COMMUNITY - BASED
HIV/AIDS PREVENTION CARE AND SUPPORT PROJECT
(COPHIA)

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COMMUNITY - BASED
HIV/AIDS PREVENTION CARE AND SUPPORT PROJECT (COPHIA)

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ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
ARV	Antiretroviral
BUCOSS	Butula Community-based Services
CBO	Community Based Organizations
CHW	Community Health Worker
CIC	Community Implementation Committee
CII	Community Implementing Initiative
COPHIA	Community-based HIV/AIDS Prevention, Care and Support Project
FP/RH	Family Planning/Reproductive Health
HBC	Home-based Care
HIV	Human Immuno-deficiency Virus
IAP	Integrated AIDS Program
IGA	Income Generating Activities
LIP	Local Implementing Partners
MADA	Mukuru AIDS and Drug Agency
NACC	National AIDS Control Council
NASCOP	National AIDS and STI Control Program
NGO	Non-governmental Organization
OFFLACK	Oscar Foundation Free Legal Aid Clinic in Kenya
OI	Opportunistic Infection
OVC	Orphans and Vulnerable Children
PMO	Provincial Medical Officer
PLWHA	People Living with HIV/AIDS
PMTCT	Prevention of Mother To Child Transmission
RAAG	Ruiru AIDS Awareness Group
REEP	Rural Education and Economic Empowerment Program
RGC	Redeemed Gospel Church
SDP	Service Delivery Points
TOT	Trainer of Trainers
VCT	Voluntary Counseling and Testing
USAID	United States Agency for International Development

EXECUTIVE SUMMARY

Overview

Prior to COPHIA's commencement, when discharged from a hospital most Kenyans with AIDS were cared for by family, friends or volunteers with limited nursing knowledge and skills, no professional back-up, and very little understanding of the virus and its consequences. Fear of the disease and stigma aimed at those infected by household and community members and even healthcare workers, meant that many HIV-infected people received little or no care and were simply left to die. To address the overwhelming need for home-based care, USAID/Kenya awarded Pathfinder International a cooperative agreement to launch the Community-Based HIV/AIDS Care, Support, and Prevention (COPHIA) project in June 1999. COPHIA was designed to meet the entire spectrum of needs experienced by People Living With HIV/AIDS (PLWHA) and their families—physical, social, psychological, emotional, and spiritual—by providing comprehensive home-based care. And in doing so, COPHIA responded to the devastating toll the HIV/AIDS pandemic has taken on Kenyan families and communities, both in terms of human and development losses. Initially envisioned as a three-year, $2 million initiative, the program evolved into a $7.5 million, 6-year program, which continued beyond this project period with funding from other sources.

Investing in care not only reduces suffering and improves the quality of life of PLWHA, but it also prolongs economically- and socially-productive activity. This helps PLWHA care for their families, regain self esteem, and remain productive members of society. Furthermore, when others see PLWHA living normal lives, they are less likely to discriminate against PLWHA out of fear and misunderstanding.

When first implemented in 1999, COPHIA was the largest care and support program supported by USAID in Kenya. The project's two objectives were to:

- Improve the ability of communities to identify their needs and to develop and carry out activities focused on home-based care and support for PLWHA and their families, and
- Improve the capacity of local organizations to manage and implement care, support, and prevention services.

Three areas were initially selected for inclusion in the COPHIA project: Mombasa in Coast province, Nairobi/Thika in the Central province, and Kakamega/Busia in Western province. In 2004, the project expanded to Rift Valley Province. By the end of June 2005, Pathfinder was implementing activities through 54 local partners in 5 geographic areas and 11 target districts, with a catchment area of over 2.6 million people. More than 30,000 vulnerable households were served by the project, which were characterized by having:

- A household member, aged 15-49, who had been seriously ill and unable to perform normal duties and responsibilities for at least three months;
- A household member, aged 15-49, who had died within the previous twelve months and who had been seriously ill for at least three months preceding the death; or
- Households with children who had lost one or both parents.

Project progress:

The first year of the project set the stage for program implementation, which very much evolved over the six year project period. Start-up activities included: introductory visits, identification and selection of LIPs, community mobilization, leaders sensitization workshops, community needs assessments, service provider training and start-up of home-based care services. The second year witnessed an intensification of these activities. Project activities in all sites recorded satisfactory progress following sustained training and deployment of Community Health Workers (CHWs) who in turn continued to train caregivers. In the

third year, the project was further strengthened through training of more caregivers and making CHWs training more comprehensive and holistic in order to better address clients' needs by introducing additional components, such as RH/FP, PMTCT, counseling, voluntary counseling and testing (VCT) and tuberculosis (TB). In order to increase the coverage of HBC services to the vulnerable households, in the fourth and fifth year COPHIA expanded to new locations and consolidated its activities in the older sites.

In year six, through the President's Emergency Program for AIDS Relief (PEPFAR) funding support, COPHIA's main emphasis was on reinforcing and improving the two original strategic results of COPHIA by:

- Enhancing long-term sustainability of local implementing partners through expansion of capacity building activities focusing on home-based care and support and OVC program management.
- Utilizing lessons learned in the successful stigma reduction efforts of COPHIA in the community
- Building the skills, status, and confidence of CHWs through ongoing supervision and continuing education in areas of reproductive health (RH) prevention of mother to child transmission (PMTCT); issues related to ART, and nutritional support for PLWHA.
- Expanding the scope and quality of home-based care activities by increasing the numbers of CHWs and clinical supervisors in existing areas of operation.
- Strengthening the two-way referral system from community to medical facility, including face-to-face relations between the facility providers and the community providers and their LIPs, as well as forging linkages with comprehensive care clinics and other ARV - providing facilities to expand the number of HBC clients accessing ART.
- Expanding HIV counseling services through the training of additional HIV/AIDS counselors affiliated with clinical service facilities or community-based support centers, providing clients, caregivers, OVC, guardians, and family members greater access to supportive psychological counseling to enhance their coping mechanisms.
- Working with CHWs, community leaders, PLWHA support groups, and AIDS support programs to create awareness of HIV/AIDS care, treatment and support options available in the community and at local health facilities with a view to increasing the demand for comprehensive, quality care, treatment and support services.
- Training additional paralegal advisors to provide legal aid services in their communities.
- Supporting orphans and other vulnerable children through the LIPs and developing linkages with existing resources and agencies in the communities.
- Obtaining and distributing standard HBC kits and ensuring a functional logistics and reporting system in all program sites.
- Documenting and disseminating lessons learned for program replication in Kenya as well as other countries in Africa.
- Strengthening monitoring and reporting systems, management information systems, and improving feedback on activities and outputs between local partners, communities, area offices and country office.

In addition to USAID support for the implementation of COPHIA in eleven districts, continuing support from UNDP facilitated the scale-up of the COPHIA model in Busia and Siaya Districts. While the COPHIA award ended in June 2005, Pathfinder continued implementation through a subaward from Family Health International, and then from a separate award from USAID. Further, a new partnership with the Christian Children's Fund (CCF) allowed a similar replication of the model in Kiambu as well as strengthening of the existing Thika program.

