ACTION FOR WEST AFRICA REGION
aware
HIV/AIDS

PROMISING AND BEST PRACTICES IN HIV/AIDS PREVENTION AND CARE FOR WEST AND CENTRAL AFRICA

USAID
FROM THE AMERICAN PEOPLE

fhi Family Health International

Futures GROUP

PROMISING AND BEST PRACTICES IN STI/HIV/AIDS PREVENTION AND CARE IN WEST AND CENTRAL AFRICA

AWARE-HIV/AIDS

This publication was made possible through the support of the United States President's Emergency Plan for AIDS Relief through USAID under the Cooperation Agreement 688-A-00-03-00066-00 with Family Health International (FHI). The opinions expressed herein are those of the authors and do not necessarily reflect the views of FHI or USAID.

ACKNOWLEDGEMENTS

The AWARE-HIV/AIDS Project team wishes to express its sincere gratitude to the following for their cooperation and contribution: West Africa Health Organization (WAHO), National AIDS Control Councils and Programs of Benin, Burkina Faso, Cameroon, Cape Verde, Chad, Côte d'Ivoire, The Gambia, Ghana, Guinea, Guinea Bissau, Liberia, Mali, Mauritania, Niger, Nigeria, Senegal, Sierra Leone and Togo, the World Health Organization (WHO), UNAIDS and Advance Africa.

We would also like to thank all those who have contributed to the success of the process for selecting and documenting promising and best practices. A special thanks goes to the task force members, leaders of organizations/institutions that initiated the selected experiences, and colleagues from Family Health International in Arlington and The Futures Group International in Washington.

This document is the result of excellent collaboration between Family Health International (FHI) and its different partners: The Futures Group International, Population Services International, Care and Health Program, Bureau d'Appui en Santé Publique'96, John Hopkins Program for Information and Education of Gynecologists and Obstetricians, Centre Hospitalier Universitaire de Sherbrooke and Centre Hospitalier Affilié à l'Université de Québec.

We hope that these selected and documented experiences, will serve as a source of inspiration for some to initiate similar interventions in their setting and for others to improve and strengthen ongoing interventions.

PREFACE

Sub-Saharan Africa is the region most affected by the HIV/AIDS pandemic. Indeed, the region alone accounts for about two thirds of the People Living with HIV/AIDS (PLHA) in the world. Though, the West African Region does not have as high a prevalence as part of sub-Saharan Africa, factors such as political instability, armed conflicts, mobility of people, and poverty often result in situations that encourage high risk behaviors and expose individuals to HIV. Therefore, to avoid an explosion of the epidemic, the West Africa Region must benefit from substantial support in order to intensify and scale up HIV/AIDS prevention and care treatment interventions. In view of this, it is critical to stimulate and maintain the political commitment of leaders at all levels of society in order to intensify prevention activities and ensure access to treatment. In response to this critical need in the region, USAID through its AWARE-HIV/AIDS project has as one of its key strategies, the facilitation of the exchange of experiences between countries through the identification, dissemination, and support for the replication of successful interventions in the fight against HIV/AIDS.

The prevention of new infections and the care and support of people infected and/or affected by HIV/AIDS are crucial strategies in the response to the pandemic as stipulated in the declaration of commitment of countries during the United Nations Special Session on AIDS in 2001. These strategies are also the pillars of recently launched important initiatives such as the Global Fund on AIDS, Tuberculosis and Malaria, the President's Emergency Plan for AIDS Relief of the Government of the United States of America, and the "3 by 5" initiative. The achievement of such commitments and initiatives requires the following: 1) the creation and the maintenance of a favorable policy environment for HIV/AIDS interventions, 2) the intensification of prevention activities, especially through behavior change communication 3) the optimal management of traditional sexually transmitted infections, 4) the improvement of access to HIV counseling and testing, 5) the strengthening of prevention of mother-to-child transmission (PMTCT) of HIV, 6) the improvement of the accessibility of care and treatment for PLHA, and 7) the strengthening of community response.

The selected experiences described in this collection cover the technical areas cited above and each demonstrate particular aspects that make them Promising and Best Practices (PBP), capable of stimulating the development of new approaches and adding value to initiatives which are already in progress.

Considering the negative impact of HIV/AIDS on populations and the development of countries, and the urgency of mounting an effective response, it is imperative that those involved in the fight against HIV/AIDS have access to this collection of Promising and Best Practices (PBP). Its use will help us gain time in our response to the pandemic by drawing inspiration from successful experiences in other countries.

_____

Jatinder Cheema, Ph.D
Director,
USAID/WARP

TABLE OF CONTENTS

LIST OF ACRONYMS AND ABBREVIATIONS ---------- 6

LIST OF TABLES ---------- 9

INTRODUCTION ---------- 10

ADVOCACY FOR POLICY CHANGE ---------- 13

ADAPTATION AND ADOPTION OF THE LAW ON HIV/AIDS IN BENIN ---------- 14

THE EXPERIENCE OF RELIGIOUS NETWORKS IN COMBATING HIV/AIDS IN MALI ---------- 18

BEHAVIOR CHANGE COMMUNICATION ---------- 24

COMMUNICATION FOR BEHAVIORAL CHANGE IN SEX WORKERS FOR THE PREVENTION AND MANAGEMENT OF STI/HIV/AIDS ON MIGRATORY ROUTES IN TOGO: "SISTER-TO-SISTER" PROJECT ---------- 25

APPENDIX ---------- 31

BEHAVIOR CHANGE COMMUNICATION (BCC) TASK FORCE ---------- 32

SEXUALLY TRANSMITTED INFECTIONS ---------- 33

"ADAPTED SERVICES" FOR SEX WORKERS AND THEIR SEXUAL PARTNERS: A STRATEGY TO REDUCE THE TRANSMISSION AND MINIMIZE THE PREVALENCE OF STI/HIV/AIDS ---------- 34

APPENDIX ---------- 42

SEXUALLY TRANSMITTED INFECTIONS (STI) TASK FORCE ---------- 43

PREVENTION OF MOTHER-TO-CHILD TRANSMISSION ---------- 44

RAPID SCALING-UP OF PREVENTION OF MOTHER-TO-CHILD HIV TRANSMISSION (PMTCT) IN RURAL AREAS IN CAMEROON ---------- 45

INTEGRATION OF PMTCT INTO PRE-SERVICE TRAINING CURRICULA OF NATIONAL TRAINING INSTITUTIONS IN CÔTE D'IVOIRE ---------- 55

APPENDIX ---------- 63

PREVENTION OF MOTHER-TO-CHILD TRANSMISSION (PMTCT) TASK FORCE ---------- 64

VOLUNTARY COUNSELING AND TESTING FOR HIV ---------- 65

STRENGTHENING ACCESS TO VOLUNTARY COUNSELING AND TESTING FOR YOUNG STUDENTS IN BURKINA FASO ---------- 66

APPENDIX ---------- 72

VOLUNTARY COUNSELING AND TESTING (VCT) TASK FORCE ---------- 73

CARE AND TREATMENT FOR HIV/AIDS ---------- 74

CARE FOR PEOPLE LIVING WITH HIV THROUGH A "MEDICO SOCIAL ASSISTANCE CENTER" (PROJECT CASM), CÔTE D'IVOIRE ---------- 75

DECENTRALIZATION OF ACCESS TO ANTIRETROVIRAL DRUGS IN THE CLINICAL MANAGEMENT OF PEOPLE LIVING WITH HIV/AIDS IN SENEGAL ---------- 84
INTRODUCING COMPREHENSIVE HIV CLINICAL CARE IN A DISTRICT HOSPITAL SETTING: THE ROLE OF DISCLOSURE AND TREATMENT MONITORS IN ENSURING HIGH ADHERENCE – EXPERIENCES FROM MANYA KROBO DISTRICT, GHANA ---------- 94

APPENDIX ---------- **103**
CARE AND TREATMENT TASK FORCE ---------- 104

COMMUNITY FINANCING MODELS IN COMBATING HIV/AIDS ---------- **105**
UNION OF COMMUNAL MUTUAL HEALTH INSURERS OF BEMBÈRÈKÈ (UCMSB) IN BENIN ---------- 106
"THE TANTINES": A NOVEL EXPERIENCE IN THE REPRODUCTIVE HEALTH OF ADOLESCENTS AND THE FIGHT AGAINST HIV/AIDS IN CAMEROON ---------- 116
DEVELOPMENT OF INCOME GENERATING ACTIVITIES WITHIN AN ASSOCIATION OF PLHA: THE CASE OF HIRASSO IN CAMEROON ---------- 124
MUTUAL HEALTH INSURANCE PLAN BY "UNACOIS" IN SENEGAL ---------- 130
"MICRO-CREDIT" OF THE ASSOCIATION "ESPOIR 27" OF KOUMRA IN CHAD ---------- 137
CENTER FOR INFORMATION, COUNSELING, CARE AND SUPPORT FOR PEOPLE LIVING WITH HIV/AIDS (CESAC) IN MALI ---------- 141
NETWORK OF ASSOCIATIONS OF PEOPLE LIVING WITH HIV IN TOGO (RAS+TOGO) ---------- 149
RISK-SHARING EXPERIENCES IN THE INSURANCE PLANS OF NKORANZA AND DANGME IN GHANA ---------- 155
NATIONAL HEALTH INSURANCE SCHEME: THE GHANAIAN EXPERIENCE ---------- 163

EXPERIENCES TAKEN FROM THE BEST PRACTICES COLLECTION OF UNAIDS ---------- **171**
BEHAVIOR CHANGE COMMUNICATION ---------- 172
PREVENTION AND MANAGEMENT OF SEXUALLY TRANSMITTED INFECTIONS ---------- 173
VOLUNTARY COUNSELING AND TESTING FOR HIV ---------- 174
CARE AND TREATMENT FOR HIV/AIDS ---------- 175

LIST OF ACRONYMS AND ABBREVIATIONS

AFAS	:	Women's Association for Assistance and Support for Widows and Orphans of HIV/AIDS (Association Féminine d'Aide et de Soutien aux veuves et orphelins du VIH/SIDA)
AFSC	:	African Family Study Center
AIDS	:	Acquired Immune Deficiency Syndrome
AIM	:	AIDS Impact Model
AIPEF	:	Islamic Association for Progress and fulfilment of the Family (Association Islamique pour le Progrès et l'Epanouissement de la Famille)
AMAS	:	(Association Malienne d'Aide et de Soutien aux PVVIH) Malian Association for Assistance and Support for PLHA
AMN	:	National Health Insurance Policy
AMUPI	:	Malian Association for Islamic Unity and Progress (Association Malienne pour l'Unité et le Progrès de l'Islam)
ARCAD/SIDA	:	Association for Research, Communication and Home Support of People Living with HIV/AIDS (Association de Recherche de Communication et d'Accompagnement à Domicile des Personnes vivant avec le VIH/SIDA)
ARV	:	Anti retroviral drugs
ATC	:	Approved Treatment Center
AWARE	:	Action for West Africa Region
BHAPP	:	Benin HIV/AIDS Prevention Program
BHS	:	Bank for Housing of Senegal
WB	:	World Bank
BA	:	Board of Directors
BCC	:	Behavior Change Communication
CBCHB	:	Cameroon Baptist Convention Health Board
CEFA	:	Study Center for the African Family
CESAC	:	Center for Information, Counseling, Care and Support for People Living with HIV/AIDS
CHU	:	Teaching Hospital
CHU FANN	:	FANN Teaching Hospital
COGEA	:	Management Committee for Health Centers in Administrative Districts
CPN	:	Pre-natal Consultation
CTG	:	Central Technical Group
DMHIS	:	District Mutual Health Insurance Scheme
DYNA	:	DYNA Enterprise (Specializing in Loans)
EB	:	Executive Board
EGD	:	Essential and Generic Drugs
EGPAF	:	Elizabeth Glaser Pediatric AIDS Foundation
EU	:	European Union

FAAPPD	:	African and Arab Forum of Parliamentarians for Population and Development
FCFA	:	The Franc CFA: Currency of the Francophone African Community
IGA	:	Income Generating Activities
IMF	:	International Monetary Fund
FNPJ	:	National Fund for the Advancement of the Youth
GA	:	General Assembly
GAC	:	Ghana AIDS Commission
GED	:	Gender and Development
GTZ	:	German Technical Co-operation
HGT	:	Gabriel Touré Hospital
HIRASSO	:	Hope is Rising Association
HIS	:	Health Insurance Scheme
HIV	:	Human Immuno Deficiency Virus
IEC	:	Information, Education, and Communication
IMAARV	:	Malian Institute for Access to Antiretroviral
ISAARV	:	Senegalese Initiative for Access to Antiretroviral
JHPIEGO	:	John Hopkins Program of Information and Education for Gynecologists and Obstetricians
KI	:	Kilimandjaro Institute
LIMAMA	:	Islamic League of Imams and Schools in Mali
M&E	:	Monitoring and Evaluation
MACP	:	Multi-sectorial AIDS Control Program
MAMC	:	Commercial Mutual Health Insurance
MAMD	:	District-Based Mutual Health Insurance
MAMP	:	Private Mutual Health Insurance
MHO	:	Mutual Health Organization
MPH	:	Ministry of Public Health
NACP	:	National AIDS Control Program
NAP+	:	African Network of People Living with HIV/AIDS
NGO	:	Non Governmental Organization
NHIS	:	National Health Insurance Scheme
OI	:	Opportunistic Infections
OVC	:	Orphans and Vulnerable Children
PAMAC	:	Global Community Support Program
PCR	:	Polymerase Chain Reaction
PEC	:	Care and support
PLHA	:	People Living with HIV/AIDS
PMTCT	:	Preventing of Mother to Child Transmission of HIV
PROMUSAF	:	Support Program for Mutual Health Insurance in Africa

PSAMAO/AC	:	Prevention of HIV/AIDS on West and Central Africa migratory routes
PSI	:	Population Services International
PTG	:	Provincial Technical Group
SC	:	Supervisory Committee
STD	:	Sexually Transmitted Disease
STI	:	Sexually Transmitted Infections
RéCAP	:	Cameroonian Network of Associations of People Living with HIV
RETROCI	:	Côte d'Ivoire Retrovirus Project
RHYA	:	Reproductive Health of Young Adolescents
RNAM	:	National Regime of Health Insurers
RNILS	:	National Islamic Network for Combating AIDS
ROASTO	:	Network of NGOs and Associations of People Living with HIV
RPUA	:	Recognized Public Utility Association
SA	:	Sexually Transmitted Infection Services for Sex workers
SFPS	:	Family Health and AIDS Prevention
SW	:	Sex Worker
SWLH	:	Sex Workers Living with HIV
SWOT	:	Successes, Weaknesses, Opportunities and Threats
TBA	:	Traditional Birth Attendant
UNAIDS	:	Joint United Nations Program on HIV/AIDS
UNDP	:	United Nations Development Program
UNFPA	:	United Nations Population Fund
UNICEF	:	United Nations Children's Education Fund
USAID	:	United States Agency for International Development
VCT	:	Voluntary Counseling and Testing
WAEMU	:	West Africa Economic and Monetary Union
WAHO	:	West African Health Organization
WHO	:	World Health Organization

LIST OF TABLES

Table No. 1	:	Evolution of the practice of UCMSB from 2002 to 2004
Table No. 2	:	Strengths of the practice of UCMSB in Combating AIDS
Table No. 3	:	Weaknesses of the practice of UCMSB in Combating AIDS
Table No. 4	:	Situation of the Tantines in October 2000
Table No. 5	:	Table of the Situation of the Tantines at the end of 2003
Table No. 6	:	SWOT Table of Tantine Projects
Table No. 7	:	Activities carried out by beneficiaries of the tontine.
Table No. 8	:	SWOT Table of HIRASSO
Table No. 9	:	Illustration of Solidarity of UNACOIS members
Table No. 10	:	Health Care Activities of Patients at CESAC
Table No. 11	:	Strengths and Weaknesses of CESAC
Table No. 12	:	Strengths, Weaknesses and Potential of RAS+ Togo
Table No. 13	:	Beneficiaries of the Dangme and Nkoranza Mutual Health Insurance Schemes
Table No. 14	:	Background of the Dangme and Nkoranza Mutual Health Insurance Schemes
Table No. 15	:	Types of Collaboration with Health Centers
Table No. 16	:	Audit of the Funds of the Dangme and Nkoranza Mutual Health Insurance Schemes
Table No. 17	:	Search for Funding by Dangme and Nkoranza
Table No. 18	:	Illnesses covered
Table No. 19	:	Preventive Coverage and HIV/AIDS-related Opportunistic Illnesses
Table No. 20	:	Care Coverage and Support for HIV/AIDS
Table No. 21	:	Means of Awareness Creation by Dangme and Nkoranza
Table No. 22	:	Strengths, Weaknesses and Potential of Dangme and Nkoranza
Table No. 23	:	Strategy for the Harmonization of Risks in the National Health Insurance Scheme
	:	
Table No. 24	:	Current Issues in the National Health Insurance Scheme
Table No. 25	:	Strengths, Weaknesses and Potential of the National Health Insurance Scheme

INTRODUCTION

The AWARE-HIV/AIDS project is a regional project that covers 18 countries including 16 countries in West Africa (the 15 ECOWAS countries plus Mauritania) and two countries in Central Africa (Cameroon and Chad). AWARE is funded by USAID through the West Africa Regional Program (WARP). It is implemented by Family Health International in collaboration with two key partners, Population Service International (PSI) and The Futures Group (TFGI), and five associate partners including, Bureau d'Appui en Santé Publique'96 (BASP'96), Care and Health Program (CHP), Johns Hopkins Program for Information and Education of Gynecologists and Obstetricians (JHPIEGO), Centre Hospitalier Affilié à l'Université du Québec (CHA), and Centre Hospitalier Universitaire de Sherbrooke (CHUS).

As a first phase of AWARE-HIV/AIDS' efforts on Promising and Best Practices (PBP) in the fight against STI and HIV/AIDS in the Sub-Region, a consensus building regional workshop on PBP was organized by the AWARE-HIV/AIDS Project in Dakar in March 2004. Participants included National AIDS Councils and Commissions, National AIDS Control Programs from countries in the region, UNAIDS, Advance Africa, WHO and West Africa Health Organization. At the end of the workshop a consensus was reached on the definition for promising and best practices. The criteria for the selection and the process for selecting best and promising practices were defined. The terms of reference of the task forces and the profiles of their members were also defined during the workshop.

At the workshop in Dakar, a promising and best practice was defined as "an experience, initiative or program that has proven its effectiveness and its contribution to the response to the HIV/AIDS epidemic, and that can serve as an example and inspiring model for others (program planners, managers, and implementers)". To be accepted as a promising and best practice, the experience should meet the following criteria: It should be; useful and relevant, effective, innovative, produce results within a reasonable time, efficient/cost-effective, ethically sound and sustainable.

The following steps were identified during the workshop held in Dakar as necessary in the selection process for promising and best practices:

- Designation of a committee of experts in charge of the selection (working groups)
- Preparation of operational tools for the process (submission form, call for abstracts, application form for candidates, explanatory notes on processes and criteria, and guide for selection)
- An inventory of existing Best Practices, identified in previous literature (Summary Booklet of Best Practices UNAIDS, Compendium of Best Practices of Advance Africa etc.)
- Call for submission and nomination of PBP candidates
- Selection of Promising and Best Practices by working groups
- Publication and dissemination of selected Promising and Best Practices.

The candidates for membership of the working groups satisfied the following profile:

- Experience in the given technical field
- Previous involvement in an intervention similar to the selection of best practices
- Experience in a project evaluation process
- Good knowledge of the West African Region in the area of HIV/AIDS and STI Control
- Availability at all times

Based on the recommendations and the propositions made by workshop participants, five task forces were constituted in the five technical areas, namely: behavior change communication (BCC), voluntary counseling and testing (VCT), sexually transmitted infections (STI), prevention of mother-to-child HIV transmission (PMTCT) and care and treatment (C&T). The working groups held their first meetings in June 2004 during which the members were oriented on the process of selecting promising and best practices as stated at Dakar. Selection tools were also developed during these meetings. Some submissions were reviewed and the first promising and best practices were selected.

Following the working groups first meetings, AWARE-HIV/AIDS' team consolidated and harmonized the developed selection tools. Then, a call for submissions was launched within the region with the support of the National AIDS Councils/Control Programs for wider dissemination in the countries. About 50 submissions were received and examined by task force members. The abstracts which were unanimously scored as "excellent" by the task force members were documented as best practices. The other submissions on which there were diverging views among working group members have been put on hold pending a re-examination towards eventually harmonizing the points of view.

In addition to the other working groups, a group of experts was constituted to examine submissions for advocacy for policy change and community based health financing.

In the area of advocacy for policy change, there have been two experiences. One is being implemented in Mali and the other comes from Benin. The first relates to the involvement of religious authorities in the fight against HIV/AIDS in Mali and is being implemented by religious networks there. It describes the process of involvement of the religious authorities in the fight against AIDS. The second relates to the adaptation and adoption of a model law on HIV/AIDS in Benin. It demonstrates the stages to follow to achieve the adoption of the law on HIV/AIDS. The model law is a tool which speeds up the process for an adaptation in the local context.

With regards to the HIV prevention, one experience was selected in the area of Behavior Change Communication (BCC) which is being implemented by a local NGO in Togo named FAMME. It involves a behavior change communication intervention targeted at sex workers or sex workers which uses education by peers as a strategy to bring them to systematically use condoms with their clients and to get themselves medically checked out for sexually transmitted infections. Given the level of involvement of the target group in executing this intervention, the system of providing and distributing condoms in the community and the involvement of the local authorities, the "Sister-to-Sister" project is an example worth sharing.

An example has also been selected in the area of the management of Sexually Transmitted Infections (STI). It is being implemented in Benin and owes its selection to its strategy of linking

clinical intervention activities with the community, thereby permitting a larger uptake by members of the target group. This example is also a model of successful integration in the national health system, thus guaranteeing its sustainability.

Two other experiences were selected in the area of the Prevention of Mother to Child Transmission of HIV (PMTCT). These are being implemented in Cameroon and Côte d'Ivoire. The first shows how quickly one can scale up a PMTCT program using a bottom up approach. The second is an example of the integration of PMTCT training in the curricula of pre-service training institutions.

With regards to Voluntary Counseling and Testing (VCT) for HIV, an experience being implemented in Burkina Faso has attracted the attention of the experts. It aims at improving access for in school youth to voluntary counseling and testing while emphasizing its preventive value in that knowing ones HIV status reinforces the adoption of less risky behaviors. The advocacy strategy which has allowed the participation of young people and the taking over of the intervention by the education sector committee has made this a model experience.

With reference to Care and Treatment, three experiences being implemented in Côte d'Ivoire, Senegal and Ghana have attracted the attention of experts. The first, the CASM project shows the role that community based organizations can play in caring for persons living with HIV and demonstrates the type of partnership which ought to exist between civil society organizations and public authorities in the care and treatment of HIV/AIDS. The second experience falls within the framework of the initiative for access to antiretrovirals in Senegal and demonstrates that it is possible to prescribe antiretrovirals in new remote areas of developing countries using a mentorship system for prescribers. The third experience, the START project, emphasizes sharing one's HIV status with a trustworthy confidant as a means of reinforcing and maintaining the adherence to quality therapy, and the management of data in antiretroviral treatment.

Nine examples of community health based financing in the fight against AIDS have been chosen as Promising and Best Practices. They portray various types of financing in the fight against AIDS at a community level. They are being in Benin, Cameroun, Chad, Ghana, Mali, Senegal and Togo.

This collection of Promising and Best Practices is a summary of all these experiences. It is hoped that various stakeholders involved in the HIV/AIDS response in the Sub-region, will use it to improve their interventions and to take the fight against HIV to a higher level.

ADVOCACY FOR POLICY CHANGE

ADAPTATION AND ADOPTION OF THE LAW ON HIV/AIDS IN BENIN

SUMMARY

The AWARE-HIV/AIDS Project, in collaboration with the African and Arab Forum of Parliamentarians for Population and Development (FAAPPD) and the ECOWAS Parliament, ratified a model law on HIV/AIDS during a regional workshop held in N'Djamena in September 2004 with the participation of 18 West and Central African countries. On return to their respective countries, the participants designed an action plan for the adaptation, adoption and promotion of the Law.

Leon BIO BIGOU, Member of Parliament and Chairman of the Benin Network of Parliamentarians for Population and Development (FAAPPD) represented his country at this workshop. On his return from N'Djamena, he proposed a bill on the prevention, care and control of HIV/AIDS in Benin, which led to the adoption of Law 2005-31. This law endows the various stakeholders with a legal framework to fight more efficiently against HIV/AIDS.

The process used in the adaptation and adoption of the HIV Law was identified as an experience worth sharing. This process was quite expeditious (eleven months) and exemplary. All concerned partners were involved (Government, National Assembly, Civil Society and Development Partners). It was carried out with success, and it motivated all parties involved to claim ownership of this law, thereby creating the optimal conditions for its implementation.

IMPLEMENTING ORGANIZATION

Organization:

- Network of Parliamentarians of Benin for Population and Development
  P. O. Box: 217, Abomey-Calavi
  Benin

Contact person:

- Leon BIO BIGOU
  Tel: +229 21 36 02 05
  Fax: +229 22 21 61 51
  E-mail: biobigou_leon@yahoo.fr

IMPLEMENTATION CONTEXT

Even though the HIV/AIDS epidemic in West Africa has not reached the alarming proportions seen in Eastern and Southern Africa, this region must promote large-scale prevention and care and support programs to avoid the explosion of this epidemic.

In the past 20 years, the HIV/AIDS epidemic has become one of the main causes of death in Africa. The prevalence rates have reached high levels in several countries, indicating that mortality will still be significant for decades to come[1].

In addition, the current consequences of the epidemic are still devastating: high mortality among the active population and an increase in the number of orphans. The human rights of people living in Africa infected or affected by HIV/AIDS are consistently violated and they face violence, often in situations of pronounced insecurity. Children are denied educational opportunities.

Widows and orphans find it difficult to exercise their inheritance rights and, in some cases, they are driven out of their homes, etc. Stigmatization and discrimination linked to HIV/AIDS pushes those infected into hiding, which creates the ideal conditions for the spread of the disease. It therefore appears to be vital to have the appropriate legal framework for fighting against HIV/AIDS-related stigmatization and discrimination.

It is in this light that AWARE-HIV/AIDS, in collaboration with the African and Arab Forum of Parliamentarians for Population and Development (FAAPPD) and the ECOWAS Parliament, organized a workshop in N'Djamena in September 2004 with the aim of providing African governments with a model law to fill the legal vacuum in almost all of these countries. The model law on HIV/AIDS was ratified at this workshop and an action plan was drawn up for its adaptation, adoption and promotion.

FUNDING

The funding for this process came from various sources. Development partners like UNFPA and USAID, through its Benin HIV/AIDS Prevention Program (BHAPP), contributed to the funding of this process. About 10 million FCFA were spent to cover all the activities (drawing up of the document, advocacy, round table, validation workshop, etc.).

BENEFICIARIES

This law tackles the process to create an enabling environment for HIV prevention, care, treatment and support. Infected and affected people, as well as stakeholders in the fight against HIV/AIDS, will benefit greatly from it.

DETAILED DESCRIPTION

Leon BIO BIGOU, the Beninese Member of Parliament and Chairman of the Network of Parliamentarians in Benin for Population and Development, had developed a draft bill on the HIV/AIDS Law two years earlier. The meeting in N'Djamena was therefore an opportunity that he seized with commitment and determination.

[1] 25.8 million Sub-Saharan Africans are infected, compared to a world total 40.3 million. Thus, sub-Saharan Africa remains the most affected region in the world, representing 64 % of the world total.

After his return from N'Djamena, BIO BIGOU's priority became the adaptation and adoption of a model law on HIV/AIDS before the end of the year. Therefore, with the help of a national legal expert, he merged the two texts[2] into one. Continuous and sustained advocacy began to mobilize funds, to look for partnerships and to convince skeptics. Advocacy strategies were constantly reviewed and adapted.

Though this advocacy process was initiated privately, the government[3] as well as development partners, such as UNFPA, WHO and USAID,[4] were also involved. The draft bill was reviewed by international organizations, NGOs, Civil Society and the National HIV/AIDS Control Program. A validation workshop allowed for the finalization of the text, which became a bill.

The National Assembly then began the process of adopting the document. This was facilitated by dynamic and effective lobbying. The text was unanimously voted into Law and became Law 2005-31. The Minister for Public Health honored the deliberations of the Parliamentarians[5] with her presence.

The major steps required for qualitative policy formulation regarding the HIV/AIDS law in Benin were as follows:

- Identification of problems;
- Acknowledgement of policy requirements for facing these issues;
- Development and examination of the policy document in a participatory process involving all parties;
- Approval and adoption of policy document;
- Implementation of the policy document adopted in close collaboration with all concerned parties.

These five stages were supported by the use and analysis of adequate information, as well as the implementation of an appropriate advocacy plan.

Active involvement of concerned parties

The involvement of all the concerned partners (Government, National Assembly, Civil Society and Development Partners) was effective throughout the process. Their involvement improved the quality of the outcome.
The participatory process was carried out successfully, which motivated all the involved parties to claim ownership of this Law, creating optimal conditions for its implementation.

Current situation and future steps

A law that has been passed has no executory force until it has been officially announced. This was slated for December 2005. But a law can also remain non-binding if the proper implementation documents are not prepared and if it is not properly advocated for and translated

[2] The one they initiated before the meeting in N'Djamena and the adopted model law.
[3] The Minister of Health.
[4] Under USAID funding, BHAPP (the Benin HIV/AIDS Prevention Program) showed great interest and allocated the expected funding to organize the validation workshop.
[5] She sat through all the deliberations and the adoption sessions, assisted among others by the Coordinator of the National HIV/AIDS Control Program (NACP).

into concrete actions. An outreach plan has been developed and steps have been taken for the development and adoption of implementation documents.

Strengths of the process

1. The law was written and voted in record time (11 months);
2. All 40 participants received a copy of the draft law 48 hours before a validation workshop so they could supply suggestions, proposals and amendments;
3. Flawless involvement and support of all the development partners solicited;
4. The funding of the validation workshop was done by BHAPP in record time;
5. The National HIV/AIDS Control Program (NACP) actively participated in the development of the law and was involved in the entire process;
6. There was a round table for the media regarding the development of the law;
7. The model law played an important role in the development process of the bill;
8. The commitment of the Chairman of the Network, major partners and other stakeholders was real;
9. The presence of the Minister of Public Health and the coordinator of the NACP at the National Assembly during the voting process was effective;
10. There was a sense of patriotism and commitment in the National Assembly, which resulted in a unanimous vote for Law N0. 2005-31 of 18 September 2005 by all 83 Parliamentarians;
11. The law offers a legal framework for every activity concerning HIV/AIDS in the Republic of Benin;
12. The process of publicizing the law is ongoing;
13. There is commitment on the part of the Parliamentarians to popularize and disseminate the law.
14. The support of the West Africa Health Organization (WAHO) was useful to the Beninese National Assembly in promoting a model Law on HIV/AIDS;
15. The leadership was generally high profile;
16. The level of political commitment was appreciable.

USEFUL INFORMATION FOR REPLICATION

Replication requires:

- Convinced, committed, devoted, enterprising, enthusiastic and available people;
- Advocacy specialists who can accept failure and convert it into positive experiences;
- Involvement and support of all stakeholders;
- Quality Leadership;
- Availability of funds;
- Political will on the part of decision-makers.

PRINCIPAL CONTRIBUTORS

- Leon BIO BIGOU — Member of Parliament of the Republic of Benin
- Marie-Thérèse GOMES — Consultant

THE EXPERIENCE OF RELIGIOUS NETWORKS IN COMBATING HIV/AIDS IN MALI

SUMMARY

The population of Mali is 90% Muslim. Islamic education and practice start very early in the family and continue throughout life. Issues related to sexuality are usually considered taboo and difficult to discuss. Communities are organized into youth, women and men's associations which carry out activities combating HIV/AIDS.

The Christian community has several organizations that are partners in the HIV response. The health and nutritional centers affiliated to these organizations provide support to people living with HIV/AIDS (PLHA).

The effective involvement of Muslim and Christian religious leaders combating HIV/AIDS has been a long process. Decision-makers and religious leaders did not have clear and precise information on HIV/AIDS, especially regarding personal protection. The belief of many religious leaders that AIDS was a divine curse led to many people lowering their perception of danger surrounding the disease.

In Mali, the major phases of the involvement of religious leaders in the fight against HIV/AIDS appear as follows:

- A phase of mistrust during which the leaders were not concerned by the illness;
- A phase of commitment by religious leaders, with the following highlights:
  - The Nioro Meeting of the Sahel held from 10 to 12 August 2001, initiated by Population Services International (PSI);
  - A day of AIDS advocacy organized by POLICY/USAID and the Ministry of Health in collaboration with Plan International, PSI and other partners under the chairmanship of Mr. Alpha Oumar Konare[6];
  - A day of AIDS advocacy organized by POLICY/USAID in collaboration with LIMAMA, AMUPI in Bamako on 20 August 2002 under the aegis of Amadou Toumani Touré, the President of Mali.

The results can be grouped into four categories: (1) the commitment of the leaders; (2) setting up consultations; (3) capacity building; (4) design and dissemination of sensitization and advocacy tools.

[6] Then the President of Mali

IMPLEMENTING ORGANIZATION

Organization :

- Network of Religious Leaders of Mali

Contact person :

- Modibo Maïga, Policy Project Mali
  Tel : +223 229 2844
  Fax : +223 229 2844
  E-mail : m.modibo@tfgimali.com

IMPLEMENTATION CONTEXT

According to the EDSIII-M study, the prevalence of HIV/AIDS in Mali is estimated at 1.7%. The analysis of this rate allows one to see strong disparities between regions and age groups. The most exposed groups remain: sex workers, street vendors, domestic servants, etc.

AIDS has a great impact on all sectors of economic life: agricultural production, industrial production, the trade sector and the standard of family life. The commitment of religious leaders constitutes an important opportunity to control and limit the impact of the epidemic. The Policy Project plays an influential role in the effective participation of religious leaders in combating HIV/AIDS in Mali.

DETAILED DESCRIPTION

The first years of combating HIV/AIDS were characterized by mistrust from religious leaders who were not concerned about the epidemic and were opposed to most of the prevention methods. This situation can be explained by the following:

- The supervisory structures were not sufficiently equipped to define the public education and advocacy messages;
- The former coordination structures did not develop partnerships with religious leaders;
- Religious leaders did not have relevant information on HIV/AIDS which would enable them to understand the key issues and to address the faithful in mosques and other places of worship.

The religious leaders became more committed after being encouraged by the Policy Project. The process was long and difficult. The implemented strategies were based on training, outreach and advocacy. Several support institutions also contributed to this process.

The alliance of religious leaders in Mali, which began in October 2004, enabled the achievement of significant results. This Islamo-Christian alliance turned out to be effective in the fight against the epidemic. The objectives of this alliance are to:

- Strengthen the synergy between the various religious denominations in Mali;
- Strengthen the leadership of religious leaders in the face of HIV/AIDS;

- Contribute to decreasing the spread of HIV/AIDS in Mali;
- Build the capacities of religious associations with reference to prevention and psycho-social and spiritual care in the context of HIV/AIDS.

Major stages of the process

The major stages observed in Mali in this process of advocacy against stigmatization and discrimination in combating HIV/AIDS are:

- Identification of problems;
- Awareness of the need to act to face these issues;
- Definition and adoption of coherent strategies with the appropriate tools in a participatory process involving all parties;
- Implementing strategies in close collaboration with all concerned parties.

These four stages were supported by the use of adequate data which was analyzed and used appropriately.

Active involvement of the parties concerned

The involvement of the major partners is real. Religious leaders of all denominations, Civil Society, Government and Development Partners contributed actively from 1994 to 2004 to the important stages in the following ways:

- *1994*: The Pivot Santé group (Health Pivot Group), through its Project Islam and Health, in collaboration with the National HIV/AIDS Control Program, organized a three-day meeting at the Islamic Center that brought together more than 350 Imams and scholars of AMUPI from the Bamako District and the eight regions of the country. The meeting helped deliver messages and train religious leaders on the impact of HIV/AIDS.

- *February 1999:* SEBENIKORO meeting**:** The Catholic and Protestant Communities met for the first time to discuss strategies for the fight against the AIDS pandemic. Political, health and various church leaders were present.

- *August 2000*: The preparatory workshop of the national forum on ''Islam and AIDS'' at Sélingué from 10 to 14 August 2000[7] helped to:
  - Take stock of the difficult family and couple issues posed by the challenge of HIV/AIDS and Islam;
  - Take stock of Islamic verses that can help work out these issues;
  - Define the role of the Ulémas in regard to resolving issues.

- August 2001: the Nioro workshop of the Sahel organized by Population Services International (PSI) with the technical support of the NACP. The AIDS Impact Model (AIM model) developed by the Policy Project was used during this meeting and it

[7] This workshop was organized by the Islamic Association for Progress and Development of the Family (AIPEF). The funding was supported by UNFPA with technical support from the NACP (PNLS).

enabled religious leaders to receive appropriate information[8]. Important recommendations were made to empower religious leaders.

- *2001:* A day[9] of advocacy on AIDS under the Chairmanship of the President of the Republic, Alpha Oumar Konaré, brought together, about 10 Ministers, Ambassadors and over 600 community and religious leaders. The result was a live talk show on national television hosted by the sheriff of Banamba[10] (one of the highest religious authorities in Mali) on AIDS and his appeal to religious leaders to get involved.

- *August 2002:* A day of advocacy[11] presided over by the President of Mali, Amadou Toumani Toure, was indeed a success[12], resulting in engaging 200 Imams and erudite Muslims in the political dialogue of HIV/AIDS.

- Christian communities are organized in association with the youth, women and men who constitute partner structures in their interventions aimed at combating HIV/AIDS[13]. At the parish and local church level, small trainings and information meetings are organized. Christian leaders have established health centers, maternity centers, dispensaries and nutrition centers where agents are trained to actively take care of the people[14] all over the country.

Strategies and tools developed by religious leaders to combat HIV/AIDS

The Policy Project worked on a participatory approach. The approach consists of (1) capacity building; (2) the development of advocacy and awareness creation tools; (3) the development of advocacy models adapted to different religions, the religious AIM[15]; and, (4) the implementation of advocacy and outreach.

Capacity building has helped to develop activities for:

a) Training leaders in developing an understanding of HIV/AIDS;
b) Training the leadership in networking with other religious leaders, managing social life, the formulation of small projects and fundraising;
c) Training in presentation techniques of advocacy models for better awareness and more effective advocacy on the part of decision-makers;

[8] Present were Muslim religious leaders, women and men from Sikaso, Mopti, Gao, Timbuktu, Bamako, Segou, Kayes and Kouliko regions.
[9] Organized by POLICY/USAID and the Ministry of Health, in collaboration with Plan International, PSI and other partners.
[10] Unedited in Mali
[11] Organized on August 20, 2002 by POLICY/USAID and the NACP in collaboration with AMUPI, the LIMAMA with funding from USAID.
[12] Present were the Prime Minister and the entire Government, Parliamentarians, Ambassadors accredited to Mali and Development Partners.
[13] In the Protestant Church, the leaders included the Pastors and the Church Elders or Deacons. Leaders of the Catholic Church included Bishops and Priests who are trained to train others and create awareness about HIV/AIDS.
[14] Some centers are more advanced than others in the fight against the pandemic. Generally, the activities are about training and awareness creation for leaders, the organization of publicity caravans, etc.
[15] AIDS IMPACT MODEL

d) Travel for exchange of experiences, which enables Leaders to enrich themselves with experiences from other Leaders in the sub-region.

