World Vision®

Global Health

HIV & AIDS

The Hope Initiative: Final Report

Working in maternal and child health, nutrition, HIV and AIDS, and water, sanitation and hygiene

THE HOPE INITIATIVE: A JOURNEY

A desperate need

In the early years of the HIV crisis, much was done to respond to the effects of HIV and AIDS on key populations at higher risk. At the same time, a great deal of stigma existed in much of the church because those most often affected by HIV and AIDS were perceived to all have lived questionable lifestyles. However, AIDS was wreaking havoc in the less developed parts of the world—especially sub-Saharan Africa—and little to no work was being done to address the impact of the disease on children.

An awakening

In 1998, two months after joining World Vision United States (WVUS) as its president, Richard Stearns went on a field trip to Uganda. There he met a household of three boys—ages 11 to 13—who lived alone after being orphaned by AIDS. After meeting these boys, he learned of the then-estimated 10 million African children living in very similar circumstances. He learned that, at the time, World Vision was doing very little to respond to the AIDS pandemic. It became increasingly apparent that, if World Vision didn't respond, the impact of HIV and AIDS would reverse much of the progress World Vision had made in its development work.

Mr Stearns spoke out forcefully for the next two years, challenging his senior leadership, "Why, as a child-focused organisation, are we not addressing the AIDS crisis?" Amidst the many other critical global issues World Vision sought to address, however, many found it difficult to prioritise HIV and AIDS.

Chronology of the Hope Initiative

- **August 1998:** WVUS president visits Uganda and becomes aware of the impact of AIDS on children
- **July 2000:** Vice-president of Africa region appeals to Strategy Working Group for help to fight AIDS in Africa.
- **December 1, 2000:** WVI Chief Executive Officer announces World Vision's commitment to the fight against HIV and AIDS.
- **January 12, 2002:** Hope Initiative officially launched at a conference in South Africa.
- **April 2003:** World Vision appoints two church leaders living openly with HIV.
- **2003:** World Vision received its first Global Fund on HIV, TB and Malaria grant for HIV programming
- **2005:** Scale-up of HIV initiated outside of Africa and appointment of regional advisors in MEER, APR and LACR
- **2005**: Longitudinal operations research project started in Kembe ADP, Zambia and Katwe ADP, Uganda
- **2006:** WV's initiated it's Staff Assistance for Life Threatening diseases (SALTI) programme
- **2008**: World Vision's HIV funding reach its peak at $92 million.
- **2009**: CoH Study in three countries affirms the importance of addressing stigma through faith communities and mobilisation towards community initiatives such as the CCCs.
- **December 1, 2010:** The Hope Initiative ceases to exist as HIV and AIDS programming becomes a more mainstreamed and integral part of World Vision's overall programming approach.

Two years later, Wilfred Mlay, then-Africa Regional Vice President, made a powerful presentation to World Vision's strategy working group: "AIDS is killing our people. It is devastating our work, our families, our staff. I really need your help." Within a few months. Time magazine ran an article that discussed the then-estimated 10 to 12 million children left orphaned because of the AIDS pandemic.

This groundswell of attention to the disease led to the appointment of Bryant Myers, Vice President of International Programmes Strategy, to lead an internal study of World Vision International's commitment to the AIDS crisis. The study found that World Vision had 900,000 sponsored children in the 30 countries worst-hit by the AIDS crisis, and nearly 2 million sponsored children at risk worldwide. The crisis also directly affected World Vision staff--many with extended families affected by HIV and AIDS and who had, with their own resources, were caring for orphans in their own homes.

A few months later, on World AIDS Day, December 1, 2000, World Vision International's then-President Dean Hirsch announced that World Vision would launch a $30 million initiative to address the AIDS crisis. This initiative was announced, without a formalised name or a strategy, based on the belief that this was the right moment to launch. Over the coming months, he prepared a plan called "The HIV/AIDS Hope Initiative," outlining the need and scope of the problem.

Charting a course

Just two months after Hirsch's announcement, in February 2001, Ken Casey was appointed to lead this new initiative. After taking his position, he embarked on a six-month process of discussion with World Vision's regional and national leaders, assuring ownership from all aspects of the Partnership as well as ensuring that the ambitious fund-raising and programme goals were realistic from a field perspective.

After months of dialogue and meetings with key people from across the Partnership, the team determined the three HIV and AIDS programme areas: prevention, care and advocacy, aiming to:

1. **Prevent** new cases of HIV by contributing to the reduction of national incidence rates, especially among children, high-risk groups, and pregnant and lactating mothers.
2. Provide measureable improvements in the quality of **care** for children affected by HIV and AIDS, including those orphaned by AIDS, living with HIV-positive parents, and in households fostering children orphaned by AIDS.
3. **Advocate** for the adoption of public policies and programmes that would minimise the spread of the disease and provide care for those living with or affected by HIV and AIDS.

On January 12, 2002, the real rollout of the Hope Initiative took place in South Africa, bringing together the national directors, senior programme officers and area development managers from the 17 African countries hardest hit by the crisis. . Ken Casey asked them to tackle HIV and AIDS with the same energy with which they worked to bring communities clean water, education, health care, food security and economic development.

Giving life to HIV programming

During its existence, the Hope Initiative not only transformed the lives of millions of children, families and communities, it had a tremendous impact on World Vision's way of working. For instance, the Hope Initiative launched "Models of Learning," a way to design, test and incubate new project models. The Models of Learning team piloted and documented promising practices of HIV and AIDS programming in Uganda and Zambia. This led to the development of the first toolkit for HIV/AIDS programming, which was field tested in Africa, and later adapted to other regional contexts.

