World Vision

World Vision Zambia
Core HIV and AIDS Project Models

QUALITATIVE STUDY FINDINGS FROM ZAMBIA

Published by Global Health and WASH on behalf of World Vision International

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Cover photo: Home-based caregivers in Zambia, with their Caregiver Kits supplied by World Vision and the World Bicycle Relief bicycles they received through World Vision/RAPIDS.
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World Vision Zambia

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

QUALITATIVE STUDY FINDINGS FROM ZAMBIA

FINAL REPORT

JULY 2009

AKNOWLEDGEMENT

This study would not have been completed without the contributions of many individuals and organisations. We appreciate the various Chibombo District and Keembe ADP community members who provided valuable information and implemented the interventions. Mulako Nabanda and Evelyn Mwila-Mbulo of TWIZA Associates Limited (consultancy firm) of Zambia conducted the final qualitative evaluation and drafted the report. The final version of this report was edited by Jennifer Franz-Vasdeki (consultant). Keembe ADP community members provided information and implemented the interventions; Keembe ADP staff supported the project from inception in 2005, especially Isabel Mutembo and Nathan Chitelela who were ADP Managers, Ekwase Msoni who was the M&E Officer, and Annie Kaseketi-Mwaba, who was the HIV and AIDS Project Development Facilitator during the project implementation period. Over the life of the project, various Project Implementation Team Members provided technical and management support: Chikondi Phiri, Siyani Zimba, George Musonda, Faith Ngoma, Maurice Sepiso, Jenny Nyirenda, Tita Lupiana and Kennedy Nkwemu. The work was coordinated and supported by the Hope Initiative Team members: Jane Chege (PI), Martha Newsome, Mark Lorey, Christo Greyling and Logy Murray. World Vision United Kingdom provided the bulk of the funding and World Vision United States also provided financial support that enabled the implementation of the project.

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Contents

ACRONYMS AND ABBREVIATIONS

ADP	Area Development Programme
AIDS	Acquired Immune Deficiency Syndrome
ARV	Antiretroviral
CATF	Community AIDS Task Force
CBO	Community-based organisation
CCC	Community Care Coalition
CDW	Community development workers
CHARMS	Core HIV and AIDS Response Monitoring System
CHAT	Congregational Hope Action Teams
CLUSA	Cooperative League of the United States of America
COH	Channels of Hope
DATF	District Aids Task Force
FBO	Faith-based organisation
FGD	Focus group discussion
HIV	Human Immunodeficiency Virus
HV	Home visitors
MCDSS	Ministry of Community Development and Social Services
MoE	Ministry of Education
MOH	Ministry of Health
MSYCD	Ministry of Sports, Youth and Child Development
M&E	Monitoring and Evaluation
NGO	Non-governmental organisation
ORP	Operations Research Project
OVC	Orphans and Vulnerable Children
RAPIDS	Reaching HIV/AIDS Infected People with Integrated Development and Support
SSI	Semi Structured Interview
VCT	Voluntary Counseling and Testing
WVZ	World Vision Zambia

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 Zambia (WVZ) Area Development Programme (ADP) of Keembe.

Zambia is one of the hardest hit countries in the sub-Saharan African region by the HIV and AIDS epidemic. As of 2007, approximately 14 per cent of 15 to 49 year olds were affected (ZDHS 2007 Summary Report), resulting in major developmental setbacks.

While the effects of the HIV and AIDS pandemic are widespread among the population, orphans and vulnerable children (OVC) are among the most vulnerable group. The HIV and AIDS epidemic has an inter-generational gap resulting in children becoming increasingly dependent on elder caregivers no longer able to generate income (Nabanda 2007). It is estimated that between 750,000 and 1,200,000 children have been orphaned, and many have no hope of obtaining an education (Republic of Zambia and National HIV/AIDS Council 2006). Nearly one third of all young people between 15 and 24 years of age in Zambia have never been to school and the majority of these are orphaned (Ministry of Sports, Youth and Child Development 2004). Orphaned children are more likely to drop out of school than children with both parents alive. In 2005, nearly one in four children were living in a household with only one living parent, a 6 per cent increase since 2000. According to the Ministry of Sports, Youth and Child Development, orphans were 26 times less likely to attend primary school than children with both parents, and double orphans demonstrated the greatest drop-out rate (Ministry of Sports, Youth and Child Development 2004).

There is a clear need to accelerate programmes that enable an effective response to supporting OVC. In 2005, WVI began an OR project in the Keembe constituency of the Chibombo district in order to determine the effectiveness and impact of three HIV and AIDS programme models. The three models included an HIV Prevention model targeting children 5 to 17 years; a care and support model for OVC and the chronically ill, and the Channels of Hope (CoH) model that promotes engaging with and equipping church and other faith-based organisations' leadership with skills and knowledge to spearhead information dissemination, care and support of the vulnerable community members. The ORP evaluation highlights important lessons for future programming.

The factors that have contributed to the success of a project include:

- The ability of WVI to provide quick and effective response mechanisms to vulnerable members of society; caregivers assigned to monitor OVCs and chronically ill individuals in the community provide regular visits because they have the means (bicycles)
- Training on HIV prevention and the use of the Adventure Unlimited curriculum provided to teachers in schools and churches have presented a platform for reaching out to the majority of children in schools and in the church
- Other WVI projects have promoted activities related to the ORP; project success is likely to be enhanced if other complementary support activities are included
- The project has a strong community-based response mechanism, wherein members of the community are directly involved and thus more capable of identifying and responding to vulnerable persons
- Involvement of key stakeholders has enhanced the effectiveness with which community mobilisation has occurred and has propagated good values in the communities.

There are more churches and other faith-based organisations (FBOs) that have received training through their selected leaders; these have spearheaded HIV and AIDS sensitisation and information on stigma and discrimination.

