A Case Study

The Tumaini Home-Based Care Program

MEASURE Evaluation
&
CARE International

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The Tumaini Home-Based Care Program

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Cover photo by Felix Masi/Voiceless Children, courtesy of Photoshare.

Acronyms

ART	antiretroviral therapy
CBO	community-based organization
COUNSENUTH	Centre for Counseling, Nutrition and Health Care
CSO	civil service organization
DSW	Tanzania Department of Social Welfare
FBO	faith-based organization
FHI	Family Health International
GOT MoHSW	Government of Tanzania Ministry of Health and Social Welfare
HBC	home-based care
IGA	income-generating activities
MOG	Mwanza Outreach Group
MUCHS	Muhimbili University College of Health Sciences
MVC	most-vulnerable children
MVCC	most-vulnerable children committee
NBS	National Bureau of Statistics
NGO	nongovernmental organization
OVC	orphans and vulnerable children
PLHA	people living with HIV and AIDS
TACAIDS	Tanzania Commission for AIDS
UNICEF	United Nations Children's Fund
USAID	U.S. Agency for International Development
VCT	voluntary counseling and testing

Executive Summary

An estimated 12 million children aged 0-17 have lost one or both parents to AIDS in sub-Saharan Africa (UNICEF, 2006). Despite recognition of the magnitude and negative consequences of this problem, there is little evidence on "what works" to improve the well-being of children affected by HIV and AIDS. In an attempt to fill this knowledge gap, MEASURE Evaluation is conducting targeted evaluations of five programs for orphans and vulnerable children (OVC) in five unique settings — two in Kenya and three in Tanzania. Case studies are the first activity of MEASURE Evaluation's targeted evaluations and begin the process of information sharing on lessons learned in programming for orphans and vulnerable children. Additional evaluation activities include an impact assessment and costing activity for each of the five selected programs.

This case study was conducted to impart a thorough understanding of the Tumaini Home-Based Care Program model and to document lessons learned that could be applied to other initiatives. While the Tumaini program addresses the needs of both people living with HIV and AIDS (PLHA) as well as OVC, the case study focuses particular attention on specific services and program impact for OVC. Case study information-gathering activities included program document review; program site visits, including discussions with sub-grantee staff, volunteers, beneficiaries, and community members; and observations of program activities. The primary audience for this case study includes OVC program implementers in Tanzania and elsewhere in Africa, as well as relevant policy makers and funding agencies addressing OVC needs.

The Tumaini program was selected as a priority program for the evaluation. The program is funded by the U.S. President's Emergency Plan for AIDS Relief and implemented by an organizational alliance initially headed by CARE International, with technical partners Family Health International, Heifer Project International, Health Scope Tanzania, Muhimbili University College of Health Sciences, and Centre for Counseling, Nutrition and Health Care. The Tumaini model draws upon the potential of civil service organizations to respond to the needs of children, youth and families. Twenty-three local sub-grantees are supported to provide home-based care (HBC) for families affected by HIV and AIDS in five regions of Tanzania. Program goals are to provide care and support to OVC; to provide care and support to PLHA;

and to build the capacity of local organizations to provide sustainable HBC services.

To accomplish program goals, the following key program activities are implemented:

- building the capacity of local sub-grantees through training, provision of HBC kits and funding sub-grantee capital and operational expenses;
- providing HBC through community-based volunteers;
- providing professional services and material support utilizing center-based sub-grantee staff (i.e., counseling [pre-test, adherence, supportive], youth clubs and activities; voluntary counseling and testing, income-generating activities (IGA), stigma reduction and support mobilization, advocacy, referral, medication, nutritional support, and school materials); and
- strengthening extensive referral networks to ensure comprehensive care.

With program goals to address the needs of both PLHA and OVC, the model focuses at the family level, acknowledging the importance of family systems in the lives of children and youth and aiming to strengthen those systems to improve OVC well-being. The unique advantage of this holistic approach is a direct benefit to OVC through targeted activities as well as an indirect benefit through improved well-being of adult PLHA family members and through increased sub-grantee capacity and focus on OVC issues.

While all sub-grantees provide a basic level of core services, sub-grantees vary in the depth of services provided in each core category according to their individual capacities and resources. The range of services provided include health care services, food and nutritional support, psychosocial support, education and vocational training support, IGA, shelter and care services, family services, and, to some extent, child protection services. The Tumaini model provides a comprehensive range of services. Nonetheless, unmet needs include addressing the specific needs of adolescents, strengthening or scaling up economic opportunity/strengthening services, and community sensitization.

The case study identified several program challenges. Sub-grantees and their community volunteers have found it difficult to meet the overwhelming needs of families in the community. As training and program resources are

heavily focused on the needs of PLHA, volunteers are sometimes unprepared to identify and address the specific needs of children and adolescents made vulnerable by parental illness or death. At the sub-grantee level, organizations themselves are challenged to design and implement youth activities such as kids clubs. CARE has identified the necessity of assisting sub-grantees in creating detailed work plans to implement such activities. Finally, pre-determined IGA activities designed by Heifer Project International have been met with limited success; sub-grantee staff and beneficiaries note a more successful and sustainable IGA approach would give clients input into selection of locally viable IGA activities.

The Tumaini HBC program is an innovative model for OVC care and support because it strengthens the capacity of families to care for children by addressing the needs of PLHA caregivers. Healthy caregivers with viable economic opportunities are well positioned to address their children's basic needs. The strength of the Tumaini model is its focus on building local capacity. The model capitalizes on the strengths and resources of local sub-grantees and further strengthens their capacity to serve the needs of children and families affected by HIV and AIDS. Sub-grantees mobilize community volunteers including HIV positive individuals and provide them with ongoing supervision to carry out HBC activities. Initially focused on PLHA, the model has strengthened mechanisms to increase support to OVC by building the capacity of staff and volunteers to identify OVC needs and implement child-focused activities.