*The development of advocacy and awareness creation tools: D*eals with the design and the dissemination of teaching materials. Muslim leaders engaged in deep reflection for the preparation of sermons, the production of brochures and the production of films[16].

The implementation of advocacy and awareness creation: In the context of HIV/AIDS, the AIM model is the advocacy tool. A religious AIM[17] with emphasis on the role and responsibilities of religious leaders was developed.

Current situation and future steps

These results include the commitment of religious leaders and the implementation of consultative frameworks.

1. *Commitment of leaders:* The unquestionable commitment of religious leaders in combating HIV/AIDS is founded on Koranic verses and specific hadiths. For Christians, specific verses from the Bible were highlighted to justify the involvement of the leaders.

The direct consequences of this commitment of religious leaders are:

- Compassion and support from religious leaders towards people living with HIV/AIDS during their testimonies;
- Collection of money by religious leaders in mosques and churches to assist PLHA;
- Extraction of verses from the Holy Koran and the Holy Bible which helped inspire the confidence of religious leaders in their fight against HIV/AIDS;
- Commitment by religious leaders to create awareness in mosques, churches and public places among the religious community for greater tolerance towards PLHA;
- Increased confidence of Malian religious leaders following study tours and meetings in the sub-region;
- Effective participation of religious leaders in the fight against HIV/AIDS through the function of their organizations and through specific activities;
- The achievement of a higher level of confidence by the leaders who have become more proactive in the fight against HIV/AIDS.

2. *Consultative frameworks:* Two structures have been put in place to ensure direct and permanent dialogue between the institutions and the people at all levels. These institutions are the National Islamic Network for combating HIV/AIDS (RNILS) and the Muslim and Christian Religious Leaders Alliance.

3. *The National Islamic Network for combating HIV/AIDS (RNILS)*: All the religious associations in Mali are represented on the Executive Committee. The RNILS is represented at the regional level by the Islamic Regional Network for combating

[16] *The development of advocacy and outreach tools* deals with the design and the dissemination of teaching materials. Muslim leaders engaged in deep reflection for the preparation of sermons, the production of brochures and the production of films.

[17] The main aspects of the AIM model are: (1) general information on HIV/AIDS; (2) the epidemiological situation; (3) knowledge of HIV/AIDS and types of prevention; (4) information of HIV epidemic projections (Women and AIDS, responsibilities of religious leaders): (5) some perspectives and conclusion.

HIV/AIDS (RRILS)[18]. RNILS has established a partnership with the State, Development Partners and other Civil Society organizations.

4. *The Alliance of Religious Leaders against AIDS, which brings together Muslim and Christian Leaders*: Christian and Muslim Religious Leaders have created a body called Islamo-Christian Alliance against HIV/AIDS.

USEFUL INFORMATION FOR REPLICATION

- Capacity building for religious organizations in the following areas is a prerequisite:
  - Project management;
  - Leadership and governance in order to foster real social life;
  - HIV and development, key concepts in reproductive health (RH) and child survival;
  - Training in advocacy techniques;
  - Translating the AIM model into Arabic.

- Providing mini grants for advocacy activities is necessary to ensure sustainability from the beginning of the projects;
- The translation of advocacy teaching support materials into Arabic and the major national languages;
- Support from Charismatic religious leaders is a necessity. In Mali, the very popular El Hadji Chérif Ousmane Madani Haïdara, Imam and preacher of great renown, issued important messages broadcast by the media and on the Internet. His very progressive stance concerning the prevention of AIDS won him the nickname "Red Imam" ("imam rouge"). In addition, we must acknowledge the pioneering work done by the late El Hadj Kady Dramé and El Hadj Sidi Konaké. Also, the labor of El Hadj Thierno Hady Oumar Thiam, an accomplished teacher and the work of the learned El Hadj Mamadou Traoré, indefatigable scholar and researcher, cannot be overemphasized.

CONTRIBUTORS

- Modibo MAIGA — Director, POLICY/Mali
- Bakary KANTE — Consultant

[18] RNILS has human resources trained in HIV and development in its leadership, in the governance of its associations, in its project development and in the presentation of advocacy tools. These various training programs have helped RNILS itself to carry out a decentralized training program, preaching and giving important sermons throughout the country.

BEHAVIOR CHANGE COMMUNICATION

COMMUNICATION FOR BEHAVIORAL CHANGE IN SEX WORKERS FOR THE PREVENTION AND MANAGEMENT OF STI/HIV/AIDS ON MIGRATORY ROUTES IN TOGO: "SISTER-TO-SISTER" PROJECT

SUMMARY

The sister-to-sister project is a sexual behavior change communication project, which targets sex workers along the Lome – Cinkasse route. The sister-to-sister approach utilizes peer educators recruited from the target population of sex workers, to carry out social mobilization among their peers, in HIV/AIDS/STI prevention. Once identified and trained, the peer educators try to

- Change the perceptions of sex workers about the risks of infection.
- Encourage proper and systematic use of male and female condoms for intercourse with clients or regular sexual partners
- Help their peers to have improved management of STIs and easy access to voluntary counseling for HIV and to condoms at all sex work sites.

The project started in September 1998 with the technical support of PSI/Togo and SFPS/PSAMAO and funding from DFID. Supervisors from the NGO, FAMME oversee the activities of peer educators, with technical assistance from the IEC/STI/HIV/AIDS focal points of the health districts that cover the sex work sites under the project.

From September 1998 to date, 100 trained peer educators have been helping to improve the use of preventive methods and the adoption of "responsible" sexual behaviors among the target population. A little over 1,402,600 male condoms and 85,800 female condoms have been distributed by the peer educator network at the sex work sites covered. Surveys conducted in 1998 and 2000 revealed that 69% of sex workers (SW) know that one may be seropositive but healthy looking as against 69% from 1998 to 2000. Sex workers have a better perception of their risks of contracting HIV, with the percentages increasing from 45% to 63% from 1998 to 2002. The level of condom use during the last sexual intercourse for protection against STI/HIV/AIDS rose from 85% in 1998 to 99% in 2002. (PSAMAO Evaluation 2002).

Today, to sustain the gains of the project, 10 kiosks for information and the distribution/sale of condoms have been put up at the major sex work sites covered under the project, with funding from the Global Fund to fight AIDS, Tuberculosis and Malaria.

IMPLEMENTING ORGANIZATION

Organization:

- ONG FAMME
  P. O. Box 12 321 Lome, Togo
  E-mail: fa_org2000@yahoo.fr

Contact person:

- Dométo K. SODJI,
  Executive Director

Tel.: +228 912 37 57
E-mail: dometo_99@yahoo.fr

IMPLEMENTATION CONTEXT

The project is being carried out in Togo and covers all the major sex work sites along the Lome – Cinkasse road. Togo is situated in West Africa, between Ghana in the West and Benin in the East, the Atlantic Ocean in the South and Burkina Faso in the North. The country's population in 2003 was estimated at 4,970,000 inhabitants, with an annual growth rate of 2.4% and life expectancy at 49.9 years. The literacy rate is 44% for women and 73% for men. There are about 130,000 people living with HIV, with a sero-prevalence of 4.8% in the sexually active population (15 to 49 years). Sero-prevalence in sex workers or sex workers (SWs) was about 78% in 1992 and 54% in 2003 in Lome (Source NACP/STI-SIDA3).

Today, Togo has a strategic framework for HIV/AIDS control, with 14 priority areas. The major determinants fueling the epidemic in Togo include, the high rate of sex among the youth, multiple sexual partners, the lack of perception of the risk of infection, denial of the disease, socio-economic subordination of women, poverty, high sex work rate and mobility within the country and in the sub-region and high illiteracy rate, especially among women. The project goals are well in line with the National AIDS Control Strategic Plan. The project goals include contributing to the reduction of HIV/AIDS transmission through social marketing of condoms and minimizing the spread of HIV/AIDS among vulnerable groups such as sex workers and their partners.

The Lome – Cinkasse route runs from the south (Lome – terminal du Sahel/Agoe) to the North (Cinkasse), via several towns, the major ones being Notse, Atakpame, Anie, Sotouboua, Sokode, Kara, Niamtougou, Mango and Dapaong, each of these has one or several sex work sites. The "Sister-to-Sister" project has at 15 implementation sites - four in Lome and 11 in the interior of the country.

FUNDING

USAID (through the SFPS/PSAMAO project) and DFID (through PSI/Togo) funded the project's major start-up activities. The Global Fund to fight AIDS, Tuberculosis and Malaria and the SIDA3 project then took over the funding of the activities at the sex work sites. The total contribution from partners to FAMME, over five years, amounts to approximately 58 million FCFA.

BENEFICIARIES

Sex workers in Togo are estimated to be about 4,000 for all categories. The Lome – Cinkasse route alone is home to half this number, i.e. about 2,000 SWs. They are divided into three large groups: sex workers behind closed-doors (800 of these), sex workers who go to the hot spots and the ones who work from home. 34% of these girls are illiterate, 45% reached the primary level,

19% the secondary level and 2% the university level. 95% of them have at least one child, with an average of two children per SW.

Those who work behind brothels are foreigners, mainly Ghanaians (90%), while the Togolese, Beninese and Nigerians are mostly found at hot spots (bars, hotels, restaurants, etc). The "sister-to-sister" project beneficiaries are between 18 and 50 years. The duration of residence in a locality varies from one week to six months and the number of year in the profession varies from one week to 15 years, with an average of six months for over 70% of the girls. 53% of them engage in income-generating activities, in addition to being in sex work. Those in brothels receive on average of five clients a day compared to one client on average per day for those who go to the hot spots. They charge between 200 and 8,000 FCFA per session, and 1,000 to 15,000 FCFA per night.

DETAILED DESCRIPTION

With a sero-prevalence of 78.86% observed among sex workers in 1992 (source NACP/STI/1992), sex work remains a major determinant of HIV/AIDS transmission in Togo. Sex work is fueled by the mobility of the population (in Togo and in the sub-region), by socio-cultural factors, such as illiteracy and the economic dependence of women on men, and Togo's strategic location as a crossroads of two major highways – the Abidjan-Lagos corridor and the Lome – Ouagadougou route.

It is against this background that FAMME, in partnership with PSI/Togo chose to work with sex workers to help curb the transmission of HIV in the population. The "sister-to-sister" project is in line with this dynamic and uses the peer education strategy.

The first part of the project started off in September 1998 and ended in August 2002, with funding from USAID and DFID. Activities continued after the disengagement of DFID/PSI with funding from the Global Fund's AIDS3 and recently from USAID through the AWARE-HIV/AIDS project.
The goal of the project is to contribute to efforts being made by the National AIDS and STIs control Program, by encouraging the adoption of safe sex and "responsible" sexual behavior by sex workers or SWs. Specifically, the project aims to:

- Increase the dissemination of information on STI/AIDS and their prevention methods to the target populations;
- Substantially improve the availability of both male and female condoms;
- Reduce sexual behavior among SWs that put them at risk of STI/HIV infection.

In order to achieve these objectives, the project has laid out a number of activities. These include training of peer educators, organization of education and information activities, sale and distribution of condoms, and referral to STI management and voluntary counseling and testing centers.

Selection of peer educators

Peer educators are selected using a two-pronged approach. The first is participatory and entails asking the direct beneficiaries of the intervention to choose from among themselves, those who

they would like to have as peer educators. The second approach is a selective one, involving youth leaders who are members of FAMME. At meetings and during discussions with the people put forward by the beneficiaries, the youth leaders identify those capable of playing the role of peer educators, on the basis of qualities like the ability to learn and understand, the ability to forge social relations, the ability to conduct and direct discussions, etc. The last stage entails securing the agreement of the sex workers identified to serve as peer educators. These girls are then trained to become peer educators.

Training of peer educators

The training program was initially prepared by FAMME. Other documents and approaches have been added, including the peer educator training manual developed by PSI as part of the PSAMAO project. The training method is participatory, using educational games, theory and practical exercises. The practical aspect is the most developed because most of the would-be peer educators have very little schooling. The training focuses on improving their knowledge of STI/HIV/AIDS and communication. The training is also geared toward providing these girls with skills to motivate their peers to protect themselves by using condoms, showing them how to use the condoms and getting them to make use of health services to manage STIs and attend HIV voluntary testing centers.

Peer education

At the end of the training, the peer educators draw up a work plan. The plan comprises two group discussions and four counseling sessions per week. The group discussions are communication activities on average in groups of five, aimed at behavioral change. The counseling sessions, on the other hand, are individual activities. During these activities, peer educators inform their peers about the means of transmission, the methods of prevention and treatment of STI/HIV/AIDS, the referral centers and services available, and the negotiation tactics to make their clients wear condoms. They also give demonstrations on how to wear the male and female condoms.

The peer educators are supervised by two categories of supervisors: internal supervisors and external supervisors, called technical supervisors. The internal supervisors are sex workers who have acquired a solid experience in peer education through several years of practice. The technical supervisors are health workers from referral health centers, who handle STI management. They conduct supervision visits to sex work sites twice a month. Each technical supervisor supervises about five peer educators. The peer education equipment called “IEC kit” has a brochure, a demonstration mannequin, a wooden penis, condoms, spermicides, picture boxes, etc. The internal supervisors keep this equipment and the peer educators can obtain their supplies for them.

Sale and distribution of condoms

The condoms are ordered through the local PSI office, which delivers them to FAMME. There is an agreement between the two institutions to ensure that the expiry date of the condoms is beyond three months. FAMME has a system whereby an initial donation of condoms is made to the peer educators (PEs), enabling them later on to obtain further supplies. Once the condoms are supplied, the FAMME project management team makes packages according to the sites and

number of peer educators at each site. The packages are then pre-positioned with the PE technical supervisors, who then supply the PEs they supervise. The condom price is marked up by about 50% as an incentive for the PEs and supervisors. This covers their transportation costs when they go to distribute them. For instance, the female condom is purchased at 60 FCFA with PSI and sold on the ground at 100 FCFA each. After they've sold the first lot of condoms, the PEs go for more supplies from the technical supervisors. The expiry date is checked during the supervision visits, and if the date has expired, the condoms are systematically withdrawn from circulation.

Referral of sex workers to STI management centers and anonymous voluntary counseling and testing (VCT) centers

During counseling sessions, peer educators actively ask about symptoms of STIs among their peers. They check the monthly check-up form and convince SWs to do their check-ups or go for voluntary HIV testing. Depending on what is found, SWs are referred to the health centers for management of their STIs or for routine check-up, and to the VCT centres for HIV testing. The SWs are given a referral slip, which they show to the PE, who is based at the referral center. The PE receives the referred SWs and introduces them to the health workers. In addition to the referral activities of the PEs, a mobile clinic, run by a voluntary FAMME doctor, conducts regular visits to the sex work sites in Lome to provide care and monitor sex workers who refuse to or who cannot go to the appropriate health care center.

Project management

The implementation of the "sister-to-sister" project involves the use of one coordinator, two community leaders, 10 technical supervisors, 15 internal supervisors (SWs) and 100 peer educators.

The community leaders go on monthly rounds to supervise the intermediaries on the ground (technical supervisors and peer educators). This supervision is meant to help improve the services of the peer educators and supervisors.

From the start of the project to date, peer educators have carried out 7,950 group discussions in small groups of five and 85,000 individual sessions. These activities have reached 28,600 people, including SWs, their partners and clients. Peer educators have sold 1,402,600 male condoms and 85,800 "Protective" female condoms. They have also carried out 1,500 medical referrals, including 930 for the treatment of STI infections and 570 for HIV/AIDS testing. Condom use, both male and female, increased by 85% in 1998 among clients and by 99% in 2002. The level of knowledge of HIV/AIDS among sex workers increased from 69% in 1988 to 90% in 2002, and their level of perception of the risk of contracting STI/HIV/AIDS during unprotected sex rose from 45% in 1988 to 63% in 2002. Furthermore, SWs are increasingly agreeing to go to the appropriate centers for regular medical monitoring.

The implementation of this project was faced with some challenges. These include:

- Refusal by SWs to go to STI and voluntary testing centers;
- Inconsistent use of condoms with customers or regular partners;
- Refusal to go for voluntary HIV testing for fear of stigmatization, and
- Illiteracy among a greater majority of sex workers.

The fact that peer educators, who are SWs themselves handle the condom distribution network, has helped to build trust within the group and support for the project.

Appropriate services are needed to improve STI management among SWs. While the female condoms provide better protection, they are not all that popular because of difficulties in inserting them and the painful inflammation caused by the inside ring when not well adjusted.

Monitoring and Evaluation

The following indicators were used to evaluate the project's activities:

- Number of sex workers informed about modes of transmission;
- Number of SWs who correctly and systematically use condoms during sexual intercourse;
- Number of SWs who negotiate the use of condoms by clients;
- Number of SWs who understand their personal risk of contracting HIV/AIDS;
- Number of SWs who go for regular medical check-ups.

Tools used for the project monitoring and evaluation, are as follows:

- Monthly report form;
- Equipment and condom stocks management form;
- Peer educator and supervisor monthly work plan ;
- Peer educator and SW supervision forms.

FAMME used the "mystery client" approach to evaluate the quality of PE activities in the field and improve their technical capacity during monitoring visits and re-fresher training.

USEFUL INFORMATION FOR REPLICATION

Increasing the sale price of condoms, as an incentive to SWs and supervisors is an element which will enable the project to survive when donors are no longer available.

With the support of the Global Fund to fight AIDS, Tuberculosis and Malaria, information and condom distribution/sales kiosks have been put up at major sex work sites. These kiosks are managed by peer educators who are given a stock of condoms as working capital. These sale points also provide basic items to the community. Plans are far advanced to train these peer educators at the kiosks as community health workers to enable them to sell generic drugs to the target populations. The kiosks are thus meant to enable peer educators who manage them to fend for themselves when donors withdraw for good.

CONTRIBUTORS

- Raymond K. SODJI — Executive Director of FAMME, Togo
- Epiphanie SOMENOU — Officer-in-charge of community activities, FAMME, Togo
- Barthélémy LAWSON — Epidemiologist, in charge of the FAMME mobile clinic

APPENDIX

BEHAVIOR CHANGE COMMUNICATION (BCC) TASK FORCE

NAME	POSITION	INSTITUTION	COUNTRY
Sodji Raymond Dometo	Executive Director	FAMME	Togo
Moussa Traoré	Journalist, S/D BCC	Ministry of AIDS Control	Côte d'Ivoire
Seydou Nourou Koita	Marketing Officer	ADEMAS	Senegal
Annette Epanya	BCC Officer	Catholic Health Organization	Cameroon
Issaka Sangaré	Communication Officer	NACP	Mali
Bako Bagassa	Communication Officer	Multi-sectoral Committee on AIDS Control	Niger
Kodjo Lokko	Deputy Managing Director	Ghana Social Marketing Foundation (GSMF)	Ghana
Dipoko Embola Degrando	Technical Officer	PSI/AWARE-HIV/AIDS	Ghana
Marie-Louise Baleng	Facilitator	PSI /AWARE-HIV/AIDS	Ghana

SEXUALLY TRANSMITTED INFECTIONS

"ADAPTED SERVICES" FOR SEX WORKERS AND THEIR SEXUAL PARTNERS: A STRATEGY TO REDUCE THE TRANSMISSION AND MINIMIZE THE PREVALENCE OF STI/HIV/AIDS

SUMMARY

In Benin, which is regarded as a country with moderate HIV prevalence in the general population (2-4%), interventions which specifically target "core groups" are vital and justified. Thus a pilot intervention, aimed at reducing STI and HIV transmission in the population, was initiated in 1993, reinforced in 1995, and has now gradually been extended to urban centers. The strategy consisted of establishing Adapted Services (AS) for sex workers (SWs), a marginalized group of low socio-economic standard who are working in an illegal context.

The interventions consist of regular medical check-ups, a fixed or advanced strategy for the active testing and management of STI, in a broad-sense counseling and integrating the promotion of HIV voluntary testing and care for sex workers living with HIV (SWLHIV) and prevention and care for opportunistic infections. The strategy owes its efficiency to linking clinical care in AS with Behavior Change Communication (BCC), community outreach activities, after an enabling approach involving consultation with security forces and sex work site owners, as well as regular follow-up activities.

Quite encouraging results were noted, with a statistically significant reduction in the STI and HIV prevalence from 1993 to 2002 in the intervention areas, compared with the non-intervention areas. Finally, the model of establishment of adapted services for SW and their sexual partners as a means of reducing STI and HIV transmission is efficient and cost effective. The involvement of the national stakeholder in anchoring this model within the national strategic plan is an important factor for sustainability. Hence, to achieve real success, it is important to study and consider the operational mode of the national health system of the intervention country and take into account the peculiarities and specific concerns of the target population from the onset of the process in view of its actual empowerment vis-à-vis STI and HIV prevention.

IMPLEMENTING ORGANIZATION

Organization:

- AIDS 3 Project– Benin (CHA / CIDA)
  08 BP 0 900 TRI POSTAL
  Cotonou, BENIN
  Tel: +229 30 34 71
  Fax: +229 30 96 71

Contact person:

- Marguerite NDOUR
  National Coordinator,
  E-mail: mndour@intnet.bj, ndourmarguerite@yahoo.fr

IMPLEMENTATION CONTEXT

HIV infection is an increasingly distressing public health and development issue in Benin. Benin has noted an increasing prevalence from 0.4% in 1990 to 4% in 2001 in the general population, with regional and group variations. A rapid growing HIV infection was observed in the Sex Worker population and HIV prevalence increased from 3% in 1986 to 55% in 1999. Benin has developed a national STI/HIV/AIDS Control Strategic Framework with 14 overall objectives including the reduction of STI and HIV prevalence among sex workers and their clients. Benin belongs to the moderate prevalence (2 – 4%) countries, according to the national sentinel surveillance survey undertaken in 2002/2003. In this context, interventions targeting the *"high risk groups"*, including sex workers and their clients, appear to be potentially effective.

The pilot intervention which consisted of a feasibility study on reaching and tracking sex workers started in 1993 in Cotonou, the economic capital and the largest city in Benin. Cotonou comprises an estimated 665,100 inhabitants (2002 demographic statistics), or 10% of the national population. The intervention first targeted the neighborhoods with most widespread sex work then was later scaled up to the whole city in 1995. Conscious of the fact that sex worker clients constitute a "bridge" in spreading the infection to the lower risk general population, activities among the sex worker clients started in 1998. National scaling up occurred gradually to cover the city of Porto-Novo, the political capital of Benin, in 2000, the cities of Bohicon and Abomey (historical capital of Benin), Lokossa and Parakou, in 2001, as well as the Northern frontier cities, Kandi and Malanville, in 2003, at an estimated 75% coverage of urban centers in the country.

FUNDING

The Project is funded by the Canadian International Development Agency (CIDA) for $2,625,000 over 5 years (an average of $525,000/year). The present phase runs until 2006. It must be noted that some research aspects were funded by other donors, including the Institut de Recherche en Santé du Canada (Canadian Institute of Health Research, IRSC) and Contraceptive Research and Development (CONRAD) among others, at about $500,000.

BENEFICIARIES

The project targets especially self-declared and clandestine SWs, as well as their male sexual partners. In Benin, female sex work (self-declared or clandestine) is tolerated but not legal. One can observe more and more women engaging in this practice, most of them operating clandestinely. STI and HIV prevalence among SWs is 10 to 20 times higher than in the general population. Sex work in Benin is cosmopolitan, with sex workers coming from Nigeria, Ghana, Togo, etc. with the Beninese operating as clandestine sex workers most of the time. The median

age of SWs is 28 years (last 2002 survey). It must be noted that 70% of these SWs have attended school but have dropped out.

Among the ones who have attended school, the highest level reached is primary school in 43% of cases, secondary school in 56% of cases and higher level in 1% of cases. 35% of SWs are engaged in an informal sector activity (petty trade, hairdressing, and barmaid), with very low pay. This socio-economic and socio-professional pattern is a vulnerability factor for most (65%) of these women of whom the majority has no occupation and makes their living out of sex work.

At first, the Project targeted the various sex work sites in Cotonou, (brothels, bars, motels and all other formal places of sex work). On the whole, 174 sex work sites were identified in the city where sex workers (518 estimated self-declared SWs) ply their trade. This intervention was later extended to the five other major urban centers in Benin (693 sites and 2,532 SWs). It is carried out under the supervision of the National AIDS and STI Control Program (NACP) which is responsible for national primary health care facilities.

DETAILED DESCRIPTION

The interventions began in 1993 and determined the feasibility and relevance of working closely with and establishing STI screening services for sex workers. Interventions took place first of all in Cotonou, and were progressively extended to the other towns. With the project being constituted in five year phases, the current phase ends in March 2006.

The Project aims at providing:

- Proper treatment of curable STIs among SWs and their sexual partners, and staff working in the sex work environment and vulnerable socio-professional categories;
- Regular follow-up of SWs: active STI screening and treatment, Behavior Change Communication (BCC) in STI/HIV/AIDS prevention, "HIV Voluntary Counseling and Testing" promotion, co-trimoxazole prophylaxis for opportunistic infections among SWs living with HIV (SWLHIV) and presenting with AIDS symptoms and signs;
- Links between STI care activities and support to community participation: outreach interventions taking into account gender and development concerns (GAD) and clients empowerment vis-à-vis STI/HIV/AIDS preventive measures;
- Specifically adapted quality service provision to the targeted clientele, both at the clinical, preventive and promotional levels.

The strategy consists in establishing Adapted Services (AS) for sex workers (SW) and their male sexual partners, linking them with community support activities and including gender concerns. In these AS, primary health care services are provided to the client/clients, in a respectful atmosphere, free of stigma, at low cost, in privacy and confidentiality.

Penetrating (Community entry) the target population starts with meetings and the collaboration of resource persons of influence in the sex work environment, identified with the help of local administrative leaders whose contribution is critical in mapping sex work sites and SWs. Level of community entry was largely dependent on the degree of involvement of the target group and influential people (brothel owners for example) in the activities and the degree of linkage

between community support activities and the provision of trust building clinical care services free of stigma.

Police involvement is initiated through sensitization workshops for police authorities about the country's epidemiological situation and the role of "core groups" in the dynamics of transmission. It must be noted that the Focal points in the Ministries of Health and of the Interior participate in these workshops and endorse the findings of these workshops.

Collaboration with the Ministry of Health has been operationalized through decentralized structures of the NACP/Ministry of Health in the implementation and monitoring of the activities in various intervention areas in the field.

The activities carried out include:

- Building of institutional capacity on a technical level by; supporting the proper layout of service premises for greater privacy, providing material equipment (examining table, sterilizable specula, disposable gloves, disinfecting materials, low cost condoms and lubricants, etc.) training health workers in service provision adapted to these specific clients, through a clinical consultation and gender negotiated approach;

- The monthly medical follow-up (with a follow-up record) of SWs referred by workers of community organizations called "relay organizations" (ROs), project implementation partners and peer-educators for STI testing and care, promotion of voluntary testing for HIV, prevention and care for opportunistic infections and referral to SWLHIV care centers free of charge for SWs, the same care provided to SWs' regular partners (boyfriends) (with referral coupons), and SWs' clients (care service promotion forms);

- SW medical care advanced strategy interventions by AS providers at sex work sites which are far from care services and asymptomatic urethritis testing sessions among SW clients by the LED TEST (leucoesterase sticks) on a periodic basis at sex work sites, followed by single-dose treatments provided to detected STI cases;

- Community support activities (sensitization, BCC, education, condom use promotion and improved condom availability, promotion of solidarity as source of self-esteem and self-efficacy, enabling mobilization and target referral to AS and satellite services) conducted by health workers in the adapted services, in synergy with project partner local community organizations and the peer-educators trained, equipped and motivated for that work.

- Collaboration with security forces and brothel owners and managers through quarterly workshops/meetings;

- Supervised training of health workers and members of community organizations in the use of supervision forms and regular service provision quality controls (2 controls in 5 years), conducted in collaboration with national teams;

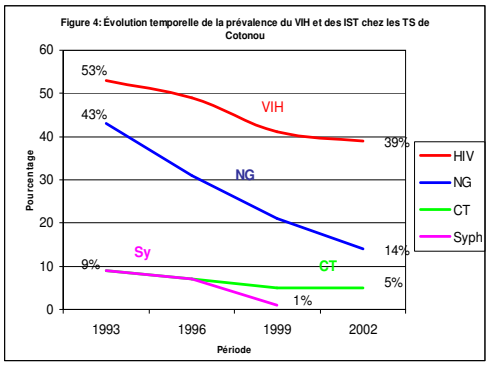
- Monthly data collection which will serve to develop databases to monitor the progress of behavioral variables and STI cases;

- Operational research towards future readjustments for improved performance.

These interventions enabled the project to undertake and regularly update (every 2 years) a census survey of sex work sites, SW and facilities likely to ensure activities with SWs. Capacity building activities resulted in training: 10 national supervisor trainers, 83 care providers in holistic SW care, 13 drug and medical consumable managers and 53 NGO members/workers, 252 peer-educators.

Visits by SWs to health service centers have increased notably. This is true for Cotonou 1 STI Dispensary where patient visits have grown from 200 a year, at the beginning of project implementation, to 2,534 in 2003, even exceeding 200 monthly visits in some months since 1999.

The overall results of this intervention indicate a positive impact in Cotonou, conveyed through the increased proportion of SWs always using a condom with their clients from 23 % in1993 to 81 % in 2002. This could partly explain the significant falls in STI and HIV rates noted in these women in Cotonou over the same period (43 % to 14 % for Neisseria gonorrhoeae; 9 % to 1 % for syphilis; 53 % to 39 % for HIV). Illustrated by the adjacent graph.



Several studies have revealed that the spread of HIV and STI in the general population was mainly due to the fact that SWs' sexual partners also have regular and occasional sexual partners in the general population. Besides this, a mathematic modeling exercise revealed that the intervention with SWs in Cotonou may have prevented about 50 % of new HIV cases among them since 1993, as well as one third of new cases in the general population. Indeed, HIV prevalence in the general adult population in Cotonou, set at about 3 % in 1998 according to a UNAIDS survey, would have exceeded 5 % at that date without the interventions. It should also be noted that, unlike Cotonou, SW HIV prevalence rather increased in the other regions in Benin (36 % in 1993, 51 % in 1995/1996, 55 % in 1999 and 59 % in 2002), and condom use also remained very low in these areas (53 % in 2002).

Community empowerment is very high especially among Ghanaian SWs who display a remarkable solidarity through associations of Ghanaian nationals living in Benin, which they belong to. They benefit from group solidarity in difficult times.

When faced with violent clients and those who refuse to use a condom, SWs, whatever their nationality, unite and develop a collective protection against the violent clients in throwing them out with the help of brothel owners with whom they hold regular meetings to discuss their working and housing conditions. Some SWLHIV in Porto-Novo have developed an association ("SONAGNON" association) which receives funding from other donors in the field.

The problem of reducing the cost of STI drugs in a context of cost recovery in care facilities and SWs' very high mobility between Benin and the other countries along the Lagos-Abidjan

corridor (Nigeria, Togo, Ghana) have been the major constraints of the Project. The high turn over of staff and non-permanent workers recruited to work in the different units to support the project's activities constitutes a risk for sustainability and ownership.

We have learned the following lessons from this experience:

- BCC activities conducted in relation to STI care activities with SWs and men associating with the sex work environment ("clinical services/community support" combined approach) enable a better control of STI/HIV spread at least among the sex worker population and their clients;

- Building a collaboration with security forces ensuring reduced police raids (dispersal of SWs), reaching SWs in sex work sites and encouraging their visits at AS for a regular medical follow-up and STI management to minimize HIV transmission;

- Interventions fostered or guided by operations research data help concrete and tangible results to be achieved rapidly, especially as the beneficiary groups are sensitized and mobilized for action and are effectively involved;

- Directing early HIV/AIDS interventions towards the most at risk target-groups, that is SWs and their sexual partners had a measurable impact on HIV and curable STI prevalence (syphilis, gonorrhea and Chlamydia);

- SW STI management for effective reduction of the incidence of HIV requires this particular adapted service strategy for an integrated regular SW follow-up, where the strategy is different from the one to be applied to the general population in STI management.

Monitoring and Evaluation

The Project has developed a performance measurement framework. Result indicators are outlined in it and are instrumental in attaining the overarching goal which consists in minimizing the transmission of HIV and sexually transmitted infections (STI) within target populations. The main objective is to ensure effective and sustained STI control through AS networks for the most vulnerable clientele, through women's empowerment and with the presence of strengthened community associations. Some of the main indicators are as follows:

- Periodic determination of HIV, gonorrhea and Chlamydia prevalence rates among the Project clientele by sex and age;
- Number of visits
- Number of STIs detected in health facilities, stratified by type of patients, type of STIs and by sex;
- Rate of condom use in target clientele by age and sex;
- Number of health workers trained by rank and sex;
- Proportion of people having consulted and received drug prescriptions deemed effective by class of clientele;
- Clientele satisfaction concerning health and prevention services by sex, age, and profession;
- Availability of STI generic drugs;
- Number of trained members of relay organizations (RO).

USEFUL INFORMATION FOR REPLICATION

Experience has shown that a triangular strengthening approach is needed based on:

- Training of service providers for the holistic care of SWs, not forgetting the necessary steps to inform and involve the local health authorities,
- Clinical Care including the selection of health center; rehabilitation, minimum equipment,
- Establishment of the linking facility; between community support activities and clinical care.

The institutionalization of the approach is the ultimate step in the implementation process for planned sustainability.

- close follow-up of AS establishment and development, as recorded in a specific guide to this effect;
- collaborating with security forces to facilitate SWs' empowerment to visit AS, in motivating the staff dedicated to this care, in strengthened collaboration between health workers and community workers in a common approach of SW outreach;
- Partnership with other linked facilities/institutions likely to accompany SWs for non health problems.

The effectiveness of Adapted Services basically depends on the quality of community workers' outreach work, reception, counseling and other service delivery.

In an AS, there should be at least two permanent full time or part time trained health workers (according to the number of visits) for clinical care, at least one person at the reception desk, another in the educational waiting room and one for any kind of counseling; multiple tasking is possible if the number of visits is not too high. For the premises layout, equipment and possibly STI drugs allocation, a minimum estimated at Canadian $15,000 in 2002 is required in the Benin context.

The intervention can be sustained if the following are taken into consideration:

- Compliance with the AS establishment guide;
- Understanding the country's organizational and health context from the outset, and more particularly the AS establishment area and environmental factors;
- Planning long-term health benefits have sustaining elements over time;
- Planning strategy institutionalization as a critical sustainability element, going through the local authority sensitization stages, and aiming at adoption of the strategy eventually;
- Involvement in the piloting of interventions to attain results are likely to lead to ownership and national health strategic plan mainstreaming;
- Baseline health worker training and, overall, integrating this strategy in medical and para-medical training institution curricula is fundamental for sustainability, as that technical motivation per se can foster strategy institutionalization in the long run.

CONTRIBUTORS

▪ Marguerite NDOUR	Coordinator, AIDS 3 Project, Benin
▪ Michel ALARY	Centre Hospitalier Universitaire Affilié du Québec (CHA), Canada
▪ Clarisse GOMEZ	AIDS 3 Project, Benin
▪ Georges BATONA	AIDS 3 Project, Benin
▪ Félix AGBLA	AIDS 3 Project, Benin
▪ Honoré MEDA	WHO Africa Region, Harare
▪ Cyriaque GNINGTOUNGBE	Ministry of Public Health/BASP'96, Benin

APPENDIX

SEXUALLY TRANSMITTED INFECTIONS (STI) TASK FORCE

NAME	POSITION	INSTITUTION	COUNTRY
Traoré Adama	Aggregate Professor/ Doctor	University of Ouagadougou	Burkina Faso
Affana Gislaine	Unité IST	NAC/GTC	Cameroon
Dzokoto Agnes	Medical Doctor/ STI Focal Person	National AIDS Control Program (NACP)	Ghana
Cissé Diallo Aissata	Medical Doctor/ STI Chief of Unit	STI Focal Person NACP	Mali
Karim Seck	Medical Doctor	Project BHAPP	Benin
Amouzou Amegnona	Medical Doctor/ Venereologist	NACP	Togo
Bello Yessoufou	Medical Doctor/ Coordinator	NACP	Benin
Béhanzin Luc	Medical Doctor/ Technical Advisor STI	CHA/ AWARE	Benin
Ettiegne T. Virginie	Medical Doctor/ Technical Advisor STI	Project RETRO-CI	Côte d'Ivoire
Agbodjavou K. John	Medical Doctor /Facilitator	JHPIEGO/AWARE	Togo
Sidibé G. Souko	Medical Doctor	SOUTOURA	Mali
Diouf Daouda	Medical Doctor/ Coordinator	Enda-tiers monde	Senegal

PREVENTION OF MOTHER-TO-CHILD TRANSMISSION

RAPID SCALING-UP OF PREVENTION OF MOTHER-TO-CHILD HIV TRANSMISSION (PMTCT) IN RURAL AREAS IN CAMEROON

SUMMARY

In February 2000, the Cameroon Baptist Convention Health Board (CBCHB) began a Prevention of Mother-to-Child Transmission (PMTCT) program in two provinces of Cameroon with the support of the Elizabeth Glaser Pediatric AIDS Foundation (EGPAF). After a successful pilot phase, the CBCHB embarked on the implementation with an overall goal to reduce the incidence of HIV infections in children by scaling up the PMTCT services in six of the 10 provinces of Cameroon, covering at least 100,000 pregnant women by 2007.

Specifically, the program objectives were to:

- Integrate PMTCT services into routine antenatal services in two provinces by 2004;
- Adopt a community-based approach in service delivery (bottom-up approach);
- Intensify training of trainers and raise the number of counselors from 21 in February 2000 to 500 by December 2005 and
- Collaborate with the National AIDS Control Committee (NACC) in the training activities.

Many strategies were developed including:

- Training of senior counselor trainers who trained the health workers from potential sites;
- Voluntary HIV counseling and testing of pregnant women in ANC with opt out approach and same day results;
- Care for the mothers including antenatal care and follow-up for HIV-positive women, counseling for HIV-negative women to avoid the risk of infection; provision of ARVs (nevirapine) to HIV-positive women and their newborns to reduce the risk of mother-to-child transmission of HIV; counseling on infant feeding; involvement of male partners;
- Involvement of local communities in service delivery through Trained Birth Attendants (TBAs);
- Supervision of activities; monitoring and evaluation;
- Partnership at the national and international levels.

After 5 years of implementation, the Cameroon Baptist Convention Health Board Prevention of Mother to Child Transmission (CBCHB PMTCT) program has scaled up activities from two active health facilities in February 2000 to 124 in March 2005. These PMTCT sites are distributed in six of the 10 provinces of Cameroon. During the same period, 492 counselors and other health care workers were trained, and a total of 79,307 women counseled in antenatal care (ANC). About 91.5% (72,513/79,307) of the counseled women agreed to undergo HIV testing during ANC and 97.5% of these (70,693/72,513) received their results on the same day. Among the women tested, 8.6% (6,255/72,513) were found to be HIV positive and about 40% (2,507/6,255) of infected mothers and their newborn babies were treated with nevirapine. Tracking treated mothers and their babies was very difficult given that some of the sites did not have maternity services. About 15% (162/1079) of the babies screened were found to be HIV positive by the Polymerase Chain Reaction (PCR) test at six weeks of age.

HIV positive mothers were organized into 24 functional Support Groups of about 800 mothers, for psychosocial support and counseling on infant feeding. About 100 TBAs were trained in PMTCT at the community level and in their turn counseled more than 1,600 women at primary healthcare centers.

A solid partnership has been developed with the National PMTCT program coordinated by the Ministry of Public Health with the support of other public and private, national and international partners. An Excel spreadsheet has been developed and is used for an effective monitoring of program activities.