Overall the OR project has increased community cohesion in the following ways:

- **HIV prevention for children aged 5 to 17 years through value-based life skills training**

  Under the prevention model, there was an increase in knowledge about HIV and AIDS among children and the general community. Sensitisation of children and other members of the community reduced the stigma and fear of HIV testing. Similarly, there was an increase in the number of people seeking Voluntary Counselling and Testing (VCT) services.

  On the whole, participants reported a decline in early marriages, sexual exploitation of children (especially among females), as well as teenage pregnancies.

  There was evidence of increased assertiveness among the OVC, particularly females, who previously reported cases of attempted sexual abuse and relationship seeking from teachers and fellow pupils. However, in some areas, there was an apparent disconnect between children's perceived increase in knowledge of HIV and AIDS and behaviour, as indicated by the increase in number of female children falling pregnant and getting married (see Box 1). This appears to be the case in areas along major routes where there was increased interaction with people from 'outside' the area as well as increased exposure of children to locales where alcohol is consumed.

  The sustainability of this model requires devolving further responsibilities of HIV and AIDS information dissemination to the communities, including targeting youth subcommittees to spearhead sensitisation of children and youth in the community. Institutionalisation of prevention strategies in community-based structures would ensure long-term sustainability of prevention activities.

- **Care for orphans and vulnerable children (OVC) through mobilising and strengthening community care coalitions (CCC)**

  This model forms the core of the whole ORP. The strategy through which the model is formulated at the community level encourages community stakeholders to play an increased role in promoting a sense of ownership of the project activities. As a result, members of the coalitions have been empowered to coordinate advocacy, care and support for vulnerable community members.

  The CCCs have been at the forefront of campaigning against negative traditional practices and other vices that marginalise and perpetuate the situation of OVC, women and other socially isolated groups. The banning of some traditional ceremonies in some zones signifies the high sense of responsibility and ownership.

  Support for children has increased as CCCs have started to devise strategies to generate resources with which to support their OVC population. Most importantly, a change in attitude has been observed from individual members of community-based structures.

  The active CCCs in the Area Development Programme (ADP) are working to become community-based organisations (CBOs). Five zones have talked of increasing resources towards the registration of their CCC into a CBO in order to become a source of support.

Major challenges that have been observed with this model include leadership capacity, as the CCCs are not all performing at the same level.

There remains a shortage in trained individuals and a gap in the transfer of information from trained staff to subordinates.

- **Engaging and equipping churches and other faith-based organisations (FBOs) through the Channels of Hope (CoH)**

  WVI has taken an active approach in training church leaders in the areas of HIV prevention, care and support, which facilitates attitude and behaviour change. The approach breaks the silence around HIV and AIDS and reduces stigma and discrimination among young people and adults.

  This model is generally perceived to be the most likely to facilitate change in the behaviour of children because it promotes abstinence.

  One major concern reported with the implementation of this model was an inadequate number of trained congregational leaders compared to the number of people within the community.

Recommendations

The following recommendations are made in order to improve programme efficacy:

- WVI should consider expanding the number of training recipients in order to meet demand; refresher courses are also necessary to reinforce the training
- WVI should strengthen the CCCs and Community AIDS Task Force (CATF) links in order to enhance sustainability of activities at the end of the project
- Expand training in the Adventure Unlimited curriculum
- Monitor quality of information disseminated at the community level to avoid the dilution effect and misinformation; monitoring should include the Adventure Unlimited curriculum as well as Trained Trainers
- Monitoring and Evaluation (M&E) strategies should utilise information for project learning at the community level rather than only to the WVI ADP office
- WVI should ensure it provides basic training on site-specific utilisation of data monitoring to promote a rapid response from community-based structures; community development workers (CDWs) should become front-runners in on site monitoring of programmes by involving CDWs in capacity building
- Strengthen income-generating activities and management to improve sustainability
- Complementing the Adventure Unlimited manual with additional material as it is weak on critical messages on HIV and AIDS such as gender, stigma and discrimination
- Improve the supply of approved materials on HIV and AIDS to schools and churches in order to reinforce information given by the teachers and to avoid the ad hoc use of materials
- Implement a monitoring system to insure quality and level of knowledge obtained
- Promote ownership among teachers and church officials
- Strengthen existing mechanisms to reach ‘out-of-school’ and ‘out-of-church’ children
- Expand coverage to include HIV and AIDS clubs
- Increase funding for OVC programmes
- Provide training and learning materials in the local language
- Enhance the role and involvement of community workers to promote WVI’s presence in the different zones

- Develop and communicate a sustainable exit strategy
- Tailor programmes to cover zones that are affected by different factors that promote illicit sexual activities among the youth and children
- Support the joint implementation and monitoring of all model activities with relevant stakeholders and partners
- Promote child rights using community radios and the help of community-based structures
- Facilitate proposal writing, resource mobilisation and financial management skills in all zones.

INTRODUCTION

HIV and AIDS in Zambia

Zambia experienced a rapid increase in the prevalence of HIV after the virus was first reported in the country in 1984, with the rate of new infections peaking in the mid-1990s (as high as 20 per cent). Zambia has one of the world's most devastating HIV and AIDS epidemics with more than one out of every seven adults living with HIV.[1] In 2009, an estimated 200 new infections occurred each day and although there has been a reduction at the national level, in some urban areas infection rates are as high as 25 per cent.[2]

Like many sub-Saharan African countries, Zambia faces an increasing number of orphans and vulnerable children (OVC), as many children have lost either one or both parents to AIDS and are increasingly dependent on older grandparents. The extended family system has been the greatest means of support for OVC in Zambia; however, with people living at or below the poverty level, traditional coping mechanisms for OVC are declining.

As of 2007, there were an estimated 600,000 children orphaned as a result of AIDS in Zambia, making up 50 per cent of all orphans in the country.[3] While many orphans are abandoned due to stigma or a lack of resources, many have run away due to mistreatment by foster families.[4] Civil society has supplemented government efforts to cushion OVC against the impact of the HIV and AIDS epidemic.

