

A Faith-Based Response to HIV in Southern Africa: the *Choose to Care* Initiative

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Abbreviations and acronyms*

AIDS	Acquired immunodeficiency syndrome
ARV	Antiretroviral (drug)
CMMB	Catholic Medical Mission Board
HBC	Home-based care
HIV	Human immunodeficiency virus
SACBC	Southern African Catholic Bishops' Conference
OVC	Orphans and vulnerable children
PEPFAR	President's Emergency Plan for AIDS Relief

* UNAIDS' preferred style is to spell out in full abbreviations and acronyms. In this document abbreviations and acronyms have not been expanded when they are included in direct quotations; they are found also in lists.

Introduction

In any country or region an effective response to HIV requires the participation of the widest possible range of partners working together. Faith-based organizations, which often are active in even the smallest and most remote of communities as well as large urban centres, are uniquely well placed to reach people to provide a range of services to those in need.

Faith-based organizations in Africa were on the ‘front lines’ as soon as the epidemic became known there. Although some religious leaders and their followers were reticent to deal with a problem that required reflection and discussion on such uncomfortable topics as sexual activity outside marriage and injecting drug use, many others responded immediately to the imperative to care and to educate the human family on ways to prevent the further spread of HIV. Although some religious leaders and their followers condemned those living with the virus, many others mounted a non-judgmental compassionate response without questioning how those seeking their help became infected with the virus.

Today faith-based organizations, both on their own and in partnership with others, play a vital and expanding role in the comprehensive response to HIV: empowering people to avoid risk of exposure to HIV, providing physical and spiritual care to those infected and affected and combating stigmatization and discrimination.

This study describes the work of the *Choose to Care* initiative of the Catholic Church in Southern Africa which began in 2000. It shows that effective scaling-up of programmes in the response to HIV does not necessarily have to be the expansion of a single central service. Working through the diocesan and parish system, coordinated by the AIDS Office Southern African Catholic Bishops’ Conference, and originally funded by the Catholic Mission Medical Board and other Catholic funding agencies, the Catholic Church scaled up service provision by the replication of smaller scale programmes rooted in and responsive to the needs expressed by local communities in this five-country area. This study shows that such an approach is effective when undertaken within common guidelines and given central support.

Personal testimony of both programme professionals and volunteers, and people living with and affected by HIV as well as objective evaluations by experts in academic institutions in the region, show that *Choose to Care* initiatives are valued both for their compassion and their practical effectiveness. It is a testimony to the strength of the initiative that many of the programmes inaugurated are continuing and are sustained by new sources of support after the initial five-year development period.

Overview of HIV in Southern Africa

*Good News: "... that they may have life and have it to the full."*¹

**AIDS is so limited
It cannot cripple love
It cannot shatter hope
It cannot corrode faith
It cannot take away peace
It cannot kill friendship
It cannot silence courage
It cannot invade the soul
It cannot reduce eternal life
It cannot quench the spirit
Our greatest enemy is not disease
But despair²**

In its update report released in June 2006 to coincide with the United Nations General Assembly High Level Meeting on AIDS³, UNAIDS made the following observations concerning the evolution of the epidemic in Southern Africa.

- An estimated 930 000 [range 790 000–1.1 million] adults and children died of AIDS-related illnesses in Southern Africa in 2005—one third of all AIDS-related deaths globally.
- **South Africa's** HIV epidemic—one of the most intense in the world—shows no evidence of a decline. Based on its extensive antenatal clinic surveillance system, as well as national surveys of HIV testing, and mortality data from its civil registration system, an estimated 5.5 million [4.9 million–6.1 million] people were living with HIV in 2005. An estimated 18.8% [16.8%–20.7%] of adults (15–49 years) were living with HIV in 2005.
- There are no clear signs of declining HIV prevalence elsewhere in Southern Africa—including in **Botswana, Namibia and Swaziland**, where exceptionally high numbers of new infections continue to be observed.
 - In **Swaziland**, national adult HIV prevalence is estimated at 33.4% [21.2%–45.3%]; prevalence among pregnant women attending antenatal clinics rose from 4% in 1992 to 43% in 2004 (Ministry of Health and Social Welfare Swaziland, 2005).
 - **Botswana's** epidemic is equally serious, with national adult HIV prevalence estimated at 24.1% [23.0%–32.0%] in 2005.
 - **Lesotho's** epidemic seems to be relatively stable at very high levels, with an estimated national adult HIV prevalence of 23.2% [21.9%–24.7%].

¹ John 10:10

² From *African Women, HIV/AIDS and Faith Communities*, ed. Isabel Apawo Phiri et al., Pietermaritzburg: Cluster Publications, 2005.

³ 2006 Report on the Global AIDS Epidemic, UNAIDS, June 2006.

- In parts of sparsely populated **Namibia**, the epidemic is as intense as in some of its neighbours, with HIV prevalence estimated at 19.6% [8.6%–31.7%] among adults nationally.

Dr. Des Martin, of the South African HIV Clinicians Society and the University of Pretoria, offered the following concise but compelling description of the epidemic in this country.

‘South Africa is host to a burgeoning HIV epidemic of catastrophic proportions. The country has the dubious honour of having the most HIV-infected individuals in the world. The roots of the epidemic are complex and lie within a web that embraces poverty, lack of empowerment of women, gender violence and the legacy of the apartheid era. This has led to migrant workers, single-sex hostels and fragmentation of the normal family structures that would be protective in this epidemic. The epidemic in South Africa has further been fuelled by the inaction of both past and present governments and has spawned a society that has discriminated against and stigmatized those who suffer from the disease. The impact of this epidemic on various segments of society may well be disastrous. Is it too late?’⁴

The two organizations of this study

Catholic Medical Mission Board

The Catholic Medical Mission Board (CMMB) has been described as “a global leader in international health care”. It supports capacity-building in existing community-based organizations, faith-based hospitals and dispensaries, and churches, to address urgent health-related issues. The Catholic Medical Mission Board operates as a technical partner by replicating viable treatment, care and prevention projects and by building local and national monitoring capacity. The Board also assists partners to deliver health education at national, provincial, and local levels. Finally, the Board collaborates with local and national organizations to reduce stigma and improve care and support for those living with HIV.

In 2003, the Catholic Medical Mission Board celebrated the 75th anniversary of its founding; at that time, it reported, as its primary concern and focus, “strengthening [the] health of vulnerable children and women.” The Board bases its programmes on national priorities and guidelines and maintains its activities within World Health Organization protocols. The Board collaborates with some 350 faith-based organizations in 100 countries of the world⁵.

The Southern African Catholic Bishops’ Conference (SACBC) AIDS Office

The Southern African Catholic Bishops’ Conference (SACBC) AIDS Office coordinates the Catholic Church’s response to AIDS in South Africa, Botswana and Swaziland (the three countries constituting the territory of the Conference). In addition its work extends to Lesotho and Namibia, through supplementary agreements with the Bishops’ Conferences of those countries.⁶ For many years, the Catholic Church in Southern Africa was involved in locally-based HIV responses, such as education, home-based care and hospice programmes.

⁴ Des Martin, “Perspectives on HIV Medical Care in South Africa,” in *Health Care in Rural South Africa: An Innovative Approach*, ed. by Adri Vermeer and Hugo Tempelman, Amsterdam, VU University Press, 2006, p. 26.

⁵ “CMMB as a Catalyst for a Faith-based Response to HIV/AIDS”, by Jack Galbraith, President and CEO, and Dr. Rabia Mathai, DrPH, MPH, MS, PhD, Global Director of Programs, presentation given at Catholic AIDS Funding Network Group Meeting on ARV Programming, April 2003.

⁶ See Appendix A for a more detailed description of the area served by the SACBC AIDS Office.

Such a widespread and diverse response, however, lacked coordination and central direction. In 1999, meetings were held among the nationally-based, church-related agencies that were most involved—the Catholic Institute of Education (CIE), the Catholic Health Care Agency (CATHCA) and the Development and Welfare Agency (DWA—now known as Siyabhabha Trust), all of which identified AIDS as the single most important issue facing society in Southern Africa. This resulted in the formation of the Southern African Catholic Bishops' Conference AIDS Office in January 2000, with one member of staff and an operating budget of less than US\$ 10 000.

When they established the Southern African Catholic Bishops' Conference AIDS Office, the Catholic bishops of Southern Africa identified as their goal the provision of assistance to the Church in the region to:

- coordinate AIDS response in the region;
- raise funds for Diocesan and local projects⁷;
- facilitate training and exchange possibilities;
- scale up existing programmes;
- establish new programmes in poorly resourced areas;
- provide monitoring and evaluation support;
- facilitate the sharing of best practice models for prevention and care;
- respond to the needs of persons living with AIDS and their families;
- address the increasing needs of orphans and vulnerable children; and
- do advocacy, especially in the areas of access to treatment, children's issues, budget reform⁸.

In 1999, as Bristol-Myers Squibb was considering its potential philanthropic responses to the HIV pandemic, the United Nations Secretary-General, Kofi Annan, asked the company to take a leadership role in bringing assistance to those living with HIV in Africa. Thus Bristol-Myers Squibb and the Bristol-Myers Squibb Foundation, joined forces and significant resources with partners in Africa and with the global organizations responding to the pandemic to establish *Secure the Future*. Initially, Bristol-Myers Squibb and the Bristol-Myers Squibb Foundation committed US\$ 100 million over a five-year period to provide care and support for women and children living with and affected by HIV in sub-Saharan Africa. The company then set out to deliver on its *Secure the Future Pledge*. Over the years, the programme grew in size and scope to support some 200 individual programmes through a commitment totalling US\$ 150 million.

In 2000, the Catholic Medical Mission Board and the Southern African Catholic Bishops' Conference AIDS Office entered into a co-funding agreement with *Secure the Future* in order to launch *Choose to Care* and thus to increase the capacity of community-based projects responding to HIV in Southern Africa. According to the agreement, projects meeting the requirements of both Bristol-Myers Squibb and the Catholic Medical Mission Board were referred to the Bristol-Myers Squibb technical advisory committee for approval. If selected, they were co-funded by Bristol-Myers Squibb and the Southern African Catholic Bishops' Conference/Catholic Medical Mission Board. In addition, the Board pledged additional funds (50% of the total funding made available under *Choose to Care*) in order to support other projects that were reviewed and approved by the Southern African Catholic Bishops' Conference AIDS Office.

⁷ See Appendix D for listing of funding criteria utilized by the SACBC AIDS office.

⁸ As listed in published report entitled, *Evaluation of CMMB/SACBC HIV/AIDS Projects 2003*, p. 14.

During the intervening years, the work and reach of the Conference AIDS Office has grown exponentially. As of August 2006, the office reported employing fourteen staff members and coordinating outreach to thousands of those living with or otherwise affected by HIV by means of a vast network of staff and volunteers working in local projects. This outreach is made available to all those in need irrespective of national, ethnic identity or religious affiliation. Now recognized as a leading player in the Southern African response to AIDS, the Southern African Catholic Bishops' Conference AIDS Office also has succeeded in promoting strong partnerships among faith-based and community-based organizations, private industry, government offices, and academic institutions.

"Since 2000 the SACBC AIDS Office has co-ordinated the response of the Catholic Church to AIDS in South Africa, Swaziland and Botswana, strengthening and building on existing programmes, and helping to initiate new ones. The Continuum of Care in most of the programmes and projects linked to the SACBC has seen commitment to prevention, care and support to people infected and affected by AIDS."

Mr. Johan Viljoen, Programme Manager of Choose to Care Project, in a presentation at Second South African AIDS Conference, Durban, 7-10 June 2005

Choose to Care

In 1999, Bristol-Myers Squibb launched *Secure the Future*—a five-year programme through which US\$ 100 million was committed to respond to AIDS in five Southern African countries (South Africa, Namibia, Swaziland, Botswana and Lesotho), the same countries that are served by the AIDS Office). In February 2000, the Catholic Medical Mission Board established a partnership with the Southern African Catholic Bishops' Conference AIDS Office and the two latter organizations entered into a co-funding agreement with Bristol-Myers Squibb in order to make available financial resources and technical assistance to the Conference AIDS Office. This new initiative, which would promote the development and long-term sustainability of HIV prevention education, care, and support in Southern Africa, was called *Choose to Care* and was described as follows⁹.

'The *Choose to Care* initiative—a five-year, US\$ 5 million commitment to fight HIV/AIDS in South Africa, Namibia, Swaziland, Botswana and Lesotho—is our response to Southern Africa's overwhelming needs. Since February 2000, *Choose to Care* has helped build the capacity of more than 140 community-based organizations focused on care of the dying, orphan care and placement and HIV/AIDS education. To date [according to this 2003 report], *Choose to Care* has provided medical, psychosocial and educational support to more than 144 000 patients and orphans.'

Choose to Care now reaches 98% of South Africa's Catholic dioceses with HIV education or home-based care programmes. Because of *Choose to Care*, 45 schools in eight of South Africa's nine provinces have integrated HIV education into their standard curricula. The Catholic Medical Mission Board's activities throughout Southern Africa are carried out in collaboration with the Southern African Catholic Bishops' Conference.

⁹ http://www.cmmb.org/What/choose_to_care.htm; see also Appendix B for Complete listing of *Choose to Care* Projects and Appendix C for complete statistics related to South Africa alone, for the period 2002-2004.

Since the cosponsored *Choose to Care* initiative officially concluded in 2005, the Southern African Catholic Bishops' Conference AIDS Office, together with its various partners at diocesan, parish, and organizational levels, has successfully identified additional funding and sources of technical assistance in order to maintain and expand its programming. Funding has been obtained from parishes, dioceses, foundations, and generous individuals and families within and outside Southern Africa; from international Catholic donor and partnership organizations; from the Government of South Africa at provincial and local levels; and from government assistance programmes, including the President's Emergency Plan for AIDS Relief (PEPFAR).

Values underlying the *Choose to Care* initiative and their expression in day-to-day action

In establishing the *Choose to Care* partnership, both the Catholic Medical Mission Board and the Southern African Catholic Bishops' Conference were operating within their framework of Catholic Church-related identity. The values underlying their collaboration, however, could easily be recognised as similar to those that motivate many other faith-based organizations and that equip faith-based organizations to work so tirelessly, efficiently, and effectively in the response to the HIV pandemic at global, regional, national, and local levels. In a later section of this study some factors that are common to the responses of faith-based organizations to HIV are examined as well as some of the challenges faced by such organizations as they attempt to scale up that response. In this section the specific motivation and values articulated by the Catholic Medical Mission Board and the Southern African Catholic Bishops' Conference with regard to their establishment of the *Choose to Care* initiative are focused on.

The Catholic Medical Mission Board states its vision as “A world in which every human life is valued and quality healthcare is available to all” and its mission as follows.

‘Founded in 1928 and rooted in the healing ministry of Jesus, Catholic Medical Mission Board works collaboratively to provide quality healthcare programmes and services, without discrimination, to people in need around the world.’

The Southern African Catholic Bishops' Conference AIDS Office articulates its links and grounding in the Catholic Church in unambiguous fashion. Clearly, the programmes associated with this Office, as well as those who support them, would insist on fulfilment of the same standards of professional excellence, fiscal transparency, and careful accountability to government authorities, donors, and the people being served, that are demanded of other organizations in this field. However, the Bishops' Conference AIDS Office and its partner organizations also see something unique about their “Catholic identity”. In reporting on an independent evaluation of Southern African Catholic Bishops' Conference HIV projects conducted in 2002, Fr. Stuart Bate asserted that 14 of 66 respondents to his questionnaire “emphasized that the Church was not a nongovernmental organization providing a service for people but rather that the Church **was** the people: those Christians involved in the project and ready to respond to the needs of those suffering in that place.¹⁰”

In another evaluation report, Dr. Maretha de Waal noted:

‘Faith plays an important role in the lives of many of the programme staff. Personal belief systems drive and sustain individuals and teams, without dominating the treatment care programme: “*They say: Feed him. Clothe him. Heal him. And when he asks why? Then you say: Jesus. That’s the difference.*” [Quote from interview with programme staff person].¹¹

Bishop Kevin Dowling, of Rustenburg, South Africa, and former chairperson of the Southern African Catholic Bishops' Conference AIDS Office Committee, presents the vision of these efforts eloquently.

¹⁰ Stuart Bate, D.Theol. “Catholic Pastoral care as a response to the HIV/AIDS pandemic in Southern Africa”, St. Augustine College (Catholic University of South Africa), p. 16.

¹¹ Dr. Maretha de Waal, University of Pretoria, *Turning of the Tide: A Qualitative Study of SACBC Funded Antiretroviral Treatment Programmes*, January 2005, p. 25.

‘The Church views the HIV/AIDS pandemic as a call from God to a response which is intimately linked to its mission in the world, a response which must be based on and reveal fundamental Gospel attitudes/values, such as compassion, solidarity, care for the vulnerable, striving for justice and commitment to overcoming unjust structures in society.¹²’

He then described the practical actions that should flow from such a vision.

