Catholic Relief Services - USCCB

Aids Mitigation Initiative To Enhance Care and Support in Bukavu, Lubumbashi and Matadi (AMITIE Project)

FINAL REPORT

Cooperative Agreement Number: 623-A-00-05-00342-00

Grant Period: October 3, 2005 – October 2, 2009

Submitted: December 30, 2009

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LIST OF ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immuno-Deficiency Syndrome
AMITIE	The AIDS Mitigation Initiative to Enhance Care and Support in Bukavu, Lumbumbashi and Matadi
ART	Anti-Retroviral Therapy
ASCA	Accumulated Savings and Credit Associations
CBO	Community Based Organization
CCC	Community Care Coalition
CODILUSI	*Comité Diocésain pour la lutte contre le SIDA* (diocesan HIV and AIDS committee)
CRS	Catholic Relief Services
DRC	Democratic Republic of Congo
ECC	*Eglise Christ du Congo* (Church of Christ in Congo)
FANTA	Food and Nutrition Technical Assistance
FBO	Faith Based Organization
FFP	*Fondation Femmes Plus*
HBC	Home Based Care
HIV	Human Immunodeficiency Virus
IGA	Income Generating Activities
NGO	Non Governmental Organization
OVC	Orphans and Vulnerable Children
PAC	Program Advisory Committee
PLHIV	People Living with HIV or AIDS
PMU	Program Management Unit
PNLS	*Programme National de Lutte contre le SIDA* (National AIDS Program)
PNMLS	*Programme National Multisectoriel de Lutte Contre le SIDA* (National Program for Multisectoral Response to AIDS)
RFA	Request for Application
TB	Tuberculosis
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing
WFP	World Food Program
WV	World Vision

EXECUTIVE SUMMARY

The AIDS Mitigation Initiative to Enhance Care and Support in Bukavu, Lubumbashi and Matadi (AMITIE) Project was developed in response to response to Part B: Care and Support Interventions of USAID RFA No. 623-A-05-018. This four-year community-led, cross-sectoral project worked to reduce transmission and mitigate the impact of HIV and AIDS in three of Democratic Republic of the Congo's (DRC) major urban centers through sustainable, community-led and multisectoral support to People Living with HIV (PLHIV) and Orphans and Vulnerable Children (OVC). In this consortium project, Catholic Relief Services (CRS) was joined by World Vision International (WV) the Church of Christ in Congo (ECC), and several local faith-based organizations (FBOs) or community-based organizations (CBOs): AMO-Congo, Fondation *Femme Plus* (FFP), and the Bukavu diocesan HIV and AIDS committee (CODILUSI). The project received $3,499,998 in USAID federal funding and provided an additional $3,819,744 as cost-share or in-kind contribution.

AMITIE worked to improve the quality of life for PLHIV and OVC by increasing capacity of communities and CBOs to provide home-based care (HBC) and OVC services; by increasing resilience of OVC and PLHIV households through needs-based support packages; by strengthening the enabling environments that support well-being of OVC at national, provincial, district and local levels; and by strengthening the health services that support and link with home-based care.

AMITIE's community-based approach reinforced the capacity of CBOs/FBOs, community leaders, church leaders, community members and health center staff to address PLHIV and OVC needs in their communities. The project's three CBOs/FBOs consortium members each received extensive capacity building as key implementing partners for the project's activities. At the community-level, the project organized twelve Community Care Coalitions (CCCs), training 153 members in community-led response to HIV. Church leaders received training in mobilizing to respond to OVC and PLHIV needs. AMITIE also trained 300 home visit volunteers in provision of key services to OVC and/or PLHIV. Finally, staff from health centers where OVC and PLHIV were referred for care received trainings organized by the project in conjunction with the National AIDS Program (PNLS).

In terms of service provision, the AMITIE consortium exceeded their overall beneficiary targets. In total, 11,920 direct beneficiaries were reached over four years (compared to a target of 11,250), including 7,623 OVC (3,861 Males & 3,762 Females) and 4,279 PLHIV (1,263M & 3016F). An estimated 48,750 family members also benefited as indirect beneficiaries. OVC beneficiaries were provided with a needs-based package of essential services defined in accordance with international standards and community-identified needs. Over the four years, the project's 7,623 OVC received over 123,414 psychosocial support visits. In addition, 5,176 OVC (2,585M & 2,591F) received educational assistance, 603 (166M & 437F) received vocational training, and 1,820 families with OVC received support for income generating activities (IGA). Finally, 4,507 nutritional kits and 5,841 material kits were distributed to OVC.

The 4,270 PLHIV beneficiaries also received a needs-based package of care and support services that included psychosocial support and home based care (81,989 visits made), support for IGA (2,102 beneficiaries), nutrition counseling and support, and legal support. PLHIV received nutrition counseling from volunteers trained using Food and Nutrition Technical Assistance (FANTA) modules; those suffering from moderate or severe malnutrition also received nutrition kits. The project provided 10,213 nutrition kits to PLHIV; a partnership with the World Food Program (WFP) made available an additional 38,426 nutrition kits for project beneficiaries. AMITIE also offered legal assistance – such as preparation of wills and assistance in inheritance disputes – to both PLHIV and OVC, though this was one of the projects least used services, with just 39 beneficiaries making use of legal assistance.

To strengthen the health system, AMITIE formed formal partnerships with several hospitals as well as at least one health center per health zone. Referral networks were established both with these health centers and hospitals, as well as with voluntary counseling and testing and prevention services provided through other USAID-financed projects. Facility staff received briefings about the project and its referral and counter-referral networks as well as training in key project services (such as treatment of opportunist infection and basics of anti-retroviral therapy) and in-kind support such as medications. In all, 10,125 PLHIV and 2,227 OVC received referrals for medical care, 663 OVC were referred for HIV tests with parental consent, 3,201 PLHIV were referred for antiretroviral therapy, and 418 PLHIV were referred for Tuberculosis (TB) screening.

AMITIE also worked to strengthen enabling environments for PLHIV and OVC well-being. AMITIE's staff worked liaised frequently with other Non Governmental Organizations (NGOs) as well as with relevant government agencies to advance OVC and PLHIV policies in country. The AMITIE team actively participated in the forums and workshops that led to the development of the 2010-2014 national strategic plan for AIDS response. AMITIE also participated in the process of preparing national guidelines and standards for OVC and PLHIV programming.

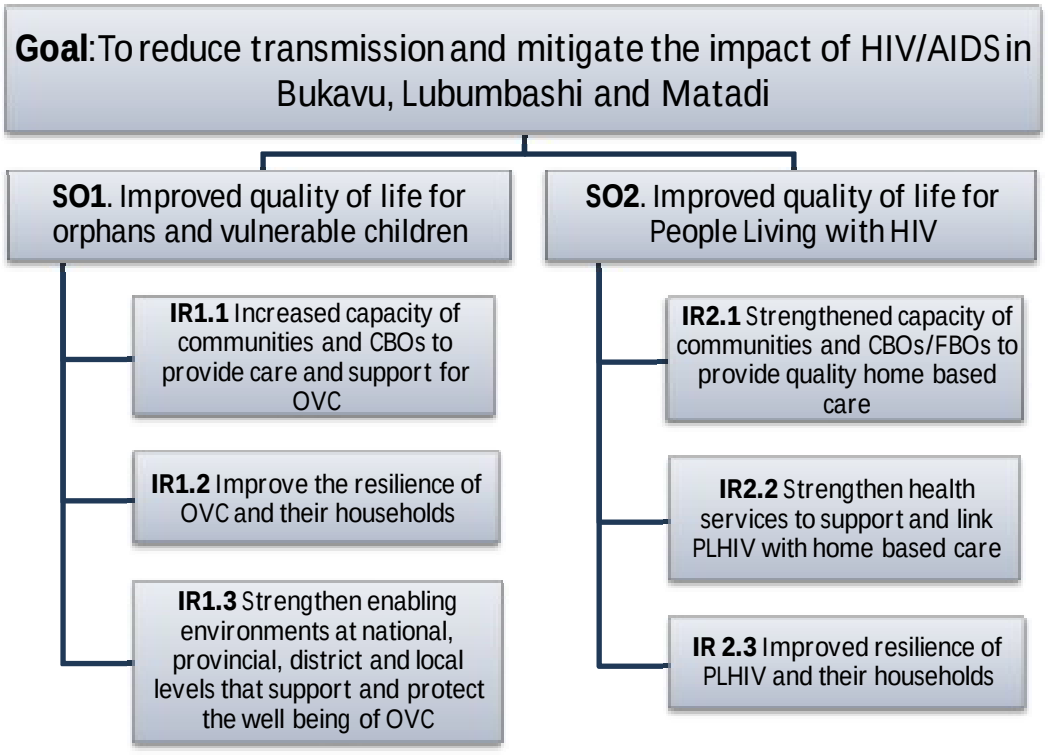
As one of the first projects of its kind in the DRC, AMITIE faced a few challenges which can contribute to the knowledge base for implementation of future projects. First, delays in clearing the project's substantial gifts-in-kind had a minor impact on the availability of quality free or reduced price health services to OVC and PLHIV. The AMITIE team therefore recommends that future projects plan for reserves or alternative procurement. Secondly, the AMITIE team found that by the time formal briefings were held with local partners, both local partners and beneficiaries had formed expectations about services and service delivery models. This experience underlined the importance of collaborative workshops as early on in the project as possible. Gathering data on counter-referrals from external services was also difficult, highlighting the need for finding alternative ways of gathering this information – such as from beneficiaries instead of from providers. Finally, the project found lower demand for three of its services – home-based medical care, legal services, and protection - than it had expected. In response, the AMITIE team worked to understand and address barriers to uptake of these services.

PROJECT GOAL, OBJECTIVES AND STRATEGY

The AIDS Mitigation Initiative to Enhance Care and Support in Bukavu, Lubumbashi and Matadi (AMITIE) Project was a four-year community-led, cross-sectoral project with the goal of reducing transmission and mitigating the impact of HIV and AIDS in three of the Democratic Republic of the Congo's (DRC) major urban centers. AMITIE sought to bring sustainable, community-led and multisectoral support to People Living with HIV (PLHIV) and Orphans and Vulnerable Children (OVC), with a focus on increasing their quality of life. The project emphasized a holistic focus on the client, gender equity, and the involvement of children and PLHIV.

The project included two strategic objectives. The first strategic objective was improved quality of life for OVC, while the second was improved quality of life for PLHIV. Intermediate results related to improved quality of life for OVC included increased capacity of communities and Community Based Organizations (CBO) to provide care and support for OVC; improved resilience of OVC and their households; and, strengthened enabling environments at the national, provincial, district, and local levels that support and protect the well being of OVC. To improve the quality of life for PLHIV, the project sought the following intermediate results: strengthened capacity of communities and CBOs/Faith Based Organizations (FBOs) to provide quality home-based care (HBC); strengthened health services to support and link PLHIV with home based care; and, improved resilience of PLHIV and their households. Figure 1 shows the project's results framework, including goal, strategic objectives, and intermediate results.

