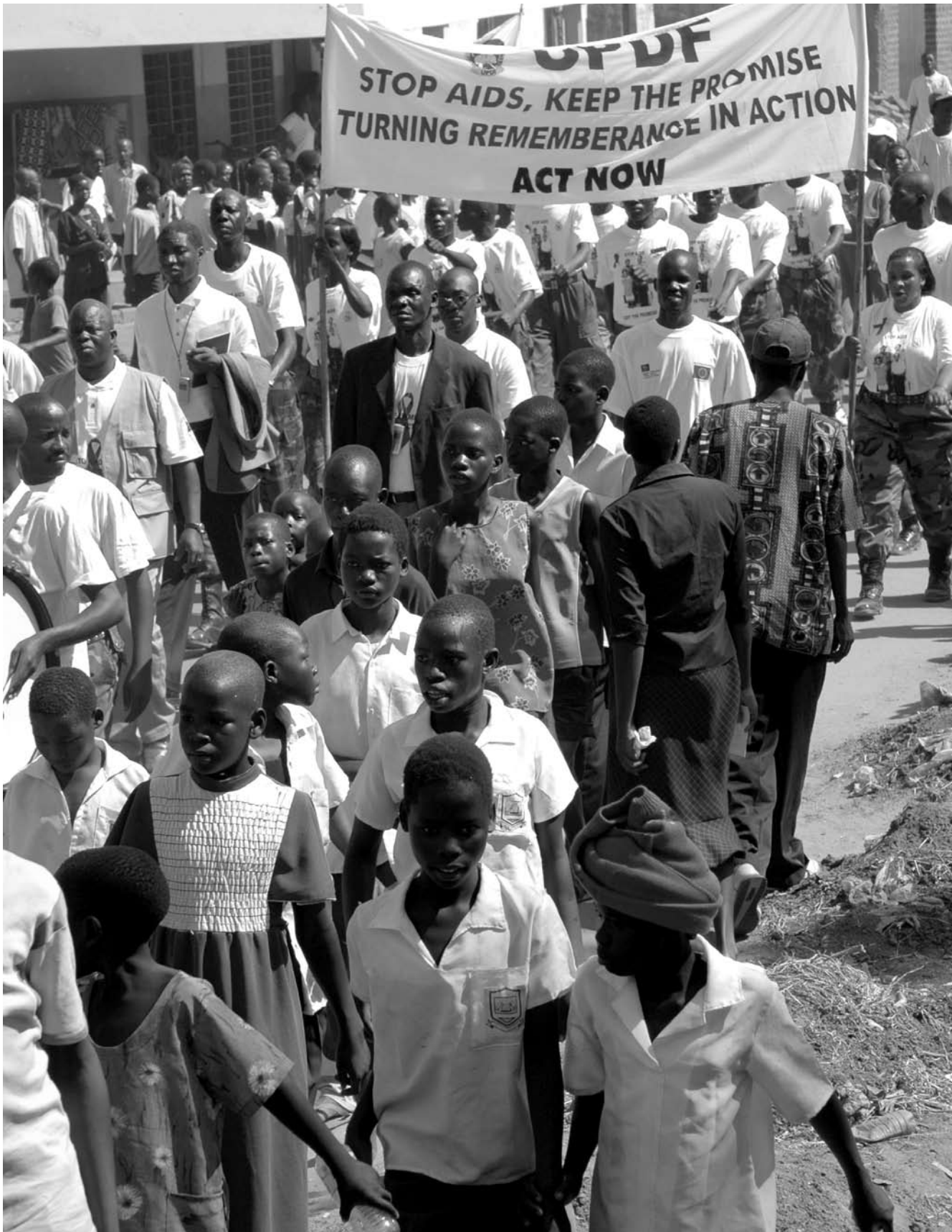


Hope Initiative for HIV & AIDS - Africa



# Looking back, Looking forward

*Lessons learnt from HIV and AIDS Research and Programming in Africa*



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# Acronyms

ABC	Abstinence, Be faithful and use a Condom
AIDS	Acquired Immunodeficiency Syndrome
ADP	Area Development Program
CBO	Community-Based Organisation
CCC	Community Care Coalition
CCG	Community Care Group
CHARMS	Core HIV/AIDS Response Monitoring System
CHATs	Congregational HIV and AIDS Task Team
CHW	Community Health Worker
CoH	Channels of Hope
COHIF	Channels of Hope Interfaith Foundation
CRS	Customer Relations Service
DADD	Do Assure Don't Do
FBO	Faith-Based Organisation
HBC	Home Based Care
HIV	Human Immunodeficiency Virus
HPC	High Prevalence Countries
HV	Home Visitor
IGA	Income Generating Activities
KATSO	Kenya AIDS Treatment and Support to Orphans and Vulnerable Children
MED	Micro-Enterprise Development
MHAP	Mainstreaming HIV/AIDS Program
NGO	Non Governmental Organisation
NO	National Office
OCB	Organisational Capacity Building
OR	Operations Research
PLHIV	People Living With HIV and AIDS
PMTCT	Prevention of Mother-To-Child Transmission
RC	Registered Children
ToT	Training of Trainers
WV	World Vision

# About this resource



This resource was developed for WV staff to provide an overview of key HIV and AIDS programming considerations within the African context. The resource documents lessons learned, including successes and shortcomings, and provides recommendations for future HIV programming. The information and learnings contained in this resource were sourced from a number of key studies on WV operations in Africa, including:

- Africa Hope Child Evaluation Report
- WVI, Models of Learning 4 Country Community Care Coalition Study Synergy Report
- Operations Research Study conducted in Zambia and Uganda
- Kenya AIDS Treatment and Support to Orphans and Vulnerable Children Project
- RAPIDS Project (Zambia)
- World Vision Canada Mainstreaming document

An overview of each of these studies is included in the table on page 6. While WV staff are encouraged to read these studies, locating and finding the time to read complete studies may not be feasible for many. This resource has been developed to enable WV staff to more easily access some of the key information and learnings from these studies. The key findings and lessons learned from these studies are organised according to six themes:

1. Linkages, partners and networks
2. Community mobilisation
3. Volunteerism
4. Capacity building
5. Sector integration
6. Child protection and sexual abuse



# Studies referenced in the resource:

Document Title	Overview
Evaluation of HIV & AIDS Projects in four Hope Child Countries in East and Southern Africa (2006)	This evaluative study provided an opportunity for WV staff to examine what is working and what is not working in WVUS-supported HIV and AIDS responses across relevant ADPs. This extensive report covers core models, programming, funding/grants and the factors affecting success and suggests directions for moving forward.
World Vision International, Models of Learning 4 Country Community Care Coalition Study Synergy Report (2007)	WV conducted a study from August-November 2006, visiting a total of 24 CCCs in eight project locations in Ethiopia, Mozambique, Uganda and Zambia. The study was undertaken in order to analyse the strengths and weaknesses of the CCC structure as it has been operationalised in various contexts, with a view that the results that emerged will inform and guide WV's future orphans and vulnerable children programming. Key recommendations and lessons learnt are presented.
Operations Research Study – Baseline and Post Intervention (Zambia Keembe ADP, Uganda Katwe ADP) a. CCC OR Report b. Prevention OR Report	In order to enhance its understanding about the costs, effectiveness and impact of rolling out its three core HIV and AIDS programming models, World Vision designed an Operations Research (OR) project to be conducted in two Area Development Programs (ADPs) where these models had not been previously implemented – Uganda and Zambia. Early tests of these models found them to be feasible, acceptable and effective for the communities. The findings described in OR documents are based on the baseline data collected between July and August 2005 and on the first round of post-intervention qualitative data collected in April 2006, and quantitative surveys conducted in November 2006.
Kenya AIDS Treatment and Support for Orphans and Vulnerable Children (KATSO): Evaluation Report (2006)	The KATSO project included three intervention components: orphans and vulnerable children care and support; palliative care; and psychosocial support to people affected by HIV and AIDS. This study used quantitative and qualitative methods to assess the effect of the interventions on the beneficiaries and record the perceptions of the interventions. The study provides recommendations for ongoing and future programs for people affected by HIV and AIDS.
RAPIDS Project - Zambia (2005)	The overall goal of RAPIDS is to improve the quality of life of Zambians affected by HIV and AIDS. This is to be done through a systematic scale-up of successful models of home-based care and support to orphans and vulnerable children, as well as interventions targeting youth livelihood opportunities and life skills, including abstinence and prevention initiatives. This report describes quantitative and qualitative research activities conducted during 2005 as a baseline for the multi-round impact assessment of RAPIDS in Zambia.
WVC Mainstreaming Document (2005)	World Vision Canada (WVC) initiated the Mainstreaming HIV/AIDS Program in Canada-funded ADPs in fiscal year of 2005. The goal of the Mainstreaming HIV/AIDS Program (MHAP) is to mitigate the impact of the AIDS epidemic in the communities we serve through mainstreamed approaches based on the Hope Initiative's Continuum of Care, encompassing prevention, care, treatment, support and advocacy. This document evaluates and reports on the successes and failures of implementing the program, from program and fundraising perspectives, and aims to determine its progress toward meeting its stated goals and objectives.

All documents listed above are accessible at [www.worldvisionministry.org](http://www.worldvisionministry.org) Follow the quick links HIV and AIDS.

# Three core programming models



The high HIV prevalence in most Sub-Sahara African countries has had a tremendous impact on efforts to reduce poverty and improve the health and wellbeing of individuals and communities in these countries. The impact of HIV and AIDS on children has been particularly immense. In many countries in eastern and southern Africa, the proportion of orphans and vulnerable children is growing dramatically.

The extended family network and other safety nets that have traditionally been responsible for caring for orphans and vulnerable children have been severely strained by the simultaneous and self-perpetuating incidence of HIV and AIDS, conflicts, natural disasters and other diseases.