The Operations Research Project in Keembe ADP

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 Keembe ADP in Zambia and in the Katwe ADP in Uganda where these models had not been previously implemented.

The models are based on the three core elements:

- Prevention for children aged 5 to15 years through values-based life skills training
- Engaging and equipping churches and other faith-based organisations (FBOs) through the Channels of Hope (CoH) methodology
- Care for orphans and vulnerable children (OVC) by mobilising and strengthening community care coalitions (CCC).

The models are designed to empower stakeholders to coordinate and lead HIV and AIDS prevention, care and support in their respective communities.

The OR project in Zambia was conducted in 12 of 17 zones in WVI's Area Development Programme (ADP) located in the Keembe constituency of the Chibombo District in Central Province.

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[1] UNAIDS (2008) 'Report on the global AIDS epidemic'.

[2] UNAIDS/WHO (2008) 'Epidemiological Fact Sheet – 2008 Update, Zambia'.

[3] UNAIDS (2008) 'Report on the global AIDS epidemic'.

[4] Government Republic of Zambia (2010, April) 'Zambia Country Report: Monitoring the Declaration of Commitment on HIV and AIDS and the Universal Access Biennial Report'.

Baseline data were collected in July and August 2005, and model implementation began in September 2005. This report was conducted to assess the project impact after four years of implementation.

Objectives

The goal of the OR is to provide information to WVI and other HIV and AIDS programme managers and donors contributing to the improvement of HIV and AIDS prevention, advocacy and care programming in communities highly affected by HIV and AIDS.

The specific objectives of this OR study are to assess the effectiveness and impact of the three models in the following areas:

- Strengthening community engagement and leadership in care and support for OVC and chronically ill household members
- Strengthening community engagement and leadership in protecting children from HIV infection
- Increasing HIV prevention, care and support attitudes and behaviours, breaking the silence around and reducing the stigma among young people and adults related to HIV and AIDS
- Improving the status, well-being, and general quality of life of OVC
- Implementing programmes at the community level
- Ensuring sustainability of the communities' prevention, care and support activities if WVI phases down or out
- Accumulating evidence of impact that can be used as a basis for organisational learning, advocacy and resource mobilisation.

Evaluation

This evaluation reviews project strategies, operations and business processes to assess relevancy, effectiveness, efficiency, impact, sustainability and lessons learned in order to improve organisational learning, advocacy and resource mobilisation. The following steps were undertaken to understand the effects of the intervention:

- Assess and document the experience of FBO leaders, teachers, community leaders, District AIDS Task Force (DATF) members, volunteer OVC and chronically ill caregivers with WV HIV and AIDS models, including attitudes and suggestions on programme sustainability.
- Compare and contrast HIV and AIDS responses of FBOs, CBOs, NGOs and other community groups.
- Compare and contrast the experiences of households caring for OVC and those of OVC themselves.
- Compare and contrast the experiences of households caring for chronically ill and those of the chronically ill individuals.
- Explore and document experiences, achievements and challenges faced by community volunteers and teachers providing prevention information and skills services, care for OVC and care for chronically ill at the community level.
- Explore and document socio-cultural and other community factors that have enhanced, and those that have hindered, the effectiveness and impact of the various interventions for HIV and AIDS prevention, care and support.
- Identify factors associated with various forms of sexual abuse of females and males.

Research Process and Methodology

Intervention zones were selected based on a number of factors, including distance from the ADP headquarters and level of community engagement. Semi Structured Interviews (SSI) with various district based WVI partners were conducted, including government ministries, non-governmental organisations (NGOs) and faith-based organisations (FBOs) within the district.

Community-based interviews and discussions were conducted with traditional leadership, development committee members, youth leaders, OVC, chronically ill patients, caregivers, church leaders, school teachers as well as CDWs.

A preliminary report was presented to ADP staff, helping to clarify a number of issues that had arisen during the fieldwork.

Qualitative research techniques were used for this evaluation, including FGDs, group discussions and Semi Structured Interviews (SSI) with key informants. Within the focus and group discussions, Participatory Learning and Action (PLA) tools were used, including institutional analysis (Venn diagramming), ranking exercises, trend analysis, thematic mapping and testimonies of OVC and chronically ill patients.

Site Description

The OR Project in Keembe ADP was implemented in 12 of the area's 17 zones. Six of the zones were intervention (experimental) zones, while the other six were comparison sites.

The sampled sites included Kafululu, Mwanje, Chititi, Malambanyama, Kakunka, Mubimba, Chiyuni and Lubundi, and extended to Shimukuni B and C to assess the spill-over effects of the OR project.

Kafululu, Malambanyama and Chiyuni are along a main route for fish and other traders from Lusaka to Lukanga swamps, and thus have greater interaction with people coming from outside the area; these zones were therefore found to be more 'urbanised' with activities promoting the spread of HIV, e.g. beer houses.

HIV PREVENTION MODEL

The HIV Prevention model was designed to focus on HIV prevention for children aged 5 to 15 and reduce the transmission of HIV by equipping children with the knowledge and key life skills in communication, negotiation and decision-making. The strategy of the HIV Prevention model was to build capacity of school teachers, Sunday- and Sabbath-school teachers, children, members of community-based groups (such as the community care coalitions [CCCs]), home visitors (HVs), FBO leaders, peer educators and traditional leaders.

Volunteers were trained to use the Adventure Unlimited curriculum as it is both appropriate for this target age and is value-based, emphasising abstinence and marital fidelity as the primary modes of HIV prevention.

The prevention of HIV through behaviour change may be the best chance in the fight against the pandemic. Shaping children's behaviour, education and morals at a young age through appropriate skill acquisition and training will help them reduce risky behaviour and, therefore, vulnerability to HIV infection.

