Review Panel Report
2011 Cordaid HIV and AIDS Award
Linking community- and formal health and care services for people living with HIV

This report highlights the outcomes of the 2011 Cordaid HIV and AIDS Award, an award which is handed out to organisations showing vision, leadership and commitment in the field of HIV and AIDS. This year's focus is on the linking of community- and formal health and care services for people living with HIV.[1]

Cordaid received 263 valid nominations (182 nominations from Civil Society Organisations and 81 nominations from Faith Based Organisations). Most of them came from Africa (199) followed by Asia - excluding Central Asia (47), Europe and Central Asia (8), the America's (8) and the Middle East (1). Countries with the largest number of nominations submitted were Kenya (39), Uganda (33) and India (25).

An impressive number of nominations was received from numerous countries. Nominations were received from grassroots community based organisations, government related organisations, organisations managing health facilities, faith-based health networks and networks of people living with HIV. Many organisations represented key populations at higher risk of HIV exposure such as sex workers, men having sex with men, LGBT, people who inject drugs and prisoners. Obviously this years' theme was something many organisations could relate to.

The review process comprised of three review rounds. The 1st review round was carried out by 22 internal review members (266 nominations were each reviewed by at least 2 reviewers)[2], the 2nd round by 8 external review members (66 nominations were each reviewed by at least 2 reviewers) and the 3rd round by 1 internal and 7 external review members (12 nominations were each reviewed by 8 reviewers).

Review members were asked to assess the nominations based on whether the organisations:

- Displayed vision and leadership around linking community- and formal health and care services for people living with HIV;
- Provided evidence of substantial impact and/or success achieved in this field;
- Demonstrated innovative ways to strengthen linkages between community- and formal health and care services for people living with HIV;
- Demonstrated an active involvement of people affected and infected by HIV in programme development and implementation; and
- Considered sustainability (and scaling up) of their linking activities at local, national and/or regional levels.

The award winners are the two organisations – one Civil Society Organisation (CSO) and one Faith-Based Organisation (FBO) - which obtained the highest scores in the 3rd review round. These organisations are awarded € 10,000 each, funds which are to be used to further strengthen linkages between community- and formal health and care services for PLHIV. The awards will be handed out during the 15th "National

[1] Award topics in the previous years were: Faith-based Leadership in the Fight against AIDS (2008), Home Based Care for People Living with HIV (2009) and Sexual and Reproductive Rights of Women Living with HIV (2010).
[2] Two organisations were registered twice and one miscount.

Congress Soa*Hiv*Sex in Amsterdam, the Netherlands on World AIDS Day by the Dutch SRHR and Aids Ambassador, Marijke Wijnroks, on behalf of Cordaid and the Review Panel members.

Award Winner Category: Civil Society Organisations
Giramatsiko Post Test Club - Uganda

Giramatsiko Post Test Club is an outstanding example of a grassroots organisation of HIV-positive women who have managed to improve the position and well-being of PLHIV in general and women living with HIV in particular by combining their own strengths with those of others. Strong partnerships have been developed with formal health care providers, communities, local governments and churches, and other development organisations active in the region to be able to provide its members with the health and care services that they deserve and require.

The organisation was founded in 2002 by seven women who were HIV-positive and registered in 2003 as a Community Based Organisation (CBO). Membership has risen over the years to 490 HIV-positive women, the majority being widows and illiterate. The objectives of the organisation are to empower WLHIV with skills and knowledge for prevention, care, support and treatment for HIV, advocate for the rights of women living with HIV and their families and empower WLHIV with livelihood skills and expertise. The project is largely driven by volunteers and is essentially self-funded through successful income-generating activities. From sales of handcrafts, vegetables and piglets, members are able to keep their children in school and improve the quality of life.

Giramatsiko Post Test Club has established 17 Post Test Clubs in Kigarama, Kyangyenyi and Kagango sub counties and Kabewohe Town Council. These Clubs serve to educate and inform HIV-positive people on the importance of coming to terms with their status and disclosing their status so that they can live positive and healthy lives and can serve as role models for others. Club members also provide counselling as well as treatment and adherence support to those who are on medication.

A total of 84 HIV-positive Peer Educators have been trained and placed at health centres to assist health workers, resulting in increased manpower at these facilities and improved service delivery. The peer educators who serve as role models are part of the community and are therefore trusted intermediaries between those who require services and those who provide formal health and care services for PLHIV. They have referred thousands for Voluntary Counselling and Testing, Prevention of Mother to Child Transmission (PMTCT), TB/HIV screening and treatment, STIs screening and treatment and Sexual Reproductive Health and Rights including Family Planning. 514 people living with HIV are on ARV treatment thanks to referrals made by the peer educators.

Giramatsiko Post Test Club is a member driven organisation which continuously tries to respond to the needs and requirements of its members. A social health protection insurance scheme has been founded for its members to cater for emergent health needs. Likewise members themselves manage the distribution of scarce resources received, such as basic care packages. The selection of the beneficiaries, distribution of the items and monitoring of its use is done by the members themselves. The organisation has managed to scale-up its activities over the years due to strong partner relationships built and successes achieved.

