

ICA HIV/AIDS PREVENTION INITIATIVE

REPORT ON A DECADE OF WORK 2001-2010



Institute of Cultural Affairs



November 2010



THE ICA HIV/AIDS PREVENTION INITIATIVE

THE INSTITUTE OF CULTURAL AFFAIRS INTERNATIONAL was founded in 1977 in Brussels, Belgium. It is an international non-governmental association, which facilitates the activities of autonomous, national member ICAs and their global relationships.

THE INSTITUTE OF CULTURAL AFFAIRS facilitates social innovation, participation, and community building in all sectors of society.

From over thirty years of working with villages, communities, and organizations, ICA has developed facilitation methods – *Technology of Participation*® (ToP®) – that enable groups to gather information from all present, analyze that information, and come to a common decision about how to act on it.

The HIV prevention curriculum for village residents wishing to lead others in HIV prevention and management activities relies on *Imaginal Education*, a method that facilitates behavior change by changing an individual's "image" of who they are and what is important to them.

IMPLEMENTING PARTNERS

ICA Benin
ICA Cote d'Ivoire
ICA Ghana
ICA Kenya
ICA Nigeria, NIRADO, Esto Perpetua Development Initiative (EPDI)
ICA South Africa
ICA Tanzania
ICA Togo
ICA Uganda, Safe Neighborhood Communities Foundation
ICA Tanzania
Zambia, OPAD
ICA Zimbabwe
ICA Nepal

SUPPORTING PARTNERS

ICA USA
ICA Canada
ICA UK
ICA Japan



ICA HIV/AIDS PREVENTION INITIATIVE REPORT ON A DECADE OF WORK 2001-2010

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ACKNOWLEDGMENTS

This *2010 Report on the ICA HIV/AIDS Initiative* is the fourth for the ICA Africa HIV/AIDS Prevention Initiative over the last decade. We drop the Africa in the title because this report reaches beyond Africa. It reports on a long time project in Nepal and includes reports from ICA Canada and ICA UK.

The report is written from the responses of “implementing partners” and “supporting partners” to questionnaires about their work since 2008 - the date of the last report - but it also looks at their experience over the decade. Thank you to all who took time to think back and document what you are doing.

As many of you know, the ICA USA Board decided in October 2006 to discontinue international work. As the 2007 report shows, in 2006 projects were hitting their stride. They needed the continued support of those of us in the US who had been engaged in that work. We thank Elizabeth Houde for immediately jumping into the breach and forming a 501(c)3 to fill the vacuum. International Consultants and Associates provided a base for Dick Alton, Mary Laura Jones, Louise Singleton and Bruce Williams to continue the partnerships - raising money, fielding volunteers, and assisting African partners to strengthen their programs.

We have lost several very important people in the last few years. Dr. Don Elliott from Denver who attended the first launch in 2002 in Golokwati in Ghana died in September 2009. He was an enthusiastic volunteer and supporter. He had a way of showing up where he could be helpful bringing his knowledge and enthusiasm with him. Mary Coggeshall couldn't travel in the last years, but her support was wise and helpful.

Three committed, skilled and valued HIV Prevention Project colleagues died in 2006. Moddie Siafunda worked in Mwanamainda, Zambia and was going to Lusaka to be trained in HIV counseling when she died. She was replaced by Florence Chikatula who died after a short time. In Kenya, Mary Wafula who had worked in Machakos for many years and directed an impressive project in Muthetheni Location died of inadequately treated breast cancer. It is difficult to replace such excellent skills and commitment.

We wish to thank all who have contributed to the HIV Initiative over this decade: individual and organizational supporters - particularly churches and Rotary Clubs. Over forty volunteers have contributed their skills. But first and foremost, we thank our partners, those on the ground, doing the work. They have confronted this epidemic first hand and responded with determination and practical knowledge and clear thinking.

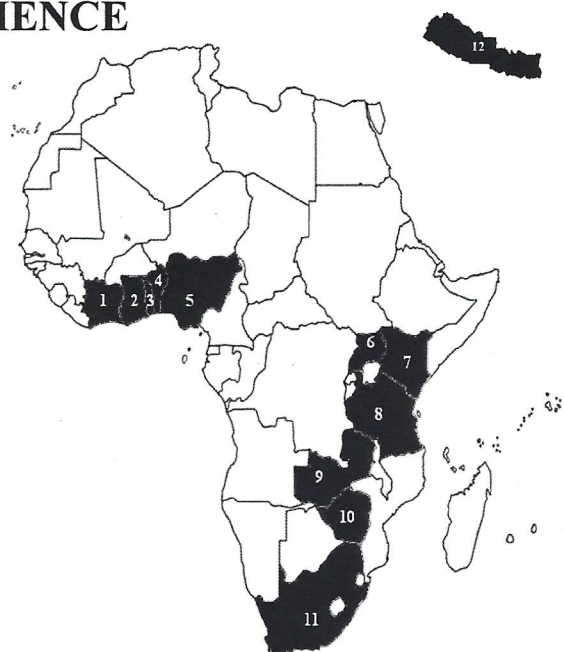
The current ICA USA Board decided to re-engage in international work. ICA USA has a new program called the International Initiative, with a new part-time employee named Seva Gandhi. We welcome her and look forward to working with you.

Louise R. Singleton MSPH
Richard H. T. Alton
Seva Gandhi

ICA HIV/AIDS PREVENTION INITIATIVE A DECADE OF EXPERIENCE

HIV/AIDS was first recognized in 1986. In 2000 at the every four-year international conference of the Institute of Cultural Affairs (ICA), participants, particularly those from Africa, understood that HIV/AIDS was a major problem as they planned for the 21st century. ICA's international work for forty years had been in the human dimension of development. It was clear that you could not seriously address development in Sub-Saharan Africa without confronting the devastating impacts of AIDS. Now, in 2010, these impacts and the struggle to tame the epidemic are well known. For ICA, individuals infected or affected by HIV/AIDS, and for those working to prevent the disease and manage its impacts on individuals, communities, and families, these ten years have been quite a journey.

1. Cote d'Ivoire
2. Ghana
3. Togo
4. Benin
5. Nigeria
6. Uganda
7. Kenya
8. Tanzania
9. Zambia
10. Zimbabwe
11. South Africa
12. Nepal



**ICA HIV/AIDS
PREVENTION
PROJECTS
LOCATIONS**

Here are several statistics from UNAIDS then and now.

HIV/AIDS Statistics	2001 (from UNAIDS, 2002)	2008 (from UNAIDS, Epidemic Update 2009)
People in world living with HIV	40 million	33.4 million
People in Sub-Saharan Africa living with HIV	28.5 million 5.8% prevalence rate	22.4 million or 5.2% prevalence rate
% of people in Africa who are women	58%	60%
# of deaths in Africa from HIV	2.2 million/year or 6,000/day	1.4 million/year or 3400/day
# of new cases/day	3.65 million or 10,000/day	1.9 million or 5200/day
# of orphans (0 – 14)	11 million	14 million
% of population receiving necessary treatment	2% in 2003	44%

Other information: (from UNAIDS Fact Sheet, 2009)

- All countries in southern Africa have an adult HIV prevalence of greater than 10%
- As a result of treatment, people are living longer. In Kenya, AIDS-related deaths have fallen by 29% since 2002.

- Young women 15 – 19 are particularly vulnerable to HIV. In Kenya they are three times as likely as males that age to be infected.
- Zambia, Tanzania, and Zimbabwe have each experienced a decrease in incidence.
- Heterosexual intercourse remains the most common means of transmission.
- Transmission to newborns and breastfed babies is still extensive, although 45% of HIV+ pregnant women received antiretroviral drugs as opposed to 9% in 2004.
- HIV prevention programs may be having an impact on sexual behaviors. In southern Africa more young men and women chose safer sexual behavior in 2008 than in 2002.

Appendix 1 shows a History of HIV from 1980 to 2005 (2008 Report on the Global AIDS Epidemic). Broad statistics show improvement; the world of HIV has changed dramatically, but it is also makes clear that the pandemic is still very much with us.

This *2010 Report* looks at those changes as reflected in the experience of the ICA HIV/AIDS Prevention Initiative. For ICA, the focus of our work has not changed: ICA seeks to assist communities to solve their own problems. ICA is not in the health care or medical business, but works to help people in communities organize their lives and access the resources available to them. In the arena of combating HIV/AIDS, ICA seeks to assist communities to undertake their own efforts to prevent and manage the disease, by providing training, information, and creating activities that inspire and organize action. It stresses accessing the resources of government and non-profit agencies, especially available health facilities and services.

This overview describes ICA's decade of HIV/AIDS engagement in three phases: 2001 – 2004, Phase I, Preparation and Demonstration; 2005 – 2006, Phase II, Broader and Deeper; and 2007 – Present, Integration and Expansion. (See Appendix 1 for history of HIV/AIDS from 1980 – 2005.)

We have participated in many changes. During this time, we have seen HIV confronted, named, the impacts assessed, and programs created to address them. The infrastructure and capacity of country health systems has stretched toward the unreached and underserved. Treatment has become a reality. ICA African staff has created and sustained major HIV/AIDS programs and integrated those programs into their ongoing development activities, staff and funding. Many partners and over forty volunteers have worked on the program. Methods, training, and materials were created and adapted to assist local needs. The Initiative has expanded from eight countries to twelve in Africa plus Nepal. Funding early in the decade came mostly from individuals, churches, Rotary, and ICAs in the US, and Canada, Great Britain and Japan. Now the majority comes from outside the ICA network as grants funded directly to African ICAs.

It is difficult to know how many people have been involved and affected by HIV/AIDS Initiative programs over the decade. Numbers in the following chart are estimates at best and there are not for all countries. However, they give an idea of the scope of work.

CUMULATIVE TOTAL IMPACT OF HIV/AIDS PROGRAMMES 2002 – 2010					
(Estimated numbers)					
Country	Number of villages worked with	Total population of target group(s)	Number of participants involved in programs	Number trained as leaders to work with others	Extended indirect impact (families, etc.)
Benin (since 2006)	15	3200	625	236	4250
Cote d'Ivoire	25	60,000	42,645	59	85,290
Ghana					
Kenya	68	10,070	504 groups	1,008	50,350
Nigeria					
South Africa					
Tanzania					
Togo (since 2006)	18	21,000	6,500	40	8,000
Uganda					
Zambia	1,320	11,000	11,000	440	66,000
Zimbabwe	50	178,000	5,000	1,200	40,000
Nepal					

The Table in Appendix 2 provides better estimates for those who have been direct participants in the project in the HIV Prevention Initiative in the last few years. About 1700 peer educators have been trained to discuss reliable information about HIV prevention and AIDS care with their neighbors. 59,000 have been reached with reliable information about prevention and care. Testing campaigns and services have gone local; 9,700 people have been counseled and tested. Close relationships with health services facilitate people who are HIV+ to receive treatment. 800 people living with HIV/AIDS (PLWHA) have been in Positive Self-Management groups to sit together and learn to take charge of their disease. About 15,000 individuals infected and affected by the disease are in groups learning improved agricultural methods and income producing skills. 28,000 youth in and out of school are learning the facts about HIV and how to modify their behavior. Stigma toward those with the disease has been greatly reduced. But people still die; families are still hungry; individuals still are without treatment. A new generation is coming on. There is much to do.

Phase I - Preparation and Demonstration, 2001 – 2004

In 2001, virtually no one in the ICA network knew anything about HIV/AIDS except that in Africa, people, especially young adults at the peak of their working lives, were getting sick and dying at astounding rates, leaving remaining family members and children to be cared for by relative and friends. And no one would talk about it. The health infrastructure was badly inadequate outside all but capital cities areas and larger district towns. National governments were just beginning to take note that there was a problem and begin to plan how to gear up to meet it. People in rural villages where ICA staff worked were without assistance.

At a meeting in 2001, convened by Dick Alton, Secretary General of ICA International, staff from African ICAs, ICA International and others concerned about the problem made the decision to undertake HIV/AIDS prevention projects in eight countries: Ghana, Nigeria, Kenya, Zambia, Tanzania, Uganda, Zimbabwe, and South Africa. The question was, how can ICA USA and other ICA partners assist eight African ICA country staffs to

combat HIV/AIDS in the villages where they were already working in development? Teams traveled to countries to learn what it would take to begin to fight the disease.

The learning curve was steep. The Hesperian Foundation which published *Where There is No Doctor*, had recently published a book called *HIV/AIDS and Your Community* by Reuben Granich, MD, MPH, and Jonathan Mermin, MD, MPH. It quickly became the bible for accessible, basic HIV information and how communities might confront the epidemic. People began to think about how ICA teaching and community organizing methods could be applied to combating HIV in communities where we were working.