The Tumaini program ended in December 2006. However, to complement lessons learned through this case study, MEASURE Evaluation plans to conduct an impact assessment of the model in 2007 in Iringa region, focused on the work of sub-grantee Allamano. Household surveys will be conducted with current program beneficiaries as well as children and families slated to receive the program during scale-up. The impact assessment provides opportunity to explore the extent to which the model strengthens family and caregiver capacity as well as the impact of this strengthening on OVC well being.

Introduction

A young girl who lost her parents to HIV/AIDS sits at the doorstep of her classroom at a rescue center for AIDS orphans in Kenya's largest slum Kibera. On her pair of socks she has an AIDS campaign logo which tells it all. The little girl is not only an orphan but also a crusader in the fight against the killer disease. 2005. Photo by Felix Masi/Voiceless Children, Courtesy of Photoshare.

Worldwide, the number of children under age 18 who have lost one or both parents to AIDS stands at more than 14.3 million (*UNAIDS, UNICEF & USAID, 2004*). Many more children live with one or more chronically ill parent. The vast majority of these children live in sub-Saharan Africa. Despite recognition of the magnitude and negative consequences of this problem, there is little evidence on "what works" to improve the well-being of children affected by HIV and AIDS. Given the lack of information on the impact of care and support strategies for OVC, there is an urgent need to learn more about how to improve the effectiveness, quality, and reach of these efforts. In an attempt to fill these knowledge gaps, MEASURE Evaluation is conducting targeted evaluations of five OVC programs in five unique settings — two in Kenya and three in Tanzania. The Tumaini Home-Based Care Program was selected as a priority program for the evaluation.

CARE leads an alliance of organizations that provides organizational and technical support to local sub-grantees. The alliance is funded by the Emergency Plan through the U.S. Agency for International Development (USAID). At the time of the case study, Tumaini Alliance technical partners included Family Health International (FHI), Heifer International, and Centre for Counseling, Nutrition and Health Care (COUNSENUTH). Drawing on the potential of civil service organizations and in response to the needs of children, youth, and families, Tumaini Alliance partners collaborate in supporting 23 local sub-grantees to provide HBC for families affected by HIV and AIDS in five regions of Tanzania. Tumaini program strategies are in alignment with Emergency Plan strategies for serving OVC, particularly the strategies focused on strengthening the capacity of families to protect and care for OVC, and on ensuring OVC access to essential services. The program addresses both PLHA and OVC needs through support to local HBC providers serving families affected by HIV and AIDS. Sub-grantee

services aim to strengthen family systems by addressing the needs of PLHA caregivers as well as increasing caregiver capacity to meet OVC needs. Access to essential services is strengthened through referral and provision of direct material support. Services aim to improve OVC and PLHA emotional and psychological well-being, perceived coping capacity and social support, behavior, knowledge of HIV prevention and other health information, health and nutritional status, community and household discrimination, and school attendance and performance among primary school age children.

This case study was conducted to impart a thorough understanding of the Tumaini Home-Based Care Program model and to document lessons learned that could be applied to other initiatives. While the Tumaini program addresses the needs of both people living with HIV and AIDS (PLHA) as well as OVC, the case study focuses on specific services and program impact for OVC. The primary audience for this case study includes OVC program implementers in Tanzania and elsewhere in Africa, as well as relevant policy makers and funding agencies addressing OVC needs. The case study is informed by program document review; program site visits including discussions with sub-grantee staff, volunteers, beneficiaries, and community members; and observations of program activities. The program model is described in-depth, including a description of key program activities, methods of beneficiary selection, services delivered, unmet needs, and approaches to working with the community. Program innovations and challenges are also detailed. It is our hope that this document may stimulate improved approaches in the effort to support OVC in resource-constrained environments.

Case studies are the first activity of MEASURE Evaluation's targeted evaluation. Additional evaluation activities include an impact assessment and costing activity of each of the five selected programs, including the Tumaini program. Best practices relating to improving the effectiveness of OVC interventions will be identified and disseminated. This document seeks to begin the process of information sharing on lessons learned in OVC programming.

Orphans and Vulnerable Children in Tanzania

A Shaloom Care House volunteer reviews schoolwork with a child during home visiting. Photo by Megan Littrell.

HIV and AIDS prompted declaration of a national disaster in Tanzania and the epidemic is a top government priority development issue. AIDS has contributed to declines in life expectancy and in gross domestic product and productivity, as well as increased infant and child mortality, poverty, household dependency ratio, and absolute number of orphans (*TACAIDS, NBS & ORC Macro, 2005*). UNAIDS (*2006*) estimates 6.5% adult HIV prevalence. According to the Tanzania HIV/AIDS indicator survey 2003-04, orphan prevalence (children under 18 who have lost one or both parents) is 11% (T*ACAIDS, NBS & ORC Macro, 2005*). UNAIDS (*2006*) estimates a total of 1.1 million children orphaned by AIDS are living in Tanzania.

Children affected by HIV and AIDS often live in households undergoing dramatic changes, including intensified poverty; increased responsibilities placed on young members of the family; poor parental health that may increase emotional or physical neglect; stigma and discrimination from friends, community members, or extended family; and parental death. These changes often result in reduced household capacity to meet children's basic needs. Orphaned children may undergo a transition to a new household or, in relatively few cases, be forced to head their own households. Orphans are more likely to live in households with higher dependency ratios, may experience property dispossession, often miss out on opportunities for education, may live in households experiencing food insecurity, and often experience decreased emotional and psychological well being due to such dramatic life changes, challenges, and losses (*UNICEF, 2006*).