FIGURE 1. AMITIE PROJECT RESULTS FRAMEWORK

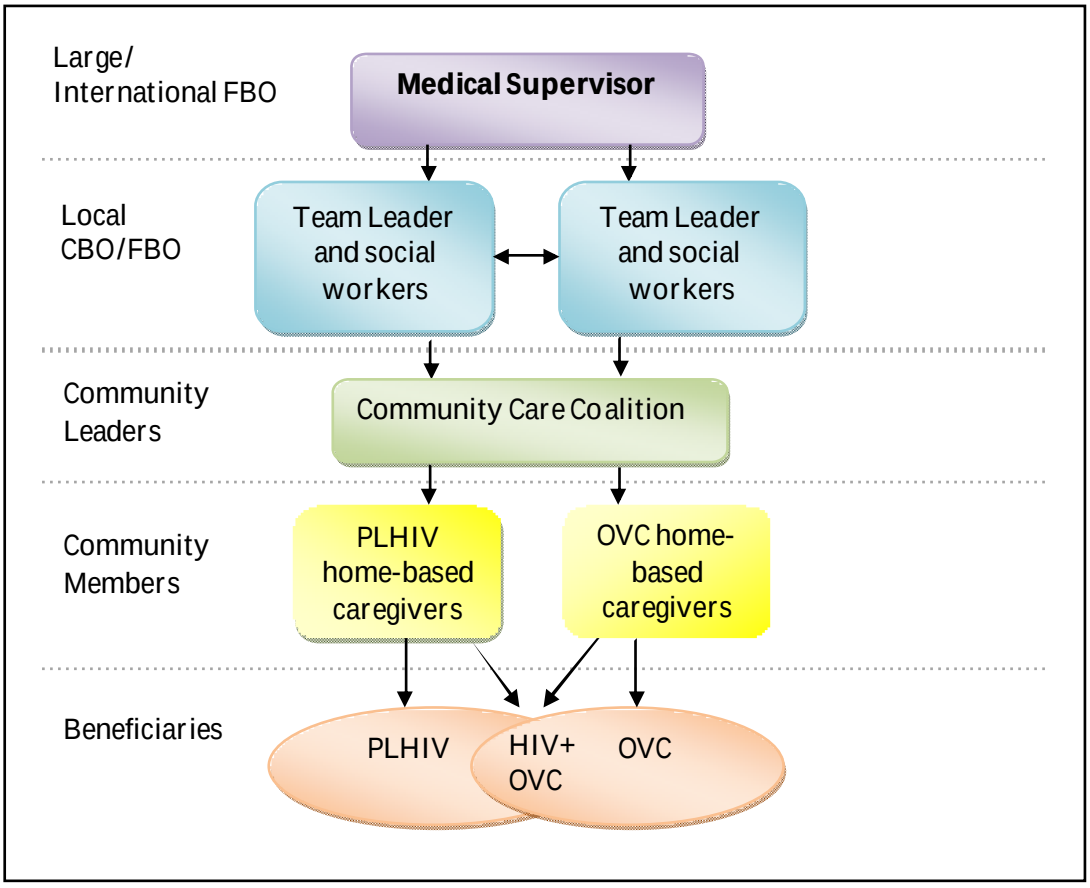


IMPLEMENTATION STRATEGY

AMITIE's community-focused implementation strategy worked to build a strong bridge between the large international FBOs leading the project and the beneficiaries. This approach focused on creating capacity at the community and local CBO/FBO level, as well as creating a sustainable, and community-based response to the HIV pandemic. The project model is shown in Figure 2.

Each of the major partners – CRS in Bukavu, WV in Lubumbashi and ECC in Matadi – engaged a medical supervisor who provided both technical and managerial leadership to the project in one city. At the team leader level, staff from each local FBO/CBO partner (Amo-Congo in Lubumbashi and Matadi and FFP and CODILUSI in Bukavu) was paired with and mentored by a team leader from CRS, WV of ECC. Four social workers per city completed the project technical staffing structure.

FIGURE 2. IMPLEMENTATION MODEL



The pillar of AMITIE's approach was the Community Care Coalitions (CCC). CCCs brought together community leaders **-** representatives of churches and other FBOs, PLHIV associations, other NGOs, government, and local businesses - to function as committees that lead community-level responses to HIV. AMITIE strengthened existing CCCs and created additional CCCs so that there was one CCC in each of the 12 health zones where the project worked. CCC members received training in a variety of

modules (see Box 1). The CCCs had three key responsibilities: 1) aid in the recruitment of HBC and OVC volunteers for care and support of PLHIV and OVC; 2) coordinate volunteer activities; and 3) provide information to the voluntary counseling and testing (VCT) centers and other institutions for referring PLHIV or OVC to the program. The CCC was also involved in developing eligibility criteria and overseeing the process of OVC recruitment. CCCs were thus vital in identifying, monitoring, assisting and protecting OVC and PLHIV.

Box 1. Selected CCC Training Modules

- HIV and AIDS and the impact on children
- Psychosocial and spiritual needs of children and their caregivers
- Addressing the physical needs of children
- Equipping OVC for the future
- Child Protection
- Proposal Writing

Community care coalition members also provided support and on-going supervision of PLHIV and OVC home-based caregivers. Like CCC members, these community-level volunteers were an integral part of the project and received extensive training and capacity building in a variety of topics (described in detail in project achievement section). Volunteers provided PLHIV with psychosocial support; basic health care; referrals for health services, Anti-Retroviral Therapy (ART) and Tuberculosis (TB) screening; nutrition counseling; support for income generating activities; and, help with finding solutions to other problems. OVC received similar support emphasizing life skills and livelihood activities. OVC were also eligible for educational assistance or vocational training; those receiving educational support had their progress in school monitored through a partnership of volunteers, guardians, and school staff. Home visit volunteers also referred OVC for no-cost medical care at partner clinics and to VCT centers for HIV screening (with parent consent).

Home visit volunteers served an average of 25 beneficiaries (including OVC and/or PLHIV). Volunteers were asked to conduct a minimum of three home visits per week. Since many households had multiple OVC or both OVC and PLHIV, beneficiaries could be served with acceptable frequency without overburdening volunteers. Volunteers were not paid but did receive incentives throughout the life of the project. Incentives varied from partner to partner, but included items such as job tools (for example pens and notebooks, bicycles, umbrella, shoes), livelihood support (food items or clothes), or items to help build their capital (for example, plastic chairs which they could rent for supplemental income). In addition, many volunteers received training in microfinance approaches such as World Vision's Accumulated Savings and Credit Associations (ASCA) and many formed ASCA groups.

CROSS CUTTING THEMES

Cutting across the Results Framework and the overall project strategy, were several transversal themes: community mobilization and participation, gender, advocacy and policy, capacity building and involvement of PLHIV.

Community mobilization and participation. Community mobilization and participation were at the core of AMITIE's approach. AMITIE worked closely with CBOs/FBOs, including as consortium members and implementing partners, as well as the recipients

of capacity building activities. The program also worked closely with community leaders, church leaders, and community members to mobilize them in addressing PLHIV and OVC needs in their communities. World Vision's "Guide to mobilizing and strengthening community–led Care for OVC" was a key resource for the mobilization process. Likewise, the Channels of Hope methodology helped to engage and mobilize church leaders to tackle HIV and AIDS issues in their communities. Following mobilization, community members and leaders were given opportunities to participate in project design and implementation, including through membership on CCCs or as home visit volunteers. A majority of the home visit volunteers surveyed at the end of the project indicated that they would continue at least of some of their activities after the end of the project, indicating that this capacity building will have lasting effect.

Gender. AMITIE incorporated throughout its various approaches specific means of addressing gender inequality inherent in HIV and AIDS. Though gender patterns are not simple to change, AMITIE targeted gender inequalities with message dissemination, advocacy efforts, promotion of women's groups, a focus on girls' education, and involvement of men and livelihood support activities for women. All beneficiary data was disaggregated by gender to allow analysis and comparison of gender trends. Educational support was one of the project's greatest successes in this area. Just over half of the OVC receiving educational assistance were girls (2,585M & 2,591F), with girl OVC receiving education assistance at a slightly higher rate their male counterparts (68.9% of girls compared to 67.0% of boys). In addition, the project made efforts to reduce the burden of women in care-giving by involving men as home visitors. Just over half of the home visitors were male. Having both male and female volunteers helped the project better match volunteers to beneficiaries.

The project also addressed women's limited ability to manage or maintain family assets with legal assistance to PLHIV and OVC. Frequently, women fall victim to property grabbing when they are widowed, and may be rejected by their husband's family, thus being left to care for their children without resources. The project offered legal assistance to women seeking recourse and helped 33 PLHIV prepare wills to ensure their inheritance wishes will be carried out. All OVC seeking legal assistance were female and two-thirds of PLHIV preparing wills were women.

Advocacy and Policy. AMITIE considered advocacy for policies and laws supporting and protecting the rights of OVC and PLHIV extremely important. The consortium drew on WV's experience in child protection in the DRC through its USAID-funded "Separated and Abandoned Children Associations" in the Beni area of North Kivu to implement this aspect of the project. Protection was a central theme throughout the project with both CCC members and home visit volunteers trained in child protection, including child rights, prevention exploitation, and identifying signs of abuse.

AMITIE also was actively involved in national forums for OVC and PLHIV issues, including at the National AIDS Program (PNLS) and the National Program for Multisectoral Response to AIDS (PNMLS). In these forums, the AMITIE partners were able to contribute to the development of the 2010-2014 national strategic plan for AIDS response, as well as the development of guidelines and standards for OVC and PLHIV programming.

Capacity building. A focus on building local capacity to respond to PLHIV and OVC needs was integrated throughout AMITIE's approach. Capacity-building efforts were carried out with the intention of creating the most sustainable program possible. At the CBO/FBO level, a team leader from each was paired with a mentored by the team leader from CRS, WV of ECC in both technical and managerial aspects of PLHIV and OVC programming. Through these relationships, CBO/FBO partner staff were able to benefit from extensive mentoring. Partner staff also received several targeted trainings, for example in grant management and organizational capacity building.

Community-level capacity was built through the training of CCC members, home volunteers and church leaders. These community members received numerous trainings as described in Box 1 (above) and Box 3 (below) to allow them to implement high-quality OVC and PLHIV programs. In addition, efforts were made to build their capacity to continue activities even beyond the end of the AMITIE program. For example, training in proposal writing aimed to build their capacity to seek other sources of funding at the end of the project to continue their programs serving OVC and PLHIV.

Participation of PLHIV. AMITIE sought to involve PLHIV in planning and implementation of interventions in order to take their perspectives into full consideration. To this end, PLHIV were actively sought for participation on CCCs, with at least one PLHIV per CCC. Where possible, representatives of PLHIV groups were sought for involvement in CCCs. PLHIV and OVC parents or guardians were also periodically asked for input and feedback on the program's services and implementation.

PROJECT ACHIEVEMENTS

As one of the first and largest OVC and PLHIV programs in the DRC, AMITIE counts among its most significant achievements the creation of community-level capacity for OVC and PLHIV programming. The training and mentoring provided to the consortium's three local CBO/FBO partners, the 153 CCC members and 300 home visit volunteers is expected to extend well beyond the life of the project. AMITIE also had significant achievements in terms of service provision. The project exceeded its overall beneficiary targets, reaching 11,920 direct beneficiaries over four years (compared to a target of 11,250). Beneficiaries included:

- 7,623 OVC (102% of target); 3,861 males and 3,762 females
- 4,279 PLHIV (114% of target); 1,263 males and 3,016 females
- An estimated 48,750 family members also benefited as indirect beneficiaries

In addition to providing services, AMITIE worked to improve the enabling environments for both PLHIV and OVC at national as well as local levels. AMITIE's community mobilization activities and its community-based approach helped create knowledge and catalyze HIV-related activities at the community-level, particularly through local churches and FBOs. AMITIE also worked to reinforce the health system. To this end, health zone leadership and health zone staff received trainings in relevant services. Moreover, the AMITIE team worked both with the local health system and other NGOs to supporting referral linkages between communities, health centers, and VCT centers. At the provincial and national levels, the AMITIE team was active both in participating and lobbying for national policies and guidelines for OVC and PLHIV.

The project's key achievements are described below by strategic objective and intermediate results.

SO1. IMPROVED QUALITY OF LIFE FOR OVC

AMITIE worked to improve the quality of life of its 7,623 direct OVC beneficiaries, while also creating lasting changes that could benefit all OVC in the DRC. Intermediate results related to improved quality of life for OVC included increased capacity of communities and CBOs to provide care and support for OVC; improved resilience of OVC and their households; and, strengthened enabling environments at the national, provincial, district, and local levels that support and protect the well being of OVC.

IR1.1 Increased Capacity of Communities and CBOs to Provide Care and Support for OVC

To increase the capacity of communities and CBOs to provide care and support for OVC, AMITIE worked to mobilize relevant local groups and stakeholders, to create and strengthen Community Care Coalitions (CCCs), and to train and support home visit volunteers.

During the first year of implementation, community mobilization activities were undertaken to inform relevant stakeholders about the AMITIE project and the CCC

approach. WV's "Guide to mobilizing and strengthening community–led Care for OVC" was key resource used during the mobilizing process. The project organized three training sessions in order to mobilize church leaders, reaching 42 such leaders. Each session took five days and the WV Channels of Hope guide manual was used.