Implementation Strategy

Pupils from various schools were trained as peer educators, while trained FBO leaders targeted children attending Sabbath and Sunday School. Information on HIV prevention was also provided to

children outside schools and FBOs through organised drama performances, poems and singing. Other modes of implementation included preaching of HIV prevention messages by church leaders to their congregants irrespective of age, as well as community meetings organised and facilitated by traditional leaders and/or community-based groups such as the CCCs and HVs.

Training of Trainers (ToT) is a critical strategy within the HIV Prevention model that aims to equip as many community members as possible in HIV prevention. Although the HIV prevention strategies try to focus on children aged 5 to 15, information dissemination included 16- to 17-year-olds. Spillover effects have been noted as adults benefited from information on HIV prevention from CCC members, as well as their own children.

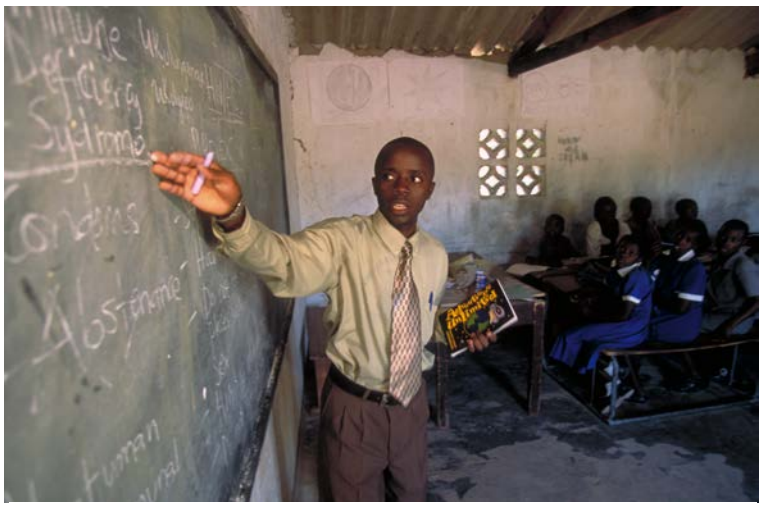
Box 1 Adults benefit from information

> *'I have learnt quite a lot about HIV not only from the CCC but from my children who get their knowledge from school.'*
>
> *'The parents are benefiting from the knowledge which children have on HIV.'*
>
> *'Children perform drama before us and we get quite a lot of useful messages from that.'*
>
> *'We have been trained on HIV by WV and continue to learn from our children whenever they come back from school or church.'*

Capacity Building

Capacity building is a core component of the HIV Prevention model designed to prepare, strengthen and broaden community engagement, and increase knowledge and life skills around HIV and AIDS.

WV conducted numerous HIV- and AIDS-related training activities with volunteers, covering various aspects of HIV prevention including life-skills training (particularly for children), general training about HIV and AIDS, Voluntary Counselling and Testing (VCT), and in some cases, training in antiretroviral therapy (see Tables 1 and 2).



Mufalo Setwin teaches HIV and AIDS education, using the Adventures Unlimited curriculum, at Kamfinsa Mission School (a government school) in Zambia.
Photo: Jon Warren/ World Vision

Table 1: Community members engaged and type of training received

Community	Type of training	Observations
School teachers	• Adventure Unlimited training programme	• Approximately two teachers have been trained per school
Sunday School and Sabbath teachers	• Adventure Unlimited training programme • Training on how to take care of HIV and AIDS patients • Training in promoting VCT	• Teachers reported 'out-of-church' children also targeted • Both male and female teachers trained • Project faced some challenges of mistrust from some denominations that doubted WV's motives in providing trainings.
School children	• Adventure Unlimited training programme (trained by their teachers)	• Students in Grade 1 to 7 trained
Child facilitators	• Adventure Unlimited training programme	• From the eight zones studied, only Lubundi and Mwanja indicated training of children; in Lubundi a total of eight children trained; these children in turn trained eight more children who have continued the activities of sensitising others in the school • In the Mwanje zone, one girl was reported to have been trained and has since trained five more at the time of the evaluation
Traditional leaders	• Training in dangers of HIV and AIDS, child rights, negative cultural practices	• Few traditional leaders actually trained • Widespread requests for refresher courses and additional capacity building • All males
FBO leaders	• Training in various HIV prevention aspects	• Leaders from various FBOs and churches have been trained
CCCs and Home Visitors (HVs)	• Training in HIV and AIDS advocacy • Training in paralegal issues	• All CCC have been trained on HIV prevention, life-skills training • Youth sub-committee of the CCC trained to promote child rights through paralegal training
Peer educators	• Trained in HIV and AIDS • Relationship skills • Assertiveness • Creative thinking • Negotiation skills • Refusal skills	• Peers trained by WV to train as well as to sensitise their peers

Table 2: Number of trained people under the HIV Prevention model[5]

Year	Staff	Schools reached	Children			Peer educators			Peer education clubs
			M	F	Total	M	F	Total	
2005									
2006	12	21	594	497	1,091	37	26	63	43
2007	1	–	450	283	733	39	29	68	11
2008	–	–	308	396	704	0	0	0	0

The Adventure Unlimited training programme was used in all surveyed zones and reinforced by the Ministry of Education (MoE), which has mainstreamed HIV and AIDS education within schools. In order to reinforce the implementation of the HIV-prevention messages, school children perform HIV-related awareness activities on important days; anti-AIDS Clubs have also proven an important outlet for information dissemination. The majority of trainees are involved in the dissemination of information to all age groups through church and community meetings.

Teachers trained by WVI passed on HIV-prevention information to children in schools in the OR intervention and comparative zones. The time lag in comparative zones had no particular effect on the implementation strategies of the HIV Prevention model.