Very early on, World Vision realised the need to identify its unique contribution; develop a few core models focused on prevention, care and advocacy; and build the capacity of staff to use these core models. It was also clear that World Vision needed quality staff at regional, national and community levels in order to implement these programmes. The World Vision Partnership committed to support and fund the Hope Initiative, which included new sponsorship products such as "Hope Child" which provided specific support to children and families made vulnerable by HIV and AIDS.

THE HOPE INITIATIVE: PROMOTING PREVENTION

Contributing to the reduction of risk and vulnerability to new HIV infections

From the onset, World Vision realized that HIV prevention for youth should be core to our HIV response to ensure that children and youth acquire the values, knowledge and skills they need to protect themselves as they enter later adolescence and young adulthood. In the early years of the Hope Initiative, World Vision utilised "Adventure Unlimited," a school-based life skills education curriculum developed by Scripture Union.

Over time, World Vision discovered that socio-cultural and gender norms were hindering behaviour change among children even after being exposed to the Adventures Unlimited life-skills training. Global evidence on HIV prevention also revealed that lasting behaviour change is achieved if children receive continuous, multi-level exposure to comprehensive, mutually reinforcing behavioural messages and skills, and also experience consistent positive support for new behaviours from peers, parents and community members. World Vision's Abstinence and Risk Avoidance for Youth Project (ARK), funded by the President's Emergency Plan for AIDS Relief (PEPFAR), demonstrated positive results with such a comprehensive, multi-level project.[1] World Vision Africa therefore adopted an "ecological model" for HIV prevention, which includes a blend of interpersonal behavioural communications interventions at the individual, community and social/cultural environment levels.

Addressing HIV among migrant populations in Georgia, Armenia and Azerbaijan

Mobility was identified as an important vulnerability factor in the transmission of HIV in MEER and Southern Caucasus countries, which led World Vision to mobilise three national offices – Georgia, Armenia and Azerbaijan – to respond starting in 2007. The regional HIV and advocacy initiative utilised joint civil society and government organisation efforts to address migrant's socio-cultural vulnerabilities and worked to increase access to improved and sustainable prevention, care and support services in both the home and destination countries. Specifically, advocacy addressed vulnerability of migrants to HIV and other sexually transmitted infections, as well as other related human rights concerns, gender issues and family violation. To accomplish this, World Vision is partnering with organisations for people living with HIV in the three participating countries.

This led to the development of the Expanded HIV Prevention for Children and Youth model which is a comprehensive, multi-level package of behavioural communications and social change interventions which provides age-appropriate, values-based life skills materials and training to a range of community members, including teachers; community, church and faith community leaders; and children themselves as peer educators. This model also seeks to integrate prevention with other key Hope Initiative models, including Channels of Hope and Community Care Coalitions, in creating "360 degrees" of support to enable children and youth to protect themselves from HIV infection. Expanded prevention has been pilot-tested in Ghana and Kenya, while Zambia, Sierra Leone, and Mozambique have begun training in the model. During this same time frame, the Latin America and Caribbean Region piloted an HIV prevention project model based on life skills, education on sexual and reproductive health, and an enabling environment that accounts for the involvement of parents, schools, peers, churches.

A new social change intervention called Community-Change (C-Change) was developed that links to the expanded prevention model and engages communities in a broad dialogue focused on transforming harmful cultural norms. C-Change was pilot-tested in two area development programmes (ADPs) in Ethiopia between 2008 and 2010. The evaluation results indicate that this model effectively transforms norms and behaviours that increase children's vulnerability to HIV risk behaviours; empowers communities to protect the rights of women and girls; and increase women and girls' ability to fight for their rights.

In each context, the Hope Initiative aimed to identify or develop materials that are culturally sensitive and acceptable to the community. The Latin America and Caribbean Region (LACR) has taken the lead in developing a comprehensive values-based life skills curriculum (in Spanish) based on sound social learning theories such as the Theory of Multiple Intelligence, Theory of Resilience and Risk, and the Theory of Constructivist Psychology. The

1 World Vision & USAID: Abstinence and Risk Avoidance for Youth Project Report (ARK) - End of project evaluation for Haiti, Kenya and Tanzania, August 2010, p62

LACR life skills curriculum includes curriculum modules for ages 5-8, 9-11 and 12-18, and covers 17 essential and applied skills, as well as a full course on sexual and reproductive health.

Table 1: Children reached through prevention (as of 2010)

Africa	Latin America and Caribbean	Middle East and Eastern Europe
602,346 children receiving values-based life skills (VBLS) education	**149,252** children participating in organised community activities	**12,223** children received values-based life-skills education
43,663 child peer HIV educators trained	**3568** trained facilitators involved in values-based life skills training	**405** child peer educators trained
3,990 peer support groups formed		
70% area development programmes in Africa implementing VBLS HIV prevention for children (on average		