The COPHIA model for community home based care in part informed the design of USAID/Kenya's follow-on program, the AIDS, Population and Health Integrated Assistance Program (APHIA II), which provides HIV/AIDS and TB prevention, treatment, care and support, along with integrated RH, FP, malaria and maternal and child health (MCH) services. Further, the COPHIA model has been adopted in other countries outside of Kenya.

PROJECT DESCRIPTIONS AND ACHIEVEMENTS

The COPHIA Team

The Pathfinder COPHIA team included a number of international and Kenyan organizations that contributed specific expertise and skills, namely Population Services International (PSI), Kenya Rural Enterprise Program (K-Rep), and the Kenya Association of Professional Counselors (KAPC). Partners provided technical inputs and reinforced complementary project activities in social marketing, advocacy, information, education, behavior change communication interventions, income generation, and work place service delivery.

Throughout the life of the project, Pathfinder worked closely with the Ministry of Health and the private sector to facilitate two-way referral linkages between community home-based care programs and local health facilities, as well as to help health facilities strengthen treatment, care and support services for PLWHA and their families. From the outset, the project worked to ensure local ownership and sustainability of activities. Local administration as well as traditional and religious leaders, and Ministry of Health staff were included in the planning phases, and networking continued throughout the life of the project. Government of Kenya District and Provincial Health Management Teams contributed to COPHIA planning, as did the District AIDS Sexually Transmitted Infections (STI) Coordinating Officer. Pathfinder also strengthened linkages with collaborating agencies and facilities that offered complementary services, such as prevention of mother to child transmission and anti-retroviral therapy. The communities where COPHIA projects were implemented were deeply involved in project planning and execution.

PROJECT MODEL AND ELEMENTS

The COPHIA model is structured around six interconnected components, namely community mobilization, home-based care, prevention, income generation activities, support initiatives, and institutional capacity building. Following is a description of each element and highlights of achievements over the six project years.

Community Mobilization

An open and honest response to AIDS is one of the most effective ways to reduce stigma and discrimination. COPHIA placed community mobilization and participation at the center of the project's approach, with the result that it is a community-owned project which has ensured both its success and its future sustainability. Community leaders, including district officers, chiefs and assistant chiefs were involved from the outset of the project through participatory planning, problem solving, monitoring, resource mobilization, and development processes. Pathfinder aimed to enhance community capacity in and has mobilized local communities, to identify their needs around HIV and AIDS and to develop and carry out prevention, care, and support activities.

Engaging Community Leaders
Community mobilization workshops heightened community leaders' knowledge, awareness, and empathy concerning HIV/AIDS and created a more supportive environment for COPHIA to carry out its work. The involvement of the traditional chiefs, for example, is of paramount important in Kenya where, without their support, few infected people would be so willing to openly seek services. Local leaders, with assistance from Pathfinder, were actively involved in the development of community action plans. A total of 2,834 district and divisional leaders attended sensitization seminars.

More than 500 religious leaders attended workshops on the emerging challenges in providing care and support services to people infected and affected by HIV/AIDS. The workshops increased the preparedness of religious leaders to play a more active role in providing material and psychosocial support and to support previously controversial campaigns like universal condom use for both youth and married couples, while ensuring the optimal visibility of the COPHIA project. Sensitization was extended to other people of cultural influence such as traditional circumcisers. The main objectives were to teach the circumcisers, administrators, and the public the risks of using one knife to cut several initiates.

Community Level Advocacy
The project trained community-level advocates that included PLWHAs to educate people on HIV/AIDS. They worked with other such as Chiefs and religious leaders to help formulate activities to reduce stigma. By the end of Year 6, annual contacts for community advocacy activities was over 236,000 people.

Community advocacy activities created awareness and encouraged some participants to come out openly about their HIV status. For instance, in Mombasa two Kenya Airports Authority staff voluntarily declared their HIV positive status to the management. In addition, people who had family and friends infected with the disease started coming out openly and talking about it. There was an increased demand for VCT services and a number of people expressing the interest to be involved in the program.

Community Implementing Committees (CICs)
Community Implementing Committees were formed to supervise HIV/AIDS activities in target communities and to link them with other related community activities and support initiatives. By project end 32 committees had been formed in five areas. The committees oversaw the activities of the local partners which ensured project ownership and formed the basis for sustainability. The committees included members of local partner organizations, women's groups, religious organizations, and youth groups as well as local leaders, and representatives from local administration and line ministries. The Community Implementing Committees linked with other committees working in the area such as the Constituency AIDS Control Committees. The committees resulted in fully-committed local partners who understood and helped to formulate and work to achieve the objectives of the project.

Local Implementing Partners
By the end of project, 54 local implementing partners had participated in COPHIA. Local partners included mission hospitals, government clinics, women's and youth groups, widows and orphans societies, and a number of community development groups. Several non-governmental organizations such as Kenya Women With AIDS (KENWA) and Gospel Redeemed Church were also selected as local partners. Eligible partners were integrally involved with their communities and understood local values, means of communication, health problems and prevailing community structures.

Building the capacity of all partners toward sustainability and creating a climate of ownership among managers and staff was a major focus of Pathfinder and COPHIA. Institutional development efforts with

COPHIA's partners have included strengthening systems for better management and program efficiency as well as promoting alternative sources of financing and cost-effectiveness measures.

Greater Involvement of People Living with HIV/AIDS

COPHIA encouraged the involvement of PLWHA in its activities at all levels. Many of the project's Community Health Workers (CHWs) were living with HIV/AIDS. Not only did they provide home-based care and support services but, more importantly, they portrayed a picture of positive living and helped reduce stigma associated with the disease. Their advocacy work was a powerful tool for behavior change in their communities. Denial and stigma are still strong in Kenya and involving PLWHA in HIV/AIDS programs is a highly effective educational tool for the community. Many PLWHA provided personal testimonies at the workshops held for community leaders as part of the effort to reduce discrimination and stigmatization of PLWHA and their families. Such public declarations had a tangible and lasting effect on prevention for the community at large. PLWHA work actively as CHWs and sit on most representative bodies in and around the project.

COPHIA has left a big mark at the community level: During the life of the project, many clients expressed their appreciation of how the project had assisted them in various ways. Even as the project came to a close, still many persons came forward to express the satisfaction with COPHIA's contribution in the fight against HIV/AIDS pandemic. The letter below by a TOT/Counselor from Shika Adabu BI (a COPHIA LIP) tells it all:

SHIKA ADABU B.I.
P.O.BOX 96069.
MOMBASA.
28/8/06

TO PATHFINDER INTERNATIONAL,
COPHIA PROJECT.
MOMBASA.

Dear Sir,
RE: APPRECIATION.
"We take this opportunity to thank the initiators of the project in Mombasa and particularly our location [Shika Adabu]. This has enlightened the whole community in many terms especially in capacity building in terms of mobilizing resources and caring for the sick.

