



BEST PRACTICES IN HIV/AIDS RESPONSE IN ERITREA



**World Health
Organization**

Country office of Eritrea





**THE GOOD SAMARITAN:
A HOME BASED CARE and SPIRITUAL - PSYCHOSOCIAL
COUNSELING EXERCISE**

&

**INCOME GENERATING SCHEMES FOR WOMEN LIVING
WITH HIV & AIDS**

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Acronyms:

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ART	Antiretroviral Therapy
ARV	Antiretroviral
BCC	Behaviour Change Communication
BIDHO	The Association of People Living with HIV & AIDS
CSO	Civil Society Organization
ESMG	Eritrean Social Marketing Group
GS	The Good Samaritan
HAMSET	HIV, AIDS, Malaria, Sexually Transmitted Infection and TB
HBC	Home Based Care
HIV	Human Immunodeficiency Virus
IG	Income Generating
MOH	Ministry of Health
MSM	Men who have sex with men
MTCT	Mother to child transmission (of HIV)
NATCoD	National AIDS and TB Control Division
NGO	Non Governmental Organization
NUEW	National Union of Eritrean Women
NUEYS	National Union of Eritrean Youth and Students
PHC	Primary Health Care
PMTCT	Prevention of Mother to child transmission (of HIV)
PLHA	People Living with HIV & AIDS

Executive Summary

The AIDS epidemic has not only killed and maimed people it also imposed heavy burdens on families, communities and on the economy of many countries in Africa and elsewhere. The catastrophic situations caused by the infection are too big and sadly enough women in almost all societies become the victims. HIV is common among young adults and a significant part of the generation of young parents are lost forcing rapid change in family composition and in the political and economical landscape in many areas of Africa. Female headed house holds are increasing, elderly grand parents are taking responsibility of grand children and in many families households are headed by young orphans.

Best Practices in HIV & AIDS are often associated to community mobilization and programmes that flourish through community based initiatives and actions. They are based on traditions and cultures of communities and on their adaptation or resistance to outside influences. Best practices in communities in the context of HIV and AIDS, are based on formal and informal power structures, personalities and actors within the given community structure and their interaction, involvement, built in economical and infrastructural capacity. They are empowered as the assessment of felt needs, understanding and by the overall educational levels and attitudes of the many actors involved in community based initiatives.

In resource constrained situations where only a few actors and providers are involved, Best Practices in HIV & AIDS programmes in which community centred initiatives and actions would be dominant can not be easy to locate. In Eritrea, HIV related community based programmes are a few, rudimentary, inconsistent that offer little in terms of measurable achievements and impacts.

The Good Samaritan Programme of the Catholic Church metamorphosed from a stand alone home based care for people who live with HIV & AIDS to a place where spiritual and psychosocial counseling is provided with care and devotion.

It provides comprehensive services that play critical role in enabling HIV infected and affected people to access ART, as well as to attend monitored follow up that allows for in depth assessment of situations that are dominant factors in the households of PLHA.

The Good Samaritan programmes operated in five church groups of the Catholic Church consistently follow the impact of the project on individuals and groups who attend monthly *Coffee Ceremonies* and who receive spiritual and psychosocial counseling while “home based care” is provided at home on regular bases. It managed to succeed in fulfilling the ‘core criteria’ for best practice by being consistent and sustainable. Rewards are expressed by the people who are brought back to life and who learned to look ahead and to forget their past. Suicidal intentions and feelings of desperations are discarded and stigma is defeated, members of the Good Samaritan are now leading purposeful lives, that possess clear objectives and persistent determinations. The 301 men and women that once lost the meaning of life are now helping others to live.

The young men and women who willingly offered themselves to helping and caring for people with HIV & AIDS are the backbones of the Good Samaritan programme of the Catholic Secretariat. They are the ‘precious’ resources of the programme while the kindly nuns are the source of love and care to many affected households. The symptoms of stress and burnout feelings the young care providers may feel can only be treated by their own spiritual orientation, family upbringing and by the love and unassuming nature they developed during the last six years of action oriented experience. Non the less, their over involvement with people who live with the infection and their daily contact with affected members; the unmet needs and the inadequate recognition of their daily services are the most commonly reported causes of stress on their part.

The success of the income generating project pursued by the 23 women living with HIV & AIDS in Mendefera is largely influenced by the quality of work they are currently presenting and by the depth of change and satisfaction it created in

their once troubled lives. After six months of skills training and the additional sessions on the basic facts on HIV/AIDS and positive living, 30 HIV positive women started the long trip of self support despite their health problems and poor physical conditions they endured.

The national association of people living with HIV and AIDS both at the central and zoba level are determined to help them to carry on their own weight by working diligently and by producing competitive garments and clothing materials for sell. However, the unavailability of raw materials and the soaring cost pose as immediate challenge to their economical independence and psychosocial well being. The scarcity and/or the high cost of raw materials may gradually destroy the good intentions of BIDHO, the health management team and the funding agency besides ruining what is designed as a model of good practice in communities.

The Good Samaritan project of the Catholic Church and the efforts of the weaving women play important rolls in mitigating the effects of stigma and discrimination. For the purpose of documenting Best Practices in Eritrea, the two activities are identified and recommended for deeper study by the National AIDS and TB Control Division (NATCoD) and the National Association of People Living with HIV & AIDS (BIDHO).



COUNTRY PROFILE:

Eritrea is a former Italian colony (1890–1941) which later fell into the hands of the British Military Administration under the UN Trusteeship from 1941 to 1952.

The UN imposed a federal union with Ethiopia followed only to be abrogated by the government of feudal Ethiopia which annexed Eritrea as its 14th province in 1962. The unilateral action of annexing Eritrea triggered a 30 years armed struggle for self determination that was terminated with Eritrea's liberation in May 1991 and official independence independence in 1993.

Eritrea has an area of 122,000 sq km and possesses about 1,212 kilo meters of coastal area on the Red Sea in the east and shares border with the Republic of the Sudan in the north and west, Ethiopia in the south and with Djibouti at its south eastern tip. Administratively, Eritrea is divided into 6 Zobas (regions) and 56 sub Zobas. Asmara is its national capital and largest city and Massawa and Assab, the two commercial sea ports, possess strategic locations on eastern coast.

The country has yet to do a population and housing census but its population is estimated at about 3.6 million of which 80 percent is rural based. Annual growth rate is estimated at 2.46% and total literacy rate is 51 % (male 61% and female 48%).