In addition, twelve CCCs were organized – three in Bukavu, four in Matadi and five Lumbumbashi. Each CCC had 15 to 20 members and served approximately one urban health zone. Examples of groups represented on the CCC are shown in Box 2. In total, 153 CCC members were trained in a broad range of modules including: HIV and AIDS and the impact on children; psychosocial and spiritual needs of children and their caregivers; addressing the physical needs of children; equipping OVC for the future; child protection; and proposal writing, among others.

Box 2. CCC Membership

- PLHIV associations
- Churches and FBOs
- NGOs
- Social Service Department
- Ministry of Social Affairs
- Health Zone Leadership
- Local Businesses

AMITIE also trained OVC home visit volunteers in a variety of topics, building their capacity to respond to OVC and needs in their communities. A sample of training modules is provided in Box 3. A total of 300 home visit volunteers were trained (100 per city), of which 150 (50 per city) were focused on providing services to OVC. Many of these volunteers built lasting capacity that they will use to continue serving their fellow community members: 37 of 42 (88%) of volunteers surveyed in Matadi in September 2009 said they planned to continue carrying out home visits even after the end of the project.

Box 3. Selected Home Visitor Training Modules

- HIV and AIDS and the impact on children
- Psychosocial and spiritual needs of children and their caregivers
- Addressing the physical needs of children
- Equipping OVC for the future
- Child Protection
- AMITIE program tools
- Accumulated Savings and Credit Associations (or other IGA model)

TABLE 1. PLANNED ACTIVITIES AND ACCOMPLISHMENTS FOR IR1.1

Activity Planned	Status	Accomplishment
Mobilize community groups for creation of CCC	Achieved	Community groups were mobilized using World Vision's "Guide to mobilizing and strengthening community–led Care for OVC" and the Channels of Hope methodology.
Create CCC	Achieved	12 CCC's created including 3 in Bukavu, 4 in Matadi, and 5 in Lubumbashi.
Organize and train CCC	Achieved	153 Members of 12CCC's trained in a variety of topics including: HIV and AIDS and the impact on children; Psychosocial and spiritual needs of children and their caregivers; Addressing the physical needs of children; Equipping OVC for the future; Child Protection; and, Proposal Writing.

Activity Planned	Status	Accomplishment
Carry out rapid OVC situational analysis	Achieved	Rapid situation analyses were carried out in all three cities served by the project in late 2006.
CCC and caregivers identify OVC needing home-based care	Achieved	7,623 OVC were recruited including 3,861 Males and 3,762 Females.
Select home visit volunteers	Achieved	150 OVC home visit volunteers (50 per city) were recruited.
Train home visit volunteers in provision of basic package and OVC tracking	Achieved	Necessary training modules were identified, modified or developed, and volunteers were trained in a variety of topics (see Box 3).
Home visit volunteers carry out OVC household visits and provide minimum package of services	Achieved	Volunteers recorded over 123,000 home visits during the project.
Develop tools for monitoring of OVC by home visit volunteers	Achieved	AMITIE developed a package of 20 different program tools, inclosing those designed for monitoring OVC.
Train community, religious and FBO leaders for community-based OVC care	Achieved	OVC training materials appropriate for community, religious and FBO leaders were identified.
CCC supervise the home-based caregivers	Achieved	Volunteers submitted monthly reports and received regular supervision from the CCC.
NGO and sub-grantee staff supervise CCCs	Achieved	Project staff (social workers, team leaders and/or medical supervisors) regularly attended CCC meetings.
NGO and sub-grantee staff hold monthly meetings with caregivers	Partially achieved	OVC caregivers were consulted periodically for feedback on the project, but not all partners held these meetings monthly.

IR1.2 Improved Resilience of OVC and their Households

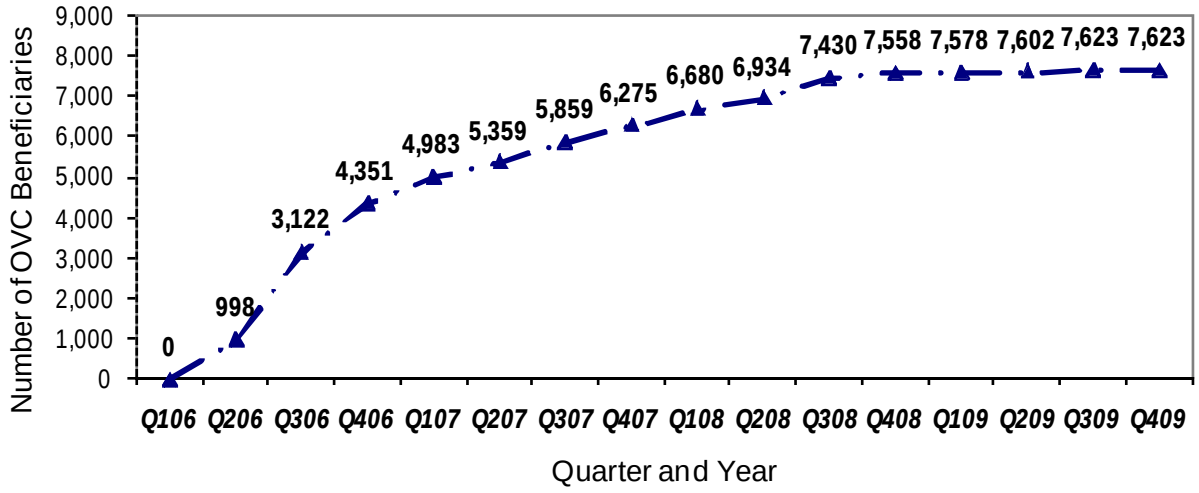
To improve the resilience of OVC, a needs-based package of essential services was defined in accordance with international standards and community-identified needs. Services were then provided to OVC and their family, primarily through home visit volunteers. During their visits, home visit volunteers assessed OVC needs and collected information about the OVC and the household. Information was sent to CCC in monthly reports, which allowed the CCC to tailor service provision to local OVC needs.

The project goal was to reach 7,500 OVC overall (2,500 per city), recruiting 1,644 OVC per city (4,932 overall) in year 1, with a 15% increase per year. While enrollment was slightly below target at the end of Year 1 (4,351 compared to 4,932, or 88%), enrollment continued faster than expected in years 2 and 3 such that overall beneficiary targets had been exceeded by the end of year 3. In light of the targets being met and the limited resources (financial and human) available for additional beneficiaries, recruitment of

new beneficiaries was limited in year 4 and HIV positive OVC were prioritized to ensure that the most vulnerable OVC could benefit from the project. In total, 7,623 OVC were served including 3,861 Males and 3,762 Females, representing 102% of target. Recruitment trends are shown in figure 3. Girls represented between 46% and 50% of program beneficiaries throughout the program (data not shown).

Services available for OVC included psychosocial support, educational assistance and/or vocational training, assistance for IGA, nutrition support, referrals for free medical care and HIV testing, legal assistance, and gifts in kind to help meet basic material needs. Achievements in each of these areas are highlighted in Box 5, and described in more detail below.

FIGURE 3. OVC BENEFICIARY RECRUITMENT



Psychosocial Support services were provided on an on-going and continuing basis to OVC and their families based on needs identified during home visits. Psychosocial support was provided by skilled home visitors and social workers, devoted peers and spiritual guidance counselors during home visits or group support meetings. Both the OVC and their family members benefited from psychosocial support. In total, 123,414 psychosocial support visits were recorded. OVC support groups were also available for OVC and their families. Other activities designed to support the psychosocial well-being of OVC were also organized, such as soccer tournaments and other recreational activities during holidays and school breaks. These were intended to help OVC maintain a positive outlook on life and be able to enjoy pleasurable childhood experiences.

Educational Assistance was the service most recognized by project beneficiaries, volunteers, and CCC members as the project's greatest contribution. AMITIE supported 5,176 OVC (2,585M & 2,591F) with educational assistance and 603 (166M & 437F) with vocational training. In terms of educational and vocational training to OVC, AMITIE provided school kits to OVC and contributed to school fees at primary and secondary schools. Older OVC benefited from vocational training such as arts and crafts, needlework, mechanics, and woodwork, among others. Home visitors and social

workers also collaborated with OVC guardians and schools to closely monitor and ensure OVC performance in school or vocational training. This partnership helped 94% of OVC who received educational support succeed in their studies (as measured by passing exams). Success rates were higher for boys (99.8%) than for girls (90%), despite project efforts, and reflecting the lower value often placed on girls' education.

The original project goal was to support 600 OVC with educational kits and 2,700 OVC with vocation training. As community members identified education assistance as the greater need, and vocational training was relevant only for older OVC, AMITIE ended up by dramatically over-achieving its educational assistance goal (863%), but not achieving its vocational training goal (22%). Overall, the number of children benefiting from educational assistance (school kits, school fees, or vocational training) was more than double the project's goal.

Box 4. Success Spotlight:
OVC Combine Vocational Training and IGA to Ensure Brighter Future

After completing their vocational training, some OVC received additional support from their local CCC in terms of support for Income Generating Activities (IGA). Groups of OVC with similar vocational training often joined together to form workshops in their area of speciality. Several groups of young women, for example, used their IGA support to form clothes shops where they make and sell clothes on sewing-machines bought with IGA support.

Assistance for Income Generating Activities was provided to OVC families to help them become more self-sufficient by increasing their overall income as well as their capacity to meet their basic needs. Beneficiaries were trained in business skills and savings and loan models, such as WV's Accumulated Savings and Credit Association (ASCA) model. In addition, some beneficiaries received start-up grants of key business inputs (for example flour for a bread-making business, or sewing machines for a clothing business). In total 1,820 OVC families received support for IGA. The project goal was to reach 2,700 OVC with IGA activities; since most families have multiple IGAs, the AMITIE team is confident this target has been reached. While data was tracked for IGA success rate, unfortunately, the data was not well understood by all partners, resulting in single families being counted multiple times as having a successful IGA if their IGA continued to be successful at subsequent follow-up. While this problem was noted, data was not able to be adequately retroactively cleaned so information on the success rates of IGA is not available.

Nutrition Support was also provided to OVC determined to be in need. Home visit volunteers routinely assessed the nutritional status of the children they visited through observation and periodic informal surveys of recent meals. The CCCs used information

on nutrition status to plan for both shorter and longer term strategic interventions, ranging from the provision of vitamin supplements, to direct targeted food assistance either through CCC contributions or through linkages to other programs. In total, 4,507 nutrition kits were distributed to OVC, including 2,180 to male OVC and 2,327 to female OVC.

Referrals for medical care and HIV testing services were made to OVC based on need and parent consent. Relationships were established with specific health centers to provide care to referred OVC. These facilities received briefing about the project and its goals to facilitate referrals and counter-referrals. In addition, facility staff received training on OVC care organized by the project in conjunction with the National AIDS Program (PNLS). Selected facilities were also provided with medications as gifts-in-kind through the AMITIE project. OVC were eligible for free services and medications at these centers, increasing their access to important medical care. In all, 2,227 OVC received referrals for medical care (1,063M and 1,163F) and 663 (354M and 309F) were referred for HIV tests at VCT centers with parental consent.

Box 5. OVC Service Highlights

7,623 OVC served (3,861 M & 3,762 F)

5,176 OVC provided educational assistance (2,585M & 2,591F)

94% Educational success rate

603 supported for vocational training (166M & 437F)

1,820 families received support for IGA

4,507 nutrition kits distributed

2,227 referrals for free medical care

663 OVC tested for HIV

5,841 OVC helped to meet basic material needs

Protection and Legal Services were also made available to OVC. Both CCC members and HV were trained in child protection issues and worked to prevent, identify and address child abuse. Through partnership with Diocesan Justice and Peace Commissions, free legal assistance was offered to OVC for abuse cases, inheritance or estate issues. However, only three OVC made use of legal services. CRS and field partners worked to resolve most abuse issues at the community-level reducing need for formal legal action Likewise, it was found that most inheritance and estate laws conflict with local customs and that these issues are still most often addressed at the family- or community- level and not through the courts. Greater information about the relevant laws at the community level is needed achieve greater uptake of these important services.