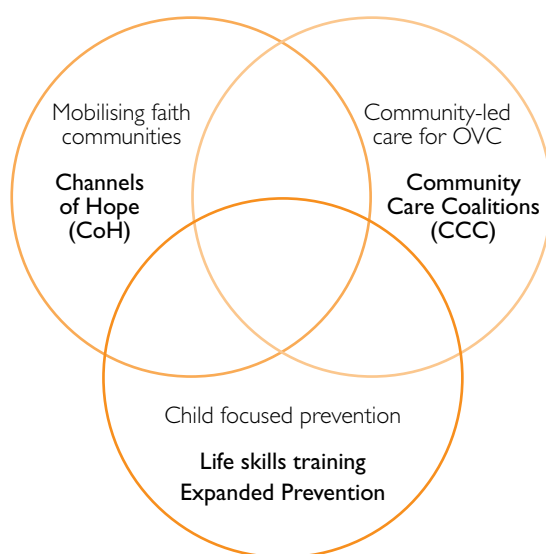
In 2001, World Vision launched the 'HIV and AIDS Hope Initiative', to mobilise the organisation for an effective response to the HIV across the world, and especially in Africa.

Each of the studies reviewed in this document focuses on the implementation of core programming models developed by the Hope Initiative. To facilitate the scale-up of effective, evidence-informed and theory-based HIV programming, World Vision has developed three core models and several additional models for use in generalised HIV epidemics in sub-Saharan Africa.

The choice of these models reflects World Vision's identity as a child-focused, Christian and community-centered, Non-Governmental Organisation (NGO). On their own, these models do not represent a complete response to HIV. Rather, they are intended to complement and cooperate with the work of other agents that deliver services and programs outside the scope of World Vision's programs. The models contain considerable flexibility, to allow interventions to build on the existing strengths of communities, government services and partner agencies, and to be sensitive to variations in cultural, economic and epidemiological contexts.

Below is a short introduction to the three core models. For further information, an 'Implementation Guide' and additional resources have been developed to guide projects in design implementation of these core models. These are accessible via [www.worldvisionministry.org](http://www.worldvisionministry.org) - follow the quick links HIV and AIDS.

## Hope Initiative Core Models



<sup>1</sup>The Hope Initiative's strategic framework and draft 'Do, Assure, Don't Do' framework are included as Appendices 3 and 4.

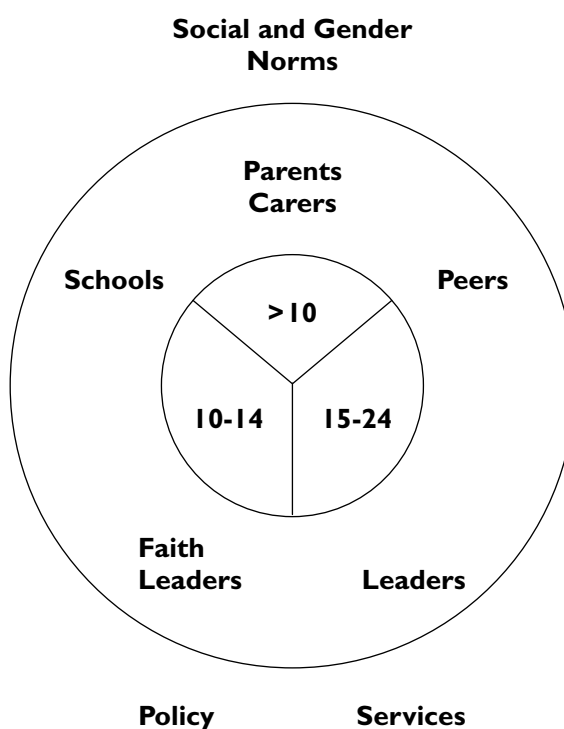
## Core model one: HIV Prevention for Children and Young People

World Vision's core model for HIV prevention for children and young people combines two approaches, life-skills education and peer education. These aim to reduce the transmission of HIV by equipping children with knowledge about HIV and how to avoid infection, and with skills to enable them to build healthy relationships and sustain safe behaviours.

World Vision programs provide capacity building opportunities and materials to teachers and volunteers to become life-skills trainers for in-school and out-of school youth. World Vision also provides training for peer educators and supports formation of "anti-AIDS clubs" and similar peer groups to provide a platform for behaviour-change communication.

While developing knowledge and skills for HIV prevention are very important, reviews discussed in this report and a growing body of literature on HIV prevention suggest that these approaches may not be enough on their own to protect children and young people from HIV. Children are members of families, communities, cultures, religions and societies. They face a range of influences and constraints that can help or hinder them in adopting and sustaining safe behaviours. The Hope Initiative team is responding to these findings by developing and piloting an expanded prevention model. This model will combine the strengths of the existing approach with additional methods that work with a range of stakeholders who influence children's decisions and relationships.

In the diagram below, the inner circle represents children and young people of different age groups. The outer circle represents the context, or environment, that children are part of. The circle in between represents people who can influence children through their relationships and interactions with them, and who can stimulate change in the patterns, norms and expectations that direct children's relationships and decisions. The expanded prevention model will include approaches for working with each of these groups.



## Model two: Community Care Coalitions (CCC)

A major programming approach for WV's Hope Initiative is the mobilisation, training and monitoring of CCCs. CCCs strengthen community leadership and foster ownership of community-based initiatives for orphans and vulnerable children care and other HIV responses. A key aim of CCC empowerment is to improve the quality of life of orphans and vulnerable children by providing relevant care and support. WV involvement with CCCs aims to strengthen CCC capacity to:

- Coordinate, monitor and report on orphans and vulnerable children care, and HIV prevention activities in their area
- Identify and register orphans and vulnerable children, chronically ill adults and volunteer caregivers
- Advocate for orphans and vulnerable children and raise resources for meeting identified needs of orphans and vulnerable children.

WV has worked to mobilise and build the capacity of CCCs in countries with high HIV and AIDS prevalence across east and southern Africa. As the CCC structure is intended to be flexible and adaptable to local contexts, CCC activities will vary depending on the needs identified in the community. CCCs fall into one of two categories:

- Type one: CCCs or "Community Care Groups (CCGs)":

These are groups of volunteer home visitors (HVs) who provide direct support and care to orphans and vulnerable children. CCGs may perform some coordination functions. CCGs often come under the umbrella of a type two (Coordinating) CCC or a community-based organisation (CBO).

- Type two: CCCs or "Coordinating CCCs"

CCCs typically include representatives from churches and other faith-based organisations, government, business and other local NGOs/CBOs in the community. Their role is to support and help coordinate volunteer HVs who provide ongoing care and support to orphans and vulnerable children. The primary role of type two CCCs is to ensure support for children is well coordinated; avoiding duplication of effort and maintaining effective referral systems. Type two CCCs often coordinate resources and provide funding, training and material support for HVs. A single type two CCC may cover a much larger area or administrative unit than a type one CCC, and may provide support to several CCGs at any one time.