Health services in Eritrea focus on primary health care (PHC) which is available for all. The strategy emphasizes the development of basic health services at the

peripheries and expands to reach the general population with preventive health services that includes epidemic control, environmental health and prevention and control of communicable infections. As a national response to the HIV & AIDS epidemic, Eritrea maintains 135 VCT centers and 93 facilities that integrate ANC and PMTCT services. Antiretroviral drugs are provided in 17 health facilities including those owned and administered by faith based organizations and military establishments.

HIV & AIDS in Eritrea:

Globally, women account for half of all people living with HIV and AIDS worldwide and for nearly 60% of HIV infection in sub Saharan Africa. Over the last 10 years, the proportion of women among people living with HIV has remained stable globally, but increased in many regions.¹

- Globally, of the 33.4 million adults and children estimated to be living with HIV and AIDS 22.4 million (67%) came from sub Saharan Africa;
- Young people aged 15 – 24 account for an estimated 45% of all new HIV infections;
- An estimated 390,000 children younger than 15 years became infected with HIV in 2008;
- Of the 280,000 children estimated to have died in 2008, an estimated 230,000 of them are Africans, south of the Sahara;
- In 2008, a daily estimate of 7,400 HIV infections occurred globally. An estimated 6,200 are adults of which women constitute 48% and men cover about 40%;
- There were an estimated 33 million people living with HIV & AIDS in 2007; and
- An overall, 2.0 million people died due to AIDS during the same year.

Since the first AIDS case was detected in 1988 at the port town of Assab, the number of cases and the estimation of HIV infection are mainly based on health facility reports and sentinel sero-prevalence surveys conducted among pregnant women attending antenatal care services in the country. According to HMIS (2007), the number of reported cases has increased from an average of 1,500 new AIDS cases per year before 2003 to about 2500 and more after the reporting system started taking shape.

¹ HIV/AIDS Epidemic Report 2008 (UNAIDS)

Children under 15 years make about 6.0% of the facility based AIDS reports. The peak age for AIDS infection in Eritrea is 29 to 34 among males and 20 – 24 among females. The 2007 sentinel seroprevalence survey conducted among pregnant women who attend antenatal care (ANC) services in urban and rural sites of the country indicated a national prevalence of 1.3%².

Clinical reports and periodic studies indicate that HIV transmission is heterosexual in close to 95% of the cases while a little above 5.0% of the transmission is attributed to vertical or mother to child transmission (MTCT). HIV transmission via injecting drug use or MSM is not documented and HIV transmission via traditional practices such as scarification, tattooing, or ear/nose piercing is negligible although not ruled out completely. Moreover, the result of the sero survey showed that:

- HIV infection show higher prevalence in urban centers with 3.0% while rural communities report less than 1.0 percent;
- HIV infection is disproportionately high among urban unemployed young single women who are also moderately educated.

Extrapolated from the results of the sentinel survey, close to 48,000 people are estimated to be living with HIV & AIDS in Eritrea of which about 7,182 are estimated to be eligible for treatment based upon the recommendation of examining physicians. By end 2009, a cumulative total of 5,098 AIDS cases started treatment with first line drugs. The peak age for ART treatment is 26 to 49 years.

According to NATCoD, 5,000 to 6,000 cases of sexually transmitted infections are treated at out patient department (OPD) services of health facilities each year and the ANC based sentinel sero survey showed a syphilis prevalence of 1.10% among pregnant women included in the study. As many of the infected cases depend on self treatment at pharmacies and drug vendors, the magnitude of STIs is not clearly documented.

² HIV & Syphilis Sentinel Surveillance among ANC attending Pregnant Women 2007 – NATCoD MOH, March 2008.

Voluntary counseling and testing (VCT) and prevention of mother to child transmission (PMTCT) are activities of long standing in Eritrea. As fewer sites provide both ANC and VCT services, the proportion of women receiving PMTCT is lower than the number of women who attend antenatal care services. Sero positive tests in voluntary counseling and testing units decreased from 4.3 percent in 2003 to 2.6 percent in 2008 and the country's PMTCT programme showed a decrease of HIV positive test results from 2.5% in 2004 to 0.8% in 2008. The decline of sero positive results documented in both VCT and PMTCT services may be attributable to the gradual expansion of services to rural communities and to the increasing number of people that are presently accepting similar services.

A good network of condom promotion and distribution is laid by of the Eritrean Social Marketing Group (ESMG) who packs and sell 'Abuselama' condom on nominal cost margin and health facilities that traditionally provide free condoms to people who request for them. On the average six million male condoms are distributed each year at health facilities and through 2,000 outlets ESGM established through the years. Such condom outlets once reached close to 8,000. Because of lack of population based studies pertaining to condom distribution and use, the proportion of people who appropriately use condoms during sexual relationships and the average age of sexual debut are not established.

The Ministry of Health of the State of Eritrea, in partnership with the World Bank/ HAMSET project launched HIV prevention projects by initiating community based behaviour change communication strategy in community peer groups organized among different populations. Consequently, community women, the youth & students at schools, female sex workers, the military, truck and bus drivers and factory workers used the BCC approach with considerable success.

HIV & AIDS in Zoba Dehub:

Zoba Dehub shares its entire southern border with Ethiopia and is famous for its agricultural produce and livestock. Over 80% of its population lives in rural area. The

major towns of Zoba Debub are Mendefera the capital and Adi Quala, Dekemhare, Ado Keyih, and Senafe. Other urban and semi urban centers such as Areza, Dibarewa and Segheneiti are as important in their population mobility and activities of trade and commerce.

The time when the first AIDS case of the zone was detected is not known, however, earlier prevalence surveys indicate that most of its urban centers had significantly high infection rate. Given that most of its urban centers served as the military stronghold of the Ethiopian army during the earlier days of the war, the high number of sex workers and transactional sex was relatively high. The ANC sero surveys in Debub zone showed HIV infection rates of 1.1% in 2003, 1.65% in 2005 and 0.6% in 2007 and the tests done for syphilis showed 1.1% and 0.3% in 2005 and 2007 respectively.