OVC also received other complementary services on a need basis. For example, 5,841 material kits (clothes and shoes) were distributed to OVC with significant need.

TABLE 2. PLANNED ACTIVITIES AND ACCOMPLISHMENTS FOR IR1.2

Activity Planned	Status	Accomplishment
GIK sources for OVC school supplies are identified and GIK are distributed to OVC by home visit volunteers.	Achieved	In-kind or reduced priced school supplies were procured and made available to OVC as part of their educational assistance.

Activity Planned	Status	Accomplishment
Work with schools and CCCs to ensure OVC access to primary education (advocacy for free education, provision of block school grants, provision of school uniforms and materials and teaching aids)	Achieved	AMITIE worked with schools and CCCs to ensure access to OVC for primary education. The project paid school fees (entirely or a percentage based on OVC need) and provided uniforms and school supplies. Where possible, the project negotiated reduced rates for OVC. Some schools accepted gifts –in-kind (GIK) in place of cash. This reduced the amount of cash needed to pay school fees and also ensured that certain critical supplies were purchased. Examples of such GIK include: better roofs, maps, chalk, paint for boards and walls, etc. The GIK approach also helped improve the quality of schools.
Work with local health centers to ensure OVC have access to free services (provide Gifts-in-kind of medicines/materials)	Achieved	Agreements were negotiated with local health centers (approximately 1 per Health Zone) to receive medications in exchange for free service to project-supported OVC. Health centers also received training in OVC issues and care, and received briefings on the project to facilitate referral and counter-referral.
Identify appropriate opportunities; Promote and support income generation activities for OVC households (i.e. small business development, organize savings clubs, linkage with micro-credit services)	Achieved	In total 1,820 OVC families received support for IGA. Beneficiaries were trained in business skills and savings and loan models, such as the ASCA model. Before being selected for participation in IGA, there was an initial assessment of needs and skills at the family level. Not all project participants were selected for IGA, as for IGAs to succeed, the beneficiaries need to demonstrate a certain business competence, as well as the health necessary to carry out business activities. IGA beneficiaries are involved in various activities including selling maize flour, bread and doughnuts, rearing chickens, selling beans and running restaurants, among others.
Arrange vocational training for older OVC (i.e. driving, tailoring, information technology, and hair dressing)	Achieved	603 (166M & 437F) benefited from vocational training. Vocational training topics arts and crafts, sewing, needlework, mechanics, and woodwork, among others.
Promote improved nutrition (i.e. gardening, crop diversification and food utilization, small animal husbandry, improved sanitation and hygiene)	Partially Achieved	Home visit volunteers received training in nutrition through FANTA modules, and provided information to households on proper diet and nutrition. OVC nutrition was periodically addressed through observation and meal recall. Malnourished OVC received nutritional kits of local products. In total, 4,507 kits were provided. More sustainable solutions such as gardening and animal husbandry proved difficult both because of the urban environment and because it was difficult to change beneficiaries and partner expectations for hand-outs.

IR1.3 Strengthened Enabling Environments at the National, Provincial, District, and Local Levels that Support and Protect the well being of OVC

AMITIE worked to strengthen enabling environments that support and protect the well-being of OVC in order to have a long-term and lasting impact on OVC throughout the

DRC. At the national-level, AMITE liaised with other NGOs as well as relevant national bodies (particularly the PNMLS and the PNLS) and participated in forums and workshops relevant to the well-being of OVC in the DRC. For example, the AMITIE team participated in workshops organized by CARITAS to set standards for IGA activities for OVC. The AMITIE project director also was a key participant in activities that led the development of the 2010-2014 national strategic plan for AIDS response (which includes a section on OVC), as well as the development of guidelines and standards for OVC and PLHIV programming (which are still being finalized).

At the District and Provincial Levels, AMITIE partners were also actively engaged with other NGOs and with the PNMLS and the PNLS and their activities. For example, AMITIE teams participated in the Provincial-Level workshops that contributed to the development of the national strategies described above. In addition, AMITIE partners participated in a variety of OVC related activities including mapping of relevant OVC services, campaigns to improve knowledge about PLHIV and OVC rights, and meetings geared toward coordination and collaboration of OVC services.

AMITIE was most active creating enabling environments at the local level. At the local level, AMITIE focused heavily on creating environments that supported child rights and child protection. All CBO partner organizations, CCC members, and home volunteers were trained in child protection. Volunteers shared protection messages with families and helped to identify signs of abuse as well as to report abuse and find appropriate solutions – such as moving the child to alternative housing. Most abuse cases could be resolved at the family level through intervention from the volunteer and social workers. When solutions could not be found and in case of severe abuse, the Diocesan Justice and Peace Commission provided free legal services to OVC.

AMITIE also engaged a range of other activities at the local level to help promote enabling environments for OVC. For example, each year, AMITIE teams organized events in celebration of World AIDS day, which helped to raise awareness in communities about HIV and AIDS, including the impact on OVC. In addition, AMITIE provided training to health zones staff to inform them of pertinent issues related to OVC. AMITIE also attended local government planning meetings to ensure topics relevant to OVC and PLHIV were considered and discussed.

TABLE 3. PLANNED ACTIVITIES AND ACCOMPLISHMENTS FOR IR1.3

Activity Planned	Status	Accomplishment
At the national level, liaise with various agencies and NGOs (i.e. Min. of Social Affairs, UNICEF, SCF, etc.) concerned with child welfare and rights	Achieved	The AMITIE project director was a key participant in activities that led the development of the 2010-2014 national strategic plan for AIDS response (which includes a section on OVC), as well as the development of guidelines and standards for OVC and PLHIV programming (still being finalized).
Advocate at the national and provincial level for creation or improvements to existing child /OVC laws and policy	Achieved	The AMITIE project director was an active participant in the development of national OVC programming guidelines (ratification underway).

Activity Planned	Status	Accomplishment
At the community level, train teachers, CBOs, CCCs, and Catholic Justice and Peace Commissions (CDJP) on OVC and child protection issues.	Partially Achieved	Partner CBOs, all CCC members and home visit volunteers were trained in child protection issues. Teachers were not specifically targeted for training, except as members of CCCs.
Identify and appoint child protection monitors	Achieved	Project social workers (12 total) served as child protection monitors.
Community – CBOs/CCCs/CDJPs process and monitor child protection and abuse cases with local authorities and relocates children to other foster family if necessary	Achieved	The project favored finding local solutions to abuse issues, with volunteers first trying to solve the problem within the family setting. When volunteers were unsuccessful in resolving the situation, they sought help from Social Workers. Where possible, children were relocated to other possible care-givers. The project supported such transfers through provision of basic needs (for example mattresses) to new foster families as well as increased home visits during the first few months. Only when local solutions were not found, the case file was left with the Diocesan Justice and Peace Commissions.
At the community-level, trained home visitors to assess and identify child abuse/protection issues and channel to appropriate persons	Achieved	Volunteers working with OVC were trained in child protection and how to assess and identify abuse cases. The project favored finding local solutions to these situations, and volunteers were trained to discuss first with families to find solutions. If this failed, social workers were also informed to intervene in the situation. As a final resort, Diocesan Justice and Peace Commissions were engaged for formal legal action.
At the community level, facilitate birth registration of all orphans and vulnerable children	Partially Achieved	The project made available through home volunteers information about the importance of birth registration and offered assistance in this area. However, more widespread behavior change communication efforts are needed to change perceptions about the importance of birth registration as many families remained uninterested.

SO2. IMPROVED QUALITY OF LIFE FOR PLHIV

The project's second strategic objective was to improve the quality of life for 3,750 PLHIV. Intermediate results related to improved quality of life for PLHIV include increased capacity of communities and CBOs to provide quality home based care; strengthened health services to support and link PLHIV with home based care; and, improved resilience of PLHIV and their households. Below, the project's achievements related to each of these intermediate results is described in more detail.

IR2.1 Increased Capacity of Communities and CBOs to Provide Quality Home Based care

To increase the capacity of communities and CBOs to provide care and support for PLHIV, AMITIE worked to mobilize relevant local groups and stakeholders, to create and strengthen Community Care Coalitions (CCCs), and to train and support home visit volunteers. The project's definition of home-based care was broad – including psychosocial support, nutrition counseling, ART counseling and adherence, and referrals for medical care. Traditional home-based medical care was a limited component in light of input from PLHIV that this could be a significant source of stigma and discrimination for them. In addition, as ART because increasingly available in country, the need for in-home medical care reduced. At the end of the project, 75% of PLHIV beneficiaries were receiving ART. As a result, the term "home visit volunteer" is often used in place of "home- based caregiver" to more accurately reflect their role.

During the first year of implementation, community mobilization activities were undertaken to inform relevant stakeholders about the AMITIE project and the CCC approach. The WV Channels of Hope guide was used for the mobilization process. In addition, twelve CCCs were the organized – three in Bukavu, four in Matadi and five Lumbumbashi. Each CCC had 15 to 20 members and served approximately one urban health zone. In total 153 CCC members were trained in a broad range of modules as described in IR1.1.

AMITIE also trained 150 home visit volunteers (50 per city) in a variety of topics, building their capacity to respond PLHIV needs in their communities. A sample of training modules is provided in Box 6. The nutrition component included information such as how to use local seeds and food supplies for improved nutrition. Many of these volunteers built lasting capacity. The majority surveyed during the final month of the project indicated that they will use to continue serving their fellow community members.

Box 6. Example PLHIV Home Visit Volunteer Training Modules

- HIV/AIDS and nutrition (using FANTA training modules)
- ART literacy
- ART counseling
- Adherence support
- AMITIE Tools
- Rights of PLHIV
- IGA Approach

TABLE 4. PLANNED ACTIVITIES AND ACCOMPLISHMENTS FOR IR2.1

Activity Planned	Status	Accomplishment
Support the activities of community leaders to integrate in their regular activities: HIV/AIDS information, promotion of HIV screening including for couples, stigma reduction and non-discrimination within families.	Achieved	Community leaders, including church leaders, received information and skills to support these activities in their community through the Channels of Hope methodology. The Channels of Hope methodology provides two key modules: 1) HIV and AIDS: more than the basics; and, 2) Mobilizing for HIV and AIDS.
Establish CCC and sensitize	Achieved	153 members from 12 CCCs were trained in a variety of

Activity Planned	Status	Accomplishment
them to the needs of PLHIV and issues of stigma and discrimination		topics including PLHIV rights.
Review/modify existing PLHIV training materials for workshop of health personnel; Workshops for Health Zones, Supervisory Nurses, Health Center Nurses, CCCs on the topic of HIV/AIDS and PLHIV care and support	Achieved	Local PNLS staff and health zone teams were trained in HIV/AIDS basics, Care of HIV/AIDS and Opportunistic infection, and ART basics.
PLHIV participate in the design and implementation of home-based care initiatives	Achieved	PLHIV and/or PLHIV Associations were represented on all 12 CCC where they were able to input into the service and delivery packages.
Work with CCCs/PLHIV identify home-based care givers for PLHIV and use some youth as HBC givers	Achieved	150 home visit volunteers for PLHIV were identified in conjunction with CCCs. Just over half of volunteers are men, and some volunteers were also youth.
Train home-based care givers in a *basic package* of care using PNLS protocols and/or training materials	Achieved	Home visit volunteers were trained in psychosocial support, nutrition counseling, and ART counseling and adherence aspects, as well as referral procedures.
Supply and re-supply care kits to home-based care givers (home-based caregivers and/or household caregivers)	Not Achieved	PLHIV consulted during the detailed design phase saw home-based care visitors with kits as signaling to others in the community that they were HIV positive, leading to stigma and discrimination. Instead, a system of referral to partner health facilities and hospitals was put in place.
Support and encourage PLHIV associations to provide peer psycho-social support to PLHIV and become involved in HBC, as desired	Achieved	PLHIV associations were involved in the process of establishing PLHIV support groups in the project's sites.
Home-based caregivers train household caregivers in basic hygiene and sanitation and practical care (nutrition, psychosocial support, etc)	Achieved	Where PLHIV accepted disclosure to their family members, home visit volunteers adopted a family-centered approach to home visits and provided information to household caregivers as well as the PLHIV.
Mobilize religious leaders and members using Channels of Hope for community home-based care	Achieved	Religious leaders were trained using the Channels of Hope approach which provides information on HIV and AIDS, encourages church leaders to become involved in the fight against stigma and discrimination and provides information and tools to help mobilization.