The decision was made to launch an eight-country demonstration project in Ghana in Golokwuati for three weeks in July 2002. The project would stand on three legs:

- train twenty local volunteers as peer educators – a local skilled core workforce;
- assist and engage the community in creating a plan to manage the epidemic;
- engage community leaders, local government agencies, and the health system.



A key event was a public launch of the project to introduce the newly trained peer educators and engage the people in the village in this new happening in their village – the beginning of a community-wide HIV prevention campaign.

During those three weeks, thirteen key staff from the eight countries and seven volunteers from the US refined a draft training curriculum, trained peer educators about HIV and how to teach others about it, wrote a draft of what became *A Field Guide for HIV/AIDS Prevention Education for African Communities*, facilitated a community planning process, and were themselves trained to be trainers in their own countries. Community leadership was consulted and involved; government agencies and non-profits were visited; and a baseline survey was made of relevant knowledge, attitudes and behavior in the village. The platform was built to launch projects in the remaining seven countries during 2002 and 2003. Staff strengthened their knowledge and skills working in cross country leadership teams for those seven launches. In 2002 and 2003, 172 peer educators in 23 villages in eight countries were trained. Each community had a plan for action in the following year. The *Field Guide* and *Peer Training Manual* were refined.

During 2003 and 2004, each of the eight countries focused on HIV prevention awareness. In communities, stigma against those with the disease produced paralysis. Peer educators took their *Field Guides* house to house to talk with people about the disease. They became a force within the community to influence knowledge, attitudes, and behavior. Public meetings were held in churches and under trees. Dramas were created. People began to understand the needs of those in their community who were sick, and they began to work out ways to offer home care, and assistance. “Break the Silence;” was the cry of

the Minister of Health who spoke at Zambia's project launch. That was the major task of Phase I – to break the silence. HIV/AIDS moved out of hidden back rooms into the public dimension. A second wave of expansion reached another 82 villages in 2004, training another 260 peer educators. By the end of 2004, there were 432 peer educators trained in 105 villages in eight countries.

Phase II –Broader and Deeper - 2005 – 2006

After assessing what had happened in eight countries, it was clear that although they had started with the same three-legged program, the results of a year's work were different. Projects experimented with ways to improve the lives of People Living with HIV/AIDS (PLWHA), their families and their communities. The needs, expertise, and opportunities in each country prompted new strategies to complement prevention education:

- Kenya: Women's empowerment to address conflict between legal rights and cultural practices
- Zambia: Food security and nutrition to improve diet and food supply for HIV+ families
- Nigeria: Prevention education in school setting to develop a high school curriculum
- Tanzania: HIV testing and counseling, home care and systematically introducing Voluntary Counseling and Testing (VCT)
- Zimbabwe: Women's economic security – small loan credit to encourage economic self sufficiency for those infected and affected by HIV/AIDS
- South Africa: Youth HIV prevention activities in high schools and secondary schools.



In 2005 Acceleration Teams visited each country, assessing the work of the first phase, and helped create work plans to develop these new strategies. Fundraising assured a staff person and operating funds for the next two years in six countries. Overall, more than 29,000 people benefited from the six projects. Approximately 5,100 were direct participants – in economic clubs, in agriculture projects, as trained caregivers, community educators, and VCT counselors. Work with youth in South Africa, Zimbabwe, and Nigeria used Youth as Facilitative Leaders to train young people to be peer educators. 4500 youth were educated about HIV and leadership. The shape of community participatory prevention and disease management was becoming clearer.

At the same time, major strides were made in most country health systems. Treatment became available – although mostly in district towns, making it still effectively unavailable for many people without the means and ability to travel for treatment. With the promise of treatment to prevent death and improve life, testing became an invaluable tool to individuals and communities to move beyond prevention awareness to care for people living with HIV and AIDS. It was now possible to know who was HIV+ and begin to address their needs. Prevention received a huge boost. People who know their status can act accordingly and people in treatment have lower viral load, thus lowering their likelihood of infecting others.

In 2006, three new opportunities broadened our experience, thinking, and action.



- In collaboration with the Kenya Ministry of Health, a five-day seminar in Nairobi introduced thirty public health officers from thirteen districts to community participatory prevention.
- Training and experience with Living Well with HIV/ADS, Stanford University's Positive Self-Management Program, was introduced by ICA UK in Kenya with a grant from the Elton John Fund in UK,

training trainers to train others to work with groups of HIV+ people.

- A demonstration project developed by volunteers from ICA Canada, worked in Il Ngwesi, a village in a Maasai Ranch - a hard to reach population in Laikipia District in Kenya. Over 8,000 tests were conducted in a total population of 9,500 (some were repeat tests.) Ideas were sharpened about what is required to "get HIV/AIDS under control."

2005 – 2006 was a pivotal phase for the Africa HIV/AIDS Prevention Initiative. It was clear that prevention education and engagement was essential to begin to address HIV/AIDS, but it was just the beginning. Assisting communities to meet the needs of PLWHA and their families required a variety of strategies and programs. Many of the tools were now in sight. Partners contributed their thinking and expertise. How to refine and integrate interventions, evaluate and adapt them in the face of tragic deaths of trained ICA Africa staff, institutional changes in the US, and shortages of funding would be the challenge for the next phase. In 2006 ICA US decided not to engage in international work and a new organization International Consultants and Associates (IC&A) was created to provide a not-for-profit base in the US for international work.

Phase III – 2007 – 2010 – Integration and Expansion

The phrase, "getting HIV under control," coined by the Il Ngwesi Project in Kenya developed by ICA Canada, had a significant impact on our thinking. The question became, not only how can we prevent it – assisting individuals and communities to change behavior, resist stigmatism, deal with the problems openly, develop skilled village leaders and workers – but how can a community put in place and sustain the efforts that will be needed for the foreseeable future to be able to live with this scourge, as they live with malaria and TB? How can they get it under control?

Prevention is clearly still at the top of the list, but what does prevention really mean? The dream of a vaccine isn't happening. Treatment for maternal child transmission is improving. Testing and treatment of those who need it give people hope and reduce illness and death, and the likelihood of transmission that comes with a high viral load. The health system is becoming more competent and responsive further into the countryside, but it has a long way to go. Prevention begins to look like a whole complex of activities, attitudes, decisions, cultural norms, resources, and capabilities, set in the fabric of the needs of the community as a whole.

In 2008 a series of one-week consults appraised the progress of each project and again, assisted with planning and training, concentrating on programs that are helpful to PLWHA and their families.

- **Living Well**, the Positive Self Management Program (PSMP) is included in four countries with several African staff and US volunteers going to Stanford for training.
- **Self-Help Programs** provide mainly HIV+ women or family members of those infected an opportunity to gain some control of their economic life, while learning more about HIV and prevention. In Zimbabwe, a leader from each of 48 Self- Help Groups will be trained this fall as peer educators.
- **Mobile VCT** is needed in areas where testing is not easily accessible. It reflects a very useful partnership between the health system and community HIV workers. Campaigns are set up and recruited in the community, serving the community and using the time of health officers and VCT workers effectively.
- **Youth as Facilitative Leaders** is a program to train young people in leadership skills. Combined with HIV/AIDS prevention training, it equips young people to talk with their peers about prevention, testing, and HIV management.



The chart in Appendix 2 shows participants currently involved in these programs in each country and Appendix 3 provides a description of major program component.

Zambia, Kenya, and Tanzania have moved on to new project locations. Zimbabwe, with assistance from a Rotary International grant is demonstrating what it looks like to scale up to size, to serve 178,000 people in a peri-urban area. Tanzania is realizing the results of patiently gaining the trust of a Maasai village that “did not think they could get AIDS.” Uganda has trained young people in eight villages as peer educators and under the leadership of Safe Neighborhood Foundation, is applying for major grants. South Africa and Nigeria continue to work with programs targeting youth in both school and informal settings. Benin and Togo have new projects begun in 2006 that are showing promise, working with youth and pastoralists.

Methods: Community prevention, changing images, making life decisions.

The task of HIV/AIDS prevention and management is daunting. Individuals and communities are confronted with a major paradigm shift in their lives. With the onset of the HIV/AIDS epidemic, the long-held individual and community patterns around sexuality no longer work. *Abstain. Be faithful. Use a condom.* ABC puts a new demand on individuals to change the old image of their sexual life to the possibility of a new safer, healthy image that can lead to changed attitudes and behavior.

This internal change requires a process that is not often facilitated by billboards and one way instruction. A process is needed to work through to a new place – a shift to a new image of reality and a new decision. Individual lives are embedded in a community, so support of the community is necessary to create new expectations and new ways of behaving to reinforce the new demands of prevention. This means that the community as a whole has to come to a new understanding and a new decision. For both individuals and communities the process goes something like this: know; reflect; seek options; decide; plan; act. All the steps are necessary for effective behavior change. For example, a community may understand the need for safe sex and their plan may point to the necessity for having condoms easily available in the community. An individual may decide that it is important to use one, but without the agreement of the partner and immediate availability at the time of need, it will not happen. Changing behavior is a complex process. Training of peer educators gives training in how to assist this process. (Appendix 4 is an overview of the five-day training curriculum.)

ICA's participatory methods called the Technology of Participation (ToP®) underlie and form the foundation for all ICA HIV programs. Those methods help individuals to actively participate, to take the demand to change seriously and work through what will be necessary in the next sexual encounter. ICA methods assist a community to think about what is required of it, to examine what it wants for the future of the community and make a plan for taking action. (See Appendix 5 which explains the underlying dynamics of these methods.)

In a project which implements what is required to prevent and manage HIV, testing is at the center. When an individual decides to be tested or a community decides to sponsor a testing campaign, there is a decision to take HIV and AIDS seriously. It is at that point that the project has traction. Preparation, ongoing support, evaluation, and ongoing plans for sustaining a project are critical underpinnings of any project.

A daunting job begun a decade ago shows accomplishment and promise for the future. African villages and the country offices that serve them have taken the initiative and are securing their own project funding and establishing program innovations and program expansion. Increasingly, HIV/AIDS work is an integral part of any ICA development work undertaken and the funding for that work. The question remains for those of us who have been privileged to be part of this effort: How can ICA USA and other ICA partners assist African ICA country staffs to combat HIV/AIDS where they are already working in development, prepare for expansion, and meet the needs of the next decade?

Following are reports from each country focused primarily on work from 2008 to the present. There are also a report from Nepal which has had a project for many years and reports from ICA Canada and ICA UK about their work in HIV/AIDS during this decade.

A Conclusion discusses what we have learned together during this decade, and points to directions in the future.

BENIN

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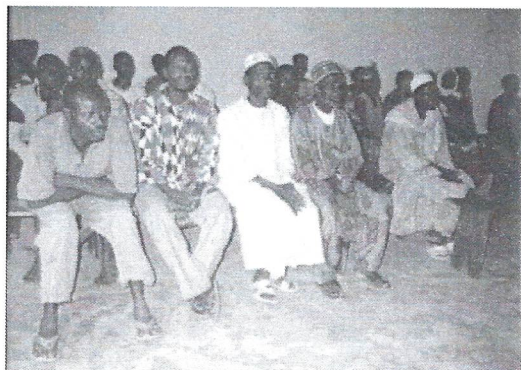
Benin, located in east Africa, had a relatively low HIV rate in 2008 of 1.2% of adults 15 – 49. (UNAIDS 2008)

There are 64,000 people including 37,000 women and 5,400 children. There have been 3,300 deaths from AIDS and there are 29,000 orphans. In Benin the official rate is estimated at 3%.

ICA Benin began HIV/AIDS activities in 2006 with primary and secondary schools in the region of Donga focused on children and teachers, including teacher training and mobilization of local religious leaders. It was also the lead organization in the Donga region for the 2006 World AIDS Day activities, which were orchestrated nationally by a coalition of national and international NGOs. The events culminated with a public march on 7 December, which included at least 300 pupils from the town of Diougou.

Current HIV/AIDS work (2009 – 2010)

In 2009 the target beneficiaries changed and became the pastoralists in the district of Ouake initiated in collaboration with the National Commission against HIV/AIDS, a government organization. In this program, 500 people benefited from HIV/AIDS prevention activities; 30 community leaders were trained as volunteers. Important changes have been noticed within our local communities. People who refused to go for testing are now going freely to specialized centers open for this purpose. As opposed to earlier, our latest sensitization meetings were very full and people were impatient to know more about this pandemic. Since 2006, at least 3200 people have been involved in these activities. This project was initiated in collaboration with a governmental agency. As the implementing organization we were not always free to conduct activities as we want. Sometimes the methods are not suitable to the situation of the beneficiaries.