The National Association of PLWHA (BIDHO):

BIDHO, which is Tigrigna for challenge, was formally established as the National Association of People Living with HIV and AIDS in 2002. Its commencement was graced by the presence of state ministers, religious leaders and other dignitaries. The main objectives of the association are:

- To encourage HIV infected individuals to unite under one association and solicit medical, psychosocial and economical support as a homogenous entity;
- To provide skills training to as many members as possible and encourage self help programmes that aims at initiating income generating schemes for affected and poor households;
- To promote positive living through training and spiritual and psychosocial support system;
- To expand awareness programmes through different methods and approaches including 'personal testimonies', the mass media, school based health and HIV clubs, national festivals and similar occasions;

Members of BIDHO are trained and serve as VCT and ART counselors, home based care (HBC) providers, life skills trainers and promoters of positive living³. Currently, BIDHO has an expanded network of branch offices in all zones and in many highly populated urban centers. An average size of group (7–10) people living with HIV can create the cell of the association in any part of the country. Many are assisted to support themselves and households through cottage industries such as weaving, bee and poultry farming. The association receives technical and administrative assistance from the Ministry of Health and is guided by a democratically elected executive board. The nation wide BIDHO membership is close to 6,000 with about 15,000 affected dependants.

BIDIHO in Zoba Dehub:

The branch office of BIDHO in Zoba Dehub was established in 2003 and has a membership of 654. Females make 56.7% of the total while 43.2% are men. Fifty seven percent of the women are married, 17.0% are single and 26.0% are widows while 82.0% of the men members are married, 8.0% are single and another 9.0% lost their spouses. Close to 22.0% of the men currently live with spouses or long term partners that are not infected with HIV. A little over 51% are on treatment with antiretroviral drugs. The association provides care and support for 74 children who lost both parents. Many live with their grandparents.

The association provides HBC services using 52 trained members many of whom live in sub zones and lead monthly ‘Coffee Ceremonies’ in different HBC groups. Sub Zoba administrators and other members of the local administrations and community leaders often attend the coffee ceremonies and participate in the discussions as part of the advocacy and social mobilization initiatives against stigma and discrimination.

³ BIDHO Annual Report 2008.

PART ONE

THE GOOD SAMARITAN:

A HOME BASED CARE and SPIRITUAL AND PSYCHOSOCIAL

COUNSELING AT THE CATHOLIC SECRETARIAT EPARCHY

OF ASMARA

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The Good Samaritan: A Home Based Care Initiative of the Eritrean Catholic Church

The establishment of home based care (HBC) service was conceptually designed by the GOE/World Bank HAMSET Project right after the inception of the HAMSET programme and was introduced to participating government sectors, civil society organizations (CSOs) and faith based organizations. Consequently, the Good Samaritan programme grew and matured from the home based care services that was generally agreed upon and established by the National AIDS and TB Control Division (NATCoD) and participating sectors selected and trained volunteer care providers and the home based care programmes have began in 2003.

Since 2003, the simple and plain HBC programme of the Catholic Secretariat Eparchy of Asmara grew to become a community forum for education and understanding among PLHA assigned to receive HBC services under care providers operating under the Catholic Church. The result yielded a perfect atmosphere of bliss and harmony; love and compassion among people who live with HIV and AIDS and who once considered their lives as doomed.

The Catholic Secretariat Eparchy of Asmara, as a faith based organization received the responsibility with care and compassion. Spiritual and psychosocial counseling both at homes of infected individuals and during monthly meetings became routine activities. The Church's inherent capacity to guide and teach and the services of the devoted and spiritually moulded young care providers gave the Church the strength to move foreword and deal with the problems of individual and groups who live with the infection and to lessen the effects of the new challenges that are changing the patterns in their lives. The church depended on and solicited the strength of its caring spiritual parishioners and on the hard working and saintly nuns to carry out the responsibility. Its indefatigable and remorseless young care providers and its supportive leadership paved the way to help PLHA with solace and hope during their most difficult moments of their lives.

Stigma and discrimination are often given the extra weight when HIV related programmes are considered and as a result they are persistently perceived as cruel deterrents to effective care and support even if the extent and magnitude of the stigmatizing activities and actions are not properly measured and estimated. What ever the scale and size of existing stigma within communities, the church was determined to conquer all challenges that may surface at any given moment.

As expected, the financial and material capacity of the Church could not carry a broad support system to its HIV infected members whose health is often compromised by the debilitating effects of the HIV infection especially when food and/or other necessities are scarce. The Church's share of the HAMSET support is limited to material and nutritional support that are made available to needy households with children. And yet, the church had to go through a situation where every other person is as poor and/or as sickly as the next other person with many children involved. The strategies for supporting any number of PLHA who are sent to the church for home based care services naturally needed more of everything that was not seriously given due attention during the formative periods of the HBC programme.

After a long and serious deliberation, however, the 'coffee ceremony' was introduced into the different church groups and was used as an entry point for members to meet and discuss about their health situations and that of their family members. The gathering created a situation in which members learn the basic facts about HIV & AIDS by attending video shows, participating in study groups and listening to guest speakers. It also offered rare opportunities for PLHA to visit and support each other and to report on the health conditions of absent members and enabled the group to be up to date about its members. On the other hand, the coffee ceremony and related amenities, the routine home based care and the material support proved to ask more than what it takes to run a simple home based care. Therefore,

- The kindly Catholic nuns became the first to offer full support to the 'coffee ceremony' project and contributed a part of their own less than sufficient budget;

- The monthly meeting was introduced in five different church groups that are encouraged to run their own separate programmes and manage their own affairs;
- Church groups were formed according to living area so that members can check on each other through their own networking.

Money contributed by the nuns, individual members and through other means is used to cover for cash or material support for bed ridden members and to take care of the expenses of the monthly coffee programme

The Good Samaritan programme was thus started with 42 members in 2003 grew to 301 assigned to any one of the five churches by the church administration when referred by their counselors, their physicians and sometimes by BIDHO. The home based care is provided by 52 trained volunteers.

Goals & Principles of the Good Samaritan Programme:

The Catholic Church has a long and celebrated tradition of services in areas of health and education in Eritrea and for decades, both the urban and rural communities have appreciated the services the church provided as educators of children and as health care providers. The service provided by the Church was often noted for its quality and for the level of understanding, compassion and devotion applied in delivering it. For many years, the Church has been profoundly involved in developing innovative and effective responses to control the spread of contagious infections and to reach the unreached, to expand education and health services and to help communities in all areas of development. With the advent of HIV & AIDS infection, innovative and effective responses are once again provided to restrain all forms of HIV transmission and mitigate the ill effects of the epidemic.