‘We stand with, we want to be with the little ones, the people who do not count, who will never be listened to because they are not given access to anything or any structure; those who are lost in some outlying rural community or urban slum which will rarely, if ever, be visited by anyone; the little ones who end up simply being a number, a statistic whether it be in terms of the escalating infection rate or in terms of the escalating numbers of dead in the mortuaries awaiting a pauper’s funeral, sometimes for months on end because families cannot be traced. We want to be with the poorest and alienated communities, to be present to and involved with them in their reality.¹³’

“Those who come from outside the culture have to be very careful not merely to impose the solutions that seem sensible to them. The diverse mix of projects that have emerged in the Catholic AIDS effort seems to reflect some cooperation with local views. Western institutional approaches can be very powerful in dealing with urgent medical, material and some psychological needs. But the community based projects, which may respond more directly to the cultural concerns of the people on the ground, are essential to respond to a situation as prevalent as HIV/AIDS in Southern Africa.”

Stuart Bate, “Catholic Pastoral care as a response to the HIV/AIDS pandemic in Southern Africa”, St. Augustine College (Catholic University of South Africa), p. 21.

Sr. Alison Munro, O.P., Director of the Southern African Catholic Bishops’ Conference AIDS Office, detailed, as follows, the key stakeholders of this office and of its affiliated partners and activities.

‘Commitment to the response of the Catholic Church to AIDS comes from all levels. Bishops who take a “hands-on” approach inspire the laity to take seriously the call to serve God in their brothers and sisters. When clergy, as gatekeepers, open the gates to various initiatives of their parishioners, much good work ensues. Even when clergy are obstacles to various ventures, many of the laity find innovative ways to offer their own response as local church. The commitment and involvement of religious sisters and retired nursing professionals is often the inspiration behind the response of other women whose sheer generosity is the backbone of the Church’s response to the pandemic. What is emerging clearly in many areas throughout the region is that people are taking seriously the call of the gospel to love their neighbour in need.¹⁴’

¹² Bishop Kevin Dowling, in Foreword to *Joint Southern African Catholic Bishops’ Conference and Catholic Relief Services HIV/AIDS Assessment*, South Africa, September 2000, p.iv.

¹³ *Ibid.*, p.v.

¹⁴ Sr. Alison Munro, OP, Southern African Catholic Bishops’ Conference AIDS Office, Pretoria, South Africa, unpublished document, 2003, p. 1.

"Being treated with dignity, reverence, acceptance, etc., can't but talk to the depth of a person...and that brings about untold transformation, a sense of worth, self-respect. It does not stop there but ripples on. The other values then just follow."

Sr. Emanuel Nyeka, of Holy Cross Home, response to questionnaire designed by Rev. Robert J. Vitillo, May 2006.



Staff and visitors at Botshabelo

Programmes developed as a result of the *Choose to Care* initiative

In a progress report on *Choose to Care*, Bishop Dowling reported that those working under the banner of the Bishops' Conference AIDS Office had identified and implemented action on the following priorities.

- Community-based care for the sick and dying, and care for orphans, as immediate and urgent needs. This...include[s] counselling, home-based care and other support initiatives, including hospices where the need is clear, which involve and capacitate people and communities to respond creatively and in a sustainable way to their actual situation and needs through basic care programmes.
- Holistic and value-based awareness and prevention campaigns, particularly among young people and young adults, with the primary focus on peer ministry and activity within communities. The main aims of which are:
 - to develop attitudes and commitment which will promote personal responsibility for self and others in terms of behaviour choices, especially concerning sexual behaviour;
 - [to discourage]...irresponsibility [and to alert people to] the danger and the social cost of having multiple sexual partners;
 - to make people aware of factors such as the unequal power relationship between genders and to discourage behaviour choices that can reinforce gender inequality and dehumanize both men and women instead of recognizing, promoting, and enhancing their equal dignity;
 - to develop education/awareness and conscientisation programmes that can address the issues of "silence" and "stigma", and deal with all the cultural issues/dimensions with sensitivity;
 - to encourage the development of enlightened and caring communities to respond to the need to care for orphans and those who are alienated because they are infected;
 - to focus, in the medium to longer term, on economic uplifting/ transformation and job creation; and
 - to diminish and, in the long-term, eradicate the poverty that is so intrinsically connected to the spread of HIV.

“Some projects started by dealing with the sick, and have now realized they have to deal with orphans as well, others have realized that they have to include prevention education, if they are to make any difference.”

Interview with representative of Catholic Health Care Association (CATHCA) in), in Evaluation of CMMB/SACBC HIV/AIDS Projects 2003, The Department of Sociology, University of Pretoria, p. 17.

Bishop Dowling concluded this list of priorities with the following observation, “This has to do with the promotion of values, the deeper, spiritual level of human living and interaction, and the motivation required for persevering commitment to action.¹⁵”

¹⁵ Bishop Kevin Dowling, in Foreword to *Joint Southern African Catholic Bishops’ Conference and Catholic Relief Services HIV/AIDS Assessment*, South Africa, September 2000, p. v.

The *Choose to Care* Initiative in action: prevention, care, treatment and services for orphans and vulnerable children

Major expressions of HIV education and service that were developed as a result of the *Choose to Care* initiative¹⁶, included those focused on:

- prevention
- care
- treatment
- services for orphans and other vulnerable children
- advocacy
- capacity building
- interfaith involvement
- theological reflection.

Prevention

In view of the fact that some 50% of new HIV infections worldwide are found among the 15–24-year-old age group, the Southern African Catholic Bishops' Conference recognized in the earliest stages of *Choose to Care* that, if the pandemic were to be turned around, life skills and prevention programmes with young people would need to be key activities.

Moreover, the Conference noted the following sociopolitical and economic factors that made young people in Southern Africa particularly vulnerable to exposure to HIV.

- Migrant labour and forced removals under *apartheid* tore apart the fabric of family life in black communities.
- Years of student front-line militancy and revolt against the apartheid regime led to the collapse of parental authority.
- Extreme poverty impels many young women to attempt income generation through sex work.¹⁷
- The vulnerability of teenagers is exponentially increased by the rise in child-headed households—a direct result of parents dying in large numbers from AIDS-related illnesses.¹⁸
- Everywhere youth are bombarded with the message that it is fine to have sex, as long as they do it “safely”.

As one of the social institutions in this zone respected for its moral influence and authority, the Catholic Church felt the need to “step into the fray”. A number of programmes for youth were implemented at that time and continue into present time. *Education for*

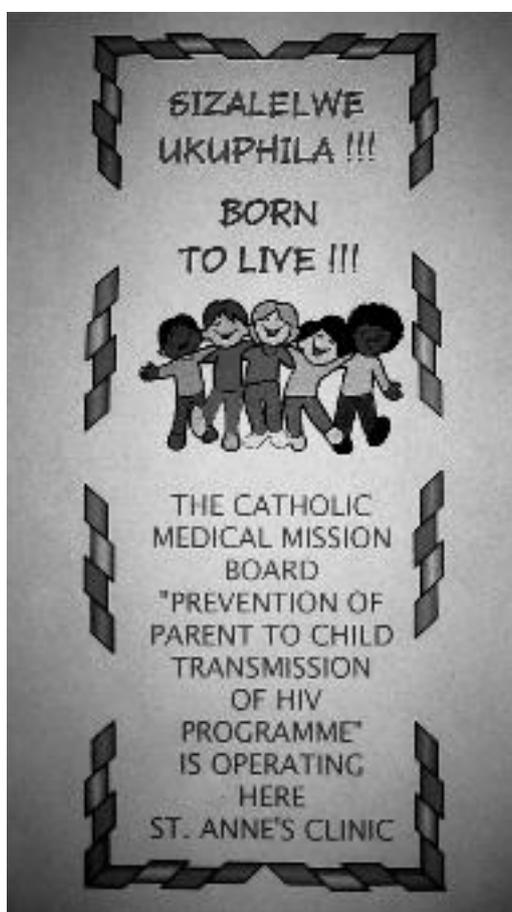
¹⁶ Excerpted and Adapted from “CMMB and SACBC: A Partnership for Progress, February 2000 to November 2003,” by Sr. Alison Munro, OP, SACBC; Mr. Johan Viljoen, SACBC; and Terrence Brennan, Global Peers USA.

¹⁷ The SACBC AIDS office conveyed reports made by Catholic religious sisters working in communities that are on major trucking routes, such as Middelburg and Nelspruit, that the families of young girls often send them to truck stops to sleep with truck drivers, sometimes in exchange for as little as a packet of frozen fish, *Ibid.*

¹⁸ Again, the SACBC AIDS office reports that, in northern KwaZulu-Natal, thirteen year old girls sell home brewed liquor to get money to feed their younger siblings. From there, sex work is but a short step away, *Ibid.*

Life was adopted by the full plenary meeting of the Southern African Catholic Bishops' Conference as the chief prevention programme among youth. Originally developed in Uganda, and anecdotally credited with playing a significant role in reducing the rate of new infections in that country, it stresses long-term abstinence and life-long and mutual fidelity among marital spouses. The various dioceses of the Southern African Catholic Bishops' Conference territory have been divided into clusters of three. In every cluster, intensive training of trainers and follow up refresher courses take place. The momentum is maintained through the establishment of *Youth Alive* clubs in every place.

The *ABCD* programme was designed by the Association of Catholic Tertiary Students and Chiro, with the support of the Southern African Catholic Bishops' Conference Youth Desk. It stands for "Abstain, Be faithful, Change your lifestyle, or you are in Danger of contracting AIDS." *Love Waits* and *Love Matters* are two other programmes being implemented in this area. In Namibia, Catholic AIDS Action uses the *Stepping Stones* programme.



At St. Mary's Hospital in Mariannhill, more than 3000 babies and their mothers have benefited from the Born To Live programme, which reports a success rate of 94% in preventing mother-to-child transmission.¹⁹

The Catholic Institute of Education (CIE) has access to about 400 Catholic schools in South Africa. It conducts life-skills programmes in all of these, as well as the training of teachers. It recently published a manual, *Courage to Care*, which has already been adopted as a text book by the University of the North in Limpopo Province.

Prevention also includes the use of antiretroviral medications to reduce the risk of transmission from HIV-positive mothers to their children, especially during the birth process. The Catholic Medical Mission Board helped to establish prevention of mother-to-child transmission (PMTCT) programmes at selected sites in KwaZulu-Natal, as well as North West Province. In most instances, these Catholic Church-based prevention of mother-to-child transmission programmes were established before those of the government.

Care

It might be said that the Catholic Church has made its most significant response to the HIV epidemic through its services to care for the sick and dying. In Southern Africa, this caring network has grown to include more than 40 home-based care programmes in all parts of South Africa. Some of these (such as the *Caring Network* in Cape Town) already were in existence for many years and, in fact, were founded to care for cancer and other bedridden patients. With the onset of the HIV epidemic, they were adapted to new needs and, at present, focus almost exclusively on caring for people living

¹⁹ Information Sheet on "Specific HIV/AIDS Treatment and Care Programme" produced by St. Mary's Hospital, Mariannhill.

with HIV. *Caring Network* alone has more than 100 caregivers, each one looking after five patients in the poorest areas of the city.

Others, such as *Zanethemba* in Newcastle, have been in existence for a shorter period of time but already provide such good services and have so much credibility that the local state hospitals have entered into partnership with them by providing continued training and medications and referring patients to them. In densely populated areas, such as Winterveld, outside Pretoria, the local Catholic clinics (Sisters of Mercy, St Peter's, Good Shepherd and St John the Baptist) have joined forces by dividing the area on a geographic basis in order to ensure that every patient is reached. In sparsely populated, desert areas, such as the Karoo, *Good Shepherd Hospice*, the only care provider in the entire area, provides care to patients in nine far-flung villages within a radius of almost 300 kilometres. Models such as these have been adapted to suit local conditions in every area.

Some home-based care projects e.g. *Thembaletu*, near Malelane, are entirely community-based. Some, e.g. *St Francis Care Centre*, in Boksburg, are linked to clinics or hospices. Others, such as *Malusi Omuhle*, in Hlabisa, where the ladies of the Sacred Heart Sodality had themselves trained by the matron of the local hospital, were started with a more limited, church-based focus but now are caring for their sick neighbours throughout the area, without regard to their faith affiliation or lack thereof.

The Catholic Church in South Africa has been very active in sponsorship of training programmes. This pattern has been carried forward into its home-based care programmes, and is recognized by the State and by institutions of tertiary education. For example, Durban-based *Sinosizo* is used by the health authorities as the 'master trainer' in the province of KwaZulu-Natal. Moreover, completion of training in caregiving, when provided by the *Holy Cross Sisters*, receives credits when candidates register at nursing colleges.

The importance of ensuring good nutrition in caring for HIV patients is beyond dispute. This becomes particularly critical in situations of extreme destitution. Most Bishops' Conference-supported home-based care programmes are responding creatively to this challenge. In King Williams Town, *Empilisweni* has started successful pig- and chicken-farming cooperatives for people living with or affected by HIV. At *St Francis Hospice*, in Port Elizabeth, people previously compelled to scratch around on the municipal rubbish dump for something to eat now are assisted to start vegetable gardens and to use the same refuse as fertilizers.

Treatment

Through its many home-based care and hospice programmes, as well as its clinics, the Catholic Church in Southern Africa provides treatment for HIV-related opportunistic infections. This is often done in partnership with government health structures. Catholic hospices, for example, that look after people living with HIV suffering from tuberculosis, access TB treatment for them from the nearest government facility.

Services for Orphans and Vulnerable Children

"I have the case of five children whose parents died 18 months apart. First it was the father then the mother. Both died of AIDS. The children did not know what had killed their parents. There are four girls and one boy. The eldest girl was 16 years when she became a guardian of her siblings. She now heads a sibling family and had to provide for their needs with support from the local Council and good hearted people. Today this girl is pregnant and is HIV positive. Her two younger sisters are also pregnant and positive from the so-called "good Samaritans" who helped them with food and basic needs."

Bishop Frank Nubuasah, SVD, Bishop of Francistown, Botswana, in a talk "The Church's Response to AIDS in Southern Africa", given at The Hague, May 2004.

The strong involvement of Bishops' Conference-affiliated programmes in home-based care almost inevitably resulted in a similarly strong commitment to care for orphans. Since orphans frequently have no one to care for them after the death of their parents, home-based care programmes have found it necessary to expand their focus to include the needs of such surviving children. In addition, there are more than 20 Catholic Church-sponsored programmes in the region that care exclusively for orphans. Since a significant number of orphans living with HIV are shunned by their relatives and communities, programmes e.g. *Nazareth House* have stepped into this void by providing excellent care.

In this regard, there are a number of successful models, oriented according to local needs.

- Day care shelters that provide food, medical care and education to orphans who otherwise are looked after by grandparents or elder relatives. Examples are *Tirisanyo*, in Gaborone, Botswana and *Tumelong* in Winterveld.
- Although the ideal is to keep children in their communities, it is not always possible. In some cases, they are ostracized by neighbours and even by relatives and simply cannot count on anyone to look after them in their local communities. Thus institutional care, while not ideal, becomes a necessity. Catholic programmes such as *Nazareth House*, in both Cape Town and Johannesburg, are famous worldwide for the quality of care they provide.
- In many places, the South African Bishops' Conference-related programmes sponsor feeding schemes where orphans can access at least one nutritious meal per day after school. *Sizanani*, near Bronkhorstspuit, for example, provides sustenance to several hundred children.
- Where children prefer to stay with elder siblings, the church-related programmes assist such child-headed households. *Thembaletu (Malelane)* has a network of more than one hundred monitors and care-givers who visit the children daily and ensure provision for their health, nutrition and clothing needs.
- In rural areas, where traditional family structures remain strong, orphans are placed in traditional homesteads. These homesteads then are strengthened financially (mainly through agricultural development), to care for the increased number of children. *Orphanaid Swaziland* has pioneered this model of orphan care.

- In urban areas, the focus has often been on recreating a family setting. Six or seven orphans are placed in a house with an adult “mother” or “father” to look after them. *St Philomena’s* in Durban and *Nazareth House* in Cape Town are two examples of institutions that are implementing this model with great success.
- The ultimate goal of some programmes is the placement of these children in adoption or, at a minimum, in long-term foster care. *The Love of Christ Ministries*, in Johannesburg, has succeeded in arranging such placements for more than 200 abandoned orphans. A programme that merits particular recognition is *Bethany House*, in Umtata, which, contrary to popular expectations, has been quite successful in placing orphans living with HIV with adoptive families, including some who themselves live in poverty and in rural, isolated areas.
- Orphans also are assisted with scholarships and other means to enable them to stay in school. A religious sister in Gingindlovu, Kwa Zulu Natal, presently helps many such children to continue their education.

“There is apathy among these children. They have no sense of the future, especially among teenagers; Children feel lost and angry; some resort to alcohol and drugs because of frustration...You ask them what they want and they tell you straight that relatives ‘don’t want me so I don’t know what to do’; The psychological effects are great, even for those children who seem to lead a normal life.”

Interviews with project participants, as reported by Tessa Marcus, “To Live a Decent Life: Bridging the Gaps,” in Health Care in Rural South Africa: An Innovative Approach, ed. by Adri Vermeer and Hugo Tempelman, Amsterdam, VU University Press, 2006, p. 238.

The following objectives were defined by participants in Southern African Bishops’ Conference programmes serving orphans and vulnerable children²⁰.