Secondly it has created awareness of the magnitude in which HIV/AIDS has penetrated and affected and infected the people of the area thus reducing stigma and embark in seeking possible interventions.

COPHIA Project is the only project of an NGO whose efforts to address pertinent issues of the area has been seen-KUDOS.

We hope through what has been done, the other projects will find partners to further each other's endeavors in the community.

We remain confident that we will work with APHIA II in utmost good understanding and relations.

Yours in anticipation,

Signed,

[MWAMRAH].

Home Based Care

The emphasis of the COPHIA program is the provision of home-based care and support services by multi-purpose community-based health workers to vulnerable households in the geographic focus areas that are coping with the burden of caring for seriously ill family members or caring for orphans and vulnerable children. The COPHIA community-based health workers, with the support of clinical and non-clinical supervisors, provide the direct physical and emotional care and support services to PLWHA and orphans and vulnerable children in the project catchment area with the support of trained primary caregivers.

Community Health Workers

The backbone of the COPHIA project has been its CHWs. CHWs are community members who volunteer to care for their fellow community members living with AIDS. The CHWs provide life-saving physical and emotional care for their clients, but early in the project it became clear that the CHWs could not meet all of their clients' needs. By partnering with relevant community organizations, the project was expanded to address issues such as household food security and the special nutritional needs of PLWHA, the need for community-level counseling services, support groups, microfinance and income generating activities for project beneficiaries, care and support for Orphans and Vulnerable Children (OVC), and access to legal services and succession planning.

Pathfinder used a cascade approach to training CHWs. Pathfinder staff trained a group of master trainers, who in turn trained larger groups of trainers, who then trained even larger groups of CHWs and HIV/AIDS counselors in community home-based care. Through this process almost 1,500 CHWs were trained by just 252 master trainers. The CHWs trained and provided continuing support to over 71,000 primary care givers.

CHWs taught primary caregivers simple nursing skills such as the proper way to turn a client, how to wash the client in bed, nutritional needs of PLWHA, proper storage of drugs and monitoring adherence, and the importance of encouragement and avoiding stress. Primary care givers—usually family, friends, or neighbors—also learned basic infection prevention measures in the home and were educated about HIV/AIDS enough to actively help dispel stigma in their communities. Caregivers were provided with HBC kits containing the following items: Jik 750ml bottles, Panga Soap-bars, Tissue paper, Cotton wool, Vaseline 50gm, Gloves (pairs), Talcum powder 100gm, Salt 500gm, Nail Cutter, Scissors, Neem Soap, and Wooden Spatula.

Pathfinder-trained CHWs also helped PLWHA and their families identify resources such as food security and financial support provided by local community and faith-based organizations. CHWs, many of whom were PLWHA themselves, became "agents of change" by bringing new, healthy concepts and practices into communities. They offered powerful testimonies about the realities, concerns, pain, and also hope they encounter living with the disease. Through these testimonies, these HIV-positive CHWs showed that they are still productive members of society. Community members could identify PLWHA rather than think of HIV as a remote, faceless disease. This was a powerful tool in reducing stigma and discrimination as well as promoting prevention in the community.

Prevention

Experience gained in the process of implementing Pathfinder's community-based HIV/AIDS care and support project activities has shown that stigma related to HIV/AIDS often cripples efforts to combat the spread of the epidemic in an efficient, effective way. People living with HIV/AIDS are some of the people most hurt by this widespread stigmatization since the consequences of admitting their status can be devastating to themselves and even their relatives. PLWHAs often face discrimination such as ostracism

within the family or workplace and withdrawal of healthcare services and benefits. However, HIV negative people are also deeply affected by stigma since shame and embarrassment hinders efforts to protect their HIV negative status, like accessing VCT services or buying condoms.

A coherent response to the HIV/AIDS epidemic should seek to link care and prevention support and treatment activities. Well-designed HIV prevention activities can lead to increased use of VCT services, which then lead to broader and quicker access to treatment for PLWHA and also other resources for positive living. Such activities can also reduce fear and stigma around the virus, thus improving the quality of life for PLWHA. Women who learn their HIV positive status can access services that reduce the chance of passing the virus to the child if they become pregnant. PLWHA need prevention messages as much as the wider, uninfected community. Many people infected with HIV do not understand the importance of avoiding re-infection, which can result in accelerated progression to AIDS and the possibility of acquiring drug-resistant strains.

In July 2000 Pathfinder partnered with Population Services International (PSI) to implement prevention activities with COPHIA. COPHIA's prevention activities placed a special emphasis on vulnerable groups, mainly youth and adolescents, in and out of school. They attempted to reach this audience through radio and television messages discussing condom efficacy, high-risk behavior, cross-generational relationships and stigma reduction, and by training PLWHA to be community advocates. Using PLWHA as counselors and CHWs proved to be an extremely effective mechanism for promoting behavior change, VCT, and other prevention messages.

To reach youth more effectively, PSI used several approaches including essay writing competitions, support groups, and training of peer educators and youth in puppetry and drama. COPHIA fully engaged the community in formulating locally-appropriate messages. This resulted in open discussion about HIV/AIDS and dispelling myths associated with the disease, which contributed to prevention in the targeted communities. A summary of some key COPHIA prevention activities is as follows:

Summary COPHIA Prevention Activities

Type of Activity	Achievements by Year: Year 1 to Year 6						
	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	**Year 1-6**
No. of schools involved in Essay Writing Competition		48	37	78	17	0	**180**
No. of students involved in Essay Writing Competition		280	880	3,964	3,550	-	**8,674**
No. of community drama outreach presentations		171	1,138	2,089	1,288	2,464	**7,150**
No. of people reached/attended community drama outreach and community advocacy campaigns by PLHWAs		42,091	385,499	662,922	627,570	331,250	**2,049,332**
No. of students involved in post-Essay Writing Competition feedback sessions			8,496	19,960	4,230	22,861	**55,547**

Income Generating Activities

Pathfinder recognizes that poverty is at the core of the HIV epidemic and that PLWHA and their families need income to survive. Further, CHWs cannot sustain their volunteer efforts and community mobilization activities without income to feed their own families. COPHIA was committed to providing economic opportunities for clients and their caregivers, mature orphans, and CHWs by providing training in business skills and promoting income generating activities. Providing individuals with the tools necessary for income generation is a sound means of ensuring sustainability of project objectives. It leads to improved business skills, increased household income and savings, improved household food security, and reduced dependency. The ability and means to support oneself and family results in increased self esteem which is vital for people affected by HIV/AIDS.

In partnership with the Kenya Rural Enterprise Program (K-REP), a microfinance development organization, COPHIA supported a system of village banks in the project areas. Additionally, line of credit activities were implemented for PLWHA and their families. Clients were able to access financial services such as savings and credit through group-based lending.[1] The intervention included activities to help participants save money, credit to start or expand business, and training in business management skills.

By end of project, a total of 2,197 loans amounting to $604,805 had been disbursed. Women accounted for 81 percent of borrowers. Most clients invested their loan money in starting or expanding businesses, which ranged from petty trade, through the construction or renovation of rental houses.