The goal of the Good Samaritan project is to reinforce traditional values and practices of Eritrean people in which tolerance, understanding and respect are most dominant and which the Church can efficiently blend with its spiritual sessions and teachings of good neighbourliness, compassion, cooperation and support for each

other. In general, the home based care and the principles of the Good Samaritan programme are designed to:

- Develop the confidence of PLHA against the impending threats of stigma and marginalization through spiritual and psychosocial counseling;
- Convert the negative attitudes of family members, friends, and neighbours into a tolerant and understanding support system;
- Promote and encourage family members to provide treatment & care for their sick members in the privacy of their homes with love and compassion.

The Principles of the Good Samaritan include:

- That the right of persons infected or affected by HIV/AIDS is supported medically, emotionally, spiritually and socially without any bias or difference of whatever nature;
- That the people who are infected and affected by HIV/AIDS cultivate high self-esteem for themselves and hope, care and respect for life, including care and support for their dependants;
- That the people who live with the infection trust and depend on each other and develop a sense of companionship and relationship with each other;
- That the right of communities to protect its members from the spread of HIV is respected and their responsibility to support and care for persons and households that are infected or affected by the HIV and AIDS is realized and strengthened.

Although the Church refrain from propagating for the use of condom to prevent sexual transmission of HIV, the question of promoting safe sexual behaviour and adherence to treatment is dealt with by reminding their members in each group to follow the advice and instruction of their physicians and counselors.

Major Elements of the Project:

When the project began in 2003, the Church developed a vision for a holistic approach to care & counseling and dealt with the first batch of 42 men and women

that were referred to the Catholic Secretariat. The Church, on the other hand, used the support of NATCoD to train 52 young men and women to carry out the home based care activities.

The project created the following elements of support to facilitate and strengthen HBC activities, spiritual and psychosocial counseling:

- Fund raising initiatives began through contributions and funding by each church, by its members and by the contributions received from individual members;
- Home based care providers are given the task for providing care services to 3–5 PLHA and household. The service includes treatment and care to bed ridden cases and spiritual and psychosocial counseling. Where available, provision of material support is part of the general concept of HBC;
- Cell groups are organized by areas of residence to facilitate information about the health situations and the whereabouts of defaulting members
- Religious teachings, short drama, poems, and talent shows are used to offer both education and entertainment during the coffee ceremonies;
- Children receive attention and care as full fledged members of the different groups at the coffee ceremonies;
- Annual retreats are organized to entertain and refresh members in each group. The area for the retreat is generally decided by the financial resources each group command. Some go to Massawa and others are satisfied with a day at Mai Serwa, a recreation centre on the outskirts of Asmara;

Each group elected a management committee that includes supervising nuns, PLHA and care providers in order to administer and oversee the affairs of group members as one family. The 301 core members are divided into five different Church groups and each group have their separate days of monthly Coffee Ceremony, scheduled and announced at the end of every meeting. The programme coordinators select the men and women who will organize the next coffee programme, from preparation of the meeting hall to making tea and coffee, ahead of time.

No	Group	Male	Female	Total
1	Daughters of Charity	17	55	72
2	The Capuchin Nuns	24	30	54
3	Orsollini Nuns	10	21	31
4	St. Antony Clinic	21	42	63
5	Kidane Mihret Church	28	53	81
Total		100	201	301

PLHA Church Groups and their distribution

- 73.0 % are presently on ART;
- 64.0 % are females;
- About 32.0 % of all are married;
- Close to 22.0 % are single;
- 38.5 % lost their spouses to AIDS;
- 14 couples married after meeting at the Good Samaritan;
- 33 HIV positive children are supported;
- 16 orphan children who lost both parents and 116 who lost one parent are provided with minimum support and efforts are made to make the support as substantial as possible;
- The family registration book of the Good Samaritan shows a total of 721 children (324 males and 397 females)
- 75 children are born to women members in the different groups and 74 or 98.6% tested HIV negative at 18+ months of age. All pregnant women attended ANC/PMTCT services in their neighbourhoods;
- 8 deaths are registered since 2005 (onset of ART) and 2 episodes of suicide are documented. Natural deaths registered prior to ART are 10;
- All members in the Good Samaritan programme are registered members of the National Association of People Living with HIV & AIDS;
- Not all members of the Good Samaritan programme are Catholics. True to the principles of the Good Samaritan, membership in each group consists of Coptic and Protestant Christians of different denominations and Islam as well as Catholics.

Although PLHA in all five groups developed unshakable trust in what the Church can do to support their needs and boost their morale, the absolute poverty many of them currently experience failed to demonstrate the all rounded positive outcome the Church envisaged and aimed at during the early years of the programme. The

beautiful programme is over shadowed by the poverty that hovers in individual households.

Although additional information may be recommended to present a qualified measurement of the pros and cons of the of the Good Samaritan programme of the Catholic Secretariat and the services the Churches provide, the personal interviews and the in depth discussions held with members of different church groups offer the following highlights:

- The Good Samaritan programme has built confidence among members that is strong and powerful enough to repel the ill effects of stigma and discrimination;
- It developed love, respect and compassion among all members;
- All members, even those that are rich or busy hate to miss a coffee session if they can help it and love to be part of the group and the interactions involved.

Counselors & Home Care Providers

The first activity of the home based care initiative was to train lay counselors and home care providers from among the young men and women who are closely linked to the church and to its many functions. The religious upbringing of the young people added up to their personal inclination offered the factors that influenced them to volunteer to the noble cause. At least post secondary level education was solicited and many follow classes of theology and philosophy. The HBC training was a ten day training programme and included elements of nursing and palliative care, spiritual and psychosocial counseling, gender issues, and sexual and reproductive health services. The training is further complemented by regular and periodic refresher training while supervision of activities and the assessment of the general condition of members are on going.

Each group, led by programme coordinators and the assigned HBC providers/ counselors, occasionally allocate time and resources for field retreat where all members go to. Depending on the amount of financial resources they can spend for the occasion, the management committee decides where they should go for fun, pleasure and serious discussion. Most of the time, their children are also included.

The role played by programme coordinators, the nuns and the young and inspired young boys and girls in executing their responsibility is the key to the success of the spiritual and psychosocial support PLHA receive through the Good Samaritan programme of the Catholic Secretariat Eparchy of Asmara.