Methods and Tools

In sensitization activities within schools, we used meetings, games, songs, poems and drawing. With pastoralists communities tools used were HIV/AIDS related films, sensitization meetings, condoms distribution

meetings, and awareness raising activities. Since 2006, we have produced tee-shirts, sensitization leaflets, songs and poem. These methods are appreciated by the communities because they are adapted to their needs.

Relationship with Health System

The project has partnered with public and private health centers which provide free testing and needed treatment after sensitization activities, increasing the success of our activities.

With the contribution of NGOs, people living in rural areas are beginning to be involved in HIV/AIDS initiatives. Rural people do not want to work with government agencies. Progress is being made in HIV/AIDS education, but much remains to be done about testing and treatment.

ICA Benin is in charge of conducting the National Alliance of Women Home-Based Caregivers initiated by the Huairou Commission.



Lessons Learned

The first thing we learned is that HIV/AIDS really does exist and continues to silently kill people in our region. Projects have been too short (3 to 6 months) to significantly improve prevention and community cooperation. In Benin it is important to include NGOs in decision making about HIV/AIDS program processes.

Funding and Partners

ICA Canada

National Commission against HIV/AIDS



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Cote d'Ivoire is a French-speaking country in West Africa. In 1998, when the HIV rate in the country was 12%, ICA Cote d'Ivoire began working on HIV. Three hundred people participated in two public sensitization programs in Brobo. As a result, they learned about HIV, how it is transmitted and learned to use a condom.

Current HIV/AIDS work (2009 – 2010)

The HIV rate in the country is now 4.7%. In addition to working on sensitization programs in Brobo, ICA Cote d'Ivoire is working to take care of the people infected by HIV and their families. 3,230 people have participated in sensitization programs. Two hundred eighty-nine people are receiving care. As a result, many people now use a condom and it is possible to talk about HIV anywhere.

Lessons Learned

ICA Cote d'Ivoire has learned that working with HIV/AIDS is a long term effort, and good results are difficult to sustain without adequate funding. There are many people who do not accept change.

Funding and Partners

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KENYA

ICA Kenya

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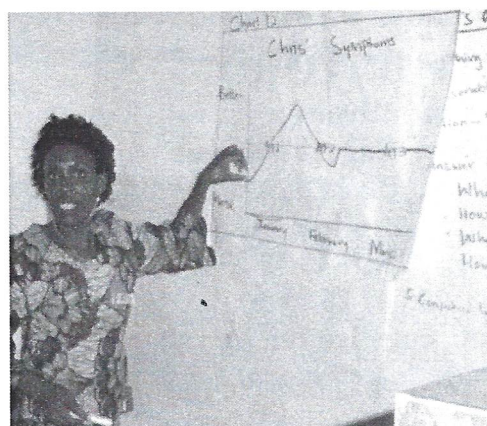
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In 2008, work in HIV/AIDS in Kenya was expanded to Ikalaasa Location in Mwala District adjacent to Muthetheni Location where work has been ongoing since 2003. From 2003 – 2006 in Muthetheni Location, 500 people were trained in HIV/AIDS prevention education; 205 accessed VCT and 35 people who are HIV+ were trained in Positive Self-Management. It is estimated that over 7000 people were reached during that time.

The population of Mwala District is 90,000 people in 17,000 households. The HIV prevalence rate is estimated to be 5.9%, an increase since those infected are being treated with ARTs. Current work is primarily in Ikalaasa Location.

Current work includes four key areas of intervention: (2007 – 2010)

Key areas of intervention	Those directly affected
<ul style="list-style-type: none">▪ HIV and AIDS prevention education▪ Mobile VCT▪ Positive Self-Management Program (PSMP) for people living with HIV (in all of Mwala District)▪ Self-Help Groups formed from those trained in self-management	<ul style="list-style-type: none">▪ 300 people trained▪ 1500 have accessed VCT facility▪ 155 HIV+ trained▪ 7 self-help groups have saved 18,000 Kshillings each.▪ 2,035 persons and households have been impacted.

Results of Interventions:

An evaluation report conducted in March 2009 indicated that:

- People in the community have changed behaviors, perceptions, attitudes and beliefs and are living more responsibly.
- Stigmatization for people living with HIV (PLWHA) has been significantly reduced.
- People know their status and have begun to take control of their lives rather than just surviving.
- Those in the Positive Self-Management groups have tools to be in control of their condition. 700 people in Mwala District receive ART and need Positive Self management Training.
- District health office has increased village interaction, including mobile testing campaigns.

- There is mandatory testing and education about mother to child transmission for pregnant women in clinics. ICAK HIV/AIDS prevention education also creates awareness.

Methods and Tools

- Baseline information about HIV and AIDS in community provides information to design the program.
- Prevention curriculum was reviewed and revised in 2007 and Positive Self-Management training manual was reviewed and revised in 2010 to be relevant and focused on the community.
- Staff was trained in curriculum: ICAK has three trained personnel and two community resource persons able to deliver prevention education and Positive Self-Management trainings.
- Neighborhood community groups of 15 – 20 are trained, monitored and evaluated.
- The director received train-the-trainer training in PSMP from Stanford.

Relationship with Health System

The relationship between ICAK and the Mwala District Health Services has been good and prevents duplication of efforts. ICAK is a member of Mwala District Health Stakeholders Forum. Ministry of Health staff conducts mobile volunteer counseling and testing (VCT) in the communities with the assistance of ICAK staff and community resource people. ICAK works in ministry satellites where people living with HIV and AIDS receive ART and VCT to conduct PSMP training with PLWHA.

Lessons Learned:

- Community involvement in HIV/AIDS trainings is very important.
- Do needs assessment and baseline studies to guide community knowledge and behavior
- Community resource persons are key to sustainable projects.
- Empowered people living with HIV/AIDS are the best ambassadors to train others living with HIV.
- VCT facility and/or testing should be provided in the community so everyone knows their status.
- Partnership and collaboration is important for any development organization that will make an impact in development work.

Future work

ICAK expects to scale up these interventions and will train additional leaders who will conduct the trainings in the community as we scale up. HIV rate in district has increased as more people are being treated and survive to live with AIDS.

Partnerships and Funding

- ICAK has trained Ministry of Health on prevention and Positive Self-Management training.
- National AIDS Control Council funds ICAK prevention work in Mwala District.
- Bread for the World, IC&A, and National AIDS Control Council are major funders.

NIGERIA

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Esto Perpetua Development Initiative (EPDI)

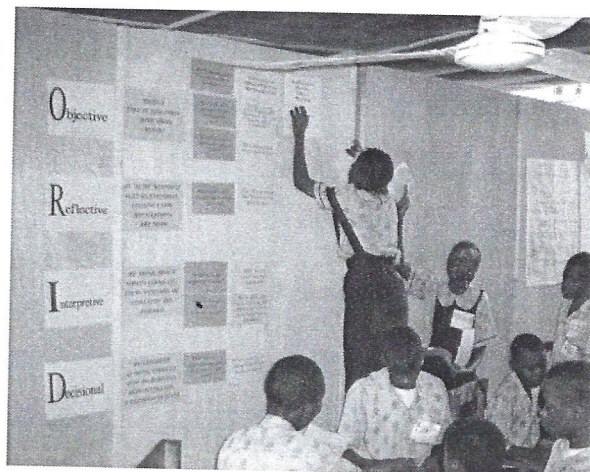
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In 2001, two million Nigerians were living with HIV, and in 2007 there were 2.4 million. (2008 Report on global AIDS epidemic.) Now the number is 2.6 million. (www.avert.org/africa-hiv-aids-statistics.htm.) The prevalence rate is relatively low at 3.1% compared to many countries in Sub-Saharan Africa, but Nigeria's population is large and growing fast. The population is expected to double in the next 20 years, which will leave Nigeria with a large burden from HIV unless the prevalence rate is reduced. Although attendance at secondary school is only about 29%, Nigeria decided to target young people with prevention education and skills to try to reduce future impact. The national government agreed to a new high school HIV/AIDS curriculum, and between 2006 and 2008 NIRADO set up a relationship with three Lagos High schools and implemented a program with five elements: a baseline survey to ascertain knowledge, attitudes, and beliefs; 57 students trained as peer educators; Health Club formed in each school led by the trained students; a plan of action at each school; and continued support for the young leaders with further education and leadership development. 800 kids were in clubs and about 1500 benefited through sharing information.

Current work is being implemented by Hannah Anighoro, Director of Esto Perpetua Development Initiative (EPDI) who is working with two Secondary Schools in Ikeja area of Lagos State. As a result, youth are better informed. (See the student testimonies on the next page.)

Current HIV/AIDS work (2009 – 2010)

Key areas of intervention	Those directly affected
<ul style="list-style-type: none">▪ HIV and AIDS prevention education▪ Life Skills & Sexuality Education for Youth▪ Empowerment/Entrepreneurship Seminar/workshop▪ Health Awareness Campaign for women	<ul style="list-style-type: none">▪ 61 youth in two Secondary Schools in Ikeja local government area of Lagos State▪ Over 200 youth in Delta State▪ Over 100 women

Methods and tools

Program designs are highly interactive, which actively engage the youth. The program is registered with Ikeja Local Action Committee on AIDS (LACA) and Lagos State AIDS control Agency (LSACA), which gives credibility to the program.

Lessons Learned

- Youth lack knowledge that one thinks they should know.
- Youth need someone in whom they can confide and trust.
- More awareness/education is needed, especially among youth.

SOME COMMENTS BY THE STUDENTS

It has affected my life positively and it has changed the way I do things (negatively) to positive ways. Also I have learnt a lot of helpful things which make me positive in everything I do and everywhere I go. - Morayo

The programme has affected my life very positively. It is the best way of teaching and I love listening to the teaching - Godswill

It has really affected my life positively because I learnt that choices have consequences, I keep it at the back of my mind any time I want to make a choice. It also helped in choosing my career and I know a lot of things that I value from it. – Schola

*The program has enlightened me about the challenges teenagers face and how they can deal with it. It has also given me a sense of maturity and I have the strength to deal with any challenge that tries to distract me from where I am going and where I want to be.
– Victoria Edom*

*It has affected my life positively. I love the program because it teaches me more about things out there in the world and how to face it confidently, therefore, it has affected my life so much.
- Christiana*

I have now known that life has ups and downs, positive & negative sides. I now do things in a better way and I now view life from a better perspective. I have now found out that there is a star in me and I have to make the star shine so bright. – Joseph Daniel

It has affected me positively, because since you started the program I am now a new Person. There was somebody who has been asking me for something but since your counseling and your discussion it made or taught me the answer to give the person most especially I thought about the repercussions and then I knew that it was bad. Thank you, Mrs. Anighoro I love you. – Lasoye Tolulope

The program has affected me because it taught me how to do things right and how I should behave when I grow up and I should be careful in what I do. – Alex Ozagha

I learnt how not to misuse my sexuality because of money and gifts and to always focus on my books to fulfill my dream/vision. – Tinuola Adekoya

SOUTH AFRICA

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An estimated 5.7 million people were living with HIV in South Africa in 2009. In 2008, over 250,000 South Africans died of AIDS. National prevalence is around 11%, with some age groups being particularly affected. Almost one-in-three women aged 25-29, and over a quarter of men aged 30-34, are living with HIV. HIV prevalence among those aged two and older also varies by province with the Western Cape (3.8%) and Northern Cape (5.9%) being least affected, and Mpumalanga (15.4%) and KwaZulu-Natal (15.8%) at the upper end of the scale.

The current work of ICA- South Africa on HIV focuses on educating and actively engaging with youth on HIV/AIDS related issues. Their Youth as Facilitative Leaders training is informing the Youth about HIV/AIDS and their role in prevention.

Current work includes the following key areas of intervention:

Key areas of intervention	Those directly affected
<ul style="list-style-type: none">▪ Youth as Facilitative Leaders (YFL) training focuses on gender, HIV/AIDS, communication and facilitation skills as well as the relationship between HIV/AIDS and gender based violence.▪ Implementing various group activities – awareness raising events focused on the spread, prevention and care of HIV along with workshops.▪ Working closely with the Department of Health. They have been able to assist in providing Testing Centers over the years during VCT Campaigns.▪ Changing individual and community images about taking responsibility for their illness▪ Development of action plans in schools to identify what can be done to create a positive impact on the community.	<ul style="list-style-type: none">▪ From 2009 until now, 240 youth have been trained on HIV/AIDS both in school and out of school. Another 250 were involved in VCT Campaigns and 85 were tested.▪ Every year about 250 Youth receive direct training on HIV/AIDS and facilitation.

Results of Interventions

- VCT and prevention education campaigns resulted in **change in high risk sexual behaviors:**

- At least 150 in school and out of school students benefited through training and learning.
- Young people reported deeper thinking about gender and HIV.
- Shift in attitudes toward testing and Increase in use of condoms.
- Youth facilitators grew into the challenges of working with this population.
- Communities are well informed about AIDS and care for AIDS patients.

