Report of the SACBC AIDS Office, December 2004

Sr Alison Munro

Prevention, Care, Support

- While there are small signs that the rate of HIV infection is beginning to slow down among young people, there remains an enormous amount of work to be done to help young people remain uninfected. Education for Life training and ABCD campaigns have been supported in different dioceses. One of the biggest concerns has to do with continued adult support and mentoring of young people, not just on an ad hoc basis.
- Home based care projects throughout the country continue to provide thousands of people the opportunity to die with dignity. A number of new Catholic hospice sites have opened during 2004. A concern in this area is of course long-term sustainability since institutions are costly to maintain unless they can be supported by various sources of funding , and by links to other activities.
- Growing numbers of orphans are supported across the SACBC region. Many have been helped to access the social grants provided by the South African Department of Social Development.

ARV Support

- Major funding and major effort has gone into the setting up of twenty two anti-retroviral sites, twenty of them supported by PEPFAR funding. The programmes in Francistown and Manzini are supported by CORDAID.
- Meeting the conditions of the department of health of the various provinces has proved a major difficulty, and some provinces have yet to provide us with the written signed agreement for us to operate in collaboration with provincial authorities.
- Meeting the regulations of the US government and the AIDSRelief Consortium (led by CRS) have also demanded a lot. But we are happy to note that at the end of September 840 people had been put on treatment. The figures for South Africa , through the Department of Health, were 11 000 for the same period.

Training, Advocacy, Support

- Considerable funding was allocated during the year to capacity building and training in a number of areas: home based care, food security, advocacy, lifeskills/Education for Life, project management, financial management, proposal writing.
- The SACBC AIDS Office sponsored forty nine retreats and Living in Wellness workshops for care-givers in different projects. These were in addition to similar events organised at project level.
- Advocacy has continued to focus on access to treatment (around which we have continued to work with TAC, the Treatment Action Campaign), and children's issues (around which we have worked with a number of networks and consortia).

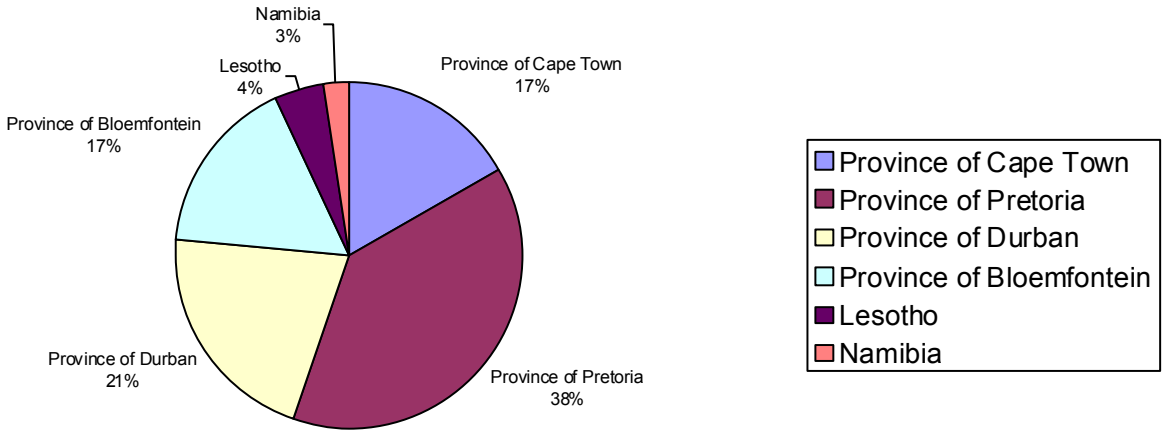
SMALL PROJECTS
01/01/2004 - 31/10/2004

DIOCESE	AMOUNT	PERCENTAGE
Conferences	18482.00	1.67%
Training	746061.00	67.42%
Retreat	289041.00	26.12%
Study	25110.00	2.27%
Publications	27851.00	2.52%
TOTAL	**1106545.00**	**100.00%**

PROJECTS GRANTS TO METROPOLITAN PROVINCES
01/12/2003 - 31/10/2004

DIOCESE	AMOUNT	PERCENTAGE	NO.
Province of Cape Town	1887400.00	16.67%	27
Province of Pretoria	4364770.00	38.56%	62
Province of Durban	2394060.00	21.15%	29
Province of Bloemfontein	1878000.00	16.59%	21
Lesotho	504863.00	4.46%	4
Namibia	290269.50	2.56%	2
TOTAL	**11319362.50**	**100.00%**	

PROJECTS GRANTS TO METROPOLITAN PROVINCES



Research

- A major study originally requested by CAFOD investigated what the Church is doing in twenty nine projects supporting children. Major findings of the study show among other

things what gets people involved in the first place, and why they remain caring for other people's children. Some of the projects struggle against a number of different odds – but at the same time provide assistance that no one else is providing.

- A second study, commissioned by CORDAID, has investigated what happens to people when they are able to go on treatment, and where they are given hope, often for the first time since their diagnosis. One of the key findings has been that there is a breakdown in stigma and discrimination, and a greater willingness to disclose.