Sister Letehaimanot: Coordinates home based care and spiritual and psychosocial counseling of the Good Samaritan programme in the group known as the Daughters of Charity. She and her staff including the young care providers organize and lead the monthly Coffee Ceremony, distribute resources to needy members, and provide their support as needed. The good nun is always at the centre of discussion and is quick to respond to all negative feelings members may demonstrate. Sister Letehaimanot is a popular leader who struggles to make significant difference in the lives of her group members. She loved and respected in her group. There are 15 nuns serving in the Good Samaritan programme in all five Church gropes of Asmara.



Zemichael Yemane: He is one of the 52 young men and women who provide care, support and counseling services to individuals and households that are infected and affected by HIV & AIDS. Zemichael is also a member of the Sisters of Charity and with his special talents he has become an indispensable asset in his group. He is a good teacher of health related issues and the Gospel. He prepares and directs quick but serious drama and is also a practical joker who pleasantly amuses the whole group. Zemichael is student of Theology and Philosophy and loves his share of responsibility as a home based care provider to 4–5 households.

Mitigating the Effects of Stigma:

The Church realizes that stigmatization of people living with HIV & AIDS has grown out of a mistaken link between sex and low moral with a perceived judgemental connotations of sin and eternal shame. As a result sex is made to carry the stigma of

sinfulness and is condemned among other sins. The fact that sex and the responsible use of sex is part of God's way of creation is often neglected.

One of the goals of the home based care programme and counseling services is to mitigate the negative effects of stigma through continuous teaching to members in all groups and if possible to wash away stigma and discrimination from the society. The Church and its leaders are making extra efforts to explain the evils of stigma and discrimination around HIV and AIDS in all their Church based teachings including during mass and Sunday Schools. However, in its short term plan, the Good Samaritan programme prefers to put emphasis on empowering its members to stand firm against stigma and repel its effects as hard and as much as they possibly can.

Foe this document, the individual stories and the details of the situation that caused the current situation of every member of the church groups may be too much to narrate. However, some case histories are selected to help understand the grave situations HIV infection caused in the lives of people and the compelling measures the Good Samaritan programme is taking to improve them.

Zeineb Ahmed:

She is referred to the Good Samaritan (Sisters of Charity) as a widow with two children. Her younger son who is 9 years old is HIV positive. She learned about her own positive status when she was pregnant with her twins who eventually died because of the infection and soon she learned that one of her sons is also infected. After two years of tears and desperation that was putting her closer towards self destruction, she was introduced to the Good Samaritan programme through the BIDHO association.

"As a Moslem, I was apprehensive and worried but as the days went by, I learned that religion is not an issue at any one of the Good Samaritan programmes. My faith did not bother any one – as always, the nuns are kind hearted and caring and the counselors are highly dedicated", she said. Talking about her counsellor, she simply said that Allah answered her prayer to give her hope and courage. "He washed away my tears and became an older brother to my children when everybody else stood at a distance", she finished.

During the in-depth discussions held with different members, the majority of women blame their spouses or steady sex partners for the infection. Obviously, some may be referring steady sexual partners as their husbands when they not officially married to

them and neither has any legal responsibility over the other. Domestic violence after the post test counseling is high even when the men know that their wives are not responsible for their infection. Many do not even care whether their wives are infected or not. Women believe that their men folks refuse to accept their infection gracefully and turn to drinking which may cause domestic violence. Others live with male spouses or partners that are in denial of their situations and refuse to have any part of the coffee ceremony or refuse to register at BIDHO, the PLHA association while they are at peace with the involvement and participation of their wives in the Good Samaritan project.

The Home Based Care, the counseling and the teachings at the Church provide sound advice on how to live positively. It promotes and builds on the human dimensions of sexuality that should promote improved relationship between people of both sexes and demonstrate responsible behaviour towards each other. The relationship that developed at the different groups gave members of the Good Samaritan programme the strength to withstand all forms of stigma and discrimination on one hand and appreciate what they currently have in terms of children, other members of their family, friends and the whole community of people who gives them courage and good wishes.

Partnership and Alliances:

The Home Based Care project is introduced by the National AIDS and TB Control Division, the Ministry of Health, and Good Samaritan programme became an innovation of the Catholic Secretariat. Training is often provided through the NATCoD and financial support for food and other material distribution including incentives to HBC providers and counselors is made available by the Ministry of Health through the HAMSET (World Bank) and now from the Global Fund. Refresher training of the counselors is carried out by NATCoD.

Facility based medical treatment for PLHA under the Good Samaritan programme is coordinated by care providers who keep their relationship with all hospital staff and

the ART units very strong. The National Association of PLHA (BIDHO) provides skills training to members and liaise with UN Agencies and NGOs for support.

Assessment & Monitoring:

The day to day encounter between the care providers and their clients provides the basis to draw preliminary opinion about the project's activity, the needs and feelings of the people who receive the care/support and counseling services. The monthly Coffee Ceremony provides ample opportunity for discussion and feed backs which are carefully noted by supervising nuns and the coordinators for future amendment and correction. Problems, failures and successes and special events in the lives of the PLHA are carefully noted.

Sick and bedridden members are reported by the counselors and group members and programmes are made to visit the sick, provide financial and other support (often contributed by members). The goal of increasing the quality of life and the enhanced safety net including the respect and admiration of the people who serve them comes out during the monthly discussion periods. It is safe to conclude that the PLHA in any group are happy, their will live increased, behaviour change set in among most members, adherence to treatment is high and that the union and relationship forged between all people in the Church programme is well established.

Strength of the Programme:

Management: The home based care and counseling project is structured in such a way that each volunteer becomes responsible for 3 to 5 households infected with or affected by people HIV and AIDS. At least two visits are made each week.

Harmony & Bonding: The Coffee Ceremony created compassion, openness, love and respect between members. At home, the relationship between care providers and their cases yield understanding and compassion. The care and support they provide to each other is based on love and respect and is reflected during monthly meetings.

The Coffee Ceremony also provides the space for members to discuss problems and concerns. Care providers & counselors and programme leaders are rewarded by the happiness, satisfaction, changed behaviour and improved life style of the people they serve. A great majority of them take pride in the strength and determination they developed through spiritual and psychosocial counseling they consistently provide.

PMTCT: Consistent teaching and counseling in the past influenced all pregnant women to follow ANC/PMTCT services and to attend post test services for the purpose of receiving the complete course of prophylactic ARV. Close to 99% of the children born to HIV infected women avoided HIV infection during the last two years.