Methods and Tools

ToP)[®] Methods in the delivery of trainings, questionnaires collecting data, and logical framework to measure the impact of the projects have been useful.

Partners and Resources

ICA- South Africa has worked closely with the Department of Health, and the agency has assisted them in providing Testing Centers during VCT campaigns. The agency has distributed condoms during sensitization workshops. ICA South Africa believes that working with the health department improves the quality of delivery services they can provide within their communities. Also building partnerships with local organizations and funders is key to the success of HIV/AIDS work.

Future Trends and Needs in HIV/AIDS prevention and management

- To actively survey and evaluate current programs, and use the results to expand VCT program to other surrounding areas.
- To have more organizational collaboration, and continue building local and international partnerships with organizations working on HIV/AIDS in order to provide complementary and well-rounded services.
- To promote support groups among PLWHA and their families to sustain better living.

Lessons Learned

There have been a variety of lessons learned throughout the years for ICA- South Africa.

- Some HIV/AIDS stakeholders don't recognize the pressing issues of youth in the area of HIV/AIDS. Partnership and coordination with government entities is a major part of the project effort and of a long-term development of youth HIV/AIDS awareness.
- Data collection, program evaluation, and information dissemination cannot be overlooked. If you aren't monitoring the programs closely, there is no real way to measure effectiveness.
- Emphasize ownership by beneficiaries to increase enthusiasm for expansion. Groups created by persons living with HIV/AIDS for support tend to help increase both independence and a feeling of acceptance within their community.
- It is important to build stakeholder partnerships with radio stations, AIDS agencies and organizations representing the target groups to develop the use of the media to prevent HIV/ AIDS and to promote Stakeholder HIV/ AIDS measures and initiatives. It is important to remember though, that the media is not the magic cure to HIV/AIDS as was assumed in the 1980s. Social and behavioral change cannot be separated from such issues as policy, economic and social circumstances, personal attitudes, and social norms.

Funding and Partners

Rotary Club International
ICA Canada
Foundation for Human Rights

Men As Partners
Engender Health

City Of Johannesburg
UNICEF

REPUBLIC OF TANZANIA

ICA Tanzania

Director: Doris Mutashobya

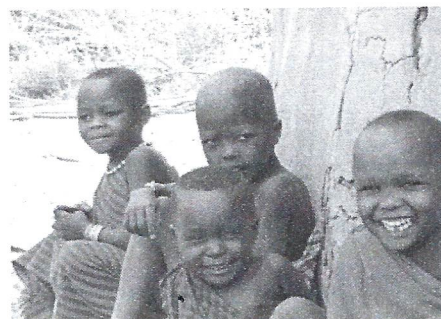
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HIV/AIDS prevention work began in ICA projects in 2003. The goal was to mobilize communities to look for community solutions to the problem. Gradually the program implemented a number of activities that address the problem. The program changes as communities understand the problem and look for sustainable solutions. Since 2003, over 15,000 people were counseled and tested; 1000 people were trained in various skills; 30 villages were reached with awareness programs; 10 youth groups were formed and three of them received seed money to start income generation activities; 6300 orphans and most vulnerable children were supported. As a result there has been an increased knowledge about the spread and prevention of the disease; the acceptance by the Maasai community, long closed to the possibility that the disease does affect them; decreased denial and more AIDS patients receiving ARVs. ICA Tanzania's capacity to implement HIV/AIDS related programs has increased.

Current work includes two key geographic areas of intervention

Key areas of intervention	Those directly affected
Monduli and Longido Districts <ul style="list-style-type: none"> ▪ Mobilization of communities to fight HIV/AIDS problem ▪ Running a VCT Centre at Mto wa Mbu township ▪ Mobile VCT ▪ Home counseling and testing 	100 people have been tested; 60 people counseled on issues besides HIV/AIDS and 150 homes visited resulting in <ul style="list-style-type: none"> ▪ increased knowledge of HIV/AIDS leading to testing; ▪ reduced stigma – particularly at the family level; ▪ most young Maasai males are starting to think differently about the culture of many wives.
Handeni and Kilindi Districts <ul style="list-style-type: none"> ▪ Provision of support to Global Fund Orphans and Most Vulnerable Children (MVC), including support for primary, secondary, and Vocational School: under five nutritious food, bedding, clothes, health services, scholastic supplies, and psychosocial support. ▪ More than 30,000 receive free medical services 	Served: 3025 primary students; 60 secondary students; 60 vocational training students; food 996; shelter, 1104; psycho-social support, 196. As a result: <ul style="list-style-type: none"> ▪ Self confidence created among students ▪ School drop out rate decreased ▪ Employment increased for vocational students ▪ Shelter provided for abused children

Methods and tools

ICA Tanzania works with communities to assist them to address their needs so the program is directly connected to community needs. ICATZ is known by the community and has a mechanism to receive and evaluate feedback from community members. We use participatory methods and respect the opinion of leaders/elders, involving them in each stage of the program. We respect the confidential information of individuals, particularly related to HIV/AIDS. Over 1000 people have been trained; posters and leaflets, and sign boards assist in presenting information. A video is in the making. ICATZ is the only stand alone national NGO in Monduli and Handeni Districts working with communities.

Relationship with Health System

The local health system is our greatest partner. We provide complementary services and they provide assistance: since 2004, the Monduli VCT Centre has received supplies like testing kits, and we assist their mobile VCT. In Handeni, funds to support health services are paid to the District Hospital which in turn provides cards which we distribute to orphans and MVC and their families. We compare data with National HIV/AIDS Policy regional and district data, and get updates on what is happening in other institutions.

Lessons learned

- Local government and communities can assume greater responsibility and become the center of their own development when central government stays within its proper bounds.
- Ownership of programs by the communities is vital for local development. Communities need to be involved in identification of problems, planning, implementation and evaluation of programs which result into share/joint ownership of development programs and determination of their own destiny.
- Capacity building of local institutions is important for sustainable development. When the donor funded program ends and the community has no capable structures, there will be no continuity of what was started.
- Networking at different levels is one of the important ingredients for positive program outcomes. As different actors and individuals in the same area network, the result is collective action.
- ICA Tanzania has continued a program for two years without funding using the community and volunteers as leads.

Future directions

Still needed in our project areas and in the country are more education on mother to child transmission, more VCT and ARV distribution centers, and increased programs targeting youth and women.

Funding and Partners

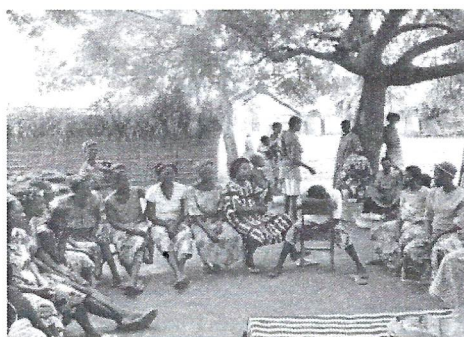
Baring Foundation
Northwater Foundation
Individuals from USA, Canada, and Tanzania
Tanzania Commission for AIDS

Monduli/Longido District Councils
Handeni District Council
PACT Tanzania
Save the Children - Tanzania

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In Togo, HIV prevalence is at 3.2%. 88,000 children are currently orphaned due to AIDS. 94% of these children who have been orphaned or made vulnerable do not receive any medical, educational or psychological support. Only 6.1% of HIV positive pregnant women receive anti-retroviral treatment (ARV) to reduce the chances of mother to child HIV transmission.

Since ICA Togo's inception in 2006, we have expanded our HIV/AIDS campaign into rural areas. This decision was made because individuals in rural areas are often overlooked and tend to be in the most vulnerable situations. Some of the programming that has been implemented thus far includes: an awareness raising program; peer educator training; support for disenfranchised youth; and workshops on income generating activities and loan management for the youth.

Current work includes the following key areas of intervention:

Key areas of intervention	Those directly affected
Worked with individuals in rural areas to assist an underserved population to know and understand their HIV status, and provide clothing to children in the area.	In 5 communities in the Zio District <ul style="list-style-type: none">▪ Six peer educators have been trained▪ Assisted 25 individuals in getting tested
Started an awareness raising program, trained peers educators on prevention, trained youth about income generating activities and loan management, and then disbursed micro-credit loans.	15 communities in the Zio District in Togo were involved. <ul style="list-style-type: none">▪ About 6000 people participated in our campaign led by peer educators▪ 20 women were trained and received loans▪ 40 children were supported▪ 20 peers educators were trained▪ Thousands of condoms were distributed to the communities

Results of Interventions:

We believe that through the campaign, we have started successfully demystifying and destigmatizing HIV/AIDS, and have seen parents more willing to speak openly about sex with their children, and unwed couples were more willing to go get tested together.

People were more likely to encourage each other to get tested, and there was an increase in the use of condoms. Communities are better informed about how to care for those with AIDS. The training provided helped build the capacities of the youth that participated in them.

Methods and Tools

We have translated "*A Field Guide For HIV Prevention Education For African Communities*" into French and are using it for training, as well as dispersing the information at the local level. We are combining it with the arts and are disseminating the information through dramas and plays. Individuals that have been trained are both male and female community members.

Partners and Resources

ICA Togo has partnered with the health system in Togo. It has been a beneficial partnership that has allowed for individuals in the communities we work with to receive services they wouldn't otherwise. There is currently not a mobile VCT in this area, but they are able to bring those who want to know their status to the health center in a nearby town. The relationship with the health system has helped us reach some of their goals and objectives.

Future Trends and Needs in HIV/AIDS prevention and management

Food security is a large problem for those living with AIDS. Due to lack of adequate food and nutrition, it is very hard for people to take their ARVs. There also needs to be a greater national push to properly inform individuals of Togo about HIV/AIDS, and an even larger one to help de-stigmatize it. HIV has left a lot of children orphaned, further propelling the cycle of poverty. These youth need to be properly engaged and looked after, and should not be left to fend for themselves.

We would like to continue with our HIV prevention program, and focus more on support for HIV orphaned children. It would also be beneficial to combine HIV programs with rural economic improvement for the most vulnerable populations. We would like to train those who have the disease to run peer groups and help with other campaign programs. We hope to get a mobile VCT into the more rural regions. If we can create a center for information with audiovisual equipment for youth in the rural areas, we can engage the youth and promote more positive behaviors.

Lessons Learned

Through our work we have learned that it is imperative to work with other organizations and local partners to implement an effective program. The services we can provide by partnering with other organizations are much greater than any service we could provide on their own. We have learned that although keeping a long-term framework is very important, assisting with immediate needs is sometimes the only way to get people to engage in looking at the bigger picture. The link between HIV/AIDS and poverty is undeniable, and only by combating the two together will positive progress be made.

Funding and Partners : ICA UK, ICA Canada, ICAI

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Uganda has a long history of involvement with HIV/AIDS beginning in the early 80's when it was recognized as a major threat by President Museveni. The rate then was over 20%. The result of a major push to address the epidemic by all levels of Ugandans was remarkably successful. Now the country rate is about 6%.

In 2003, 45 men and women in Nabuganyi Parish in Kayuga District were trained as peer educators and a community plan was created. Good cooperation was developed with the district health office, but very few services were available to the district and almost none outside the district town. Despite very little staff support, the 2005 project evaluation revealed continued enthusiasm and involvement of the 2003 participants. Concern was expressed that youth understand the full threat of HIV. Stigma was very high and youth often continued unhealthy sexual habits because to change behavior might mark them as being HIV positive.

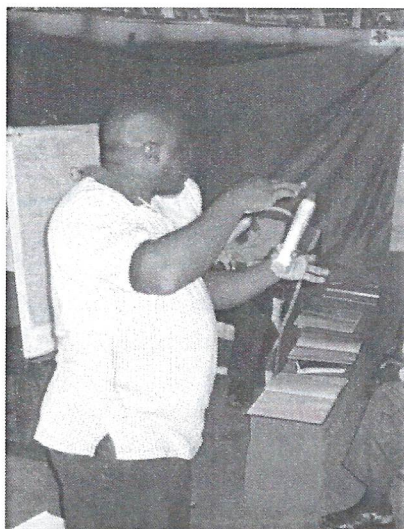
In 2008, a project to train youth leaders was funded by Rotary Club of Boulder, Colorado in cooperation with the Kyambogo Rotary in Kampala. Bob and Sandra True went to Kayunga District to assist in a five-day Youth Awareness and Mobilization Training. Thirty male and female out of school youth ages 18 – 25 from each of eight villages in Busana District participated, a total of 240 youth. The youth are primarily ages 18 – 25, and both men and women. During the lesson on VCT, more than 90% were tested and received their results immediately. As part of training, participants formed campaign teams to go door to door to urge people to be tested. This complemented the Ministry of Health initiative to promote voluntary door to door testing. In addition, a Living Well group was formed and began training. The program was not refunded by Boulder Rotary, although Kyambogo Rotary in Kampala was enthusiastic.