Award Winner Category: Faith Based Organisations
Cambodian HIV/AIDS Education and Care (CHEC) – Cambodia

CHEC, formerly Quaker Services Australia, is an outstanding example of a capacity building organisation doing an important job in the field of HIV and AIDS prevention and mitigation with an impressive outreach record. It has been operational since 1994.

The organisation empowers communities and the general public to address HIV and AIDS, TB and STIs and to reduce stigma and discrimination against PLHIV and their families by providing counselling and support to them (for example psycho-social, spiritual, nutritional and economic support) as well as health education, mobilising communities and training village leaders, community health centre staff and village health volunteers. The organization operates in 7 districts[3] within Cambodia and has trained over 10,000 people.

CHEC has successfully linked community and formal health and care services for PLHIV through the establishment of Community Action Groups (CAGs), community Home Based Care (HBC) teams and Self Help Groups (SHGs) of PLHIV which closely collaborate with local health care services. The CAGs provide counselling as well as referrals for voluntary confidential counselling and testing (VCCT) and treatment while many PLHIV, orphaned and vulnerable children (OVC) receive drugs and support on a regular basis through the HBC teams. In 2009/ 2010, the CAG and HBC teams worked together with 73 government health centres to refer over 3.700 community members for VCCT, including more than 1.300 pregnant women. Moreover, the organisation provided transport support for over 300 HIV-infected persons so that they had access to antiretroviral treatment as well as treatment for opportunistic infections and diseases including TB.

The organisation has enhanced the capacities of government health staff in HIV and AIDS programming, supported the integration of HIV education into regular activities of Commune Councils, strengthened the collaboration between these councils and the CAGs as well as enabled local government officials and others to support and protect PLHIV and OVCs through improved policy and legislation and the channelling of resources to the communities. CHEC has strengthened community networks, mobilised community leadership and enhanced the capacities of HBC leaders, SHG leaders and PLHIV/ OVC care givers to engaging in discussions among others with formal health care providers through communication and advocacy training programmes.

CHEC actively involves PLHIV in the design, implementation and monitoring/evaluation of its programmes and activities through their participation in CAGs, HBC teams and SHGs. Moreover, the organisation is committed to develop long term sustainability of the programme by working closely with these community groups as well as the local health and care service providers to develop a sustainable exit strategy that will allow the program to continue in the long term. CHEC hopes to strengthen the CAGs, HBC teams and SHGs over the coming years to the point where they are able to become formal community based organisations that can raise funds and implement the programme independently of CHEC.

THE REVIEW PANEL CONGRATULATES THE TWO AWARD WINNING ORGANISATIONS!

[3] Sa Ang and Ta Khmao (Kandal Province), Kampong Tralach and Boribo (Kampong Chhnang Province), PreahSdach (Prey Veng Province), Chhouk (Kampot Province) and SreySanthor (Kampong Cham Province)