Support Initiatives

COPHIA encompassed a wide range of support services to maximize services for those who were infected with and affected by HIV. One crucial component of the support initiatives was establishing referral linkages with existing health facilities for voluntary counseling and testing (VCT) and home-based referrals for treatment of STIs, TB, malaria, family planning, and nutrition. Other support services included counseling, post-clubs, a variety of support groups; paralegal support; food support, services for OVCs, advocacy strategies, and mobilizing youth in home-based support strategies.

Two-way referral linkages between facility and community services

Referral links and availability of quality services at affordable cost are imperative to the success of a home-based care project. Two-way referral systems between facility-based and community-based care ease the burden on facilities while ensuring that clients receive necessary testing, counseling, and treatment of opportunistic infections.

To ensure access to these services, Pathfinder early on identified private and government facilities in the COPHIA catchment areas and facilitated workshops for a total of 502 providers on HIV/AIDS, home-based-care, specific mechanisms for client referral, and enlisted the involvement, support, and ownership of the home-based care services by the health care providers. An additional 153 staff were trained or retrained as HIV/AIDS counselors. Twelve health facilities were upgraded and equipped to provide high-quality VCT. Twenty-nine community-based client support centers were established to provide counseling for people affected by HIV.

[1]. The groups meet on a regular basis to deposit savings and make loan payments. The savings collected during each group meeting is deposited in a group savings account. This acts as partial collateral for the loans given to the group members.

A number of these providers acted as clinical supervisors for CHWs in their area. CHWs referred clients with needs they could not meet to the supervisor. As part of the support and supervision for the CHWs and to improve the quality of the two-way referral system, clinical supervisors accompanied CHWs on visits to new clients to develop a personal care plan for each client, specific to his or her needs. The plan established the client's current status and identified referral requirements and nursing, nutritional, and support service needs. It listed necessary tasks for the primary caregiver to perform, outlined issues to be addressed by the CHW, and served as focal point for follow up. The CHW followed the plan with the caregiver and referred the client in to the facility when needed. With input from the CHW and primary care giver, the care plan was adapted to the changing needs of the client. Ongoing supervision of CHWs by the clinic supervisor—through weekly meetings and during periodic supervisor-client visits—ensured careful administration of the plan and provided educational updates for the CHW.

Support for clients on ART

In early 2004, with the US government's introduction of the President's Emergency Plan for AIDS Relief, ART became much more readily available to Kenyans. This meant that discovering one's status through counseling and testing was a more desirable option, because there was hope for a longer, healthier life. This in turn brought new clients for COPHIA home-based care.

As an increasing number of eligible PLWHA received ART, CHWs began reporting that clients were no longer dying in such appalling numbers and that some, bedridden and thought to be dying, had recovered strength and were able to go about their lives once again. The availability of ART gave hope to many and changed the nature of the relationship between CHWs and their clients. With clients once again mobile, it was soon clear that the relationship between health worker and client could be much longer, and of a changed nature, than that experienced before ART. Client needs shifted from bed-care to other issues such as adherence to drug regimens, legal issues, economic viability, and family matters. The two-way referral system between the CHWs and health facilities and links with comprehensive care clinics and other ART-providing facilities increased home-based care clients' access to ART.

As clients began to live longer, CHWs realized that their emotional needs were not being met. In response, COPHIA increased counseling services through the training of additional HIV/AIDS counselors affiliated with health care facilities or community-based support centers. This provided clients, caregivers, OVC, guardians, and family members greater access to supportive psychological counseling to enhance their coping mechanisms. By the end of the project, 153 trained counselors were providing psychosocial support for people living with or affected by HIV/AIDS.

Experiences of clients on ART are very encouraging as demonstrated by the following personal testimony. The case also depicts issues of CHW involvement in adherence counseling and monitoring, and the complexities of delivering HBC services for PLWHAs. There are also challenges in ensuring adherence to ART. Often COPHIA CHWs find cases of PLWHA that have been dissuaded from taking drugs either under the pretext that prayer would work miracles or that local herbs were more potent than ARVs. The case of Mary Masai below is an example of such a case and how CHWs handle them.

Mary Masai: Mary Masai, a PLHWA, is a 47-year-old single mother from Kesses Division in Eldoret. She has eight children under her care. Sylvia Sang, a CHW, started visiting her last year on a regular basis and convinced her that it was a good idea to start accessing the AMPATH (Academic Model for the Prevention and Treatment of HIV/AIDS) Clinic in Burnt Forest, where she would be able to start taking ARV drugs.

After starting the medication, Mary was doing much better until a friend told her that she did not need to go to the clinic anymore because there was an herbal clinic in Nandi where she could go for herbal remedies. Mary then started taking herbs that consisted of mixed roots and sisal leaves, which she took five times a week, while completely refusing to go back to the clinic at Burnt Forest. She became hostile to Sylvia and her caregivers, especially when they reminded her to take the ARVs and to go for follow up at the ART clinic at Burnt Forest Health Center. Mary refused to go back to the health center, and when the CHWs resorted to pill counts during home visits, they discovered that she had been keeping ARVs in the house.

After a while, Mary became very sick again and finally agreed to go back to the clinic for ARVs. She is now doing well again after adhering to the medicine for 2 months. She and Sylvia are now good friends and she has become a member of the Support Group. Sylvia visits her quite often and regularly counts her drugs to ensure that she is taking them well and according to instructions.

Mary had the good fortune of being started on second regimen of ARVs that include Protease Inhibitor (Ritonavir) by the AMPATH program. Not many patients in Kenya would have access to this second line regimen of ARVs after developing resistance to 1st line regimen. Clearly the role of CHWs in ensuring adherence to ART through counseling and pill count is vital.

Formation of support groups

COPHIA encouraged clients living with HIV/AIDS to help form and join post-test clubs and support groups, some of which were hosted by COPHIA referral clinics. Well over 500 such groups were formed and provided psychosocial support for clients, their families and caregivers. In addition, the groups helped members find support services such as income generation activities, legal services, and food security. The members of the support groups, with their personal experience of HIV/AIDS, were excellent candidates for counseling and paralegal training.

Support for Orphans and Vulnerable children[2]

The increasing number of OVC in Kenya is a constant challenge to programming. By 2004, there were an estimated 1.7 million Kenyan orphans whose parents had died of AIDS.[3] By 2010, 15.4 percent of all children under age 15 in Kenya will have lost one or both parents.[4] Significant numbers of orphans and vulnerable children in Kenya are without sustenance and exist without hope for a future. The project baseline assessment in 1999, revealed the extent of child vulnerability in project sites, ranging from nine percent in Embakasi, Nairobi to an alarming one in three children in Budalangi, Busia in Western province.

