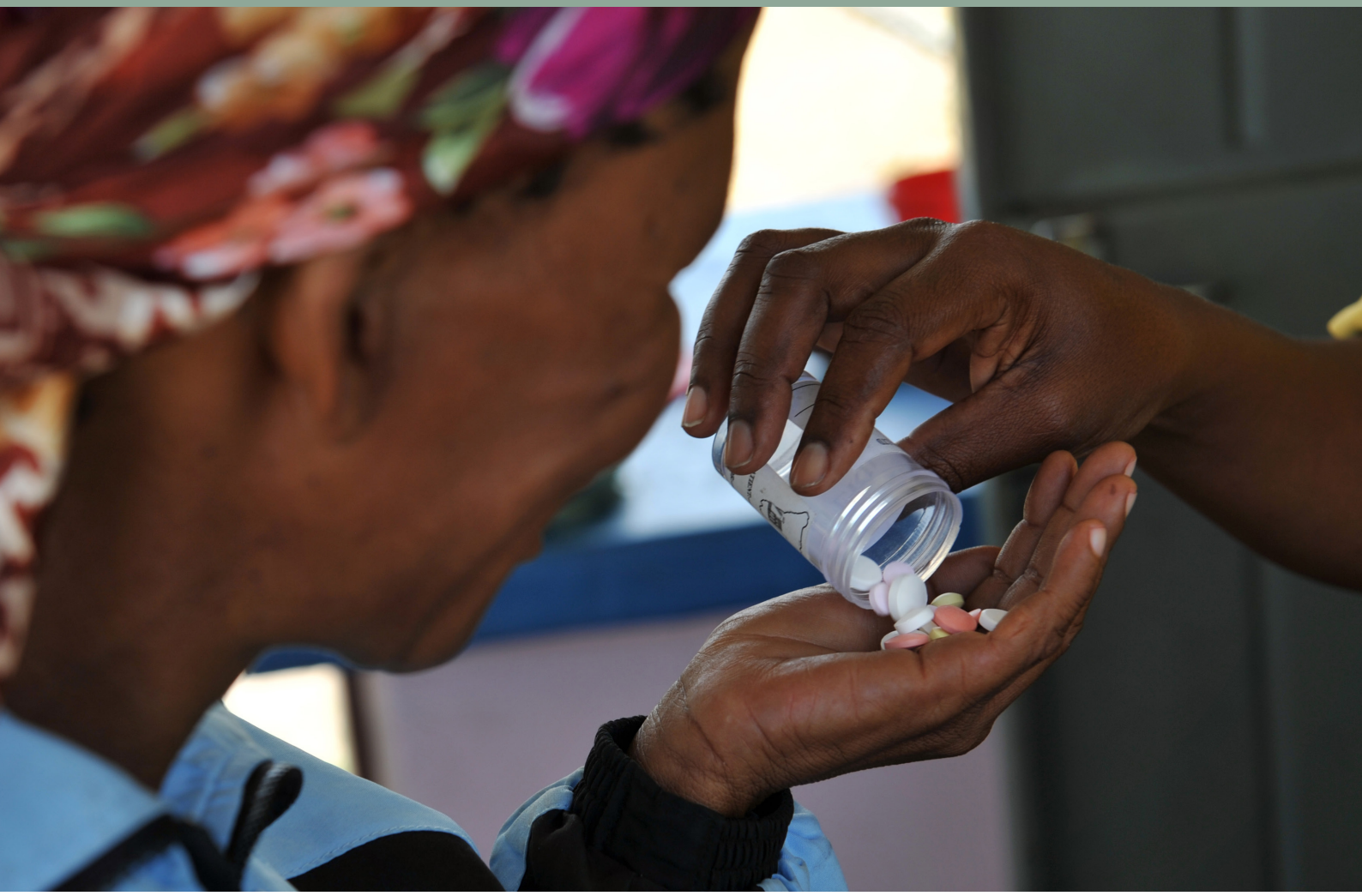
# LEARNING FROM THE CIVIL SOCIETY CHALLENGE FUND: PROVIDING SERVICES FOR PEOPLE LIVING WITH HIV/AIDS



**KEY INSIGHTS**

1 Those projects that engaged and mobilised target communities widely with clearly articulated roles were most effective in raising awareness, reducing stigma and discrimination and improving access to and quality of care.