Sunday School and Sabbath teachers underwent training in various aspects of HIV prevention for children aged 5 to 12 and young adults aged 13 to 18. Adult members of various churches have also been included as beneficiaries of the HIV-prevention messages. Findings did not suggest any significant variation in information dissemination between zones.

WVI trained child facilitators to promote learning among other children on matters related to HIV prevention through drama, dance and poems. Each trained child facilitates a group of children and is closely monitored by a trained teacher. Child facilitators and those children being trained also disseminate HIV-prevention knowledge to their parents and guardians.

Peer educators were trained in HIV and AIDS from World Health Organization (WHO) and Cooperative League of the United States of America (CLUSA) in 2006. Following the training, peer educators formed youth groups and held meetings in communities that sensitised people on HIV and AIDS. Since the initial training, there has been no monitoring of the trained educators.

Community leaders have benefited from training and are equipped with knowledge pertaining to HIV and AIDS. Trained community leaders include traditional leaders, leaders of FBOs and members of the CCC/HVs who are also leaders in their own right. Community leaders have organised and/or facilitated community meetings on HIV prevention with all members of the community.

Traditional leaders (headmen) have taught on the dangers of HIV and have been instrumental in organising and/or facilitating meetings in their respective villages as well as other community groups, such as CCCs. Some headmen have been at the forefront of ensuring harmful practices – such as sexual cleansing, sexual abuse of children, and early marriages – are stopped.

[5] CHARMS Report 2006–2008

Church leaders have formed drama groups in order to communicate messages on HIV prevention, especially among children.

CCCs and HVs underwent training organised by WV in various aspects of HIV prevention and have been successful in disseminating knowledge on HIV prevention to children and the wider community. Sensitisation has included issues pertaining to prevention and child abuse, as well as cultural practices that facilitate the transmission of HIV.

Impact

The HIV Prevention model has changed the lives of children and adult members in the community. Increased knowledge has led children as young as age 5 to speak openly and confidently about HIV and AIDS without a sense of embarrassment, fear or shame. Children are also more confident in the dissemination of HIV information to their peers and other members of the community (including parents and guardians) through drama, songs, poems and dance.

Assertiveness among female children has increased, and early marriages have declined among both girls and boys. Negative cultural practices such as sexual cleansing have also decreased. Although sexual cleansing is still being practiced in some places, it is not occurring on the same scale as prior to the model implementation. Some youths, as a result of the knowledge obtained, are undergoing VCT and youths aged 20 to 25 have been involved since the beginning. The implementation of the model has also resulted in the creation of church partnerships that did not exist previously.

The model has been designed to raise awareness among children through outreach in schools. School teachers spend more time with children than their parents/guardians and are thus more likely to influence behaviour. The level of understanding of HIV and AIDS among teachers is generally higher and their facilitation skills better than other community members. The institutionalisation of HIV prevention into the curriculum increases levels of exposure among in-school children.

Model implementation was found to have effectively raised the level of knowledge on HIV and AIDS among children, when compared to before the WV intervention. Children aged 10 to 17 years highlighted the following as ways through which HIV can be contracted and transmission prevented:

Contracted	***Transmission prevented***
Sharing blades	Abstinence
Touching blood of infected person	Avoid sharing needles
Sex	Condoms

While the HIV Prevention model successfully facilitated prevention among children and adults, there nevertheless remained a disconnect between an increase in knowledge of HIV and AIDS and continued risky behaviour in some zones (Box 1).

Box 2 Risky behaviour

Rose is an OVC interviewed by WV in 2006. She lived with her aunt, Matroni Zambezi, in a four-bedroom furnished house that is electrified. The family has a small field where they cultivate maize and cotton. All of Rose's schooling requirements were met by her foster family, including school shoes, uniforms and books.

Matroni Zambezi explained Rose could not be interviewed as she was out of town in Monze where she had gone in February this year (2009) to continue with her grade 10 education. She explained that Rose was a well behaved girl and that the family was shattered to learn that she had become pregnant. She later gave birth to a baby boy in 2008. She is now in a position to continue with her education in grade 10. She was supposed to be in grade 10 last year but she had to stay away from school in order to look after the baby. She became pregnant from a married man who lives in Chiyuni. Matroni said she restrained herself from taking the man to the police for fear that she would appear to be too hard on Rose because she was an orphan.

Sustainability

A lack of monetary support for teachers may harm the long-term sustainability of the model. The sustainability of the model relies on the following key factors:

- ToTs of children and teachers, thereby ensuring continuity of programme activities
- The provision of adequate reference materials on HIV and AIDS
- Engagement of community leaders to embrace, appreciate and drive the model agenda forward.

Despite some of the challenges faced in the implementation of the model, it has empowered the community to impart HIV knowledge and life skills through capacity building, and has strengthened community engagement and capacity to protect children. While an impact has been seen among children aged 5 to 15, it has also been relevant to other children beyond the target age and to adult members of the community who have reported an increased knowledge of HIV and AIDS.

Challenges

Although the HIV Prevention model has been an overall success, some primary challenges to effective implementation include:

- The Adventure Unlimited manual insufficiently addresses gender, stigma and discrimination with respect to HIV and AIDS
- Poor access to adequate reference materials on HIV and AIDS
- Training materials provided in English only, thus creating a learning barrier
- Insufficient monitoring and evaluation by WV leads to poor motivation among trainers
- Poor involvement among CDWs resulted in irregular/insufficient supervision of programme implementation at the community level, thereby reducing the quality of the programme
- Absence of a feeling of ownership of the model reduces effectiveness
- Lack of quality control over information learned among children
- Young adults (aged 18 to 24) and out-of-school/church children not adequately targeted
- HIV and AIDS clubs not adequately targeted as an outlet for transmitting prevention information
- Inadequate training of traditional leaders reduces access to wider community

- Poverty and other social/cultural factors present obstacles to successful model implementation and a reduction in risky behaviour
- Educational staff are subject to transfers while the trained pupils eventually graduate or drop out of school
- Not all community members involved in disseminating information on HIV and AIDS
- have been trained in the Adventure Unlimited curriculum
- Limited reference material has resulted in teachers using improvised materials of questionable quality, thereby potentially jeopardising the HIV and AIDS messages being communicated
- Risky behaviour, such as beer drinking and illicit sex, continue to pose a challenge to the implementation of the model, particularly in zones located along major roads
- Minimal M&E has resulted in a lack of information on the quality of knowledge obtained by targeted children.