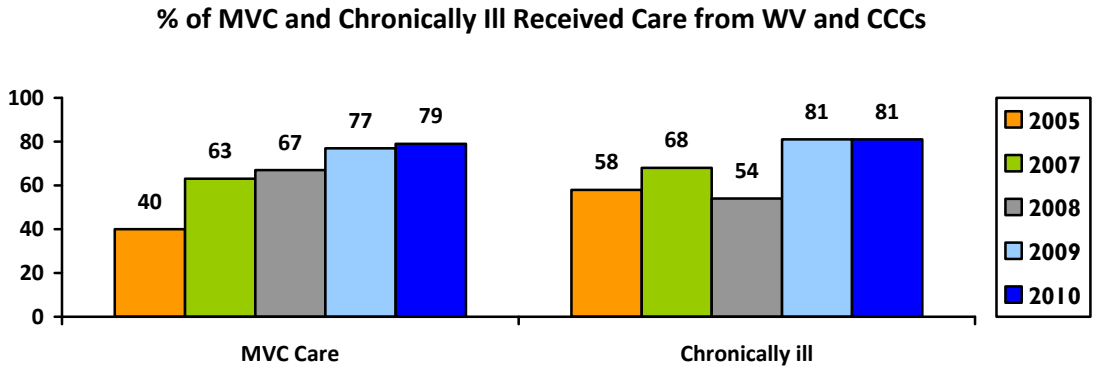
THE HOPE INITIATIVE: MOBILISING CARE

Protecting and improving the well-being of children affected by HIV

As the death-toll of HIV and AIDS rose, more and more children were left without parents, and the crisis of so-called "AIDS orphans" began (later changed to "children orphaned by AIDS to prevent stigmatising them). In areas with both high poverty and high HIV prevalence, the number of orphans increased dramatically as did the number of children made vulnerable by the impact of HIV was having on their families and communities. Children were increasingly left in the care of aging grandparents who didn't have the means to care for all their grandchildren. These realities challenged the global community to find the best solution to care for these orphaned and vulnerable children (OVCs). World Vision realised the answer does not lie in building expensive and unsustainable orphanages, but to equip the community to do what they have always done: to care for the weak and vulnerable.

The Community Care Coalitions model (or CCC, also known as Community Child Coalitions), was designed to empower communities to respond to care needs in a systematic way, demonstrating the importance of community ownership and capacity to care for the most vulnerable children (MVC) within communities. These coalitions coordinate and provide care to the MVC and chronically ill caregivers, and they recruit volunteer home visitors who take responsibility for identifying, monitoring, assisting and protecting the MVC in the community, including orphans and others affected by HIV and AIDS. World Vision's role is to mobilise these coalitions where necessary; strengthen their technical and organisational capacities, including training of volunteer home visitors; provide modest amounts of financial and material support; link them to other sources of support; and advocate for more resources to be made available for their work. Community Care Coalitions are strengthened by Channels of Hope (CoH), which mobilises faith leaders, who then mobilise more home visitors, who then reach more children.

Between 2002 and 2010, the Hope Initiative piloted and scaled-up CCCs in Africa ADPs and began pilot-testing an adaptation for low-prevalence context in Godavari ADP in India in 2009. The WV India CCC adaptation has a strong focus on child participation, MVC advocacy, HIV stigma reduction, and community sensitisation to child participation and to addressing special needs of people with disability, including children. Results from the Core HIV&AIDS Response Monitoring System (CHARMS) launched in 2005 in Africa show significant increases in the number of vulnerable children and chronically ill adults identified by the CCCs and per cent receiving care.



Results from the core HIV and AIDS models operations research indicated that this model was effective in increasing the systematic response of faith-based groups and community-based organisations to care for MVC and chronically ill adults and in improving many aspects of the well-being of MVC, including increased school enrolment and participation, birth registration, access to insecticide-treated nets, adequate food and medical care when sick.

The Organisational Capacity Building (OCB) training for CCCs, another Hope Initiative complementary intervention, has proven to be effective to build the capacity of CCCs in their role and provide the necessary skills to function optimally as a self-sustaining body.

Since 2002, World Vision has implemented interpersonal psychotherapy for groups (IPT-G) to treat HIV and AIDS-related depression in African communities with high HIV prevalence, mostly in East Africa, which showed great results in reducing major depression. There were more than 40 per cent fewer cases of major depression among group participants than non-group participants. In IPT-G, a trained community-based volunteer facilitates a discussion group of people who have been diagnosed with depression to make sense of their emotions and build skills to improve functioning and emotional support over a period of several months. The CCCs play a vital role to identify orphans, caregivers, children and adults living with HIV to take part in IPT-G. The health and HIV team will continue to support the utilisation of IPT-G for OVC and their caregivers as an essential support mechanism. Over the next five years, the HIV team will collaborate with WVI's Child Protection group and the psychosocial working group to take ownership for this vital process.

Table 2: Outputs of care interventions as of 2010

Africa	Latin America and Caribbean	Middle East and Eastern Europe
4222 Community Care Coalitions	**2950** adolescents receiving help through community support groups	**11,584** children received basic support from World Vision
73,486 active home visitors	**1454** PLHIV had access to care facilities within the ADP influence	**440** PLHIV received support from World Vision programming
1,562,424 most vulnerable children identified and **1.2 million** OVC receiving care		
127,654 chronically ill identified		
445 ADPs with care interventions		

THE HOPE INITIATIVE: EMPOWERING ADVOCACY

International advocacy

In 2003, World Vision established the HIV and AIDS Advocacy Network in 2003, which produced an advocacy strategy in May that year. The strategy focused on four issues:

- Strengthening care for orphans and vulnerable children
- Reducing the vulnerability of girls and women to HIV
- Increasing access to treatment and care
- Mobilising resources for expanding the HIV and AIDS response.