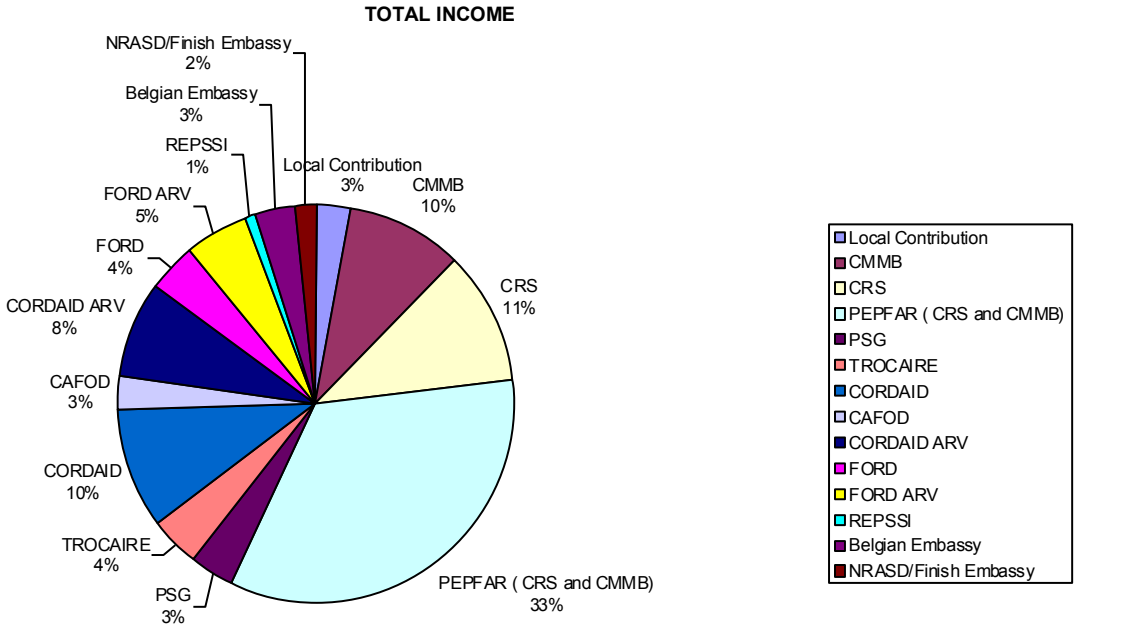
Staff

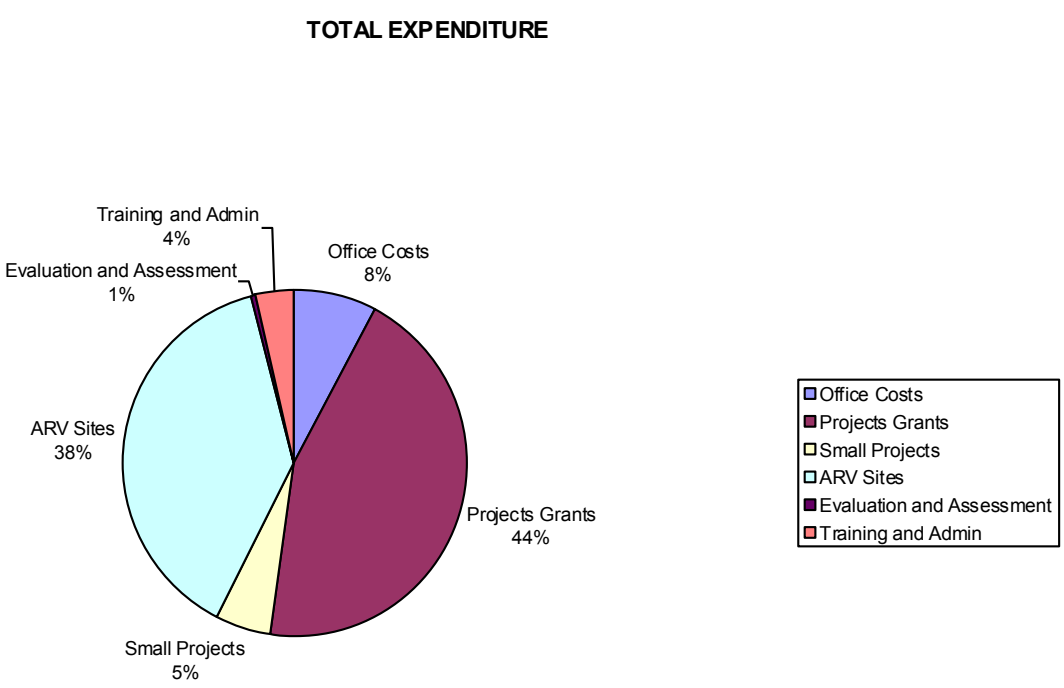
- Co-ordinator; Sr Alison Munro
- Two ARV project managers: Johan Viljoen, Malebo Maponyane
- Three care and support project managers: Hector Rakhetsi, Emmanuel Modikwane, Anthony Ambrose
- Two officers for training and advocacy (one of them seconded by the University of Pretoria): Luyanda Ngonyama, Richard Montsho
- Two finance officers: Keith Glass, Dudu Seleke
- One administrative assistant: Dineo Monyepao

Funding

- New funding has been received from the Ford Foundation for the dioceses of Ingwavuma and Dundee, mostly to assist to get a few more people on treatment.
- A new funding application has been submitted to PSG for a two year grant.
- CAFOD has entered into a new funding partnership with the SACBC.
- Difficulties have been experienced with the Belgian Embassy which is behind in its payments.
- CMMB has undertaken to meet its commitment, but at a later date than originally agreed.
- PEPFAR funding to provide treatment is received through CRS, the lead agency in the AIDSRelief Consortium in South Africa.FUNDING RECEIVED, December 2003-November 2004

FUNDING RECEIVED,December 2003-November 2004





Expenditure, December 2003 – October 2004

APPENDIX 1

Sisters for Sisters:
Religious Congregations affected and infected by AIDS

Sr Alison Munro, OP, SACBC AIDS Office, Pretoria

(to be published in Forum Weltkirche, in Germany)

The time in which we find ourselves in Southern Africa today is a time of profound challenge to the Church. AIDS has impacted on every level of society, every class of people, professional as well as the unemployed, people with a high profile and those who live in desperate poverty. The Church itself has AIDS, if by the Church we understand "the people of God, the body of Christ". Its members, clerical, religious and lay are both infected and affected.

On looking back over Nicholas' living and dying, I have come to many profound awarenesses. The first most profound is that no one can walk this journey alone. Nicholas' parents shared that they had been at their wits' end when I was introduced to them. I seemingly had little to offer and yet the more I shared, the more help came our way. A neighbour, a caring nurse at the hospital, my own community, the Catholic women in the village, and many other people came to provide support and got involved irrespective of race, creed or color. Nicholas did not walk this journey alone. He sought and found God, the core message he left in writing to be read at his funeral. (Story 1).

Women belonging to religious congregations form much of the backbone of the Church's response to AIDS in many parts of the sub-continent, often inviting professionals and volunteers to assist them along a continuum of work in AIDS education, care of the sick, the care of children and now the treatment of people who qualify for ante-retroviral therapy. This pattern mirrors one seen in the broader society where women quite clearly and very openly spearhead the response to AIDS in various sectors of society. The response to AIDS across the sub-continent would be severely weakened, if not stopped altogether in some places, were women to be taken out of the equation.

The beloved niece of a religious sister phoned her one day and told her she was not well, but did not say what illness she had. The sister responded after several conversations by a letter saying, that if it was a disease that she was afraid to speak about, she must know that she is still loved. The niece was surprised by this response but encouraged. Knowing that she was still loved by her religious aunt and by God, gave her the courage not to deny the disease any more but accept it and disclose to others that she was HIV positive. As she became more ill with AIDS her aunt visited her along with two priests. Her niece was happy to be loved in such a way and to be prayed with, and to have an opportunity of confession. That was on a Saturday. She passed away peacefully two days later – knowing that she was loved. (Story 2)

Religious congregations of women themselves are also affected, and often enough captive to the same kinds of secrecy and denial that one so often encounters in the broader society. Many sisters have to deal with HIV/AIDS within their families, among their siblings, among relatives.
I asked my Provincial Superior to allow me to give the Sisters of my province education about HIV and AIDS. She did not understand me the first time but I persuaded her. In the end she agreed and we held the workshop. The province was divided into two groups. Through the workshops she found out that many sisters are affected. She also learned from that day the reason for many sisters going home. But still many sisters are in great denial of the problem. (Story 3)

Well known too, of course, is that women are both more vulnerable to HIV infection, and more burdened by the effects of AIDS in their families and local communities, bearing the brunt of care of the sick and dying, than are men. Statistics show clearly that girls are more vulnerable than boys to infection at a younger age (because of physiological development, and cultural and socio-economic factors among others). Some of this vulnerability may be the experience of some religious women as well, either before they enter religious life, or once they are novices or members of a religious congregation. This is not the time or place to enter a discussion about sexual abuse issues within religious congregations, but the point is nonetheless noted.