In 2004, two important steps were taken to ensure the care of OVC in Kenya: the Kenyan OVC National Steering Committee was formed and UNICEF published a report outlining the five key strategies for caring for OVC. Both the steering committee and UNICEF recommended:

- Strengthening the capacity of families to protect and care for OVC;
- Providing economic, psychosocial and other forms of support;

[2] Children, under 18 years, who have lost one or both of their parents or are otherwise made vulnerable by HIV/AIDS.
[3] USAID Mission to Kenya for PEPFAR, Interagency Team, *Strong Networks for a Sustained Response,* n.d., p.5. In 2003, an important study reported 650,000 AIDS orphans in Kenya. UNICEF/UNAIDS/USAID, *Children on the Brink 2004,* Appendix 1. UNGASS, Kenya Country Report, 2006, p.11.
[4] *Children on the Brink*, 2002.

- Mobilizing and supporting community-based responses; and,
- Increasing OVC's access to essential services including food and nutrition, education, health care, water and sanitation, and housing.

The UNICEF report further recommended that governments protect vulnerable children through policy and legislation and by channeling resources to families. COPHIA implemented these strategies and particularly worked to ensure the availability of essential services for OVC.

Many children orphaned by AIDS have been traumatized long before their parents' deaths. When their parents die it is often difficult for the CHWs to assist the children adequately, especially emotionally. COPHIA trained child counselors and teachers to support OVC and also work with their guardians.

In 2004, the Kenyan government established universal free primary education, allowing many OVC to access primary school education. Pathfinder continued to support local partner and community initiatives to keep the younger children in primary school, by providing assistance with uniforms and books. Pathfinder partnered with technical schools to expand their enrollment of mature OVC by providing the schools with the necessary tools and supplies.

With capacity building from COPHIA, various local partners provided assistance for OVC with school fees, uniforms, stationery, instruction in informal schools, food, clothing, and placement to institutions, foster homes, or adoption by local families. The project also provided support for mature OVC such as IGA and skills training, access to micro-credit, adolescent sexual reproductive health services, etc.

The COPHIA project also received assistance from private organizations. In 2003, Barclays Bank funded vocational training for 41 orphaned youth and purchased equipment for two vocational centers in Kakamega District, Western Province. Beginning in 2005, Citigroup supported skills training for 54 OVC affiliated with Pathfinder local implementing partners.

Nutrition and Food Security

With the introduction of antiretroviral drugs, many Kenyan's lack of proper food and nutrition was further highlighted. Many drugs must be taken before, with, or after a meal to maximize efficacy and minimize side effects. A person's overall health status, closely associated with their nutritional status, is a determining factor in the progression of AIDS. CHWs, local implementing partners, and PLWHA identified access to food for a balanced diet as a major challenge to their successful AIDS therapy. Pathfinder collaborated with organizations such as the Kenya AIDS Intervention Prevention Project Group to provide PLWHA and CHWs basic training on the use of locally available foods rich in micronutrients, and food management of HIV/AIDS symptoms. Clients and caregivers were trained in the value of using food as a therapeutic aid, how to access and prepare local foods, and how to diversify diets at little or no cost. COPHIA also counseled clients on dietary habits, key foods and nutrients, and water, hygiene, and food safety to prevent diarrhea.

In rural areas, food security issues were addressed by improving farming methods and adopting new, nontraditional methods of farming that boost food production and food quality. COPHIA collaborated with the Kenya Institute of Organic Farming (KIOF), an NGO that focuses on sustainable improvement of the livelihood of small farmers through organic farming. KIOF provided a five-day course on organic farming using waste water and locally found vegetation, tailored to the needs of COPHIA beneficiaries, which focused on the needs of people with small parcels of land and with special needs such as PLWHA. Participants in the course taught what they learned, including nutritional information, to others in the community and helped create community gardens.

COPHIA also addressed food security through community food banks, alternative cropping methods such as using gunny sack gardens, which maximize yield and minimize land use, school-feeding programs for OVC and distribution of supplementary foods. In Coast and Western provinces, COPHIA collaborated with the Ministry of Agriculture's extension workers to train community groups and OVC in cultivation techniques. Individuals and businesses also donated food to COPHIA clients. The Ruiru AIDS Awareness Group in Thika was particularly successful in soliciting food contributions from the community, as were various community implementing committees in other regions.

Paralegals

Community leaders such as chiefs, local implementing partners, and community implementing committee members were faced with daily requests for legal advice on problems and issues related to HIV/AIDS, yet they did not have the knowledge or the skills to address these needs. In partnership with the Oscar Foundation, an organization of lawyers who provide free legal advice to the disadvantaged, the Children's Legal Network (CLAN), and other legal aid and paralegal training organizations, COPHIA provided paralegal training to selected community leaders. The training covered a wide range of legal issues related to HIV/AIDS such as:

- HIV/AIDS and legal implications in Kenya - human rights in regard to employment, testing for HIV, and disclosure of one's HIV status;
- Antidiscriminatory and protective laws - workplace discrimination because of HIV, involuntary testing, wrongful dismissal, and lack of confidentiality in dealing with test results;
- Human rights and HIV/AIDS - matrimonial rights in regard to HIV/AIDS, forced marriages, harmful cultural practices like wife inheritance, employer/employee rights, and confidentiality;
- Legal and ethical issues governing wills - types of wills, validity of a will, and how to prepare a will; and
- Children, gender, and HIV/AIDS – children's and women's rights in cases of bigamy/polygamy, and willful transmission of communicable diseases such as HIV/AIDS.

The introduction of paralegal training in the COPHIA project is a good example of how Pathfinder responds to the needs of the community. The AIDS epidemic in wide regions of Sub-Saharan Africa has revealed the enormous disparities within gender relations. Women are not only the most affected physically by the virus, but, additionally, they suffer enormously because of cultural factors such as unequal relations within marriage. Children often suffer because of lack of recognition of their basic human rights. It is common practice for the wives of deceased husbands to lose their homes, land, and other major possessions such as tools and cooking pots to her in-laws. They may even have to relinquish custody of their children to the husband's clan. This is a cultural practice which has only in recent years been challenged by law. Paralegals can help women and children stay together and keep their land and possessions after a father's death. By the end of June 2005, a total of 332 people had been trained as paralegals.

Institutional Capacity Building

Building the capacity of all partners toward sustainability and creating a climate of ownership among managers and staff was a major focus of Pathfinder and COPHIA. Institutional development efforts with COPHIA's partners have included strengthening systems for better management and program efficiency as well as promoting alternative sources of financing and cost-effectiveness measures.

Grants Management and Sustainability
Based on institutional assessments of partners' managerial, financial, and technical capacity simple proposals and Memorandum of Agreements (MOAs) were developed for a number of LIPs to secure grants from Pathfinder targeting HIV/AIDS prevention, care and support activities. COPHIA also disbursed rapid response funds (RRF) grants to support of OVC programs and HIV/AIDS training/workshops. Part of this support benefited 546 OVC.

ICB Workshops
COPHIA conducted a series of workshops on Proposal Writing Skills and Program Management for managers from local implementing partner organizations.

