World Vision Uganda
Core HIV and AIDS Project Models

QUALITATIVE STUDY FINDINGS FROM UGANDA
World Vision Uganda

ASSESSING THE EFFECTIVENESS AND IMPACT of WORLD VISION CORE HIV AND AIDS PROJECT MODELS

QUALITATIVE STUDY FINDINGS FROM UGANDA

FINAL REPORT

JULY 2009
ACKNOWLEDGEMENT

Many people contributed to the successful implementation of this multi-year operations research project. Development, Management and Training Consultants, located in Kampala, conducted the final evaluation and drafted the report. The final version of this report was edited by Jennifer Franz-Vasdeki (consultant). Katwe ADP community members provided information and implemented the interventions; Katwe ADP staff supported the project from inception in 2005, especially ADP Coordinator Martin Okello, M&E Officer Isaac Galiwango and Angella Naluminsa, the HIV and AIDS Project Development Facilitator. Over the life of the project, various Project Implementation Committee Members provided technical and management support: Godfrey Isingoma, Jenninah Kabiswa, Flavia Nakayima, Joan Mugenzi, Richard Wamimbi and Joshua Wandera. The work was coordinated and supported by the Hope Initiative Team members: Jane Chege (PI), Martha Newsome, Mark Lorey, Christo Greyling and Logy Murray. WV Canada provided the bulk of the funding and WV Australia also provided financial support that enabled the implementation of the project.

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# ACRONYMS AND ABBREVIATIONS

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<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>ADP</td>
<td>Area Development Programme</td>
</tr>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>CBO</td>
<td>Community-based organisation</td>
</tr>
<tr>
<td>CCC</td>
<td>Community Care Coalitions</td>
</tr>
<tr>
<td>CDF</td>
<td>Community Development Facilitator</td>
</tr>
<tr>
<td>CoH</td>
<td>Channels of Hope</td>
</tr>
<tr>
<td>FBO</td>
<td>Faith-based organisation</td>
</tr>
<tr>
<td>FGD</td>
<td>Focus group discussion</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>HV</td>
<td>Home visitor</td>
</tr>
<tr>
<td>KII</td>
<td>Key informative interview</td>
</tr>
<tr>
<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-government organisation</td>
</tr>
<tr>
<td>OR</td>
<td>Operations Research</td>
</tr>
<tr>
<td>OVC</td>
<td>Orphans and vulnerable children</td>
</tr>
<tr>
<td>PIASCY</td>
<td>Presidential Initiative on AIDS Strategy for Communication to the Youth</td>
</tr>
<tr>
<td>ToT</td>
<td>Training of Trainers</td>
</tr>
<tr>
<td>VCT</td>
<td>Voluntary counselling and testing</td>
</tr>
<tr>
<td>WVI</td>
<td>World Vision International</td>
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<tr>
<td>WVU</td>
<td>World Vision Uganda</td>
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</table>
EXECUTIVE SUMMARY

World Vision International (WVI) designed and piloted three HIV and AIDS programme models in Uganda and Zambia from 2002 to 2004. The results from the pilot implementation phase revealed the models were feasible, acceptable and effective. To enhance the understanding of the effectiveness and impact of the models, WVI designed an operations research (OR) study, which started in September 2005 in Uganda and Zambia. This report presents the qualitative results of implementing the three HIV and AIDS programme models in the World Vision Uganda (WVU) Area Development Programme (ADP) of Katwe.

To strengthen community engagement and capacity to protect children from HIV and AIDS, WVU adopted the HIV and AIDS prevention model to equip children aged 5 to 15 with knowledge and life skills. This was carried out by training teachers, peer educators and community volunteers using the Adventure Unlimited curriculum developed by Scripture Union. The implementation of the prevention model enhanced the creation of a formal and reliable channel for accessing HIV and AIDS information and helped to break the silence around, and foster diffusion of, HIV and AIDS knowledge. The result of this endeavour was a pool of peer-to-peer educators, the acquisition of values-based life skills, and behavioural changes amongst children aged 5 to 15.

Shortcomings of the prevention models included failure by some schools to create platforms for the dissemination of HIV and AIDS messages and a lukewarm response by the community to protect children against HIV and AIDS. The HIV prevention model is replicable, although its effectiveness would be greater if positive parenting sessions were aggressively pursued, in- and out-of-school AIDS Clubs strengthened, and the planning and monitoring meetings revived.

The community-led orphan and vulnerable children (OVC) Care model was designed to strengthen community leadership and enhance the capacity of households and communities in responding to the needs of OVC and chronically ill household members. To implement the model, stakeholders were brought together to establish Community Care Coalitions (CCC). The CCC model enhanced the community response to the needs of OVC and chronically ill household members and ultimately improved their rights and quality of living.

The sustainability of the CCC model could be jeopardised by an inability to mobilise necessary local resources due to high poverty levels among households. Income-generating projects, enhanced networking, and transformation of CCCs into community-based organisations (CBOs) may improve the long-term sustainability of the model, as well as create a forum for planning and coordinating CCC implementation, monitoring and advocacy issues at the ADP/cluster level.

The objective of the Channels of Hope (CoH) model was to strengthen church and faith-based organisation (FBO) engagement and leadership in HIV prevention, as well as care and support within the community. To implement the CoH model, the FBO and congregation leaders underwent significant training to respond more effectively to the impacts of HIV and AIDS within their congregations and communities. The implementation of the CoH model contributed to breaking the silence about HIV and AIDS, as well as lessening HIV and AIDS stigma and discrimination, while deepening care and support for OVC and chronically ill household members. The capacity of churches and FBOs to effectively implement the CoH model was constrained by their inability to mobilise adequate resources due to rampant poverty amongst the Katwe ADP residents. Thus, to improve the effectiveness of the CoH model implementation, churches and FBOs should conduct sensitisation campaigns targeting able bodied and mature adults; thereby, aggressively engaging in resource mobilisation as well as improving livelihoods of community members. WVU should
collaborate with local governments to enhance joint planning, implementation and monitoring of developmental activities.

There is a need to clearly communicate the implementation approaches of the HIV and AIDS models and WVU ADP programmes to the beneficiary community. For example, the Children in Programme (CIP) are given handouts, which are not part of the HIV and AIDS OVC model. Furthermore, some of the HIV and AIDS model home visitors (HVs) doubled as CIP Monitors, which caused friction and mistrust between the beneficiaries and community volunteers. Hence, it is imperative to help the community clearly distinguish between HIV and AIDS models and WVU ADP interventions and types of support accruing to the beneficiaries.