- To bring life to these children so that they can live like other children.
- To make the lives of orphans and vulnerable children a fulfilling and enjoyable experience.
- To rescue abandoned babies, giving them a quality of life, and finding adoptive parents.
- To alleviate hunger and the need for care.
- To look after the well-being of the whole child—spiritually, emotionally, and psycho-socially.
- To restore children’s dignity, humanity, and trust and help them continue their education.
- To remove the focus on death and help children turn to life.



Children at Hlabisa

Staff and volunteers in these programmes recognise the necessity of forming an active partnership with the children whose lives are so deeply affected by HIV. They refuse to treat the children as passive objects of bureaucratic mechanisms or

²⁰ Tessa Marcus, “To Live a Decent Life: Bridging the Gaps,” in *Health Care in Rural South Africa: An Innovative Approach*, ed. by Adri Vermeer and Hugo Tempelman, Amsterdam, VU University Press, 2006, p. 240.

as statistics to be counted in order to receive additional funding. Thus, in a participatory action/reflection session convened by the Catholic Agency for Overseas Development, of the United Kingdom, representatives of Bishops' Conference-supported services for orphans and vulnerable children identified the following *Guiding Principles for Sourcing Information and Identifying Concerns and Needs of Children*.

- Child participation is vital. It requires a safe environment, trust built over time and relationships managed appropriately and carefully for children to have equal participation with adults.
- Be aware of your biases and power and the implications of these. Ask open-ended questions and be open to the responses that come back.
- Ask what already exists and what is working. Map the wider human and natural resources already existing. This will help you see where your response can be complementary and reduce unnecessary duplication.
- Be aware of the power of words: rather than focus on the 'needs' of communities, consider the 'challenges' or 'concerns'.
- Use existing networks and activities to raise issues that concern you.
- When you carry out a situation analysis make sure you also think about its SWOT (strengths, weaknesses, opportunities and threats/challenges).
- Verify and check information carefully including with the children to whom you are trying to respond.
- Consult government sources and find out about accessibility and availability of services²¹.

²¹ Sinethemba – *We Have Hope*, A Reflection by CAFOD Partners in South Africa on Responding to Children Affected by HIV and AIDS, London: CAFOD, 2006, p. 21.

The *Choose to Care* initiative in action: advocacy, capacity building, theological reflection, and interfaith involvement

Advocacy

The Southern African Catholic Bishops' Conference AIDS Office prioritises advocacy for and with those living with and affected by HIV. In acknowledgement of its leadership in this field, this Office was asked to delegate its advocacy official as the *ex officio* representative of the faith sector on the executive committee of the Treatment Action Campaign. The Treatment Action Campaign had exerted pressure on the South African Government to start prevention of mother-to-child transmission programmes in all state ante-natal clinics. It also is leading the campaign to make antiretroviral treatment available to all who need it, through the government's health infrastructure.

Together with the Catholic Parliamentary Liaison Office and the Southern African Catholic Bishops' Conference Justice and Peace Department, the AIDS Office advocates for legal reform regarding various issues, particularly with regard to children's rights. These include maintenance grants and free education for orphans and disability grants for the sick.

The AIDS Office belongs to various advocacy networks in the region. Even after the establishment of national policies and legislation with regard to government grants and access to treatment, problems with access continue to be experienced at local government level, where these policies are supposed to be implemented. To deal with this, the Conference AIDS Office has taken its work down to the grassroots level, by implementing a vigorous advocacy training programme at diocesan level. Through this programme, people at community level are trained and empowered to lobby for better access to treatment, better access to government grants and other services. In various dioceses, programmes are also in place to assist those who qualify, to obtain the necessary documentation, and then to get grants.

The leadership of the Catholic Church in Southern Africa has not been silent on such advocacy issues. During their recent Plenary Assembly in August 2006, the bishops voiced deep concern for the situation of children made orphans by AIDS in the region. The bishops focused on the comprehensive needs experienced by such vulnerable children: "It is not only a question of funds...These orphans need not only food but also psychological and pastoral care, a healing process of the whole person." They noted the importance of training caregivers skilled in psychology and the social sciences. They complained about the delayed responses of political leaders, "At the political level there is a lot of talk but little action."²²

²² "Catholic Bishops of Southern Africa call for "more attention for psychological and spiritual treatment of AIDS orphans", Agenzia Fides, 05 September 2006.

"People get sick sooner because they are poor; they don't eat properly...we are lobbying the Department of Agriculture to get involved in establishing food gardens."

Interview with Gabriel Jama from Maskihulisane organization in KwaZulu- Natal, 2003.

"There's no point in doing 'traditional' clinic work—like dispensing medicine—if people have no food to take the medicine with. Thus the extra services came about."

Interview with Sr. Naomi of Good Shepherd Clinic, Winterveldt, 2003.

Both quotes appeared in Evaluation of CMMB/SACBC HIV/AIDS Projects 2003, The Department of Sociology, University of Pretoria, p. 17.

The bishops also challenged the stigma and discrimination that sometimes is generated internally within communities of faith. Thus in their January 2005 Plenary Session, they said:

*'The stigma of HIV and AIDS is often a great burden to families and caregivers, sometimes a greater burden than the person who is ill...Our service of the suffering humanity demands that we confront head on misconceptions around HIV/AIDS and destructive attitudes such as judgement and social stigma, fear of being labelled and ostracised...There is an increased need to focus on being Communities of Care. People infected and affected by HIV need to find comfort, support, information and care in our church communities.'*²³

Capacity Building

The Southern African Catholic Bishops' Conference AIDS Office has been aware of the need to build capacity among its affiliated programmes so that the latter could acquire skills and expertise in proposal and report writing and well as in fiscal management. Thus it has sponsored initiatives such as the following.

- Price Waterhouse Coopers (an international company of accountants) was engaged to facilitate a series of *organizational development and financial management workshops* for all affiliated projects. These were so successful that similar workshops are now held on a regular basis.
- The AIDS Office also offers regularly scheduled *Caring for the Carer* retreats.
- Together with the *National Religious Association for Social Development*, the AIDS Office sponsored a series of training workshops on *mobilising religious leaders* in response to AIDS as well as another series of workshops on *upgrading standards for home-based care*.
- Ongoing *formation of youth trainers* is held with various clusters of dioceses.
- Together with Siyabhabha Trust, the development agency of the Bishops' Conference, the AIDS Office works to *build capacity in parishes to care for orphans in their communities*.
- Before implementing antiretroviral programmes, the Bishops' Conference AIDS Office facilitates and coordinates training of medical doctors and professional nurses who are designated to engage in such services.

²³ Press Release by the Southern African Catholic Bishops' Conference, 30 January 2005.

Theological Reflection

In February 2003, the Conference AIDS Office, St Augustine College of South Africa and the Catholic Theological Society of South Africa hosted a theological conference entitled *Responsibility in a Time of AIDS*. The conference attempted to examine the theological underpinning of the faith-based response to HIV.

"If it weren't for the SACBC, I doubt we ever could have started in our own Diocesan HIV/AIDS Response. Our very first funding came through them and from there we are constantly expanding and growing our program. The SACBC communicates well with us and gives us opportunities to apply through them for funding for the various programmes in which we are involved. They keep us up-to-date with current trends and responses in the HIV/AIDS field and we look to them for guidance and advice in many instances."

Sr. Sally Duigan, FDNSC, Kurisanani, Diocese of Tzaneen HIV/AIDS Parish Based Response – in response to questionnaire designed by Rev. Robert J. Vitillo, May 2006

DEDICATION PRAYER FOR AIDS CAREGIVERS

WE BELIEVE that we are part of God's dream for the church and the world,
and that God is shaping us, as the potter shapes the clay,
into the kind of human and church community
that is the dream in God's heart.
We believe that God has called and chosen us
as the potter carefully chooses a lump of clay
to make what he has in mind.
We believe that when God sees that the church and the world
are not coming out right, not according to the divine dream,
God does not discard the clay and take another piece,
but re-works the same clay, shaping and moulding it
with firm but gentle hands, on the wheel of life.
We believe that God is shaping and reshaping us
through our response to the AIDS pandemic
to be like Jesus, the compassionate one,
as we continue the mission of Jesus in the world.

WE CONFESS that we sometimes become discouraged and disheartened
with the weight of people's suffering.
We confess that we sometimes grow weary
and forget that God is with us,
when we feel overwhelmed by the enormity of people's pain,
their grinding poverty, their desperation.
We confess that we sometimes forget

that God does provide and our needs will be met.
We confess that our faith in humanity is shaken
when people with AIDS feel abandoned and judged
and are treated as outcasts.

WE COMMIT OURSELVES TO:

being gentle with the crushed reed, the wavering flame,
so that the crushed reed will not be broken
nor the flickering flame quenched.
We commit ourselves to healing, helping and educating
so that the AIDS pandemic will be overcome in Southern Africa.
We will do what we can for the orphans,
and for others whose lives are bent or broken by AIDS.
We commit ourselves to shaping with gentle hands
the fragile and vulnerable clay which is each precious person
given to us. We will treat them
with the same loving patience we ourselves feel
in the hands of the divine potter.
We will open our ears to listen like disciples
as God leads us forward on the next part of the journey,
the journey we are on together.
And we will join hands as we continue along the way,
the way of salvation.²⁴

Interfaith Involvement

The Conference AIDS Office is represented on such international networks as the *World Conference on Religion and Peace (WCRP)*, and such national networks as the *National Religious Association for Social Development (NRASD)*, which serves as a working arm of the *National Religious Leaders Forum (NRLF)*.

Collaboration also extends to academic institutions. The Conference AIDS Office and Siyabhabha Trust worked together with the University of Pretoria Centre for the Study of AIDS in order to build capacity of nongovernmental organizations and community-based organizations in Limpopo Province, Mpumalanga and Gauteng.

The Director of the AIDS Office has served as the representative of the faith communities on the *South African National AIDS Council (SANAC)*. The AIDS Office also participated in the UNAIDS-hosted series of consultations to plan for *future scenarios on AIDS in Africa*²⁵.

²⁴ SACBC AIDS Office La Verna Conference, October 2001

²⁵ AIDS in Africa: Three scenarios to 2005, UNAIDS; Geneva, 2005

Evaluating the *Choose to Care* initiative

The speedy success of the initial *Choose to Care* projects led to their rapid replication in South Africa, Swaziland, Botswana, Lesotho, and Namibia. In 2003, the Catholic Medical Mission Board and the Southern Africa Catholic Bishops' Conference engaged the Department of Sociology at the University of Pretoria to serve as an independent evaluator of the overall initiative as well as its 61 participating projects²⁶. The following summary conclusion was drawn by the evaluators.

‘While there is a general acknowledgement within the Church itself that the Church was initially slow to respond to the magnitude of the problem of HIV/AIDS, during the recent past, as the effects of HIV/AIDS within the congregations and communities of the Church have become progressively more evident, the Catholic Church has emerged as an increasingly central role-player in a range of initiatives to combat the pandemic²⁷’.

The evaluators also made the following additional observations.

- Since the establishment of the SACBC AIDS office, at least one Catholic response to HIV in each of the forty Dioceses in Southern African countries has been initiated.
- One of the major advantages of the Church as an institution responding to the HIV epidemic within the Southern African context is an extensive, well-established network among congregations throughout Southern Africa, including some of the most isolated and under-developed communities in the region.

“The Church is one of the primary...resources for AIDS work in South Africa. The Church’s interventions often seem more successful than government interventions. The Church has the infrastructure, passion, and dedication to address HIV/AIDS”.

Interview with representative of Catholic Health Care Association in South Africa (CATHCA), in Evaluation of CMMB/SACBC HIV/AIDS Projects 2003, The Department of Sociology, University of Pretoria, p. 14.

- The challenge remains to mobilize every diocese and parish from Church leadership level to congregation member in order to address the effects of HIV.

“The involvement of the religious structures is essential to widen the base to reach more people since the faith-based organizations are community-based, acceptable to the local community and willing to get involved and their approach fits well into the culture of the community.”

South Africa Department of Social Development, 2002; as quoted in Evaluation of CMMB/SACBC HIV/AIDS Projects 2003, The Department of Sociology, University of Pretoria, p. 15.

- While it is widely acknowledged that the Church can play a critical role in addressing the impact of HIV, it is clear that there are still significant challenges within the Church itself, including stigma, denial and discrimination.

²⁶ Cf., published report entitled, *Evaluation of CMMB/SACBC HIV/AIDS Projects 2003*.

²⁷ *Evaluation of CMMB/SACBC HIV/AIDS Projects 2003, The Department of Sociology, University of Pretoria, p.14.*

“Church leaders are, more often than not, men, like myself; and unless one is dealing firsthand and experiencing the reality of AIDS on the ground in the appalling conditions in which people are forced to live, especially disadvantaged women and girl children, leaders and priests/pastors can at times fail to fully appreciate just how difficult are the issues which need to be addressed.”

Bishop Kevin Dowling, as quoted in Evaluation of CMMB/SACBC HIV/AIDS Projects 2003, The Department of Sociology, University of Pretoria, p. 15.

Faith-based organizations are true partners in the response to HIV

The findings of the above-mentioned evaluation seem to be consistent with those of a study report with broader focus, also undertaken by the Catholic Medical Mission Board, in concert with the Global Health Council, and entitled *Faith in Action: Examining the Role of Faith-based Organizations in Addressing HIV/AIDS*²⁸.

This report made the following conclusions.

- Faith-based organizations have long been leaders in delivering social, educational and health services in many countries.
- WHO estimates that one in five organizations engaged in HIV programming is faith-based.
- Up to 40% of health care in poor countries is delivered by private religious organizations.
- The global community is urgently seeking to identify all relevant partners
- But the evidence-based body of knowledge on the role of faith-based organizations in addressing HIV has been limited.

Several key findings also were communicated in this report; they included the following.

Faith-based organizations are mitigating the impact of HIV in the following important areas of work.

- Providing clinical, home-based care for people living with HIV:
 - faith-based organizations play substantial role;
 - quality of care and services is considered high;
 - home-based care is one of the strongest areas.
- Offering Spiritual/social support for affected/infected:
 - counselling;
 - preparation for death;
 - guidance against stigma.
- Expanding access to antiretroviral drugs:
 - where faith-based organization health infrastructure is strong;
 - collaborative efforts with governments and donors;

²⁸ *Faith in Action: Examining the Role of Faith-based Organizations in Addressing HIV/AIDS*, Report by Catholic Medical Mission Board and Global Health Council, published by the Global Health Council, 2005.

- faith-based organization networks have greater capacity;
- focusing on supporting roles and the need for sustainability.



Infant in Care Nazareth House

Finally, the *Faith in Action Report* posed some important questions and challenges, such as the following.

“How can faith-based organizations...?”

- Leverage vast assets to strengthen and scale up in-country response?
 - Monitor, evaluate, document and disseminate best practices systematically?
 - Contribute collectively and individually toward enhancing evidence-based knowledge through scientific studies?
- Increase their funding at all levels to reflect the scale of their work?
 - Increase and strengthen collaboration with other secular organizations in mounting a scaled-up HIV response?
 - Help religious leadership and other clergy to increase their knowledge about HIV prevention, care, support and treatment?

“Faith-based organizations play a crucial role in the fight against HIV/AIDS. The involvement of faith-based organizations is multifaceted and includes organizational, spiritual, emotional, psychological and value-related issues. Faith leadership plays an important role in motivating people to become involved in HIV/AIDS-related work...Faith underpins and propels the response of the Church as an institution to the HIV/AIDS epidemic. The morality of care and compassion obliges individuals and organizations to become involved in the prevention of spread of HIV and to care for the sick or those whose lives are affected by the sickness or death or family members.”

Dr. Maretha de Waal, University of Pretoria, Turning of the Tide: A Qualitative Study of SACBC Funded Antiretroviral Treatment Programmes, January 2005, p. 10.

Choose to Care initiative—strategic preparation for the Universal Access initiative

It is the hypothesis of the Catholic Medical Mission Board and the Southern African Catholic Bishops' Conference AIDS Office that the experience of the *Choose to Care* initiative confirmed many of the findings of the *Faith in Action* report and provided the framework for resolving the questions and challenges posed by this report. Within these organizations, one encounters the additional belief that the *Choose to Care* initiative served to motivate and enable the Southern African Catholic Bishops' Conference to serve as a "central role-player...to combat the pandemic."

"The rapid expansion of many of the projects funded by the SACBC into a variety of related activities is indicative, both of the complexity of the challenges faced by organizations attempting to combat HIV/AIDS, and the rapidly changing nature of the epidemic as the death toll rises and increasing numbers of children are orphaned."

Finding listed in Evaluation of CMMB/SACBC HIV/AIDS Projects 2003, The Department of Sociology, University of Pretoria, p. 17.