From this experience, one can gather that the bottom-up approach ensures the full involvement of the community as a key component for the ownership of a PMTCT program and that the Opt-out approach in VCT as well as same day rapid test results are essential to increasing acceptability of HIV testing during the antenatal period. The Opt-out consists of systematic offer of HIV test (as part and parcel of ANC) to each pregnant woman while allowing her the chance to withdraw from the process at any time. All the same, support group activities involving HIV infected women should be part of each PMTCT program for the early management of psychosocial problems and other related issues. Finally, trained birth attendants qualified to provide PMTCT services in rural areas have been found to be very useful.

Major challenges to be addressed are: geographical accessibility to some remote areas, partner involvement, burn out of the central management team and clinical staff, sustainability of supplies (HIV tests), follow-up of mothers and their infants, and access to affordable care and antiretroviral treatment for infected mothers and children.

IMPLEMENTING ORGANIZATION

Organization:

- Cameroon Baptist Convention Health Board (CBCHB)
  P.O Box 1 Bamenda, Cameroon
  E-mail: cbchsc@aol.com

Contact person:

- Tih Pius MUFFIH, MPH, PhD
  Director of Health Services
  Tel: +237 776 47 81/769 84 59/750 40 70
  E-mail: piustih@aol.com

IMPLEMENTATION CONTEXT

Cameroon is a country in the Central Africa Region with an estimated 15.8 million inhabitants and a population growth rate of 2.2%. Cameroon's Human Development Index was 0.528 in 1998, representing a slight improvement of 1.7% in eight years. It is organized into 10 provinces. The per capita income is 560 USD (2001) and 40.2% of the population lives below the poverty line (ECAM, 2002); the country was declared eligible for funding from the Highly Indebted Poor Countries (HIPC) initiative in September 2002.

The HIV seroprevalence in the general population is 5.5% (DHS-III, 2004). HIV transmission is primarily heterosexual and women are more vulnerable, with 17 infected women for every 10 infected men. The prevalence among pregnant women in sentinel sites had a 23-fold increase in 15 years, from 0.5% in 1987 to 11.8% in 2002. The most infected age groups are 30 to 34 and 35 to 39 years. HIV/AIDS has had a negative impact on Cameroon's economy at national, community, and household levels. The fight against HIV/AIDS in Cameroon has been declared a major health priority and a critical economic priority as well.

Since early 1996, the Cameroonian political leadership has expressed a clear and strong commitment to the fight against HIV/AIDS. In September 2000, the government launched the Multi-sectoral National Strategic Plan for the period 2000-2005 that includes partnership with civil society and local communities. To ensure efficient management, the National AIDS Control Committee (NACC) was instituted and its structures decentralized.

In the recent past, Cameroon has developed strong programmatic capacity in HIV/AIDS prevention and has been able to scale-up prevention activities. VCT and PMTCT services, behavior change activities, social marketing of condoms, and safe blood supply all benefit from strong national and international technical and financial support. With its recent admission in 2004 to the Global Fund and "3 by 5" initiatives, Cameroon will improve accessibility and quality of overall case management for Persons Living with HIV/AIDS (PLHA) and support for Orphans and Vulnerable Children (OVC) in order to complete the range of services through the scaling-up of successful pilot initiatives, and integration of critical programming innovations.

Prevention of mother to child transmission (PMTCT) in HIV infected mothers is a major priority of the strategic plan and the National PMTCT program which is being implemented through the coordination of the Ministry of Public Health in close partnership with the public and private sectors. Since 2000 the Cameroon National PMTCT Program has made huge strides in scaling-up of PMTCT activities to more than 272 health facilities in the 10 provinces in 2004 and in integrating PMTCT interventions as a component of Reproductive Health Care services. The CBCHB is one of the major partners of the Ministry of Public Health in these achievements.

The health services run by CBCHB are located in six of the 10 provinces of Cameroon, namely the Northwest, Southwest, Centre, Littoral, Adamaoua and West Provinces with an estimated total population of 10 million inhabitants. According to a sentinel surveillance survey conducted in 2000, the HIV prevalence in these provinces varied from 6.2% for the Littoral to 17 % for the Adamaoua province.

The fight against HIV/AIDS in these provinces is coordinated by the Provincial AIDS Control Committee through the Provincial Technical Group which implements a multi-sectoral action plan with the support of all local partners. At the level of subdivisions and villages, local committees to fight against HIV/AIDS have been organized for community mobilization and sensitization.

PMTCT activities in these provinces are implemented by both the government, CBCHB and other partners (UNICEF, Glaxo Foundation, European Union, and Plan Cameroon) Faith-based, or health facilities based in both rural and urban areas in these provinces.

FUNDING

The CBCHB PMTCT is funded essentially by Elizabeth Glaser Pediatric AIDS Foundation (EGPAF) based in USA. Other funding partners include:

- ABBOTT Laboratory which donates test kits and nevirapine,
- The Cameroon government,
- UNICEF Cameroon which supports training,
- Center for Disease Control and Prevention (CDC) Atlanta which provides Technical Assistance by performing PCR tests free off charge for infants of positive clients and analysis of data collected,
- USAID through its West Africa Regional Program (WARP) and the Action for West Africa (AWARE) project.

CBCHB contributes to the funding of these PMTCT activities through cost sharing.

BENEFICIARIES

The target population of the PMTCT program implemented by CBCHB is estimated at 500,000 pregnant women by 2007 from the Northwest, Southwest, Centre, Littoral, Adamaoua and West provinces. According to sentinel surveillance survey conducted in 2000, the HIV prevalence in these provinces varied from 6.2% for the Littoral to 17 % for the Adamaoua province. Factors which predispose women to HIV infection in these regions are low educational levels, poverty, low capacity to negotiate sex, the social status of women in society, early marriages and polygamy.

DETAILED DESCRIPTION

The CBCHB is a Faith-Based, non-profit making organization with a mission to assist in the provision of health care to all who need it as an expression of Christian love. It runs three (3) hospitals, twenty one (21) Integrated Health Centers and forty two (42) Primary Health Centers. Banso Baptist Hospital (BBH) and Mbingo Baptist Hospital (MBH) are two of its main hospitals and they serve as referral hospitals in the North West Province of Cameroon. The Baptist Integrated Health Center Mutengene in the South West Province has evolved into a hospital since July 2004 and has been named Baptist Hospital Mutengene. In February 2000, the Cameroon Baptist Convention Health Board (CBCHB) began a PMTCT program in two provinces of Cameroon with the support of the Elizabeth Glaser Pediatric AIDS Foundation (EGPAF).

After a successful pilot phase, the CBCHB embarked on the implementation of the extension of PMTCT services in six out of 10 provinces in Cameroon, to cover at least 100,000 pregnant women by 2007, with the overall hope of generally reducing the incidence of HIV in children.

Specifically, the program objectives were to:

- Integrate PMTCT services into routine antenatal services in two provinces by 2004;
- Adopt a community-based approach in service delivery (bottom-up approach);

- Intensify training of trainers and raise the number of counselors from 21 in February 2000 to 500 by 2005;
- Collaborate with the National AIDS Control Committee (NACC) in training activities.

Many strategies were developed including:

- The training of senior counselor trainers who trained the health workers from potential sites;
- Voluntary HIV counseling and testing of pregnant women in ANC with an opt-out approach and same day results;
- Care for the mothers including antenatal care and follow-up for HIV-positive women; counseling HIV-negative women to avoid the risk of infection; provision of ARVs (nevirapine) to HIV-positive women and their newborns to reduce the risk Mother-To-Child Transmission of HIV (MTCT);
- Counseling on infant feeding; involvement of male partners;
- Involvement of local communities in service delivery through Trained Birth Attendants;
- Supervision of activities; monitoring and evaluation;
- Partnership at the national and international levels.

Prior to the commencement of activities, training is usually carried out by the CBCHB PMTCT staff in all the health Districts in these Provinces to make sure the trainees (Doctors, Laboratory Technicians, and Nurses) are well versed in the norms and standards of the PMTCT program.

Counseling procedures include group facilitated discussion, individual pre-test and post-test counseling during antenatal clinic. Antenatal clinics (ANC) in Cameroon are open every day but most of them receive women coming for first visits on particular days. The CBCHB takes advantage of this and counsels the women in groups through a method known as "group facilitated discussion". Health lectures are given on various topics including HIV. Essential information on HIV/AIDS is provided. The various tests undertaken by the women during antenatal care are discussed and emphasis is laid on HIV testing. The women are informed that they can choose not to do any of the tests at any time (opt-out approach) if they so wish.

The pre-test counseling is performed by a trained counselor and comes after the group facilitated discussion. During this step, information gained from group facilitated discussion on HIV is reviewed and the client decides whether to do the test or not. The client is given an identification number by the counselor, which is written on the laboratory form. She is then sent to the laboratory for the test. During the testing the laboratory technician does the test and personally takes the results to the counselor. Confidentiality is maintained between the laboratory staff and counselors, by a coding system established between the counselor and the laboratory technician. The result of the HIV test is also coded at the laboratory. The HIV result's code is known by both the laboratory staff and the counselors.

During the post-test counseling, the counselor receives the test result, counsels the client, and discloses the test result to the client. Counseling on staying negative is done for those who are negative, while those who are positive are given information on how to cope with their condition. The CBCHB routinely gives the results to clients on the same day. This strategy has increased the number of those who received their results to 97.5% (70,693/72,513).

After five years of implementation, the CBCHB PMTCT program has scaled up activities from two active health facilities in February 2000 to 124 by March 2005. These PMTCT sites are distributed in the six provinces covered by the program. During the same period, 492 counselors and other health care workers were trained, and a cumulative 79,307 women counseled in ANC. About 91.4% (72,513/79,307) of the women counseled accepted to undergo HIV testing during ANC and 97.5% (70.693/72,513) received their results. Among the women tested, 8.6% (6,255/72,513) were found to be HIV positive and about 40% (2,507/6,255) of infected mothers and their newborns were treated with nevirapine.

The tracking of treated mothers and babies has been very difficult because some of the sites do not have maternity services. About 15% (162/1079) of the babies screened were found to be HIV positive at six weeks using the PCR test. HIV infected mothers were organized into 24 active Support Groups with about 800 mothers, for psychosocial support and infant feeding counseling.

One hundred TBAs were trained on PMTCT at the community level and they have counseled more than 1600 women at primary health centers. A strong partnership has been developed with the National PMTCT Program coordinated by the Ministry of Public Health and with other public and private partners both nationally and internationally. An Excel spreadsheet has been developed which is used for an effective monitoring of the program.

Major challenges to be addressed are; the geographical accessibility of some remote areas, the involvement of partners, burn out of the central management team and clinical staff, sustainability of supplies (HIV tests), follow-up of mothers and their infants, provision of replacement feeding and access to affordable care and treatment for infected mothers and children.

Lessons learned from this experience are as follows:

- Community AIDS education serves as the fore-runner of PMTCT. Most women who have been educated on HIV/AIDS come to the clinic already aware of PMTCT which facilitates counseling,
- Integrating PMTCT into routine antenatal care is a key factor for rapid up scaling of PMTCT services,
- Group facilitated discussions and the opt-out approach are critical and useful,
- Same day test results lead to a high rate of acceptance for HIV testing and of the results,
- Using skilled Trained Birth Attendants is effective in the scaling up of PMTCT services,
- Support groups provide added human resources for psychosocial and nutritional support in scaling up PMTCT services,
- Developing the Excel spreadsheet helped to meet national needs in the monitoring of PMTCT activities.

Monitoring and Evaluation

Indicators are conceived based on the overall goal of reducing MTCT by 50% and the variables to be monitored are selected based on the requirements of the funding organizations and the government. Tools for collecting and analyzing data are developed and discussed with the service providers and the staff of the coordination office to ensure good understanding and cooperation.

Key indicators being tracked include:

- Proportion of ANC clients counseled who agreed to be tested;
- Proportion of the clients tested who receive test results;
- Proportion of women tested who are HIV positive;
- Proportion of the mothers who are treated with prophylactic ARV;
- Proportion of newborns who are treated with prophylactic ARV ;
- Proportion of infants HIV infected (PCR at 6 weeks or serology at 18 months).

Monthly and annual forms are developed and sent to service providers to collect data on a continuous basis. These are collected and forwarded to the coordination office for analysis and reporting. Quarterly and biannual reports are prepared for the government, international organizations and for coordination purposes. Coordinators use the monitoring reports to detect sites that have counseling and testing problems and follow-up for correction. Quarterly feedback on reports are given to the sites

The tools for M&E include registers, data collection forms, monthly report forms, annual report forms and follow-up forms for positive mothers and their infants. Excel spreadsheets, Epi Info 6.04.INC and other computer software are used for compiling and analyzing data. This spreadsheet is constantly modified to meet the increasing needs following program expansion.

USEFUL INFORMATION FOR REPLICATION

Bottom-up approach

This approach implies the implementation of PMTCT services starting from the community instead of the central level (Referral hospitals, etc.). The slogan "Use what you have to do what you have to do" is used. Through the use of TBAs, more communities are served. A Community AIDS Program was initiated to increase the awareness of the population on HIV/AIDS; it has served as a "community pre-counseling" or "fore runner" for PMTCT services.

The program has helped the people in the community to understand their potential, get involved in it and own it. They are trained and recruited on an as needed basis.

At the provincial level, a partnership is being developed with the Government and other interested partners. The CBCHB is sharing lessons learned at the national level, helping to train leaders, promoting transparency and helping in the preparation of national policies and guidelines. The CBCHB started PMTCT in February 2000 and had only five sites by the end of 2000. CBCHB initially expanded slowly by doing on-the-site training but in 2002 developed a new strategy which enabled a rapid expansion. This strategy involved group training of counselors and laboratory technicians. This new strategy was reinforced in 2003 when Prof Tih received the EGPAF International Leadership Award (ILA) which permitted CBCHB to carry out PMTCT leadership training. The ILA enabled training of PMTCT service providers and leaders in four out of the 10 provinces of Cameroon, and a steady expansion of PMTCT in these provinces. A team of trainers was set up and a modular training manual was created. A monitoring plan for PMTCT is also available. When service providers are trained and a site is ready for implementation of PMTCT, a team of coordinators is sent to facilitate the implementation and follow-up visits are done regularly to ensure effectiveness. Activities are

regularly monitored and evaluated. Attempts are made to follow-up the infants of HIV+ mothers. At six weeks, PCR specimens are collected for testing, while rapid tests are done at 15 – 18 months.

While recognizing the impressive achievements of this bottom-up approach in the rapid expansion of PMTCT, to ensure the sustainability and quality of such programs, it is critical that the central level gets involved early enough in order to coordinate the expansion process, supervise the efforts on the ground, and ensure the quality of services offered.

Group facilitated discussion combined with individual pre-test counseling

Antenatal clinics (ANC) in Cameroon are open everyday, but most of them reserve particular days to receive women coming for first visits. The CBCHB takes advantage of this and educates the women in groups. Health lectures are given on various aspects including HIV. Essential information on HIV/AIDS is provided.

The various tests the women undertake during ANC are discussed and emphasis is laid on HIV testing. The women are informed that they can choose not to do any of the tests (opt-out approach). Individual pre-test counseling follows immediately and information gained on HIV is reviewed and the client decides whether or not to do the test.

Same day rapid results

The patients flow is organized to reduce waiting time. At the end of group-facilitated discussion, the counselors continue into individual pre-test counseling. Once a woman consents to the test, she is sent to the laboratory where specimens for all her lab tests including HIV are collected. She goes back and continues with normal ANC procedures while the lab technician does the tests using rapid HIV tests. The laboratory technician takes the results to the counselor immediately he finishes and post-test counseling can begin. It should be noted that some centers offer entertainment (television). The counseling is usually convincing and all the women are anxious to get their results.

PMTCT integrated into routine antenatal care

PMTCT is part of the minimum package for antenatal care. The staff involved in antenatal care (midwives, nurses, counselors, laboratory technicians and doctors) is trained and they offer PMTCT services as part of their normal activities. However, additional time is needed for pre-test and post-test counseling. The staff is made to understand the goals and objectives of the program, and the importance of their contribution in reducing the spread of HIV in children. They monitor their activities, prepare reports and request for assistance in case of difficulties.

Support Groups (PLHA)

The rationale for support groups is that “people of the same condition can easily discuss and find solutions to their problems”.

The overall objective of the support group is to create a forum for people in a similar condition to promote learning from each other on how to cope better with HIV/AIDS.

When positive women come back to the clinic for subsequent visits, they are individually asked if they would like to share their experience with other positive women. Those who are willing are assisted to meet and are given some time to talk between themselves. This proves to be very useful and they may wish to meet again. Other HIV positive women are invited in this way and the group grows. The support groups have proven to be very useful and serve as a means of improving follow-up of mothers and babies. The members serve as peer educators in their communities and some have been recruited as counselors to reduce stigma and discrimination.

Community AIDS Education

Sensitization of the community and training of volunteers as community educators helps to give information on HIV/AIDS to the public. MTCT is mentioned during the course of these interventions. Therefore, intensive community education serves as a "fore runner" for PMTCT. When women know about MTCT before coming to the clinics, it makes counseling easier and they easily accept to do the test.

Monitoring and Evaluation System

Programs like the PMTCT program need effective, visionary and available leadership at all times to ensure that the program runs well. Regional Coordinators/Supervisors are appointed, and they carry out supervisory visits to the sites to facilitate matters. A leader is chosen at each site to process the monthly reports. A solid management team monitors the smooth running of the program. Responsibilities are delegated and coordination meetings held regularly to evaluate the program.

When a site is created, registers are provided for data collection. At the beginning of each year, monthly and annual report forms and pre-addressed envelopes are sent to each site. The coordinators visit the sites to give explanations if needed. The staff at the sites completes the monthly report forms and returns them to the central coordination office. The data collected is entered into the Excel spreadsheet. Monthly and quarterly reports are produced.

The quarterly reports are sent to the Government and funding agencies while summaries per site are sent to the sites for information, feedback and self evaluation. Annual and bi-annual reports are produced from this database which is constantly updated.

Cost effectiveness

The use of available clinic staff and Trained Birth Attendants lowers cost of salaries. The proximity of the program to rural populations allows for wider coverage. Integrating PMTCT activities into ANC services allows for the multi-functional use of staff.

Challenges and constraints

A program like this one cannot run without difficulties and challenges. The CBCHB faces challenges such as; follow-up of positive mothers and their babies, poor road network which hinders supervision in remote areas, provision of free replacement food, information on feeding

options to mothers, and an adequate supply of reagents. Some solutions were the start of support group initiative and requesting for free test kits and Nevirapine from Axios Foundation.

Sustainability

CBCHB is very concerned with the sustainability of the PMTCT activities that it supports. The involvement of the National PMTCT Program of the Ministry of Public Health from the onset in the project has enabled the integration of the PMTCT into the Maternal and Child Health Program of the Ministry. In addition, the staff sensitize the clients on the need to contribute towards their HIV testing and treatment which will not always be available in the future. Also, an "adopt a health care worker" account has been opened and the staff voluntarily donates at least 1% of their salary each month. Money from this account is used to treat infected staff. This can also be used to sustain the program for a while if funding is unavailable.

CONTRIBUTORS

- Tih Pius MUFFIH — MPH, PhD, Executive Director, Cameroon Baptist Convention Health Board (CBCHB), Cameroon
- Thomas K. WELTY — MD, MPH, CBCHB, Cameroon
- Marc BULTERYS — MD, MPH, CBCHB, Cameroon
- Cathy WILFERT — MD, CBCHB, Cameroon
- Joseph NKAFUSAI — CBCHB, Cameroon
- Godlove NKOH — CBCHB, Cameroon
- George NDIKINTUM — CBCHB, Cameroun
- Janet KAYITA — Family Health International

INTEGRATION OF PMTCT INTO PRE-SERVICE TRAINING CURRICULA OF NATIONAL TRAINING INSTITUTIONS IN CÔTE D'IVOIRE

SUMMARY

Information, education, and training are important components of Prevention of Mother-to-Child Transmission of HIV (PMTCT) efforts. To be more effective, they must target health workers and be integrated into pre-service health training institutions. Until recently, in Côte d'Ivoire, only 32 maternal and child health centers provided PMTCT in a country that has more than 2700 health centers in the public and private sector combined. There are more than 3000 physicians, pharmacists, biologists, and dentists and 9000 nurses, midwives, laboratory technicians, and social workers in these health facilities. The majority of these health workers working in the field had not received formal PMTCT training that would allow them to take care of pregnant women. Considering the high HIV prevalence in the country, the Côte d'Ivoire Ministry of Health (MOH) recognized the necessity of integrating PMTCT training for health service providers in the programs of training institutions.

The over-all goal of the program is the promotion of long-term quality, sustainable PMTCT-related training and the development of a cadre of PMTCT expert trainers.
The following specific objectives must be achieved:

- Evaluate existing PMTCT in-service and pre-service training materials for physicians, midwives, nurses, social workers, and laboratory technicians;
- Establish a national steering committee to oversee the process and monitor progress;
- Mobilize 250 trainers and opinion leaders to engage in the PMTCT roll-out through a participatory process to sensitize them about roll-out plan and training needs;
- Develop or adapt in-service and pre-service training materials drawing on existing French and English language training materials (including generic WHO/CDC PMTCT training documents);
- Establish on the basis of the developed PMTCT materials, a pool of expert trainer's representative of all the pre-service and in-service institutions.

In November 2003, the John Hopkins Program of Information and Education for Gynecologists and Obstetricians (JHPIEGO) was asked to conduct a needs assessment at Abidjan University, the National Institute of Social Training, and the National Institute of Specialized Training, to determine how best to integrate PMTCT into pre-service and in-service health training curricula. This assessment found that there were no standardized PMTCT training materials used for in-service interventions by implementing partners. In pre-service training institutions, there were no formal PMTCT modules and very little time on their timetables addressed to HIV/AIDS as a subject.

A stakeholders meeting was held to share the findings of the needs assessment. Stakeholders created a steering committee of 20 persons to oversee and provide important leadership to the development and standardization of PMTCT in-service and pre-service training initiatives.

The first action of the steering committee was to mobilize 250 university professors and assistant professors to involve them in the PMTCT roll-out through a participatory process. The purpose of the meeting was to sensitize universities and training institutions about the new national PMTCT policy as well as the new directives, implementation plan, and training needs.

From April to June 2004, French language PMTCT training materials (PMTCT reference document, training manual for trainers and for training participants) were developed for service providers/counselors. The methodology was to collect and review PMTCT training materials available in Africa, as well as the new WHO/CDC PMTCT generic training curriculum. A list of training modules was adopted and PMTCT documents were developed. In September 2004, a validation workshop was organized and additional comments and suggestions were integrated in the documents.

A pool of 44 expert trainers, representative of all the pre-service and in-service units was put together on the basis of newly developed PMTCT training materials. Participants were carefully selected. With reference to pre-service training institutions, the head of each department was chosen to organize subsequent training workshops for his peers in his department, as well as to facilitate PMTCT modules integration in the department curricula. Two groups were trained through 10-day sessions for each group, using JHPIEGO's approach in competency-based training skills (including 5 days for training skills and 5 days for PMTCT issues) in September 2004 and January 2005.

The approach to sensitizing and training key professors in pre-service training institutions was in reality the first step of integrating PMTCT modules into the current curricula of universities and training institutions. The newly trained professors promptly adapted their respective courses to integrate PMTCT when appropriate. The overall program provided over the course of time a critical mass of health workers capable of mastering PMTCT practices throughout the country.

The next steps for the second year of the program are to modify the number of hours allocated to HIV/AIDS as a subject within the curricula of training institutions through a departmental order which will make the strategy effective.

IMPLEMENTING ORGANIZATION

Institution:

- CDC/Project RETRO-CI
  C/o Embassy of the United States, 5 rue Jesse Owens,
  01 BP 1712 Abidjan 01, Côte d'Ivoire
  Tel: +225 21 25 41 89
  Fax: +225 21 24 29 69

Contact persons:

- Monica NOLAN, MD, MPH
  Director, CDC/Project RETRO-CI
  E-mail : mgn1@cdc.gov

- Mathurin Soumahoro OULAÏ
  Director of Training and Research
  Ministry of Health, Côte d'Ivoire

IMPLEMENTATION CONTEXT

Situated on the West coast of Africa, the Côte d'Ivoire covers 322,462 square kilometers and is bordered by the Atlantic Ocean and five countries; Liberia, Guinea, Burkina Faso, Mali, and Ghana. It is the world's largest cocoa producer and also produces large volumes of coffee, rubber, palm oil, cotton, and timber. It also has highly developed road, rail and shipping networks and infrastructure. It is an economic, transport and migratory hub for the sub-region. The official language is French. The total population is estimated at 16.8 million inhabitants (World Bank 2002).

The birth rate is 41 per 1,000 (DHS 1998) and annual population growth rate is estimated at 3.3%, which will result in a doubling of the population in less than 25 years. Approximately 54% of the population lives in rural areas. The population is mostly young with an age structure as follows: 0-14 years 46.2%, 15-64 years 51.6%, and 65 years and over 2.2%, with a male/female ratio close to 1:1 in all age groups (census 1998). Life expectancy at birth is 50.9 years.

Infant and child mortality is also high; 93.6 and 140 deaths per 1,000 live births respectively (1998 DHS). Infectious diseases, primarily malaria, diarrhea, respiratory infections, measles and tetanus, and increasingly HIV/AIDS account for most of the illness and death among children. Maternal mortality is 1200/100,000 live births.

Contraceptive use is very low (7.3% use modern methods) and fertility rates are high in Côte d'Ivoire with a total fertility rate of 5.2 children (1998 DHS).

Côte d'Ivoire has long been the country with the highest HIV prevalence in West Africa, with an estimated stable adult population prevalence of 7% in 2004 (UNAIDS 2004).

AIDS has been the leading cause of death among adults (15-49 years) since 1998. Both HIV-1 and HIV-2 coexist but HIV-1 is much more prevalent among pregnant HIV-positive women. HIV antenatal sentinel surveillance reveals an urban prevalence of approximately 10% and a prevalence greater than 5% in most rural sentinel sites in 2002. In 2004, UNAIDS estimated there were 420,000 children who had lost one or both parents to AIDS. An estimated 54,000 infants are born to HIV-infected women each year, of whom approximately 1/3 are infected in the absence of PMTCT interventions. In 2003, only 2.4% of HIV-positive pregnant women received a complete course of ARV prophylaxis to reduce the risk of mother to child transmission. This demonstrates to what extent PMTCT interventions are necessary.

FUNDING

The overall program was funded through the US President's Emergency Plan for AIDS Relief. The U.S. Center for Disease Control and Prevention, through its Retro-CI Project which has since 1988 been working to address HIV prevention in Côte d'Ivoire, and the Johns Hopkins Program for Information and Education of Gynecologists and Obstetricians provided technical assistance and expertise to the program.

BENEFICIARIES

The program directly targeted 314 professors, assistant professors, health workers, and opinion leaders. But around 12,000 health workers working currently in the various health centers throughout the country were indirectly targeted as well as all the students attending the national pre-service health training institutions.

DETAILED DESCRIPTION

Information, education, and training are important components of preventing mother-to-child transmission of HIV (PMTCT). To be more effective, they must also be targeted to health workers and integrated into pre-service health training institutions. Today, only 32 mother and child health centers in the Côte d'Ivoire provide PMTCT services although it has more than 1300 health centers in the public sector and 1416 clinics, private infirmaries, and pharmacies in the private sector. These public and private health centers are run by more than 12,000 service providers (physicians, chemists, biologists and dentists, nurses, midwives, laboratory technicians, and social workers). All these people have received their pre-service training at the University's Research and Training Units for Medical Sciences, Biological and Pharmaceutical Sciences, Odontology and Stomatology, and at the National Institute of Social Training for social workers and the National Institute of Specialized Training for paramedics. The Ministry of Health recognized that most of the health workers working in the field did not have the formal PMTCT training that would allow them to take care of pregnant women in the country with a high HIV prevalence, and recognized the necessity of integrating PMTCT training in pre-service training institutions. In response to this need, the National HIV Care and Treatment Program and Training and Research Direction of the Ministry of Health drew on the assistance of the U.S. Centers for Disease Control and Prevention, through its Retro-CI Project, and the technical expertise of JHPIEGO to work with universities and health training institutions to rapidly develop a long-term training approach for pre-service national training institutions.

The overarching program goal was the promotion of long-term quality and sustainable PMTCT-related training and the development of a cadre of PMTCT expert trainers. The specific objectives for a one-year period were to:

- Evaluate existing PMTCT in-service and pre-service training materials for physicians, midwives, nurses, social workers, and laboratory technicians;
- Establish a national steering committee of 20 persons led by the Training and Research Director of the Ministry of Health, with representatives from universities and health training institutions, organizations implementing PMTCT, and UN technical agencies, to oversee the process and monitor progress;

- Mobilize 250 trainers and opinion leaders to engage in PMTCT implementation through a participatory process to sensitize them about the national PMTCT policy and guidelines, roll-out plan and training needs;
- Develop or adapt in-service and pre-service training materials (national guide, trainers' manual and participants manual adapted for the different professional groups) drawing on existing French and English language training materials (including generic WHO/CDC PMTCT training curricula and existing French language training materials from other African countries);
- Create, using PMTCT materials, a pool of expert trainers' representatives of all pre-service and in-service units by selecting Heads of Department or members of the Educational Committee at University or Training Institutions to facilitate the integration of PMTCT modules in the existing curricula.

The following activities were planned and implemented:

Needs assessment

JHPIEGO conducted a needs assessment at Abidjan University, National Institute of Social Training and National Institute of Specialized Training, to determine how best to integrate PMTCT into in-service and pre-service health training curricula.

The assessment found that in pre-service training institutions there were no standardized PMTCT training materials and there were few lectures at the time addressing HIV/AIDS.

Creation of National Steering Committee

A stakeholders meeting was held to share the findings of the needs assessment. Stakeholders created a steering committee of 20 persons to oversee and provide important leadership in the development and standardization of HIV/AIDS in-service and pre-service training initiatives, starting with PMTCT. This committee was led by the Training and Research Direction of the Ministry of Health, and comprised key stakeholders from in-service training sectors and from faculty members. This committee also included representation from NGOs of Persons Living with HIV/AIDS (PLHA) and resulted in a representative sample of the national PMTCT committee open to other HIV/AIDS actors. The terms of reference of the steering committee were to encourage the application and effectiveness of initiatives, make recommendations, and provide political and technical support. This steering committee was included in the mission of the Training and Research Office of the Ministry of Health through a departmental order and worked closely with the National HIV/AIDS Care and Treatment Program, JHPIEGO and CDC for implementation of activities. The process resulted in the mobilization and strong involvement of national opinion leaders including Deans and/or Directors of the training institutions, as well as senior representatives of the various professional bodies. This group became a new force in the advocacy for rapid PMTCT implementation as well as expanded HIV services.

Mobilization

The first action of the steering committee was to mobilize 250 university professors and assistant professors to engage in the PMTCT roll-out through a participatory process. The purpose of

mobilization was to sensitize universities and training institutions about the new National PMTCT Policy and Guidelines, roll-out plan and training needs.

The approach was to reach as broad an audience as possible as well as key individuals heading department chairs at universities and professional health schools. To sensitize and inform the directors and deans about the training program and what it would entail, the National HIV Care and Treatment Program, the Research and Training Direction of the Ministry of Health, and CDC/Project RETRO-CI sent letters to the organization directors and deans and met them for a briefing on the background and rationale for the training. This opportunity was taken to emphasize the need for nominated key persons to attend all the sensitization sessions. Five One-day workshops were held in March 2004 for the Research and Training Units of Medical Sciences, Biological and Pharmaceutical Sciences, Odontology and Stomatology as well as the National Institute of Social Training and the National Institute of Specialized Training. During these workshops, presentations were made on the content of national PMTCT Policy, and Guidelines, as well as the PMTCT scaling-up plan. Discussions followed presentations to strengthen participants understanding. Around 50 participants attended each workshop, and national PMTCT documents were distributed to each of them.

Identification of national and international PMTCT experts

The process of developing PMTCT training materials was conducted by three JHPIEGO consultants, six national consultants, and PMTCT resource persons of the CDC/Project RETRO-CI, and the French project DITRAME Plus. National consultants came from university and national health training institutes. Selection criteria were; status of university professor or assistant professor, member of the educational committee responsible for curriculum development with related volume of hours, member of the National Steering Committee, and at least three years experiences in PMTCT.

Development of draft PMTCT training materials

From April to June 2004, French language PMTCT training materials (PMTCT reference document, training manual for trainers and for training participants) were developed for service providers/counselors. The methodology was to collect and review PMTCT training materials available in Africa, as well as the new WHO/CDC PMTCT generic training curricula. A list of training modules was adopted and included:

- HIV/AIDS overview
- Integrated PMTCT services as part of MCH care with routine counseling and voluntary on-site HIV testing, ARV prophylaxis and infant feeding counseling
- Promotion of partner/couple involvement in counseling
- Link to family planning services
- Social support and post-test support groups
- Comprehensive family-based HIV care and continuum of care
- Reduction of stigma and involvement of PLHA
- Program management, monitoring and evaluation
- Staff support and supervision.

Draft documents were developed and reviewed with the contribution of PMTCT experts in and outside Côte d'Ivoire.

Validation of PMTCT training materials

In September 2004, a validation workshop was organized and additional comments and suggestions were integrated in the documents.

Training of trainers for pre-service and in-service training institutions

A pool of 44 expert trainers, representative of all the pre-service and in-service units was trained with the newly developed PMTCT materials. Participants were carefully selected.

With reference to pre-service training institutions, the Head of each Department was chosen to organize subsequent training workshops for his peers in his department, as well as to facilitate PMTCT modules integration in the department's curricula. The training was accomplished through two 10-day training workshops with the JHPIEGO approach in competency based training skills in September 2004 and January 2005. Before each workshop began, trainers gave a preliminary questionnaire to all nominated participants. This questionnaire was not a test of knowledge. It rather sought information on participants' expectations and prior experience in developing or using training skills and PMTCT materials. Its purpose was to give the trainers insights into the participants and their backgrounds and levels of experience. The task of the trainers, therefore, was to accommodate all participants in a way that maximized the strengths of each. Trainers used participatory training methodologies and group work. JHPIEGO trainers administered a mid-course questionnaire to obtain feedback from the participant of the trainings. Many offered favorable comments, illustrating that the time spent focusing on competency based training skills and afterwards on PMTCT modules was worthwhile.

Integration of PMTCT modules into curricula of pre-service training institutions

The approach to sensitize and train key professors of pre-service institutions was in reality the first step of PMTCT modules integration into the current curricula of universities and training institutions. In fact, without delay the newly trained professors adapted their respective courses to integrate PMTCT when it was appropriate to do so.

As a result of this program, PMTCT training modules have been developed and teachers in training institutions have been trained. The teaching of the developed modules has started in the training institutions. The next steps for the second year of the program are to modify the amount of time allocated to the subject of HIV/AIDS within the curricula of training institutions through a departmental order to make the strategy effective.
In September 2002, the Côte d'Ivoire was plunged into an extended political, socio-economic and humanitarian crisis with an attempted "coup d'état" which resulted in rebel occupation of large cities and towns in the northern parts of the country. This situation brought about the disorganization of public services including the health services, and slowed down the implementation of the program.

The following are the lessons learned:

- The full involvement of all PMTCT stakeholders, (donors, NGOs, PLHA, training institutions) right from the beginning is very helpful.
- Review of the draft PMTCT training materials by others PMTCT experts inside and outside the Côte d'Ivoire for review and comments helped improve them.

- The use of generic WHO PMTCT training materials as reference material facilitated the process of training materials development.

Following are the next steps planned:

- Organize three-day workshops bringing together educational committees of each pre-service institution to review current curricula in institutions and propose a modified number of hours to integrate the HIV/AIDS subject into the curricula of training institutions;
- Organize a training of trainers workshop for 20 faculty members of each pre-service institution to accelerate integration of PMTCT modules into the current curricula of universities and training institutions, and facilitate the training of a critical mass of health teachers and students;
- Assure periodic follow ups of recommendations in each pre-service department using terms of references, work plans and quarterly reports given by health pre-service institutions to the Research and Training Office of the Ministry of Health

Monitoring and Evaluation

The key indicators tracked were;

- Number of training sessions held
- Number of people trained
- Number of hours attributed to PMTCT training
- A developed review schedule for training modules.

USEFUL INFORMATION FOR REPLICATION

The involvement of national experts and government officials has been fundamental to the success of the program. The use of the Office of Training and Research of the Ministry of Health to play the steering committee's role is a possible alternative to address the issue of motivation of steering committee members.

The participatory process with established and motivated public pre-service training institutions, motivated trainers, and the methodology to integrate PMTCT modules in the curricula of pre-service institutions ensures a sustainable approach.

MAIN CONTRIBUTORS

▪ Edith BONI-OUATTARA	CDC-Projet RETRO-CI / Elizabeth Glaser Pediatric AIDS Foundation, Côte d'Ivoire
▪ Monica NOLAN	Center for Diseases Control and Prevention (CDC), CI
▪ Laurence BEQUET	Project ANRS DITRAME Plus, PACCI Program, CI
▪ Paul SOSSA	JHPIEGO, Côte d'Ivoire
▪ Simplice ANONGBA	Training and Research of Medical Sciences Dept, CI
▪ Anthony TANOH	National Program for care and support to PLHA, CI
▪ Mathurin Soumahoro OULAÏ	Office of Training and Research, Ministry of Public Health, CI
▪ Coulibaly MAKAN	UNICEF, Côte d'Ivoire

APPENDIX

PREVENTION OF MOTHER-TO-CHILD TRANSMISSION (PMTCT) TASK FORCE

NAME	POSITION	INSTITUTION	COUNTRY
Adeyanju Isidore	Medical Doctor/ Coordinator	PRETRAME, NACP	Benin
Boni-Ouattara Edith	Medical Doctor/PMTCT Technical Advisor	Retro-CI Project/Elisabeth Glaser Pediatric Foundation	Côte d'Ivoire
Tih Pius Muffih	Director	Cameroon Baptist Convention Health Board	Cameroon
Boni-Ouattara Edith	Medical Doctor	Project Retro-CI	Côte d'Ivoire
William Kwabena Ampofo	Virologist	Noguchi Memorial Institute for Medical Research, University of Ghana, Legon	Ghana
Agnes-Soumahoro Justine	Medical Doctor/ Trainer VCT	Espoir-CIPS	Côte d'Ivoire
Njom Nlend	Medical Doctor	GTC/NAC	Cameroon
Charles Zouzoua	Medical Doctor/ Trainer VCT/ Director	FHI	Côte d'Ivoire
Claudes Kamenga	Facilitator/ Deputy Director	AWARE-HIV/AIDS	Ghana

VOLUNTARY COUNSELING AND TESTING FOR HIV

STRENGTHENING ACCESS TO VOLUNTARY COUNSELING AND TESTING FOR YOUNG STUDENTS IN BURKINA FASO

SUMMARY

Targeted strategies in prevention and voluntary counseling and testing (VCT) constitute a qualitative development in effective interventions in HIV/AIDS control. It is in line with this process that the project by the Program of Support to Community-based Organizations, PAMAC (Programme d'Appui au Monde Associatif et Communautaire) is scaling up youth access to voluntary HIV counseling and testing in Burkina Faso. Every year, the project organizes a national HIV/AIDS voluntary testing campaign in schools and universities to enhance voluntary counseling and testing in this specific environment as well as to promote low risk HIV/AIDS behaviors.