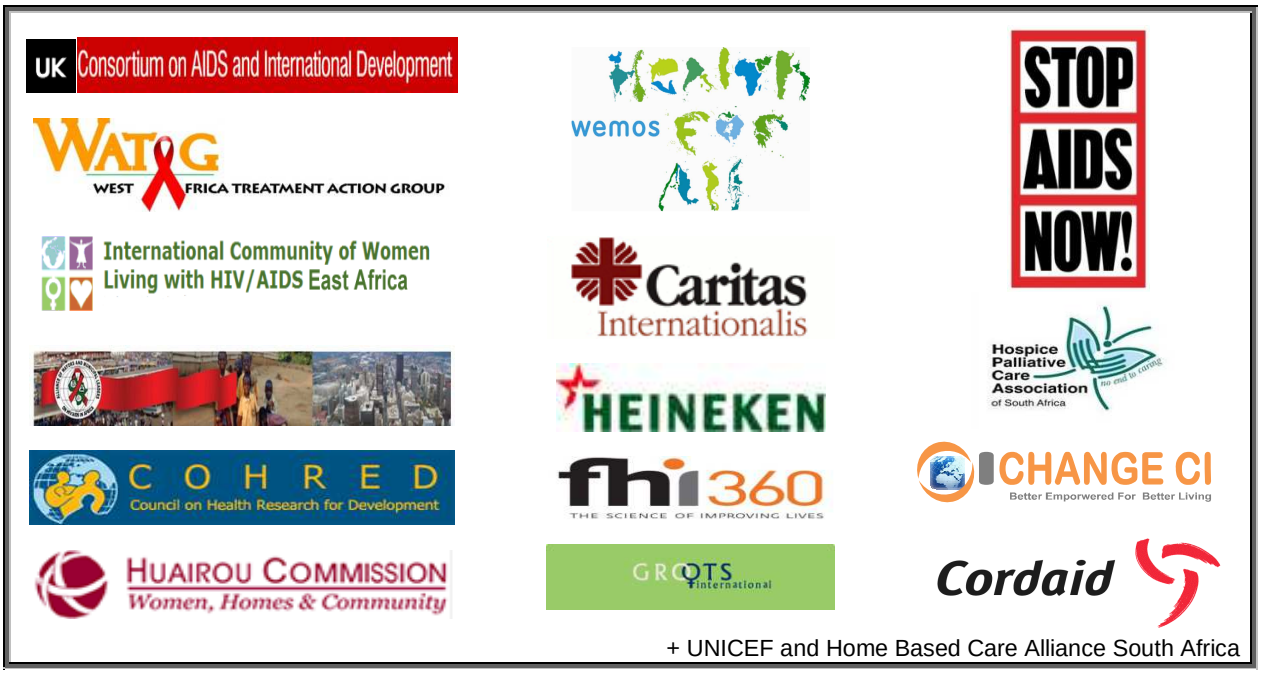
Trend analysis

Please refer to the annex for more detailed information on trends observed among the nominations received as well as the top 12 list of organisations nominated.

Acknowledgements

Cordaid thanks the large number of organisations which shared their valuable experiences in terms of linking community- and formal health and care services for PLHIV. The important work done by many of these organisations in this field should receive greater recognition. For more details, refer to the award website.[4]

Likewise, Cordaid thanks the many review panel members who were involved in the review process and contributed through their commitment to the outcome highlighted above; namely: Angela Make - Hospice and Palliative Care Association of South Africa; Becca Asaki - HuairouCommision/ GROOTS International; Ben Simms - UK Consortium on AIDS and International Development; Carel IJsselmuiden– COHRED; Caroline Brants – CaMaComaCoBrants Consultancy; Cyriaque Yapo Ako – ICHANGE CI; Emily Tjale - Home-Based Care Alliance South Africa; Henri van Eeghen + 21 Cordaid staff members - Cordaid; James Titus – AMICAALL; Kimberly Green – FHI 360; Kreeneshni Govender - UNAIDS; Lillian Mworeko - ICW Eastern Africa/Women & Families in Africa; Odette Salden and Jennifer Bushee – Stop AIDS Now!; Remco van de Pas – WEMOS; Robert J Vitillo - Caritas Internationalis; Stefaan Van der Borght – Heineken International; and Sylvère Bukiki – WATAG.



[4] http://www.cordaidpartners.com/groups/?address=hiv_and_aids_award@cordaid.

ANNEX
Trends analysis[5]

Linking community- and (semi) formal health and care services for PLHIV is a development strategy actively promoted by governments, development organisations, PLHIV networks and religious institutes to optimise the use of scarce resources, enhance the access of PLHIV to essential and quality services and promote the sharing of tasks and responsibilities in this field. While CSOs and FBOs strongly rely on and benefit from partnerships with (semi) formal health and care service providers for PLHIV, the opposite is also true.

Partnerships highlighted by community service providers

- **Partnerships with the government** including amongst others Ministries of Health, Ministries of Education and Ministries of Social Welfare, to: i) gain access to government schemes and resources such as National Treatment and Support Programmes and National Health Insurance Schemes, ii) make government programmes and activities more responsive to the needs of PLHIV and therefore more effective, iii) improve information sharing/ exchange with local and district level health sector representatives,[6] iv) ensure that responsibility is shared in terms of service delivery and resources are used to their maximum, v) ensure greater and meaningful participation of PLHIV in National HIV and TB response programmes, and vi) advocate for changes relating to health and care for PLHIV.

- **Partnerships with organisations/ institutions providing formal health- and care services for PLHIV** to: i) enhance the access of PLHIV to services provided by these organisations/ institutions and improve service delivery as community members - often PLHIV - are attached to health workers,[7]ii) reduce the costs of care for PLHIV by building the capacities of community members so that they can provide health and care services at the community level, iii) ensure regular information exchange between the providers and receivers of formal health and care services, and iv) promote accountability of service providers to the community.

- **Partnerships with likeminded non-profit organisations** such as global health organisations, (inter)national development organisations, other CSOs/ FBOs and networks to: i) gain access to resources (such as funding support, training support and information), ii) technical backstopping of programmes and activities, iii) capacity building of organisations as well as community health workers and peer educators, iv) strengthen the capacities of PLHIV to organize themselves in support groups as well as improve their livelihoods through, for example, income-generating activities,[8] saving programmes and/or insurance schemes, v) information exchange at community,

[5]The examples provided in this section have been obtained from the 12 highest scoring nominations (6 CSOs and 6 FBOs).
[6] ACE Africa (Kenya), for example, indicated that community health workers regularly complete information tools to capture individual health surveillance data on behalf of the Ministry of Health.
[7] Members of Giramatsiko Post Test Club (Uganda) serve as treatment and adherence supporters of PLHIV in the district. 84 WLHIV have been trained and placed as peer educators at Health Centres. These peer educators have been selected from the community, are HIV positive and role models. They provide referrals for services (such as Voluntary Counselling & Testing, Prevention of Mother to Child Transmission (PMTCT), TB/HIV screening and treatment, STIs screening and treatment) and inform clients on their Sexual Reproductive Health Rights.
[8]Giramatsiko Post Test Club (Uganda) started revolving income-generating activities with external funding. Up to-date members of 17 Post Test Clubs have managed to set up such activities. The process is lead and managed by WLHIV and the beneficiary

district, regional and national levels, vi) share resources e.g. for the development of IEC materials, vii) strengthen leadership and coordination mechanisms between service providers and service receivers, and viii) collectively advocate and lobby for change.