This same initiative also strategically prepared the Southern Africa Catholic Bishops' Conference AIDS Office to establish a firm foundation for the efforts, initiated in 2006, to attain Universal Access to HIV prevention education, care, and support, as well as to antiretroviral treatment. These efforts are being promoted, with much vigour and determination, by UN agencies, as well as by public health and development experts and by the entire human family that knows only too well the tragic impact of the HIV pandemic during these past twenty-five years. Thus, in this regard, the United Nations Secretary-General attached an accompanying note to the UNAIDS report prepared for the 2006 High Level Meeting on AIDS to review progress toward achieving the goals established by heads of state and other government leaders at the United Nations General Assembly Special Session on AIDS held in 2001. Mr. Kofi Annan also recalled for the UN member states the General Assembly resolution 60/224:

'In that resolution, the Assembly requested UNAIDS and its Cosponsors to assist in facilitating such processes, with the aim of coming as close as possible to the goal of universal access to treatment by 2010 for all those who need it, including through increased resources, and working towards the elimination of stigma and discrimination, enhanced access to affordable medicines and the reduction of vulnerability of persons affected by HIV/AIDS and other health issues.²⁹

This Universal Access initiative strives to complement the "3 by 5" initiative which was launched in 2003 by the World Health Organization and UNAIDS with the goal of placing three million people living with HIV (and in need of such treatment) in low- and middle-income countries on antiretroviral therapy by the year 2005. The success of the initiative might be considered to have been only partial since, as of December 2005, only 1.3 million people had received treatment,³⁰ but, to the contrary, the experience of the Southern

²⁹ *Towards universal access: assessment by the Joint United Nations Programme on HIV/AIDS on scaling up HIV prevention, treatment, care and support*, United Nations document, A/60/737, 24 March 2006.

³⁰ WHO/UNAIDS, *Progress on global access to HIV antiretroviral therapy: A report on "3 by 5" and beyond*, March 2006.

African Catholic Bishops' Conference AIDS office would confirm the following progress assessment of the "3 by 5" initiative:

'From crowded metropolis to isolated village, structures are being put into place that allow hundreds of thousands of people to access a level of medical care that, just a short time ago, was unimaginable.³¹

The Universal Access initiative expands the focus of "3 by 5" to reach access to prevention, care, support and treatment for all those who need them. The characteristics of "universal access" were well defined in the UNAIDS Assessment report³² that was prepared in anticipation of the High Level meeting. These characteristics define the necessary process in which governments and civil society must engage.

The concept of universal access implies that all people should be able to have access to information and services. Scaling up towards universal access should be:

- equitable
- accessible
- affordable
- comprehensive
- sustainable.

The Southern African Catholic Bishops' Conference, in cooperation with the Catholic Medical Mission Board as well as with its participating programme partners in Southern Africa, prepared itself for the goals of Universal Access by serving as one of the "pioneers" in gaining access to antiretroviral medications in this region and then in building capacity among its partners so that these medications would be administered in the most responsible manner. It was convinced of the urgent need to embark on antiretroviral therapy programming because of its painful experiences in accompanying people living and affected by HIV through its care, support, and education programmes. The comment of Sr. Regina, Missionary Sister of the Most Precious Blood, Mariannhill, South Africa, passionately summarizes the dilemma felt by helping persons before their entry into antiretroviral treatment services: "Nurses today say, 'we are just nursing for the cemetery.'³³

Comment of Cardinal Wilfred Napier, Archbishop of Durban, South Africa re: the potential of the Catholic Church to promote Universal Access:

"There is a great consciousness that we are a Church for service to the whole community...the Church could play a bigger role if more resources were made available. Many parishes cannot employ people to help with the response ... we need more resources."

Interview with Rev. Robert J. Vitillo, on 04 July 2006

At the end of 2003, the Southern African Catholic Bishops' Conference AIDS Office and Cordaid (Catholic international aid and development agency located in the Netherlands) entered into a funding agreement to initiate five antiretroviral treatment sites under the sponsorship of the Bishops' Conference. This funding included provisions for the following.

³¹ *Progress on Global Access to HIV Antiretroviral therapy: A Update on "3 by 5", UNAIDS and World Health Organizations, 2005, p. 5..*

³² *Towards Universal Access, op.cit.*

³³ From video about St. Mary's Hospital, Mariannhill, South Africa.

- Laboratory costs for CD4 count and viral load tests as a baseline test and henceforth the same tests every six months (including courier costs for sending the blood samples to a central laboratory in Johannesburg).
- Training costs and salaries for a nurse, a part-time doctor and a part-time coordinator for each site.
- Budget for transport, training and office equipment.
- A small budget for medicines to treat opportunistic infections (such as TB, pneumonia, candidiasis, shingles, meningitis, etc.).³⁴

In 2004, the United States President's Emergency Programme for AIDS Relief (PEPFAR) agreed to fund antiretroviral treatment in South Africa and several other countries. One major PEPFAR grant for treatment is being channelled through the AIDS Relief Consortium which is coordinated by Catholic Relief Services (CRS – the overseas relief and development agency of the United States Catholic Bishops' Conference) and of which Catholic Medical Mission Board, the originator of the *Choose to Care* initiative, is a participating member.³⁵ In collaboration with the AIDSRelief Consortium, the Bishops' Conference AIDS office coordinates the antiretroviral therapy programming for some twenty sites providing therapy in South Africa.

As of August 2006, the SACBC AIDS Office reported engagement with 18 anti-retroviral care sites and accounted for 7000 ARV patients in South Africa

Source: Report of the SACBC AIDS Office to the Plenary Assembly of the Southern African Catholic Bishops Conference, August 2006

In a qualitative study commissioned by the Southern African Catholic Bishops' Conference, Dr. Maretha de Waal, of the University of Pretoria, noted the foundation upon which Bishops' Conference and its programme partners built their antiretroviral services.

'The SACBC AIDS office has been actively fostering the development of local community-driven initiatives in their response to the HIV/AIDS pandemic, including provision of food aid, income generation/skills training, HIV/AIDS awareness, home-based palliative care, hospices and orphan support ... Plans for the implementation of ART through funding secured by the SACBC AIDS Office commenced in 2002, at a time when there was no commitment from the South African government to make ARV treatment available.'³⁶

One should not conclude, however, that the Bishops' Conference works in competition with, or even parallel to, the official government AIDS strategy. Dr. de Waal observed that the Bishops' Conference programmes are very much in concert with and complementary to those of the government:

'The ARV sites of the SACBC aim at complementing government programmes in areas where government-funded ARV-treatment is not available, notably in resource-poor communities. All SACBC sites work with government referral sources and use the government's treatment protocols and treatment regimens. Staff are trained in government accredited programmes. It was agreed to also use the government's patient tracking forms, so the patients who move around may be able to continue treatment. In addition, SACBC ARV programmes also

³⁴ Ricus Dullaert, "The ARV Therapy Distribution Project", in *Health Care in Rural South Africa: An Innovative Approach*, ed. by Adri Vermeer and Hugo Tempelman, Amsterdam, VU University Press, 2006, p. 190.

³⁵ Other Consortium members include the Institute of Human Virology (IHV), the Futures Group, and the Interchurch Medical Assistance (IMA).

³⁶ Dr. Maretha de Waal, University of Pretoria, *Turning of the Tide: A Qualitative Study of SACBC Funded Antiretroviral Treatment Programmes*, January 2005, p. 6.

accept patients on long waiting lists at government hospitals and are open to both South African and non-South African citizens. Patient numbers are reported to government using the government format.³⁷

These programmes are acknowledged to be comprehensive in scope and thus include all the elements of HIV education and service seen as necessary to attain Universal Access:

‘The programme operates along a continuum of prevention, care and treatment, involving all aspects of AIDS. ARV treatment is linked to prevention, in that people receive counselling about not becoming re-infected and not infecting other people. Treatment is also linked to holistic patient care, regardless of whether this takes place in the context of a hospital, hospice or clinic. Home-based care is the backbone of the treatment programmes.’³⁸

Antiretroviral Therapy Programme preparation, including staff recruitment and training, commenced in February 2004 in the various sites selected by the Bishops’ Conference. Each site employed a physician, a professional nurse, and a project coordinator. After the nurses and physicians had been trained and accredited by the Foundation for Professional Development, drug literacy courses were offered to home-based caregivers, to other medical staff, and to patients themselves. In order to avoid unnecessary delays and to expedite delivery of services and medications, each site employs the same procedures which include the following.

- Home-based caregivers identify patients who, in their opinion, meet a number of criteria³⁹; they arrange for the patient to receive a blood test at the antiretroviral therapy centre.
- The physician and nurse draw blood from patients on site; this is sent by courier service to a laboratory in Johannesburg for CD4 count, viral load, and full blood count (where necessary, liver function tests also are performed).
- The sites are informed of the results by e-mail.
- Adult patients with CD4 counts below 200 are initiated on antiretroviral medication.
- An electronic order for medications is submitted by the site physician to a pharmaceutical company in Johannesburg; these are pre-packaged individually for each patient and delivered to the site, where they are given to the patients.
- Before commencing with antiretroviral therapy, each patient is required to undergo adherence training and treatment for opportunistic infection(s).⁴⁰

In the book *Health Care in Rural South Africa: An Innovative Approach*, Ricus Dullaert describes the home-based caregivers as the “backbone” of these antiretroviral therapy programmes and describes the terms of their engagement as follows:

‘Members of a home-based caregivers team under the SACBC AIDS Office in general have a 59-day government-approved training. Each home-based caregiver has a workload of around twenty HIV patients who are visited once or twice a week. The home-based caregivers are supervised by a professional nurse and work twenty hours a week on a voluntary basis. They receive a stipendium for their work. These home-based caregivers identify the patients who need ARVs, help to educate them about ARVs (drug literacy

³⁷ *Ibid.*, p.7.

³⁸ *Ibid.*, p.7.

³⁹ See Appendix E for a list of criteria for admission to SACBC ARV programme.

⁴⁰ Johan Viljoen, “The SACBC’s roll-out: a narrative report, 2 September 2004, unpublished report.

training), encourage them to disclose their status to one or more members of their household, and do an adherence follow-up once the patients are on treatment.⁴¹

Below are highlighted a few examples of the antiretroviral programmes that have been promoted and supported by the Southern African Catholic Bishops' Conference AIDS Office and how they model various facets of the Universal Access Framework that was detailed above.

Nazareth House, Johannesburg, advocating for equitable treatment of Children Living with HIV and AIDS and addressing the comprehensive needs of neighbourhood residents living with HIV⁴²

One SACBC collaborating partner, *Nazareth House*, in Cape Town, was the first Catholic orphan care institution in the country to provide paediatric antiretroviral medications for the HIV-positive orphans it serves. Its sister organization, directed and staffed by the same order of religious sisters, quickly followed in the same direction. The latter institution is located in the Yeoville section of inner-city Johannesburg, which is renowned for its crime, substance use and commercial sex, as well as for its highly transient population (including a significant percentage of refugees and economic migrants coming from all parts of Africa). During their 116-year history of service to this neighbourhood, the Sisters of *Nazareth House* have changed their focus to meet the evolving and growing social needs of the people who have lived there. *Nazareth House* is home to people living with mental disabilities, frail old people and destitute, terminally ill people. It also is home to HIV-positive abandoned and orphaned babies and children. The Sisters and lay staff care for 35 children made orphans by AIDS, 20 adult AIDS patients, 78 frail aged and 18 mentally challenged women. Most of the residents of *Nazareth House* can no longer adequately care for themselves or be maintained by family or community. *Nazareth House* was one of the first sites where the Bishops' Conference started its roll-out of antiretroviral therapy. Initially, the orphans living with HIV and residing in the centre were tested for CD4 levels. Out of a total of 35 such children, 14 had CD4 counts below 200. There was little discussion of treatment for children at that time, but the Sisters could not tolerate the continued loss of life among these children, many of whom had already been subjected to abandonment, rejection, abuse, and near starvation; they insisted that the children be given a chance on antiretroviral therapy. Treatment was initiated immediately for the children who needed it. About two months later, treatment was started for adults and outpatients.

The outpatient department operates three days per week. The multidisciplinary staff team includes two part-time physicians. A support group meets on a weekly basis so that patients can have ample opportunity to discuss their issues and concerns. One of the Sisters works in an outreach programme within the inner city settlement areas; she addresses the spiritual, emotional and social needs of local people living with or otherwise affected by HIV. She supports and provides specialized home-based care when required. The programme also distributes food, clothing and support especially to grandparents and single parent families who care for orphaned children. *Nazareth House* works in partnership with government, business and the community. For example, the home-based volunteers are supervised, trained and supported by government health workers. Three schools assist the children with their homework. Local businesses donate food, including baby food and

41 Ricus Dullaert, "The ARV Therapy Distribution Project", in *Health Care in Rural South Africa: An Innovative Approach*, ed. by Adri Vermeer and Hugo Tempelman, Amsterdam, VU University Press, 2006, p. 188.

42 Much of this material is excerpted and adapted from Dr. Maretha de Waal, University of Pretoria, *Turning of the Tide: A Qualitative Study of SACBC Funded Antiretroviral Treatment Programmes*, January 2005, pp.16-18.

immense booster supplements. The HIV Clinicians Society provides a 24-hour telephone support service.

Nazareth House works in close collaboration with the Johannesburg General Hospital and the United Nations High Commission for Refugees (UNHCR). The arrangement was made for *Nazareth House* to accept patients (South African citizens) on the Johannesburg General Hospital antiretroviral therapy waiting list until they obtain appointments at the Hospital, after which they are accepted into the government programme. In addition, *Nazareth House* accepts the non-South African citizens⁴³ who applied for treatment at Johannesburg General Hospital but who are not eligible for government-funded treatment. UNHCR supports the treatment of the latter patients and utilizes the services of French- and Portuguese-speaking counsellors who help to facilitate the partnership. Also, in order to strengthen relationships and to build partnerships, health care workers attend lectures at Baragwanath Hospital once a month; these sessions focus on HIV issues in children's homes and on issues relating to coping and grief and loss.

St. Mary's Hospital, Mariannhill, struggling to provide accessible and sustainable services⁴⁴

St. Mary's Hospital is situated at Mariannhill, on the western outskirts of Durban. It is one of only two remaining mission hospitals in South Africa and serves the 'Outer West' health district of metropolitan Durban. The area has a population of approximately 750 000 people who, mainly, are very poor, unemployed, and living in informal settlements. *St. Mary's* represents the only major hospital between Durban and Pietermaritzburg, both of which cities are difficult to reach since local residents lack private automobiles and since public transportation is virtually non-existent. This is one of the areas with the highest HIV prevalence in the country. Hospital officials estimate that the prevalence among adults in the area is 33% and that 75% of all patients coming to the hospital are living with HIV. The hospital has been on the forefront of providing care to people living with HIV.⁴⁵ It has been offering antiretroviral therapy for a number of years at its *iThemba* clinic (in association with Harvard University).

Despite the extraordinary success of these programmes, the hospital currently faces problems in sustaining these services. With the termination of the previous funding in 2004, *iThemba* patients were transferred to the current Bishops' Conference antiretroviral therapy programme. The hospital has made great efforts to integrate its *iThemba* and *St. Anne's Clinic* programmes into its mainstream services. *St. Mary's* maintains some 3000 patients on antiretrovirals. In order to assure future sustainability of its antiretroviral programming, the hospital has been approved as a government rollout site and now receives its antiretroviral medications from the provincial authorities.

The multidisciplinary team has a daily one-hour pre-clinic conference to discuss their patients and to discuss various HIV-related topics. One day per week is set aside for team-building, staff education, patient case review, sharing of clinical cases, invitation to guest speakers and sharing of patient support, methods and tools.

The therapeutic counsellors provide an important link among the patients, the clinic and the community. They undertake home visits, provide counselling and support and

⁴³ In an unpublished presentation entitled, "South Africa – 10 years on: The Political-Socio-Economic Context and the Role of the SACBC Agencies," SACBC staff note that there are between 1-2 million Zimbabwean refugees in South Africa (many of them young people – 15% of the total Zimbabwean population) and, according to estimates from the South Africa Department of Home Affairs at some 6 million "illegal" economic migrants.

⁴⁴ Much of this material is excerpted and adapted from Dr. Maretha de Waal, University of Pretoria, *Turning of the Tide: A Qualitative Study of SACBC Funded Antiretroviral Treatment Programmes*, January 2005, pp. 21-22.

⁴⁵ Estimates cited by hospital officials during interview with Fr. Robert Vitillo, 04 July 2006.

are able to identify side effects and barriers to adherence before non-adherence occurs. A patient support group meets on a weekly basis. Basic health and treatment literacy workshops are offered to HIV-positive people, and other educational talks are given during selected support group meetings. Also, a range of community-based activities is coordinated with and supported by the therapeutic counsellors.

Tapologo Outreach Programme, Rustenburg, built on the hallmarks of accessibility and affordability⁴⁶

Due to the sustained high prices of platinum, Rustenburg, the world's largest source of platinum, is quickly becoming one of the fastest growing towns in South Africa. Mainly migrant labourers from various African countries, the mineworkers live in single-sex hostels close to the mineshafts.

Following in their wake, women have set up informal settlements close to the gates of the hostels and provide various income-earning services and networks to the mineworkers. Over time, re-trenched workers have erected shacks in these settlements as well, in the hope of finding employment again. Thus shack settlements have grown around the gates of the hostels in order to accommodate poor, desperate and uprooted people. All these settlements are on Bafokeng tribal land. Taking their cue from Bafokeng tribal leaders who are opposed to the onslaught of newcomers to their land, local authorities are unable to provide services or to provide tenure to the new settlers. There is a high incidence of HIV infection in the area; causes identified for the growth of this 'local' epidemic include the extreme poverty of its inhabitants, the absence of extended families and the consequent failure to preserve and observe traditional values, and the lack of personal and community resources.