2 Tangible improvements have been made to HIV/AIDS related services, particularly at local and regional level in CSCF projects. Where improvements have been made, close involvement of front line health staff and people living with HIV/AIDS has been important, as has providing alternative income sources for community volunteers.

3 Achieving policy change for HIV/AIDS support and treatment can be challenging within the 3-5 year time span of a CSCF-funded project. Where it has been achieved, some key success factors have been identified, as outlined in this paper.

## MOBILISING COMMUNITIES

Projects which effectively mobilised target communities achieved more in changing behaviour and improving services. Projects have observed in their reporting that changing attitudes and behaviours is particularly important in Africa and Asia, where stigma around HIV/AIDS remains widespread and myths about prevention and transmission still exist.

CSCF projects have worked with existing community group structures as an entry point to educate people about HIV/AIDS, encourage people to access testing and support and

The **CIVIL SOCIETY CHALLENGE FUND** (CSCF) was a demand-led fund which aimed to enable poor and marginalised people to have a voice on issues that affect them and to be included in local and national decision making forums. Running from 2000 to 2015, it supported 526 projects in Africa, Asia, the Americas and the Middle East, each with a grant of up to £500,000 and running for 3 to 5 years.

This learning brief is one of six, prepared upon completion of the CSCF, focusing on key areas of best practice within the fund. These briefs aim to share learning with practitioners and civil society learning networks, and help inform future fund management in DFID and beyond.

**TARGET GROUPS**

Of the 14 HIV/AIDS-focused projects supported by CSCF from 2010 to 2015, target groups included prison communities in Kenya, people living with HIV/AIDS in India and Africa, children with life limiting illnesses in Malawi and India, advocacy coalitions, civil society groups and government officials.

galvanise communities to demand improved HIV/AIDS services. These trusted community groups have provided a helpful entry point to address HIV/AIDS and in some cases have extended the reach of existing service providers by supporting initial case identification and referrals.

For example, in India, a project to reduce TB/HIV co-infection worked with existing women's self-help groups, training 8,677 group members to recognise symptoms of TB and HIV and means of transmission. They encouraged 1,337 people to be tested, of which 126 were diagnosed.

The project also set up new adult and child support groups. More than 300 adult members were trained in TB sputum collection and have been supporting local collections by transporting samples to testing centres. By working through community groups, the project improved community knowledge of and attitude towards TB/HIV, individuals' knowledge of their TB/HIV status and access to testing and support.

Some projects have created new multi-stakeholder groups with representatives from across the community. Particularly in areas where existing structures were not present, these new groups have provided a platform from which to raise awareness on HIV/AIDS prevention and transmission, tackle stigma and discrimination and advocate for improved services.

Projects working on HIV/AIDS under the CSCF have found that mobilising key influential figures and opinion formers in the community, such as religious leaders, to support the project, can be particularly effective in large scale behaviour change. Involving such individuals can also enhance the potential sustainability of change, as they have access to large numbers of people within the target community and a broad range of key actors and change makers, with whom they interact on a regular basis.

## BETTER ACCESS TO BETTER SERVICES

CSCF projects have secured improvements in service access and provision for people living with HIV/AIDS, particularly at local and regional level. The benefits of mobilising communities themselves to raise awareness, facilitate access to, and improve quality of services have been highlighted above. Some further common success factors are set out below:

### Involving people living with HIV/AIDS in the provision of services

Those projects that engaged people living with HIV/AIDS in the design and implementation of service provision found that the services being offered were better received by the target communities. By involving such individuals, a higher level of trust was built and there was greater willingness to come forward for testing and to participate in support services such as counselling and treatment adherence groups.

### Training of front line health staff

Health staff and health premises in the countries where CSCF projects operated often did not have the skills, or enough resources, to raise awareness, educate and provide a range of services on HIV/AIDS. CSCF projects filled this gap and found that by spending time with front line health staff in health centres of different types, to raise their knowledge and skills, significant and potentially lasting improvements in practices could be made despite limited resources. For example, in Malawi and India, a project on palliative care for children, including those with HIV/AIDS, trained 2,228 health workers in palliative care. This improved the quality of care delivered, access to pain relief, communication with children, timeliness of treatment and recording

of health information. Caregivers and children expressed satisfaction with the way the child palliative care units interacted with them, their willingness to listen to them, their empathy and compassion as well as thoroughness in assessing their problems, either physical or emotional.