The first campaign was organized April 13 - 23, 2004. 20 testing centers, including 12 community centers traditionally funded by PAMAC, were mobilized. PAMAC set up a consultative committee to formulate a strategic approach and collaborative strategy that took the sensitive nature of the school environment into account. The committee comprised the Ministry of Secondary and Higher Education, the Ministry of Health, the Permanent Secretariat of the National Council for AIDS control (SP/NAC), the Program of Support to Community-based Organizations (PAMAC), three representatives from testing centers and one representative from youth organizations. To significantly scale up access to testing, an appropriate strategy was put in place with free testing and pre-test counseling for students, onsite at the schools and campuses. Activities envisaged under the project include:

- Supplying all partners testing centers with reagents and consumables,
- Promoting testing in schools and on university campuses,
- Organizing counseling and testing at schools and campuses,
- Issuing of test results at testing centers,
- Supervising and monitoring the quality of services.

In the campaign, 21,551 students and teachers underwent voluntary counseling and 30,000 people benefited from condom distribution and/or demonstration on condom use. Doctors, psychologists and experienced counselors were on hand to supervise, conduct quality control and evaluate all these services, with the support of the national HIV/AIDS referral laboratory. The project was financed by the Embassy of Denmark and UNDP at a cost of 38 million CFA francs.

IMPLEMENTING ORGANIZATION

Organization:

- PAMAC
  Le Programme d'Appui au Monde Associatif et Communautaire – Burkina Faso
  11 BP 1023 CMS Ouagadougou 11

Contact Person:

- Jean-François SOME
  Counseling and Community Management Officer
  Tel: +226 50 30 18 16/17/
  Fax: +226 76 61 38 04
  E-mail: jfsome.pamac@undp.org

The Program of Support to Community-based Organizations –PAMAC (Programme d'Appui au Monde Associatif et Communautaire) is a program of the permanent secretariat of the National AIDS Council (NAC). This program was established in 2003 to provide specialized support to local AIDS control NGOs and associations in the following priority areas: VCT, community management of diseases and technical and operational capacity building of community-based organizations.

IMPLEMENTATION CONTEXT

Burkina Faso is a landlocked country in the heart of West Africa with a population of about 11 million. With its six borders, the country serves as a crossroad between the Sahelian and costal countries. Burkina has its fair share of both internal and external migration. Internal migration involves the populations of the Sahel zone and those of the north toward the south and the west in search of greener pastures and fertile land. External migration stems mainly from individuals from coastal countries like Côte d'Ivoire and some Central African countries such as Gabon, in search of gainful employment. These movements contribute to the relatively high HIV/AIDS prevalence rate, estimated by UNAIDS at 4.2% (2004 Report).

The Permanent Secretariat of the National AIDS Control Council (SP/NAC), which is attached to the President's office, coordinates AIDS control activities in Burkina Faso. In 2001, Burkina adopted a five-year (2001-2005) National Strategic Framework for HIV/AIDS and declared a multi-sectorial approach to the fight against HIV/AIDS. The second HIV/AIDS strategic framework is under preparation and should cover the period 2006-2010.

A study conducted by UNDP in 2001 revealed the impact of the pandemic on the education sector. Several behavioral studies also showed the persistence of risky behaviors in this area, despite the relatively good access to information. Unwanted pregnancies and premature sex are still common among students. Likewise, infrequent condom use and sex between students and teachers are a cause of concern in schools and university campuses. The establishment of a ministerial committee on AIDS control for secondary schools with units in all schools nationwide has helped to create awareness about the disease. Similarly, the emergence of several student AIDS control organizations, the formulation of projects specialized in organizing AIDS control activities in schools, are all concrete actions aimed at providing answers to the concerns of education authorities with regards to AIDS control.

FUNDING

The project cost 38 million FCFA francs for the first campaign and 50 million for the second one, in 2005. The lead donor is the Royal Danish Embassy, which funded the two campaigns. Two other partners also contributed to the financing of the activities of the first campaign. These are:

- UNDP, which financed supervision work (field travel for supervision teams, fuel and campaign secretariat);
- SP/NAC, which paid for reagents for 10,000 tests.

Consultations are ongoing with the Ministry of Secondary and Higher Education and Scientific Research to include the funding of this campaign in their action plan starting from 2006.

BENEFICIARIES

The target population is young students living in towns and villages in Burkina Faso. For now, the campaign is focusing on young people aged at least 18 at the time of the exercise, in accordance with the provisions of VCT norms and guidelines in place. For the sake of efficiency, the large cities, which host most of the major secondary schools and universities and vocational schools, have been targeted. The campaign targeted about 55,000 people, accounting for 2/3 of the target population nationwide. This young population was targeted because of its vulnerability to HIV/AIDS and the persistence of certain risky sexual behaviors such as, sex with multiple partners and other factors like exchange of sex for money among students.

DETAILED DESCRIPTION

The project to scale-up access of the youth to HIV voluntary counseling and testing in Burkina Faso was implemented to provide VCT services that were tailored to this vulnerable category of society.

It is expected to be for a two year period (2004 – 2005). During these two years the voluntary counseling campaign gets organized at a date that is mutually agreed date between all the stakeholders. For 2004, it took place from April 13 to 24, 2004. In 2005, it was planned for May 16 to 21, 2005. The implementation period for the campaign must not exceed 10 days in order not to disrupt the normal activities of the schools and universities.

From 2006, the project will be maintained by the Ministerial Committee for Secondary and Higher Education and Scientific Research which has incorporated the intervention into its plan of action.

Several reasons influenced the implementation of this project, namely:

- The need to promote VCT among the youth;
- The urgency to enhance low risk behavior among the youth who have not yet settled into permanent sexual habits;
- The persistence of certain risky sexual behaviors, (sexual relations between students and teachers, non-consistent use of condoms, etc.).

The project aims to improve the access of young students to voluntary counseling and testing by organizing a special voluntary testing campaign targeted at them and formulating a sero-surveillance strategy adapted to their environment.

Organization and implementation of the campaign

The plan at the start of the project was to provide counseling and testing to 15,000 students and teachers, and distribute and/or carry out demonstrations on the correct use of condoms for 30,000 persons. The practical organization of the campaign started with the setting up of a consultative committee. The committee comprised of PAMAC, the NACC permanent secretariat, The AIDS control sectorial committees of the Ministries of Education and Health, VCT representatives and representatives of youth associations. The committee was responsible for defining the approach and role of every stakeholder. PAMAC was responsible for coordination and making recommendations on strategies and roles. These proposals were then discussed, amended and validated by the members of the committee. The committee put in place a system based on anonymity; it also distributed roles and outlined any major issues for consideration as regards sexuality among the youth, with the support of psychologists.

The Ministry of Education sent out a circular to all the selected schools, requesting their heads to provide appropriate premises for the campaign. Mostly, school dispensaries were used for pre-test counseling and taking of blood samples. The VCT centers chose the counselors from among their staff. The VCT norms and guidelines in place in Burkina Faso were used to ensure anonymity and confidentiality. Post-test counseling and disclosing of results were carried out at the VCT centers. The equipment was taken to the sites on public transport and rented vehicles.

The 2004 campaign promoted HIV voluntary testing in 140 schools in eight towns, with the assistance of teachers, support units and youth associations. During the campaign, 30,000 people, including students, teachers and the administrative staff of schools witnessed demonstrations on the use of condoms, and condoms were distributed to them. In addition, 21,551 students and teachers of secondary and higher institutions were tested, following pre- and post-test counseling. Of this number, 47% were women and 53% men. Two hundred and seventy eight (278) people tested positive, 60.4% of them women and 39.6% men, making an overall sero-prevalence rate of 1.3%.

Supervision and control of the campaign

The supervision and quality control of the campaign mobilized 23 people, mainly doctors, psychologists and experienced counselors, to assess the technical quality of counseling, testing and organization of the campaign.

The tools developed for this purpose include the supervision form, the counseling form and the satisfaction questionnaire. The teams visited all the campaign sites. The evaluation established a satisfaction index with questions on the quality of the reception, waiting time, trust in the system of patient anonymity and confidentiality of results, quality of information received and the counselor's listening ability. Based on all these, a satisfaction index was calculated, which showed that 76.6% of clients were satisfied with the services of the campaign.

The many challenges and constraints encountered during the implementation of the project included the following:

- Budgetary constraints, which made it impossible to cover a larger number of schools;
- Coordination problems, especially the distribution of roles among the different stakeholders who were not used to working together;
- Problems with the supply of reagents and consumables at the local level, which delayed the distribution of equipment on the ground;
- The minimum required age of 18 for HIV testing was the subject of frequent debates among students and some education professionals.

This experience showed us that involving administrative authorities at the central level does facilitate work on the ground. Likewise, involving the youth in the basic design process of the approaches affords them the opportunity to participate more fully in the exercise.

Monitoring and Evaluation

Monitoring and evaluation of the campaign were carried out at three levels. Supervision was done by a joint group made up of PAMAC, the Permanent Secretariat of NAC, the Ministerial Committee on AIDS control of the Ministry of Health and the Ministerial Committee on AIDS Control of the Ministry of Education and Scientific Research. Seven three-man teams carried out the supervision.

An external person - a public health doctor of the Faculty of Medicine of Marseille - conducted the evaluation of the process. The quality control of tests was done by Yalgado Ouedraogo hospital, which is the HIV/AIDS referral laboratory in Burkina Faso.

Tools were prepared at every level. Some of them are:

- Supervision form ;
- Supervision technical explanatory note ;
- Pre-test survey card and the post-test survey card ;
- Non-participant questionnaire ;
- Counseling form and
- Sample collection form at the laboratory.

Key monitoring and evaluation indicators identified as part of this campaign are as follows:

- Number of schools involved in the campaign;
- Number of counselors mobilized and VCT centers involved;
- Number of people having received pre-test counseling;
- Number of people who came back to collect their results (post-test);
- Number of people who took part in demonstrations on condom wearing;
- Number of people who benefited from condom distribution.

USEFUL INFORMATION FOR REPLICATION

The issue to be considered for potential replication of this experience is the active involvement of the Ministry of Education. The education environment is a closed setting, which is very delicate to deal with. Any approach to penetrating this environment will not succeed unless the

traditional stakeholders are involved right from the outset. We worked closely with the ministerial committee on AIDS control, which we had to convince about the relevance of our action. It then adopted the idea and took over from us. Through sheer commitment, the committee was able to have the Minister of Education send a circular to all school heads, asking them to adhere fully to the process. The circular was relayed by all school support units and this facilitated the introduction of VCT in schools. Furthermore, information from the administrative authorities was key to the success of these activities.

The mere fact of actually going to the schools encouraged students and teachers to participate in the testing. However, an efficient system should be put in place to ensure confidentiality during counseling and declaration of results, especially among the youth.

Right from the outset, the Ministry of Education was involved, through its Ministerial Committee on AIDS Prevention. This Committee has an action plan which it champions among its partners. The Committee is committed to gradually owning the activity by 2006, from then it will include the activity in its action plan. This will guarantee the sustainability of the intervention. The NACC permanent secretariat is also mobilizing funds to organize similar testing campaigns each year, because they contribute greatly to promoting testing and also provide a wider access that testing at fixed centers cannot achieve.

CONTRIBUTORS

- Jean-François SOME — Programme d'Appui au Monde Associatif et Communautaire (PAMAC), Burkina Faso
- Fodé SIMAGA — Programme d'Appui au Monde Associatif et Communautaire (PAMAC), Burkina Faso
- Gabrielle BANDRE — Ministerial Committee to fight HIV/AIDS, Ministry of Secondary and Higher Education and Scientific Research (MESSRS), Burkina Faso
- Wamarou TRAORE — Permanent Secretariat/NACP, Burkina Faso
- Michel NIKIEMA — Ministerial Committee to fight HIV/AIDS, Ministry of Health, Burkina Faso
- Jean-Marie TAPSOBA — Centre D'information, de Conseil et de Documentation sur les IST/VIH/SIDA (CICDoc), Burkina Faso
- Bagnomboé BAKIONO — Réseau des Jeunes de Lutte contre le SIDA (RAJS), Burkina Faso

APPENDIX

VOLUNTARY COUNSELING AND TESTING (VCT) TASK FORCE

NAME	POSITION	INSTITUTION	COUNTRY
Charles Zouzoua	Medical Doctor Trainer in VCT /Director	FHI	Côte d'Ivoire
Somé Jean-François	Medical Doctor Coordinator	PAMAC/PNUD	Burkina Faso
Zahra Fall	Trainer/Coordinator	NAC/UDAG	Mauritania
Bouba Bassirou	Medical Doctor/ VCT Coordinator	GTC/NAC	Cameroon
Agness Soumahoro	Medical Doctor/ Trainer	Espoir-CIPS	Côte d'Ivoire
Araba Sefa- Dedeh	Clinical Psychologist	University of Ghana	Ghana
Dodzro Charles	Medical Doctor/ In Charge of VCT	PSI/ATMAS	Togo
Alexis Boupda	Facilitator/Director	CHP	Cameroon

CARE AND TREATMENT FOR HIV/AIDS

CARE FOR PEOPLE LIVING WITH HIV THROUGH A "MEDICO SOCIAL ASSISTANCE CENTER" (PROJECT CASM), CÔTE D'IVOIRE

SUMMARY

HOPE worldwide Côte d'Ivoire, supported by the Ministry of Health, opened the Socio-Medical Support Center (Centre d'Assistance socio-médicale/CASM), in February 1991. The center operates as a day-clinic. Its mission is two-fold: to provide appropriate medical, psychological, social and nutritional care to People Living with HIV/AIDS (PLHA) and their families; and to strengthen the continuum of care.

Since it was established, CASM has hosted over 5000 people from health and social facilities, Voluntary Counseling and Testing (VCT) centers, organizations working in the area of HIV/AIDS and PLHA associations. Initially designed to serve Abidjan and its surroundings, the center has also welcomed people from the hinterland.

The center covers two kinds of activities: on-site activities (at the center) and external activities carried out within the communities.

Major on-site activities are:

- Medical care (consultations, care, patient follow-up, provision or purchase of drugs, case observation, etc.);
- Psychological care (counseling, focus-group, referral to self-support groups, etc.);
- Social care (income generating activities, educational support, etc.);
- Nutritional assistance (breakfast and meal service for patients under observation, food package distribution, etc.);
- Community workers training in care and support of PLHA and Orphans and Vulnerable Children (OVC).

Community activities comprise of home visits and care by volunteers, community workers and physicians from the center; community capacity building for care and support for PLHA and OVC.

IMPLEMENTING ORGANIZATION

Institution:

- HOPE Worldwide Côte d'Ivoire
  BP 1021 Cidex1 Abidjan 06, Côte d'Ivoire
  Tel.: +225 21 24 43 79 / 21 24 74 65
  Fax: +225 21 24 43 79
  E-mail: hwci@aviso.ci

Contact persons:

- Blaise FEUMBA
  Managing Director HOPE Worldwide Côte d'Ivoire
  Tel: +225 05 05 88 18
  E-mail: feumbar@africaonline.co.ci

- Isabelle KOUAME
  Technical Director
  Tel: +225 07 078 819/08 041 008
  E-mail: isabelle_kouame@yahoo.fr

HOPE worldwide Côte d'Ivoire is an agency of HOPE worldwide, an American faith-based non-governmental organization. In Côte d'Ivoire, HOPE worldwide has a headquarters' agreement with the Government. The Headquarters for Africa is in Johannesburg, South Africa. HOPE worldwide also has offices in Nigeria, Zambia, Botswana and Kenya

IMPLEMENTATION CONTEXT

The **« CASM »** project is being implemented in Côte d'Ivoire, the most severely affected country in West Africa, with an HIV/AIDS prevalence estimated at 7% (UNAIDS 2004). This epidemic mainly affects the young and sexually active 15-49 age group representing the country's able manpower. More than one million people are living with HIV/AIDS.

The Socio-Medical Support Center (CASM) is set in Abidjan, a city with 3 million inhabitants. Abidjan, the economic capital of Côte d'Ivoire, is modern and has its hot spots and tourist attraction spots. The HIV prevalence which is estimated over 10% in the city is one of the highest in the country. In terms of HIV/AIDS control, this city accounts for the greatest number of PLHA and the highest number of facilities and infrastructure. Indeed, the most experienced NGOs operate mostly in Abidjan and most care and treatment and ARV sites can be found there.

FUNDING

Since its establishment in 1991, financial resources for CASM have come from diverse sources, namely:

- HOPE worldwide USA and HOPE worldwide Côte d'Ivoire provide funds which have helped implement CASM activities in the absence of any other external funding.

- The United Nations Development Programs (UNDP) made funds available for PLHA income generating activities;

- USAID through Family Health International (FHI) provided funds for the care and support of Orphans and Vulnerable Children in the community;

- The American Government provided funds through the Center for Diseases Control (CDC) and RETROCI Project which helped to develop community mobilization, PLHA

and OVC care activities and to build community capacity in HIV/AIDS prevention and care for PLHA and OVC;

- Donations generated by Hope Week (a fundraiser), from Côte d'Ivoire's First Lady, local companies and organizations and private persons for patients' breakfasts, from the sale of goods, donations of medical equipment, materials and drugs, and patient's lump-sum contributions to cover care activities and some fees. Besides, patients also pay for ARV drugs at prices subsidized by the Ivorian government.

CASM has not experienced any discontinuation in its activities since its establishment.

BENEFICIARIES

CASM is open to any needy PLHA and family, irrespective of race, nationality and religion. Since the establishment of CASM more than 14 years ago, over 5000 people have benefited from its activities.

DETAILED DESCRIPTION

The HIV/AIDS epidemic spread quickly in Côte d'Ivoire, engendering a growing number of PLHA seeking relevant care and support. Most PLHA must face several challenges within their families and communities, including: marital conflicts, rejection, stigmatization, discrimination and human rights violations.

In view of their growing number, hospital facilities are overloaded by PLHA often abandoned in hospital beds by their families and left to an overworked, sometimes powerless and helpless medical staff. Very few community-based care and support projects can take over from the health facilities and reinforce the PLHA care continuum from hospital to home. This is the background, in which the Socio-Medical Support Center (Centre d'Assistance Socio-Médicale/CASM) was developed, to: decongest health facilities to some extent; provide compassionate care to PLHA; strengthen the links between PLHA, their families and communities.

CASM began its activities in February 1991. HOPE Worldwide Côte d'Ivoire envisages continuing to pursue its activities as long as the financial and the political environment permit. In spite of the socio-political crisis in Côte d'Ivoire over the past two years, CASM has continued to offer its indispensable services to an ever rising number of PLHA whose situations the crisis, among other things, has exacerbated.

The evolution of CASM can be divided into three different periods.

From 1991 to 1994, focus was on supporting patients often abandoned in the infectious diseases unit at the Treichville Teaching Hospital through hospital visits, physical care and psycho-social and financial support (drugs, food and clothing distribution); developing out-patient care of needy, stigmatized PLHA, coming from hospital units or referred by health centers.

Between 1995 to 2000, due to a number of challenges encountered the objectives of the center were changed. The main challenges were high patient numbers, increased morbidity, high numbers of loss to follow-up and home deaths as a result of poverty, recurrent admission to hospital due to progression of the disease, transportation problems in reaching the center, difficult access to the patients' dwelling places, lack of family and community support, increased stigmatization and number of rejected PLHA. The main objective of this phase was to reinforce PLHA continuum of care by:

- Facilitating cohesion between PLHA, their families and communities;
- Developing home-visits and care;
- Building partnerships between PLHA and OVC care facilities;
- Committing PLHA in care, prevention and resource mobilization activities (training, income generating activities);
- Facilitating the constitution of a support group that eventually established a PLHA Association ("Le Club des Amis" comprising over 500 members today).

From 2001 to date, the main objective is to reinforce community care through:

- Decentralized psychological and social care with the development of self-support groups or PLHA support groups in the 10 communes of Abidjan and Grand-Bassam with the involvement of health facilities;
- Training community stakeholders (facilitators) for PLHA and OVC care ;
- Mobilizing religious and community leaders to combat stigmatization and discrimination and to support PLHA.

The Socio-Medical Support Centre (CASM) has committed itself to the mission of improving the quality of life of PLHA and their families through improved medical, psychological, social and nutritional care. The success of such a mission implies meeting the following objectives:

- Improving PLHA and OVC's access to care;
- Reinforcing PLHA and OVC's continuum of care;
- Assisting and encouraging PLHA and their families to live positively;
- Building community capacity in care and support of PLHA and OVC.

In order to achieve this, other projects have been initiated that aim at extending CASM prevention and care activities within identified communities. They are the "HIV/AIDS Control Community Capacity Building Project" and the "Orphans and Vulnerable Children (OVC) Community Response Strengthening Project".

PLHA care and support were developed through the five following strategies: medical care, referral system, psychological and social care, nutritional care and community care. The main activities driven by these strategies are outlined in the attached table.

Medical care of PLHA and their families

Medical care at the center

This activity was developed through a partnership with the Ministries of Health and AIDS Control. Care is provided as out-patient treatment by a team composed of two full-time and two part-time physicians, a nurse, a pharmacy assistant and some volunteers. The center has four beds for patients under observation and infusion treatments. Most patients who visit the center are poor or people abandoned by their families. Upon arrival at the center, they pay a registration

fee of about 6 dollars. Medical consultations and patient follow-up are free regardless of the number. Drugs are provided through two sources: either they are donated and are provided to patients free of charge; or they come through the Public Health Pharmacy (Government Pharmacy) and patients pay for them at reasonable rates set by the Pharmacy.

Patients may be referred, as appropriate, to authorized centers, referral facilities and "support" centers for antiretroviral (ARV) treatment, special care (specialist examination, biological tests and radiological examinations, hospitalization) and palliative care. This activity resulted in care for over 5000 poor PLHA with an average 20-30 new patients recorded every month and more than 500 patients incorporated in ARV treatment access initiatives.

Home visits and care

Such visits are made to bedridden and poor PLHA. The team in charge of this activity is composed of a community facilitator or a volunteer, and a nurse and a physician if necessary. Patients are identified by the service providers of the center, the community facilitator, the family or the community. The community facilitator, may be a PLHA who has disclosed HIV status, is provided with a home-based care package including : the community care manual, a notebook, a thermometer, a sphygmomanometer, a home follow-up form, sanitation products, dressings, massage materials, drugs mainly composed of oral rehydration salts and Paracetamol. Home visits and care aim to:

- Provide medical care to the patient.
- Refer patients to specialist facilities and palliative care centers (hospices) as necessary;
- Help with medication compliance
- Train and inform the patient and his family in HIV/AIDS and hygiene;
- Provide psychological support to the patient;
- Train the family in care and support for PLHA and OVC ;
- Facilitate family support to the PLHA;

Thus, more than 100 home visits with medical staff are carried out every year to bedridden and destitute patients. Besides, over 300 PLHA have been reintegrated into their families and 57 family-networks have been established to provide PLHA with home care. To date, more than 6700 home visits have been carried out. An especially designed care package for this purpose comprises consultation materials and drugs (anti-diarrhea, anti-malaria, antibiotics, solutes, iron, antifungal, vitamins, etc.).

Development of a referral system

The referral system has been put in place thanks to a collaboration with the other PLHA care stakeholders such as CDC/RETROCI, the Teaching Hospitals (CHU) in Abidjan and particularly with the infectious disease service and dermatology services at the Treichville Teaching Hospital, Non Governmental Organizations (NGO) and HIV/AIDS control associations, especially PLHA associations.

This referral system was established according to the following:

- Building partnerships with entry point facilities downstream (Voluntary Counseling and Testing centers, health facilities, social centers, PLHA associations) and specialist care facilities upstream (accredited centers, support centers, Teaching Hospitals). The

objective was to provide the patients with some care and service free of charge or at reduced costs.

- Developing a referral and counter referral mechanism with PLHA partner care facilities. To carry this out, some tools were developed such as referral and counter referral forms, the referral register, etc.
- Strengthening internal referral (within a center) between medical and psychological care provision and community activities (PLHA support groups, social and spiritual support).

This system, which brought 51 health facilities together, made it possible to address PLHA and OVC's needs for comprehensive care.

Psychosocial care for PLHA and their families

This includes individual and group counseling activities, Information, Education and Communication (IEC) sessions on hygiene, nutrition, treatment compliance, childbearing, HIV/AIDS and other support activities such as: food collection, financial assistance for biological and radiological investigations, income generating activities (IGA), recreational activities for OVC. In the context of this activity, many counseling and training sessions were held as well as activities during Christmas festivities. PLHA involvement and active participation in counseling, information sessions and testimonies helped develop a PLHA association called "Le Club des Amis". This association is to facilitate information relay, encourage its members to live positively and develop IGAs.

Nutritional care for PLHA and their families

Every morning, patients coming for a consultation are offered breakfast. For a great number of our visiting patients, this meal is the only one they will have in the day. This breakfast is a time for relaxation, communication and sharing among the PLHA. This time reinforces psycho-social support. Food donations originating from ad hoc collections and a monthly distribution of food packages are organized for the most destitute/bedridden patients and widows. 350 breakfasts are provided to patients every month and 540 food packages are distributed every year.

Community-based care

This is carried out through:

- Mobilization of community and religious leaders for PLHA and OVC support;
- Identification and training of community facilitators for PLHA and OVC care;
- Forming PLHA and OVC self-support/assistance groups in partnership with health facilities.

Through these community care activities, more than 20 community facilitators, 40 volunteers, 154 resource persons in the community were trained and over 300 religious leaders were engaged in PLHA and OVC support. Over 20 PLHA support sessions are held everyday throughout the 10 communes of Abidjan and in the district of Grand-Bassam.

Difficulties encountered

The major challenge is linked to availability of funds. Donors are typically reluctant to fund a comprehensive approach of PLHA care. Moreover, high medication costs, increasing household impoverishment and the socio-political crisis prevailing in Côte d'Ivoire for more than two years have exacerbated the challenges met in activity implementation. Further challenges must be noted:

- Exponential growth of patients visiting the center which increases the workload of the CASM team, hence the need for community involvement;
- Low staffing levels and lack of resources to recruit trained and salaried staff;
- Smaller work space with the increasing number of patients to care for;
- Inadequate involvement of families and communities;
- Fear of disclosure of HIV-positive status because of stigmatization and discrimination.

Lessons learned

After 14 years of experience, we have learned enough lessons which have enabled us to improve and strengthen our interventions. Some are mentioned here as examples:

- The false belief that a PLHA cannot be taken care of is widespread. This undermines the utilization of the care service;
- The involvement of religious leaders and the training of community facilitators and committed volunteers facilitates support for PLHA and OVC ;
- Networking care facilities and developing partnerships are critical to strengthening PLHA and the OVC care continuum;
- The involvement of PLHA in the various care and prevention strategies is essential to enable them to live positively and prevent HIV infection from spreading;
- Home visits and care foster a link between PLHA, their families and the community and also help improve PLHA and OVC's quality of life;
- Confidentiality is a highly prized virtue in all approaches with people living with HIV;
- PLHA have real skills and can contribute to HIV infection care and prevention, if only given the opportunity.

Monitoring and Evaluation

HOPE worldwide has developed a monitoring and evaluation plan (operating plan) for all its programs. This plan is reviewed and monitored on a yearly basis. Monitoring and evaluation are ensured by the project managers and at all levels (intervention units). Monitoring is achieved through service meetings, weekly coordination (staff) meetings and monthly field visits and on request. Evaluation is conducted according to the funding cycle. As a matter of fact, at the end of each funding, an evaluation is conducted in two stages: an internal one by the staff and an external one by an external evaluator identified by the donor. Monitoring and evaluation are conducted based on the following indicators:

Medical care

- Total patients and new patients consulted;
- Number of patients on primary prophylaxis for opportunistic infections (cotrimoxazole);
- Number of patients who received home medical visits and care.

Psychological care

- Number of clients seen in counseling;
- Number of clients who received home visits;
- Number of home visits made;
- Number of people referred to support groups;
- Number of people trained in communities.

Social and nutritional care

- Number of people supported for para-clinical check-ups;
- Number of meals/breakfasts served;
- Number of people who received meals/breakfasts;
- Number of food packages distributed.

Data collection tools were developed to record the indicators. These are collection forms, consultation, counseling, patient identification forms and registers, patient records, activity progress reports, computer files, attendance lists, data sheets (daily, weekly and monthly), etc.

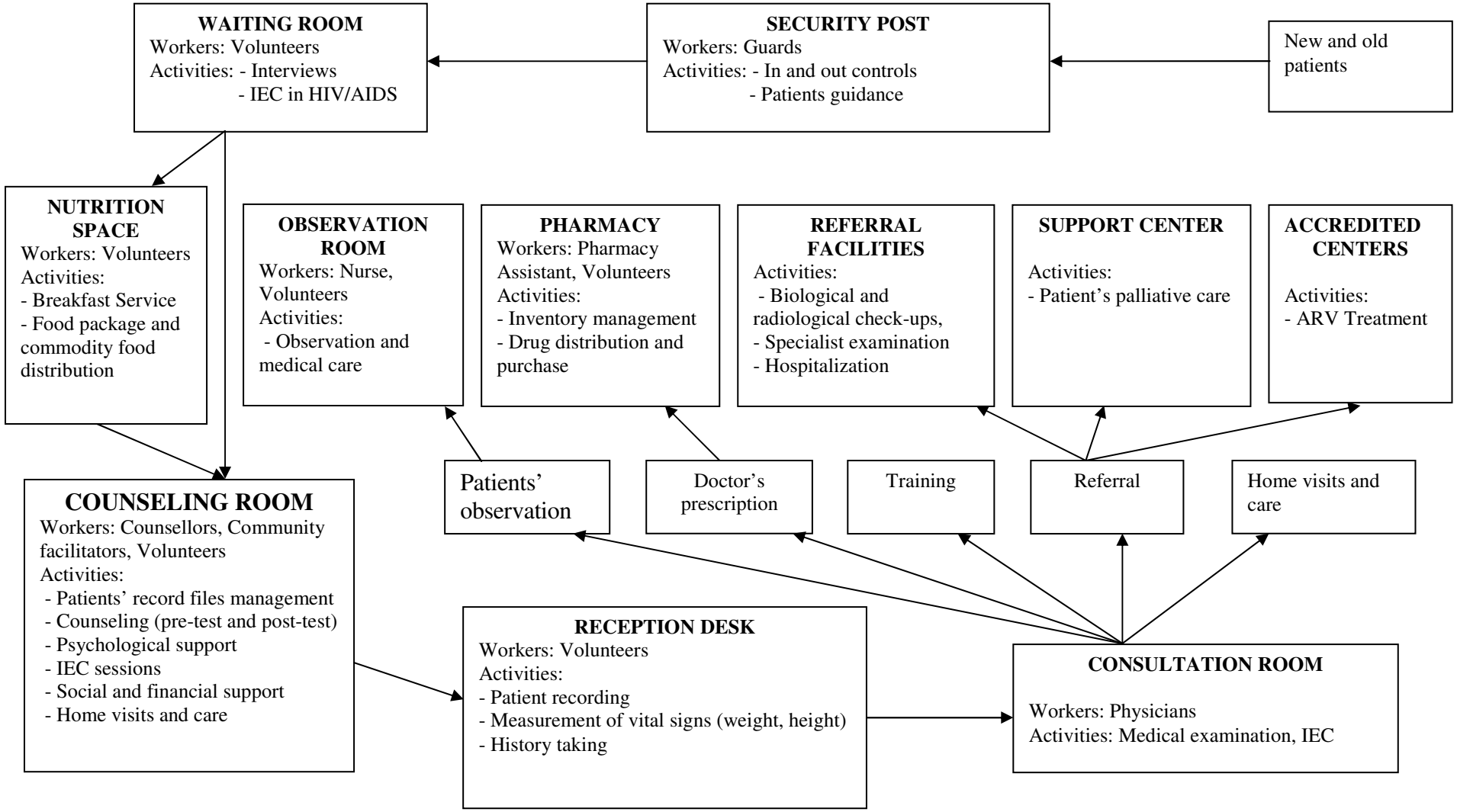
USEFUL INFORMATION FOR REPLICATION

The project implementation strategy combines several approaches: Government involvement, advocacy, community mobilization, partnership/collaboration and networking with PLHA care facilities and PLHA training and involvement and the training of numerous volunteers engaged in activities. This approach enabled the project to be carried out and removed barriers. The success of the intervention rests mainly on the availability of funds and competent staff. The center is a community care facility for PLHA and their families. It is a very important link in the care continuum. The management of this facility is not very costly. The sustainability of such an endeavor requires a self-financing capacity by the implementer in the absence of donors. The development of income generating activities might be a solution.

CONTRIBUTORS

- Isabelle KOUAME — Technical Director, HOPE Worldwide Côte d'Ivoire
- Mark OTTERWELLER — Managing Director, HOPE Worldwide Africa
- Marc AGUIRRE — OVC Program Manager/M&E Officer, HOPE Worldwide South-Africa
- Patrice Assi YAPI — Deputy Coordinator in charge of care and support for PLHA, HOPE Worldwide Côte d'Ivoire
- Solange BALOU — Medical Doctor, CASM, HOPE Worldwide Côte d'Ivoire
- Romain EKRAKOU — Officer-in-charge of community care and support, HOPE Worldwide Côte d'Ivoire
- Désiré G. KOKREU — Officer-in-charge of psycho-social care, HOPE Worldwide CI

DIAGRAM OF CASM ACTIVITIES



DECENTRALIZATION OF ACCESS TO ANTIRETROVIRAL DRUGS IN THE CLINICAL MANAGEMENT OF PEOPLE LIVING WITH HIV/AIDS IN SENEGAL

SUMMARY

Senegal is situated in the Sudano-Sahelian zone of West Africa. It has an area of 192,722 square kilometers and a population of about 9,200,000 inhabitants, with an average population density of 47 inhabitants per square kilometer. The country currently has 809 health posts, 53 health centers and 17 hospitals. Health coverage in 1999 was one health post to 11,500 people, one health center to 175,000 people and one hospital to 545,800 people. The HIV situation in Senegal is characterized by a stable epidemic and low sero-prevalence of about 1.5% among the population as a whole. The two HIV virus serotypes (HIV-1 and HIV-2) are present and the main mode of HIV transmission is heterosexual. The cumulative number of cases rose from one in 1986 to 5,500 cases in 2004. In September 1997, an international workshop was held in Dakar on the role of ARV drugs among people living with HIV in Africa. At the International Conference on AIDS and STI in Africa (ICASA) held in December 1997 in Abidjan, a consensus was reached on the indications for antiretroviral treatment in African countries.

The Senegalese Antiretroviral Drug Access Initiative (ISAARV) was established in 1998, following a pilot feasibility phase. The findings, after an 18-month period of ARV use on a cohort of 180 patients, demonstrated the clinical, immunological and virological effectiveness of triple combination antiretroviral therapy in Senegal.

In 2001, the decentralization phase of HIV infection management was initiated, through a holistic approach, with the establishment of HIV testing centers, the introduction of the Prevention of Mother-to-Child Transmission of HIV program (PMTCT), and alternative strategies for determining CD4 lymphocyte counts. The goal was to put 7,000 patients on ARVs by 2006.

The process of accessing antiretroviral drugs involved the gradual establishment of a referral system, starting with the Teaching Hospital in the capital Dakar, between 1998 and 2001. The process was then assessed and extrapolated to the other regions, starting with the regional hospital. Once the experimental phase was consolidated, the next stage entailed introducing antiretroviral drugs in the districts. In order to ensure that the process was active and controlled, a number of activities were carried out, namely:

- Theoretical and practical training for the multi-disciplinary regional management team. The training was in two parts: theoretical training (lectures, clinical case studies, group discussions) and practical training (on the job training at the treatment site;
- Improving the laboratory's technical capacity by providing equipment for evaluating CD4 T-lymphocytes, using the Dynabeads method;
- Harmonizing treatment regimens for antiretroviral drugs;
- Updating management guidelines for each level of the health pyramid;
- Instituting a regional mentoring system by national experts;
- Appointing a regional technical coordinator for the management of PLHA;

- Developing tools for the collection of data
- Routine supervisory training activities by the mentor.

Several constraints and challenges were encountered during the implementation of ISAARV. Some of these were:

- Long delays in antiretroviral drug and reagent supply;
- High cost of biochemical and hematological tests;
- Insufficient number of voluntary HIV testing centers;
- Delays in the implementation of the prevention of mother-to-child transmission program;
- Inadequate involvement in the management of PLHA associations, NGOs and the community;
- Lack of a national database of patients receiving antiretroviral treatment.

The findings of ISAARV showed that it was possible to use antiretroviral drugs in resource-limited sub-Saharan African countries. The Senegalese model of decentralizing the management of PLHA in general, and of access to ARV drugs throughout the country, was gradually consolidated, using an approach that took health referral levels into account.

IMPLEMENTING ORGANIZATION

Organization:

- Ministère de la Santé et de la Prévention Médicale,
  Division de la Lutte contre le SIDA et les IST
  (Ministry of Health and Preventive Medicine, AIDS and STI Control Division)
  Dakar. Senegal

Contact persons:

- Abdoulaye Sidibé WADE
  Head of AIDS and STI Control Division,
  Ministry of Health and Preventive Medicine
  Dakar, Senegal.
  Tel.: (221) 822 90 45.
  E-mail: sabwade@hotmail.com

- Papa Salif SOW
  Officer in charge of clinical management of PLHA,
  Head of Infectious Diseases, Fann Teaching Hospital,
  P. O. Box 5035, Dakar, Senegal.
  Tel.: +221 869 18 81.
  E-mail: salifsow@sentoo.sn

IMPLEMENTATION CONTEXT

Senegal is situated in the Sudano-Sahelian zone of West Africa. It has an area of 192,722 square kilometers and an estimated population of 9,200,000 inhabitants with an average population density of 47 inhabitants per square area. The population is unevenly distributed. The capital, Dakar, which occupies 0.3% of the country's total area, has about 24% of the population.

Senegal is ranked among the least developed countries (LDCs) with an annual per capita income of about 545 Euros. Over 60% of the population is in the rural areas and lives largely on subsistence, rain-fed farming. Over 50% of the population lives below the poverty line, set at 392 FCFA (0.6 Euros) per adult per day. Unemployment, especially among the youth, is high (40% in urban areas and 38% in rural areas). The literacy rate in Senegal is 43.9% and 71.5% among women and men respectively. The enrollment rate is low (44% for girls and 55% for boys).

The population is very young, with about 57.7% under 20 years of age, and comprises 52% of women. Infant and child mortality rates are 63.5 per 1000 and 143 per 1000 respectively. The total fertility index was estimated at 4.8 children per woman in 2000. Life expectancy at birth is estimated at 51 years for men and 53 years for women.

Senegal currently has 809 health posts, 53 health centers and 17 hospitals. In 1999, the country had one health post for 11,500 people, one health center for 175,000 people and one hospital for 548,800 people. In terms of human resources, there was one doctor for 17,000 people, one nurse for 8,700 people and one mid-wife for 4,600 women of childbearing age. Health expenditure accounted for 8.24% of the State's budget. In 2002, the health operating budget amounted to 30.9 billion FCFA (about 47.2 million Euros), i.e. about five euros per inhabitant per annum. The health system in Senegal is in five levels, from the bottom up, as follows:

- Health hut: This is the grassroots level of the health system. Unlike the rest of the health pyramid, the structure here is community-based. It is run by a community health worker (CHW). According to WHO, there should be one health hut for 500 inhabitants, situated at over five kilometers from each other.

- Health Post: This is the first level of health facilities that falls under the administrative framework. It is run by a State Registered Nurse, or, in areas with a shortage of nurses, by a health worker. Primary health care activities are carried out at the health post. These include vaccinations, IEC, primary care and ANC. According to WHO, there should be one health post for 10,000 inhabitants.

- Health Center: This is the first level where a doctor can be found. Activities here include treatment, admissions, antenatal consultations and some laboratory tests. This is the referral institution for health posts. According to WHO, there should be one health center for 250,000 inhabitants.