Also in 2003, WVUK dedicated a full-time staff member to advocacy for HIV and AIDS, lobbying initially in UK and then increasingly supporting World Vision colleagues across Europe and globally.

In our global-level advocacy work, World Vision advocacy staff worked to form partnerships with civil society networks such as the Ecumenical Advocacy Alliance, AIDS-Free Generation, the UK Children and AIDS Working Group, and EU CONCORD HIV Group. Through its lobbying, World Vision has been able to increase the commitments for children in global-level policy documents, such as the 2004 OVC Framework developed by several organisations such as UNICEF, UNAIDS and USAID, and the 2006 Political Declaration of HIV issued by the UN General Assembly Special Session on HIV (UNGASS). The Hope Initiative has also successfully advocated to donor organisations for significant increases in funding for children and AIDS, for instance, ten per cent of the AIDS budget for children from the UK and US governments. Another success was in 2007 when WVUK, as co-chair of the Resource Mobilisation Working Group of the AIDS Free Generation, successfully lobbied UNAIDS to increase the OVC financial resource estimates for 2009-15, which resulted in increasing the figure for 2010 from the original estimate of $740 million to $4.4 billion.

The role of the Child Budget Network (CBN) in influencing budget allocation and resource utilisation for children in Zambia

World Vision Zambia is a member of the Child Budget Network (CBN), which it co-chairs with the Zambia Civic Education Association (ZCEA). The CBN is a loose network of Civil Society Organizations (CSOs) that advocate for the effective and efficient allocation and utilisation of resources in the national budget to advance the rights of Zambian children in general and that of orphans and vulnerable children in particular. In 2009, when the Ministry of Finance and National Planning called for 2009 budget proposals, the network submitted a proposal calling for the government to increase the budget allocation to the education sector from 15.4 per cent in 2008 to at least 19.5 per cent in 2009 as projected in the Fifth National Development Plan (FNDP). The government, in part due to the CBN lobbying, made a significant increment in allocation to the education sector from 15.4 per cent in 2008 to 17.2 per cent in 2009.

National-level advocacy

World Vision, through the Hope Initiative, has also played an increasingly active leadership role in several civil society networks advocating for children and AIDS. This has resulted in the inclusion of stronger commitments for children in a number of public policies. One such example has been in Zambia where World Vision has been a very active member of the Child Budget Network.

Community-level advocacy

At community and national levels, the advocacy pillar of Hope Initiative was rather slow to get off the ground. However, with the appointment of a team leader for the Africa HIV and AIDS Advocacy and OVC Team, advocacy for the rights of orphans and vulnerable children began in earnest. A situational assessment about World Vision's advocacy for OVC in six countries in east and southern Africa highlighted weaknesses that were subsequently addressed through the Vulnerable Child Advocacy programme in those countries and more widely. Excellent progress has been made in enabling communities to address the rights of vulnerable children, including monitoring the implementation of policy commitments. In Africa in 2010, more than 870,000 community members (including children) were involved in local HIV advocacy, addressing issues such as property grabbing and inheritance rights, child labour, access to education especially for the girl child, female genital mutilation/cutting, birth registration, early marriages, harmful traditional practices, budgetary allocation for OVC, sexual exploitation and harassment. The programme of Vulnerable Child Advocacy (VCA) was expanded to 20 countries in Africa, and has become a project model for World Vision's Integrated Programming Model (IPM), and serves as a means of confronting socio-cultural practices that are harmful for children. One such example of vulnerable child advocacy comes from Northern Ethiopia where as a result of being given advocacy training the Tamsalet Community Care Coalition embarked on a highly successful campaign to tackle the practice of early marriage. See additional stories about VCA.

Prevention of Early Marriage in Northern Ethiopia:

The practice of early marriage is a widespread and culturally deep-rooted practice in northern Ethiopia. Children as young as nine are given away in marriage and suffer the emotional and physical consequences. The Tamsalet Community Care Coalition (CCC) recognised the dangers of early marriage and decided to find ways to tackle the issue. The Tamsalet CCC took their campaign against early marriage to the match makers who perpetrate the practice because they have a vested social and financial interest in the practice. Initially, the CCC advised matchmakers to stop arranging early marriages by informing them of the dire emotional and physical damage it inflicted. Eventually as the CCC became more confident and its campaign more socially acceptable, it engaged law enforcement agencies. As a result, two matchmakers were prosecuted and were not only fined but also sentenced to five months in prison.

Their campaign succeeded in rescuing girls and boys from entering into marriage. Indeed 155 planned early marriages were postponed while twenty-seven children had their age tested and nine of the children were found to be underage.

Table3: Outputs of advocacy interventions as of 2010

Africa	Latin America and Caribbean	Middle East and Eastern Europe
528 ADPs and other programmes engaged in advocacy for OVC care	**10,000** leaders sensitised to HIV issues	**14** HIV-related advocacy initiatives took place in 4 national offices
More than **871,000** community members (including children) were involved in local HIV-advocacy	112,516 children trained in sexual and reproductive rights	

THE HOPE INITIATIVE: A LEGACY OF FAITH

Assisting faith and community leaders to respond

World Vision values the partnership with churches and faith communities. It was therefore no surprise that the Models of Learning team identified the need for a project model that will strengthen and mobilise faith communities towards non-judgemental, caring responses to HIV and AIDS. The Channels of Hope (CoH) project model,

developed by CABSA (Christian AIDS Bureau for Southern Africa) was chosen as the most appropriate approach to fit the aims of the Hope Initiative and the needs within the communities where we work. A licence agreement with CABSA enables World Vision to implement this model globally, providing scope to adapt the curriculum to be applicable in the various contexts we work in, while maintaining the high quality of training and assessment designed by CABSA.