IR2.2 Strengthened Health Services to Support and Link PLHIV with Home Based Care

Though not a facility-based project, AMITIE nonetheless worked to involve and integrate selected health facilities to ensure the availability of a continuum of quality care services for its beneficiaries. Formal partnerships were formed with several hospitals as well as with at least one health center per health zone. These partner facilities received targeted trainings in conjunction with the PNLS (see Box 7) as well as essential medications and supplies as gifts-in-kind. Refresher courses were provided during the second half of the project life. In exchange, these health centers served as referral points for project beneficiaries and provided reduced- or no-cost services. AMITIE also worked in collaboration with related projects led by Family Health International and Population Services International to foster linkages and referral networks between VCT centers, prevention services, and AMITIE's care and treatment services.

Box 7. Trainings Provided to Health Facility Staff

- HIV and AIDS basics
- Care of HIV and AIDS and Opportunistic Infections
- ART basics
- AMITIE Project including referral systems

TABLE 5. PLANNED ACTIVITIES AND ACCOMPLISHMENTS FOR IR2.2

Activity Planned	Status	Accomplishment
Train health care providers who are involved in MCH, STI, HIV/AIDS health services to support home-based care and give refresher courses	Not Achieved	As mentioned previously, after input from local PLHIV, the project took a facility-based rather than home-based care approach for medical care to PLHIV.
Establish a supervisory system using health center staff and/or NGO/CBO/CCC staff to ensure quality of HBC and support home-based care givers	Achieved	Supervisory structures were established in each project area. Because the project was not able to provide significant support to health center staff, it was unrealistic to expect them to be the primary supervisors for home visit volunteers. In order to assure high quality supervision, home visit volunteers were supervised jointly by CCCs and project social workers.
Create ties with other health structures capable of treating OI, TB, STI, and ART	Achieved	The project identified at least one health center per health zone which would serve as a referral point for project patients. Health zones have an average population of 100,000 people; because the project worked only in urban and peri-urban areas, these facilities were largely accessible to beneficiaries. Partner health centers and hospitals received training and supplies.
Create a two-way referral system with local health care center staff for testing at VCT and treatment of OI, TB, STI, and ART and HBC givers	Achieved	For VCT, AMITIE worked with a project implemented by Family Health International to create referral and counter-referral systems. For OI, TB, STI, and ART services, the project created linkages with health centers and hospitals which were supported with training and medical supplies. All supported health

Activity Planned	Status	Accomplishment
		facilities were briefed on the AMITIE project and its services to enable effective counter-referral. Home volunteers were likewise fully informed of services available at partner health centers in order to make referrals.

IR2.3 Improved Resilience for PLHIV and their Families

To improve the resilience of PLHIV, a needs-based package of essential services was defined in accordance with international standards and community-identified needs. Services were then provided to PLHIV and their family (based on their disclosure), primarily through home visit volunteers. During their visits, home visit volunteers assessed PLHIV needs and collected information about the PLHIV and the household. Volunteers sent monthly reports to the CCC, which allowed the CCC to better tailor service provision to local PLHIV needs. Services available for PLHIV included psychosocial support; assistance for IGA; nutrition counseling and support; referrals for medical care, including basic care, ART, and CD4 count testing; and, legal assistance.

The project goal was to reach 3,750 PLHIV overall (1,250 per city), recruiting 800 PLHIV per city (2400 overall) in year 1, with a 15% increase per year. As with OVC enrollment, recruitment was slightly below target at the end of Year 1 (2,026 compared to 2,400, or 84%). But, enrollment continued faster than expected in years 2 and 3 such that overall beneficiary targets had been exceeded midway through year 3. In light of the targets being met and the limited resources (financial and human) available for additional beneficiaries, recruitment of new beneficiaries was limited in year 4. In total, 4,279 PLHIV were served (114% of target) including 1,263 Males and 3,016 Females. Recruitment trends are shown in Figure 4. Women represented between 68% and 73% (figure 5) of PLHIV beneficiaries in the project, reflecting the increased vulnerability of women to HIV as well as the higher uptake of counseling and testing services by women. PLHIV service delivery achievements are described below and highlighted in box 8.

FIGURE 4. PLHIV BENEFICIARY RECRUITMENT

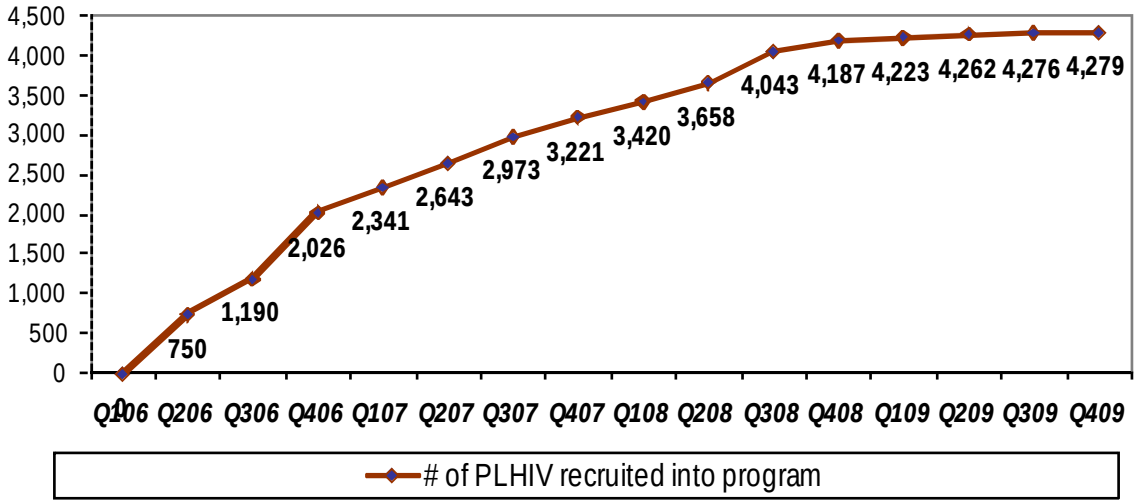
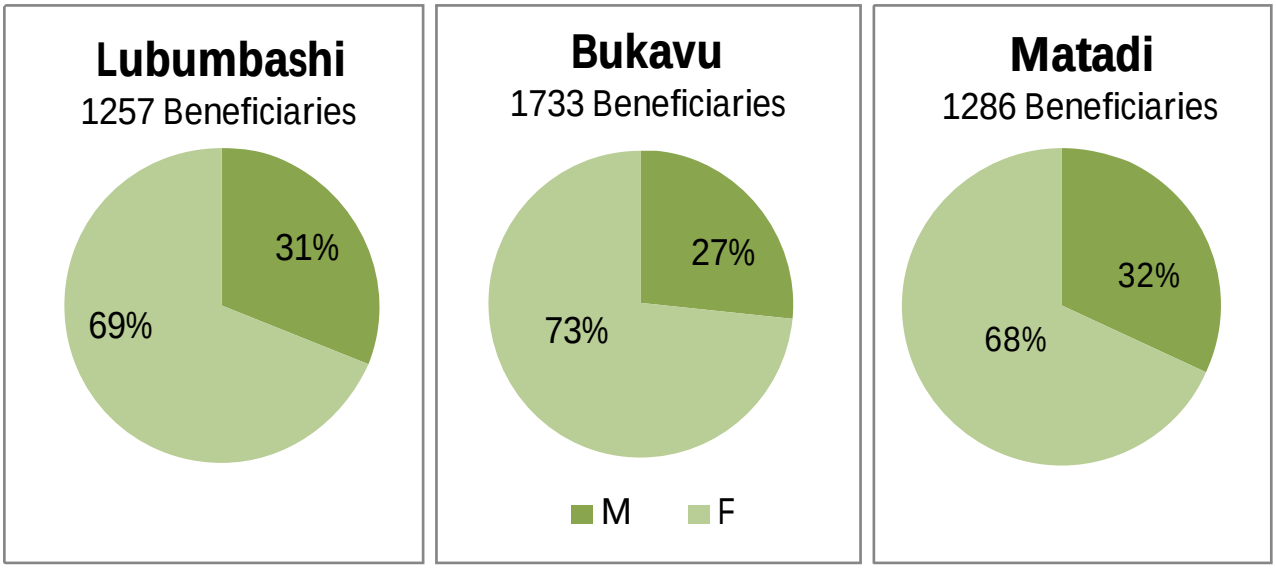


FIGURE 5. PLHIV GENDER RATIOS BY CITY



Psychosocial Support services were provided on an on-going and continuing basis to PLHIV based on needs identified during home visits. The focus of the psychosocial support was to encourage positive living and mitigate depression. Family remembers of PLHIV who had disclosed also received psychosocial support and were supported in providing on-going daily psychosocial support in the home. PLHIV who had not yet disclosed were encouraged to do so. Psychosocial support was provided by skilled home visit volunteers, social workers, devoted *peers* and spiritual guidance counselors during home visits or group support meetings. In total, 81,989 psychosocial support visits were recorded. In addition, support groups for PLHIV were organized throughout the project.

Assistance for Income Generating Activities was provided to PLHIV or families with the goal of making them more self-sufficient and increasing their overall income as well as their capacity to support their needs. The target was to reach 450 PLHIV with these services. Beneficiaries were trained in business skills and savings and loan models, such as WV's Accumulated Savings and Credit Association model. In addition, some beneficiaries received start-up grants of key business inputs (for example flour for a bread-making business). In total 2,120 PLHIV families received support for IGA (471% of target). While data was tracked for IGA success rate, unfortunately, the data was not well understood by all partners, resulting in single families being counted multiple times as having a successful IGA if their IGA continued to be successful at subsequent follow-up. While this problem was noted, data was not able to be adequately retroactively cleaned so information on the success rates of IGA is not available.

Nutrition Counseling and Support was also provided to PLHIV determined to be in need. Home visit volunteers, trained with FANTA training modules, provided nutrition information, such as planning a balanced diet and the promotion of home gardens, to PLHIV and their families. Targeted food assistance was also made available to

moderately or several malnourished PLHIV. PLHIV initiating ART received six-month food supplementation as recommended by the WFP.

Project-provided food assistance was nutrition kits developed based on FANTA recommendations and made of selected local foods. The nutrition kit was designed to supply the beneficiary with a minimum amount of 1,000 kcal per day to supplement their existing diet. The project distributed 10,213 kits including 3,351 in Bukavu, 2,677 in Lubumbashi and 4,185 in Matadi.

Box 8. PLHIV Service Highlights

4,279 PLHIV served (1,263 M & 3,016 F)

2,120 families received support for IGA

48,639 nutrition kits distributed including 38,426 provided by the WFP and 10,213 purchased by AMITIE

10,125 referrals for free medical care

418 referrals for TB screening

1,285 referrals for ART

74% of beneficiaries receiving ART

7,131 material-needs kits distributed

The project also partnered with the WFP which made available rations for PLHIV meeting eligibility criteria. In total, the WFP provided 38,426 monthly rations to AMITIE's PLHIV beneficiaries, including 26,750 in Bukavu, 10,518 in Lubumbashi, and 1,158 in Matadi. Because the WFP scaled down operations in the DRC during the life of the project, rations were not available in Matadi after 2007. As a result, Matadi had the lowest coverage of WFP food support. To partially compensate for the limited external resources available in Mataid, AMITIE allocated the highest coverage of project support there. Overall, the largest number of food rations was distributed in Bukavu, reflecting the greater food insecurity there as a result of the conflict and displacement.

Referrals for medical care, TB testing, ART, and CD4 count tests were made to PLHIV based on need. Relationships were established with specific health centers and hospitals that were provided training on care for PLHIV as well as medications as gifts-in- kind through the AMITIE project. Facility staff received training in topics such as HIV and AIDS basics, Care of HIV, AIDS and Opportunistic Infections, and ART basics. Facility also received information about the AMITIE project and it services as well as how to refer other HIV positive patients for home visitor services. In total, 10,125 referrals were made for medical care (including cotrimoxizole prophylaxis), 418 referrals were made for TB screening, and 1,285 referrals were made for ART. With the scale-up of ART through the national health system, 3,201 of 4,279 (74%) of project beneficiaries were receiving ART by the end of the project.