- Regional Hospital: This hospital has several doctors, and ENT, X-Ray, Ophthalmology and Gynecology-Obstetrics specialists. Patients receive treatment here, admissions take

place, and laboratory tests and X-rays are carried out here. A qualified pharmacist manages drugs. This is the referral hospital for health centers.

- Teaching Hospital: This is where the very specialized departments are found, and where students are trained in medicine, pharmacy, dentistry, etc.

HIV status in Senegal is characterized by a stable epidemic and low sero-prevalence of about 1.5% among the population at large. It is a concentrated type of epidemic, because, while sero-prevalence is below 2% among pregnant women and blood donors, it is over 5% among other groups at risk targeted by the sentinel surveillance program. These groups include sex workers and men who attend STI clinics and patients with tuberculosis. The two viral blood types (HIV-1 and HIV-2) are present and the main mode of transmission is heterosexual. The cumulative number of cases rose from one in 1986 to 5,500 in 2004.

The stability and low prevalence rate of HIV in Senegal stems from a combination of factors which include the significant involvement of political authorities in the fight against HIV/AIDS, the early timing of the extended and multi-sectoral response to the epidemic, with strong community involvement (religious leaders, women's groups and the youth), and training programs for people involved in HIV/AIDS management. Very early in the process, complementarity between prevention and access to care was developed and implemented; HIV/AIDS awareness and information activities, the psycho-social management of persons living with HIV/AIDS and the treatment and prevention of opportunistic infections.

The advent of multiple antiretroviral therapies in 1996 in the developed world significantly reduced HIV-related morbidity and mortality. However, countries with limited resources like Senegal could not afford the high cost of these drugs. Negotiations were started with pharmaceutical laboratories to make ARVs available in poorer countries. In September 1997, an international workshop was held in Dakar on the role of ARVs for people living with HIV in Africa. It was organized by the NACP of Senegal in collaboration with IMEA, ANRS, WHO, UNAIDS, EU and IAS. In 1997, at the ICASA in Abidjan, consensus was reached on the indications of ARV treatment in African countries.

It was after this meeting in 1998 that the Senegalese Antiretroviral Drug Access Initiative (Initiative Sénégalaise d'Accès aux Antirétroviraux - ISAARV) was established. The feasibility pilot phase of the program was able to take-off after the government had allocated an annual budget for purchasing ARV drugs and reagents (CD4 and plasma viral load kits), pharmaceutical firms had reduced the cost of triple therapy, and national experts had given their commitment, in collaboration with their partners from the North. The results after 18 months of ARV use on a cohort of 180 patients demonstrated the clinical, immunological and virological efficacy of triple therapy in Senegal. Furthermore, therapeutic adherence was good, compared to that of the developed countries.

FUNDING

In 2004, a total of US$ 7,386,000 was allocated to ISAARV, by the following: Senegalese Government, USAID/FHI, IDA, ESTHER, the Global Fund for AIDS, TB and Malaria and the Government of France.

BENEFICIARIES

In May 2005, 2,800 patients were put on antiretroviral treatment. Over half of these patients (52.3%) were females. The standard of living of the majority of these patients (65%) was low, with a daily wage of under a dollar. The program covered all the socio-professional categories for meeting the clinical and immunological criteria for eligibility for being given ARV treatment.

DETAILED DESCRIPTION

ISAARV was established in August 1998, with a pilot program, which assessed the feasibility of ARV drug access. The active and controlled decentralization phase started in 2001 with plans to achieve national coverage in all 11 regions of Senegal. By February 2005, antiretroviral drugs were being distributed throughout the country; likewise, health workers were trained in the management of PLHA.

In 2001, the decentralization phase of HIV management began, based on a holistic approach, with the establishment of HIV testing centers, the introduction of the prevention of the mother-to-child transmission of HIV (PMTCT) program and the introduction of alternative strategies for determining CD4 lymphocyte counts. Within the public health context, the decentralization phase entailed formulating strategies and carrying out activities in both the public and private sectors, for the management of people living with HIV/AIDS throughout the country. In December 2003, the Senegalese government introduced free blood testing, free ARV drugs and free immune-virological monitoring tests (CD4 and viral load), reflecting thus, its firm commitment to improving the quality of management of PLHA, and ensuring equity in public health care delivery. The country's goal was to treat 7,000 patients by 2006.

The antiretroviral drug access process entailed the gradual establishment of a referral system, starting with the Teaching Hospital in Dakar, the capital (1998 – 2001). The process was then assessed and extrapolated to the other regions, starting with the regional hospitals. Once the pilot phase was up and running, the next phase entailed introducing antiretroviral drugs in the districts.

A number of activities were carried out to ensure an active and controlled decentralization process. These activities were:

- Theoretical and practical training of the regional management team;
- Improving the laboratory's technical capacities by providing equipment for evaluating CD4 T-lymphocytes, using the Dynabeads technique;

- Harmonizing the prescription system for antiretroviral drugs;
- Updating management guidelines, by defining delivery of care at each level of the health pyramid;
- Setting up a region-wide mentoring system by national experts;
- Appointing a technical management coordinator of Global Care at the regional level;
- Routine supervisory training activities by the mentor.

Training of Service Providers

Training of the regional management team, which is multi-disciplinary, involves doctors, biologists, pharmacists, social workers, nurses and midwives. The training is in two parts: theoretical training and practical training.

The theoretical training is conducted by national experts who travel in the capital of the selected region. Various modules are used at these training sessions, namely:

- Physiopathology of HIV infection;
- Natural history of HIV infection;
- Diagnosis and treatment of opportunistic diseases;
- Psycho-social management of people living with HIV/AIDS;
- ARV drugs: class and pharmacokinetic study;
- Modalities and indications of antiretroviral drugs;
- Secondary effects of ARVs and clinical monitoring;
- Accidental exposure to blood: risk assessment, administrative measures, proposals for ARV treatment;
- Adherence assistance system;
- Role of the laboratory in monitoring ARV therapy;
- Resistance to ARV drugs;
- Management of children living with HIV/AIDS;
- Prevention of mother to child transmission of HIV;
- Palliative care;
- Role of communities in the prevention and management of people living with HIV/AIDS;
- Setting up a system for managing PLHA in a public health context (at health posts, health centers, the regional hospital and the teaching hospital);
- Role of the pharmacist in the ARV drug dispensing system.

This theoretical training is in the form of workshops over a period of seven days, and is made up of lectures, clinical case studies and group discussions.

The practical training follows the theoretical one and takes place in Dakar at the usual PLHA management sites. Trainees participate in the clinical consultations for PLHA, undergo supervision in prescribing ARV drugs and visit management sites. Each trainee is supervised by an expert.

Definition of care activities by level in the health care pyramid

The minimum package of activities for the management of people living with HIV/AIDS according to the health pyramid in Senegal was determined during the update of the management guidelines for PLHA, as follows:

- ***At the health post level (nurse and midwife)***

- Prevention of HIV infection: information and awareness creation among the people;
- Psycho-social management (pre and post-test counseling);
- HIV serology: a man or a woman with a sexually transmitted disease, a TB patient, a pregnant woman, a patient with clinical signs of immune-suppression (Herpes zoster, chronic diarrhea, weight loss, thrush, generalized dermatitis);
- Symptomatic treatment of clinical signs of immune-suppression using essential drugs;
- Providing adherence support for patients on antiretroviral treatment;
- Monitoring of a pregnant woman on antiretroviral chemo-prophylaxis to prevent mother-to-child transmission of HIV;
- Referral of cases falling within the remit of the health center doctor.

- ***At the health center level (doctor, nurse, midwife, social worker)***

- Testing of HIV infection using the strategy proposed by the national referral laboratory;
- Clinical diagnosis of signs of immune-suppression (Candida, Herpes zoster, muco-cutaneous herpes);
- Cotrimoxazole chemotherapy for PLHA who meet inclusion criteria;
- Etiological diagnosis of tuberculosis;
- Putting a pregnant woman living with HIV/AIDS on antiretroviral chemotherapy;
- Initiation of antiretroviral treatment;
- Clinical and biological monitoring of a patient living with HIV/AIDS, undergoing triple ARV therapy;
- Assessing the risk of accidental exposure to blood (or sexual exposure) and initiation to antiretroviral chemo-prophylaxis;
- Nutritional support for PLHA.

- ***At the central level: regional hospital and teaching hospital***

- Initiation of antiretroviral treatment;
- Etiological diagnosis of bacterial, parasitic and viral opportunistic infections such as extra-pulmonary tuberculosis, isosporosis, cryptococcosis neuro-meningitis, shigellosis, salmonellosis, bacteriemia, cerebral toxoplasmosis;
- Immunological monitoring (CD4 cell count) of patients on ARV;
- Determination of viral plasma load;
- Assessing sensitivity of HIV strains to antiretroviral drugs.

Establishment of a mentorship system

A mentoring system for new prescribers has been introduced and consists of an expert in Global Care at the national level, choosing a region and ensuring that continuous supervisory training is provided. Together with colleagues in his region, this expert had to identify the management needs of the region, to ensure continuous care in terms of testing, diagnosis and treatment of opportunistic infections, the availability of drugs for opportunistic infections and triple antiretroviral therapy. The mentor remains in constant touch with colleagues in his region (by telephone or email) and suggests solutions to possible problems in patient care, and in the prescription of antiretroviral drugs.

Supervision

A supervisory training mission was planned every three months to review antiretroviral therapeutic regimens and the quality of medical files in terms of data gathering, as well as to discuss the action to take in the event of non-optimal clinical and immunological responses, and the management of side effects. This mentoring was useful in encouraging greater involvement and motivation of health staff.

Difficulties and constraints

The constraints and difficulties encountered in the implementation of ARV drug access have greatly slowed down the decentralization process. These constraints include:

- Long delays in the supply of antiretroviral drugs and reagents, owing to the contract award process within the UEMOA (West African Economic and Monetary Union) zone;
- High cost of bio-chemical and hematological tests (12,000 FCFA on average), which are not subsidized by the government. Due to this, poor patients could not afford ARV drugs, while those being managed were also deprived of regular monitoring;
- Slow decentralization process (lengthy transfer period from regional to district level);
- Insufficient number of voluntary testing centers in communities in Dakar, the capital and in other regions in the country;
- Considerable delay in the implementation of the prevention of mother-to-child transmission (PMTCT) of HIV program (transition from pilot phase to decentralization phase within the context of public health took three whole years);
- PLHA associations, NGOs and communities were hardly involved in management;
- Lack of a computerized national database of people on antiretroviral drugs, for regular and permanent overview of ARV cohorts in the various prescription sites;
- Little involvement of tuberculosis control program in the management of people living with HIV/AIDS and vice-versa.

Results obtained

The results obtained by ISAARV have shown that it was possible for even sub-Saharan countries with meager resources to use antiretroviral drugs. Patient adherence was comparable to that of patients of the North. This ARV access decentralization model has made it possible, today, to multiply the number of treatment centers by eight and the number of healthcare staff

trained in the management of PLHA by 30. Patients treated in their home regions expressed their satisfaction with the exercise. Practitioners were very pleased with the medical coordination meetings held to discuss the clinical and immunological cases of patients. They shared experiences in strategies for prescription of therapeutic schemes and discussed clinical cases that required second-line treatment.

Monitoring and Evaluation

The objective of Senegal's ISAARV program is to put 7,000 people living with HIV/AIDS on ARVs by December 2006. A number of indicators have been identified:

- Number of doctors trained in antiretroviral therapy;
- Number of antiretroviral treatment centers;
- Number of patients on ARV;
- Number of PMTCT centers;
- Number of voluntary HIV testing centers;
- Number of health services that provide HIV serology;
- Number of treatment centers equipped with an immune-fluorescent microscope for determining CD4 cell count;
- Percentage of resistance to antiretroviral drugs;
- Level of adherence to antiretroviral drugs by patients treated and by centers at both regional and national levels.

USEFUL INFORMATION FOR REPLICATION

In order to achieve an active and controlled decentralization process of the management of people living with HIV/AIDS, there must be:

- Strong political commitment, reflected by the availability of material and financial resources;
- Full involvement of health staff (doctors, pharmacists, social workers, nurses, midwives);
- Cooperation with institutions (of the North and/or South) with experience in access to care for PLHA, to share experiences;
- Motivation among health staff, who should be trained in the management of PLHA;
- Regular supply of antiretroviral drugs to avoid shortages.

MAIN CONTRIBUTORS

- Papa Salif SOW — Officer-in-charge of medical care and support for PLHA, Fann Teaching Hospital, Dakar – Senegal
- Ndella DIAKHATE — Service des Maladies Infectieuses, Fann Teaching Hospital, Dakar – Senegal
- Papa Alassane DIAW — Bacteriology-Virology Laboratory, Le Dantec Teaching Hospital, Dakar – Senegal

- Ndèye Fatou NGOM-GUEYE — Centre de Traitement Ambulatoire, Fann Teaching Hospital, Dakar – Senegal
- Papa Mandoumbé GUEYE — Service de Médecine Interne, Hôpital Principal, Dakar – Senegal
- Ndèye Coumba TOURE-KANE — Bacteriology-Virology Laboratory, Le Dantec Teaching Hospital, Dakar – Senegal
- Bara NDIAYE — Central Pharmacy, Fann Teaching Hospital, Dakar – Senegal
- Ndèye Khoudia SOW — STI/AIDS Control Department, Ministry of Health, Dakar – Senegal
- Haby SIGNATE-SY — Albert ROYER Children's Hospital, Fann Teaching Hospital, Dakar – Senegal

INTRODUCING COMPREHENSIVE HIV CLINICAL CARE IN A DISTRICT HOSPITAL SETTING: THE ROLE OF DISCLOSURE AND TREATMENT MONITORS IN ENSURING HIGH ADHERENCE – EXPERIENCES FROM MANYA KROBO DISTRICT, GHANA

SUMMARY

The availability and access to antiretroviral drugs (ARVs) has transformed HIV from a terminal to a chronic disease in the developed world. Unfortunately the treatment which is available reaches less than 2% of Africans who need it. The START program is a joint effort by the Government of Ghana and Family Health International and other stakeholders to offer comprehensive HIV/AIDS care including antiretroviral therapy to Persons Living with HIV/AIDS (PLHA) in the Manya and Yilo Krobo Districts of the Eastern Region of Ghana.

The clinical care component is an important aspect of the HIV/AIDS program and it involves prevention and treatment of opportunistic infections and HIV related illnesses as well as the use of antiretroviral therapy. ARVs are increasingly becoming available in resource-constrained settings as a result of a drop in prices. Excellent adherence is the cornerstone of successful therapy. Adherence of more than 95% is required for maximal virologic suppression. In developing as well as developed countries, maintaining high levels of adherence is a huge challenge where innovative strategies are required to ensure the success of therapy.

The START program is a collaborative effort between Family Health International and many stakeholders in Ghana, including the District Health Management Team, District Response Initiative, the Ghana AIDS Commission (GAC), Ghana Health Services (GHS), the National AIDS/STI Control Program (NACP), DFID, UNICEF, UNAIDS and others.

The goal of the START Program is to improve the quality of life for PLHA and their families in the Manya and Yilo Krobo districts by providing comprehensive HIV/AIDS prevention, care and treatment services. The program offers comprehensive services including Behavior Change Communication (BCC), Voluntary Counseling and Testing (VCT), Prevention of Mother-to-Child Transmission (PMTCT), clinical care for the prevention and management of Opportunistic Infections (OI), Antiretroviral Therapy (ART), palliative care, home-based care, and, eventually, support for Orphans and Vulnerable Children (OVC). All the above services are linked and integrated into the existing care services making it possible or easy for HIV sero-positive clients to be referred for clinical care services. Before the initiation of the therapy, patients were required to satisfy medical as well as social criteria. The medical criteria were WHO Stage III or IV or a CD4 count of 250 or less.

In addition, patients are encouraged to disclose their sero-status to an adherence monitor who is a partner, a family member, or a close confidant of his/her choice. The patient is required to complete adherence-counseling sessions with the adherence monitor. The residence of the client/patient is also verified.

Within a week after initiation of ART, the adherence counselor undertakes home visits to assess and provide support to the client/patient. Adherence is measured during clinic visits through self-reports, pill counts, pharmacy records and client exit interviews.

Excellent adherence was observed in nearly all patients irrespective of the patient's level of literacy. Most of the patients attended the clinic with a partner, relative or friend who supported them during treatment. We learned from this experience that:

- Involving adherence monitors improved the level of adherence by clients/patients.
- Disclosure to a close confidant increased the level of support for PLHA and helped to minimize the stigma among community members.
- Community involvement, especially the active promotion of services including treatment and adherence by community groups such as NGOs, enhances the use of services.
- Training, retraining, and supervision improved the clinical skills of adherence counselors tremendously and this has resulted in the increase of patient load.

IMPLEMENTING ORGANIZATION

Organizations:

- National AIDS/STI Control Program
  Ministry of Health/Ghana Health Services
  P. O. Box KB 493, Accra, Ghana

- Family Health International (FHI), Ghana
  1st Floor Demmco House
  1st Dzorwulu Crescent, West Airport
  P.O. Box CT 4033, Accra, Ghana

Contact persons:

- Nii Akwei ADDO
  Program Manager, NACP Ghana
  E-mail: nacp@internetghana.com

- Derek ARYEE
  Country Director, FHI Ghana
  E-mail: daryee@fhi.org.gh

IMPLEMENTATION CONTEXT

Ghana is a country located in West Africa between the Atlantic Ocean (South), Côte d'Ivoire (West), Togo (East) and Burkina Faso (North). Ghana has a population of about 20 million inhabitants and HIV prevalence was estimated at 3.4% in 2003 and 3.1% in 2004 (National AIDS/STI Control Program). This experience is being implemented in the Manya and Yilo Krobo districts in the Eastern Region which is bordered by districts in the Volta, and Greater Accra Regions.

The Akosombo Dam which created the largest man-made lake and provides hydroelectric power to the whole country is located within 10 km. The districts share the characteristics of a strong traditional leadership and District Health Management Team.

The population in Manya and Yilo Krobo districts is largely agrarian and made up predominantly of subsistence farmers. There are a lot of traders and artisans in the informal sector contributing to the local economy. There are two markets in Somanya and Agomanya with brisk commercial activities. As in the rest of the country, women are at a higher risk of infection and account for a majority of PLHA because of biological and social factors. Some of the social factors include lack of employment opportunities, economic dependency on men, and their inability to negotiate for safer sex thus increasing their risks of contracting the virus.

FUNDING

- British Department for International Development (DFID);
- USAID;
- Family Health International (FHI)

BENEFICIARIES

The START Program targets the general population of the Manya and Yilo Krobo districts with comprehensive HIV care and support interventions. These include VCT, BCC interventions and care and treatment interventions specifically for PLHA and their immediate families. The population of the Manya and Yilo Krobo districts is over 250,000. The area had an HIV prevalence rate of 9.2% in 2003. At the time of preparation of this paper, 1,500 infected persons had benefited from clinical care activities and 650 others were on antiretroviral treatment (ART) in Manya Krobo. About 7,500 persons had accessed VCT services. 14,000 pregnant women had benefited from PMTCT services, and 6,000 of them had accepted voluntary counseling and testing.

DETAILED DESCRIPTION

The program began in January 2002 and was integrated into the healthcare system.

The set up of the START Program began with participatory stakeholder meetings and baseline assessments. The assessment covered the availability of and accessibility to VCT, PMTCT, clinical care, and laboratory services and the existence of management information systems and a community component.

Integration of ARVs into existing health services in areas with limited resources required the development of key program components; some key aspects were selected and implemented in order to create a better context for success such as:

Development of National Guidelines

With the introduction of HIV-related clinical services, national guidelines were developed for the first time in 2002 for ART, VCT/PMTCT, and OI management to serve as a standard for health care workers. The involvement of the Ministry of Health, partners and other stakeholders provided a forum for sharing ideas and stakeholder buy-in. It allowed the Ministry of Health and the Government to own and move the process forward.

Setting up Voluntary Counseling and Testing services

The program identified office space for VCT and this was refurbished to ensure confidentiality and privacy. Health workers were identified and then trained as counselors. All other members of staff were sensitized about VCT and other services available in the facilities. With the training of the counselors and subsequent introduction of the Voluntary Counseling and Testing, there was a dramatic change with a positive approach to clients, which boosted clients' confidence in their providers. Newly diagnosed patients were very hopeful and this facilitated the work of clinicians enormously. Many of them came in with close relatives to whom they had disclosed their sero-status. These relatives were very supportive of the patients/clients.

Setting up PMTCT Services

Provision of Nevirapine to prevent mother-to-child transmission of HIV was integrated into Antenatal Clinic services. Pregnant women were offered group counseling and subsequently one-on-one counseling. The women who opted to take the HIV test were tested and those who were sero-positive were given Nevirapine tablets to take home and take at the onset of labor. They were advised to bring their babies within 72 hours after delivery for Nevirapine syrup at the hospital.

Review of the record system

The record system was assessed and suggestions were made on ways to improve the system to enable the institution to offer quality care to PLHA. Areas covered under the assessment included the following: capacity of the record staff, state of the records department, filing system, processes involved in patient flow, and gaps in the record keeping system.

After the assessment, a draft of initial patient assessment and follow up forms were developed. Clinicians involved in HIV/AIDS care were consulted to enable the forms to gain wider acceptance.

Development of Health Management Information Systems

The development of a Health Management Information System is important for patient care, monitoring and evaluation and operational research. This is helpful in documenting lessons learned and mainstreaming them into policy. The process started with the development of clinical forms which were pre-tested at multiple sites. Initially patient information collected from the clinical forms was used to generate monthly reports manually. This was subsequently

computerized. Its development took about a year as it had to go through several revisions to meet the needs of the facilities. The software was designed to track patients and alert staff when a client defaults from treatment after a couple of weeks and enable prompt defaulter tracing.

Developing the capacity for enhanced laboratory services

Based on the assessment, hematological and chemistry analyzers, microscopes, sample containers, counting chambers and other laboratory materials were provided. The capacity of the hospitals was built to perform hematological and chemistry analysis on site. Samples for CD4 were transported to a specialized laboratory 45 km off-site twice a week.

Developing clinical care protocols

A Clinical Care Protocol was developed to help clinicians in patient management. The core of the protocol was adapted from the National Guidelines on ARVs. However, modifications were made in certain areas and additional criteria introduced where the guidelines did not deal adequately with those issues. In initiating antiretroviral therapy, social criteria were developed and included in the protocols to improve adherence and promote patient follow-up.

Building the capacity of care providers

FHI organized training for antiretroviral therapy for all the doctors in Atua and St Martin's Hospitals in November 2003. Since this was a very new area and most doctors lacked the expertise pertaining to it, it was deemed necessary to have all the doctors present. After the training, the ARVs did not arrive until about 6-7 months later. Even after the refresher training, some doctors were more confident than others in initiating the antiretroviral therapy. It is very normal that there is a lot of unease at the initial phase. It was important that clinicians should be mentored by more experienced colleagues.

FHI organized an adherence training program for doctors, nurse counselors and dispensing technicians. One of the issues observed was that people without basic counseling skills did not do well in the adherence counseling process. In fact the nurses who had had training in ARVs and OI formed the backbone of the adherence counselors in the hospitals. The service was organized such that when patients were eligible they were referred to the adherence counselors.

Offering clinical services

Delivering clinical care services for HIV patients in the absence of antiretroviral therapy and in a situation of widespread poverty is a huge challenge. As a result of the improved counseling services, most patients disclosed their sero-status to a family member, a friend or spouse. The patients were treated for their opportunistic infections. Some of the patients were offered OI prophylaxis. During the clinical sessions, clients were offered general preventive messages and messages on preventing HIV re-infection were reinforced. Improved personal hygiene, good nutrition, reduced alcohol intake were discussed. The use of the male and female condom was demonstrated for clients, especially couples.

Delivering ART services

To qualify for ART, the patient had to be symptomatic (at WHO Stage III or IV) or have a CD4 count of less than 250, regardless of stage. The patient must also disclose his/her sero-status to a friend or family member and must have at least one session of pre-treatment counseling. On the average, each patient had two or three sessions of pre-treatment counseling. Their residence is also verified to ensure follow-up. When all these criteria have been satisfied then treatment is initiated. The adherence counselors visit the patient within the first week to see how he or she is coping with the treatment. The patient is seen within two weeks of treatment at the hospital for review, then subsequently for monthly appointments for three consecutive months. If there are no problems, the patient is then given a scheduled appointment every two months. However unscheduled visits can take place if the patient is unwell.

Reducing Stigmatization

HIV/AIDS-related stigmatization has been a challenging issue in Manya and Yilo Krobo. The results of four formative research studies conducted by START reveal a great deal of prejudice and discrimination against PLHA at a variety of levels, including discrimination by service providers. Stigmatization has critical implications for service delivery, both quality and effectiveness of service, as well as demand for services. Fear of stigmatization and discrimination is likely to limit the number of people seeking VCT and clinical care services. In addition, actual discrimination by health care providers reduces access and quality of care and treatment for PLHA.

Focus group discussions among PLHA and community members on stigmatization and discrimination were recorded and played back to the health care workers at a sensitization seminar. At the seminar, many health care workers conceded that they did not know some of their actions and inactions amounted to stigmatization and discrimination. A lot of these actions and inactions, though well intended, promoted stigmatization and discrimination. Subsequent client exit interviews after the sensitization showed a marked improvement in clients' perception of stigmatization and discrimination occurring within health facilities.

Community involvement

FHI worked with the communities through partner local NGOs. The local NGOs were trained in the rudiments of VCT services, PMTCT and clinical care including STI services. The NGOs in turn trained a number of peer educators in the communities. The Voluntary Counseling and Testing model was used as an entry point for care and support. The benefits of VCT i.e. promoting preventive measures, planning for the future, screening for TB, nutritional counseling, antiretroviral therapy, etc were aggressively promoted.

Preparing the community for comprehensive care was very critical, especially in a community which was largely in denial. However, in preparing the community, there was the need to correct some misconceptions and perceptions e.g. ARVs cure AIDS, ARVs kill HIV patients. Issues related to adherence, information about ARVs and how they work among other things are key components of the community preparation process.

The Role of disclosure and treatment monitors in ensuring high adherence

The clinical care component is an important aspect of the program and it involves correct treatment of opportunistic infections and HIV-related illnesses as well as the use of antiretroviral therapy. It aims to ensure maximal suppression of viral replication by encouraging high levels of adherence to therapy. The program aims at ensuring high levels of adherence to antiretroviral therapy by PLHA in the Manya and Yilo Krobo Districts.

Before the establishment of the clinical care component, a VCT/PMTCT service was set up in St Martin's and Atua Government Hospitals. The nurses were trained as counselors in both VCT and PMTCT. Some of the Nurses/Counselors from the VCT Unit and Dispensing Technicians were then trained in adherence counseling. The training covered the mechanism of action of ARVs, Classes of ARVs, specific antiretroviral drugs, side effects and toxicities and how they are managed, ARV regimens in the context of National Guidelines, Adherence Counseling and the processes involved. The adherence counseling and practice sessions took 70% of the training time.

The organization of service and patient flow was discussed. Patients medically eligible for antiretroviral drugs were referred to the adherence counselor. The patient would then be required to disclose his/her sero-status to a trusted friend, partner or family member who would act as an adherence monitor. They would then go through 2-3 sessions of adherence counseling. The counselor would verify his/her residence for follow-up visits. When the patient was assessed to be ready, he/she would be referred to the doctor for the prescription of ARVs. The patient would then go back to the adherence counselor (nurses or dispensing technician) in the adherence counseling room/dispensary where the drugs are issued after all unclear points have been clarified. Within two weeks after initiation of ART, the adherence counselor would undertake home visits to assess and provide support to the patient.

Measuring Adherence

At every clinic visit, adherence is measured through self-reports, pill counts and pharmacy records. Using drug cards for ARVs, the adherence counselor or clinician is able to determine if the patient refilled medications at the scheduled time.

Patients are always congratulated when they report as scheduled or pay unscheduled visits and when they take their drugs well as discussed. Those having difficulties with taking their drugs are referred for adherence support counseling by the adherence counselor.

Documentation

The adherence counseling process for each patient has been documented. Patients who default on their clinic appointments are followed-up at home to find out the reason for non-attendance.

Adherence counselors and clinicians measure adherence during clinic visits. This is done through self-report, pill counts and review of appointment cards. A week's recall is used in the self-report. The results indicate over 99% of clients never missed any of their medications. Out

of 132 patients seen from May 2003 to December 2003, only one had medications discontinued on account of poor adherence and had to re-start adherence counseling with a different adherence monitor to address his peculiar adherence challenges before treatment was re-started.

FHI undertook an adherence monitoring survey between November 2003 and January 2004 to independently assess patient's adherence to antiretroviral drugs. 25 patients took part in the survey. Even though there were reported delays in taking the drugs ranging from 'a few minutes' to 'about one hour', none of the patients missed a dose. The delays were attributed to 'food not being ready' or 'brief forgetfulness'.

In order to further independently assess the success of the antiretroviral treatment program and the high level of adherence, patients who had been on treatment for four months or more were selected and viral load measurements performed by the Abbott LCX system for HIV-1. Out of 36 patients, 27 patients were found to have viral loads below the level of detection by this assay. This indicates an estimate of about 75% treatment success in reducing viral load of HIV-1. The percentage increases to almost 90% when only patients who have been on therapy for six months or more are considered.

This experience offers the following lessons:

- Excellent adherence is observed in nearly all patients even in illiterates and the poorly educated
- Disclosure of sero-status is a critical element in ensuring adherence
- Training of health care workers in adherence counseling is essential in achieving the desired objective.

Monitoring and Evaluation

The key indicators tracked were:

- Adherence (Measured at each clinic visit and quarterly)
- Quarterly maintenance visits with clients to evaluate adherence
- Viral loads as a marker for adherence (Special studies)
- Number of patients on continuous ART for more than 12 months
- Number of patients lost to follow-up after each quarter

USEFUL INFORMATION FOR REPLICATION

The program used already-trained counselors and built their capacity to perform adherence counseling duties. The counselors do adherence counseling on clinic days whilst they perform general counseling and other duties on other days. This allowed them to perform different and multiple functions.

Counseling duties were incorporated into the time-table of the hospital ensuring that nurse counselors are always available as well as fully integrating the service in the health care delivery system. Some of the adherence counselors in the facilities were trained to become master trainers and they retrained and mentored the other counselors.

Disclosure of sero-status to a trusted friend or family member has been integrated into the national guidelines as a prerequisite for antiretroviral therapy. This novel strategy uses voluntary disclosure to improve adherence. It engages family/community members to support patients undergoing treatment.

The START program worked in collaboration with District Health Management Team, the traditional authorities and community-based organizations (CBOs) and non-governmental organizations (NGOs). The NGOs/CBOs were trained in the area of comprehensive care including care and treatment. They worked in the communities to promote the service as well as strengthen prevention messages. The communities were partners and were involved in the planning before the initiation of the project. Formative assessments, community engagement and preparation were critical steps that required minimal resources but had a lasting impact on the program.

The intervention strategies have been integrated into the health care delivery system. The adherence counseling protocols and standards have been incorporated into the National Guidelines. The approach is low cost or no cost and translates into results in a short time.

CONTRIBUTORS

- Nii Akwei ADDO — National AIDS/STI Control Program, Ministry of Health/Ghana Heath Service, Accra, Ghana
- Derek ARYEE — Family Health International, Accra, Ghana
- Henry NAGAI — Family Health International, Accra, Ghana
- Kwasi TORPEY — Family Health International, Accra, Ghana
- Richard AMENYAH — Family Health International, Accra, Ghana
- Samuel BENEFOUR — Family Health International, Accra, Ghana
- Regina AKAI-NETTEY — Family Health International, Accra, Ghana
- Hannah ENNINFUL-ATUA — Atua Government Hospital. Atua, Ghana
- Theresa TETTEH — St. Martin's Hospital, Agomanya, Ghana

APPENDIX

CARE AND TREATMENT TASK FORCE

NAME	POSITION	INSTITUTION	COUNTRY
Mame Awa Traoré	Medical Doctor/ Regional Technical Advisor on Care and Treatment	FHI	Senegal
Boka Raoul	Biologist/President	Red Ribbon	Côte d'Ivoire
Kwesi Torpey	Medical Doctor/ Regional Technical Advisor on Care and Treatment	FHI	Ghana
Safiatou Thiam	Medical Doctor/ ISAARV	NAC	Senegal
Lawson Godefroy	Executive Director	Espoir-Vie	Togo
Pascal Niamba	Medical Doctor /Director	CICDoc	Burkina Faso
Christopher Akolo	Medical Doctor	Department of Medicine Department of Infectious Diseases and Immunology Jos Teaching Hospital	Nigeria
Aliou Sylla	Medical Doctor /Director	CESAC	Mali
Kouamé Abo	Facilitator	AWARE-HIV/AIDS	Ghana

COMMUNITY FINANCING MODELS IN COMBATING HIV/AIDS

UNION OF COMMUNAL MUTUAL HEALTH INSURERS OF BEMBÈRÈKÈ (UCMSB) IN BENIN

SUMMARY

The Communal Union of Mutual Health Insurance of Bembereke (UCMSB) was developed in Bembereke in northern Benin with counterpart funding from the Mutual Health Insurance Support Program in Africa (PROMUSAF). Seven mutual health insurers[19] which were operational in February 2002 decided to create a Communal Union of Mutual Health Insurance with 1066 members, targeting about 4057 beneficiaries. The HIV/AIDS response by the mutual health insurance groups of the Bembereke Commune was launched in 2002 by the Mutual of Tuko Saari of the Central District. In 2003, this activity was extended to the mutual health insurance of Su Tii Déra of Gamia in partnership with the Multi-Sectorial AIDS Control Program (MACP).

The program highlights the experience of HIV/AIDS prevention through mutual health insurance plans. Throughout the course of the year, the facilitation committees of the mutual health insurance plans affiliated to the Communal Union of Mutual Health Insurance of Bembereke (UCMSB) organizes information and exchange meetings regarding the AIDS pandemic. They also invited the communities to accept people living with HIV/AIDS to become members of society. These activities are facilitated by public outreach meetings in the suburbs and villages as well as in the schools and colleges of the Commune. The insurance plans are supported by the community radio, FM Nonsina in the Bembereke Commune.

The main aim of this mutual health insurance activity is to inform the people of the Bembereke Commune in general, and the members of the mutual plans in particular, about the modes of transmission and prevention of HIV/AIDS. The objective is to reduce the spread of HIV in the area.

IMPLEMENTING ORGANIATION

Organization:

- Communal Union of Mutual Health Insurance of Bembereke (UCMSB)
  P. O. Box 47, Bembereke
  Benin

Contact persons:

- Ousmane KOTO-YERIMA (Chairman)
  E-mail: kotoyerimaa@yahoo.fr
- Bio Guio YAROU (Secretary)
- Adiza OROU-GUIDOU (Treasurer)

[19] Mutual Health Societies: Tuko Saari of Bembèrèkè, Su Tii Dera of Gamia, Sango Gninin of Bouanri, Su Kianan of Béroubouay; Nonnin of Ina; Su Tii Dankin of Guesso-Sud; Su Nomma Ninnan of Kokabo

IMPLEMENTATION CONTEXT

Bembereke is one of the 77 Communes in Benin. Situated in the District of Borgou, in the North of Benin, this locality covers an area of 3,348 square kilometers and in 2004 had a population estimated at 94,580, giving it a population density of 28 inhabitants per square kilometer. The Commune is subdivided into 5 Administrative sub-divisions covering 42 administrative villages. Several ethnic groups live together in this area. The major ethnic groups include the Bariba (52.4%) and the Fulfulde (35.6%). Muslims constitute the majority and represent 55.9% of the population; animists represent 15.9%, while Christians represent 9.9% of the population.

The Community has a hospital with more than 100 beds (Evangelical Hospital of Bembereke). Some years ago, this hospital was elevated to the status of a referral hospital for the Area (Health District)[20]. Like other Communes in Benin, the use of health services in Bembereke is low. The search for solutions for this situation led to the development of mutual health insurance plans.

FUNDING

Equity capital

Each of the seven mutual health insurance plans in Bembereke Commune has the following financial rules:

- Membership fees: 1000 FCFA;
- Dues: 200 FCFA per person per month;
- Period of Observation: 6 months;
- Coverage limit: 2 beneficiaries;
- Services covered: The entire package of activities of the health centers;
- Premium: 25%.

Funds provided by partners

- 500,000 FCFA for outreach activities. This fund was given by the mutual health group of the Luxemburg Province (Belgium);
- 300,000 FCFA for broadcasts on the community radio of Bembereke, funded by PROMUSAF (Support Program for Mutual Health Insurance in Africa);
- Population Services International (PSI) supplied condoms and AIDS-related comics to the mutual health insurance plans.

BENEFICIARIES

The direct beneficiaries of the activity are the mutual health insurance members and the people of the Commune of Bembereke. Indirectly, taking into account the influence of the community radio, which covers seven Communes (Bembereke, Sinende, Nikki, Kalale, Perere, N'dali and

[20] This is the Health Zone of Bembereke-Sinende. In addition to the hospital, the Commune has 5 district health centers, 4 isolated dispensaries and one garrison health center.

Gogounou), the activity benefits at least half of the population of the radio coverage area, which includes more than 400,000 people.

DETAILED DESCRIPTION

UCMSB's program to reach seven mutual health insurance groups of the Bembereke Commune to combat HIV/AIDS is part of Bembereke's global plan of health education. This prevention program deals mostly with illnesses, such as: malaria, cholera, HIV/AIDS, malnutrition, meningitis, typhoid fever as well as other illnesses caused by lack of hygiene/sanitation.

At the beginning, PROMUSAF suggested to the mutual health insurance groups to undertake the activity within the Commune. PROMUSAF encourages the prevention plan to reduce household health expenses and morbidity as a way to counteract the difficulties people face in dealing with health care, given their moderate incomes and the recovery rate of mutual health plan members. In this light, emphasis was placed on AIDS to avoid many people becoming infected.

The HIV/AIDS response by the mutual health insurance of the Commune of Bembereke began in 2002 through the initiative of the Tuko Saari Mutual Health Insurance Plans of the central administrative district. In 2003, the activity was extended to the Su Tii Dera mutual of Gamia.

To carry out this activity, the two mutual groups had to apply successfully to the Multi-sectorial AIDS Control Program (MACP). To do this, they benefited from the technical support of PROMUSAF and the Kilimandjaro Institute (KI), which was the intermediary NGO of MACP in Borgou.

Each of these two mutual health groups obtained funding to:

- Train 10 peer educators in HIV/AIDS within the limits of its capability;
- Ensure outreach campaigns regarding HIV/AIDS within the communities, the suburbs and the villages of each administrative district;
- Ensure the sale of condoms during the entirety of the project.

Trend of the Plan from 2002 to 2004

The HIV/AIDS response by the mutual health insurance groups of the Bembereke Commune against AIDS has evolved with time. This evolution can be seen in the strategy employed, the localities reached and the implementation stakeholders associated with the initiative. The table below provides more details on it.