- **Partnerships with representatives of traditional care systems and other key actors active at the community level** to: i) support and strengthen existing community level cultural and traditional coping mechanisms which provide care and support to PLHIV,[9] ii) to improve access to health and care services for the infected and affected at the community level by supporting local actors such as Community Health Care Workers, Community Based Health Care Distributors, Community Pharmacies, Traditional Birth Attendants, Women and Youth Groups and Community level Health Committees, iii) attain greater recognition and support for programmes and activities implemented at the community level, thus making these programmes and activities more effective and sustainable and reducing the pressure on formal health and care services.

- **Partnerships with religious institutes** to: i) mobilise and sensitise large numbers of people and obtain wide support for health and care support activities for PLHIV, ii) offer health and care services to PLHIV - often in remote and hard to reach areas, iii) provide spiritual support to those affected and infected, iv) reduce the discrimination and stigmatisation of PLHIV[10] and v) build the capacities of a large cadre/ congregational response groups to respond appropriately to the epidemic and enable community members, including PLHIV, to make well-informed and voluntary decisions with regard to their reproductive and sexual health.

Remarkably very few organisations highlighted the importance of partnerships with formal profit organisations, for example, to reduce treatment costs and/or develop income-generating activities. This is a field of collaboration which still needs to be further explored by most organisations and provides room for further development.

Reasons for formal service providers to link with community service providers

As mentioned above, formal health and service providers also strongly depend on CSOs and FBOs when it comes to providing health and care services to PLHIV. They rely on and benefit from these organisations as they: i) mobilise and sensitise communities in general and vulnerable groups in particular on HIV, TB and STIs and fight stigma and discrimination within communities, ii) identify individuals who might be HIV/TB infected and make referrals, iii) directly interact with PLHIV and enhance their access to required services,[11] improve treatment adherence and track down defaulters, iv) reduce direct costs at

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determines which item she is interested in that suits her capacity and skills (ranging from cows, goats and piglets rearing to poultry and retail shops). This is aimed at improving the quality of life of women living with HIV and enables them to access health care services.

[9] Traditional Birth Attendants, for example, require information as well as knowledge, skills and resources to provide good care and support, particularly in areas where communities have little access to formal health and care services.

[10] AGREDS (Ghana) noted that one of the major challenges encountered by Faith Based Organisation in the past was how to elicit and mobilize faith communities and resources for HIV/AIDS interventions. This was partly because of the negative media representation of HIV/AIDS and more particularly due to the fact that the first HIV/AIDS cases diagnosed were often people who engaged in commercial sex. This has now been reduced through series of national programmes such as the "Compassion campaign" and active involvement of religious bodies in recent times. The (inter)national networks of religious leaders living with or personally affected by HIV and religious leaders openly expressing their support for those infected and affected has had a great positive impulse on reducing the stigmatisation and discrimination of PLHIV.

[11] PLHIV often relate much more comfortably with community health workers, in particular if they are peers, as opposed to government health officials. These community health workers provide home based care, conduct follow-up on clients, counsel on the importance of adhering to medication regimes and attending appointments at the health facilities, make referrals, track down defaulters, provide psychological support and nutritional support and assist PLHIV and their families to establish income-generating activities). For more information on this topic refer to documents published by Cordaid on home base care leadership/ Cordaid HIV and AIDS Award 2009.

health facilities through task sharing within the facilities and the transfer of health and care services for PLHIV to the community level, v) establish key community structures at the village level in support of PLHIV, vi) provide psycho-social-, medical- and nutritional support to those infected and affected, vii) enhance the knowledge and skills of PLHIV and empower PLHIV to create support groups or set up income-generating activities, and viii) collect data within communities,[12] report on the needs of those infected and affected and ensure that HIV programming is context specific and relevant.

Impact

The main impact of the existence of strong linkages between community and (semi) formal health and care services for PLHIV is an increased demand for and uptake of these services, thus resulting in an overall improved health and well-being of PLHIV and their families. Other major outcomes highlighted are reduced operational costs at (semi) formal health facilities, reduced congestion at in-patient facilities, reduced workload of formal health workers, reduced loss of clients through improved follow-up activities, increased treatment adherence, improved nutrition of HIV-positive persons, reduced stigma and discrimination of PLHIV and increased participation of beneficiaries and community stakeholders in decision-making processes relating to health and care services for PLHIV.