Key issues that WVU and other stakeholders can learn from the implementation of the three HIV and AIDS models is that they contributed to breaking the silence about HIV and AIDS and deepened knowledge about HIV and AIDS care and support of OVC and chronically ill household members. Through the model implementation, access to basic services increased, as did positive living amongst OVC and chronically ill household members. There is a need for clearer communication about HIV and AIDS models and the WVU ADP programme implementation approach in order to enhance community ownership and participation. Scaling up of the HIV and AIDS models requires the mobilisation of resources to improve the livelihood of OVC and chronically ill household members, networking with local governments, and engaging in advocacy activities.
1. INTRODUCTION

1.1 Background to the Operations Research

World Vision designed and piloted three HIV and AIDS programme models in Uganda and Zambia from 2002 to 2004. The results from the pilot implementation phase revealed that models were feasible, acceptable and effective. In order to enhance the understanding of the effectiveness, impacts and costs of the three HIV and AIDS programme models, WV designed an operations research (OR) study. The OR study was implemented in the Katwe Area Development Programme (ADP) in Uganda and Keembe ADP in Zambia, where these models had not been previously implemented.

The models are based on three core elements of WVI’s HIV and AIDS response:

- Prevention for children aged 5 to 15 through values-based life skills training
- Engaging and equipping churches and other faith-based organisations (FBO) using the Channels of Hope (CoH) methodology
- Care for orphans and vulnerable children (OVC) through mobilising and strengthening community care coalitions (CCC).

In Uganda, the OR study was implemented in three adjacent sub counties of Bukomero, Muwanga and Dwaniro in the Kiboga district, totalling 15 parishes (see Table 1). WVU Katwe ADP started implementing the models in six parishes in the intervention sites and another six parishes in the control sites after 14 months.

Table 1: Katwe ADP OR study implementation period by parish

<table>
<thead>
<tr>
<th>2006</th>
<th>2007</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervention Parishes</td>
<td>Control Parishes</td>
<td>Advocacy Parishes</td>
</tr>
<tr>
<td>Mataagi</td>
<td>Kikooba</td>
<td>Nakasengere</td>
</tr>
<tr>
<td>Kyomya</td>
<td>Kagogo</td>
<td>Kateera</td>
</tr>
<tr>
<td>Muwanga</td>
<td>Nakasozzi</td>
<td>Mwezi</td>
</tr>
<tr>
<td>Nabwendo</td>
<td>Bikko</td>
<td></td>
</tr>
<tr>
<td>Kalokola</td>
<td>Katalama</td>
<td></td>
</tr>
<tr>
<td>Kakinzi</td>
<td>Lwakonge</td>
<td></td>
</tr>
</tbody>
</table>

Two Katwe ADP Community Development Facilitators (CDFs) and Monitoring and Evaluation (M&E) specialists were trained as Training of Trainers (ToTs) to provide training for key stakeholders. An additional 11 Katwe ADP staff were mentored through meetings to enhance the implementation of the models. After four years of implementing OR in Katwe ADP, a study to assess the effectiveness and impact of three HIV and AIDS programme models was conducted and the qualitative findings are presented in this report.

1.2 Purpose of the Study

The purpose of the OR was to gather and provide information on the implementation of three programme models in order to improve HIV prevention, and advocacy and care programming in communities highly affected by HIV and AIDS. The OR study assessed how the models achieved the following:

- Strengthened community engagement and leadership in the care and support for OVC and chronically ill household members
• Strengthened community engagement and leadership in protecting children from HIV and AIDS infection
• Increased positive HIV prevention, care and support attitudes, breaking the silence around HIV and AIDS and reducing stigma
• Improved status, well-being and quality of life of OVC
• Led to implementation of the three HIV and AIDS programme models at the community level
• Contributed to the sustainability of the communities’ prevention, care and support activities if WVU phases down or out
• Extent to which capacity building at the community, church and FBO levels contributed to improved delivery, access and utilisation of services
• Documented evidence of impact that can be used as a basis for organisational learning, advocacy and resource mobilisation.

1.3 Approach and Methodology

A qualitative approach was used within this study, including documentary reviews, key informant interviews (KII), focus group discussions (FGD), case studies and verbal debriefing sessions. Various documents were reviewed1 in order to obtain relevant information about the design, implementation and performance of the three HIV and AIDS programme models as captured by WVU and other stakeholders. Key informant interviews were conducted with relevant persons (Table 2) and these aimed to reveal implementation experience, performance and challenges.

Table 2: Key informant interviews by category

<table>
<thead>
<tr>
<th>Participant category</th>
<th>Number of Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teachers</td>
<td>6</td>
</tr>
<tr>
<td>Local and community leaders</td>
<td>18</td>
</tr>
<tr>
<td>Health workers</td>
<td>5</td>
</tr>
<tr>
<td>NGO/CBO/FBO staff</td>
<td>3</td>
</tr>
<tr>
<td>In-depth exit interviews</td>
<td>8</td>
</tr>
<tr>
<td>Case studies</td>
<td>3</td>
</tr>
</tbody>
</table>

Focus group discussions (FGDs) were conducted to enhance comparison and reliability of information gathered. An enquiry and open discussion strategy was adopted with participants (Table 3), including, testimonies, brainstorming and plenary discussions using FGD guides. A total of 82 FGDs were conducted with 777 participants.

1 See source list
Table 3: Categorisation of FGD participants

<table>
<thead>
<tr>
<th>Model</th>
<th>Category of participants</th>
<th>Number of FGDs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Intervention</td>
</tr>
<tr>
<td>Model 1:</td>
<td>Peer educators (12 to 16 years)</td>
<td>3</td>
</tr>
<tr>
<td>HIV Prevention</td>
<td>Primary school children (9 to 16 years)</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Female adolescents in school (12 to 17 years)</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Male adolescents in school (12 to 17 years)</td>
<td>3</td>
</tr>
<tr>
<td>Model 2:</td>
<td>Female OVC (7 to 17 years)</td>
<td>3</td>
</tr>
<tr>
<td>CCC</td>
<td>Male OVC (11 to 18 years)</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Household caregiver</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>CCC members</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>CCC home visitors</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Female community members</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Male community members</td>
<td>2</td>
</tr>
<tr>
<td>Model 3:</td>
<td>Female FBO leaders</td>
<td>1</td>
</tr>
<tr>
<td>CoH</td>
<td>Male FBO leaders</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>FBO home visitors</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Female youth</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Male youth</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Female adolescents out of school (16 to 19 years)</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Male adolescents out of school (17 to 18 years)</td>
<td>2</td>
</tr>
</tbody>
</table>

Verbal debriefing sessions were held with relevant WVU and local government staff in order to validate information gathered during the study; opinions and comments generated have been taken into account while preparing this report. All informants participating in this study volunteered and privacy and confidentiality has been ensured by omitting names within this report. Permission to record proceedings and take pictures was obtained from key informants and FGD participants prior to the interviews by WVU.