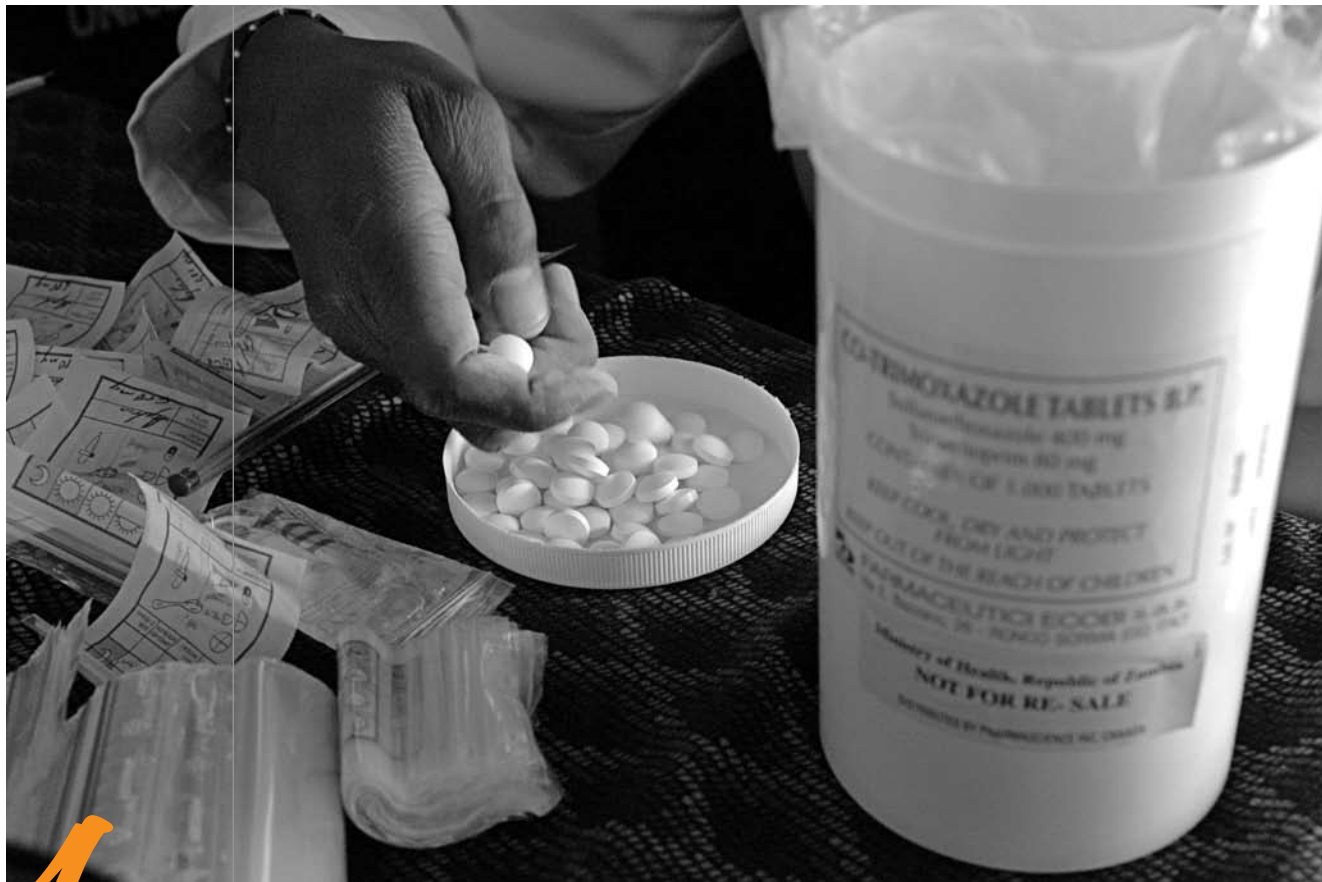
## Model three: Channels of Hope

Channels of Hope (CoH) aims to expand and broaden existing relationships between communities and Faith-Based Organisations (FBOs) to sensitise and empower FBOs to respond more effectively to HIV prevention, care and advocacy within their communities. A key aim of this core model is to promote changes in the attitudes and behaviour of religious leaders, in order to reduce HIV-related stigma and discrimination within communities. By working with FBOs and providing the needed support during training and as they form Congregational Hope Action Teams (CHATs), WV builds the capacity of churches and FBOs to:

- Provide, monitor and evaluate coordinated and quality HIV and AIDS activities to reduce HIV-related stigma and discrimination
- Prevent HIV infection
- Increase care and support for orphans and vulnerable children and the chronically ill in their congregations and community
- Advocate for appropriate HIV and AIDS services in their communities
- Have CHATs actively involved in local CCCs or CCGs.

# Lessons learned in key programming areas

Six key program areas have been identified and explored in this section.



## 1. Linkages/Networks/Partners

As part of WV's programming approach to HIV and AIDS in Africa, effective advocacy and long-term partnerships are important for ensuring the sustainability of the Hope Initiative's HIV and AIDS core programming models. The **Hope Child Evaluation** report provides a detailed overview of WV advocacy and partnership initiatives in the region. The report highlights the need for solid partnerships to help ensure that strong channels of communication and opportunities for advocacy exist. It does, however, note that these factors were found to be limited by resources and staff constraints at local and national levels.

### Key findings

Developing and strengthening partnerships between the different regional stakeholders focused on HIV and AIDS is a key aspect, together with advocacy, of WV's overall approach to HIV and AIDS programming and a major focus of WV core models. The WV Africa HIV&AIDS Strategy describes this as a commitment to "Modeling cooperation and partnering to stimulate lasting change."

WV national and ADP office staff are involved in advocacy activities to varying extents as participation in advocacy efforts is often limited at a national and local level by the availability and capacity of staff. Grant-funded programs, it was found, were more likely to ensure that staff are available and equipped for strong networking and advocacy. Programs such as RAPIDS in Zambia have enabled WV staff to be closely involved and effective advocacy agents, even having input into national policy development.



**The evaluation report found that strong partnerships, such as those between WV programming staff/volunteers and religious leaders or other community leaders, could assist in increasing the scale of programs as well as the sustainability of HIV and AIDS prevention and care efforts.**

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The evaluation report highlighted a number of examples of partnerships WV has been involved in at both national and local levels. For example, partnerships with community leaders or people of influence in the community were highlighted as important to the promotion and overall success of WV interventions. On the other hand, it was noted that programs that did not communicate or consult effectively with program partners, such as community leaders, risked major setbacks to their activities. In this respect, it was found that ongoing communication with program partners was essential to the success of any quality initiative.

The multi-sector and coordinating role of Type two CCCs requires effective linkages and partnerships in communities within which they are delivering support to orphans and vulnerable children. The strength of these partnerships depends largely on the initial community mobilisation efforts and also on the composition of the CCC. The better the mobilisation and the more inclusive the membership, the better the links with other CBOs, churches, schools, health facilities, etc, will be. For example, in some instances there was evidence of excellent cooperation and synergy between the local CCC and CoH programs, whereas in other cases they seemed to be operating in isolation of each other. This is despite the fact that both groups are linked to WV. When working together, CoH workshops and follow-on activities can be highly effective in setting the stage for community action. The CCC can complement this by mobilising the services and support of people in the community to provide direct support to those most vulnerable. This is one example of the benefits of creating linkages and partnerships at a local level.

The Channels of Hope (CoH) program has proven successful in transforming participants' understandings of HIV and increasing their awareness of HIV-related stigma and discrimination. Results of WV post intervention surveys in Zambia and Uganda indicate a number of positive developments regarding FBO response and synergies between FBO leaders and congregations in tackling HIV and AIDS issues. Overall, surveys indicate that there has been a coordinated and systematic FBO HIV and AIDS prevention education in intervention sites.

FBO response and participation in WV mobilisation activities, and synergy with CCC was effective in both ADPs studied. For example, **more than 75 percent of all the congregations in the intervention sites in Zambia and Uganda participated in CoH workshops.** In both countries, there was increased participation of FBO leadership in HIV prevention activities, with significant increases in FBO leaders reporting that they discuss HIV ABC messages with their congregations.

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**As a result of CoH advocacy, activities such as awareness raising were conducted by participating FBOs in an effort to reduce the practice of sexual cleansing and sexual abuse.**

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In addition, there was a reported increase in the number of FBOs encouraging condom use as an alternative prevention measure. FBO leaders reported that the CoH workshops have had a personal impact on them, making them more active advocates for addressing HIV and AIDS in their congregations.

Evaluations indicate that WV core models were effective in increasing FBO/CBO and NGO agencies' participation in caring for orphans and vulnerable children and chronically ill household members, and in participating in HIV prevention activities targeting children and adults.

*(Reference: Evaluation of HIV and AIDS Projects in four "Hope Child" Countries in East and Southern Africa)*

*(Reference: Operations Research Study)*



## Issues

There are a number of challenges to establishing partnerships, most notably:

- **Terminology:** The RAPIDS partnership of six organisations found that the use of terminology associated with specific organisations interferes with breaking down institutional barriers to collaboration. WV, for example, uses the term “CCC” to describe community committees that care for children, whilst other groups use different terminology. Thus, an attempt is being made to use terms that are more generic and can be accepted and used by all the partner institutions.
- **Conflicting donor requirements:** Sometimes donor requirements unintentionally interfere with partnerships. This is the case within RAPIDS, where partners are expected to meet certain targets. When an individual beneficiary has received inputs from a number of members of the partnership, it is only the partner who made the initial contact that can count that beneficiary toward fulfilling its targets. Of course, this can be problematic during implementation.
- **Coordination:** There is sometimes a gap in coordination among national level stakeholders. Even at the local level, this leads to confusion and redundancy in HIV and AIDS efforts and presents a challenge to effective collaboration among the stakeholders. For example, lack of coordination has resulted in different national level organisations building community care centres in the same locations.

Creating and maintaining links with government structures can help to provide CCCs with a permanent “institutional home”. However on the whole, strict-level vertical links have generally proven difficult: CCCs usually do not have the size, capacity, or influence to engage effectively with district-level bodies, and are usually dependent on WV to facilitate these links. CCC integration with ADPs also varies across programs and is often not carefully thought out. A common result of poor integration is that there are problems with registered children (RC) receiving more benefits than orphans and vulnerable children in the same area.

## Recommendations

- All projects should ensure that CCCs have established strong inter-community links at local levels with existing services such as health, education, social development, child protection and women’s affairs.
- WV needs to investigate ways of improving links between CCCs and district-level government structures. WV should continue to facilitate these links in the short term. WV should also assist CCCs to begin to provide regular monitoring and other information to relevant government bodies.
- It is important to establish formal referral systems between CCCs and government services, especially those dealing with child protection and health.
- In regard to the potential for learning environments, WV should formalise and support increased opportunities to document and foster information exchange and lessons learned among WV staff at, and between, all levels – international, national, ADP, as well as between community partners.
- As acknowledged in the findings above, a key advocacy focus area is in strengthening staff capacity, in order to promote the role of WV in their advocacy efforts at national and local levels. Areas of staff capacity that require particular attention include increasing availability of staff and improving technical expertise.
- WV should continue to foster strengthened partnerships among national and local level stakeholders in order to increase the reach and the sustainability of interventions that affect orphans and other vulnerable children now and in the future.



## 2. Volunteerism

*(Reference: Evaluation of HIV & AIDS Projects in four Hope Child Countries in East and Southern Africa and WVI Models of Learning 4 Country Community Care Coalition Study Synergy Report)*

**Volunteers are central to WV's community-based approaches to HIV programming.** CCC members and leaders, orphans and vulnerable children HV, peer educators, life-skills trainers, CHATs team members and Home-Based Care workers all perform their roles as volunteers. In general, volunteerism has been successful in WV's programs, but many have experienced challenges in retaining volunteers and maintaining their motivation.

### **Factors that can increase volunteer capacity, retention and sense of value:**

- Many volunteers have a link with a church or other faith congregation and site biblical or spiritual inspiration as a key motivator. The CoH methodology is an effective way to motivate faith-based volunteers.
- Strong community demand for the HV services. Strong demand results from understanding and appreciation of the work of HVs as a function of the CCC. An effective, participatory, CCC mobilisation process helps to build this understanding and it can be increased as guardians see the impact of home visits.
- Involvement of traditional leaders in selecting and supporting volunteers. Selection by a person in position of authority or influence, such as a traditional leader can be viewed as an honor by volunteers, and can reinforce their motivation. It can give their work legitimacy and increase a sense of responsibility to the wider community.