Main beneficiaries

People living with HIV and their families are the main beneficiaries of the mutual linkages established. They have greater access to health and care services for PLHIV due to: i) their greater knowledge and understanding of HIV as well as health and care services offered for PLHIV,[13]ii) increased opportunities for HIV and TB testing in particular in remote areas,[14]iii) increased service delivery at the community level by community health workers, iv) reduced stigmatisation and discrimination of PLHIV at the community level, v) improved service delivery systems due to a greater and more meaningful involvement of PLHIV in the design, implementation and monitoring/ evaluation of HIV and AIDS programmes and activities as well as lobby and advocacy activities, and vi) the empowerment of PLHIV and their families. PLHIV are in a better position to take care of their personal needs (e.g. nutritional needs, pay for medical bills and transportation to health facilities) and other needs because of their greater access to health and care services as well as support services (such as peer support groups and PLHIV networks, health insurance schemes, legal support and the provision of (revolving) funds for income-generating activities)[15] .

Other beneficiaries are:

- **Key populations at higher risk of HIV exposure** such as sex workers and their clients, men having sex with men, prisoners, people who inject drugs and seronegative partners in serodiscordant couples as they are in a better position to protect themselves and their partners from becoming HIV (re)infected and/or discover their HIV and TB status.

12For example, to determine whether formal health facilities provide the required range of services for PLHIV.
[13]Giramatsiko Post Test Club (Uganda) noted that the establishment of peer support groups can be seen as an investment in community systems strengthening for health and care services as PLHIV can take the lead in demanding for quality and accessible services. It enhances the principle of “nothing for us without us” a way of putting the beneficiaries of the services at the centre and ensuring value for money.
14 Many formal health facilities as well as CSOs and FBOs work with community outreach clinics and mobile HIV and TB testing facilities to reach remote communities.
[15]Brethren In Christ Church-Lobengula HIV Project (Zimbabwe), for example, supports income generating projects for support groups which are self-initiated and funded. For instance a candle making project which started with contributions of US $ 2 per member is currently supplying candles to local shops and the income generated is used by the members to sustain the families. The 105 men and women involved in this activity come together to make candles for sale, to share information on HIV as well as to inspire each other spiritually, thus linking livelihood and faith matters.

- **Volunteer home based care givers** who receive incentives to support their activities (such as financial support, medical kits and nutritional supplements) and/or enhance their skills and knowledge as well as receive greater recognition for the important work done.

- **Formal health workers** who operate in health facilities where tasks have been shifted to the community level, such as the mobilizing of clients, information sharing, referral making, conducting follow-up visits and the tracing-down of defaulters.[16]Increased community awareness also makes their work easier as stigma is reduced and clients are better informed.

- **Communities at large** since they have greater knowledge of and access to health and care services provided for PLHIV at the community level and district level and the overall improved health and well-being of PLHIV and their families.

A shifting focus within FBOs and CBOs providing health care and support services for PLHIV

Three obvious shifts can be observed, shifts which are generally also supported and promoted by donors/ funding agents:

Although many organisations still focus on HIV prevention, treatment and care a clear move can be observed towards an **increased focus on the empowerment of PLHIV, support for PLHIV leadership and the establishment/ strengthening of PLHIV support groups and networks**.[17] This can be ascribed to the improved health and well-being of PLHIV and their families as advances in antiretroviral therapy have transformed HIV infection from a deadly infection into a chronic illness. PLHIV can live a healthy and productive life, can support their families and take care of their personal and family needs and can effectively contribute to society.

Likewise, organisations increasingly support an **active and meaningful participation of PLHIV** in the design, implementation and monitoring/ evaluation of their HIV and AIDS programmes and activities.[18] Rational behind this development is to ensure that responsibility is shared with the target group, use of scarce resources is maximized and sustainability is promoted as PLHIV are actively involved programmes and activities which have a direct impact on their lives. Many organisations promote an active involvement of PLHIV at health clinics by providing them with the skills and knowledge to provide support services to PLHIV who come to the clinic. As a result, PLHIV are increasingly becoming an integral part of clinical care for PLHIV. Their tasks include the registration of new and returning PLHIV, providing sexuality education and information on HIV/TB counselling and testing, making referrals, offering nutritional supplements and basic medication, supporting treatment adherence, carrying out follow-up visits on clients who miss an appointment, the tracking down of defaulters, encouraging HIV positive pregnant

[16] For example, ACE Africa (Kenya) members who are community health workers provide counselling services at home and at community resource centres within health care facilities. They address issues such as sexuality education, HIV counselling and testing, distribute nutritional supplements as well as provide basic medication in partnership with the Ministry of Health and make referrals to Comprehensive Care Clinics and other health facilities for ARV and treatment.

[17] For example, in the case of Dhammayietra Mongkol Borei (Cambodia), a peer support group has encouraged the establishment of credit groups which have led to the development of a Network of PLHIV experts, i.e. someone who knows how to take care of his/her health and manage his/her disease effectively and who can pass these skills on to others. These experts assume responsibility for the PLHIVs in 2-8 villages in their immediate area. If there is a new PLHIV, someone beginning ART or someone missing an appointment, the support group calls upon the expert to make a home visits. Monthly meetings are held with the experts to ensure follow-up on their activities and to continue developing the knowledge, skills and role of these persons.