1.4 Beneficiary Impression on the Magnitude of HIV and AIDS

The majority of participants still consider HIV and AIDS a major problem within the WVU Katwe ADP. HIV and AIDS continue to claim the lives of the able-bodied and most productive members of society. The loss has led to a reduction in food production, depletion of family resources due to rising expenditures on HIV and AIDS treatment, and increased poverty. HIV and AIDS also contributes to the disintegration of the family unit, early marriages, dropping out of school, increased child labour and hopelessness. The voices and responses presented in Box 1 reflect the respondents' perception of the gravity and impact of HIV and AIDS in WVU Katwe ADP.
### Box 1: Voices reflecting the perceived impact of HIV AND AIDS in WVU Katwe ADP

<table>
<thead>
<tr>
<th>Quote</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>‘HIV and AIDS is still spreading like a bush fire, leading to loss of parents which brings us a lot of pain and leaves a gap in addressing our needs.’</td>
<td>Peer educator, intervention and control sites</td>
</tr>
<tr>
<td>‘HIV and AIDS has claimed many lives, leaving behind many suffering orphans who lack parental guidance and move around villages begging for survival. Some orphans have become a nuisance and problems in the community.’</td>
<td>CCC member, Nabwendo control site</td>
</tr>
<tr>
<td>‘Many orphans come to our houses for help and our homes have ended up being like nursery schools yet we do not also have anything.’</td>
<td>Male FBO leader, Kyomya intervention site</td>
</tr>
<tr>
<td>‘Because of the increased poverty, the parents infected with HIV and AIDS sell off all their property including land to raise money for treatment. By the time of their death, nothing is left for the orphans.’</td>
<td>HV, Mataagi intervention site</td>
</tr>
<tr>
<td>‘Our mother went away leaving us with nothing, so I am the one looking after my siblings. I find it hard and suffer a lot trying to provide food and beddings for the rest of the family. It’s a relief when good Samaritans provide us with some food.’</td>
<td>Female OVC, Kakinzi intervention site</td>
</tr>
<tr>
<td>‘Since OVC lack parental guidance, they grow up ruthless, and this puts the community in great danger.’</td>
<td>Female youth, Bukomero control site</td>
</tr>
<tr>
<td>‘The orphans are very many now and their caregivers are elderly grandparents who cannot afford to look after them since they are not energetic enough to work.’</td>
<td>FBO HV, Mataagi intervention site</td>
</tr>
<tr>
<td>‘I have five OVC and I am an old man who cannot even support and care for them well. Even others have the same problem like me, since we do not have enough energy to dig and provide food for these people as well as to guide and follow up these OVC.’</td>
<td>OVC caregiver, Kitama control site</td>
</tr>
<tr>
<td>‘I and my two siblings stay with my grandmother who is too weak to look after us. She cannot do any work so we have to do all the work when we come back from school.’</td>
<td>Female OVC, Kakinzi intervention site</td>
</tr>
<tr>
<td>‘I stay with my grandmother who is very old and cannot support herself, therefore she cannot work to get money to pay for my fees or for supporting us.’</td>
<td>Female OVC, Katalama control site</td>
</tr>
</tbody>
</table>
2. HIV PREVENTION MODEL

The main objective of the HIV prevention model was to strengthen community engagement and capacity to protect children from HIV and AIDS. The model was designed to equip children aged 5 to 15 with knowledge and life skills that would change the way they view themselves and others living with HIV and AIDS. The following sections explore the implementation, effectiveness, impact, sustainability and challenges of the HIV prevention model.

2.1 Implementation

For the community to impart HIV prevention and values-based life skills, World Vision Uganda (WVU) increased the capacity of volunteers, including teachers, community counselors, club leaders, FBO leaders and youth leaders, to train in-school and out-of-school children aged 5 to 15 years using the Adventure Unlimited curriculum developed by Scripture Union. Schools were the main platform for implementation of the HIV prevention model. To implement the HIV prevention and values-based life skills model, Katwe ADP undertook the following activities:

- Conducted parish-based workshops targeting District Education Officers, head teachers, teachers, parents, members of the school management committees, religious leaders and community volunteers
- Trained peer educators
- Equipped parents, religious leaders and school management committee members with HIV prevention messages and life skills
- Trained youth and club leaders
- Provided peer educators and AIDS clubs with musical instruments and costumes

Peer educators were selected based on their knowledge of HIV and AIDS, ability to speak in public, and good character, as well as their interest in teaching others about HIV and AIDS. Peer trainers communicated HIV and AIDS preventive messages through speeches, poems, debates, music, dance and drama and through informal interactions with their peers.

Parenting sessions were held to expose parents and school management committee members to positive parenting and HIV prevention life skills, while community volunteers were trained as peer educators for youth and out-of-school children.

During the FGD, poverty was highlighted as a key driver in continued sexual harassment of children, especially young girls (Box 2). While early and forced marriages have been reduced, the practice continues in secret with parents being the primary perpetrators and a key gap was noted by FGD participants in the training of parents. Sexual abuse has also reduced but reporting cases to the police remains a challenge to some parents; a female from the Kalokola control site noted: ‘World Vision only trained the teachers to train children, but the parents who look after those children were not trained.’

Table 4 summarises the performance of the HIV prevention and life skills model of Katwe ADP as compiled from various documents.
2.2 Effectiveness and Impact

The discussion of sex-related issues was considered taboo amongst children but has steadily improved with the model implementation. Peer educators reported speaking more openly about the dangers of HIV and AIDS and how it can be prevented (see Box 2 below).

Box 2: Breaking the silence: community response to child abuse

‘I encouraged my friend to go for HIV and AIDS testing so that she can know her status because her mother had died of AIDS. I informed her that even if her mother had died of AIDS, it was not automatic that she had HIV. She took my advice and went for the test and fortunately she was found to be HIV negative and she is happier now.’

- Male OVC, Mataagi intervention site

‘I encouraged my mother to go and deliver her baby in hospital because if she gave birth at home, the baby could be infected with HIV and AIDS, if she is HIV positive.’

- Primary school child in Kasokolindo, Mataagi intervention site

‘When I got the information about HIV and AIDS, I told my mother to stop sharing razor blades with us, because if the razor cuts her, we may contract HIV and AIDS in case she is infected.’

- Female OVC, Kyomya intervention site

‘There was a girl who used to stay with her father who was a drunkard. One day he came to her room and wanted to force her into sex but the girl ran out of house and the next day told us about her ordeal. The peer educators reported the matter to the deputy head teacher, who went to the father but he showed no concern. The deputy teacher then traced the girl’s other family members and her grandmother decided to stay with the girl.’

- Peer educator, Kayunga Church of Uganda
Primary pupils and OVC attending school reported greater awareness of risky behaviour and of ways to avoid contracting HIV and AIDS (one should avoid having sex before testing, abstain or use a condom if one cannot, and avoid sharing sharp instruments).