The most consistent finding of the study was the universally positive impact of the CoH workshops on faith leaders and other participants. Virtually all faith leaders interviewed spoke of the transformative power of the workshops on their views and attitudes to HIV and AIDS in general, and towards people living with HIV as individuals. There is no ambiguity at all to this finding. The impact of the CoH workshops on faith leaders has been shown to be universally positive, powerful and transforming. (External Research Consultant. Three country CoH Study – 2009)

CoH is a faith response to HIV and AIDS. It uses a transformational process, based on adult learning principles, to guide the local faith leader and his/her congregation towards compassionate, non-discriminatory responses to HIV and AIDS. Congregations form CHATs (Congregational Hope Action Teams), and through CoH are empowered to plan their response, linked to and integrated with the CCC and Expanded Prevention models where applicable. Two separate CoH operations research studies (one in Africa, and one in MEER) captured lessons learned, indicating reasons for the success of the model, and providing guidance for future implementation.

World Vision started to implement CoH with a small team of trainers in Africa in 2003. Soon it was evident that this project model is highly successful and would need more regional staff to respond to the huge demand from the field. In 2005 two additional Africa regional staff (Logy Murray and Siyani Zimba) were appointed to lead the scaling up of implementation in Africa, which led to implementation in other regions. Within three years' time, CoH was introduced to Latin America and Caribbean, Middle East and Eastern Europe, and Asia Pacific regions, and soon all the regions had dedicated CoH regional advisors/coordinators to assist national offices in their implementation of CoH, through technical advice, training of facilitators and mentoring.

The Middle East and Eastern Europe Region was the first to adapt Channels of Hope for a secular audience, utilising it as an entry point for other HIV prevention interventions (such as life skills training and peer education) among children under 18, street children and migrant populations. Channels of Hope helped change the mindset of participants from the region who had no prior understanding of HIV and its impact on people.

CoH was also included in the Operations Research (mentioned previously), and the results indicated a significant increase in HIV knowledge and HIV testing as well as significant HIV stigma reduction as a result of CoH implementation.

Table 4: Reach of Channels of Hope since 2003

Training of CoH facilitators	• 2,994 facilitators were trained across 55 countries (2003 – 2010) • 34 per cent of new facilitators trained were from partner organisations, and 6 per cent were Muslims
CoH Workshops	• 13,174 CoH workshops reached 307,304 participants – 74894 were senior faith leaders • 18,705 congregations formed Congregational Hope Action Teams (CHATs) • 17,613 congregations joined forces with their local CCCs • 42,862 volunteers in Africa were involved in care for OVC and chronically ill (FY10 only)

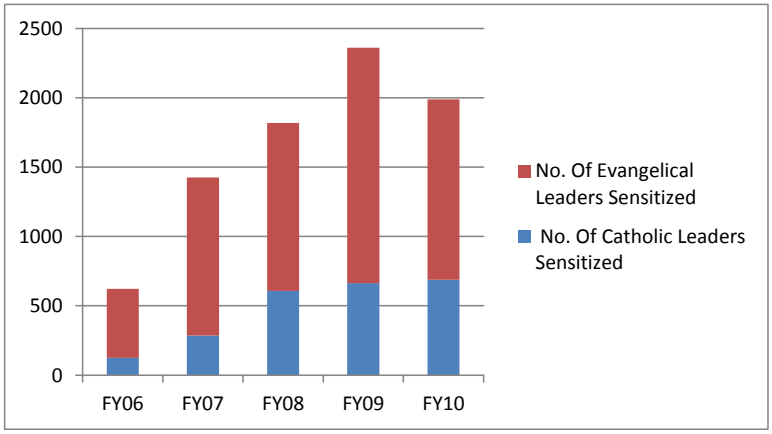
Channels of Hope to address gender

"Having sat through the two days of this workshop, I and the leadership are convinced that this tool is appropriate for our communities and Ethiopia as a nation … I have been challenged at a very personal level and do trust that different ones that will be exposed to this tool will be encouraged as I have been." **Tenagne Lemma - WVE National Director.**

Very soon it became clear that HIV cannot be addressed without touching on the deep-rooted gender inequality and harmful cultural gender practices in communities. This led to the development of CoH for Gender, a curriculum that can be facilitated on its own, or following the CoH for HIV workshops. During 2007 – 2010 the Church partnership on Gender and Development (CPGD) project developed and piloted this curriculum in Africa. Two staff members were appointed to work a psychologist from Canada on contextualisation and adaptation of the content. With the same transformational approach, CoH for Gender showed the potential to become an indispensable tool in the package to address HIV and AIDS, and scaling up in Africa and beyond started in FY11.