A sister was found to be HIV positive. She had entered at the time when testing was not done. During her initial formation she experienced some ill health which was not suggestive of HIV, or the congregation did not realize it. In her temporary professed years, she manifested the symptoms of full-blown AIDS. She was badly off health-wise. It was at this point that the congregation did not know how to handle the situation. The congregation did not know whether to admit her to final vows or not. Eventually the family stepped in and took her home. The congregation supported from afar while the family did all the care until she died. This was a painful experience for all. The sister had been infected before she entered the convent. (Story 4).

As scenarios play themselves out it is obvious that some women religious are dealing with AIDS on many fronts. Within their own families where siblings and relatives have become ill, lost their jobs, and often died in desperate circumstances. Within the local NGO and Church projects where they minister. And sometimes within their own communities where a member becomes sick and dies. Some communities have been better able to handle this than have others. And clearly where secrecy and denial have been confronted head on communities have been in a better space than have others who have been unable to deal with the facts and reality confronting them.

A sister, who had been with a congregation, left; it is not clear if she got married, but she was working for some time. She was a nurse. Eventually she became sick. As tim went on she became weaker and it became clear that she was HIV positive. The sisters to whom she had belonged took her back into their care. They never questioned as to when or how she became HIV positive, but cared for her until she died. She died in their hands and was buried in their cemetery alongside the deceased sisters. (Story 5).

Stigma and discrimination are present in religious communities, as indeed they are in the wider society, often fueled by ignorance and fear, as well as by cultural beliefs and taboos, and a narrow understanding of the Church's teaching in the area of sexuality.

A sister was diagnosed with the virus. She suggested that she would leave the congregation. Her sisters said no, you are our sister, you must remain , we will take care of you. The greatest of care was given, one sister in particular stayed by her bed side day and night. Many visitors all found the patient in good spirits, well cared for. Sister died, knowing that she was loved and not judged nor stigmatized. (Story 6).

Similarly

There was a priest who was HIV positive and his congregation rejected him. But a certain congregation of sisters too him in and cared for him. When he was about to die the sisters called his superior to come and see him. At first he resisted, but at last he came, and the dying priest asked for pardon, and thanked the sisters for all they had done. He died peacefully, and the provincial learned something. (Story 7)

Denial of HIV, as well as a refusal to recognize the circumstances in which it may have been contracted (which in the story below are not the work circumstances even though that may be the inference of some readers) is like a virus itself, spreading from one person to another, until eventually it is clear that because no one is prepared to admit the truth, everyone suffers.

One of the nursing sisters pricked herself when screening patients. She informed the doctor at once, showing him the syringe and her pricked finger. They also went together to tell the superior. The whole community was informed of the situation and they prayed until the test results were available that they would be negative. It turned out that both the patient and the sister were HIV positive. Some members of the community did not believe it, nor did the family of the sister. The sister cried a lot and died in denial of her illness. Life had been a misery for herself, the sisters and the family. None of the family came to the funeral. (Story 8).

Another problem is that of secrecy and silence, often confused in practice with confidentiality, which quite rightly needs to be protected. Where the silence can be broken in a loving environment, earlier rather than later, both an infected person and the others around him or her can benefit.

A young sister working with people infected with HIV, one day expressed her desire to talk to another one, who was a nurse there. It was difficult situation, but with the nurse's good listening skills, she disclosed to her that she was HIV positive, and asked her to keep that between the two of them. One day the sick sister phoned the nurse to tell her that she was sick. The nurse arranged for her to go to the doctor, who booked her off for ten days. She went to the mother-house during her sick leave. She became worse; when the sick leave expired she was taken back to the doctor. She finally disclosed to him as well about her HIV status. So, the secret was then among the three of them. For a long time the sisters in her congregation had been pressing on their nursing sister to tell them what was wrong with their sister. But the latter could not disclose without the sick sister's permission (consent). Last year on Good Friday, she eventually broke the news to the sisters. They were so shocked, afraid and the situation became so tense as if somebody had died. They were taught protective measures in caring for her. She was relieved and died last year July. She requested her status to be disclosed to everybody at her funeral. (Story 9).

Clearly work situations can be a source of possible infection, and while difficult they are often socially more easily dealt with than are situations in which sexual behaviour is suspected as the possible source of infection

There was a sister who was in direct contact with fresh blood of a client. She then took the emergency cocktail treatment. This was very painful, as she was becoming sick. The congregational members were very concerned and they supported her very much. She felt very much cared for and experienced a sense of belonging. (Story 10).

The stories told in this article are all true, coming from the experience of sisters who gathered from several African countries in South Africa in early 2004 to share their experiences of how HIV/AIDS has affected religious life. My own assessment of these stories is that they are essentially no different from those which could be told by any other women in the broad Christian society. The same fears and guilt, similar stigma and discrimination, comparable heroic acts in the face of enormous odds. What perhaps is missing from these particular stories, and that is natural given the context in which they were told, is a recounting of the many instances in which lives have been touched in positive ways at grassroots level where women religious serve alongside volunteers and others, reaching out to the poor and marginalized, continuing the mission of Jesus to those who are sick and in need of healing. These stories tell of projects been run on shoe-string budgets, of orphaned and vulnerable children being sought out, of the sick being allowed to die with dignity, of

new efforts in the area of prevention, of the joys associated with being able to bring hope along with anti-retroviral therapy to those who would otherwise die.

The story of women religious in the fight against AIDS is part of the story of the Church in our time. A Church attempting to proclaim the gospel in a world affected by globalisation, poverty, unemployment, inequities of every kind, a world in which instant gratification and pleasure is so often the order of the day, a world in which more than ever the good news needs to be proclaimed.

Note

1. The All Africa Conference Sister to Sister was sponsored by Mercy Sisters International, and took place near Pretoria in 2004. Eighty five sisters attended from nine African countries.

APPENDIX 2
Belgian Funded Project

Sisonke Project Completed Activities and Outcomes

Activity	Province	No.	Outcome
Youth and advocacy training (27 Jan, 25 – 26 March, 07 – 11 June & 21 August 04) Food Security Workshop (14 – 18 & 21 – 25 June 04) Project Management (28 March to 02 April) Advocacy Seminar (19 August 04)	**GAUTENG**	68 52 41 30	• Education for Life diocesan youth facilitators teams has been established • The diocesan youth team runs Education for life awareness workshop at parish level. • Most of the participants have established vegetable garden projects in their respective parishes. • Most of the participants have indicated that their skills with regard to report writing, proposal writing and basic financial management skills have improved drastically. • The delegation from the Department of Social Development gave the participant the handbook. • The handbook clearly explains different types of Social grants, procedures for applying for grants and most importantly the definition of the means test and how is calculated for different grants.
Lobbying and Advocacy (22 – 27 February 04)	**LIMPOPO**	**43**	• A small campaign was established in Polokwane (Subiaco) to assist orphans to access social grants. • To date about nine (9) orphans who

			struggled for sometime to access the social grants are now receiving the grants.
59 Days Home Based Care (In process) Food Security Youth and Advocacy training		38 40	• The participants have been taught how to assist the infected and the affected to cope with their situation. • Also the caregiver has been taught how to keep the recording of their visits. • A small vegetable garden has been established at Subiaco. • Each diocesan coordinator has been given seeds to give to the participants for implementation • Also the service provider has offered himself to assist the participants whenever the need help. • Integration process is busy unfolding.
Youth and Advocacy training (31Oct to 05 Nov 04 & 08 – 12 November 04) Food Security (1- 3 and 7 – 10 Nov)	**MPUMALANGA**	22 47	• Education for Life deanery youth facilitators' teams has been established. • Each deanery has 6 members' teams. • The formation of the education for Life diocesan team is on process. • Three vegetable gardens have been established in Mhluzi, Bongani and Mashabela. • The participants have been advised on how to start vegetable projects in their parishes and seedling are made available for free for the participants.