COMMUNITY CARE COALITION MODEL

The Community Care Coalitions (CCC) model was designed to improve the quality of life of OVC by strengthening community leadership in protecting and caring for OVC and their households, as well as enhancing the capacity of households and communities to respond to the needs of OVC and chronically ill community members.

This model forms the backbone of the OR project as it challenges the community to analyse their own situation, thereby promoting a community-based response and, thus, long-term solutions to the problems facing children.

Both civil society and government have contributed to the success of the model. The Ministry of Sports, Youth and Child Development (MSYCD), as well as the Ministry of Community Development and Social Services (MCDSS), have implemented support mechanisms for vulnerable people including children. To ensure collaboration between civil society and government, WV coordination between various actors has proven essential.

The Mwamba Community Care Coalition, in Zambia, is a group of 20 volunteers who have dedicated their lives to helping vulnerable children.
Photo: Kwenda Paipi/World Vision

Implementation Strategy

The CCCs spearheaded the promotion of community-led care and support for OVC and chronically ill patients. CCC members were provided with bicycles to facilitate activities. Based on WV criteria, the home visitors (HVs) identified the most vulnerable and needy OVC and chronically ill community members. Across zones, communities' primary concerns for children included education and

health, child abuse (including child labour, use of children in sexual rituals such as sexual cleansing, and early marriages), and food security.

Members of the CCCs included male and female stakeholders interested in the welfare of OVC within their community (see Table 3). The CCCs identify OVC from their respective communities and an executive committee then selects a group of caregivers or HVs. The HVs undergo various types of training and are responsible for providing care and support to OVC and chronically ill community members. In extreme cases, the HVs may intervene, for example, where there is evidence of child abuse.

Life-skills training was provided by the CCCs to help children protect themselves against HIV infection, as well as provide skills with which to generate income. CCCs have coordinated the distribution of bedding, mosquito nets, clothes and school supplies from WV to OVC. In some cases, the unequal distribution of goods to OVC, depending on availability, has caused some resentment among community members.

Care and support of the chronically ill involves the identification, enlisting and provision of palliative and psychosocial support. Most CCCs and HVs provide services similar to Home Based Care (HBC) groups. Other forms of care and support include HVs using bicycles provided by the project (Reaching HIV/AIDS Infected People with Integrated Development and Support: RAPIDS) to transport sick individuals to health facilities.

Table 3 Number of CCCs formed and OVC reached with care and support[6]

Year	CCCs newly formed	CCCs received additional training	Home visitors received additional training			OVC received care from WV or CCC			Community members trained on HIV and AIDS advocacy		
			M	F	Total	M	F	Total	M	F	Total
2005											
2006	11	11	175	57	232	1,639	1,840	3,479	0	0	0
2007	8	6	198	118	316	1,316	1,237	2,553	54	40	94
2008	0	13	87	68	155	4,013	4,075	8,088	0	0	0

Capacity Building

The CCC members received training in advocacy, HIV prevention, leadership and psychosocial support (covering physical, spiritual and emotional), legal/constitutional information as well as awareness/avoidance training around abuse. Once the main CCC members are trained, they are expected to train others within the community. HVs are trained by WV in household tasks, mentoring, psychosocial support, and protection and are referred to the CCC for material assistance.

Impact

WV activities have been essential in the lives of many community members, especially in improving the situation of OVC and coordinating various advocacy activities (Box 2).

[6] CHARMS Report 2006–2008

Traditional leadership has become engaged in the activities of the project. The involvement of chiefs and headmen has facilitated participation of the rest of the community members and, in particular, helped to eliminate some negative traditional practices, including the use of children (female) in sexual cleansing, early marriages, sexual abuse and child labour. Headmen trained under the programme have supported the enforcement of community initiatives to reduce child abuse and have advocated for the abolition of some practices, such as sexual cleansing; as a result, there has been a marked reduction in sexual cleansing following the sensitisation of community members.

The formation of community-based structures has sparked a sense of responsibility among household members who were previously ignored, and has encouraged greater efforts among OVC caregivers, thus increasing the sense of unity within the community. CCC members noted an increase in school attendance and visits to OVC; likewise, children were reported to be more open and communicative in voicing challenges faced. Following extensive sensitisation, there has been a significant reduction in early marriages, teenage pregnancy and child labour.

Prior to the intervention (2005), malaria and hunger were considered the most threatening factors to OVC. After the intervention (2009), however, malaria was no longer a main problem (due primarily to the distribution of mosquito nets), whereas hunger and poor access to basic goods (clothing) remained significant. Furthermore, a major achievement highlighted by all CCCs was the training received on caring for chronically ill community members, and many have been on antiretroviral therapy.

The effectiveness of this model lies in its ability to respond quickly to situations. For example, the formation of CCCs ensures the needs of different groups within the community are considered. Communities have in the past neglected chronically ill household members, especially when illness is associated with HIV and AIDS. Where community based structures have been involved, there has been a marked improvement in the quality of life for chronically ill household members. It remains essential, therefore, for WV to promote the capacity of communities themselves in order to ensure sustainability of the model. After training from WV, CCCs and HVs spearheaded a campaign for caregivers on the importance of educating OVC and getting children back in school. Although not homogenous across zones and groups of children, OVC received support from WV towards school supplies, uniforms and shoes. This type of support, however, has had some negative consequences as it can create situations of dependency.