Emerging information on the impact of the epidemic on children has increased attention on orphans and other children affected by HIV and AIDS. The Tanzanian Department of Social Welfare (DSW) recognizes how HIV and AIDS may result in children affected by chronic poverty, disability,

and other social problems. In response, DSW with support from the United Nations Children's Fund (UNICEF) developed guidelines for support to most-vulnerable children (MVC). MVC are defined based on criteria agreed upon by community members. Based on initial identification of MVC in 19 districts, an estimated 5.3% of all Tanzanian children can be classified as MVC (*GOT MoHSW, 2006*). The Costed MVC Action Plan 2006-2010 (*GOT MoHSW, 2006*) outlines guidelines for MVC identification and service provision. Key components of the plan include mobilization of community MVC committees (MVCCs) responsible for identification and support to MVC, in collaboration with local government and with support from community members. National civil service organizations and international nongovernmental organizations (NGOs) are expected to work in collaboration with MVCCs to provide a package of services outlined in the plan. Efforts are currently underway to implement the plan with specific definitions of service package components.

In the civil service sector, civil service organizations (CSOs) including faith-based organizations (FBOs), community-based organizations (CBOs), and local NGOs are involved in community projects serving the needs of PLHA and OVC with scarce human, monetary, and technical resources and without proper HBC training. Often drawing on dedication and commitment of community volunteers, these organizations have great potential to address the needs of PLHA and OVC in their communities; however, they require capacity building, including training, ongoing support, operational costs, and HBC supplies. Tumaini facilitates a stronger and larger scale CSO response to the needs of PLHA and OVC through capacity building support. In addition, Tumaini supports DSW MVC initiatives through encouraging sub-grantees to work with MVCC and to serve OVC identified by the MVC identification process.

Methodology

Nyakato AIDS Outreach staff member Ms. Lyatuu reviews a clinic card during home visiting. Photo by Megan Littrell.

Information Gathering

Case study activities were completed during June through August, 2006 and included interviews and group discussions with CARE staff, sub-grantee staff, volunteers and community members; program document review; and observations of program activities such as home visiting, youth club meetings and activities, and volunteer supervision sessions. From five regions of operation, CARE selected Mwanza region for a two-week program site visit. Within Mwanza region, site visits focused on sub-grantee service provision in Mwanza city.

Focal Site

Mwanza City is the focal site for this case study report. Mwanza region HIV prevalence is 7.2% and orphan prevalence 10.5% (*TACAIDS, NBC & ORC Macro, 2005*). As the second largest city in Tanzania, Mwanza is an economic center for the entire Lake Victoria region. Located on the southern shore of the lake, which is African's largest, Mwanza is central to several major transport routes (lake, rail, and road) connecting the city to other regions within Tanzania, as well as to neighboring Uganda and Kenya.

Due to population growth, Mwanza's classification changed from "town" to "city" status in 2000. The rapid rate of population increase has resulted in a growing number of unplanned housing neighborhoods and an increase in land rights cases. Rural migration to Mwanza city is common; migrants are often young people leaving villages in search of employment. In addition, men migrate from villages to obtain short-term employment in the city during the dry season (June to October). Petty trading is the primary occupation for most unskilled workers. Approximately 20% of city residents are employed in the service sector and 10% in industrial activities (e.g. food processing, textile mills) (*Whitehouse, 2002*).

Tumaini supports five sub-grantee home-base care providers in Mwanza region. This case study included program site visits with two sub-grantees operating in Mwanza city — Mwanza Outreach Group (MOG) and the Archdiocese of Mwanza. The archdiocese implements multiple HBC projects serving different catchment areas. Two of these projects serving Mwanza city residents were visited during the case study: Shaloom Care House and Nyakato AIDS Outreach.

Program Model

A Nyakato AIDS Outreach volunteer assists with household chores during home visiting. Photo by Megan Littrell.

Overview and Framework

Emergency Plan funds were initially awarded to an alliance of six partners in 2004: CARE International as lead agency; Heifer International, responsible for technical assistance in IGA; FHI to provide OVC technical assistance; COUNSENUTH responsible for nutrition technical assistance; Health Scope Tanzania, responsible for program monitoring and evaluation; and Muhimbili University College of Health Sciences (MUCHS) addressing anti-stigma initiatives. MUCHS and Health Scope later left the alliance and their responsibilities were assumed by CARE.

Drawing on the potential of CSOs and in response to the needs of children, youth, and families, Tumaini Alliance partners collaborate in supporting 23 local sub-grantees to provide HBC for families affected by HIV and AIDS in five regions of Tanzania. Program goals are to provide care and support to OVC; to provide care and support to PLHA; and to build the capacity of local organizations to provide sustainable HBC services. With program goals to address the needs of both PLHA and OVC, the model focuses at the family level, acknowledging the importance of family systems in the lives of children and youth and aiming to strengthen those systems to improve OVC well-being. The unique advantage of this holistic approach is a direct benefit to OVC through targeted activities, as well as an indirect benefit through improved well-being of adult PLHA family members and through increased sub-grantee capacity and focus on OVC issues. Though sub-grantee services are provided to both PLHA and OVC, in practice, assessment and service provision addresses the needs of families rather than individual PLHA or OVC. Intended outcomes at family, community and individual OVC levels are described in the subsequent framework on pages 20-21.

Key Program Activities

Key activities are carried out by the alliance and its sub-grantees and center on capacity building and HBC service provision.

Building the capacity of local sub-grantees — The Tumaini model focuses on building the capacity of local organizations to provide HBC and to strengthen and utilize community referral networks. Capacity-building mechanisms aim to ensure well-trained and financially secure HBC providers equipped with necessary tools to provide essential services. Training is a key capacity-building mechanism and includes provision of the national HBC training to sub-grantee staff and volunteers as well as periodic thematic trainings for sub-grantee staff. To address the palliative care component of pain, illness, and infection management, service providers also receive HBC kits for volunteers and center use. Sub-grantee capacity is additionally strengthened through the provision of capital and operational expenditure funding including staff salaries and volunteer incentives.