Through its *Freedom Park Clinic*, the *Tapologo Programme* of the Diocese of Rustenburg serves the mining community which stretches north-west to north-east of the town. Housed in converted shipping containers, the clinic provides primary care services, home-based care, adult education and child day care facilities. Due to overwhelming demand, services have been extended to all the surrounding squatter settlements. Thus *Tapologo*



Bongani, the first child to be enrolled in the anti-retroviral therapy programme at Freedom Park, Rustenburg. He now has returned to school and acts as treatment monitor for both his parents who also participate in the same programme.

has established a network of home-based caregivers in a programme that is supported financially by the platinum mines and that provides services to all these communities. *Tapologo* is currently constructing an administrative centre and a hospice on the grounds of *St. Joseph's Mission* in Rustenburg.

Services offered through the *Tapologo Outreach Programme* include counselling and emotional support, HIV education and awareness, positive living, support groups and antiretroviral therapy adherence support. The outreach programme staff comprises an outreach manager, eight professional nurses and 96 community caregivers who provide care to approximately 2700 patients. During 2003, the caregivers recorded 28 000 home visits and enrolled 836 new patients.

⁴⁶ Much of this material is excerpted and adapted from Dr. Maretha de Waal, University of Pretoria, *Turning of the Tide: A Qualitative Study of SACBC Funded Antiretroviral Treatment Programmes*, January 2005, pp. 23-24.

Sinosizo, a community-based, accessible service that also has distinguished itself for local capacity-building⁴⁷

Sinosizo was established in 1995 by the Catholic Archdiocese of Durban. It provides home-based care, an orphan and vulnerable children programme, and training and antiretroviral therapy services. Its standard of training has made it one of the foremost training organizations in South Africa and it is frequently called upon to provide training on all aspects of HIV care and services. It also has a large network of caregivers, who assist the terminally ill in all parts of Durban.

In February 2004, when the organization decided to participate in the Southern African Catholic Bishops' Conference's antiretroviral therapy programme, it identified the rurally-located Groutville, in Northern KwaZulu-Natal (outside Stanger), as its target area. *Sinosizo* is unique as an antiretroviral therapy provision site in that it is not linked to a clinic, hospice, or hospital. Patients suffering from opportunistic infections, as well as HIV-infected children and pregnant women, are referred to Stanger Hospital. The Groutville centre is located next to an independent voluntary counselling and testing centre; it works in close collaboration with the governmental Department of Social Development, which sends, on a weekly basis, an official, to assist with social grant applications. The antiretroviral therapy programme connects to its other programmes in important ways; for example, records of children who are referred to the paediatric section of Stanger Hospital, are kept and followed up by their programme officers.

Preliminary results and lessons learnt by the Southern African Catholic Bishops' Conference antiretroviral therapy programming

The above-outlined programmes show that the Bishops' Conference efforts are well on their way to fulfilling the framework for universal access. Below is some direct testimony from those living with the virus about the impact of these services on their quality of life and on the realization of their God-given human dignity.⁴⁸

- “The health care workers were very good. *I got the best love from the care workers.* They are very good when it comes to working with people. They gave me support all the way until I delivered the babies.”
- “I disclosed to my Mother...She gave me love like she did when I was suffering from TB. She has not changed. She brings me money every month...They are happy that I am better and beautiful. They love me so much.”
- “I told my employer first, immediately after getting the results. He was shocked and heartbroken, but he accepted. After that I told my brother and then the rest of my family and relatives. They have all accepted and life is normal. They are happy that I am getting treatment and that I will be getting out of the hospital. My colleagues and co-workers do not know what is wrong with me.”

⁴⁷ Much of this material is excerpted and adapted from Dr. Maretha de Waal, University of Pretoria, *Turning of the Tide: A Qualitative Study of SACBC Funded Antiretroviral Treatment Programmes*, January 2005, pp. 18-19.

⁴⁸ *Ibid.*, pp. 34-37

After completing an extensive review of the Bishops' Conference-supported antiretroviral therapy sites, Dr. Maretha de Waal noted the following positive features of this treatment programme; these might serve as guidelines for development of future services in this field.

1. Integration of AIDS treatment activities into the basic package of holistic care, including voluntary counselling and testing, prophylaxis of opportunistic infections, HIV prevention and psychosocial support.
2. Decentralization of treatment services down to the primary care level to ensure wide coverage of geographic areas and community involvement in care and referral.
3. Setting up simple regimens with standardized clinical guidelines to sequence the use of drugs and manage adverse events, encouraging ease of adherence for the patient and follow-up for the healthcare professionals.
4. Availability of reliable supplies of antiretroviral drugs and laboratory services at a manageable cost.
5. Establishment of multidisciplinary teams, including home-based care with an emphasis on psychosocial support.
6. Adoption of a comprehensive approach to adherence, including counsellors, support groups and significant treatment literacy.
7. Provision of special services, for example for referral of children to paediatric programmes and effective treatment of opportunistic infections and emergencies;
8. Addressing the specific challenges of long-term adherence to antiretroviral treatment.⁴⁹

⁴⁹ *Ibid.*, pp. 43-44.

Conclusion: taking stock and looking to the future

It may seem inappropriate to speak of the *Choose to Care* initiative as “good news” or as “life-giving”, since it was developed in response to the most destructive health crisis known by modern-day Southern Africa. However, if this initiative had not been developed, one might be much more pained to imagine the thousands of additional lives that would have been lost, or seriously affected by recurrent opportunistic infections, malnutrition, abject poverty, exclusion, stigmatization, and the additional psychosocial impact of the collective burden of HIV in this region. The Southern African Catholic Bishops’ Conference AIDS Office played a crucial role in eliminating such suffering for some and in alleviating the impact for many more persons living in the five-country territory where it has been operational. Independent evaluator, Tessa Marcus, of the National Research Foundation, in Pretoria, summarized that role as follows:

- procurement or assistance with the provision of funding to help projects meet their objectives;
- education and training in order to develop project and stakeholder capacity and skills in the areas of their work;
- networking to encourage sharing of experiences and resources;
- information provision and sharing in order to ensure that projects and programmes keep up to date with developments in their specific areas as well as in the larger policy environment; and
- creating a platform for innovative thinking and strategic planning.⁵⁰

Neither the Southern African Catholic Bishops’ Conference AIDS Office, nor the Catholic Medical Mission Board, nor any other responsible organization could lay claim, at the present time, to a comprehensive and durable solution to HIV in Southern Africa, or, in that matter, to any other part of the world. In his opening address to the XVI International AIDS Conference, Dr. Peter Piot said that this was a time of great “hope...and opportunity” in the history of the pandemic, since we finally were seeing some results in terms of lives saved because of effective prevention and access to treatment. These words might help us to recall the opening reflection for this study which warned that “Our greatest enemy is not disease, but despair”⁵¹. Dr. Piot also asserted, however, that it was too early to speak of “success” in the responses to the pandemic. He called for an acknowledgement that “long term sustainability [in the global HIV response] does not mean five or ten years, but twenty-five years and more.”⁵² He urged that HIV be maintained as an “exceptional” priority on political agenda. He delineated the following key actions:

- We must ensure that adequate funds are made available.
- We must make the money that is mobilized work for those who need it.
- We must accelerate scientific innovation.
- We must address in new and more aggressive ways, the social drivers of this epidemic.

⁵⁰ Tessa Marcus, “To Live a Decent Life: Bridging the Gaps,” in *Health Care in Rural South Africa: An Innovative Approach*, ed. by Adri Vermeer and Hugo Tempelman, Amsterdam, VU University Press, 2006, p. 258.

⁵¹ From *African Women, HIV/AIDS, and Faith Communities*, ed. by Isabel Apawo Phiri et al., Pietermaritzburg: Cluster Publications, 2005, p. 269.

⁵² Dr. Peter Piot, UNAIDS Executive Director, Speech: “AIDS: The Next 25 Years,” Toronto, XVI International AIDS Conference, 13 August 2006, document provided by Conference Media Office.

- We must work in concert—as a coalition of genuine partners with genuinely shared goals.

Through humble beginnings in the *Choose to Care* initiative and through the strategic financial and technical support offered to it by Bristol-Myers Squibb and the Bristol-Myers Squibb Foundation, the Catholic Medical Mission Board, other international Catholic donor agencies, and locally-based universities and professional agencies, the Southern African Catholic Bishops' Conference has leveraged an efficient and effective response to the HIV epidemic as it ravages the poorest and most vulnerable populations in its five-country target area of Southern Africa.⁵³ To continue to care for the infected and affected the Bishops' Conference, with its affiliated partner organizations, will strive to maintain its strong resolve, its clear sense of vision and purpose, its commitment to transparency and accountability, and its tradition of professional excellence until Universal Access to HIV education, care, support, and treatment can become a reality in Southern Africa and, even more importantly, until we can see an end to the HIV epidemic in this region and throughout the world. It is to be hoped that the positive experiences and lessons learnt, as well of challenges faced, may serve as model and inspiration for countless other faith-based and community-based organizations with similar sense of vision, mission, values, and practice.

⁵³ Cf. Appendix F for the most recent listing of SACBC-supported projects, many of which can trace their roots to the Choose To Care Initiative.

Appendix A

The Southern African Catholic Bishops' Conference serves South Africa, Swaziland and Botswana, with linkage to the Bishops' Conferences of Namibia and Lesotho.

South Africa covers 1 219 912 square kilometres at the southern tip of the continent of Africa. Natural resources include gold, chromium, uranium, diamonds and platinum. Only 12.1% of the land is arable and permanent crops make up less than one percent (0.79%) of the used land. Population is estimated (2006) to be 47 432 000. Life expectancy at birth: women, 49 years; men 47 years. Percentage of people with less than US\$ 2 per day: 34.1%.

Number of people living with HIV: 5 500 000 [4 900 000–6 100 000].

HIV prevalence adults (aged 15–49) 18.8% [16.8–20.7%].

Children aged 0–14 living with HIV: 240 000 [93 000–500 000].

Orphans aged 0–17 due to AIDS: 1 200 000 [970 000–1 400 000].

Swaziland lies in Southern Africa between South Africa and Mozambique, covering 17 363 square kilometres. Land use: 9.8% is arable land of which 0.7% is used for permanent crops. Population is estimated (2006) to be 1 032 000. Life expectancy at birth: women 39 years; men 36 years. Percentage of people with less than US\$ 2 per day—data not available.

Number of people living with HIV: 220 000 [150 000–290 000].

HIV prevalence adults (aged 15–49) 33.4% [21.2–45.3%].

Children aged 0–14 living with HIV: 15 000 [5500–32 000].

Orphans aged 0–17 due to AIDS: 63 000 [45 000–77 000].

Botswana is located to the west of South Africa and has a growing economy in which diamond mining plays an important part. Land area is 600 370 square kilometres; land use 0.7% arable of which 0.01% is used for permanent crops. Population is estimated (2006) to be 1 765 000. Life expectancy at birth: women 40 years; men 40 years. Percentage of people with less than US\$ 2 per day 50.1%.

Number of people living with HIV: 270 000 [260 000–350 000].

HIV prevalence adults (aged 15–49) 24.1% [23.0–32.0%].

Children aged 0–14 living with HIV: 14 000 [6100–32 000].

Orphans aged 0–17 due to AIDS: 120 000 [110 000–150 000].

Namibia lies between South Africa and Angola with a land area of 825 418 square kilometres. Less than one percent (0.99%) is arable with no permanent crops. Population is estimated (2006) to be 2 031 000. Life expectancy at birth: women 55 years; men 52 years. Percentage of people with less than US\$ 2 per day 55.8%.

Number of people living with HIV: 230 000 [110 000–360 000].

HIV prevalence adults (aged 15–49) 19.6% [8.6–31.7%].

Children aged 0–14 living with HIV: 17 000 [5800–40 000].

Orphans aged 0–17 due to AIDS: 85 000 [42 000–120 000].

Lesotho is a land-locked country entirely surrounded by South Africa. Land area is 30 355 square kilometres: land use 10% arable with no permanent crops. Population is estimated to be (2006) 1 795 000. Life expectancy at birth: women 44 years; men 39 years. Percentage of people with less than US\$ 2 per day 56.1%.

Number of people living with HIV: 270 000 [250 000–290 000].

HIV prevalence adults (aged 15–49) 23.2% [21.9–24.7%].

Children aged 0–14 living with HIV: 18 000 [6900–34 000].

Orphans aged 0–17 due to AIDS: 97 000 [88 000–110 000].⁵⁴

⁵⁴ Land area and use from CIA World Factbook <http://www.cia.gov/cia/publications/factbook/geos/sf.html>; HIV statistics from *Report on the global AIDS epidemic*, UNAIDS, Geneva, 2006.

Appendix B

Summary of Projects Developed During the Five-Year *Choose to Care* Initiative⁵⁵

1. KwaZulu-Natal

Centocow, “The Hands of Love”, Umzimkulu Diocese

This programme, located in rural KwaZulu-Natal, is operated by a Catholic Mission and is situated next to a hospital in an area of very high unemployment, no local industries, high proportion of migrant workers, dense population and families decimated by HIV. Households are headed by women, children, and the elderly; HIV prevalence is estimated at 36%. The programme collaborates with the local hospital to train home-based and community care workers, primarily women from the parish. Administered by a religious congregation, this project suffers from the marginal literacy of the home care workers. Tuberculosis infection is commonplace; training in Directly Observed Therapy Short-term (DOTS) is in place. The primary programme focus is on provision of care and support for the ill, with concurrent support to orphans and vulnerable children. Prevention activities include training in universal precautions. Currently, the project has trained upwards of 80 home-based care workers, each serving five to six families.

The Blessed Gerard Centre, Diocese of Eshowe

This programme, located along the coast of KwaZulu-Natal, serves a rural area hardest hit by the HIV pandemic, with large numbers of orphans and vulnerable children. Operated by the ancient Roman Catholic Knights of Malta, the project is a large centre comprising a 40-bed inpatient hospice, an extensive network of home-based caregivers, and a home for orphaned and abandoned children. The programme is staffed by professional nurses and serves as a resource for complementary community efforts.

Holy Cross Hospice, Diocese of Eshowe

This programme located on the grounds of a former Franciscan monastery consists of an eight-bed hospice and undertakes community outreach to orphans and vulnerable children. The programme meets a vital need in a particularly hard-hit area, supporting and training home-based care workers who serve hundreds of people in the local community. Additionally, prevention is a major component of the programme’s work. Caregivers provide patient education with a special focus on women and children; they also provide information on human sexuality, disease transmission (including HIV infection), prevention, infection control, and address issues of abuse. Care and support consist of holistic palliative care, day-care programmes for children and the most vulnerable, and training, supervision and support of volunteer home-based caregivers. Orphan and vulnerable children support includes subsistence, educational support, targeting child-headed households, and providing care for 130 orphans living with HIV in cooperation with communities and families. The programme also helps to facilitate foster support, wherever possible. This programme is in Gingindlovu-Emoyeni, KwaZulu-Natal, an area with high levels of both HIV and reported physical abuse. Priorities set by the programme were the needs of abandoned, grieving, and stigmatized children orphaned by AIDS and other vulnerable children. The day-care centre provides respite care and support for 854 orphans. Seventy home caregivers have been trained by the project to date, with 879 homes benefiting from their services.

⁵⁵ It should be noted that the *Choose to Care* initiative was funded for a five-year period and is no longer operating as such, although many of these projects continue to serve their focus populations through the support of other funding partners.

Duduza Care Centre, Diocese of Dundee

This programme is a longstanding centre of excellence in care provision and training and supervision for home-based and palliative, holistic caregivers. The programme has been asked by the government to extend its outreach into public schools to train trainers. Even though invited to serve as a pilot site for antiretroviral therapies, it chose, instead, to focus on end of life palliative support as well as monitoring the needs of persons most vulnerable to HIV.

Pomeroy Clinic, Diocese of Dundee

This clinic, located in Zululand, serves a very traditional rural population. It identified training as a priority, and requested support to train home-based care workers. The clinic is staffed by religious women. Currently, its activities centre on the recruitment, training, and ongoing support of home-based care workers.

Rosary Clinic, Newcastle, Diocese of Dundee

This programme serves a very poor area with large populations of migrant workers in extended, informal settlements. The programme trains home-based caregivers and provides food parcels for families in need, especially orphans and vulnerable children, while also increasing access to health care. It has been involved in the use of antiretroviral medication to prevent mother- to-child transmission of HIV.

Osizweni Catholic Church, Northern KZN, Diocese of Dundee

This programme, situated near Newcastle, is a training programme for home-based caregivers, with no permanent staff; it is staffed entirely by volunteers. Workshops were conducted by Price Waterhouse Coopers to increase capacity for garnering needed support. This is a first-rate example of mobilizing parish members to respond to the epidemic, but it has been observed that full capacities and potentials are still largely unrealized.

Sinomlando, The Oral History Project, Archdiocese of Durban

This project, begun in 1999 and led by a professor and social worker from the University of Natal, was motivated by a commitment to encourage dying parents and children to create “Memory Boxes”—stories, documents, and items prepared by the dying for those they leave behind. The programme itself provides great benefit in terms of bereavement support and counselling.