Box 3 Evidence from the community care coalition model

At the time of conducting the Operations Research baseline survey in 2005, 49-year-old Charity, a widow, was chronically ill. One of her three youngest children, Debbie, had to drop out of school to nurse her mother and watch over her grandmother, who is in her seventies.*

On 15 July 2008, Charity exhibited a joy and energy while coming to meet her guests, showing no signs of an ailing person, once unable to move. Her Muyabira village falls under one of the intervention areas (Chabona Zone) of the operations research by Keembe ADP, and because of that, Charity was lucky to have her situation turn around. 'Caregivers came to visit me,' she says with a broad smile. 'It made me happy, especially so that when they visited me, my health improved.

'Before that, my health was failing me. It was difficult for me to cultivate. My three children dropped out of school,' she narrates. A member of Chabona Home Based Caregivers, is the one charged with visiting Charity, besides four other people. 'I started caring for Charity in July 2006,' said the caregiver. 'We got information from the neighbours that she was not well.'

The caregiver is one of the 11 people who were trained as Home Based Caregivers in the zone under World Vision's RAPIDS programme. After the training, each caregiver was assigned a village, and each of them is assigned no more than five chronically ill people to look after.

When he started visiting Charity, he took her to hospital, and she was diagnosed with HIV, her CD4 count was measured, and she was put on ARVs. One of the caregiver's tasks now is to ensure that Charity adheres to the drugs. He is able to check on Charity because of a bicycle that he was given, which enables him to traverse the vast Muyabira village. 'Every time the caregiver comes, he asks me questions about my personal health, and asks about the children,' says Charity.

Debbie was also interviewed during the baseline survey, and in that interview, she was shedding tears, lost all hope, having dropped out of school to look after her mother. Today, she notices the difference: 'There has been improvement; my mother is well. She was very sickly at first. The fear I had then was if she died, who was going to look after her.'

Sustainability

The sustainability of the CCC model relies on the ability of communities to generate their own resources and plan their own agendas. Both aspects require skill training in long-term project management.

Challenges

Varying levels of commitment by CCCs has affected the level of success of the model in different zones. In part, a lack of commitment has resulted from infrequent monitoring on the part of WV, as well as a clear explanation on the role of CCC members.

The primary challenges with the implementation of the CCC model included:

- A lack of leadership in some of the CCCs
- WV support did not always coincide with priority needs of the OVC
- A lack of appropriate support and networking among groups, i.e. the legal group was not linked to the police
- A lack of mobility restricted the involvement of some HVs; for those HVs with bicycles, they said a lack of spare parts was a problem and a financial drain
- Headmen involvement was necessary to insure proper organisation.

CHANNELS OF HOPE MODEL

The Channels of Hope (CoH) for HIV model was designed to transform the attitudes of religious leaders and reduce stigma surrounding HIV and AIDS in order to enable churches and other faith-based organisations (FBOs) to respond more effectively to the impacts of the pandemic within their congregations and communities. The model strengthens engagement and leadership among churches and FBOs to provide, monitor and evaluate coordinated quality HIV and AIDS prevention activities and care and support for OVC and chronically ill household members, and advocate for appropriate HIV and AIDS services within communities.

Implementation Strategy

This model has been designed in order to address knowledge and attitudes leading to behavioural change. The CoH model is based on scripture and scientifically accurate prevention messages.

Capacity Building

Under the CoH model, workshops for both faith leaders and lay congregations were conducted by WV in order to empower them with skills to identify, plan and implement HIV prevention, advocacy, and care and support activities. The congregational representative leaders were trained on HIV and AIDS issues, including stigma reduction, encouraging testing for HIV, as well as how to make action plans. Following the CoH mobilisation workshops, congregations are supported to form Congregation Hope Action Teams (CHATs) that lead the congregations' responses to HIV and AIDS. These CHATs are encouraged to link with other groups in the community through the CCC.

Priest Kennedy Lwao counsels a young pregnant woman before telling her the results of her HIV test at the Zamtan Prevention of Mother-to-Child-HIV-transmission clinic, Zambia.
Photo: Jon Warren/World Vision

Table 4: Channels of Hope workshops and active CHAT members[7]

Year	CoH sensitization workshops	CHAT workshops	People who attended CoH workshops			CoH workshop participants who were faith leaders			Active CHAT members		
			M	F	Total	M	F	Total	M	F	Total
2005											
2006	3	5	187	127	314	84	35	119	70	57	127
2007	1	2	83	70	153	21	21	42	97	84	181
2008	3	0	34	26	60	8	1	9	110	98	208

Impact

This model helps to transform ways of thinking as it uses spiritual teachings to propagate information on HIV, OVC care and support, and stigma and discrimination. The model appears, however, to have achieved the least among the three models.

Sustainability

In order to ensure long-term sustainability of the CoH model, it is necessary to increase capacity among leaders within the community.

Challenges

The primary challenges associated with the implementation of the CoH model included:

- Trainings confined to only a few church-based leaders
- Trained church leaders would leave, resulting in gaps within the congregations
- Some FBOs refused to work with WV
- The model was less likely to reach non-congregants (non-churchgoers).

[7] CHARMS Report 2006–2008.

LESSONS LEARNED

The OR project has demonstrated the three HIV and AIDS models have improved the situation of traumatised children through appropriate support provided by trained caregivers. WV has played a critical role in improving the food situation of households, as most did not have adequate food prior to WV intervention. Children reported that food and good clothes were priorities above all else, and lacking these basics can lead to vulnerability. While food security packs are not part of the OR project, success may be enhanced if other types of support operate in conjunction with the project.