- Links with government structures, such as health services, child protection officers, child welfare departments, etc. Official recognition can help to reinforce the value of the CCCs' work, both for volunteers and for the community. Official linkages can also provide opportunities for support and capacity building.
- Maintaining a manageable workload. Volunteers who are over-worked may become 'burnt out' and lose their motivation. CCCs need to have realistic expectations regarding the frequency of visits and the number of children a HV can support. Visiting each child once a week or once every two weeks was manageable for HVs in most settings in the CCC study, but visiting more than once a week often became a burden.
- Ongoing capacity building opportunities for volunteers, such as community-to-community exchange visits, refresher training, or advanced training in certain topics.
- CCCs can improve volunteer motivation by accessing funding to resource HV activities and to provide material support to orphans and vulnerable children and their guardians.
- Organisational capacity building (OCB) for CCCs. OCB helps CCCs manage many of the difficulties that can undermine them. It teaches skills such as how to resolve conflicts and challenges, how to access finances and how to handle them responsibly.

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**It is important to consider the needs and motivations of volunteers so that:**

- \* **Volunteers are able to deliver support to orphans and vulnerable children in the most effective way**
  - \* **Volunteers will remain with the program for as long as possible**
  - \* **A sense of pride in what volunteers are doing for their community is encouraged**
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*Stipends or allowances*

A stipend or allowance is a regular payment made to volunteers. One grant-funded program included in the CCC study paid stipends, but most programs did not. There are different views on whether volunteers should be paid.

- **Advantages:**

Stipends can be motivating for volunteers. Volunteers work hard and learn complex skills, and deserve to be rewarded for their efforts. Paying stipends also injects cash into a local economy, which may have broader benefits.

- **Disadvantages:**

Paying stipends can undermine the sustainability of a volunteer-based support program. If volunteers have come to expect stipends, they are unlikely to continue their work once project funding ends and stipends stop. Stipends may also cause jealousy in a community, especially if volunteers in other community-based initiatives do not receive similar support.

In some countries, government regulations require that all volunteers, or certain types of skilled volunteers (such as Home-Based Care workers) be paid a stipend. Project managers need to research government regulations and abide by them. Where no regulations exist, CCCs may be able to decide on whether stipends are appropriate in their communities, and if so, what level of payment is appropriate. Project managers can also consult with community leaders and other organisations working in an area to decide on the best course of action.

Generally speaking, WV Hope Initiative does not encourage stipends. It is strongly felt that the disadvantages outweigh the advantages and sustainability becomes a major issue when stipends are introduced. Our experience has shown that – though there have been some exceptions – most volunteer-based programs using stipends collapse when the stipends stop. If CCCs pay stipends, they should be paid from local fundraising efforts and not from WV funding sources.



Who administers stipends?

If stipends are to be paid, it may be possible for the CCC or a CBO to manage the payments. As the CCC matures and gains experience in handling finances, it may be able to source grant funding from a source other than the project, so that stipends can be provided on a sustainable basis once the project phases out. However, CCCs should not be entrusted with finances until they have received capacity building in this area and have established strong financial and accountability systems. Also, it will need to be investigated whether there are government regulations that stipulate that an organisation must be formally constituted as a CBO before it can administer finances.

### *Supplies and material support*

Typically, volunteers have very limited resources of their own to use in their activities or to share with beneficiaries. External resources can significantly increase volunteer ability to reach vulnerable households with the additional support they need.

Supplies for HV fall into two categories, (i) supplies and equipment, and (ii) material support.

#### (i) Supplies and equipment

In order to perform their core duties, HV and other volunteers utilise resources, such as bicycles, uniforms and stationery. These items can also represent incentives, and help to motivate volunteers. Some supplies, such as bicycles, make volunteers more efficient, enabling them to assist more children, and reducing the time and energy they need to undertake specific tasks.

Who owns the assets?

Rather than giving certain assets of value to volunteers, it is preferable to loan them so that they remain as communally owned property. Depending on the context and the capacity of each group, assets may be managed by, for example, a traditional leader; the village council, the CCC or a community group, such as a PLHIV support group. It is more beneficial if the asset, such as a bicycle, is used by two or three volunteers working on different days, and at the same time remain the property of the CCC rather than individual volunteers.

Who maintains the assets?

It is also important to establish who is responsible for keeping assets in good working order, especially as volunteers may not, for example, be able to afford repairs to bicycles or to replace worn out uniforms. The CCC, or other group, may need to keep a maintenance fund for these purposes.

How many volunteers?

While providing supplies can make volunteers more efficient and effective, it can create difficulties for recruitment of new volunteers. If WV has provided, for example, 15 uniforms and 15 bicycles, it will be very difficult to recruit volunteer number 16, as they will also expect a bicycle and a uniform. Ideally, the CCC will take on responsibility for acquiring additional supplies as volunteer numbers increase.

#### (ii) Material support

Material support is often provided by HV to orphans and vulnerable children or their guardians during home visits. Items can include, soap, clothing, school supplies or food, etc. HVs often provide material support from their own limited resources, or resources that are mobilised by the CCC. The impact and value of a home visitation program should not be underestimated, even when HVs are unable to provide any form of material support to orphans and vulnerable children and households. However most orphans' and vulnerable children's households are extremely poor and in need of material or monetary support in addition to the benefits of home visits. In every study, location volunteers and guardians expressed frustration at the lack of material support. This represents a major source of contention within the communities and in all programs.

Providing any type of material support can cause frustration in a community, as some people will inevitably receive more assistance than others. Those who receive little, or nothing, are likely to complain of favouritism. Indeed favouritism does occur in some cases, as volunteers and CCCs naturally feel loyalty to their own friends or relatives, and may face considerable pressure to show favouritism even if they do not want to. It is very important that CCCs have a transparent process for deciding who receives what benefits. Generally CCCs need capacity building on how to distribute resources fairly before they can provide material support effectively. The preferred method is cash grants to CCCs who have sufficient capacity. They can then decide what the most appropriate resources are to support HV on an ongoing basis.

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**Volunteer training and capacity building in relation to the equitable distribution of resources is an essential component of any WV core programming model initiative.**

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*Resource mobilisation*

*(Reference: WV Models of Learning 4 Country Community Care Coalition Study Synergy Report)*

If supplies and equipment, material support or stipends are required, it is important that they are provided in a sustainable manner; or the long-term viability of CCC activities can be undermined. If volunteers become accustomed to WV providing supplies, they tend to lose motivation if the supplies stop. Volunteers may feel they are no longer able to be effective, and guardians may become hostile to them if volunteers stop bringing material support. The discussion below addresses a range of alternatives for CCCs to mobilise resources.

The following strategies have been used by CCCs for resource mobilisation. The ADP Toolkit, CCC Implementation Guide and OCB modules provide more assistance on these approaches:

- **Member contributions:** CCC members and HVs have often given generously not only of their time but of what little they have in the way of material and cash resources. While this is an excellent beginning, there are limits to what volunteers can give, and what little they have cannot be expected to stretch very far.
- **Community gardens:** Simple community gardens can be a good way of producing nutritious food suitable for distribution to orphans' and vulnerable children's households and PLHIV. Surplus produce can also be sold to provide a limited source of financial income.
- **Local fundraising:** The CCC study noted an example of a CCC in Ethiopia that wrote letters to the member organisations, businesses and government departments to attract further funding. As communities have limited resources to share, this approach will only be able to mobilise relatively small amounts.
- **Income Generating Activities (IGAs) and Micro-Enterprise Development (MED):** IGAs are business activities undertaken by the CCC, with profits used to fund CCC activities. The main advantage of IGAs is that, if successful, they provide an ongoing source of funding that is not reliant on an external funding source. On the other hand, IGAs can be time consuming and distract the CCC members from their child care focus; can require an injection of resources to get started; and it can be difficult to make them profitable. MED, or micro-finance initiatives, may be a good way for CCCs to access start-up capital for their IGA activities. CCCs may need assistance to understand the market and test the viability of their proposed business. As few HIV and AIDS projects have staff with suitable expertise to support MED or IGA activities, it is usually preferable to connect CCCs with another project that is better placed to help them. The ADP or another NGO may have an economic development project that can include CCCs among its beneficiaries, or a micro-finance institution, such as Vision Fund, may be operational in the project area.

- **WV grants:** WV may choose to give small grants to CCCs that have successfully completed an intense capacity building program. Such grants would enable CCCs to target assistance more accurately than the current WV Gifts in Kind (GIK) mechanisms allow, and would enable CCCs to gain experience in managing and accounting of money. To avoid fostering dependency, this could be treated as an interim solution or a 'bridge' to help CCCs develop capacity to apply for grants from government or other external sources.
- **Competitive funding:** As the organisational capacity of CCCs is raised, they may begin to compete for grants from such sources as the Global Fund and World Bank funding mechanisms. WV may assist CCCs in forging these linkages and submitting proposals. OCB should be seen as a pre-requisite for assisting CCCs to compete for such funding, as it is important that CCCs have the necessary skill to manage the grant resources effectively.

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**It is worthwhile building the capacity of CCCs to understand and explore the opportunities for program sustainability, such as income generating activities and community gardens. This might mean that support is available to vulnerable individuals and groups when the initial funding finishes. It can also motivate volunteers to continue their work with the program.**

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#### *Resource committees*

Resource mobilisation can be time consuming and require a different set of skills to the hands-on caring roles that HVs and home-based care workers play. This is especially true of IGA, MED and grant acquisition activities. To avoid creating an unrealistic workload for these hands-on volunteers, many CCCs form resource committees whose sole purpose is to mobilise and manage resources. People with business expertise and networks can be very useful on these committees.