Regardless of gender and whether one was living in the intervention or control site, a formal channel through which school pupils can access correct and reliable information about HIV and AIDS has been strengthened and institutionalised.

With the implementation of the model, there has been a community-wide increase in education for values-based skills; this has enabled peer educators, primary school children and OVC to make better decisions and choices so as to avoid contracting HIV and AIDS (see Box 3).

**Box 3: Voices reflecting acquisition of values-based life skills**

- ‘One day I found children going to have sex and I urged them not to do it. They obliged and thanked me for stopping them from doing something that can lead to the contraction of HIV and AIDS.’
  - Peer Educator from Kayunga Church of Uganda Primary School

- ‘I make sure that I go to the well during daytime and if my parents tell me to fetch the water at night, I refuse because I might get raped.’
  - Female OVC, Building Tomorrow Kiyamba Academy Primary School

- ‘My mother usually sends me to the shops at night, but after WVU’s teaching us that it is bad to walk alone at night, I ask my elder brother to escort me.’
  - Female OVC, Building Tomorrow Kiyamba Academy Primary School

- ‘In the past we used to enter teachers’ houses when they send us there; but these days if a male teacher sends me to his house, I ask a friend to escort me.’
  - Female adolescent from Lutii Primary School

- ‘If a boy says that “I love you”, you tell him that I love you too. But when he asks for sex, you say NO and avoid him.’
  - Female OVC from Kyomya

Primary school children, OVC and peer educators reported a significant change in behaviour, e.g. sexually active children started using condoms to protect themselves from contracting HIV and AIDS. Overall, girls were found to be resisting inappropriate advances, and incidences of early pregnancies in schools have declined.

**2.3 Sustainability, Challenges, Conclusions and Recommendations**

**2.3.1 Sustainability**

Beneficiary schools have a pool of peer trainers and educators who will continue teaching about HIV and AIDS through the weekly school general assembly.
Peer educators reported they have at least two dedicated staff teaching about HIV and AIDS, and some have already integrated HIV and AIDS messages into their learning scheme.

‘We never used to have full time and dedicated teachers to teach about HIV and AIDS issues, but this has changed in WVU beneficiary schools where pupils have at least two teachers with whom they can talk with openly about issues related to HIV and AIDS.’

2.3.2 Challenges

The following were noted as key challenges to the implementation and sustainability of the HIV and AIDS model:

- Appropriate platforms for the dissemination of HIV and AIDS messages
- Adequate and effective follow up by peer trainers to sustain dissemination of HIV and AIDS information
- Parent restrictions prohibit children in the dissemination of HIV and AIDS messages and information
- Unwillingness of parents to openly discuss with primary school children about HIV and AIDS
- Inadequate number of peer trainers
- Reliance on WVU to sustain outreach activities
- Heavy workload among peer trainers impinges on implementation of the model.

Paul Mukisa is a science teacher at Bukomero Junior Primary School in Uganda. Along with four of his co-workers, he has received training from WV on prevention education for HIV and AIDS. Paul has also been instrumental in starting up peer educator groups at the school. Previously a taboo subject, HIV and AIDS has become a commonly discussed subject interwoven into classroom discussions, extra-curricular activities and even between the teachers.

Photo: Paul Bettings/World Vision
2.3.3 Conclusions

Implementation of the HIV prevention model increased the diffusion of HIV and AIDS messages within schools and the community, especially in schools where peer educators had a formal platform and engaged in outreach activities. Successful implementation of the model helped to attract donors and amplify the government’s Presidential Initiative on AIDS Strategy for Communication to the Youth (PIASCY) initiative.

Peer educators remain reluctant to disseminate HIV and AIDS information beyond immediate family members, friends and neighbours. A coordinated community response to protect children from HIV and AIDS has been hindered by poverty and lack of commitment by some parents.

2.3.4 Recommendations

The HIV prevention model implemented through primary schools would have a greater impact if parents were aggressively targeted through positive parenting sessions. To address this, the following recommendations are made:

- Aggressively pursue parenting sessions so as to enhance parents’ understanding of the need to protect their children from contracting HIV and AIDS
- Organise awareness seminars for head teachers to explain life skills training and streamline platforms for peer educators within the normal school routine activities, e.g., using school assemblies and integrating HIV and AIDS messages within the existing curricula
- Increase training of peer trainers and peer educators
- Strengthen HIV and AIDS peer clubs
- Train more youth and adolescent trainers to enable greater diffusion of HIV and AIDS messages to youth and the adolescents out of school
- Revive the quarterly preventive life skills schools executive planning and monitoring meetings at the parish, sub county and ADP levels
- Create a forum for monitoring the youth and out of school club leaders’ preventive life skills activities at the parish, sub county and ADP levels.
3. COMMUNITY CARE COALITION MODEL

The community-led OVC care HIV and AIDS model was designed to strengthen community leadership and capacity to respond to OVC and chronically ill household members. The implementation process of this model entailed mobilising stakeholders who work with OVC and the chronically ill to come together and establish Community Care Coalitions (CCC). This section reviews the implementation of the CCC model, its effectiveness, impact and sustainability.

3.1 Implementation

WVU Katwe ADP facilitated the grassroots implementation of the model via the following actions:

- Mobilised, sensitised and identified stakeholder groups to implement the CCC model
- Formed and identified HVs
- Trained HVs in home-based care for OVC and chronically ill household members
- Assisted HVs in performing their roles of caring for OVC and chronically ill household members
- Trained caregivers of OVC and chronically ill household members
- Supported the CCC to collaborate with CBOs and NGOs to mobilise funds and other resources for OVC and chronically ill household members’ care and support
- Supported government in the formation of a District OVC Committee and undertook community outreach for children’s rights campaigns.

CCC members were trained to disseminate HIV and AIDS information, provide care for OVC and chronically ill household members, mobilise resources and raise funds. Bicycles were provided to facilitate members in their duties. WVU field offices were also used for official meetings and CCC business. As part of their duties, the CCC guarded OVC rights and helped to protect their property, trained caregivers for OVC and chronically ill household members, and worked to sensitise the community about HIV and AIDS. CCC members mobilised and lobbied for funds to take care of the OVC and chronically ill needs when necessary and were responsible for overseeing the distribution of resources and preparing monthly reports on the OVC and chronically ill household members.

CCC members elected HVs responsible for overseeing 10 to 15 OVC and chronically ill household members within walking distance of their homes. HVs were selected based on interest, character, love for OVC and chronically ill, a responsible and trustworthy nature, as well as a commitment to serving the community. HVs made monthly visits to the OVC and chronically ill household members, operating either as individuals or in groups through door-to-door visits, school visits, community gatherings and/or organised OVC group functions. HVs acted as an interface between OVC and chronically ill household members and the CCC executive and received training from WVU in child care and counseling, child rights protection, psychosocial care and preparation of local herbs to treat ailments.