Table N° 1: TREND OF THE PLAN OF UCMSB FROM 2002 TO 2004

Year	Strategy Adopted	Target Localities	Leaders	Partners	Specific Improvements	Difficulties encountered
2002	- Grouping people at one location; - Thematic Facilitation by a health worker.	One meeting at Bembereke administrative district headquarters.	Agent of state-owned Health Center (Medical Officer or nurse).	- PROMUSAF; - Health Center; - Mutual health Insurance.	Engaging public dialogue on HIV/AIDS.	Participation difficult for the aged, especially discussions with Muslim women.
2003	- Training peer educators on AIDS within mutual health insurance plans; - Facilitating meetings of peer educators with the support of health officials; - Meeting facilitation in the various suburbs and headquarters of the administrative districts.	- 10 suburbs of Bembereke; - 8 suburbs of the city of Gamia.	- Leaders of mutual health insurance (peer educators); - Health Agents supporting peer educators.	- MACP; - Health Center Mutual health insurance; - KI; - PROMUSAF.	- Expanding the target; - Extension to various administrative suburbs; - Introduction of the sale of condoms; - Learning about using condoms.	- Organization of outreach meetings in the evening; - Free condoms (on demand).
2004	- Program expansion to every administrative district; - Training 25 mutual health insurance leaders on HIV/AIDS education; - Facilitation by mutual health leaders; - Media Coverage of some village sessions; - Spreading public awareness clips on AIDS each month, including Junior Secondary Schools in the Commune.	- On the average, 6 villages and suburbs of the administrative district; - 4 Junior Secondary Schools in the Commune.	- Leaders of the mutual health insurance plan; - PROMUSAF Facilitators (exclusively in the colleges).	- Mutual health insurance of Arlon (Belgium); - PROMUSAF - Nonsina FM Radio; - Mutual health insurance of the Commune.	- Intensified awareness; - Taking into account the non stigmatization of AIDS victims and the need to support them; - Invite people for voluntary testing.	- Lack of condoms; - Fear of animators themselves to be tested.
2005	Same as 2004	Same as 2004	Same as 2004	Same as 2004	Same as 2004	Same as 2004

Current situation and future steps

The mutual health insurance companies of the Commune of Bembereke, through UCMSB, work exclusively in prevention. They create public awareness campaigns on the AIDS threat for people of their respective localities and invite them to arm themselves against the scourge. They educate the public on behaviors to adopt to avoid becoming infected, thereby decreasing the spread of the virus. They also invite the people to accept those living with HIV/AIDS as complete human beings and as members of society.

The implementation of their activities is carried out through public awareness meetings in the suburbs and in the hamlets of various administrative districts in the area as well as in Commune's junior secondary schools. The sessions are facilitated by the leaders of the mutual health insurance plans who have been trained. In this activity, the mutual health insurance groups are supported by Nonsina FM, the community radio of the Commune of Bembereke. This benefit was initiated from the partnership that PROMUSAF has arranged with the radio station for all the mutual health insurance groups.

After the experience of the MACP in 2003, the mutual health insurance groups no longer continue to sell condoms. They direct clients to the health centers.

The mutual health insurance groups currently do not engage in medical care of AIDS patients. But they take care of opportunistic infections for PLHA members of mutual health insurance groups. The health insurance groups do not organize testing for their members.

PROMUSAF and the mutual health insurance of Arlon are currently the partners that support UCMSB in its HIV/AIDS Response.

The UCMSB future steps in the fight against HIV/AIDS are presented as follows:

- Pursuit and intensification of outreach campaigns;
- Creation of sales points for condoms for mutual health insurance groups;
- Creation of exchange centers and counseling the people on HIV/AIDS;
- Organization of voluntary testing for mutual health insurance members;
- Support to AIDS patients;
- Begin medical care for AIDS;
- Help to OVC.

Strengths, Weaknesses and Opportunities

Strengths

The strengths arising from the practice of UCMSB in terms of the fight against HIV/AIDS are indicated in the table below:

Table N° 2: Strengths of the practice of UCMSB in terms of combating AIDS:

Strengths	Remarks
Strategy of integrated communication	In its public outreach, the mutual health insurance of UCMSB combines several channels of communication, particularly talk shows, the media (radio) and interpersonal communication. This enables it to reach more people.
Community-based Initiative carried out by local stakeholders	Contrary to some initiatives, UCMSB's initiative is not implemented from outside. The practice is conducted by local people, which undoubtedly reduces operational costs.
Long-sustaining activity	Begun in 2002, this activity has been institutionalized within the union and has become a permanent program of mutual health insurance groups.
Involvement of local community health stakeholders	In carrying out this activity, the mutual health insurance group brings together health service workers in their areas with members of COGEA as well as other leaders who can help in mobilization and to better spread the message.
Periodic contact of mutual health insurance groups' leaders with the members	During each month, the leaders of mutual health insurance groups are in contact with the mutual health insurance members and the entire population for dues collection and public awareness campaigns. These occasions are capitalized on to remind people of the AIDS message by playing the radio clips. Thus, information is continuous and the message is not forgotten.
Good Facilitation capacity of trained leaders	By virtue of practice, the trained leaders ended up by gaining mastery of the topic and adopting good facilitation techniques.
Opening up towards other institutions in combating AIDS	The mutual health insurance groups, through their meetings, seized the opportunity to conclude partnership agreements with various national or international institutions that intervene in the fight against AIDS. This possibility of establishing partnerships has enabled the leaders to build their capacities and eventually to do the work better.

Weaknesses
Some weaknesses characterize the practice of UCMSB in the fight against HIV/AIDS. These weaknesses are as follows:

Table N° 3: Weaknesses in the fight against HIV/AIDS

Weaknesses	Remarks
Strong dependence on external funding	The activities of UCMSB in the fight against HIV/AIDS are funded by external partners. That does not guarantee the sustainability of the activity if the equity capital is not put into use.
Low project development capacity of UCMSB leaders	Even though devoted to its implementation, the leaders show serious weakness when it comes to translating their ideas into projects and taking steps to implement them. In the future this aspect should be seriously taken into account by the union.
Lack of facilitation suitable for UCMSB (project material, awareness campaign posters, fliers and other training materials)	In most cases, the mutual health insurance groups do their facilitation without other media. It is often useful to leave some posters and fliers after the session.
Facilitation solely in the Batonon language, marginalizing the Peuhl language	Given the size of the Peuhl community (35.6%) in the Commune of Bembereke, UCMSB should work to expand its facilitation in the Peuhl camps and to also conduct outreach in this language.
Practice solely centered on prevention	The fight against HIV/AIDS covers several aspects. UCMSB should expand its actions to other areas while strengthening public outreach.
Lack of financial resources to: - undertake more activities; - ensure monitoring; - continually build the capacity of facilitators; - Maintain the partnership with radio.	UCMSB, in collaboration with PROMUSAF, health agents and locally elected leaders, should reflect upon finding a global strategy in the fight against AIDS with financial and material contributions from the area.

Opportunities
Despite the weaknesses highlighted above, we must take note of the presence of a real potential linked to the practice of UCMSB in the fight against HIV/AIDS. This potential is presented as follows:

Existence of a homogeneous and well structured Group: UCMSB is the umbrella institution of mutual health insurance plans of Bembereke Commune. It is structured from the bottom up; therefore it is represented in each of the Commune's administrative districts and even in some villages that have isolated dispensaries, such as Kokabo and Guessou-South.

It is therefore easy to circulate information and to ensure the rapid mobilization of members for the speedy implementation of an activity at the communal level.

Integrating the practice in a set of mutual health insurance activities: UCMBS' fight against HIV/AIDS is not an isolated and sporadic activity. Its vast health program includes prevention and health education for members and the general public. These activities are repeated year after year in an effort to bring about improvements.

Organization of mutual health insurance work: Every month, each mutual health insurance group develops a micro-action plan. This plan traces the major thrust of activities the mutual health insurance group hopes to undertake in the upcoming month, particularly concerning:

- Outreach campaigns during membership drives and to develop customer loyalty;
- Due collection;
- Information, Education and Communication (IEC) on health;
- Organization of meetings of management bodies of the mutual health insurance groups.

Collaboration with health agents of the Commune: There is frank collaboration between the health agents of the Commune. Beyond simple care delivery, mutual health insurance and the health centers of the Commune act as true partners for the promotion of community health in general and mutual health insurance in particular.

Existence of a qualified human resource potential: Institutionally, UCMBS has a highly trained resource staff in the fight against HIV/AIDS. They are available, devoted to the task and can effectively carry out the activity.

Availability of an appreciable global treasury: Since their implementation, no mutual health insurance has recorded deficits. Each plan has been able to regularly pay their various bills in state-owned health centers. In addition, they were able to make a yearly profit with a cumulative total of 6,765,333 FCFA by June 30, 2005. With a bit of good will, UCMSB can contribute to a local fund for the fight against AIDS.

Credibility of Mutual Health Insurance Plans in the Commune: Because of the methods taken to cut members' medical expenses and the program's effective outreach campaigns, the mutual health insurance plans enjoy the confidence of the people. They are increasingly listened to and solicited in some decisions concerning community health. They are the only true community associations within the health field with any real force in the area.

Health as the sole area of responsibility for UCMSB: Contrary to several associations in the country, health is the prime objective of the mutual health insurance plans. In the case of UCMSB, aside from curative care, prevention occupies an important place in its activities.

Existence of community radio accompanying the movement: The partnership between PROMUSAF and Nonsina FM Radio is another tool the plans benefit from. The availability of this radio to support the movement and its prevention activities allows UCMSB to achieve interesting results.

Support from PROMUSAF: The mutual health insurance plans are doing well in the Commune of Bembereke with the aid of the Support Program to Mutual Health Insurance Plans in Africa (PROMUSAF). UCMSB enjoys technical, material and financial support to carry out its activities. However, it must be said support of this institution is limited, hence the need to look for other partners. UCMSB must therefore work in this direction in the future.

Gradual profit sharing with locally elected officers: In their work, mutual health insurance plans lobby locally elected officials of the commune (the Mayor, Administrative District Chief Executives, village chiefs and heads of suburbs). This has started to yield results, especially given the fact that many locally elected officials are already contributing their quota to the mutual health insurance plans in their administrative districts. This is expressed either by registering their families in the mutual health insurance, or by supporting public outreach, by making appeals on the radio or by providing a plot of land to the mutual health insurance plan to build a headquarters.

Existence of a counseling center in the Commune: The other potential for UCMSB in the fight against HIV/AIDS is the existence of a counseling unit at the Bembereke Hospital where UCMSB has an agreement for hospital care benefits. It will therefore be easy for the members to move from awareness campaigns to counseling.

Representation of women: Women are represented in every mutual health insurance plan affiliated to UCMSB. The rate of representation varies between 14% (Gamia) and 44% (Bembereke). 43% of the Executive Board of UCMSB are women and hold positions of vice-chairperson and treasurer. On the Board of Directors, women hold 24% (5) of the 21 seats.

Choice of services covered by the mutual health insurance plans: In the choice of services covered by the mutual health insurance plans affiliated to UCMSB, maternal health care features prominently, particularly pre-natal visits and delivery. In the hospitals, UCMSB also takes care of difficult delivery cases, including caesarian sections.

Choice of days and times of meetings and outreach activities: To ensure the effective participation of women in various activities (management meetings and publicity bodies), the mutual health insurance plans avoid meeting on market days. Meeting times are often chosen to take into account household chores that could occupy women at home and prevent them from participating in activities.

Participation of women in facilitation: For prevention activities, five people, including one woman, are trained in each mutual health insurance plan. Thus, after the training, they facilitate the outreach sessions and are very useful in demonstrating the use of the female condom.

Monitoring and Evaluation

The primary mission of mutual health insurance is to guarantee its members qualitative health care. UCMSB, through the mutual health plans that constitute it, works to improve the quality of care in the state-owned health centers and to maintain the cost of care within acceptable limits. It

is in this regard that there are periodic evaluation meetings between the health training sessions and the mutual health insurance groups.

USEFUL INFORMATION FOR REPLICATION

The UCMSB program for combating HIV/AIDS is still recent. Like any new initiative it lacks certain things (see the paragraph concerning weaknesses). However, for the sake of replication, the following aspects must be taken into account:

1. To break the taboo that surrounds AIDS in a highly Islamized area requires tact and an appropriate strategy. Talking about sex in a public meeting is not easy, especially with women and young girls. The actions of mutual health insurance groups must gradually lead to an opening in this area;
2. Making people gradually adopt the condom as a means of protection constitutes a real challenge where no one can become complacent;
3. Changing public opinion concerning AIDS and making people less reticent about information and exchanges about the illness is not easy. This requires great perseverance.

The leaders of mutual health insurance plans enjoy various training packages that enable them to manage the mutual health insurance of the Commune of Bembereke at the administrative, national and promotional levels.

On the financial front, they have an account that enables them to satisfy the needs of their members in terms of active care. In terms of the reserves built up at the end of the year, they can look at the future with serenity

The question of viability centers on the position of UCMSB as a reinforcement authority for affiliated mutual health insurance plans and an institution that must carry out initiatives at the communal level. Thus, the principle of having subsidiaries can avoid suffocating mutual health insurance groups at the grassroots level, and vice-versa.

All things being equal, it is evident that the pursuit of this activity is of great concern to the plans' members. They envisage it not only with the help of foreign partners, but also with their own contributions, along with support from the commune. Sustaining this program will therefore require a better balance between local efforts and foreign contributions.

MAIN CONTRIBUTOR

- Aboubacar KOTO-YERIMA — Coordinator, Support Program to the Health Insurance Schemes in Africa, Benin

"THE TANTINES": A NOVEL EXPERIENCE IN THE REPRODUCTIVE HEALTH OF ADOLESCENTS AND THE FIGHT AGAINST HIV/AIDS IN CAMEROON

SUMMARY

The German-Cameroonian health program on AIDS has carried out studies that show that adolescent boys and girls were exposed to teenage pregnancy and STI/HIV/AIDS. These studies also revealed that adolescents confide in their schoolmates when problems arise. The "Adolescent Reproductive Health" aspect of the program has therefore developed a system of counseling support for adolescents piloted by the "Tantines": Teenage Mothers Trained in the Prevention of Teenage Pregnancy and STI/HIV/AIDS.

These "Tantines" play the following roles:

- Education/supervision of other adolescents;
- Listening/counseling of adolescents on the issue of sexuality;
- Information/awareness creation;
- Sharing through testimonials.

The process of setting up a Tantine project takes six stages, which are:

1. Studying area for project feasibility;
2. Advocacy and mobilization;
3. Programming interventions;
4. Training/capacity building;
5. Visiting educational institutions and the community;
6. Creating associations of "Tantines".

These methods helped reduce STIs 60% and teenage pregnancies in some schools.

IMPLEMENTING ORGANIZATION

Organization:

- GTZ, Cameroon, German-Cameroonian Program on Health/AIDS
  Project for Adolescent and Youth Reproductive Health
  E-mail: srjacameroun@yahoo.fr

Contact person:

- Chantal NJOMOU
  P. O. Box 7814, Cameroon
  Tel: +237 221 18 16/221 91 18
  Fax: +237 221 91 18

IMPLEMENTATION CONTEXT

The "Tantines Project" of the German-Cameroonian Health/AIDS Program of GTZ Cameroon was born out of a study carried out with 2000 out of 5000 adolescents from three provinces that GTZ supports, namely: the Littoral, North West and South West Provinces The results of this study are[21]:

- 9% of adolescents are sexually active at the age of 12 years old. This rate increases to 67% (out of which 60% are girls) at 16 years;
- More than one adolescent in five (21%) has an unwanted pregnancy. Among them, 36% on average have a voluntary abortion. In some Provinces, this proportion reaches 51%;
- One girl out of three (1/3) and two boys out of three (2/3) have sexual intercourse with more than one partner (between 2 and 8) per year. 11% out of them declare having contracted a sexually transmissible disease during the preceding 12 months;
- More than half (51%) of sexually active youth admit having had unprotected sexual intercourse;
- More than 63% of those who declare having used condoms do not do so during all instances of sexual intercourse;
- More than 84% do not use or do not know another modern method of contraception;
- With 4000 teenage mothers:
    - 64% had their first sexual intercourse between the ages of 12 and 16;
    - 10% gave birth before the age of 16 and 62% before 19 years;
    - 37% quit school because of pregnancy; 31% did not see their partner again and 46% care for their baby alone;
    - 26% declare having contracted STIs during the previous 12 months.

This study led GTZ to create a section called SRJA: ADOLESCENT Reproductive Health with the German-Cameroonian Health/AIDS Program.

A second detailed study led to the following data: In the case of issues related to pregnancy and STDs, 58.0% of girls and 55.3% of boys prefer to turn to their friends and companions for advice. 27.5% of girls turn to their parents and 9.3% turn to health personnel. On the other hand, 19.5% of boys turn to their parents, while 20.1% turn to health personnel.

Counselors now have great influence in matters of adolescent sexuality, which was a role that previously fell to aunts ("tantes"). This is now practically no longer the case. That is the reason why the project wanted to reassign the role of aunts ("tantes") to serve as counselors to adolescents in matters of sexuality. As it is the adolescents' friends of their own age who are their greatest confidantes, the idea of "Tantines", young aunts to serve as mentors, has been made concrete. There are also some "Tontons" (uncles) in the project.

FUNDING

The funding is provided by GTZ funds; the Tantines formed tontines for self-financing purposes. According to the figures supplied by the Project, the training of a Tantine costs between 16,000

[21] GTZ brochure on the Tantines (Teenage Mothers Trained in the Prevention of Teenage Pregnancy and STI/HIV/AIDS)

FCFA and 27,000 FCFA for modules that bring together 60 to 100 people per health district. The average cost per health district is estimated at between 1 million and 1.6 million FCFA.

BENEFICIARIES

The evaluation report from GTZ in April 2005 provided the following figures:

- 3,000 Tantines who had been organized ;
- 70,000 young girls trained in the schools by the 'Tantines' ;
- Reduction in unwanted pregnancies ;
- Reduction in STI prevalence from 28% to 5% in the schools and communities that were targeted for sensitization.

DETAILED DESCRIPTION

The Tantines were trained to accomplish very specific objectives:

1. The education/supervision of teenagers to encourage the adoption of less risky behavior patterns:
   - In primary schools (Class 5 and Class 6);
   - In secondary schools, and,
   - In the community.

2. Listening to/counseling teenagers on their sexual life ;

3. Information/outreach on problems related to early sexual relations, unwanted pregnancies and STI/HIV/AIDS;

4. Sharing experiences through testimonies on the difficulties faced regarding early pregnancies.

By definition, "Tantine" is a girl who fulfils the following criteria[22] :

- Age (12-24 years). This age was raised to 30 years in 2004;
- A teenage mother with at least one child;
- Unmarried;
- Unemployed and not attending school;
- Have given birth between the ages of 12 and 18;
- Received training in the prevention of teenage pregnancy and STI/HIV/AIDS;
- Serving on voluntary basis; must be dynamic and committed to render counseling services in reproductive health and prevention of STI/HIV/AIDS.

The "Tontons" define themselves as males falling into the following categories:

- Between 15 and 50 years;
- Should have impregnated a girl of between 12 and 18 years;
- Married or may be a bachelor;

[22] The Tantines: a journal exchanged by the Tantines NO2

- Should have been trained;
- Committed to counseling others in reproductive health and prevention of STI/HIV/AIDS.

It must be noted that generally speaking, the concept of "Tontons" was not as successful as the concept of "Tantines".

Current situation and future steps

The project surveys were conducted mainly in May/June 2000 and were focused on Nkondjock in the Nkam Division in the Littoral Province. The project was subsequently developed in Manjo, in the Moungo Division in the same Province before being extended to the three provinces targeted for intervention by GTZ, which are the Littoral, the South West and later the North West.

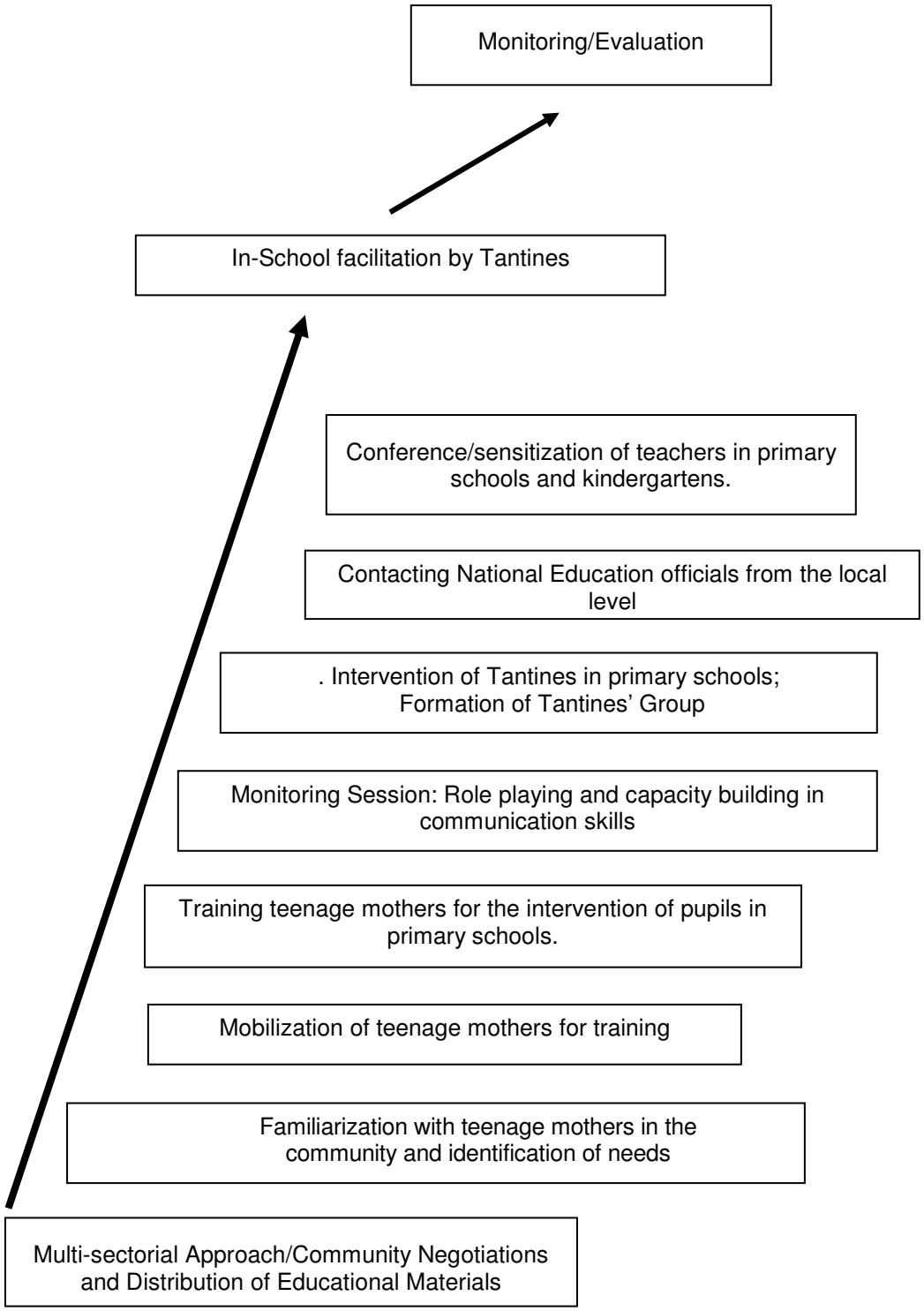
Table N° 4 : The Distribution of membership in Tantines/Tontons in October 2002:

Province	Tantines	% of membership	Tontons	% of membership
North West	792	95.42	38	4.58
South West	331	96.22	13	3.78
Littoral	476	95.77	21	4.23
Total	**1599**	**95.70**	**72**	**4.30**

Table N° 5 : The Tantines Situation at the end of 2003

Province	Number of locations/Associations	Number of people trained and active		TOTAL
		Tantines	Tontons	
North West	8	1003	43	1046
South West	5	331	13	344
Littoral	8	571	21	592
Total	**21**	**1905**	**77**	**1982**
Note: four control locations (two in the West Province and two in the Center) have a total of 310 trained Tantines.				

MONITORING OUTLINE FOR THE CREATION OF THE "TANTINE" PROJECT



Strengths, Weaknesses, Opportunities and Threats

The SWOT (success, weaknesses, opportunities and threats) structure, presented in table 3 will help to carry out the analysis.

Table N° 6 : SWOT Structure for the Tantines Project

SUCCESS	OPPORTUNITIES
▪ Great Impact on the reduction of STI/HIV/AIDS as well as unwanted pregnancies among the youth; ▪ Significant Impact on youths' moral balance and position in society; ▪ Considerable reinforcement of societal values; ▪ Opening up on sex-related issues in communities and schools; ▪ High project visibility.	- Increase resources of the project from 2006; - High level of voluntary commitment from Tantines; - Southern Cameroon has a relatively open culture with few taboos; - The Tontines of the Tantines Associations promote mutual assistance and exchanges; - The project is spreading, and the communities themselves are directly asking for their creation.
WEAKNESSES	**THREATS**
▪ The process requires effective organization and substantial outlays for launching and monitoring; ▪ Teenagers give woefully inadequate priority to abstinence; ▪ The Catholic schools reject any discussion of condoms; ▪ Poor perception of the Tantines by some teachers; ▪ Low level of linguistic expression by some Tantines; ▪ Some Tantines are viewed as illiterate girls who are bringing their bad example to adolescents; ▪ The Tontons did not achieve the same level of success as the Tantines.	- A large turnover of the Tantines which sometimes creates the need to retrain new Tantines in some suburbs/villages; - Danger of copying a methodology used in different environments; - The application in the community as a whole does not run as well as in the schools; - Limited Voluntarism.

Compared to the Tantines, the experience of the Tontons, men who had children with young girls, did not achieve the same level of success because the consequences of such pregnancies are usually borne by the girls. However, the Tontons played quite an important role in the communication of the message against STI/HIV/AIDS. How can we explain the success of the Tantines as against that of the Tontons? Is there a gender-related dimension?

As a women's group, the Tantines has an influence on society because the role of child care is the preserve of women, giving them standing in reproductive health matters. The Tantines used their status as women to mobilize more young girls/women than young boys/men.

On the contrary, the Tontons' initiative shows that in a patriarchal society, it is acceptable that a man (or young boy) brings a child into the world**.** There is therefore no motivation for the man to assume such status.

Monitoring and Evaluation

Monitoring is gradually becoming erratic. The problem is the high turnover rate of the Tantines, who are getting married, traveling, finding jobs or passing the acceptable age limit.

The tools for monitoring are as follows:

1. A Discussion Manual with young single mothers;
2. A Pedagogical Form developed to monitor young mothers during seminar;
3. A Training Program;
4. A Pedagogical Form: "Intermediate Training Session: "How to carry out an educational intervention in a school";
5. A methodology for the formation of a Tantines Group or Association;
6. A Program named: "Conference for Primary and Kindergarten School Teachers";
7. A Pedagogical Card on the Teachers' Conference;
8. Form entitled: "Action Plan for Tantines and Activity Monitoring";
9. Form entitled: "Implementation of a Tantines' Intervention in Schools";
10. Discussion Manual for outreach;
11. Summary Table on Tantines Activity focusing on more than one Year;
12. The various themes proposed during the Tantines school facilitation.

USEFUL INFORMATION FOR REPLICATION

It is a high quality practice. This is significant, judging from the following indicators:

- The establishment of the project is a very painstaking and well-thought out process;
- The monitoring tools are well designed;
- The selected trainers are generally very competent;
- There are highly committed and competent Tantines.

Nevertheless, the selection of Tantines should be done with a lot more care. Moreover, the objective of covering all locations should be discarded in favor of more careful work considering the Tantines' level of training, discretion and their commitment to behaving in a responsible manner.

Any young Tantine who gives birth for the second time automatically loses her status. All the same, some Tantines who are well-informed on protection strategies consistently change partners and thus lose their respectability.

The project design is linked to the issue of adaptation to various localities. Thus, between two and four weeks are devoted to studying the environment and understanding local customs and traditions to avoid making any harmful errors. However, if people managing the process are from that specific area, and are familiar with the environment, financial resources and time can be saved by circumventing these studies.

Can the project generally be adapted to other environments? In some communities an adolescent who has given birth is automatically considered a curse or a shame and is denied the possibility of expressing herself. Thus, it is very critical to analyze the social context.

The viability of the project depends on its capacity to operate after the financial supporters or project developers have left the scene.

A young auntie ("Tantine") receives only two training stints: The first centers on a foundational message to be disseminated to the public and the second relates to a deeper thematic appreciation of certain subject areas. She is then expected to be independent in her duties. By forming these Tantine Associations and organizing tontines, these girls are able to learn some job-related skills, especially as these Tantines only work in their villages/suburbs.

Unfortunately, there is a high turnover of Tantines. It is estimated that a young auntie is active for only a period of 2 to 3 years. After this period, she either gets married or finds a paid job, thus creating the need to train a new young auntie in the same area.

Thus, in spite of the high turnover of the Tantines which compels project organizers to regularly train new Tantines, perhaps the District Health Administrations or local NGOs could undertake these training sessions at a very low cost after the initial investment has been made.

The project's sustainability could without a doubt be improved by transferring these additional training sessions to a local NGO, a Church or a Health Insurance Society.

CONTRIBUTOR

- Deogratias Ntima NIYONKURU — Deputy General Secretary, Support Service to Local Initiatives for Development (SAILD)

DEVELOPMENT OF INCOME GENERATING ACTIVITIES WITHIN AN ASSOCIATION OF PLHA: THE CASE OF HIRASSO IN CAMEROON

SUMMARY

HIRASSO, which stands for "Hope Is Rising Association," is a group of people living with HIV/AIDS in the Anglophone South-West Province of Cameroon. Its membership is made up of about 20 people. Originally, this association was set up as a tontine aimed at developing income-generating activities. A limited group of people (which varied between 6 and 8 members) began, outside the purview of this association, to contribute 10,000 FCFA per month to a fund which was given to a single member to undertake an income generating activity that had been previously reviewed and adopted by the group. Thus, the six members were able to execute interesting and viable projects (like opening a video club, a bar, repairing a bush taxi, etc). All the people involved in this tontine are now productive members of society.

IMPLEMENTING ORGANIZATION

Organization:

- HIRASSO: Hope is Rising Association
  P. O. BOX 504 BUEA CAMEROON

Contact person:

- James Clovis KAYO
  President of RéCAP+
  Te: +237 745 47 12/972 59 32
  E-mail: hirasso@yahoo.fr

IMPLEMENTATION CONTEXT

Faced with persistent poverty-related issues, opportunistic infections and difficulties in buying ARVs on a regular basis, the PLHA found themselves compelled "to do something for themselves." Thus, a small group of people voluntarily launched an income-generating activity guided by specific rules and objectives.

The small group formed an association and initiated a monthly tontine, in which the benefiting member had to set up an income-generating activity whose feasibility had been previously discussed within the group.

The ambition of HIRASSO's members is to become a large-scale NGO that will receive substantial support at the international level like other organizations based in Douala. Moreover, the members want to "create a food enrichment production unit for PLHA, babies and people who have not yet been infected." The launching of a solidarity fund by the members, with the support of the community, the elite, business enterprises and other partners, would facilitate access to treatment.

FUNDING

The project is entirely self-financed through monthly contributions (tontine) of 10,000 FCFA per person.

BENEFICIARIES

The beneficiaries of the project are HIRASSO members.

DETAILED DESCRIPTION

The "Hope Is Rising Association" (HIRASSO) is an Association of PLHA[23] that was created in 2000 in Cameroon. Its headquarters is in Buea, capital of the South-West Province. The overall objective of this Association is to "promote self-sufficiency among its members by promoting the development of Income-Generating Activities."

HIRASSO was founded by James Clovis KAYO, current Executive Secretary of RéCAP+, the Cameroon Network of Associations of PLHA and with the support of Dr. Jacqueline MATSEZOU, District Medical Director in Buea. From the onset, it was directed at bringing together all PLHA to enable them to give support to one another and to share experiences.

In 2001, the first cluster made up of five members, devoted themselves to counseling in hospitals and homes as well as participating in various self-help projects. To evaluate their counseling work, the members met four times a month.

According to traditional ground rules of tontine groups, each beneficiary in turn receives an amount of 60,000 FCFA. The President is the last beneficiary in the tontine round.

Currently, they have submitted a proposal to set up a corn mill machine to the NAC through RéCAP+ which will enable them to make income for enriched food.

Once the founders set the tontine's rules and a timetable was drawn up, members strictly adhered to them. Traditionally, the tontine was held on the first Saturday of each month, in conjunction with the ordinary association assembly meetings, the Tontine always being the last item on the agenda. That is how the following activities (see table N°7 below) were carried out by the beneficiaries of the tontine:

[23] People Living with HIV/AIDS

Table N° 7: Activities carried out by the beneficiaries of the tontine

MONTH/YEAR	NAME OF BENEFICIARY	IGA SET UP
March 2003	Azia	Video-club, then a bar
April 2003	Mad. Myriam	Sale of smoked fish
May 2003	Jonathan	Repair and running of minibus transport
July 2003	Rachel	Sale of underwear
August 2003	Valentin	Restarting a bar business
September 2003	James Clovis, Chairman	Had to leave to join RéCAP+

All the activities initiated through this tontine are operating successfully, and the PLHA, who were previously viewed as marginal elements in society have succeeded in regaining their financial standing. In fact, the commercial success of Valentine's bar (referred to above) became a living testimonial.

Only James Clovis KAYO, the tontine's Chairman, did not benefit from the plan as he had to leave Buea for Yaounde, to take up a new appointment as the coordinator of RéCAP+, the Cameroonian Network of Associations of People Living with HIV/AIDS, the national faith-based umbrella organization of associations of PLHA.

With their success, the members decided to add "a solidarity fund for the group" to the tontine with a monthly contribution of 500 FCFA per person. This contribution allowed members to purchase Cotrimoxazole (Bactrim), a highly recommended antibiotic for people living with HIV/AIDS, effective in stemming opportunistic infections.

In view of this success, the District Medical Director proposed that members pool resources together to buy drugs in bulk. To achieve this goal, he motivated the rest of the group to participate in the monthly contribution. Thus, 25 members are now engaged in the activity. They are now able to purchase the drug at 4 FCFA instead of the retail price of 10 FCFA. These bulk purchases will bind the group together.

Current situation and future steps

In the short term, HIRASSO hopes to enroll new members. Some association members have taken six-month temporary positions as counselors in voluntary screening centers. As part of their mission, they have been charged to convince at least six of their clients into becoming HIRASSO members.

HIRASSO expresses its sorrow at the death of two of its members. Three other members have joined other associations because HIRASSO succeeded in finding them counseling jobs, most notably at PTG[24] and ATC[25] in Limbe.

The activities that begun with tontine funds are still operational and have substantially contributed to improving the image of PLHA in the region.

However, it must be lamented that the tontine aimed at IGA is no longer operational in part because James and Rachel have left Buea. However, the monthly contribution of 500 FCFA for the bulk purchase of Bactrim is ongoing.

The tontine has ceased operations, not only because the leaders have left the locality, but also because HIRASSO is now well-known and is able to access separate funding through the Provincial Technical Groups of the National AIDS Control Program (PTG).

Thus, between 2003 and 2005, the group received cumulated funding of 3,500,000 FCFA which enabled it to pursue the following activities:

1. Purchase and sale of mashed corn and soya at 1000 FCFA to members and 1200 FCFA to non-members;
2. Assistance to the poor;
3. Provision of small gifts during visits to members in homes and hospitals;
4. Counseling at the testing centers;
5. Family counseling in case one feels ostracized;
6. Assistance to orphans (with the support of some NGOs);
7. HIV/AIDS public awareness (in women's groups, the youth at lorry parks, in mini hostels, at the hair salons, in prisons, in schools and colleges, etc), which includes and the correct way of wearing the condom, promotion of voluntary testing, etc;
8. Testimonies;
9. Spiritual Retreats;
10. Capacity building of members;
11. Renting a place for meetings;
12. Contribution to the creation of new associations of PLHA throughout the region.

HIRASSO is also deeply involved in job searching for its members, especially in the area of counseling in hospitals. Seven of its members have already been recruited at PTG, CTG[26] and ATC where they work as counselors or consultants. The organization attaches great importance to the training of its members. The members who get jobs are obligated to pay 5% of their salary to the association and those who receive per diems from seminars where they represent the organization pay 10% of the per diem. Because of the distance between Buea and villages in the region, some members living in the surrounding villages have received support from HIRASSO towards the creation of new PLHA associations in their respective locations. To date, HIRASSO has succeeded in facilitating the creation of four associations.

[24] Provincial Technical Groups of the National AIDS Control Program
[25] Approved Treatment Center
[26] Technical Group Center of the National AIDS Control Program

Strengths, Weaknesses and Opportunities

These factors will be analyzed using the SWOT structure: Success, Weaknesses, Opportunities and Threats as in Table No. 8.

Table No. 8: SWOT Structure for HIRASSO

SUCCESS	OPPORTUNITIES
▪ Generally speaking, HIRASSO operates well when decisions are arrived at by consensus; ▪ The activities created by the Income-Generating Tontine are still operational and are becoming diversified; ▪ The contribution for the bulk purchase of Bactrim is operating effectively; ▪ The organization's counseling services are in high demand in hospitals and homes; ▪ The members who left were able to create other PLHA associations; ▪ The success of the project helped the PLHA to develop themselves and to regain their dignity.	- The small tontine group was made up of highly trained university graduates with a lot of ambition; - The founder is now the Executive Secretary of RéCAP +; - Ideas for interesting projects: Production Unit for Enriched Foods; - High level of commitment of members; - Transparent management.
WEAKNESSES	**THREATS**
▪ Since HIRASSO started receiving external support, the tontine has ceased; ▪ Departure of some members who have found jobs; ▪ The high monetary amount contributed by members for the income-generating tontine has sidelined a majority of the members.	- International aid destroys internal dynamics; - Departure of trained members for highly paid jobs; - Limits to voluntarism; - A certain amount of segregation between the haves and have nots.

USEFUL INFORMATION FOR REPLICATION

In view HIRASSO's success, it can be stated that in practice:

- The idea is simple and is well-integrated into the region's local culture;
- Its operation is run by consensus;
- The members of HIRASSO are relatively well-trained and serve as role models for other associations.

However, the fact that the tontine, aimed at income generating activities, involved only a certain category of people created a sense of frustration and exclusion. This could have been rectified through a better internal communication mechanism for establishing a middle-level contribution (for example 5000 FCFA).

The tontine principle is well-integrated into several environments. Of course, there are certain parts of Africa where the concept is unknown, but experience has shown that in many African countries it is an easy concept to develop.

In any case, for people who are already financially deprived, as is the case with most of the HIV patients who must seek treatment by traditional medical practitioners, it is difficult to put together resources to make contributions. For PLHA to undertake an Income Generating Activity, it is vital that they regain confidence in themselves.

This initiative is designed for people who do not have external assistance. The projects have been clearly identified, studied and executed even if the amounts allocated for their execution are not substantial. However, the contribution of external resources is not always beneficial[27].

A constructive sign of support could be to provide the organization with funds to speed up the round or double the payment in the tontine.

CONTRIBUTOR

- Deogratias Ntima NIYONKURU — Deputy General Secretary, Support Service to Local Initiatives for Development (SAILD)

[27] Risk of destabilization with easy money

MUTUAL HEALTH INSURANCE PLAN BY "UNACOIS" IN SENEGAL

SUMMARY

The Senegal National Traders and Industrialists Union (UNACOIS) is an informal sector association whose principal members are traders.

These traders are from the same geographical region (the Baol) and belong mainly to one religious group (Muridism) who have settled in the urban markets as street vendors. Those who had financial resources became business operators, importers and exporters of diverse goods. They developed a system of mutual assistance, which led to the creation of Mutual Savings Societies. Each commercial center[28] has its own mutual health insurance society.

UNACOIS is a unique association because it combines mutual health insurance plan with a network of savings and credit societies. This provision increased the financial and logistical resources with the bargaining power of the mutual health insurance society. This allows group members to negotiate beneficial prevention and treatment agreements with health institutions. The UNACOIS health plan is committed to the prevention of HIV/AIDS.

In its development agenda, UNACOIS receives technical and financial support from partners such as PHRplus.