> *"Tumaini did for us all that can be done for an organization like us; they have built our capacity well." — MOG program coordinator*

Support to MOG by the alliance has consisted of advice on program activities given through periodic visits. Support generally focuses on meeting targets and following grant guidelines, particularly in regards to reporting. Assistance has been particularly strong during budget and work-plan formulation stages. An important resource for technical assistance is the CARE regional technical officer, who visits regularly and is available to assist with challenges and questions. Key sources of training include the 21-day HBC course for volunteers funded by Tumaini and conducted by governmental national facilitators. Sub-grantee staff members are offered periodic thematic trainings given by alliance members (e.g. nutrition, OVC care and support). MOG's project coordinator notes that staff and volunteer trainings are key sustainable facets of Tumaini capacity building.

Sub-grantee HBC provision utilizing community volunteers — HBC is generally provided by volunteers who are occasionally accompanied by sub-grantee staff for technical support or supervision. HBC volunteers typically carry a caseload of 10 to 15 households and report spending 15 minutes to one hour per visit, with a frequency of visiting one to two times per week.

Frequency and length of visits are driven by client needs. Overall, volunteers estimate spending approximately eight hours on home visiting activities during a typical week.

Home visiting generally serves clients with education, stigma reduction and support mobilization, and counseling and support. Volunteers are typically focused on identifying problems faced by the family, providing support and encouragement, educating family members, providing adherence counseling, and referring clients to the center to access center-based services or to meet with center staff responsible for making external referrals. Some volunteers may ask children or youth to show them recent school work and/or encourage them to continue attending school and performing well. Volunteers can access pain management medications from HBC kits and deliver to clients in need. They can also fill client prescriptions at the sub-grantee office or center and distribute during home visits. When center-based sub-grantee staff accompany volunteers on home visits, they can provide additional services according to their training including medical treatment and supportive counseling.

Provision of professional services and material support utilizing sub-grantee staff — Professional services and material support vary according to sub-grantee human and financial resources; however, in general, center-based sub-grantee staff provide counseling (i.e. pre-test, adherence, supportive), IGA activities, stigma reduction and support mobilization, advocacy, and referral. Staff nurses can dispense HBC kit prescription drugs when clients have a prescription. Staff or volunteer doctors can prescribe and dispense HBC kit prescription drugs. Some sub-grantees offer voluntary counseling and testing (VCT) and laboratory services.

Distribution of material support is generally the responsibility of sub-grantee staff and includes nutritional support; school materials, uniforms and/or fees; medication; insecticide-treated bed nets; and bedding. Food is distributed on a monthly basis to families most in need (i.e. PLHA with low body-mass index or malnourished OVC); family circumstances are reassessed each month to prioritize distribution. All other supports are typically distributed once per year.

While sub-grantees are encouraged to engage children and youth in clubs and activities, these services vary widely according to sub-grantee capacity (i.e. human and financial resources, space and interest). Sub-grantees providing

substantial center-based activities for youth have additional sources of funding for staff and activities (e.g. youth counselors or staff to implement after-school programs).

Referral for additional services — Sub-grantees are encouraged to develop strong and extensive referral networks to ensure comprehensive care. Staff are familiar with community services and additionally strive to cultivate personal relationships with specific service providers to facilitate prompt service provision for clients. External referrals are most often made for VCT, antiretroviral therapy (ART), and medical treatment. Less frequent referrals are made for psychotherapy, spiritual care, legal services, memory books, and birth registration. Referral and follow-up are the responsibilities of sub-grantee staff; volunteers report identified referral needs to staff or advise clients to contact staff for referral linkages.

Beneficiaries

Tumaini sub-grantees strive to meet the specific needs of both PLHA and OVC, yet in practice, services tend to target families affected by HIV and AIDS. Material support in particular (i.e. food and medicine) considers needs of families rather than individuals. Families served are overwhelmingly headed by a parent or parents living with HIV and AIDS, with a small percentage of HIV-positive OVC. The program also provides support to orphans living with HIV-negative guardians, as well as youth-headed households. Families with PLHA are identified through referral from local medical providers, current clients, community members, and volunteers, as well as through self-referral. In addition to referral mechanisms, families may be identified through consultation with local leadership structures, including village leaders and MVCCs. Sub-grantees may take referrals from MVCCs or other local leaders, conduct an informal assessment of family needs, and make a decision regarding enrollment.

The overwhelming majority of OVC beneficiaries are aged 5-18 years, and while all children and adolescents benefit from family strengthening efforts, OVC-specific services generally target and are most appropriate for primary school age children (aged 8-14 years). For example, education support is generally limited to primary school support (school materials and uniforms). Post-primary school adolescent needs (i.e. vocational training, secondary school, income generation) are not addressed.

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1. To provide care and su
2. To build the capacity of local organizat

CARE and Alliance Activities

Build sub-grantee capacity through:

- Initial and ongoing training
- Ongoing technical support
- Provision of operational funds and HBC supplies

Sub-grantee Activites Targeting OCV & PLHA

Carried out by sub-grantee staff and community volunteers:

- Health education
- Counseling and social support
- Material support (food, school uniforms, materials or fees, HBC-kit drugs)
- IGA
- Peer support and recreational activities
- Household sensitization to PLHA/OVC issues
- Advocacy for access to services and support
- Referral (e.g., VCT, ART, medical treatment, legal services)

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tions to provide sustainable HBC services

Family and Community Outcomes

- Healthier, consistent, and attentive parents and guardians
- Increased access of families to basic needs and rights
- Improved physical and mental health of parents and guardians, particularly PLHA
- Increased household economic security
- Stigma reduction at the household and community levels

Child and Adolescent Outcomes

- *Education:* increased school attendance and performance
- *Psychosocial and Child Protection:* improved emotional and psychological well-being; increased perceived coping capacity and social support; improved behavior, particularly reduced externalizing behaviors; reduced child labor; relationship/secure attachment to a caring adult — volunteer, parent, or guardians
- *Health and Prevention:* increased knowledge of HIV/AIDS prevention; increased knowledge of health information (e.g., nutrition); improved health status; improved nutritional status
- *Community Support:* reduced community discrimination (e.g., school, peers, neighbors); reduced household discrimination (abuse and neglect)

OVC are counted as served upon enrollment, and while all children benefit from home visiting services, other services are provided based on individual family needs and sub-grantee resources. The quarterly report for April through June 2006 provides a snapshot of numbers served with various services. From a total of 30,685 OVC supported, 5,606 received food support, 4,107 medical care, 4,107 school materials, 1,220 uniforms, 531 school fees, 4,371 nutritional counseling, and 1,464 participated in Kids Club activities.