Monitoring and Evaluation

WV has invested in elaborate equipment for data collection and transmission able to collect information at the individual level. HVs collect primary data from households and transmit the information to CCCs for consolidation before being sent to ADP headquarters. Information collected is recorded in various types of tools/books including:

- Minutes book: minutes of meetings and resolutions are recorded
- OVC beneficiary list: registered OVC are recorded
- Treasury book: financial reports related to the project are kept
- OVC visitation book: captures the number of visits each child has had, dates of the visits, type of support provided per visit and the signature of the guardian to acknowledge receipt of the support.

Challenges

A number of concerns were raised around appropriate M&E activities. For example, the reporting format requires a certain level of education and thus some caregivers found the equipment difficult to use. A major concern raised across zones was that the reporting mechanism is unidirectional, with no feedback to the community. The lack of feedback reduces effective monitoring and evaluation (M&E) by the community members themselves.

Collaboration

World Vision has listed a total of 15 organisations in the ADP with which it has partnered on developmental initiatives, particularly those related to children and HIV and AIDS at the district level. WV has provided logistical support to government departments in exchange for specific support in a particular area. WV also works with the Ministry of Education and provides training to teachers and children in age-appropriate life skills. WV also works with the Ministry of Health (MoH) through the District Health Management Team (DHMT), helping to supply drugs, medical supplies, transport and other logistics during national immunisation days (Child Health Week).

Collaboration with the government has also resulted in the formation of a Community AIDS Task Force (CATF), which is expected to spearhead all HIV- and AIDS-related activities within the community. Cooperation and collaboration with the government has increased WV's legitimacy, thereby contributing to the sustainability of the programmes as the ministries may take greater responsibility for the programmes with which they have been involved.

WV works with various NGOs and has been instrumental in facilitating HIV- and AIDS-related programmes of other organisations. WV has created partnerships with strategic organisations that depend on and support each other, thereby ensuring the harmonisation of activities and careful distribution of available resources, while at the same time avoiding the duplication of efforts, thereby increasing operational efficiency.

At the community level, WV has built collaborative relationships with key partners, including schools and churches, through trainings and continued collaboration. The nature of the collaboration is primarily around facilitation in forming community structures (such as CCCs and CATFs) and training community members in various capacities.

PROJECT SUSTAINABILITY

Sustainability of the OR project was evaluated from two levels: 1) project model activities and 2) ability to acquire resources to enable the continuation of the models.

The training programmes are considered crucial to the OR project success as the trained community members go on to train and disseminate appropriate information, thereby ensuring continuity. The degree to which the different zones have generated resources varies. For zones where CCC management has shown commitment to the project activities, sustainability activities are proving successful, i.e. in one community a group has managed to generate income from the sale of chicken eggs.

Most of the CCCs were trying to generate sufficient resources to register as a community-based organisation (CBO) in order to receive support from donors and funding agencies. The transfer of trained personnel away from the project area and the contraction of HIV and AIDS were considered the primary factors limiting the sustainability of project activities in the different zones. Similarly, the level of involvement of the CCC is key to the self-regulation of the CB structures and, thus, income generating activities; where the CCCs are weak, dependence on external support remains high.

Capacity building among community members has helped to ensure long-term sustainability of the models. In terms of identifying and focusing support for the needy, the models rely on a strong presence of volunteers with knowledge of the community.

The HIV Prevention model provides a platform for increasing knowledge levels among children on prevention of HIV (and other sexually transmitted infections). Its design promotes outreach for school children to promote accurate prevention information, allaying myths and misconceptions, and reducing the rate of HIV prevalence within the community.

The community Care and Support model appears to be the best initiative of the OR project as it has demonstrated the ability of communities to drive their own health agendas. The CoH model has helped to transform attitudes; however, like the HIV Prevention model, it still targets only those members of the community who attend church; therefore, it has a limited reach across the wider community.

CONCLUSION AND RECOMMENDATIONS

The impact of the Care and Support model of the OR project has received overwhelming recognition in all the communities (zones), except those with weak management structures. Overall, the models have demonstrated an ability to successfully promote local-level HIV and AIDS prevention, care and advocacy.

Based upon the findings from this work, the following recommendations are made:

- Consider expanding the number of training recipients in order to better meet demand; refresher courses are necessary to reinforce knowledge learnt.
- Strengthen the CCCs and CATF links in order to enhance the long-term sustainability of the project activities.
- Expand training in the Adventure Unlimited curriculum, and recommend to the community care providers a curriculum targeted at children.
- Monitor more closely the information being disseminated at the community level to avoid the dilution effect and counter the spread of misinformation.
- Focus monitoring and evaluation strategies on project learning at the community level; provide basic training on data monitoring in order to ensure that M&E data prompts immediate response and an opportunity for community-based structures to respond; CDWs become front-runners in monitoring and capacity-building activities concerning the model.
- Strengthen income-generating activities and management of financial resources.
- Improve the Adventure Unlimited manual to better tackle critical messages on HIV and AIDS, such as gender, stigma and discrimination; provide more information, education and communication materials on HIV and AIDS to schools and churches.
- Incorporate a mechanism of periodic assessment of the knowledge levels gained by children in order to be certain of the quality of information dissemination.
- Address the issue of appropriate incentives and remuneration among volunteers.
- Devise a more effective mechanism of outreach for out-of-school and out-of-church children.
- Increase support of HIV and AIDS clubs where they exist as they are very active and attract a lot of children.
- Advocate for more funding for OVC programming (because need far outweighs available resources).
- Enhance the role and involvement of community workers in the communities in order to promote WV presence in different zones.
- Introduce a weaning process in all community-based projects in order to promote steps towards long-term sustainability of activities.
- Tailor programmes to cover zones affected by different factors promoting illicit sexual activities among the youth and children.
- Promote joint monitoring of model activities with relevant partners.
- Facilitate proposal writing, resource mobilisation and financial management skills in all zones.
- Tailor training/learning materials to the local environment for improved understanding.

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