St. Philomena’s, Archdiocese of Durban

This project is a home in Durban for orphans and vulnerable children who have been sexually abused and are living with HIV. With good organizational capacity, linkages with hospitals and schools, and a staff of five, it is a best practice model for service to orphans and vulnerable children.

Siyaphila Community Based Organization, Archdiocese of Durban

This project is exclusively staffed by persons living with HIV—200 volunteers addressing needs in slum areas for others living with HIV and orphans and vulnerable children. It provides subsistence support and seeks to build the capacity of individuals to support themselves and meet their health care and other needs in the community. There are, at the time of writing, no formal linkages to specific health care institutions.

Malusi Omuhle, Diocese of Ingwavuna

This project is situated in Hlabisa, a marginalized district with the highest levels of HIV prevalence in all of South Africa. A number of nongovernmental organizations,

have focused on this area but few services seem available to most of the residents. This programme provides home-based care for the sick, with training and supervision provided by a local professional nurse. Home-based care is provided by the Sacred Heart Sodality, which consists of about 40 volunteers. Capacity for expansion or antiretroviral therapies is limited by the marginal literacy of the volunteers. Nevertheless this programme offers a good home-based care programme serving a very needy Zulu community.

Unkulunkulu Unathi, “God Is With Us”, Diocese of Ingwavuma

This home-based care programme in KwaZulu-Natal focuses on parish-based nursing. In this instance, home-based caregivers were trained with the assistance of the Department of Health.

Ndumo School Orphans Project, Diocese of Ingwavuma

Located along the border between Zululand and Mozambique this programme serves an under-developed area including significant transient populations. It was started through the leadership of nine Catholic school principals who observed that significant and increasing numbers of their students were living with or affected by HIV. The programme focuses on purchasing food from local providers, visiting the homes of orphans and vulnerable children, and ensuring that nutritional support is provided and other basic needs of the children are met. Capacity is limited in part by lack of transportation infrastructure, water, electricity, and other resources, yet each of the nine schools reaches and supports about 70 children each (n=630). This project is an excellent example of how a faith-based organization and educators can work together to meet the needs of the children in their care.

Diocese of Kokstad

This programme provides training of home based care-givers and implementation of a home based care programme in one of South Africa’s poorest areas.

2. Eastern Cape

Good Shepherd Hospice, Diocese of De Aar

This programme which operates on the grounds of a hospital, serves a rural population of “coloured,” Afrikaans-speaking persons. The area is sparsely populated, with youth leaving to find employment and, too often, returning to the area to die after they become ill. The programme serves nine small villages, providing capacity building by training community and home-based care workers. It has professional nurses on staff; they administer DOTS in this area which has an extremely high prevalence of tuberculosis. It is a best-practice site for training, working in conjunction with the provincial health department and providing holistic care. Because many people are diagnosed with HIV while outside the region, local statistical reports may underestimate true HIV prevalence.

Imfobe, Queenstown Diocese

A home-based care programme operated by the development office of this diocese. It works closely with the Caring Network in Cape Town, and is a superb example of linkages and partnerships among funded projects that increase the strategic capacity of each.

St. Francis, Eastern Cape, Diocese of Port Elizabeth

This programme serves an area of extreme poverty, with the lowest per capita income in South Africa. Fully staffed with physicians, professional nurses, and ancillary support, it served as a hospice during the 1980s and later shifted to care for persons living with AIDS. The quality of the care provided is excellent, and its outreach with home-

based care extends to squatter settlements literally built on the municipal rubbish dump. Its administrative leadership is exemplary, with proposal development, planning, and reporting consistently matching the quality of the services it delivers.

Care Ministry, Diocese of Port Elizabeth

This is an HIV awareness programme for parishes now starting to train home-based caregivers. The goal of the training is to implement parish-based projects to help persons living with HIV, orphans, and other vulnerable children.

Woodlands Care Centre, Empilisweni, Diocese of Port Elizabeth

This large project concentrates on education as well as development and subsistence.

Sabelani Home, Umtata Diocese

This programme focuses on supporting persons living with HIV through small clinics in the slums around Umtata. The programme has identified as priority the lack of adequate, appropriate care for people living with HIV and for the dying, and has documented the inability of families to provide appropriate in-home and end-of-life care.

Umtata Child and Family Welfare, Bethany Home, Diocese of Umtata

This home for abandoned orphans found on the streets of Transkei in the Eastern Cape is located in an area that attracts squatters and “informal settlements”, with a population of approximately 100 000 people. Unemployment is very high; many residents are migrants in search of work. The project is well organized and managed by a religious sister of the Precious Blood from Philadelphia, Pennsylvania, USA. The programme provides support for orphaned children, about 25% of whom are living with HIV, and identifies, as its first priority, the facilitation of foster care placements; however the impoverishment of the local community makes this difficult.

3. Western Cape

Helderberg, Archdiocese of Cape Town

This programme is centred at a hospice outside Cape Town that had planned to train and support home-based caregivers in two slum communities. Funding was intended to support expansion of services, but there has been no expansion to date.

The ABBA Trust, Archdiocese of Cape Town

Situated in the Western Cape serving urban Cape Town, with a satellite in the Eastern Cape (East London), this project serves persons living with HIV while also effectively addressing issues of mother-to-child transmission. The urban programme is well implemented and is closely supported by private physicians and governmental programmes in the Western Cape. In contrast, in the Eastern Cape, this project provides service in huts and tribal settlements of deeply rural areas, where implementation of such therapies is challenged by lack of infrastructure, particularly roads, and by difficulties in bringing together patients and providers for regular appointments.

St. Luke's Hospice, Archdiocese of Cape Town

Centred at a longstanding hospice this programme shifted from providing end-of-life care for white South African cancer patients to providing care for black persons living with HIV. It has an excellent training programme for home-based care providers which it coordinates with The Caring Network so as to avoid service duplication. This interfaith

partnership has a capacity for 35 inpatients in the hospice unit and reaches persons with HIV living in the poorer parts of the city.

Lizo Nobanda, Archdiocese of Cape Town

This programme works in collaboration with Nazareth House and St Luke's Hospice providing Day Care for HIV-positive infants near Cape Town. Its focus is on infants and small children living with HIV.

Goedgedacht Trust, Archdiocese of Cape Town

This programme serves a farming community facing high rates of alcohol abuse as well as rising levels of HIV infection. The community itself identified training of home-based caregivers as a priority, and some 50 volunteers have been trained and currently are providing services. Capacity is limited by widespread alcohol abuse and dependence; levels of tuberculosis also are extremely high.

Joy For Life, Archdiocese of Cape Town

This is a care and support programme that has been active for about ten years, providing home-based caregiver training, and a drop-in centre for people living with HIV, and complementary therapies. It serves a highly marginalized population in the inner-city of Cape Town, including sex workers and injecting drug users. The project and its volunteers also provide HIV education and prevention workshops for government and private industries.

The Caring Network, Archdiocese of Cape Town

Described as a "flagship" programme of Southern African Catholic Bishops' Conference, this project serves the poorest slum communities plagued not only by great poverty but also by illiteracy and high rates of HIV and Tuberculosis. The quality of care provided is outstanding, and this project has been identified as a strong candidate for the implementation of antiretroviral treatment.

AIDS Programme, Diocese of Oudtshoorn

This programme works primarily with the "coloured" communities of Oudtshoorn. Providing care and support for persons living with HIV, teaching self-sufficiency skills, and attending to the needs of orphans and other vulnerable children, it features some of the best training for home-based care workers, working cooperatively with the government in a 59-week training course. The programme builds capacity by strong networking with clinics, hospitals, government and nongovernmental organizations serving the area. Even though the official estimate of HIV prevalence is relatively low in the Oudtshoorn area (about 7%), this site supports DOTS for tuberculosis. The project operates with one full-time staff member and a strong network of volunteers.

St. Boniface Knysna, Diocese of Oudtshoorn

This parish-based programme lies on the border between the Western Cape and the Eastern Cape, an emerging area of luxury resorts and squatter camps. The programme represents a response to the new and growing numbers of orphans, vulnerable children, and the need for subsistence support and home-based care. Approximately 200 people receive services from the members of the parish who address issues of health and food security.

4. Northern Cape

Keimoes-Upington Diocese

Located in the Northern Cape, this programme reaches out into the Kalahari Desert, along the Orange River, serving both the local peoples of Bushman/Khoisan descent

and the migrant workers of Tswana descent who travel seasonally to harvest grapes. While HIV prevalence here is relatively low in comparison to the rest of South Africa, the migrant workers experience higher levels of HIV infection. But a higher percentage of intact families is found here than in other areas, which makes particularly suitable this project's focus on youth prevention education. In addition, this project trains home-based care workers in cooperation with the local hospital and thus also addresses the high prevalence of tuberculosis in the area.

Zenzeleni Wellness Center, Diocese of Kimberley

Operating in the Kimberley area, this project is led by the wife of an Anglican priest and staffed by her son and 10 volunteers. It focuses on the needs of orphans and vulnerable children and provides transportation by minibus as well as day care, medications, and support for orphan-headed households and children who are living with HIV (about 40 children).

Tshepong, Diocese of Kimberley

This programme, located in the former black township of Kimberley, is led by the local bishop who purchased a house now used to provide respite care for persons living with HIV as well as to train home based caregivers. The project is staffed entirely by volunteers among who is a professional nurse. The quality of care provided is high, and outreach of the home-based caregivers continues to expand.

5. Gauteng

Good Shepherd Clinic, Winterveld, Archdiocese of Pretoria

This programme, based in an established clinic, offers training and support for home-based caregivers and community health workers. It was a pilot site for the use of antiretroviral medications in the prevention of mother-to-child transmission. Here, home-based caregivers deliver holistic care for persons ill and in late-stage HIV disease, while also tracking and supporting those orphans and vulnerable children created by their parents' deaths. Although relatively small, its capacity, as indicated by Directly Observed Therapy Short-term (DOTS) training and delivery, suggests it as a strong partner as antiretroviral therapies become more available.

Sizanani, St. Joseph's Care Centre, Archdiocese of Pretoria

This project supports an on-premises hospice, an extensive home-based care network for surrounding villages, and two orphan and vulnerable children projects. Primarily serving rural slums, this programme serves persons living with HIV as well as orphans and vulnerable children. It has noteworthy capacity to develop proposals and report on activities.

Loreto Convent, Archdiocese of Pretoria

The programme provides specific funding for orphans and vulnerable children seeking to start a peer-to-peer programme. Small grants funded students and teachers to attend prevention training. Loss of the teacher and graduation of the students derailed the programme as there was no provision for follow-through or back-up.

Holy Cross, Archdiocese of Pretoria

This programme is primarily a home in urban Pretoria providing residential care for ten people living with HIV and supporting a training programme and home-based care network. This network of home- and community-based providers reaches out to a squatter

settlement called “Plastic View”, so-called because most of the residences are constructed of pieces of plastic. The programme is noted for high standards and high quality of care, with interaction between service sites and the University of Pretoria. Workers from the sites earn credits in the University of Pretoria Nursing Programme, and students in the programme, as well as trainees from government programmes, perform clinical rotations at the centre and reach out into the community. This is a “best practice” site for training, perhaps the best training in the service area. It is staffed by physicians and professional nurses who supervise and coordinate the activities of 30 home-based care providers. It has excellent capacities to appropriately deliver antiretroviral therapies.

Nazareth House, Archdiocese of Pretoria

This new programme has two foci: a hospice providing accommodation and care for persons living with HIV, on one hand, and outreach to a squatter area outside of Pretoria to train home-based care workers, on the other. Staffed by religious women and volunteers, this project is new and results have yet to be assessed.

St. John the Baptist, Archdiocese of Pretoria

Serving the sparsely populated northern region of Winterveld, this programme works closely with a clinic, funds home-based care, and facilitates support groups. Already having served as a site for antiretroviral therapies to prevent mother-to-child transmission, this is a promising site for effective use of antiretroviral therapies as access improves.

Archdiocese of Pretoria

This programme specifically was designed to support a diocesan coordinator of HIV programmes, build the archdiocesan capacity to screen applications, visit projects, and advise the scores of applicants for HIV funding. Primary duties include mobilizing parishes to address HIV in their communities.

Tumelong Hospice and Orphan Care, Winterveld, Archdiocese of Pretoria,

Winterveld is northwest of Pretoria, a densely populated area of about 260 000 people, with high prevalence of HIV and tuberculosis. This resettlement area is a transient community, where there is little electricity or water, high crime, sex work, carjackings, and a large population of the recently incarcerated. The programme, a day shelter for orphans and vulnerable children, was cited by the World Health Organization as a best practice programme. It provides transportation, medicine, and coordinates a network of home-based care workers. The “Saturday Club” offers young people (beginning with seven-year-old children) bereavement counselling, life skills training, sex education, and other programmes that are age appropriate. The hospice itself provides holistic care for up to 35 persons who cannot be maintained at home or in the hospital, with two home-based care teams and three “orphans’ havens”. Services for orphans and vulnerable children include respite care, orphan support, referral, fostering, education provision and supportive subsistence care. This programme has built capacity by training trainers, recruiting volunteers, supporting families, guardians, and relatives, including legal and administrative assistance to families seeking to adopt orphans. It also supports the development of skills for self-sufficiency and subsistence. At its peak, the project specialized in palliative care and reached over 600 orphans in the community. On average at least 19 workers attended training on HIV, bereavement, and related topics on a regular basis. As with many projects, this one benefited from capable leadership, specifically a physician and his wife, a nurse, and a social worker who are no longer with the programme.

Sisters of Mercy Winterveld, Archdiocese of Pretoria

The programme serves the Winterveld area with a school and clinic on-site as well as home-based caregivers. Support from the Southern African Catholic Bishops' Conference primarily makes possible youth-focused prevention education, HIV awareness programmes, and development/support for peer-to-peer networks. The programme is outstanding in its development of drama presentations addressing HIV and also in the impressive number of students reached.

Sacred Heart, Diocese of Johannesburg

The programme, located in central Johannesburg, serves uprooted people without family or other social support. Working in conjunction with local hospitals, it is a 15-bed hospice that cares for patients with end-stage disease, providing holistic and palliative care.

Nazareth House, Diocese of Johannesburg

This programme is situated in an area of high population density next to the settlement area of Yeoville, with high estimated prevalence of HIV among the population served. There are two primary foci of this project, the first being provision of hospice care for about 20 people in end-stage disease and the second being support for abandoned infants, children, and adults. The project runs a residential care environment for orphans and vulnerable children, provides outreach to adults and is expanding its adult services. Further, with support of a professional social worker, it has reached out into the settlement areas, where, despite the poverty and illness it encourages and educates local families to support children and provide foster care. The project provides residential and respite care for 35 infants and children and has strong linkage to other projects and programmes, including volunteers, visiting doctors, and students from local schools. It networks with and provides liaison services for local nongovernmental organizations, trains and supports staff, and consults with the Yeoville Clinic, Johannesburg General Hospital, Hillbrow Hospital, and the Gauteng Health Department.

Othandweni, Diocese of Johannesburg

The programme serves the inner-city of Johannesburg and Hillbrow, with a focus on street children, the homeless, the mentally ill, and persons with alcohol and other substance use problems. The population has high HIV prevalence and associated illnesses. The hospice serves about 20 patients, usually in late-stage disease, with professional nurses operating a mobile clinic that provides care "on the street" for this population. The hospice experiences high patient turnover due to illness and death; the programme for orphans and vulnerable children provides subsistence and health support.

St. Anthony's, Boksburg, Diocese of Johannesburg

An adult education programme (no longer running) that identified 50 people living with HIV and provided training, education, and job placement in the skilled trades.

CARE, Diocese of Johannesburg

This programme began as a faith-based initiative meant to "humanize" care provided for persons living with HIV. The programme provides 'wraparound' services including counselling, support and coordinating efforts for education. It has strong links with the provincial hospital and to the infectious disease programme at the University of the Witwatersrand Medical School (which provides clinical rotations at the clinic). This programme serves thousands of people each year and clearly is a best-practice setting for care, support, and capacity building. Further, this project exemplifies interfaith initiatives,

with members of all religious groups (Christian, Moslem, and Jewish) on its board. Since its inception, the programme has demonstrated impressive growth and has taken steps to ensure sustainability, with many patrons and high media profile.

The Love of Christ, Diocese of Johannesburg

The programme focuses on abandoned children, of whom about 25% are living with HIV. It attempts to find foster care and facilitate adoptions, but the needs of the community leave about 32 children in residence. Currently, the capacity to provide service is high but insufficient to meet the needs. This programme relies heavily on relatively short-term foreign volunteers, who while doing valuable work, may disrupt the support and bonding needed for close bonding of children to adult figures; but the programme does effectively address pressing needs for the care of abandoned children. The programme works in concert with professional physicians, and some of the children are currently on antiretroviral therapies

HIVSA, Baragwanath Hospital, Soweto, Diocese of Johannesburg

A nongovernmental organization formed to provide social services to persons in the densely populated area of Soweto in Johannesburg. Site of the original nevirapine studies demonstrating effectiveness in reducing the mother-to-child transmission of HIV, this programme is linked closely to the University of the Witwatersrand Medical School as well as the state-run hospital. The project provides post-discharge support for patients needing subsistence (food security) and home-based care, with primary focus on women and a secondary, though not insignificant, focus on orphans and vulnerable children. This project illustrates “best practices” in view of its strong linkages with other community agencies and with the thousands of people whom it serves.