[18] ACE Africa (Kenya), for example, engages PLWA in prevention activities as well as care and support activities and programme design, implementation and evaluation. Through positive examples of improved health and wellbeing more community members are willing to access services. Through greater empowerment, PLWA are actively involved in the production of nutritious vegetables, (gardens) nutritious supplements (soya, amaranthe production) protein and other food sources (e.g. dairy goats, fish production).

women to deliver at a hospital and the linking of PLHIV to peer support groups.[19] PLHIV generally feel more at ease to discuss their conditions and problems with peers rather than government health officials.

Finally, many organisations focus on **HIV and TB** in order to provide an adequate response to the HIV epidemic as increasing numbers of HIV individuals are TB-HIV co-infected. TB is a leading cause of death among people who are HIV-positive as HIV weakens the immune system. Someone who is HIV-positive and infected with TB is more likely to develop active TB than someone infected with TB but not infected with HIV.

Sustaining the linkages built

The continuation of programmes and activities implemented by organisations in the field of service provision for PLHIV strongly depends on the relationships and partnerships established with formal health-care facilities and providers, (non)-governmental organisations, faith based institutions, communities and direct beneficiaries. Organisations try to strengthen and sustain these linkages by: i)supporting local ownership of programmes and activities, ii) not seeking to substitute existing structures but rather strengthen these structures,[20] iii) developing activities which are easy to adopt and do not require a lot of resources to run, iv) strengthening the capacities of communities,[21] groups as well as key persons to manage programmes and activities providing quality health and care services for PLHIV,[22] v) strengthening the involvement of primary beneficiaries in the design, planning, implementation and monitoring and evaluation of service provision, by recognising the importance of community level health and care services in overall health and care structures, vi) sharing information on a regular basis (for example through meetings, newsletters, progress reports, press releases, radio programmes etc.), vii) empowering PLHIV and vulnerable groups to stand up for their right to quality health and care services, and viii) advocating and lobbying for change if linkages are not functioning as they should, e.g. PLHIV are hindered to acquire health and care services.

Challenges encountered

The challenges highlighted by the nominated organisations in terms of maintaining and strengthening the linkages built are predominantly resources related. Many organisations noted that they had insufficient financial resources for support and care activities in extremely remote or difficult to access areas; to adequately build the capacities of communities and individuals to manage programmes and activities providing quality health and care services for PLHIV as well as for organisational strengthening. Others referred to the high levels of staff turnover in particular within the government sector and partner organisations; difficulties to hold on to community health workers who are an important link in the chain as

[19]Giramatsiko Post Test Club (Uganda), for example, has trained and posted 84 WLHIV at Health Centres. They were selected from the community, are HIV positive and role models. This has enhanced the principle of Meaningful involvement of people living with HIV and empowered these women

[20] MANERELA+ (Malawi), for example, has trained members from the HIV support groups, young adults and religious leaders in various HIV thematic areas including: advocacy, capacity building, treatment adherence and livelihoods. These will continue to mobilise other people within their communities to support HIV programmes. In addition, the existing local structures are directly linked to the government health structures operating from within their communities. This means that the communities will continue get all the needed support from the government field staff including those from the district for all their HIV and AIDS programs.

[21]Through an empowered community, MANERELA+ (Malawi) hopes that the voices of marginalized and vulnerable people will be heard and that this will lead to improved service delivery.

[22] The ACE Africa (Kenya) 10 year programme is a rights based approach towards service delivery including social mobilization (for participation) and lobbying and advocacy at local, district and national level (for policy change) thereby aligning activities within existing national and international guidelines. Divided into three phases with a clear exit strategy; phase one involves the identification of need, systems of support and gaps in service provision, the establishment of support groups, training and direct aid, phase two involves increasing beneficiary reach through building capacity of groups and partners and phase three, further capacity building of groups, government and partner networks.

they generally work on a voluntary basis and receive little or no incentives for the hard work often done;[23] overburdened, demotivated and discriminating formal health workers; and inadequate access to information, education and communication materials by health workers for their own use and/or distribution purposes. Finally, a number of organisations mentioned challenges such as the changing focus of donor programmes, a lacking involvement of clients in health and care service delivery systems and difficulties in transferring full responsibility to peer support groups, networks and community based organisations.[24]

Innovations/ best practices

Numerous innovations/ best practices were presented by the nominated organisations relating to the linking of community- and formal health and care services providers for PLHIV. A number of these innovations have been highlighted below.