#### *Gifts in Kind (GIK)*

One strategy for providing supplies or materials support is to use GIK: goods procured by a project through a support office or another donor. However, GIK has several potential disadvantages that are considered below:

- GIK can undermine local economic development – unless items are purchased locally, supplying goods can undermine local producers and retailers, and impact negatively on the local economy. It is very difficult to sell an item if your customers can access the same item for free from WV or from the CCC. If you cannot sell your goods, your business will fail.
- GIK supplies are not reliable. GIK are usually provided on a one-off basis and cannot be relied on for items that need to be replenished regularly, such as home care kits.
- GIK is 'supply driven'; goods provided are typically what WV can access, rather than what CCCs need for their HVs to provide care and support to vulnerable houses and children.
- GIK supplies are not always suitable for local conditions. This is most apparent with bicycles. Bicycles sourced from wealthy countries are usually lightweight with many technical and expensive parts, and used bicycles may be in poor condition when they arrive. They are very likely to break down and may be expensive or impossible to repair.

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**There are many benefits of GIK; however, before the WV staff member moves forward with this approach they should consider the potential implications for the program, its beneficiaries, and for the wider community.**

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### 3. Community mobilisation

*(Reference: WWI Models of Learning 4 Country Community Care Coalition Study Synergy Report, Operations Research Study and WVC Mainstreaming Document)*

#### **Key findings**

The strength of community ownership and program sustainability is directly linked to the degree and effectiveness of initial and ongoing community mobilisation.

In most cases there was improved community awareness and concern for the needs of orphans and vulnerable children, and increased perception that the orphans and vulnerable children problem was a whole-of-community problem rather than a problem for individual households. It is nevertheless the case that most orphans' and vulnerable children's households are extremely poor and in need of material and/or monetary support in addition to the benefits of home visits.

The concept of CCCs has not only been implemented by WW ADPs, but has also been adopted by other stakeholders, thereby benefiting more children than could be reached by WW alone. Overall CCC success is dependent on the inclusiveness and effectiveness of entry point, community mobilisation and capacity building (technical and organisational). Involvement of traditional leaders, PLHIV, orphans and vulnerable children and government agencies are also keys to this core programming model's success.

The greater the variety of CCC membership, the greater the innovation shown in understanding the needs of orphans and vulnerable children and accessing services for them. The success of the CCCs depends to a large extent on the inclusiveness and effectiveness of the initial community mobilisation. Good investment in this in the beginning is essential for long-term ownership and understanding. For example, while children have rarely been involved in existing CCCs, there are benefits to involving representatives from the beneficiaries group at different stages of the program. Creating opportunities for child participation in the future will not only help to shift the balance of power in communities in favour of children, it will also help the CCC and HVs to view orphans and vulnerable children not just as beneficiaries but as active participants.

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**One study indicated that orphans and vulnerable children generally have clear preferences as to the type of person they would like for a HV. Developing mechanisms to encourage orphans' and vulnerable children's involvement in the selection of HV process is not only appropriate for enshrining a child's right to participation, but will help improve program quality and effectiveness.**

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While volunteerism in CCCs appears to be genuine, there are various factors that will contribute to the sustainability of the CCC program, including:

- Strong community demand for the CCC/HV services and the involvement of traditional leaders
- Better CCC links with government structures
- Organisational capacity building for CCCs
- CCC access to funding through fundraising, income-generating activities, sub-grants/cash transfers, or competing for government or other grants.

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**Past experience has shown that the greater the diversity in the membership of the CCC, the more innovation shown when delivering services and support to children in the community. Investing time and energy in this early stage of the program can result in longer-term benefits.**

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Community groups, especially CCCs, are often better placed if they are identifying orphans and vulnerable children, and understanding vulnerability according to criteria developed by the community. In this regard communities often perceive sources and types of vulnerability that WV staff, as outsiders, may not be aware of.

Post intervention there has been a noticeable increase in orphans' and vulnerable children's access to external support and in recognition of WV as a source of support for orphans and vulnerable children. Thus, project implementation and, in particular, CCC mobilisation has had an impact on the livelihood of orphans and vulnerable children. Particular impact has been noted through CCC involvement and increasing FBO/NGO/CBO participation in orphans and vulnerable children and chronically ill care activities. However, the interventions did not change the overall psychosocial wellbeing of the children categorised as orphans and vulnerable children, but rather provided more material and physical support.

### Issues

The strength of community ownership is linked with the degree and effectiveness of community mobilisation. Ownership is variable across CCCs but the perception is generally that the CCC “belongs” to WV. Most CCCs struggle to experience and communicate an identity independent of WV, or a full sense of ownership by the community. It is very important that CCCs operate with reference to their context – some have imposed inflexible structures that do not reflect the fluid dynamic communities within which they operate (for more information on this refer to the Africa Hope Child Evaluation). Studies show that CCC capacity to tackle contextual gender and cultural factors (early marriage, abduction, domestic violence, rape, etc) is limited.

It was also noted that the OR project design did not target traditional leaders who are often very influential in their communities and this is one of the factors that contributed significantly to the observed suspicions and resistance to change within some communities. In most settings there was also insufficient participation of government representatives and orphans and vulnerable children in CCCs.

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**Enabling the CCC to establish its own identity, unique to its community and separate to WV's, can result in more widespread ownership by the community, resulting in a more relevant and effective program for beneficiaries.**

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## Recommendations

- Considerable emphasis should be placed on the initial community mobilisation. The parameters of the project should be clearly explained, and this should involve all stakeholders including orphans and vulnerable children and PLHIV. CCCs, during the start up phase, need to undergo intense capacity building to ensure community ownership, committed HV, transparency and community-based accountability. ADPs may need National Office (NO) support during this stage.
- WV should not provide (even if asked by CCCs) t-shirts or uniforms to volunteers that have a WV logo on them, as this can undermine the CCC's own identity. If, in instances, WV does support a uniform, then the CCC should use their own CCC name, logo, colours and messages. Accompanying this can be a small WV logo with a statement that WV supports the uniform.
- Overall, CCC membership should be as multi-sectoral as possible. Participation of traditional leaders, government representatives and teachers is very important, as are faith-based groups. CCCs should also actively promote the participation of beneficiaries, eg, orphans and vulnerable children, PLHIV and women. Some CCCs may consider forming orphans and vulnerable children sub-committees to this end.
- It is best if the CCC structure can remain flexible in response to local contexts but this is sometimes constrained by the inputs WV provides and the need to budget for this. New projects should develop budgets keeping in mind the range of possible CCC members, and leave the decision of actual composition up to the individual CCC.
- Member organisations of Type two CCCs should remain as independent service delivery organisations with their own identities, memberships and beneficiaries. The CCCs, in turn, should remain as coordinating structures and not usurp the role of the member organisations.
- Where the ADP is supporting both CoH and CCC in the same location, ensure that the roles and responsibilities of the various structures are clarified and that coordination of efforts is addressed from the beginning.
- There is a need to facilitate the integration between selection of RC and the community processes that identify orphans and vulnerable children. This can be done by encouraging the use of the orphans and vulnerable children registries to select replacements and new RC. The role of RC selection committees and Customer Relations Service (CRS) workers and their relationship with the CCCs needs to be reconsidered, as does the criteria for selecting RC (such as the age requirements) in the context of the Hope Child countries. In these contexts, the impact of HIV and AIDS adds another dimension of vulnerability to the lives of young people in those areas affected by the disease.
- It is clear that a supportive environment is required to help facilitate attitude and behaviour change, particularly where gender-based and socio-cultural factors are influential. Therefore, both community mobilisation strategies and individually focused behaviour change strategies will be necessary if the prevention program is to address this range of issues effectively.
- As an integral component of HIV prevention programs, there is a clear need to sensitise communities, including children, on what constitutes sexual abuse, thus mobilising communities to take action against sexual abuse. Furthermore, work needs to focus on increasing community knowledge of sexual offence laws and gender-specific rights enshrined in the country's constitution.



# 4

## 4. Capacity building

*(Reference: WVI Models of Learning 4 Country Community Care Coalition Study Synergy Report and Operations Research Study)*

While it is clear that the WV volunteers are benefiting from training opportunities, as evidenced in the quality of benefits and services delivered to communities, more need to be made available. The training provided to CCCs and HVs to date, while successful in building certain basic skills, must be considered introductory only.

### Issues

The CCC Guide requires a minimum of 5-10 days of training to cover the appropriate topics thoroughly. However, many HVs have received only 2-3 days of training, and most could not recall the details of what they learned.

Many CCCs had a low level of understanding of HIV and AIDS, psychosocial care and child rights and protection. Many of the CCCs studied also showed a lack of innovation in local fundraising, with some CCCs highly dependent on WV support. In some cases, NOs may consider secondment of staff to district government structures to assist with capacity building and to create and/or improve their own links with CCC programs.

CCCs and HVs demonstrated some technical capacity with regards to the content of The CCC Guide, but consistently lacked important knowledge as a result of insufficient training opportunities. Similarly, some CCCs demonstrated some of the common indicators of organisational capacity, however, this varied widely across programs and there is consensus that the organisational capacity building (OCB) will be of widespread benefit.