Specialized training
With both private resources and through project support, Pathfinder sponsored multi-country training opportunities. For example, some key staff attended Advocacy in Reproductive Health and HIV/AIDS, facilitated by Center for African Family Studies (CAFS) in Nairobi for two weeks. Another course attended was the 5-day ARV training organized and facilitated by MSF-Spain in Busia, whose objectives were to assist service providers/participants to: - update participants on key issues fundamental to the ARV/ART such as: indications for starting and altering therapy; basic skills in ARV counseling; standard regimens and their major side effects; how to clinically and biologically monitor the patients; basic knowledge of ARV treatment in children; knowledge and skills on how to safely prescribe ARV; and care for and support the client on ARV/ART.

In addition, inter-project exchange visits were carried out to foster an exchange of ideas between COPHIA Areas. The North Rift COPHIA team which visited Coast Area made the following observations:

- ✓ Communities can significantly support OVC and other initiatives if effectively mobilized.
- ✓ Referral systems and mechanisms between health facilities and CHWs can be improved.
- ✓ CHWs are playing an important role in TB treatment management and ensuring adherence in ARV/ART.
- ✓ PLWHAs support can play an important role in reducing stigma and promoting proper use of ARV drugs.
- ✓ CICs can eventually evolve to CBOs and become more supportive in mobilizing and allocating resources for community use.
- ✓ The "Community Monitoring Board" being used by BI's was seen as an impressive and replicable method of providing community information at a glance.
- ✓ ARV/ART is provided at a cost and PLWHAs can still be able to pay for it and maintain adherence similar to those who are getting ART for free.

CHALLENGES/LESSONS LEARNED

COPHIA has been a successful demonstration that home-based care can be effectively provided by the community. Further, the important linkages between home and health facility are enhanced, even established, through the efforts of the community health worker. The program has been a resounding success in very basic areas of caring for those infected with HIV or suffering AIDS. A good example derives from Western Province where one elderly caregiver, the mother of an ill middle-aged daughter, explained that her neighbors often request her assistance with their own ill family members, not necessarily related to HIV-related diseases. The neighbors said they had never known that a sick person could be washed in bed. They also express relief and surprise that touching, caring for, a person with HIV/AIDS poses no danger to their own health when simple precautions are taken. These may appear minor changes

to the outsider, but in the context of semi-literate and deeply frightened rural people, these simple observations have made an enormous difference to the degree of stigma and fear surrounding HIV/AIDS and fear for the sick and the dying (as PLWHAs are often referred). People are now cared for rather than shunned as in the recent past.

Community Health Care Workers: A principal challenge to the program is the sustainability of the considerable commitment of the volunteer CHWs. For decades, the general consensus has been to maintain the volunteer nature of their work. The motivation and retention of community health workers is seminal to the success of home-based care. Objectively, it is not realistic to continue to expect community health workers to maintain and substantially increase their commitment especially in light of the burdens many of them bear as a direct result of the impact of HIV/AIDS on their own lives and families. For example, CHWs in all COPHIA areas have reported that as a result of their close and often long relationship with an ill person who later dies, it is common for the children of the deceased's household to simply move into the home of the health worker. The children view the health worker as a natural extension of the family bond. Some workers are over-burdened with orphaned children, ranging from their own deceased kin to those of deceased clients. 'Burn-out' is a real threat to the sustainability of CHWs and caregivers who often experience considerable emotional stress and burnout. The sustainability of home-based care is critically important in resource poor environments such as Kenya and where the health facilities are stretched to their limits and where they may also be geographically or economically inaccessible to a large percentage of the population.

Food Security and Nutrition: Throughout all the phases of COPHIA**,** a challenge that was often voiced in all COPHIA sites is the great need for food and nutritional supplements to enhance the health of clients. This challenge became more apparent with the advent of anti-retroviral treatment. While food security is a serious need for a majority of rural and a large proportion or urban Kenyans, for those on a course of anti-retroviral drugs, the lack of food can undermine the efficacy of treatment. In most rural households, it is not uncommon for people to have only a cup of tea or a mug of porridge for breakfast and no other food until late in the evening when a meal may be available. Furthermore, the lack of proper nutrition impacts further on an already stressed and lowered immune system.
Although leaders and communities made great effort to provide food support to PLWHAs and OVC, access to food still remains a challenge to many impoverished households nursing clients and this has tended to negatively affect adherence to ART and other drugs.

Integration of RH/FP into Home-based Care The care and support of people living with HIV/AIDS needs to be integrated with other services. Information about and access to reproductive health and family planning services is critical to PLWHAs. It is important to ensure that all people living with HIV/AIDS are fully and correctly informed about their reproductive choices and limitations. Information is required by *both* men and women as the former are often the major decision-makers regarding reproduction. This approach has become more necessary in the era of ART. ART and good nutrition have changed the scenario in HIV/ AIDS management. Clients who were bedridden and incapacitated are now mobile and are participating in family and community affairs. As a result a major challenge that has recently emerged is the number of women (majority widows) becoming pregnant after improving on ART and men engaging in unprotected sexual relationships while on ART.

Multi-sectoral Approach: In the process of COPHIA implementation, it has been observed that the nature and impact of HIV/AIDS is not merely a health issue. HIV/AIDS is a socio-economic calamity that requires a multi-sectoral approach as it affects all aspects of society. Poverty is the underlying issue and it imposes a vicious cycle for PLWHA, families and communities. To address this situation, COPHIA realized early that HIV/AIDS strategies required a must be multi-sectoral in to fully address the needs of

HBC clients. As a result COPHIA established referral networks with local health facilities and service providers to ensure clients received drugs for opportunistic infections, through K-Rep started IGA activities that help the families and the communities provide for basic needs. IGA training skills were also linked to access to micro-finance schemes for HBC providers and affected members of the community including OVC. Integrating micro-credit with home-based care was a great motivation for PLWHA and caregivers. The majority of the clients appreciated the fact that they could access loans to expand or start up their businesses.

Access to Health Services: The home-based care program can relieve the patient burden on the formal health sector. However, PLWHAs need to access health services for routine monitoring, special problems and other health issues. Access for people weakened by HIV or ill is very often extremely difficult involving distance and expense, which preclude necessary visits to health facilities. It is very common, for example, for a CHW to either personally accompany or assist a client with transport costs. This is not a sustainable nor continual option. Clients also need to access health facilities capable of supplying proper drugs for a variety of opportunistic infections. Clients need to access a reliable supply of anti-retroviral drugs, which can also be a challenge involving expense and long distance travel. Access to treatment of opportunistic infections is still a challenge for HBC clients. Most of the health facilities that serve as referral points suffer from periodic shortages of VCT kits, OI drugs, and FP methods. Also, most tests to qualify for ARVs are not free.

Staff Shortages in Health Facilities: Many health facilities, particularly those in the public sector, are understaffed. In addition to the obvious impact of lack of staff on health care provision, the lack of sufficient staff has a negative impact on the success of a referral system. A sound, two-way referral system is a mark of the success of a well organized home-based care program but it will only work properly if the client finds a service at the end of a referral. However, it has been observed that staff shortages at referral points, hampers not just referral process, but also service delivery by limiting types of services available.