HV were motivated by a desire to build good relationships with the OVC and chronically ill household members, as well as the appreciation, trust and confidence given to them by community members. See Box 4 for a summary of the performance of the CCC members and HVs as reported during the FGD.
Box 4: Performance of the CCC members and home visitors as reported during the FGD

‘The home visitors are doing a great job by helping OVC and regularly checking on them.’

‘The CCC members and home visitors taught people how to care for the chronically ill household members, which has improved on the quality of their life.’

‘For me am very proud of the home visitors because if an OVC is sick you simply see a group of home visitors surrounding your home.’

Adequate technical and financial support by WVU led to an overall quality performance of the CCC members and home visitors; regular follow up by the WVU staff resulted in a smooth implementation of activities.

While CCC members and HVs performed their roles enthusiastically at the outset, a withdrawal in support by WVU resulted in a reduction in performance by home visitors. Some HVs attributed this change in performance to the failure of WVU to meet their promise of providing bicycles, gumboots, raincoats and resources to support the needs of OVC and chronically ill household members.

Over the OR study implementation period, there was a problem of providing timely feedback to the community members on the implication of the WVU restructuring process.

CCC members and HVs also lamented that the OVC and chronically ill household members expect WVU to continue providing them with more material assistance in terms of scholastic materials, animals and bedding, and less counselling; high expectations created mistrust amongst the community members, which negatively affects morale and commitment of the CCC members and HVs.

A summary of the CCC model implementation performance is presented in Table 5.

Table 5: Performance of CCC model from 2006-2008

<table>
<thead>
<tr>
<th>Key Item</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community leaders sensitised</td>
<td>1,550</td>
<td>420</td>
<td>450</td>
</tr>
<tr>
<td>CCCs formed (cumulative)</td>
<td>6</td>
<td>17</td>
<td></td>
</tr>
<tr>
<td>CCC members</td>
<td>180</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CCCs who undertook Training of Trainers</td>
<td></td>
<td>32</td>
<td></td>
</tr>
<tr>
<td>CCC members trained in CCC model</td>
<td>173</td>
<td>120</td>
<td>30</td>
</tr>
<tr>
<td>CCC leaders provided with bicycles</td>
<td></td>
<td></td>
<td>26</td>
</tr>
<tr>
<td>Home visitors (HV) trained in OVC and chronically ill care (cumulative)</td>
<td>229</td>
<td>624</td>
<td></td>
</tr>
<tr>
<td>HVs trained in psychosocial support</td>
<td>72</td>
<td>120</td>
<td></td>
</tr>
<tr>
<td>HVs trained in child rights care and protection</td>
<td></td>
<td>33</td>
<td>30</td>
</tr>
<tr>
<td>Bicycles provided</td>
<td>36</td>
<td>26</td>
<td></td>
</tr>
<tr>
<td>OVC identified and registered (cumulative)</td>
<td>3,602</td>
<td>5,174</td>
<td>5,454</td>
</tr>
</tbody>
</table>

Source: Compiled from WVU Katwe ADP Annual Reports of 2006, 2007 and 2008
3.2 Effectiveness and Impact

Following WVU interventions, chronically ill household members were less stigmatised and discriminated against. Caregivers confirmed CCC members and HVs have given them the necessary knowledge to care for OVC and chronically ill household members, as well as an understanding of nutritional needs. The CCC has played an active role in HIV and AIDS sensitisation activities through music, dance and drama; members are demonstrating increased responsibility towards the well-being of OVC and chronically ill household members. The creation of the CCC has also helped foster relations with FBOs to improve the welfare of OVC and chronically ill household members.

‘While some community members were interested in helping the OVC and chronically ill household members, there was no organised platform that championed the process of helping in a coordinated manner beyond the immediate family relatives.’

- Male Local Community Leader, Key Informant Interview, Kyomya intervention site

The creation of the CCC and regular visits from HVs has increased the visibility of and renewed community spirit around caring for OVC and chronically ill household members beyond the family sphere.

‘We used to be more concerned about ourselves and most community members only cared about their individual problems, - everybody for himself and God for us all – but this attitude has changed. The remaining challenge within the community is a problem of inadequate resources to assist all the OVC in the community. However, we share the little we have at times, though it may not satisfy the needs of the neediest.’

- Male FBO leader, Kagogo control site

The CCC and home visitors strengthened linkages between chronically ill household members and health centres, which has increased the number of household members seeking treatment.

The implementation of the WVU community-led OVC care model has contributed to the reduction of HIV- and AIDS-related stigma and discrimination. Self stigmatisation amongst people living with HIV and AIDS and OVC has reduced; community members are now courageously declaring their HIV status publicly and openly seeking treatment.

Counseling has led to positive behavioural changes among OVC, resulting in a reduction in delinquents and early pregnancies.

CCC members and home visitors reported they have sensitised community members to respect and protect the rights of OVC and chronically ill household members. CCC members reported a reduction in the violation of rights of OVC and chronically ill household members (see Box 5).
Box 5: Voices reflecting increasing respect for the rights of OVC

‘People regarded the younger OVC as useless because they believed that they would die anytime and saw no need of giving them medical care. However, this has changed and the OVC are loved after realising that they are innocent. Besides, mistreatment of the OVC has reduced due to legal procedures that emphasise protection of child rights.’

- CCC member, Nabwendo control site

‘An 8-year-old child was staying with her stepmother, who used to give her heavy work like fetching a 20-litre jerry can of water, washing clothes, fetching firewood and cooking, as well as abuse her physically. One day the stepmother hit the girl with a panga and cut her on the lower chin for failure to carry out her work. Concerned community members reported the matter to the local authorities and police, but we were not satisfied with the lenient way the issue was handled. We organised a village meeting and called the family including the girl’s stepmother whom we warned and fined some fees. Since then the stepmother has stopped mistreating the girl and she was also taken back to school and her life has really changed for the better.’

- OVC caregiver, Kyomya intervention site

‘Based on the workshops provided, the cases of child abuse have reduced in the community – especially corporal punishments – since we also act as examples to the community after we get the trainings.’

- CCC member, Kyomya intervention site

‘People in the community are now concerned about mistreatment of OVC and come to report those who mistreat the OVC.’

- Male FBO leader, Kyomya intervention Site

Due to CCC interventions, key informants and FGD participants reported OVC and chronically ill household members are increasingly accessing various services, including acquiring scholastic materials and uniforms, which has contributed to the improvement in their quality of life. School key informants, CCCs and leaders voiced that OVC are regularly attending school (see Box 6).
Box 6: Voices reflecting regular attendance of school by OVC

‘The assistance provided has improved the lives of the OVC and chronically ill household members and the OVC now attend school regularly and there are reduced incidents of school drop outs.’