APPENDIX 3

THE SACBC'S ARV ROLL OUT

Johan Viljoen

Introduction

The SACBC officially launches its ARV programme in South Africa, Botswana and Swaziland, during the January 2005 plenary session of the bishops during a Mass celebrated at Regina Mundi Church in Soweto.

Training of doctors and nurses began towards the end of 2003, and during 2004 the provision of ARVs began in 22 sites.

Eighteen sites, across seven of the provinces, are in South Africa, and are funded through the PEPFAR initiative of the United States Government. They are mostly in outlying areas not yet served by the South African Department of Health.

The Dutch Catholic Agency, CORDAID, supports an outreach programme of Good Shepherd Hospital in Siteki, Swaziland, into remote rural areas. In Francistown, Botswana CORDAID supports on treatment foreign patients who are not citizens of Botswana.

The Ford Foundation supports additional people on treatment at two sites in KwaZulu Natal.

Fifteen hundred patients, including children, were on treatment at the end of December, with others beginning adherence training and due to begin treatment over the coming weeks.

A study commissioned by the SACBC and shortly to be released applauds the breakdown of stigma where people are on treatment and are given hope and new chances. It also notes the challenges around the provision of treatment to children.

PEPFAR-Funded Sites

1. St Mary's Hospital, Mariannhill
St Mary's Hospital is situated at **Mariannhill**, on the western outskirts of Durban.. It serves the 'Outer West' health district of metropolitan Durban – an area with a population of close to 750 000, consisting mostly of very poor, mostly unemployed people living in informal settlements. Due to its track record, it has been named as a 'Centre of Excellence' under the **PEPFAR funded AIDSrelief** programme. It continues to provide technical support, human resources and training to many of the SACBC's ARV roll out sites in KwaZulu/Natal.

2. Tapologo, Rustenburg
Tapologo is the programme of the Diocese of **Rustenburg.** Rustenburg is the world's largest source of platinum – numerous mines dot the landscape in an arc stretching north-west to north-east of the town. Currently Tapologo has a network of home based caregivers running a programme that is financially supported by the platinum mines, providing services to all of these communities. Tapologo has paid particular attention to treating families as units. The strength of the programme lies in the way family members of patients are trained and utilised as treatment supporters, reinforced by home based caregivers.

3. St Joseph Care Centre, Sizanani, Bronkhorstspruit
Sizanani is situated at **Bronkhorstspruit**, 45 km east of Pretoria**.** It is the base of a well trained and well organised home based care organization. Its services are so widely recognised, that it was named as one of the country's top five models of best practice for home based care and palliative care by the Department of Health. Sizanani has so impressed Department of Health officials with the quality of its service, that it was selected by JSI (the organization developing the computerised patient tracking system for the government) as one of the sites where the proposed patient tracking system would be field tested.

4. Nazareth House, Johannesburg
Nazareth House is situated in Yeoville. It serves the inner city of **Johannesburg,** an area with extremely high rates of crime, substance abuse and prostitution, and a highly transient population (including a very high percentage of refugees and economic migrants from all over Africa). It houses mentally disabled people, frail old people and terminally ill people. It also has a home for HIV positive abandoned children, many of whom are now on treatment Nazareth House was one of the first sites where SACBC started its ARV roll out.

5. St Francis Care Centre, Boksburg
St Francis is one of the oldest Catholic hospices in the country. It is also the largest. St Francis is situated in **Boksburg** – a mining and industrial area 30 km east of Johannesburg.. It is expected to scale up rapidly. With funding from other sources, an ARV clinic has been built. Already, St Francis is receiving numerous enquiries from potential patients in the Boksburg-Vosloorus-Reiger Park area. It has adults and children on treatment.

6. Bethulie
Bethulie is in the middle of nowhere. Situated on the banks of the Orange River, **between the Southern Free State and the Karoo**, it is surrounded on all sides by arid semi-desert, and is more than 200 km away from the nearest significant population centre – **Bloemfontein**. That is also where the nearest hospital is. A survey published jointly by the Human Sciences Research Council and the Nelson Mandela Foundation identified the Free State as the province with the highest HIV infection rate in the country – higher even than KwaZulu/Natal.

7. Mtubatuba, Diocese of Ingwavuma
Mtubatuba and Hlabisa are the two largest towns in the **Hlabisa Magisterial District**. They have a combined population of over 200 000. This is the Zulu heartland. The area also has the dubious distinction of being the place with the highest HIV infection rate in the country. It only has one hospital – at Hlabisa. In 2000, the Catholic parish at Mtubatuba formed the Unkulunkulu Unathi Home Based Care programme – a Zulu term meaning 'God is with us'. Two years later the patient numbers had become so large, that a second home based care organization was formed: Melusi Omuhle (meaning 'The Good Shepherd') at Hlabisa.

8. Holy Cross Home, Pretoria
Holy Cross is situated in **Pretoria**. It used to be a hospital and maternity home serving Pretoria's former black township of Lady Selbourne. When the black population was removed under the Apartheid government's policy of forced removals to Ga Rankuwa (40 km away), Holy Cross became a frail care centre. Five years ago it opened a Hospice with ten beds. In 2001 it was named in a survey by the Pretoria News, as the institution providing the best quality of care in the Pretoria area. The Home also has an outreach and home based care service in the nearby informal settlement of Plastic View – a dismal place, so called because its residents live under sheets of plastic. The introduction of ART has "turned the way in which the Home functions around." In stead of patients coming there to die, they now come to get better and be discharged.

9. Sinosizo, Archdiocese of Durban
Sinosizo is the home based care organization of the Archdiocese of **Durban.** It provides a standard of training that has made it one of the foremost training organizations in South Africa. It also has a large network of caregivers, providing care to the terminally sick in all parts of the city. Sinosizo has done a thorough job of getting all its policies in place and formalising referral arrangements with the local hospital. In this, it has served as a model for all the other SACBC ART sites. It faces a formidable challenge, being the first roll out site that is only a home based care organisation, not

linked to a clinic, hospice or hospital. It has also provided valuable service to other SACBC sites, providing them with training in adherence monitoring and drug literacy.

10. Blessed Gerard Care Centre, Diocese of Eshowe
Blessed Gerard Care Centre is situated at **Mandini**, in Zululand, approximately 100 km north of Durban. It is the service organisation of the South African branch of the Knights of Malta. The Centre has a large and well equipped hospice, a home for abandoned Aids orphans, and a home based care organization. It has now procured the services of a doctor and a professional nurse, and started with PEPFAR funding at the beginning of August. 2004.