Oasis Rover Crew HIV/AIDS Information, Training, and Counselling Centre

The programme primarily focuses on prevention, including Voluntary Counselling and Testing (VCT) for people in settlements and squatter camps and general awareness-raising about all aspects of HIV.

Johannesburg Society of the Blind, Diocese of Johannesburg

The programme develops HIV educational material for the blind in large print, Braille, and on audio cassettes. Plans include projections for creating peer-to-peer counselling and developing interventions appropriate to the blind and visually impaired/partially sighted as well as to the sighted population.

Witwatersrand Hospice, Soweto, Diocese of Johannesburg

The programme provides hospice care with training satellites serving Soweto.

Diocese of Johannesburg

The funds received by this initiative support a diocesan coordinator for HIV efforts.

Sithand'izingane, “For the Love of Children”, Diocese of Johannesburg

This programme comprises a farm outside squatter camps that provides “shelter”—respite care—for orphans and other vulnerable children.

Orange Farm Parish, Ikhanyezi, Diocese of Johannesburg

The programme serves a squatter area outside of Johannesburg marked by high population density, high HIV prevalence, and high crime rates. It serves the most vulnerable and marginalized, mobilizing parishioners to care for members of the community. The programme itself provides services for the seriously ill, with two feeding stations for

orphans and vulnerable children. It excels in training caregivers, including home-based care providers and orphan care and support.

6. Free State

Gethsemane Health Care, Ficksburg, Bethlehem Diocese

This home-based care programme and hospice is on the border of Lesotho. The hospice has eight beds and serves those in late-stage illness or in transition from local clinics. The hospice provides training of caregivers who, in turn, address gaps in service by coordinating with the local clinic. Support from the Southern African Catholic Bishops' Conference is transitioning out as Catholic Relief Service support increases. End-of-life care is provided both at the Health Care Centre and through home-based care workers. The programme secures medical supplies from local clinics and hospital, provides weekly medical supervision through community doctors, with additional assistance provided by an outside occupational therapist and social worker. Strengths here include volunteer recruitment, training and support, with capacity-building workshops, training, and support for home-based caregivers.

Good Samaritan Hospice, Bethulie, Diocese of Aliwal North

The programme serves small, rural villages populated by black workers who have been displaced due to decreasing demand for farm labourers as farms modernize with better technologies. High HIV prevalence and widespread unemployment combine to present severe challenges to this programme, which is linked with a local clinic. Primary services provided are hospice- and home-based care for the sick, with staffing provided by two professional nurses. In addition, this project provides training for home-based caregivers and coordinates a network of about 65 such workers. Founded in 2002, this project has distinguished itself by mobilizing people across racial groups to meet the social services needs of the community. The population served includes white, black, coloured, and foreign nationals. With support from the local Catholic religious community, this is truly an interfaith initiative as there are few Catholics in the area.

Naledi Hospice, Bloemfontein, Diocese of Bloemfontein

The programme provides training for home-based and palliative care workers throughout the Free State. Training is led by the woman who designed the home-based care curriculum adopted by the government.

7. North West Province

Rustenburg Justice and Peace

Members of staff of this programme provide outreach to the squatter camps that surround the mining communities. The programme identifies orphans and vulnerable children and helps them apply for support from the government. This is difficult due to the extreme poverty, marginal literacy, and often absence of necessary documentation required by government officials. Despite the challenges, this has been an extremely successful project, with 270 orphans now receiving government assistance as a result of programme efforts. Two other dioceses have requested training through this programme so that they might initiate similar programmes.

Freedom Park, Diocese of Rustenburg

This programme supports a clinic and home-based care activities serving the squatter camps next to hostels of the mining camps. Among its challenges is a high preva-

lence of HIV among migratory and transient workers and those who serve them. The clinic is staffed by physicians, professional nurses, and a home-based caregiver force that includes nearly 100 volunteers. Much of the care and support is provided to single mothers.

8. Mpumalanga

Sisters of Mercy, Bethal, Diocese of Dundee

The area served by this programme is populated by coal miners and migrant labourers, with a high number of slums and informal settlements. There are few intact families, with a high percentage of orphans, vulnerable children, and child-headed households. In addition to high HIV prevalence, tuberculosis is also widespread. This programme specializes in providing transitional services for those entering and leaving local hospitals and clinics and coordinates care among local health care providers. With professional and volunteer staff, it also provides education and subsistence support for orphans and vulnerable children in the community.

Lehlabile Development Commission, Diocese of Witbank

The programme is diocesan-based and targets approximately 20 parishes to promote their responses to the HIV pandemic. Located in an area with high HIV prevalence, the diocese contains vast rural areas, great cultural diversity, and a large population of refugees from Mozambique. This is a programme designed to galvanize coherent, effective responses from the Church.

Thembaletu, Shongwe Mission, Diocese of Witbank

This programme operates along the border of Mozambique, Swaziland, and South Africa, an area populated by very poor persons and by war refugees. Due to the illegal status of much of the immigrant community, there is little systematic support for care nor hope of government assistance. This well-run programme provides care for more than 200 orphans found abandoned and unable to attend school. Malnutrition is the norm among this population. The programme initially began as a refugee service and now concentrates on the impact of the HIV within the local area. Approximately 50 home-based caregivers provide support primarily for orphans and vulnerable children in the community.

HBC Damesfontein, Diocese of Dundee

Located on the border of Swaziland, this programme provides home-based care and covers a rural area populated by Swazi-speaking people. Mobilization workshops by the Bishops' Conference led to creation of this programme which was just beginning in 2005 to train home-based care workers. It utilizes the government training program outline (59 days); training will be provided by a local nurse or teacher.

9. Limpopo

Diocese of Tzaneen

This diocese serves the northernmost province of South Africa, which suffers from extremely high rates of poverty. There is great influx of refugees and persons living in informal settlements, with high rates of unemployment that are second only to those found in the Eastern Cape. In 1999, the area experienced devastating floods. Conservative estimates of HIV prevalence are around 11.2%; the concurrent problems of poverty, migrant labour, and unemployment continue to facilitate the spread of HIV. This programme supports the *Education for Life* programme as well as home-based caregivers who travel to villages,

where they in turn identify and support orphans, vulnerable children, and child-headed households.

10. Lesotho

Women and Orphan Care, Lesotho, Lesotho Catholic Bishops' Conference (LCBC)

This is primarily an income-generating project for destitute persons living with AIDS. The area has suffered horrendous famine and food crises among a population of approximately one million people. The area is located in close proximity to the capital city, from which men travel out of the country to pursue employment in the mining industry. Involvement and leadership by the Bishops' Conference is one of the hallmarks of this programme, which addresses issues of food security for orphans and vulnerable children. Project leadership is currently in transition, with a professional nurse recently hired by the Bishops' Conference. HIV prevalence in the local area parallels the very high country-wide statistics for Lesotho.

Christian Health Association, Lesotho

This project involves a network of four hospitals (three of which are Catholic), that sponsor income-generating programs for persons living with HIV, facilitate care and support, and identify and address the needs of orphans and vulnerable children. The national Christian Health Association helped villages form committees to set priorities and develop sustainable responses.

Mission Aviation, Lesotho

This programme covers remote areas and, by means of light aircraft, services 11 clinics in areas that are populated by the Basotho people. About 68% of its focus population are designated as falling below the poverty line; HIV prevalence nationally is estimated at 30–40%. The goals of this programme are to support home care for these persons, train and support nurses in local clinics, and train and support home-care providers in the remote communities.

Beautiful Gate, Lesotho

Beautiful Gate Lesotho is part of the larger *Youth With A Mission* nongovernmental organization, which has been working in Southern Africa since 1976. Beautiful Gate has a sister facility in Cape Town, founded in 1994, that has provided development, training, and other support to the Lesotho site since it opened in June 2001. The estimated number of orphans in the service area was 67 876 as of 2001. Of the infants served by the programme 25–35% are living with HIV. In cooperation with a local hospital, this programme seeks to provide care for abandoned infants while working to place children with adoptive families. It collaborates with the Social Welfare Department to establish a foster care programme, working also with child service and legal rights organizations. Efforts include advocacy to revise existing adoption laws and foster care legislation. In addition, this programme seeks to provide HIV training to the community, specifically to persons wanting to be involved in practical caregiving to infants and children with HIV. The training features attention to spiritual issues and cites biblical traditions of care.

11. Swaziland

Diocese of Manzini, Swaziland

This programme consists of two efforts, providing care and support for orphans and helping vulnerable children in traditional homesteads. *Orphanaid* supports abandoned

orphans and augments subsistence farming. In the past, this programme has excelled in proposal development and reporting, as well as in sustainability, which has been enhanced by the variety of supporting agencies including various Caritas organizations and the Government of Swaziland. The programme also supports 12 cottages located next to a clinic, providing respite care, hospice, and a family-based care training site with Hope House, another *Choose to Care* project.

12. Botswana

Tirisanyo, Gaborone Diocese, Botswana

Botswana launched a national initiative to make antiretroviral treatment available to all persons living with HIV who need them. Located in a country with one of the highest levels of HIV prevalence in the world, this programme focuses on the needs of orphans and vulnerable children, with an Orphans Centre and home-based care in areas of greatest need. The programme operates with one full-time staff member and four volunteers, providing service to about 60 orphans at any given time. The programme is a day care centre for orphans and vulnerable children that provides love and care and seeks to minimize the trauma of being orphaned. The programme places a priority on access to quality education, thereby better equipping these young people for life. Grounds have been levelled and made safe for children to play, with 47 children hosted daily. The Orphans Centre not only provides education and basic subsistence support but also trains its own volunteers. Some recent staffing changes may bring into question capacities for proposal development and reporting, but due to its overall quality, this project was chosen by the Botswana government as a model of best practice.

Holy Cross Gaborone, Botswana

The programme is based at an Anglican Church hospice. It trains home-based caregivers, provides some day care for orphans and vulnerable children, and offers marginal training for persons with living with HIV toward self-sufficiency (i.e. beadwork projects).

13. Namibia

Catholic AIDS Action Namibia

This programme focuses on capacity building and coordination of efforts for the three dioceses of Namibia, with a central office employing 70 full-time people in thirteen local offices. It has funding support from many sources, including the Global Fund for AIDS, Tuberculosis, and Malaria. The project runs sessions of the well-known prevention programme “Stepping Stones”.

Lifeline/Childline Namibia

This programme was originally a suicide hotline that made a transition to an AIDS information programme, with a focus on bereavement issues and telephone counselling. The project serves primarily orphans and vulnerable children, and funding has been used to train bereavement counsellors.

Phillipi, Namibia

The programme focuses on the psychosocial needs of orphans and vulnerable children, and the training and development of group leaders. It features a “Listening and Responding Skills Course” as well as experiential learning camps. By mid-2003, 65 female and 51 male trainers had taken the course, and the aforementioned camps had reached 76 female and 67 male children.

14. National

SACBC Youth Desk, National Project

This project was funded for the development of the ‘ABCD’ awareness and prevention campaign.

Catholic Health Care Association (CATHCA), National

The programme provided three HIV awareness training sessions for some 20 priests in each of the dioceses of Klerksdorp, Johannesburg, and Kroonstad. A training manual was developed, and the diocese of Klerksdorp subsequently developed a programme for home-based caregivers.

Catholic Institute of Education, National

The programme is country-wide for the Republic of South Africa, providing capacity-building (approach, policies, guidance) for schools, teachers, and administrators who are facing an estimated 12–18% HIV prevalence among teachers and growing numbers of orphans, vulnerable children, and students living with HIV (estimate 25–40% of teenagers). A workbook for educators and administrators provides guidelines for discussions about HIV, including its transmission and impact. The workbook also offers guidance on how to develop local policies and procedures to support and care for persons living with HIV. Also included in this work is significant attention to issues of gender and abuse. The prevention focus is on educational programmes, training of trainers, implementation of *Life Skills* and other programmes that address gender-related issues. These programmes help educators, schools, and parishes to assess and address the needs of persons living with HIV, especially colleagues and children in the almost 400 Catholic schools. Training of educators reached 34 teachers in Gauteng province, 101 in KwaZulu-Natal, 30 in Limpopo, 20 in the Northern Cape, 51 in the Eastern Cape, and 86 teachers in Northwest (n=322). Workshops on Pastoral Care and Policy Development also were held in each of these regions

Development and Welfare Agency, Children of Saint Kizito, National

The purpose of this programme is to assist each diocese in the Southern African Catholic Bishops’ Conference service area to form and go forward with plans for providing care for orphans and vulnerable children at the parish level.

Appendix C

Catholic Medical Mission Board-Southern African Catholic Bishops' Conference Choose to Care Programme Partners

Activities and Statistics 2002–2004⁵⁶

Summary (numbers covered for South Africa)

Orphans and vulnerable children covered through services 8982

Patients (adults and children) covered through home-based care 40403

Community volunteers trained for care and support of orphans and vulnerable children (OVC), and home-based care (HBC) 5390

S/No	Project Name	Activities	Volunteers trained	Orphans cared for	HBC patients	Inpatients
1	Centocow, Umzimkulu	HBC, orphan care	100	336	476	
2	Umtata Child + Family Welfare	OVC	3			
3	Good Shepherd Hospice, De Aar	Hospice, HBC	40		400	6
4	Masikhulisane Lifeskills, Ixopo	Prevention	15			
5	Gethsemane Health Care, Bethlehem	HBC, Hospice	15			11
6	Sabelani Home, Umtata	HBC	19	120	225	
7	Tumelong Hospice + Orphans, Winterveldt	OVC, Hospice	15	100		32
8	Loreto Convent Pretoria	Peer education				
9	Diocese of Manzini	HBC, OVC	88	1000	400	16
10	Holy Cross, Eshowe	OVC, hospice	25	180	1198	366
11	SUCCESS, Pretoria	Prevention	12			
12	Keimoes Diocese	HBC, Prevention	10	15	140	
13	Duduza Care Centre, Dundee	Hospice, HBC, OVC		200	100	8
14	Sisters of Mercy Bethal	OVC, HBC	40	30	200	
15	Diocese of JHB Youth Dept	Prevention 1500 youth				

⁵⁶ It should be noted that the "Choose to Care" Initiative was funded for a five-year period and is no longer operating as such, although many of these projects continue to serve their target populations through the support of other funding partners.

S/No	Project Name	Activities	Volunteers trained	Orphans cared for	HBC patients	Inpatients
16	Empilisweni	Prevention, HBC				
17	Diocese of Tzaneen	OVC, HBC	240	50	1000	
18	CIE	Prevention				
19	DWA Orphan Program	OVC				
20	St John The Baptist, Winterveld	Clinic, HBC, PMTCT	22			
21	Diocese of JHB	Coordination				
22	Unkulunkulu Unathi	HBC, OVC	127	300	1000	
23	Sithand'izingane	OVC	26	100		
24	Zenzeleni Wellness Centre	OVC	14	60		
25	Orange Farm Parish	HBC, OVC	85	200	400	
26	Tirisanyo, Gaborone	HBC, OVC	12	330	184	
27	Sacred Heart-Raskob	Hospice				15
28	CATHCA-Raskob	Training clergy				
29	Diocese of Kimberley	HBC	20		161	
30	Diocese of Pretoria	Coordination				
31	Mercy, Winterveld	HBC, OVC	800		186	100
32	TLC	OVC	28	60		
33	Diocese of Oudtshoorn					
34	Lehlabile Dev. Com.	Coordination				
35	St Anthony's Boksburg	HBC	60		200	
36	St Luke's CA	Hospice, HBC	32		150	32
37	Rustenburg J+P	Advocacy	2			
38	Oral History	OVC				
39	St Francis PE	Hospice HBC	114		500	25
40	St Boniface Knysna	HBC, OVC	15	36	20	
41	Helderberg Hospice	HBC, hospice	8		90	7
42	Good Shepherd Clin	Clinic, HBC	10	100	200	
43	Lizo Nobanda	OVC	9	102		
44	Osizweni Catholic Church	HBC, OVC	20	180	466	
45	Blessed Gerard Cntr	Hospice, HBC, OVC	573	35	400	21

S/No	Project Name	Activities	Volunteers trained	Orphans cared for	HBC patients	Inpatients
46	Themba lethu	OVC, HBC	100	3000	1500	
47	Ndumo Orphans	OVC		600		
48	HIVSA	HBC			4200	
49	Good Samaritan	Hospice, HBC	12	200		6
50	Malusi Omuhle	HBC, OVC	21		479	
51	Siyaphila CBO	OVC	30			
52	Goedgedacht	Prevention	44			
53	Joy for Life	HBC, hospice				6
54	Freedom Park	HBC, hospice	150		1700	
55	Sizanani	HBC, Hospice	33	277	360	57
56	ABBA Trust	Advocacy				
57	Holy Cross PTA	Hospice	16			20
58	Othandweni (JHB)	HBC	37		6155	
59	Caring Network	HBC, OVC	70	100	394	
60	Catholic Aids Action Namibia	HBC, OVC	1726		8000	
61	Rosary Clinic	PMTCT, HBC	12		200	
62	Nazareth House (PTA)	Prevention				10
63	Imfobe	HBC	20		260	
64	Pomeroy Clinic	HBC	26	180	2034	
65	HBC Damesfontein	HBC	15		400	
66	Lesotho Catholic Bishops Conference	HBC, OVC				
67	St Francis Boksburg	Hospice, OVC, HBC	112	35		48
68	Diocese Kroonstad	OVC, HBC	47	781	6000	25
69	Bophelong	OVC, HBC	20	240	125	
70	Nazareth House (JHB)	Hospice, OVC		35		15
71	Kokstad Diocese	OVC, HBC	300		500	
	TOTAL		5390	8982	40403	826

Appendix D

APPLICATION FOR SACBC AIDS OFFICE FUNDING⁵⁷

Part 1 - Explains the Criteria that projects must fulfil. Please read these carefully.