## Income generation for sustained delivery

Many projects have worked with and through community groups to expand the access of the target population to local services. Community volunteers on CSCF projects have provided services such as:

- sputum testing for TB
- identification of and prevention of HIV/AIDS in prisons
- support for referral and treatment adherence
- support and treatment adherence clubs in remote communities
- design and delivery of HIV/AIDS education and nutrition education
- a range of advocacy activities with health services, resulting in improved and more extended service provision

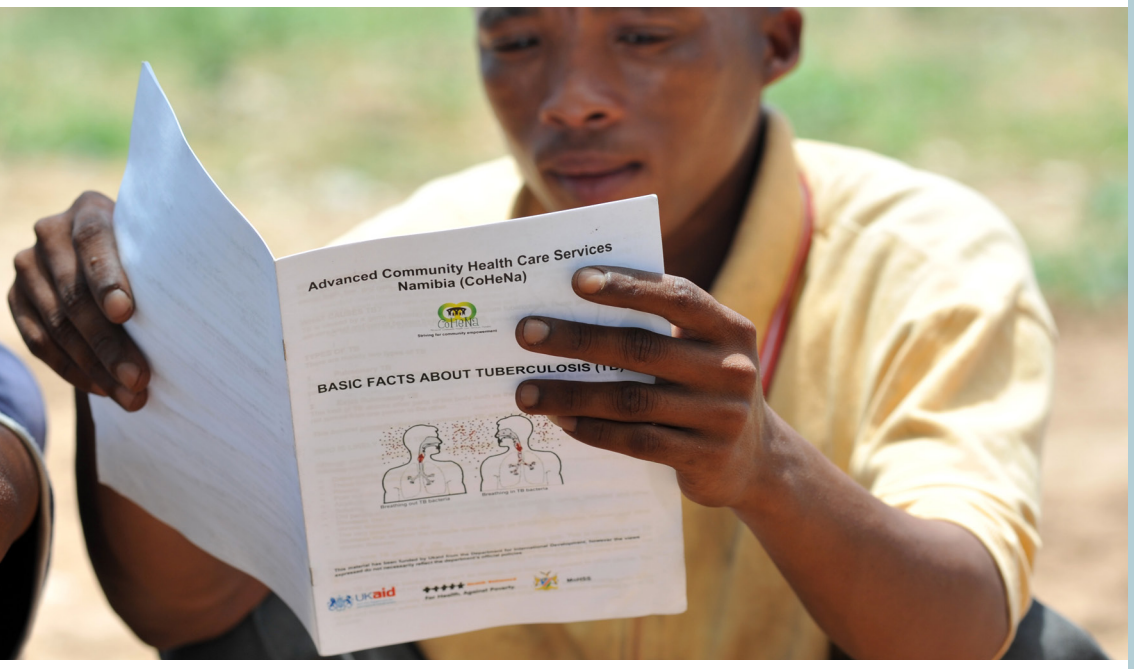
Project evaluations have found that those projects where volunteering has been combined with developing a source of income/finance generation for those volunteers and their groups/networks, have shown greater chances of service activities being sustained.

One such project in Uganda, working in remote communities, established project advisory committees (PACs) (which acted as a platform for HIV/AIDS activities, support to services and advocacy) and integrated a savings and loan scheme into the PACs. This provided incentive for community members to remain active in the group and to benefit from accessing cheap financial services to support their small scale economic activities, and helped to sustain the work of the PACs at the same time. The project also focused on achieving legal registration of the PACs as community based organisations, enabling them to apply for funding in their own right.

## Involvement of health staff service provision in project activities

Full collaboration with health service provision was critical in improving services. There are some strong examples in the portfolio of civil society and health service provision working alongside each other to improve services, with mutual benefits in staff capacity building, trust, openness to new practices, and extension and greater depth of services.

For example, a project in Zambia addressing the TB/HIV pandemic, had strong collaboration between seven civil society organisations, and the health centres and management in the target areas, who worked together on community awareness-raising and content of information




### CSCF AND HIV/AIDS

From 2010-2015, the CSCF has supported 14 HIV/AIDS-focused projects, with a total value of £6.75 million. These projects have reached nearly four million men, women and children.