11. Winterveldt, Archdiocese of Pretoria
Winterveld is an impoverished peri-urban area with a population of about 240 000, situated 45 km north west of **Pretoria**. Under the Apartheid government it was made a part of the Bophuthatswana homeland. As such, it was used as a dumping ground for people who were forcibly removed from areas that were declared 'white". It has no infrastructure, no running water, sanitation or electricity. With the exception of three government clinics, health care is provided by a network of six Church clinics. These clinics provide curative services and home based care. The Winterveldt clinics are also one of CMMB's PMTCT sites. With the availability of PEPFAR funding, Winterveldt started screening patients for their CD4 counts at the beginning of August.

12. Botshabelo, Archdiocese of Bloemfontein
The Siyathokoza Clinic in Botshabelo is a collaboration between the Holy Cross Sisters and the Holy Family Sisters. Botshabelo itself was started as a resettlement area during the apartheid era, for people who were removed from their homes in areas that were declared 'white'. It presently has a population of more than 400 000, making it **the largest township in the Free State**. Like in most other resettlement areas, provision of basic services was neglected for many years. Today the Sisters provide an invaluable service, and also have a home based care network that looks after many patients in their homes. The commitment of the Sisters to their patients causes many Botshabelo residents to bypass the government clinics, to seek treatment at Siyathokoza.

13. Centocow, Diocese of Umzimkulu
Centocow is situated in the Diocese of **Umzimkulu**. It is a very rural area, taking in the southern parts of KwaZulu/Natal, and parts of Griqualand East (which falls under the Eastern Cape). The mission was built at the turn of the century by the Mariannhill Fathers. Centocow has excellent relationships with St Appolinaris Hospital. The ARV programme is a joint collaboration between the Hospital and Izandla Zothando. Izandla Zothando operates out of a mobile caravan, on the hospital grounds, where they are seen by the doctor and the nurse. All laboratory tests are done through the hospital, and drugs are also procured through the hospital. The patients are then followed up and their adherence is monitored by Izandla Zothando's caregivers, in the various communities.

14. Newcastle, Diocese of Dundee
Newcastle is the third largest urban centre in **KwaZulu/Natal** – with the townships of **Madadeni, Osizweni and Blaauwbosch** it has a population of approximately 400 000. The area's main source of employment is its collieries, and the Iscor steel foundry. It therefore attracts a large number of job seekers from all over the province. The parishes in Osizweni, Madadeni and Blaauwbosch are run by the Consolata Fathers. The ARV programme is a collaboration between the three home based care organizations of the parishes. Each one has a counsellor and a number of adherence monitors. The programme makes use of the services of a doctor in the town. It also employs a full time professional nurse. There is a considerable amount of expertise locally concerning ARV's.

15. Thembalethu, Mpumalanga
This newly established site operates in the **Shongwe area of Mpumalanga** north of Swaziland and west of Mozambique, in the diocese of Witbank. Many people served in the home based care programme are from Mozambique. Fruitful discussions with the Mpumalanga health authorities saw the programme taking off shortly before the end of 2004.

16. Bethal, **Mpumalanga**
The Mercy sisters home based care programme in the Bethal area of the Dundee diocese will bring new partnerships into play, with a collaboration with SASOL and the local health authorities. It began its ARV rollout towards the end of 2004.

17. Good Shepherd Hospice, Middelburg
Good Shepherd Hospice, Middelburg in the Diocese of De Aar, serves parts of the Karoo. Sr Cathy Thomas, a well-known figure in the area, has been instrumental in helping to establish hospice facilities in a number of Karoo towns. Middelburg is perhaps the best known. An ARV rollout was begun towards the end of 2004.

18. InKhanyezi , Orange Farm
Orange Farm, a sprawling township south of Johannesburg, is home to home based care services in an area thatboasts poor housing and inadequate services. People are under the threat of being moved yet again to make way for the building of roads and various development projects. The ARV project has got off the ground towards the end of 2004.

19. Good Shepherd Hospital, Siteki (non PEPFAR)
Good Shepherd Hospital in **Siteki, in the diocese of Manzini, Swaziland**, received funding through the Global Fund to provide ARVS. Additional assistance through the SACBC has enabled hospital staff to provide ARVs in more remote areas not within easy access to the hospital.

20. Francistown, Botswana (non PEPFAR)
The **Vicariate of Francistown** has been able to use SACBC funding to enable a small number of patients to receive treatment in Francistown. Although ARV treatment is widely and freely available in Botswana, at least in theory, distances are enormous, and not easy for people who are ill. And the Botswana government does not treat foreign nationals who are therefore the target of this programme.

21. Bela Bela, Diocese of Pietersburg
Bela Bela was formerly known as **Warmbaths**. It is situated 100km north of Pretoria, in **Limpopo Province**. The project is situated on the grounds of the local clinic, and has been providing counselling and home based care to people with Aids for a number of years. The site has also been providing ARV's to a small number of people, with private funds. Because of its proximity to the clinic, the project has an excellent referral system with the local hospital. This site will be funded by PEPFAR once the Limpopo health authorities sign an agreement.

22. Kurisanani
Kurisanani is the AIDS ministry of the **Diocese of Tzaneen**. It serves a poor, very rural area in the northern parts of Limpopo Province, along South Africa's border with Zimbabwe. It has been providing home based care for a number of years, and also has an extensive care and support programme for orphans. The ARV programme is based at the former St Joseph's Clinic, near Thohoyandou. The clinic has been refurbished, and a congregation of nuns, all of who are nurses, have moved into the convent on the premises, to run the programme. The home for HIV positive orphans at Ofcolaco is a satellite of this programme, with treatment being provided to those orphans

who need it. This site is awaiting provincial agreement at which time it will be funded by PEPFAR.

APPENDIX 4

Project Reports
By Project Managers

Caring Network

Things at the Caring Network are in place. The main activity of the project has been to transfer all matters related to Home Care Coalition (HoCC) to NACOSA. They have been mandated in the western Cape to host the project and now that it has began to have a life of its own and funding was coming forth for it (EU). We had contributed some money to get it going and that has been achieved.

The organisation has proved useful in the Western Cape because it has brought most organisation dealing with HIV/AIDS together and they even managed to secure funding from the European Union. Because of this organisation projects in the Cape have managed to survive the constant changes in the provincial government with out getting their programmes stalled.

I would be of the opinion that the Caring Network should be kept as our main partner in the Western Cape in order for them to be able to mentor and guide other projects that we are likely to fund in the province. Of concern though is that they should not dictate to the small project but guide them. They also should not expect them to have sophisticated systems in place for they would not have funding for such.

Currently they are servicing four areas, viz. Khayelitsha, Bishop Levis. Wallecedene & Bloekombos, and Mbekwene in Paarl. The most significant achievement over the past year has been the organisation's ability to access state funding (almost 1 million Rand) for their community health workers.

Helderburg Hospice

They still have some money from the Raskob Foundation and have been using it for the outreach program called Integrated Community-based Home Project. They paid 10 care givers for three months Having had a conversation with them I realised that there is no need for us to continue funding them They seem to have enough money to run their outreach programme without our funding.