Sustainability through partnerships

One of the findings of the CoH study in Africa indicated the potential of sustainability through the training of partner organisations. Since FY07 many churches and faith-based NGOs requested assistance to implement CoH, resulting in one third of all new facilitators trained to conduct CoH workshops coming from international and local partner organisations. World Vision has also expanded its partnership with the Orthodox and Catholic Churches, moving toward practical collaboration with Russian and Armenian Orthodox Churches and Catholic Churches and using materials adapted for these partners. The CoH manual and materials were revised to relate more effectively to these participants. As a result CoH became an effective tool towards church partnership, especially with the Roman Catholic Church in both workshops and facilitators trainings. See figures from LACR below:



Bringing Christians and Muslims together

Dr Iqbal Karbanee, Islamic Relief South Africa:: "*I must honestly say that I had many doubts before this training. But now I am convinced this is the way to go. This approach of CoH allows people from both faiths to address a common issue. It creates an environment where they can share the common principles while respecting the differences. What I like is the fact that it did not try to make the faiths all the same, but built respect for one another.*"

As 25 per cent of the countries where World Vision works are predominantly Muslim countries, and many others are mixed Christian/Muslim contexts, it soon became necessary to adapt the Christian-only content of CoH to also be used within mixed faith contexts. The process started in 2005 when a Muslim Mufti from Zambia, was trained as a CoH facilitator and tasked to write the Muslim specific content for the facilitator's manual. With approval from the WVI Board Ministry Committee, and supported with the guidance of an advisory committee from

different sectors within World Vision, the CoH manual and materials were adapted to mobilise Muslim faith leaders in partnership with Islamic Relief International South Africa. This has built trust amongst people of faith who have been distrustful and afraid of one another.

HIV IN EMERGENCIES

People living with HIV can be more vulnerable during emergencies and unstable environments caused by conflict and other disasters can increase people's exposure to HIV.

World Vision's strategic goal for integrating HIV in emergencies is to contribute to the well-being of children, their families and communities, during conditions of turmoil and disruption in times of crisis, through HIV prevention, care and advocacy measures.

'According to the UN, a disaster is any serious disruption of the functioning of a society, causing widespread human, material or environmental losses which exceed the ability of a society to cope using only its own resources (OCHA, 1996). There is no doubt that HIV meets this definition…..and could have been prevented but ignorance, stigma, political inaction, indifference and denial have all contributed to the deaths of millions of people.' IFRC, World Disasters Report. 2008

A number of documents were developed to assist World Vision teams to integrate HIV within an emergency;

- Introduction paper on integrating HIV in HEA
- Staff assessment tool – how much basic HIV knowledge do staff have and how well prepared are they to respond to HIV in emergencies
- Programmatic check list tool – How affective are your programme activities (all sectors) currently in addressing HIV in emergencies
- The revised IASC guidelines for responding to HIV in humanitarian settings (developed in conjunction with the IASC Task Force)

Monitoring trips were carried out in Zimbabwe to train staff and the above check list tool was promoted for use amongst sectors in the recent Haiti emergency.

A research project was conducted in South Sudan, Democratic Republic of the Congo and Kenya to understand the relationship between humanitarian organisations and faith-based communities (FBCs) and how the church can better respond to emergencies.

Key points from the research project

- FBCs may be the first port of call for local people during a crisis, and often continue to provide HIV-services
- Humanitarian actors need to help FBCs build up their emergency capacity on HIV services
- To work effectively with humanitarian actors, FBCs should address stigma, theological misunderstandings and discrimination

As a response to the findings a reference tool kit was developed to encourage self-assessment and sensitisation of religious leaders to promote comprehensive approaches to HIV in emergencies including combating stigma and gender issues. This was launched at an event attended among others by the Archbishop of Kenya.

ASSISTANCE TO STAFF LIVING WITH HIV OR OTHER LIFE-THREATENING ILLNESSES

During 2006 the leaders of the Hope Initiative realised that it was imperative to introduce a programme that will address the effects of catastrophic illnesses, such as HIV, among World Vision staff. World Vision's core values state

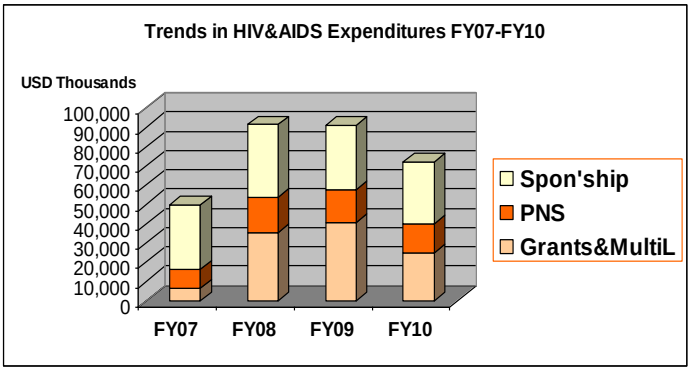
that **we value people** and respect the dignity, uniqueness and intrinsic worth of all people, therefore we must respond compassionately not only with the communities we serve but with our staff.

At the time very few staff living with HIV had access to antiretroviral treatment, and, without intervention, many would face the realities of AIDS and death. The lack of appropriate care for staff would call into question the credibility and integrity of the Hope Initiative, and staff could not bring hope and the promise of life in all its fullness to communities if World Vision did not first provide hope for affected staff and their families.

This realisation led to the design and implementation of the Staff Assistance for Life-threatening Illnesses (SALTI), a programme that did not solely focus on HIV but on a wide variety of illnesses such as ischaemic heart disease, tuberculosis and more. An adapted Channels of Hope training programme was developed for SALTI to address HIV awareness, discrimination and stigma in the workplace.