Group Composition: The beauty of the Coffee Ceremonies held at different Catholic Churches is that non Catholic Christians and followers of Islamic faith are active participants in all activities of the Good Samaritan programme. Love and unity is the dominant theme of each group.

Failures:

Failures are limited to financial problems and the limited capacity to meet the felt needs of PLHA in all church groups. Food for the family, home to live in; school uniforms and materials for children and transport expenses in time of emergency medical care for members has become unreachable to the Secretariat.

Threats:

Stigma: Although not clearly visible, stigma is spread and severe in poor neighbourhoods of Aba Shawel, Akria, Edaga Arbi and Haddish Adi. Rough episodes of stigmatizing remarks are reported in different groups, often coming from elderly female neighbours and landladies who throw unkind remarks during small disagreements. In the absence of advocacy programmes against stigma and marginalization of PLHA, people often get it wrong and mix HIV with promiscuity and low morale. Despite the remarkable achievement of the Church and the care providers, the cruel remarks thrown at PLHA in front of their children are unnerving to many. Efforts should be made to stage advocacy and social mobilization exercises

against stigma at every level in order to change the concepts and attitudes of people in communities and among family members. It is also clear that community leaderships should take serious steps to discourage such inconveniences in the lives of PLHA.

Resources: The level of poverty in many affected families has become unbearable to the young counselors who get emotionally disturbed over the pathetic situations they often observe in affected households. There is a marked shortage of food in many households and children are most vulnerable. HBC delivery becomes difficult when hunger in a family has a dominant presence. The amount of cash incentive paid to care providers is reduced and most of the time delayed.

Training: Counselors and home based care providers would like their activity recognized by the national authorities and considered for advanced training.

The Future:

Expansion: The success of the Good Samaritan programme has begun to influence other Churches and branches of the Secretariat and as a result the programme is picking up in Dekemhare, Mendefera, Segheneiti (Digssa) in Zoba Debub and in Massawa and Assab in the Northern and Southern Red Sea Zones. Close to 200 PLHA currently enjoy the programme in the mentioned areas.

A high number of referral from physicians and counselors is made to include more PLHA for membership, however, shortage of resources and lack of space in church premises limit the number. Programme coordinators believe that services will expand to the other churches in Asmara and elsewhere as soon as the current limitation of financial and material resources is solved.

Capacity Building: Efforts will be made to enhance the capacity of the care providers and counselors. Many believe, the amount of training they received is not sufficient to fully carry out their given responsibility.

Advocacy: The Church makes efforts to solve some of the many problems group members face in terms of shelter, food & nutrition, management of AIDS orphans and vulnerable children.

Criteria of Best Practice:

The Good Samaritan Project of the Catholic Church was launched in 2003 and attracts many that are infected with and affected by HIV & AIDS. Over the years, the five different groups provided care and support at home and in groups, built confidence in the men and women who were once discouraged. It gave peace and serenity to lonely individuals that once lived amid the fear death and hopelessness created by HIV positive test result.

Relevance: The goal of the Good Samaritan is to mitigate the ill effects of Stigma around HIV and AIDS through spiritual and psychosocial counseling and provision of home based care. The achievements made so far can be expressed by what the Church and its counselors managed to accomplish in cultivating the spiritual, psychological and morale capacity of their cohort and bring them back to live positively and to enjoy and appreciate each day.

Effectiveness: The spiritual and psychosocial counseling and home care services of the Good Samaritan helped members of the different Church groups to live in peace and to gracefully accept their infected status. They found peace in knowing that their personal problem is not worse or better than their friends in the group. They sincerely offer their support as needed.

The project promoted self care and self reliance and inculcated it in the lives of every member. The spiritual teachings and songs, the presentations and the sessions of in depth discussion brought about profound change into the life of each member. The support system that is eventually developing continues to play significant role in gaining the trust of all members. The evils of stigma is curtailed and repelled by continuous teachings, morale support and confidence building exercises.

Efficiency: Despite its limited resources, the activities of the Good Samaritan tried to solve the problems faced by many of its members. The home based care and counseling and the monthly meetings over coffee used the scanty resources collected from Church members with care and efficiency.

Money contributed by the members and the management of the church are used to support members in income generating activities. Financial or material support for bed ridden members, annual retreats and other activities are paid for from the group's treasure chest.

Ethical Soundness: The Good Samaritan project puts great emphasis in mitigating the effects of social stigma and its success is measured by the determination, firmness and the supportive attitude when confronted by any level of stress.

Sustainability: At present, the project finds itself in dire financial problem as the needs of members grow day by day as a result of the economic downturn that affects the whole world to day. Apart from the personal contributions of the cohort group and the negligible amount of local donations, the Ministry of Health and the Catholic Secretariat are its only sources of support.

PART TWO

INCOME GENERATING PROJECT

WOMEN LIVING WITH HIV AND AIDS IN MENDEFERA,

ZOBA DEBUB.

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Income Generating Project: Women Living with HIV & AIDS in Mendefera Town, Zoba Debub

For over two decades, health authorities had repeatedly stated that HIV/AIDS is by far the deadliest epidemic that tormented this world. Millions of people have already lost their lives and currently many more individuals are living with the infection. The misery and devastation already caused by the infection is enormous in every country and although Eritrea is experiencing less HIV sero prevalence than many African countries south of the Sahara, it is taking its share of the misery and devastation in terms of economic loss and in increased number of orphans and vulnerable children.

For households that are affected by HIV, the negative impact originates from the loss of earnings and the increased expenditure for medical care. The need for income increases with the demand for medicine, food, and other expenses and for transportation to health facilities. The shortage of cash becomes more pronounced as adult bread winners are incapable to work any longer or are bed ridden eventually resulting in loss of income. As more people in the productive age succumb to AIDS, a larger number of households fall into deeper poverty and their household savings slowly eroded. Gradually, women are left alone to bear the bigger burdens as heads of family, as mothers, as primary care givers and often, as the people who are at the receiving end of the infection. The factors to their vulnerability and to their eventual HIV infection may include the following:

- Their limited access to economic independence and to education opportunities;
- Their passive roles in sexual preference, biological vulnerability and their unwilling partnership in risky sexual relationships. Sentinel sero surveys and other studies suggest that a high proportion of female cases are acquiring HIV infection in long term stable relationships;
- Their busy schedule, household roles & responsibilities live little time for their own health and wellbeing. They seek health services when they are already weak and incapacitated;

In Eritrea, poverty and food insecurity remains wide spread and growing, accentuated by the recurring draught and more noticeably by the lingering effects of the border conflict with Ethiopia which caused immense social and economic damage, including displacement, deportation and loss of assets. In 2007, the National HIV sero prevalence rate is reported to be 1.3%, a rate that represents close to 48,000 people who are living with HIV and AIDS. Based on VCT unit reports, more than half of the HIV infected cases are females.