# 4

**Providing training and ongoing support to CCCs and HVs will increase capacity to deliver more effective support and address issues around sustainability, for example, by reducing the likelihood of burnout among volunteers by equipping them to manage workloads and responsibilities better.**

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## **Recommendations**

- Studies suggest that much more attention should be given to training and follow up support for CCCs and volunteers. The entire quality of the home visitation program is affected if volunteers are insufficiently trained. Where possible, there should only be one training of trainers (ToT) carried out directly with those facilitators who will be working with CCC, to avoid the dilution that results in cascade trainings with many links. This ToT should include a practicum component.
- Programs should develop plans for carrying out technical and organisational capacity building with CCCs and HVs. NOs may need to assist ADPs to develop these plans in some instances.
- WV may want to consider supplementing the WV-led capacity building approach with an approach that would see CCCs themselves becoming trainers and mentors of other CCCs in the medium term. Overall, WV should encourage CCC-to-CCC learning visits as a means of encouraging peer education and motivating volunteers.
- CCC OCB needs should be integrated into the ADP OCB process and NOs should consider establishing an OCB unit to manage this.
- ADPs should work on enhancing child protection mechanisms, including child participation, CCC capacity building, and links with the respective government offices in each location. Furthermore, consideration should be given to assist CCCs to address the material needs of orphans' and vulnerable children's households through various fund-raising mechanisms. This should only be in addition to HV, as without a HV program, material support becomes nothing more than a direct distribution program.
- With a view to promoting greater long-term genuine ownership, ADPs should be careful not to control, straightjacket or standardise the CCCs with regard to structure, activities, procedures or requirements.
- ADP provision of financial capital to CCCs for small businesses/IGAs can be encouraged as a good first step in allowing CCCs to gain experience in managing and accounting for money. ADPs should assist CCCs to study the market potential for any small business activities they are proposing to carry out, to avoid situations of over-saturation of the market (all CCCs doing the same thing) and/or non-viable business ideas, and the consequent poor use of the capital investment.
- As CCCs reach higher levels of organisational capacity, based on agreed indicators through OCB, ADPs should assist these CCCs to develop and submit proposals for funding through the relevant government and/or other channels in each country.
- ADPs may consider inviting other community organisations to CCC/HV capacity building events to avoid an outcome whereby CCCs become stronger and better resourced than other local organisations. Furthermore, CCCs should be encouraged to carry out community-wide activities, such as recreation for children, and to hold periodic informational meetings, with a view to strengthening community demand and support for CCC services.
- In the short term, ADP focus should be to continue training CCCs in monitoring, using WV forms and with longer-term vision, to assist CCCs to use government monitoring forms to enable them to report directly to government structures.
- Strategic consideration and planning should accompany attempts to scale-up the reach and capacity of HV's and ADP's expansion into the newer area of support for home-based care. In this regard, issues that need to be considered include: linkage between HV for children and those for the chronically ill; training; work load; burn out; ongoing supervision and management; and context specific support for ongoing community workers.



## 5. Sectoral integration, especially food security/livelihood

### Findings

*(Reference: Evaluation of HIV & AIDS Projects in four Hope Child Countries in East and Southern Africa)*

There is broad consensus about the need to integrate and link HIV and AIDS related interventions with those of other development sectors. The World Food Programme Social Protection Report suggests that HIV and AIDS programs are more effective when combined with interventions that aim to reduce poverty.

ADPs are in a strong position to tackle the challenges of integrating HIV and AIDS with other development work. For example, joint targeting can be undertaken, whereby the lists of orphans and vulnerable children who have been identified by the CCCs are also used to target ADP development interventions. WV has much to offer its staff, as well as other stakeholders, by documenting and sharing lessons that facilitate integration between HIV and AIDS programming and programming implemented by other development sectors.



**There are many lessons that have already been learned in WV ADPs about the mechanisms and the opportunities for integrating HIV and AIDS with other development sectors. Opportunities should be made available to encourage ADP, zonal and national level staff to share this learning.**

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### **Issues**

It is noted that whilst community empowerment interventions to address orphans' and vulnerable children's needs are effective in reducing food insecurity among orphans and vulnerable children, food insecurity remains a great challenge for all children.

Some interventions, such as those that were specific to food security, may require more careful follow-up. In some instances, for example, animals that were provided to community members died and there was no apparent follow-up or monitoring to ensure that the interventions had increased resources to beneficiary households.

### **Recommendations**

- Careful monitoring of communities to determine the short and long-term effects of food insecurity on children is vital.
- There is an urgent need for OR on the relative effectiveness of different mechanisms of providing food for orphans and vulnerable children, eg, through school-feeding programs, provision to households, voucher schemes or cash transfers.
- In highly affected communities, the proportion of children who are orphaned or vulnerable is extremely high and consequently, strategies targeting all households with children to improve basic food security may be needed while HIV affected households in need of additional critical food security assistance could complement a general child-focused food security approach.
- One of the ways to achieve integration between HIV and AIDS interventions and other development sectors is through joint targeting, in which a single process of identifying and selecting target beneficiaries is utilised for HIV and AIDS targeting but can also be used by other sectors.
- At a community level, the increasing number of program components is confusing to most people and NOs should attempt to integrate various programs to include CCCs, ADPs, CoH and others. This integration is particularly important in regard to ensuring consistency of support provided to RC and orphans and vulnerable children in the same areas.



## 6. Sexual abuse and other child protection issues

*(Reference: Operations Research Study)*

### **Key findings**

Findings from the baseline surveys highlighted the facts that:

- While exposure to HIV knowledge was high, knowledge of methods of HIV transmission and prevention was low, particularly among children
- While many respondents in the OR study reported that they could wait until marriage to have sex, a high percentage reported to have already had a sexual experience
- Gender-based cultural practices play a significant role in increasing children's vulnerability to sexual abuse. For example, forced early marriage and sexual initiation and moving into accommodation separate from the family at an early age.

**Baseline survey** findings indicate that a high number of children and adults have received information about HIV transmission (radio was a common method of receiving information). However, while exposure to HIV knowledge was high, knowledge of HIV transmission and prevention was low among children. Many respondents had incorrect knowledge about HIV transmission and misconceptions, such as the belief that a person can contract HIV through a mosquito bite.

Gender-based, socio-cultural factors can increase children's vulnerability to HIV. While it is acknowledged that some HIV related issues can be addressed by increasing HIV awareness, knowledge and prevention skills, others issues are context-specific and need to be addressed through the creation of a supportive environment in which sustained behaviour change can occur.

In other words, the baseline survey highlighted that both community mobilisation and individually focused behaviour changes strategies are needed in order to address a range of issues effectively. For example, sensitising communities, including children, about what constitutes sexual abuse, and capacity building of parents and religious leaders in order to increase their HIV related knowledge and skills.

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**Information alone is not enough to bring about sustained behaviour change. Significant community mobilisation to create a supportive environment and individually focused behaviour change strategies are needed in order to effectively address a range of HIV related issues.**

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**Following the collection of baseline data and a period of program intervention, the OR highlighted that the WV core HIV models were effective in increasing:**

- HIV and AIDS knowledge (reducing misconceptions and changing attitudes)
- Some positive HIV prevention behaviours, such as access to VCT, couple communication and religious leaders' HIV communication
- People's understanding and acceptance of HIV and AIDS related issues, i.e., a reduction in HIV related stigma
- Orphans and vulnerable children's access to psychosocial support.

### Issues

Whilst there were many documented outcomes and benefits following the implementation of the prevention model OR, significant sexual behaviour change was not clearly identified. This should cause WV to reflect on the information and activities they implement (including the synergy of these activities) in various areas. No significant difference between intervention and control sites was noted in:

- Early initiation of sex among children
- Proportion of children whose first sexual experience was forced upon them
- The culture of silence and blaming the victim, particularly in relation to sexual abuse. This is still a challenge.
- Reported self-perpetration of sexual abuse among all the groups
- Reported experience of sexual abuse past six months amongst all groups
- Condom use among the adult household members and the FBO/NGO/CBO representatives
- The number of people from adult households who were supportive of providing ABC information to children.

### Recommendations

- Practitioners considering the implementation of the Hope Prevention model within the communities they work are encouraged to review the prevention model material, taking care to ensure the information provided is relevant, correct and comprehensive.
- Studies show that the use of more than one communication method when passing on prevention messages to children (ie, radio, parents, teachers, peers, community and traditional leaders, etc) can be highly effective. It is important to ensure relevant Regional and National Office staff visit ADPs and provide technical support in this area.
- OR suggests that the prevention message needs to be repackaged to go beyond the ABC message, thus expanding on life-skills training to address social, cultural and gender drivers of the pandemic such as sexual abuse and early marriage.

# APPENDIX I:

## Quick reference table - Core models

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### Prevention

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#### Linkages/Partners

- Foster strong partnerships with FBOs and religious leaders to develop and maintain community initiated HIV and AIDS care and advocacy.

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#### Volunteerism

- To be effective, volunteers must be well educated and informed.

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#### Community mobilisation

- Significant sexual behavior change can take much longer than the OR process to this point.
- If considering implementing the Hope Initiatives prevention model, review the material. Ensure relevant and correct information is disseminated. Use multiple sources eg, radio, parents, teachers, peers, community and traditional leaders, etc. Regional and National Office staff visit ADPs and provide technical support.
- OR suggests the prevention message needs to go beyond ABC, and address social, cultural and gender drivers of the pandemic eg, sexual abuse and early marriage.
- Sustained behaviour changes needs a supportive environment, individual skills and knowledge building, particularly where gender-based and socio-cultural factors are influential.
- Sensitise communities, including children, on what constitutes 'sexual abuse', to take action against it.
- Increase community knowledge of sexual offense laws and gender-specific rights enshrined in the country's constitution.

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#### Capacity building

- For a comprehensive behaviour change approach, all community stakeholders, including parents, children, community leaders, politicians, teachers, etc, need support and capacity building

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#### Sectoral integration

- HIV prevention must be combined with interventions that reduce poverty. WV leadership should officially adopt the expanded definition of HIV and AIDS programming, emphasising effective integration of HIV-specific and HIV-related interventions.