Services

Sub-grantees provide HBC in the community and additionally often implement program activities at a center operated by their program staff and volunteers. Center-based program activities vary depending on sub-grantee capacity; the range of activities includes distribution of material support, psychosocial support activities, IGA, healthcare services, and voluntary counseling and testing.

While all sub-grantees provide a basic level of core services, sub-grantees vary in the depth of services provided in each core category. For example, where some sub-grantees are just starting to form monthly Kids Club activities for OVC, others have long-standing youth services provided on a daily basis by full-time youth counselors. Service variation is dependent on training and experience of sub-grantees (e.g. counseling training) as well as sub-grantee possession of additional sources of funding to supplement Tumaini funds. Moreover, individual need and availability of resources also contribute to service variation. PLHA and OVC who are on ART as well as youth-headed households are reportedly prioritized for material support and more frequent home visits. As resources are limited, sub-grantee staff generally re-examine family needs on a monthly basis to target direct support accordingly. In addition, volunteers adjust the frequency and duration of home visits according to assessed needs of the family. Finally, service provision reportedly varies between rural and urban communities. Urban-based HBC can link clients with services that are simply unavailable or difficult to access in rural areas. In addition, home visit frequency may reportedly be higher in urban areas due to physical proximity of clients to volunteers. Though services are not uniform across OVC or sites, the range of services potentially provided is described below.

Health care services — Services include medicine from HBC kits, as well as referral and follow-up for healthcare such as medical treatment, VCT,

and ART. Health education covers nutrition and basic hygiene. Insecticide-treated bed nets are provided for clients in need, as well as bedding materials. In addition to general healthcare services, HIV-positive children receive ART adherence counseling, support, and strategies to live positively through individual or group support/counseling to HIV positive OVC. Additional HIV and AIDS services include heath education on care and support for PLHA and prevention education generally provided during home visits as well as by a number of sub-grantees during youth clubs and activities.

HBC kits — Tumaini provides sub-grantees with HBC kits that include prescription drugs to be distributed at the sub-grantee center, as well as over-the-counter drugs and supplies for HBC volunteers to carry in the field.

Volunteer kits include a backpack or bag, nutrition assessment card with malnutrition criteria and information on local nutritious foods, drug instruction card, oral rehydration salts, materials to dress wounds, mackintosh sheet, pain medication, vitamin B, condoms, flashlight, raincoat, umbrella, and gumboots.

Center-based kits contain prescription drugs including anti-fungals, antibiotics including Cotrimoxazole given as prophylaxis, folic acid, and vitamin A.

Sub-grantees with a staff or volunteer medical doctor provide diagnosis and treatment. Sub-grantees without a medical doctor disburse medication to clients who have obtained a prescription for the medication from a health facility.

Food and nutritional support — Food distribution targets a limited number of food insecure households. Other support includes nutrition education provided to caregivers.

Psychosocial support — Clubs for children and youth are provided, along with various levels of counseling and support, such as professional pre-test and supportive and ART adherence counseling. Volunteers provide general support and advice during home visits. Stigma and discrimination reduction activities are generally limited to the household level and aim to facilitate family integration of PLHA and OVC, stronger family relationships and prevention of family abuse and/or neglect of PLHA and OVC.

Education and vocational training support — School materials (exercise books, pens), school uniforms, and, when feasible, payment of secondary school fees are provided. Secondary school fees are a rare service provided, as sub-grantees generally cannot guarantee support throughout a student's entire secondary school education. Vocational training is generally not supported by sub-grantees.

Economic opportunity/strengthening — Support is provided to a limited number of families via IGA. Facilitated by Heifer International, IGA is food-based and is meant to supplement both family income earning potential as well as household food supply. IGA activities include goat and poultry raising, power flour production (specially formulated mixture for nutritional porridge), solar drying, and bio-intensive agriculture.

Child protection — Sub-grantees marginally address child protection. They rarely make referrals for legal services and do not engage the community or families in discussion surrounding child and/or human rights. A small number of sub-grantees include birth registration referral among services provided.

Shelter and care — PLHA clients are assisted by identification of potential guardians for their children in the event of the client's death. Because sub-grantees are involved in the lives of children with HIV-positive parents, volunteers and staff play an important role in ensuring succession of care for children who lose their parents. A volunteer working with a family continues to visit the orphans following parental death, ensuring provision of proper shelter and care by family or community members. Sub-grantees additionally address other concrete shelter issues as they arise by supporting a small number of beneficiaries (e.g. shelter-insecure youth-headed households) with shelter repair or mobilization of rental assistance.

Family services — OVC served are generally children of PLHA clients. As a result, OVC caregivers typically receive multiple services including medicine, counseling, peer support groups, IGA, food, health and nutrition education, and referral. In addition, OVC guardians are provided education (e.g. health, nutrition, caregiver skills) and psychosocial support to assist and encourage them in orphan care.