As a result, a grant proposal written by Charles Wabwire, assessed the serious impacts of HIV/AIDS on the diverse population of Kayunga District. While the prevalence rate in the country as a whole is 6.2%, in Kayunga District it is 9.2%. Many households are headed by women or children and there is an ever increasing number of orphans who drop out of school due to lack of financial support or need to care for sick family members. Forty percent of families are living below the poverty line. ICA Uganda proposed an intervention that would address the broader impacts of HIV/AIDS while continuing to promote prevention and awareness including: strengthening HIV/AIDS services; promoting positive behavioral change; strengthening the institutional capacity

of the District and Kayunga community to respond to the epidemic; and improving the lives of people infected and affected by HIV and AIDS by organizing and training Living Well and Self-Help groups. Funding is being sought for this proposal. Charles Wabwire received train-the-trainer certification from Stanford Living Well Program in 2008. In 2009, the youth of Nabuganyi Parish hosted twenty five young people from Montview Presbyterian Church, exchanging ideas and ways of working.

Another NGO, Safe Neighborhood Foundation, Uganda, which has worked with ICA Uganda, and whose director Richard Kirya has received extensive ICA methods training with ICA International Belgium, ICA USA in Phoenix, Arizona, and is currently with ICA UK, is interested in working with HIV/AIDS prevention and is seeking funds to do so. It proposes to work in Budaka District in Eastern Uganda, targeting young people aged 10 – 30 years, mostly those out of school and unemployed, a high-risk population. It proposes to train peer educators in behaviour change communication skills to reach 2400 young people and form 24 youth clubs to assist in sustaining behaviour change. Partners would include Youth Alive Uganda, a national youth-led NGO with a long history of HIV/AIDS prevention work with youth, and Budaka Health Centre HIV/AIDS Department, Anti-Retroviral Section which would provide information on prevention services available in the district while Safe Neighborhood works to mobilize the communities and conduct awareness creation and behaviour change activities. Safe Neighborhood plans to train young people in income generating activities and initiate groups in micro credit and savings as a way to improve living conditions. Particular attention will be given to young women and girls since they are more vulnerable in the spread of HIV.

There is a strong foundation for HIV prevention and control in Uganda, both nationally by policy and locally by trained people to undertake work. But funds and further training and implementation are necessary.



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Zambia reported its first case of HIV in 1984. The epidemic peaked in the 1990's at 16%, then leveled off to its present rate of 14% of those 15 – 49 years. Now, 236 new cases occur every day – more women than men.

The current work of OPAD on HIV focuses on the intersection of poverty and HIV infection in areas where prevalence rates are higher than the rest of the country: Central province, 17.5%.; Lusaka Province, 20.8%; and Southern Province 14.5%. Work has shifted from HIV/AIDS prevention awareness and care in 2003 in Mwanamainda area to VCT awareness because most Zambians are aware of HIV/AIDS and how to prevent it.

Current work includes the following key areas of intervention

Key areas of intervention	Those directly affected
<ul style="list-style-type: none">▪ Strengthening community based structures and response groups in order to effectively meet the development needs of HIV/AIDS affected families and PLWHA▪ Increasing food diversity and security for :PLWHA and HIV/AIDS affected families▪ Reducing socio-economic impact of HIV/AIDS among women and their families through income earning initiatives.	<ul style="list-style-type: none">▪ 1300 people seriously affected by HIV/AIDS in 3 provinces▪ 70 PLWHA▪ 3600 tested; 5000 targeted in 2010▪ 4000 households in food security programs▪ 600 women in money earning programs belong to Self-Help Groups

Results of Interventions

- Increase in CD count of 100% for 75% of those HIV+
- 100% recorded increase in weight for 75%+ of households
- Increase in the number of meals from one to three for more than 90% of the targeted households
- Low stigma among PLWHA
- Increased income of between 50% and 100% for all women involved in business development

Methods and Tools

The methods used in OPAD place emphasis on building strong local structure that are involved in planning and implementation of project activities as well as monitoring and evaluation. The approach stresses gradual increasing responsibilities of community-based groups. Principles of our work include:

- Target resource-poor households with potential to improve their economic insecurity.
- Provide equal access to activities and benefits taking into consideration gender, disability and HIV/AIDS status.
- Promote self-reliance and empowerment of target groups using participatory methods.
- Promote a sustainable livelihood approach. A holistic approach to improving food security is encouraged, including sustainable farming practices, natural resource management and income generating activities.
- Promote co-ordination with other organizations including local government structures
- Adopt a learning approach and encourage innovation to ensure constant improvements and wider dissemination of lessons learned. This includes planning, monitoring and evaluation systems to ensure learning is captured, shared, and integrated into the project as it evolves.
- Influence opinions at village, district, and national level through community-led advocacy activities to raise awareness of issues important at the community level.

Partners and Resources



OPAD has established strong relationships with agencies and organizations to provide services to those in the HIV/AIDS and food security projects. These services are expected to continue after the projects are concluded.

- Ministry of Agriculture and Cooperatives provides technical expertise in training in sustainable agriculture and food security.
- Ministry of Health assists with training of Care and Prevention Teams.
- National Food Commission and Biodiversity Conservation Network provide information

on nutritive values of available food stuffs and formulation of appropriate diets.

- Zambia Users of ARVs shared information with beneficiaries and help with formulation of diets for people with HIV.
- New Start Centre (NSC) provides free condoms and mobile VCT.
- Zambia Health Education and Communication Trust (ZHECT) provides education materials and training in HIV/AIDS and opportunistic infections.
- Micro finance institutions provide services to households that need additional capital to expand their businesses.

Future Trends and Needs in HIV/AIDS prevention and management

The government is committed to improving the quality of life for all Zambians including health. In 1991 radical health policy reforms moved from a strongly centralized health system to one which supports and guides decentralized services. The Primary Health Care (PHC) program has implemented the Basic Health Care Package (BHCP) at all levels of health care, providing efficient and cost-effective quality basic health care services as near the family as possible. Current priorities are based on epidemiological analysis and include nutrition, environmental health, control and management of communicable disease, epidemic and disaster prevention, school health and oral health. There is currently a realization that prevention has to go hand in hand with nutrition and poverty reduction to reduce the high prevalence of HIV/AIDS.

Lessons Learned

The following have led to more effectiveness and efficiency in achieving project outcomes:

- OPAD has successfully incorporated community members in participatory monitoring which produces good qualitative information. But we also need quantitative information. Forms have been designed to capture quantitative data.
- The “power of gift giving” embodies African tradition of giving during times of stress. The introduction of goats and chickens through gift giving has been a greatly appreciated intervention.
- OPAD works and consults with local-level traditional leaders and structures to secure project buy-in and improve the chances of sustaining activities after the project is completed.
- Technologies such as technologies for sustainable agriculture must be seen to provide immediate benefits if they are going to be adopted. Linkages are made with Ministry of Health and Ministry of Agriculture, Cooperatives and other organizations to assist post project sustainability.
- Participatory planning tools such as focus group discussions, wealth ranking and mapping, Venn diagrams, problem-tree analysis and participatory meetings engage the community in planning, implementing, and monitoring outcomes.

Funding and Partners

Self Help Africa (UK)
Development Fund of Norway
Elton John AIDS Foundation
UNDP: Global Environmental Facility
American Embassy
Kindernolthif
World Bank Small Grants
Zambia National AIDS Network
American Jewish World Service
ICA Canada
IC&A
ICA:UK

ZIMBABWE

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In 2002 ICA Zimbabwe launched the HIV/AIDS program focusing on prevention in Mufakose District, a peri-urban area outside Harare, with 4000 families directly involved, resulting in extended impact to 40,000 people. The HIV rate was 24%. In 2003 Rotary International became a partner. In 2007 a needs assessment in five communities – Mufakose, Kambuzma, Budiriro, Rugare and Crowborough North – resulted in a three-year program launched in 2009 called Hunger, Humanity, and Health (3H) which focuses on business development, savings, youth training, HIV/AIDS awareness training and Living Well. The program evolved based on the needs identified in the communities. During that time, 50 small and medium enterprises have been launched resulting in income for welfare and education. More people go for HIV testing, resulting in increased HIV/AIDS knowledge. In 2007 alone, 700 disclosed their HIV status. The prevalence rate has dropped from 24% to 16%.

Current work includes the following key areas of intervention (2009 – 2010)

Key areas of intervention	Those directly affected
<ul style="list-style-type: none">▪ Women's microcredit program▪ Self Help Approach▪ Living Well Program▪ Youth as Facilitative Leaders▪ Prevention – included as part of every project	<ul style="list-style-type: none">▪ 600 people are working in 48 groups▪ Group savings from January to August were \$26,000. Each group has an economic project such as making peanut butter, poultry, sewing.▪ Number of school children has increased and places are hard to find.

The geographic population in eight communities surrounding Mufakose District is 178,000. ICA works in five of those communities. More than 2500 project beneficiaries have been trained with extended impact of 20,000. 2000 people have been tested and 700 have openly disclosed their status. The results have been:

- increased knowledge about HIV/AIDS increasing the number of those tested;
- people are able to plan and work on their individual and group projects;
- people do not stand and wait for something to happen, they are now engaged;
- increase in female and male condom use;
- reduction in HIV/AIDS infections because of awareness of the disease and availability of condoms; reduction in culture of stigmatization.

Methods and tools

ICA Zimbabwe relies on a number of participatory approaches to carry out its HIV/AIDS programs: Technology of Participation (ToP®); Action Planning; Appreciative Enquiry;

Open Space; drama and theater. These are facilitation methods that can be easily learned and adapted to all programs and encourage participation of all involved. There are 24 associate trainers, 2300 trained in facilitation, HIV/AIDS and Home Based Care. A Self Help Manual was developed by Kindernothe; Business Skills Manual and Perm Culture Manual were developed by ICA Zimbabwe. The ICA *Field Guide* is in use.

Relationship with Health System

Because of a successful relationship and reputation earned working with the Department of Social Services, ICA Zimbabwe has developed a strong relation with the Health Department and the Ministry of Health. We have free access to training and use of facilities. Currently the youth program is housed in a local clinic. In addition there is free referral to bigger health institutions. The relationship has provided access to future funding and information.

The key partner is the community itself which believes in ICA methods and has accepted work in the community. The community trusts ICA's work because results have been phenomenal. A key to success has been respect for the vulnerable and confidentiality.

Lessons Learned

The program has adapted its response to need by encompassing indigenous knowledge systems and by listening. New programs are developed such as the Self Help program and Living Well. Other lessons learned:

- The power of networking has resulted in finding new partners
- International volunteers provide technical expertise
- A clear vision and mission help achieve required results
- Staff development is key to success of program implementation
- Acknowledge local leadership
- Use a peer review mechanism to evaluate and design program.

Future Directions

In spite of years of work in HIV/AIDS prevention and management, we are scratching the surface. We are actively involved in all aspects of the changes taking place:

- Prevention, including mother to child transmission, VCT, behavior change, sexually transmitted infections (STIs), condom promotion and distribution, blood supply safety, high risk groups, and infection control;
- Mitigation of impacts and support including orphans and vulnerable children, income generation, PLWHA, nutrition; Care for infected including ART, opportunistic infections, tuberculosis, home based care and palliative care;
- Workplace including youth in school and out of school
- Capacity building and infrastructure particularly staff training.

Funding and Partners

American Jewish World Service

Rotary International

International Consultants and Associates (IC&A)

NEPAL

ICA Nepal

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Nepal is ranked 144th out of 182 countries in the UNDP Human Development Index in the *Human Development Report 2009*, a country with Medium Development. Most African countries have a ranking of Low Development. In 2005 its HIV rate was 0.3%. It does not have a significant HIV problem. Nevertheless, ICA Nepal has addressed HIV as part of its capacity building efforts in Nepal since early in the decade.

In 2002 – 2003, ICA Nepal worked with UNDP on Transformative Approaches to HIV/AIDS, and it worked with the Global Fund teaching teachers about life skills methods. These programs were carried out in the whole of the country and resulted in teachers beginning to integrate HIV/AIDS issues with life skills in their schools and classes. In 2009 and 2010, there are awareness campaigns in ICA Nepal's project areas, mostly in far West Nepal. As a result local women now inform their migrant husband to be aware of HIV.

ICA Nepal is working with the government of Nepal to strengthen the health system in Nepal by developing local level leadership.

Methods and Tools

More than 1000 people have been trained and five new manuals have been developed with the new curriculum. Useful methods found to be effective are **transformative approaches**, life skills, ToP[®]. Initially this training was developed in pilot projects and later replicated to other areas.

