options if they wanted them. The groups were linked to legal personnel who were able to help them deal with cases of assault and failure to pay. As a result of the initiative, Busia District Hospital provided them with a specially designated room and personnel to deal with their specific health issues as well as offering them VCT services.

All the target groups report changes in their risky behaviors. Boda boda operators claim that they are now straight and are no longer tempted to accept payment in sexual favors. Some carry and distribute condoms on their bikes and report that they take the opportunity to educate their customers while they are transporting them. CSWs report that they no longer have unprotected sex with clients and many of them have reduced the number of sexual partners they have. Amongst the fishing communities the practice of "fish for sex" continues, but significant numbers now know their HIV status as a result of VCT promotions amongst these communities.

One of the key factors contributing to the success of this initiative was the level of involvement and ownership by the groups. The non-judgmental approach that guaranteed confidentiality to the groups and their members meant that the program was able to offer support that was needed and requested rather than dictating what people's needs were. This allowed for a collaborative and supportive relationship between APHIA II Western and the program beneficiaries that facilitated communication and empowered individuals to take responsibility for their health issues and to change their risky behaviors.

Home Based Testing

IPT - G

3.9 OVC Support

OVC Care and Support Model – Best Practice

The majority of children who have lost one or both parents to HIV/AIDS live in sub-Saharan Africa. UNGASS figures estimate that Kenya has a population of 2.4 million orphans, of whom half are orphaned by HIV/AIDS. In Western Province, 16.4% of the children are OVCs, making a total population 260,000 OVCs. Only 56.1% of children in the province live with both their parents and only 17.8% of OVCs are receiving any kind of external support .

Orphans and vulnerable children are subject to a wide range of interconnected problems. Underlying all of these is the psychological distress associated with losing one or both parents, or simply caring for a sick parent. OVC households face greater strains on their household resources, often having lost a major breadwinner. They often lack food, clothing, health care and proper shelter. They frequently have problems staying in school due to financial constraints or the fact that they are responsible for caring for sick parents or younger siblings. Without parental protection these children are more vulnerable to physical and emotional abuse, discrimination and exploitation in their community. Widows and orphans are often deprived of their inheritance and lose all their possessions and property. The scale of numbers and the impact of HIV on society have meant that traditional community mechanisms in place for supporting these children, such as extended family, are under great strain.

The OVC Support Program started in 2007 and aimed to extend care and support to 60,000 OVCs in Western Province and specifically to provide support to 45,000 OVCs in three or more core service areas and to train 1,200 community volunteers in caring for OVCs. By June 2010, a total of 69,458 OVCs in the province were receiving support through APHIA II Western. Of these, 62,930 were receiving support in three or more of the core service areas. A total of 12,722 caregivers had been trained in OVC care and support. A breakdown of numbers who received specific support is listed below:

Core Service Area	No. of OVCs receiving benefit
Health	51,333
Education	48,769
Nutritional support	57,185
Shelter and care	41,435
Protection Support	66,535
PSS	69,274
Livelihood and economic support	18,592

35. KAIS 2007

Previous OVC support programs had been implemented through CHWs based in the communities. These efforts have shown little sustainability. In order to achieve its targets, the program adapted its approach to work through CBOs and local NGOs (LNGO) who manage the community volunteers, providing support to the OVCs. Activities ran through a network of 24 CBOs that managed a total of 2,649 community volunteers who provided care and support to the OVCs. Due to the varied nature of the problems faced by OVCs, it was also necessary to develop strong working relationships with several government ministries. The Ministry of Children and Social Services played the lead role and their Area Advisory Committees were key players in coordinating the regional and district OVC support efforts and benefited from capacity building support provided by APHIA II Western.

The CBOs and their team of community volunteers managed and carried out the actual OVC support activities. Each team consisted of team leaders, each of whom who was responsible for supervising and supporting ten community volunteers, who were in turn responsible for 15-20 OVCs.
CBOs were given capacity-building training in program implementation, management, supervision and monitoring and evaluation skills. They were also supported to develop their financial management skills and fundraising capacity. Community volunteers participated in a four-day training that equipped them to support OVCs and understand the project's reporting requirements. They compile household visit forms, which are submitted to their team leaders. In turn, the team leaders compile their reports and submit them to the CBO management for forwarding to the APHIA II Western OVC team who carry out weekly supervision visits. The technical team and the CBO leadership hold quarterly review meetings to evaluate progress and map out the best way forward.

The CBOs worked with community members to identify OVC households requiring support. Once the households were identified, a community volunteer visited them on a monthly basis.

To avoid issues of stigma and discrimination, material support was given to the entire household, rather than focusing on individual children. At each of these visits the caregiver carried out a psychosocial assessment of the children in the household as well as a review of their physical wellbeing and support needs. These needs are reviewed in the following seven core service areas:

1. Health – medical checks and routine treatment; HIV counseling and testing and prevention; life-skills training; access to clean water
2. Education – fee support; uniform; schooling items; sanitary towels
3. Nutrition - kitchen gardens; livestock and poultry; food supplies
4. Shelter and Care – housing; bedding; kitchen utensils; home clothing
5. Protection – registration of births and deaths; protection of parents property; legal services
6. Psychosocial support – regular CHW visits; psychosocial and spiritual counseling
7. Livelihood and economic support – vocational training, business skills training, links to MFI

Based on their findings from these visits, CHWs took action as necessary. They linked children to appropriate organizations such as health facilities or other elements of the APHIA II Western PLWHIV/ OVC support initiative. They also made sure that the CBO provided recommended material support such as clothing and household materials and utensils. They took responsibility for motivating the community to help with shelter reconstruction and renovation when necessary. Any future interventions need to take a close look at the issue of CHW compensation. Under the current model they receive minimal stipends for their efforts and the considerable time they spend in carrying out their duties. Paying these stipends takes up a large part of the project budget and is difficult to sustain. The Area Advisory Committees (AACs) under the Ministry of Children, Gender and Social Services would benefit from a more concentrated capacity-building initiative.

This initiative has significantly improved the quality of life of OVCs in Western province in terms of the care and support they are now receiving. It has also developed a more sustainable support system based in the community itself, who now have a stronger sense of their collective responsibility for these children. The model itself has made it possible to reach large numbers of children in a wide geographical area using relatively few, well targeted resources. As a result of the CBO structure, APHIA II Western has been able to support and supervise these extensive activities with a team of just two people.