Shaloom Care House — Through support from the Tumaini Alliance,

Shaloom Care House in Mwanza City is able to offer a range of HBC services. In addition to core HBC services, additional sources of funding allow for the following:

- center-based VCT
- laboratory services to identify common illnesses
- on-site medical diagnosis and treatment (medications from Tumaini HBC kids are dispensed by a doctor)
- various classes and groups including a pre-treatment ART class attended by PLHA and a designated caretaker
- post-test clubs for HIV-positive adults
- a support group for guardians of orphans
- income-generating activities, including production of nutritional flour, sewing school uniforms and creating handicrafts
- referral and follow-up (e.g. legal services, medical care) and counseling (i.e. pre-test, adherence and supportive).

In 2006, Shaloom Care House added a facility dedicated to youth. The youth center is staffed with two youth counselors and has a library, study rooms complete with school books that children can borrow, a kitchen, activity rooms and games, and is equipped with a television and VCR and a staff computer.

Center-based services provide age-specific activities for two groups: OVC ages 13 and under and 14 and above. Monthly youth meetings devote time to life skills, behavior change or health education, issues identified by children and youth, and socializing. The center is open to youth weekdays for recreation activities or one-on-one meetings with a counselor.

Unmet Needs

The Tumaini model provides a comprehensive range of services. Nonetheless, identified unmet needs include addressing the specific needs of adolescents, strengthening and scaling-up economic opportunity/strengthening services and community sensitization.

Adolescent needs — The needs of adolescents are largely unaddressed. While all children and adolescents benefit from family-strengthening efforts, OVC-specific services (e.g. education support, psychosocial support) generally target and are most appropriate for primary school age children. According to sub-grantee staff and volunteers, post-primary school adolescents are

in need of services to build livelihoods and life skills, including vocational training, financial support for secondary school attendance, age-appropriate psychosocial support, HIV prevention education and risk behavior reduction activities. Without appropriate support, adolescents are vulnerable to HIV, addictions, crime, commercial sex work and chronic poverty.

Improving economic well-being — Client needs for economic well-being reportedly outweigh current efforts. IGA activities are provided to a limited number of clients, but the need is great, particularly due to improved health and nutritional status of PLHA and the success of OVC in primary school. PLHA and young adults reportedly need IGA training and skills to achieve self-sufficiency.

Communities generally not sensitized to PLHA/OVC issues — Sub-grantee volunteers note that community members do not take ownership or responsibility for OVC and PLHA in their communities. In addition, stigma against children and families affected by HIV and AIDS persists at the community level. Volunteers, sub-grantee and Tumaini staff note that community sensitization and mobilization efforts, as well as increased collaboration with local government and stakeholders, should be intensified for greater community ownership and sustainability as well as reduced stigma and discrimination.

Community Ownership

Volunteers, sub-grantees, and Tumaini staff note ongoing challenges faced in attempting to engender community responsibility for families in need and ownership of program services. While the program relies on community volunteers who take pride and ownership of their work, they reportedly tend to identify as sub-grantee or Tumaini workers rather than community workers. Furthermore, sub-grantee community sensitization efforts are limited and, as a result, communities are generally not well sensitized to PLHA and OVC issues. Sub-grantee volunteers note that community members do not take ownership or responsibility for OVC and PLHA in their communities. One volunteer explained that family and community members "come to us and say 'your patient is sick,' or 'your OVC needs help.' This is your problem." Volunteers, sub-grantees, and Tumaini staff note that community sensitization and mobilization efforts, as well as increased collaboration with local government and stakeholders, should be intensified for greater community ownership and sustainability.

While not a primary focus of the Tumaini model, engendering community ownership is supported through the following strategies.

Sub-grantee leadership — HBC services in the community are associated with local sub-grantees rather than with CARE or other Alliance members. It is the local sub-grantee that has day-to-day contact with beneficiaries and other community members. With their roots in the communities served, sub-grantees can tailor services and service provision to local needs and conditions.

Community volunteer participation — Volunteers are given the opportunity to serve their community through contributing to the work of a local sub-grantee organization. Regular individual and group volunteer supervision provided by sub-grantee staff fosters community and peer support among volunteers and strengthens volunteer identity, pride and commitment.

PLHA participation — PLHA clients participate as HBC volunteers. PLHA volunteers speak of a deep conviction for HBC service work based on personal experiences, and express a sense of pride in their work and the work of the sub-grantee.

Encouraging sub-grantees to engage in community sensitization — Sub-grantees are encouraged to engage local leaders and community members in sensitization to the impact of HIV and AIDS on children and families. They are given freedom to make their own connections and develop their own strategies for sensitization. Strategies employed have included meetings with local leaders and drama performances by kids clubs. For example, Nyakato AIDS Outreach of the Archdiocese of Mwanza has a Youth Alive Club, whose members plan and implement community drama events targeting youth and focused on risk behavior reduction and HIV awareness.

Community-identified OVC beneficiaries — Sub-grantees are responsive to community-identified OVC and may engage local leaders in assisting with beneficiary identification. Where community-based MVCCs are in place, sub-grantees can serve children and families identified by communities during the MVC identification process.

The Tumaini model provides an example of efforts to go beyond direct

service delivery to service delivery through community participation. John Williamson, a senior technical advisor to USAID's Displaced Children and Orphans Fund, describes a typology of interventions for OVC that categorizes programs as direct service delivery; service delivery through community participation; or community owned, led, and managed activities (*Williamson, 2003*). The Tumaini model supports direct service delivery by professional sub-grantee staff, allowing for dependable services provided by trained personnel. While professional services are available at sub-grantee centers, the bulk of direct service provision is dependent on community participation and is provided in households by community volunteers. Community members carry out specific HBC activities with training and support from CARE and the Alliance. Williamson notes that direct service delivery models, even with community participation, foster community dependence upon external funding. As a set of initiatives introduced from an outside agency, communities and sub-grantees likely view responsibility for HBC program continuity as residing with Tumaini. Sub-grantees report that continuing HBC care in its current comprehensive form would not be possible without external sources of funding. Nonetheless, although they would lack the means to provide the comprehensive care offered through the Tumaini model, volunteers are committed to their clients and communities, and would continue providing supportive visits in the absence of external funding.