Legal Services were made available to PLHIV through a partnership with the Diocesan Justice and Peace Commissions that allowed PLHIV to access legal services free of charge. For PLHIV, legal services were available to help them settle inheritance issues and prepare notarized wills and testaments so that their wishes could be carried out in the event of their death. Legal services were among those least sought from AMITIE, with just 36 PLHIV making use of these services to prepare wills and testaments. The low service utilization rate shows that there is need for greater information about the

relevant laws at the community level to achieve greater uptake of these important services.

PLHIV also received other services on a need-based basis. For example, 7,131 material kits (clothes and shoes) were distributed to PLHIV with significant need over the life of the project.

TABLE 6. PLANNED ACTIVITIES AND ACCOMPLISHMENTS FOR IR2.2

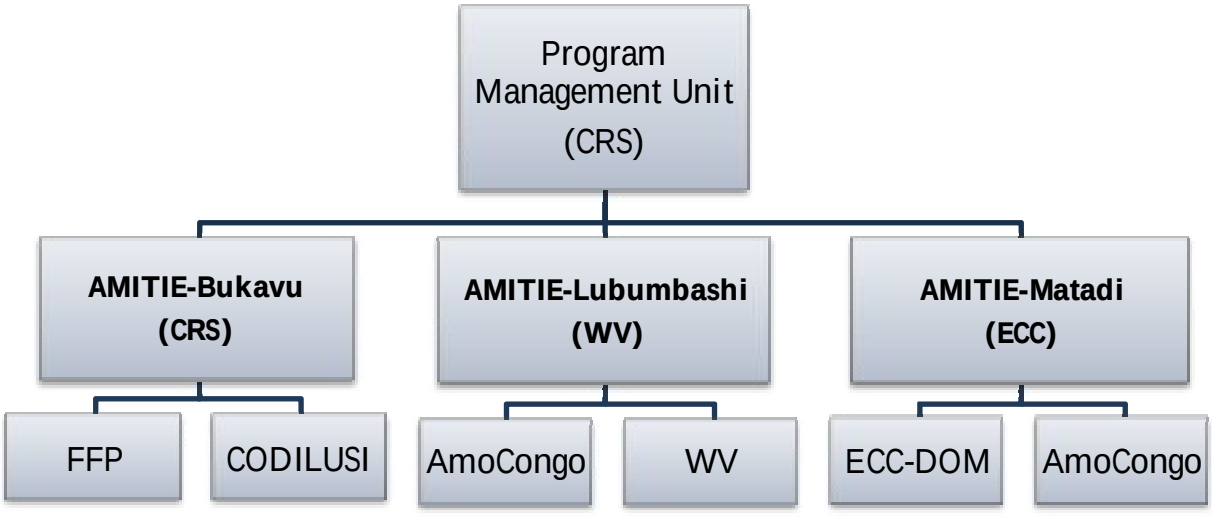
Activity Planned	Status	Accomplishment
Train caregivers and PLHIV assns in positive living	Achieved	Positive Living was a part of the psychosocial support training provided to the 150 PLHIV home visit volunteers
Home visit volunteers and PLHIV associations promote positive living (consumption of locally available, healthy and immune boosting foods, etc.)	Achieved	Positive Living promotion was part of routine psychosocial support visits and was also addressed at PLHIV support groups. Additional training of volunteers with FANTA modules helped add extra emphasis to the nutritional aspects of Positive Living.
Train home-based caregivers to teach about health nutrition	Achieved	Home visit volunteers were trained in nutrition promotion using FANTA training modules.
Promote improved household nutrition through household gardening, production of low labor and immune boosting crops, targeted emergency food assistance.	Partially Achieved	Home visit volunteers were trained in nutritional aspects including promoting relevant locally available crops and home gardens. While the promotion was carried out, the uptake of household gardening was small. As the project was implemented in urban areas, PLHIV and their households struggled to access free space for gardening. Community gardens were particularly difficult.
Identify, promote and support appropriate income-generating activities for PLHIV	Achieved	2,120 beneficiaries were trained in business skills and savings and loan models, such as the ASCA model. Before being selected for participation in IGA, there was an initial assessment of needs and skills at the family level. Not all project participants were selected for IGA, as for IGAs to succeed, the beneficiaries needed to demonstrate a certain business competence, as well as the health necessary to carry out activities. The beneficiaries are involved in various activities including selling maize flour, bread and doughnuts, rearing chickens, selling beans and running restaurants, among others.

MANAGEMENT HIGHLIGHTS

The AMITIE consortium brought together a range of local and international FBOs and CBOs under the leadership of Catholic Relief Services (CRS). CRS, World Vision International (WV) and Church of Christ in Congo (ECC) were each responsible for leading project efforts in one of the targeted cities. Keeping its emphasis on building local-level capacity, AMITIE also welcomed with several national-level FBOs and CBOs to the consortium team: AMO-Congo, Fondation *Femme Plus* (FFP), and Bukavu's diocesan HIV and AIDS committee (CODILUSI). All of the program partners were joined under the leadership of a Program Management Unit and Program Advisory Committee.

The Program Management Unit (PMU), based in the CRS office in Kinshasa, was directed by Dr Raphael Bajay Tchumah. Dr Tchumah is a Congolese national with extensive HIV and AIDS programming experience. Providing leadership to the PMU, Dr Tchumah ensured the technical and managerial quality of interventions and overall administration of the grant. Dr. Tchumah was also be supported by the additional HIV and AIDS technical and management support of CRS' regional and headquarters-level technical assistance team, including Dr Ruth Kornfield and Mr Walsh. At the onset of the project, Dr. Kornfield devoted 20% of her time to AMITIE, bringing her extensive African experience in VCT and HBC as well as research methodology, monitoring and evaluation, and grant management. Mr. Walsh likewise supported the project at its onset with 20%, contributing his significant management and monitoring and evaluation experience.

FIGURE 6. PROJECT MANAGEMENT STRUCTURE



A Program Advisory Committee (PAC) functioned as an advisory unit to the PMU. The PAC included leadership and technical staff from each of the major consortium partners. The PAC met quarterly to review program progress, ensure that targets are met and interventions are carried out to the highest quality. The PAC also worked closely with the PMU to quickly and effectively resolve challenges identified in program implementation.

Field Offices were established in each of the project's intervention cities. Field Offices were under the leadership of the consortium charged with leading implementation in the city. The Field Offices managed the program in the field and oversaw the local collaborators who are the direct program implementers. Field Offices included at least two experienced senior staff (for example a medical supervisor and grant manager) and a team of support staff. As shown in the implementation model (Figure 2, above), the Medical Supervisor was charged with creating and supporting the system which delivered services to beneficiaries. Medical supervisors also worked closely with district and provincial leaders to foster enabling environments. The Grant Manager was in charge of administrative and financial management of the program.

Each Field Office was supported by the PMU, who carried out field visits to each Field Office at last quarterly. PMU field visits served to provide technical assistance, and share information and lessons learned from the PMU to the different field offices. Field Offices, in turn, conducted supervision of their local collaborators to verify program progress, correct data collection and complete record keeping. They also monitored activity implementation plans, engage in problem identification and solving, conducted quarterly project reviews and identified best practices and success stories to share.

CHALLENGES, LESSONS LEARNED AND RECOMMENDATIONS

The AMITIE Project exceeded its beneficiary services and achieved nearly all of its planned activities. The project nonetheless faces several challenges, notably with regard to the delivery of gifts-in-kind contribution, managing local partnerships, ensuring strong referral networks and linkages, and, meeting beneficiary expectations in a culturally appropriate manner.

Gifts in Kind Clearance

Gifts-in-kind - including medications for partner health facilities, school supplies, and material kits for the neediest OVC and PLHIV - made up a significant part of the project's activities and overall budget. While the project was able to distribute more than US$3.4 million worth of gifts-in-kind, the customs clearing process was difficult and slower than the project had anticipated. As a result, no gifts-in-kind were distributed during the project's first year, and the largest gifts in kind shipments (in terms of value) were not distributed until the project's final year.

As the project team became more familiar with the customs clearing process and timeline for item delivery, they were able to make adjustments in their planning. However, the availability of gift-in-kind items remained unreliable throughout the life of the project, despite the delivery of approximately $800,000 worth more in gifts-in-kind than planned. Instability in availability had a particular impact on the quality of free medical care available to OVC and PLHIV at partner health facilities. In some cases, OVC and PLHIV were required to pay for care at other facilities since the partner facilities lacked the essential medicines provided through the gifts-in-kind supply chain.

Recommendation: Projects with significant gifts in kind components should have a good understanding of the time associated with the gifts in kind pipeline, as well as possible challenges. A reserve line of cash or supplies should be made available to cover possible essential gaps.

TABLE 7. PLANNED AND ACTUAL GIFTS IN KIND DELIVERIES

Year	FY 2006	FY2007	FY2008	FY2009	Total
Planned	$529,200	$635,222	$701,785	$865,407	$2,623,074
Realized	$0	$624,313	$1,222,199	$1,580,795	$3,427,304

Managing Local Partnerships

The AMITIE approach sought to create local capacity to support an ongoing response to OVC and PLHIV needs. While this strategy allowed the project to have significant impacts in terms of local partner and CBO, and CCC technical knowledge, project implementation experience, and managerial systems, it was not without challenges.

Notably, the AMITIE team had to overcome different approaches toward meeting the project's goals. The AMITIE team had to dialogue extensively with local partners to streamline the project's strategies with partners' skills, experiences, and other programming. Many of the local FBOs and CBOs chosen as AMITIE partners had previous or ongoing experience with projects responding to OVC and/or PLHIV in their

communities. However, many of these existing projects were more relief-oriented, whereas the AMITIE project was interested in creating *resilience* among OVC and PLHIV families through a development-oriented approach. During the early phase of the project, the AMITIE team struggled to achieve mutual understanding and acceptance of project strategies from all partners and beneficiaries. Many partners and beneficiaries were experienced with programs that provided OVC and PLHIV with donations of tangible items, and were expecting a similar strategy from AMITIE. Since many PLHIV, for example, were used to food aid, it was difficult for the project to garner the buy-in needed to make more sustainable alternatives, such as home gardens, fully successful. The AMITIE team continued to work with local partners to build their capacity in these new, more sustainable approaches. This process however took time and reduced the coverage of these interventions compared to others. As described in Box 8, this experience underlined the importance of taking the time early on to develop mutual understanding of the project strategies and goals with partners and beneficiaries.

Box 8. Key Lesson: Effective Partnerships

AMITIE was designed with sustainability and self-sufficiency in mind. But, beneficiaries and local partner organizations were at first reluctant to accept this approach and favored instead donation-oriented activities with which they were more familiar. Throughout the life of the project, AMITIE made gradual headway, gaining increasing acceptance for activities such as home gardens in place of food aid. Overall, however, project leadership was slightly disappointed that these interventions were not more widespread.

This experienced showed both the value and necessity of in-depth meetings and workshops with local partners and beneficiaries as soon as possible after project financing. While partnership meetings were held throughout the project, partners and beneficiaries had already heard about the project and formed expectations. Workshops scheduled earlier during the process could have helped to prevent misconceptions about project services, and build mutual acceptance and understanding of partner past experience, as well as project goals and strategies.

Of course, differing opinions between partners may persist, despite in depth discussions and commitment to partnership. One potential solution, if local partners remain reluctant to buy-in into project strategies, is to encourage and implement small-scale operations research that compares partners existing approach to the proposed project strategy. Doing so would allow different ideas to be tested side by side while building local and international.

Recommendation: Projects working in conjunction with local partners should meet with partners and beneficiaries as early after project funding as possible. Meeting should be geared toward developing a common understanding of the projects goals, objectives, strategies, and the contributions of various stakeholders (implementing agency, local partners, beneficiaries, etc). Sufficient time should be allotted to these exercises to develop widespread consensus and allow the project to move forward seamlessly. In addition, the forums must be conducted in an environment of mutual respect so that partner's feel If partners able in voicing opinions differing from the project team without risk of loosing funding or status as partners. If different points of view toward project strategies persist, experimentation and operations research should be considered and

encouraged to allow partners to see first hand the effects of the different strategies – while also contributing to the local and international knowledge bases.