Part 2 - Application and questionnaire

PART 1: CRITERIA FOR SACBC AIDS OFFICE FUNDING

1.1 The project must:

- a) Be located in an informal settlement or deprived community.
- b) Deal with home-based care or care for children infected and affected by AIDS, or with prevention, under a holistic approach.
- c) Directly enhance the lives of the most marginalized groups of society, infected and affected by AIDS.
- d) Promote capacity building through collaboration and partnerships with other networks.

1.2 For applications from South Africa the SACBC AIDS Office gives preference to projects which demonstrate that:

- a) caregivers are/will be trained according to Department of Health / Social Development accredited training.
- b) application for funding has been made to Department of Health / Social Development and other relevant sources.
- c) application for stipends has been made to relevant government departments.
- d) application for social grants has been made where applicable.
- e) application for food parcels has been sought through the Department of Social Development.
- f) there are different sources of funding

2. THE APPLYING ORGANIZATION MUST BE A CHURCH-BASED PROGRAMME:

- a) Be a non-profit organization. In South Africa organizations should preferably be registered in terms of the Non-profit Organizations Act, Act No 71 of 1997 or be registered as a PBO.
- b) Be linked to a Catholic parish/diocese/religious congregation, and be run by a management committee, of whom at least two thirds (66%) are residents from within the target community.
- c) Contribute at least 20% of the resources needed for the project.
- d) Have been working in Southern Africa before December 2001

3. THE FUNDING PROPOSAL MUST:

- a) Include the signature of the local Catholic Bishop. The Diocesan AIDS Committee and AIDS Coordinator should vet and recommend the proposal for submission to the Bishop for his signature.

⁵⁷ As amended 4 March 2005. Note: SABC funding is no longer available; this text is provided as background information to the *Choose to Care* Initiative.

- b) Reflect a collaborative approach with other institutions/organizations involved in HIV/AIDS interventions.
- c) Demonstrate capacity for community outreach or linkage to community- based programmes.
- d) Show contact with/to local or provincial government structures; i.e. Local Municipality Health and Social Services
- e) Clearly present the problem and the community involved.
- f) Give a well-designed intervention programme that clearly stipulates goals, and expected near and long term outcomes.
- g) Be consistent with best practice approaches to HIV/AIDS.
- h) Demonstrate capacity to provide training, services, programme evaluation and the development of programs that are replicable.
- i) Show the quality, experience and appropriateness of programme staff.
- j) Contain verifiable statistics from official sources about the rate of HIV infection and the prevalence of AIDS locally.
- k) Show other means of funding and the amount of funding applied for and received.

4. USE OF FUNDS:

- a) Grant funds are to be used only for payment of direct project costs. Salaries/ Stipends may not cover more than 15% of the total budget applied for.
- b) SACBC does not fund the purchase of vehicles or the construction of buildings.
- c) The SACBC Project Manager shall have access to all aspects of the programme using SACBC funds.
- d) Ordinarily separate bank accounts are to be kept for SACBC money, as well as all original-supporting documents of income and expenditure.
- e) All unused money is to be paid back. The SACBC reserves the right to cancel the grant if the money is not spent according to the approved budget.

5. AUDIT AND EVALUATION

- a) The SACBC reserves the right to ask for an audit.
- b) SACBC will use an independent firm to conduct an evaluation of the programme's impact.

6. CATEGORIES OF FUNDING

- a) A reasonable budget that is no more than R200 000
- b) A reasonable budget that is no more than R100 000

7. DISQUALIFICATION

- a) Any organization or individual that uses threats or intimidation to attempt to access funding will be permanently disqualified from receiving SACBC funding.

8. WAIVER

- a) The SACBC reserves the right to waive criteria at its discretion.

9. FUNDING CYCLE

- a) Normally the SACBC funding is granted for one year.
- b) Normally the SACBC will not fund projects for more than three years.

PART 2: APPLICATION FORM

A fully typed proposal is to be submitted. (See Section A as a Guide).

The questionnaire given below in Section B is to be answered fully on the application form.

SECTION A: PROPOSAL GUIDE

Please draw up your proposal under the following headings (with the help of the listed questions)

1. An overview of the problem (What problem/s does your project address? Why is it important?)
2. Specific project objective/s and expected outcome/s (What does your project expect to accomplish? What have you accomplished to date? How will you determine success? Why are these goals important? How do they enhance the quality of life of women and children?) (Aims and Profile/Structure of Organization / Objectives / Activities / Activity Plan / Budget in relation to Activities / Monitoring and Evaluation)
3. Methodology (How will you accomplish your project goals? What method will be used? How will progress be measured?)
4. Implementation plan (Who will conduct the project? What experience and qualifications do they have? How long will the project take? What are the key milestones to be achieved? What other sources of support are you pursuing? Who are your partners? What plans for community outreach do you have? How will you provide training, and evaluation of the programme? How do you plan to disseminate the information learned?)

Budget proposal

- How much funding do you need? How will these funds be spent?
- At least 20% of funding needs to be local/from other sources.

Appendix E

ADMISSION CRITERIA FOR SACBC ANTIRETROVIRAL TREATMENT PROGRAMMES, (which correspond with the Patient Selection Criteria for the National Department of Health [South Africa, 2004])

- Adult patients must have fewer than 200 CD4 cells per 100ml of blood (the point at which HIV is defined as AIDS).
- Patients must live in an area where home carers are working and must agree to be supervised by one of these home carers.
- They must have informed the people they with of their HIV status.
- They may not have taken AIDS inhibitors before and must be prepared to take them for the rest of their lives.
- They must keep a lifestyle suited to treatment with AIDS inhibitors (including no alcohol addiction...eating as healthily as possible).
- They must have followed a drug literacy course and must have a basic understanding of HIV, and AIDS inhibitors⁵⁸.

⁵⁸ Dr. Maretha de Waal, University of Pretoria, *Turning of the Tide: A Qualitative Study of SACBC Funded Antiretroviral Treatment Programmes*, January 2005, p. 8. Note: UNAIDS does not use the term 'inhibitor'; this text is quoted as background information.

Appendix F

List of Projects Supported by the Southern African Catholic Bishops' Conference
AIDS Office as of 06 September 2006

Diocese / Country	Project Name
1. Aliwal North	St Francis Parish-House of Hope Centre
2. Aliwal North	AIDS Awareness
3. Aliwal North	Diocese of HIV/AIDS Programme
4. Aliwal North	Good Samaritan HBC Association-Diocese of Aliwal North
5. Aliwal North	Good Samaritan HBC Association
6. Aliwal North	Masabalane Youth Centre
7. Aliwal North	Lesedi Hospice, Mmusong
8. Aliwal North	Youth Apostolate
9. Bethlehem	Hlokomela Wa Heno-St Kizito's OVC Programme
10. Bethlehem	Sekwele Centre for Social Reflection
11. Bethlehem	Gethsemane Health Care Centre
12. Bethlehem	Hlokomela Wa Heno-St Kizito's Programme
13. Bloemfontein	Siyathokoza
14. Bloemfontein	HIV/AIDS Co-ordinating Office(Lesedi Centre of Hope)
15. Botswana	Little Friends Centre for OVC
16. Botswana	Association of Women Religious of Botswana
17. Botswana	Vicariate AIDS Ad hoc Committee
18. Botswana	Catholic Vicariate of Francistown
19. Botswana	Positive Living Helper Cells
20. Botswana	St Francis of Assisi Catholic Mission
21. Botswana	Corpus Christi Catholic Mission
22. Botswana	Lesang Bana Care Centre-Divine Mercy Catholic Miss
23. Botswana	Reneetswe Happy Home -Mmankgodi Catholic Miss
24. Botswana	Northern Kgalagadi Catholic Mission
25. Botswana	Tshipidi Pre-School and Day Care Centre
26. Oudtshoorn	Breede River Hospice
27. Cape Town	SACBC National Youth Desk
28. Cape Town	Prosperity Youth Centre
29. Cape Town	Nazareth House/Lizo Nobanda
30. De Aar	Nightingale Hospice
31. Dundee	Slindokuhle HBC
32. Dundee	Vusisizwe Roman Catholic HBC
33. Dundee	Osizweni HBC

Diocese / Country	Project Name
34. Dundee	Yakhumndeni Catholic Project
35. Dundee	Damesfontein Home Based Care
36. Dundee	Duduza Care Centre
37. Dundee	Sakhimpilo Home Based Care Project
38. Dundee	Zanethemba Home Based Care Association
39. Dundee	Philisa Home Based Care/HIVAIDS Services
40. Dundee	Noyi Bazi Clinic(Pomeroiy)
41. Dundee	Mhlumayo HBC Care Givers
42. Dundee	Siyabasiza HBC Project
43. Dundee	The Light of Life
44. Dundee	Light of Hope HBC
45. Dundee	Sakhisizwe HBC
46. Dundee	Misokuhle and Siyabusiza HBC
47. Durban	St. Clement's HBC Project
48. Durban	Vuleka Trust
49. Durban	Mother of Peace
50. Durban	Right to live Campaign
51. Durban	Esigodini Counseling Project
52. Durban	Siyaphila CBO
53. Durban	Lusisandla Community Outreach Project
54. Durban	Siphithemba Caregiver (Holy Family)
55. Durban	Refugee Pastoral Care
56. Durban	Sinosizo OVC Project
57. Durban	St Philomenas Community Care Programme
58. Eshowe	Nardini Welfare Programme
59. Eshowe	Thandukuphila CBO
60. Eshowe	Sizanani Outreach Programme
61. Gaborone	Divine Mercy Catholic Mission HBC
62. Gaborone	Mafulong Day Care Centre for OVC
63. Gaborone	Holy Cross AIDS Project
64. Gaborone	Tirisanyo Catholic Commission
65. Johannesburg	Sizonqoba
66. Johannesburg	St Joseph Ithuteng Campaign
67. Johannesburg	Touch of Care
68. Johannesburg	HIVSA-Aha Tshepo Feeding Scheme
69. Johannesburg	Bosco House
70. Johannesburg	Reginald Orsmond Counselling Services
71. Johannesburg	St Joseph Ithuteng Campaign

Diocese / Country	Project Name
72. Johannesburg	Family and Community Services
73. Johannesburg	Impilo Health Care Programme
74. Johannesburg	Community AIDS Response
75. Johannesburg	Dominican Counselling Project
76. Johannesburg	Nqobile Women Development Project
77. Johannesburg	Sacred Heart House
78. Johannesburg	Nazareth House
79. Johannesburg	Sithandizingane Care Project
80. Johannesburg	Diocese of Johannesburg HIV/AIDS Dept.
81. Johannesburg	Tshwaranang
82. Johannesburg	Maforonation HBC
83. Johannesburg	Inkanyezi HIV/AIDS Organization
84. Johannesburg	Campanha de Consciencializaco sobre HIV/Sida
85. Johannesburg	Love of Christ Ministries
86. Johannesburg	Tshegetsang Support Group
87. Ingwavuma	Malusi Omuhle Aids Project
88. Ingwavuma	Unkulunkulu Unathi AIDS Project
89. Keimoes	Diocese of Keimoes Upington
90. Kimberly	Tsibogang Christian Action Group
91. Klerksdorp	Bophelong Home Based Care
92. Klerksdorp	Rorisang Men & Youth Development Services
93. Klerksdorp	Justice and Peace Commission
94. Durban	Sinosizo HBC
95. Kroonstad	Diocesan AIDS Management Committee
96. Kroonstad	AIDS Management Committee
97. Kroonstad	Diocese of Kroonstad OVC Programme
98. Lesotho	St Camillus HBC Centre
99. Lesotho	Mamohau Mission
100. Lesotho	St Leonard Health Centre
101. Mariannhill	Mpharane Community Based Organization
102. Mariannhill	Himmelburg HIV/AIDS Youth Project
103. Mariannhill	Assisi Children's Shelter
104. Mariannhill	Masikhulume Project
105. Mariannhill	Mariannhill Diocesan HIV/AIDS Committee
106. Manzini	Diocese HIV/AIDS Programme
107. Oudtshoorn	BOKO
108. Oudtshoorn	Knysna AIDS Council
109. Pietersburg	Bophelong Day-Care Project

Diocese / Country	Project Name
110. Pietersburg	Bela Bela HIV/AIDS Prevention Group
111. Port Elizabeth	Blue Crane Hospice
112. Port Elizabeth	Assumption Sisters
113. Port Elizabeth	Care Ministry
114. Port Elizabeth	Good Samaritan Hospice
115. Port Elizabeth	St Francis Hospice
116. Port Elizabeth	Missionary Sisters of the Assumption
117. Port Elizabeth	St Kizito's St Anne's Project OVC
118. Pretoria	CWA Home Based Care, Siyathokoza
119. Pretoria	Goitse Modimo & Support Group & Skills Development
120. Pretoria	Mercy Aids Project/Kopano Lerato
121. Pretoria	Chariots of Hope-St Peter Claver
122. Pretoria	Good Shepherd Mission
123. Pretoria	St Joseph's Care and Support Trust
124. Pretoria	Sunrise HBC
125. Pretoria	Nazareth House
126. Pretoria	Holy Cross Home
127. Pretoria	Tshwaranang Hospice-Archdiocese of Pretoria
128. Pretoria	St John the Baptist Catholic Clinic
129. Queenstown	Imfobe HIV/AIDS Initiative
130. Queenstown	Ntaba Maria Care Project
131. Rustenburg	Rustenburg Catholic Justice and Peace Commission
132. Rustenburg	Tapologo
133. Mandeni	Brotherhood of Blessed Ge'ard
134. Mthatha	Diocese of Mthatha
135. Mthatha	Glen Avent Convent
136. Tzaneen	St. Brendans School
137. Tzaneen	Dwars River Parish-AIDS-Badielegi Community Project
138. Tzaneen	St Joseph's Community Centre
139. Tzaneen	Nzhelele HBC Project
140. Umzimkhulu	Izandla Zothando Centocow AIDS Project
141. Witbank	Asiphilenikahle HBC Organization
142. Witbank	Uthando House
143. Witbank	Diocese HIV/AIDS Co-ordinating Committee
144. Witbank	Masisukumeni Women's Crisis Centre
145. Witbank	St Kizito Glen Cowie Support Group
146. Witbank	Diocese AIDS Office

The Joint United Nations Programme on HIV/AIDS (UNAIDS) brings together ten UN agencies in a common effort to fight the epidemic: the Office of the United Nations High Commissioner for Refugees (UNHCR), the United Nations Children's Fund (UNICEF), the World Food Programme (WFP), the United Nations Development Programme (UNDP), the United Nations Population Fund (UNFPA), the United Nations Office on Drugs and Crime (UNODC), the International Labour Organization (ILO), the United Nations Educational, Scientific and Cultural Organization (UNESCO), the World Health Organization (WHO), and the World Bank.

UNAIDS, as a cosponsored programme, unites the responses to the epidemic of its ten cosponsoring organizations and supplements these efforts with special initiatives. Its purpose is to lead and assist an expansion of the international response to HIV/AIDS on all fronts. UNAIDS works with a broad range of partners – governmental and nongovernmental, business, scientific and lay – to share knowledge, skills and best practices across boundaries.

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- is a series of information materials from UNAIDS that promote learning, share experience and empower people and partners (people living with HIV, affected communities, civil society, governments, the private sector and international organizations) engaged in an expanded response to the AIDS epidemic and its impact;
- provides a voice to those working to combat the epidemic and mitigate its effects;
- provides information about what has worked in specific settings, for the benefit of others facing similar challenges;
- fills a gap in key policy and programmatic areas by providing technical and strategic guidance as well as state-of-the-art knowledge on prevention, care and impact-alleviation in multiple settings;
- aims at stimulating new initiatives in the interest of scaling up the country-level response to the AIDS epidemic; and
- is a UNAIDS interagency effort in partnership with other organizations and parties.

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A Faith-Based Response to HIV in Southern Africa: the Choose to Care Initiative

This study describes the work of the Choose to Care initiative of the Catholic Church in Southern Africa. It shows that effective scaling up of programmes in the response to HIV, and work towards making Universal Access a reality, does not necessarily have to be the expansion of a single central service. Through the Choose to Care initiative the Church scaled up service provision by the replication of smaller scale programmes rooted in and responsive to their immediate communities' needs. The study shows that such an approach is effective when undertaken within common guidelines and given central support.

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