- School key informant, Bukomero Junior Primary School

‘The regular provision of scholastic materials has changed my life and the teachers no longer send me away from school like they used to before the assistance.’

- Female OVC, Katalama control site

‘Before WVU, OVC never used to go to school because guardians felt that they would die any time, but now the OVC are enrolled in schools.’

- CCC member, Nabwendo control site

‘Whereas some parents do not attach much value to education, especially in Ddwaniro sub county, they have allowed the OVC to attend school.’

- CCC member

‘The support to the OVC in terms of scholastic materials has relieved caregivers and saved resources that are now channeled to expenses that are not catered for by WVU.’

- Male community members, Katalama control site

Through WV’s trainings and active involvement in a CCC, Oliver Buganyi Kkaaya, 44, of Uganda has become an agent of change: caring for and protecting orphans and vulnerable children, promoting children’s rights and educating people on basic children’s rights.

Photo: Davinah Agnes Nabiryel/World Vision
The OVC and chronically ill household members reported that home visitors and CCC members now refer them to health centres built by WVU, where they are counselled and get medical care (see Box 7).

**Box 7: Voices reflecting improved health status of OVC and the chronically ill**

- **‘Because of our work, people have changed their attitudes towards HIV and AIDS and are increasingly seeking for medication which was not the case in the past.’**
  - HV, Kikooba control site

- **‘In the past, people with HIV and AIDS used to get visible opportunistic symptoms, but now due to the treatment and care they receive, a person can hardly notice one with HIV and AIDS.’**
  - FBO leader, Nabwendo control site

- **‘We are given food, blankets, medicine for opportunistic diseases and offered free HIV testing. In addition, if found positive with a lower CD4 count, [we are given] ARV.’**
  - Person living with HIV, Bukomero Health

- **‘The free medical treatment got from Muwanga hospital has helped household members and OVC to remain healthy and able to carry out their activities.’**
  - Caregiver, Kitama control site

- **‘A widow and her three children were sleeping in a leaking house that could collapse any time, the community working with World Vision built a permanent house for them.’**
  - Male community member, Kyomya intervention site

- **‘One OVC was given a goat which reproduced and the kids sold off; the proceeds were used to buy a cow that is now producing milk; which is sold off and the money used to buy scholastic materials and paying school fees.’**
  - CCC member, Nabwendo control site

Caregivers and OVC reported they have received blankets, clothes and mosquito nets, which have reduced both the incidence of malaria and medical costs associated with the illness. Households have been taught how to prepare herbal medicines to relieve pain associated with HIV and AIDS. CCC members reported that despite the rising numbers of OVC, their quality of life is much better, especially amongst those living in the intervention sites.

### 3.3 Sustainability, Challenges, Conclusion and Recommendations

#### 3.3.1 Sustainability

There are mixed sentiments among key informants and FGD participants regarding the sustainability of the CCC structure. Those who think that the CCCs are sustainable pointed out that its membership consisted of volunteers, caregivers and individuals who are committed to improving the status of OVC and chronically ill household members. They pointed out that WVU had moved a step further by transforming the CCCs into CBOs to increase the functional ability and capacity of
the CCCs; already five out of 16 CCCs have transformed themselves into CBOs. There is evidence, therefore, some of the CCCs have the ability to mobilise resources beyond WVU and are partnering with other NGOs, such as Sikyomu - One World Foundation, to implement OVC-related programmes within their communities.

‘WVU has given us the knowledge that can be used to continue teaching others and even write proposals. Our CCC has now developed into a CBO and will be able to offer support to the community after WVU withdraws.’

- CCC member, Kyomya intervention site

On the other hand, several factors may negatively affect future performance and sustainability of the CCC model. CCCs do not have their own resources to address the needs of OVC and chronically ill household members. Larger CBOs and NGOs failed to embrace CCC membership and are not active participants.

There is a perception among community members, including the CCC, that WVU will be permanently responsible for providing support and facilitation.

Due to the absence of a national safety programme within Uganda, the CCC model has become the central platform within the community to handle OVC needs, beyond the immediate families. However, the OVC questioned the capacity of the CCC to provide materials, such as books, pens, school meals and school fees, as well as health care beyond WVU (see Box 8).

**Box 8: Voices reflecting complaints from CCC members and home visitors (HVs)**

<table>
<thead>
<tr>
<th>Quote</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>‘Home visitors have inadequate resources, which hinders our work of helping the OVC and chronically ill household members.’</td>
<td>HV, Kikooba control site</td>
</tr>
<tr>
<td>‘Some of the household members are not happy to see us especially if we do not go with tangible things. Even one time a woman I had gone to visit decided to hide away from me!’</td>
<td>CCC member, Kyomya intervention site</td>
</tr>
<tr>
<td>‘Because of lack of facilitation in terms of transport, we end up not regularly visiting the OVC and chronically ill household members.’</td>
<td>HV, Mpangala</td>
</tr>
</tbody>
</table>

**3.3.2 Challenges**

The CCC members and HVs raised various challenges negatively affecting their effectiveness at many levels.

The practice of secretly marrying off girls under the age of 18 has continued, especially among the Balaalo2 in the Ddwaniro sub county through their cultural practice of okusitula. This practice has led

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2 Balaalo are cattle keepers, one of the local communities living in Ddwaniro sub county that makes up
to some girls acquiring HIV and prevails due to ignorance, illiteracy and rampant poverty, particularly as Balaalo parents look at female children as a source of income.

The migrant nature of the pastoralists, especially in Ddwaniro sub county, does not ensure constant representation of some of the members nominated to the CCC when they relocate outside the Katwe ADP area. Follow up of OVC and chronically ill household members by the HVs is thus compromised where communities are in transit.

Poverty has reduced the capacity of community members to provide sustainable support for OVC and chronically ill household members. Home visitors frequently cite discomfort in visiting poor homes empty handed, with discontent and rejection resulting among all parties.

In the absence of WVU monitoring and supervision, a decline in performance and willing volunteers was noted.

### 3.3.3 Conclusion

The implementation of the CCC model has created a community structure, with trained persons available to support their respective communities and attract local development partners. The performance of the CCC model, however, is undermined by limited resources within the community and rampant household poverty. Motivation and performance of volunteers is similarly a challenge in the absence of WVU monitoring.