In addition, project such as this one operating in multiple geographic areas should strongly consider organizing Communities of Practice (CoPs) at various levels throughout the project. While AMITIE's PMU/PAC model was effective in sharing across sites from the top down, CoPs organized among social workers, CCC members, or even home visit volunteers, could have facilitated sharing of positive experiences across sites (increasing acceptance of new strategies). As an added benefit, these CoPs are often lasting networks of people with similar interests and goals which contribute to on-going problem-solving.

Referral Networks & Linkages

As one of three USAID-financed HIV and AIDS programs operating in Matadi, Lubumbashi and Bukavu during the time period, AMITIE sought to build linkages and create referral networks to provide the most complete service coverage to beneficiaries. To this end, the following referral links were established:

- People testing positive at VCT sites supported by Family Health International were referred for care and support services provided by AMITIE.
- AMITIE beneficiaries who did not know their HIV status (such as OVC, PLHIV partners, and other OVC and PLHIV family members) were referred for VCT at clinics supported by Family Health International.
- OVC and PLHIV needing medical care were referred to partner facilities for basic medical care (free or reduced-cost), cotrimoxizole prophylaxis, CD4 count testing, ART, or TB screening based on their need.
- OVC and PLHIV seeking medical care at partner facilities were referred to the home-based services available through the AMITIE program.

However, the program faced two key challenges with these referral networks: lack of control of quality of referral services, and ensuring effective counter-referral.

AMITIE understandably lacked control over quality of some of the external services to which beneficiaries were referred. While the project supported certain facilities and services through trainings and supplies, most services (for example CD4 count, ART, TB screening) fell beyond the scope of the project. As a result, AMITIE could not ensure that its referrals were effective (to quality services). For example, AMITIE noted that some beneficiaries referred for ART at local health facilities, faced disruptions in their medications due to supply chain problems in the health system. These quality issues were frustrating to the AMITIE team since they were nearly impossible for the project to address. While linkages with external projects are always a challenge, regular meetings with referral points are important to develop mutual understanding of service availability and expectations.

Another related challenge faced by AMITIE was ensuring the effectiveness of counter-referral mechanisms. While the project was able to ensure that referrals from AMITIE to other projects were occurring, it was more difficult for AMITIE to know whether and to what external services were referring beneficiaries to AMITIE. This reflects the inherent difficulty of requesting services, information and data collection from people and

facilities that are not directly supported by the project. A partial solution which will be considered for future programming is tracking on beneficiary enrollment forms how they came to know about the program. This approach will not reflect the total number of referrals made, but will provide some insight into how and where beneficiaries come to know about the program. Periodic surveys or observations at referring facilities could provide additional information.

Recommendation: When counter-referral systems rely on external actors, projects should work to identify ways to incentivize referrals and the collection of associated data. If external data remains problematic, projects should consider other sources of information on the effectiveness of referral networks – such as surveys of beneficiaries to find out how they learned about the project or service of interest.

Meeting Beneficiary Expectations in a Culturally Appropriate Manner

Three of the project's planned services were difficult to implement as planned, due to beneficiary expectations and local cultural norms. The affected services were medical home-based care, legal services, and protection services.

As described above, the project had originally planned to offer medical home-based care as a significant part of the home-based care package to PLHIV. However, PLHIV indicated that home volunteers visiting with home-based care kits could be a signal to others in the community that they are HIV positive, leading to stigma and discrimination. As a result, PLHIV strongly preferred medical care be provided through facilities. Other options were also considered, such as providing one kit per PLHIV rather than one kit per volunteer so that the kit would not have to travel. However, in light of the reduced need for home-based medical care associated with increasing access to ARVs, AMITIE chose to honor the beneficiary's preference for facility-based care, by supporting selected facilities to offer free or reduced-cost services to referred beneficiaries.

Another planned project service that faced cultural acceptance barriers was legal services. Only 36 beneficiaries made use of legal services such as preparing notarized wills or settling inheritance disputes. The difficulty was twofold. First, notarized will were rare in the community and there was little knowledge of the law regarding wills. As a result, even though the project worked to inform PLHIV and OVC caretakers about the need for notarized wills, the information had minimal effect on behavior change. Secondly, the official laws about which the project was informing its beneficiaries were often contradictory to local customs. Since beneficiaries were used to settling inheritance matters at the family or community level, there was little interest in formal legal services.

The final planned service that faced cultural acceptance barriers was protection services for OVC and PLHIV. AMITIE's volunteers and CCC members were all trained in child protection aspects, and the project set up systems to prevent, identify, mitigate, and address child abuse. Nonetheless, differing understandings of what constituted abuse persisted, with minor cases of abuse – such as a child being occasionally hit by a parent – were rarely identified as abuse through the project. Similarly, some beneficiaries and volunteers were reluctant to report abuse when alternative housing was not available. An abused OVC for example, often was often willing to accept their situations when the

perceived alternative was being homeless. The project worked to instill confidence in beneficiaries about their commitment to find alternative care environments, but developing this level of trust often takes time.

Recommendations: When beneficiaries are reluctant about a service or delivery mechanism for cultural, projects should remain flexible in how that identified need is met. Beneficiary preferences should be taken into account, and compromises should be sought as long as quality and the project's objectives are not compromised. Several suggestions for addressing legal and protection services are provided below.

To be effective, projects addressing legal services should either include or be paired with a comprehensive information campaign about relevant laws that reaches the entire community and not just project beneficiaries. This is necessary to change the pervading cultural norms that can block uptake of these services.

Dealing with sensitive issues such as child abuse will often be both a challenging and a gradual process. Nonetheless, several strategies can be adopted to speed the process. For example, the project should work to identify a "child's rights champion". This spokesperson – an abuse survivor – can share with others in their situation that abuse is unacceptable and that there are alternatives. This kind of personal testimonial may have greater impact on other victim's willingness to report abuse and seek help for changing their situation than counseling from volunteers or social workers. Projects may also wish to consider putting in place a stand-by network of willing foster families, so that there is always a readily available alternative arrangement for PLHIV and OVC in need. This is often extremely challenging in low resource settings however, and taking in a non-relative can be culturally counter-indicated. Finally, as with promoting legal services, projects must work not only at the beneficiary level but also at the community level to begin changing the underlying cultural norms that lead abuse to go unaddressed.

ANNEX 1. PROJECT INDICATORS

Key services provided to beneficiaries			FY06			FY07			FY08			FY 09			Total		
			M	F	Total	M	F	T	M	F	T	M	F	Total	M	F	Total
1	*Nb of OVC recruited into program*	**BKV**	708	644	1352	292	307	599	339	302	641	0	0	0	1,339	1,253	2,592
		LBB	988	1065	2053	192	179	371	82	86	168	0	0	0	1,262	1,330	2,592
		MTD	512	434	946	478	476	954	239	235	474	31	34	65	1,260	1,179	2,439
		TOTAL	**2208**	**2143**	**4351**	**962**	**962**	**1924**	**660**	**623**	**1283**	**31**	**34**	**65**	**3,861**	**3,762**	**7,623**
2	*Nb of PLHIV recruited into program*	**BKV**	201	604	805	104	263	367	151	393	544	5	12	17	461	1,272	1,733
		LBB	246	541	787	112	209	321	34	115	149	0	0	0	392	865	1,257
		MTD	129	305	434	153	355	508	104	168	272	24	51	75	410	879	1,289
		TOTAL	**576**	**1450**	**2026**	**369**	**827**	**1196**	**289**	**676**	**965**	**29**	**63**	**92**	**1,263**	**3,016**	**4,279**
3	*Nb of OVC provided with Education assistance*	**BKV**	173	146	319	293	294	587	50	44	94	25	22	47	541	506	1,047
		LBB	250	185	435	356	425	781	164	182	346	770	792	1,562	1,540	1,584	3,124
		MTD	115	115	230	85	95	180	280	266	546	24	25	49	504	501	1,005
		TOTAL	**538**	**446**	**984**	**734**	**814**	**1548**	**494**	**492**	**986**	**819**	**839**	**1,658**	**2,585**	**2,591**	**5,176**
4	*Nb of OVC assisted for vocational training*	**BKV**	5	6	**11**	38	56	**94**	10	6	**16**	4	14	**18**	57	82	139
		LBB	0	0	**0**	0	124	**124**	0	88	**88**	0	0	**0**	0	212	212
		MTD	5	29	**34**	15	53	**68**	76	61	**137**	13	0	**13**	109	143	252
		TOTAL	**10**	**35**	**45**	**53**	**233**	**286**	**86**	**155**	**241**	**17**	**14**	**31**	**166**	**437**	**603**
5	*Nb of OVC in school age (> 5ans):*	**BKV**	0	0	0	799	738	1537	0	0	0	0	0	0	799	738	1,537
		LBB	0	0	0	894	1136	2030	8	8	16	0	0	0	890	1,132	2,022
		MTD	0	0	0	733	682	1415	53	54	107	25	29	54	811	765	1,576
		TOTAL	**0**	**0**	**0**	**2426**	**2556**	**4982**	**61**	**62**	**123**	**25**	**29**	**54**	**2,500**	**2,635**	**5,135**

Key services provided to beneficiaries			FY06			FY07			FY08			FY 09			Total		
			M	F	Total	M	F	T	M	F	T	M	F	Total	M	F	Total
6	Nb of OVC which succeed in their school	BKV	0	0	0	362	276	638	492	451	943	31	48	79	885	775	1,660
		LBB	0	0	0	473	418	891	136	207	343	N/A	N/A	1,390	609	625	2,624
		MTD	0	0	0	175	190	365	418	408	826	408	391	799	1,001	989	1,990
		TOTAL	**0**	**0**	**0**	**1010**	**884**	**1894**	**1046**	**1066**	**2112**	**439**	**439**	**2,268**	**2,495**	**2,389**	**4,884**
7	Nb of nutritional kits served to OVC	BKV	94	89	183	258	329	587	213	238	451	71	68	139	636	724	1,360
		LBB	66	90	156	227	340	567	39	62	101	23	39	62	355	531	886
		MTD	501	386	887	458	448	906	86	80	166	144	158	302	1,189	1,072	2,261
		TOTAL	**661**	**565**	**1226**	**943**	**1117**	**2060**	**338**	**380**	**718**	**238**	**265**	**503**	**2,180**	**2,327**	**4,507**
8	Nb of OVC fam- provided wassistance for IGA	BKV	42	58	100	75	89	164	72	98	170	39	46	85	228	291	519
		LBB	53	1	54	98	130	228	215	232	447	5	17	22	371	380	751
		MTD	18	44	62	64	107	171	121	141	262	23	32	55	226	324	550
		TOTAL	**113**	**103**	**216**	**237**	**326**	**563**	**408**	**471**	**879**	**67**	**95**	**162**	**825**	**995**	**1,820**
9	Nb of OVC's IGA that succeed	BKV[1]	27	39	66	83	105	188	56	90	146	112	152	264	278	386	664
		LBB	0	0	0	14	23	37	143	209	352	204	263	467	361	495	856
		MTD	15	15	30	54	69	123	58	62	120	67	143	210	194	289	483
		TOTAL	**42**	**54**	**96**	**151**	**197**	**348**	**257**	**361**	**618**	**383**	**558**	**941**	**833**	**1,170**	**2,003**
10	Nb of OVC provided with material kits	BKV	77	66	143	392	369	761	281	330	611	560	382	942	1,310	1,147	2,457
		LBB	145	92	237	38	63	101	68	226	294	721	953	1,674	972	1,334	2,306
		MTD	86	54	140	346	468	814	0	0	0	56	68	124	488	590	1,078
		TOTAL	**308**	**212**	**520**	**776**	**900**	**1676**	**349**	**556**	**905**	**1,337**	**1,403**	**2,740**	**2,770**	**3,071**	**5,841**

[1] Problems have been recognized in the collection of this indicator with the Bukavu-based teamwho have been multiplying counting successful IGAs (for example, an IGA is counted as successful if it is still succeeding at its first follow up visit, but is counted again if it is still successful at second follow up visit). Unfortunately, the programwas not able to retroactively clean all the data so errors persist.