To date the programme is implemented in 26 countries in Africa and 7 countries in Asia. Approximately 15,320 employees with life-threatening illnesses have access to healthcare and psycho-social support service. Of those who participated in SALTI, 75 per cent opted to utilise the testing and services offered.

FUNDING THE HOPE INITIATIVE



Funding for the Hope Initiative was kicked off with a number of grants, notably from the US President's Emergency Response for AIDS Relief (PEPFAR) and the Global Fund to Fight HIV, TB and Malaria. By FY05, ADPs had started using a greater proportion of their sponsorship budgets for HIV response. Funding for the Hope Initiative from support offices grew steadily and peaked at $92 million in FY08. The increase in commitments from FY06 was partly due to several innovative support office programmes – including the WV Canada "mainstreaming HIV" and WVUS "Hope Child," as well as increased grant funding from bilateral sources and the Global Fund. Funding held steady in FY09, then decline in FY2010 to approximately $71,875,000, partly due to end of the large RAPIDS grant in Zambia and the Guatemala Global Fund grants.

World Vision has been awarded 23 grants for HIV and AIDS from the Global Fund in 16 countries for a total of $75.1 million since 2002. Fourteen of these grants in the amount of $14.1 million were awarded between FY08 and FY10. To leverage Global Fund grants and expand the reach and depth of programmes, World Vision national offices have also been able to raise internal financial and non-financial resources either locally or through partnering with World Vision support offices. Significant bilateral grant funding from USAID, the Netherlands government and AusAid have funded World Vision's largest and most innovative HIV and AIDS programmes, which have piloted innovations in gender-based approaches, integration into conflict-affected areas, and public-private partnering, while greatly increasing the number of children and families reached with prevention and care. AusAid also funded key projects in Central Asia, namely Afghanistan and Uzbekistan.

In FY08-09, private non-sponsorship grew dramatically, mainly due to the increased contribution of gifts-in-kind for home-based care kits from WVUS and WV Canada, much of which was used as match for public grants. Grants from governments and multilaterals declined in 2010, but still represented 35 per cent of the total HIV and AIDS portfolio. World Vision US continues to be the top earning support office for HIV fundraising efforts, followed by Canada, Australia, Global Fund or other local income, Hong Kong and Germany.

THE HOPE INITIATIVE: WHAT WE'VE LEARNED

Based on the research *HI Lessons for the Future*[2], *Looking Back, Looking Forward*[3] and *Lessons for World Vision's long term HIV response*[4], five characteristics of the Hope Initiative can be highlighted that have facilitated its progress:

1. *Core Models*: The Hope Initiative's programming platform consisted of three core models based on strong theoretical frameworks and pilot-tested for rapid rollout and high quality, evidence-based programming- Channels of Hope (CoH), Community Care Coalitions (CCC) and HIV Prevention for children and young people.
2. *Technical expertise across all operational levels*: Dedicated HIV staff were rapidly recruited and placed at global, regional, national and ADP levels, including a highly qualified and experienced global core team engaged in programme operations, monitoring and evaluation (M&E), research, and advocacy with strong links to the regional and national-level operations through the work of regional advisers and teams. The Hope Initiative was able to place HIV and AIDS facilitators in a significant number of ADPs who mobilised and provided technical support and training to the community but also to other ADP staff.
3. *Clear strategy from the outset supported by a strong M&E framework*: Intentionally designed to deliver rapid and high quality scale up of core programme models, the strategy included clear targets and indicators supported by a monitoring system that was new to World Vision: the Core HIV and AIDS Response Monitoring System (CHARMS), which allowed the Hope Initiative to closely examine coverage and capacity and measure progress against pre-determined targets.
4. *Multiple and innovative funding channels*: Partly due to high-level support within World Vision Partnership entities, the Hope Initiative experienced unprecedented levels of funding for HIV programmes. It successfully mobilised multiple sources of funding from securing ADP commitments, accessing grants from major funding bodies like the Global Fund to innovating strategies that linked marketing with programming. One such strategy was the Hope Child, launched by WVUS and WVC to ask sponsors to increase their contributions to directly fund HIV programmes. In 2006, it accounted for 50 per cent of all WVUS sponsorship income, sponsoring over 250,000 children
5. *External engagement and building partnerships*: World Vision often engaged in coalition-based advocacy particularly in support offices like WVUK. At the national and field office level, core Hope Initiative models – CoH and CCC – necessitated the planned cultivation of external partnerships. The multi-organisation Zambia RAPIDS programme demonstrated the importance of transparency, coordination and equity among partners. In LACR World Vision has partnered at regional level with The Pan American Health Organization (PAHO) and a Jesuit organisation in Colombia to develop a values-based life skills education program. The ten manuals produced are used extensively by ministries of health in the region. Finally, the Hope Initiative has engaged considerably with academic and research institutions to strengthen its evidence-based approaches – for example, the Abstinence and Risk Avoidance (ARK) project in collaboration with Johns Hopkins University (JHU).

BEYOND THE HOPE INITIATIVE: WE DARE NOT STOP

With the end of the Hope Initiative as initiative, and the integration of HIV into the Global Health and WASH sector, some people within World Vision might have understood that World Vision has deprioritised, or even stopped our work on HIV. Nothing could be further from the truth.