Addressing the Needs of Orphans & Vulnerable Children: COPHIA has made commendable efforts to address the needs of orphans and vulnerable children through both its prevention and its support programs of school fees, uniforms, supplies and training. However, due to the ever-increasing numbers of OVC, care and support for OVC still remains a challenge. For instance, CHWs continue to be over-burdened with the care of children left behind by clients who have died. Additionally, the OVC require more psychosocial support in order to cope with their enormous challenges. Due to age range of OVC, it is important to recognize the fact that each age range has special needs. For instance, counseling needs of adults differ significantly from that of children hence the need to train a cadre of child counselors to address the needs of younger OVC. Health service needs for the under 5 is also different from the older OVC hence the need to re-orient service providers in pediatric service provision.

In all COPHIA sites LIPs and local government representatives made commendable efforts to generate resources in support of OVC. This was in terms of providing food support, clothing, school fees, paralegal support etc. Despite these efforts, the care and support for OVC remains a big challenge because of the sheer numbers, and the fact that the very same communities that are generating resources are also resource-poor.

Community Mobilization: Community involvement activities to establish the foundation upon which to build project interventions in the community and to combat stigma, generate resources to enhance care and support of PLWHAs and OVC, and also ensure community ownership of the initiative remained a crucial component of COPHIA throughout the program. In all areas, community involvement and support activities continued to be one of the pillars of COPHIA. Communities were involved in

fundraising/resource mobilization for causes raging from education, food and nutrition support, clothing, payment of hospital/health services, and relocation of clients to rural homes etc. Other community mobilization activities included, stigma reduction, paralegal education at community level, health education, HIV/AIDS prevention etc. that are all critical for the success of the project.

Annex I: Project Achievements

Table: Summary of COPHIA Achievements, July 1999 – June 2005

Activity/Indicators	Achievements Jul 99 -Jun 05	Targets Years 1-6	% Target Achieved
Community Mobilization			
# of district/ divisional leaders attended sensitization seminars	2,834	2,450	116%
# of religious divisional leaders attended sensitization seminars	513	645	80%
# of CICs formed	32	36	89%
Home-based Care			
# of TOT/Master trainers (clinical supervisors/trainers) trained	252	190	133%
# of TOTs/Master Trainers (clinical supervisors/trainers) provided refresher/orientation training in HBC clinical supervision	215	235	91%
# of new CHWs trained	1,471	1,240	119%
# of CHWs attending refresher/update training	1,398	1,670	84%
# of home-based caregivers trained	71,132	35,870	198%
# of clients seen/served	37,889	19,765	192%
# of VCT referrals	40,725	18,556	219%
# of Clients on ART	3,053	-	-
Prevention			
# of Peer educators and youth trained in puppetry	118	50	236%
# of schools involved in essay writing competition	76	120	63%
Income Generation Activities			
# of people trained in IGA	1,318	800	165%
# of people linked to micro-finance institutions (loans)	1,434	1,725	83%
# of group leaders trained in IGA	74	20	370%
# of persons trained in food security and production	525	220	239%
Support Initiatives			
# of Orphans supported through COPHIA	81,893	16,806	487%
# of SDPs with trained counselors providing HIV/AIDS counseling services	4	4	100%
# of health facilities upgraded and equipped to provide high quality VCT services	6	8	75%
# of HIV/AIDS counselors attending refresher training	131	120	109%
# of public/private sector clinic based service providers provided orientation training on HIV/AIDS	502	400	126%
# of HIV/AIDS counselors participating in basic/initial training in counseling	153	75	204%
# of persons participating in Para-legal training	274	100	274%
Institutional Capacity Building			
#. of LIPS involved in inter-project exchange program	10	21	48%
# of LIPS receiving block grants	10	-	-
# of LIPs provided grants/direct funding	25	16	156%
# of CBOs/NGOs receiving rapid response funds	15	10	150%
# of persons participating in management development workshops	114	100	114%

(1) VCT services in COPHIA sites began in March 02

Annex II: COPHIA Project Sites and Population[5]

District	Division	Location	Population			# Households
			Male	Female	Total	
Nairobi	Central	Mathare	39,737	29,266	69,003	24,525
		Huruma	48,150	41,926	90,076	27,841
	Embakasi	Dandora	57,353	52,811	110,164	36,691
		Umoja	45,856	47,398	93,254	24,725
		Kayole	49,834	48,688	98,522	29,318
	Kasarani	Korogocho	24,257	19,545	43,802	14,665
	Makadara	Mukuru Nyayo	18,936	17,296	36,232	10,224
		Kariobangi	38,945	32,392	71,337	23,237
	Westlands	Kangemi	31,746	27,542	59,288	19,298
	Dagoretti	Kawangware	47,555	39,269	86,824	29,918
		Riruta	34,322	31,636	65,958	20,191
		Waithaka	9,863	10,074	19,937	5,752
		Mutuini	7,458	7,063	14,521	4,334
Thika	Municipality	Thika Municipality	47,091	42,141	89,232	29,270
		Gatuanyaga	9,145	8,797	17,942	5,083
	Ruiru	Ruiru	56,982	52,592	109,574	34,274
		Juja	21,613	19,523	41,136	12,420
	Kamwangi	Chania	13,079	14,153	27,232	6,258
		Githobokoni	12,082	12,793	24,875	5,633
		Gituamba	9,070	9,449	18,519	4,209
		Mangu	13,710	15,124	28,834	6,507
Busia	Busia Township	Township	8,582	8,897	17,479	4,380
		Maenje	3,686	3,993	7,679	1,632
	Budalangi	Bunyala South	2,482	2,495	4,977	1,256
		Bunyala West	6,145	6,517	12,662	3,020
	Butula	Bumala	3,575	4,302	7,877	1,957
		Bujumba	6,841	8,087	14,928	3,432
		Marachi Central	10,893	12,918	23,811	5,437
		Elugulu	6,636	7,824	14,460	3,198
		Elukhari	4,589	5,236	9,825	2,210
		Marachi East	11,395	13,193	24,588	5,261
Kakamega	Shinyalu	Muranda	11,724	12,463	24,187	4,962
		Shibuye	14,584	16,057	30,641	6,243
	Ikolomani	Iregi	3,328	4,220	7,548	1,629
		Shirumba	7,485	8,399	15,884	3,467
	Kabras	Kabras East	14,687	15,560	30,247	5,686
		Kabras West	9,229	9,922	19,151	3,824
		Kabras South	15,747	16,509	32,256	6,567
	Municipality	Shieywe	17,563	17,874	35,437	9,405
		Bukhungu	19,425	19,253	38,678	8,995
Butere/Mumias	Khwisero	West Kisa	4,611	5,032	9,643	2,235
		Central Kisa	7,612	8,904	16,516	3,760