Furthermore, they have very few caregivers and in my opinion they have taken into training more than HBC. Further funding for this project is not recommended.

St. Lukes

Like the latter they have an outreach programme but it looks much bigger and more effective than the Helderburg one. They have a dedicated nursing sister who runs the programme and I had the pleasure of meeting her and discussing some concerns. One of my main concerns was whether they were not serving the same areas as the Caring Network but was assured that that is not the case. To the contrary the Caring Network is said to be referring some patients that need palliative care to them. Furthermore the hospice seems to be more interested in children in their outreach programme.

They also have links with Nazareth house also. On the whole I think there is a neat network of Catholic facilities.

Joy for life

This project we have been supporting for the past three years and has been running a day care centre in the city. They have developed an outreach programme in Khayelitsha and Gugulethu.

There was not much activity when I was there but I was assured that much takes place during the day. We have given the grant recently and that should be our last partnership with them.

Potential projects.

The first one is based in Paarl and the priest was visited by Luyanda . What I could gather from him is that the priest does not want to be accountable by way of writing reports if a grant is given. I think what is in operation is the old missionary attitude were one receives money and spends it without any given budget but at the same time serving the needs of the people. Subsequently Luyanda went again but to date we have not received any positive outcomes. He offered our help in terms of writing a proper proposal but to no avail.

The second project is Wala Nani which is providing training and we were informed that we could use them as service providers if there is a need. We cannot give them a grant to train people who are not our partners because we will not be in any position to monitor and evaluate whether the has been any impact or not after the training.

Zenzeleni

As per the request from the Bishop my visit was to dine with Fr. Ademmer. We both went to see Mrs Ngoako and had good reception. We were shown the place and how they have managed to survive with the help of funding from Spoortnet and Coca-Cola. We saw the kids that they take care of and all of them are orphans and stay in their respective homes with their care givers. Care givers are encouraged to contribute to the centre in kind given the poverty of the people they serve. They have to come to the centre once a week and help out with the chores.

One of my concerns is that I do not think that the Bishop is willing to sign the proposal while these people are dong great work. I am aware of the condition set in our criteria but doesn't this kind of attitude undermine our intervention and assistance to those who need our help. I suggest that we have further discussions in this regard.

Tshepong

This project is in the township of Kimberly called Galeshewe. A house was donated to the Bishop and that was converted into centre from which the Diocesans AIDS project can operate.

I met with the 15 care givers who are part of the programme and they shared their experiences. There are mainly two things that they are concerned about. The first one is the question of transport. They have very little resources available for travel and they cover a large area. Secondly there seems to be a lot of competition among projects that do HBC in the area. I advised them that there is no need to compete, all that they have to do is be very professional in executing their work and they will reap the results thereof. Also that they should aim for areas that other projects don't want to cover and provide their services there.

I am rather concerned that I tried to get the Williamson's to be part of the discussions but to no avail I think all the administration of the project should take place from Galeshewe once capacity has been put in place.

Thembisile HBC

June Sibiya is no longer Project Manager and his position is taken over by Johanna Skosana. They have managed to get access to State money (R70 000) but were required to spend it very quickly and with specific budget lines. This money has helped them pay care givers and the management of the project.

One plan that they have is the construction of a hospice in the area. They have managed to secure land from the municipality and there is a Dutch donor who is willing to give them money. I raised some concerns as to their capacity to run a hospice. They would have to get in touch with Sizanani and get advice in that respect.

They have also stated a self help project with PLWA's and they do gardening. A number of female PLWA's have received training from the department of Agriculture and seem ready to implement their expertise.

I am rather encouraged by the progress of this group given that they are youth and have taken such huge responsibility for their community. They have also been good in practising the skills gained from the workshop run by Pat Cane on stress relief and trauma relief.

Solofelang Botshelo

This is an ophans programme in the north part of the Archdiocese of Pretoria. Fr Ambrose is the one leading the project with the assistance of his women parishioners. They have identified over 30 orphans in the surrounding area of the parish; that does not include Orphans in the out stations.

They wanted to start a day care centre for the children but were discouraged by the local social worker who wants the building to be turned into a place of safety claiming that is in line with government policy. The advice given is that it is not a government programme and in as much as it is government policy to start places of safety but at the same time it is not opposed to day care centres.

The project was also delayed due to the fact that the local social worker wanted to verify the names of the children that they were going to attend so that they do not service the same children. Subsequently there discovered only two children overlapped and now they can proceed providing food parcels to children that they have identified.. In time the children that they serve will have to be absorbed by the state system and we take over new entrants.

This project is going to need a lot of guidance since it very new and added to that the parish is soon going to be moved. We would have to capacitate the local people who have been working with the priest so that they can sustain the project.

Queenstown, Imfobe

I met with Ms Siphuka and discussed the possibility of getting her to do the co-ordination of the diocesan projects, and not necessesarily run any particular project in the diocese. We will have to use the current Imfobe committee as the diocesan AIDS committee and they would have to oversee her. They subsequently would update the Bishop on any developments as they usually do.

To date Komani which is the development wing of the diocese has been paying the salary of Ms Siphuka for doing her AIDS work but we would have to relieve them of that responsibility because

they indicated that they are no longer able to fund that post. I gave some guidelines as to what would be expected of the incumbent.

I further briefed Bishop Lenhof who was positively exposed to the idea and gave his approval. I think we need to work on both the person taking the position in terms of her responsibilities and also the responsibilities of the committee.

Ntaba Maria
Progress is very slow with this project. Sr. Luthuli seems to be working on her own and find it very difficult access training and other resources. I think once we get the diocesan co-ordinator in place she will be able to assist this project in terms of getting care givers trained.

Whenever I am in this project there always seem to be indications that they will get training but that never happens . I have asked Ms. Siphuka to make it her priority project since they have money from us to get training but have not used it.

Umtata
The situation in Umtata is very desperate like most parts of the Estern Cape. The diocese has got some initiatives providing milk and some food stuffs for people. There is no co-ordinated AIDS work in the diocese and I have initiated discussions with the secretary to Bishop Hirmer about the possibility of getting a diocesan co-ordinator. The person like in Queeenstown and other dioceses will have to go to the rural parishes and animate them to start and help them get capacitated in relation to their response.

I have provided her with the models used in other dioceses so that they can start developing some thing from that. I intend to return to them before or by November 2004

Dundee Diocese

This project operates from Damesfontein mission under the leadership of Fr. Hector. This is in terms of the administrative aspects. The objective of this visit was largely to conduct the CAFOD study and partially to evaluate and assess the project. The interviews were successfully completed as the respondents were lined up. One also had an opportunity to speak to Miss Sonto Gibane who is a Coordinator for caregivers. One must confess that they are really operating in a very huge area of the former Ka-Ngwane Homeland. This includes Fernie and now expanding to Mayflower. The project has trained Zanele to supervise the project in terms of HBC givers.

The project is serving the rural-unemployed destitute people. Based on the statistical report, the project is benefiting 200 individuals. Fifteen Home Base Care-givers help these beneficiaries in terms of food parcels and cleaning them. In terms of orphans the project is still battling to access social support grants. The problem encountered is the distance for volunteers. Like I've mentioned that the area is quite huge, it makes it a bit difficult for them to operate effectively. Fr. Hector indicated that they appreciated the training done in Dundee but they would like to see a similar thing dealing only with financial management. Overall the project is running very fine.