### 3.3.4 Recommendations

To improve upon the effectiveness and impact of the community-led OVC care model, WVU should:

- Work with other stakeholders to support OVC and chronically ill household members with income-generating projects to improve their livelihoods
- Lobby and increase networking and collaboration with large CBOs and NGOs with adequate financial resources to ensure that they become effective members of the CCC in their respective areas of operation
- Lobby local governments and the Ministry of Gender, Labor and Social Development, as well as develop partner organisations, to ensure that the established CCCs are supported technically and financially and transformed into CBOs in order to sustain their activities
- Lobby national and local government to put in place legislation and by-laws to ensure and protect the rights of OVC and chronically ill community members
- Organise community sensitisation meetings aimed at providing information about the implication of the recent WVU restructuring of its operations within Katwe ADP
- Put in place a forum for planning and coordinating the implementation, monitoring and advocacy issues of the CCC at the ADP/cluster level.
4. CHANNELS OF HOPE MODEL

The Channels of Hope (CoH) model aims to strengthen the engagement and leadership of churches and faith-based organisations (FBOs) in HIV prevention, care and support within their communities. The model also aims to build FBO capacity to provide, monitor and evaluate coordinated quality HIV and AIDS activities and provide for OVC and chronically ill household members, as well as advocate for appropriate HIV and AIDS services within their communities. The goal is to transform attitudes of religious leaders to respond more effectively to the impacts of HIV and AIDS within their congregations and communities. Through training, the FBO and congregation leaders would be empowered to identify, plan and implement HIV prevention, advocacy, as well as care and support activities that would lead to congregations’ responses to the impacts of HIV and AIDS.

4.1 Implementation

WVU Katwe ADP conducted several workshops to sensitise church and FBO leaders and supported them in identifying Congregation Hope Action Teams (CHATs) to implement the model at the grassroots level. For the CoH model, the following activities were planned:

- Mobilise and sensitise the community by targeting churches and FBO leaders to implement the model
- Support FBO leaders to identify members of their congregation to form CHATs
- Train FBO leaders and CHATs in HIV prevention, care and support of OVC and chronically ill household members
- Support CHATs to link up with other groups in the community through the CCC
- Support FBO leaders to coordinate and advocate for HIV prevention, care and support of OVC and chronically ill household members
- Support CHATs to pass on HIV prevention messages and life skills training to children and members of their congregations.

Minziro Church catechist’s assistant Ndagula Joseph participated in WV Channels of Hope training. “My preaching really changed after that,” he admits. Other church members joined his ‘Hope Team’, and senior church members who were formerly reluctant were persuaded that preventing HIV transmission and helping orphans is the right way to go.

Photo: Nixel Marsh/World Vision
The FBO leaders benefited from scriptural-based and scientifically accurate HIV prevention training facilitated by WVU Katwe ADP staff. Leaders were provided with skills in resource mobilisation, as well as bicycles, drums and costumes for faith-based Sunday schools. Trained Hope teams were formed at the congregational level to guide, care for and counsel OVC as well as chronically ill household members, and were charged with mobilising food, clothes and other material support for the OVC and chronically ill.

CHAT members were selected based on their willingness to work as volunteers, their people skills, as well as their personality and character. CHATs carry out their work by visiting OVC and chronically ill household members, either as individuals or in a group, at least once a month. Table 6 shows a summary of the achievements of the CoH model implementation by WVU Katwe ADP.

Table 6: Performance of CoH model from 2006 to 2008

<table>
<thead>
<tr>
<th>Key Item</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>Congregational Hope Action Teams (CHATs) trained in CoH methodologies</td>
<td>62</td>
<td>150</td>
<td>264</td>
</tr>
<tr>
<td>CHATs strengthened and empowered to care and support OVC and chronically ill household members</td>
<td>-</td>
<td>70</td>
<td></td>
</tr>
<tr>
<td>Number of CHAT members trained</td>
<td>154</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HVs trained in OVC and chronically ill household members care and support</td>
<td>270</td>
<td>70</td>
<td></td>
</tr>
<tr>
<td>Faith-based leaders trained in resource mobilisation and book keeping</td>
<td>-</td>
<td></td>
<td>45</td>
</tr>
</tbody>
</table>

Source: Compiled from WVU Katwe ADP Annual Reports of 2006, 2007 and 2008

CCC chairpersons and WVU field staff were responsible for monitoring home visitors; monitoring was carried out by conducting on-site visits with the CHATs and attending CCC meetings. FBO leaders and their respective CHAT representatives also participated in review meetings and prepared monthly reports for submission to WVU.

4.2 Effectiveness and Impact

Based on discussions with key informants and transcripts provided from the FGD, the following is a summary of key outcomes from the implementation of the CoH model in the WVU Katwe ADP.

FBO leaders, CHATs and FBO HVs revealed that prior to the intervention, they viewed having HIV and/or AIDS as being a punishment from God due to man’s adulterous and promiscuous ways. Youth and out-of-school adolescents in the FGD reported that before WVU programme implementation, some of the community members believed HIV and AIDS was caused by witchcraft and didn’t know how to protect themselves against it. However, the integration of HIV and AIDS messages into the spiritual teachings created another formal platform through which the community members of the Katwe ADP can access HIV prevention messages.

WVU training helped to raise awareness of OVC and chronically ill household members within WVU Katwe ADP and various congregations have embraced the spirit of helping them.

WVU’s HIV and AIDS CoH sensitisation campaign in Katwe ADP has increased the demand for voluntary counseling and testing (VCT), resulting in an increase in outreach programmes. Community members have embraced condom usage and those who are HIV positive are seeking treatment. Youth, however, remain the most reluctant group to embrace VCT.
‘The youth are still reluctant and when you ask them to go for testing, they say that we are trying to market HIV testing.’

- Female community member, Kalokola intervention site

‘The youth resist the advice and the information given to them especially when it comes to using condom and HIV testing.’

– Male CCC member, Nabwendo control site

Stigmatisation and discrimination against members of the community living with HIV and AIDS has declined.

‘These days people know that one cannot contract HIV through touching or using the same cups and plates, they now share and eat together with persons with AIDS.’

– FBO leader, CHAT FGD participant, Mataagi intervention site

4.3 Sustainability, Challenges, Conclusion and Recommendations

There were mixed feelings regarding the sustainability of the CoH model. HIV and AIDS messages about abstinence and being faithful as well as care and support of OVC and chronically ill household members are now part of the spiritual teachings. Religious groups have formed working committees to ensure their work can continue beyond the life of the WVU Katwe ADP; through these committees they will seek assistance from their congregations and supporters locally and internationally. Despite the positive outcomes of the CoH model implementation, there are a number of challenges to the sustainability of the activities in the long run.

The number of community members who attend religious functions continues to decline, with attendance dominated by children and the elderly. This decline makes it difficult to mobilise sufficient resources to support FBO activities in a timely manner. Similarly, promoting condom usage among faith communities is widely seen as equivalent to promoting prostitution and adulterous practices. Therefore, when condom usage is discouraged and people do not abstain, the risk of infection increases. Furthermore, the issue of using condoms as a preventive measure against HIV and AIDS has triggered animosity between CCC members and FBO leaders.