## Community Care Coalitions

- Maintain strong (horizontal) links at local level with health, education, child protection and women's affairs.
- Improve vertical links with district-level government structures.
- Assist to provide regular monitoring and other information to relevant government bodies.
- Establish formal referral systems between CCCs and government services, especially regarding child protection and health.
- Contentious that volunteers and guardians have a lack of material support for beneficiaries.
- Significant benefits for orphans and vulnerable children even when HVs are unable to provide material support.
- Encourage CCC-to-CCC learning visits for education and motivation.
- Emphasise the initial community mobilisation: explain project parameters clearly; involve all stakeholders including orphans and vulnerable children and PLHIV; undergo intense capacity building for community ownership, committed HVs, transparency and accountability.
- Consider NO support.
- Membership to be as multi-sectoral as possible, with participation of traditional leaders, government representatives, teachers, FBOs.
- Actively promote the participation of beneficiaries, eg, orphans and vulnerable children, PLHIV and women.
- Consider forming orphans and vulnerable children sub-committees.
- CCC structure should remain flexible to local contexts; however, inputs and budgets can constrain this.
- New projects should budget within a range of total CCC members, but leave the actual composition of criteria to each CCC.
- More attention must be given to training and follow up.
- Consider supplementing the WV-led capacity building approach with one that would see CCCs becoming trainers and mentors of other CCCs.
- For greater long-term genuine ownership, avoid controlling and/or standardising CCCs with regard to structure, activities, procedures or requirements.
- NOs may consider secondment of staff to district government structures to assist with capacity building and to create and/or improve their links.
- WV should formalise and support opportunities to foster information exchange among WV staff at, and between, all levels – international, national, ADPs and between community partners.
- Strengthen staff capacity to increase the role of WV in advocacy efforts at national and local levels, focusing on availability of staff and technical expertise improvement.

## Channels of Hope

- Foster strong partnerships with FBOs and religious leaders to develop and maintain community initiated HIV and AIDS care and advocacy.
- Retain support from FBOs for volunteer retention.
- If ADP is supporting both COH and CCC in the same location, clarify roles and responsibilities and address effort coordination.
- Consider developing a coordinated and systematic FBO HIV and AIDS prevention education intervention.

## APPENDIX 2:

# Quick reference table - Issues, findings and recommendations

<b>Key programming area</b>	<b>Findings</b>
Linkages/Partners	<ul style="list-style-type: none"><li>• Advocacy to reduce HIV-related stigma and discrimination a major component of WV interventions.</li><li>• Advocacy efforts are limited at national and local levels by staff availability and capacity.</li><li>• Grant funded programs more likely to ensure staff are available and equipped for networking and advocacy.</li><li>• Strong partnerships are essential to enhancing the scale and sustainability of HIV and AIDS prevention and care efforts.</li><li>• Partnerships with people of influence in the community are important to intervention success.</li><li>• Partnerships with PLHIV groups (if existing), can benefit program effectiveness.</li><li>• The strength of these links is dependent on the initial community mobilisation and on the composition of the CCC.</li></ul>

## Issues

- The RAPIDS partnership of six organisations found that the use of organisation-specific terminology interferes with institutional collaboration.
- Sometimes donor requirements unintentionally interfere with partnerships.
- There is sometimes a gap in coordination among national and local level stakeholders.
- Poor integration of CCCs and ADPs can result in problems with RC receiving more benefits than orphans and vulnerable children in the same area.

## Recommendations

- All projects should ensure that CCCs have established strong inter-community links at a local level with existing services such as health, education, child protection and women's affairs.
- WV needs to study ways of improving links between CCCs and district-level government structures.
- It is important to establish formal referral systems between CCCs and government services, especially those dealing with child protection and health.
- WV should formalise and support more opportunities to document and foster information exchange, and have lessons learned among WV staff at, and between, all levels – international, national, ADP - as well as between community partners.
- Staff capacity must be strengthened to bolster WV advocacy efforts at all levels.
- WV should continue to foster strengthened partnerships among national and local level stakeholders, to increase the reach and sustainability of interventions affecting orphans and other vulnerable children.

# APPENDIX 2:

## Quick reference table - Issues, findings and recommendations

<b>Key programming area</b>	<b>Findings</b>
Volunteerism	<p>Volunteers are central to WV's community-based approaches to HIV programming. Different studies suggest that volunteerism has been successful, however, some programs did experience challenges in retaining volunteers and maintaining their motivation.</p> <p>Many volunteers have a link with the church and a faith-led approach has proven effective in mobilising orphans and vulnerable children support.</p> <p>All CCCs have been successful in mobilising volunteers to visit orphans and vulnerable children in their homes. The consensus seems to be that weekly or bi-weekly visits are reasonable.</p> <p>Unpaid work by community members is key to WV's programming approach, and there is consequently a large need for resources (whether as "support" or as "incentives").</p> <p>ADPs need to focus on ensuring that support to community volunteers and community structures is provided in a way that facilitates and enables long-term community work, but does not undermine community initiative.</p>



## Issues

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WV-provided incentives contribute to volunteer motivation but this means that numbers of volunteers are often predetermined by WV budgets for these inputs, resulting in rigid CCC membership.

Some examples of WV provided GIK have proven contentious within communities and among guardians in many cases.

In every study location, volunteers and guardians expressed frustration at the lack of material support for beneficiaries. Large caseloads, together with minimal support for the work that they do, threaten the prospects for long-term involvement of these community workers.

## Recommendations

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The impact and value of a home visitation program should not be underestimated, even when HVs are unable to provide any form of material support to orphans and vulnerable children and households.

Besides resources for volunteers, resources available to share with beneficiaries are small, and external resources could significantly increase volunteer ability to reach vulnerable households with the additional support that is needed.

WV should not distribute GIK within communities or to CCCs until the administrative capacity of the CCCs to manage the GIK is built.

GIK should only focus on agricultural inputs and/or HBC material, not clothing, shoes, etc, as these can create tensions in the community.

WV should encourage CCC-to-CCC learning visits as a means of encouraging peer education and motivating volunteers.

## APPENDIX 2:

# Quick reference table - Issues, findings and recommendations

<b>Key programming area</b>	<b>Findings</b>
Community mobilisation	<ul style="list-style-type: none"><li>• Improved community sensitisation to the needs of orphans and vulnerable children</li><li>• Increased perception that the problem of orphans and vulnerable children is a community problem</li><li>• Most orphans and vulnerable children households are extremely poor</li><li>• CCC concept adopted by other stakeholders beyond ADP areas</li><li>• CCC success is dependent on inclusiveness, and effectiveness of entry point, community mobilisation and capacity, involvement of traditional leaders, PLHIV and government agencies</li><li>• The greater the variety of CCC membership, the greater innovations in accessing services for orphans and vulnerable children</li></ul>
Capacity building	<p>The effect of CCC activity is reported to be beneficial to communities, particularly in regard to HVs and childcare support. The training provided to CCCs and HVs to date, while successful in building certain basic skills, must be considered introductory only.</p>

## Issues

- Risk of perception that CCC 'belongs' to WV
- Some CCCs have inflexible structures that do not reflect community dynamics
- Limited capacity of CCC to tackle contextual gender and cultural factors
- Insufficient participation of government representatives in CCCs
- Orphans and vulnerable children participation is absent in almost all CCCs

Many HVs have only received 2-3 days of training, and most could not recall the details of what they learned.

The more links there are in a cascade-type training program, the more the content becomes diluted by the time the training finally reaches the CCC.

CCCs do not have a lot of capacity in regard to HIV and AIDS information, psychosocial care and child rights and protection. Many of the CCCs studied also showed a lack of innovation in local fundraising, with some CCCs highly reliant on WV support.

Some CCCs show the common indicators of organisational capacity, but this varies widely across programs. There is a consensus that the organisational capacity building (OCB) process will be important for all.

## Recommendations

- Mobilising communities to understand and take action against sexual abuse
- Capacity building for CCC during start up to ensure community ownership and community based accountability
- CCC membership should be as multi-sectoral as possible

More attention should be given to CCC training and follow up. Programs should develop plans for carrying out technical and organisational capacity building with CCCs and HVs.

WV should encourage CCC-to-CCC learning visits as a means of encouraging peer education and motivating volunteers.

ADPs should work on enhancing child protection mechanisms, including child participation, CCC capacity building, and links with respective government offices in each location.

Strategic consideration and planning should accompany attempts to scale-up the reach and capacity of HVs' and ADPs' expansion into the newer area of support for home-based care. In this regard, issues that need to be considered include: linkage between HVs for children and those for the chronically ill; training; work load; burn out; ongoing supervision and management; and context specific support for ongoing community workers.

ADP management needs to ensure that there are sufficient human resources available to provide capacity building to CCCs and their HVs. Experience shows that for 10 CCCs there is need for at least one full time, capacity building staff person. Such staff costs are 100% ministry costs.

## APPENDIX 2:

# Quick reference table - Issues, findings and recommendations

<b>Key programming area</b>	<b>Findings</b>
Sectoral integration	<p>It is important to consider the strong inter-relationship between poverty and food insecurity. The relationship applies with regard to both vulnerability as a result of AIDS (care and support) and increased risk of becoming infected with HIV (prevention).</p> <p>Studies suggest that HIV and AIDS programs are more effective when combined with interventions that reduce poverty.</p> <p>ADPs may be in a strong position to tackle the challenges of integrating HIV and AIDS with its other development work.</p> <p>WV has much to offer its staff, as well as other stakeholders, by documenting and sharing lessons that facilitate integration between HIV and AIDS programming, and programming implemented by other development sectors.</p>
Sexual abuse/Child protection	<ul style="list-style-type: none"><li>• Although exposure to HIV knowledge was high, knowledge of methods of HIV transmission and prevention was low, particularly among children.</li><li>• Gender-based cultural practices also play a significant role in increasing children's vulnerability to sexual abuse.</li><li>• Post intervention, there was improved access by orphans and vulnerable children to psychosocial support, insecticide treated nets, adequate food, health-care and schooling.</li></ul>

## Issues

Some interventions, such as those that were specific to food security, may require more careful follow-up.