ICA Nepal has learned that building human capacity is essential. There is a huge interest in participation of people including infected people.

The Future

Nepal needs accessible centers for voluntary counseling and testing (VCT) and for condom distribution. ICA Nepal will respond to these needs by building human capacity and developing district and local level strategic plans. "We want to transform the society tackling to the source."

Funding and Partners

UNDP

Global Fund

District Development Committees

ICA CANADA

Director: Nan Hudson

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ICA Canada has been a partner in several African HIV/AIDS projects, providing funding support and the training, materials, methods to build the capacity of communities to undertake the fight against HIV/AIDS.

The exemplar one-year demonstration is Il Ngwesi, a community on a Maasai Ranch in the Great Rift Valley in Kenya. It was there that the phrase “getting HIV under control” was coined. It was a difficult population – isolated, with no concept of disease as communicable, and therefore no sense of disease as preventable. Sickness was a curse. Nevertheless, the leaders recognized that people were dying and asked ICA Canada for assistance in figuring out what to do about it. The project was unique in that it co-created the project with the entire village – from leadership to young people, including women; it had adequate funding, and enthusiastic assistance from a team of young Canadians who altogether spent a year there.

The project concentrated on training 200 peer educators who went door to door doing education, and 10 young Maasai went to Nairobi to be certified to do voluntary counseling and testing. More than 8,000 tests in a total population of 9,500 were conducted in a roving tents program (some were repeat tests). HIV became part of life and stigma was reduced. People who tested positive were assisted to receive treatment. Condom use increased. In the evaluation interviews 81% said that a program volunteer had visited them at home to provide information. A volunteer educator said the community believed it had conducted a “rescue” operation of those who otherwise would have died.

Il Ngwesi Project Development 2006 –2007

May – Community leader decide to act and seek outside help and money.

June – A household survey gathered baseline information.

August – Leadership and ICA Canada volunteers co-develop the approach

October – Awareness campaign begins

November – December – door to door awareness campaign; the community agrees to the project, the whole community plans the project; Beginning of training of 200 volunteers.

January 2007 – Outside testers begin one-week testing campaign in three test tents. People are encouraged by door-to-door visits and dramas.

January to June – Tents are set up in each neighborhood. Follow-up care provided for those testing positive.

August – Local organization takes the program and runs with it. Sends local staff for formal counseling and testing training.

Since August, 2007 – Extending of approach to other communities. Training of health personnel in Laikipia District, including national Ministry of Health personnel

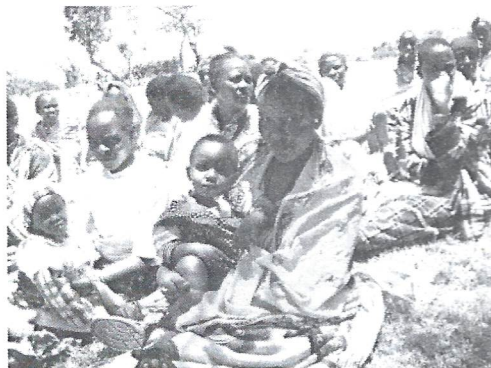
Other supporting partnerships include supporting a community-based mobile HIV Outreach program in Monduli District where 746 people had been tested as of May 2010; 23 outreach workers continue the project; eight groups of persons with HIV are engaged in micro-credit lending with 8 million TZ Shillings and 100% rate of return. Zambia and South Africa have also received small grants.

Methods and tools

The Il Ngwesi project responded to the needs of the community, co-developed and co-designed the approach and then used local volunteers to run the program. Local ownership resulted in local empowerment resulting in the local decision to expand to neighboring group ranches and to initiate overall district health plan through training of local health service officers.

Lessons Learned

- Success in raising awareness of HIV and dealing with its devastating results comes when the community itself decides to deal with the issue.
- Creating a safe space to discuss traditional thoughts of HIV is imperative for shedding light on errors in thought as well as building safety.
- Bringing information to people is much more effective than having people come to information.
- Include leaders and underrepresented populations (youth, women).
- Pay special attention to how a community is organized and work within it.
- Once goals were decided by the villagers, help villagers set up steps needed to success this includes skills to raise money, train volunteers, and make connections with other Kenyans in HIV/AIDS prevention programs.



The Future

ICA Canada is working with the Il Ngwesi project to develop a health curriculum for training group ranch management and communities, including resource mobilization strategies, networking concepts and community development. We are also exploring next steps in collaboration and replication of what we call the “Il Ngwesi Model.”

Funding and Partners

Il Ngwesi Group Ranch
Family Health International
Kenyan Ministry of Health
ICA USA
IC and A
Northwater Foundation
Patterson Donations

ICA: UK

Director, International Programmes:

Jonathan Dudding

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Manchester M15 5RF, UK**

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ICA: UK, SUPPORTING THE FIGHT AGAINST HIV/AIDS IN AFRICA

ICA: UK, through its international programme, has been supporting ICAs in Africa both individually and collectively since its inception in 2000. Since 2008, ICA: UK has established a more rigorous set of criteria for partners, and has begun to include non-ICAs in its programme.

What have we done?

At the **network level** in ICAs in Africa, HIV/AIDS has been assuming greater importance as the pandemic grew and local organisations recognised the need to respond effectively to the challenge both of the disease itself, but also to the social, economic and political implications. The ICAs' efforts were boosted significantly by the ICA USA initiative launched in 2001.

ICA: UK's contribution has been:

- To manage a grant from Misereor (initially granted to ICA International) for two workshops held in 2005 to review the progress of the HIV/AIDS work so far, to explore the current reality, and to plan for future interventions.
- To work with Living Well and Thames Valley University to pilot the Living Well approach for people living with HIV/AIDS in Kenya and Uganda in 2005/06. The Living Well approach is based on the Positive Self-Management Programme (PSMP) developed at Stanford University, and draws on several years of experience working with HIV+ people in the UK. The pilot and its subsequent evaluation were funded by the Elton John AIDS Foundation.
- To work with all the ICAs in Africa to develop a HIV/AIDS strategy for Africa. Developed initially as part of a grant application, it became recognised as a key document setting out ICAs' approaches to HIV/AIDS, the underlying principles and future priorities.
- ICA: UK also played an active role in assisting ICA International develop a policy on HIV/AIDS for the whole network, a policy which remains in force until today.

At the level of **individual ICAs**, ICA: UK's contribution to their efforts to fight HIV/AIDS include:

- Sharing up-to-date information and funding opportunities, and supporting individual ICAs to submit proposals for funding available locally.
- Working with ICA Canada to fund and support a one-year intervention in Zio District, Togo, training and supporting peer educators and elderly to look after orphans.
- Supporting ICA Canada in a successful application to the Elton John AIDS Foundation for an HIV/AIDS programme in Zambia.
- Working with SCR (a new Kenyan NGO) to roll out Living Well further in Kenya.

What have we learned?

- Capacity building efforts need to be integrated with any HIV/AIDS approach to enable communities to implement their own plans, demand rights, etc.
- The key role of peers in the delivery of programmes, e.g. People Living With HIV/AIDS (PLWHAs) is delivering programmes aimed at other PLWHAs
- The need for more robust evidence-gathering systems both ongoing (monitoring) and at certain times (evaluation)
- The value and added impact of a holistic, adaptable, creative and integrated approach to HIV/AIDS, addressing the issue at all levels
- The importance of deepening and widening spheres of influence (Public Relations/ advocacy) and developing partnerships at that level
- The key role that behaviour change plays in any HIV/AIDS strategy
- The need for increasing the amount of exchanges, project visits as means of sharing ideas and experiences and deepening the learning
- The importance of ensuring a gender-equitable approach
- The positive effect that the Living Well Programme can have with PLWHAs, improving their self-confidence and decision-making, increasing their ability to access and manage medicine, improving their quality of life and assisting them to acquire new knowledge

How has our role changed?

- With increasing amounts of funding available for HIV/AIDS in-country, we receive fewer requests from partners to assist directly with fundraising, although support for proposal writing and the identification of donors is still requested.
- Although ICA: UK has always given emphasis to capacity development, this has increased during the decade and is now the main priority of the programme with partners.
- The nature of the sort of programme support sought by partners has become more specialised and technical. ICA: UK is not well placed to respond to this, and it is encouraging our partners to establish new relationships in order to access this kind of information.
- We have become more pro-active in our approach, not always waiting for a partner's request, but introducing new ideas and seeking funding for them. This is how the Living Well approach came to be piloted.

The future

ICA: UK remains committed to supporting its partners in the fight against HIV/AIDS. Future directions could include:

- Seeking the funding and the opportunity to enable exchange visits between countries for both staff and community members for the purpose of demonstration and learning
- Training and advising partners on data gathering and use in response to the increased demand for evidence-based programming
- Supporting joint programmes between countries, encouraging mutual learning and support within the network
- Strengthening the capacity of partners to increase their advocacy role and broaden their relationships in order to be more influential at a national level.




WHAT WE HAVE LEARNED AND DIRECTIONS FOR THE NEXT DECADE

*When the lion runs and looks back, its not that he is afraid,
rather he is trying to see the distance he has covered. African Proverb*

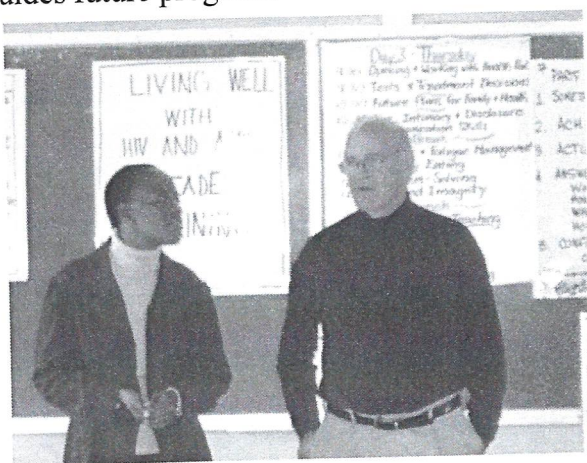
Each of the ICA African offices reported on their work in the last decade and summarized what they have learned during implementation. Their insights fall in four categories: engage the community; build capacity and expand partnerships; link HIV prevention and management to other community issues; and assess and evaluate work for effectiveness and sustainability. These are hard-won insights from working on the ground to make a difference. (See country reports for details.) Following is a gestalt of what those in the field have learned; what we as partners working to assist have learned using the same categories but from a different perspective; and finally a summary of directions for the future.

What implementing partners have learned over the last decade:

- **Engage the community.** Community and local government can be the center of their own development and their own management of HIV/AIDS. It is essential to engage the community, local leadership including traditional leaders and structures to ensure buy-in. The community must own not only the project but their effort to fight HIV. It is important to create a safe space to discuss traditional thoughts about HIV, so that errors are recognized and new decisions are made. There are many tools available within the network to enable this, including the graceful African tradition of the “power of gift giving” in Zambia. Tanzania has shown that the community will continue the project although there has been no funding for two years, using community and volunteers as leadership. There is still the resistance to the needs of youth and women and children within communities. They must be included. Clear vision and mission on the part of all leads to results.
- 
- **Build capacity and expand partnerships for effective sustainable implementation.** Building capacity stretches its fingers in many directions. Collaboration and developing partnerships with agencies and other NGOs are important to provide needed services that ICAs cannot provide and to make an impact. Networking at different levels provides collective action. This requires that there is joint planning and understanding of ICA approach and methods. The institutional capacity of district and community government needs to be increased to respond to the epidemic. People Living with HIV/AIDS (PLWHA) are a powerful resource to train others. They need to be empowered with the skills to do this, to be transformed to leaders rather than victims. Living Well and Self Help Groups provide structures for this. The same is true for youth. Testing (VCT) is needed in the community so all know their status.

It is through building capacities and skills of leaders, community members, individuals, and expanding their roles that HIV work will be self-sustaining after the project ends. International volunteers can provide technical expertise. Improving local ability to access funding is an essential part of the capacity to accomplish all of the above.

- **Address HIV/AIDS within the context of other community issues.** A response from Togo notes that the link between HIV/AIDS and poverty is undeniable. We must combat the two together. In Zambia, the Primary Health Care program has implemented the Basic Health Care Package (BHCP) at all levels of health care, providing efficient and cost-effective quality basic health care services as near the family as possible. There is a realization that prevention has to go hand in hand with nutrition and poverty reduction to reduce the high prevalence of HIV. A new grant proposal for Uganda project seeks to address all impacts of HIV/AIDS along with prevention, including poverty. The lives of those with HIV need to be improved. New technologies and programs need to address immediate needs and produce results to be adopted, even though they are included in a long-term framework. The media can be a useful tool, but social and behavior change cannot be separated from policy, economic and social circumstances, personal attitudes, and social norms.
- **Assess and evaluate work for effectiveness and results.** Assessment and evaluation of program results has been a challenge for ICA projects. But almost all projects mention that evaluation is important for project results. Assessment and baseline studies guide community knowledge and behavior as well as planning and implementation of effective program. Data collection, program evaluation and information need to be disseminated for all to see. A peer review mechanism and participatory monitoring produce good qualitative information for evaluation and program design, but quantitative information is also necessary. Funding, evaluation methods, and training are necessary for evaluation, which gives data and results that guides future program.