Resources

Nyakato AIDS Outreach volunteers assist with household chores during home visiting. Photo by Megan Littrell.

Donors

The Tumaini program is fully funded by the Emergency Plan. More than half of donor funds go directly to local HBC programs to support sub-grantee labor and materials. Aside from direct sub-grantee support, donor funds cover alliance member operational costs to ensure program management as well as technical training and support to sub-grantees. At the sub-grantee level, there is great variation in human and financial resources; some lack additional substantial sources of funding outside of Tumaini while others have multiples sources of private and grant funding.

Program Staff

Important resources include alliance members and program staff. Current technical partners FHI, Heifer International, and COUNSENUTH each have a focal staff person to provide assistance with sub-grantee budget and work-plan formulation, thematic trainings, and ongoing technical assistance.

Responsible for management, CARE program staff are based both at headquarters in Dar es Salaam as well as within each region of operation. At the headquarters level, CARE Tumaini staff include a chief of party; deputy chief of programs; deputy chief of grants, finance and administration; five grants officers (one for each region of operation); an administrative officer; two technical officers, including one OVC technical officer; three drivers; and an office assistant. CARE Tumaini additionally utilizes CARE country headquarters departments and staff based in Dar es Salaam, including assistance in accounting and procurement to fulfill key program positions. In each of the five regions of operation, CARE employs a regional technical officer responsible for providing assistance and guidance as well as monitoring sub-grantee work (regions contain four to five sub-grantees each). A driver is also employed at each field office, and often a local intern volunteers at each field office. Regional technical officers are an important link between

sub-grantees and headquarters. They monitor sub-grantee progress towards targets, receive and compile sub-grantee monthly reports for headquarters, and ensure that program procedures and activities are carried out according to plan. Regional technical officers visit sub-grantees regularly to check on operations and assist with problem solving. With a medical background (e.g. in nursing or as a doctor), they can provide important technical assistance to sub-grantees where needed (e.g. instructions for drug storage). In addition, regional technical officers hold quarterly supervision meetings bringing members of all sub-grantees' staff together.

In most cases, Tumaini funds the following sub-grantee positions: project coordinator, accountant, two field officers, one OVC focal person and one PLHA focal person. Sub-grantees serving large catchment areas may have additional field officers. Focal persons and field officers are responsible for supervising the work of volunteers and providing technical assistance. Supervision often takes the form of monthly volunteer meetings wherein volunteers submit monitoring forms and discuss experiences and challenges. At monthly meetings, focal persons may provide training sessions on relevant topics. They draw upon training received from the alliance such as a recent OVC care and support training attended by OVC focal persons. In addition to structured supervision, field supervisors and focal persons are important supports for backstopping volunteers with technical support. While volunteers generally lack medical training, field officers and focal persons may be trained nurses, midwives, or counselors and can provide guidance to volunteers as well as direct support to clients in need. They can dispense medications to clients with prescriptions as well as facilitate group counseling, youth groups/clubs, and post-test clubs for PLHA.

Volunteers

> *"Without volunteers, you can't do anything. The volunteer is the engine of this machine. They are really working hard." — a sub-grantee program coordinator*

Volunteers are a vital program resource. They come from the communities that they serve, sharing culture and norms with clients and possessing a commitment to serve their own community. With knowledge of their community and connections with local leaders, they are an important resource for targeting households most in need. Tumaini provides monthly incentives

(20,000 TSH or approximately U.S. $16) to HBC volunteers. In addition, volunteers receive bicycles and equipment to assist them in home visiting including rain jackets, boots, umbrellas and flashlights.

Volunteers are both male and female, and some may be PLHA. Volunteers report being motivated to volunteer after being touched by the plight of OVC and PLHA in their communities and witnessing forms of stigma and discrimination. Some volunteers are PLHA who have received assistance from the organization. Sub-grantees may utilize volunteers from previous projects or recruit new volunteers through their own networks or through local leadership referrals. Volunteers receive the 21-day government HBC training.

Tumaini HBC volunteers must be able to read and write for reporting purposes, and should be able to keep confidentiality. Volunteers note additional essential characteristics, including development of relationships with all family members, being employed or financially capable of donating volunteer time, and being trained and capable of nursing the sick.

Community In-Kind Contributions

Community donations do not contribute substantially to program resources, however some sub-grantees receive limited community support. For example, Shaloom Care House reported occasional community donations of school exercise books. Also, a community member donates maize on a monthly basis to Shaloom Care House for distribution to families.

Lessons Learned

A MOG volunteer reviews schoolwork with a child during home visiting. Photo by Megan Littrell.

Experience has afforded many lessons learned regarding implementation. Both sub-grantees and CARE staff identify lessons learned through innovations, successes, and challenges encountered over time.

Program Challenges

Sub-grantees and volunteers — Sub-grantees and volunteers encounter overwhelming needs from families in the community. The burden of identifying problems without being able to alleviate them is great. For sub-grantees, this challenge must be overcome with smart targeting and utilization of resources to serve the most needy. Volunteers must rise to the challenges with a commitment to serve and support families, even when they cannot meet all of their needs. Both volunteers and staff often find it necessary to give clients goods or money from their own pockets, particularly when there is a pressing need for transportation or food. Sub-grantee staff and volunteers report that clients often hold high expectations that are impossible to meet. It is personally frustrating and heartbreaking for committed staff and volunteers when they cannot meet these expectations. In addition, clients may be less receptive to available services (e.g. counseling, support, education) when more basic services they need, such as food or transportation, are not available.