Whilst community empowerment interventions to address orphans' and vulnerable children's needs are effective in reducing food insecurity among orphans and vulnerable children, food insecurity remains a great challenge for both orphans and vulnerable children and non-orphans and vulnerable children.

## Recommendations

- Careful monitoring by WV of the short and long-term effects of food insecurity on children is vital.
- There is an urgent need for OR on relative effectiveness of different mechanisms of providing food for orphans and vulnerable children, eg, through school-feeding programs; provision to households; voucher schemes or cash transfers.
- One of the ways to achieve integration between HIV and AIDS interventions and other development sectors is through joint targeting, in which a single process of identifying and selecting target beneficiaries is utilised for HIV and AIDS targeting and also used by other sectors.
- At a community level the increasing number of program components is confusing to most people and NOs should attempt to integrate various programs to include CCCs, ADPs, CoH and others. This integration is particularly important in regard to ensuring consistency of support provided to RC and orphans and vulnerable children in the same areas.

No significant difference between intervention and control sites was noted in:

- Early initiation of sex among children
- Proportion of children whose first sexual experience was forced upon them
- The culture of silence and blaming the victim, particularly in relation to sexual abuse, remains a challenge. Reported self-perpetration of sexual abuse among all the groups.

Reported experience of sexual abuse over the past six months amongst all groups:

- Children discuss ABC with their parents/guardians and church/religious leaders in both ADPs.

Mechanisms for ensuring child protection are weak across the board, although CCCs do try to respond to abuses when these occur.

- Studies suggest the use of multiple sources when passing on prevention messages to the children (ie, radio, parents, teachers, peers, community and traditional leaders, etc). It is important to ensure relevant Regional and National Office staff visit ADPs and provide technical support.
- OR suggests that the prevention message needs to be repackaged to go beyond the ABC message, thus expanding on life-skills training to address social, cultural and gender drivers of the pandemic such as sexual abuse and early marriage.



# APPENDIX 3: Hope Initiative Strategic Framework summary



The strategic framework is aligned to WV International policies and strategies to serve as a guide to WV regional offices, national offices and support offices for developing strategies and programs for HIV responses. The framework is still at draft stage and will be reviewed and refined periodically to reflect changes in the rapidly evolving HIV pandemic.

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**Overall goal** To reduce the global impact of HIV and AIDS on children, enabling them to live life in all its fullness

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Tracks	Prevention	Care	Advocacy
<b>Goals</b>	Contribute to the reduction of risk and vulnerability to new HIV infections	Protect and improve the wellbeing of children and their households affected by HIV	Promote policies and practices that reduce stigma and uphold the rights of children and adults affected by HIV
<b>Target groups</b>	Girls, boys and youth ages 5-24, their families and communities, and vulnerable population groups in emergencies	Orphans, children living with HIV, other vulnerable children and their households	Policy makers, decision makers, and implementers (local, national, regional and international)
<b>Values</b>	Bring a Christian, community-based, child-focused HIV and AIDS response, reflecting God's unconditional love for all people and the affirmation of each individual's dignity and worth		
<b>Partners</b>	Work with a wide range of partners for scaled-up and sustained HIV response at local, national, regional and international levels, with a special focus on faith communities, people living with HIV, children and youth organisations.		

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## Guiding principles – World Vision’s HIV response:

- Creates an enabling environment by transforming risk-increasing religious, social and cultural practices
- Is designed, monitored and evaluated to achieve large-scale, cost-effective results with high quality
- Is aligned with global best practices and national policies, coordinating mechanisms and monitoring frameworks
- Facilitates and empowers communities for scaled-up and sustainable response
- Is contextualised to diverse local settings
- Is integrated with all aspects of WV’s transformational development, relief and advocacy work using evidence-based Hope core project models
- Targets gender-based vulnerabilities, stigma and poverty as root causes and drivers of the HIV pandemic
- Uses learnings from WV’s community-based programs to inform and influence national and international policy and practice
- Is child rights based and ensures child participation
- Considers the spiritual and psychosocial wellbeing of children and families
- Engages both public and private donors as active partners
- Addresses the impacts of HIV among WV staff

## APPENDIX 4: Do, Assure, Don't Do framework

The draft "Do, Assure, Don't Do" framework below is the result of a lengthy process. In it, WV's global HIV and AIDS programming was examined through the lens of the Partnership's Integrated Focus and other strategic documents. This draft is current as at 1 June 2008.

### *Explanation of categories:*

**Do:** Responses that are effective and fit with WV's integrated focus, policies, competencies and strategic frameworks. In relevant contexts, these activities will usually be WV's first priorities.

**Assure:** Responses or services that are effective and essential, but may not fit as well with WV's integrated focus, policies, competencies and strategic frameworks. If these are not available or not effective in program operational areas, WV's may need to act to assure that they become available, by (i) advocating to appropriate government agencies or services providers; (ii) identifying and working with partner organisations; and (iii) implementing community-based activities to improve accessibility and uptake of services. If these assurances are ineffective or not possible, WV can include some of these activities in its programs.

**Additions:** Are responses that aligned with WV's integrated focus, policies, competencies and strategic frameworks, but may be a lower priority than core interventions. Usually, these should be undertaken only if resources permit once 'Do' and 'Assure' categories are covered.

**Exception only** are responses or services that are effective, but may not fit as well with WV's integrated focus, policies, competencies and strategic frameworks, and are only suitable for WV to implement in the specific circumstances identified under 'criteria for exception.'

**Don't Do** describes responses that are either clearly outside WV's competencies, in direct contradiction of formal WV Partnership policies, or harmful. Usually, these are quite specific, and it is important not to extrapolate from these to related activities. For example, "purchase or provide antiretroviral drugs" is included in Don't Do because WV cannot guarantee sustainable supply, and is not competent to deliver antiretroviral treatment services. However, WV recognises that a comprehensive continuum of care for people living with HIV must include antiretroviral treatment (ART), so ART is included in the 'Assure' category, and community level activities to improve access to ART are encouraged.





**Recommended Core Focus for WV’s contribution:**

**DO**

**Strengthen household and community childcare capacity** (eg, Community Care Coalitions) to protect and improve the wellbeing and resilience<sup>2</sup> of orphans, girls/boys made vulnerable due to HIV and adults living with HIV, their families/caregivers and households

**Sensitise, equip and mobilise faith-based institutions/organisations** – with skills for caregivers/faith leaders etc. for HIV prevention, care, advocacy, and stigma and discrimination

**Value-based life skills and peer education – Participatory** HIV prevention for/with girls/boys and young people, using comprehensive values-based life skills education<sup>3</sup> and peer education

**Expanded prevention – Comprehensive** behaviour change model to reduce underlying drivers of the HIV epidemic<sup>4</sup> for girls/boys/youth by working with parents/caregivers, faith and community leaders/groups, WV staff, and most at risk populations

**Key partners for core focus**

Local churches and faith-based institutions, schools, government and ministries responsible for children and HIV and AIDS, National AIDS Councils, PLHIV associations; local grassroots and community-based organisations and businesses; Global Fund for AIDS, TB & Malaria, UNICEF, UNAIDS, Global Partners Forum, PEPFAR, EU, Better Care Network, WFP, partner NGOs

**ASSURE**

**Assure the rights and meet the needs of girls/boys and adults infected and affected by HIV and AIDS** through advocacy - at the local, national, regional and global levels to change policies and practices

**Facilitate access for HIV-related continuum of quality care and prevention services** – Demand creation, treatment support, monitoring, and promotion of access to VCT, ART (children/adults), treatment for OI/STI, nutrition, effective PMTCT+, and condom availability

**Facilitate integration of HIV prevention and care** within WV’s disaster mitigation and emergency assessment and responses as well as within primary healthcare, sexual and reproductive health, drug demand reduction, STI management, and economic strengthening

**ADDITIONS**

*Other complementary areas of work, if the core focus is being addressed. Additions are generally undertaken with partners, since these would not be WV core technical competencies.*

- Community conversation and outreach combined with targeted community radio and mobile communication initiatives, within a broader behaviour change communication strategy
- Promote youth friendly reproductive health services
- Advocate for safety in healthcare settings (blood supply safety, universal precautions, post exposure prophylaxis etc.)

**Phase down and transition “Don’t Do” and Exception Only activities**

**EXCEPTION ONLY**

- Access to VCT, ART, treatment for OI/STI, and effective PMTCT+
- Purchase and distribution of clean needles and syringes for provision outside of healthcare setting

**Criteria for exception**

- In emergencies and failed or highly unstable states
- In special circumstances in interventions with key populations at high risk

**DON’T DO**

- Purchase or provision of ARVs, testing equipment for viral loads and CD 4 counts, other laboratory or paediatric diagnostic equipment
- Major healthcare infrastructure, including building VCTs, laboratories etc.
- Abuse the dignity and rights of people living with HIV or children affected by HIV for media or marketing purposes
- Act as an agent for international adoption
- Build/finance orphanages or hospices/houses for orphans

<sup>2</sup> Definition of wellbeing and resilience – A holistic concept where basic human and child rights are met

<sup>3</sup> Comprehensive life skills to cover topics including: HIV prevention, sexual and reproductive health, gender issues, child rights and protection, drug demand reduction, and citizen education.

<sup>4</sup> Examples of drivers of the HIV epidemic include sexual behaviour (unprotected sex, multiple partners), vulnerability to HIV infection stemming from lower economic status, harmful gender and cultural practices, abuse, migration, and intravenous drug use.





