ICA Country Offices also report unmet needs where they work:

- More education on Mother to Child Transmission
 - Expanded VCT, ARV, and condom distribution
 - Increased programs targeting youth and women
 - Prevention, including increased VCT, behavior change, condom promotion and distribution,
- decreased sexually transmitted infections (STIs), improved blood supply safety, attention to high risk groups, and improved infection control
- Mitigation of impacts and support for orphans and vulnerable children, income generation, improved lives for PLWHA, nutrition

- Care for those whose disease has progressed to AIDS, including ART as needed, opportunistic infections, tuberculosis, home based and palliative care
- Training for additional train-the-trainers for expanding work
- Sufficient duration of project to see results (3 – 6 months too short)
- Capacity building, particularly staff training and infrastructure
- Expanded health care infrastructure geographically and HIV related skills
- Adequate nutrition making it possible for people to take ARVs
- Reduced stigma related to HIV
- Support groups for PLWHA and their families
- Increased organizational collaboration, both local and international in order to provide complementary and well-rounded services.

What supporting partner organizations have learned. As mentioned in the introductory overview, learning about HIV and AIDS and what might be done about it, has been a steep learning curve over the decade for ICA USA, ICA Canada, ICA UK and ICA Japan. We've been well taught by our African colleagues. The four main categories they mention also work for us, but our perspective has been different. Using those categories, we add what we have learned from our point of view, as those who stand behind and offer aid and ammunition.

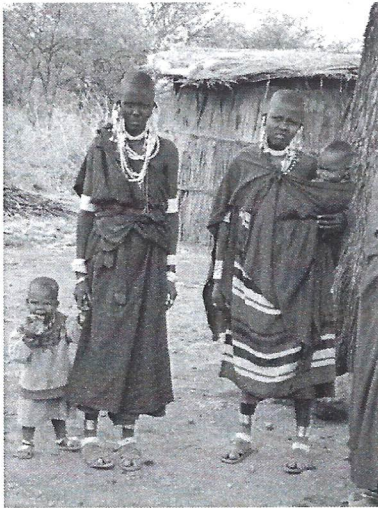
- **Engage the community.** All three legs of the three-legged stool – train peer educators who deliver prevention education; engage the community in creating a plan, and engage community leaders, local agencies, and the health system – point in this direction. We learned people want to be engaged. In Uganda 45 people showed up to be trained as peer educators when 20 had been invited. We learned a public launch was important so that all could participate and recognize the new role of peer educators. We learned that for peer educators to move smoothly from training to working effectively as volunteers required continuing training and support. A trained staff person living in the village was helpful. Support of local leaders – especially traditional leaders is essential. Behavior is cultural and ingrained in every villager; changing behavior requires changing how a whole community thinks about its customs and needs. The community has to own both the problem and ways to address it. Stigma was and still is often a major block to change.



- **Build capacity and expand partnerships for effective sustainable implementation.** ICA UK noted that capacity building needs to be integrated into any HIV/AIDS approach to enable communities to implement their own plans. ICA Canada worked from the ground up in Il Ngwesi so that the community itself designed the project and were trained simultaneously. ICA USA assisted staff to launch programs in eight countries in villages where they were already working which trained peer educators but

also provide intense training for staff. For that, we developed a training curriculum and a teaching tool, *The Field Guide*, and a scenario for a several week project launch. This approach provided the tools and methods to assist project creation. It also provided a core of trained village leaders who were willing and able to volunteer their work to combat HIV. Those tools – often modified - have been used in program expansion. It is not necessary to recreate every project from scratch, although they are adapted to community plans and needs.

- Strength and stability of country ICAs are key to project success. A strong local organization is needed to raise funds, administer program, and train staff. Grounding in ICA methods is essential. Partner organizations can assist, but they cannot do what country ICAs do not do for themselves.



- Agencies such as the ministries of health, have had a major struggle to play catch up. ICA believes that participatory prevention is essential to change. Local health services need to understand the importance and techniques for engaging community members in the community where they work rather than receiving and treating sick people. Treatment is necessary, but it may not change behavior, and it has no multiplier effect. When community projects and the health system work together, the work of both is intensified and multiplied. Mobile VCT campaigns are an

example. Community educators recruit people to be tested in the village at a specific time and health professionals provide the testing.

- Funding and grant implementation is a major area of need of capacity building for country offices. Increasingly funding is best accessed at the country level. Country offices need to be proficient in grant writing for well thought through and evaluated projects.
- Intra-Africa staff teams are invaluable for the knowledge gained by exchanging information about what is working well and building the skills to do it. We, as partners, can assist by being part of those teams and helping create opportunities for them to happen, both through funding and program.
- **Address HIV/AIDS within the context of other community issues.** ICA has always been involved in human development in its international work. Empowering a community to comprehensively address its problems and create the depth will, energy, and skills to do that, is standard operating procedure for ICA's. So it is uniquely qualified to look at the whole complex of causes and effects that leave Africa particularly vulnerable to the HIV/AIDS epidemic. Poverty remains a root cause. It brings with it desperate need, ignorance, hunger, poor health, and a diminished spirit. We know that prevention is essential and that depends on behavior change. But individuals cannot do it alone. Understanding and change in community life is necessary. Change is encouraged by community projects that are multi-faceted and urgent. Community campaigns begin to make a dent in ongoing everyday life.

But results and change must be seen in these underlying problems for HIV prevention to gain much traction. Programs like Living Well, Self-Help groups, farmer's clubs for improved food security, provide workable structures for learning and work.

- **Assess and evaluate work for effectiveness and results.** Donors want to know if a program is successful. Staff and villagers want to know if it has made a difference. Future program design depends upon it. At this time, about all we have is numbers of people who have participated in a given intervention or program. That is good. There is anecdotal evidence of reduced stigma; that condoms are available; that people are more careful. But we don't know have quantitative data about changed attitudes and behavior. UNAIDS now gathers data that tells how many people know what causes HIV; how many people have used a condom during their most recent sexual encounter. But this kind of survey is not at the village level. We may never be able to have the kind of resources that would let us conduct a control trial of a project design and compare the results of its implementation with a similar village which has not experienced implementation. A major indicator of success is reduction of new infections. And causes of new infections are so varied, that you probably still would not know if improved incident rates were the result of these specific interventions.

Sustaining a program requires attention from the beginning: leadership; skills; intention; systems; evaluation; success. One thing is certain: this is not something you can do just once and consider it done.

Future Directions, or as Africans say: The Way Forward.

So what about the next decade? A recent article in *Foreign Affairs* entitled "No Good Deed Goes Unpunished" (July/August 2010), discussed the implications of the ever increasing cost of treatment. In 2009, new infections outpaced AIDS related deaths by 35 percent. ARV therapy is needed over a lifetime – three or four decades. The decade just past made great strides in medical treatment. It has been shown that the poorest people will observe difficult treatment regimen and that it not only saves lives, but returns people to productive lives. But it is expensive and has badly strained the health systems of African countries. No vaccine is in sight. President Obama has said he wants to level this country's funding of PEPFAR. There are questions about the continued level of funding for the Global Fund. For the future, prevention in all its complexity, not just treatment and care for those with HIV/AIDS, is still the name of the game.



A major addition to our intentional learning and future activity is **enabling behavior change**. Education and prevention awareness, testing, testing and treatment for HIV+ expectant mothers, small group support, increased family income, community social expectations, individual life decisions, and poverty – a root cause - all play a part in

changing behavior. We need to do research and develop additional methods to improve our train-the-trainer capacity in this arena. Every program and intervention needs to ask how it will facilitate healthy changes in behavior.

Capacity building is clearly an important role for partner ICA's. Working with those on the ground, we can develop, print (or use electronic means,) and make curriculum and manuals available. A number of those already exist in the network and could be used more intentionally for staff and project training.

Cross training teams and evaluations, including volunteers will assist in staff development. Every country needs a Living Well certified trainer. That means sending staff to Stanford. Information about how to set up and run other programs such as Self-Help are known, but could be made more accessible. What are other programs shown to be effective, that we might use?

Building capacity to prepare and administer grants is a key skill. One of the encouraging trends over the last few years is the ability of countries to obtain funding locally. Ability to construct and carry out program evaluation and reporting is important to refunding.

The similarity of ICA HIV programs in 2010 is striking, although they have developed from different perspectives in response to different needs. The components of programs are fairly clear. We are now ready to **expand our HIV efforts** and need to devise a way to do that efficiently, at low cost, with good results, and have activities and results sustained over time. Creating this common "model" would enable training, funding, and evaluation, and promote expansion. Development of what we know has taken a long time; those who benefit from that knowledge needs to increase exponentially.

Research about useful **data collection and evaluation** methods and the training to use them is needed. New projects in the future need to have a clear evaluation plan and then be implemented. Ongoing participant evaluation of the program is important for guiding a project, but expansion demands that we have clearer documentation than we currently have of project results to build on proven interventions.

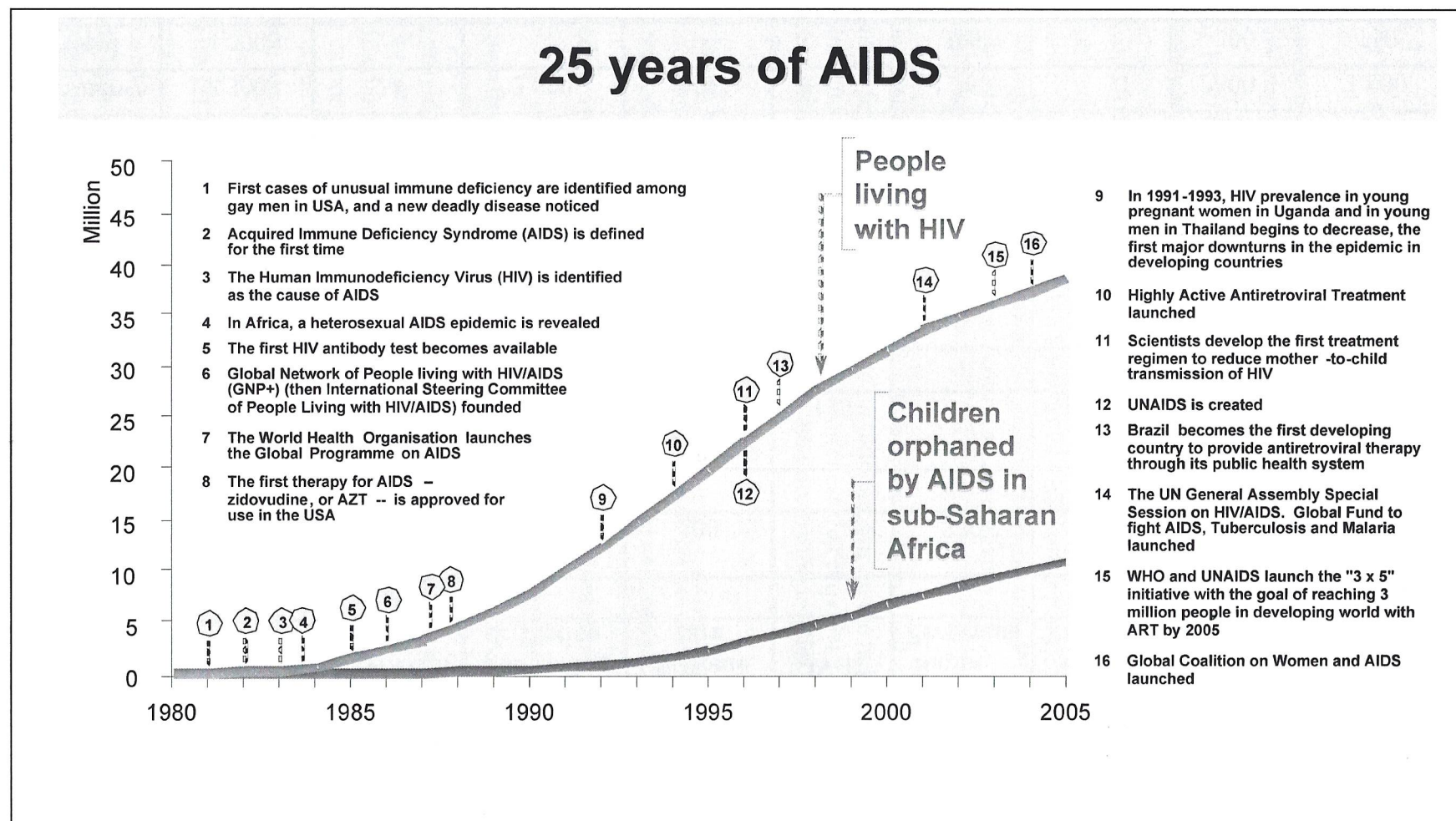
Adequate **funding** continues to be a challenge. Significant expansion requires improved success in grant funding outside the ICA network and its supportive contacts. The institutional base is now in place to seek and administer large grants. A track record is there. Attention to focusing ICA's program and seeking partners that wish to fund and work with us is a high priority for the next few years.