Volunteers unprepared for child and adolescent needs — A lack of training and relatively few resources dedicated to OVC services (as compared with PLHA) have been barriers to comprehensive OVC care and support during the first two years of the program. A recent sub-grantee monthly report noted that "in general, support given to OVC is still very minimal compared to their different needs as children." Volunteers and staff reiterated this sentiment and highlighted the need for additional resource provision directly to OVC, as well enhanced volunteer capacity to address children and OVC specific needs. For example, volunteers felt ill-equipped to address child and adolescent behavioral reactions to trauma and loss (i.e. withdrawn or externalizing/acting out).

IGA success is highly variable — IGA activities are pre-determined by the alliance, based on the expertise of Heifer International in food-based IGA. Food-based IGA activities (e.g. raising goats or poultry) are reportedly particularly successful in rural communities. In relatively urban settings, however, alliance-selected IGA approaches face multiple challenges. Families given livestock find the animals to be a burden in an urban setting. Furthermore, the market for goat milk is non-existent in many regions where cow milk is preferred. Sub-grantee staff and beneficiaries in Mwanza city feel a more successful and sustainable IGA approach would give clients input into selection of viable IGA activities.

Support in developing detailed work plans — Although Tumaini has introduced a participatory process for creation of action plans, project monitoring revealed that sub-grantees were not implementing all planned activities. For example, most sub-grantees failed to initiate kids clubs within the time period allotted, due to a lack of understanding of steps necessary to plan and implement such activities. Tumaini management identified insufficient details in work plans as the cause of the problem; the plans created were general instead of specific. Without an operational plan, sub-grantees may be unfamiliar with necessary steps to carry out activities. The participatory workshop approach could reportedly be strengthened by adding more time to operationalize work plans fully.

Program Innovations and Successes

Comprehensive caregiver services — The Tumaini model strengthens the capacity of families to care for children by addressing the needs of PLHA caregivers. Medical, nutritional, psychosocial, and economic strengthening services for PLHA aim to improve caregiver physical and psychosocial health, as well as economic status. Healthy caregivers with viable economic opportunities are well-positioned to address their children's basic needs.

Building staff capacity — To address recently identified program capacity needs, Tumaini added staff at multiple project levels to focus specifically on OVC issues and services; these included an OVC technical officer at headquarters as well as an OVC focal person position placed within each sub-grantee office. In addition to supporting sub-grantees, the OVC focal person will build the capacity of volunteers to address youth needs by providing training and technical support to HBC volunteers as well as implement

recently added kids club activities. Program staff and sub-grantees recognize the value added of having specialized staff with sufficient knowledge and expertise to adequately identify and address OVC issues.

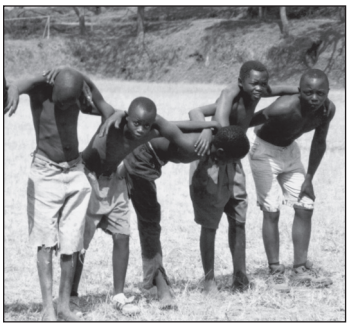
Participatory planning with sub-grantees — For the grant period from April to September 2006, the alliance implemented a new participatory planning process whereby program coordinators were brought together in a workshop and provided a work-plan template with freedom to select activities. Sub-grantees created their own work plans to fit their own individual organizational culture, mission, and objectives. Alliance staff provided suggested activities to meet objectives and encouraged sub-grantees to add innovative activities of their own. While the new planning process could benefit from increased operationalization of work-plans (as outlined above), the alliance still deems the process as a success because of the leadership and empowerment afforded to sub-grantees and the innovative strategies that emerged from this process.

Better volunteer supervision — Tumaini currently funds sub-grantee staff positions responsible for volunteer supervision. These sub-grantee staff are able to devote their time to supervision and technical backstopping of HBC volunteers through monthly meetings and ongoing availability for consultation and support. Funding adequate supervision at the sub-grantee level was not part of the initial operational plan but was introduced when Tumaini recognized unmet volunteer supervision needs. Individual and group supervision for volunteers ensures program implementation as planned, provides volunteers with professional resources when they need assistance, and fosters a sense of support and community among volunteers.

Capitalizing on strengths/talents of established organizations — Tumaini sub-grantees have experience with outreach work and are well connected within their communities as evidenced by presence of a strong network and referral system and linkages with local leaders. They have experienced and trained professional staff with qualifications such as counseling, nursing, or other medical training. Managerial, organizational, and financial accounting structures are in place prior to granting of funds, and a number of sub-grantees have additional sources of funding. Strong organizational structures and other sources of funding mean a lower level of sub-grantee dependency on Tumaini funding and the capacity to provide services above and beyond those that can be provided with Tumaini funds (e.g., additional food support, youth activities, VCT).

PLHA beneficiaries as active program participants — Initially, volunteers did not have access to program services and, as a result, PLHA participation as volunteers was very low. Sub-grantee and program management soon realized that this policy discouraged PLHA involvement and made changes accordingly. PLHA volunteers now have full access to sub-grantee services, and their involvement and perspective as HBC providers reportedly strengthens service provision.

The Way Forward



Adolescent boys playing a game at a youth camp for orphans. David Awasum/CCP, Courtesy of Photoshare.

As of June 2006, 16,477 PLHA and 30,685 OVC were served in five regions by the Tumaini Alliance and its sub-grantees. The CARE Tumaini project ended in December 2006. A follow-on project, Tunajali, is being implemented by an alliance of partners led by FHI.

To increase understanding of the difference the Tumaini program made on the lives of children, families, and communities, MEASURE Evaluation plans to conduct an impact assessment of the program in spring 2007. A post-test study design will be applied, to gather immediate data concerning program impact. Surveys measuring a variety of aspects of child and adult well-being are planned. The intervention group will consist of CARE Tumani beneficiaries receiving services from Allamano, a CARE Tumaini sub-grantee based in Iringa town in Iringa region. The comparison group will include future Tunajali beneficiaries in Njombe town in Iringa region. The impact assessment provides opportunity to explore the extent to which the model strengthens caregiver capacity and OVC well being.

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