Nine of the CSCF HIV/AIDS projects were sole-purpose HIV/AIDS projects, working directly with people living with HIV/AIDS or those particularly vulnerable to the disease. Approaches included:

- Working in coalitions and through self-help groups to raise awareness with target communities for behaviour change and to reduce stigma.
- Capacity building of frontline government health workers.
- Advocacy to persuade local and national governments to improve or introduce pro-poor policies to enhance the quality of services.

A further five projects mainstreamed an HIV/AIDS component into work on other issues such as health, livelihoods or social inclusion. Target beneficiaries included farmers in Mozambique, ethnic San and their neighbours in Namibia, fishing communities in Uganda, as well as government officials and civil society partners. These projects used similar approaches to the HIV/AIDS-focused projects.

The achievements of these projects include:

- A demonstrated contribution to improving national and local policies and budget allocations to combat HIV/AIDS, TB and malaria.
- Widened access to higher quality services.
- Increased awareness and behaviour change, including safer sexual practices and stigma reduction.

materials. The project increased skills and capacities of the staff; generated mutual trust, and increased openness to adopt new practices. It also provided an advocacy entry point; the project secured a large new waiting area in a Kitwe Health centre, well ventilated and bright, helping to reduce transmission of TB between patients. This was supported and developed with clinic staff and funded by the government. In Katete (Eastern Province), the civil society organisation partner successfully advocated to increase the number of clinic staff from 1 to 3.

**CASE STUDY 1.** BEST PRACTICE

A project working to improve palliative care for children in India and Malawi, partnered with the Palliative Care Association of Malawi (PACAM) and the Indian Association of Palliative Care (IAPC) who were already active on palliative care and well networked. It partnered with two key hospitals who were able to demonstrate best practice to other hospitals and lower levels of health care provision. It carried out national-level advocacy with ministers and other decision-makers, involving HIV+ children and those with other life-limiting illnesses, advocating directly for improvements in services. The final evaluation of the project found this to be a deciding factor in changing the guidance on pain relief for children nationally and making pain relief more available.

**CASE STUDY 2.** INTENSIVE ADVOCACY

In a multi-country project working in six African countries to improve access to pain relieving drugs for people with HIV/AIDS, numerous sensitisation meetings were carried out throughout the duration of the project, targeting policy-level leadership including the Ministry of Health, drugs regulatory authorities and HIV/AIDS councils. This advocacy involved people living with HIV/AIDS and was a significant influence on decision-making. It resulted in palliative care being integrated into all six countries' national health and HIV/AIDS strategies, and palliative care drugs being included on all countries' essential drugs lists.

## ACHIEVING POLICY CHANGE

It has been challenging to achieve policy change to support HIV/AIDS in the lifetime of a CSCF project (3-5 years). Where it has been achieved, some key success factors can be found:

- Working with an active advocacy network or lobbying association in the target country with specific experience in the issues being addressed.
- Demonstrating best practice as an advocacy tool to show policy decision-makers and health managers the positive impacts of a particular approach. (For an example of a project that showed success in this area, see Case Study 1.)
- Involving people living with HIV/AIDS, either the individuals or their carers, in advocacy for improved services, particularly at a high level, can be effective in engendering change.
- Some projects underestimated the amount of engagement required with decision-makers. Intensive advocacy at national level (or regional if that is where policy change is sought) throughout the period of the project, in order to raise the awareness of national policy makers, is essential to creating an environment where change to policies can be agreed. (See Case Study 2.)
- Organisations who have been working in a target location before CSCF funding had a longer time to build awareness and relationships with decision-makers and therefore tended to be more likely to achieve policy change within the 3-5 year project time period.

**REFERENCES**

Triple Line and Crown Agents, 2014, HIV/AIDS policy brief, Civil Society Challenge Fund and Global Poverty Action Fund projects

**Photos (front cover and inside)**

Health Poverty Action, Health education, access, and rights for the San (HEARTS)

**This report was prepared by Triple Line Consulting in joint venture with Crown Agents. Any views within are not necessarily held by DFID.**

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The CSCF has been managed by Triple Line and Crown Agents from 2010-2015.

This paper looks at the learning and achievment of 14 HIV/AIDS-focused projects funded by the CSCF.