The work is there and it is not going away. A new generation of young people has to choose what HIV/AIDS means for their lives, and shoulder the impacts of the disease in their communities. We can help. Our **community** must continue to create new liveliness in this work, with each other, and with our African partners. We need to know what each other is doing and to the extent possible, plan programs and events that use the resources and skills of all of us wisely. Like the Pied Piper, we must attract a whole new generation of those who invest their lives in combating HIV/AIDS.

APPENDIX 1

UNAIDS HISTORY OF HIV FROM 1980 – 2005

(2008 Report on the Global AIDS Epidemic, Fig. 1.1)



APPENDIX 2

ICA HIV/AIDS PREVENTION INITIATIVE 2008 - 2010 COMMUNITY PROGRAMS TO PREVENT AND MANAGE HIV/AIDS – NUMBER OF <i>Direct Participants</i>									
	Prevention Education and Testing			Care for those with HIV/AIDS		Improved Livelihood			Youth
Country	Prevention Education	Peer HIV/AIDS training	Voluntary Counseling & Testing	Treatment & Home care	Living Well	Economic Support Programs	Food Security Programs	Self Help Groups	Youth Programs
Benin	500	30							3,200
Cote d'Ivoire	30,345	59		200		270	1500	4	17,600
Ghana	350	23						30	784
Kenya	300	20	1,500	280	155		4,800	155	
Nigeria	1,500	80							1,500
South Africa	1,800	240	800	150					250
Tanzania	200	450	1,200			150		35	3,145
Togo	6,000	20	25			20			40
Uganda	120	57	220		20	50			240
Zambia	11,000	440	4000	1200	600	750	4,000	600	0
Zimbabwe	2,300	24	2,000	100	35	1,250		600	1,000
Nepal	4,000	250				500		200	750
TOTALS*	59,000	1,700	9,700	1,900	800	3,000	10,300	1,700	28,500

* Figures are estimates and the totals are intentionally rounded to the nearest 100.

APPENDIX 3

DESCRIPTION OF FREQUENTLY USED PROJECT COMPONENTS

The following program components have been developed and put to use over the last eight years to meet HIV challenges.

Peer Educator HIV/AIDS Prevention Training

When a community agrees to confront HIV, community leaders are selected and participate in a week-long train-the-trainer training. They receive in-depth information on What HIV/AIDS is; How I Can Avoid HIV/AIDS; Practicing Safer Sex; Caring for those affected by HIV/AIDS and Leading the Community Response. (See the curriculum chart in Appendix 4.) Participants learn correct information and what they need to know to talk with other people. They learn about the importance of testing and care for those who are HIV+. They become the volunteer working group in the village to take leadership in educating and mobilizing the community. They are the skilled backbone of any project.

Prevention Awareness and Education. Misinformation is abroad in the streets and school yards. Information frequently comes to people on billboards or on the radio or word of mouth that is incomplete and often wrong. Prevention awareness that provides correct information and engages people in thinking about the choices that the information implies is essential to any prevention program.

Community Plan to Manage HIV

The peer educators and as many of the community and agencies as possible develop a plan using ICA planning methods to give guidance to the project for the next two years. Each develops a vision, problems with meeting that vision, strategies, and an action plan. The action plan is adjusted as needed. Additional planning occurs when new needs become apparent and new community decision and action is needed.

Voluntary Counseling and Testing (VCT) Campaigns have become central to prevention efforts because people who know their status are more likely to change behavior than those who don't. Testing provides information (if released by the client) to know who is infected and who is not. This information is needed to manage the impacts of the disease, including the need for antiretroviral treatment, home care, and reduction in stigma toward those with the disease. Mobile testing campaigns are used in villages with the cooperation of local trained health clinic personnel who come to the village from their clinics and test people recruited by peer educators. This cooperation has worked well for both the health personnel and for those who are reluctant to travel, often, miles, to be tested. There is now an example of door to door testing in Uganda.

Living Well with HIV/AIDS: Living Well is a positive self-management program, developed at Stanford University which has demonstrated significant results. It is a program for people with HIV which is conducted in 2_ hour sessions over seven weeks. It is facilitated by trained leaders who, like the participants are living with HIV. The program creates a support community among participants and equips them with the information and tools to deal with both the physical and

the emotional impact of the disease on their lives. Using weekly individual action planning and group problem-solving, participants gain the ability to cope with the challenges that the disease presents and make choices that result in a better health status and more productive lives.

Self Help Groups: Self Help Groups (SHG) are a central element of a system for addressing poverty and HIV/AIDS. The SHG program was developed by the German development organization, Kindernothilfe (Help for Children) which brought it to Africa from India. Key understandings of the system are: Self-help groups are made up of 15-20 members that meet weekly to share issues they face in their daily lives, discuss solutions, and pool their resources in a weekly discipline of savings, and group decision-making about how to invest the funds. The group members are given capacity building training to develop their individual and group skills and leadership qualities. Over time participants in self help groups develop a new identity. They soon realize that they are no longer alone; a new relationship of trust develops, overcoming the isolation that poverty imposes. Through the process of saving and applying the pooled resources to projects of their choice, they develop a new-found "can do" attitude toward tasks and they dare to develop goals through an economic development process.

Food Security and Improved Nutrition. In many countries poverty results in chronic malnutrition, particularly in the months right before harvest, when the last food supply has run out. And when food is available it may lack protein and vegetables. People who are living with HIV/AIDS need a secure food source and good nutrition to keep their immune system healthy and withstand the toll which treatment takes on the body. Farmer's groups to learn improved agricultural and storage methods assist this problem. Special programs for PLWHA and their families improve the variety of food available including animals like chicken and goats.

AIDS Treatment and Home Care. ICA projects do not directly provide treatment. They work closely with the health providers and assist PLWHA to access care. Projects have village members trained to provide home care. These are often peer educators with special training.

Youth Programs. Young people are a continuing challenge. Some have said that working with young people is like dealing with a different culture. But it is a population that is at risk because of lack of information, lifestyle, and peer pressure. A new cohort joins the target population every year. Project youth programs educate young people to educate their peers. It makes leaders of them. An ICA program called Youth as Facilitative Leaders has often been the basis for these trainings. Projects are in both informal setting like the youth corners in Zimbabwe and in a school setting like Nigeria.

All of these programs provide the opportunity for participation and dealing with the hazards of the disease in a direct way. Groups bring people together around common concerns and participants find themselves being leaders.

OVERVIEW OF WEEK'S TRAINING FOR COMMUNITY HIV/AIDS EDUCATORS

ICA African HIV/AIDS Prevention Initiative

Learning Objectives: 1) Know the basics of HIV prevention information; 2) know how to teach it to others; 3) know ways to help others decide to choose safe practices of behavior; 4) know the importance of their work.			Experiential Objectives: 1) Feel the teams of educators to be a strong core of community leaders prepared to assist the community to discuss and deal with HIV/AIDS; 2) feel well-prepared; 3) feel committed to lead the community to mobilize against HIV/AIDS		
Daily Schedule	Day 1 – What is HIV/AIDS?	Day 2 – How Can I Avoid HIV/AIDS?	Day 3 – Practicing Safer Sex	Day 4 – Caring for those affected by HIV/AIDS	Day 5 – Leading Community Response
Daily Objectives	Understand need for prevention and care for those who are sick. Learn basic mechanism of HIV. Experience telling info to others.	Know how HIV is spread. Know how to avoid the disease. Know how to practice safer sex. Feel able to teach others.	Know how to use a condom. Know women are at risk. Understand influence of community norms. Feel able to talk about lessons.	Know simple methods of home care and nutrition. Listening, most important part of counseling. Feel there are resources to help and hope to manage the disease.	Know expectations for the year. Present key messages. Feel confident and committed. Feel able to work as team
Opening context & conversation	Introductions Health and sickness in your community	Community attitudes about HIV/AIDS	Community customs and beliefs about courtship and marriage	What did you learn about the community? When did you or your family need help with a problem?	When did community work together to solve a problem?
Lessons	Lesson 1 – How shall we fight HIV/AIDS? Lesson 2 – What is HIV/AIDS?	Lesson 3 – What are the symptoms of HIV/AIDS? Lesson 4 – How is HIV spread? Lesson 5 – How can I avoid HIV/AIDS?	Lesson 6 – How can I practice safer sex? Lesson 7 Does safe sex conflict with common practice? Lesson 8 – Why are women at greater risk?	Lesson 9 - How does the HIV test work? Lesson 10 – How can I have HIV and live a healthy life? Lesson 11 – How can we care for someone with AIDS? Lesson 12 – What should a person with HIV/AIDS eat?	Lesson 13 – What medical treatment is available for HIV/AIDS? Lesson 14 – How can the community respond? Lesson 15 – Review: What have we learned?
Review and practice	Small group work to tell what was in lectures.	Small group work to tell what was in lectures.	Workshop Demonstration Barriers to safe sex	Role Play – groups create situations illustrating individual or family HIV/AIDS problems.	A Festival of Presentations – prepared by groups.
Whole group - Reporting and discussion	List 5 things each group knows about HIV/AIDS. List 5 things they must learn to answer people's expectations Review project expectations.	Small group demonstration of lecture to whole group. Conversation about teaching and learning; about experience of talking about safer sex. How teach this material?	Review data from workshop. Discuss how beliefs and customs influence choices. How to use this information in their work.	Reflect on plays. Counseling: listening and problem-solving.	Reflect on presentations – What makes effective presentation?
Lunch					
Workshops & practice	Making effective presentations to small groups The Discussion Method Listening	Making effective presentations to large groups Event planning	Field visit to see the community with new eyes. Practicing teaching Practicing team work Planning how to teach during the year.	Demonstration/practice home care, nutrition Workshop – nutritious menus	Preparing for Year's Work Certificate Celebration
Conversation and closing	Listening and learning Review of Day 1	Successful events Review of Day 2		What resources are available? Review of Day 4	What are your hopes for the project? Evaluation

APPENDIX 5

ICA METHODS

To some participants, it seems that the ICA methods work magic. They may not be magic, but they do have a way of coalescing a group's thinking and determination to carry out plans for the future. There are three elements that are hallmarks of many of the methods ICA uses: Participation, Connection/Consensus/ and finally Energy focused on Commitment to the Task.

PARTICIPATION

The methods that ICA uses generate great participation from everyone in the group. Often the methods do this by first suggesting that each individual do some thinking on their own. This allows both the quick thinkers and the careful thinkers to come up with responses to whatever question has been asked. Next the methods suggest some kind of pair or team brainstorming together. Finally the results of this brainstorming are shared through a group discussion during which some documentation occurs.

CONNECTION/CONSENSUS

Just stopping at participation rarely allows a group to move forward. Often there is so much information generated that a group can't really determine what the information is communicating. Beginning to see the emerging themes or the connections among the data helps the group to make sense of what has been shared. Even in a guided conversation, participants are making personal connections with events or stories being shared. Sometimes the emerging themes lead to a consensus or decision on a direction to take.

ENERGY—COMMITMENT TO THE TASK

When genuine participation has occurred and authentic connection or consensus has happened, there is a natural energy that emerges that can then be focused on the task at hand. In this way ICA methods can result in a deep commitment to the task at hand and the team responsibilities.

Underlying all of ICA methods, is the possibility of image change. Five fundamental beliefs underscore the possibility of image change. The first is that **everyone operates out of images**. In other words, everyone has internal images about themselves and the world. The second belief is that **images govern behavior**. Everyone's behavior is strongly influenced by these internal images. The third belief is that **messages shape images**. This suggests that various methods shaped and formed these images that finally govern behavior. The fourth belief is that **images can be changed**. Messages that beam a different image can alter these internal images. Finally, **shifted images change behavior**. People who have lived with the image that they are worth nothing can begin to see and believe they have gifts to offer. Communities who have lived helplessly can begin to grasp they have power to change their future. This is the heart of ICA methods.

R. Bruce Williams

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