[2] Davies, N (2008) HI: Lessons for the Future. Davies and Lee Consultancy
[3] World Vision Australia (2008) Looking Back, Looking Forward.
[4] Rachel Samuels (2010) Lessons for World Vision's long term HIV response: examining the influence of the Hope Initiative

Notable progress has been made. More than half (53 per cent) of all pregnant women living with HIV in lower and middle income countries received antiretroviral (ARV) prophylaxis or treatment in 2009, up from 15 per cent in 2005. In that same year, Botswana, Namibia, South Africa and Swaziland, along with Argentina, Brazil, Thailand, the Russian Federation and the Ukraine had all achieved at least 80 per cent coverage with ARVs for PMTCT.[5] These national successes and declining HIV prevalence in many countries since 2005 provided the impetus for a global goal to eliminate new HIV infections in children. However, advancement on other indicators has been less encouraging. Only half of the mothers receiving prophylaxis were assessed for their own ARV needs in 2009, and only 15 per cent of exposed infants were tested for HIV during the first two months of life.[6] Leaders and stakeholders therefore recognise that rapid scale up to achieve the global goals by 2015 will require programmes to go well beyond doing "more of the same."

HIV programming will continue to be an integral part of our development and relief work. In line with the new HIV strategy, our HIV work will have a very specific geographic and programmatic focus.

We will focus our work on the World Vision countries with a high HIV prevalence or concentrated epidemics, as identified by our Triggers for Action document. We will give high priority to the UNAIDS priority countries and the 20 countries prioritised by UNAIDS's global plan to eliminate mother-to-child transmission.

We will focus our HIV programming on three issues: community-based prevention of mother-to-child transmission (cPMTCT), the reduction of gender-based vulnerabilities, and integration with other World Vision programmes and sectors.

Community-PMTCT

The Countdown to Zero global plan towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive recommends actions to be taken at global, regional, national and community levels to stop new HIV infections in children. New resources are being mobilised, and countries are expected to work with development partners to assess gap areas and put national plans in place for achievement of these exciting goals.

An important feature of the Countdown to Zero plan is its emphasis on community engagement as an integral part of the scale up strategy. Community engagement for PMTCT must work hand-in-hand with efforts to improve PMTCT services at health facilities. Demand created within communities must be linked to adequate, stigma-free and client-sensitive service delivery. Community-based PMTCT includes the concept of combining prevention and treatment, both for the mother and child, and integrates well with other World Vision prevention and care models. It also incorporates improving male involvement; antenatal, delivery and post-natal care -- including maternal-child health and reproductive health; and it provides a vital entry point for tracing HIV-exposed children so that they can be diagnosed and receive both prophylactic care (co-trimoxazole preventive therapy) and anti-retroviral therapy as needed.

Community-based PMTCT interventions are integrated with Timed and Targeted Counselling, an approach that assures families receive the necessary information and counsel they need in good timing and in an appropriate way for better health and well-being. These community-based approaches are delivered through community health workers. Channels of Hope (HIV and MCH) and local level advocacy (using both Citizen Voice and Action and Child Protection Advocacy models) can be utilised for stigma reduction, elimination of socio-cultural barriers, community

[5] UNAIDS 2011
[6] WHO, UNICEF and UNAIDS 2010

mobilisation and enhanced demand creation. Expanded prevention programming will be utilised to equip girls and boys with the adequate skills to avoid infection with HIV.

Gender vulnerability

At the same time we will be utilising programme models such as CoH on Gender and C-Change to reduce gender-based vulnerability and harmful traditional practices that drive HIV infection rate and violate the rights of women and children. We will strengthen the gender lens in all models that facilitates the greater participation of men as partners and strives for biblical gender relations and equity.

Integrating HIV models with other World Vision programming

It will be irresponsible to treat HIV only as a health issue. We will therefore work strongly with other sectors and departments at World Vision toward greater integration and ownership of HIV within their programming. Work is underway to integrate all the different versions of Channels of Hope within Christian Commitments as an ideal way to partner with churches and faith communities in our development work. We will work in close collaboration with child protection toward shared ownership for the care and protection of most vulnerable children through the work of CCCs in our communities. This will be done together with integrated programming to assure that organisational capacity building will continue as part of IPM to assure the sustainability of CCCs. In working with the school-based working group from the Education team, we will ensure that HIV-related life skills training is included in the development of new life-skills curricula. We will continue to work with Humanitarian and Emergency Affairs to ensure that HIV will continue to be addressed within emergencies. Nutritional issues are inseparable from nutrition, therefore we will continue to work with nutrition, livelihoods and food security to ensure that the nutritional aspects of HIV vulnerability gets addressed sufficiently.

CONCLUSION

When we look back over the ten years of the Hope Initiative, we thank God for his wisdom, open doors and guidance, and His provision of leadership within World Vision. We stand in awe when we look at the numbers of children, families and communities who became instruments of advocacy and care. We praise him for the resources provided -- both financial and in human capacity. We thank God for the changes in attitudes towards people living with HIV, both within World Vision as well as in the communities we serve, and for the advances in treatment and the successes achieved through combined advocacy. We thank each staff member and every member of the World Vision partnership who join hands and stood up to the challenge HIV and AIDS presented us.

Now we pray that we will continue our work on HIV and AIDS with the same diligence. Let's stand behind the vision of UNAIDS and the World AIDS day theme of 2011: “Getting to Zero – Zero New HIV Infections; Zero Discrimination; and Zero AIDS-related Death.” With our combined efforts, no child needs to become infected by 2015. Let this be our motivation to continue the work, and to strive to reach further and do more.