[5] Figures based on 1999 Kenya population Census

District	Division	Location	Population			# Households
			Male	**Female**	**Total**	
		Mulwanda	9,155	10,495	19,650	4,405
		North Kisa	6,637	7,667	14,304	3,156
		East Kisa	4,603	5,415	10,018	2,199
		Kisa South	4,437	4,901	9,338	2,067
Bungoma	Sirisia	Sirisia	11,334	12,186	23,520	4,505
		Namwela	10,054	10,514	20,568	3,889
	Malakisi	Lwandanyi	5,386	5,768	11,154	2,330
		Malakisi	7,095	7,390	14,485	3,066
		Nabubila	5,207	5,196	10,403	2,049
Mombasa	Likoni	Mtongwe	11,696	9,485	21,181	5,649
		Shika Adabu	7,686	6,644	14,330	4,091
		Likoni	33,462	25,910	59,372	19,933
	Kisauni	Kisauni	62,557	55,332	117,889	34,223
		Kongowea	49,367	37,311	86,678	26,336
		Bamburi	24,268	21,026	45,294	9,319
	Changamwe	Mikindani	17,692	14,793	32,485	9,637
		Miritini	17,412	13,883	31,295	8,665
		Port Reitz	30,252	23,832	54,084	16765
Malindi	Malindi	Malindi/Township	42,516	38,205	80,721	19,402
		Watamu	8,384	8,195	16,579	19,402
Uasin Gishu	Kapsaret	Langass	32,155	28,818	60,973	18,177
	Ainabkoi	Olare/Burnt Forest	5,103	5,268	10,371	2,166
		Timboroa	5,045	4,848	9,893	2,048
		Lenguse	6,550	6,427	12,977	2,604
		Tarakwa	6,906	7,011	13,917	2,607
		Kipkabus	3,257	3,127	6,384	1,214
		Chepngóror	2,822	3,036	5,858	1,039
Nandi South	Nandi Hills	14 Locations	40,779	36,375	77,154	18,733
Nandi North	Kapsabet	8 Locations	62,410	62,705	125,115	25,289
Total			**1,361,830**	**1,268,896**	**2,630,726**	**737,894**

Annex III: List of COPHIA Implementing Partners, Program Focus and Geographic Sites

Name of Local Implementing Partner	Program Focus	Geographic Site
WESTERN		
St. Elizabeth Mukumu Mission Hospital	Home-based care, VCT, OVC support	Shinyalu, Ikolomani,
Kabras Jua Kali Association	Home-based care, youth mobilization, vocational training and OVC support	Kabras division, Kakamega
Kakamega Municipality CIC	Home-based care, IGA community mobilization and OVC support	Kakamega Municipality,
Port Victoria Sub-district Hospital	Home-based care and VCT	Budalangi division, Busia district
Sirisia CIC	Home-based care and OVC support	Sirisia division,
Khwisero CIC	Home-based care and OVC support	Khwisero division
Widows and Orphans Welfare Society of Kenya	Home-based care, IGA, OVC support and food supplements	Busia Township
Misikhu Mission Hospital	VCT, OVC support	Bungoma District
Malakisi CIC	Home-based care and OVC support	Bungoma District
Rural Education and Economic Enhancement Program (REEP)	Home-based care, VCT, OVC support	Butula division
Butula Community-based Services (BUCOS)	Home-based care, VCT, OVC support	Butula division
Coast		
Mtongwe Community Initiative	Home-based care, OVC support and food supplements	Likoni division
Soweto Mwasalafu BI	Home-based care, OVC support and food supplements and OVC support	Likoni division
Shika Adabu BI	Home-based care, OVC support and food supplements	Likoni division
Ananda Marga Mission	Home-based care, OVC support and food supplements	Likoni division
Miritini BI	Home-based care, OVC support and food supplements	Changamwe division
Bangladesh BI	Home-based care, OVC support and food supplements	Changamwe division
Bomu Mkomani Clinic	HBC Clinical Services	Changamwe division
Jomvu Kuu BI	Home-based care and food supplements and OVC support	Changamwe division
Chaani BI	Home-based care and OVC support	Changamwe division
Mtopanga BI	Home-based care and food supplements and OVC support	Kisauni division
Mishomoroni BI	Home-based care and food supplements and OVC support	Kisauni division
Majaoni BI	Home-based care and OVC support	Kisauni division
Kisauni/Frere Town BI	Home-based care, Ecumenical groups, food supplements and OVC support	Kisauni division
Kongowea BI	Home-based care, Ecumenical groups, food supplements and OVC support	Kisauni division

Name of Local Implementing Partner	Program Focus	Geographic Site
Fikirini Support Group	OVC support and food supplements	Kisauni division
Tsetserani Support Group	Home-based care and OVC support	Malindi division
Watamu HIV/AIDS Program	Home-based care and OVC support	Malindi division
Thika		
Integrated AIDS Program (IAP)	Home Based Care, Clinical services, OVC and nutritional support	Kamwangi Division
Mugutha Women Group	Home-based care and OVC support	Ruiru Division
Ruiru Baptist Church	Home-based care, ecumenical support and youth services	Ruiru Division
Ruiru AIDS Awareness Group (RAAG)	Home-based care and OVC support	Ruiru Division
Speak and Act	Home-based care and OVC support	Thika Municipality
Nairobi		
Kabiru Health Care Trust	Home-based care, OVC support and clinical services	Dagoretti division
Riruta Health Center	Home-based care and OVC support	Dagoretti Division
Waithaka Health Center	Home-based care and OVC support	Dagoretti Division
Kenya Network of Women with AIDS (KENWA)	Home-based care, clinical services, OVC and food support	Korogocho, Mathare, Soweto
Dandora I Health Center	Home-based care, OVC ecumenical group formation and support	Dandora, Embakasi Division
Dandora II Health Center	Home-based care, OVC ecumenical group formation and support	Dandora, Embakasi Division
Redeemed Gospel Church	Home-based care, OVC, youth, vocational training, clinical services, VCT and ecumenical support	Huruma, Baba Dogo, Korogocho, Mathare, Soweto
Kivuli Center	Home-based care, OVC support, VCT and clinical services (comprehensive care services)	Dagoretti division
Mukuru AIDS and Drugs Alliance (MADA)	Home-based care and OVC support	Embakasi Division
St. John Ambulance/Kangemi H/C	Home-based care and OVC support	Dagoretti division
North Rift		
St. Mary's Health Center	Home-based care, food support and clinical services	Eldoret Municipality
St. Brigitta Health Center	Home-based care and clinical services	Eldoret Municipality
St. Jude's Pioneer HIV/AIDS Group	Home-based care and OVC support	Eldoret Municipality

Name of Local Implementing Partner	Program Focus	Geographic Site
Kayanet HBC Program	Home-based care, clinical services and OVC support	Kesses Division
Neighbors in Action	Home-based care, clinical services and OVC support	Ainabkoi Division
Sigot HBC Group	Home-based care, clinical services and OVC support	Eldoret Municipality
Savani tea Estate	Home-based care, clinical services and OVC support	Nandi Hills
Kapsumbeiywo Tea Estate	Home-based care, clinical services and OVC support	Nandi Hills
Olemila Support Group	Home-based care, clinical services and OVC support	Kapsabet
Christian Industrial training Institute (CITC) - ACK	Home-based care, clinical services and OVC support	Kapsabet