Prevention, treatment and care	
Serving remote and hard-to-reach areas	**Bwindi Community Hospital (Uganda)** operates in an area where most patients travel more than 50km through the forest and hills to access care. Therefore, the hospital opened outreach clinics in specific places selected by community members to increase accessibility for services. About 75% of its clients are now treated at community outreach clinics where patients are met for appointments. A mobile CD4 machine was also acquired, which provides results right in the community. The team for each outreach is comprised of a clinician, a laboratory technician, nurses, counsellors and records assistants.
	The **Archdiocese of Tororo, HIV/AIDS Focal Point (Uganda)** operates on the basis of faith-based structures which are located in areas considered to be remote and hard to reach, hence bridging a critical gap in HIV/TB service delivery.
VCT plus Model	VCT sites are complemented by HIV care clinics where people who test positive are ensured referral and entry to treatment and care. **Liverpool VCT, Care and Treatment (Kenya)** has been able to ensure referral and entry to treatment and care of 97% people who test HIV positive in these model sites. Three of such sites have been established.
Tools to identify challenges faced by PLHIV	**MANRELA+ (Malawi)** use score cards to help orientate religious leaders and communities on challenges faced by people living with HIV AIDS; this tool actively involves communities, religious leaders and service providers in identifying and discussing the gaps in accessibility and availability of services and enhances ownership and promotes accountability of service providers to the community.
Referral and tracking system	**Hope Community VCT (Kenya)** has developed a comprehensive referral and tracking system. Client's contacts and demographic information are collected and are recorded once they test positive. The counsellors thereafter call the clients to confirm whether they went for care and treatment in the places where they were referred to. Positive clients who may have screened as susceptible for sexually transmitted Infections, addictions to drugs and substances and tuberculosis are also referred and tracked. The organization has come up with a comprehensive referral directory for referral for care and treatment. The directory has contacts for both government of Kenya and privately owned facilities. For the clients who may not be reached by telephone, they are traced by visiting them at their physical addresses. The organization also partners with the referral health facilities to ensure that the clients who are referred there get the help that they need and if there are any challenges then the organization is able to come in and assist in any way possible. An end month report on this activity is always written down to assess the effectiveness. The referral system includes referral for free voluntary medical male circumcision.

[23] ACE Africa (Kenya) noted that there is need to factor in incentives for the Community Health Workers including stipends, continuous training and supportive supervision. The organisation has engaged and sustained community volunteers, many of whom are PLHIV, in service provision through the benefits that they gain from increased food and economic security.

[24] Currently Dhammayietra Mongkol Borei (Cambodia) funds the peer support group (MMM) as a partner. They manage their budget and activities. The MMM assuming full management responsibility has been and remains a challenge. Mongkol Borei is a rural district and finding PLHIVs with prior experience is difficult. Tasks, such as keeping accounts or collecting statistics, are learned but vision and broad oversight are more difficult to instil. The dream is for the CBO Board of Directors to assume responsibility for the MMM and PE Network and that the MMM be funded separately from DYMB. There are Board members with potential and realizing this is the awaiting challenge.

Purchase of essential drugs	The expansion of the National Essential Drugs List, something that has strongly been advocated amongst others by **ACE Africa (Kenya)**, has enabled the organisation to purchase essential drugs for distribution at health facilities, therefore increasing the access of PLHIV to essential Drugs (National Drug Policy 2008.)

Support Schemes	
Community health membership scheme	The 'eQuality' health membership scheme is an innovative partnership between **Bwindi Community Hospital (Uganda)** and International Medical Group (the leading provider of private medical services in Uganda) to help the people of the Bwindi area access quality and affordable health services. All members of the Bwindi community have the chance to 'subscribe' to this scheme by making a single annual payment of UGX 6000 ($3) per person which entitles them to use Hospital Outpatient and Inpatient services including investigations, drugs and even operations at a cost of only UGX 1000 (0,40 US $) per visit. This scheme enables people to pay for health care collectively and in advance, instead of waiting until they become sick and fearing the cost of care. It protects the poor, and enables them to have some control over their health care. It also maintains high quality services for the people of the Bwindi area for the future.
Social protection insurance scheme for PLHIV	Likewise, but on a much smaller scale **Giramatsiko Post Test Club (Uganda)** has supported the creation of a social protection insurance by women living with HIV - they contribute 500 Uganda Shillings regularly to cater for emergent health needs of the most needy amongst the needy. By doing so, these women have greater access to formal health and care services provided, e.g. because they can pay the transportation costs to health clinics/ hospitals.
Community saving groups	**CHEC (Cambodia)** has developed 22 Self Help Groups of PLHIV who meet on a monthly basis, provide social support to each other and save money collectively which can then be used to give loans to individual group members to cover emergency expenses or expand livelihood activities.
Legal support	**The Brethren In Christ Church -Lobengula HIV project (Zimbabwe)** has helped children acquire essential documents such as birth certificates and death certificates of deceased parents as well as helped children reclaim their inheritances from greed relatives. The same project successfully reclaimed together with Habakkuk Trust a municipality owned local clinic that had for years been rented out to private doctors at the expense of the local community. The opening of this clinic for the community meant that members no longer needed to travel the 10-15 km to access health services including TB treatment and ARVs.