The Health Management Team of Zoba Debub, in association with the national Association of PLHA and the Swiss Inter Church Aid designed a response strategy that is based on income generating activities among women in Mendefera, the capital of Zoba Debub with an estimated population of 55,000. The income generating strategy fostered by partners is believed to enhance the social and economical status of HIV infected women by increasing their capacity to support their needs and that of their households without risking further infections.

A skills training on weaving opened a way to a kind of cottage industry for 30 women who underwent a training period of six months. ACCORD, a non governmental organization and a training consultant provided training to thirty HIV positive women and during the six months training period, the women were paid a monthly fee of 600.00 Nakfa financed by the Swiss Inter Church Aid. Upon a successful completion of the skills training, the women received a rehabilitation fee of about 20,000.00 Nakfa cash assistance or a supply of raw materials from the branch office of the Ministry of Labour & Human Welfare. Further more, the Swiss Inter Church Aid provided each woman with a modified weaving instrument that is similar to the one they used during the training. The selection criteria based on family size, personal inclination and learning potential of the women.

Goals & Principles:

Marriage presents one of the greatest risks for HIV infection among women in Africa including in Eritrea who, in considerable number of occasions, are infected by the

people with whom they formed a long term and stable marital relationship. The paradox of this type of transmission often defeats the existing conventional approaches and methods to HIV prevention which often encourages safe sex. In this particular scenario, abstinence in a married relationship is not an option that is available to women. Unilateral fidelity does not work, and a determined request for condom can often ignite domestic violence that may result in ugly results.

Statements regarding marriage and family building, faithfulness and fidelity in the Eritrean context are mainly anecdotal. The statements often suggest that most men feel free to seek extra marital pleasure so long as they continue to provide economic support at home and maintain respectful public image by keeping their affairs well guarded and secret. Consequently, the number of women who are getting infected every year is increasing and the need for socio economic support for women, widows and mothers cannot be over emphasized. The expected results of the income generating mechanisms are:

- Improved income and economic security for HIV affected households;
- Empowered and relatively confident women who will plan and live their lives carefully and effectively;
- Improved nutritional status for children and women in the household.

The group effort in solving personal problems stimulates knowledge and awareness about and promotes behaviour change with an enhanced and high powered motivation and determination for sexual abstinence.

Major Elements of the Project:

With the support from the Swiss Inter Church Aid, and a skills training partnership provided by ACCORD, the Health Management Team of Zoba Debub and the BIDHO leadership helped 30 women living with HIV and AIDS to produce national garments that will be on sell in the open market. As stated above, only 23 of the 30 women are making use of the skills they developed and of the materials they received to do the job. The remaining seven women are not participating due to different reasons

including debilitating ill situations, inconvenience and overloaded responsibilities at home. All but five are on ARV treatment provided free of charge by MOH. The major objectives and goals of the project are:

- To enhance women's to economical strength and independence to decide over their financial earnings, increase the level of household consumption including improvement in food intake for children and adults;
- To provide women with opportunities to education, innovative thinking and participation in issues and concerns of the society and plan to improve its livelihood socially and economically;
- To provide affected and infected women with counseling and to increase their negotiating skills that enables them to prevent themselves and their children from farther infection and vulnerability;
- To help women understand the advantage of timely and routine check up of their conditions in health facilities and seek health services as necessary.

Mitigating the Effects of Stigma:

The second most important goal of the project is to set the women free and out of the bonds of fear and stigma related feelings and to develop their confidence in order for them to live positively and succeed in their businesses. The positive living training often provided by BIDHO gave extra strength to their way of thinking and boosted the sense of their rights to work and act as full fledged members of the society.

The group of women who once developed negative feelings of hopelessness, pessimism and defeat are now planning and implementing activities that are directly related to their quality of life both as heads of the family, producers of garments, and members of the society. They are now negotiating business deals with confidence and reasonable certainty. They believe that the periodic psychosocial and spiritual support services provided by their counselors, peers and home care providers help them feel confident about themselves.

In-depth discussions with the weaving women made it possible to explore a few of the situations and feelings in general and see the changes made by the income generating activity. Discussions over coffee brought forward a few of the achievements and the challenges the women are going through. Please note that all names are altered.

Wudasse Yohannes:

In her late thirties, Wudasse is a single mother of 6 children with ages ranging between 6 and 18 years. She knew about her HIV positive status in March 2006. Although she developed very bad feelings and intentions right after she learned about her positive status, she said she has a lot to thank God for. She believes that the psychosocial and spiritual teachings she received at BIDHO and in faith based organizations gave her the courage to live positively and to raise her children as best as she possibly can.

After she was selected to participate at the skills training in November 2006 her daughters took the responsibility to take care of the household chores and to care for younger siblings even though they were forced to skip class at times. Her poor health posed constant challenges during her training but she was determined to complete her course in order to make something of her self.

Upon graduation she received a waving machine and 15,000.00 Nakfa worth of raw materials for her weaving industry. She produces women's national dress of the latest fashion and design (the Raya) for 1,500.00 Nakfa or USD 100.00 and a top shawl for 450.00 Nakfa (USD 30.00). Wudasse is grateful that none of her children contracted the infection. She believes that she got her infection from her long time sexual partner and father of some of her children who is also married to another woman.

Nebiat:

At 35, she looks young and attractive than her age would suggest and she is a mother of three young children. She was not formally married but lived with a male

partner without legal commitment. She knew about her sero status in 2005 when she was pregnant with her third child and although she was irritated and nervous about her infection at first, she is now grateful that none of her three children became infected. She is feels strong and healthy and believes that she will not need the ART for many years to come. After her child was born, she registered at the branch office of BIDHO and the support system helped Nebiat to closely understand her situation and to have a deeper understanding about HIV and AIDS.