	Key services provided to beneficiaries		FY06			FY07			FY08			FY 09			Total		
			M	F	Total	M	F	T	M	F	T	M	F	Total	M	F	Total
11	Nb of OVC provided with legal assistance	BKV	0	0	0	0	0	0	0	0	0	0	2	2	0	2	2
		LBB	0	0	0	0	1	1	0	0	0	0	0	0	0	1	1
		MTD	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
		TOTAL	**0**	**0**	**0**	**0**	**1**	**1**	**0**	**0**	**0**	**0**	**2**	**2**	**0**	**3**	**3**
12	Nb of home visits to OVC/psychosocial assistance	BKV	688	642	1330	2096	1805	3901	4836	4461	9297	3,821	3,616	7,437	11,441	10,524	21,965
		LBB	660	864	1524	4709	5237	9946	7680	9612	17292	6,019	7,278	13,297	19,068	22,991	42,059
		MTD	2830	2158	4988	7143	8648	15791	11001	11638	22639	7,926	8,046	15,972	28,900	30,490	59,390
		TOTAL	**4178**	**3664**	**7842**	**13948**	**15690**	**29638**	**23517**	**25711**	**49228**	**17,766**	**18,940**	**36,706**	**59,409**	**64,005**	**123,414**
13	Nb of referrals for medical care	BKV	0	0	0	120	100	220	100	103	203	3	10	13	223	213	436
		LBB	69	70	139	191	219	410	128	169	297	42	73	115	430	531	961
		MTD	0	0	0	140	148	288	183	190	373	87	82	169	410	420	830
		TOTAL	**69**	**70**	**139**	**451**	**467**	**918**	**411**	**462**	**873**	**132**	**165**	**297**	**1,063**	**1,164**	**2,227**
14	Nb of OVC referred for testing (paient consent)	BKV	0	0	0	50	61	111	36	36	72	16	27	43	102	124	226
		LBB	0	0	0	49	42	91	15	23	38	5	7	12	69	72	141
		MTD	3	5	8	46	47	93	14	16	30	120	45	165	183	113	296
		TOTAL	**3**	**5**	**8**	**145**	**150**	**295**	**65**	**75**	**140**	**141**	**79**	**220**	**354**	**309**	**663**
15	Nb of OVC testing positive	BKV	16	15	31	20	16	36	96	114	210	1	1	2	133	146	279
		LBB	0	0	0	0	0	0	6	3	9	3	2	5	9	5	14
		MTD	0	0	0	18	14	32	9	5	14	64	52	116	91	71	162
		TOTAL	**16**	**15**	**31**	**38**	**30**	**68**	**111**	**122**	**233**	**68**	**55**	**123**	**233**	**222**	**455**

Key services provided to beneficiaries			FY06			FY07			FY08			FY 09			Total		
			M	F	Total	M	F	T	M	F	T	M	F	Total	M	F	Total
16	Nb of OVC deaths	BKV	0	0	0	6	2	8	3	1	4	4	4	8	13	7	20
		LBB	0	0	0	2	8	10	3	14	17	1	1	2	6	23	29
		MTD	0	0	0	5	0	5	1	1	2	0	1	1	6	2	8
		TOTAL	0	0	0	13	10	23	7	16	23	5	6	11	25	32	57
17	# of OVC prim direct benef (EDU+ IGA+ PSS)	BKV	0	0	0	0	0	0	496	438	934	40	44	84	536	482	1,018
		LBB	0	0	0	0	0	0	930	1061	1991	1,216	1,245	2,461	2,146	2,306	4,452
		MTD	0	0	0	0	0	0	134	172	306	21	26	47	155	198	353
		TOTAL	**0**	**0**	**0**	**0**	**0**	**0**	**1560**	**1671**	**3231**	**1,277**	**1,315**	**2,592**	**2,837**	**2,986**	**5,823**
18	Nb of nutritional kits served to PLHIV	BKV	105	454	559	429	1549	1978	156	330	486	82	246	328	772	2,579	3,351
		LBB	198	632	830	313	638	951	261	449	710	61	125	186	833	1,844	2,677
		MTD	158	339	497	567	1339	1906	241	633	874	259	649	908	1,225	2,960	4,185
		TOTAL	**461**	**1425**	**1886**	**1309**	**3526**	**4835**	**658**	**1412**	**2070**	**402**	**1,020**	**1,422**	**2,830**	**7,383**	**10,213**
19	Nb of PLHIV provided with IGA assistance	BKV	26	114	140	33	158	191	3	30	33	38	90	128	100	392	492
		LBB	29	20	49	93	197	290	76	184	260	85	156	241	283	557	840
		MTD	23	105	128	66	298	364	28	115	143	41	94	135	158	612	770
		TOTAL	**78**	**239**	**317**	**192**	**653**	**845**	**107**	**329**	**436**	**164**	**340**	**504**	**541**	**1,561**	**2,102**
20	Nb of IGA that succeeded for PLHIV	BKV[2]	0	0	0	0	0	0	16	53	69	163	223	386	179	276	455
		LBB	0	0	0	0	0	0	100	203	303	130	294	424	230	497	727
		MTD	0	0	0	0	0	0	16	64	80	72	145	217	88	209	297
		TOTAL	**0**	**0**	**0**	**0**	**0**	**0**	**132**	**320**	**452**	**365**	**662**	**1,027**	**497**	**982**	**1,479**

[2] Problems have been recognized in the collection of this indicator with the Bukavu-based team who have been multiplying counting successful IGAs (for example, an IGA is counted as successful if it is still succeeding at its first follow up visit, but is counted again if it is still successful at second follow up visit). Unfortunately, the program was not able to retroactively clean all the data so errors persist.

Key services provided to beneficiaries			FY06			FY07			FY08			FY 09			Total		
			M	F	Total	M	F	T	M	F	T	M	F	Total	M	F	Total
21	Nb of PLHIV provided with material kits	BKV	74	366	440	352	1048	1400	270	539	809	435	532	967	1,131	2,485	3,616
		LBB	160	311	471	126	213	339	37	361	398	392	865	1,257	715	1,750	2,465
		MTD	25	52	77	233	520	753	26	77	103	53	64	117	337	713	1,050
		TOTAL	**259**	**729**	**988**	**711**	**1781**	**2492**	**333**	**977**	**1310**	**880**	**1,461**	**2,341**	**2,183**	**4,948**	**7,131**
22	Nb of PLHIV provided with legal assistance	BKV	0	0	0	1	1	2	0	4	4	1	0	1	2	5	7
		LBB	0	0	0	0	1	1	0	0	0	0	0	0	0	1	1
		MTD	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
		TOTAL	**0**	**0**	**0**	**1**	**2**	**3**	**0**	**4**	**4**	**1**	**0**	**1**	**2**	**6**	**8**
23	Nb of home visits to PLHIV/psychosocial assistance	BKV	273	822	1095	876	2340	3216	2824	6764	9588	3,033	6,814	9,847	7,006	16,740	23,746
		LBB	193	550	743	1789	3272	5061	3812	6843	10655	3,262	5,585	8,847	9,056	16,250	25,306
		MTD	846	1790	2636	2244	4025	6269	4807	10846	15653	3,022	5,357	8,379	10,919	22,018	32,937
		TOTAL	**1312**	**3162**	**4474**	**4909**	**9637**	**14546**	**11443**	**24453**	**35896**	**9,317**	**17,756**	**27,073**	**26,981**	**55,008**	**81,989**
24	Nb of PLHIV referred for medical care	BKV	0	0	0	89	239	328	42	112	154	14	22	36	145	373	518
		LBB	0	0	0	329	827	1156	1011	2203	3214	572	760	1,332	1,912	3,790	5,702
		MTD	0	0	0	451	887	1338	674	1224	1898	237	432	669	1,362	2,543	3,905
		TOTAL	**0**	**0**	**0**	**869**	**1953**	**2822**	**1727**	**3539**	**5266**	**823**	**1,214**	**2,037**	**3,419**	**6,706**	**10,125**
25	Nb of PLHIV referred for ART	BKV	0	0	0	14	183	197	33	82	115	37	67	104	84	332	416
		LBB	0	0	0	0	0	0	86	269	355	12	22	34	98	291	389
		MTD	0	0	0	0	0	0	148	330	478	2	0	2	150	330	480
		TOTAL	**0**	**0**	**0**	**14**	**183**	**197**	**267**	**681**	**948**	**51**	**89**	**140**	**332**	**953**	**1,285**

	Key services provided to beneficiaries		FY06			FY07			FY08			FY 09			Total		
			M	F	Total	M	F	T	M	F	T	M	F	Total	M	F	Total
26	Nb of PLHIV under ART	BKV	0	0	0	0	0	0	269	722	991	25	41	66	294	763	1,057
		LBB	0	0	0	0	0	0	232	393	625	404	633	1,037	636	1,026	1,662
		MTD	0	0	0	0	0	0	148	331	479	2	1	3	150	332	482
		TOTAL	**0**	**0**	**0**	**0**	**0**	**0**	**649**	**1446**	**2095**	**431**	**675**	**1,106**	**1,080**	**2,121**	**3,201**
27	Nb of PLHIV deaths	BKV	3	6	9	13	25	38	9	26	35	14	18	32	39	75	114
		LBB	0	0	0	14	17	31	25	31	56	5	5	10	44	53	97
		MTD	13	18	31	13	24	37	5	14	19	2	10	12	33	66	99
		TOTAL	**16**	**24**	**40**	**40**	**66**	**106**	**39**	**71**	**110**	**21**	**33**	**54**	**116**	**194**	**310**
28	Nb of PLHIV provided with food (WFP)	BKV	91	209	300	0	0	0	4552	9637	14189	3,588	8,673	12,261	8,231	18,519	26,750
		LBB	91	209	300	321	664	985	2901	6332	9233	0	0	0	3,313	7,205	10,518
		MTD	91	209	300	353	505	858	0	0	0	0	0	0	444	714	1,158
		TOTAL	**273**	**627**	**900**	**674**	**1169**	**1843**	**7453**	**15969**	**23422**	**3,588**	**8,673**	**12,261**	**11,988**	**26,438**	**38,426**
29	Nb of PLHIV referred for testing	BKV	2	8	10	52	109	161	16	67	83	39	104	143	109	288	397
		LBB	0	0	0	0	0	0	33	109	142	2	5	7	35	114	149
		MTD	2	2	4	59	110	169	1	12	13	0	0	0	62	124	186
		TOTAL	**4**	**10**	**14**	**111**	**219**	**330**	**50**	**188**	**238**	**41**	**109**	**150**	**206**	**526**	**732**
30	Nb de PVVIH who issued their will/testament	BKV	0	0	0	8	18	26	3	3	6	0	1	1	11	22	33
		LBB	0	0	0	0	0	0	1	2	3	0	0	0	1	2	3
		MTD	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
		TOTAL	**0**	**0**	**0**	**8**	**18**	**26**	**4**	**5**	**9**	**0**	**1**	**1**	**12**	**24**	**36**

Key services provided to beneficiaries			FY06			FY07			FY08			FY 09			Total		
			M	F	Total	M	F	T	M	F	T	M	F	Total	M	F	Total
31	# of PLHIV referred for TB	BKV	0	0	0	0	0	0	154	192	346	5	7	12	159	199	358
		LBB	0	0	0	0	0	0	23	33	56	3	1	4	26	34	60
		MTD	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
		TOTAL	**0**	**0**	**0**	**0**	**0**	**0**	**177**	**225**	**402**	**8**	**8**	**16**	**185**	**233**	**418**
32	# of PLHIV Primary cat benef (APS-AGR-NUT)	BKV	0	0	0	0	0	0	89	239	328	57	205	262	146	444	590
		LBB	0	0	0	0	0	0	296	525	821	281	365	646	577	890	1,467
		MTD	0	0	0	0	0	0	116	497	613	21	44	65	137	541	678
		TOTAL	**0**	**0**	**0**	**0**	**0**	**0**	**501**	**1261**	**1762**	**359**	**614**	**973**	**860**	**1,875**	**2,735**