Another project is located in Bethal (eMzinoni) under the leadership of Vangile as a Project Coordinator. They are working very closely with Sr. Claire who was on a holiday overseas during the visit. The purpose of the visit was largely to conduct the CAFOD study on orphans. In her absence I spoke to Vangile and Sizakele who is a caregiver at the project. According to the Coordinator, Sr. Claire assists the project by purchasing disposals for children. Their only concern is that they would like to engage in distribution of food parcels but due to shortage of funding the project is not off the ground. Vangile indicated that the caregivers receive a stipend of R250 a

month from CSA. Regarding the project, I think is running fine but one can't say much as I'm not really clear of their relationship with Sr. Claire. I will have to get clarity when Sr. is back. It came out in our discussions with the coordinator that the project was started by Sr.Claire and handed it over to CSA. The question I asked myself is whether this project is assisted by Sr. Claire with the funding we gave it to her or with some private funding from somewhere else. In any case I will get to the bottom of this when she is back.

Kroonstad Diocese
I met with Fr. Steven who is the administrator of the diocese of krooonstad. We had some interesting discussion around issues in the Diocese. One of the burning issues was regarding the center based in the Knights of Da Gammas at St. Helena (Welkom). Fr. Steven indicated that there is a possibility that they might move the center to Thabong due to highcosts of renting . They indicated that negotiations are on with Anglo Gold mining to donate a House for the center. The mining is still searching which house can be donated for them. I think it makes sense to get the center to Thabong because the community will have easy access to the center. In turn, it will benefit the caregivers in terms of transport to commute daily to the center.

Fr. Steven further indicated that another issue pertaining to the Nights is that they are expanding in such a way that they are being squeezed out. Having mentioned all these details, he asked if the AIDS Office could assist in terms of getting the center at least 15 beds and some funding for renovation of the building. In response to this, I told him that I would give it to the Office to decide on the issue. The other issue pertains to the full-time coordinator for the Diocese and I gave him a go ahead to begin to think of the relevant for the task. This came out recently when he was reviewing calls for proposals from the projects that they are actually increasing.

Brennikmeijer Relief Centre
The project manager in-charge is Mr. Gabriel Mathuli. The centre basically admits the terminally ill patients and institutionalizes them at the relief centre. Gabriel indicated that the centre is running fine except that he has a problem with high rent costs. In terms of administration, the center works as a team with AIDS management committee, Development committee, and Justice and Peace.

The Relief center operates with 12 caregivers who are each receiving a stipend of R800 a month. The project manager receives a salary of R3300 every month. This is made possible by a longstanding relationship with the Dept. of Social Development in the Free State. Recently the center received R84000 from the government for the maintenance and smooth running of the Relief Centre. But this money is given to the center over a period of 12 months. Which makes it R7000 every month.

The Relief center has close to 15 patients that are taken care of by the caregivers. Mr. Gabriel highlighted the fact that these caregivers rotate as the Centre is operational 24 hrs. The also have mortuary that accommodate three corpses only. I must say that the centre is running in the right direction.

Name of Project: Diocese of Kroonstad Joint Commmittee
This project is based at Meloding in Virginia. The project specializes in Home Based Care activities and orphans and vulnerable children as well. To a certain extent their programme touches on Education for Life. The purpose of the visit was to complete a questionnaire for the CAFOD study and project assessment and evaluation. I must point out that the interviews went very well as respondents were properly lined up.

Fr. Paul mentioned that they are planning to run HBC training for another 25 candidates. And also do a follow up training at a parish level for Education for life. Other trainings involves advocacy for

the rights of HIV/AIDS infected and affected people. Most important was the establishment of the bank in order to encourage communities or churches to donate food, blankets, and other financial support. In terms of new Developments, Fr. Paul and other stakeholders grouped all the projects doing a related work together and name that Matjhabeng Joint Venture for OVC's which is funded by Nelson Mandela Children's fund.

Regarding training, Fr. Paul indicated the first phase of their 59 days training of home Based Cares from various parishes of the Diocese of Kroonstad. Accordingly, 25 candidates attended the course. The counseling course that was supposed to be held at the Relief Centre was moved to Winburg around early July this year. We also touched on the computer centers in the Diocese as they are working quite well. Following the merging of institutions in South African Higher Education, former Welkom College and TOSA College came together to form FTI. As a result, the four centers in the Diocese write external exams and receive an accredited certificate from this Institution. Overall things are up and running except that Mr. Lebotsa who used to coordinate a computer center in Thabong passed away.

APPENDIX 5

PROJECT MANAGEMENT

By Project Managers

Since the inception of the AIDS Office three years ago, the number of current projects that are funded by it and that need to be visited has risen to over130. There is no clear distinction between the areas of responsibility of the different project managers. As a result, project visits take place on an ad hoc basis. Some projects (like Caring Network) get visited regularly, whilst others (like Ndumo School Orphans) almost never get visited. With the rise in the number of projects and the increase in the number of project managers, there is only one way to ensure that projects are visited regularly and systematically - by subdividing the country into regions, and allocating each specific region to a specific project manager. This will ensure that there is no overlap, and no neglect.

In this scheme the five countries have been divided into three regions. Region 1 has 45 projects. Regions 2 has 46, and Region 3 has 47 projects. This ensures an equitable distribution of the work. Each region forms a geographic unit. Project Managers will therefore be able to visit several projects on the same trip.

PROJECT MANAGER 1

NO	NAME OF PROJECT	PLACE	FUNDER
	Archdiocese of Durban		
1	Oral History Project	Durban	CMMB
2	Siyaphila	PMB	CMMB
3	St Philomena's	Durban	CMMB
4	St Albert Parish	PMB	CIDSE
5	St Anne's Parish	Chesterville	CRS
6	Sinosizo	Durban	CRS
7	Vuleka Trust	Pinetown	CRS
8	Clermont Resource Centre	Clermont	CRS
9	Archdiocese Youth Commission	Durban	CRS