Her healthy condition and active nature gave her the chance to go around and sell her products to selected clients who offer good price. Her friends and relatives are her best clients, supporters and her source of morale. However, Nebiat expressed her dissatisfaction with the lack of understanding and the unsupportive and unjustified attitudes of shop owners who offer prices that are much lower than the standard because as women working alone, they have no where else to go. She would love to see a place in town where she and her peers display and sell their products.

Semira Mohammed Berhan:

Widowed at a tender age of 16, Semira is the youngest and the only childless member of the income generating group. At first she had a problem coping with her situation and faced mental and emotional problems and was living with her dotting and understanding parents after the death of her husband and the disclosure of her own status. She found peace when she joined BIDHO who gave her courage and the art of living positively with the infection. Consequently, the local BIDHO selected her to the weaving course and upon completion of the training, she felt that she found some thing she enjoys doing. She is now married to a fellow member of PLHA association and feels that her life has become meaningful.

Semira started taking ART in August 2005 and receives psychosocial counseling and support from her counselor and the support group. Her parents who live nearby are her guardians and protectors. Like Nebiat, Semira would like to have a retail shop in which they sell their products.

Weini:

She is the only non infected widow of a man who died because of AIDS related infections. Although she does not understand how she became sero discordant, Weini is the victim of the situation that took her husband on long field work that provided the opportunity for illicit sexual relations with other women. Her husband worked in road construction for most of their married life and he brought home a daughter by other woman a few months before his death. Including the step daughter who also lost her mother, Weini currently heads a family of five. None of the children are infected.

She is happy at what she does and her uninfected status gave her the ability to work hard and tirelessly. She has concerns and fears about the ever growing cost of raw materials which may force her and her friends to stop weaving and destroy everything that was invested on them.

Partnership and Alliances:

The weaving project is firmly linked with the Office of the Health Management Team of Zoba Debub, the offices of BIDHO in Asmara and Mendefera, and the HECKs Switzerland for funding, supportive supervision and project assessment.

The Ministry of Labour and Human Welfare played significant role by providing them with the rehabilitation cash assistance provided by HAMSET or the Global Fund.

The testing and counseling services and the referral hospital in Mendefera provided significant support through counseling, testing, treatment of opportunistic infections and periodic check ups (CD4). The hospital provides supplies of ARV drug that is enough for a period of six months for all cases that are eligible for treatment. ACCORD made a commendable job in training the women with weaving skills and more importantly, in influencing them to enjoy doing what they have learned.

Monitoring and Evaluation:

The Ministry of Health and the Association of People Living with HIV and AIDS are in touch with the tasks performed by the women and are responsible for monitoring and evaluation of the project.

The activity is strengthened by the concurrent supervision of the Communicable Diseases Control Section of the Zonal Health Department and the branch office of BIDHO.

Strength of the Programme:

During the initial period, the management of the income generating programme was taken care of by the MOH and BIDHO offices. However, during the following months of production, individual members of the group soon learned to take care of their business affairs and started doing well. At first, there was a plan to provide them with a big workshop to produce their cloths in through a regimented working programme. However, the house hold problems and the daily chores made it difficult. However, there are a few women who would opt for a common work place. The waiving looms that are provided to them take small portion of a room at home and the row materials were sufficient for about half a year.

The strength of the programme lies in the capacity of the women that are involved in the garment production to manage their affairs properly and in their handling their household matters without much of outside help.

Weakness of the Programme:

Resources: Weaving materials are hard to get and are unreasonably expensive when they are available. Important components of weaving materials such as threads and the colouring materials are no longer produced in the country and the women are forced to depend on travelling merchants at a big profit margin.

The sales and distribution of produced fabrics is going through difficult problem as the women are forced to sell it to shop owners at prices that is far too low to cover

their household needs. A few of them made links in Mendefera, Dibarewa, Adi Quala and Asmara to sell their produce. A common shop for selling their products had been repeatedly suggested by members of the weaving group.

The continuity of the weaving programme is threatened by the scarcity of important materials and the women are caged to try to work in a programme they know would collapse any day if the right materials are not available for them to buy and produce. An association of credit through a revolving fund would have provided the women the chance to pick vocations from larger and more feasible choices.

The Future:

Expansion: If resources are secured and the essential materials are available, the weaving project and possibly other projects of income generating schemes have the potential to expand to Dekemhare, Adi Keyih, Adi Quala and other towns depending on the PLHA's attitude, their willingness to accept new techniques and the time they may have to learn the skill. Swiss Inter Church Aid has it in its future programme to support expansion of similar programmes in many other places and the Dekemhare training programme has begun already.

Best Practice Criteria:

The Weaving Project provided vocational training to HIV positive women who single handily head households started in 2006/2007. As it currently stands, the project benefits 23 women who produce and sell their material locally.

Relevance: The goals and objectives of the weaving project in Mendefera town created a change in the lives of women who lost their spouses to AIDS and who eventually developed the infection themselves. In some cases, their children may be living with the virus. The new skill followed by the production of cotton based garments for the local community empowered them to handle their business transactions with confidence and enabled them to believe that whatever their conditions are, there is sustenance in working.

Effectiveness: Despite their conditions, the women that are involved in the weaving industry have succeeded in winning the respect of their neighbours, friends, and business associates. They are supported by their counselors, their friends at BIDHO branch office and the CDC section of the zonal health department. Although they appreciate the support provided to them by the different organizations, they have learned to be determined and independent to rise for their own daily needs and livelihood.

Efficiency: Although only a small proportion of people living with or affected by HIV & AIDS have come out in the open, these women declared their sero-status or admitted that they are personally affected by the infection and became very strong and powerful catalysts in the country where people obviously are misguided by fear and self afflicted stigma.

Ethical Soundness: The weaving skill and the income it generates not only did it support the women and their children but it also gave a human face to the infection. It made it clear for people who believed that there is no life after AIDS by showing them that they can live positively and that denial, fear and stigma have no place when people are determined to live and to support themselves.

Sustainability: The main challenge is to sustain the project by continuing to provide on going training as well as supporting the women in order for them to fulfil their expected roles. This depends largely on the availability of resources and the conducive atmospheres in which they will be able to sell their produce while being protected from exploitative & manipulative shopkeepers.

The increasing cost of raw materials is making them out of reach for both producers and consumers. The future will depend on the availability of raw materials without which the skilled women will be forced to lose momentum with no income and hurt pride.