IMPLEMENTING ORGANIZATION:

Organization:

- UNACOIS
  Avenue Cheikh Ahmadou Bamba, opposite the Dakar Obelisk/Colobane
  P. O. Box: 3698 Dakar Peytavin
  Website: www.UNACOIS.sn
  Association E-mail: UNACOIS.as@UNACOIS.sn; UNACOIS.as@sentoo.sn
  Health Insurance Plan E-mail: UNACOIS.sante@hotmail.com;

Contact persons:

- Ibrahim DIOP
  E-mail: ibrahimdiop_UNACOIS@hotmail.com

- President of the Mutual: Medoune DIOP
  Telephone: +221 821 60 48
  Fax: +221 822 01 85

[28] And later each market

IMPLEMENTATION CONTEXT

In 2001, more than 51% of the Senegalese population lived below the poverty line. As a group, the poor had low access to health care.

The health infrastructure includes 809 health posts, 53 health centers and 17 hospitals, representing one health post per 11,500 inhabitants, a center per 175,000 inhabitants and a hospital per 545,800 inhabitants. There are several private clinics but the cost is too prohibitive and marginalizes the extremely poor. In 1975, the State made Health Provident Institutes mandatory for the formal sector. From 1995, mutual health insurance societies were developed for the informal sector and rural communities to improve access to health care. These health plans are supported by the government at the political and technical levels.

FUNDING

The mutual health plan linked to the mutual credit plan was created in 2000. The membership fee is 5000 FCFA per person and contributions vary between 500 FCFA and 1000 FCFA per month per beneficiary, depending on the type of service required by the member.

In fact, the UNACOIS health insurance society had more substantial resources than the average health insurance society because of contributions (which varied depending on income), and the number of potential members was estimated to be 10,000. However, its resources remained modest.

BENEFICIARIES

The UNACOIS mutual health insurance society is made up of informal sector traders who come from the same geographical region (Baol) and belong to a single religious group (the Murids). This plan includes more than 25,000 enterprises, 80,000 members from across the length and breath of Senegal, including 30,000 members in the Dakar region alone. Traders represent 93% of the total membership, followed by importers (5%), industrialists and service providers represent 1.5% and 0.5% respectively. Of the retailers who are part of the mutual health society, most rent (51%) their place of business, while 38% own the property.

DETAILED DESCRIPTION

The General Assembly oversaw the birth of UNACOIS in 1990. According to the bylaws of this body, membership is open to any trader, industrialist, commercial enterprise or local craft company, any company undertaking commercial ventures or an officially approved group with economic interests.

Since its creation, UNACOIS has taken many measures to promote the interest of its members. To ensure the proper functioning of its operations, UNACOIS set up a General Assembly, a Management Committee, a National Office and Regional Offices.

The uniqueness of this experience stems from the fact that after the creation of mutual health insurance, a decision was taken to merge it with the mutual savings though these two types of societies are different: The Mutual Savings Society is a micro-financing mechanism whereas the health insurance plan is geared at responding to a social need, yet both of them target the same population.

Current situation and future steps

UNACOIS is structured into a network and operates in all 11 regions of the country. It has a national office and regional offices. UNACOIS relies on a vast network of markets and commercial centers. The markets are organized into units, which bring together:

- Members established in these markets;
- Traders whose attention is focused on these markets;
- Members who are not traders but established in the zone.

UNACOIS has members spread across the entire nation and in the Diaspora, particularly in Europe and the United States. The distribution of the membership today is as follows:

- 65% retailers
- 20% mid-level wholesalers
- 9% wholesalers
- 0.5% industrialists

The primary objective of UNACOIS is to become an important partner contributing to national economic development and the organization has distinguished itself in the area of development projects. UNACOIS currently works with several development partners, in particular with USAID through the DYNA Company, the BHS and the FNPJ.

UNACOIS also obtained a Housing Cooperative in Dakar and acquired 99 serviced plots in the Pattes d'oie (Crow's Feet) neighborhood. The condition of UNACOIS members has improved considerably since they joined the group. In fact, 75% of respondents admit that their condition has improved since they became members.

UNACOIS also carries out relationships with employers' organizations. Its strategy is to defend some common objectives by continually advocating important issues to its members
Unity is a critical factor in this organization. The majority of UNACOIS members interviewed (91%) indicated that unity had been demonstrated at various levels (See Table No. 9 below).

Table No. 9: Illustration of obligations by UNACOIS' members

Evidence of met interests	Percentage %
Collecting goods without paying	51%
Mutual assistance in business	14%
Money lending	11%
Social life	10%
Relationships	9%
Ease in selling goods	3%
Ethnic and religious solidarity	2%
Total	**100%**

In the case of mutual savings and credit, banks have been set up and they constitute opportunities for traders. Thus in 2004, UMECUDEFS, which is the network of mutual savings and credit of UNACOIDEFS, distributed 9 billion FCFA in more than 12,000 credit operations. The outstanding savings as of December 31, 2004 was more than 6 billion FCFA. This Network is made up of more than 60 mutual societies from every corner of Senegal. The breakdown of UNACOIS membership by gender shows that men represent 76% of total membership compared to women's 24%.

The association launched a community micro health insurance plan with the support of PHRplus to ensure a social protection system for association members, which is very important because often informal sector workers lack coverage. Before launching the program, the association created a pilot project in two regions: Dakar and Kaolack. The mutual health society is also distinguishable by its dynamic prevention policy and it organizes periodic outreach campaigns regarding the fight against HIV/AIDS and opportunistic infections.

Strengths, weaknesses and opportunities

The major strength of UNACOIS's mutual health insurance plan is the density and size of its membership. In addition, the alliance of the mutual savings and credit helps the mutual health plan to be financially viable.

The major potential of UNACOIS's mutual health plan is its ability to negotiate with various partners (Department of Health Institutions at the Ministry of Health and Prevention, the Dakar Medical Region and all the Health Districts). Agreements were signed with Health Institutions in the Dakar Medical Region. These agreements consist of:

- Agreement with Albert Royer National Children's Hospital;
- Agreement with the Fann Teaching Hospital;
- Agreement with the Grand Yoff General Hospital, ex CTO.

Other agreements are currently being negotiated. These include the Framework Agreement with all Health Centers in Dakar in conjunction with the Department of Social Welfare of the Dakar City Council. Thus, 17 operational health centers, including those in the process of opening, are located within the target areas. Agreements with Health Centers will follow in collaboration with the Communes and Management Committees.

Monitoring and Evaluation

There is a monitoring and evaluation system that PHRplus is developing in conjunction with UNACOIS/Kaolack to reinforce field monitoring by local actors (in one pilot region only, apart from Dakar).

The UNACOIS monitoring and evaluation system includes an operational activity plan in conjunction with the proper officials, the monitoring/evaluation of programmed activities, key parameters and finances. In other words, the monitoring focuses on programmed activities, fundamental parameters and resources. For this reason, the following tools are used:

Tool A: Planning Tool

The Activity Planning Tool helps to systematically monitor the level of implementation of activities. It is on the basis of this action plan that the monthly support planning activity has been designed.

Planning Form

Actions	Targets	Partners	Officer in charge	Local contribution	Timeframe

Tool B: Monitoring and Evaluation Tools

This pertains to the tools developed to monitor the mutual society's activity implementation, then collect data relating to the development of some key parameters (including membership and the recovery rate for contributions) and finally to examine the trend in financial resources.

1. ***Planned Activities Monitoring Form***

Activities	Take-off		Timeframe		Results		Observations
	Projected	*Achieved*	*Projected*	*Achieved*	*Projected*	*Achieved*	
Activity 1							
Activity …							

2. ***Key Parameters Monitoring Form (Membership, Beneficiaries, Contributions)***

Period	Target Population	No. of Members	No. of Beneficiaries	Paid-up Members in good standing
Period 1				
Period 2				
Period …				

3. ***Financial Resources Monitoring Form***

Period	Contributions collected	Membership Fees	Other resources	Cumulative
Period 1				
Period 2				
Period …				

Monitoring approaches are as follows:

- Participation in preparation and implementation of activities;
- Dispatch of activity reports by the Mutual Society's administrative authority;
- Regular collection of day-to-day information by the PHRplus operations official;
- Holding of periodic meetings between PHRplus and the Executive Bureau;
- Close evaluation by local consultants.

USEFUL INFORMATION FOR REPLICATION

To ensure replication:

1. The independence of the faith-based mutual society should be maintained. In the case of the Senegalese experience, UNACOIS Mutual Health in Dakar has remained independent as a distinct legal entity from the Mutual Savings and Credit Societies, yet UNACOIS houses those offices.

2. The Mutual Health Society's support of the Branch Offices helps transfer financial management knowledge.

3. The synergy with the Savings Societies has a lot of advantages:

- The use of a single secure network for collecting contributions;
- The respect for procedural norms for dues collection and the principle of legality and transparency;
- The proximity of collection offices compared to the locations of members' businesses.

4. The experiences gained from outreach campaigns and mobilization of actors from the informal sector help in the acquisition of know-how in the provision of some services[29].

[29] A campaign for popularizing the project from February to April 2003 and an outreach campaign from January to March 2004

5. The UNACOIS association is a traders' organization with a majority of its members working in the private sector. Most of the informal service workers are particularly prone to health risks in view of their risky working conditions, lack of caution on the job as well as low and/or irregular incomes. In view of their low level of education, these workers have limited access to information and preventive measures against diseases. This vulnerability is the real basis for funding in the area of healthcare and it is the first determining factor in the set up and function of the mutual society.

6. The viability of the UNACOIS Health Insurance Society is also linked to the economic development of its members. In fact, UNACOIS is an association of traders generating economic activities. It has developed a micro-financing initiative by creating a network of savings and credit societies throughout Senegal. This environment facilitates mutual assistance in terms of healthcare. It gives financial resources to the members to pay their contributions regularly.

7. The third positive factor is the sense of solidarity. In fact, there exists a primary associative link among members of the mutual health society, which is the membership to the "UNACOIS" association. This common link is a further boost to the solidarity existing in the mutual insurance system.

8. UNACOIS has sufficient resources and is a heavyweight in the economic and socio-political environment in Senegal. It is an important association that develops other strategic services (finance, housing, land access etc.) for the benefit of its members. It is also a powerful counterbalance in the economic and socio-political environment. It has a great influence on the government's strategies and policies, particularly in the area of trade and industry.

However, one of the major constraints to the viability of UNACOIS health insurance plan is the non-availability of members from statutory bodies. Building capacity of the mutual society's leaders, particularly in the Dakar office, is also a challenge that needs to be overcome, especially in light of their general lower education levels.

CONTRIBUTORS

- Mamadou MBAYE — Program Officer, PHRplus /Senegal
- Salimata NDIAYE — Consultant/Economist

"MICRO-CREDIT" OF THE ASSOCIATION "ESPOIR 27" OF KOUMRA IN CHAD

SUMMARY

Since 2003, the Association "Espoir 27" of Koumra has granted micro-credit loans to people living with HIV/AIDS for the creation of small-scale business activities. Their objective is to help these able-bodied people undertake business ventures to satisfy basic needs, like accommodation, feeding, buying ARVs, etc. The conditions for accessing the Association's credit are as follows: being a member of the association; regular payment of contributions; respect for the association's constitution; and, choice of an income generating activity. The membership fee is 1000 FCFA and contributions are 500 FCFA per month. The association has a relationship with two hospitals for the management of opportunistic infections. Only PLHA who are salaried workers of COTONTCHAD are on ARV. The association is also engaged in prevention activities.

Testimonies provided by beneficiaries and other association members indicate that its performance has raised the morale of members who are PLHA and enhanced their solidarity as well as their desire to campaign for the association.

It is a simple practice that can be replicated and adapted to other communities with modest resources in a reasonable period. It can be sustained because of its simplicity: the positive results and fund repayment without interest. It is suitable for women because of the diverse activities that can be carried out with the funds.

IMPLEMENTING ORGANIZATION

Organization:

- Espoir 27 Association in the Mandoul Region (AE 27 PVU/MANDOUL)

Contact persons:

- Tchori OUINGUE
  Tel: +235 36 00 60

- Djimrabeye NAODINGAR
  Tel: +235 44 79 99

IMPLEMENTATION CONTEXT

Situated in the South, Koumra is a major town within the Mandoul Region, one of Chad's 18 administrative regions. Mandoul is made up of three districts, East Mandoul (Koumra), West Mandoul (Bedjondo) and Barh-Sara (Moissala). It contains 11 sub-prefectures. Koumra is a crossroads town as it links various sub-prefectures in the Mandoul Region and facilitates connections with neighboring regions, especially the petroleum producing zone of Eastern

Logone, Tandjile and Middle Chari. Koumra is a cosmopolitan town where people from all walks of life are engaged in business activities or farming. Two teaching hospitals (one public and one faith-based) are operational.

During the first half of 2005, 841 people were tested for AIDS, and 205 tested positive, a 23.53% incidence rate.

FUNDING

- Equity Capital: 75,000 FCFA.
- Funds from partners (voluntary contributions): 100,000 FCFA.

Note: Apart from micro-credit, the association receives funding for other preventive activities.

BENEFICIARIES

- The direct beneficiaries are 11 people, 8 women and 3 men.
- The indirect beneficiaries are 24 people.

DETAILED DESCRIPTION

The association "Espoir 27" of Koumra was established in March 27, 2003 following a brainstorming session on the methods of support for people living with HIV/AIDS. Organizations such as the NACP, the SODER, the ATE and the Health Directorate in the region participated in the event. The objective of the brainstorming was to facilitate the socio-economic integration of PLHA and AIDS orphans through solidarity action. With assistance provided by UNAIDS, micro-credit funds were granted to members to establish income-generating activities to provide basic needs, namely food and health.

The micro-credit funds stemmed from a very simple idea: PLHA were in the habit of going to the headquarters to share their concerns, their feelings and material problems.
Some were widows with dependent children; others were disadvantaged and could not meet their basic needs. Thus, the need to build a solidarity chain by granting micro-credit. The support provided by UNAIDS helped to bring

R.B.

I was born on 18th November, 1969 in Pala. My mother died when I was two years old. My father worked at Sarh and was killed in 1983. I was in the fourth class. Life was not easy for me and my guardian. At 16, I decided to marry a civil servant working at ONDR in 1987 and the following year, we had a daughter. My husband was transferred to Sarh. He was often ill… He travelled a lot in connection with his work. I knew that he had girl friends. After countless relapses, the doctor asked for a full-scale laboratory investigation. He agreed… They found out he was HIV positive. I therefore agreed to go through the same tests and they proved positive. In fact, I found out that I had been infected in 1999, the year my husband died. In 2003, on 27th March, I was the first woman in Koumra to publicly declare my HIV status. In the beginning, it was difficult to make ends meet with my three children but thanks to the micro-credit provided by our Association, I sell food products and this enables me to meet some needs…

By Sainta N'Dem NGOIDI
Koumra, August, 2005

about this plan.

The micro-credit plan aims at assisting members who are still strong enough to meet their own needs, particularly food, accommodation and eventually to gain access to ARVs.

The association's emphasis is on member solidarity. The resources come from the membership fees (1000 FCFA per person) and a monthly contribution of 500 FCFA. Some well-wishers that assist do so out of a sense of solidarity[30].

Current situation and future steps

The association "Espoir 27" was established in March 2003 and it received official authorization to operate in April 2003 according to order No. 025/MAT/RM/DMLOR/SG/03. The micro-credit plan started two years ago (2004 and 2005). In the first year, there was lack of organization. Thereafter, there was a significant improvement in the living conditions of the micro-credit beneficiaries and their social levels. The living condition improvements are not yet sufficient, but there is hope with the plan. Moreover, new members have registered.

Espoir 27 has 175,000 FCFA to give out in credits to its neediest members. The credit varies from 10,000 to 25,000 FCFA, is interest-free and repayable over a 12 month period.

Strengths, Weaknesses and Opportunities

The strengths of this plan are:

1. The solidarity and effective participation of PLHA and their sympathizers;
2. The determination and motivation of members to fight for their survival;
3. The significant improvement in living conditions of members receiving credits; and,
4. The wealth of ideas presented by members.

The weaknesses are:

1. Insufficient resources;
2. Lack of training for officials and members;
3. Lack of the association's own office, giving them renter's status;
4. Lack of working tools (documentation, mobility and communication);
5. Difficulties in accessing ARV and managing opportunistic infections.

The Opportunities are:

1. Existence of PLHA associations and networks;
2. Availability of health services for the management of psycho/medico/social needs.
3. Existence of community-based organizations;
4. Dynamic and motivated members;
5. Technical support from partners;
6. Existence and determination of partners to combat HIV/AIDS;
7. Strategic position of the region in terms of trade.

[30] MAF, MSF, UNAIDS, WORLD VISION, Baptist Church

The association "Espoir 27" provides an opportunity for women who are affected and infected by HIV/AIDS to undertake a variety of income generating ventures.

As compared to most men, these women do not consider their PLHA status as a taboo, thus facilitating their specific contribution to the prevention of the pandemic. They are active in the psycho-social care of association members and other PLHA.

Monitoring and Evaluation

The monitoring of the association's activities takes place every two months during the statutory meetings at the association's headquarters. It is completed by the Management Committee, made up of the President, a Treasurer, an Auditor and a Purchasing Officer.

As the Committee has not yet been trained, it is not very qualified to thoroughly carry out evaluation activities.

USEFUL INFORMATION FOR REPLICATION

The experience:

- Can be easily replicated and adapted in communities within a reasonable amount of time and at little cost;
- Reflects solidarity concerns and community participation

Sustainability is possible because of its:

- Simplicity
- Potential results recorded in a reasonable timeframe.
- Effective repayments of interest free funds.

CONTRIBUTOR

- Sainta NDEM NGODI,
  Coordinator – Community Health Program, Chad

DN:

I was born on 9th January, 1970 in Abeche. In 1984, the year my father retired, he sent me to his friend to be my new guardian. He was an ex-military man who had become a trader. I was put in charge of his sugar warehouse and I went to school in the afternoons. As I had some resources, I had a young girl friend in Koumra. This adventure led to her pregnancy… I quit school to carry out some business activities. I rented a vehicle and ran a transport business. Thus, I come into contact with money and consequently manipulated women….

My sexual relations were unprotected. I did not know my HIV status until my fourth child (who was our last) fell ill and died. The possibility of my HIV status only grew. Some of my previous partners had already died. My wife and I were tested voluntarily. It was positive and I accepted it without expressing any surprise. She was the first to join the Espoir 27 Association. I appreciate the kind of solidarity that exists in the group, especially the micro-credit plan provided to some members which my wife and I benefited from. This contributed to boosting not only our morale but to meeting some basic needs like soap, kerosene and other expenses. I also make burnt bricks and sell them to meet other family needs in the hope that an anti-AIDS drug will be discovered before death snatches us away….

By Sainta N'Dem NGOIDI
Koumra, August, 2005

CENTER FOR INFORMATION, COUNSELING, CARE AND SUPPORT FOR PEOPLE LIVING WITH HIV/AIDS (CESAC) IN MALI

SUMMARY

The CESAC, Center for Information, Counseling, Care and Support for People Living with HIV/AIDS, was established in September 1996 to provide a medical and psycho-social response to the problems faced by people living with HIV/AIDS. This center was established with financial support from the French Cooperation Agency in collaboration with two institutions: The Ministry of Health, Aged People and Solidarity and the Association of Research, Communication and Home Support for People Living with HIV/AIDS (ARCAD/SIDA). ARCAD/SIDA is in charge of the group's management and facilitation. The project lasted for three years (September 1996-1999) with a budget of 300 millions FCFA[31].

The objectives of CESAC are:

- To provide a meeting, orientation, information, medical and psycho-social support center for people living with HIV/AIDS;
- To carry out voluntary testing, including counseling and an out-patient center for people living with HIV/AIDS;
- To promote training of actors in management;
- To promote the inclusion of people living with HIV/AIDS in the management of their own affairs.

The management at CESAC is all-inclusive. CESAC, which is the Care Center for the ARCAD/SIDA, is presently a referral center for the Government's Initiative designed to provide access to ARVs.

IMPLEMENTING ORGANIZATION

Organization:

- CESAC
  Center for Information, Counseling,
  Care and Support for People Living with HIV/AIDS
  Bamako, Mali

Contact person:

- Aliou SYLLA
  Director of CESAC
  Tel: +223.223.64.47 / 675 55 35

[31] FAC 82/CD/94: Support to HIV positive and AIDS patients.

IMPLEMENTATION CONTEXT

CESAC is managed by ARCAD/SIDA, which was established in 1994.

A partnership agreement was signed between the Ministry of Health, the French Cooperation Agency and ARCAD/SIDA to provide a suitable approach to meet the medical and psycho-social needs of PLHA. CESAC was created in September 1996, following the signing of the partnership agreement.

CESAC's strategy is aligned with the objective of the National AIDS Control Program: "Reduce the Socio-Economic Impact of HIV/AIDS on the individual, the family and the community." The idea was to work with infected people and their close relatives in the hope of improving conditions relating to their social, medical, economic and psychological care.

FUNDING

The funds originate from contributions, project grants, government budgets[32] and donations. In the beginning, CESAC funds were provided solely by the French Cooperation Agency due to a signed three-year agreement (1996-1999). External multilateral[33] and private[34] partners also provide funding for CESAC's activities.

BENEFICIARIES

The beneficiaries of CESAC's programs are men, women and children affected and infected by HIV/AIDS, as well as various socio-professional organizations. On the average, there are 100 to 160 consultations per day for a whole range of problems, including 20 to 25 daily counseling sessions related to testing. In all, 1800 people on ARVs are cared for at CESAC.

In 2003, more than 16,000 people benefited from CESAC's services. Through CESAC's support, 107 patients (out of 254) received free or reduced-cost laboratory examinations. In all, 200 patients benefited from emergency relief funds. 71 children received sponsorship. Visits to schools made an impact on 197 children with problems relating to drop-outs, learning issues or school attendance. Nutritional support was provided to 274 people.

In 2004, more than 21,000 people benefited from CESAC's services: 3,211 were tested for HIV, out of whom 2,276 were declared HIV positive. More than 10,000 children were identified, out of which 3,500 were HIV/AIDS orphans who had lost their father, mother or both parents. The emergency relief funds for disadvantaged patients helped support 213 people.

---

[32] The Ministry of Social Development, Solidarity and Aged People, which designated October as a month of solidarity, financed some of CESAC's activities. Similarly, the Ministry of Health set aside December for Combating AIDS and the Ministry of Women, Children and Family Affairs on the occasion of CESAC's commemorative celebrations from 31st July to 8th March, provided grants for activities related to the selected theme

[33] MAP Fund, Global Fund, and ADB Fund

[34] Sidaction (ECS), Solidarité SIDA, Glaxo Smith Kline Foundation (GSKF), BMS, ESTHER Project

DETAILED DESCRIPTION

The idea of establishing an institution to cater for people living with HIV/AIDS came up in the 1990s after a group of Malians participated in workshops on the provision of care for PLHA in Abidjan, Côte d'Ivoire[35] and in Ouagadougou, Burkina Faso. The Malian participants met to design a six-month project regarding the care of PLHA which needed to be funded. A draft was made in collaboration with a multi-disciplinary team[36].

The French Cooperation Agency funded this project on condition that the NGO involved in the management of people infected with HIV should be the implementing agency. It is for this reason that Dr. Aliou Sylla, who managed care of infected persons at CSCom in Serebenicoro, was appointed Medical Director of CESAC. At the time, no policy had been designed for care as the financial partners only invested in prevention care.

People living with HIV/AIDS remained hidden and could not openly declare their status because of the stigma and discrimination associated with infected people. Communities were confronted with a whole range of problems.

It was only in 1995 that a Malian named Mamadou Barry for the first time ever, broke the silence and publicly testified about his status. Many people did not believe in the existence of AIDS in spite of Mamadou Barry's public declaration.

In 2004, adherence clubs were formed after training on HIV treatment.

Current situation and future steps

CESAC employs a holistic approach to HIV-infected or affected people. The inclusion of PLHA in the group from its inception helped incorporate their concerns regarding medical, social, economic and psycho-social care.

Prevention: In conjunction with PLHA associations, CESAC undertakes HIV/AIDS prevention activities in hospitals and homes. Outreach and social mobilization are carried out during facilitation sessions in health centers. Radio and television broadcasts are made during anniversary celebrations.

Medical care and the prevention of opportunistic infections: The medical aspect completes the group's counseling/testing activities. It includes medical consultation, treatment, nursing, home care and counseling. Clients receive medical observation for a flat rate of 500 FCFA per month. The consultations are free, as are the following generic equivalents of brand-name medications fighting opportunistic infections (subject to availability): cotrimoxazole, loporamide, antibiotics (Amoxicillin), analgesics (Paracetamol), antiparasitics (Quinine, Metronidazole, and

[35] Council for AIDS Prevention in the Anti AIDS counseling programs from 26th to 30th June 1989 in Abidjan, Côte d'Ivoire

[36] PNLS: psychologist, Head of AIDS Project targeting the youth, the Head of FHI Project for High Risk Groups, a representative for Health Education (Medical Director), a representative from Social Affairs, a representative of Africare

Mebendazole), fungicides (Fungizones, Nystatins and Nizoral), dermatological products (antihistamines, salicylic Vaseline).

Biological and clinical investigations of opportunistic infections are carried out, and if necessary, clients are given cotrimoxazole as a prophylactic. The most commonly encountered opportunistic infections are: Diarrhea, dermatomes (skin diseases), oropharyngeal mycosis, respiratory and bronchial infections, tuberculosis, sexually transmitted diseases, dietary problems, toxoplasmosis, Kaposi's Sarcoma.

The monitoring of patients on ARV is organized with necessary support.

Dietary counseling is provided to stem food-related diarrhea and remedy any loss.

People living with HIV/AIDS diagnosed with tuberculosis are put on an anti-tubercular treatment without thiacetazone.

CESAC proposes out-patient hospitalization for a maximum of about 12 hours. For patients who may need specialized treatment that entails a longer period of hospitalization, a reference system is organized in conjunction with specialized hospitals.

Medical care activities for patients under observation by CESAC are indicated in the table below:

Table N° 10: **Medical Care Activities for Patients by CESAC**

Activities	1997	1998	1999	2000	2001	2002	2003
Counseling/Screening	1093	2230	2553	2600	2451	2637	2586
HIV positive results	614	1128	1388	1417	1567	1657	1727
Medical Consultations	2880	4930	6696	6600	7303	8112	9453
Home Visits (VAD), Hospital Visits (VH), Home Care	523	417	493	472	1190	1359	1177
Services provided on phone	-	70	50	30	10	101	150

1. *Social Care:* This aspect is based on a certain number of activities:
   - Home visits (VAD);
   - Hospital Visits (VH);
   - Telephone Services;
   - Socio-economic integration of people living with HIV/AIDS;
   - Facilitation by CESAC;
   - Income Generating Activities (IGA).

2. *Psychological Care:* Psychological care includes the individual and close relatives. It is made up of individual and group counseling sessions.

3. *Support to children affected or infected by HIV/AIDS:* Care for infected children consists of the following actions:
   - Regular medical observation (consultation, treatment of opportunistic infections);
   - Availability of reduced-cost medication;
   - Dietary support (milk, flour and dietary counseling);
   - School support;
   - Proposal to test the mother.

   Care for affected children consists of the following actions:
   - Support at school (enrolment, stationery and school fees);
   - Social support (clothing);
   - Home visits;
   - Visits to schools (with the consent of the parent) when a child faces academic problems.

4. *Coverage for other forms of support:* Another achievement is the establishment of the DONYA Training Center for people caring for PLHA. Its objective is to increase access to anti-AIDS treatment by training those engaged in the war against AIDS. This is necessary for the dissemination of information, for prevention and for voluntary testing. It is also aimed at strengthening public response nationally in the anti-AIDS campaign of health institutions and to train local care teams to provide decentralized access to treatment.

   The training was provided in partnership with ESTHER, a community project in methodology training that focuses on comprehensive HIV care (medical, psychological, economic, dietary, legal, etc.) and educating the local network management.

Strengths, Weaknesses and Opportunities

CESAC has successes as well as challenges; some of which are indicated in the table below:

Table N° 11: Successes and challenges of CESAC

SUCCESSES	CHALLENGES
Medical care for PLHA ▪ STIs; ▪ OI; ▪ ARVs.	- Inadequate qualified human resources; - Inadequate medicines; - Inadequate daytime space for hospitalization; - Patients cannot pay for bio-medical laboratory analysis; - Break in testing; - Low confidentiality management; - Lack of prevention programs for mother-to-child transmission of HIV; - Lack of national procedural norms for extending care to people living with

SUCCESSES	CHALLENGES
	HIV/AIDS; - Low quality of service provided (reception, waiting time and patients' tours).
Social care ▪ Support to children; ▪ Clothing support; ▪ School support.	- Inadequate qualified human and economic resources; - Organization of activities by the social welfare department.
Psycho-social Care - Conversation Group; - Personal Interview; - Home visit; - Hospital visit; - Devotion and commitment by the team.	- Inadequate qualified human resources; - Inadequate logistical resources for home visits and home-based care.
Socio-economic reintegration of PLHA ▪ IGA (Income Generating Activities); ▪ Humanistic Care Practices; ▪ Inclusion of PLHA; ▪ Improvement in the quality of life of PLHA.	- Difficulties encountered in cost recovery for income generating activities.
Recreational Activities ▪ Food preparation activities; ▪ Youth Holiday Camps.	- Sustainability
Other types of support ▪ School visits; ▪ Care for OVC; ▪ Legal support.	- Lack of financial resources and qualified human resources; - Lack of reliable data on vulnerable orphaned children; - Lack of counseling units in the institutions that care for sick children; - Inadequate resources to provide dietary support or medicines for infected children; - Inadequate funding, as this aspect of child care is not catered for financially in the agreement.
Weekly meeting of CESAC staff	
▪ Partnership; ▪ Reference to specialized health institutions; ▪ Signing of an agreement with the Government; ▪ Government budgetary line; ▪ Existence of financial partners, private, denominational, public health institutions; ▪ Networking (other NGOs); ▪ Staff Motivation; ▪ Technical and Financial Partners.	- Poor system for monitoring and evaluating activities.
▪ Free medical care for PLHA.	- Sustainability.
▪ Emergency Relief Fund.	- Very small location.
▪ Training, Expertise.	

Monitoring and Evaluation

The fund management is audited regularly at CESAC and expenses are made in accordance with an annual planned program. However, the monitoring and evaluation system needs to be improved upon.

USEFUL INFORMATION FOR REPLICATION

CESAC employs a good and promising plan for a comprehensive care program directed at PLHA. There is a need to replicate this system in other countries, taking local circumstances into account. To achieve this, it is important to include members of the PLHA associations in the project design stage.
To ensure replication, it is vital to ensure a detailed analysis of the following indicators:

- *Quality of services: the* quality of services provided (reception, waiting time, patients' round) must be guaranteed.

- *Capacity for adaptation/innovation:* CESAC adapted to the trend in caring for PLHA by taking the medical, moral, economic and social aspects into account. The programs are always drawn-up to address new challenges.

- *Good relations with the official health system:* CESAC signed an agreement with the public sector, represented by the Minister of Health in 2001, to become a Recognized Public Utility Association (RPUA). CESAC enjoys relations with community health centers managed by community health associations, health centers in the communes, referral health centers, hospitals, associations and AIDS-related NGOs, including PLHA associations. All these bodies and institutions refer patients to CESAC, which in turn refers patients who need specific care to them.

  The social unit intervenes in health centers to facilitate inexpensive care for patients, sometimes at no cost at all or by reducing the cost (half price for bio-medical tests and hospitalization).

- *Good relations with private enterprise: A*greements were signed with several private partners*:* Sidaction (ECS), Solidarité SIDA, Glaxo Smith Kline Foundation (GSKF), Bristol-Meyers Squibb Foundation (BMSF). CESAC enjoys relations with religious health institutions and profit-making private clinics.

- In the near future, CESAC plans:
  - To set up a counseling service in Pediatric Units, at the National Blood Transfusion Center, Maternal and Child Health Centers (6) and in Community Health Centers (6);
  - To provide care for PLHA by creating Support Associations and social-health centers involved with regional networks;
  - To set up a think-tank investigating access to ARVs;
  - To perform operational research on preventing mother-to-child transmission;

- To develop CESAC into a reference training center to care for people living with HIV/AIDS;
- To set up a DONYA training center for practical internship.

The beneficiaries make monthly health care contributions of 500 FCFA. The Government also allocates an annual budgetary line to CESAC, in addition to grants provided by several ministries. Though these grants are intermittent, they help the center meet objectives. Many national and international partners also support CESAC.

In case partners leave, the DONYA Center could contribute to the financial viability of CESAC. But the sustainability of the program could be jeopardized because the cost care is very high.

MAIN CONTRIBUTOR

- Boubacar KANTE Administrator « Systèmes d'Information "SI" », Mali

NETWORK OF ASSOCIATIONS OF PEOPLE LIVING WITH HIV IN TOGO (RAS+TOGO)

SUMMARY
The Network of Associations of People living with HIV in Togo (RAS+Togo) was established by eight associations which formed a support program called "Positive Action," which was subsequently funded by Glaxo Smith Kline and the African Family Study Centre (AFSC). RAS+Togo is a network working for the restoration of the dignity of PLHA and to protect their determination to combat HIV/AIDS. In 2002, the Network was registered at the Ministry of the Interior and recognized by the National AIDS Control Program (NACP). It is an active member of the National AIDS and STI Council (NAC) and is represented at the UNAIDS thematic group level.

RAS+Togo has the following objectives:

- Intensify the fight against HIV in remote locations;
- Provide care for the majority of PLHA;
- Lobby to ensure the availability and free distribution of ARVs;
- Ensure free access to health care for PLHA;
- Widen the network of associations of PLHA and care and support;
- Negotiate for partnership with a large number of national and international institutions.

The network organizes training activities in different areas, including management, lobbying, design, execution, project monitoring and evaluation, and capacity building. RAS+Togo is open to all associations of PLHA and global care and support that are officially recognized. It has put in place a strategic plan for 2002-2006. The network has national, regional and international partners. Its technical and organizational viability are good. However it remains financially vulnerable.

IMPLEMENTING ORGANIZATION

Organization:

- RAS+ Togo
  Network of Associations of people living with HIV in Togo

Contact person:

- Augustin DOKLA,
  President of RAS+;
  Tel: +228 917 23 75/251 46 56

IMPLEMENTATION CONTEXT

Togo is a West African country, and after Cote d'Ivoire, has the region's second highest HIV prevalence rate. The major determinants of the pandemic are: increased sexual activity among the youth; multiple sexual partners; the non-perception of risk; the denial of the existence of the disease; the socio-economic subordination of women; the poverty of women, including sex work that is widespread in the country and throughout the sub-region.
For a long time, the main strategy for combating the pandemic has been population outreach regarding the risk of transmission of the virus and the psychological care of infected people. But the continual increase in the number of people living with HIV/AIDS and the morbidity and mortality linked to opportunistic infections shows that prevention alone is not enough to effectively combat HIV/AIDS.

Since 1996, medical care for HIV/AIDS has reinforced existing strategies. Combating HIV/AIDS has been marked by the creation of networks and associations of people living with the disease and caring for PLHA.

FUNDING

Funding of RAS+Togo comes in part from special contributions and ordinary membership dues as defined in the bylaws. The network currently depends on external funding, particularly from the Global Fund.

BENEFICIARIES

RAS+Togo has a membership of about 4,500 infected and affected persons who belong to 10 member Associations[37] .

DETAILED DESCRIPTION

In Togo, the beginning of the HIV/AIDS response was characterized by the creation of associations of people living with HIV and the care of these PLHA.

A survey on the needs of Togolese associations and NGOs engaged in combating HIV/AIDS brought the following results:

- Existence of several Global Care and Support associations;
- Existence of an association of PLHA in Lome;
- Existence of an association of PLHA in Kara;
- Independent development of associations of PLHA and care and support;

[37] Action Against AIDS (ACS), Association Espoir pour Demain (AED), Actions and Initiatives for Health and Social Development (AIDSS), Medical Aid and Charities (MAC), Association for the Advancement of Women (ASPROFEM), Espoir Vie-Togo (EVT), Lolonyo, Promotion and Human Development (PDH), Live in Hope, Live Better.

- Absence of coordination among these different associations made up of PLHA and care and support;
- Stigmatization and discrimination against PLHA.

The activities carried out by these associations to combat the pandemic were mostly uncoordinated due to the lack of a coordinating body.

Through the initiative of the "Positive Action" program, funded by Glaxo Smith Kline, some associations decided to form a network. RAS+Togo was established following a networking workshop held in Kpalime in May 2001, which was organized and facilitated by the African Family Study Centre (AFSC) that brought together 20 participants from eight associations. Through the initiative of eight PLHA associations, a constituent General Assembly for RAS+Togo was formed on August 19, 2001 with the adoption of a constitution, bylaws and the election of a five-member executive board.

Current situation and future steps

The objectives pursued by RAS+Togo include:
- Involve the PLHA in national, regional and international decision-making bodies;
- Constitute a pressure group to advocate and to defend the rights of PLHA;
- Carry out advocacy for better psychological, medical, nutritional care of PLHA;
- Contribute to the creation of a suitable program for the development, support and social integration of people living with HIV/AIDS;
- Support member associations in the creation of income-generating activities for the welfare of PLHA;
- Build the capacity for associations of PLHA and those of care and support;
- Promote research of HIV/AIDS on the epidemiological, socio-cultural, therapeutic, medical and ethic and legal levels;
- Encourage members to create new associations of PLHA and integrate them into the network;
- Create an ethic and legal framework suitable for open testimonies from people infected and affected by HIV/AIDS.

To implement these activities, RAS+Togo uses several methods:
- Contribution from member associations;
- The search for needed resources (financial, material and human), which are useful to achieve the network's objectives. RAS+Togo has effectively developed a project intensifying the fight against HIV/AIDS, which has been funded by the Global Fund since 2004;
- Coordination, supervision and monitoring of member associations' activities:
- Cooperation with national, regional and international financial and technical partners;
- Organization of exchange visits, training programs (symposia, conferences, seminars, workshops, etc).

The five-member Executive Board oversees the network's management and administration. It collaborates with various member associations to organize and implement some actions and

tasks; this effectively leverages the network's management. It also has tools for administrative management.
The various training programs for members have strengthened capacity. These training programs have empowered research and the mobilization of financial and human resources in RAS+Togo and within member associations.

The network has relationships with national, regional and international partners. At the national level, RAS+Togo is in partnership with the NAC and the NACP; religious and opinion leaders, and ROASTO (Réseau des ONG et Associations des PVVIH au Togo/Network of NGOs and Associations of PLHA in Togo). At the international level, UNAIDS, UNICEF, UNPD, UNFPA WHO, WB, GTZ, Glaxo Smith Kline and the AFSC support RAS+Togo.

Strengths, Weaknesses and Opportunities

SUCCESSES	CHALLENGES	OPPORTUNITIES
• Existence of an institutional and organizational framework; • Decentralized representation of member associations (the five regions of Togo); • Development and existence of a strategic plan for the period 2001-2006; • Existence of activity monitoring systems of member associations; • Participation in the plan for increasing the HIV/AIDS response (Global Fund); • Availability of logistics for implementing activities; • Training RAS+Togo members; • Involvement of PLHA in decision-making; • Documentation on RAS+Togo developed in 2001.	▪ Some PLHA assoications do not prepare systematic activity reports; ▪ PLHA associations do not have competent people in network administration and management; ▪ Communication gaps between executives and member associations; ▪ Member associations lack clear understanding of networking requirements; ▪ PLHA associations have inadequate funding sources to implement strategic plan; ▪ Majority of members of grass-roots associations have a (general) low level of education.	o Presence of competent resource people within member associations (doctors, medical assistants, sociologists, accountants, psychosocial counselors, nutritionists, etc); o Organizational management system of every member association; o Increase in the number of PLHA becoming members; o Determination shown by PLHA in the fight against HIV; o Visibility of PLHA in outreach activities; o Involvement of religious groups in the fight against the infection; o Support from local, bilateral and multilateral partners.