Capacity building	
Changing the role of PLHIV	**Dhammayietra Mongkol Borei - DYMB (Cambodia)** has managed to change the role of PLHIV providing peer support at clinics to become more meaningful and recognized. Whereas in the past the only role of peer members was to facilitate a large monthly self-help group meeting, the national model has changed and now runs parallel to the peer support group concept established by DYMB in Mongkol Borei with paid peer support staff carrying out a wide variety of important activities and smaller self-help groups throughout the communities.
	Giramatsiko Post Test Club has trained and placed 84 peer educators at health centres to assist formal health workers at these centres. They are selected from the community, are HIV positive and are role models. This approach supports the principle of a meaningful involvement of PLHIV, leads to increased manpower at health facilities and improves service provision for PLHIV.
Families Matter Programme	The programme which is implemented by **Hope Community VCT (Kenya)** is useful in ensuring that parents who are living with HIV get to learn how to communicate to their children about their status and advise them on how they can protect themselves from becoming HIV infected.
Establishment of networks/ organisations	**Hope Community VCT (Kenya)** has managed to establish a network of 21 organizations and facilities within Dagoretti District where clients are referred to and later tracking is done.
	DYMB (Cambodia) has supported a process where a peer support group, self-help groups and credit groups have come together to form a community-based organization. Members elected a Board of Directors in March this year. All Board members are PLHIVs.
Strengthening of PLHIV associations	**AGREDS (Ghana)** facilitates and provides funding and capacity building support in the establishment and management of Associations of PLHIV in Ghana. The formation of these associations now enable PLHIV to have access to formal health care services such as drugs, nutritional and other supplements as well as benefit in most HIV/AIDS interventions initiatives across the country.
Mainstreaming of HIV/AIDS into Church programmes	**AGREDS (Ghana)** managed to design and mainstream HIV/AIDS into the Assemblies of God churches programme with the support of other organisations. Regional Response teams have been established which develop annual work plans that help local congregations, community members and leaders to address HIV in families, communities and local churches and act as the first referral point of linking PLHIV to communities and formal health and care service providers.

Access to information	
Community theatre/ drama	**SAGETA** (**Tanzania)** uses participatory community theatre to reach out to fishing communities in each of the 38 islands covered by the organisation. Trained theatre artists mix songs and drama with HIV prevention messages, share information on available health services provided for PLHIV at the Care and Treatment Centre of the District Hospital and promote the importance of early HIV testing and treatment.
Resource centres	**AGREDS (Ghana)** has established regional resource centres in all 10 geographical regions of Ghana which offer Christians and Community members' appropriate visual, audio and printed up-to-date information on HIV/AIDS prevention, care and support.
Information officer	**Hope Community VCT (Kenya)** has a community liaison officer who works closely with trained community health workers who ensure that the community is conversant with the current HIV and AIDS treatment updates and that they can access them. S/he acts as the reference point for the community. S/he ensures that the community gains access to health services that they may not have known of before and thus creates a demand for these services.

Sustainability	
Engaging and sustaining community volunteers	**ACE Africa (Kenya)** works with 4,000 community volunteers. The volunteers are committed and able to provide and sustain support in their households and to the wider community as they too benefit from the support services offered (e.g. are also involved in food production and nutrition based income generating activities) .
Establishment of community action groups	After community education training, **CHEC (Cambodia)** helps facilitate the formation of Community Action Groups (CAGs). These groups include representatives from the community who have strong links to the formal health care services in the area. Their role is to work with the health centres and referral hospitals to ensure community members receive the counselling, referrals, and HIV education they need. The CAGs also work to reduce discrimination against PLHIV, and to educate community members and refer them to voluntary confidential counselling and testing (VCCT).
Building strong relationships and partnerships	**Giramatsiko Post Test Club (Uganda)** was formed on the basis of voluntarism and most of the activities have been carried out neither with funding nor external support. The organisation had established strong relationships and partnerships with health-care facilities and providers, Faith Based Institutions, the Community and beneficiaries.

Conclusion

The nominations received have highlighted the importance of linking community- and (semi)formal health and care services for PLHIV. If done appropriately and in a sustainable manner, this development strategy can generate a positive drive towards improved community care, will contribute to achieving MDGs and other goals related to the inclusion, empowerment and mainstreaming of vulnerable groups as well as their participation in economic programs and conflict transformation.

Cordaid believes that civil society- and faith based organisations alike have a crucial role to play in the building of strong foundations for the provision of community- and formal health and care services for PLHIV. However, caution should be taken that the responsibility and task-sharing shift towards communities does not become a major burden for communities and in particular women who are generally the main care takers in society. Voluntary community health workers and home based care should not be considered a cheap alternative to formal health care but should rather receive recognition and compensation for the important work done.

Top 12 list of organisations nominated

2011 CORDAID HIV AND AIDS AWARD			
	Name Organisation	**Country**	**Average score**
CSO			
1	Giramatsiko Post Test Club	Uganda	24,4
2	Liverpool VCT, Care and Treatment (LVCT)	Kenya	22,7
3	Dhammayietra Mongkol Borei	Cambodia	21,1
4	Bwindi Community Hospital	Uganda	20,0
5	ACE Africa	Kenya	19,5
6	SAGETA – Save Your Generation Tanzania	Tanzania	16,1
FBO			
1	CHEC - Cambodian HIV/AIDS Education and Care	Cambodia	21,1
2	Archdiocese of Tororo, HIV/AIDS Focal Point	Uganda	19,2
3	Brethren In Christ Church-Lobengula HIV Project	Zimbabwe	18,2
4	AGREDS Ghana - Assemblies of God Relief and Development Services	Ghana	17,7
5	Hope Community VCT	Kenya	17,5
6	MANERELA+	Malawi	16,1