‘Religious leaders oppose the idea of training CCCs from churches and mosques saying that some words are not supposed to be said in the house of God. For example, telling people to use condoms from the place of worship is considered evil.’

- CCC Member, Nabwendo control site
Inadequate resources among the FBO CHATs has reduced motivation and operating as a volunteer without the necessary means reduces performance, leading to frustration amongst both the volunteers and the OVC and chronically ill.

‘The biggest challenge is that we are obliged to visit OVC and chronically ill household members every month, but we have no resources to offer them. At times you visit a pupil in school who has a very strong appetite since he/she is on ARVs, but you do not have money to buy him/her anything, and the advice you give ends up being meaningless. Sometimes you tell the chronically ill household members and their caregivers to go and pick medicine from the health centres, but they tell you that they had no transport, yet you have no money to give them and they are far away from the nearest health facility.’

- Home visitors’ FGD participant, Mataagi intervention site.

4.3.3 Conclusion

FBO leaders helped to transform attitudes towards HIV and AIDS through their support of OVC and chronically ill household members. FBO capacity to provide coordinated support to reduce HIV and AIDS has been constrained by their failure to embrace condom use as one of the preventive measures against HIV. Rampant poverty amongst the majority of residents in WVU Katwe ADP has hindered the mobilisation of resources to support OVC and chronically ill household members.

4.3.4 Recommendations

To increase the effectiveness and impact of the CoH model, the following recommendations are made:

- Churches and FBOs should adopt door-to-door sensitisation campaigns to win back able-bodied and mature adults to their functions to enhance their ability to mobilise resources and disseminate HIV- and AIDS-prevention messages, as well as care and support campaigns
- WVU should lobby churches and FBOs to wholly integrate condom use as part of the spiritual teachings
- WVU should work with churches and FBOs to aggressively engage in activities that contribute to improving the livelihoods of community members
- WVU should collaborate with local governments to enhance joint planning, implementation and monitoring of developmental activities in their respective operational areas.
5. ORGANISATIONAL LEARNING, ADVOCACY AND RESOURCE MOBILISATION

5.1 Organisational Learning

The following key issues emerged as central messages from the implementation of the three HIV and AIDS models.

The adoption of formal mechanisms and school outreach programmes to disseminate prevention messages about HIV and AIDS helped to reach school children aged 5 to 15. In addition, the CCC and CoH structures have created alternative channels for diffusion of HIV and AIDS messages within the community. As a result, there is increased openness, communication and dialogue about HIV and AIDS amongst teachers, pupils, health workers and local leaders.

The implementation of the three HIV and AIDS models has enabled community members to benefit from a pool of trained resource persons that include CCC members, HVs, and FBO leaders with increased knowledge about HIV and AIDS care and support. As a result, there is positive behavioural change towards HIV prevention and the needs of OVC and chronically ill household members.

The models increased access to basic services for those living with HIV and AIDS, OVC and chronically ill household members, and implementation of the HIV and AIDS models has improved support from churches, FBOs, community members and the local government.

The implementation of the models has significantly reduced open discrimination and stigmatisation, which has improved the quality of life of chronically ill household members; they feel loved, have hope, are more inclined to seek treatment and are able to plan for their family.

One significant change triggered by the implementation of HIV and AIDS models has been the community response towards volunteer counselling and testing (VCT) services. Local governments, in collaboration with other development partners, have responded to the rising demand for VCT by conducting outreach programmes and supporting health centres to ensure adequate provision of VCT services.

Linkages with local government health centres has enhanced the referral of OVC and chronically ill household members for psychosocial and health needs to the health centres. As for the CoH model, WVU worked with churches and FBOs to enhance the diffusion of HIV and AIDS messages, thereby amplifying care and support for OVC and the chronically ill to the wider community. WVU Katwe ADP achieved its objectives of building linkages and structures that can lead to the sustainable implementation of HIV and AIDS models. Furthermore, although the models were driven by volunteers, facilitation and supervision of their work enhanced performance and efficacy.

Financial support provided by WVU was instrumental in ensuring that the HIV and AIDS models were implemented in a coordinated and smooth manner. Proper training enabled participants to acquire knowledge, build confidence and perform their roles.

The implementation of the three models requires a timeframe beyond the four years, as strengthening community engagement and capacity requires time to translate into changes within the community. Similarly, strengthening community leadership in protecting and caring for OVC requires time to lobby big community players, developmental partners and local governments to actively support the CCC. For the CoH model, the CCCs were strategically better positioned to coordinate
and advocate for appropriate HIV and AIDS services, since they had a broader membership composition compared to the FBOs.

There is a need to clearly communicate the implementation approaches of the HIV and AIDS models and WVU ADP sponsorship programme to the beneficiary community. For example, by the time of data collection, the Registered Child (RC) was given handouts, which are not part of the HIV and AIDS OVC model. Furthermore, some of the HIV and AIDS model HVs doubled as RC monitors, which caused friction and mistrust between the beneficiaries and community volunteers because OVC families thought that WVU had given HVs handouts to give to OVC which they were withholding from them. Hence, it is imperative to help the community clearly distinguish between HIV and AIDS models and WVU ADP interventions and types of support accruing to the beneficiaries.

There is a need to sensitise and support the beneficiary communities to take ownership and leadership of the model implementation process as well as long-term sustainability.

5.2 Advocacy

As for the advocacy issues arising from HIV and AIDS model implementation, several key issues emerged that require WV to take the following actions:

- Lobby key stakeholders at the district and local government level to target out-of-school youth and adolescents with HIV and AIDS sensitisation campaigns
- Lobby national and local governments to integrate HIV and AIDS messages during primary school assemblies and as part of co-curricular activities
- Lobby national and local governments to prioritise and increase funding for HIV and AIDS activities and services, such as VCT outreach programmes and provision of ARVs
- Lobby key agents and players to join in supporting CCC activities
- Lobby local governments to put in place by-laws that protect the rights of OVC and the chronically ill, and children in general, and discourage early marriages
- Lobby local governments and development partners to recognise the CCC concept as a community structure that can play leadership and coordination roles in addressing the needs of OVC and chronically ill household members

5.3 Resource Mobilisation

Scaling up the HIV and AIDS models requires the following:

- Improving the livelihood and support of OVC and chronically ill household members with income generating projects
- Lobbying development partners and networking with local governments to increase the flow of financial resources for CCC activities
- Organising exchange visits among the HIV and AIDS model implementers to share experiences for learning purposes
- Actively engaging in advocacy activities.
REFERENCES

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World Vision serves all people regardless of religion, race, ethnicity or gender.