The roles played by the three female members of RAS+Togo's executive board are an inspiration for other women to participate and benefit from Network services. The enormous participation of women in the Network's activities will help to break socio-cultural barriers. It will also provide them an opportunity to fight against discrimination and stigmatization, which affects women greater because of their social status. These three female board members is a significant example for other associations where women do not occupy high positions. These women have a great mobilization capacity and their voices can reach very far in the fight against HIV/AIDS.

Monitoring and Evaluation

The Strategic plan (2003-2006) calls for the Executive Board and a special technical committee to oversee and monitor RAS+Togo's activities. An annual action plan has been drawn up with the tools for monitoring and account management. Financial reports are prepared and submitted to each financial partner.

USEFUL INFORMATION FOR REPLICATION

To ensure replication of this practice, it is useful to consider the following points:

Current difficulties being faced by RAS+Togo:

1. The creation of Network technical committees for the training, development and management of projects. These can be ad-hoc or regular committees. The competencies acquired through the network's training benefit every association and are mainly used by its members;
2. The RAS+Togo organizational chart revision to separate the Chairman's functions from the Coordinator. Currently the Chairman of the network serves in these two capacities. The Chairman could be in charge of political orientation of the network while the Coordinator takes the responsibility to implement tasks and activities;
3. The need for the network to have an operating budget, which could enable it to employ adequate staff;
4. Creating a sustainable system fund mobilization: RAS+Togo depends mainly on financial partners, and the contributory capacity of member associations of the network is very weak and limited.

Equipment

Satisfactory equipment is necessary for the smooth running of RAS+Togo (one desktop computer, one laptop computer, one 4x4 vehicle, one motorbike, one headquarters). It is also necessary to have defined collaboration and efficient coordination among member associations. This constitutes a guarantee of visibility for PLHA at the national, regional and international levels.

Viability

Institutional and organizational viability

RAS+Togo has laws, rules and regulations to provide its official recognition. Statutory organs have been put in place for it to function well. The quality of members forming the network is a good sign for the viability of activities.

Economic and financial viability

RAS+Togo is in contact with national and international partners that subsidize the majority of its activities. The revenues generated through RAS+Togo training courses create an alternative funding source for other projects. However, to program its activities, RAS+Togo depends mainly on financial partners because of the poor and limited financial capacity of member

associations. The sustainability of the financial plan could pose problems if the partners withdraw.

Social and cultural viability

The traditional solidarity enjoyed by PLHA within the member associations is an opportunity for long and viable projects. Furthermore, the activities undertaken by RAS+Togo are contributing to the fight against discrimination and stigmatization.

CONTRIBUTOR

- Ghislaine SAIZONOU BROOHM — Program Co-ordinator, Social Protection Trainer and Head of Francophone West Africa zone

RISK-SHARING EXPERIENCES IN THE INSURANCE PLANS OF NKORANZA AND DANGME IN GHANA

SUMMARY

In Ghana, civil society, particularly the Catholic Church, has been a pioneer in the implementation of the country's health insurance system. It is through this that the first health insurance scheme (HIS) of the Nkoranza Community, an initiative of the St Theresa Catholic Hospital, was established in 1992. The Dangme West Health Insurance Scheme followed in 2000.

The Nkoranza Community and the Dangme West Health Insurance Scheme had financial support from partners such as DANIDA, the European Union (EU) and the St Theresa Catholic Hospital of Nkoranza.

In addition to foreign, technical and financial support, membership subscriptions remain a source of budgetary support. The premium payment through an installment plan helps the poor to honor their obligations. The Nkoranza Community Health Insurance Scheme covers hospital admission bills while the Dangme West Scheme covers basic out-patient treatment and care.

With the introduction of the National Health Insurance Policy the two plans partner with health centers to provide health service to their members.

IMPLEMENTING ORGANIZATIONS

Organizations:

- Dangme West Health Insurance Scheme
  Dodowa, Ghana
- Nkoranza Community Health Insurance Scheme
  Nkoranza, Central Region, Ghana

Contact persons:

- Fiifi ARKORFUL
  Tel: +233 244 60 23 14
- S. Opoku BROBBEY
  Tel: +233 244 81 09 90

IMPLEMENTATION CONTEXT

During colonial times, medical facilities provided billed services which became free after independence in 1957 when the Government began financing health services through taxes. However, in the face of economic difficulties confronting the State, resources allocated to the

health sector began to shrink, thereby leading to the deterioration of the health system and health facilities.

In order to tackle this situation, the Hospital Bills Act[38] was passed in 1971 but this law did not apply to public health institutions. In 1985, the government introduced user payment for health care, called the "cash and carry[39]". This "cash and carry" system became an obstacle to access, denying health services to 80% of Ghana's population. This led to a low attendance at health facilities.

In order to rectify this trend, the Government of Ghana decided in 2001 to create a health insurance plan within its poverty reduction strategy. The introduction of this plan at the national level began in January 2005. It was based on the experiences of existing pilot projects: the Afram Plains District, Dangme West, Damongo, Nkoranza Community, Jama North, Jama South, Tano and Kwahu projects.

FUNDING

The program received financial and technical support from partners such as DANIDA, the European Union (EU) and the St. Theresa Catholic Hospital of Nkoranza. Member subscriptions also remained a source of financing. They include:

- Dangme West HIS: 15,000 Cedis/year/person aged 5 to 69 years and 6,000 Cedis for children younger than 5 and adults older than 70;
- Nkoranza Community HIS: 42,000 Cedis/year/person.

The modes of subscription vary according to the system and depend on the economic environment. The premiums are determined by social status and the ability to pay. With Government involvement[40], the annual subscription fee was fixed at a minimum of 72,000 Cedis per person. Children younger than 18 and people older than 70 are exempted from paying contributions. The contributions of destitute people are paid by the Government.

BENEFICIARIES

Table No. 13: Beneficiaries of Dangme West and Nkoranza Health Insurance Schemes

System	Year of establishment	Size of scheme	Types of subscribers	Risks covered
Dangme West Health Insurance Scheme	2000	13,000	70% informal sector and 30% formal	Primary care and out-patient consultations only
Nkoranza Community Health Insurance Scheme	1992	57,000	85% informal sector and 15% formal	Hospital admission only

[38] Law on hospital fees
[39] Advance payment
[40] National policy on insurance plan initiated in 2001

DETAILED DESCRIPTION

Table No. 14: Background to the Dangme and Nkoranza Health Scheme

Dangme West HIS	The plan was created from a recommendation made by Dr. Diana Arhil (1995) in her doctorate thesis entitled "An alternative option to the payment of bills for service provision? Studies and results from three countries." During the period of the "cash and carry" system the poor were unable to pay their bills for health care and could not receive access to health delivery. This proposal was therefore submitted to the Ministry of Health which lent support to the idea. Planning began in 1996 and in 2000 the project was launched with the support of development partners such as DANIDA and the EU.
Nkoranza Community HIS	Users of the health system often circumvented the "cash and carry" system by leaving without settling their bills, which creates consequences for the hospital administration. In 1990, during an annual meeting of the administrators of Catholic hospitals, new methods were mentioned to solve this problem. An initiative by the Catholic Church in Zaire was cited as an alternative method of financing health care delivery. In 1992, the St. Theresa Catholic Hospital of Nkoranza drew its inspiration from this idea for launching a community health insurance plan.

The West Dangme Health Insurance Scheme negotiated quality health care at a reduced cost for its policy holders. Holders were required to sign an agreement before paying the premium. This plan has also broadened the number and location of care providers, increasing the choices available to policy holders.

The registration of households is a strategy which has helped the scheme to increase the number of subscribers. Also, the scheme offers reductions to large families and obliges registered family members to renew their subscriptions to benefit from the refund. All these strategies have contributed to the increase of subscriptions and policy renewals. The registration period is made to coincide with harvest time when farmers have money to pay premiums. The waiting period for all the schemes is three months. This gives sufficient time for more equity and also for the control over the use of funds. Paying premiums by installment helps the poor to honor their commitments.

The fund is protected from depreciation because of its investment in treasury bills and fixed capital. Periodic outreach programs are carried out in the communities for prevention and to prevent the aggravation of certain conditions. The education programs regarding health and lifestyle issues have reduced the use of the funds.

The management committees are made up of stakeholders such as service providers, union representatives (i.e., teachers, nurses) and the representatives of the various contributors in the communities. This has helped to resolve policy issues in a proactive manner.

The selection of the scheme's collection agents is decided by communities who have the responsibility of choosing honest and credible people. In the past, some agents fled with

premium funds and were never found. Therefore, the communities look for people of integrity, which has brought about an improvement in the collection of premiums.

Table No. 15: Types of collaboration with health centers

Facility	Collaboration with service providers
Dangme West HIS	Public health facilities only and refund after health care
Nkoranza Community HIS	- ditto -

Table No. 16: Audit of funds for Dangme West and Nkoranza Schemes

Scheme	Mechanism for the control of funds
Dangme West HIS	To reduce fraud, the HIS office handles refunds with computer software that eliminates people who do not pay their bills and then provides the correct diagnosis, the cost of treatment and approved basic drugs. The cost is then approved by the Director of the District Health Service. An accountant reimburses the applicant.
Nkoranza Community HIS	Premium collectors are required to deposit the money received daily in the nearest rural bank. These funds are deposited at the biggest banking institution within the district. The Director, the accountant and the Chairman of the Committee are account signatories. Applications for refunds are considered on a case-by-case basis after treatment has been received. The accounts are examined by external auditors.

Both the internal and external audit of funds are effective in the two schemes.

Table No. 17: Fund-raising methods

Schemes	Fund-raising methods
Dangme West HIS	Could not find any means of financing outside the initial funds, 80% came from the Ministry of Health and 20% from development partners following the submission of proposals.
Nkoranza Community HIS	Proposal writing for initial capital and guarantees against insufficient funds obtained from development partners.

Apart from the traditional methods, fundraising is not considered an integral part of the management of funds.

Table No. 18: Illnesses covered by the Dangme and Nkoranza insurance schemes

Scheme	Ailments covered
Dangme West HIS	All out-patient primary care, laboratory tests required for out-patients, pre-natal care, delivery and post-natal care, family planning, emergency dental and medical care, cases of patients referred to specialists. A maximum of 400,000 Cedis is refunded for referral cases.
Nkoranza Community HIS	Free hospital admission, payment of normal bills for admission at the hospital on referral and all medical and surgery bills of patients on admission.

Table No. 19: Cover for and prevention of opportunistic diseases from HIV/AIDS

Scheme	Cover for HIV/AIDS
Dangme West HIS	Both plans cover opportunistic infections
Nkoranza Community HIS	- ditto -

Table No. 20: Cover for health care and support for HIV/AIDS

Scheme	Cover and support for HIV/AIDS
Dangme West HIS	No cases indicated
Nkoranza Community HIS	Cover for hospitalization

The health care coverage and support is not uniform. The Nkoranza Community Scheme provides care and support only if the HIV/AIDS victim is admitted to the hospital. The Dangme West HIS does not provide such support.

Table No. 21: Public outreach methods of the Dangme and Nkoranza Health Schemes

Scheme	Outreach methods used
Dangme West HIS	Discussions in bars and in communities, theatres, documentation in the form of brochures and promotional posters erected at strategic points in the communities; outreach in schools, radio discussions and consultation with stakeholders.
Nkoranza Community HIS	Use of local FM radio stations, documentation in the form of brochures targeting educated people within the community, through religious gatherings, district assemblies and social gatherings.

Table No. 22: Strengths, weaknesses and opportunities

STRENGTHS	WEAKNESSES	OPPORTUNITIES
▪ Traditional authorities and religious organizations support dues collectors; ▪ Giving collection agents a means of transportation (i.e., bicycles) as well as giving back to them between 5 and 10% of premiums collected has guaranteed the honesty of agents and also increased the volume of collections; ▪ Strategy for screening referred patients; ▪ Registration is open to households but on an individual basis. Reduction for large families, refund possible only when all registered members of the household have renewed their subscriptions; ▪ Screening and maximum refunds (recommendation service); ▪ Partnership with development partners.	• Tendency to manipulate and lower costs, reducing the quality of care; • Keeping the sums collected on the ground and in the offices; • Low level of managerial capacity of health plans creates obstacles for an efficient control method.	○ For the informal sector, the registration period must coincide with the harvest period when subscribers have money available to pay the premiums; ○ Community prevention education and rapid treatment training with the help of collecting agents, traditional authorities and religious organizations; ○ Motivation of collection agents; ○ Capacity of collection agents.

In the two health insurance plans of Dangme and Nkoranza, women – who are considered the most vulnerable to health problems – have participated massively in the implementation of the health insurance scheme.

In spite of the fact that they are mostly dependent on their husbands, some women are capable of making headway in this area. The two plans have brought women together in groups to do small trading and to contribute to tontines with the aim of meeting family obligations.

The men make priority for the membership of their wives and children. In return, they benefit from health care services.

Monitoring and Evaluation

Supervision and auditing are required at various levels. The Dangme and Nkoranza health insurance schemes have begun supervision and auditing of service providers and patients in order to reduce abuses. Because these audit teams have recently been set up and their low supervisory capacity, the insurance plans are often victims of abuse and misappropriations.

Regarding the service providers, a payment system for services rendered is considered an efficient method for controlling the various forms of abuse. The protection of the scheme against abuse calls for a fairly sophisticated surveillance mechanism of billing and the registration of service providers. Such a mechanism requires technical and administrative qualifications, but the schemes' low managerial levels constitute an obstacle.

The second level of supervision and control has to do with the members of the health insurance plan. It is a computerized system that processes all technical information related to the management of the policy holder and his/her assets.

These measures have enabled the Dangme West and Nkoranza insurance schemes to do their monitoring and evaluation in spite of the difficulties they have faced in the implementation process.

USEFUL INFORMATION FOR REPLICATION

- *Motivation of collectors*: A way of motivating these agents is to give them a percentage of the total amount of premiums they collect. The two plans pay between 5 and 10% of the collected subscribers' fees to the collection agents.

- *Ownership by either the community or the policy holders*: Community ownership of the plan should help promote community participation and provide the clients' perspective on the quality of care provided.

- *Partnership*: Partnership with Government is essential to the sustainability of the scheme. In effect, this plan has been established for the benefit of the poor. Therefore, Government has to provide seed capital to fill the existing gaps between the expected level of contribution and what is currently obtained on the ground. This capital must also affect the direct payment of contributions on behalf of the poor, children younger than 18 and the elderly.

- *Reinsurance*: Reinsurance is a central principle in all insurance systems to guarantee the availability of basic capital funds for refinancing the schemes in the event of catastrophic events, such as epidemics and natural disasters.

- *Management systems*: In general, the schemes are located in the premises of the providers that have created them. The possibility of the provider manipulating the scheme in order to minimize costs is very high and this tendency affects the quality of the scheme.

- *Nature of subscriptions*: Subscribers are mainly the poor who are more vulnerable to poor health due to their poverty. Subscriptions are voluntary without any obligation on well-to-do people.

- *Human resources*: This sector has recently been developed and does not have the requisite qualified personnel. Because these schemes started as non-profit programs, there are inherent difficulties recruiting qualified staff due to the low wages offered. The motivation exhibited by volunteers cannot last.

- *Technology, transport and communication*: Due to the complexity of administrating these schemes, effectively processing operations must be done by computer rather than by hand.

- *Politicization of the schemes*: Politicization slows the impact of health insurance schemes.

- *Criticism and self-criticism*: The health insurance plans should have suggestion/comment boxes for members in order to improve the supervision and control of the health centers. The situation is complicated by the fact that the insurance plans do not have agents in charge of these aspects (quality care supervisors or oversight of staff behavior towards patients, accounting, etc.).

- *Over-invoicing*: The costs of every intervention must be well defined in the contract with health centers to prevent certain over-invoicing practices.

Good risk management and the thorough inspection of fraud are essential for the viability of the two schemes. Furthermore, the capacity of the communities to become members and honor their contributions is very important relating to the significant desertion rate of the two schemes. This situation is mostly explained by the unfavorable social situation of some of the members[41].

CONTRIBUTORS

- Ken KINNEY Executive Director, The Development Institute

[41] 70% of members are from the informal sector and a majority of them do not have stable employment

NATIONAL HEALTH INSURANCE SCHEME: THE GHANAIAN EXPERIENCE

SUMMARY

The majority of sub-Saharan African countries are looking for alternative mechanisms of health financing. With this in mind, Ghana has implemented a National Health Insurance Policy[42] following an in-depth study of existing community and religious-based plans.

In so doing, the policy framework, the implementation institutions, the structures and the plans have been designed with a view of ensuring that risks are pooled together and sharing is maximized. Risk pooling is the central issue facing the National Health Insurance Scheme (NHIS) of Ghana. A majority of the population have registered and paid their premiums. Nevertheless, the reform faces difficulties because of high unemployment and poverty among members.

In order to increase the success of this process, it is advisable to combine flexibility in fixing premiums, rewards for members paying more than the required premium and the establishment of savings plans for poorer people. The involvement of civil society will strengthen risk pooling. The development of educational programs on public hygiene is equally recommended in order to create the dynamics for the success of "medical care for all" in Ghana.

IMPLEMENTING ORGANIZATION

Organization:

- National Health Insurance Secretariat

Contact person:

- Francis Andoh AGYEI
  Tel: +233 21 23 35 55

IMPLEMENTATION CONTEXT

Adequate and affordable health care and services to the poor in rural and suburban areas constitutes a great challenge in many countries. For this reason, it is important to look for alternative mechanisms for health financing.

For several years now, the impact of health insurance plans on the health care system is being recognized by all, especially by governments and donors. This has created interest in health insurance as a strategic mechanism for boosting accessibility to health care and extending social welfare to deprived rural communities and members of the informal sector. This interest

[42] National Health Insurance Scheme (NHIS)

translates into increasing political goodwill for creating health insurance programs in the majority of countries within the sub-region.

In Ghana, state intervention began with the creation of a favorable environment for the growth of Mutual Health Organizations (MHOs) which increased by financing and adopting clear regulations for the establishment and operation of these groups. The Ghanaian experience offers a platform from which other countries can draw lessons. This is due to:

- The explosive growth of community-based, religious and professional MHOs;
- The role of Government in the spread of a political program for health insurance;
- The holistic nature of this program compared to other countries within the region.

Furthermore, since March 2005, the government began implementing a National Health Insurance Scheme (NHIS) developed from the experiences of pilot projects.

FUNDING

A fund has been set up to collect the government's contribution to the National Health Insurance Scheme (NHIS) from two main sources:

- 2.5% health insurance tax imposed on some services[43] and;
- 2.5% of workers' contributions to social security (SSNIT[44])

This fund enables the poor, children and people older than 70 to be totally taken care of.

BENEFICIARIES

The NHIS decided to set up 123 District Mutual Insurance Schemes (DMHIS). 43 out of 123 districts are operational and users are deriving satisfaction from them. 40 DMHIS are expected to sign contracts with care and service providers. The Kpeshie sub-metro scheme is operating very well, having saved more than 40 million Cedis during its first year of operation.

In October 2005, about six months after launching the NHIS, 2,507,223 people were registered; 12.5% of the total population of Ghana. Of that total, 558,405 represent workers in the informal sector, which is 22% of this sector.

DETAILED DESCRIPTION

During the colonial era, health service users were billed at the time they received medical care from providers. After independence in 1957, health services became free of charge. The government of the first Republic totally financed medical care through taxation. However, other social sectors (i.e., education) also needed funding because of poor economic growth. Funding for health therefore decreased, resulting in the deterioration in health care and delivery.

[43] Communications, electricity and luxury products
[44] Social Security and National Insurance Trust (SSNIT)

In order to remedy the situation, the Law on medical bills was passed in 1971. However, this law was not applied to public health institutions. In 1983, Ghana launched an Economic Recovery Program (ERP) sponsored by the World Bank and the International Monetary Fund (IMF). Under the conditions of the Structural Adjustment Program, the government was to reduce social services. As a result, government's capacity to finance health delivery decreased. This resulted in negative consequences for social welfare. In 1985, to stop the near complete collapse of the public health sector, the government reexamined the 1971 Law on Medical Bills and began to apply it. This led to the "cash and carry" system: direct payment[45] by the users of service delivery.

Problems related to implementation[46] remained, although the "cash and carry" system exempted the poor, children younger than five, pregnant women[47] and people older than 70. This system averted the health sector's total collapse, but its implementation brought mixed results. After some time, 80% of people could not pay their medical bills. Policy makers then searched for alternative health financing solutions and finally arrived at the development of community health insurance.

In 2000, during the presidential and parliamentary elections, the abolition of the "cash and carry" system and its replacement with NHIS became an electoral promise made by the present government[48]. The launching of NHIS took place in March 2005. This has been done in conformity with the poverty alleviation strategy and on the basis of experiences acquired from the existing health insurance pilot projects.

Current situation and future steps

The first stage of the scheme was created by an Act of Parliament, Act 650 of 2003, which gave birth to the National Health Insurance Board with the mandate to regulate the National Health Insurance Policy in Ghana. The act stipulated that everybody in Ghana may become a member of any health insurance plan provided they pay contributions. The three types of schemes recommended by the law are as follows:

- Expanded District Health Insurance Scheme;
- Private Health Insurance Scheme;
- Commercial Health Insurance Scheme.

Expanded District Health Insurance Scheme (EDHIS): This has been created for all residents in every district and metropolitan area. Act 650 requires all districts to create a health insurance plan for their residents. All EDHIS, by virtue of Act 650, are subsidized to a large extent from the Health Insurance Fund.

Private Health Insurance Schemes (PHIS): the PHIS are a form of health insurance plans for groups of individuals and non-profit organizations. However, these plans only benefit their own

[45] As opposed to deferred payment or non payment
[46] The pre-identification of the poor and problems of equity between the poor and rich have not been well-defined
[47] pre-natal and pos-natal consultations
[48] Implemented in 2005

members. This type of insurance has been designed for residents eager to assess and take care of their health needs. PHIS do not get support from the NHIS Fund.

Private Commercial Health Insurance Scheme (PCHIS): Private companies can create and derive commercial benefits from health insurance plans that do not receive any financial support from government.

Table No. 23: Risk-pooling strategy in the National Health Insurance Scheme

Stages	**Actions taken**
Problem definition	Commissioned health sector study
Selection of political option	Recommendations for NHIS made to Government
Tracking of strategy	Tracking of NHIS in some communities and the experience of some community schemes already in existence
Policy review and strategy	Conclusion of policy structure
New policy direction	NHIS policy adopted by Government
Law put in place	Law 650 approved by Parliament
Preparing a bill for Parliament	The bill is developed
Implementation stage: ▪ Construction of functional infrastructure, institutions and operational structure; ▪ Public outreach; ▪ Education; ▪ Equipment for the scheme; ▪ Official launching of NHIS.	- Setting-up of NHIC; - Institutionalization of NHIF; - Establishment of the NHIS Secretariat; - Development of communication strategy; - Human resource development; - Developed operational structure at local level; - Developed a facilitators' guide; - MHIS design and implementation manual; - Service providers' manual developed; - Management of medical relations; - Software developed; - Communication concept developed; - Use of the mass media (TV, radio, posters); - Office equipment dispatched to the schemes; - NHIS launch in March 2005.

ORGANIZATIONAL CHART OF THE SYSTEM

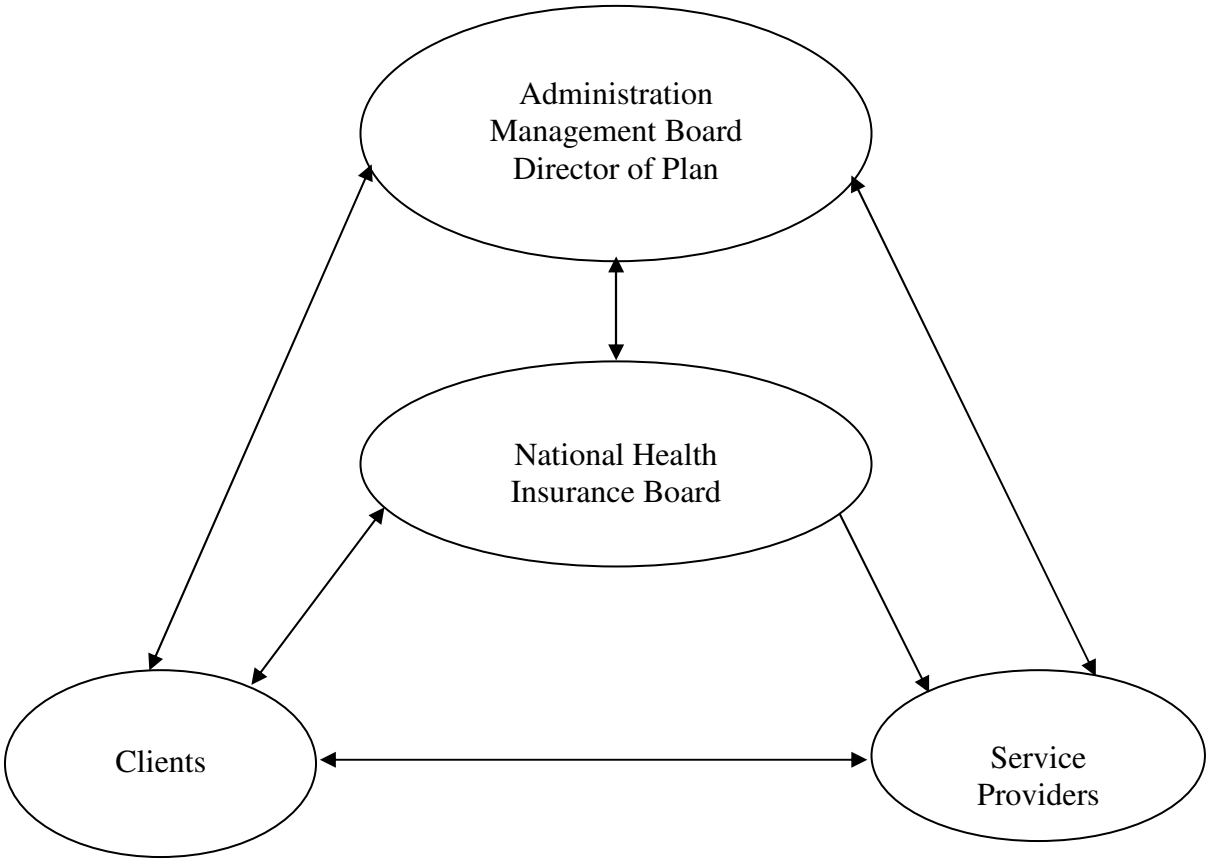


Table No. 24: Current issues of the National Health Insurance Scheme

Questions asked in relation to NHIS
• Inadequate participation of stakeholders; • 40 established DMHIS non operational; • Non-payment of subsidy by Government; • Apathetic wait-and-see attitude of communities; • Inadequacy of functional infrastructure; • Disagreement on software use; • Politicization of NHIS.

Strengths, Weaknesses and Opportunities

Table No. 25: Strengths, weaknesses, opportunities and threats (SWOT) of the National Health Insurance Scheme

STRENGTHS	WEAKNESSES
▪ No discrimination in medical care; ▪ Protection against illness; ▪ Mobilization of 30%–100% of medical expenses of members; ▪ Increased access to medical care for low-income workers of the informal sector; ▪ Promotion of a healthy society.	- Difficulty in reaching financial balance in poor communities due to the low level of revenue; - Pooling of risks not diversified in typical traditional communities; - Frequent denial of health care to poorer people when there is no subsidy.
OPPORTUNITIES	**THREATS**
▪ Investment of funds only in the health sector; ▪ Health education aimed at a more structured target group; ▪ A larger pooling of risks; ▪ Job creation for the youth as premium collectors; ▪ Influence on communities regarding quality of health.	- High level of unemployment; - Problems related to public health, for example, public hygiene; - Lifestyle that exposes them to transmissible diseases; - Low economic growth; - Teenage pregnancy; - Politicization of scheme; - Endemic malaria.

The health insurance scheme emphasizes care for groups of people from similar backgrounds who are generally pursuing the same objectives. These are poor and vulnerable people, including women and children. The criteria shall be defined for the selection of such groups in order to take care of their membership health insurance contributions.

Vulnerable groups, such as widows, the elderly and orphans will benefit from the solidarity and support of the community and government. In effect, the Nkoranza and Dangme health schemes, which have been functional since 1992 and 2000 respectively, are confronted with difficulties in implementing the policy outlining care of the poor. These difficulties are related to the selection criteria and the schemes' management, the majority of which are in the early stages of their existence. This is a handicap to the majority of target groups and especially to those people mentioned above.

Monitoring and Evaluation

Monitoring and evaluation of NHIS is not yet operational, but monitoring indicators have already been defined in four areas as follows:

- Efficiency;
- Proper functioning;
- Sustainability;
- Growth.

Nevertheless, the NHIS will need a monitoring and evaluation process capable of collecting and processing information necessary for securing the future of the plan. The management of the health districts' information system must be harmonized and the experiences of existing insurance schemes in Ghana taken into consideration.

USEFUL INFORMATION FOR REPLICATION

It is necessary to have:

1. Flexibility in order for communities to determine the amount of premiums to pay (minimum and maximum premiums) and the nature of exemptions;

2. A solidarity mechanism to support subsiding certain insurance schemes;

3. Youth education programs on reproductive health in identified communities in order to increase low-risk maternity;

4. A unit to tackle the preventive issues of public health in the Ministry of Health;

5. Engagement of traditional institutions and NGOs to better mobilize communities regarding social development issues;

6. Savings programs developed within the communities alongside insurance schemes to enable the poor to have alternative methods to pay their premiums;

7. Collaboration with community organizations to monitor reform to ensure its success;

8. The following principles must be taken into consideration:
   - *Equity*: Everyone must have access to the global program of minimum benefits, irrespective of socio-economic status;
   - *Capacity to pay*: The design of the scheme takes into account the contribution capacities of the wealthy who must pay higher premiums than the poor;
   - *Solidarity*: The well-to-do can contribute more to reduce the financial difficulties that prevent the poor and vulnerable from accessing medical care.

9. Quality care to make clients aware that health care delivery matches the value of their financial contributions. In so doing, their likelihood to use the services would increase;

10. Collecting premiums and efficient claim management;

11. A strategy for collecting premiums from the potentially large informal sector;

12. A system of service providers developed in the area of reimbursement;

13. A partnership developed among public and private institutions;

14. Good reinsurance.

To ensure viability, certain preconditions must be met:

- *The need to depoliticize the reform*: For some communities, the NHIS is considered the fruit of electoral promises and could never be considered a tool for development above these partisan considerations. This perception explains the lack of patronage in several communities;

- *Good management of NHIS*: In the area of risk management and fraud control, it is important to exhibit exemplary moral conduct and strictness.

CONTRIBUTORS

- Ken KINNEY Executive Director, The Development Institute
- Maxwell BAFFOE-TWUM
- Ronald Adom OPPONG

EXPERIENCES TAKEN FROM THE BEST PRACTICES COLLECTION OF UNAIDS

BEHAVIOR CHANGE COMMUNICATION

Program for the prevention and care and support of STI/HIV/AIDS among sex workers and their partners (PPP)

Country: Côte d'Ivoire
Organization: Ministry of AIDS Control, IEC/BCC Department

Summary: The Program started in 1991 as a pilot project covering the agro-industrial sites around Abidjan. The program was extended to nine communities in Abidjan, in the towns of Bouake, Daloa, and Abiossa in 1999. It aimed at contributing to the reduction of the transmission of STI/HIV among sex workers and their partners through information, education and communication programs and condom promotion. The principal activities were: a) a Base-line study which outlined the needs and mapped out sex work sites, b) Educational talks given by peer educators at the sex work sites, c) Condom demonstrations and condom distributions, d) Referral to health facilities for the prevention and management of STI and HIV/AIDS and HIV voluntary counseling and testing, e) Community mobilization through meetings with the authorities and community leaders.

These interventions resulted in the improvement of the level of knowledge on the modes of transmission of STI and HIV, the identification of 456 establishments for commercial sex work (sex work sites) and referral of 6000 sex workers to health facilities for management of STIs and HIV testing. This intervention showed that the adoption of a holistic approach (research, action, prevention and management or care) is necessary to achieve results in hard to reach populations such as sex workers.

Contacts: Moussa Traore, Officer in Charge of IEC/ BCC, Ministry of AIDS Control
Source: Summary Booklet of Best Practices UNAIDS 2nd Edition Pg 73- 76

Theater Wan Smolbag: Popular Theater for Health Education

Country: New Zealand, Vanuatu
Organization: Wan Smolbag Theater

Summary: The Theater was started in 1989 by targeting young people. Its aim was to improve the knowledge of the young people on reproductive health and in particular on STI, as well as family planning using developmental theater techniques. Through a series of sketches which showed how STIs are transmitted during unprotected sexual intercourse, the troupe sensitized young boys and girls (7 to 13 years) in middle school on the prevention and treatment of STIs. Each presentation took maximum 30 seconds and was followed by a session of questions and answers. The evaluation showed that the proportion of the young people who thought that traditional practices could cure STI were 22% before the intervention and 13.8% after the intervention. Similarly the proportion of young people who thought that traditional practices could not cure STI increased from 23.6% at the beginning of the intervention to 68.2% at the end

of the intervention. This intervention revealed that it is important to repeat the same messages in different forms and the sensitization will need to be supported by offering services which provide care and distribute condoms.

Contact: Jo Dorras, jopet@vanuatu.com.vu, +678 24397/27 119
Source: Summary Booklet of Best Practices, UNAIDS, First Edition 2000, pages 69-72

Life Skills Program: "My Future is My Choice"

Country: Namibia
Organization: Youth Health Development Program (YHDP), UNICEF

Summary: The program was launched in 1997 aimed at providing life skills education to 80 % of the country's young people, aged 10–18 years by providing information on Sexual and Reproductive Heath including STIs, HIV/AIDS and interpersonal communication skills. The program is composed of 10 sessions that provide young people with the information and life skills they need to make choices about their future. The Program consists of ten two-hour sessions spread over five weeks. The young people are trained as MFMC facilitators. They then facilitate other MFMC groups of 20–22 other young people who voluntarily sign up for the program. Each session is evaluated at the end. 622 facilitators and 45 master trainers were trained. 7,500 young people went through the course in 1997, 21,000 in 1998 and 20,000 in 1999.

The evaluation of the program showed that young people who have followed the program had their sexual debut later than those who had not been part of the program and significant numbers were using condoms. This intervention showed that building "ownership" of the activity in the communities where it takes place is a key component of success.

Contacts: Rick Olson, c/o UNICEF, + 264 61 229220, rolsom@unicef.org
Source: Summary Booklet of Best Practices UNAIDS second Edition 2000 Pg 18 – 20.

PREVENTION AND MANAGEMENT OF SEXUALLY TRANSMITTED INFECTIONS

Training and promoting syndromic management of STIs

Country: Philippines
Organization: Program for Appropriate Technology in Health (PATH)

Summary: PATH Philippines manages the education component of the AIDS Surveillance and Education Project (ASEP). It has assured the promotion and syndromic management of STIs in private pharmacists and dispensaries in which most patients seek care for STI. To do this, PATH developed three versions of flow charts for the management of STI designed for clinicians, drug providers, and community health outreach workers. They also developed a kit for the

management of STIs including the complete treatment for each major syndrome (vaginal discharge, urethral discharge, genital ulcer, abdominal pain, scrotal swelling, and neonatal conjunctivitis), information on the medications, condoms for the duration of the treatment, information on STIs and partner notification cards. The kit is sold at a fixed price, at half of the real cost in the pharmacies. 1200 care givers were trained on syndromic management of STI. Results of surveys conducted before and one year after training show an increase in the proportion of trainees providing STD care (from 44 to 69%) and those using syndromic management approaches (from 0 to 62%). The success of such an enterprise necessitates collaboration between public and private stakeholders.

Contacts: PATH +642 895 1580, pathphil@skyinet.net, http://www.path.org
Source: Summary Booklet of Best Practices, UNAIDS Fist Edition, 194-196.

VOLUNTARY COUNSELING AND TESTING FOR HIV

Effects of HIV counseling on sexual behavior of men frequently attending anti-STIs clinics

Country: India
Organization: National AIDS Research Institute of Pune

Summary: The Project was launched in May 1993 for male heterosexual clients at two public STI clinics. The study sought to describe changes in sexual behavior and condom use among male heterosexual clients at two public STD clinics after exposure to HIV testing, counseling, and condom promotion. The main activities were as follows: a) consultations and management of STIs, b) counseling for HIV testing c) HIV testing, d) follow-up counseling for sero-negative patients, e) condom demonstrations, f) distribution of condoms.

A total of 1,628 HIV-negative men agreed to return every three months for HIV counseling and testing. At the end of two years the number of men visiting sex workers decreased from 63 per cent at baseline to 23 per cent. Men who continued to see sex workers were 4.7 times more likely to use a condom after two years of counseling. In addition the level of knowledge of clients on HIV prevention and the consistent use of condom considerably improved

Contact: Dr. Sanjay Mehendale, Deputy Director
Tel: 91-20 791 1342 or 7911343 or 791 1280,
Fax: 91-20-791071
Source: Summary Booklet of Best Practices, UNAIDS First Edition 107 -108

CARE AND TREATMENT FOR HIV/AIDS

Socio-Medical Center for Support of PLHA (CASM)

Country: Côte d'Ivoire
Organization: Hope Worldwide, Côte d'Ivoire

Summary: The socio medical center for support of PLHA (CASM) is an out-patient clinic which opened its doors in February 1991. It aims at contributing to the improvement of care for People Living with HIV/AIDS (PLHA) by decentralizing care and support, reducing their costs, involving the community and PLHA. It also aims at encouraging the patients to live positively with AIDS, to put in place a network of care and support, and to mobilize resources for care and support interventions. The key activities are: a) care and treatment by qualified staff, b) setting up of a network of care and support with referrals to other needed services, c) psychological counseling and support at the center and home visits by a team including psychologists, counselors and PLHA support groups d) funding of income generating activities for patients, e) support to orphans and f) prevention activities for vulnerable populations in the form of information, education and communication. The center receives about 25 to 30 persons per month and the community agents conduct about 40 home visits per month. The support group is composed of more than 300 persons and the prevention activities have reached more than 200,000 people after 5 years of interventions.

In order to be successful, interventions of continuum of care and support with a large reserve of community volunteers require collaboration with other organizations working in the area of care and support and the involvement of PLHA.

The description document of this experience has been updated and is part of the experiences presented in this collection of promising and best practices.

Contacts: Dr Kouamé Isabelle : hwci@afnet.net ou isabelle_kouame@yahoo.fr, +225 07 078 819 ou +225 21 244 379
Source: Best practices booklet, UNAIDS, 2nd edition 2001.

AWARE-HIV/AIDS: Key partners

- Family Health International (FHI)
- Population Services International
- The Futures Group International

AWARE-HIV/AIDS: Associate partners

- Bureau d'Appui à la Santé Publique'96 (BASP'96)
- Care and Health Program (CHP)
- Centre Hospitalier Affilié Universitaire du Québec (CHA)
- Centre Hospitalier Universitaire de Sherbrooke (CHUS)
- John Hopkins Program for Information and Education of Gynecologists and Obstetricians (JHPIEGO)

This project is funded by the government of the United States of America through USAID

AWARE-HIV/AIDS
1st Floor Demmco House
1st Dzorwulu Crescent
P. O. Box CT 4033 Accra, Ghana
Tel: +233 21 786102/4

E-mail: aware@awarehiv.org
Web site: www.awarehiv.org