10	St Theresa's Home	Durban	CRS
	Diocese of Mariannhill		
11	Home + Family Life	Mariannhill	CRS
12	Thembalethu	Port Shepstone	CRS
13	St Mary's Hospital	Mariannhill	CRS
	Diocese of Dundee		
14	Duduza Care Centre	Wasbank	CMMB
15	Sisters of Mercy	Bethal	Ford Foundation
16	Rosary Clinic	Blaauwbosch	CMMB
17	Osizweni HBC	Osizweni	CMMB
18	Noyi Bazi Clinic	Pomeroy	CMMB
19	Damesfontein HBC	Damesfontein	CMMB
20	Diocesan co-ordinator	Dundee	Ford Foundation
21	Franciscan Community	Besters	CRS
22	Sakhimpilo HBC	Amakhasi	CRS
23	Zanethemba HBC	Madadeni	PSG
24	Concerned Christian Counsellors	Secunda	CRS
25	Agape Spiritual Care	Madadeni	CRS
26	St Anthony's Home	Blaauwbosch	Ford Foundation
	Diocese of Eshowe		
27	Holy Cross	Gingindlovu	CMMB
28	Blessed Gerard Care Centre	Mandini	CMMB
	Diocese of Ingwavuma		
29	Unkulunkulu Unathi	Mtubamtuba	CMMB
30	Ndumo School Orphans	Ndumo	CMMB
31	Malusi Omuhle	Hlabisa	CMMB
32	Sibambisene	Jozini	BMS Co-funded
	Diocese of Witbank		
33	Lehlabile Committee	Nelspruit	CMMB
34	Thembalethu	Malelane	CMMB
35	Lesedi Counselling Centre	Glen Cowie	CRS
36	Diocesan Aids Committee	Witbank	CRS
37	Masikhumene Womens Crisis	Nelspruit	CRS
	Diocese of Manzini		
38	Hope House	Manzini	CMMB
39	Orphanaid	Siteki	CMMB
40	Caritas	Manzini	CRS
	Diocese of Pietersburg		
41	Warmbaths Aids Prevention	Bela Bela	CIDSE
42	Diocesan Committee	Pietersburg	CRS
	Diocese of Tzaneen		
43	Kurisanani	Tzaneen	CMMB

44	Nzhelele HBC	Nzhelele	CRS
45	St Brennans School	Bandalierkop	CRS

PROJECT MANAGER 2

	Diocese of Johannesburg		
46	Love of Christ Ministries	JHB	CMMB
47	Diocesan Youth Dept.	JHB	CMMB
48	CIE	JHB	CMMB
49	Diocesan Aids Co-ordinator	JHB	CMMB
50	Sithand'izingane	Brakpan	CMMB
51	Orange Farm Catholic Church	Orange Farm	CMMB
52	Sacred Heart House	JHB	CMMB
53	CATHCA	JHB	CMMB
54	CARE	JHB	BMS Co_funded
55	St Anthony's Adult Centre	Boksburg	CMMB
56	HIVSA	Soweto	CMMB
57	Nazareth House	JHB	CMMB
58	Othandweni	JHB	CMMB
59	Witwatersrand Hospice Ass.	JHB	BMS Co funded
60	Oasis Rover Crew	Springs	BMS co funded
61	JHB Society for the Blind	JHB	BMS co funded
62	St Francis Home	JHB	CMMB/CRS
63	St Joseph's Ithuteng	JHB	CRS
64	Brakpan Youth Alive	Brakpan	CRS
65	Lufuno	Soweto	CRS
66	Bosco Youth Centre	Wakerville	CRS
67	Our Lady of Peace Parish	Kagiso	CRS
68	Catholic Church Carletonville	Carltonville	CRS
69	Masungulo	JHB	CRS
70	Reg. Orsmonde Counselling	JHB	CRS
71	Dominican Counselling Project	Springs	CRS
72	Maforonation	Springs	PSG
73	JRS	JHB	PSG
	Diocese of Francistown		
74	Diocesan Committee	Francistown	CRS
	Diocese of Gaborone		
75	Tirisanyo	Gaborone	CMMB
76	Holy Cross Hospice	Gaborone	BMS Co funded
	Diocese of Aliwal		
77	Middelburg Cluster	Middelburg etc.	CMMB
78	Diocesan Committee	Aliwal	CRS
79	Good Samaritan Hospice	Bethulie	CMMB
	Diocese of Queenstown		
80	Imfobe	Queenstown	PSG

	Archdiocese of Bloemfontein		
81	Naledi Hospice	Bloemfontein	BMS Co funded
82	St Anne's Sodality	Bloemfontein	CRS
83	Siyathokoza Clinic	Botshabelo	PSG
	Diocese of Bethlehem		
84	Gethsemane Health Centre	Ficksburg	CMMB
	Diocese of Kroonstad		
85	Justice and Peace	Kroonstad	CRS
86	Development Management Com.	Kroonstad	CRS
87	Diocesan AIDS Committee	Kroonstad	CRS
	Lesotho		
88	Catholic Bishops Conference	Maseru	CMMB
89	CHAL	Maseru	BMS Co funded
90	Beautiful Gate	Maseru	BMS Co funded
91	Mission Aviation	Maseru	BMS Co funded

PROJECT MANAGER 3

	Diocese of Pretoria		
92	Tumelong	Winterveldt	CMMB
93	Children of St Kizito	Pretoria	CMMB
94	St John the Baptist Clinic	Winterveldt	CMMB
95	Diocesan Co-ordinator	Pretoria	CMMB
96	Sisters of Mercy	Winterveldt	CRS
97	Good Shepherd Clinic	Winterveldt	CMMB
98	Holy Cross	Pretoria	PSG
99	Nazareth House	Pretoria	CMMB
100	Sizanani	Bronhorstspruit	PSG
101	Thembisa Catholic Church	Thembisa	CRS
102	Dingaka Association	Ga Rankuwa	CRS
103	Sipho Esihle	Ekangala	CRS
104	Fatima House	Pretoria	CRS
105	Thembalethu HBC	KwaNdebele	CRS
	Diocese of De Aar		
106	Middelburg Cluster	Middelburg	CMMB
	Diocese of Cape Town		
107	St Lukes Hospice	Cape Town	CMMB
108	Helderberg Hospice	Somerset West	CMMB
109	Lizo Nobanda	Cape Town	CMMB
110	Caring Network	Cape Town	CMMB
111	Goedgedacht	Malmesbury	CMMB
112	Joy for Life	Cape Town	CMMB
113	Prosperity Youth Centre	Cape Town	PSG
114	Lifeline/Childline	Cape Town	CRS

	Diocese of Oudtshoorn		
115	Bisdom van Oudtshoorn	Oudtshoorn	PSG
116	Breede River Hospice	Robertson	PSG
117	Dwarsrivier Parish	Dwarsrivier	CRS
118	St Boniface Parish	Knysna	CMMB
	Diocese of Port Elizabeth		
119	Empilisweni	KWT	BMS Co funded
120	St Francis Hospice	PE	CMMB
121	ABBA Trust	Mdantsane	CMMB
122	Assumption Sisters	Grahamstown	CRS
123	Caring Ministry	PE	PSG
124	King Williamstown Aids Office	KWT	PSG
	Diocese of Kimberley		
125	Tshepong HBC	Kimberley	CMMB
126	Zenzeleni Wellness Centre	Kimberley	CMMB
	Diocese of Keimoes		
127	Bisdom Vigs Ministerie	Keimoes	CMMB
	Diocese of Umtata		
128	Sabelani Home	Umtata	CMMB
129	Bethany Home	Umtata	CRS
	Diocese of Rustenburg		
130	Justice and Peace	Rustenburg	CRS
131	Freedom Park	Rustenburg	PSG
132	NICRO	Rustenburg	CRS
	Diocese of Klerksdorp		
133	Kanana Catholic Church	Orkney	CRS
134	Diocesan AIDS Team	Klerksdorp	CRS
135	Home Based Care Project	Klerksdorp	CRS
	Namibia		
136	Catholic AIDS Action	Windhoek	CMMB
137	Lifeline/Childline	Windhoek	BMS Co funded
138	Phillipi	Windhoek	BMS Co funded